Your future | Our hospital

The Princess Alexandra Hospital NHS
NHS Trust

Public Meeting of the Board of Directors

AGENDA

Date and Time: Thursday 6 June 2019 from 09.30 - 12.30
Venue: Boardroom, The Princess Alexandra Hospital, Harlow.

Time	Item	Subject	Action	Lead	Page
01 OPENING ADMINISTRATION					
09.30	**1.1**	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from meeting on 04.04.19	Approve	Chairman	4
	1.4	Matters Arising and Action Log	Review	All	14
02 STAFF STORY					
09.35	**2.1**	Growing our own staff			
03 REPORT FROM CHIEF EXECUTIVE					
09.55	**3.1**	CEO's Report	Discuss/Approve	Chief Executive	15
04 RISK					
10.05	**4.1**	Significant Risk Register	Approve	Chief Medical Officer	18
10.10	**4.2**	Board Assurance Framework 2019-20	Inform	Head of Corporate Affairs	22
05 PATIENTS					
10.15	**5.1**	Quality Account 2018-19	Review	Director of Nursing and Midwifery	25
10.25	**5.2**	Mortality Improvement Plan including: • Learning from Deaths Presentation (Medicine)	Discuss	Chief Medical Officer	112 Pres
10.45	**5.3**	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Inform	Director of Nursing and Midwifery	117
06 PEOPLE					
11.05	**6.1**	Freedom to Speak Up Self Assessment	Discuss	Director of People	128
07 PERFORMANCE					
11.15	**7.1**	ED Performance: Next Steps	Discuss	Chief Operating Officer	149
11.25	**7.2**	Integrated Performance Report	Inform	Executives	171
BREAK (10 minutes)					
08 GOVERNANCE					
11.45	**8.1**	Information Governance Update: Data Security Protection Toolkit (DSPT) Publication 31.03.19.	Approve	Chief Financial Officer	205

Your future | Our hospital

11.50	**8.2**	NHS Provider Licence Condition FT4: Self-Assessment	Approve	Chief Executive	207
11.55	**8.3**	Reports from Committees: • WFC.20.05.19 • Audit 23.05.19 • PAF.23.05.19 • QSC.24.05.19 • Strategy.24.05.19 including Terms of Reference	Inform/ Approve	Chairs of Committees	213 214 215 216 217 218
12.10	**8.4**	Report from Senior Management Team meetings held on 7 & 21 May 2019	Inform	Chief Executive	221
09 QUESTIONS FROM THE PUBLIC					
12.20	**9.1**	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.	Discuss	Chairman	
10 CLOSING ADMINISTRATION					
	10.1	Summary of Actions and Decisions	-	Chairman/All	
	10.2	New Issues/Risks	Discuss	All	
	10.3	Reflection on Meeting	Discuss	All	
12.30	**10.4**	Any Other Business	Review	All	

Public Board Meeting dates 2019/20

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

Your future | Our hospital

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

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

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public
Thursday 4 April 2019 from 09:00 – 12:00, PAH Board Room

Present:	
Steve Clarke	**Trust Chairman (TC)**
Pam Court	Non-Executive Director (NED-PC)
Lance McCarthy	Chief Executive Officer (CEO)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Helen Glenister	Non-Executive Director (NED-HG)
Andrew Holden	Non-Executive Director (NED-AH)
Helen Howe (non-voting)	Associate Non-Executive Director (ANED-HH)
Stephanie Lawton	Chief Operating Officer (COO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Andy Morris	Chief Medical Officer (CMO)
Trevor Smith	Chief Financial Officer (CFO)
Patient Story:	
Sue Wetherall	Patient's Wife
Emily Wetherall	Patient's Daughter
Sam Lundrigan	Patient's Daughter
Anthony Lundrigan	Patient's Son-in-Law
Sam Heaton	Matron – Medicine
Nicola Tikasingh	PSQ Matron – Cancer Cardiology & Clinical Services (CCCS)
Jo Ward	Associate Director of Nursing & Therapies CCCS
June Barnard	Associate Director of Nursing - Medicine
Learning from Deaths:	
Pam Humphrey	Associate Director of Nursing – Surgery
Julie Matthews	Associate Director of Operations – Surgery
Carol Austin	PSQ Matron - Surgery
Mr Jonathan Refson	Associate Medical Director - Surgery
In attendance:	
Chee Yang Chen	FY1 Doctor
Apologies:	
John Hogan	Non-Executive Director (NED-JH)
Michael Meredith (non-voting)	Director of Strategy (DoS)
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, particularly family members in attendance for the Patient Story.
1.1 Apologies	
1.2	As noted above.
1.2 Declarations of Interest	
1.3	No declarations were made.
1.3 Minutes of Meeting on 07.02.19	
1.4	The minutes of the meeting held on 07.03.19 were agreed as a true and accurate record of that meeting with no amendments. The TC reminded members that as a result of discussions at the Board development session in March, "Meeting Ground Rules" had been added to all Board, Committee and Senior Management meeting agendas.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising. The one item on the action log in relation to the Board Assurance Framework (BAF) was noted as closed.
02 PATIENT STORY	

The Princess Alexandra Hospital NHS
NHS Trust

2.1 John's Story *(50 minutes)*	
2.1	The Director of Nursing & Midwifery (DoN&M) opened the item and welcomed John's family along with members of the Medicine and Cancer Cardiology & Clinical Services (CCCS) HCGs. She handed over to John's family.
2.2	John's wife and daughter then narrated their story. John had been diagnosed in 2012 with a condition which would ultimately be fatal. For the next six years he was looked after and cared for by his family at home with relatively few admissions to hospital. John had been admitted to hospital for the final time in July 2018 where, after 14 days, his family were told he was coming to the end of his life. The one wish of John's family at that time was to get him home to be cared for in his last few days by the family who loved him.
2.3	Unfortunately that wish did not come true. The next seven days until John was finally discharged were dogged by barriers, process, inappropriate decision-making and what seemed to John's family at the time some patronising and insulting actions. They emphasised there had also been some pockets of excellent and compassionate nursing care.
2.4	Finally after seven days John was finally discharged home but by then it was too late. He suffered a very undignified arrival at home and by that time was too ill to enjoy his beautiful garden or beloved dogs. The family felt very alone with support then only from their GP. John passed away that day.
2.5	As a final point John's wife stated that the opportunity to make her husband's end of life experience the best it could possibly be, was taken from her and her family. They had been spectators to a process which made decisions by the book and not in the interest of the patient and the family. She handed over to her son-in-law.
2.6	John's son-in-law, as a former employee of the Trust, stated that he had spent four years with some of the people around the table that day improving services at the Trust and had seen compassion, hard work and improvement. He and the family were now looking for assurance from the Board that palliative care in the hospital was a priority and that it had a NED champion to oversee improvements.
2.7	He emphasised (as above) that during John's final hospital stay there had been some excellent nursing care but it appeared clinical decision-making became locked into process until it was too late. On behalf of the family he would like to see evidence, in future, that improvements had been made to End of Life (EoL) care at the Trust.
2.8	The DoN&M thanked the family for relating their experience and handed over to the Matron for Medicine (MfM) to update on actions taken since John's case had come to light.
2.9	The MfM then informed those present of the actions taken since John's complaint: • Better communication from the MDT team involved in a patient's discharge to avoid mixed messages. • District nurse email referrals now followed up with a phone call. • Clearer information around a patient's transport needs on booking. This also to be highlighted on the wards' red-to-green rounds.
2.10	The Matron for Cancer, Cardiology and Clinical Services (MfCCCS) then spoke about overarching EoL care. She emphasised that John's experience was not what the Trust wanted for any of its patients or families. The team had reflected and acknowledged there were areas where mistakes had been made. Actions taken since had been: • Discharge process meetings now held monthly to discuss and resolve issues and to include hospice leads, Specialist Palliative Care Team (SPCT), Pharmacist, Discharge Team, CCG, Community Teams and Frailty Leads. • A Discharge Steering Group to commence in April 2019 and establishment of a discharge checklist to include an EoL section. • Members of the discharge team to meet with SPCT every weekday morning to discuss patients being discharged. • Site Team to have a daily list of all EoL patients being discharged (with an indication of those on an EoL care plan/fast track pathway). • Oxygen provider now to speak to clinical member of hospital team for further information in relation to oxygen at home.
2.11	The Chief Medical Officer (CMO) introduced himself to the family and stated he was also

	the Executive Sponsor for EoL care at the Trust. He apologised to the family for their experience and acknowledged John's care had been wrong on many levels. He emphasised it was part of the Board's duty to learn from deaths and clearly there was much more that needed to be done in relation to EoL care at the Trust going forward. He requested a further conversation on EoL later that day in the private session. The TC agreed. John's wife welcomed that decision and stated her sole objective had been that no other family should suffer in the same way as hers had.
2.12	Non-Executive Director Pam Court (NED-PC) introduced herself as the NED lead for EoL and also the CEO of St. Francis Hospice. She stated that she would very much welcome further discussion in the private session particularly in relation to links with local hospices.
2.13	The CEO thanked the family for sharing their story and offered apologies on behalf of the Board for letting John and his family down. He stated that the point of hearing patient stories was so that the organisation could learn and avoid repetitions.
2.14	In closing the TC stated that he hoped John's family had heard that some improvements had already been made in relation to EoL care and that others were embedding. He thanked the family for their courage in sharing their story.
03 REPORT FROM CHIEF EXECUTIVE	
3.1 CEO's Report *(9 minutes)*	
3.1	The CEO presented his report. Key headlines were: • After much improved performance against the 95% four hour access target for urgent care in the summer, the Trust had continued to struggle to meet this standard through the winter. Performance remained significantly below where the organisation would wish it to be. • The Trust was currently part way through its latest formal Care Quality Commission (CQC) inspection. A range of staff had been interviewed on 26/27.03.19 in relation to Use of Resources. A formal inspection had then taken place 27/28.03.19 looking at six core services. The inspection had gone well with feedback identifying a significant change in the culture in the organisation and people being very open and proud of the services they provide and the care they deliver. • Well-led interviews confirmed for 23/24.04.19 and full report to be published at the end of July/early August. • Following the decision by the Trust Board on the preferred way forward for a new hospital on 07.03.19 work continued to update the Strategic Outline Case (SOC) and to work with Commissioners to develop a Pre-Consultation Business Case (PCBC). • Domestic Services were currently in the first phase of market testing and the Trust was yet to receive any responses (deadline 14.04.19). That process would provide information on how others believed they could deliver and meet standards along with required investment/cost. The Trust could then make the decision as to whether it believed it could match those solutions. There had been a series of meetings with current Domestic staff to support them and dispel rumours.
3.2	The TC thanked the CEO for his update.
04 RISK	
4.1 Board Assurance Framework (BAF) *(2 minutes)*	
4.1	This item was presented by the Head of Corporate Affairs (HoCA). She updated members there were no changes to the risk scorings that month but a summary of changes over the year was provided for noting. All risks had been reviewed at Committees as appropriate.
4.2	NED Helen Glenister (NED-HG) stated that she very much welcomed the annual summary. In response to a question in relation to the risks to be reviewed by the Trust Board it was confirmed that those risks would be assigned to the new Strategy Committee which would launch in May.
4.3	The Board approved the BAF and noted the changes made during 2018/19 and the April 2019 position.
4.2 Significant Risk Register *(3 minutes)*	

4.4	This item was presented by the CMO who updated that the risk profile had improved slightly. He highlighted there was one new risk (scoring 15) raised since 01.02.19 around security of the OPD at St Margaret's Hospital out of hours.
4.5	In response to a concern raised by NED Andrew Holden (NED-AH) the CEO confirmed in his view the organisation now had very robust risk management processes in place along with a Risk Management Group – the CQC had spoken very positively about both.
4.6	In relation to risks the Chief Operating Officer (COO) was able to update as follows: • Electronic Stent Register – manual system now in place with electronic system under development. • Reduction in flexible cystoscopies and backlog cleared. • All four vacancies for middle grade doctors in Urology filled. • Cancer standard for Urology monitored on a weekly basis with mitigations in place. • Endoscopy washers delivered and building works underway.
4.7	The Board noted the content of the SRR and took assurance from actions currently in place or planned.
05 PATIENTS	
5.1 Mortality Improvement Plan (including Learning from Deaths) *(36 minutes)*	
5.1	This item was presented by the CMO. He reminded members that two requirements for Boards were to evidence learning from deaths and also to have sight of a mortality dashboard. In terms of the latter that was still in development. In terms of deaths reviewed by Medical Examiners most organisations were aiming for around 25% and the Trust was almost at that figure.
5.2	There was also a requirement for the Board to have oversight of the tracking of projects to deliver improvement. He reminded members that a two year programme of work had begun under the Mortality Improvement Board (MIB). All projects had been scoped and KPIs agreed. Future reporting would provide high level pie charts to evidence the progress on individual projects.
5.3	The DoQI added that the paper had been well received at QSC with recognition that the right elements were now being measured. Programme Leads and Sponsors were up and running on a number of projects and the programme of work would be tied in with the NHS Ten Year Plan and the organisation's QI methodology.
5.4	Associate NED Helen Howe (ANED-HH) stated it would be good to evidence exceptions. The CMO agreed to add those.
ACTION **TB1.04.04.19/01**	**Progress on MIB projects to also include exception reporting.** **Lead: Chief Medical Officer**
5.5	NED-AH asked what the Board would have sight of in order to evidence the improvement programme was on track. In response the CMO stated that one indicator would be HSMR but he reminded colleagues that would take time to reduce. In his view there needed to be more of a focus on SHMI. Another would be the dashboard and the percentage of deaths being reviewed by the MEs. A third indicator would be the progress on each of the projects. A fourth would be the stories presented to Board but in addition to that to take learning from the living too which was an area he was keen to progress. The management of outlier alerts also needed to be more robust.
5.6	NED-HG asked whether the targets to be reported would be based on best practice rather than just trends. In response the CMO stated that they would be wherever possible e.g. Bundles of Care. There would however be some workstreams where evidence as such was not used e.g with the MEs.
Team arrive for Learning from Deaths	
5.7	In response to a question raised by ANED-HH in relation to closing down projects when actions were embedded the CMO reported that in his experience it could take two years or more for actions to become embedded. In the case of the current programme of work it was far too early to agree when it should cease. The Director of Quality Improvement (DoQI) added that evidence would suggest when it was time to step down and that the organisation could demonstrate that outcomes were being sustained. This would align to the People Strategy (to be discussed later that day) and related not just to actions but also

	to culture/response.
5.8	At this point the CMO welcomed the team from Surgery and members introduced themselves. The Associate Director of Nursing for Surgery related the story of a patient called John.
5.9	John was a 69 year old with a detailed past medical history, a learning disability and longstanding history of bladder and kidney stones. Between December 2014 and May 2018 John was diagnosed with both bladder and kidney stones and had stents inserted (at which time he was found to be suffering from sepsis). In May 2018 he was admitted for cystoscopy and change of stents. It was found that the stones were large and there was pus in the kidneys. In recovery he deteriorated and a decision was made he had un-survivable sepsis and the plan was for end of life care. John died a short time later (believed to be sepsis related).
5.10	A post-mortem was then carried out which showed the cause of death as un-natural and relating to the surgical procedure which had been carried out. Internal and external reviews were then undertaken. The results of both were identical. John had died from retroperitoneal haemorrhage with left haematoma (undetected). The case subsequently went to the Coroner and the conclusion was that John had died of a recognised complication of a necessary medical procedure.
5.11	Actions taken by the HCG since the case: • Delays in the pathway (particularly around stent removal and booking process) • Delays in escalating the deteriorating patient (including implementation of NEWS2) • Poor documentation (to include clearer post-operative instructions)
5.12	The CEO requested an update on the stent register. In response it was confirmed that there had been a review of all patients back to 2013 and the harm review process was being followed. Going forward there was now an in-house register (spreadsheet) detailing insertion dates/removal dates. The organisation had also signed up to an external registry and once that was robust it would move to join a national database for stent registry.
5.13	In response to a question from NED-HG in relation to learning around communication with carers (in respect of the stent removal) it was confirmed that the organisation had struggled to obtain information from the care home and GP surgery. The patient had not attended appointments with his purple folder (to identify him as an LD patient) but it was confirmed that the discharge letter had detailed the six week stent removal.
5.14	In response to the above the CMO stated there had been failings in the process and from recent discussions with Commissioners it was agreed that serious incident (SI) processes needed to be tightened and Commissioners involved at an earlier stage.
5.15	The DoQI queried whether process per se had been reviewed through all surgical pathways. In response the Associate Medical Director for Surgery (AMD-S) was able to provide assurance there was a similar implant of stent in biliary surgery and he had spoken to his counterpart in the Medical HCG who it was found were in a similar position with no registry. He had requested the learning be shared across the organisation and Medicine were now reviewing their procedures both internally and at tertiary centres and learning had started to be shared with colleagues.
5.16	In response to a concern raised by ANED-HH the AMD-S was able to confirm that he himself was now supporting the Urology team. The service was safe and one element he was now putting in place with the Lead Surgeon were some processes and pathways to provide assurance that implants were flagged and that those could be registered on an external database which would provide notification of removal dates. As a second point he confirmed that recruitment to the Urology team was underway but there was currently a national challenge around that. Once the team had a full complement he would be keen to agree the vision for the service and who the organisation's partners in that would be.
5.17	In response to a question from NED Pam Court (NED-PC) it was confirmed that the patient was an elective case who had died so that was an automatic trigger for post-mortem and referral to Coroner (death within 72 hours of surgery).
5.18	In response to a question from the DoN&M it was confirmed the case was about to go through the national learning from deaths process once the final report had been received.
5.19	The DoN&M queried whether as the patient had lived in a care home and was unable to

	give consent, had the "best interest decision" in his notes been explicit around consent for the procedure. In response the team confirmed that it had been explicit in the notes and the correct consent form had been used on all of his procedures, particularly the escalated risk of embedded stent.
5.20	NED-AH raised a concern about the use of a spreadsheet as a database. In response it was confirmed the data captured would eventually be submitted externally so the organisation was part of a national database. The Trust's current electronic patient record system was not appropriate and ultimately all national databases were on separate electronic platforms (which did not use the same software) so data was submitted on a spreadsheet anyway and migrated to the relevant database.
5.21	In response to a concern raised by the CEO around having a more robust process to ensure stent removal the AMD-S stated that in his view the organisation needed to define which cases in which speciality groups were given a date for an appointment before they left the hospital so that vulnerable patients and their carers had that (and their GP was made aware) before they left the building.
5.22	The TC thanked the Surgical team for their presentation and welcomed the news that learning was being shared with other teams.
5.2 Nursing, Midwifery and Care Staff Levels including Nurse Recruitment *(7 minutes)*	
5.23	This item was presented by the DoN&M and the paper was taken as read. The DoN&M drew members' attention to the table at the top of page 7 which related to establishment versus staff in post for projected workforce figures. There had been a question as to why the Band 5 establishment in the table and the vacancies were more than the overall establishment going forward. She confirmed that was due to the lag from when staff joined (not on NMC register) to when they started working as a Band 5. The narrative would be reviewed to reflect that.
5.24	NED-AH stated that what would be key going forward would be the Band 5 conversion rate and it would be helpful to know what was being delivered against the plan. The DoN&M agreed to add that to the report going forward and to indicate month by month (in the Executive Summary) whether the organisation was delivering against the plan or not.
ACTION TB1.04.04.19/02	**Monthly reporting (Hard Truths) to evidence delivery against the nurse recruitment trajectory.** **Lead: Director of Nursing & Midwifery**
5.25	The CEO thanked the DoN&M for a much improved report which now clearly showed the nursing element of the vacancy gap and where the pressure points in the organisation were.
5.26	In response to a question from NED-HG in relation to the incentive scheme for nursing staff which had been introduced over winter, it was confirmed that had proven successful (500 additional shifts filled compared to the previous year), would be extended to April and there would be a discussion at Executive Team Meeting as to whether or not it would continue through Q1.
5.3 Seven Day Services: Self-Assessment *(6 minutes)*	
5.27	This item was presented by the CMO. The Trust was now required to make a quarterly return to NHSI which required Board sign-off. There were four clinical standards against which the organisation was required to assess itself. The Trust was compliant with all four but there was some variation within those at weekends.
5.28	In response to a question from NED-PC it was confirmed there was now seven day ambulance transport in place.
5.29	The Board approved the self-assessment.
06 PEOPLE	
6.1 Staff Survey *(6 minutes)*	
6.1	The Director of People (DoP) presented her paper and was pleased to report a year-on-year improvement in results with the Trust now in the upper quartile of responses for all trusts (not just acute). There had been a significant improvement in the Trust's safety

	culture and in staff engagement. The organisation had also scored above average for immediate line manager and quality of appraisals. Each HCG was currently developing an overarching action and communications plan in response to the top five concerns and the top five achievements identified in the survey results. Those plans would detail where a particular department/team was particularly noted as requiring improvement.
6.2	The focus moving forward would be in areas where the Trust ranked below average: equality, diversity and inclusion, health and wellbeing, morale and safe environment, bullying and harassment.
6.3	All HCG action plans would be reviewed and monitored at the Staff Engagement Steering Group, chaired by the Head of Staff Engagement. Local staff experience groups were in the process of being set up and would monitor progress against action plans and make any required updates to action plans locally.
6.2 People Strategy *(2 minutes)*	
6.4	The DoP updated that the 'People Strategy-on-a-Page' had been developed in May 2018 following a workshop. That had since been expanded (to cover the next five years) to provide greater detail and context to its vison of making it a joy to work at the Trust. Key stakeholders had contributed to the detailed strategy and it had been approved at WFC and recommended to Board for approval.
6.5	The Board approved the People Strategy.
6.3 Gender Pay Gap *(1 minute)*	
6.6	This paper was presented by the DoP who emphasised it was not an equal pay report but was simply signifying the nature of the gap. In most criteria the gaps were being reduced. The biggest reduction was in relation to bonuses (Clinical Excellence Awards) where work was ongoing to encourage women to submit applications o they could be considered.
6.7	The deadline for publication of the report was 31.03.19 so the paper had already been approved at WFC. The Board noted the report.
Break – 10 minutes	
07 PERFORMANCE	
7.1 Integrated Performance Report (IPR) *(26 minutes)*	
7.1	This report was presented by the COO and was based on February data. Key headlines were provided by appropriate Executive colleagues under the organisation's 5P headings:
7.2	Patients • An increase in incidence of pressure ulcers (due to changes to national reporting requirements).
7.3	Performance • RTT - performance remained strong. • Diagnostics - teams had delivered outstanding performance again in month which placed the Trust in the top performing Trusts for achievement of this standard. • Cancer - performance had improved with detailed recovery plans in place and a clear trajectory to return to national standard in March. • ED standard - achievement of the four hour standard had proved extremely challenging in month but performance was expected to improve in March. • The CCG had started work to look at demand analysis at both GP practice level and presenting condition which would be discussed at the Local Delivery Board over the next month. • Work had commenced on the redesign of acute assessment capacity with a view to having a draft business case in place by May 2019. • Performance in Paediatric Emergency Care had shown signs of improvement with staffing levels improving and sustainability of Paediatric Ambulatory Care opening hours. • The Urgent Care Improvement Board continued to meet weekly. • Length of stay had increased in February with a number of complex long stay patients. • System discussions regarding additional support/capacity were being led by the LDB.

7.4	In response to a question from NED-HG it was confirmed that work to understand the increase in attendances was coming to an end so teams could then start to evaluate the data. In response to a second question in relation to 'breaches due to lack of an ED doctor' it was confirmed that rotas had been increased in an effort to match demand but there was still more work to do in terms of right skill mix at right time. Arrival time was also a big factor.
7.5	NED-PC raised a concern about even further increased attendances with new housing in the area. In response the COO confirmed the organisation was gathering bits of data currently but highlighted a definite increase in Paediatric attendances possibly due to 'new' patients who had not yet registered with a local GP.
7.6	In response to a question from ANED-HH it was confirmed that delayed transfers of care (DToCs) were currently at 1.7% against a national standard of 3.5%.
7.7	As a final point the COO reported that the Urology team were being met on a fortnightly basis and there were meetings with Commissioners around an STP-wide approach to Urology services. The Outpatient Modernisation Plan had launched with a strategy to cover the next couple of years in terms of Outpatient services and the Trust's Theatre Modernisation Programme was also about to launch.
7.8	<u>Pounds</u> • External financing limit delivered at end of March. • Trust had taken ownership of the modular facility (Charnley Ward) so was on target to deliver against the capital resource limit (CRL). • Income and expenditure remained tight but the Trust was fixed on delivering the target without any external support. • The organisation would hit its control total for the year. • £5.6m of sustainability funds at stake.
7.9	In response to a question from the TC it was confirmed that final numbers for 2018/19 would be concluded by the end of the following week. For 2019/20 all main contracts (value and terms) had been concluded and the final Operating Plan would be submitted that day. The TC extended his thanks to the team for their efforts.
7.10	<u>People</u> • Standards for statutory/mandatory training and appraisal met for fourth consecutive month. • 70% flu target achieved (increased to 80% of staff for 2019/20). • Focus on agency spend particularly medical.
7.11	NED-AH requested there also be a focus on bank spend. The COO and DoP agreed and confirmed there was a push on substantive roles.
7.12	In response to a question from ANED-HH it was confirmed the cohort of staff who had not been vaccinated against flu were mainly doctors. A plan for the coming year had been agreed with the emphasis on a multi-disciplinary approach, rather than solely nursing.
7.13	<u>Places</u> • High risk backlog maintenance projects achieved. • Cleaning standards slipped in-month but improvements seen in March.
08 GOVERNANCE	
8.1 Strategic Objectives *(14 minutes)*	
8.1	This paper was presented by the CEO and the Board was asked to discuss and approve the proposed strategic objectives for the organisation for 2019/20. They were based around the Trust's 5Ps and it was proposed that progress against them be monitored by the Strategy Committee (with updates to Board every two months). Risks to their achievement would be tracked through the Board Assurance Framework (BAF). A review mid-year was proposed in light of the development of 'Your Future; Our Hospital - PAH 2030' (the 10-year organisational plan).
8.2	ANED-HH raised a concern that there needed to be some narrative/milestones against each objective to ensure progress could be tracked. In response the CEO agreed and confirmed that had not yet been developed but would be and would be monitored via the

	Strategy Committee. He agreed to take that away as an action and provide an update to the Strategy Committee. .
ACTION TB1.04.04.19/03	**Provide some narrative/milestones against which each of the Strategic Objectives could be monitored to the Strategy Committee. Lead: Chief Executive Officer**
8.3	NED-PC requested the following two additions be made: • 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. • 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.
8.4	Members agreed to the above two changes, to a review mid-year review (if required) and to on-going reviews by the Strategy Committee.
8.2 Report from Committees *(4 minutes)*	
8.5	Charitable Funds Committee (CFC) – 05.03.19 – Chair NED Helen Glenister The Board noted the report. It was agreed that section 2 of the reporting template (reference to performance trajectories) would be adjusted for the following iteration.
8.6	Audit Committee (AC) – 06.03.19 – Acting Chair NED Andrew Holden Noted. . The Board approved the Committee's Terms of Reference (ToR). Changes reflected an amendment around Counter Fraud and changes to Chairmanship.
8.7	Quality & Safety Committee (QSC) – 22.03.19 – Acting Chair NED Helen Glenister • Delegated authority had been approved by the Board for QSC to sign off the action plan in relation to action 3 of the Maternity Incentive Scheme. • In relation to the VRE outbreak on ITU/HDU, QSC was assured that control measures were robust and the Committee would be updated again in April. • CEO Assurance Panel in relation to recent stillbirth cluster had taken place that week.
8.8	At the request of the DoN&M it was agreed that the term intrapartum be used rather than stillbirth.
8.9	Performance & Finance Committee (PAF) – 25.03.19 – Chair NED Andrew Holden The Committee had concentrated on two of its highest risks from the BAF namely financial performance and the ED four hour standard. There would be a further focus at the Committee's April meeting on the latter. Under delegated authority PAF had approved the interim budget with the final budget to be presented to PAF in April and Board in May 2019.
8.10	Workforce Committee (WFC) – 25.03.19 – Chair NED Pam Court Noted. . The Board approved the Committee's ToR.
8.3 Report from Senior Management Team (SMT) *(3 minutes)*	
8.11	The CEO presented the report and the paper was taken as read with no items to escalate. In relation to job-planning which was mentioned in the paper NED-AH asked whether the Board should receive an update from the Remuneration and Nominations Committee (RC). In response it was confirmed that historically there had been different views around reporting from RC to Board. It was therefore agreed it would be discussed further outside the meeting.
ACTION TB1.04.04.19/04	**Discuss the requirement for future reporting from Remuneration Committee to the Board. Lead: Trust Chairman/Head of Corporate Affairs**
8.4 Report from ICP Board *(1 minute)*	
8.12	The CEO updated members that the key headline was the discussions around the development of a formal integrated care partnership.
09 QUESTIONS FROM THE PUBLIC	
9.1	No questions were raised.

The Princess Alexandra Hospital NHS
NHS Trust

10 CLOSING ADMINISTRATION	
10.1 Summary of Actions and Decisions	
10.1	These are presented in the shaded boxes above.
10.2 New Issues/Risks	
10.2	No new risks or issues were identified.
10.3 Reflections on Meeting	
10.3	Members agreed discussions had been robust.
10.4 Any Other Business (AOB)	
10.4	The DoP reminded members there had been discussion around holding Public Board meetings offsite. It was confirmed enquiries had been made but rooms at other sites were not available on required dates.

Signed as a correct record of the meeting:	
Date:	06.06.19
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 06.06.19

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.04.04.19/01	MIB Projects	Progress on MIB projects to also include exception reporting.	CMO	TB1.06.06.19	Addressed at item 5.2 at TB1.06.06.19.	Proposed for closure
TB1.04.04.19/02	Nursing Recruitment Trajectory	Monthly reporting (Hard Truths) to evidence delivery against the nurse recruitment trajectory.	DoN&M	TB1.06.06.19	Addressed at item 5.3 at TB1.06.06.19.	Proposed for closure
TB1.04.04.19/03	Strategic Objectives	Provide some narrative/milestones against which each of the Strategic Objectives could be monitored to the Strategy Committee.	CEO	TB1.06.06.19	To be addressed at Strategy Committee meeting on 1 July 2019.	Open
TB1.04.04.19/04	Remuneration Committee Reporting	Discuss the requirement for future reporting from Remuneration Committee to the Board.	TC/HoCA	TB1.06.06.19	Rem Nom Terms of Reference being reviewed, reporting requirement will be considered as part of the review and discussed at Rem Nom.	Proposed for closure

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 June 2019

3.1

Agenda Item:	3.1
Presented by:	Lance McCarthy – CEO
Prepared by:	Lance McCarthy – CEO
Date prepared:	31 May 2019
Subject / Title:	CEO Update

Purpose:	Approval		Decision		Information		Assurance	

Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting: - Performance highlights - Urgent care and flow - CQC inspection - NHS England and NHS Improvement Regional Team - Development of ICS and ICPs - Market testing of domestic services / modernisation of non-clinical departments
Recommendation:	The Trust Board is asked to note the CEO report.

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

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

respectful | caring | responsible | committed

The Princess Alexandra Hospital NHS
NHS Trust

3.1

Chief Executive's Report
Trust Board: Part I – 6 June 2019

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

(1) Key performance headlines

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

Key Performance Indicator	Actual performance for latest month (April)	Comparison to last report
ED 4-hour performance	69.6%	↑ (better)
SHMI	116.7 (Oct 17 – Sep 18)	New indicator
CDiff numbers	1	↓ (worse)
MRSA numbers	0	→
Never Events	0	→
Incidents reported	832	→
No harm / minor harm incidents	95.5%	↓ (worse)
RTT incomplete	92.2%	↓ (worse)
6-week diagnostic standard	99.6%	→
Stat Man training	92.0%	→
Vacancy rate	11.6%	→

(2) Urgent care performance and flow

Performance against the 95% 4-hour access target remains significantly below where we would wish it to be and numbers of attendances continue to increase materially (>9% increase in April 2019 compared with April 2018).

We continue to work closely with the Emergency Care Intensive Support Team and with our local partners to improve access and flow for our urgent care patients. The key areas of focus are:

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

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

(3) CQC inspection

Since the last Trust Board meeting, our latest formal Care Quality Commission (CQC) inspection has been completed. This comprised Use of Resources interviews (26 March 2019); core services inspection (27 March and 28 March); unannounced visit (8 April) and well-led interviews (23 and 24 April). The inspection went well with CQC colleagues identifying what they described as a real and significant change in the culture in the organisation. We expect the CQC's internal ratings approval process to be completed within the next few days after which we will receive a draft report. The full report will therefore be published at the end of June / early July.

(4) NHS England and NHS Improvement East of England Regional team

The closer alignment of NHS England and NHS Improvement has taken a significant step with the commencement of the new joint Regional teams from 1 April 2019. PAHT is part of the East of

England region. The appointment to the senior leadership roles in the region has now been completed and the key individuals are:

- Regional Director: Ann Radmore
- Chief Nurse: Lynne Wigens
- Medical Director and CCIO: Dr Sean O'Kelly
- Director of Finance: Jeff Buggle
- Director of Strategy and Transformation: Simon Wood
- Director of Workforce and OD: Paul Harrison
- Director of Performance and Improvement: Elliot Howard-Jones
- Director of Commissioning: Catherine O'Connell
- Director of Public Health: Dr Aliko Ahmed

(5) Development of Integrated Care System (ICS) and Integrated Care Providers (ICPs)

The last 2 months, since the last Trust Board meeting, have seen a lot of discussion and thought across the STP about how we will transition in to an ICS over the next 2-3 years. Within this, is an emerging framework for how the ICPs may evolve.

We are continuing to work closely with our West Essex and East Hertfordshire health and care colleagues to develop system wide clinical pathways for the benefit of our patients and to create a transition programme for the integration of clinical and non-clinical services on our way to formally becoming an integrated care trust once this is possible. Musculoskeletal, respiratory and integrated urgent care services are planned to be contracted for differently during 2019/20 to facilitate their integration across all elements of the health and care sectors.

(6) Market testing of domestic services / modernisation of non-clinical departments

At the time of writing this report, the first phase of the market testing process for our domestic services (evaluation of third party responses to the specification) is coming to an end. This will then enable us to work with colleagues to determine whether our current services can change and adapt to meet or exceed our specification and determine the level of investment required in the equipment.

Myself, the Director of People and the Director of Quality Improvement continue to meet regularly with our local and regional staff side representatives and also with our domestic staff to update them on progress with the market testing process. Our regional UNISON officer has lodged a formal dispute with the Trust with regard to outsourcing our domestic services and has balloted members on taking industrial action. An unprecedented six days of action are planned in June and we remain in ongoing active dialogue with all concerned at the same time as working to ensure that appropriate mitigating factors can be put in to place to ensure the hospital can remain clean and safe should the industrial action occur. The process of market testing does not necessarily mean that our domestic services will be outsourced.

This forms part of a modernisation and transformation programme of all of our non-clinical services, using benchmarked data through The Model Hospital and Service Line Reporting information, to ensure that our clinical colleagues are better able to undertake their roles as a result of having high quality, efficient, effective and modern support. It is a fundamental step required as we drive towards delivering 'outstanding' services to our patients and develop a new hospital for Harlow.

Author: **Lance McCarthy, Chief Executive**
Date: **31 May 2019**

The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD
6 JUNE 2019

Agenda Item:	4.1
Presented by:	Dr Andy Morris – Chief Medical Officer
Prepared by:	Sheila O'Sullivan – Interim Associate Director of Governance & Quality Lisa Flack - Compliance and Clinical Effectiveness Manager
Date prepared:	29 May 2019
Subject / Title:	Significant Risk Register

Purpose:	Approval		Decision		Information	√	Assurance	√

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This paper presents the Significant Risk Register (SRR) and was produced from Risk Assure system using the risk registers for all our services. . There are a total of 81 risks with a score of 15 or more. • There are no risks with a score of 25 • 20 risks score 20 (increased from 74 in April 19) A summary of each risk and the actions planned to manage and mitigate them is detailed within this paper • 23 risks with a score of 16, (same as April 19) • 38 ↑risks with a score of 15, (Increased from 33 in April 19) 7 new risks (scoring 15 and above) have been raised since 1 April 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: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds
	√	√	√	√	√

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

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 24 May 2019. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks. There is an annual work plan so each area can be reviewed in detail on a rotation.

2.0 CONTEXT

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

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

	Risk Score				
	15	16	20	25	Totals
CCCS	5 (4)	4 (5)	1(0)	0 (0)	10 (9)
Estates & Facilities	8(6)	0 (0)	2(3)	0 (0)	10 (9)
Finance	2 (2)	0 (0)	0 (0)	0 (0)	2 (2)
IM&T and IG	0 (0)	2 (3)	0 (0)	0 (0)	2 (3)
Information Data Quality and Business Intelligence	1(0)	0(0)	0(0)	0(0)	1(0)
Non-Clinical Health & Safety	1 (1)	0 (1)	0 (0)	0 (0)	1 (2)
Nursing	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Operational	1 (0)	0 (1)	4 (4)	0 (0)	5 (5)
Research, Development & Innovation	0(0)	0(0)	1(0)	0(0)	1(0)
Resilience	1 (0)	0(0)	0(0)	0(0)	1 (0)
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Child Health	1(1)	0 (0)	0 (0)	0(0)	1 (1)
Women's Health	1(2)	2(2)	0 (0)	0 (0)	3 (4)
Medicine	4 (2)	8 (8)	7 (7)	0 (0)	19 (17)
Surgery	13 (13)	5 (2)	5 (4)	0 (0)	23 (19)
Totals	38 (33)	23 (23)	20(18)	0 (0)	81 (74)

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

The Trust does not have any risks scoring 25.

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

Patients:

- EPMAN electronic monitoring of urinary stent insertion and removal, risk to patient treatment (URO004/2018 on register since June 2018).
  Action: The team have developed a temporary solution to capture all stent patients until the electronic solution is in place.

- Reduce the backlog of patients waiting for flexible cystoscopy, (includes cancer and surveillance patients) resulting in patients being overdue their procedure currently at 6 weeks (URO010/2018)
  Action: Additional cystoscopy sessions through Alliance completing 4 sessions per weekend.

- Previously administered medications do not appear on JAC. Unless the user checks on previous prescriptions, this can result in unintentional prescribing and administration of medicines above the maximum dose frequency. (EPMA2019/05)
  Action: Classroom training is provided to all prescribers and administers of medicine. Floor walking support and training is provided during the roll out with SOPs and quick reference guides produced. System changes are being developed

- No piped oxygen, medical air or suction to 12 bed spaces on Penn ward (Penn001/2019 on register since 25 March 2019)
  Action: Patients requiring oxygen are not admitted to these bed spaces, this requires moving patients around the ward with oxygen cylinders in use. No plans currently to refurbish the ward area.

People

- Four clinical areas have insufficient numbers of Registered Nurses – Harold (JS02), Fleming (03) Saunders and Tye Green (Harold 02), all on the register since July 14),
  Action: Recruitment and retention action plans are in place with daily reviews of staffing numbers and rotation of staff to ensure safety.

- Medical Urology workforce depleted due to staff leaving, sickness and one less junior on the rotation (URO001/2015 on register since June 2015)
  Action: Agency consultants and junior doctors are in place. A rolling recruitment plan is in place to fill the Consultant vacancies. We are working with CCG partners to request external support and liaising with UCLH and Queens hospitals to develop joint posts. UCLH consultant to join NHSP and provide ad-hoc sessions

Performance

- Statutory compliance risk for failure to deliver 4 hour ED standard (001/2017 on register since April 2014).
- Quality and safe care impacted by failure to deliver the 4 hour ED standard, on Medicine teams register (MED57 on register since July 2016).
- Quality and safe care impacted by failure to deliver the 4 hour ED standard, on the Medical teams risk register (ED012 on register since July 2016).
  Action: Improvement plan in place across the emergency care pathway with trajectory set for compliance. Performance is improving across all patient flow pathways.

- No patient will spend a journey time greater than 12 hours from arrival in ED to discharge from ED (002/2016 raised July 2016)
- No ED patient to wait for longer than 12 hours to be admitted (003/2016 on register since July 16).
  Action: Improvement plan is in place across the patient pathway, trajectory set for compliance. Monitoring by the Clinical Site Manager for patients without an ED plan and trackers in place to pick up if a patient is not meeting the internal professional standards

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

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

Places:

- Effective lifts (EFM015 on register since June 2018).
  Action: Remedial work is part of backlog maintenance programme with prices for work received. A service contractor undertakes emergency work as required. Remedial work started in April 19 and expected to take 10 weeks to complete.

- Electrical mains incoming cables are unsupported to the site (EFM032 on register since April 2019)
  Action: Initial work was completed over bank holiday weekend. Confirmation of the date to complete the mains supply is to be confirmed

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

Pounds:

- Loss of 8% budget for the Clinical Research team will impact on overheads and set up fees. (R&D17.07.1802 on register since 17 July 2012, upgraded to a 20 in April)
  Action: Continued renegotiation by trust with North Thames Clinical Research Network.

3.0 RECOMMENDATION

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

Your future | Our hospital

NHS
The Princess Alexandra Hospital
NHS Trust

Trust Board - 6 June 2019

4.2

Agenda Item:	4.2
Presented by:	Head of Corporate Affairs - Heather Schultz
Prepared by:	Head of Corporate Affairs - Heather Schultz
Date prepared:	30 May 2019
Subject / Title:	Board Assurance Framework

Purpose:	Approval		Decision		Information	x	Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	Following the recent Well-led inspection the Trust received informal feedback from CQC around the wording of the BAF risks. The Head of Corporate Affairs and Executive leads are reviewing the BAF risks and a refreshed BAF aligned to the revised strategic objectives for 2019-20 (as agreed at Board on 4 April 2019) will be presented to Board in August 2019. A summary of the Board Assurance Framework risks is attached; there are no proposed changes to the risk scores this month. The full BAF is available to Board members in the resources section of Diligent.
Recommendation:	The Board is asked to note the current position and the risk scores as reflected on Appendix A.

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:	As reflected in the attached BAF.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with national legislation and regulations and the Code of Governance.
Appendices:	Appendix A - Summary of BAF Risks

respectful | caring | responsible | committed

5P	Executive Lead	BAF Risks May 2019	Current risk score
	Chief Nurse/Chief Medical Officer	1.1 Outcomes:Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	16
	Chief Finance Officer/DoI&IT	1.2 EPR Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes	16
	DoP	2.1 Nurse Recruitment Inability to recruit to critical nursing roles.	16
	DoP	2.3 Internal Engagement: Failure to communicate key messages and organisational changes to front line staff.	9
	DQI	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20
	DoS	3.3 Financial and Clinical Sustainability across health and social care system Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system.	16
	DoS	3.4 Strategic Change and Organisational Structure Capacity & capability of senior Trust leaders to influence both internally and externally the required strategic changes.	12

	DoS	3.5 Sustainability of local services Failure to ensure sustainable local services whilst the new hospital plans are in development.	**16**
	DCFO/DQI	4.1 Supporting Functions (including Finance, IT, and Estates and Facilities) Concerns around the need to modernise the systems, processes, structures, capacity & capability of the business support functions.	**12**
	COO	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	**20**
	CFO	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	**15**

The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD
6 JUNE 2019

5.1

Agenda Item:	5.1
Executive Sponsor	Sharon McNally – Director of Nursing
Prepared by:	Sheila O'Sullivan – Associate Director of Governance and Quality
Date prepared:	29 May 2019
Subject / Title:	Draft Quality Account (2018/19) for review

Purpose:	Approval	✓	Decision		Information	✓	Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]

The purpose of this paper is to discuss the content of the draft Quality Account (QA) which has been produced in line with national guidance.
QSC members are advised that the 2018/19 report details:

- Our achievements against the eight 2018/9 quality priorities:- One objective achieved, six objectives partially achieved, and one objective will be confirmed when the Trust receives the CQC inspection report (pages 24-29).
- The 2019/20 quality priorities are detailed (pages 8-9)
- Performance against all the prescribed indicators is detailed (pages 11-24)

This document has been circulated widely to key stakeholders within the hospital.
The quality account has been circulated to our external partners and the internal auditors for their review. All are expected to provide written feedback on the report and the Trust must include this within the final document.

There remain items of information that will be concluded during June, all highlighted in blue for ease of finding.

The Quality Account must be uploaded on to the NHS Choices website by 30 June 2018; to fulfil the statutory duty to submit our quality account to the Secretary of State.

Recommendation:

Board are asked to review the Quality Account and delegate the authority for final approval to the Director of Nursing and Chief Medical officer.

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

Patients	People	Performance	Places	Pounds
✓	✓	✓	✓	

Previously considered by:

The Quality Account priorities for 2019/20 were reviewed and signed off by the Senior Management Group and Executive Management Board in May 2019
The draft Quality Account report was discussed at Quality & Safety and Audit Committees in May 2019.

Risk / links with the BAF:

Legislation, regulatory, equality, diversity and dignity implications:	Providers of NHS healthcare are required to publish a quality account each year in line with the Health Act 2009 and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended in 2011, 2012, 2017, 2018 and 2019.
Appendices:	

The Princess Alexandra Hospital NHS Trust

5.1

Quality Account

2018-2019

The Princess Alexandra Hospital NHS Trust

Contents

5.1

The Princess Alexandra Hospital NHS Trust

5.1

Introduction from the Chief Executive Officer

Welcome to our annual Quality Account 2018-19, in which I am pleased to share with you our progress and achievements in the last year and the difference that this is making to our patients and the people we care for.

We started this year, 2018-19, with the fantastic news that The Princess Alexandra Hospital NHS Trust (PAHT) was approved to come out of quality special measures following an inspection by the Care Quality Commission (CQC). The CQC rated us as having improved from inadequate to requires improvement with good ratings in the caring, effective and well-led domains. In March this year (2019) we again welcomed colleagues from the CQC for an inspection of six of our core clinical services. Many of the inspectors for these recent assessment visits had been part of the team who visited the year before and we were delighted to hear their positive comments about there being a noticeable improvement in the culture of the organisation.

This sense of change is a real reflection of the enormous effort, commitment and dedication shown by all of our people, both our frontline teams and also all those who work behind the scenes to support the clinical teams caring for patients. I am very proud of them all; it is their shared commitment and focus on getting it right for our patients and providing high quality care that makes such a positive difference to our patients and to each other. The results of the recent inspection and our rating will be announced by the CQC in the summer (2019).

It is well documented that when staff feel positive about their workplace, colleagues and roles they provide better care for patients. This year I was proud to see this commitment to patient care reflected in the results of our annual NHS Staff Survey. Comments from our people placed us in the top 25% of acute trusts across the country.

Our 5 Ps strategy, which encompasses our patients; our people; our performance; our places and our pounds continues to underpin our approach to quality improvement and our modernisation plans and ambitions. Putting quality first lies at the heart of each improvement our clinicians and teams across the organisation put in place. The changes to the way we provide patient care are facilitated and delivered through our quality first improvement methodology. Quality first projects continue to go from strength to strength and in 2019-20 will extend their reach further in supporting the modernisation of our professional and support services that provide vital support to our clinical teams in delivering high quality care.

This account gives a detailed insight into how these changes are being made; how we are delivering to national standards of care and how we are putting in place quality improvements in areas where we are not as strong and need to do better.

Managing successful change relies on team work and a shared commitment to improving patient care. Every day I am proud to see PAHT people making a difference to our patients and proud to be part of their energy and determination to continue to improve the way we care for patients now, in the year to come and into the future.

The Princess Alexandra Hospital NHS Trust

I commend this quality account to you, and I am, as always, grateful to the many people who have contributed to its content. I confirm that, to the best of my knowledge, the information in this account is accurate.

Lance McCarthy

Chief executive

Statement of Director's Responsibilities in Respect of the Quality Accounts 2018/19

The Trust Directors are required under the Health Act (2009) National Health Service (Quality Accounts) Regulations (2010) and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year.

The Department of Health has issued guidance on the form and content of annual Quality Accounts which incorporates the above legal requirements.

In preparing the Quality Accounts, Directors are required to take steps to satisfy themselves that:

- The Quality Accounts present a balanced picture of the Trust's performance over the reporting period
- The performance information in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Accounts, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Accounts are robust and reliable, conform to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review. The Quality accounts have been prepared in accordance with Department of Health guidance.

The Directors confirm that, to the best of their knowledge and belief, they have complied with the above requirements in preparing Quality Accounts.

By order of the Board

Steve Clarke	**Lance McCarthy**
Chairman	Chief Executive Officer

The Princess Alexandra Hospital NHS Trust

5.1

About this report

What is a quality account?

Every year all NHS hospitals in England must write a report for the public about the quality of their services; this is called the quality account. The purpose of the report is to make the hospital more accountable to you and drive improvement in the quality of our services.

We look at our performance over the previous year, identify areas for improvement and publish this information. Through this we are making our pledge to you about the improvements to be made over the next year.

The report will tell you how well we did against the quality priorities and goals we set for the period of April 2018 to March 2019 and the areas we have improved through the year. It will also detail the priorities we have agreed for April 2019 to March 2020.

We will describe to you the areas where we have reviewed our patient care in order to evaluate the quality of services provided. This includes information and data about how the Princess Alexandra Hospital NHS Trust compares with other service providers through reviews of data and audits.

The report will contain mandated information from our B oard, along with statements from our commissioners and partners. We will provide a glossary of terms and abbreviations.

Governance Arrangements

The Princess Alexandra Hospital NHS Trust Quality Account is prepared in line with the Quality Accounts Toolkit guidance (2010-11). There are two additional considerations for inclusion in the 2018/19 report as advised by NHS England

- Provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how the Trust ensures that staff who speak up do not suffer detriment.
- Include a statement regarding progress in implementing the priority clinical standards for seven day hospital services.

In addition the Trust is required to:

- Provide a statement that evidences an improvement plan to reduce rota gaps for NHS doctors and Dentists (Schedule 6, Paragraph 11b of the Terms and conditions of Service for NHS Doctors and Dentists in Training (England) 2016).

The Trust has engaged with the Health Care Groups (HCG) and corporate teams to develop the Quality Account including all aspects identified for inclusion by NHS England. A timetable for the production of the quality account was presented and approved by the Quality and Safety Committee on 22 February 2019.

A draft of the report was shared internally with the Senior Management Team members for peer review and with external stakeholders (Clinical Commissioning Groups, Healthwatch, Health Overview and Scrutiny committees for both Hertfordshire and Essex) in addition to our Trust auditors in May 2019.

The draft quality account was presented to the Trust Quality & Safety and Audit Committees (both Board committees) for their review in May 2019.

The final draft document was presented to the Trust Board for final approval in June 2019.

The Princess Alexandra Hospital NHS Trust

Care Quality Commission rating

The Trust is registered with the Care Quality Commission (CQC) and our current status is 'registered without condition'.

Our staff have used the CQC Inspection outcome from 2018 as the foundation upon which to critically examine our services and focus on how we plan and deliver the fundamental aspects of safe care and have taken decisive action to change everyday activities which have lead to significant improvements. Our dedicated staff have worked incredibly hard to deliver the improvements over the course of 2018/9.

The current CQC ratings for the Trust is **Requires Improvement** and is detailed below

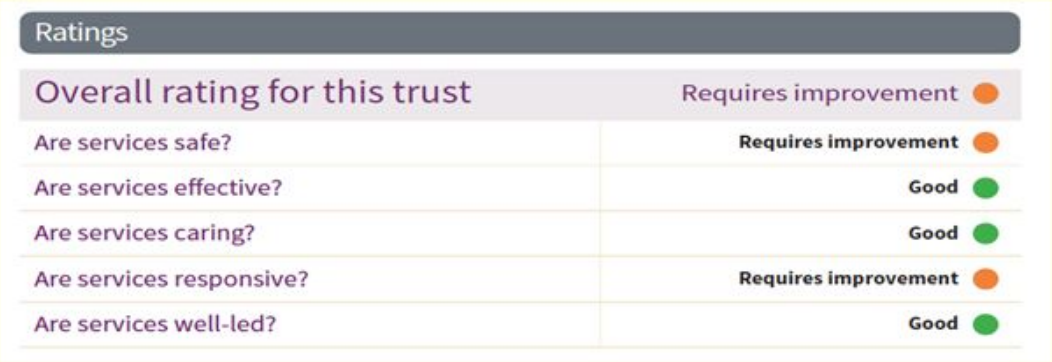


Figure 1: Current CQC ratings for the Trust

Ratings for The Princess Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Mar 2018	Good ↑ Mar 2018	Good → ← Mar 2018	Requires improvement → ← Mar 2018	Requires improvement ↑ Mar 2018	Requires improvement ↑ Mar 2018
Medical care (including older people's care)	Requires improvement → ← Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Requires improvement → ← Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement → ← Mar 2018
Surgery	Requires improvement ↑ Mar 2018	Good ↑ Mar 2018	Good ↑ Mar 2018	Requires improvement → ← Mar 2018	Good ↑ Mar 2018	Requires improvement → ← Mar 2018
Critical care	Good ↑↑ Mar 2018	Good ↑ Mar 2018	Good → ← Mar 2018	Requires improvement ↑ Mar 2018	Good ↑↑ Mar 2018	Good ↑↑ Mar 2018
Services for children and young people	Requires improvement ↑ Mar 2018	Good → ← Mar 2018	Good → ← Mar 2018	Requires improvement ↓ Mar 2018	Requires improvement → ← Mar 2018	Requires improvement → ← Mar 2018
End of life care	Good ↑ Mar 2018	Requires improvement → ← Mar 2018	Good → ← Mar 2018	Good ↑↑ Mar 2018	Good ↑↑ Mar 2018	Good ↑↑ Mar 2018
Maternity and gynaecology	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding 2016
Outpatients and diagnostic imaging	Good Jun 2016	N/A	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016

Table 1: Current CQC rating for all 8 core services

Following receipt of the CQC report in March 2018, the Trust has worked hard to address the 33 recommendations made by the CQC.

- 17 actions MUST be completed to bring services into line with legal requirements. These actions related to six services and the Trust overall.
- 16 actions SHOULD be undertaken either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services. These actions related to five services and the Trust overall.

The latest CQC comprehensive inspection of the Trust took place in March and April 2019.
The inspection focused on all of the domains; safe, responsive, caring, well led and effective and included six core services:-
Urgent and Emergency
Medical
Surgery
Children and young people
Maternity and gynaecology
End of Life Care.
We anticipate receiving the final report from the CQC in July 2019

Quality Improvement

Introduction to Quality Improvement

The Trust is committed to a clear strategic direction to improve patient services underpinned by a Trust wide quality improvement approach. This approach has been named “QUALITY FIRST”.

Putting ‘quality first’ is the principal that drives the Trust Quality Improvements.

The Quality Improvement Strategy was launched in February 2019. We define quality improvement as ‘working together in partnership to make the sustainable changes that will lead to excellence for our patients, people, places, performance and pounds.’

Quality First Team

The Care Quality Commission refer to the ‘presence of a central team that leads the provider’s quality improvement approach’ as an indication that quality improvement is embedded across an organisation. Our central team is the Quality First Team, led by a senior doctor, nurse and manager. The team work alongside our staff, patients and wider partners in health and social care focusing on the following key functions:

- Centrally coordinate quality improvement initiatives that deliver greater efficiency and productivity as well as reducing unwarranted variation.
- Support the delivery and realisation of our long term plan (Your future, our hospital), the Trusts Clinical and Quality Improvement Strategies, Lead quality improvement and organisational development to prepare the Trust for our future health and social care campus.
- Support the strategic realisation of the clinical strategy.

The Improvement Partnership

The ‘Improvement Partnership’ is our program for enrolling, engaging, involving and developing our staff in Quality Improvement. The Quality First Team runs Leading Change and Leading Projects learning and development sessions with the objective of enabling staff to deliver successful quality improvement projects. When the staff member completes a quality improvement project (capturing project outcomes in a poster), they become PAHT Improvement Partners.

Quality Improvement programme

The quality improvement programme has gained momentum in 2018/19. For the second consecutive year we have been awarded 1st Prize as the Champion Trust from the Academy of Fabulous Stuff.

This was awarded to the Trust as a result of delivering 70 improvement projects during 2018 and embedding quality improvement across the organisation.

The Princess Alexandra Hospital NHS Trust

5.1

Priorities for Quality Improvement 2019- 2020

Each year we assess our performance against previously identified quality priorities and patient outcomes; we make sure we take account of national reports, feedback from regulators, patients and staff as well as learning from incidents, complaints and litigation cases.

.

This year the outcomes from the Care Quality Commission (CQC) inspection report (March 2018) has afforded us an opportunity to build upon our programme of improvement which is underpinned by the Quality 1st approach.

Our priority and aim is to move to a CQC rating of "Good" and we have been working towards showing positive improvement in our journey to good and outstanding in our latest CQC comprehensive inspection which took place in March and April 2019. In 2019/20 the Trust will focus on addressing the recommendations from the recent CQC inspection once the report is received.

Priorities for Quality Improvement 2019/2020

Our four Quality Account priorities are identified in line with the quality elements of the Trust 5P Strategy: which covers our patients, our people, our performance and our places. These priorities will be monitored using the governance structure; through three sub committees of the Board and progress will be reported to Trust Board.
The Quality and Safety Committee will oversee the objectives for Our Patients.
The Workforce Committee will monitor Our People objectives.
The Performance and Finance Committee will monitor Our Performance and Our Places objectives.
In addition to the Our Pounds objectives which are not included within the quality account.

1.0 Our patients – Aim to reduce mortality, improve HSMR and improve our patients experience

- A reduction in the Trust mortality rate as a result of the work completed through the mortality improvement board established in December 2018. Trust aims to have a normal Hospital Standardised Mortality Ratio (HSMR) with no outlier alerts by 2021.
- A reduction in the length of stay by 10% for non-elective patients to support the flow of patients in, through and out of the hospital.
- Improve by 10% the numbers of patients that are dying in their preferred place of death (as expressed at time of imminent death)
- Ongoing improvements in our care of patients' experience measured through a reduction of 10% in the number of formal complaints received from 206 to 185. An increase of 10% the numbers of successfully resolved PALs concerns from 2827 to 3109

2.0 Our People – Aim to improve nusing staffing and our staffs culture and well being

- Introduction of a talent management programme and newly appointed consultant development programme by Q3
- Continued improvement in staff survey results of experience being consistent with the Trust's 4 values
- An ambitious programme to significantly reduce the Registered Nurse vacancy rate to less than 10%
- Unconscious bias training to raise awareness of equality and inclusion issues in attracting, recruiting and retaining our people by Q3
- Implementing a new extranet website for our people by Q4
- Implementation of new Trust website by Q2

3.0 Our performance – Aim to improve our performance against the national standards

- Achieve all key access standards, including RTT (referral to treatment) and cancer wait times
- To improve our performance for timeliness of treating patients requiring urgent care
- To commence the redesign of outpatient services, to modernise services in primary and secondary care. This is work planned to be within the Trust transformation programme. The project for outpatients including the KPIs will be set through this process.

4.0 Our Places – Improve our clinical areas and critical functions

- To work with our partners to complete a pre consultation business case by July 2019 for the preferred way forward for a new hospital
- To run a public consultation on the new hospital following the completion of the pre-consultation business case
- To complete a Strategic Outline Business Case for a new hospital by March 2020

Monitoring our progress

This year we will be strengthening our approach to monitoring compliance with regulatory standards as well as further embedding our approach to improving quality performance. We will continue to work with our staff, service users, health and social care partners as well as our commissioners, regulators and NHS Improvement to monitor our progress:

- Develop and deliver a schedule of Peer quality inspections to review compliance with the fundamental standards of quality; alongside a range of staff from PAHT, the inspectorate will include members of the Patient Panel and colleagues from both commissioning groups.
- The monthly performance monitoring meetings with executive board members for al healthcare groups and corporate teams will continue. Using a constructive and supportive approach, the presenting teams are encouraged to share their progress against agreed outcomes as well as identifying areas where support is required to achieve success.
- Where recommendations for improvement are made by regulatory bodies such as the CQC, these will be addressed using our existing 'model for improvement' methodology.
- The reporting process, including monitoring of progress, will include an executive led Quality compliance improvement group which will report progress to the Quality and Safety Committee, commissioning partners and the Trust Board.

Statements relating to quality of care provided

The Trust provides a range of services to a local population of around 350,000 living in West Essex and East Hertfordshire. The majority of services are provided from the main hospital site in Harlow, but local hospitals in Bishop's Stortford and Epping offer outpatient and diagnostic services, see table 3.

The Trust has 480 general and acute beds and provides a full range of general acute services, including; a 24/7 emergency department, an adult intensive care unit, a maternity unit and a level II neonatal intensive care unit (NICU).

Directory of our services			
Ambulatory Care	Dermatology	Intensive Care unit	Patient at Home Service
Ante-natal Clinic	Diabetic Medicine	Interventional Radiology	Pharmacy
Anticoagulant Service	Dietetics	Maternal and Foetal Assessment Unit (MAFU)	Physiotherapy
Audiology	Early Pregnancy Unit	Maternity	Post Anaesthetic Care Unit (PACU)
Birthing Unit	Emergency Department	Maxillofacial surgery	Pre Op Assessments
Breast Screening	Endocrinology	Medical Oncology	Radiology
Breast Surgery	Endoscopy Services	Neonatal Critical Care	Respiratory Medicine
Cardiac Cath Lab	ENT Clinics	Neurology	Rheumatology
Cardiology	Fleming Ward	NICU	Short Stay Unit
Care Of The Elderly Clinics	Frailty service	Obstetrics	Special Care Baby Unit
Chemical Pathology	Gastroenterology	Occupational Therapy	Speech and Language Therapy
Chemotherapy	General Medicine	Ophthalmology	Surgery Clinics
Clinical Decision Unit	General Surgery	Oral Surgery	Surgical assessment unit
Clinical Haematology	Genito-Urinary Medicine	Paediatric Ambulatory Unit	Theatres
Clinical Oncology	Geriatric Medicine	Paediatric Diabetic Medicine	Therapies
Colorectal services	GP Assessment Unit	Paediatric Oncology	Transfusion services
Colposcopy and hysteroscopy services	Gynaecology	Paediatrics	Trauma and Orthopaedics
Community Midwifery Team	Gynaecology Ambulatory Service	Palliative Care	Urology
Community Neonatal Team	Haematology Clinics	Pathology	Vascular services
Day Surgery	High Dependency Unit	Patient Appliances	

Table 2: Director of Trust Services

The review of services and all associated data is undertaken through the Trust Governance structure. This includes monthly Patient Safety and Quality Group, then through to the monthly Quality and Safety Committee which reports to the Trust Board.

Review of each services performance (in Table 2) within the Trust is monitored through the Performance and Finance Committee with external review undertaken by both Essex and

Hertfordshire commissioners at the monthly Service Performance and Quality Review Group (SPQRG).

Prescribed Indicators		
	Prescribed information	**Form of statement**
1.	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services: (a) specified under the contracts, agreements or arrangements under which those services are provided or (b) In the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider.	During 2018/19 The Princess Alexandra Hospital NHS Trust provided a range of health services listed in the Directory of Services, table 3. a) Services provided by the Trust to local/main CCGs are commissioned under standard form NHS contracts. b) Non-Contracted activity: Beyond services provided to main/local CCGs the Trust receives income for Non-Contracted activities with other Clinical Commissioning Groups. This income mainly relates to activity provided to CCGs that are not within the Trust immediate catchment area and/or where activity does not require formal contracts to be in place. In 2018/19 this level of activity totalled £3.1m. c) Sub-Contracted activity: During the year the Trust subcontracted a small number of services to private or other NHS providers. Services are generally subcontracted where either short term capacity constraints arise or specialist services are required. In 18/19 the main services sub-contracted were Urology (day case and OPD), Endoscopy surveillance and specialist clinical tests.
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period.	We have reviewed all the data available to them on the quality of care provided by the services listed in table 2.
1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1 represents of the total income for the provider for the reporting period	In 2018/19, 90% of The Trusts revenue was received for patient care activities relating to the services listed in table 2.

	under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services.	
2.	The number of national clinical audits (a) and national confidential enquiries (b) which collected data during the reporting period and which covered the relevant health services that the provider provides or subcontracts.	During 2018/19 48 national clinical audits and 4 national confidential enquiries covered relevant health services that The Princess Alexandra Hospital NHS Trust provides
	Prescribed information	**Form of statement**
2.1	The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.	During that period we have participated in 94% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
2.2	A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in.	The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2018/19 are detailed in tables 19 and 20
2.3	A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in.	The national clinical audits and national confidential enquiries that we have participated in during 2018/19 are detailed in tables 19 and 20
2.4	A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry.	The national clinical audits and national confidential enquiries that we have participated in, and for which data collection was completed during 2018/19, are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. See tables 19 and 20
2.5	The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period.	The reports of 18 national clinical audits were reviewed by the provider in 2018/19
2.6	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	The actions undertaken in the trust are detailed in table 22
2.7	The number of local clinical audit (a) reports that were reviewed by the provider during the reporting period.	The reports of 44 local clinical audits were reviewed by the trust in 2018/19
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	See table 22 for actions

3.	The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	The number of patients receiving relevant health services provided or subcontracted by The Princess Alexandra Hospital NHS Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee *948*.
4.	Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services.	A proportion of The Princess Alexandra Hospital NHS Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between NHS England – East of England Specialised Commissioning, West Essex Clinical Commissioning Group and any contract associates they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.
4.1	If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	**Not applicable**
4.2	If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, where further details of the agreed goals for the reporting period and the following 12-month period can be obtained.	Further details of the agreed goals for 2018/19 and for the following 12-month period are available in the CQUIN achievement section of this Quality Account on Table 16
5.	Whether or not the provider is required to register with CQC under Section 10 of the Health and Social Care Act 2008.	The Princess Alexandra Hospital NHS Trust is required to register with the Care Quality Commission. The current registration status is "registered without condition". The Care Quality Commission has not taken enforcement action against the trust during 2018/19.
5.1	If the provider is required to register with CQC: (a) whether at end of the reporting period the provider is: (i) registered with CQC with no conditions attached to registration (ii) registered with CQC with conditions attached to registration (b) if the provider's registration with CQC is subject to conditions, what those conditions are and (c) whether CQC has taken enforcement action against the provider during the reporting period.	
6.	Removed from the legislation by the 2011 amendments	
6.1		

7.	Whether or not the provider has taken part in any special reviews or investigations by CQC under Section 48 of the Health and Social Care Act 2008 during the reporting period.	The Princess Alexandra Hospital NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.
7.1	If the provider has participated in a special review or investigation by CQC: (a) the subject matter of any review or investigation (b) the conclusions or requirements reported by CQC following any review or investigation (c) the action the provider intends to take to address the conclusions or requirements reported by CQC and (d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period.	
8.	Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider.	The Princess Alexandra Hospital NHS Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.
8.1	If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data: (a) the percentage of records relating to admitted patient care which include the patient's: (i) valid NHS number (ii) General Medical Practice Code (b) the percentage of records relating to outpatient care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code (c) the percentage of records relating to accident and emergency care which included the patient's: (i) valid NHS number (ii) General Medical Practice Code.	The percentage of records in the published data which included the patient's valid NHS number was: 99.6% for admitted patient care 99.8% for outpatient care and 98.0% for accident and emergency care. This included the patient's valid General Medical Practice Code was: 99.9% for admitted patient care; 99.9% for outpatient care; and 99.7% for accident and emergency care.
9.	The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme.	The Princess Alexandra Hospital NHS Trust Information Governance Assessment Report overall score for 2018/19 was Standards Not Met and was graded Red.
10.	Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission.5	The Princess Alexandra Hospital NHS Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.
10.1	If the provider was subject to the Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation	

	to the provider for the reporting period prior to publication of the relevant document by the provider.	
11.	The action taken by the provider to improve data quality.	The Princess Alexandra Hospital NHS Trust will be taking the following actions to improve data quality; 1. Monthly/weekly challenge of healthcare groups using the Performance Review process 2. Monthly report into the Performance & Finance Committee, with escalation through to Trust Board if required 3. Weekly escalation through Access Board 4. Fortnightly Data Quality Operational meeting with the healthcare groups

Table 3: Prescribed Indicators 1-11

Below are the core indicators which NHS England has requested are included in the 2018 - 2019 Quality Accounts by all NHS Trusts.

The Princess Alexandra Hospital NHS Trust considers that this data is as described having been provided by NHS Digital and Dr Foster.

12	Standardised Hospital Mortality Indicator	October 2017 – September 2018	National average	Improvement action plan
	(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period; and HSMR 122.8 – Higher than expected	**116.69: Higher than expected**	100	The Trust's mortality falls into the 'higher than expected' range when compared to national data baseline. The Trust is continuing to conduct actions in line with our Morbidity and Mortality Strategy, which includes learning from all deaths. The Trust has set up work streams for improving patient outcomes which will feed into a mortality improvement board aiming to deliver improving standards and achieve an as expected rating in the future. This process is being supported by the quality first team.
	The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	3.26%	4.06%	This is an area of success in year however we will continue to deliver training for staff to understand and implement more robust documentation leading to improved clinical coding. Our clinical coders will continue to attend the wards regularly to discuss queries with clinicians. This ensures that coding difficulties can be resolved before the notes leave the wards.

Indicator 12 and Table 4: Prescribed core indicator : Standardised Hospital Mortality Indicator
Source of data NHS Digital

18. Patient Reported Outcome Measures (PROMs)

PROMs are measures of health outcomes in patients undergoing planned surgical procedures. In year the data collected for varicose vein and groin hernia has ceased following a consultation. The procedures that data collection continues for are hip and knee replacements. In England all patients having these two procedures should receive a questionnaire both before and after surgery.

Improvement Rate by Procedure and Measure for April 2018 to March 19

PAH	National
EQ5D Index Hip Replacement: 90% Knee Replacement: 83.3%	EQ5D Index Hip Replacement: 91.1% Knee Replacement: 82.9%
EQ-VAS Hip Replacement: 70% Knee Replacement: 81.3%	EQ-VAS Hip Replacement:71.1% Knee Replacement: 59.9%

Indicator 18. Table 5: Trust data on Patient Reported Outcome Measures
Source of data NHS Digital

The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is part of the Integrated Performance Report and audited Trust data.

19	% of patients re-admitted within 28 days November 2017 – October 2018	National Average Updated 2013	Improvement action Plan
Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period		National Acute (Non Specialist) 8.1% observed Lowest 5.8% Highest 10.5%	*NHS Digital has suspended the updating of this information from December 2013 pending a review of the methodology.*
(i) % of patients 0-15 years of age	PAH 0-14years 5.1 % observed	National Acute (Non Specialist) Aged 0-14 9% Observed Lowest 4.1% Highest 14.4%	Identify on our electronic patient administration system the patients who are repeat admissions. This small group of patients are monitored and any trends identified for the relevant speciality to take note and action as required. Priority referral to home team (who are familiar with patient and are able to make the best plan for the patient Internal Professional Standard that patient should be seen within 30 minutes of referral by decision maker to review if admission is needed or if alternative method of care is appropriate
(ii) 16 years and over	PAH 15 or over 8.9% observed	National Acute (Non Specialist 15 or over 8.0% observed Lowest 5.8% Highest 10.8%	

Item 19, Table 6: Trust data on Percentage of Patients readmitted within 28 days
Source: Dr Foster

The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is part of the Integrated Performance Report and audited Trust data.

20	**Trust's responsiveness to the personal needs of its patients during the reporting period. Ensuring that people have a positive experience of care.**	**2017 -2018**	**2018-19**	**Improvement action plan**
	Number of PALS cases resolved	2923 cases received Of those received: 53% were resolved within 48 hours 77% within 2 weeks 96% within 2 months Lowest number per month: 197 Highest number in a month: 290	2801 cases received Of those received 38% resolved within 48 hours 68% within 2 weeks 86% within 2 months Lowest number per month: 157 Highest number in a month: 273	The Trust performance in resolving PALS cases at a local level has deteriorated in year. The evidence shows that this is related to three issues; first: the increasing activity not being full reflected in our data due to overall volume of work, second: the service was moved to the main entrance of the hospital to improve access but this initially had the effect of increasing routine enquiries which cannot be recorded and third: staff vacancies which were not fully recruited to by the end of 2018-19. Actions needed: Bring the service up to full strength, filling all vacancies by June 2019. Continue to develop plans to increase recorded activity in 2019-20 Action needed. 1. Fill vacancies in the Patient Experience team by June 2019. 2. This will enable the team to log all of the cases which are outstanding and increase activity on 2018-19

Item 20, Table 7 : Trust responsiveness to personal needs
Source: Trust held data on Datix

The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is part of the Integrated Performance Report and audited Trust data.

21	**The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.**	**July – September 2018**	**Trust's nationally set target for this question**	**Improvement action plan**
	Friends and Family Test - staff	76% of staff 695 staff responded	DoH Target is 67%	Improve communications with all staff around survey to ensure more respondents. Continue to provide information and briefings to all staff on improvements.

Item 21, Table 8 : Staff Friends and Family test results

Source: NHS Choices

The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is part of the Integrated Performance Report and audited Trust data.

21.1	The percentage of patients who would recommend the trust as a provider of care to their family or friends.	Average for 2017-18	National Average	Improvement action plan
	Friends and Family Test – patients	96.48	National average is 93.2%	Implementation of Patient Experience Minimum Standards actions to include: 1. Implementation of Talk to Me campaign across all HCGs 2. Development of Sensory Ambassadors 3. A volunteer on every ward, every day with buddying so that staff support volunteers and monitor experience. 4. The Electronic Feedback System will go live with a patient app, staff app and ward level, wall mounted touch screen feedback devices

Item 21.1, Table 9: Patients Friends and Family test results
Source: NHS Choices

The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is part of the Integrated Performance Report and audited Trust data.

23.	March 2017	December 2018	National target	Improvement action plan
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	98.7%	98.33% Trust internally set target is 98%	95.25% England National target is 95%	Continue failsafe check lists at ward level. Continue using the VTE risk assessment proforma. Patient leaflets available in clinical areas. Patient Safety Thermometer includes a question about preventative (prophylaxis) medications being given. Process for poor compliance shared with all ward and departments

Item 23, Table 10: Percentage of patients risk assessed for VTE
Source: NHS Digital

24. The Princess Alexandra Hospital NHS Trust considers that this data is as it is Deaths in Quarter 1 (April 2017- 30 June 2017):

24. The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	No. of cases April 18 – Jan 19	PAHT Target for April 18 to March 19	Improvement action plan
C-Diff - cases on national surveillance database C-Diff - cases attributable to PAH (total less successful appeals) Rate per 100,000 bed days for PAH = 7.9 (data published by Public Health England)	Trust apportioned cases 5 13 cases in total of which 8 were successfully appealed	9	Continue with personal protective equipment and hygiene by clinical staff. Monitor compliance Continue responsible use of antibiotics Timely isolation of patients Continue thorough cleaning and monthly cleaning and hygiene code audits Continue hydrogen peroxide decontamination

Item 24, Table 11: C.difficile rate per 100,000 bed days
Source: NHS Choices

The Princess Alexandra Hospital NHS Trust considers that this data is as described as it is part of the Integrated Performance Report and audited Trust data.

25. The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death	Number of Severe harm/ Serious Incidents and incidents resulting in death	Severe Incident National Average from 1 March 18 to 28 Feb 2019	Severe harm Incident Trust Average from 1 March 18 to 28 Feb 2019	Incidents resulting in death. National Average from 1 March 18 to 28 Feb 2019	Incidents resulting in death. PAH average	Incident reporting rate National Average from 1 April to 30 Sept. 2018
The total number of incidents from April 2018 to March 2019 was 7162	29 Severe harm Incidents at time of data submission to NRLS. 5.53% (29/7162) 4 Death on NRLS at time of data submission.	0.29%	0.44% SI Trust Average is 3 SI's/month	0.25 %	0.004%	PAH data 48.5 incidents per 1,000 bed days The national data for organisations within Trust cluster (Acute non specialist) is 44.5 incidents per 1000 bed days.

Item 25, Table 12: Rate of safety incidents
Reference for National Data is as provided for Acute (non-specialist) organisation in the NRLS organisation patient safety report on six months data from 1/4/2017 to 30/09/2017 - data is only provided on severe harm levels not serious incident numbers

26. Statement on Seven Day Hospital Services - As a Trust we are working towards implementation of seven 7 day services.

Our assessment of the current position against the clinical standards for a seven day service is:

- Time to first consultant review –90% (within 14 hours)
- Access to diagnostics - 93%
- Access to consultant directed interventions - 90%
- Ongoing consultant review - 90%

27. Hospital Deaths – two alternatives proposed for presenting this data

Hospital Deaths: 2018/19		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
27.1	**Total**: **From the total there were:**	273	288	280	233	1195
	Neonatal deaths (after 22 weeks)	1	0	1	1	3
	Still births (delivered from 24 weeks)	1	2	1	3	7
	Learning Disability	3	2	4	0	9
	Severe Mental Illness	0	0	0	0	0
27.2	Total number of case reviews completed by clinical teams **From the total the following were:**	74	89	91	126	380
	Neonatal deaths (delivered after 22 weeks)	1	0	1	1	3
	Still births (delivered after 24 weeks)	1	2	1	3	7
	Learning Disability	3	2	4	0	9
27.3	Estimated number of deaths where case review identified problems with the care provided	6	4	2	2	14

Item 27, Table 13: Hospital deaths in 2018/9 (completed as recommended by NHSI)

Second option is to present the data as per National Quality Accounts requirements

Hospital Deaths: 2018/19		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
27.1	**Total**: **From the total there were:**	273	288	280	233	1195
27.2	Total number of case reviews completed by clinical teams	74	89	91	126	380
27.3	Estimated number of deaths where case review identified problems with the care provided	6	4	2	2	14

Item 27, Table 13: Hospital deaths in 2018/9

The Trust has several processes whereby a review of care given for all patients that die is undertaken. This includes mortality and morbidity reviews, responding to Dr Foster alerts, national audits in which we have participated, in addition to Maternal Newborn and Infant Clinical Outcome Review (MBRACE) and Learning Disability Mortality Review programme (LeDeR)reviews using an adapted mortality and morbidity review tool for use across all services.

The Trust has developed concise and comprehensive root cause analysis investigation templates that are used for all Trust investigations.

The Trust began piloting the Medical Examiner (ME) role in February 2019 and the patient reviews are completed using electronic software. Formal appointments to the ME role will be made in June 2019 with Her Majesty's Coroner in attendance. A lead Medical Examiner role will also be appointed over the summer with a planned starting date of the autumn 2019.

The Trust is working in partnership with our regulators the CQC and NHSI and will continue to collaborate going forward in the review of any unexpected deaths in particular services.

27.4 – A summary of learning from deaths case reviews and investigations identified in 27.3

- Maternity/Obstetric Incidents
  Further actions will be implemented on conclusion of the ongoing review of perinatal mortality. In addition the Trust is now included in Healthcare Safety Investigation Branch (HSIB) the national action plan to make maternity care safer in line with the National Maternity Safety Ambition (2015) aimed to half the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth by 2025.
- Slip, trip and falls
  Undertake lying and standing blood pressure monitoring for patients who are at risk, review drug interactions. The Trust is mindful that as we encourage mobilisation of patents to prevent deconditioning there will be an increase in the number of falls.
- Suboptimal care of deteriorating patients
  Ensure staff escalate patients of concern to senior clinicians both medical and nursing, ensure senior staff undertake clinical reviews and monitor for compliance against NEWs2 guidance.
- Diagnostic incidents
  Ensure clinical information provided at time of request details urgency of requirement for clinical investigations.

27.5 Actions are in place to address the learning from the deaths reviewed in 27.3 and itemised in 27.4.

27.6 What is the impact of the actions you have implemented?

In addition the Trust has also initiated the following actions in direct response to the learning from deaths through mortality and morbidity reviews, responding to Dr Foster alerts and national audits in during 2017/18:

- Medicalisation: The Trust has introduced treatment escalation plans for patients who have been identified and assessed as in the last year of life. The use of the new plan is ensuring that staff talk to the patient and their family/carers early about the prognosis, treatment options and outcome of their illness resulting in personalised care. This ensures the patients have a say in how much ongoing treatment they want, this will include discussing the full range of treatment options. The patient or their family and the doctors then set a ceiling on the level of treatment to be given.
- Clinical coding Improvement: The Trust continues to have coders and consultants working collaboratively to review the notes of all patients who have died. This ensure the Trust has detailed the correct diagnosisand treatment given.

- Improved diagnosis of COPD: This has been addressed through the provision of education and training for our local GPs and junior doctors and is part of a project focusing on improving the patient outcome.
- Standardisation of care: The Trust is introducing treatment bundles (which are separate items of treatment and care given for a particular diagnosis) and introduced this for patients being treated for fractured neck of femur (hip) chronic obstructive pulmonary disease, pneumonia, sepsis, acute abdomen, fluid and electrolyte management.
- End of life pathways: During 2019 the Trust will be expanding the end of life team to ensure delivery of a seven day service and to achieve the six standards from the care of the dying audit. We are working collaboratively with our community partners to aid the discharge home for patients who want to spend their last days of life in their own homes will continue.
- A review of the smoking cessation pathway and serial scans on mothers who smoke has been implemented. A Smoking cessation midwife has been appointed.

27.7 How many case reviews have been completed in 18/9 relating to care given in 2017/8: **Three**

27.8 From the case reviews can you estimate the numbers of deaths as result of problems in care given to patients in 2017/8: **One**

27.9 A revised estimate of the number of deaths during the previous reporting period detailed in 27.3 (14) and the additional case detailed in 27.8 (1) is a total of 15 patients. The total number of deaths identified in 2018/9 found to have been the result of care or service issues is: TBC%

28 The Gosport Independent Panel Report recommended Trusts develop mechanisms for Staff to speak up, provide feedback to staff who speak up and ensure they do not suffer detriment.

Our Trust has two Freedom to Speak up Guardians (FTSUG) and their purpose is to work alongside the Trust's Executive and Senior Leadership Teams to help support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely without the fear of any repercussions.

The FTSUG's receive training, guidance and support from the National Guardians Office and are an independent and impartial source of support and advice to all staff at any stage of raising a concern. Staff are advised that they are able to raise concerns in a safe and confidential way and an agreement of how the concern will be taken forward is established with the staff member.

Concerns raised relating to bullying and harassment will be addressed via the Trusts dignity at work policy and themes arising from reported cases alongside staff survey results are actioned through Health Care Group staff survey improvement plans.

The FTSUG produce quarterly reports identifying the work that they have undertaken and emerging themes. This is reviewed by the Boards Workforce Committee.
During 2018 the FTSUG supported over **65** cases to reach an outcome.
The focus over the next year will be:

- To develop FTSU Champion roles within each Health Care Group to help support and raise awareness for becoming a robust, open and transparent organisation
- To support the relaunch of the "In Our Shoes" campaign – giving staff the opportunity to learn from each other to help future development
- To continue to support Staff Council – this is open to all levels of staff across the organisation and will help create a safe and open forum for discussion.

29. The Trust has rota gaps for middle grades in most specialities. This is due to a short fall in trainees provided by Health Education England as well as vacancies in non-training posts.
This is a national problem; The Trust is mitigating this by:

- Prioritising acute and on call cover
- Daily review of the on call cover
- Active recruitment programme for middle grade doctors including overseas recruitment
- Smarter electronic roster planning by the Human Resources support team
- Improved ratio of doctors employed via NHSP bank rather than from agencies (80% of doctors are employed via the bank)
- Increased use of locum short term contracts rather than ad hoc cover
- Using an inter-ward buddy system to support staff
- The increasing use of Physicians Associates
- A pilot ward cover system for Surgery

Statement on Relevance of Data Quality

The Princess Alexandra Hospital NHS Trust continues to progress improvements in data quality:

- Regular reporting on data quality issues to the Access Board via the Trust's fortnightly Operational Data Quality Group with oversight by the Performance and Finance Committee and Board of Directors.
- We continue with clinical validation of medical records coding to ensure the accuracy of data for national and local benchmarking.
- The use of data quality risk registers to manage data quality risks/issues and monitor the actions the Trust takes to mitigate those risks.
- The Data Quality dashboard is published weekly to support monitoring and operational resolution of data quality issuesNHS Data Quality Maturity Index overall the Trust scored 97.5% (July-September 2018) and the Trust compares favourably with other local acute trusts.

Data quality, metrics and processes

NHS Number and General Medical Practice Code Validity

The Princess Alexandra Hospital NHS Trust submitted records during 2018/19 as at February 2019 to the Secondary Users Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. The percentage of records in the published data (2017/2018 in brackets):

Which included the patient's valid NHS number was:

- 99.6% (99.7%) for admitted care
- 99.8% (99.8%) for outpatient care
- 98.0% (98.3%) for accident and emergency care

Which included the patient's valid General Medical Practice Code was:

- 99.9% (99.9%) for admitted patient care
- 99.9% (99.8%) for outpatient care
- 99.7% (99.8%) for accident and emergency care

Information Governance (IG) Position Statement

The Data Security and Protection Toolkit (DSPT) replaced the previous Information Governance toolkit (IGT) in April 2018.

The new toolkit does not feature levels 1, 2 and 3. To meet the new standard, organisations were required to respond to 'all' evidence items which are identified as mandatory in order to confirm the associated 'assertions'.

As of the 27 March 2019 publication date, 23 out of 100 mandatory evidence remain red. The Trust therefore published its 2018/2019 DSPT as 'Standards Not Met', but with a view for NHS Digital to upgrade this to 'Standards Not Met (Plan Agreed)' through an Improvement Plan submitted as additional evidence within the DSPT. Timelines for compliance of the above outstanding areas range from 1 April to 31 July 2019.

The General Data Protection Regulations (GDPR) came into force on the 25th May 2018, and with robust preparation the Trust implementation plans became business as usual processes, which work in conjunction with the updated Data Protection Act 2018.

Clinical Coding Audit

Clinical coding is the process by which patient diagnosis and treatment is translated into standard, recognised codes that reflect the care that has been provided to our patients. The accuracy of this coding is a fundamental indicator of the accuracy of patient records. The results should not be extrapolated further than the actual sample audited.

In 2018/19 the Information Governance (IG) toolkit has been replaced by the Data Security and Protection Toolkit, which still encompasses the same framework for clinical coding audit. Going forward the percentage accuracy scoring requirements for a Trust are as follows (Figure 1).

Acute Trust	Mandatory	Advisory
Primary Diagnosis	>=90%	>=95%
Secondary Procedure	>=90%	>=95%
Primary Procedure	>=90%	>=95%
Secondary Procedure	>=80%	>=90%

Table 14 : Expected clinical coding performance

In the 2018/19 audit, a total of 200 finished Consultant episodes across a range of specialities were reviewed. The accuracy rates reported in line with the accuracy scoring requirements are displayed in Figure 2.

Acute Trust	2018/19	Level of Attainment
Primary Diagnosis	91%	Mandatory
Secondary Procedure	93.2%	Advisory
Primary Procedure	95.2%	Advisory
Secondary Procedure	91.3%	Advisory

Table 15 : Actual clinical coding performance

Princess Alexandra NHS Trust meets the targeted Data Protection and security toolkit attainment Mandatory level for primary diagnosis and Advisory level for secondary diagnoses, primary procedures and secondary procedures. Coding error rates are below the NHS national average of 8.7% for diagnosis and 6.8% for procedure coding as measured by the PbR assurance framework (2011-2012 Assurance Programme). The Trust will continue to improve its accuracy of coding, and will be focusing on improvements to address recommendations made as part of this audit.

PART THREE

Achievements and challenges in 2018-2019

Each year we assess our performance against the previous year's quality priorities, taking into account national reports and emerging themes.

1.0 Our Patients objectives 2018/19

1.1 Reduce mortality and improve the Trusts HSMR: Partially achieved.

Our focus	Our achievements
Reduction in the number of unexpected deaths. Reducing Hospital Standardised Mortality Ratio (HSMR) from 116.	Our 12 month average HSMR is 121, this classed as higher than expected. A positive indicators that our work programme focusing on reducing mortality is on the right track shows the last six months available data has only 1 month where our HSMR is higher than expected. The remainder are as expected
Reducing the number of mortality outlier alerts from 12 by 50% to 6.	Outlier alerts recieved: 7; this is a 42% reduction
Reducing mortality from Acute Kidney Injury (AKI) by 10% from 12.5%	Mortality from Acute Kidney Injury: HSMR for AKI is 131 with a rate of 15%, this has increased
Ensuring 90% of patients meeting the sepsis criteria would be screened for sepsis by 1/10/19.	Timely Identification of Patients with Sepsis In the Emergency Department (ED): 85% of patients were screened (by 1 October 2018). 86% of patients screened (by 31 March 2019) Across the ward areas for inpatients: 100% of in patients screened across the inpatient wards (by 1 October 2018) 90% of inpatients screened across the wards (by 31 March 2019) (Achieved).
Ensuring 90% of patients identified as having sepsis would receive appropriate treatment within 60 minutes by 1/10/10	Treatment of sepsis within 1 hour In the ED: October 2018: 91% treated March 2019: 94% treated (Achieved) In the ward areas for inpatients 100% treated by October 2018 100% treated by March 2019 (Achieved) Sepsis champions identified (Achieved)

1.2 Improve our patient's experience: Partially achieved

Our Aims	Our Achievements
Ensure patients receive personalised care and are satisfied with their experience	With regard to personalised care: Local surveys assist in showing an improvement on areas identified from the annual National Inpatient Survey. We have set objectives to improve our performance in • Confidence and trust in nurses • Care and privacy in discussing my condition • Discharge support from health or social care With regard to patient satisfaction: Evidence from 2018-19 shows a decrease in the total number of complaints received, a decrease in the number of cases upheld by the Ombudsman and in addition evidence from local surveys shows that satisfaction has improved. This includes the Friends and Family test (FFT) data which shows that we achieved the highest score to date across all services at 96.6%.
Improve inpatient survey results ensuring we reduce and eliminate questions that	We expect to receive the 2018 national inpatient survey

were rated in lowest 20%. Ensure 10 questions are placed in the top 20%. (please note the measurement completed by the National Survey in year has changed In 2017 survey marks out of 10, in 2018 survey marked as a %	results in June. This item will be updated once the results are available.
Ensure the following questions are rated in top 20%: Question 27: Confidence and trust in nurses (scored 8.7 in 2017) Question 39: Care and privacy when discussion my condition (scored 8.6) Question 54: Discharge support from health or social care professionals (scored 6.6 in 2017)	We expect to receive the 2018 national inpatient survey results in June. This section will be updated once the results are available.
Reduction in complaints received from 229 by 10% to 206 or less	Reduction in the number of complaints by 10% to 206 (Achieved)
Increase the number of PALs concerns successfully resolved by 10%	The Trust performance in resolving PALS cases at a local level has deteriorated in year. This was due to an increase in the volume of work and staffing vacancies that resulted in not all enquiries being logged.

2.0 Our People objectives

2.1 Recruitment and Retention of Registered Nurses: Achieved

Our Aim	Our Achievements
Increase the numbers of registered nurses and reduce the vacancy rate	Our vacancy rate reduced from 28% to 25.9% of registered nurses (RN) across the trust. We are working to significantly reduce RN vacancy rates further following implementation of a focused nursing recruitment campaign scheduled for deployment throughout 2019 In addition, we have worked to improve our retention rates and have seen a reduction in leavers from 17.3% to 14%

2.2 Staff experience will be consistent with the Trusts strategy and values: Partially achieved

Our Aims	Our Achievements
Every member of staff will feel the Trust values are demonstrated and evidenced from our National Staff Survey results.	Staff experience consistent with the trusts values Improved response rate for staff survey 2018 with PAHT scoring better in 15 questions compared to last year and no significant different to last year for 67 questions
Improved Trust scores against these four questions Question 17: Staff experiencing discrimination from patients and service users will improve (scored 94%) Question 17b: Staff are not experiencing discrimination from manager or colleagues (scored 91%)	Improved Trust scores against these four questions Question 15a (previously question 17): Staff experiencing discrimination from patients and service users will improve (scored 94%) Question 15.b (previously Q17b): Staff are not experiencing discrimination from manager or colleagues (scored 92%)
Question 18a Staff had training and	Question 20 (previously Q18a) Staff had training and

development (scored 71%) Question 18b Staff reported training helped me to do my job (scored 80%)	development (Score 69%) Question 18b Staff reported training helped me to do my job – no longer asked
Question 18cTraining helped me stay up to date professionally (score 82%)	Question 18cTraining helped me stay up to date professionally – no longer asked Question 19 Staff had mandatory training in last 12 months – no longer asked
Question 19 Staff had mandatory training in last 12 months (score 97%)	Replaced the three questions no longer asked with the staffs comments on the value of their appraisal Question 19a Appraisal/performance review: organisational values definitely discussed (scored 47% - 1% increase) Question 19b Appraisal/review definitely helped me improve how I do my job (scored 26% - 1% increase) Increased compliance with statutory mandatory training from 84% to 93% Increased compliance with annual staff appraisal from 78% to 92% Mental health support including Mental Health First Aiders with over 20 staff trained and Mental Health Awareness day run over the three hospital sites to support our staff Staff introduced and embedded Successful Event in a Tent 2018 which included a wellbeing day, our amazing people awards and long service awards.

3.0 Our Performance objectives

3.1 Improvement in the Emergency department (ED) 4 hour access standard: Partially achieved

Our Aims	Our Achievements
Improve the numbers of patients that receive timely treatment in the ED	Delivering the 4 hour standard has remained a challenge this year. We saw progress in improving performance in early Autumn. Due to increase in demand this has not been able to be sustained. The Trust performance improved to 74%. This is a 3% improvement in year. The numbers of patients attending has increased by 8.8% since November 2018

Reduce the time for patients arriving by ambulance to be handed over to trust staff	Reduced ambulance delays to our target performance of >80% of patients accepted in less than 30 minutes: Improved from 75% to 84% <20% of patients handed over after 30 minutes: Improved from 25.2% to 16% Having access to a Hospital Ambulance Liaison Officer (HALO) since autumn of 2018. The changes in year have been delivered by • Ensuring patients are on the correct pathway of care to either GP services, Emergency nurse practitioners in the Minor injury area or the Majors treatment area. • Opening a 20 bed clinical decision unit • Recruiting paramedic staff to support effective discharge of patients from ED Continued work with the Emergency Care Intensive Support Team (ECIST) to embed changes to ensure all internal systems and processes are optimised. Realigned the inpatient wards in year to provide additional beds and adjacencies of locations.
Reduce length of stay for conditions outside the benchmark of best practice	Reduced length of stay (LOS) for outlier conditions and variations: Cardiology: LOS 10.3 days (Mar 18) to 8.0 (March 19) General Surgery: LOS 2.9 days (Mar 18) to 2.4 (Mar 19) Respiratory: LOS 8.6 days (Mar 18) to 12.3 (Mar 19). Further work is underway in Respiratory Medicine to identify alternative pathways reviewing how acute and primary care teams can work closer together to support patients with long term conditions. The number of days for a patient to be discharged once medically fit to proceed with ongoing health and social care support has reduced by 40% through working closely with system partners; delivering better than the national standard for performance.
Timely transfer of critical care patients to wards	Transfer of critical care patients to inpatient wards has improved in year Delays of up to 24 hours: reduced from 21-23 per month in April 18 to 15 in March 19 Delays over 24 hours: reduced from 17 per month in April 18 to 5 in March 19

3.2 Improve performance against access standards: Partially achievement

Our Aims	Our Achievements
Deliver RTT incomplete standard by June 2018	Delivery of RTT incomplete performance was achieved by July 2018 after the elective care suspension of 2017/18. This has been maintained for remainder of 18/19 (Achieved)
Consistently deliver the cancer national standards	Delivery of the national cancer was challenging due to workforce issues in key specialities. This has been partially achieved

Extend one stop diagnostic services already available in breast and urology to other key specialities	Extended one stop diagnostic services to specialities managing general surgery patients on a cancer pathway and to vascular surgery.

3.3 Ensure the Trust is inspection ready to obtain a good at the next CQC Trust inspection: Unknown as Inspection outcome expected July 2019

Our Aims	Our Achievements
Deliver progress against the 33 objectives detailed in the CQC report received in 2018 (Must and Should complete items)	Progress is reported monthly. The Trust has delivered 82% of objectives as either implemented and fully embedded in practice, achieved or not graded.
Implement and deliver a CQC preparation plan	Within the Trust progress is shared through monthly Quality & Safety Committee, Patient Safety and Quality Groups to ensure the teams working across our clinical areas are aware of our progress. The reports are also placed on the Trust intranet for people to review. Quality Compliance Improvement group was established to ensure organisational readiness for the next inspection. The Trust has set up peer review inspections of our wards and departments with a wide variety of staff in attendance: Patient panel, our commissioning colleagues and a wide variety of hospital clinical and non-clinical staff. Results are shared with the wards at the end of the inspection and an action plan for improvement is developed if required.
Improve services graded as Requires Improvement	Our Quality first team have worked with staff members to embed a consistent approach to quality improvement across the Trust. This year the Trust shared over 70 completed quality improvement projects led by our staff. As a result of this work the Trust was awarded the national Fab Change champion Trust for the second successive year. The inspection of our clinical services commenced in March. We anticipate receiving the CQC report by mid July 2019, the report will demonstrate areas where we have made an improvement

4.0 Clinical areas and critical functions to be refurbished: Partial achievement

Our Aims	Our Achievements
Complete a clear risk assessed, prioritised and costed list of Estates works plan to be approved by the Trust Board	The 6 Facet Survey was completed (risk assessment). This identified a significant increase in backlog maintenance currently assessed as £105m Eleven significant backlog maintenance projects completed to the Trust's highest estate risks of drainage, refurbishment of clinical environments, work to prevent water ingress to patient areas, security and infrastructure
Bring the orthopaedic fracture clinic back onto the Harlow site	Work is underway to develop the orthopaedic fracture clinic on harlow site expected to be completed by Jan 2020
Refurbishment of our cancer care facilities	Business case will be developed to provide the

	cancer care facilities
Create an onsite education facility	This will be linked with the cancer care facility
Refurbish the lifts	Tender process completed. Work expected to be completed by September 2019
Complete work to upgrade the electricity systems	Tender process to commence in spring 2019
Address regulatory and urgent works as required	PLACE 2018 survey results delivered a significant improvement with the Trust exceeded national averages in a number of areas. Two new Maternity Theatres opened in November 2018 A new ward (Charnley), with 27 additional beds opened in January 2019 The critical care unit is being refurbished to insert additional sinks and one extra isolation area, work expected to be complted by August 2019

CQUIN achievement 2018/19

The Commissioning for Quality and Innovation (CQUINs) payment framework encourages care providers to share and continually improve delivery of care. In 2018/19 the Trust continued delivery of the second year of the 2 year scheme published by NHS England in 2017. This included addressing changes to thresholds where appropriate and ensuring that the scheme continued to support local areas on activities that would contribute to developing integrated care systems.

The increased focus on prioritising Sustainability and Transformation Partnership (STP) engagement to reinforce the critical role of local partners in delivering system wide objectives continued in the 2018/19 CQUINs, with this element being assigned 1.25% of the total financial value for the year. The remaining 1.25% is assigned to clinical quality and transformational indicators which aim to improve quality and outcomes for patients including reducing health inequalities, encouraging collaboration across different providers, and improving the working lives of NHS staff.

Table 16 and 17 detail the actual schemes and their potential financial value. Following submission of quarter 4 data, actual achievement will be confirmed by mid-June 2019.

CCG CQUIN Schemes	**Associated Financial Value (£'000)**	**2018/19 achievement Forecast Out Turn**
1. NHS Staff Health and Wellbeing	**£422**	**67%**
2. Reduction in impact of serious infections-	**£422**	**64%**
3. Improving services for people with MH needs who present to A and E	**£422**	**100%**

4. Offering Advice and Guidance	**£422**	**0%**
5. Preventing ill health by risky behaviours	**£422**	**71%**
STP involvement	**£2,110**	**100%**

Table 16 : CQUIN achievements in 2018/19

NHSE CQUIN Schemes	**Associated Financial Value (£'000)**	**2018/19 achievement Forecast Out Turn**
1. GE3 Meds optimisation	**£158**	**100%**
2. CA2 SACT		
3. NHSE Non Specialised CQUIN Oral Health	**£44**	**100%**

Table 17: NHS England CQUINS in 2018/19

CQUIN Plans for 2019/20

Published guidance for the Commissioning for Quality and Innovation (CQUIN) scheme for 2019/20 introduces a radically different approach to CQUIN. Instead of setting new goals CQUIN will simply highlight evidence based good practice that is already being rolled out across the country, drawing attention through the scheme to the benefits for patients and providers, and in doing so allow those benefits to be spread more rapidly.

CQUIN is being given fresh clinical momentum, whilst prioritising simplicity and deliverability. Broad clinical consensus exists over each included method, following wide engagement with national programmes to select from existing interventions in support of the Long Term Plan.

Alongside the new approach to the selection of areas for CQUIN, the payment rules for indicators within the CCG scheme have been simplified, allowing greater transparency over performance and earnings, based on achievement between lower and upper adoption goals for each supported intervention. 2019/20 is the first year of this new approach, and it is expected that there will be a process of refining and improving from 2020.

In 2019/20, the Trust will be commencing work on the following new schemes:

- Antimicrobial Resistance to improve adherence to national antibiotic guidance in the treatment of lower UTIs and elective colorectal surgery.
- Preventing Hospital Falls to improve older inpatients receiving key falls prevention actions.
- Same Day emergency care which aims for eligible patients to be managed in a same day setting for Pulmonary Embolus / Tachycardia / Community acquired pneumonia patients
- Trauma - to establish the validity of the current reported TARN position, identify potential causes of the deterioration and seek to establish and implement individual action plans with each Trauma Unit to address the areas highlighted.

Our Staff

Without doubt, the Trust's staff are our greatest asset, regardless of their role. In 2018 the Care Quality Commission rating for staff caring was **good**; the inspectors witnessed staff delivering care that was compassionate, involving patients in decision making and providing good emotional

support to patients and those close to them. The Trust recognises the value of a committed, dedicated workforce and over the last year has continued to support individuals to develop and improve with the following approaches:

Education - Learning, Leadership and Development

To deliver sustainable and quality services, our staff need to be well trained, professional and valued. In 2018/19 the Trust launched Our People strategy which describes the steps we are taking to develop a diverse and inclusive culture where staff feel engaged, have scope to grow and develop, are empowered to transform how services are provided and committed to delivering outstanding care. We support our staff to ensure Core (Statutory/Mandatory) training compliance is maintained at our target rate of 90%, and we will continue to offer a diverse range of delivery options, and work with our STP partners to develop a training passport. We have continued to strengthen and grow our Resuscitation training provision to include more advanced and specialist courses (both internally, and for external income generation). We continue to make effective use of our funding and with support from Health Education England, for the provision of Continued Professional Development (CPD).

Organisational Development and Engagement

An Organisational Development and Engagement Strategy is being developed and will include

- A Staff Engagement Steering Group, plus local groups to help create a feedback loop to improve culture and leadership, linked to improvements from our 2018 Staff Survey results.
- Staff Appraisal – Pay Progression - Talent Management/Succession Planning – An updated appraisal scheme with improved focus on staff wellbeing.
- Supporting staff to achieve and maintain 90% compliance of our staff having an up to date appraisal.
- A Behaviour Charter which will include updated values and behaviours workshops.
- Local and trust-wide awards/Long Service Awards
- Staff Council to generate and test staff ideas

Unsung hero of the year – Winner

Carol Jordan (Associate Theatre Practitioner)

Individual of the year – Winner

Dr Pratik Solanki (Senior Clinical Teaching Fellow)

Learner of the year - Winner

Eva Nkansah (Lead biomedical scientist)

Living the values: Respectful – Winner

Curtis Beeson (Head Porter)

Management, Leadership and Team Building

Strong management, leadership capabilities and team working across all levels and areas are required in order to deliver the size of the agenda facing the Trust. During 2018/19 we have supported over 600 staff to access a wide range of internal and external leadership and management development opportunities. We also welcomed 3 new NHS Graduate management scheme trainees to the Trust.
Moving forward, a Leadership and Management Development steering group will be established to develop a leadership framework, with a range of learning opportunities to support this, including:

- Unconscious bias sessions for all managers/leaders
- Leadership and Management Development programmes and short courses
- Team Building/Team Development
- Coaching/mentoring
- 5 o'clock leadership Network

Equality and Inclusion Steering Group (EISG)
The Trust established an equality and inclusion steering group in April 2017 which has gone from strength to strength throughout 2018 with champions for each of the 9 protected characteristics. The EISG has worked to agreed terms of reference and has contributed to a number of successes including:

- New Trust policy on equality and inclusion
- Production of a new equality and inclusion statement
- Launch of Equality and Inclusion Charter
- Co-ordination of Black History Month celebration (2x)
- Production of an equality and Inclusion calendar – to make reference and observe were necessary religious and diversity events to represent our diverse workforce
- Contribute to and support Equality and Inclusion actions in relation to the staff survey results
- Appointed equality and inclusion champions for all nine protected characteristics
- Launch of the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning plus (LGBTQ+) network
- Launch of the Black, Asian and Minority Ethnic (BAME) network
- Steering group members and Equality and Inclusion champions have completed the Managing Equality and Diversity ILM Level 4 Award Accredited Programme

The work of the Equality and Inclusion Steering Group has provided a solid foundation on which to build and with an increased focus on inclusive leadership there is confidence that the Trust will continue to commit to learning and to being the employer of choice. We will continue to focus on inclusive leadership throughout 2019/20.

Multi-professional Education
The Trust continues to support non-medical pre and post registration students in partnership with affiliated Universities; providing practice placements for student nurses (Adult, Child and Mental Health), midwives, Operating Department Practitioners ODPs), a range of Allied Health Practitioners (AHPs) and staff on Apprenticeship pathways (Associate Practitioners, Training Nursing Associates).
All students will continue to be supported by trained mentors, practice educators and practice facilitators as the Trust implements the new Nursing Midwifery Council (NMC) standards, due to commence in September 2019.
Apprenticeships, Vocational Education and Schools/College Liaison

The Trust is developing a new apprenticeship strategy, implementation plan and policy which will be launched during 2019. This will be overseen and directed by a new apprenticeship and student steering group, aiming to maximise our return on investment from payments made to the statutory Apprenticeship Levy. The Trust aims to achieve our Public Sector apprenticeship target (2.3% of workforce) by 2020. Work continues on developing existing apprentices; identify existing roles and exploring new posts that can be offered as new apprenticeship opportunities. To date the Trust has:

- Supported and facilitated 40 apprenticeships, supporting managers with workforce planning to enable inclusion of these roles.
- Provided training and assessment for achievement of the Care Certificate to all newly appointed Health Care Assistants, Maternity Care Assistants and Theatre Practitioners.
- Supported and facilitated Maths and English skills for staff via Harlow College
- Supported individuals and teams with career pathway planning

With the aim of identifying the workforce of tomorrow, the Trust has improved links with local education; creating a presence in schools as students consider their career options. Being present when careers are considered and maintaining supportive links has been achieved through a range of approaches

- Coordination and attendance at local careers fairs and events, reached out to over 2800 local young people.
- Coordinate and deploy the Trusts team of 17 Health Ambassadors
- Support Further Education colleges and schools with the delivery of their health related curriculum
- Work with local primary schools on their programmes to raise aspirations and outcomes for their pupils
- Work in collaboration with local organisations to support local young people, providing 183 work experience placement from approximately 600 requests.
- Provide programmes for potential Medical students including mock interview practice with FY1's.

Medical Education

The Trust welcome approximately 120 new trainee doctors of all grades and specialties who arrive on placement to from Health Education England each year. We continued to build on the improvements to induction and training implemented in 2017/18. Our new Junior Doctors committee will continue to help us to direct this work to ensure that trainee experience is excellent. We have improved our pastoral/emotional support to colleagues in training as part of our ambition to become a placement provider of choice.

Our first seven Student Physicians Associates joined the Trust in 2016 and we have successfully employed two from this cohort. In 2017 we welcomed a second group of six Student Physicians Associates and all six were offered employment opportunities within the Trust commencing August 2018. In September 2018 we welcomed a further group of eleven Student Physicians Associates who are currently rotating through various specialties within the Trust. We look forward to further developing this successful programme in 2019/20.

Staff Survey – 2018 Results

The annual NHS Staff Survey and the quarterly Staff Friends and Family Test are crucial barometers of how our staff view their workplace. The feedback is useful in helping us to highlight improvements that will make the hospital a better place to both work and be treated.

The results reflect the continued good progress we have made over the past twelve months to improve the quality of care we provide. However, as we already know, there is more we need to do to improve the experience of people working here and we are committed to doing exactly that.

We are now amongst the best performing Trusts in the country for:

- The quality of staff appraisals
- Support given to staff by immediate managers
- Our safety culture

What staff told us has improved:

- Staff are more satisfied with the recognition they receive for good work and feel more valued
- Staff are more satisfied with their level of pay
- Many staff agree that the Trust acts on concerns raised by our patients/service users and uses feedback from patients/service users to make informed decisions
- Most staff feel that they have been supported to receive training, learning or development identified in their appraisal
- More staff continue to positively rate their experience of their appraisal, including discussion of our Trust values and how valued they felt
- Over half of our staff feel that they have opportunities for flexible working patterns
- Many staff see care of patients being the Trust's top priority
- More staff would recommend the Trust as a place to work and a place to receive treatment
- More staff feel that communications between senior managers and staff is effective
- More staff feel that they are treated fairly when involved in an error, that the Trust takes action to learn from incidents and makes changes.

What we need to improve

- Availability of adequate materials, supplies and equipment to support staff in their roles
- Having enough staff at the Trust
- Staff working additional hours
- Some staff experience violence, harassment and abuse from staff, patients and visitors which is unacceptable
- Continued focus on improving staff health and wellbeing, in particular around stress management, and feeling pressure to come into work when not well enough

The Trust is committed to making further improvements across all of these areas with the overarching aim of improving staff satisfaction. This is particularly important if we are to deliver our quality improvement plan, which focuses on enabling outstanding care for *all* of our patients, *all* of the time.

Staff feedback from one member in year stated

> *"I have been working in the Trust for over 18 years. I was part of the first cohort of overseas nurses which was scary at first, but the staff at the Trust are incredibly friendly and helped me a lot. We offer many opportunities for our staff to grow and develop their career. As a trust, everyone works hand in hand to achieve our goals."*

Staff Friends and Family Test results 2018/19

This national survey is made available to all staff employed in the organisation on a quarterly basis. Two questions are asked in quarter 1, 2 and 4, however slightly different questions are asked in quarter 3 as part of the annual national staff survey. The questions are:

1. How likely are you to recommend this organisation to friends and family if they needed care or treatment?
2. How likely are you to recommend this organisation to friends and family as a place to work?

Results for 2018/19 show continued progress, and for both questions we met the Department of Health (DoH) targets in all 3 quarters measured.

Question	DoH Target %	Q1 2018	Q2 2018	Q4 2019
1	67%	78%	76%	75%
2	61%	65%	61%	62%

Table 18: Staff family and friends results

The organisation is monitoring the results of this feedback, and linking it to our national staff survey results, and will continue to progress improvements for the benefit of our patients and staff.

The Princess Alexandra Hospital NHS Trust

Research Development and Innovation

Active Studies 2018/19	
COMMERCIAL	ACADEMIC
27	78

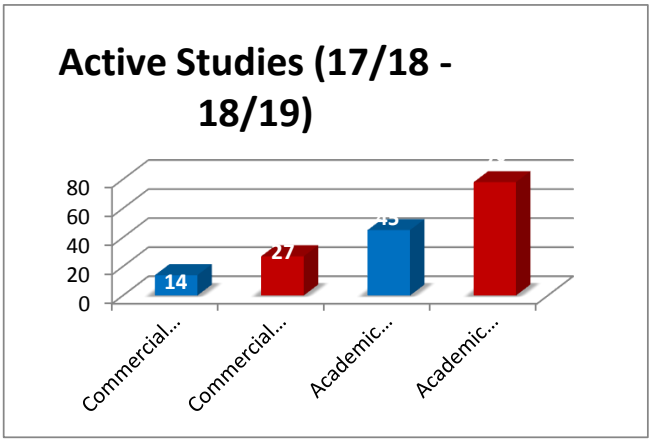
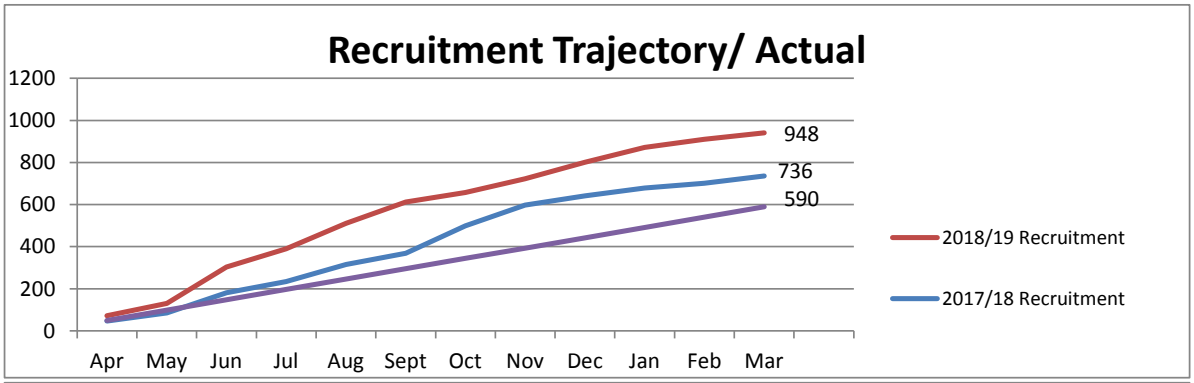
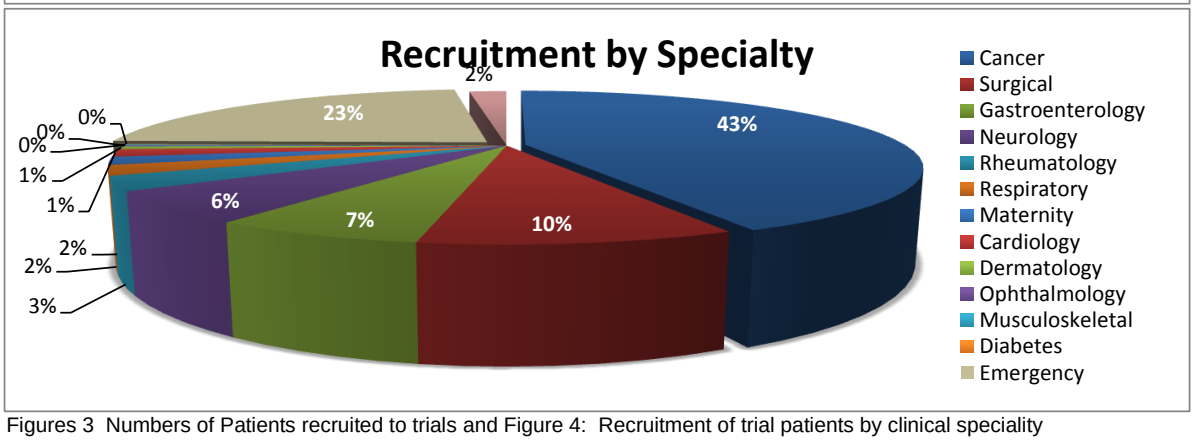


Figure 2: Active research studies

Recruitment Target 2018/19

In the beginning of 2018/19, it was agreed with North Thames Clinical Research Network that The Princess Alexandra Hospital NHS Trust would recruit a target of 590 participants into National Institute for Health Research (NIHR) portfolio adopted trials. Nearing the end of the financial year, the number of participants recruited into research is 948 as of 27th March 2019 see Figures 3 and 4





Figures 3 Numbers of Patients recruited to trials and Figure 4: Recruitment of trial patients by clinical speciality

The Princess Alexandra Hospital NHS Trust

Incident management, sharing the learning and safety improvement

Patient safety is a priority and we continuously work to ensure that incidents are managed effectively and most importantly that we learn and share the improvements from them.

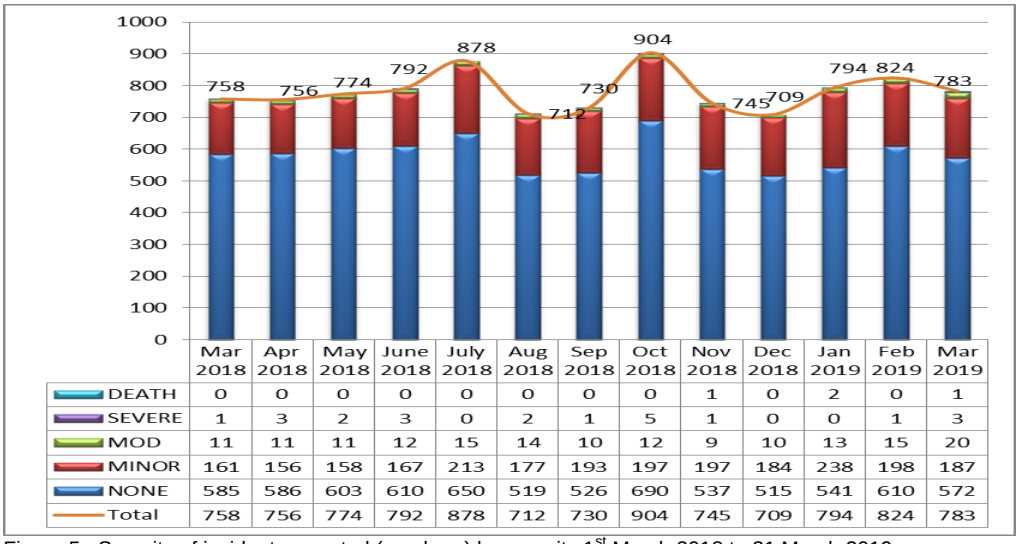
A patient safety incident or adverse incident is defined as 'any unintended or unexpected incident which could or did lead to harm for one or more patients receiving NHS funded care'. This includes all terms such as adverse incidents, adverse events and near misses, where an incident was recognised and averted.

- During the year April 2018 to March 2019, a total of 9371 incidents were reported on the Trust's incident management system (Datix), as having occurred in PAH. This is a 2% reduction when compared with 9580 over the same period in the previous year. The Trust is reporting, on average, 781 incidents per month, this demonstrates a good reporting culture which is deemed a positive step when coupled with low levels of patient harm. This developing positive culture was evidenced in our staff survey (2018) which demonstrated inmprovement in the following two key metrics: many staff agree that the Trust acts on concerns raised by our patients/service users and uses feedback from patients/service users to make informed decisions, secondly more staff feel that they are treated fairly when involved in an error, that the Trust takes action to learn from incidents and makes changes.

The majority of incidents reported were low or no harm incidents (9186) representing 97.99% of the total incidents for this period. The remaining 188 incidents (2.01%) resulted in either moderate or severe harm. There were 163 moderate harm incidents (1.7%); a reduction from 3.9% in the previous year. There were 25 incidents were the harm was assessed as severe (0.27%).

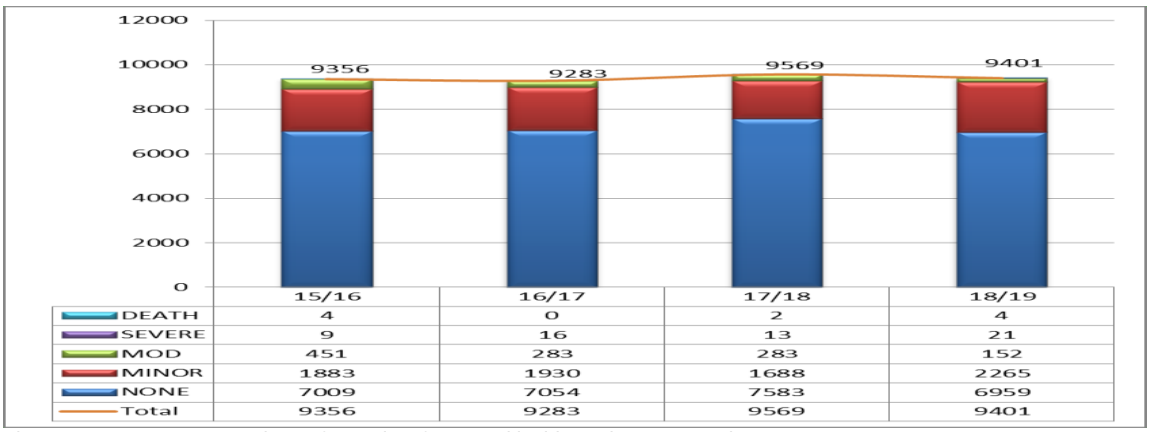
All these incidents are reported to the National Reporting and Learning System (NRLS) to enable learning and comparison with similar sized organisations to occur.

We have been working hard to ensure that staff receive feedback following the closure of an incident; currently we are achieving this for 80% of all incidents.



	Mar 2018	Apr 2018	May 2018	June 2018	July 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
DEATH	0	0	0	0	0	0	0	0	1	0	2	0	1
SEVERE	1	3	2	3	0	2	1	5	1	0	0	1	3
MOD	11	11	11	12	15	14	10	12	9	10	13	15	20
MINOR	161	156	158	167	213	177	193	197	197	184	238	198	187
NONE	585	586	603	610	650	519	526	690	537	515	541	610	572
Total	758	756	774	792	878	712	730	904	745	709	794	824	783

Figure 5: Severity of incidents reported (numbers) by severity 1st March 2018 to 31 March 2019



	15/16	16/17	17/18	18/19
DEATH	4	0	2	4
SEVERE	9	16	13	21
MOD	451	283	283	152
MINOR	1883	1930	1688	2265
NONE	7009	7054	7583	6959
Total	9356	9283	9569	9401

Figure 6: Four year comparison of severity of reported incidents (2015 – 2019)

Themes from Serious Incidents (SIs)

There have been 39 serious incidents (SIs) at the Trust during 2018/19 declared through the Strategic Executive Information System (StEIS) and reported externally in year. This excludes SIs that have been de-escalated by the CCG as the investigation demonstrated that there were either no care or service delivery problems or following the discovery of further information, they were found to not meet the SI threshold. The SI framework encourages discussion and review of incidents on a case by case basis including a discussion on the level or degree of harm caused.

The Trust ensures that an open and honest review and discussion of all SIs takes place through the Serious Incident Group (SIG). The group is chaired by either the Chief Medical Officer or the Director of Nursing and is scheduled every day from Monday to Friday to limit any delays and to enable open and frank discussion whilst the details of the incident are fresh in the minds of our staff.

All potential serious incidents are presented and discussed to identify whether they meet the national SI framework requirements. The most frequently reported SI topics during this reporting period were

- Treatment delay meeting SI criteria (14 incidents)
- Diagnostic delay meeting the SI criteria (4 incidents)
- Maternity/obstetric incident meeting the SI criteria for mother and baby (4 incidents)

Never Events

There were no Never Events in 2018/19. The last reported never event was 2015/16

Sharing the Learning Events

The Trust's Patient Safety and Quality Teams worked with relevant experts across the Trust to organise and facilitate four sharing the learning events during 2018/2019:

- **12 April 2018:** Focus on Sepsis and Acute Kidney Injury – presentation on Blood Cultures in Sepsis, a Simulation Session and two interactive games to support learning.
- **11 July 2018**: Two audit presentations – Negative Appendectomy Rate and Clerking Standards. A review of Mortality by the Chief Medical Officer and a presentation on Consent and Legal Cases by the Trust's Legal Services Manager
- **12 October 2018**: Presentations from each of our healthcare groups covering: Serious Incidents, Anticoagulation, Neutropenic Sepsis, Gastrointestinal Bleeds, Morbidity and Mortality,

CQC Musts and Should completed actions. The Quality First Team presented Adopting a Quality Improvement approach to embedding and sustaining change.

- **10 January 2019**: A Journey from a Quality Initiative to Research to Intellectual Property with external presenters as well as presentations from Quality First and the Trusts Library Team.

Being Open and Root Cause Analysis (RCA) Investigation Skills Training

The Trust continues to invest in Root Cause Analysis (RCA) investigation training as well as supporting staff through the provision of training on Being Open and Duty of Candour conversations with patients and families. In 2018/19 the Trust provided Being Open/Duty of Candour training for 10 staff and Root Cause Analysis training for 64 staff.

Clinical Effectiveness

The Trust is required to participate in National audits to ensure that we are taking every opportunity to learn and improve. During the period 1 April 2018 to 31 March 2019, we participated in 94% of the national clinical audits and 100% of the eligible national confidential enquiries (NCEPOD Studies), applicable to NHS services that the Princess Alexandra NHS Trust Hospital (PAHT) provides.

The national clinical audit and NCEPOD Studies that the Trust participated in during 2018/19 are as indicated in tables 19 and 20.

Table 19: National Clinical Audits in which the Trust is eligible to participate

Name	Participation	% Cases or Number submitted
Adult community acquired Pneumonia	Yes	Data Collection closes 31 May 2019.
Bowel Cancer (NBOCAP)	Yes	164 submitted (As reported in 2018 Annual Report).
Cardiac Rhythm Management (CRM)	Yes	176 cases submitted (18/19).
Case Mix Programme (CMP)	Yes	315 cases submitted (18/9)7 cases
Diabetes (Paediatric) (NPDA)	Yes	Data collection closes 31st May 2019.
Epilepsy 12	Yes	Data collection running between 2018-2020.
Elective Surgery (National PROMs Programme)	Yes	607 cases submitted
Falls and Fragility Fractures Audit programme (FFAP) – Inpatient Falls	Yes	No cases met the criteria for submission
Falls and Fragility Fractures Audit programme (FFAP) – National Hip Fracture Database	Yes	356 cases submitted (18/19).
Feverish children	Yes	139 cases submitted (18/19).
Inflammatory Bowel Disease (IBD) programme	No	
Learning Disability Mortality Review Programme	Yes	100% (11 cases)
Major Trauma Audit	Yes	200 cases submitted between 01/01/2018 and 01/01/2019.
Maternal, New-born and Infant Clinical Outcome Review Programme	Yes	100%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	100%
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Data collection closes 25th May.

National Audit of Breast Cancer in Older People	Yes	100%
National Audit of Dementia	Yes	100% 64 cases submitted (during 2018)
National Cardiac Arrest Audit (NCAA)	Yes	100%
Name	**Participation**	**% Cases or Number submitted**
National Asthma Chronic Obstructive Pulmonary Disease (COPD) Audit programme– Adult Asthma Secondary care	Yes	Continuous data collection started Nov18
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) – Chronic Obstructive Disease – Secondary Care	Yes	Apr-Sept18 106 cases submitted Oct18-Mar19 data submission in progress
National Clinical Audit for Rheumatoid and Early Inflammatory Audits	Yes	Data collection closes 08/05/2019.
National Comparative Audit of Blood Transfusion - Management of massive haemorrhage	Yes	100%
National Comparative Audit of Blood Transfusion - Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	No	Rarely transfuse these products Trust has opted out of participation.
National Diabetes (adult): Pregnancy in diabetes	Yes	100%
National Diabetes Audit : Foot care	Yes	100%
National Diabetes – Adults – NaDIA-Harms-reporting on diabetic inpatient harms in England	No	
National Diabetes – Adults – NaDIA – Inpatient – reporting data services in England and Wales	Yes	40
National Emergency Laparotomy Audit (NELA)	Yes	71 cases for 17/18 18/19 submission in progress – lock down Jan 2020
National Diabetes Audit National Core Diabetes Audit	Yes	Data submitted via Primary Care
National End of Life Care Audit	Yes	100%
National Heart Failure Audit	Yes	Data submission in progress
National Joint Registry (NJR)	Yes	91% (2018)
National Lung Cancer Audit (NLCA)	Yes	Data submission in progress (due to complete submission by end of May)
National Maternity & Perinatal Audit	Yes	100%
National Neonatal Intensive and Special Care (NNAP)	Yes	100%
National Ophthalmology Audit	Yes	40.1% (16/17 Data as recorded in report published 2018)
National Vascular Registry	Yes	62 Cases
Non-Invasive Ventilation - Adults	Yes	Data collection closes June 2019.
Oesophago-gastric Cancer (NAOGC)	Yes	86 submitted Data submission in progress
Prostate Cancer	Yes	Data submission in progress)

Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) – Antimicrobial Consumption	Yes	100%
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) – Antimicrobial Stewardship	Yes	100%
Seven Day Hospital Services Self-Assessment Survey	Yes	100%
Surgical Site Infection Surveillance	Yes	589 cases submitted for 2018
Serious Hazards of Transfusion	Yes	100%
Vital Signs in Adults (care in emergency departments)	Yes	142 cases submitted.
VTE Risk in lower limb immobilisation (care in emergency departments)	Yes	39 cases submitted

Table 20: Summary of NCEPOD studies that the Trust was eligible to enter data for

NCEPOD Study Title	**Participation**	**% Cases Submitted**
Cancer in Children, Teens and Young Adults	Yes	No applicable cases
Perioperative Diabetes	Yes	No applicable cases
Pulmonary Embolism Study	Yes	100%
Acute Bowel Obstruction	Yes	100%

The reports of a number of national clinical audits were reviewed by PAH during 2018/19. Examples of action taken to improve the quality of healthcare provided can be found in Table 21

Table 21: Examples of actions / key successes taken to improve the quality of healthcare relating to National Audits

Name of national audit (Quality Accounts)	**Actions completed / achievements**
Fractured Neck of Femur	• Pain relief is provided to the majority of patients within an hour of arrival. • 85% achieved whereas the national median is 30% • Aim to improve time to assessment.
National Audit of Breast Cancer in Older People (NABCOP)	• Edmonton frailty scale already in use to assess patients over 75yrs and to guide decision making and referral to other support services. • PAHT is ahead of the Audit but will continue to focus on assessing the needs of patients over 75.
National Comparative Audit of Blood Transfusion programme - Management of massive haemorrhage	• Currently awaiting completion of interface electronic Blood tracking (collection process only), • Introduction of Lab checklist to assess the necessity, urgency of transfusion and the risk of potential overload (weight & consent, Hb transfusion triggers) • MBL Care Bundle posters are displayed in key areas and MDT rooms, Adult MBL call activated (2222). • Training:- a) Blood groups and RhD included in training b) TACO checklist included in training c) Bedside checklist lanyards issued at Registered BT Training sessions d) Increased compliance in BT Training from 29% in Jan 2017 to 89% in Feb 2019 e) Blood Link trainers trained to promote correct transfusion processes • Transfusion Prescription Pathway in draft form (TACO checklist will form part of the pathway)

	• Rationale and prescription guidance displayed on JPAC for Medical staff when requesting Beriplex and Anti-D • Pursuing full Electronic Blood Tracking System. • Continue to develop Iron Service. • Complete new anti-D pathway.
Myocardial Ischaemia National Audit Project(MINAP)	• Development of the ACS pathway. Using NICE guidelines to standardise practice, and give the best evidence based care to patients.
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	• This is monitored continuously and PAHT continues to have a low incidence of hospital apportioned C.diff and MSSA, and at the time of writing this report has had no MRSA Bacteraemia since July 2014 • Ongoing data collection and sharing of results both in and out of the organisation.
Serious Hazards of Transfusions (SHOT)	• Massive Blood Loss Care Bundle posters are displayed in key areas and MDT rooms, Adult MBL call activated (2222). • Placed the Massive Blood Loss Care Bundle on the Trust Drs App • MBL Care Bundle copyrighted and presented to the Regional Transfusion Committee and Regional Trauma Network. Also presented to The Association for the Study of Medical Education (ASME) entitled “An interprofessional model to implement Massive Blood Loss Guidelines” • January 2018 we introduced Paediatric Trauma and Catastrophic bleeding SIM training • Promote SIM training • Engaging with Air Ambulance regarding trauma and major haemorrhage events to support earlier interventions in the pre hospital care setting such as; Blood on Board, reversal agents for anticoagulants and patient warming and training in blood transfusion.
National Audit of Care at the End of Life (NACEL)	• "Tea trolley" approach to teaching sessions has been completed across the wards to highlight when documentation should be used for patients approaching End of Life. • 2 new documents have been introduced to assist staff for a "daily clinical review" sheet and a "care after death" sheet
Learning Disability Mortality Review Programme (LeDeR)	• All deaths of people with learning disabilities have been reported to LeDeR in a timely manner in accordance with the requirements. • All deaths are reviewed locally by a consultant as part of our mortality review • The Trust has implemented a revised DNACPR form and Treatment Escalation Plan (TEP). with micro-teaching sessions covering the completion of the TEP forms. • End of life training is covered by the Learning Disabilities Team within their Clinical Update and Induction Programme
Diabetes (Paediatric) (NPDA)	• Good compliance with majority of key care processes inclusive of BMI, BP, Hba1c measurements. Benchmarked favourably against

	national standards.
Neonatal Intensive and Special Care (NNAP)	• Improvement on the number of babies on mother's milk at discharge, consultation with parents and parents on ward rounds.
National Maternity & Perinatal Audit	• High BMI Anaesthetic Clinic in place • Local Policy in place → All women 40 years or over are offered a Consultant appointment • Continence Specialist Midwife in post. • All PPH's >2L are reviewed and required actions taken by the Consultant on call during that period. All cases are summarised and presented at Multi-disciplinary Audit every 6 months • All term babies under 2.5Kg are reported & monitored on the monthly Maternity Dashboard • BFI Midwives in post. Skin to skin contact is regularly audited by the BFI Lead Midwife • PAH has a co-located Midwifery Led Birthing Unit.
National Audit of Dementia	• There was a notable improvement in the following areas; 1. Discharge planning documentation and discussions more robust. 2. Improved awareness of delirium and recording of assessment. 3. Nursing documentation particularly recording of risk assessments
National Diabetes Audit - Foot care	• The launch of the Diabetes Foot care MDT in November 2017
National Diabetes Audit - Inpatient Audit (NaDia) -reporting data on services in England and Wales	• Yearly participation in audit to benchmark our service complete. Introduction of new Diabetes IP service
National Diabetes Audit National Core Diabetes Audit	• New Out Patient proforma developed that records BMI and smoking status as well as other key care processes • All patients that attend diabetes clinic to have urine microalbumin test completed (unless completed in last year), • Offer structured education to all patients that attend diabetes clinic
Oesophago-gastric cancer (NAOGC)	• PAH meets targets of 100% of patients discussed, all HGD identified and discussed, lower rates of diagnosis through emergency admissions and recommended targets for chemotherapy. • Through Weekly PTL meetings and monthly Cancer Board meetings and breach reports, the pathways and processes, as a whole and for individuals are under constant scrutiny
Adult Community Acquired Pneumonia	• New pathway for management of Pneumonia has been developed.
Lung cancer (NLCA)	• Fast track pathway audit has improved pathway management with no significant internal breaches. • Highlighted delays in PET scans have been addressed • New EBUS service at PAH has shortened wait for this test and reduced travel for patients. • Recorded high workload for 2 Lung Clinical Nurse

	Specialists has led to recruitment of 3rd.
Name of national audit (Quality Accounts)	**Actions completed / achievements**
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)- Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	• Trust is meeting the BPT (Best Practice Tariff) and has made significant improvements in care and care bundles.
Bowel cancer (NBOCAP)	• Overall improvement noted between 2015-16 and 2016-17. Above national average for Pre-treatment TNM. Higher than national average for recording performance status. This is a huge improvement on the previous year. • 3rd Clinical Nurse Specialist has been recruited

The reports of 44 local clinical audits were reviewed by PAHT during 2018/19. Examples of actions completed / planned / achievements in the quality of healthcare provided can be found in Table 21

Table 22: Examples of actions completed / planned / achievements following review of local clinical audit reports

Local audit	**Actions completed / planned / achievements**
Re-Audit Suspected Neutropenic Sepsis 'Door to Needle Time'	Significant improvements have been made in the recognition of patients at risk of neutropenic sepsis & subsequent prescribing of antibiotics within one hour of presentation to ED.
Audit on colorectal cancer cases reported in cellular Pathology	The Pathology department at the Princess Alexandra Hospital (PAH) meets and exceeds the standards recommended by the College in all of the areas:
Re-audit Audiology follow up after meningitis	Re-instated and relaunched of the checklist in line with NICE guidance
The Voice of the Child	1. Improved record keeping to demonstrate the voice of the child /young person is being incorporated during assessment 2. Involvement of other practitioners who know the child 3. Share the learning 4. Re-audit planned
Inpatient Catheter insertion	1. Indications for insertion written down and mostly appropriate/valid. 2. Good percentage (78%) of patients had IP TWOC. 3. 89% of patient discharged had documentation on TTA;s
Management of patients with cutaneous CSS re-audit to ensure compliance with BAD guidance	In the first cycle of the audit, compliance with British Association of Dermatologists guidance for cSCC management was assessed and areas for improvement identified. The use of stickers with tick boxes to ensure compliance was introduced. In the re-audit the effectiveness of this intervention was checked. The use of stickers has significantly helped in increasing compliance with BAD guidelines. Providing patient's examination and information leaflet as well as documenting SCC size and prognosis were improved.
Alcohol Audit	Use of new alcohol assessment form resulted in sufficient positive data being obtained. Amount of positive cases recorded has increased by 14% from previous audit.
Local audit	**Actions completed / planned / achievements**
Early recognition of dementia in the high risk patient	The following actions have been implemented • Delirium to be recognised as an organ failure and a data base made that is easily accessible

	• As part of the National Audit of Dementia, 78 patients notes were reviewed which has highlighted a significant improvement in delirium screening and assessment • Delirium awareness week was held in July18 • Delirium conference held on 5th November • Delirium training now being explored as part of mandatory training but has become part of induction training, preceptorship training, Band 6 development programme, Band 7 development programme, junior Doctors teaching and Consultant grand round. • Delirium resource folders to be developed for ward areas • Delirium care plan to be produced • Delirium project group established supported by Quality First team • Dementia CNS to visit other areas of best practice to network and explore ideas for further improvement • Delirium screening tools/paperwork under review • Delirium Policy/pathway under review
Procedural Sedation in the Emergency Department	A standard driven policy and a procedural sedation proforma have been introduced for adult patients requiring Procedural Sedation in the ED that has been completed in all cases. The audit demonstrated the ownership of procedural sedation in ED by Emergency Medicine Physicians, with no complication or adverse event resulting from procedural sedation, including oxygen desaturation, apnoea, and cardiac arrest or absent pulse. Comparing the evidence against meeting quality standards recommended by the Royal College of Emergency Medicine, we notice significant improvement for each standard.

Information and Technology Achievements

In 2018/19 our NHS Wi-Fi for Guests/public/staff was extended into St Margaret's and Herts and Essex Hospitals. Patients no longer need to rely on pay for TV/Internet access as they are able to use their own devices across the Trust. Our NHS Wi-Fi is accessed by 19,697 unique users and consumes some 8.3 Terabytes of data every month.

During the year we have updated our radiology and imaging solutions. This ensures that we have the fastest solution possible for our clinicians to retrieve the images and improve the reporting turnaround time so as to improve patient safety, quality and outcomes.

We have implemented an Electronic Prescribing and Medicines Administration (EPMA) solution across the Trust. Electronic carts have been made available in all areas to enable clinicians to complete the prescribing process at the bed side making the most of the inbuilt patient safety features.

We have continued to proactively secure our technical infrastructure and have engaged in five NHSDigital Cybersecurity pilot schemes. Members of the Information Technology (IT) team have attended external Cybersecurity training, achieving accreditation.

We successfully deployed a replacement order communications solution to facilitate the electronic ordering of pathology, radiology and cardiology tests. The solution is being rolled out into Primary Care and Community.

The My Care Record interoperability programme has continued to deliver benefit to clinicians and patients by providing access to the patient's electronic GP and hospital record, when consent is

provided. A successful pilot of the patient's hospital events data has recently concluded and pilots with Essex County Council Social Services currently being documented.

Clinical reporting dashboards have been developed around antibiotic prescribing and the timeliness of observations on the wards. The information provided has supported discussions with clinical staff about different ways of working and transforming the way we work to benefit our patients.

Nursing and Midwifery Recruitment and Retention

The challenges associated with recruitment of nurses against a backdrop of a national shortage are well documented nationally and remain a focus for the NHS and PAH.

In 2018/19 we reviewed our recruitment plans to ensure that we meet our current and future nursing workforce gaps which currently sit at 25% of all nursing posts. The recruitment plan makes opportunity of all routes including local, national and international programmes. We have strengthened our support of the overseas programme and have condensed our very successful Objective Structured Clinial Examination (OSCE) process used to assess an individuals knowledge that we use to supports our overseas nurses practical training course for their nursing registration from 3 months to 4 weeks. We have also introduced 2 Clinical Practice Educators to support new recruits in practice when qualified to ensure our nurses make the transition to UK hospital nursing seamlessly.

We are continuing to support home grown students into nursing, working closely with our partner University providers at the University of Hertfordshire, Anglia Ruskin and the University of Essex to increase the number of practice placements for student and midwifery students as well as developing the new nursing degree apprenticeship programme. We are also supporting staff to undertake top up programmes and in 2019 we are supporting 18 Assistant Practitioners to undertake the 20 month top up programme to become registered nurses. We continue to offer student nurses and midwives in placement with the Trust automatic employment providing they meet all of the standards required in their training and placement assessments.

The numbers of student nurses who take up a permanent post at the hospital on qualification has historically been less than 25% and so we are working on how to increase the number. One of the ways we are doing this is by ensuring the balance of numbers of placements for student nurses is higher at local universities rather than those further away as we know students are more likely to take up a permanent post closer to home. We are also in the process of recruiting a Lead Nurse for Recruitment and Retention whose role will be to maximise the opportunities and best practise actions that will recruit and retain nurses to the Trust. The post holder will also work closely with the Associate Director of Nursing for Medicine who has been part of the NHSI retention support programme to ensure we maximise the learning from this national work stream.

In May 2019 the first of the new nationally introduced, Nursing Associate's will qualify and become registered practitioners with the NMC. At PAH we have 3 trainees due to qualify in May in this new role, with a further 14 in training. The new role will look after a cohort of patients under the delegation of registered nurses but have extended skills in assessment and reviewing plans of care as well as undertaking clinical skill and giving some medications. Further work will continue with clinical areas and undettake Quality Impact Assessments to review where the Nursing Associate will have the most positive impact on the skill mix of the nursing team and where the new roles will be best deployed.

We continue to offer flexibility to nurses who want to expand their experience whilst remaining at PAH with rotation programmes. These are tailor made for individual nurses based on the type of clinical experience they would like and are in addition to the offer we have to any nurse already employed in the Trust who can transfer into other vacant posts providing they can demonstrate their compliance with all standards of practice in the area where they are working. As we start to fill our vacancies formalising rotation programmes will be paramount.

Planned Care Standards

The Princess Alexandra Hospital NHS Trust (PAH) continues to deliver the Referral To Treatment (RTT) and Diagnostic national standards consistently. The delivery against the National Cancer Standards in 2018/19 has been challenging, with only intermittent delivery in Q3 and Q4.

Referral to Treatment (RTT)

Performance against the RTT incomplete standard has been recovered following the national elective care suspension with the final 52 week waiter treated in Feb 2019, due to patient choice.

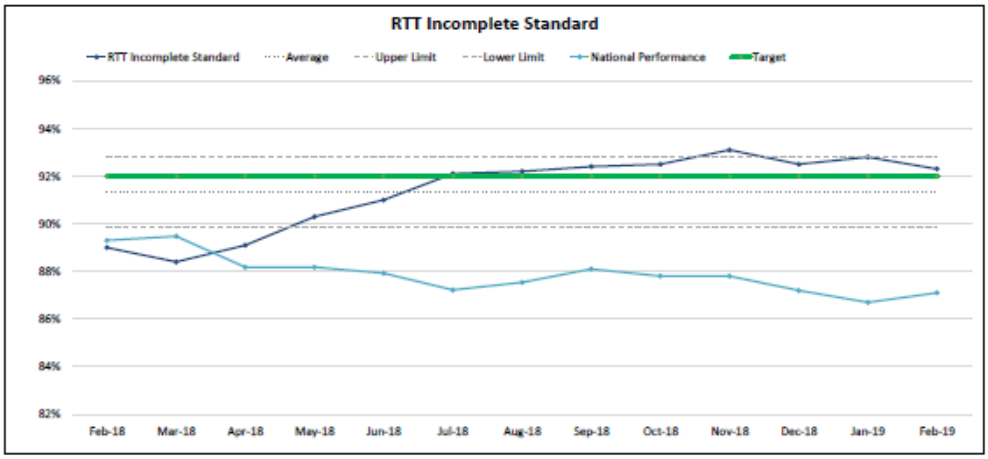


Figure 7: Referral to treatment performance

Cancer

Delivery of the National Cancer Standards was challenging during 2018/19 due to workforce issues across the medical workforce of key specialities. The Trust continues to be committed to the delivery of all National Cancer Standards and plans to have returned to consistent delivery in Q4 2018/19 and maintain delivery in 2019/20.

Performance and Service Development is monitored via the Trust's performance governance structure via the Access and Cancer Boards.

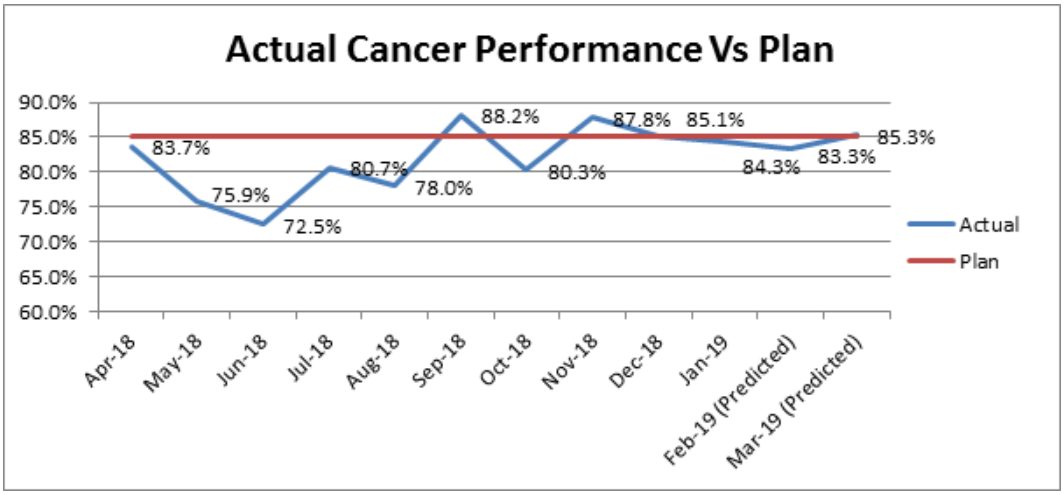


Figure 8: Cancer performance

Diagnostics Performance

The Trust has achieved the 99% Diagnostic Wait target every month for the last 4 years. This means that over 99% of all patients waiting for a diagnostic examination have this completed inside 6 weeks of the referral being made. We are proud of consistently maintaining this performance despite a 5% growth in demand, year on year.

Diagnostic Performance

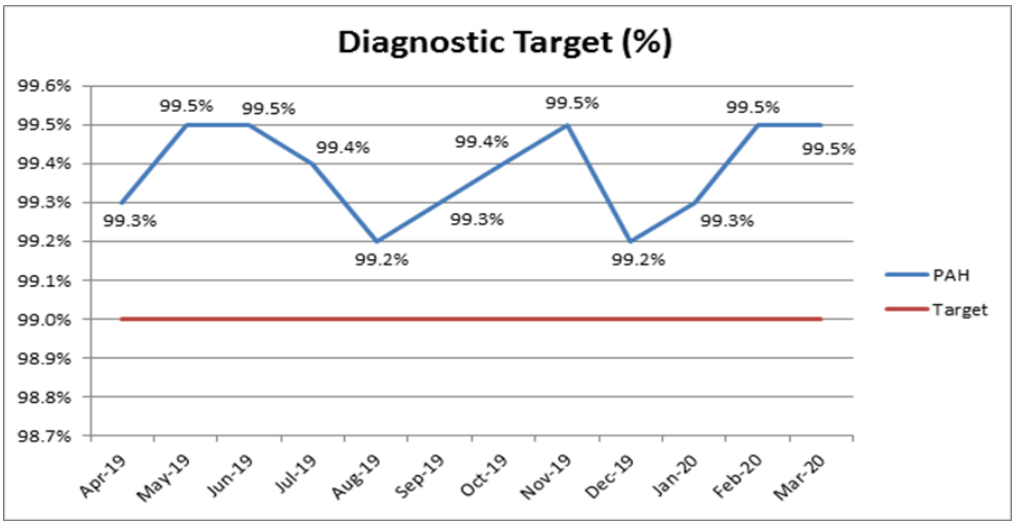


Figure 9: Diagnostic performance

Maternity Services

Our Maternity service supported the birth of 3732 babies in 2018/19. Women are offered the choice of giving birth in the consultant Led Obstetric Unit, the Midwife led Birthing Unit or at home under the care of the Community Midwifery team.

Work on the new maternity operating theatres was completed and up and running since February 2019. Importantly, the new facilities mean that women within the maternity department who require a surgical operation will no longer be transferred to the general operating theatres in the main hospital. The new operating theatres provide the necessary facilities for women in the maternity department.

Training and Development

As the result of a successful bid for money from Health Education England, in 2018 a wide range of staff including 79 midwives, 5 consultants, nursey nurses, registered nurses and maternity care assistants undertook training in the following

- Resilience Training,
- Neonatal Life Support (NLS)
- PROMPT training (which we will now be taught in-house)
- Childbirth Emergencies in the Community
- Maternal Critical Care
- Human factors.

Additional funds provided by our Local Maternity System have secured 60 places for midwives and obstetricians to attend a one day Cardiotocography (CTG) Master class. We are also supporting two midwives to undertake their Masters degrees.

Listening to service users

Maternity Voices Partnership (MVP) formally Maternity Services Liaison Committee was relaunched in 2018 and is attended by women who have recently given birth or are due to give birth within our maternity department. The chair of the group is a local national childbirth antenatal teacher. At the partnership we ask our women to share their experiences. Our aim is to use the partnership to help shape service improvements going forward. The meetings are also attended by the Matron for community Services and one of the Professional Midwifery Advocates.

Supervision and support for staff

We have four Professional Midwifery Advocates (PMA) in post at present. The role of the PMA involves the deployment of the A-EQUIP model of midwifery supervision, supporting and developing the advocacy role of midwives, supporting and guiding them through actions that will benefit women and their families. We have also funded three further midwives to undertake the PMA training course later this year to help further build the PMA team.

Health Promotion

Work continues with our Smoking Cessation Midwife and the focus on Health Promotion has broadened with the introduction of a Healthy Lifestyle midwife which supports women with not only smoking cessation but also weight management and general positive lifestyle choices.

Service improvement

We gained Baby Friendly Initiative (level 3) accreditation in July 2018.

Following Better Birth recommendations we have successfully implemented our pilot schemes for Continuity of Care for some cohorts of women with the plan to expand this in time.

Bereavement services

We continue to offer a specialised Bereavement service supporting those women who suffer a pregnancy or new-born loss and we are committed to achieving the targets detailed in the national Saving Babies Lives Document.

Gynaecological Services

We offer both inpatient and outpatients services – including a 'walk in' assessment and an early pregnancy unit. In 2018 we introduced the 'Lily room' which ensures privacy and dignity when braking bad news to women experiencing early pregnancy loss. This initiative was in direct response to feedback from service users.

Our Children's Services

Children's Services has had an exciting and challenging year with many positive changes. We have continued to successfully recruit nurses, greatly improving our vacancy position. This has greatly reduced the use of temporary staff such as bank and agency.

Dolphin Ward

We are especially proud of our Practice Development Nursing team who have been instrumental in creating a regional preceptorship programme which saw 35 newly qualified nurses from across the region meeting together for their first days' training in January 2019. Our next goal is to seek university accreditation for the training programme.

Staff morale has flourished on the ward and this is reflected in the falling levels of short term sickness, positive staff and patient feedback as well as feedback from internal quality reviews and inspections.

We have made some physical changes on the ward; relocating the school room, locker room, store cupboards and linen room. This has resulted in a less cluttered environment and with a purpose built storage; stock control has improved, making it easier for staff to locate items they require.

The Harlow District Council chairman nominated Dolphin ward as one of her charities for the year and we have received amazing support including several thousand pounds for the ward.

Paediatric Emergency Department

The Department has now been open for just over a year. Whilst there have been some challenging times due to staff authorised leave, we have managed to maintain staffing in the ED with the support of agency and bank workers. To ensure that staff have the necessary skills to care for the children attending the emergency department, we have revised our clinical assessment documentation and provided new skills and competency training.

Paediatric Ambulatory Care

The paediatric ambulatory care unit opened in April 2018 and is now running 5 days per week with plans to open 7 days per week once we have fully recruited the necessary staff. Currently the unit is open for until midnight, 2 days per week. Ambulatory services were previously provided on Dolphin ward; the new purpose built unit is delivering an improved patient experience, enabling a more efficient use of the inpatient beds on Dolphin ward and improved emergency admission flow to the ward.

Neonatal Intensive Care Unit (NICU)

We are especially proud of the results we received from our National Peer review of NICU which was positive and praised the staff team for their diligence and quality of service provided.

In 2018/19 the unit has not been as busy as previous years, with lower occupancy levels. This may in part be due to the lower than expected number of deliveries in our Maternity Unit and more babies receiving transitional care with in the post-natal wards.

Through the charitable fundraising efforts of the Land Sheriffs we have been able to send every member of the NICU team on the Family and Infant Neurodevelopment (FINE) training programme in order to help us on our way to fulfil the neonatal standards as identified by the charity BLISS.

Paediatric Outpatients

We have recruited an Allergy Nurse Specialist who is now managing the Outpatient Team as well as running nurse led services for our children, she presented at National Conference this year and has supported the team in getting the Outpatient area reorganised which is now more children friendly.

Pharmacy – Improving medicine safety

Medicines are the most common intervention in medical care, accounting for around 10% of NHS expenditure.

Progress on the Hospital Pharmacy Transformation Plan (HPTP):

Skill Mix Review

Our aim is to reconfigure staffing so that an increased percentage of pharmacist and technician time is spent in direct contact with patients.

Our Dispensary is now led by pharmacy technicians; accredited technicians carry out the checks formerly done by pharmacists. Stores are managed by a senior assistant. Progress transforming the function of our team is displayed in the table below..

Staff Group	2016/17	2018/19 (Current performance)
Pharmacists	60%	75%
Technicians	10%	30%

Table 23: Transformation progress in pharmacy: Percentage of staff time spent in patient facing activities

Independent prescribers

25% of eligible pharmacists have been trained as non-medical prescribers with 6 more in training. These pharmacists are taking on extended roles assisting with prescribing medicines in specialist clinics and writing prescriptions for patients to take home (TTAs) thereby facilitating prompt discharge from hospital.

Extended ward pharmacy service

Following a pilot in 2017-18, the extended pharmacy service is now established on 5 wards. These wards have, on weekdays, a pharmacist all day, as well as additional technician time and assistant top-up of stock medication.

This has resulted in:

- Improved 24 hour medicines reconciliation rates; 71% on wards with full time pharmacist or specialist pharmacist cover compared with 47% on other wards.
- Daily review of inpatient charts; which improves the discharge prescription (TTA) provision. Managing ward stock requests and putting away the weekly medicines; optimising safety.
- Assisting with the weekly controlled drug checks and fridge temperature monitoring; meeting regulatory standards.

Weekend ward pharmacy service

Since October 2018 a pharmacy service has been provided at weekends (6 hours/day Saturday and Sunday) on the acute admissions ward. This service includes medicines reconciliation, in-patient orders and TTAs. This has been achieved by offering adjusted contracted hours to new pharmacists starting in the trust and reduces medication delays for new patients.

Specialist Pharmacist Roles

Now embedded in critical care, gastroenterology and rheumatology to support patient care. These individuals are highly valued by the respective medical teams. Funding for a specialist dermatology pharmacist post has been agreed and we are actively recruiting to the post. The specialist posts in gastroenterology and rheumatology (as well as the long standing oncology post) have driven the successful switch to biosimilar biologics contributing significantly to the saving of £544K (year to Jan 2019) in the top 10 drugs.

Improved Pharmacy Performance

Two hour TTA turnaround increased from 71% (Dec 2017) to 83% (Dec 2018).

Medication safety

The most recent report from NHS Improvement, for incidents occurring between 1 April 2018 and 30 September 2018, showed that the proportion of reported incidents that were medication incidents was 11% for this Trust. This is average for acute (non-specialist) Trusts in England. The following have been achieved as part of the medication safety programme:

- **Training** including safe prescribing, antibiotic management and anticoagulant management for medical staff. Prescribing assessments for junior doctors and new non-medical prescribers are in place. Introduction of mandatory medicines management update training for registered nurses.
- **Incidents** Weekly review of medication incidents by senior pharmacist and nurses. A summary of prescribing incidents is presented at Grand Round, Surgical Friday and to specialist teams as required. A monthly summary of medication incident trends is presented to the Patient Safety and Quality Committee to ensure that learning is shared with all clinical staff groups.
- **Medicines Management and Incident Committee** meets monthly to review incident trends, patient safety alerts and to approve documents relating to medicines.
- **The Trust weekly staff Bulletin** Includes a 'Medication Safety Tip of the Week'.
- **Storage** Regular audits on storage of medicines across the organisation has led to the introduction of an improved system for checking expiry dates of medicines in wards and departments. Work has also taken place to ensure that rooms in which medicines are stored are maintained at the appropriate temperature, thereby meeting quality control requirements.
- **Anticoagulants** A Multidisciplinary steering group ensures that the use of anticoagulants is optimised and risks are minimised. All anticoagulant incidents are reviewed at the daily 'Oversight' meeting.
- **Patient Safety Alerts** All actions completed.
- **National medicine shortages** A system is in place to ensure that relevant staff are alerted and aware of alternative medicines that can be prescribed until supplies can be obtained.

Antimicrobial Stewardship

The approach is both pro-active (antibiotic guidelines, formulary and restriction, pathways for treatment and prophylaxis), and reactive (antimicrobial prescription review, audit, feedback).

The following has been embedded in practice:

- Establishment of Antimicrobial Stewardship Group as per NICE guidelines (NG15), taking into account the resources needed to support Antimicrobial Stewardship across all care settings.
- Provision of regular feedback to individual prescribers in all care settings through:
  A regular programme of audit, feedback, surveillance, education and review of patient safety incidents related to antimicrobial use.
- Promotion of local antimicrobial local guidelines, using shortest effective course and most appropriate route

- Monitoring and evaluating antimicrobial prescribing and how this relates to local resistance patterns. Reduction in Piperacillin-Tazobactam and Carbapenem prescribing

Electronic Prescribing and Medicines Administration (EPMA) and Chemotherapy Management System (CMS)

EPMA has been implemented across all inpatient areas. EPMA allows monitoring of drug expenditure savings and antibiotic usage.

CMS has been implemented in Oncology (70% of all oral and injectable chemotherapy). The CMS system supports safe administration of chemotherapy through barcode bedside scanning of chemotherapy drugs before administration.

Plans for the next 12-36 months

Infrastructure

Robot: The business case for a replacement of automated dispensing system (robot) is continuing with the aim to have a new robot in place in the coming year.

Technical Services (chemotherapy production) Unit is underway with the aim to have a new unit in place during 2020-21.

Education and Training

- To introduce mandatory medicines management training for all clinical staff to ensure safe prescribing and administration of medicines to reduce harm to all patients.
- To progress training as per the priorities set out in the HPTP (Independent prescribing for pharmacists, medicine management and accredited checking for technicians).

Infection prevention and control

The prevention and control of healthcare-associated infections (HCAIs) is key in the provision of high-quality, safe healthcare. We are proud of the robust infection prevention and control (IPandC) measures that we have in place to reduce HCAIs. These measures include steps to manage antimicrobial resistance as well as controlling outbreaks of infection. IPand C is an integral part of the Trust's risk management strategy and fundamental to the provision of the best clinical care.

Public Health England (PHE) mandatory surveillance programme data is provided below, presented as case numbers for PAH NHS Trust. Cumulative Trust apportioned cases (referred to as 'post 48 hr' for bacteraemia; 'post 72 hr' for C difficile) are shown as red bars, with non-Trust apportioned (pre 48 hr for bacteraemia; pre 72 hr for C difficile) as yellow bars.

MRSA bacteraemia: We have had zero cases of Trust apportioned MRSA bacteraemia and no cases since 2014.

***C difficile*:** The Trust continues to perform extremely well against the challenging *C difficile* Trust apportioned trajectory of nine cases annually for 2018-19. Trajectories are set nationally by the Department of Health based on performance during previous years, and are non-negotiable. We remain amongst the top performing of all Trusts nationally, improving again on last year. We ended this 2018/19 financial year on a total of 13 cases on the national PHE data base. Of these 13 only five of the cases are considered to be Trust-attributable and eight of 13 cases were successfully appealed at the West Essex HCAI Scrutiny Panel demonstrable evidence that there were no lapses in care given to patients that contributed to the *C difficile* infection.

As a district general hospital with a large elderly population, a busy Emergency Department and many winter pressures, this is a remarkable achievement. It demonstrates true MDT (multi-disciplinary team) working, with sustained commitment to infection prevention and control procedures. All *C difficile* root cause analysis meetings are chaired by the Trust Director of Infection Prevention and Control (DIPC) and attended by the medical Consultant who cared for the patient, with matron, ward manager, pharmacy (antimicrobials) and facilities input. Lessons learned are then disseminated for wider Trust learning.

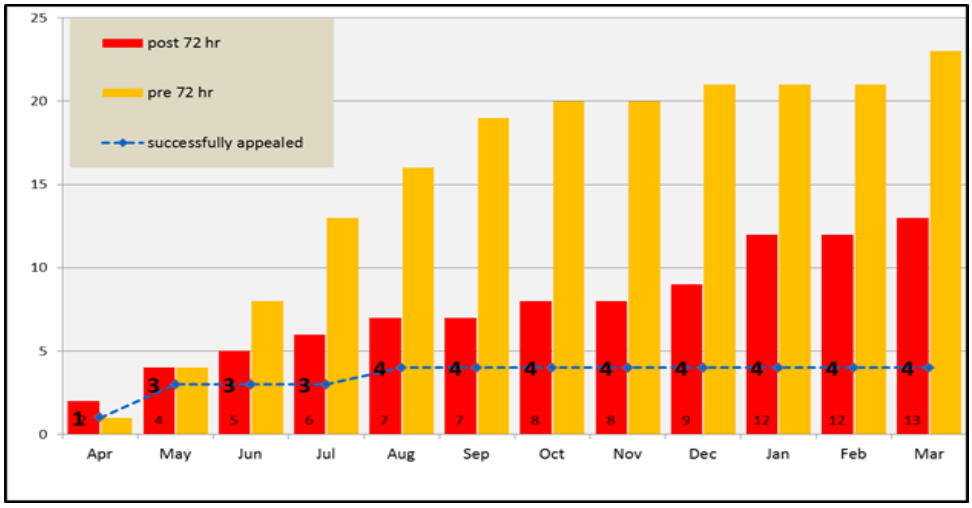


Figure 10: Cumulative case numbers of *C. difficile* at PAH NHS Trust for 1 April 2018 – 31 March 2019

MSSA bacteraemia: The Trust remains one of the top performing NHS organisations in England for our low Trust apportioned MSSA blood infections (bacteraemia). Good asepsis in relation to Intravenous lines (IV) lines has contributed to these low figures.

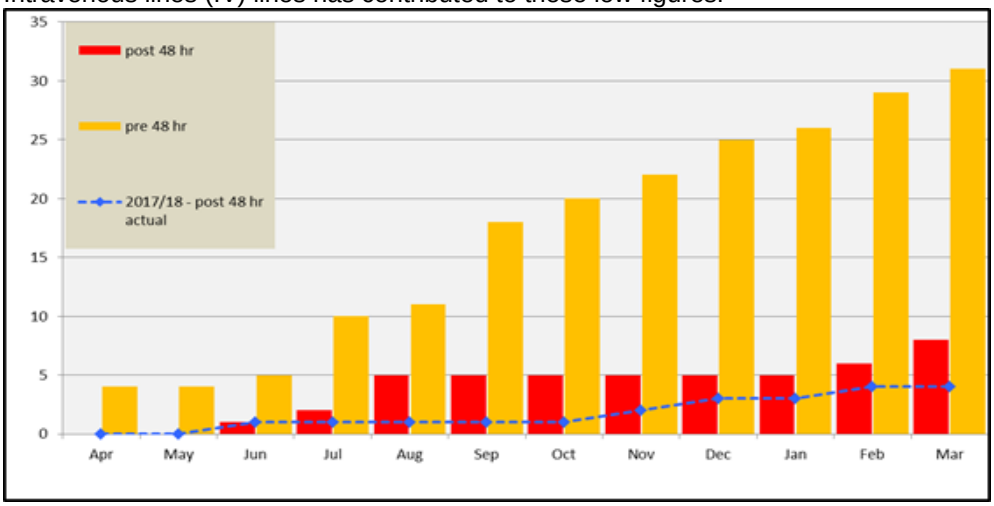


Figure 11: Cumulative case numbers of MSSA bacteraemia at PAH NHS Trust for 1 April 2018 – 31 March 2019

Gram negative blood stream infections: - From April 2017, there has been an NHS ambition to halve the numbers of healthcare associated Gram-negative blood stream infections (GNBSIs) by 2021. A healthcare associated Gram-negative BSI is a laboratory-confirmed positive blood culture for a Gram-negative pathogen in patients who have received healthcare in the community or hospital in the previous 28 days.

At PAH we can demonstrate evidence of well-informed leadership, planning and clinical interventions to address this initiative. We have evidence of assessment against the Health and Social Care Act: Code of Practice, we have DIPC / Infection Prevention and Control Team (IPCT), senior management and increasing clinical ownership of gram negative Blood Stream Infections

Our strategy for GNBSIs includes proactive training, antimicrobial stewardship (AS) and our policies ensue choice and duration of treatment is monitored through our governance arrangements. .

In addition we have clinical and operational leads working collaboratively to resolve problems, and have Patient safety walkabouts which include review of urinary catheters and device monitoring in the form of a body map, hydration checks, hand hygiene checks, and antibiotic prescribing. We have appointed a nurse to help the IPCT with clinical staff training specifically with catheter insertion and management; this nurse has in turn been trained by the Trust clinical nurse specialist in urinary catheter management.

Work is in progress to provide patients who leave hospital with a urinary catheter and those catheterised in the community, with a catheter passport documenting details of the catheterisation. We have evidence of completion of audits of compliance with catheter insertion, management and care. The existing detailed guidance on insertion and care of catheters has also been reviewed.

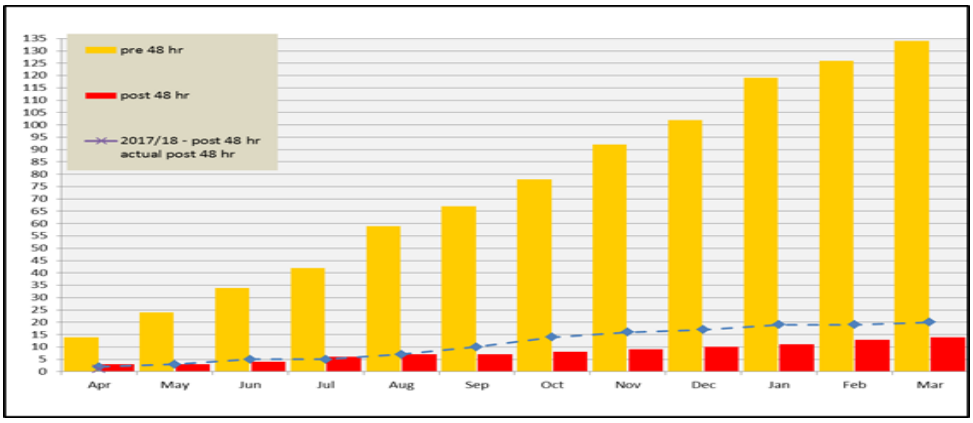


Figure 12: Cumulative case numbers of E-coli bacteraemia at PAH NHS Trust for 1 April 2018 to31 March 2019

In 2018/2019 case numbers for both Trust apportioned and non-Trust apportioned GN BSI cases by a total of 34 cases, reducing all these in-patient admissions. This is because GNBSIs are managed in hospital regardless of Primary or Secondary care origin of the infection.

Graph below demonstrates that we have successfully reduced our Trust apportioned cases of *Pseudomonas aeruginosa* BSI to just one case all year (red bar). Focus on reducing catheter associated infections and treating the primary source of gram negative infection with optimum antimicrobial therapy as informed by laboratory sensitivity profiles, has helped us achieve reductions in all gram negative BSIs.

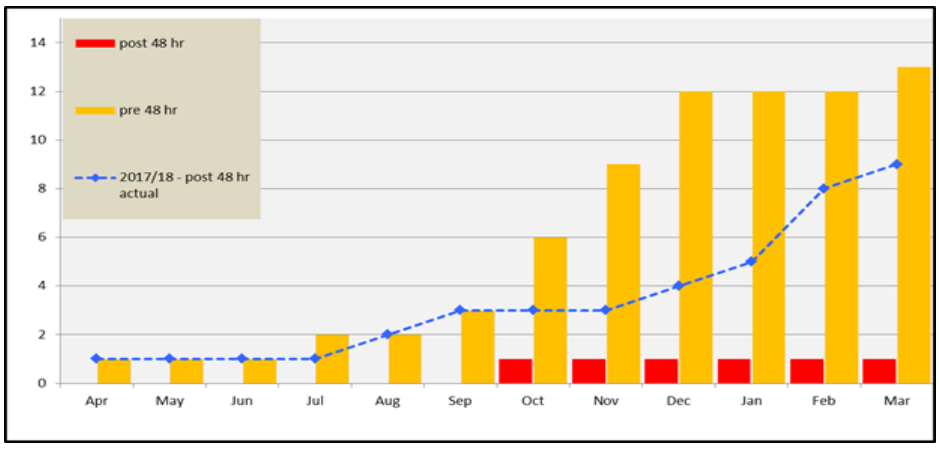


Figure 13: Cumulative case numbers of *Pseudomonas bacteraemia* at PAH NHS Trust for 1 April 2018 to 31 March 2019

Infection Prevention and Control Incidents and Outbreaks

IPC incidences occur sporadically in hospitals; the Trust has robust surveillance measures in place to ensure early identification of incidents and outbreaks to ensure they are managed in in a timely and appropriate way to minimises the risk of transmission to patients, visitors and staff. There is also excellent engagement from other specialist teams in the Trust when required.

Norovirus

Six Norovirus outbreaks have occurred in the Trust in 2018/19. These outbreaks resulted in partial or complete closure of wards. Mostly these were isolated incidents; however there were four wards closed at the same time at the height of the norovirus outbreak in January 2019. The Trust has robust systems in place for the management of outbreaks with daily meetings for the duration, led by the IPCT and supported by clinicians and senior managers.

Vancomycin Resistant Enterococci (VRE)

The Trust has had a period of increased incidence (PII) of VRE affecting patients on critical care. This PII was declared as an outbreak and control measures have been ongoing with a comprehensive multi-disciplinary team approach, including members of the Trust's Executive team, Public Health England and CCG representation at weekly outbreak control meetings. Five of the patients who were colonised with VRE were treated with Linezolid as a precautionary measure and VRE colonisation has not caused any adverse clinical impact on patients. Control measures have been multi-factorial and the number of new positive cases has reduced significantly.

MRSA Transmissions

A PII of MRSA transmission affected one medical ward in 2018-19. There were 18 patients affected between March and November. All patients were colonised with MRSA and none of them went on to develop a clinical infection. Outbreak control meetings were held and control measures were multi-factorial. In December, the PII was officially declared as over as there had been no further transmissions in over 28 days which is the approved definition of the end of an outbreak/PII.

Improving care for vulnerable patients

Patients with a Learning Disability or Autism

Learning Disability (LD) Steering Group

The steering group continues to meet quarterly with a non-executive Director as the chair of the group. The steering group oversees the work of the learning disabilities team and the completion of the learning disabilities work plan.

Learning from Incidents and Complaints

The Learning Disability team continue to review all complaints, incidents and deaths to ensure that any emerging themes are identified and that there have not been any instances of diagnostic overshadowing or instances where the level of care was variable solely due to the patient's learning disability and/or autism.

Reasonable adjustments

One of the main elements of the work plan is the implementation of reasonable adjustments. Reasonable adjustments are a legal requirement and, in general, the Trust implements them well. However, there is always more that can be done including better recording and auditing of the adjustments. The LD team have been working on this during the year and this work will continue.

Patients with Dementia

We are committed to improving the care of our patients living with dementia, those who have suspected dementia as well as supporting families and carers. A number of initiatives have been introduced and others are planned to ensure that the Trust becomes a centre of excellence for dementia care in accordance with "Living well with dementia": A National Dementia strategy (DH 2009), the Prime Minister's dementia challenge (DH 2011) and NICE Guidelines (NICE CG42 2006). In the last 12 months the Trust has made progress in the following areas:

Dementia Champions

The Trust currently has 47 dementia champions with a further 9 to complete the course in May 2019. The role of a dementia champion is to support best practice.

The Quality Mark

The Quality Mark for Elder-Friendly Hospital Wards is a subscription-based quality-improvement programme for individual hospital wards, led by the Royal College of Psychiatry. The Quality Mark process aims to support wards to focus on delivery of good-quality, essential care for older people.
Lister ward were awarded the Quality Mark in 2016 and the committee have confirmed the award should be maintained until May 2019; Ray ward achieved the Quality mark in 2018.
Further wards are working through the process to achieve the Quality Mark.

Delirium Work

Delirium is an Acute confusional state which occurs in 30-50% of hospitalised geriatric patients: patients with dementia are particularly vulnerable

- Improvement in local audit; National Audit Dementia results pending.
- Developing simulation training in delirium and dementia.
- Development of resources to support best practice.

Working together to improve the lives of our staff and their relatives/friends affected by dementia

- Successful in bid for money to purchase reminiscence software
- The developing work of the dementia sensory garden, working together with the Alzheimer's Society to develop this project further inviting persons living with dementia in the community

The purpose of the project is to landscape and transform the existing garden in Gibbered ward into a dementia friendly sensory garden. Gibbered ward is situated at the rear of Princess Alexandra Hospital and in 2017 was completely refurbished and redesigned to be a dementia friendly ward for patients living with dementia and/or who are at end of life.

Research has shown the huge benefits to the health and wellbeing of patients living with dementia who have access to a sensory garden. The smell of cut grass, the scent of flowers and herbs etc. Has been shown to stimulate happy memories, promote cognitive function and stimulate conversation, and help alleviate the "isolated "feeling so often experienced by patients during a hospital stay.

Our two Gibberd garden volunteers, both with early stage dementia, have been volunteering in the Gibberd garden since September 2018. Being able to come to the garden twice a week to plant flowers, paint the shed and clear the weeds has been an enormous help and lifeline for them. We

are determined to continue this initiative and expand the number of volunteers helping in the garden as it has and continues to prove that people living with dementia still have a huge amount to offer.

Improving the hospital stay for our patients living with dementia

- Working together with the Alzheimer's Society to implement "singing for the brain" in PAH.

Training

The Trust remains committed to ensuring that all staff has sufficient knowledge to enable them to appropriately care for patients who are vulnerable either due to learning disabilities/autism and dementia. Awareness training remains mandatory for all clinical staff and is covered in the Clinical Update study day and Trust Induction Programme for all new starters.

The Trust also runs a Virtual Dementia Tour (VDT) training session. To date over 600 staff have attended this with very positive feedback from all attendees and many staff going on to becoming dementia champions as a result of the VDT experience.

Reducing the number of hospital falls

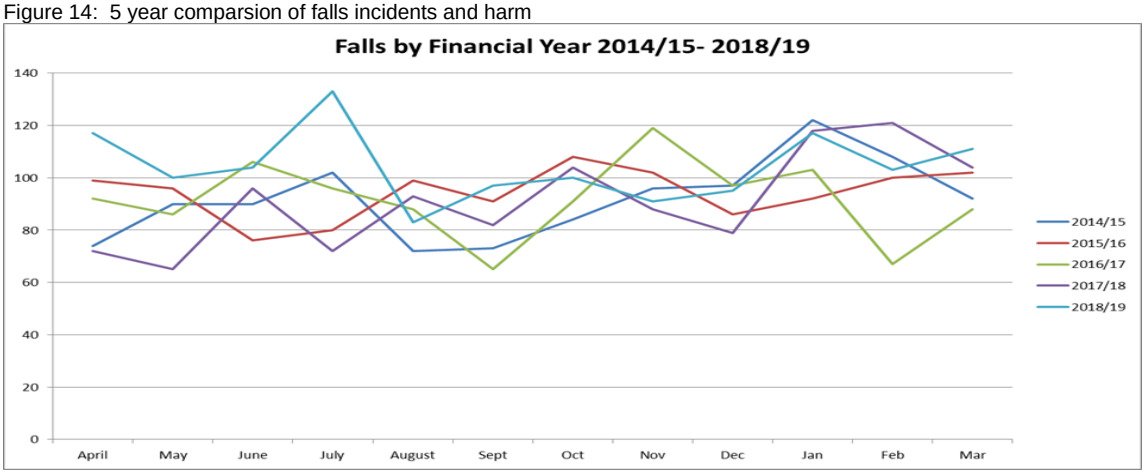
Falls in 2018 showed an increase over the calendar year when compared with the previous period. The majority of the increase came in no harm and minor harm falls incidents that reflects our initiatives to encourage greater levels of mobility in our inpatients.

Our focus this year has been to preventing deconditioning and this means an increase in total falls is expected as we are asking staff to support an increase in mobility for our patients. This results in more opportunities for falls to occur.
Despirte the overall increase incidences of moderate or severe harm continue to remain low with less than 2% of falls resulting in this level of harm which is better than the national comparisons provided by NHS I (2.5% nationally).
The focus on preventing deconditioning is critical and long-overdue across healthcare, as we have historically been primarily concerned with getting patients 'medically fit' for discharge. However this approach can result in a patients 'physical fitness' being neglected resulting in a loss of function, an increase in their acuity and an eventual loss of their independence. This directly impacts on measures such as mortality, length of stay and discharge delays. However a deconditioned patient whilst undoubtedly the subject of harm, rarely is recognised as such. Instead we record the downstream effects of deconditioning such as pressure ulcers, harmful falls and stranded patients. So the work now is to raise awareness of this more insidious harm, and importantly try to prevent it by increasing patient activity on our wards. Whilst there may be more falls, there are also other benefits including prevention of other harm events and an improved patient experience.

Table 24: Falls by Severity 2018/9 vs 2017/8

	Minor harm	Moderate	None	Severe	Total
Total 2017/18	263	21	813	1	1098
Total 2018/19	347	30	879	2	1258

Figure 14: 5 year comparsion of falls incidents and harm



Scrutiny Panel learning: All in hospital falls were a patient sustains a moderate or serious harm are investigated and the findings scrutinised. Common themes are identified and used to inform quality improvement projects. The themes this year have been as follows:

- Lying and standing BPs are not completed routinely or proactively
- A theme from the outcome of all our harm investitations is that for patients (that are not profoundly unwell) and admitted to the hospital will decondition whilst they are inpatients. This will result in them experiencing harm if they have a fall. Going forward this will now be explicitly recorded and quantified as part of our new investigation process
-

Improving pressure ulcer care

Our improvement work is delivered through our Agents for Nutrition and Tissue Viability (ANT's) programme which continues to thrive and we have now trained over 312 staff. Of the 312 staff, who have completed the programme 222 are still working in the Trust, a retention rate of 71%. The training programme has also been opened up to our local community Trust to facilitate networking and a system-wide approach to pressure ulcer reduction.

There have been changes nationally over the last 6 months on how Trusts should measure their pressure ulcer data. These changes have now been fully embedded however they make comparison with previous years difficult. We now collect and report all hospital acquired pressure ulcers and those present on admission. This includes categories 1-4, unstageable and deep tissue injuries.

The data demonstrates that the number of patients admitted with existing pressure ulcers remains high.

Hospital Acquired Pressure ulcers 2018-2019						
Hospital acquired - Category 1	***Hospital acquired - Category 2***	***Hospital acquired - Category 3***	***Hospital acquired - Category 4***	***Hospital Acquired Unstageable***	***Hospital acquired DTI***	***Total***
49	129	13	2	16	118	327

Pressure Ulcer Present on Admission to hospital 2018-2019					
Hospital acquired - Category	***Hospital***	***Hospital***	***Hospital***	***Hospital***	***Total***

2	*acquired - Category 3*	*acquired - Category 4*	*Acquired Unstageable*	*acquired DTI*	
503	103	65	61	87	819

Table 25: Pressure Ulcer data for 2018/19

We have implemented the new pressure ulcer guidance issued by NHSI in June 2018. Avoidable/unavoidable decisions have now been removed with a closer focus on learning from incidents. Our scrutiny panel process has also been overhauled to fall in line with the new information and ensure that key learning is focused at ward level.

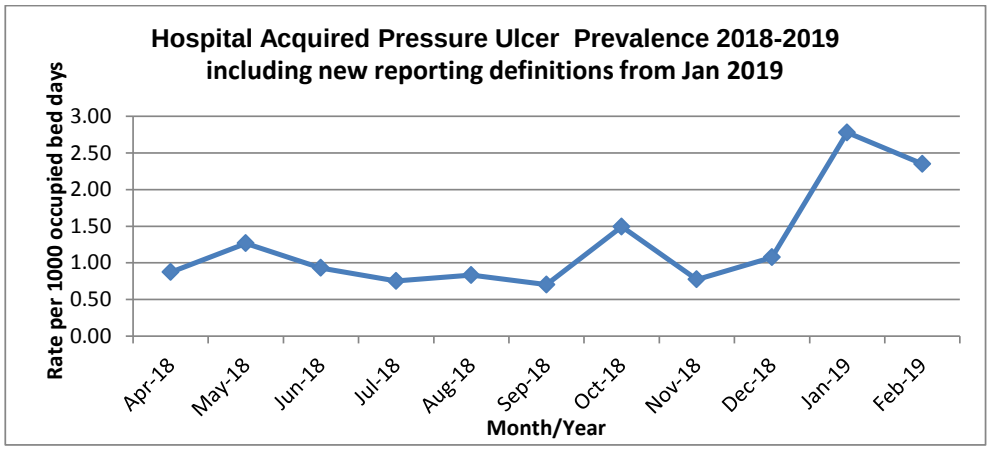


Figure 15: Hospital acquired pressure ulcer prevalence 2018-19

This increase since January 2019 is due to the addition of deep tissue injuries to our reporting in line with the new NHSI standards.

Safeguarding

Safeguarding Adults

The Trust has an established safeguarding adult scrutiny panel which meets monthly to review all safeguarding cases. The meetings are chaired by the nursing leadership team and include representation from Essex and Hertfordshire social work teams. Our objective is to ensure investigations are completed in a timely manner following a robust process. This allows the Trust to identify challenges and recurring themes. Representation from clinical teams enables shared learning across the health and social care system, improving partnership working with local authorities. Our social care partners have the opportunity to express views in a constructive and supportive manner and we are able to reflect on possible improvements for the benefit of patients, their families and carers.

Domestic Abuse

Over the yearthe Safeguarding Team has worked in partnership with Safer Places and the Daisy Project. This is a health Independent Domestic Violence Advisor (IDVA) service which increases the opportunity for victims of domestic abuse to disclose abuse within a health care setting such as the Emergency or Maternity Department at the time of an episode of domestic abuse. The IDVA supports the education of the clinical staff around domestic abuse and we have created a clear referral pathway integral to the continuing success of the services and to increase in referrals.

The team has recruited into the vacancy safeguarding adult practitioner with continued development of this post to meet the needs of the service and support the Lead Nurse - Safeguarding Adults. An additional midwifery safeguarding position is being piloted to support the Named Midwife with the increasing identification of vulnerable pregnant women.

Safeguarding Children

Child Protection (CP) Medicals:-The Safeguarding Children team support the provision of child protection medicals ensuring all requirements are met according to the Southend, Essex and Thurrock Procedures (2018). This does not include child sexual abuse medicals as a specific Essex wide care pathway is followed.

Supervision

Safeguarding supervision is provided via a 'Hub and Spoke' strategy to staff that have direct contact with Children and Young People. This includes midwives, paediatric staff working in ED, out patients and the Children's ward. We now have 15 supervisors to support the supervision strategy which will be re-launched within the FAWS health group in April 2019. Included as supervisors are five adult nurses aimed at supporting a new supervisory initiative focusing on adult patients.

Ad-Hoc supervision continues to be offered by the Team and is available to all staff across the Trust with any adult or child safeguarding problem – this includes on a professional or personal level.

Safeguarding Referrals

Safeguarding referrals made by PAH staff are monitored and stored for auditing purposes. The team have oversight of both children and adult referrals for quality and outcome assurance. Making referrals features in the safeguarding training with a robust referral pathway available on the Alex Intranet and in most clinical areas across the Trust.

Training

A safeguarding training mapping exercise for 2018/19 was completed to ensure all staff eligible for safeguarding training receive the appropriate programme according to their role and responsibilities. This reflects the new national guidance from NHS England in 2019. It takes into account differing skill and competency requirements for staff.
The Safeguarding Adults Team undertakes training that includes the Mental Capacity Act along with a bespoke practical training on the application of the Mental Capacity Act Assessment. MCA is also included in the Level 3 Safeguarding Children training in respect of 16/17yr olds and parents presenting with risk-taking behaviour, mental health or learning disability problems.
Adequate training opportunities are available to ensure every staff member can achieve their training compliance for the year and an e-learning module has been introduced to support staff for 3 yearly training for both adults and children.
The Trust supports the provision of Safer Places training to give guidance to staff that can support patients who disclose domestic abuse.

Patient Experience and Engagement

Patient Experience includes the service you use when you need to make a complaint, raise an immediate concern or provide positive feedback. This service is based at the front of the hospital and is referred to as the Patient Advice and Liaison Service or PALS. The team respond to around 2500 to 3000 concerns, queries or questions raised by patients, families or carers every year. The team, as can be seen in the green line below, also receive thousands of compliments about the work of our staff.

Patient Engagement is the work of our multiple patient groups and Voluntary Services. We have one lead patient group who we call the Patient Panel, 24 people are members of this group and come from all over our catchment area which serves 350,000 people have their views represented on this

group. The Panel works with other local patient groups of whom we know there are many, with hundreds of members to engage our local population. The Panel also produce an annual report which can be found online at www.pah.nhs.uk which describes how they support continuous improvement in our services. Some examples of how both teams have done this over the last 7 years can be seen below.

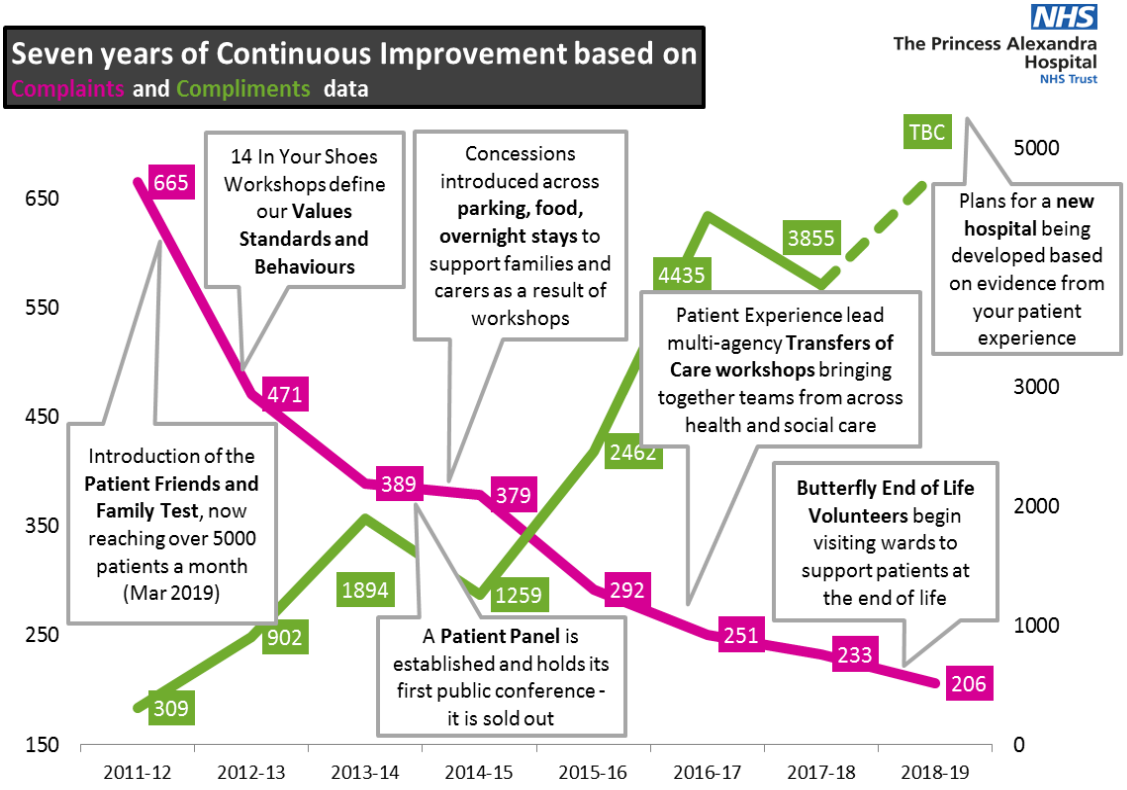
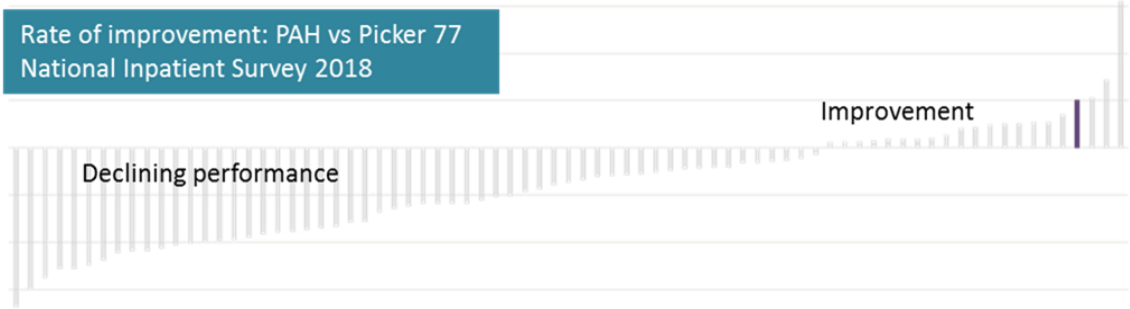


Figure 16: Seven year comparsion of patient experience

Highlights over the past year:

- The Trust was recorded as the fourth fastest improving nationally from early data comparing it to 77 other Trusts based on early evidence from the National Inpatient Survey 2018



- Complaints numbers have fallen to 206 in 2018-19, that's a fall for seven years in a row as can be seen in the downward sloping line in the above line graph.

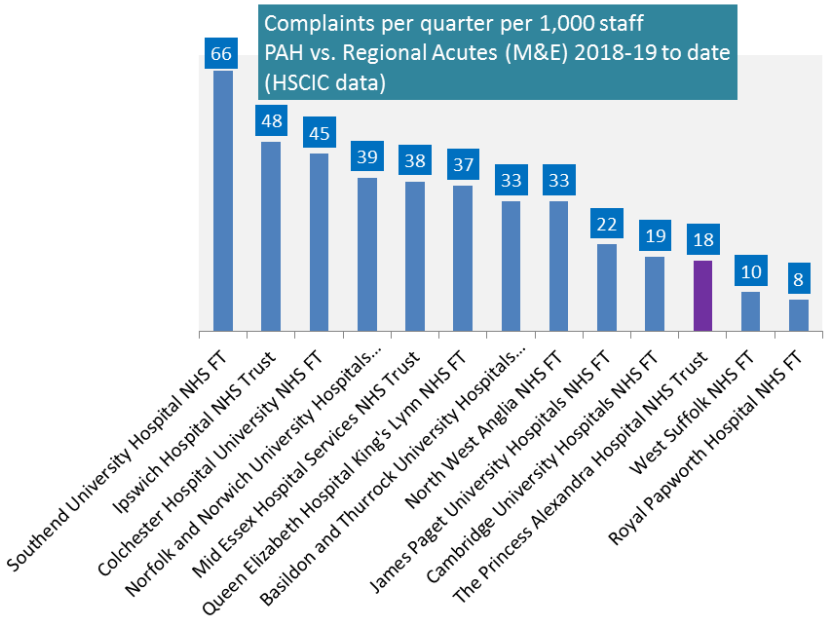


Figure 17: Comparsion of numbers of complaints revieeved by trusts in the East of England

As a result of this evidence the Trust conducted a benchmarking exercise to compare PAH to Figure other hospitals in the region and it appears that we have one of the lowest rates of complaints in the region after West Suffolk FT and Royal Papworth FT.

- 2801 PALS cases were resolved in 2018-19, fewer than the 2925 resolved in 2017-18 but with some records still to be completed as well as thousands of compliments.
- The Trust has developed a Patient Experience Concepts course for frontline staff which has been well received, this came about as a result of staff in bookings teams around the Trust being required to make highly sensitive calls to convey difficult information about the urgency of an appointment for example and needing the language and lines to support a better conversation. This is being rolled out across bookers in all outpatient services focussing on telephone manner and managing difficult conversations.
- PAH was the first Trust in England to introduce a brand new volunteering role, the Butterfly End of Life Volunteers in partnership with the Anne Robson Trust. This is a unique role where volunteers spend time with patients who are at the end of life but with no family, friends or visitors.
- Following on from this the Butterfly Volunteer Project were winners of Harlow Soup a community crowd-funded event where teams pitch their project. Kate and Jo who are volunteers won £613.86. Over 100 members of the local community attended and voted

Figure 18: PAH Butterflies the winners.

- The Herts and West Essex Local Maternity System have supported several Whose Shoes Maternity Services Improvements Events. Of the many new pledges being developed, PAH are taking forward work on reasonable adjustments for expectant parents who may have a learning disability, alongside the 40 pledges made by leaders across the maternity service at PAH in an event in November 2018.
- On 19 February a second meeting of the Addison's Support Group took place developed by a Clinical Nurse Specialist for Diabetes and Endocrinology and supported by the Patient Panel. 23 patients and their carers attended, with some carers and partners present, many of whom provide 24 hour care for their loved one.
  Participants were offered teaching sessions on the use of syringes, how to better identify adrenal insufficiency and other signs and symptoms to watch out for. This is one example of a group which will be offered affiliated group status to the Patient Panel across the region in order to better represent the view of the local community.
- A non-exhaustive list of other groups involved include:
  - The Stroke Support Group
  - Proactive, a Prostate Cancer Support Group
  - Connect, a Stoma Group
  - Breathe Easy – a British Lung Foundation Group
  - Diabetes and Addison's Disease Patient Group
  - Harlow Healthcare Forum
  - FAB Breast Cancer Fundraising Group
  - The Love your Liver Group
  - A Gastro IBD Support Group
  - The Eye Unit Patient Group
  - Maternity Voices Partnership
  - The Learning Disabilities Steering Board

Section 18 Report

Every year, the Trust must make a statement under the NHS Health and Social Care Act 2009 about how many complaints it received, their subject, the issue they raise, whether or not they were well founded and any actions taken. This is published in a separate Section of the website and also noted here:

Complaints received

The Trust received 206 complaints in 2018-19 of which 18 wee not upheld, 19 fully upheld and 10 partially upheld. With the remaining 59 incomplete as still in process.

Subjects of complaints

The most frequently occurring themes were medical care expectations (76), communication (43) and nursing (30).

Actions taken

Actions are taken over the year; table 29, represents just some of that work as some actions are routine, some are less significant. Those listed below are complete, significant and demonstrate a clear connection from the concern raised to the change the organisation has made.

Table 26 Examples of Actions taken following complaints in 2018/19

What happened?	How did the Trust respond?
A patient's daughter had concerns about the care and communication her late mother received. Additionally she also had difficulty entering the ward outside of visiting hours and wanted this to be resolved for her and for others who might experience the same event.	As a result of this feedback, this ward introduced carers cards. The card allows families and carers subsidised or free parking, an opportunity to stay overnight and support to visit at non visiting hours if needed. All staff had an opportunity to discuss the importance of contacting patients relative's when deterioration occurs in timely way with one point of contact, with preferences for how contact should be made noted consistent with GDPR and staff were reminded that families visiting patients should not be turned away from the department even outside of visiting hours if needed. The learning following a face to face meeting was shared with a wide range of groups including ward and emergency department staff.
A patient was concerned about delays in investigations and treatment following her miscarriage.	As a result of this complaint immediate changes were made to inductions for new medical staff so that all doctors now receive additional training on potential complications associated with the early stages of pregnancy in any environment where they may be working. The case study was also presented to the Obstetrics and Gynaecology Clinical Meeting for learning and improvement.
A patient was raising concerns about the delays and treatment he received in Emergency Department when attending with urinary retention.	The Emergency Department recognised that additional support was needed for all staff from the clinical educator. As a result the Trust developed and introduced catheter champions to liaise with the clinical educator and urology nurse specialists. As a result of this the team receive regular training using the 49 step cleanliness check which is to be reviewed to ensure completion by a surgical matron. The case study was created and shared at the Surgical Healthcare Group Patient Safety and Quality Meeting.

A patient had a test at PAH and paid privately as covered via his health insurance. He was raising issues regarding the manner he was pursued by the Finance member of staff.	As a result of this work a new training module has been developed, Patient Experience Concepts. This is led by the Head of Patient Experience, initial evaluations have been very positive and adapted to be delivered across all frontline telephone responders such as Radiology bookers and Outpatient appointment department booking staff.
The father of a patient raised issues regarding delays, misunderstanding and miscommunication during his son's treatment in Children's Emergency Department and associated ambulatory care.	Upon reviewing the complaint it was clear that there were gaps in providing timely patient information for this family. As a result of this the Children's Emergency Department team worked with the family to develop a parent information leaflet and appointment card. In addition, these processes have been changed and a new process for electronic booking of Paediatric Ambulatory Unit appointments has been introduced.

Our Amazing Patient Panel

The Patient Panel is a group of local people, patients, ex-patients and carers, recruited to be 'critical friends' of the hospital. They represent the views of patients in all areas and levels of the hospital, seeking ways to improve services by challenging existing practices, and bringing about changes by working in co-production with hospital teams. Some of the areas of work which the Patient Panel have participated in the last year include

The Complaints Reference Group

The purpose of the group is to monitor the quality of written complaint responses by taking a randomised sample and reviewing them from a patient perspective. The group checks to see that actions identified by the hospital to stop reoccurrence of problems have been taken.

Patient Led Assessment of the Care Environment (PLACE)

This year's annual survey of the hospital environment was, for the first time, carried out by the Patient Panel and other lay members from Healthwatch Essex and Hertfordshire without any hospital staff involvement. This gave a purely patient led perspective on the environment.

Patient Panel involvement

Members of the Panel serve as lay members at over 30 hospital committees, together with many working groups. The Panel has made contact with existing patient groups (Watford, Ipswich andHinchinbrook) and this year have helped to set up new groups (Norwich).

The Panel has assisted the formation of hospital-based focus groups for patients with specific conditions such as Addison's disease.

Panel members have participated in senior staff appointment boards, and delivered training for consultants in the application process for clinical excellence awards.

There has been regular commitment from panel members in supporting surveys, peer reviews and ward inspections, supporting the Trust in monitoring quality compliance with regulatory standards.

One panel member focuses specifically on all aspects associated with hospital food and patient mealtimes.

Another panel member has worked with our Quality First team and the surgical speciality to develop criteria-led discharge with the aim of helping patients to be discharged from the ward in a more timely manner.

Pre-Hospital Emergency Medicine (PHEM)

The Panel supported individual staff members on developing proposals to change rules on including local area ambulance staff to be allowed access to information on the patients they have treated, to maintain their professional training and expertise. This has now been agreed here at the hospital and is planned for introduction across the East of England.

2018 Conference - "It Matters to Me"

This year's conference looked at cancer services from the first visit to the GP. The Panel were aided financially by the Sustainability and Transformation Board (STPs) who, in partnership with Macmillan, offered £1,200 to promote and identify issues rising from the National Cancer Survey.

Students from Harlow College helped by undertaking a survey of GP's and producing a short film. The three key action points arising were the need for information on medication, helping young cancer patients to live as normal as school life as possible, and the needs of minority groups.

Publications

The Patient Panel produces an Annual Report, which will be distributed throughout the East of England. Articles for local newspapers were written by the Panel to optimise the press coverage for the Trust. The articles explained the work of different teams in the hospital including hospital food, organ donation and infection prevention and control.

A Patient information leaflet about having an anaesthetic was produced and will be available in large print and Easy Read to give to patients due to have surgery.

Secretary of State

The Patient Panel met with the Secretary of State for Health, asking him to consider inviting patients to participate in the co-production process for the NHS 10 year plan.

Optimising the hospital environment

Charnley ward

In 2018 the Trust finalised plans to provide 27 additional adult inpatient beds in order to enhance the services available to our patients. In partnership with Portacabin, the Trust collaborated to deliver a new and innovative approach which ensured that the new ward was positioned adjacent to the main hospital building but with no loss of essential patient car parking spaces. Charnley ward; a wonderful and modern facility for general surgical patients, was delivered on target and officially opened on Friday 11 January 2019 by Rt Hon Robert Halfon, MP for Harlow who was joined by the Chair of Harlow Council, Cllr Maggie Hulcoop and guests from partner organisations, patient representatives, including the Patient Panel, and staff.

Figure 19: Pictures of Charnley ward

Ward Refurbishment Programme:
As part of the Trust's ongoing drive to improve standards of care with ensuring uitable environments for our patients and visitors, we have refurbished two wards John Snow and Harold wards in addition to our High Dependency Unit and our Main Theatres.

New maternity theatre

The provision of a new additional operating theatre for the maternity department was successfully achieved and opened for use in 2108/19. Adjacent to the labour ward, the two operating theatres will ensure that women using the services have access to a clinical environment that conforms to the highest healthcare standards.

Figure 20: Pictures of new Maternity theatrtes

Car Park Alternation: Driven by the need to accommodate the Trust's patients and visitors, the Estates Directorate was able to increase patients and visitors parking capacity by over 250 spaces. This was achieved allocating offsite staff parking facility and redesigning the existing parking spaces we had.

The Princess Alexandra Hospital NHS Trust

Statements from Stakeholders

NHS West Essex Clinical Commissioning Group

5.1

The Princess Alexandra Hospital NHS Trust

East and North Hertfordshire Clinical Commissioning Group

5.1

East and North Herts Clinical Commissioning Group's Response to the 2018/19 Quality Account provided by Princess Alexandra Hospital NHS Trust

East and North Herts CCG (ENHCCG) has reviewed the information provided by Princess Alexandra Hospital NHS Trust (PAH) and we believe this is a true reflection of the Trust's performance during 2018/19, based on the data submitted during the year as part of the on-going quality monitoring process.

During 2018/19 ENHCCG has met regularly with both the host commissioner, West Essex CCG (WECCG), and PAH to review progress in relation to the quality of services provided.

A key focus for PAH during 2018/19 has been to improve the rate of mortality for patients at PAH, the CCG recognises the significant amount of work that the Mortality Improvement Board have identified and that there is strong executive level leadership on this important work. The CCG have been actively involved with the Patient Safety group and the Mortality Improvement Board and this has provided the necessary assurance to ENHCCG that the plans to reduce hospital mortality are robust and clinically lead. The CCG expects to see this high level of attention maintained through 2019/20 to bring about the reduction in mortality rates that are needed.

PAH has well-established 'Quality First' team which has been instrumental in supporting the on-going work following the publication of the CQC's visit which rated PAH as 'Requires Improvement, the CCG are assured of the work that has been undertaken and awaits with anticipation for the outcomes of the most recent inspection in January 2019.

The Trust has clearly identified within its Quality Account where progress has been made and where further improvements are still needed.

ENHCCG also notes the Trust's focus on its workforce, particularly in relation to staff wellbeing and recruitment and retention of registered nurses. Maintaining safe nurse staffing levels is essential, the CCG notes the work undertaken by the Trust, in particular the ambitious aim to recruit in particular the ambitious aim to recruit more overseas nurses by December 2019. The CCG acknowledges the reduction in the registered nurse vacancy rate; however, there is clearly more work to be done to achieve better registered nurse cover at PAH and the CCG will continue to monitor progress at the Quality Review meetings.

Whilst PAH has continued to perform well in relation to referral to treatment times, the CCG recognises that the fluctuation in cancer performance due to workforce issues in some specialities and expects the trust to return to its previous consist delivery of this standard in 2019/20. We note

that performance in relation to the A&E 4 hour target has been disappointing. We do expect to see improvement in this area during 2019/20.

The CCG supports the Trust's 2019/20 quality priorities and is pleased to see that reducing mortality rates and a commitment to deliver on an ambitious programme to significantly reduce the Registered Nurse vacancy rate in particular.

Overall, we acknowledge the continued emphasis on quality and patient experience undertaken during 2018/19 and wish to see this work continued and built upon during 2019/20.

We look forward to working with and supporting PAH in further developing and monitoring the quality of services it provides for patients. We hope the Trust finds these comments helpful and we look forward to continuous improvement in 2019/20.

Beverley Flowers
Chief Executive
May 2019

The Princess Alexandra Hospital NHS Trust

healthwatch Essex

5.1

Response to Princess Alexander Hospital (PAH) Account 2018-19 from Healthwatch Essex

Healthwatch Essex (HWE) is an independent organisation that works to provide a voice for the people of Essex in helping to shape and improve local health and social care. We believe that health and social care organisations should use people's lived experience to improve services. Understanding what it is like for the patient, the service user and the carer to access services should be at the heart of transforming the NHS and social care as it meets the challenges ahead of it.

We recognise that Quality Accounts are an important way for local NHS services to report on their performance by measuring patient safety, the effectiveness of treatments that patients receive and patient experience of care. They present a useful opportunity for Healthwatch to provide a critical, but constructive, perspective on the quality of services, and we will comment where we believe we have evidence – grounded in people's voice and lived experience – that is relevant to the quality of services delivered by Princess Alexander Hospital. In this case, we have received quality of feedback about services provided by the hospice, and so offer only the following comments on the Princess Alexander Hospital Quality Account.

- HWE recognises the CQC report that PAH has been rated overall as a 'Requires Improvement' organisation. It is also recognised to see that PAH was rated as 'Good' on areas of Effectiveness, Well lead and for the Care given.
- HWE is impressed by the PAH approach to management, leadership and team building which continues to promote engagement with staff.
- HWE also recognises the Equality & Inclusive steering group (EISG) which is bring useful Insight and engagement.
- HWE recognises the recruitment drive and the improvement on recruitment and the new approach to retaining trained nurses.
- HWE recognises the approach around Medical Education, training doctors and the apprenticeship scheme will allow PAH to recruit, train and retain the staff required for the hospital.
- HWE recognises the investment in IT at the hospital which includes Radiology and electronic prescribing. Also the investment in hospital Wi-Fi will have a solid and positive impact for patients.
- HWE like PAH values the feedback and insight gathered from the Staff survey. Solid and positive feedback and some strong recommendations for improvement.
- HWE is impressed with the overall approach to Dementia care for Patients, Staff, Carers and families.

- HWE recognises the great effort undertaken by the complaints and compliments team. HWE would still like to see continued reduction on complaints but are assured by the approach taken by staff and senior management to learning from the complaints.

- HWE welcomes the excellent report by the Patient panel which again shows the true value of patient voice and Lived Experience. The volunteers clearly play a solid role within PAH and are valued and used in the most productive way.
- HWE commends the PAH patient panel for their excellent conference' It matters to me' which is an excellent example of patient engagement.

Listening to the voice and lived experience of patients, service users, carers, and the wider community, is a vital component of providing good quality care and by working hard to evidence that lived experience we hope we can continue to support the encouraging work of St Clare Hospice.

Dr David Sollis
Chief Executive Officer, Healthwatch Essex
21st May 2019

Healthwatch Hertfordshire's response to Princess Alexandra Hospital NHS Trust (PAHT) Quality Account 2019

Healthwatch Hertfordshire welcomes the opportunity to comment on PAHT's Quality Account.

We would like to make the following comments:

- The Quality Account provides a clear description of what quality is and how the 'Quality Improvement strategy' underpins the Trust's approach to drive forward improvements. We support the quality priorities for 2019/20, particularly the continued focus in reducing mortality rates to improve patient outcomes as this remains a concern. Priorities for staff ('our people') encompassing recruitment, leadership and wellbeing are also recognised as key to providing an outstanding service for patients.

- It is good to see that complaints have continued to fall. The Quality Account demonstrates how the Trust learns from complaints, for example through the Complaints Reference Group which also ensures that the patient perspective has been taken into account. PALS (Patient Advice and Liaison Service) performance however has deteriorated due to a number of factors which the Trust is working through to resolve. We hope to see improvements to this service shortly.

- We are pleased to have been welcomed as a member of the Patient Experience Group and the Patient Panel. We also participated in the Patient Led Assessment of the Care Environment audit which for the first time in our experience was completely run by external assessors and without staff. This is in part thanks to a very proactive patient panel at PAH who have a strong voice and are recognised by the Trust for their valuable contribution to improve the quality of patient experience.

- There are number of ways that the Trust uses volunteers to make a significant difference to patient experience. Of particular note are the Butterfly End of Life volunteers who support end of life patients who have no family or friends to visit them. PAHT was the first Trust in England to introduce this new role in partnership with the Anne Robson Trust.

healthwatch Hertfordshire

We look forward to working with PAHT in the coming year to continue to improve patient experience and outcomes.

Steve Palmer, Chair Healthwatch Hertfordshire, May 2019

The Princess Alexandra Hospital NHS Trust

Essex Health Overview Policy and Scrutiny Committee's response to Princess Alexandra Hospital NHS Trust (PAHT) Quality Account 2019

The Trust has kept the Essex HOSC informed on the estate challenges being faced and the strategy and preferred option for a hospital rebuild. A recent site visit to PAH to see some of these challenges was really appreciated by HOSC members. The Trust has also supported the Essex HOSC in its recent review of A&E and seasonal pressures with a further follow-up discussion planned. The Essex HOSC expects to continue working closely with the Trust in the coming year on both these and other issues.

In view of the number of quality accounts the HOSC is invited to review each year, only a very limited review can be undertaken. Through HOSC discussions with PAH and feedback from local members, it is clear that the Trust faces significant demand pressures which can impact particularly on responsiveness. Local members have highlighted some issues with the booking of outpatient appointments which could have been acknowledged in the report although we believe senior management are already aware of the issues.

The Committee is aware that local Healthwatch also reviews Quality Accounts and is content that they can represent the patient and public voice and comment accordingly.

Thank you for the opportunity to comment

County Councillor Jill Reeves

Chairman, Health Overview Policy and Scrutiny Committee

The Princess Alexandra Hospital NHS Trust

Hertfordshire

5.1

Chairman
Health Scrutiny Committee

Seamus Quilty
County Councillor
Bushey South

County Hall
Postal Point: CH0147
Pegs Lane
Hertford
SG13 8DE
Tel 01992 556557
email:
seamus.quilty@hertfordshire.gov.uk

4 June 2019

I can confirm that there has been regular communication between the Health Scrutiny Committee, Scrutiny Officers and the Trust over the last 12 months. The Trust has supported the scrutiny process when approached and the Committee look forward to working with the Trust in the future.

Yours sincerely,

Seamus Quilty
Chairman
Hertfordshire Health Scrutiny Committee

The Princess Alexandra Hospital NHS Trust

Internal Auditors Assurance Report

5.1

The Princess Alexandra Hospital NHS Trust

5.1

Glossary of terms

Acute Kidney Injury - is a sudden episode of kidney failure or kidney damage that happens within a few hours or a few days.

Acute Bowel Obstruction - significant mechanical impairment of the passage of contents through the intestine (bowel) due to a blockage of the bowel.

Anticoagulation - are medicines that help prevent blood clots.

Antimicrobial – is a general term that refers to a group of drugs that includes antibiotics, antifungals used to treat a microbial infection.

Antimicrobial Resistance - is the ability of a bacteria to resist the effects of medication (antibiotics) that once could successfully treat the infection.

Antimicrobial stewardship - A coordinated intervention designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration.

Agents for Nutrition and Tissue Viability (ANTS) – ANTS are staff with specific training to identify skin issues patients may have and ensure that those at risk are getting all the right food that they need for their skin to remain healthy and thus avoid the danger of pressure sores developing.

Allied Health Practitioners - are healthcare professionals working in dietetics, occupational therapy, physiotherapy, operating department assistants, radiography and speech and language therapy. This is distinct from nursing, medicine, pharmacy and healthcare scientists.

Ambulatory Care - Medical care provided on an outpatient basis, includes diagnosis, observation, consultation, and treatment.

Ante-natal - is the care you get from health professionals during your pregnancy.

Audiology - the study of hearing and balance.

Avoidable - See unavoidable.

Cardiology - The branch of medicine that deals with diseases and abnormalities of the heart.

Care Quality Commission (CQC) - CQC is an executive non-departmental public body of the Department of Health United Kingdom. Established in 2009 to regulate and inspect health and social care services in England.

Chemotherapy - The treatment of disease by the use of chemical substances, especially the treatment of cancer by cytotoxic and other drugs.

Clostridium Difficile (C.Difficile) - Clostridium difficile, also known as C. difficile, or C. diff, is a type of bacterial infection that can affect the digestive system.

Clinical Audits - A process aimed to improve quality of patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

Clinical Coding - The process by which patient diagnosis and treatment is translated into standard, recognised codes that reflect the activity that happens to patients.

Clinical Commissioning Group (CCG) - NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Clinical Nurse Specialist (CNS) - A nurse who has advanced knowledge and competence in a particular area of nursing practice.

COSMIC - The Electronic Patient Record system we have in place at PAHT. See Electronic Patient Record.

Colorectal care - treatments for patients with symptoms of the gastrointestinal tract including colorectal cancer and inflammatory bowel disease.

Colposcopy and hysteroscopy services - a procedure used to examine the cervix and inside of the womb (uterus).

Chronic obstructive pulmonary disease (COPD) - is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.

Continuing Professional Development (CPD) - is defined as the education of physicians following completion of formal training.

CPR - Cardiopulmonary arrest means that a person's heart and breathing has stopped. When this happens it is sometimes possible to restart their heart and breathing with this emergency treatment.

CQC - The Care Quality Commission is the independent regulator of all health and social care services in England

CQUIN - Commissioning for Quality and Innovation is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.

Cryoprecipitate - is given to patients with bleeding disorders.

CTG - Cardiotocography is a recording of babies heartbeat used during pregnancy prior to birth.

DAISY project - A hospital based advocacy service offering advice and support for both staff and patients, male and female, who are victims of domestic abuse.

Datix - Softwere used in healthcare to collect patient safety incidents and for reporting adverse events.

Delirium - is a state of mental confusion that can happen if you become unwell. It is also known as an acute confusion.

Dementia Champions - a group of staff who have had specific training in dementia care. Their aim is to make other colleagues more understanding of why a patient may be more challenging and encourages them to tailor therapies accordingly.

Dermatology - The branch of medicine concerned with the diagnosis and treatment of skin disorders.

Diagnostics - Tools used to help identify disease and illness.

Diagnostic overshadowing - making an assumption that what is wrong with a patient is their Learning Disability (LD) not their medical condition.

Dietetics – a branch of healthcare concerned with the diet and its effects on health, especially with the practical application of a scientific understanding of nutrition.

DNACPR - Do not attempt cardio-pulmonary resuscitation - this is an order telling medical professionals not to perform CPR. This means that doctors, nurses and emergency medical personnel will not attempt emergency CPR if the patient's breathing or heartbeat stops.

Door to Needle Time – a national target used to measure the time from a patients arrival in the hospital until the drugs required to commence their treatment is administered.

Dr Foster – a provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service.

Duty of Candour/Being Open - A process of apologising to patients and/or their carers when things go wrong, and communicating with them in an open and honest manner.

Endocrinology - The branch of physiology and medicine concerned with endocrine glands and hormones.

Endoscopy - is a procedure that allows a view the inside of a person's body; An endoscope is a long, thin, flexible tube that has a light source and camera at one end. Images of the inside of your body are relayed to a television screen to be viewed by the doctor.

Escherichia Coli (E.coli) bacteraemia - Type of bacterial infection and a blood stream infection.

Fractured Neck of Femur – a broken hip.

Frailty service – reviews *frail* older people using a holistic assessment of physical, mental and social needs.

Friends and Family Test (FFT) - Test aimed at providing a simple headline metric which, when combined with follow-up questions, is a tool to ensure transparency, celebrate success and galvanise improved patient experience. It asks "How likely are you to recommend our services to friends and family if they needed similar care or treatment?" with answers on a scale of extremely likely to extremely unlikely.

FY1 - First year junior doctor

Gastroenterology - The branch of medicine which deals with disorders of the stomach and intestines.

Genito-Urinary - The branch of medicine relating to the genital and urinary organs.

Geriatric - relating to older people, especially with regard to their healthcare.

Governance - Establishment of policies, and continuous monitoring of their proper implementation, by the members of the governing body of an organisation.

Gram negative blood stream infections (GNBSIs) - Type of bacterial infection and a blood stream infection.

Gynaecology - The branch of physiology and medicine which deals with the functions and diseases specific to women and girls, especially those affecting the reproductive system.

Haematology - The branch of medicine involving study and treatment of the blood.

Healthcare Associated Infections (HCAI) - Infections that are acquired as a result of health care. The burden of healthcare-associated infections has mainly been in hospitals where more serious infections are seen.

Health Education England - is the new national leadership organisation for education, training and workforce development in the health sector.

Hospital Standardised Mortality Ratio (HSMR) - Calculation used to monitor death rates in a Trust.

Interventional Radiology - is a sub-specialty of radiology which utilises image-guided procedures in order to diagnose and/or treat diseases using the least invasive techniques.

Klebsiella bacteraemia - Type of bacterial infection and a blood stream infection.

Laparotomy - a surgical incision into the abdominal cavity, used for diagnosis or in preparation for major surgery.

Learning Disability Mortality Review Programme (LeDeR) - a review into the deaths of people with learning disabilities aged 4 years and over, irrespective of whether the death was expected or not, the cause of death or the place of death. This will enable Trusts to identify good practice and what has worked well, as well as where improvements to the provision of care could be made.

Maternal and Fetal Assessment Unit - Outpatient Antenatal Unit offering planned appointments for assessment of the mother and unborn baby in pregnancy.

Maxillofacial department – an area where diagnosis and treatment is provided to conditions of the mouth, face and adjacent structures.

MBRACE - confidential enquiry into maternal deaths.

Mealtime Buddies - A group of volunteers who help feed patients during mealtimes in Princess Alexandra Hospital.

MCA - The Mental Capacity Act is designed to protect people who can't make decisions for themselves or lack the mental capacity to do so.

Medicines Reconciliation - Is the process of creating the most accurate list possible of all medications a patient is taking.

Meticillin-Resistant Staphylococcus Aureus (MRSA) / Meticillin-Sensitive Staphylococcus Aureus (MSSA) – A specific bacterial infection**.**

Mitigation - The action of reducing the severity, seriousness, or painfulness of something.

Morbidity and Mortality - meetings established to review *deaths* as part of professional learning.

Musculoskeletal - conditions affecting the joints, bones and muscles.

Myocardial Ischaemia - when blood flow to your heart is reduced, preventing the heart muscle from receiving enough oxygen.

Myocardial Infarction - Commonly known as a heart attack.

Early Warning Score (NEWS) and Vital Signs - A simple system in which a score is allocated to physiological measurements already undertaken when patients present to, or are being monitored in hospital. Six simple physiological parameters form the basis of the scoring system:

a) respiratory rate
b) oxygen saturations
c) temperature
d) systolic blood pressure
e) pulse rate
f) level of consciousness

National Confidential Enquiries (NCEPOD) - National Confidential Enquiry into patient Outcome and Death.

Neonatal - New born children.

Neurology - The branch of medicine or biology that deals with the anatomy, functions, and organic disorders of nerves and the nervous system.

Neutropenic Sepsis Policy - guidance surrounding the development of neutropenia which is an abnormally low number of neutrophil granulocytes (a type of white blood cell) in the blood.

Never Events - Serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented.

NHSI - NHS Improvement is responsible for overseeing Trusts and NHS services, as well as Independent providers that provide NHS-funded care. They offer providers support to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

NICE - The National Institute for Health and Care Excellence provides guidance which supports healthcare professionals and others to make sure that the care they provide is of the best possible quality and offers the best value for money.

Norovirus - A type of viral infection that can affect the digestive system.

National Reporting and Learning System **(NRLS) -** a central database of patient safety incident reports.

Obstetrics - The branch of medicine that deals with the care of women during pregnancy, childbirth, and the recuperative period following delivery.

Oesophago-gastric care – treating patients with problems of the gullet (oesphogus) and stomach.

Oncology - The study and treatment of cancer and tumours.

Operating Department Practitioners – members of the theatre team that provide care to patients at every stage of their operation.

Ophthalmology - The study of the structure, functions, and diseases of the eye.

Orthopaedic - The branch of medicine that deals with the prevention and correction of injuries or disorders of the skeletal system and associated muscles, joints, and ligaments.

Objective structured clinical examination (OSCE) - modern type of examination used in health sciences.

Patient Advice and Liaison Service (PALs) - offers confidential advice, support and information on health-related matters. Provides a point of contact for patients, their families and their carers.

Paediatrics - The specialty of medical science concerned with the physical, mental and social health of children from birth to young adulthood.

Palliative Care - An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Pathology - The scientific study of the nature of disease and its causes, processes, development, and consequences.

Patient Panel - A group of volunteers who represent patients, families and carers of The Princess Alexandra Hospital NHS Trust.

Patient Safety Alerts - issued by NHS Improvement to rapidly warn the healthcare system of risks. They provide guidance on preventing potential incidents that may lead to harm or death.

Patient Safety Thermometer – a monthly hospital audit to measures the quanity of patients who have incurred harm through their long term care at home or whilst in hospital. The data is submitted monthly to NHS England and looks at harm from falls, tissue injuries, urinary tract infections if patient has a catheter or developing a deep vein blood clot following hospital care.

Perioperative care - occurring or performed at or around the time of an operation.

Public Health England (PHE) - an executive agency sponsored by the Department of Health with the aim of protecting and improving health, wellbeing, and to reduce health inequalities.

Physicians Associates – staff who support doctors in the diagnosis and management of patients.

Patient Led Assessments of the Care Environment (PLACE) – Annual quality assessments looking at hospital environment, information for patients and the food provided. The assessment is conducted jointly by patients, hospital staff and external partners

Post Anaesthetic Care Unit (PACU) – an area in theatre where patients are taken directly after surgery so they can wake up from their anaesthetic and will remain until well enough to go to a ward for ongoing care.

Preceptorship - A period of practical training for a newly registered nurse or mdwife or novice under the supervision of an expert.

Preferred Priorities of Care (PPC) - Document used to plan an individual's future end of life care. Includes thoughts and feelings about the patient's illness, what is happening, preferences and priorities for future care and where the individual would like to be cared for in the future.

PROMPT – training for staff working in maternity care, utalising clinical issues that have occurred where all the members of different professionsls who work together attending the training together and so learning and resolving issues together

Pseudomonas aeruginosa - A specific bacterial infection.

Public Health England - A government body with the role to protect and improve the nation's health and wellbeing and reduce health inequalities.

Pulmonary Embolism (PE) - A sudden blockage in a lung artery.

Radiology - The branch of medicine that deals with the use of radioactive substances used in diagnosis and treatment of disease.

Rapid Assessment and Treatment (RAT) - A treatment model used in emergency care to provide an early senior assessment and early treatment.

Reasonable adjustments - is a change that has been made to a service so that people with learning disabilities can use them like anyone else.

Referral to Treatment (RTT) – a constitutional standard that trusts are measured against in which a person's waiting time starts on the day the hospital receives the referral letter from a GP to the time of first appointment or treatment.

Respiratory - The act of breathing.

Resuscitation - is the process of correcting physiological disorders (such as lack of breathing or heartbeat) in an acutely unwell patient. Well known examples are mouth-to-mouth resuscitation.

Rheumatology - The study and treatment of arthritis, autoimmune diseases, pain disorders affecting joints, and osteoporosis.

Root Cause Analysis (RCA) - The method of problem solving that tries to identify the root causes of faults or problems with the goal of preventing a recurrence.

Safeguarding - Protection or defence that ensures safety.

Sepsis and Septicaemia - Sepsis is a serious blood stream infection. A serious complication is septicaemia which is when inflammation occurs throughout the body which can be life threatening.

Serious Incident Group (SIG) - A formal review of serious incidents which may need external reporting.

Serious Incidents (SIs) - An unexpected or unplanned event that caused harm or had the potential to cause harm to a patient, member of staff, student, visitor or contractor.

Stakeholders - A stakeholder is anyone with an interest in a business. Stakeholders are individuals, groups or organisations that are affected by the activity of the business. They include: Owners who are interested in how much profit the business makes

- Strategic Executive Information System (**STEIS**) – National data base to report incidents where harm is identiried. This system can be accessed by trusts, commissioners and all regulators.

Standardised Mortality ratio (SMR) and Summary Hospital-level Mortality Indicator (SHMI) - Ratio between the actual number of patients who die following treatment at the trust and the number that would be expected to die, on the basis of average England figures given the characteristics of the patients treated there.

Sustainability and Transformation Partnerships (STP) - bringing together local health and care leaders to plan the long-term needs of local communities and how care will be delivered.

Suboptimal care – care that is dissatisfactory or substandard resulting in a poor patient outcome.

Tachycardia – a heart rate that is higher than normal.

Trauma Audit and Research Network (TARN) – an audit where information is collected and analysed for patients who are moderately or severely injured after an injury. Data is submitted by trusts and a comparison can be undertaken.

Transitional Care - Refers to the coordinated and continuity of health care during a movement from one healthcare setting to another or to home.

Triage - A process for sorting injured people into groups based on their need for or likely benefit from immediate medical treatment.

To Take Away (TTA) – Medication given to patients to take after their discharge from hospital.

Trial Without Catheter (TWOC) – a trial to remove a catheter (tube draining urine from the bladder) which can be completed in the outpatient or in patient areas of a Trust.

Unavoidable - Used when an individual has been affected even though the:

- condition and risk has been evaluated
- goals and recognised standards of practice that are consistent with individual needs had been implemented
- impact of these interventions had been monitored, evaluated and recorded
- approached had been revised as appropriate

Term usually used in relation to cases of hospital acquired infections, pressure ulcers and falls.

Urology - The study of urinary organs in females and the urinary and sex organs in males.

Vancomycin resistant enterococci (VRE) - A specific bacterial infection.

Vascular surgery – specialists that treat people with diseases of the circulation which can be conditions affecting arteries, veins and where there are blockages to the flow of blood.

Venous Thromboembolism (VTE) - A condition where a blood clot forms in a vein. Most commonly in a leg where known as a DVT, a blood clot in the lungs is called a pulmonary embolism (PE).

VTE Prophylaxis - The giving of a medicine or treatment to prevent a VTE.

6 Facet Survey – an assessment of the estate which reviews backlog maintenance, condition and compliance of the environment.

Your future | Our hospital

The Princess Alexandra Hospital NHS Trust

5.2

Agenda Item:	5.2
Presented by:	Dr Andy Morris – Chief Medical Officer
Prepared by:	Quality First Triumvirate
Date prepared:	May 2019
Subject / Title:	Mortality Improvement Programme

Purpose:	Approval		Decision		Information	√	Assurance	√

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Princess Alexandra Hospital NHS Trust established the Mortality Improvement Board in December 2018 to strengthen governance, reporting, focus and delivery in efforts to improve mortality rates. This paper outlines the progress that has been made by the Mortality Improvement Board as means of information and assurance.
Recommendation:	For Trust Board to approve focus of Mortality Improvement Board and agree frequency of updates required to Trust Board

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

Previously considered by:	QSC.24.05.19
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:	

Your future | Our hospital

The Princess Alexandra Hospital NHS Trust

5.2

1. Introduction

The Trust's mortality markers remain a concern. A mortality dashboard has been developed to provide up to date information for the Sub Committees of and the Trust Board. Five programmes of work have been identified to drive quality improvements forward which are monitored via the Mortality Improvement Board (formed December 2018).

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

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

2. Purpose

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

3. Progress since last report

There has been important progress achieved in the revision and establishment of **care bundles** in speciality pathways where the trust has had mortality alerts. We know care bundles work, when you consider the introduction on the 'Sepsis Six' at PAHT and other quality improvement work completed we can evidence that since June 2017 deaths from sepsis at the trust has been steadily reducing and we have achieved our target to reduce deaths from sepsis by 20% by March 2019.

There is work underway to improve compliance of the completion and documentation of vital signs as well as the management of fluids and electrolytes (**excellence ever time – group one**). PAHT is one of the highest users of antibiotics per 1000 per patients in the NHS when compared to other hospitals. In efforts to inform decision making around the prescribing of antibiotics and compliance against trust policy a new antibiotic prescribing app will be purchased. The project team will be populating local information before making it available on app stores by August 2019. In addition, a new dashboard has been developed to identify (at consultant level) antibiotic use, so prescription practice can be reviewed and challenged in a much more informed and targeted fashion (**excellence ever time – group two**).

Hospital at night is also a focus and the project team are planning to introduce a new digital solution to support doctor handover and task allocation to improve coordination and prioritisation of care out-of-hours by early August 2019. This new way of working will be supported by development in existing NerveCentre software.

Reporting and recording of care is another programme of work that focuses on the establishment of the Medical Examiner role and strengthening our ability to learn from deaths. A software solution called Clarity has been introduced and currently more than 20% of deaths are being reviewed with a trajectory to get to 100% by the end of the financial year. Coding and documentation of care is also a part of this programme, which making targeted efforts to improve the accuracy of the care recorded to better reflect the standard and quality of care reported in our mortality rates.

Your future | Our hospital

The Princess Alexandra Hospital NHS Trust

5.2

4. Mortality Improvement Programme – Progress and Performance Tracker Update

The Mortality Improvement Board consists of 18 projects across 5 programmes. In order to monitor the high level progression of each project, each has been given at least one measure to track its success. These measures are to be presented in the Mortality Improvement Progress and Performance Tracker, alongside the latest HSMR. The tracker includes data from Dr Foster, national audits, local data collection and from the PAHT digital systems.

The tracker will be presented at the second Mortality Improvement Board of each month, to allow time for the maximum amount of the measures for the previous month to be populated.

5. Progress since last report

5.1 The tracker is now 70% populated with baseline data for the 45 measures, against a 60% trajectory for the end of April.

5.2 Of these populated measures:

- 7 are monthly on a 5 month lag (Dr Foster)
- 5 are quarterly on a 1 month lag
- 3 are quarterly on a 3 month lag.

5.3 A month by month statistical process control graph of the HSMR has been added to the front page of the tracker, alongside a graph of the monthly crude mortality rate (see figure 1).

5.4 The monthly position pages have been separated and are in the process of being fed with the populated data, with a representation of the month's performance in terms of the meeting of trajectories, broken down by programme.

6. Next Steps

6.1 Population of the tracker will continue, which is envisaged to meet the agreed timeframe as the remaining measures have plans in place for their sources.

6.2 Targets and trajectories for each measure will be set and agreed with each programme triumvirate and project team, for those measures which have not already had this done.

6.3 Meeting with the local data source colleagues to agree the expectation for timely sharing of data going forward.

7. Recommendations

Mortality Improvement Board Progress and Performance Tracker will be reviewed monthly at the second Mortality Improvement Board.

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

Date: **May 2019**

Your future | Our hospital

The Princess Alexandra Hospital NHS Trust

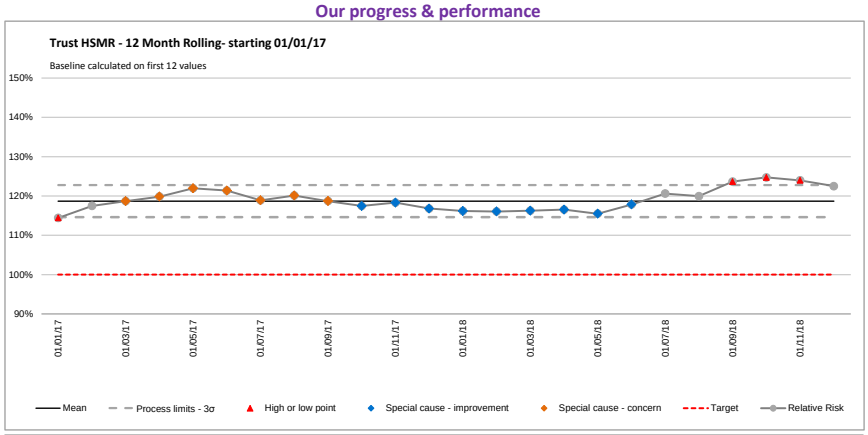
Mortality improvement progress and performance tracker (our goal)

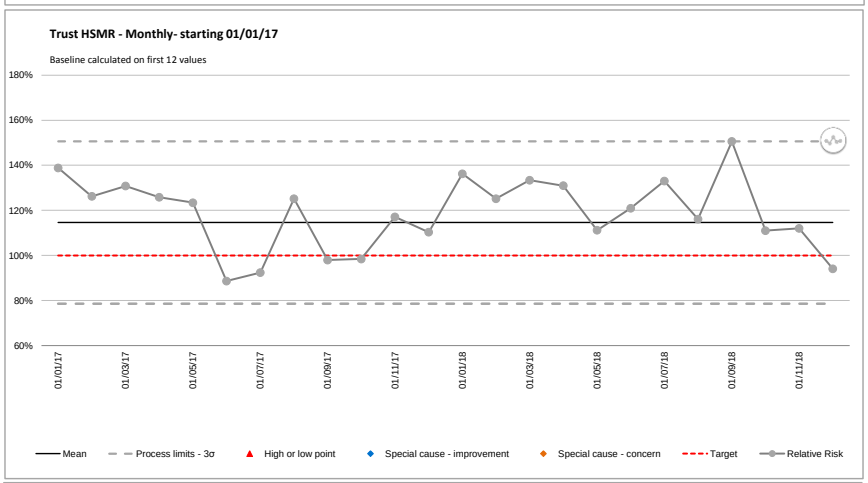
Our goal

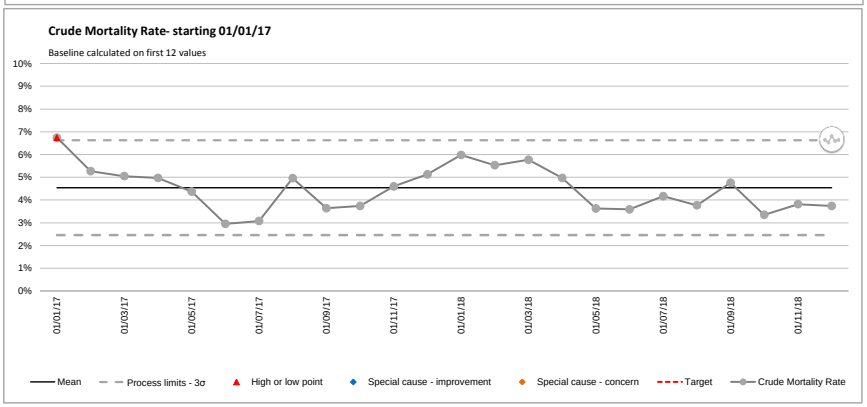
Achieve 'as expected' across all specialities, with no more than two outlier alerts over a 12 month rolling period by March 2021 and to be sustained.

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

Our progress & performance







QI st IMPROVEMENT PARTNER

respectful | caring | responsible | committed

Programme	Project		Aim	Success measures				Performance and progress tracker						
				Measure	Type of Measure	Frequency	Trajectory Vs Actual	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Care Bundles	Fractured Neck of Femur		Reduce mortality to expected level i.e. from 8.5% to 6% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	#NOF mortality rate (% of patients who died)	Outcome	Monthly, 5 month lag	Trajectory	8.3%	8.2%	8.0%	7.9%	7.8%	7.6%	7.5%
							Actual	8.3%	8.4%	7.6%				
				% #NOF patients admitted to Tye Green (NOF ward)	Process	Monthly (2 month delay)	Trajectory	90%	90%	90%	90.0%	90.0%	90.0%	90.0%
							Actual	79.0%	97.0%	85.0%	100.0%	89.0%		
				% of #NOF patients in theatres within 36 hours of arrival at A&E	Process	Monthly	Trajectory	77%	79%	74%	78.6%	79.6%	80.7%	81.7%
							Actual	77.0%	79.0%	74.0%	78.6%	70.0%	82.9%	73.0%
				% of #NOF patients in theatres within 36 hours of arrival at A&E (excluding DOAC patients)	Process	Monthly	Trajectory	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	81.7%
							Actual	94.4%	88.2%	85.3%	91.7%	84.8%	93.5%	
				% #NOF patients admitted into Tye Green within 4 hours of ED attendance	Balance	Monthly	Trajectory	73%	42%	31%	46.4%	49.9%	53.3%	56.8%
							Actual	73.0%	42.0%	31.0%	46.4%	12.5%	40.0%	27.0%
	Acute Abdomen		Reduce mortality to expected level i.e. from 8.7% to 7.1% by March 2020 (intestinal obstruction, based on Dr Foster Data from reporting period Nov17-Oct18)	Emergency laparotomy mortality rate (% of patients who died)	Outcome	Monthly, 5 month lag	Trajectory	8.60%	8.51%	8.42%	8.34%	8.25%	8.16%	8.07%
							Actual	8.60%	8.3%	6.3%				
				Case ascertainment in NELA	Process	Quarterly, 3 month lag	Trajectory	66.0%		66%	72.8%	72.8%	72.8%	79.6%
							Actual	66.0%						
				Arrival in theatre within a timescale appropriate for urgency	Process	Quarterly, 3 month lag	Trajectory	82.0%		82%	82.6%	83.2%	83.8%	84.5%
							Actual	82.0%						
				% of Em Lap patients admitted to HDU/ITU (with NELA risk score >5) post operatively	Process	Quarterly, 3 month lag	Trajectory	77.0%		77%	77.6%	78.2%	78.8%	79.5%
							Actual	77.0%						
				Consultant anaesthetist and surgeon present in theatre if NELA risk score >5%	Process	Quarterly, 3 month lag	Trajectory	83.0%		83%	84.3%	85.6%	86.9%	88.2%
							Actual	83.0%						
	COPD		Reduce mortality to expected level i.e. from 6.6% to 4.1% by March 2020 (based on Dr Foster	COPD mortality rate (% of patients who died)	Outcome	Monthly, 5 month lag	Trajectory	6.4%	6.3%	6.1%	6.0%	5.8%	5.7%	5.6%
							Actual	6.4%	7.2%	6.8%				
	Pneumonia		Reduce mortality to expected level i.e. from 19.6% to 15.3% by March 2020 (based on Dr Foster Data from reporting period Nov17-Oct18)	Pneumonia mortality rate (% of patients who died)	Outcome	Monthly, 5 month lag	Trajectory	16.1%	16.0%	15.8%	15.7%	15.5%	15.4%	15.2%
							Actual	16.1%	16.3%	16.2%				
				Aspiration pneumonia mortality rate (%of patients who died)	Outcome	Monthly, 5 month lag	Trajectory	47.0%	46%	45%	44.0%	43.0%	42.0%	41.0%
							Actual	47.0%	44.0%	43.2%				
				Chest x-ray within 4 hours of	Process	Monthly	Actual	100%	85%	87%	84.6%	47.6%	61.1%	
	Sepsis		5% reduction in Sepsis mortality by March 2020	Sepsis mortality rate (% of patients who died)	Outcome	Monthly, 5 month lag	Trajectory	20.5%	20.2%	19.9%	19.6%	19.3%	19.0%	18.7%
							Actual	20.5%	19.9%	19.1%				
				95% of all patients admitted to ED with a NEWS score of 3 are screened for sepsis by May 2019	Outcome	Monthly	Trajectory	82.0%	82.0%	82.0%	84.6%	87.2%	89.8%	92.4%
							Actual	85.0%	76.0%	84.0%	84.0%	84.0%	86.0%	
				% sepsis patients receiving treatment within one hour (ED)	Process	Monthly	Trajectory	87.0%	87.0%	87.0%	89.0%	90.0%	92.0%	93.0%
							Actual	91.0%	83.0%	88.0%	89.0%	94.0%	94.0%	
Excellence Every Time group 1	Vital Signs	Timely recording of vital signs observation and adequate & effective equipment for undertaking and recording vital signs	To improve compliance with timely vital signs observation leading to early detection and escalation of deteriorating patient	% of Observations on patients with a EWS ≥5 within 30 minutes of due time	Process	Monthly	Trajectory				70.0%	75.0%	80.0%	85.0%
							Actual				63.2%	69.0%	72.2%	75.3%
		Accurate input/ output Fluid Balance chart		% of completed fluid balance charts	Process		Actual			0%	0.0%			27.0%
	Fluids & Electrolytes	Management of Acute Kidney Injuries (AKI)	To improve compliance with fluids & electrolytes management with early detection and treatment leading to reduction in harm caused by fluid and electrolytes imbalance	Reduce mortality to expected level i.e. from 10.9% to 8.5% by March 2020 (based on Dr Foster data for renal disease comorbidity, from reporting period Nov17-Oct18)	Outcome	Monthly, 5 month lag	Trajectory	10.5%	10.4%	10.2%	10.0%	9.9%	9.8%	9.7%
							Actual	10.5%	10.4%	10.1%				
				Number of AKI alerts	Process	Monthly	Trajectory	363	494	400	583	566	549	532
							Actual	363	494	400	583	527	634	
				Number of patients with alerts that have remained the same or improved during their admission	Process	Monthly	Trajectory	86.0%	85.0%	89.0%	87.0%	91.0%	88.5%	89.8%
							Actual	86.0%	85.0%	89.0%	87.0%	91.0%	88.5%	
				Number of drug reviews for AKI patients	Process	Monthly	Trajectory	75.0%						
							Actual	75.0%						
Excellence Every Time group 2	Antibiotics Stewardship		Correct antibotic use for patient need (right drug, right patient, right time, right route) and a reduction in overall antibiotic use (and associated cost) move to middle quartile (national) by March 2020	Antibiotic usage (per 1000 admissions)	Outcome	Quarterly, 3 month lag	Trajectory			8382				
							Actual			8382				
				% of antibiotic prescriptions having an indication documented	Process	6 monthyl, 1 month lag	Trajectory		15.0%					
							Actual		15.0%					
				% of antibiotics prescribed with a review date or stop date documented	Process	6 monthly, 1 month lag	Trajectory		52%					
							Actual		52%					
				Number of the antibiotic prescriptions submitted that had evidence of review between 24 and 72 hours PLUS reviewed by an appropriate clinician PLUS a documented IV rationale	Process	Quarterly, 1 month lag	Trajectory		71.0% (Q3)			74.0%		77.0%
							Actual		71.0% (Q3)			96.0%		
	Timely Decision Making		Right patient, right ward first time	100% of EDD on Cosmic for all patients within 14 hours of admission.	Process		Trajectory							
							Actual						1.5%	
				100% Preferred ward documented for all patients.	Process		Trajectory							
							Actual						50.7%	
Reporting and recording	Medical Examiners		100% adult deaths (>16yrs) reviewed by ME and evidence of shared	% of completed Mortality Reviews including evidence of shared learning	Outcome	Monthly	Trajectory							25.0%
							Actual							17.8%
Hospital at Night	Doctor Handover		Implementation of structured handover of patients for all specialities out of hours	Percentage of unexpected return to theatres (excluding ED)	Process	Monthly	Trajectory	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%	0.93%
							Actual	0.53%	0.55%	1.15%	1.45%	0.95%	0.96%	0.99%
				Attendance at handover recorded - % of full H@N clinical team (required vs actual)	Process		Trajectory							
							Actual							
	Electronic Handover		Implementation of electronic handover	% of tasks allocated and succesfully closed by the following day	Process		Trajectory							
							Actual							
				Implementation of an electronic handover	Outcome		Trajectory							
							Actual							
	Hospital at night (task allocation)		Implementation of Hospital at Night software	Number of calls to the 2222 number out of hours	Balance	Monthly	Trajectory						53	53
							Actual						53	

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

5.3

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

Purpose:	Approval		Decision		Information	■	Assurance	■

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This paper sets out the regular nursing and midwifery retrospective staffing report for the month of April 2019 (part A), and provides an update to the workforce position (part B). Headlines: • Whilst the RN/M fill rate dropped in month, the overall fill rate (RN/M and HCA) for the wards has remained static • There has been a reduction in NHSP demand. • The overall nursing vacancy position remains broadly unchanged in M1 as is the Band 5 vacancy rate. The Band 5 pipeline recruitment plan has been slow to start picking up however the target offer rate continues to have strong focus with a projected stepped increase in the number of new starters from August 19. • An exception report detailing the analysis of the rota fill, any impact on quality and actions is included in appendix.2.
Recommendation:	The Board is asked to note the information within this report

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

Previously considered by:	WFC.20.05.19 QSC.24.05.19
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	Appendix 1: Ward level fill rates Appendix 2: Ward staffing exception reports

1.0 PURPOSE

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

2.0 BACKGROUND

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

3.0 ANALYSIS

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

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

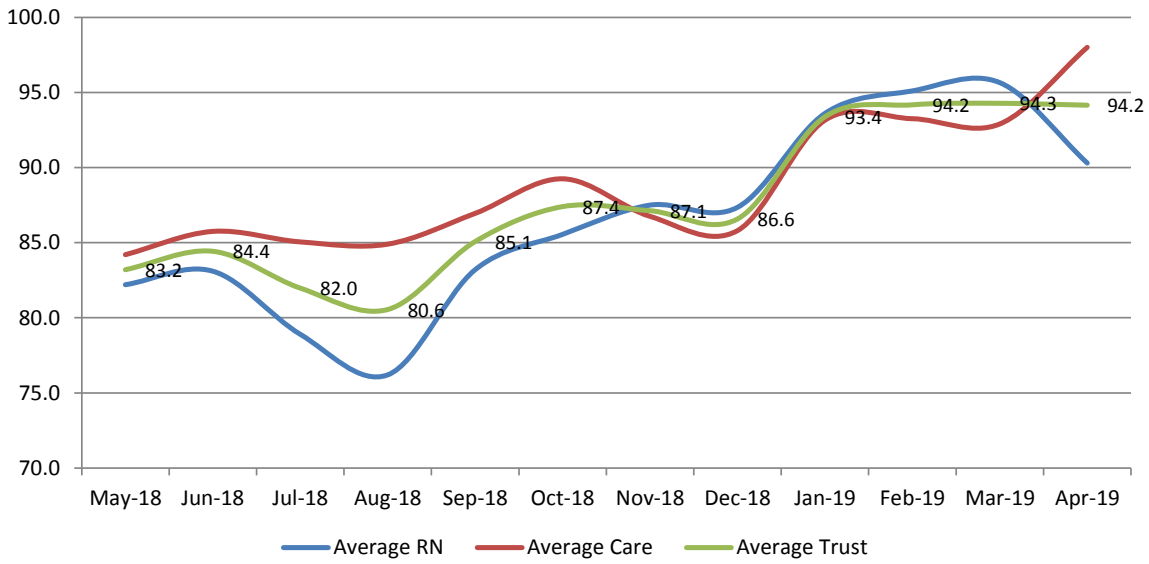
3.3 Care Hours per Patient Day* (CHPPD) has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018). From September 2018, publication of CHPPD replaced the actual v's fill dataset on My NHS and NHS Choices. CHPPD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

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

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Av RM/RN	Av care staff	Av ALL staff
Trust average	85.2% (83.3%)	84.9% (82.1%)	95.4% (108%)	111% (103.7%)	90.3% (95.7%)	98% (92.9%)	94.2% (94.3%)
Change	↑1.9%	↑2.8%	↓12.3%	↑7.3%	↓5.4%	↑5.1%	↓0.1%

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

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



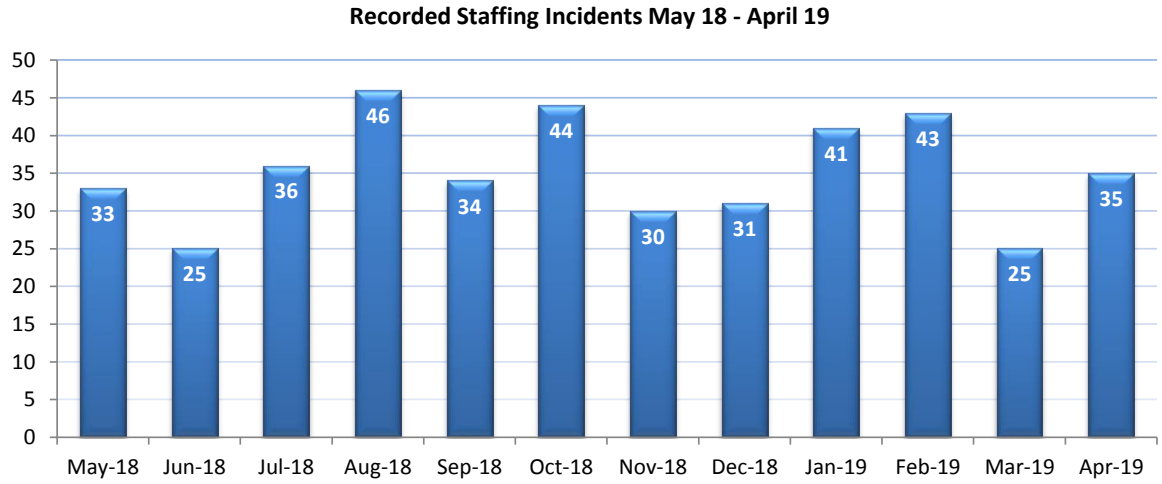
3.6 Exception reporting: Appendix 2 shows the exception report for the wards. The report includes analysis of the position, impact on quality, safety or experience and details actions in place to mitigate and improve the position where safe staffing is of concern.

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

	Day		Night	
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
A&E Nursing	86.2%	178.3%	102.4%	94.4%
PAH Theatres	80.4%	76.0%	88.0%	100.0%
Endoscopy Nursing	102.8%	88.3%	-	-

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

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

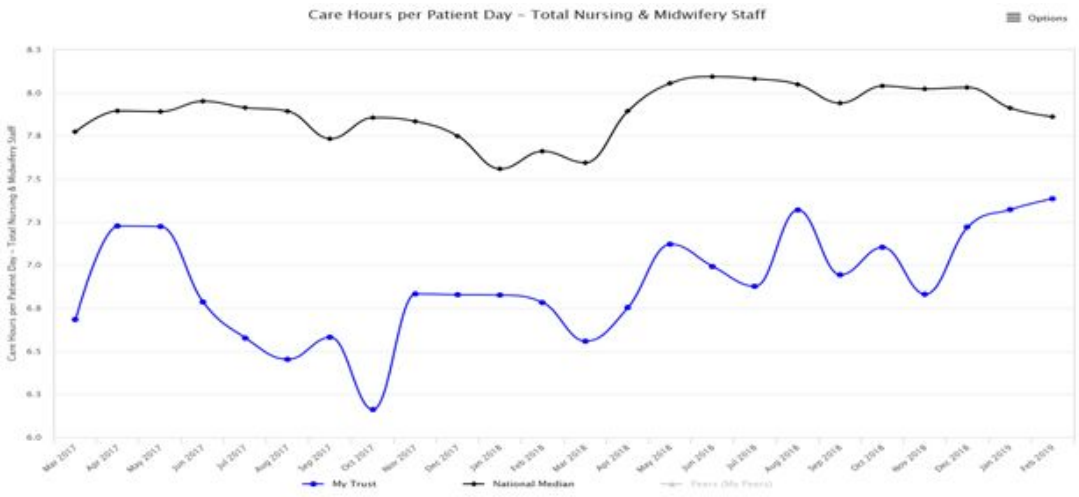


3.7.1 Led by the Deputy Director of Nursing, work is continuing on developing the process for taking forward how the Trust will use and record Red Flags alongside refreshed nurse sensitive key performance indicators.

3.8 Care Hours per Patient Days (CHPPD): Data from the Model Hospital Dashboard (updated February 2019).

	January 2019 data	Feb 2019	March 2019	National Median (Feb 2019)	Variance against national median
CHPPD Total	7.3	7.4	Not available	7.9	0.5
CHPPD RN	4.4	4.4	Not available	4.6	0.2
CHPPD HCA	3.0	3.0	Not available	3.2	0.2

The graph below shows Care Hours per Patient Day (total Nursing and Midwifery Staff) taken from the Model Hospital site (last data refresh February 2019) showing PAH against the national median.

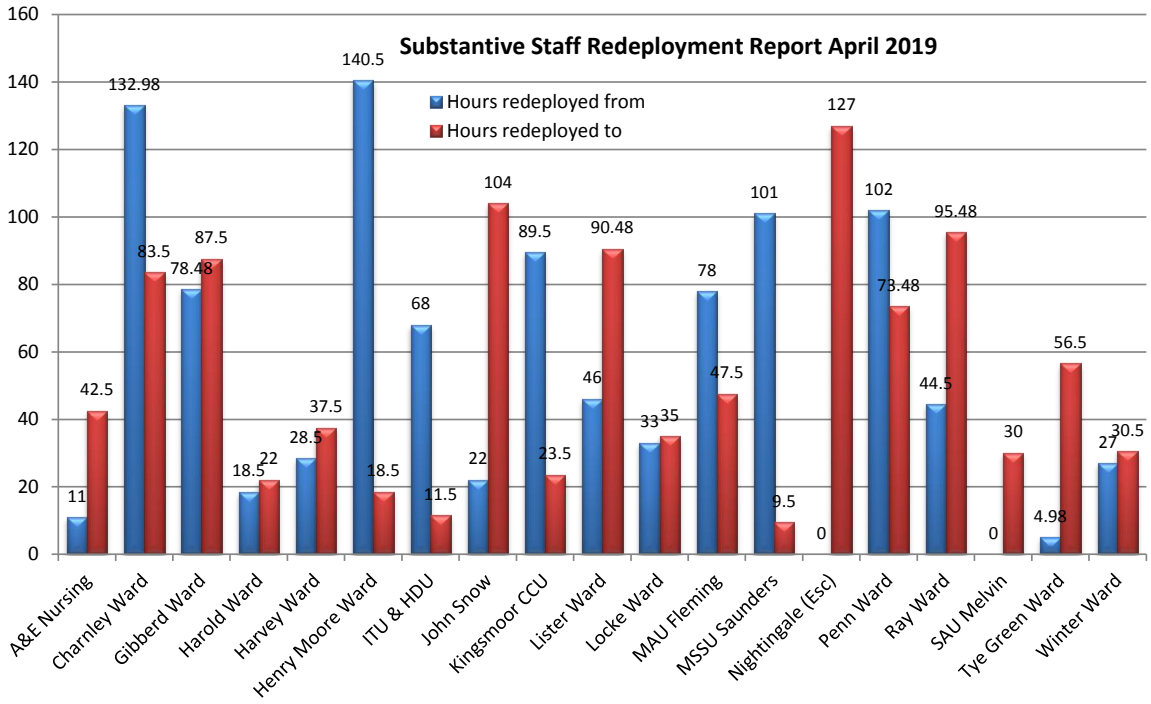


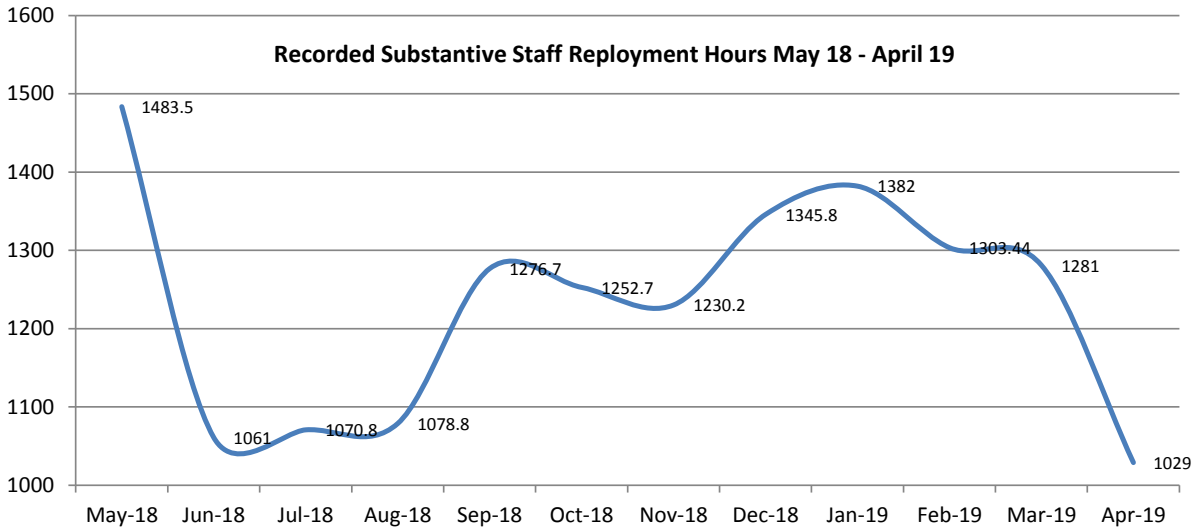
3.9 There were no beds closed as a result of staffing concerns during April 2019.

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

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

3.11 Redeployment of staff: The graph below shows each of the Safer Staffing Wards and the number of hours of staff redeployed from the ward to support safe staffing and the number of hours of staff received. The maternity wards have been excluded from this report as they flex staff across the whole service dependant on patient and service needs. The graph only shows the redeployment of substantive Trust staff and does not capture the moves of bank or agency staff.





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

3.12 Bank and Agency fill rates:

The use of NHSP continues to support the clinical areas to maximise safer staffing. The Trust has worked with NHSP to increase the availability of resource, and are working in partnership to improve this further. The table below shows that there was a significant decrease in registered demand (↓921 shifts) in April. Although there was a reduction in NHS P fill, there was an increase in agency fill resulting in an increase in overall registered fill rate. This is likely to be in line with the reduction in availability over the Easter holidays. The HCSW

demand also decreased (↓548 shifts) and though the number of shifts filled was down the overall fill rate was up against March.

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
January 2019	3,934	1,832	46.6 %	1,074	27.3 %	73.9 %	1,028	26.1 %
February 2019	4,047	1,824	45.1%	1,123	27.7%	72.8%	1,100	27.2%
March 2019	5,303	2,208	41.6%	1,387	26.2%	67.8%	1,708	32.2%
April 2019	4,382	1652	37.7%	1,407	32.1%	69.8%	1323	30.2%
April 2018	3904	1330	34.1%	961	24.6%	58.7%	1613	41.3%

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
January 2019	2,132	1,663	78.0 %	0	0.0 %	78.0 %	469	22.0 %
February 2019	2,349	1,723	73.4%	0	0%	73.4%	626	26.6%
March 2019	2,762	1,951	70.6%	0	0%	70.6%	811	29.4%
April 2019	2214	1707	77.1%	0	0%	77.1%	507	22.9%
April 2018	1996	1197	60.0%	0	0%	60.0%	799	40.0%

The December 2018 bank staffing initiative continues to be a success, and has been further extended until the end of August 2019, in order to continue supporting safe staffing and maximise the bank fill rates, the impact will continue to be reviewed and assessed. .

B: Workforce:

Nursing Recruitment Pipeline

The registered nursing vacancy rate (currently at 27.1%) remains one of the organisations biggest challenges. The bulk of this sits within the band 5 nursing establishment where currently 42% of the posts are vacant (April). The trust seeks to significantly reduce the vacancy position for band 5 nurses throughout 2019, with a concerted overseas recruitment campaign that will see an intensive programme of international nurse recruitment over the next financial year and into 2020/21. A stretch target of < 10% vacancy rate is being pursued for the end of the financial year.

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

The table below details our overall nursing vacancy and highlights our band 5 nursing establishment and the corresponding recruitment pipeline. As at end of April 2019, there were 205 WTE vacant band 5 posts. This is an increase from M12 however this takes into account the additional funding for 20WTE that was agreed at the beginning of 2019 as part of the nursing establishment review. The trajectory remains in place to reduce this to > 10% by the end of 2019/20. The pipeline is reviewed and updated each month to reflect actual starters and leavers.

Establishment 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 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	687.27	690.27	704.27	717.27	730.27	762.27	791.27	820.27	838.27	848.27	851.27	857.27
Vacancy WTE	255.34	252.34	238.34	225.34	212.34	180.34	151.34	122.34	104.34	94.34	91.34	85.34
Forecast RN Vacancy Rate	27.1%	26.8%	25.3%	23.9%	22.5%	19.1%	16.1%	13.0%	11.1%	10.0%	9.7%	9.1%

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
Band 5 Staff in Post WTE	282	285	299	312	325	357	386	415	433	443	446	447
Band 5 Starters	6	5	20	19	19	38	35	35	24	16	9	7
Projected Band 5 RN Leavers	9	2	6	6	6	6	6	6	6	6	6	6
Vacancy Band 5 WTE	206.16	203.16	189.16	176.16	163.16	131.16	102.16	73.16	55.16	45.16	42.16	41.16
Forecast Band 5 Vacancy Rate	42.3%	41.6%	38.8%	36.1%	33.4%	26.9%	20.9%	15.0%	11.3%	9.3%	8.6%	8.4%

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	Total
Band 5 RN Starter													
Newly Qualified/ Pre Reg Nurses	0	0	0	0	0	6	0	0	6	0	0	0	12
International Recruitment													
Skype Recruitment *	5	5	13	12	12	22	25	25	10	10	3	2	144
Overseas Campaigns (July + Dec 18)	1	0	7	7	7	10	10	10	8	6	6	5	77
Provisional Band 5 Starters (Total)	**6**	**5**	**20**	**19**	**19**	**38**	**35**	**35**	**24**	**16**	**9**	**12**	**233**

* Relates to buisness case

NB Funded establishment does not include any planned uplift for additional areas

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

- We are continuing to pursue the offers made to candidates on the 2 international recruitment campaigns undertaken in July and December 2018. The timeline for these nurses to commence at PAH is >12months from offer to start date which is within expected range however the recruitment team are working closely with the agencies to try speed up this process where possible and understand what the actual drop-out rate will be in order to have a more accurate picture of the nurses who will commence in post.

- Recruitment via Skype interview a more effective way of interviewing candidates as the lead in time from interview to start date is considerably shorter. We have expanding the number of recruitment agencies used to provide candidates for Skype interview with a plan to interview 50 candidates per month and expect to make offers to 25/30 nurses of these based on our experience to date.

- From the above, we average approximately 6 WTE registered nurse leavers a month; work will continue to embed the nursing retention plan to reduce this figure which will be taken forward by the new post of Lead Nurse or Recruitment and Retention when they are recruited which is expected to be by October 2019.

Attraction & Retention

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

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

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

- International recruitment buddies/network, to formalise the integration of our international recruits with existing overseas nurses. This will include;
    - Buddying for new employees

- ‘Itchy feet’ coaching for those employees who are looking for their next step
- Career development coaching

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

Effective rostering and efficient use of resources:

- A monthly roster KPI report has been developed for circulation and ownership across the HCGs. Monthly meetings have been scheduled over 2019 to focus on productivity and driving forward efficient rotas.
- Roster Perform, which provides an accessible retrospective and prospective view of rostering metrics, will be made visible and used to demonstrate performance and drive forward improvements. Importantly, the system will enable a prospective view of rota fill, and identify areas that can be actioned in advance to improve availability (peaks in annual leave, study leave). The E Roster team needs to re-focus training on this.

4.0 RECOMMENDATION

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

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

Date: 23rd May 2019

Appendix 1.

Ward level data: fill rates April 2019.

	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 (%)
Dolphin Ward	88.7%	72.6%	89.8%	147.5%
Kingsmoor CCU	88.4%	77.1%	104.2%	104.4%
MAU Fleming	55.2%	72.1%	71.2%	105.0%
Tye Green Ward	94.8%	109.2%	81.1%	116.0%
Harvey Ward	85.1%	81.0%	121.7%	102.8%
ITU & HDU	75.1%	54.7%	79.8%	-
John Snow	93.8%	91.3%	90.3%	114.4%
Charnley Ward	88.2%	83.9%	124.7%	110.7%
Lister Ward	100.7%	98.4%	151.6%	150.2%
Locke Ward	90.9%	99.1%	113.7%	159.9%
Neo-Natal Unit	98.7%	54.1%	85.3%	66.7%
Penn Ward	99.0%	97.0%	140.4%	120.7%
Ray Ward	99.5%	80.6%	149.5%	144.1%
MSSU Saunders	111.1%	100.4%	125.7%	103.3%
Harold Ward	72.7%	83.0%	127.6%	120.5%
Henry Moore Ward	84.8%	65.6%	91.0%	79.6%
Gibberd Ward	74.2%	108.6%	85.6%	107.9%
Winter Ward	67.8%	112.8%	105.4%	144.1%
Chamberlen Ward	79.6%	75.2%	72.9%	86.4%
Labour Ward	83.7%	60.1%	71.3%	71.7%
Samson Ward	113.1%	72.2%	94.9%	83.3%
Birthing Unit	86.6%	79.8%	90.7%	87.0%

Trust Performance	**85.2%**	**84.9%**	**95.4%**	**111.0%**

Appendix 2
Ward staffing exception reports
Reported where the fill is < 85% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes

April 19

	Report from the Associate Director of Nursing for the HCG		
Ward	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Fleming	Staff are not deployed to Fleming from pool due to specialist nature of Fleming however staff from Saunders are deployed. DQ issues as Allocate nit updated to reflect in real time.	No complaints received and 1 new PALS enquiry. There were no red or SI incidents reported in month.	Live adverts in place. Matron and Head of Nursing meet monthly to review current situation.
Gibberd Ward	Registered nurse numbers offset by increase in HCA numbers reflecting nature of care needs of patient group	No complaints received and 4 new PALS enquiries. There were no red or SI incidents reported in month.	Live adverts in place. Matron is working on ward every Monday and maintaining a high profile throughout the week. Ward Manager and matron meet with the Head of Nursing monthly.
Chamberlin Ward	Long term sickness within maternity and number of midwives on maternity leave.	No impact on quality or outcomes. Staff are moved across all maternity areas as part of the daily staffing huddle and senior managers are redeployed to support with workload when required.	Close monitoring of LTS alongside policy plus maternity leave Trajectory for those staff that require appraisal Daily staffing huddles reviewing red flags alongside activity so all areas are safe Review of data from Birthrate plus
Labour Ward	Long term sickness within maternity and number of midwives on maternity leave.		As above as staffing is reviewed as a unit
Neo Natal Unit	No gaps in HCSW numbers our workforce plan has changed as yet E-roster does not reflect this	No noted impact on quality or safety	Plans to amend the e-roster template to reflect our actual staffing demand
Henry Moore	Due to reduction of patient capacity within ward, shifts not	No noted impact on quality or safety	Capacity and staffing demands matched – no further

	required to be covered.		actions required.
ITU / HDU	Due to reduction of patient capacity and acuity within unit, shifts not required to be covered.	No noted impact on quality or safety	Capacity and staffing demands matched – no further actions required.

Trust Board – 6 June 2019

Agenda Item:	6.1
Presented by:	Ogechi Emeadi, Director of People, OD & Communications
Prepared by:	Ogechi Emeadi, Director of People, OD & Communications
Executive Director Sponsor	Ogechi Emeadi, Director of People, OD & Communications
Subject / Title:	Freedom to Speak Up Self Assessment

Purpose:	Approval	X	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Trust's Freedom to Speak Up self assessment is attached. The self-assessment template reflects where the Trust has met/partially met or not met the expectations along with the supporting evidence and actions. The narrative in red font reflects the current position versus the previous self -assessment reported to Board in June 2018.
Recommendation:	The Board is asked to discuss and approve the self -assessment.

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

Previously considered by:	N/A
Risk / links with the BAF:	2.1 Workforce capacity 2.3 Internal engagement
Legislation, regulatory, equality, diversity and dignity implications:	CQC – Well led
Appendices:	N/A

6.1

National Guardian
Freedom to Speak Up

NHS
Improvement

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

~~May 2018~~ May 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 ~~(frequency to be agreed)~~ three times a year. Attendance at the Trust Board as required. This self review tool is presented annually.	FTSUG attend ~~are members of~~ 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 &	~~See above~~Review of any external whistleblowing cases

		underpinning governance	(CQC insight report) to 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 ~~Partially~~ 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.
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.	~~Partially~~ 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 ~~& Head of HR~~ 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	Partially met	Continue to promote through existing communications	See above

fairly.		channels	
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 ~~Partially~~ met	Confirm NED and exec ~~(Chair of Workforce sub committee?)~~	Chair of the patient safey and quality committee is the named NED. Director of people ~~CEO~~ 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.	~~Partially~~ 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 d~~D~~irector of p~~P~~eople, ~~Head of HR,~~ 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 ~~Partially~~ 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
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 ~~in Q4~~	Reports are presented to workforce committee three times a year.~~See~~

		~~of 2018/9~~	~~above~~
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.	~~Partially~~ 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~~8~~/20~~19~~ 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~~Not~~ met	Review with CEO and Executive Team.	Themes discussed at CQC well led inspection and use of resources in March and April 2019~~TBC~~. 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, inspectors and other local FTSU Guardians	Fully met	Integrate into the regulatory timetable	Met with CQC inspectors in April 2019~~December 2018~~
Senior leaders request external improvement support when required.	~~Partially~~ Fully met	Inform FTSUG of external improvement	External improvement support obtained in numerous areas eg

		support.	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.	~~Partially~~ 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.	~~Partially~~ Fully met	Extend to include the new Director of People, OD & Communications	~~Currently a~~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 met	Integrate into the CEOs new OD programme	Numerous diagnostic reports received by senior leaders. The Trusted executive survey to top 100 leaders due in August 2019

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

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
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~~8~~/2020~~19~~ (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 2019~~8~~/~~19~~20
Operationalising the learning derived from speaking up issues.	Partially ~~Not~~ met	Consider how to operationalise the learning from speaking up issues	~~N/A~~Learning will form part of the unconscious bias training for managers and the introduction of am I a bully training.
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 ~~Partially~~ met	~~Confirm~~ a named NED to review with the FTSUG.	Named NED regularly meets with F2SUG~~Currently through the CEO~~
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	~~Partially~~ Fully met	See above	Named NED raises any issues with ~~Regular meetings~~ 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.	~~Partially~~ Fully met	Propose 'reflections and review' as a regular agenda item at Board and/or sub committee meetings	Standing item ~~Attendance~~ at Board and sub committee meetings
Role-modelling high standards of conduct around FTSU.	Fully ~~Partially~~ met	Consider incorporating a review of role modelling high standards of conduct as part of the	NEDs at workforce committee receive positive feedback on role modelling high

		new 360 tool	standards of conduct Named NEDs appraisal
Acting as an alternative source of advice and support for the FTSU Guardian.	~~Partially~~ met	See above	Named NED meets regularly with F2SUGs and provides a coaching and mentoring ~~at workforce committee act as an alternative source of advice and~~ 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~~with Head of HR~~ 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	Evidenced via corporate staff and culture surveys and local HCG surveys

		on the TTEF methodology	
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

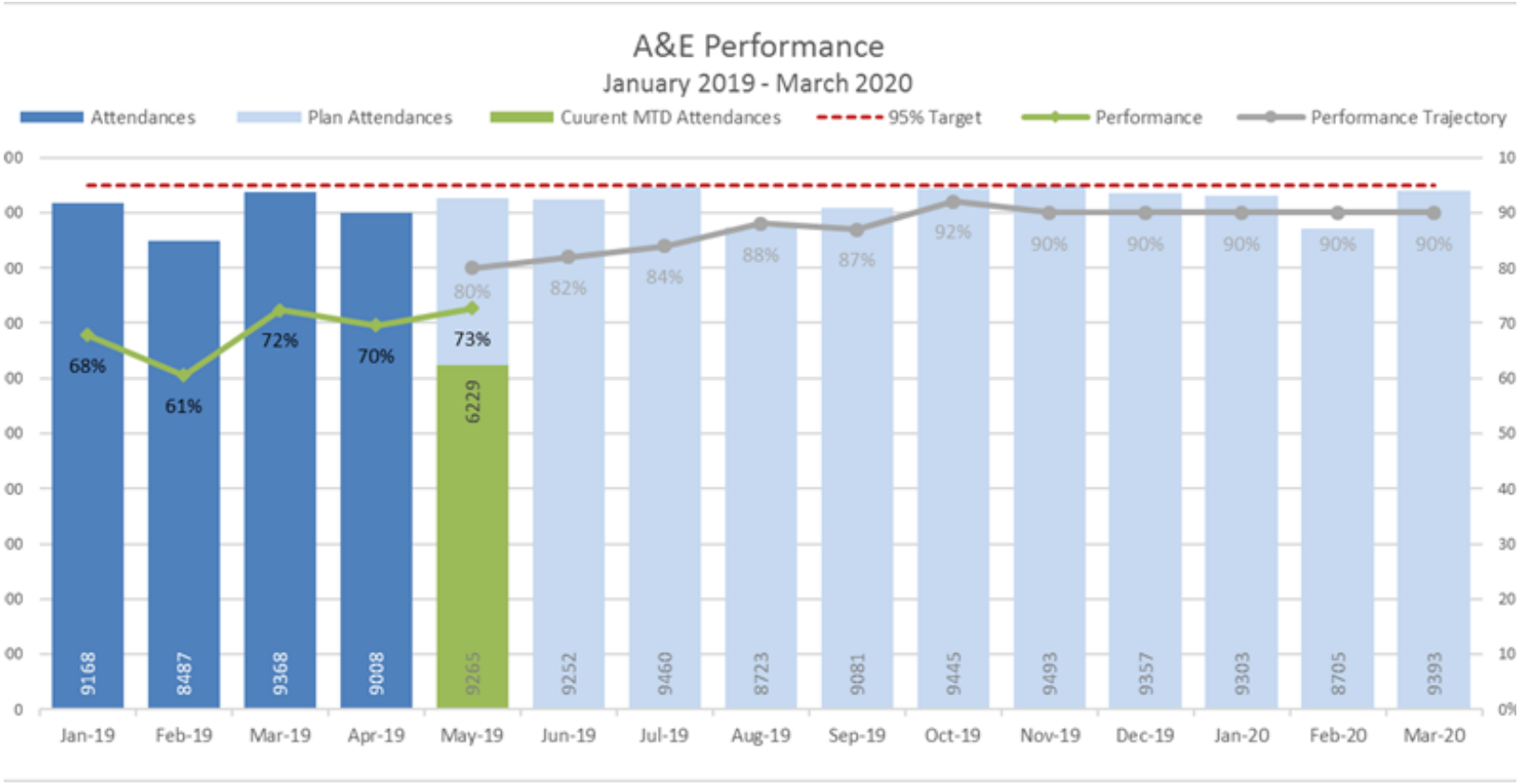
Performance & Finance Committee

Emergency Care May 2019

Content

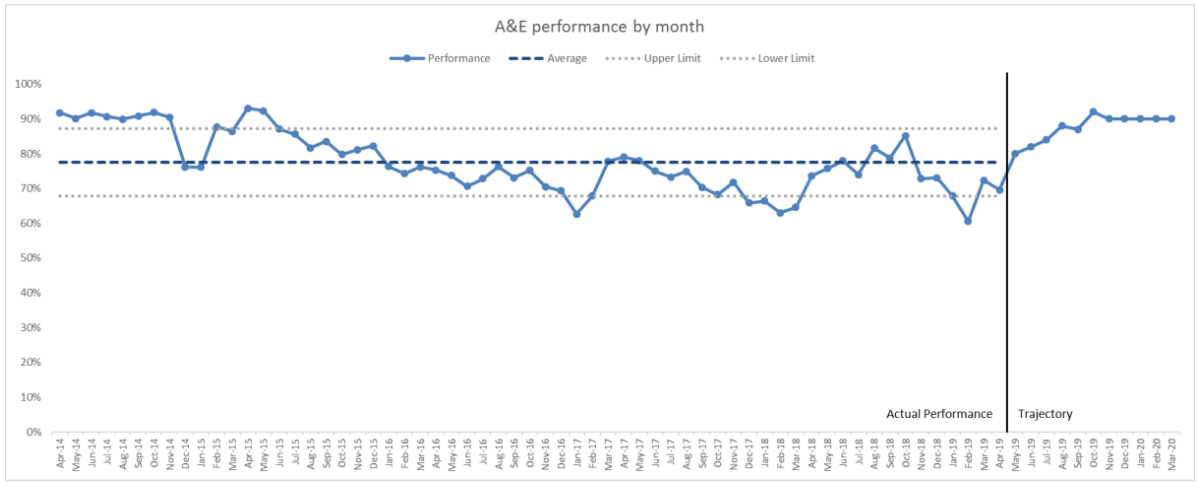
- Current Performance
- Paediatric performance
- Ambulance Handovers
- Interventions 18/19
- Interventions 19/20
- ECIST work and feedback
- New proposed emergency standards
- Streaming and GP model
- Further System Actions

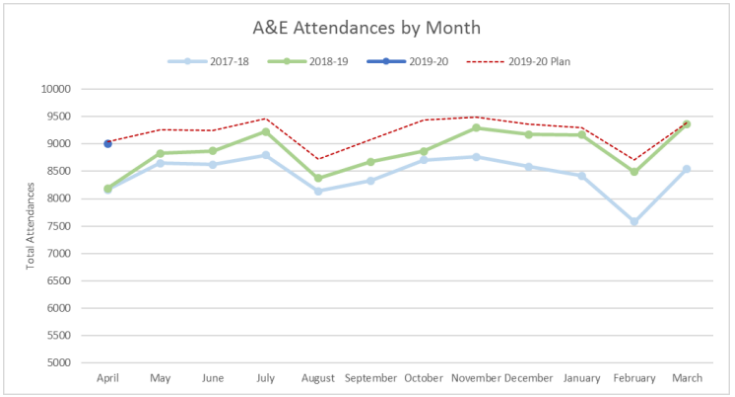
4 hour Performance

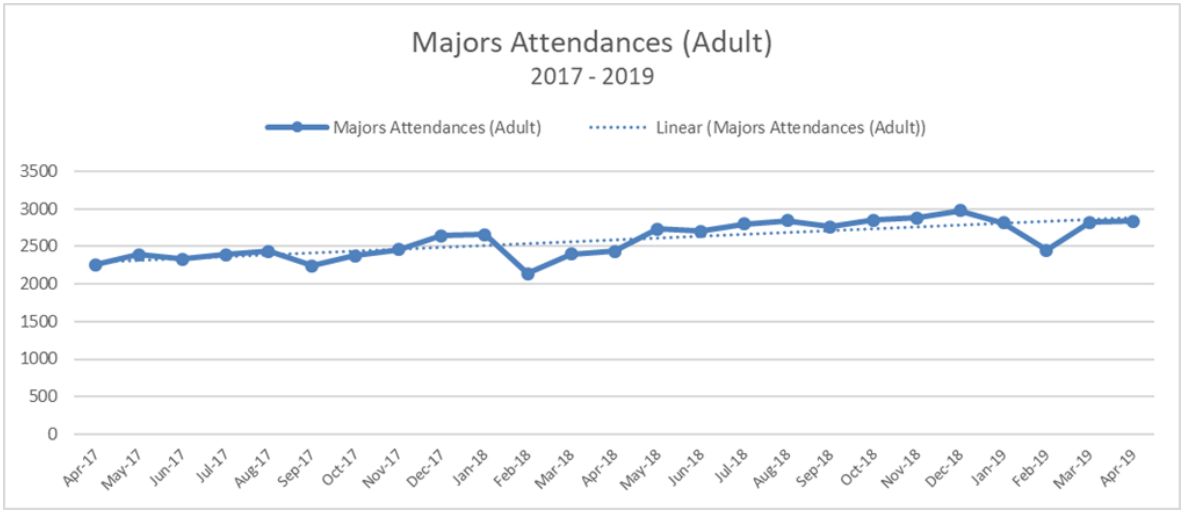


A&E Growth and Planning

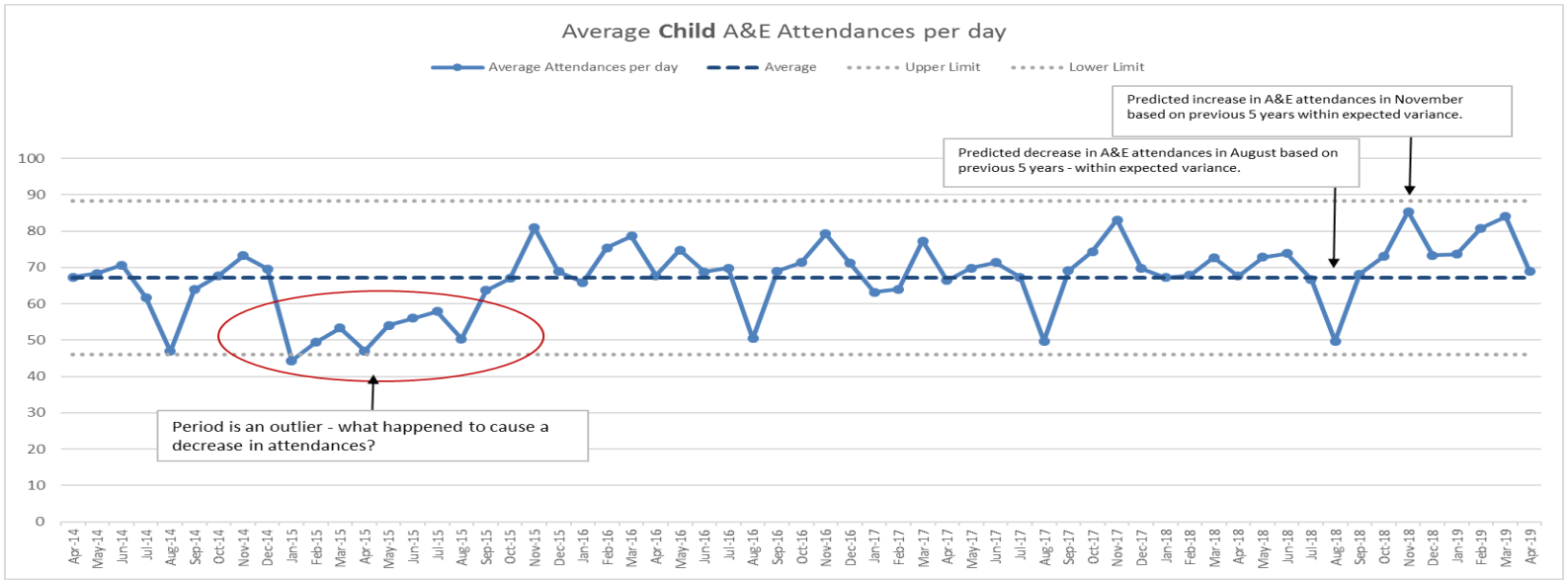
	April	May	June	July	August	September	October	November	December	January	February	March
2017-18	8164	8649	8625	8794	8141	8328	8707	8767	8583	8419	7584	8547
2017-18 %	79.0%	78.1%	75.0%	73.3%	75.0%	70.4%	68.3%	71.8%	67.3%	66.4%	63.1%	64.5%
2018-19	8192	8829	8875	9226	8373	8678	8868	9296	9173	9168	8487	9368
2018-19 %	73.7%	75.8%	77.9%	74.0%	81.6%	78.8%	85.1%	72.8%	73.1%	67.9%	60.8%	72.4%
% Change (17-18 to 18-19)	0.3%	2.0%	2.8%	4.7%	2.8%	4.0%	1.8%	5.7%	6.4%	8.2%	10.6%	8.8%
2019-20 YTD	9008											
2019-20 YTD %	69.6%											
% Change (18-19 to 19-20)	9.1%											





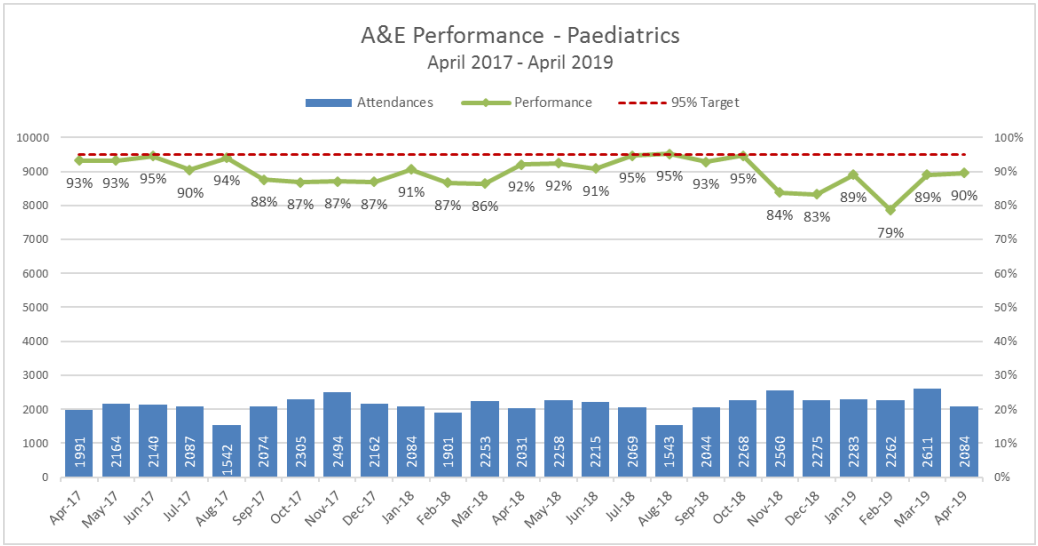


Paediatrics



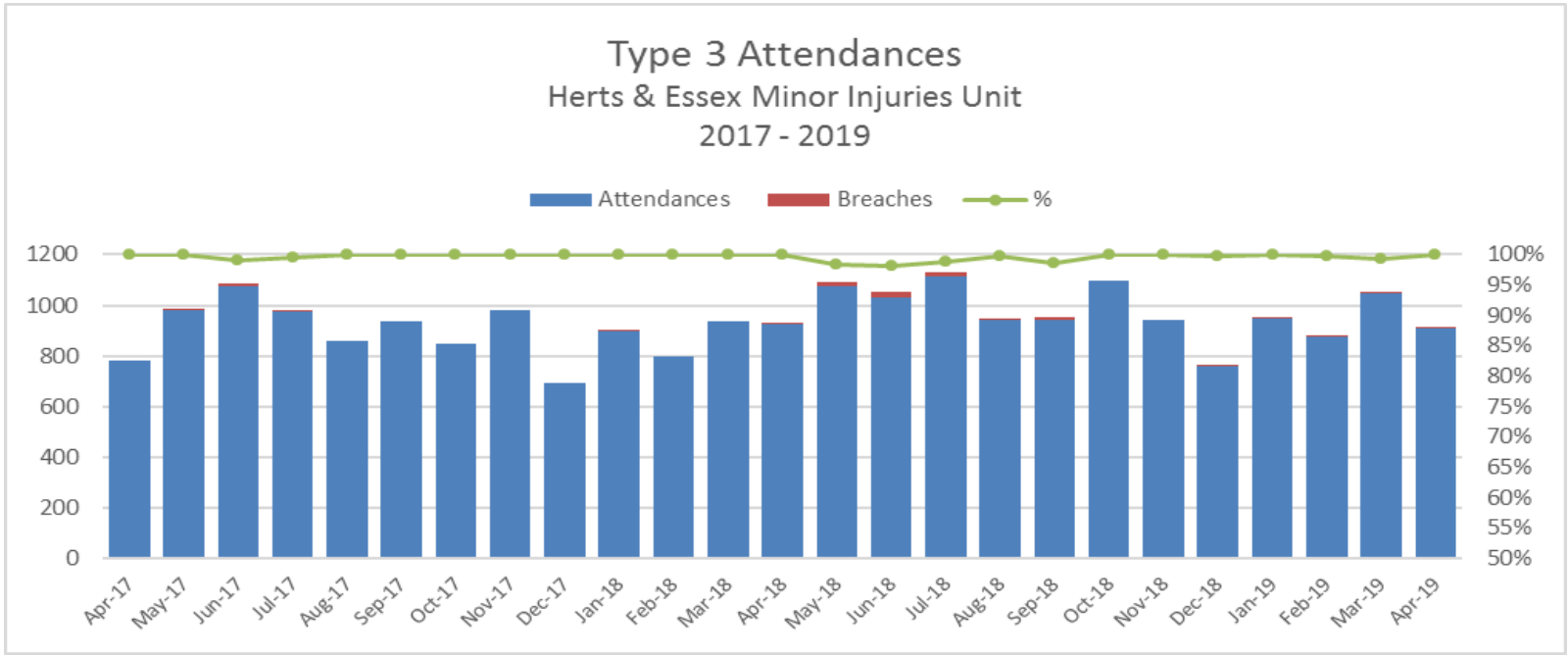
- **Actions Taken**

- Paediatric Nurse Staffing Improving position
- Additional Locum Consultant Commenced Mid May
- 5 day consultant cover in Paed ED 8-6pm
- PAU opening 7 days
- Winter Planning and Review of Rotas
- Explore GP Streaming model



Type 3 Attendances (Mon – Fri 9-5)

Attendances at HEH Minor Injury Unit have remained relatively static

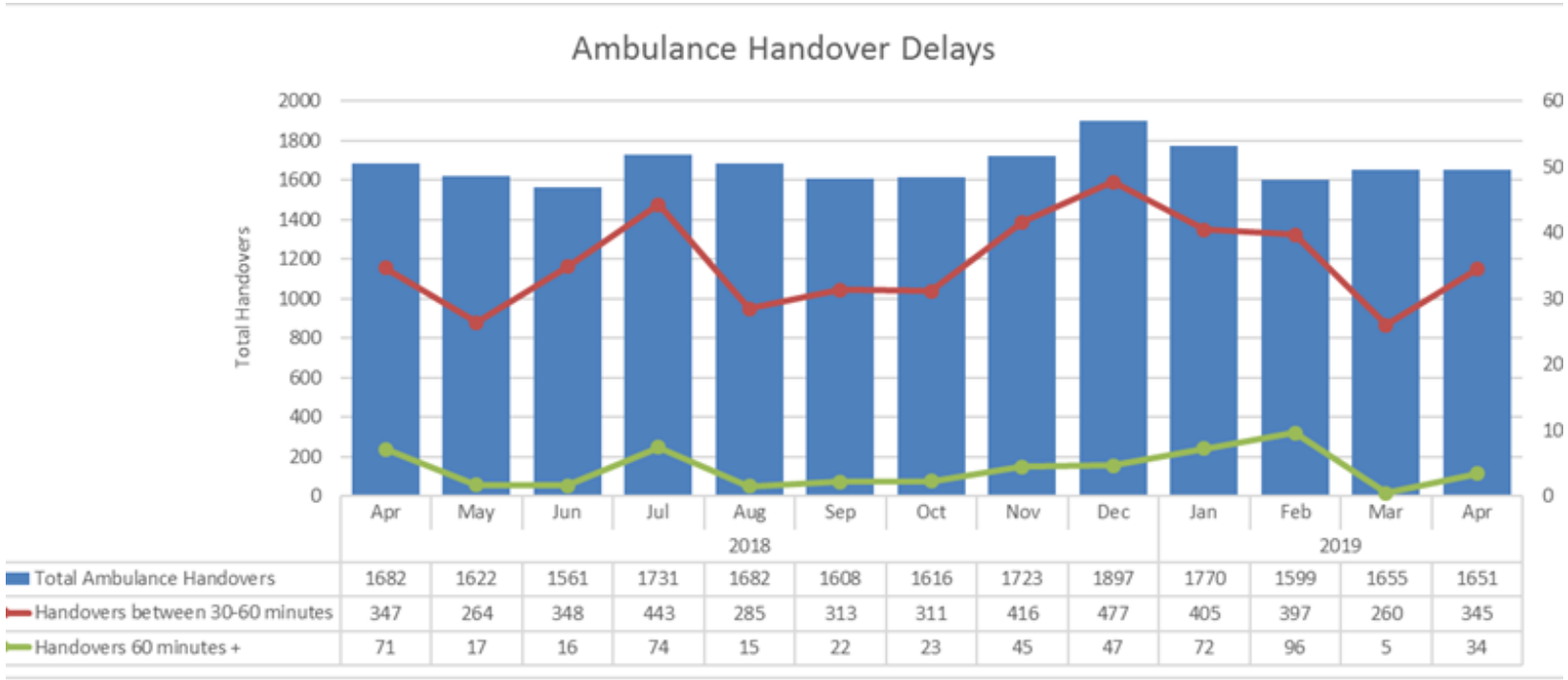


<u>Opportunities</u>

- Extend Opening Hours – 7 days
- Review diagnostic requirements
- Increase to cover minor illness
- Review skill mix
- Sign posting through 111

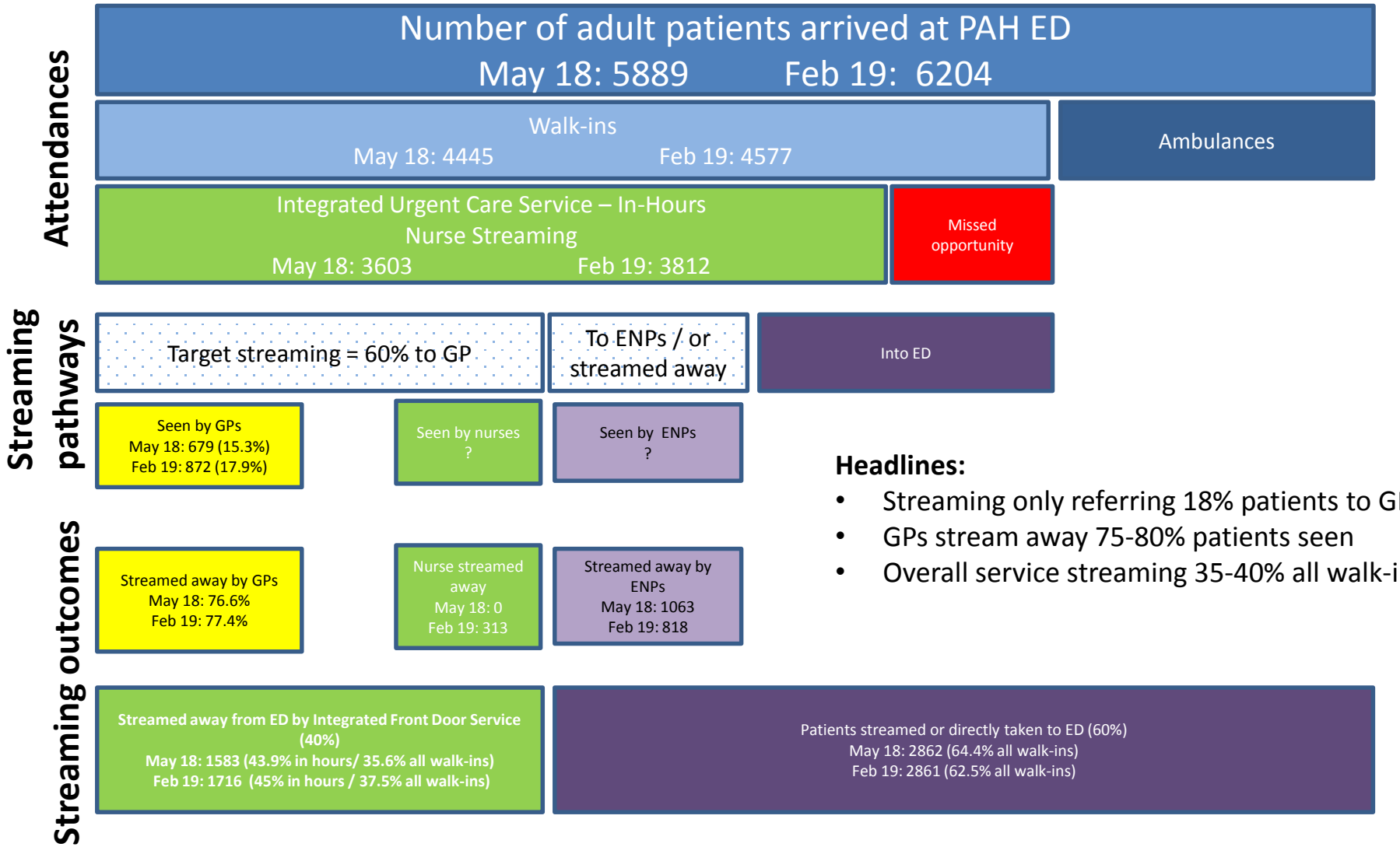
Ambulance Handovers

HALO – March 19
Ambulance Liaison Group



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
	2018									2019			
Total Ambulance Handovers	1682	1622	1561	1731	1682	1608	1616	1723	1897	1770	1599	1655	1651
Handovers between 30-60 minutes	347	264	348	443	285	313	311	416	477	405	397	260	345
Handovers 60 minutes +	71	17	16	74	15	22	23	45	47	72	96	5	34

PAH Streaming – May 18 vs Feb 19



Headlines:

- Streaming only referring 18% patients to GPs
- GPs stream away 75-80% patients seen
- Overall service streaming 35-40% all walk-ins

Improvement Actions

- Urgent Care Improvement Board
- ECIST support onsite since March 19
- Regional Emergency Care Lead May 19
- System Expert Oversight Group
- In, Through, Out work streams
- 2nd performing Trust in UK for inpatient diagnostic turnaround times
- 6th performing Trust in UK for ED diagnostic turnaround
- Long Stay Weekly Reviews – Exec led

In

GP Streaming, some success, but not as effective as it should be. System review commenced – Stellar contracts ends on 30th June

ED Flow Trackers – recruited to support doctors to manage the non admitted pathway more effectively, 7 days a week

Nurse in Charge of minors in place

New RAT process to provide very early senior plans. Some success but still person dependent

2 hourly ED huddles to supplement 1pm huddle. Review of dept with Consultant in Charge, and Nurse in Charge to assess demand and staffing profile

Increased ED medical rota to support increased demand. Some success, but need to ensure the quality of the rota on a daily basis

Hospital Ambulance Liaison Officer (HALO) in place. Significant reductions in handovers over 60 minutes

Additional CT scanning capacity planned

Through

Increased Medicine bed capacity – Frailty beds, and Fractured Neck of Femur/Care of the Elderly

Frailty Assessment Unit relocated to next to ED, increased throughput and discharge rate

Weekend Ops support to ensure issues are escalated and resolved same as weekdays

Increased weekend therapy provision to enable increased decision making and discharge planning

Dedicated medical outlier team to ensure consistency of care is provided and remove the need for 'safari ward rounds'

Consistent Social Care Input at daily board round meetings

Increased Operational Support for inpatient wards, enabling swift support, escalation and resolution

Increased performance awareness of length of stay for Consultants, Matrons and Ward Managers. Daily reports provided

Additional medical assessment space planned

Out

Reduction in Lost Bed Days from over 500 in June 2018 to consistently under 250

Exceeded the national DTOC standard for over 12 months

Increased discharge home to assess capacity provided in East and North Herts

Increased weekend integrated discharge support from all partners to increase weekend discharge planning

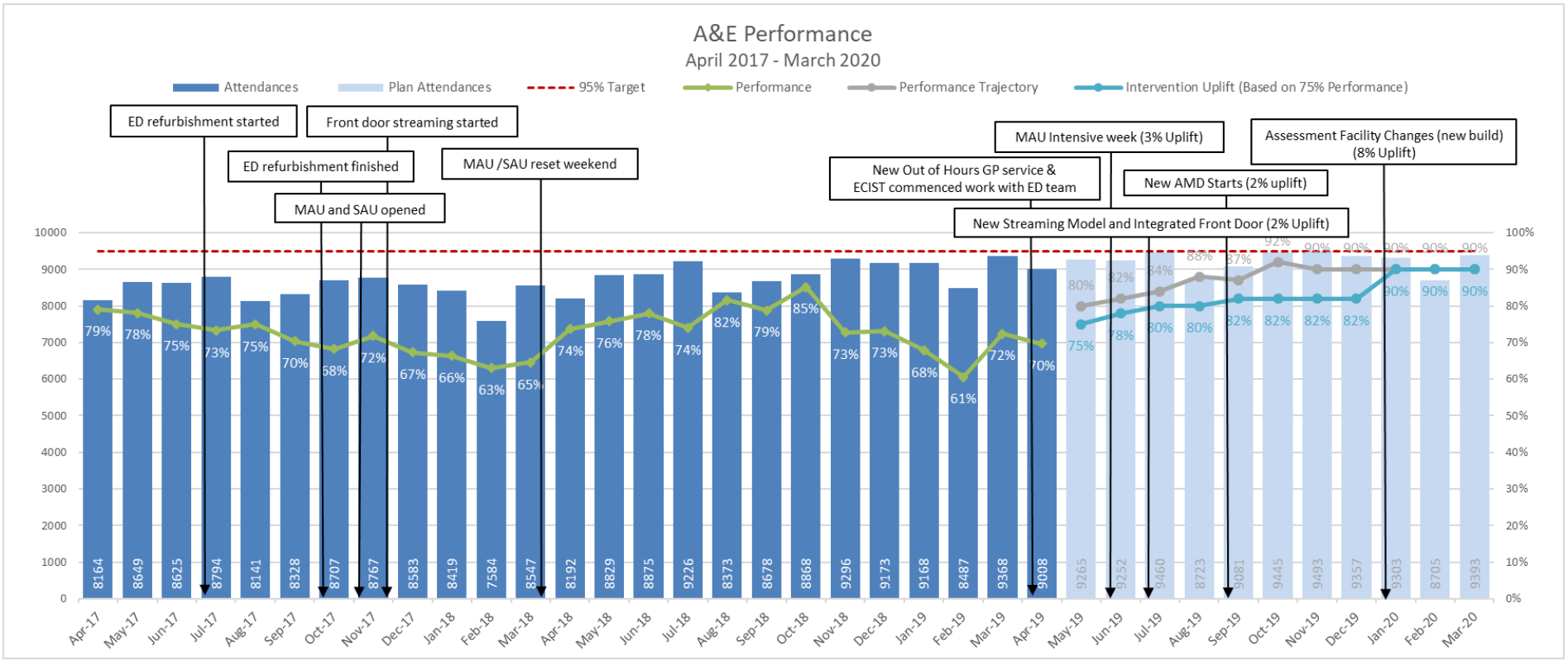
A&E Local Delivery Group established, to coordinate system priorities and responses

Increased access to Rehab and Intermediate care beds in both West Essex and East and North Herts

Executive led top 20 weekly review of longest staying patients with

Twice weekly stranded patient review to enable more effective discharge planning and decision making

Our Journey


A&E Performance
April 2017 - March 2020
Attendances
Plan Attendances
95% Target
Performance
Performance Trajectory
Intervention Uplift (Based on 75% Performance)
ED refurbishment started
Front door streaming started
ED refurbishment finished
MAU /SAU reset weekend
MAU and SAU opened
MAU Intensive week (3% Uplift)
Assessment Facility Changes (new build) (8% Uplift)
New Out of Hours GP service & ECIST commenced work with ED team
New AMD Starts (2% uplift)
New Streaming Model and Integrated Front Door (2% Uplift)
Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20

Interventions 2019/20

- HALO (March 19)
- New Integrated Front Door Team (PAH)
- Out of Hours GP service (April 19)
- ECIST Recruitment Support (May 19)
- Interim Clinical Leads (April 19)
- Internal Professional Standards
- AMD (Sept 19)
- Nursing Recruitment
- Medical and AHP recruitment
- MAU Intensive Week (June 19)
- Frailty System Workstream (Sept 19)
- Paediatric Staffing
- Executive huddles
- Winter Planning PAH
- Winter Planning System
- Intermediate Beds x 25 (Nov 19)
- Urgent Treatment Centre (Dec 19)

New proposed rota - weekdays

Doctor	Shift Time	00	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
MG	0800-1800									1	1	1	1	1	1	1	1	1	1						
MG	08:00-16:00*									1	1	1	1												
MG	08:00-16:00*									1	1	1	1												
MG Mon only	08:00-16:00*									1	1	1	1												
SHO	0800-1800									1	1	1	1	1	1	1	1	1	1						
SHO	0800-1800									1	1	1	1	1	1	1	1	1	1						
SHO	0800-1800									1	1	1	1	1	1	1	1	1	1						
SHO	0800-1800									1	1	1	1	1	1	1	1	1	1						
MG	1000-2000											1	1	1	1	1	1	1	1	1	1				
SHO	1000-2000											1	1	1	1	1	1	1	1	1	1				
SHO	1000-2000											1	1	1	1	1	1	1	1	1	1				
MG	1100-2100												1	1	1	1	1	1	1	1	1	1			
SHO	1100-2100												1	1	1	1	1	1	1	1	1	1			
MG	1200-2200													1	1	1	1	1	1	1	1	1	1		
SHO	1200-2200													1	1	1	1	1	1	1	1	1	1		
MG	16:00-00:00																	1	1	1	1	1	1	1	1
SHO	16:00-00:00																	1	1	1	1	1	1	1	1
MG	1800-0200	1	1																	1	1	1	1	1	1
SHO	1800-0200	1	1																	1	1	1	1	1	1
SHO	1800-0400	1	1	1	1															1	1	1	1	1	1
SHO	1800-0400	1	1	1	1															1	1	1	1	1	1
MG	2200-0830	1	1	1	1	1	1	1	1															1	1
MG	2200-0830	1	1	1	1	1	1	1	1															1	1
SHO	2200-0830	1	1	1	1	1	1	1	1															1	1
SHO	2200-0830	1	1	1	1	1	1	1	1															1	1
New shift	MG	8	8	6	6	4	4	4	4	8	8	11	13	12	12	12	12	14	14	13	13	10	8	10	10
Count	MGs	3	3	2	2	2	2	2	2	3	3	4	5	4	4	4	4	5	5	5	5	4	3	4	4
Count	SHO	3	5	4	4	2	2	2	2	4	4	6	7	8	8	8	8	9	9	8	8	6	5	6	6
Monday to Friday only - proposed																									

Notes

- Night shifts to be extended by 30 minutes for handover
- New day shifts to be work 08:00-12:00 shop floor, 12:00-16:00 CPD
- ENP late shift (8 hours) moved to day shift 09:00-17:00 Wednesday to Sunday
- ENP long days on Monday and Tuesday

New proposed rota - weekends

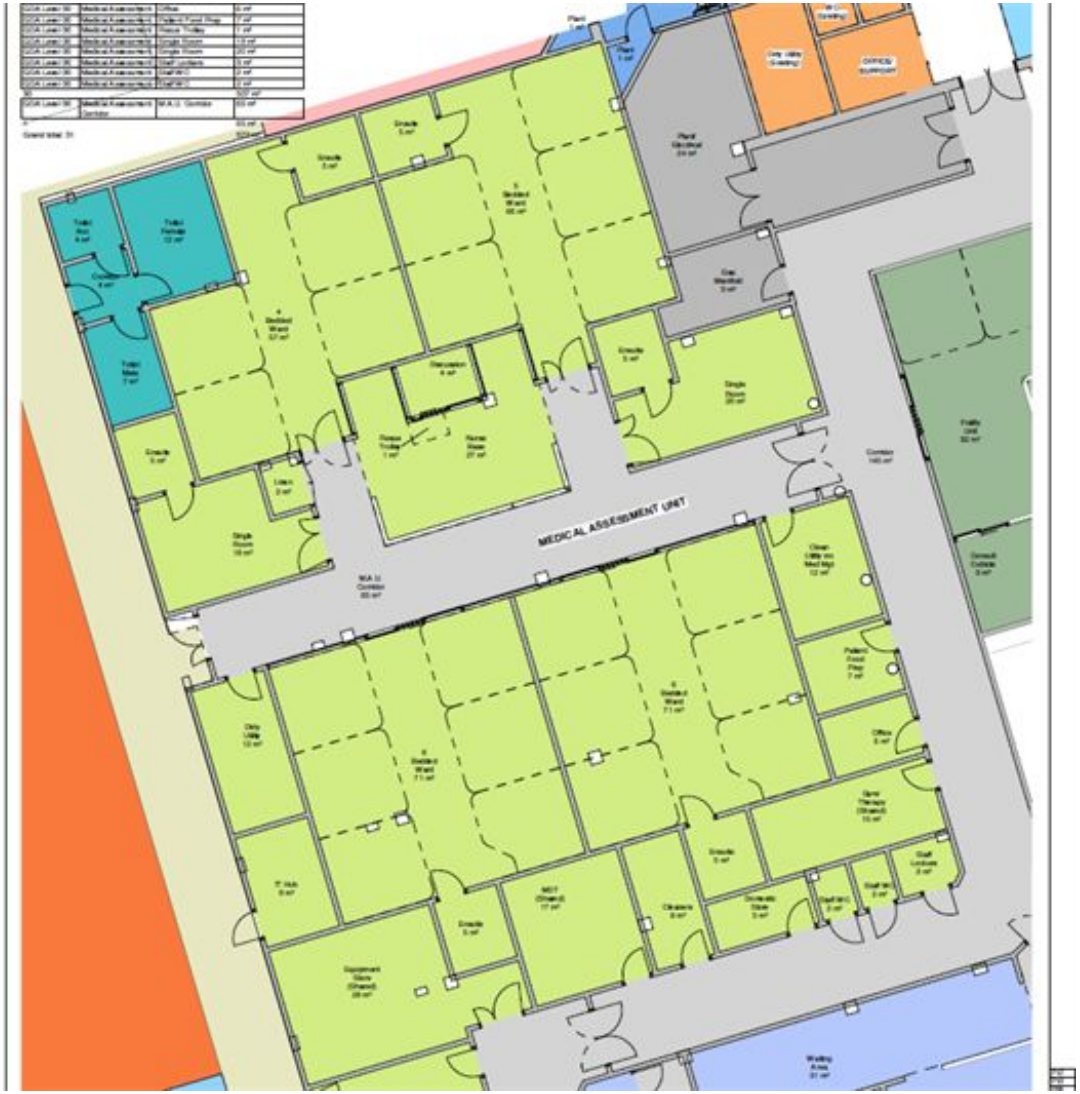
Doctor	Shift Time	00	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
MG	0800-1600									1	1	1	1	1	1	1	1								
MG	08:00-16:00*									1	1	1	1												
MG	08:00-16:00*									1	1	1	1												
SHO	0800-1600									1	1	1	1	1	1	1	1								
SHO	0800-1600									1	1	1	1	1	1	1	1								
SHO	0800-1600									1	1	1	1	1	1	1	1								
SHO	0800-1600									1	1	1	1	1	1	1	1								
MG	1000-1800											1	1	1	1	1	1	1	1						
SHO	1000-1800											1	1	1	1	1	1	1	1						
SHO	1000-1800											1	1	1	1	1	1	1	1						
MG	1100-2100												1	1	1	1	1	1	1	1	1	1			
SHO	1100-2100												1	1	1	1	1	1	1	1	1	1			
MG	1200-2200													1	1	1	1	1	1	1	1	1	1		
SHO	1200-2200													1	1	1	1	1	1	1	1	1	1		
MG	16:00-00:00																	1	1	1	1	1	1	1	1
SHO	16:00-00:00																	1	1	1	1	1	1	1	1
MG	1800-0200	1	1																	1	1	1	1	1	1
SHO	1800-0200	1	1																	1	1	1	1	1	1
SHO	1800-0100	1																		1	1	1	1	1	1
SHO	1800-0100	1																		1	1	1	1	1	1
MG	2200-0800	1	1	1	1	1	1	1	1															1	1
MG	2200-0800	1	1	1	1	1	1	1	1															1	1
SHO	2200-0800	1	1	1	1	1	1	1	1															1	1
SHO	2200-0800	1	1	1	1	1	1	1	1															1	1
New shift	MG	8	6	4	4	4	4	4	4	7	7	10	12	12	12	12	12	9	9	10	10	10	8	10	10
Count	MGs	3	3	2	2	2	2	2	2	3	3	4	5	4	4	4	4	4	4	4	4	4	3	4	4
Count	SHO	5	3	2	2	2	2	2	2	4	4	6	7	8	8	8	8	5	5	6	6	6	5	6	6
Weekends - proposed																									

Notes

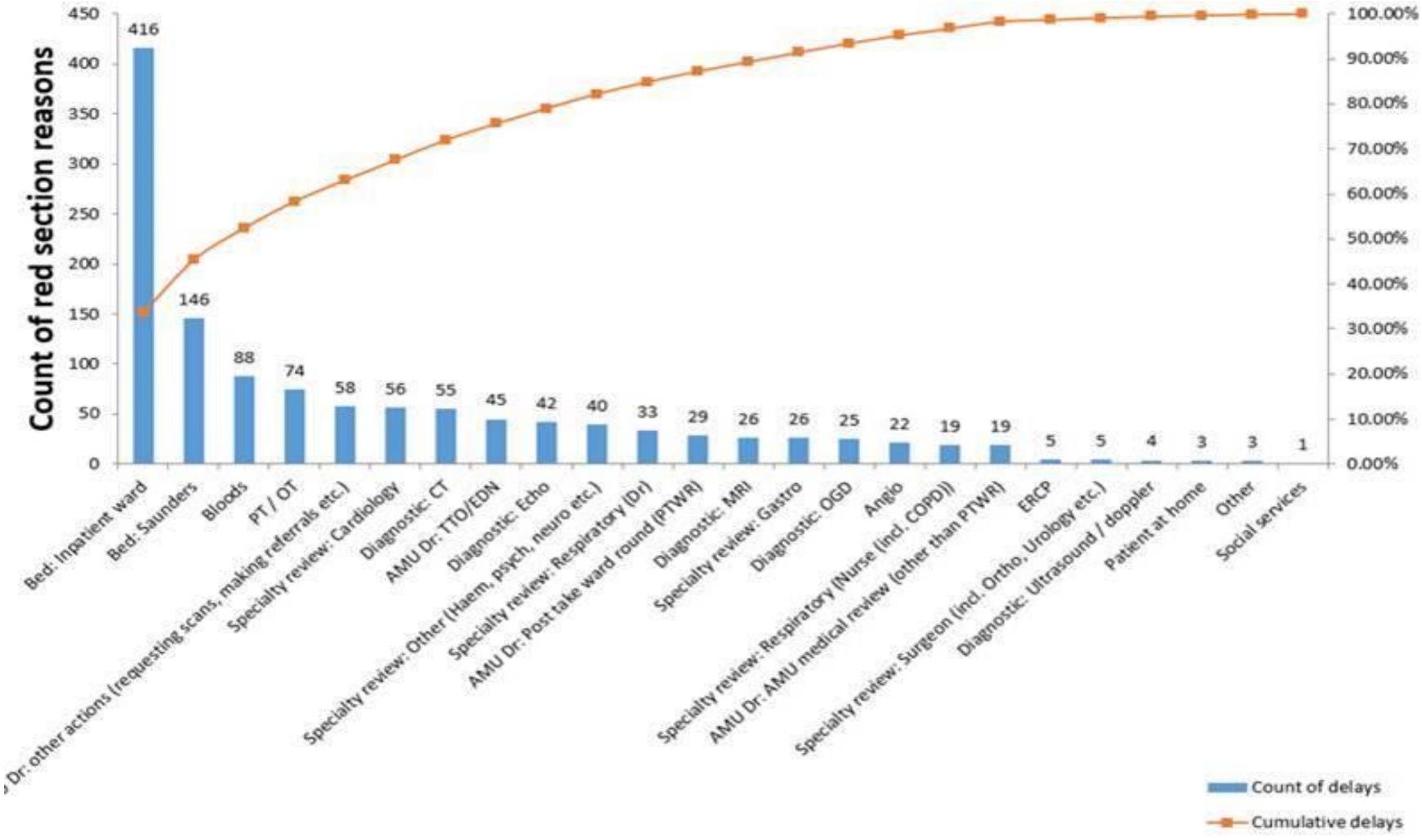
- Night shifts to be extended by 30 minutes for handover
- New day shifts to be work 08:00-12:00 shop floor, 12:00-16:00 CPD
- ENP late shift (8 hours) moved to day shift 09:00-17:00 Wednesday to Sunday
- Dropped ANP cover down to 1 on a Saturday

Planned medical assessment space

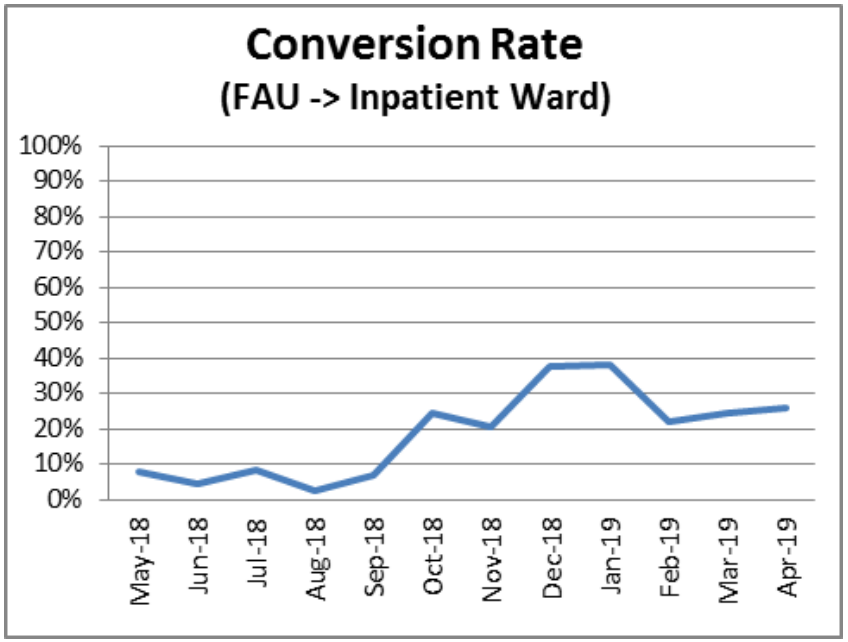
The medical take is seen here, rather than in ED, and then waiting for the next free medical bed

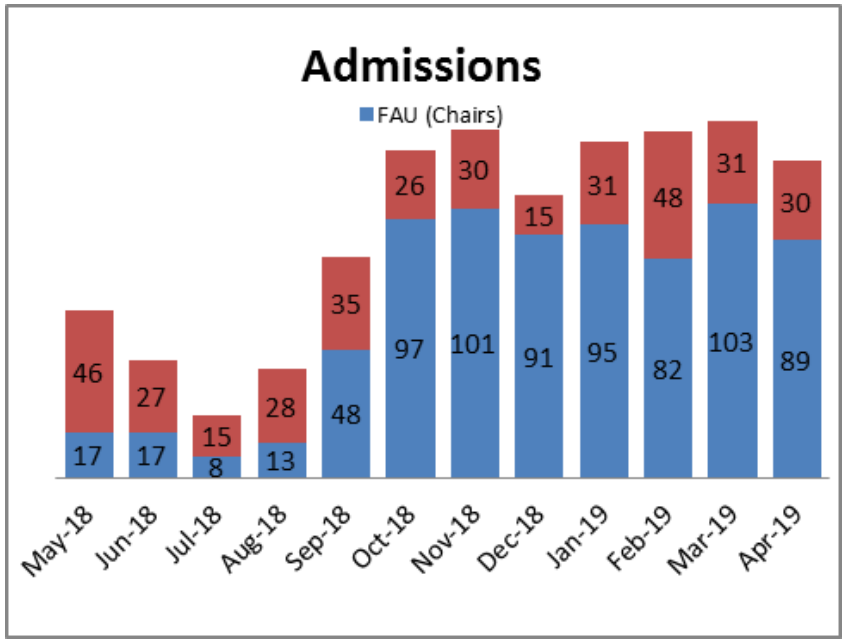


This is needed because our Medical Assessment Unit is too often full of patients needing inpatient beds



Frailty Assessment Unit Progress





Actions Taken

- The Frailty Assessment Unit moved from John Snow/Harold in October 2018
- The number of patients seen doubled when it moved to ED
- Out of the 7 months it has been open, the conversion rate has been less than 30%
- Plan to increase medical cover to 7 days a week
- Plan to recruit substantively to the nursing posts (currently NHSP)
- Review of 7 day therapy support to work alongside the MDT
- Review of the Community Nursing Team (CARS based in ED)

National UTC Criteria

	National Standards
1.	Open 12 hours a day seven days a week
2.	Provide both pre-booked same day and “walk-in” appointments
3.	Service should be available to the public via NHS111
4.	Ability for other services to electronically book appointments
5.	Walk in Patients to be assessed within 15 minutes of arrival
6.	Protocols should be in place to manage critically ill and injured adults and children who arrive unexpectedly
7.	The UTC will usually be a GP-led service and under the clinical leadership of a GP
8.	An appropriately trained multidisciplinary clinical workforce
9.	Minor illness and injury in adults and children of any age
10.	All UTCs should have access to investigations including: • Swabs • Pregnancy tests • Urine dipstick • ECG
11.	All urgent treatment centres should be able to issue prescriptions, including repeat prescriptions, e-prescriptions as well as be able to provide emergency contraception
12.	All urgent treatment centres must have direct access to local mental health advice and services
13.	Access an up-to-date electronic patient care record; this may be a summary care record or local equivalent
14.	A patient's registered GP should always be notified about the clinical outcome via a Post Event Message (PEM), For children the episode of care should also be communicated to their health visitor or school nurse, where known, within two working days
15.	Urgent treatment centres should refer to and align with the Integrated Urgent Care Technical Standards to ensure effective service and technical interoperability

New proposed A&E Standards

The hospital trusts leading testing on the urgent and emergency care proposals are:

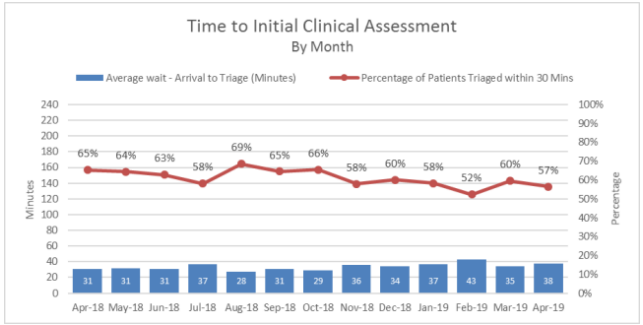
- Cambridge University Hospitals
- Chelsea and Westminster Hospital
- Frimley Health
- Imperial College Healthcare
- Kettering General Hospital
- Luton and Dunstable University Hospital
- Mid Yorkshire Hospitals
- North Tees and Hartlepool
- Nottingham University Hospitals
- Plymouth Hospitals
- Poole Hospital
- Portsmouth Hospitals
- Rotherham
- West Suffolk.

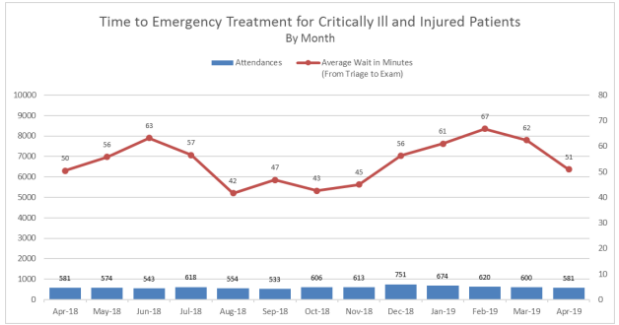
New proposed A&E Standards

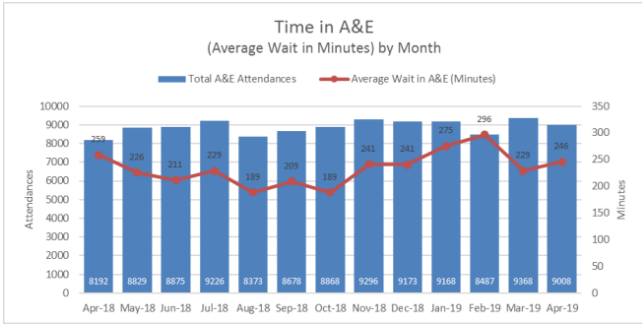
On this slide you will find a graph that shows how we have performed over the last 13 months against each of the new proposed A&E standards.

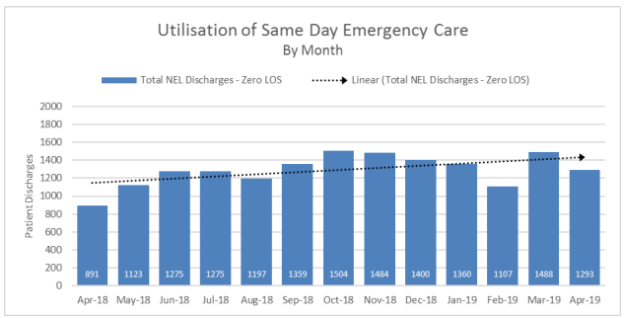
1. Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres (type 1 and 3 A&E departments).
    - This has been calculated using data on time from arrival to triage.
2. Time to emergency treatment for critically ill and injured patients.
    - This data includes all patients treated in Resus and/or patients with a NEWS score of 5 or more.
3. Time in A&E (all A&E departments and mental health equivalents).
    - This graph shows the average wait in A&E for all patients that attend the department.
4. Utilisation of Same Day Emergency Care.
    - This data shows the number of non-elective zero day LoS.

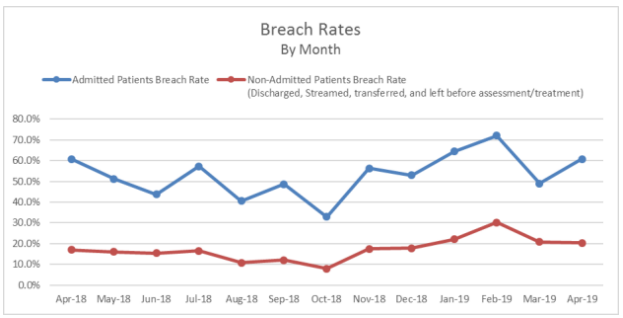
There is also data on the admitted and non-admitted breach rates for information.











Trust Board – 6 June 2019

Agenda Item:	7.2
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Information Team, Executive Directors
Date prepared:	16 May 2019
Subject / Title:	Integrated Quality and Performance Report

Purpose:	Approval		Decision		Information	✓	Assurance	✓

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	**Patients:** April saw a decrease in the absolute number of falls. The new Mental Health Quality Forum will commence in May 2019 and take forward improvement work in relation to the care and management of mental health patients. **Performance:** Access standards for RTT, Cancer and Diagnostics achieved. Emergency Care remains an operational challenge. System work to evaluate the integrated front door GP service has commenced. **People:** Continued focus on recruitment and retention, in particular registered Nursing. Maintaining stat/man training and appraisal rates are a key focus. **Pounds**: The Trusts M1 deficit is £2.7m which is £0.8m behind the M1 plan of £1.9m. The main reasons for the deficit relate to agency and temporary staffing overspends and shortfalls against delivery of CIP targets. **Places**: Work on the fracture clinic commenced in April. The new Maternity Assessment Unit is due to complete shortly.
Recommendation:	The Board is asked to discuss the report and note the current position and further action being taken in areas below agreed standards.

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

Previously considered by:	Executive Management Team, Senior Management Team and PAF.23.05.19 and QSC.24.05.19
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	

7.2

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report

April 2019

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

Contact:

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

respectful | caring | responsible | committed

Trust Objectives

The Princess Alexandra Hospital NHS Trust

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

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

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

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

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

5Ps

In this month

The Princess Alexandra Hospital NHS Trust

Patients

Performance

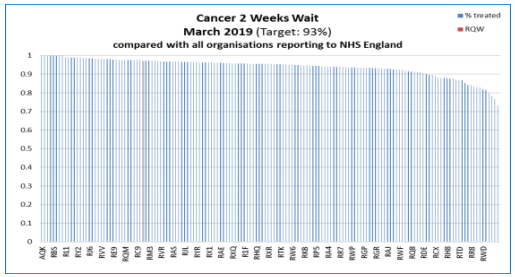
People

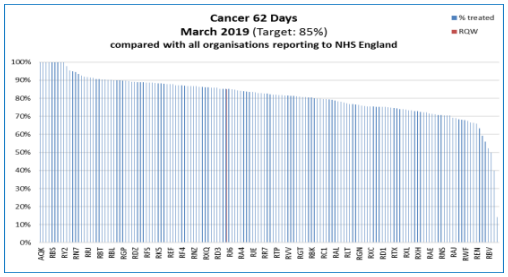
Pounds

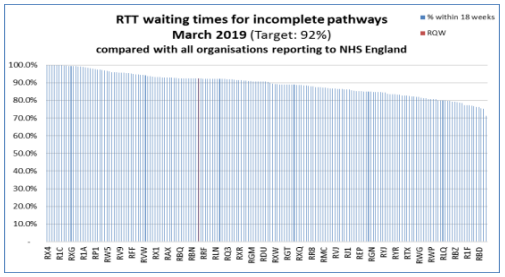
Places

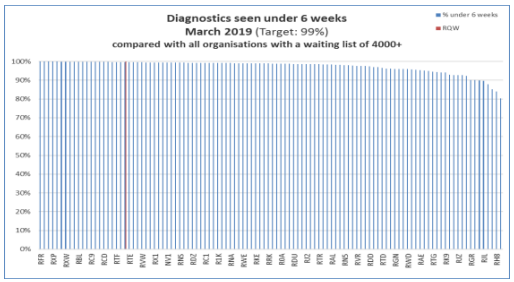
National Benchmarking
Compared with all organisations reporting to NHS England

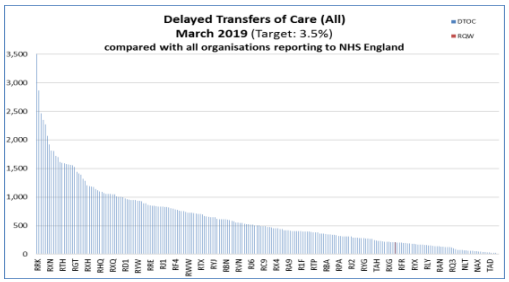
NHS
The Princess Alexandra Hospital
NHS Trust

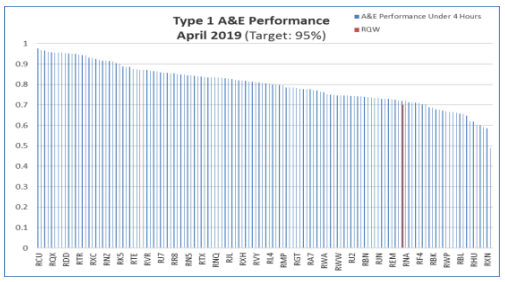


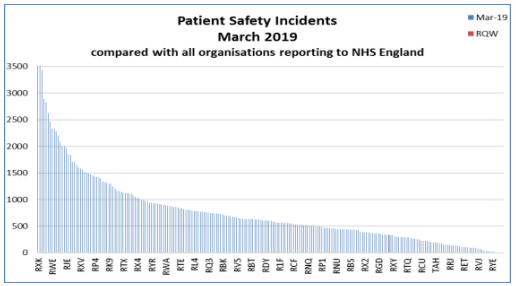


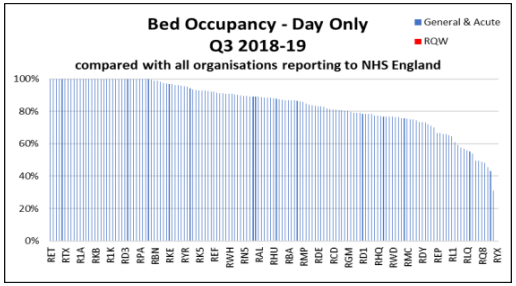


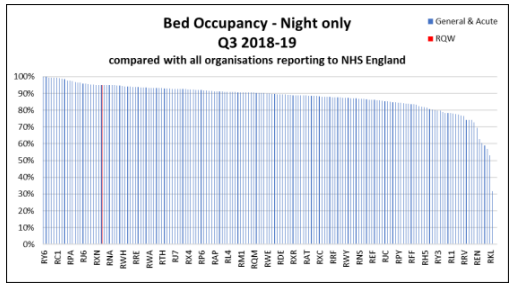












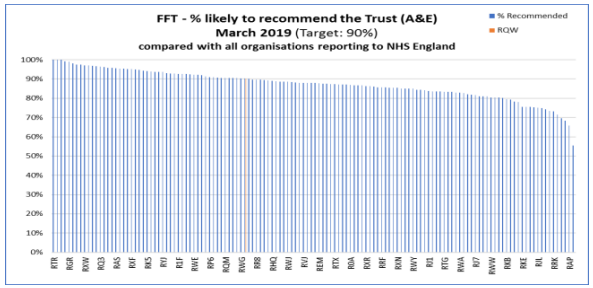
Your future | Our hospital

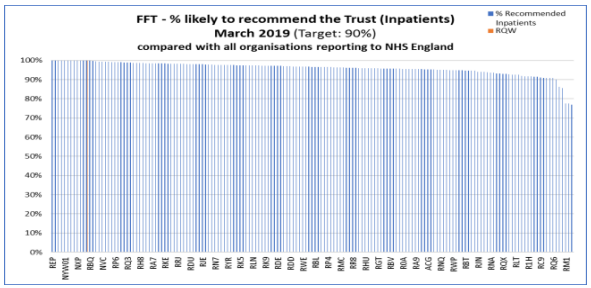
Data Source: NHS England Statistics/Public Health England/Dr Foster

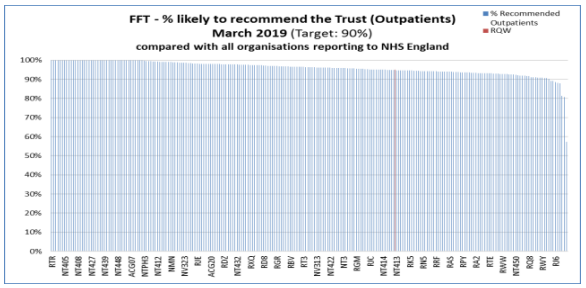
respectful | caring | responsible | committed

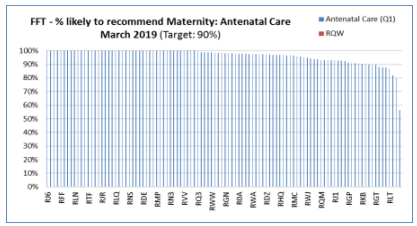
National Benchmarking
Compared with all organisations reporting to NHS England

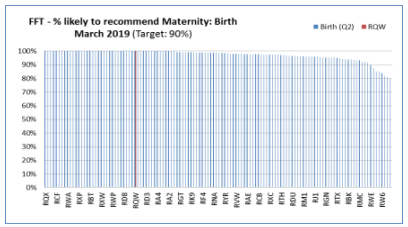
NHS
The Princess Alexandra Hospital
NHS Trust

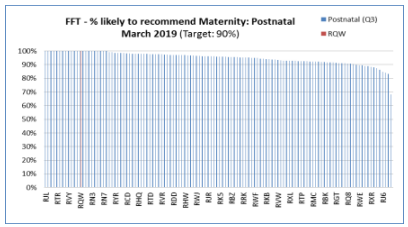


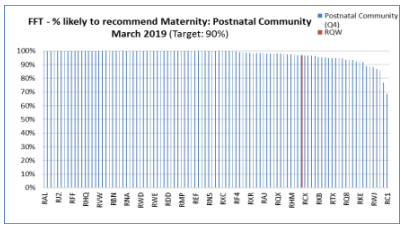


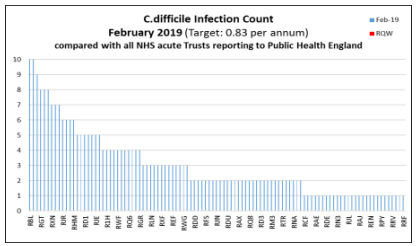


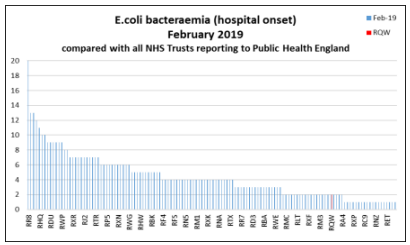


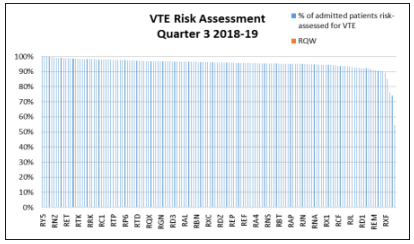


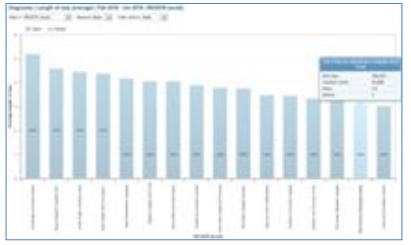












Your future | Our hospital

Data Source: NHS England Statistics

respectful | caring | responsible | committed

Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

The patient safety, experience and quality metrics remain broadly stable.
The IPR now includes information relating to the maternity dashboard and mental health.

Patient experience: As will have been noted from the previous IPR we ended 2018-19 with complaints reduced for the seventh year in a row at 206 vs 665 in 2011-12.

Incidents: In April from the total of 832 incidents, 795 (95.5%) were no or minor harm incidents. 31 (3.8%) were graded as moderate harm & 4 (0.7%) were graded severe or death.

Falls: April saw a decrease in the absolute number of falls to 97, down from 112 in March. However, the April falls rate (7.42) is higher than published national averages (6.6 per 1000 OBD) for acute providers.

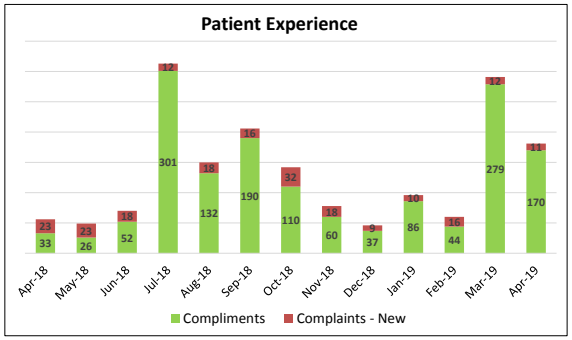
Pressure Ulcers: There were 43 hospital acquired pressure ulcers in April. The majority of category 2 and DTI pressure ulcers were found on heels. The category 4 pressure ulcer occurred on Gibberd Ward and a full RCA is being undertaken, initial review identified that the patient was non concordant with care and preventative actions including turns. Actions in place to support the ward include use of specialist adviser to support staff with teaching on the use of equipment and correct patient positioning.

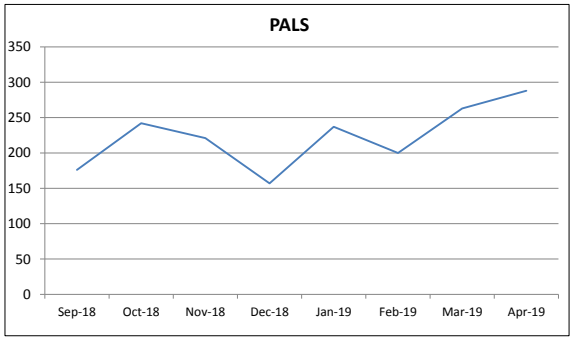
Patient Experience

1 Our Patients Summary 1.1 Patient Experience

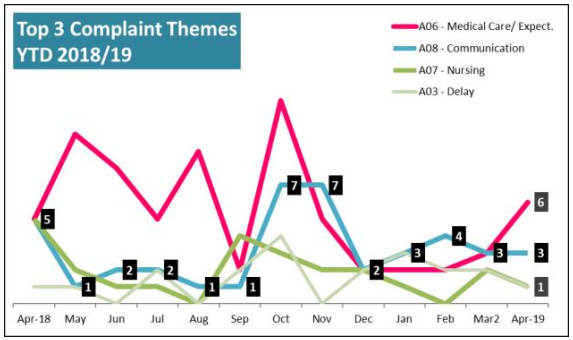
The Princess Alexandra Hospital NHS Trust

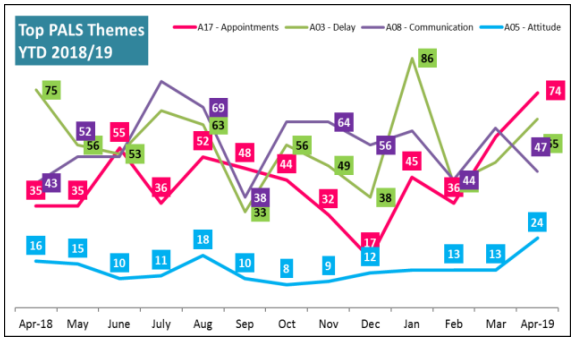
All data is within normal parameters. Of note is the significant increase in compliments recorded as a result of staffing improvements and the steady increase in trend of PALS cases recorded. As will have been noted from the previous IPR we ended 2018-19 with complaints reduced for the seventh year in a row at 206 vs 665 in 2011-12.

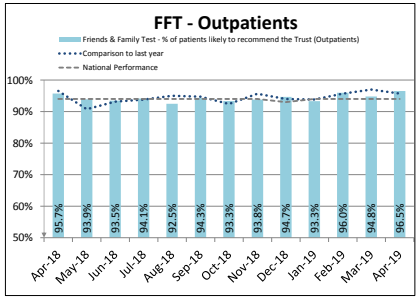


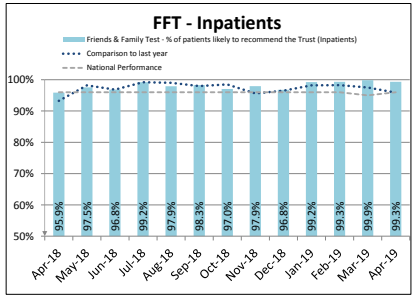


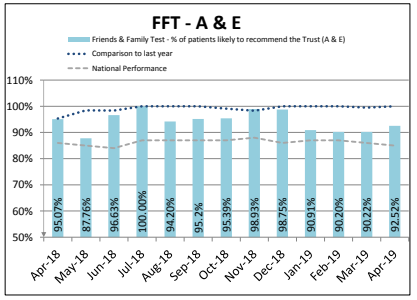
PALS converted to Complaints	
Apr-18	3
May-18	0
Jun-18	0
Jul-18	3
Aug-18	2
Sep-18	3
Oct-18	6
Nov-18	4
Dec-18	1
Jan-19	2
Feb-19	2
Mar-19	0
Apr-19	1

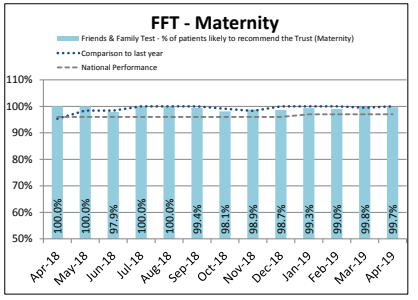












Patient Safety

1 Our Patients Summary 1.2 Patient Safety

NHS The Princess Alexandra Hospital NHS Trust

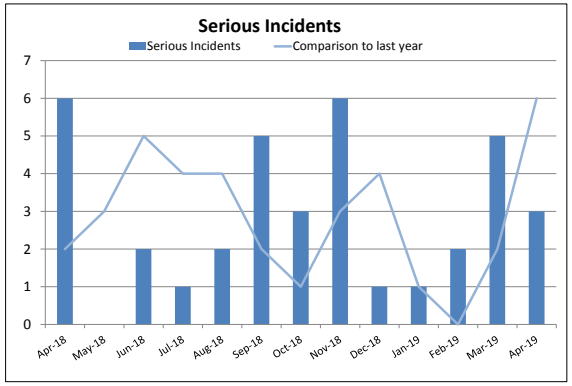
In April from the total of 832 incidents, 795 (95.5%) were no or minor harm incidents. 31 (3.8%) were graded as moderate harm & 4 (0.7%) were graded severe or death. Each of the moderate, severe & death harm incidents will be discussed at SIG once a case review is completed to ensure we assign the correct grading to the incident, determine if this meets the criteria for a serious incident requiring investigation.

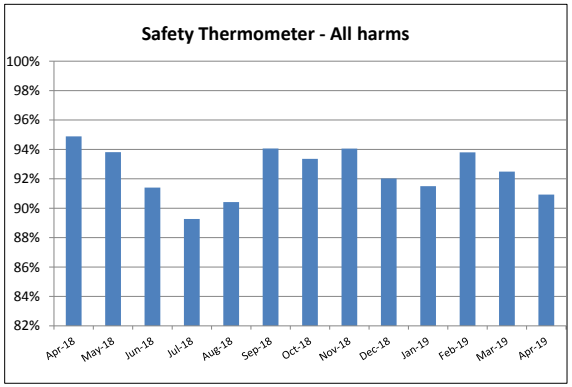
During April 3 incidents meeting the Serious Incident (SI) criteria were declared:

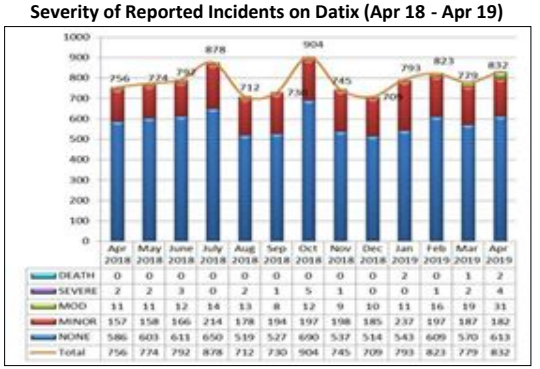
- A patient sustained an injury to their left leg by falling from their chair resulting in a deep injury requiring a blood transfusion. A Trust wide safety alert has since been circulated to alert staff of precautions to take to prevent future incidents.
- A patient deteriorated, the review highlighted a period that the patient had not been reviewed by the medical team.
- A urology patient experienced a significant delay in stent exchange.

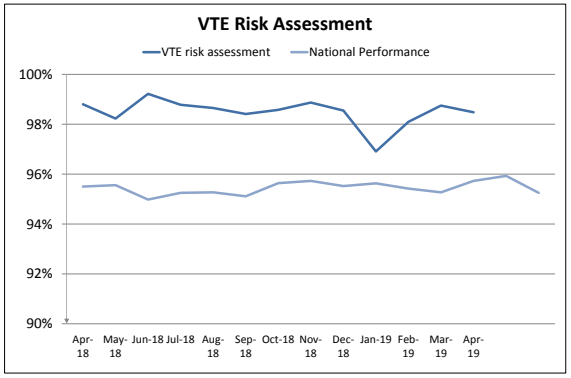
There were 2 incidents recorded as deaths:

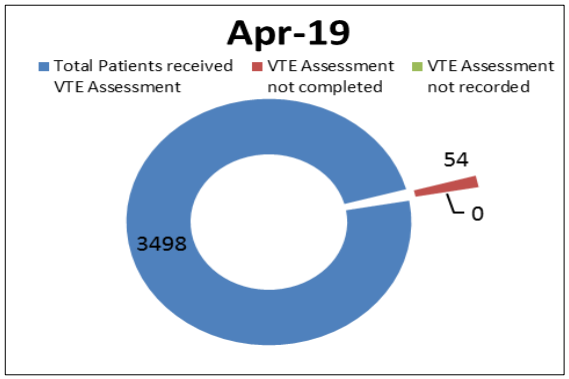
- A patient deteriorated and died, the review highlighted a period that the patient had not been reviewed by the medical team, listed above and reported as an SI.
- A patient attended ED with shortness of breath, the patient deteriorated & was moved to a cubicle in Majors for improved visibility & continuous monitoring as no capacity was available in Resuscitation room at the time. The patient deteriorated & arrested. This is under investigation as an internal incident.









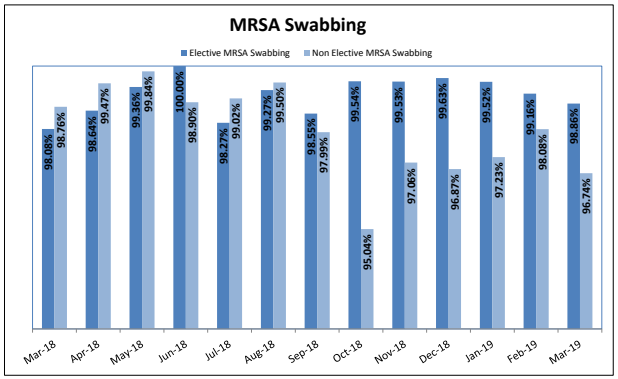


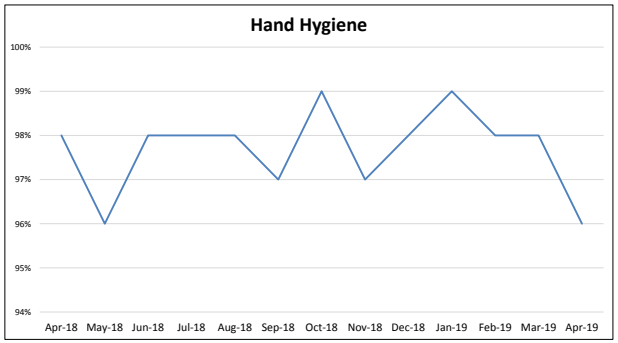
Infection Control

1 Our Patients Summary 1.3 Infection Control

The Princess Alexandra Hospital NHS Trust

MRSA – There have been no cases of Trust-apportioned MRSA bacteraemia in the Trust since 2014.
MSSA – The Trust continues to have low numbers of MSSA bacteraemia and remains in the top quarter of best performing hospitals nationally.
C.difficile - In March 2018 NHS Improvement outlined the intention to review the reporting and classification of Clostridium difficile (CDI) for 2019/20. There are four new definitions, but the two that will apply to the Trust are:
Healthcare onset healthcare associated (HOHA): cases detected three or more days after admission.
Community onset healthcare associated (COHA): cases detected within two days of admission where the patient has been an inpatient in the trust reporting the case in the previous four weeks.
The reporting period has decreased from 72 to 48 hours. This means that all patients that are tested after 48 hours will be assigned to the Trust. The consequence of this is that all cases which meet the definitions of HOHA & COHA, will be assigned to the acute Trust. This will significantly increase the cases assigned to acute providers, this has been reflected within the new objectives (27 for PAH). These cases will undergo the same robust Root Cause Analysis (RCA) & multi-disciplinary team (MDT) process as the previous post 72 hour cases required.
Gram Negative Blood Stream Infections (GNBSIs) – The Trust remains in a good position when compared nationally with other hospitals (in the top performing quarter) & we have a collaborative approach to tackling GNBSIs across the health care economy.
MRSA screening (Non Elective) – The Trust has consistently met its trajectory of over 95% compliance for non-elective MRSA screening.
Hand Hygiene Audits – All wards/clinical departments are expected to participate in monthly audits & these are undertaken as 'cross-over' audits, meaning staff do not audit themselves. The expectation is that 100% of clinical areas participate & the performance standard is 95% compliance. Wards/departments are expected to discuss their results & agree appropriate actions within their Healthcare Group.





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

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

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

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

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

Patient Safety

1 Our Patients Summary 1.4 Patient Safety

NHS The Princess Alexandra Hospital NHS Trust

Falls: April saw a decrease in the absolute number of falls to 97, down from 112 in March. This was accompanied by a decrease in the number of falls per 1000 OBD (occupied bed days) to 7.42 , down from 8.61in March. Year on year there is a decrease when compared with the March 2018 rate of 8.99 falls per 1000 OBD.

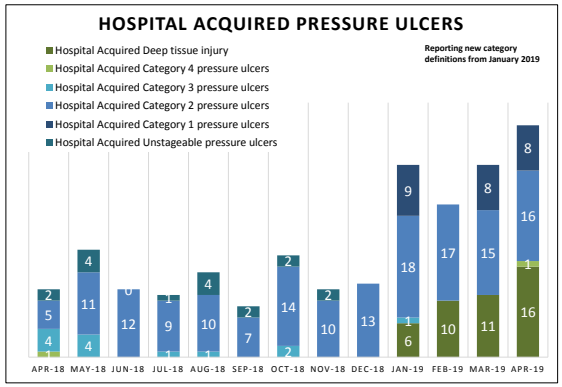
However, the April falls rate (7.42) is higher than published national averages (6.6 per 1000 OBD) for acute providers. It remains our view that this is due to the work being undertaken to encourage patients to remain mobile to reduce the effects of deconditioning which has a tendency to increase the total amount of falls. We therefore are monitoring the harm associated with falls to ensure they remains low & our levels of harm remain are within national parameters which remains the case (96% no/low harm in April).

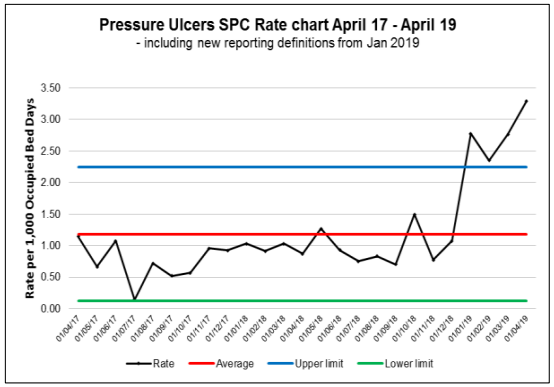
Pressure Ulcers: There were 43 hospital acquired pressure ulcers in April. Of these there were:
5 x category 1
16 x category 2
1 x category 4
2 x unstageable
19 deep tissue injury

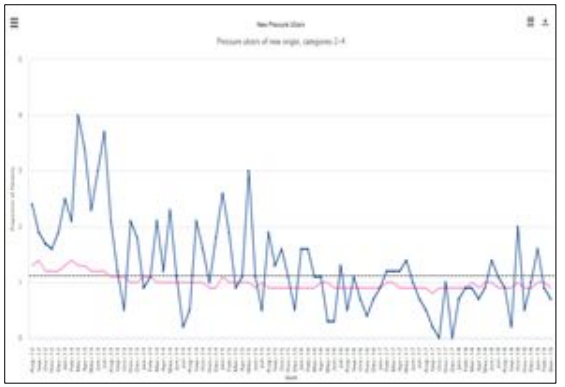
The majority of category 2 and DTI pressure ulcers were found on heels. This is supported by themes emerging from scrutiny panel including gaps in repositioning or improvement required in management of repositioning.

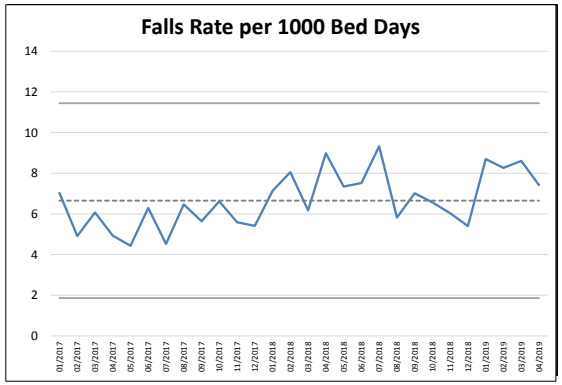
The category 4 pressure ulcer occurred on Gibberd Ward and a full RCA is being undertaken, however, the patient was non concordant with care and preventative actions including turns.

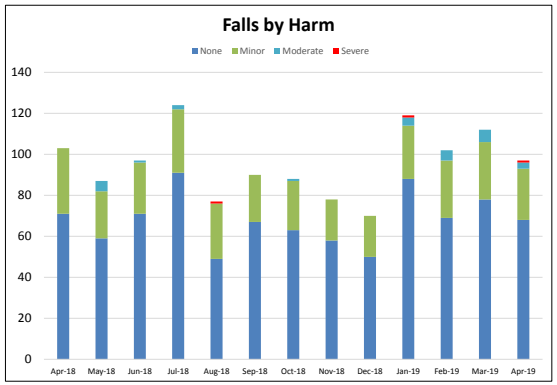
The wards that have the highest number of pressure ulcers (Lister and Gibberd) are receiving ward intensive support including weekly visits from the Medstrom Clinical Nurse Adviser to support staff with teaching on the use of equipment & correct patient positioning.











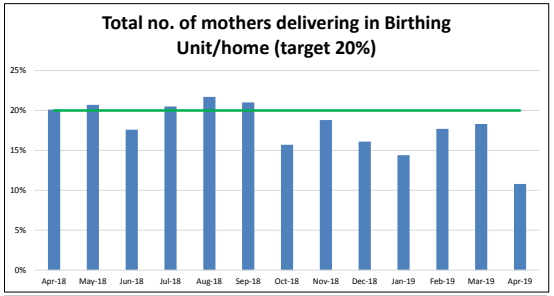
2 Our Patients Summary 1.5 Family & Women's Service

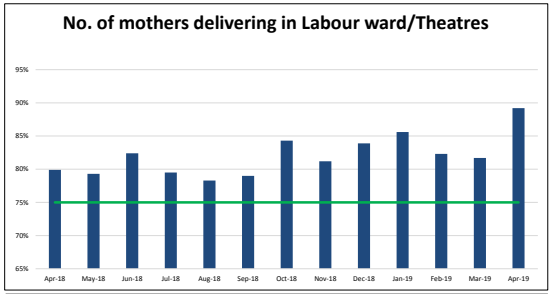
NHS The Princess Alexandra Hospital NHS Trust

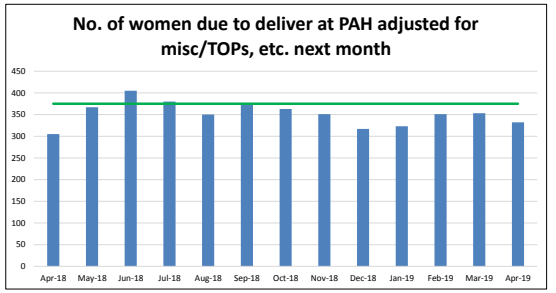
Birthing unit births were particularly low in April, work being undertaken to understand reasons for this. However there has not been an increase in the number of transfers to Labour ward.

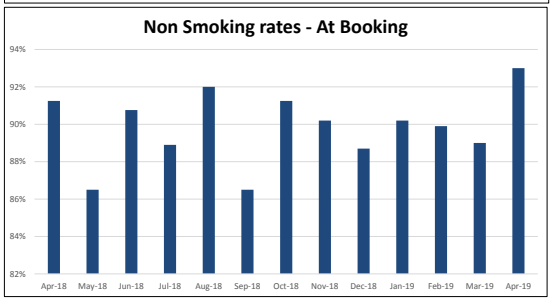
Non-smoking rates After a decline in the Non Smoking rates at delivery for the past 5 months, it is starting to increase due to a more focused recording at delivery.

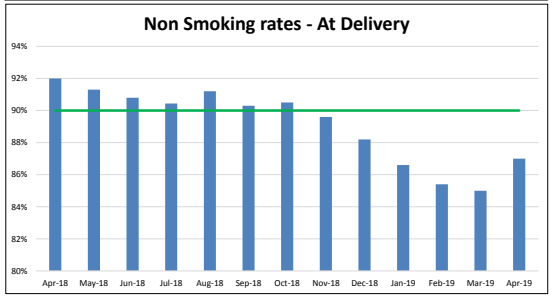
Cardiotocograph (CTG) training 4 members of staff to update for compliance (2 of these are new staff).

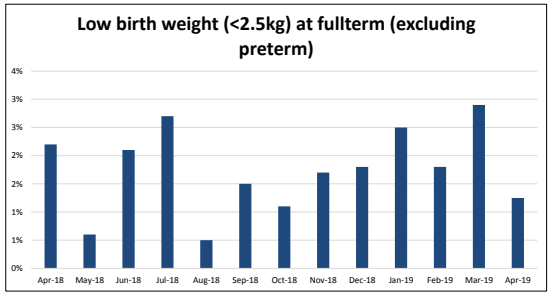


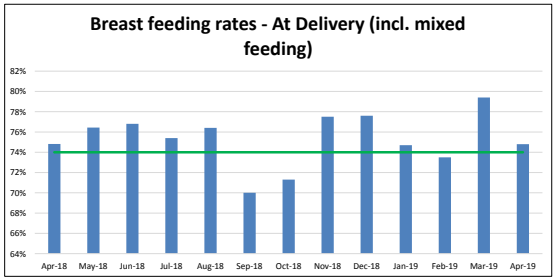


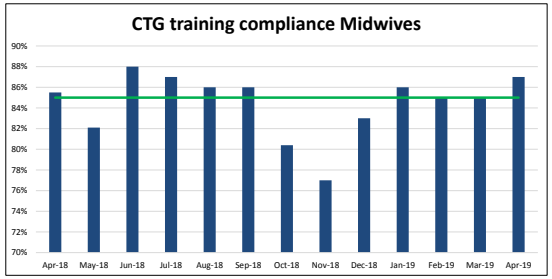


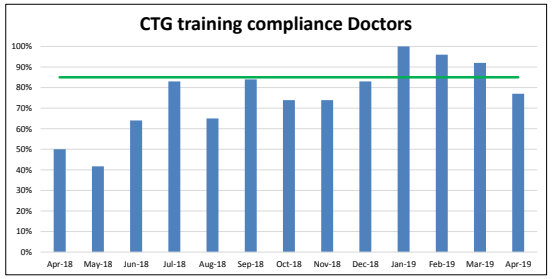










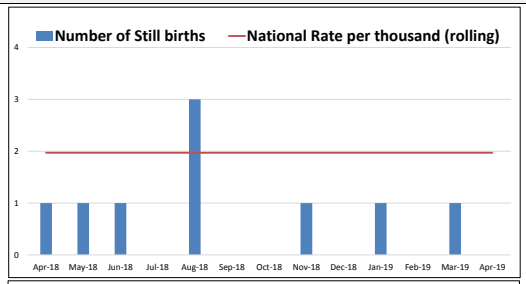


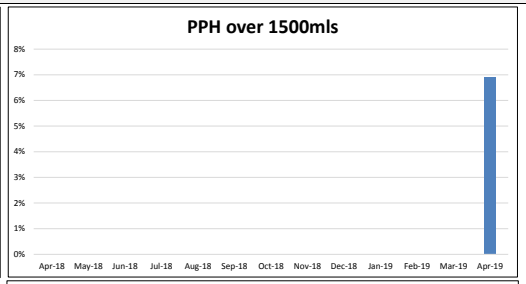
Family & Women's Service

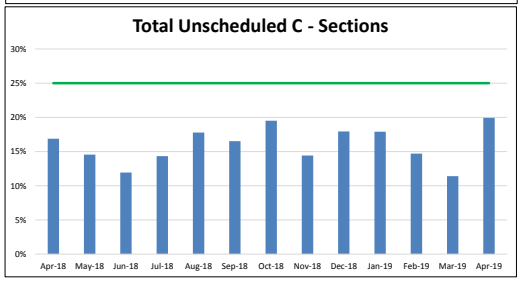
2 Our Patients Summary 1.6 Family & Women's Service

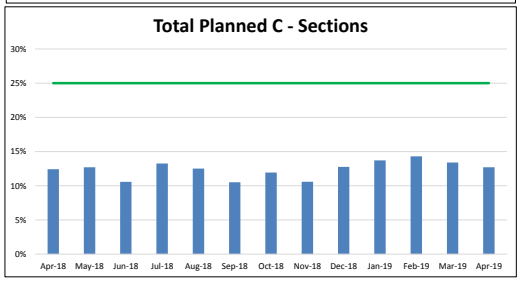
The Princess Alexandra Hospital NHS Trust

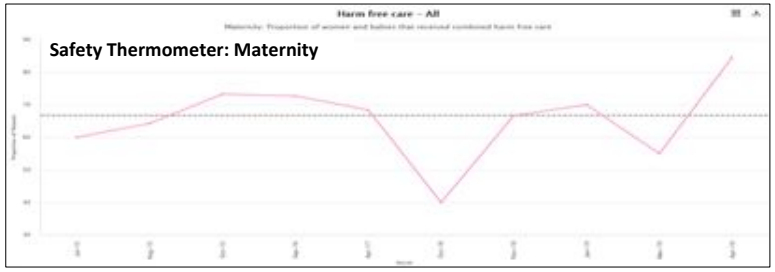
Stillbirths: No stillbirths in April, rolling rate 1.97% against national rate of 3.93% per 1000 births.

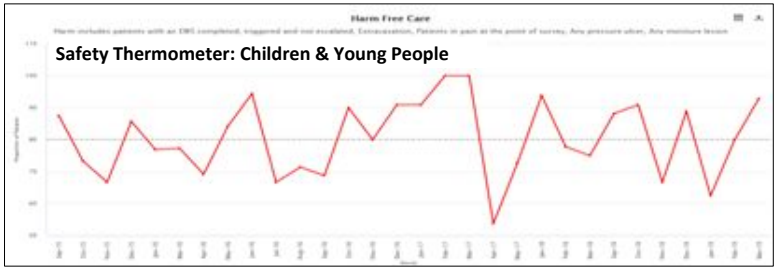










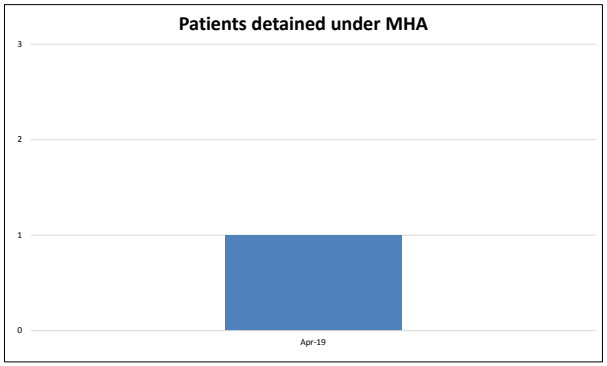


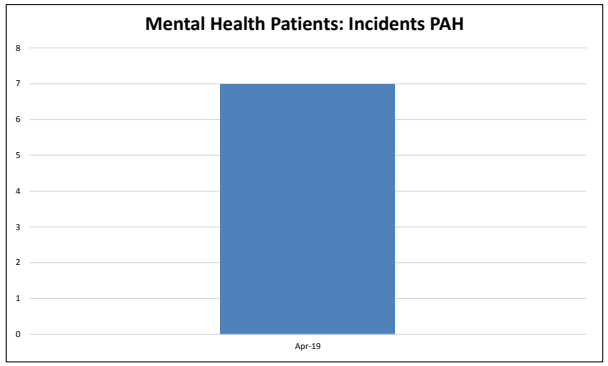
Mental Health

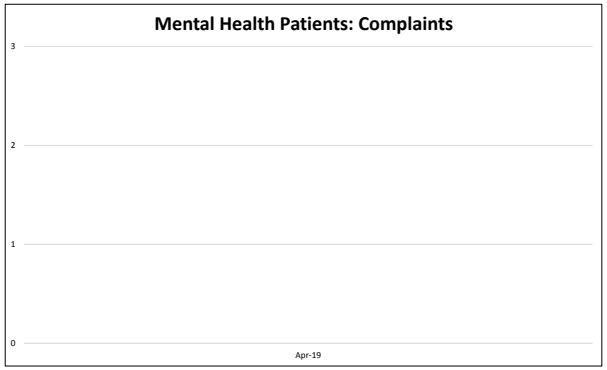
1 Our Patients Summary 1.7 Mental Health

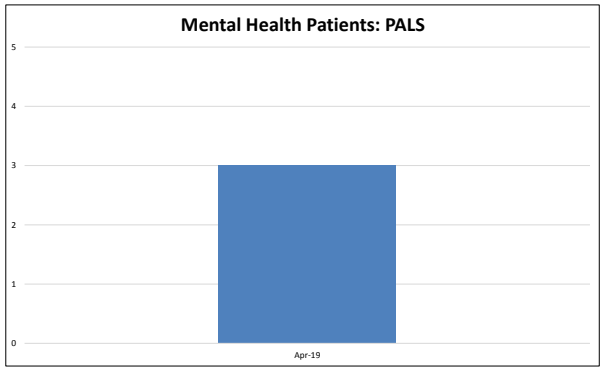
The Princess Alexandra Hospital NHS Trust

Reporting of this metric commenced in April 2019. In month there were 7 incidents reported in relation to mental health conditions, the majority of which relate to patients absconding (none of which were detained patients).
There were 3 PALs concerns reported in the month, 2 of which relate to access to appointments and 1 to a fall.
The new Mental Health Quality Forum will commence in May 2019 and take forward improvement work in relation to the care and management of mental health patients.





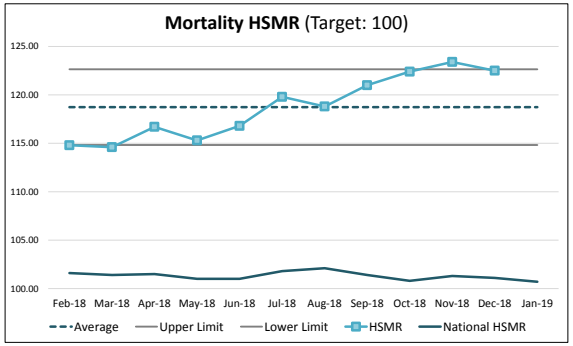




Mortality

The Mortality Improvement Board (chaired by the Chief Executive) has been in place since December 2018 reflecting the importance of this as a Trust priority. Five programmes of work have been established; led by senior doctors, nurses and managers with the objective to achieve 'as expected' (comparing ourselves alongside other hospitals in the NHS) mortality rates by March 2021.
There has been progress achieved in the revision and establishment of care bundles in speciality pathways where the trust has had mortality alerts, using the approach developed to successfully deliver Sepsis care bundles work, which achieved the PAH target of reducing deaths from sepsis by 20% by March 2019.
There is work underway to improve the:

- Compliance of the completion and documentation of vital signs.
- Management of fluids and electrolytes (excellence every time – group one).
- Decision making and prescribing of antibiotics and compliance against trust policy a new antibiotic prescribing app will be purchased.
- Hospital at night team by introducing a new digital solution to support doctor handover, task allocation and prioritisation of care out-of-hours.
- Reporting and recording of care focusing on the establishment of the Medical Examiner role and strengthening the organisational ability to learn from deaths.



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

Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

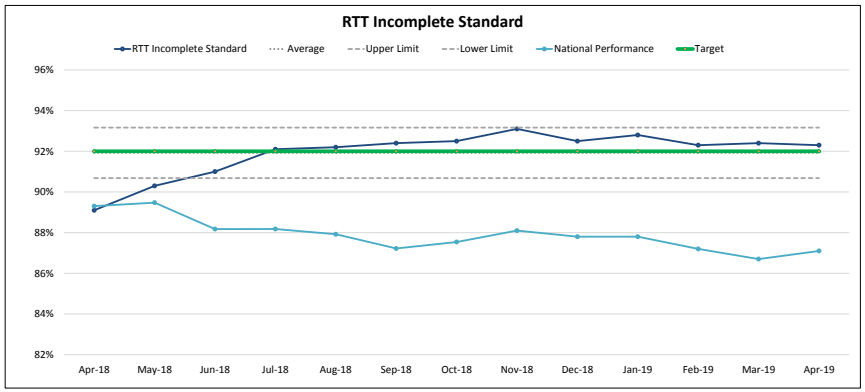
Operational performance

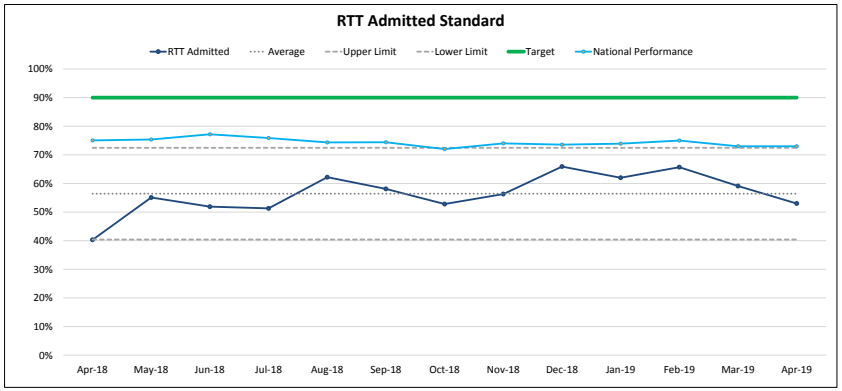
Diagnostics and RTT incomplete standards were again achieved for April (although reporting period will not close until 20th May for RTT) as well as the Cancer 62 day standard for March 2019.

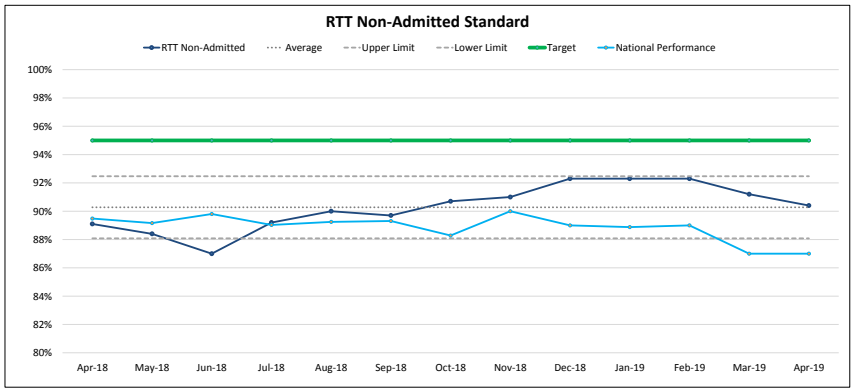
Emergency Care performance

This deteriorated further in April compounded by an increased level of acuity and a resulting increased length of stay. The average number of patients waiting in ED overnight increased in April. Length of stay reviews for patients over 21 days have commenced with the CMO, COO and Director of Nursing. Each clinical team are presenting their case reviews for all patients over 21 days with their discharge plans. The Trust has a trajectory to reduce super stranded patients (>21 days) by 40% over the financial year. Interviews were held in April for the Associate Medical Director. An appointment was made with the post-holder commencing full time from September 2019. The individual will be meeting with emergency care colleagues over the next few months to work through the improvement trajectories. Evaluation of the GP/Minor Injury service is currently being undertaken between PAH, CCG and System colleagues. Good clinical engagement from across the system is taking place to ensure the Trust has the right level and access to all emergency care services in place for the local population.

RTT


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


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

Cancer

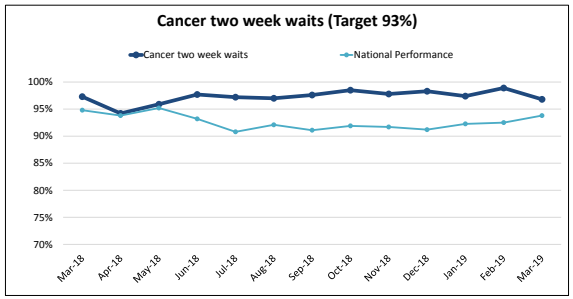
2 Our Performance Summary

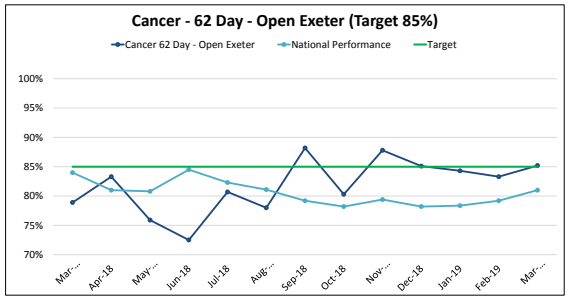
2.2 Responsive

The Princess Alexandra Hospital NHS Trust

	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Mar-18	97.70%	97.40%	100.00%	100.00%
Apr-18	98.60%	96.80%	100.00%	100.00%
May-18	95.50%	100.00%	100.00%	100.00%
Jun-18	97.70%	100.00%	100.00%	100.00%
Jul-18	98.70%	98.90%	100.00%	N/A
Aug-18	99.40%	95.20%	100.00%	100.00%
Sep-18	99.20%	97.70%	100.00%	100.00%
Oct-18	98.80%	96.70%	100.00%	100.00%
Nov-18	97.30%	96.70%	100.00%	100.00%
Dec-18	96.90%	100.00%	100.00%	100.00%
Jan-19	97.40%	97.00%	100.00%	100.00%
Feb-19	96.70%	97.30%	100.00%	100.00%
Mar-19	86.90%	96.90%	100.00%	100.00%

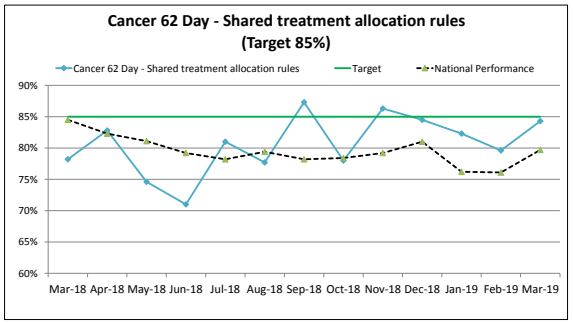
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

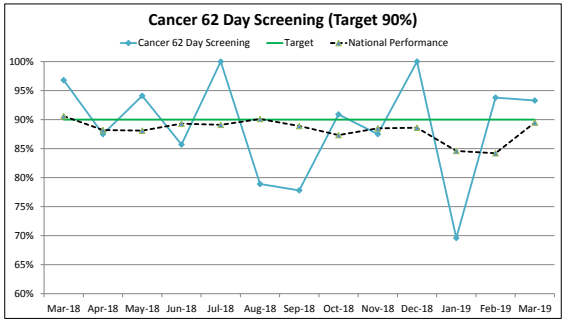


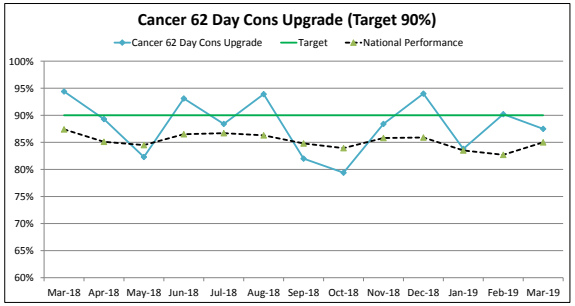


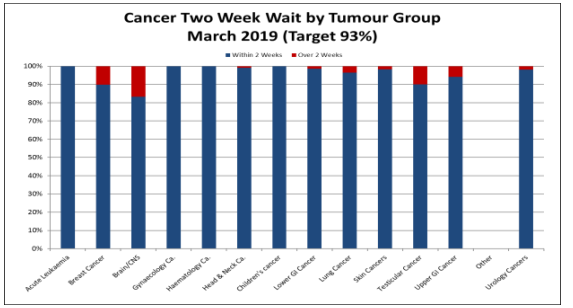
March performance by tumour group

Target Wait Group	14 day target performance %	31d day first seen performance %	62 day standard performance %	62 day Screening performance %	62d CU performance %	31d day subsequent drugs performance %	31d day subsequent surgery performance %
Acute Leukaemia	100.0%						
Breast Cancer	89.8%	89.5%	66.7%	92.9%	100.0%		100.0%
Brain/CNS	83.3%						
Gynaecology Ca.	100.0%	100.0%	100.0%		100.0%		
Haematology Ca.	100.0%	100.0%	100.0%		100.0%	100.0%	
Head & Neck Ca.	99.2%		25.0%		0.0%		
Children's cancer	100.0%						
Lower GI Cancer	98.6%	92.3%	100.0%	100.0%	60.0%	100.0%	100.0%
Lung Cancer	96.4%	100.0%			94.4%	100.0%	
Skin Cancers	98.4%	100.0%	100.0%		87.5%		100.0%
Testicular Cancer	90.0%						
Upper GI Cancer	94.3%	100.0%	0.0%		100.0%		
Other							
Urology Cancers	98.1%	100.0%	80.0%		88.9%	100.0%	100.0%
Total performance	96.8%	96.9%	85.2%	93.3%	87.5%	100.0%	100.0%
Symptomatic Breast Referrals (non Cancer)	86.9%						

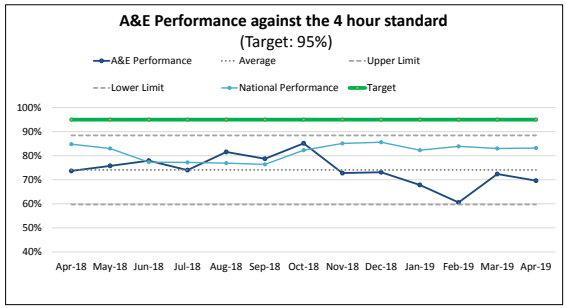


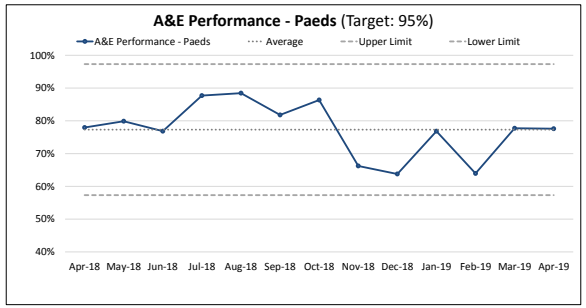


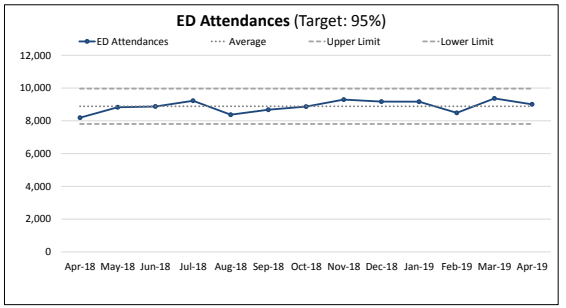


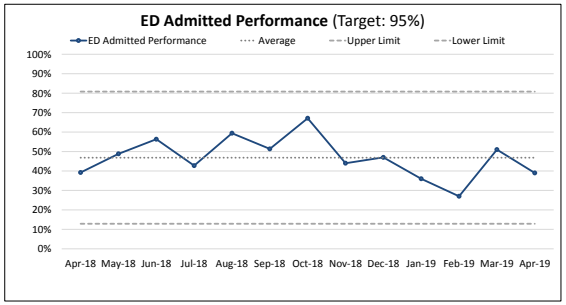


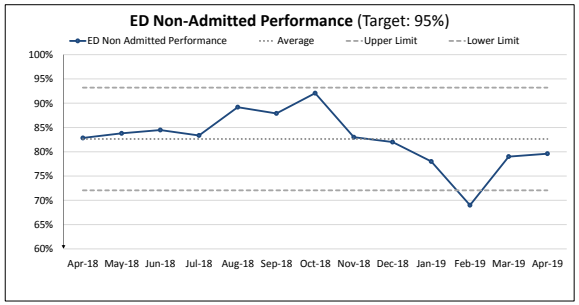
ED





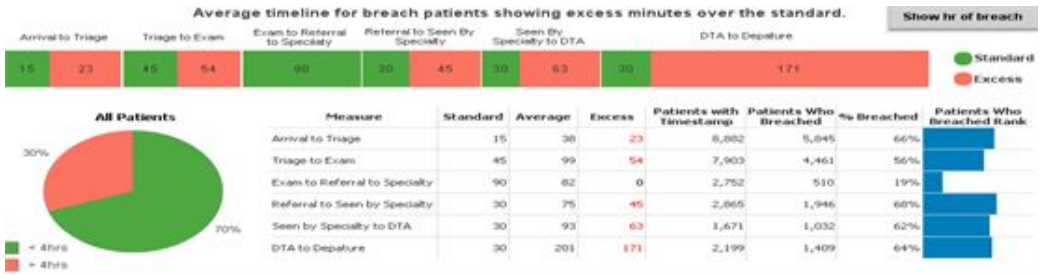




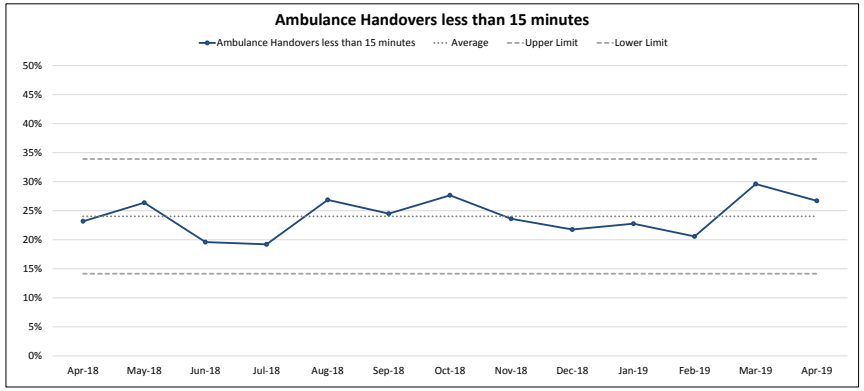


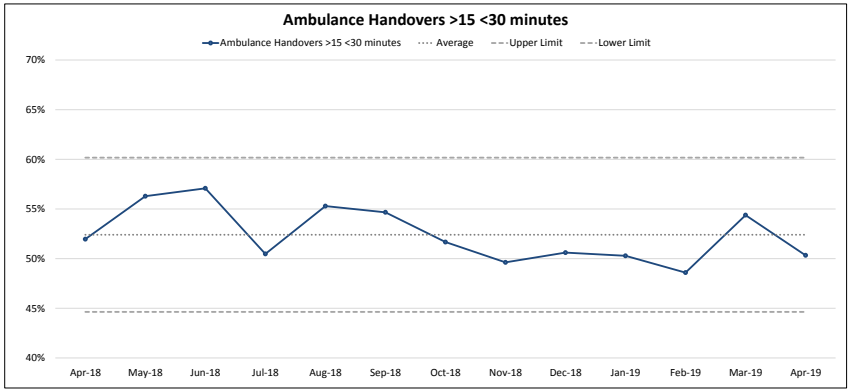
ED Internal Professional Standards

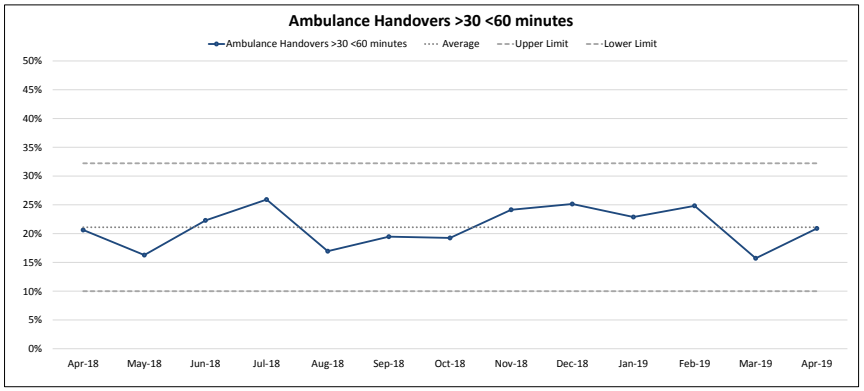
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Arrival to Triage - Average Wait (Minutes)	31	32	32	32	28	31	29	36	34	37	43	35	38
Triage to Exam - Average Wait (Minutes)	100	92	98	98	79	82	74	91	94	106	118	106	99
Exam to Referral to Specialty - Average Wait (Minutes)	87	82	75	79	74	78	72	80	83	85	97	81	82
Referral to Seen by Specialty - Average Wait (Minutes)	79	69	66	74	70	69	68	83	82	84	85	73	75
Seen by Specialty to DTA - Average Wait (Minutes)	105	91	87	91	77	86	77	94	97	105	109	82	93
DTA to Departure - Average Wait (Minutes)	381	219	160	201	119	161	123	223	209	312	308	171	197

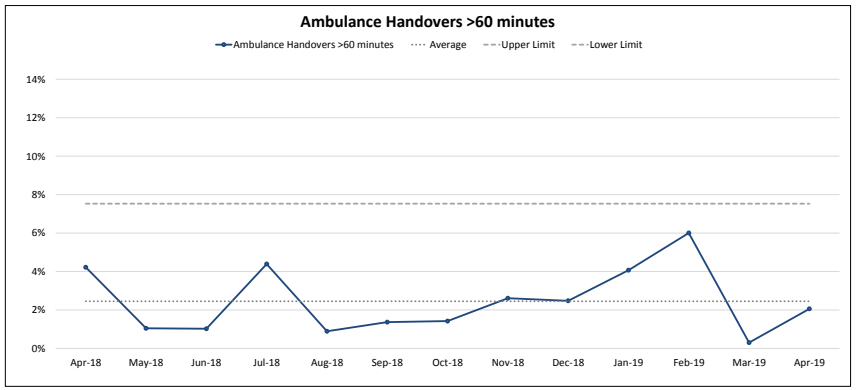


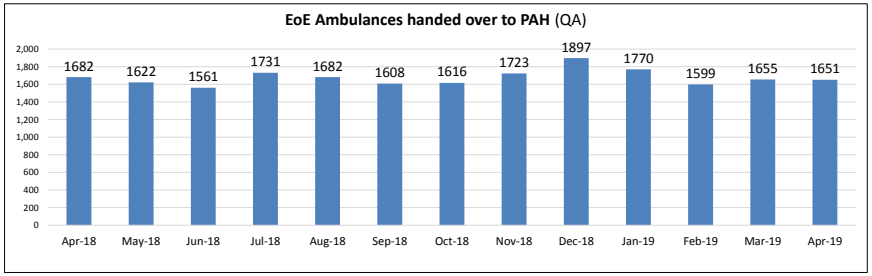
Ambulance


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

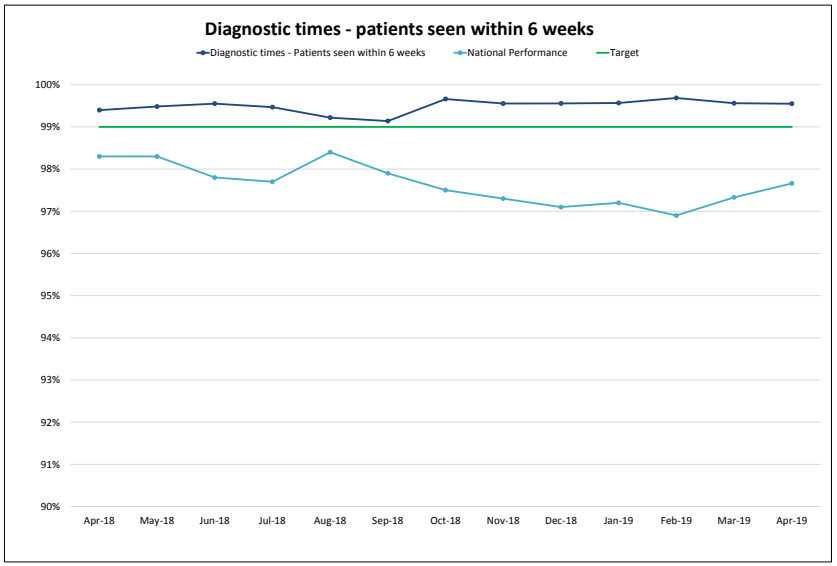

Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
70%
65%
60%
55%
50%
45%
40%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19

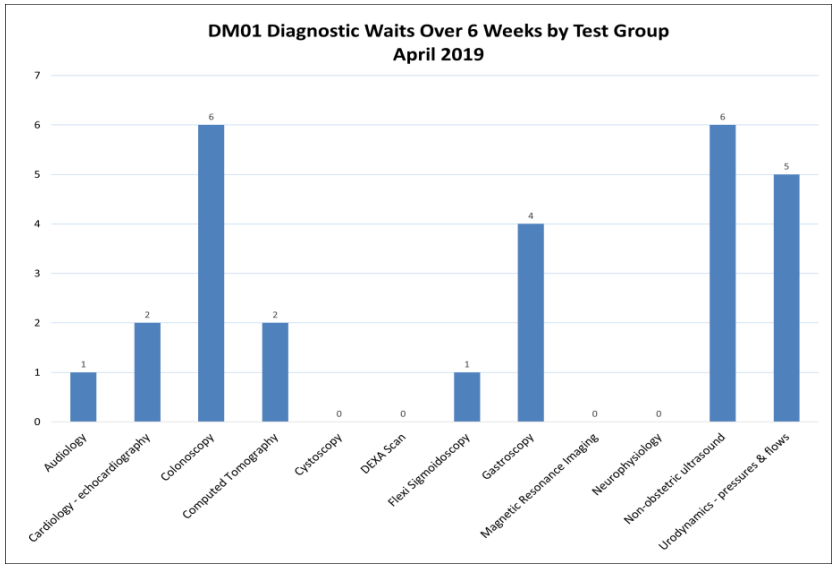

Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19


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


EoE Ambulances handed over to PAH (QA)
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1682
1622
1561
1731
1682
1608
1616
1723
1897
1770
1599
1655
1651
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19

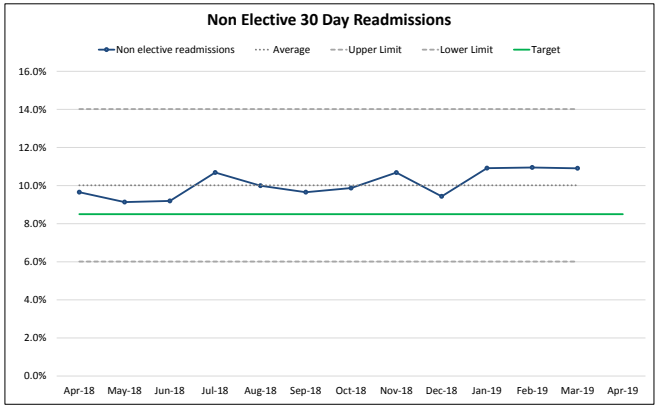
Diagnostics

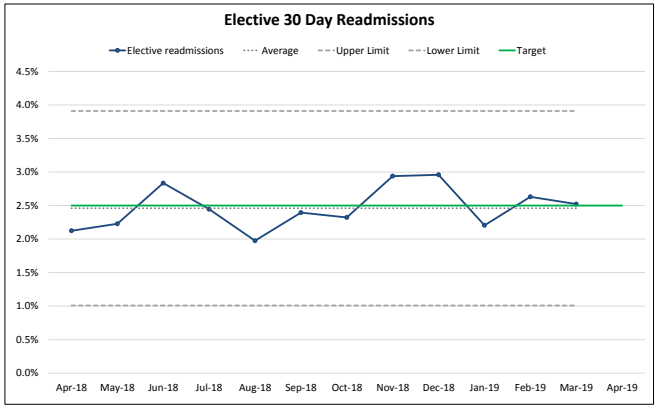


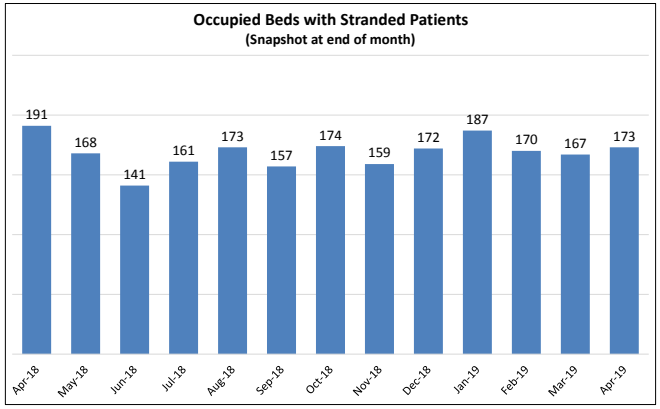


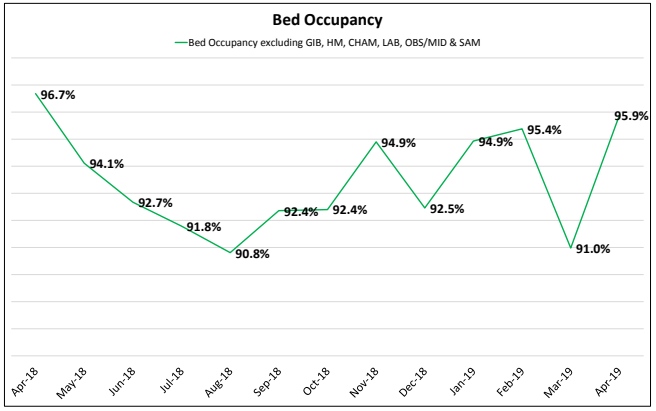
Test	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Magnetic Resonance Imaging (MRI)	99.91%	99.82%	99.72%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	99.92%
Computed Tomography (CT)	99.37%	99.22%	99.41%	100%	99.84%	99.84%	100%	100%	100%	99.51%	99.70%	99.85%
Non-Obstetric Ultrasound	99.92%	99.81%	99.96%	99.96%	99.92%	99.92%	99.71%	100%	100%	99.84%	99.66%	100.00%
DEXA	97.06%	100%	100%	99.28%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%
Audiology - Audiology Asessments	99.16%	99.25%	98.70%	100%	100%	100%	100%	99%	100%	97.51%	99.04%	98.18%
Cardiology - Echocardiography	99.37%	99.85%	100%	98.48%	95.01%	98.20%	100%	100%	100%	100.00%	100.00%	100.00%
Neurophysiology	100%	100%	100%	100%	100%	100%	93.33%	100%	100%	100%	100%	100%
Urodynamics	100%	96%	100%	88.89%	96.36%	74.47%	92.68%	57%	80%	70%	82%	90%
Colonoscopy	96.32%	97.66%	98.53%	94.97%	97.87%	89.16%	97.35%	99%	96%	98.45%	98.16%	95.24%
Flexi Sigmoidoscopy	97.37%	96.36%	100%	100%	95.12%	97.37%	96.97%	98%	96%	97.06%	100.00%	90.91%
Cystoscopy	77.78%	95.45%	66.67%	75.00%	100%	96.30%	100%	100%	100%	100.00%	100.00%	94.74%
Gastroscopy	91.75%	95.36%	96.40%	93.67%	94.87%	95.19%	97.41%	98%	92%	98.51%	100.00%	95.00%

Readmissions & Stranded Patients

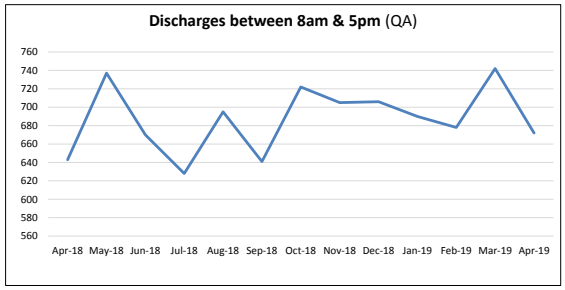


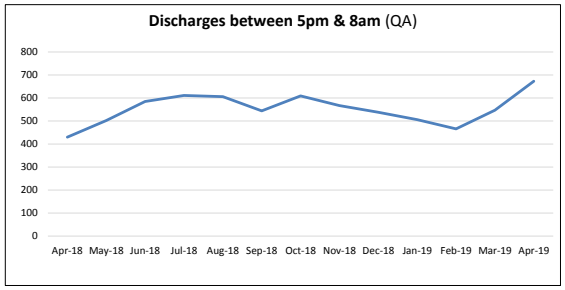


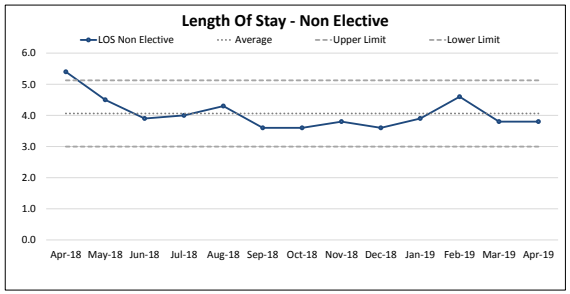


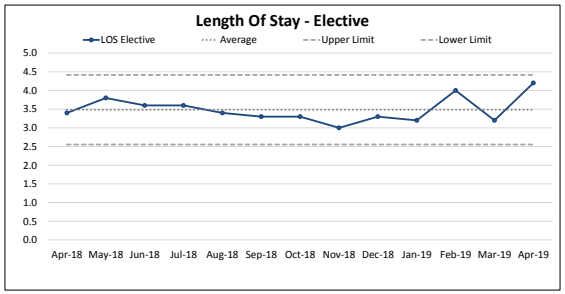


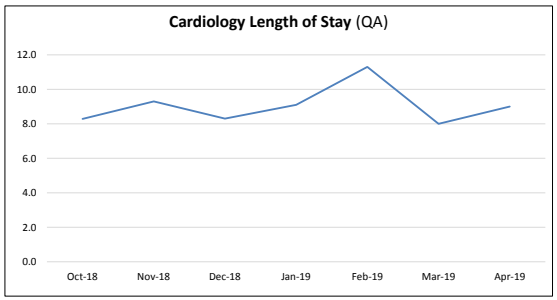
Discharges & LOS

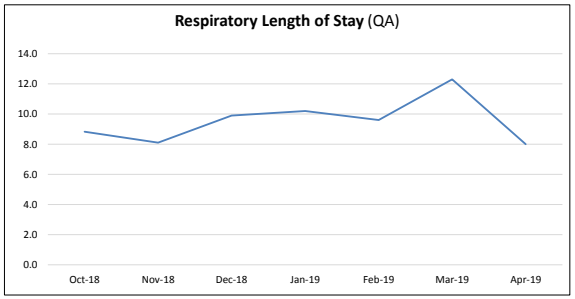


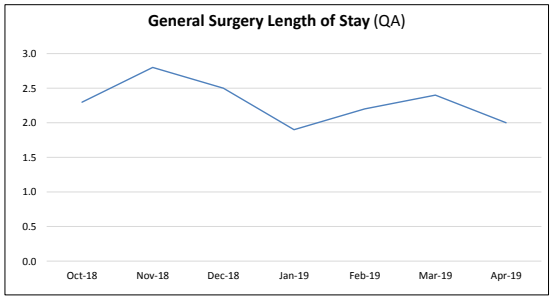




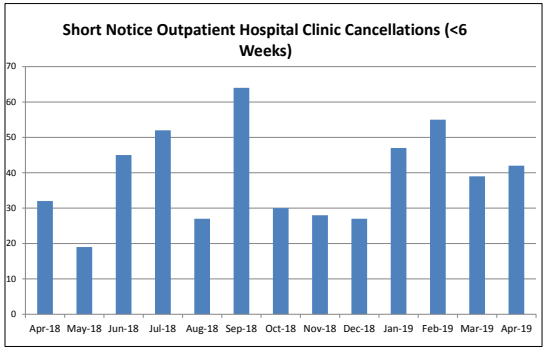


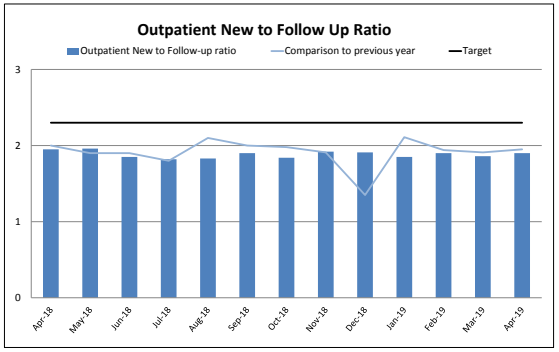


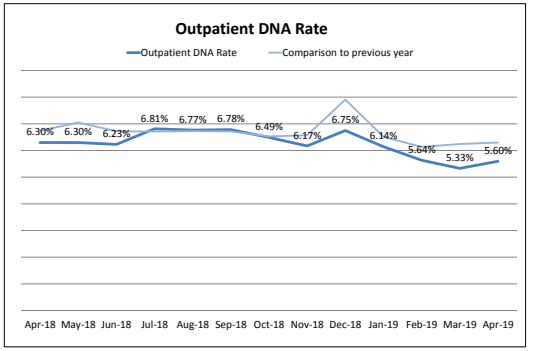


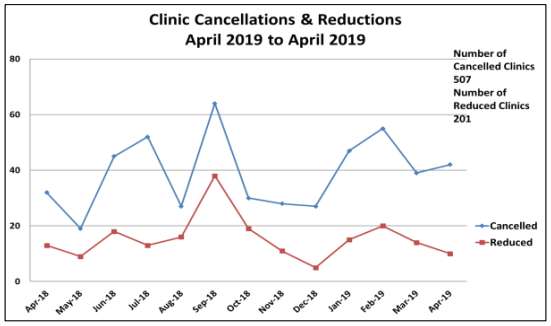


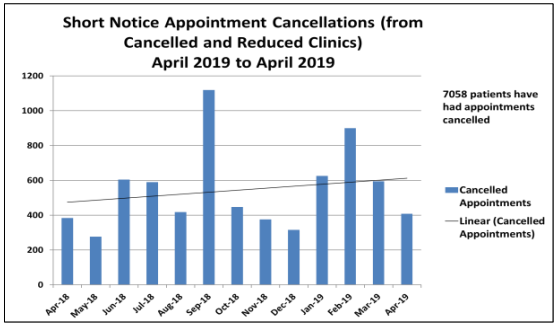
Outpatients & Cancelled Operations

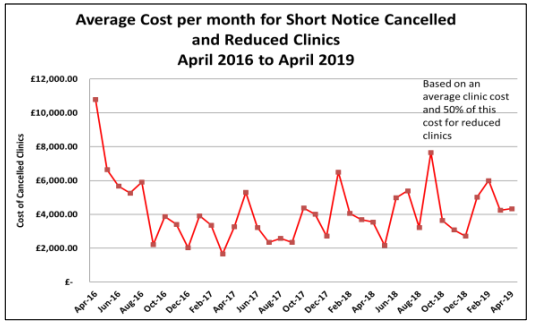












DNA Rate for Follow Up Appointments per Specialty for March

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
2.33%	6.27%	7.11%	2.78%	6.67%	1.70%	5.45%	5.77%	5.59%	1.10%	9.38%	2.31%	7.92%	10.55%	0.23%	6.97%	2.18%	2.68%	0.23%	0.00%	0.00%	3.72%	3.47%	7.73%	4.90%	6.88%	8.27%	27.78%	9.66%	9.04%	6.17%	5.48%	6.40%	4.82%	6.38%	3.70%	5.33%

Cancelled Operations	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Cancelled Operations for Non Clinical reasons	61	27	7	22	17	21	14	8	29	43	39	24	14
Cancelled Operations - breach of 28 day standard	2	1	0	0	0	1	2	0	0	3	0	1	1
Urgent operations cancelled (Non Medical)	0	2	1	5	0	0	1	0	0	0	0	0	0
Urgent operations cancelled for a second or more time (Non medical)	0	0	0	0	0	0	0	0	0	0	0	0	0

Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

Workforce:
At present the vacancy rate for the nursing staff group sits at 25.8% which has decreased since February 2019 rate (26.1%).
Band 5 nurses remain our highest vacancy rate at 41.6%. A further 34 nurses are expected to join the trust over the next 2 months. This is following international recruitment campaigns that took place in 2017/18.
Further initiatives:
- There are plans to recruit a large cohort of international nurses within the next financial year.
- Rotational posts to attract staff and broaden experience.
- Continuation of weekly skype interviews to supplement the nursing pipeline.
- 3,6,9 month check ins in for newly recruited staff. The first of these took place in March, feedback received enable the trust to review process currently in place, particularly for our international recruits.
- Review of benefits package by the Recruitment and Retention group.

Medical Vacancies are being viewed by the HCGs and People Team to ensure robust plans are in place to recruit into these vacancies and reduce the reliance on Agency staff.

This month we have achieved our organisation target compliance rate of 90% and our core training and non-medical appraisal.

Training: Highlights for this month:
- Overall Trust compliance for the month is 92% for Statutory and Mandatory training.
  Non-Medical Appraisal is 91% with actions identified to maintain compliance levels.
- Adults & Paeds Basic Life Support, Infection control Level 2 & Safeguarding level 3 which are under 90%.
  An area of concern is Immediate Life Support which is 75% compliant against a target of 90%.
- Compliance for Information Governance has seen an increase to 89% but needs to be 95% target compliance.
- We have seen an overall percentage improvement in compliance across all Health groups.
- A considerable improvement in compliance in most of the staff groups compared to the Medical & Dental staff group which remains significantly very poor in all areas.

Actions taken:
- Reminder emails sent to uncompliant staff
- Reminder emails sent to staff about to expire within 90 days
- Continued targeted compliance emails to leadership teams highlighting areas below trajectory.
- 1-1 support offered to managers to work through staff compliance figures if discrepancies between central and local data are reported.
- Continued offer of bespoke training in local departments.

Workforce Indicators Summary

Agency Spend 8.10%
Bank Spend 11.86%

Staff In Post
3096
WTE

Training
92%

Sickness
4.0%

11.6%

Turnover
13%

Medical 100%
Non-Medical 91%

Scorecard

Workforce Measures as at 30th April 2019	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3531.65	847.23	452.85	874.96	727.66	279.18	145.14	56.68	147.95
Vacancy Rate	8.0%	11.6%	2.9%	6.6%	20.2%	15.8%	5.5%	11.8%	14.3%	16.6%
Agency % of paybill	7.0%	8.1%	3.2%	4.2%	15.4%	10.2%	0.0%	2.2%	0.0%	0.0%
Bank Usage - Cost	n/a	£1,842,951	£123,098	£166,641	£948,385	£408,269	£81,416	£26,871	£9,509	£78,693
Agency Usage -Cost	£858,000	£1,257,816	£103,393	£84,685	£669,784	£371,254	£0	£28,751	£0	£0
Sickness Absence	3.7%	4.1%	3.4%	4.7%	4.5%	3.5%	7.4%	2.0%	0.8%	4.0%
Long Term Sickness	1.85%	1.8%	1.8%	1.9%	1.4%	1.5%	4.7%	0.2%	0.0%	2.7%
Short Term Sickness	1.85%	2.3%	1.6%	2.8%	3.2%	2.0%	2.7%	1.8%	0.8%	1.4%
Rolling Turnover (voluntary)	12%	13.4%	12.9%	15.3%	14.6%	13.2%	8.0%	13.7%	15.7%	14.5%
Statutory & Mandatory Training	90%	92%	97%	90%	90%	89%	96%	96%	94%	98%
Appraisal	90%	91%	96%	83%	91%	88%	94%	94%	98%	94%
FFT (care of treatment) Q2	70%	76%	76%	82%	74%	68%	85%	74%	n/a	n/a
FFT (place to work) Q2	61%	61%	59%	73%	62%	54%	55%	69%	n/a	n/a
Active Job Plans (first sign off)	90%						n/a	n/a	n/a	n/a
Time to hire (Advert to formal offer made)	45Days	44	48	34	47	57	41	28	n/a	n/a

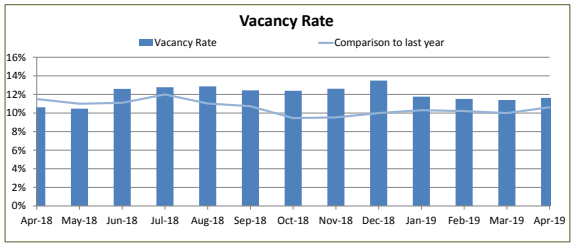
Above target	
provement from last month/above or below target	
Underachieving target	

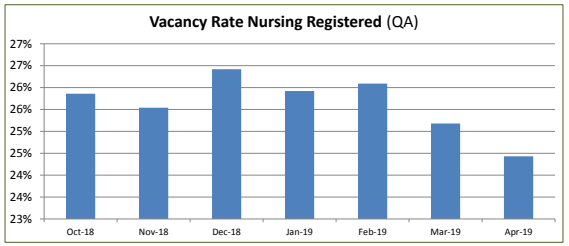
Workforce Indicators

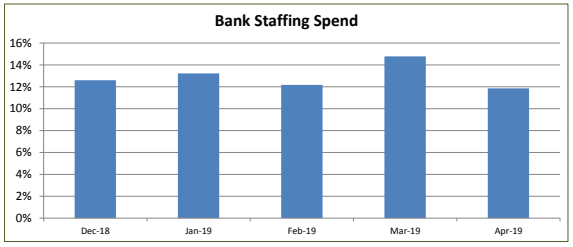
3 Our People Summary

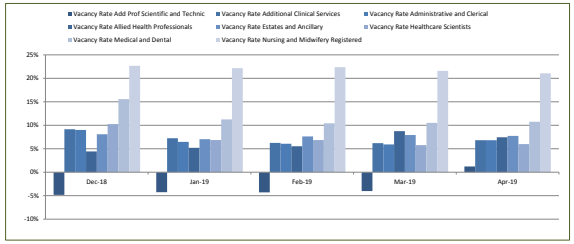
3.3 Well Led

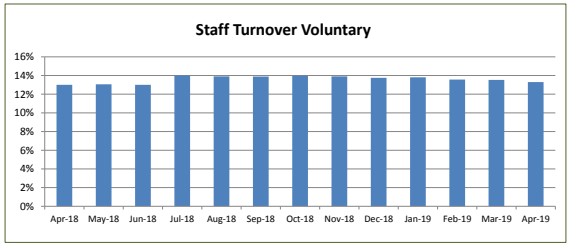
The Princess Alexandra Hospital NHS Trust

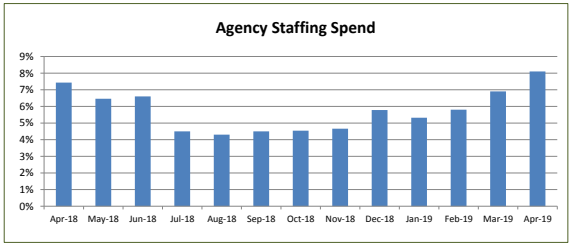


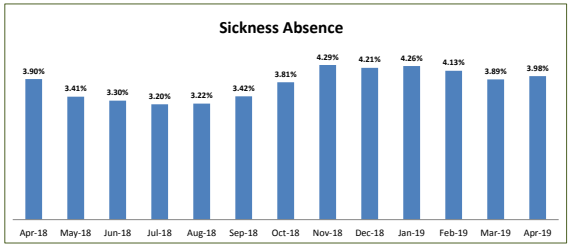


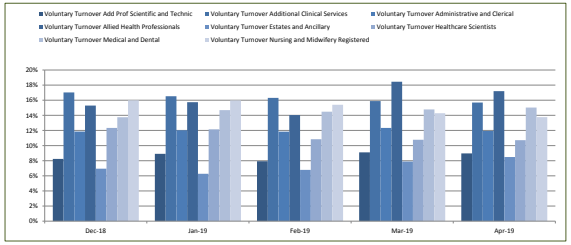


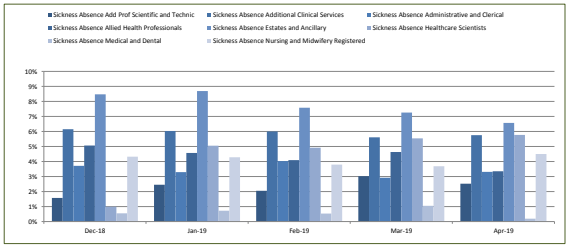




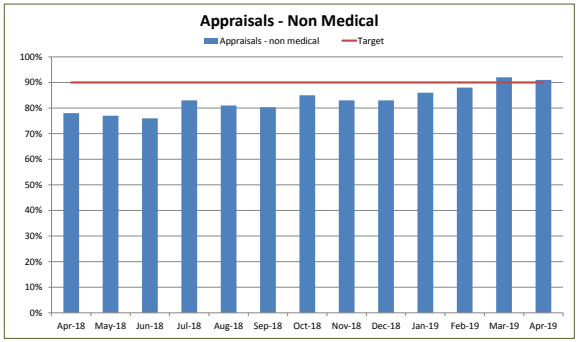


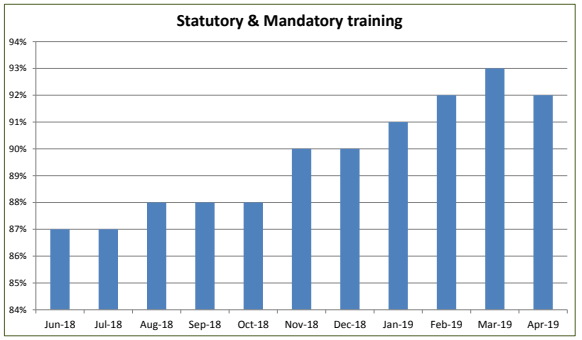


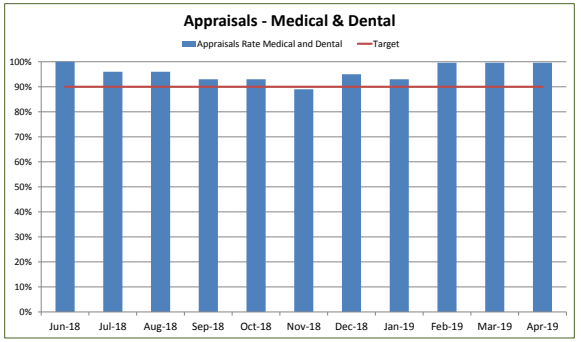


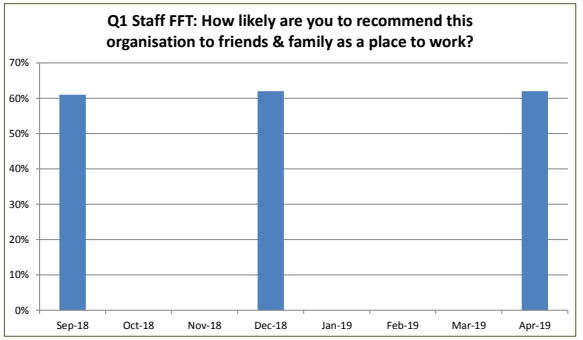


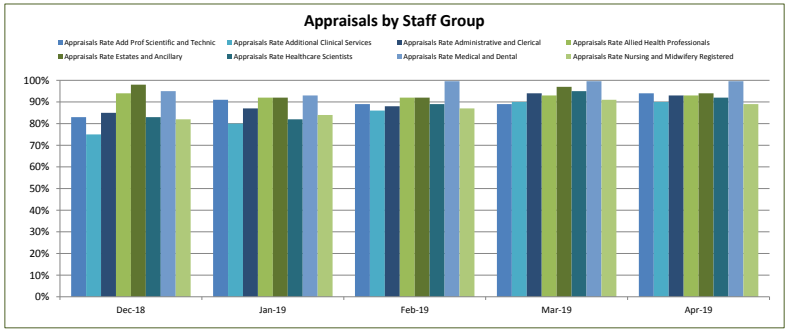
Workforce Indicators

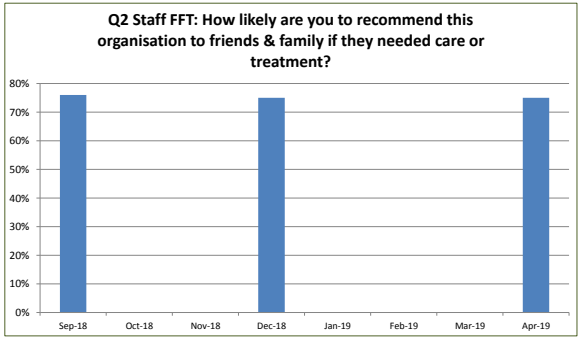












Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

Capital Services – The outline programme for 2019/20 is yet to be finalised. However, enabling works have commenced for the repatriation of the fracture clinic from Herts and Essex Hospital. The build programme will commence in mid-May and is expected to be completed in January 2020. Other backlog maintenance schemes that will take place in Q1 include the partial refurbishment of the High Dependency and Intensive Care Units, the refurbishment of the main lifts, the urgent replacement of the diesel tanks serving the main backup generators and the replacement of the timber fencing within the main boiler room and waste compound with steel palisade security fencing.

Furthermore, planning is underway for the development of the investment business cases for a new urgently needed medical assessment unit, urgent care centre, cancer unit and training and administration block. Each of the schemes will be delivered to RIBA level 2, prior to formal submission to the STP as part of wider regional bid for capital investment schemes.

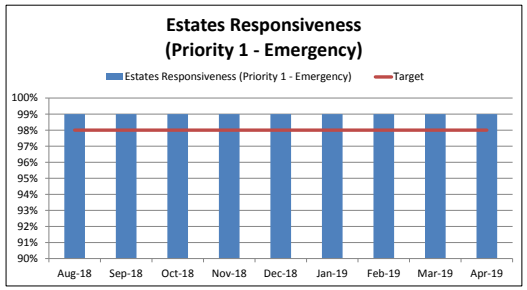
Domestic Services – All very high and high risk wards and clinic areas have been audited this period, together with the continued increased scrutiny on our wards has seen higher standards being sustained regularly. Whilst the number of audits has increased, the number of escalations reduced which has had a very positive impact on the patient care environment. In May 2019, the proposals to support collaborative working with nursing staff will if approved, release staff to maintain higher standards between 1600-2000hrs. Positively, there has been a very positive response from the public with applications for late turn vacancies.

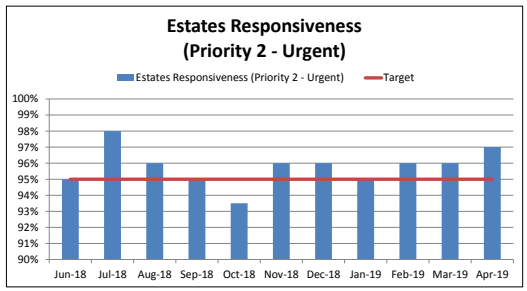
Catering Services – This month has seen a reduction of 2,310 meals ordered at ward level, following engagement at ward level with clinical and non-clinical staff. Next period will see an increase of engagement and it is expected this will have a positive impact on food waste, which whilst slowly improving month on month, a further reduction of 3% is needed to achieve national standards. The refinement of the retail offer to visitors and staff has been presented to our executive for amendment, subject to further refinement, it is expected that these changes will take effect in June 2019.

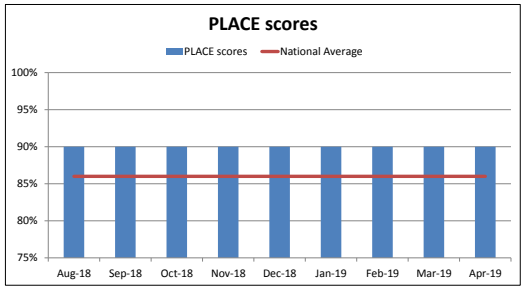
Restructuring – In this period, three new post holders took up their positions to support business improvement and compliance within the estates team, including head of capital services, engineering compliance and environmental and sustainability manager. The post holders have already had a positive impact in improving engineering compliance, the development of a Trust wide sustainability plan spearheaded changes in the development of the capital plans for 2019/20. In June 2019, two further appointments , the strategic head of facilities and strategic head of estates will take up their positions, both of which will lead on the cost improvement programme, sustainability and improved patient environment schemes. These changes are necessary to provide a sustainable and compliant estates and facilities structure.

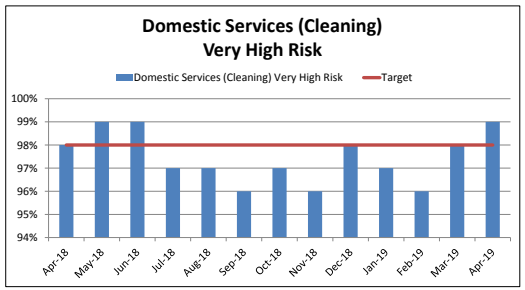
Mandatory Training and Appraisals – for three consecutive months estates and facilities have met the Trust's targets for appraisals and in April achieving 94% compliance, although this is a 3% decrease since last month, a number of staff are scheduled to complete their appraisal in early May 2019. Mandatory training remains has seen a 3% increase in month at 96%, with an anticipated increase in May 2019.

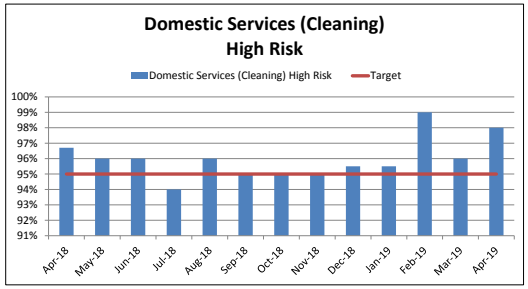
Places

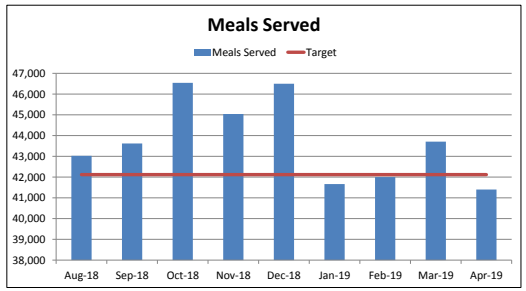

Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19

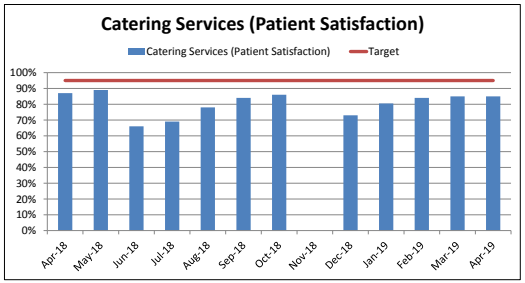

Estates Responsiveness (Priority 2 - Urgent)
Estates Responsiveness (Priority 2 - Urgent)
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19

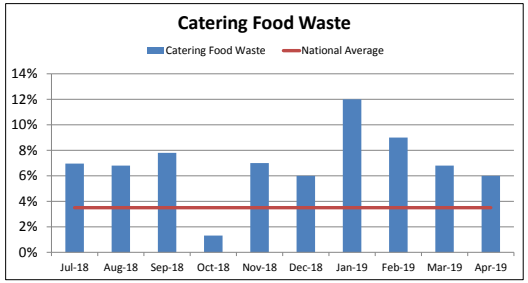

PLACE scores
PLACE scores
National Average
100%
95%
90%
85%
80%
75%
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19


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


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


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


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


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

Executive Summary Our Pounds

NHS
The Princess Alexandra Hospital
NHS Trust

Key finance risks for 2019/20 are tabled below :-

Summary of Risk	Consequence	Mitigation
CIP delivery	Shortfall in delivery of £10m target and recurrency.	Model hospital, GRFT opportunities, minimise non-essential spend. Increased engagement and oversight with HCGs.
QIPP	Contracted £0.6m of expected QIPP, CCGs target circa £2m of additional QIPP.	Joint work and sign off process for future QIPP. Main scheme is Frailty.
Reduction in temporary spend	Annualised M1 run-rate c£15m, agency target of £10.3m. recent increases in temporary staffing spend. Impacting finance, quality and workforce.	Substantive and International recruitment and controls on agency usage.
Recruitment costs	Increase in cost base including international recruitment / payback period (TBD).	Business case sign off including reduced temporary staffing trajectories and short payback period requirement. Utilisation of nursing underspends to support recruitment spend on a non recurrent basis. Budget provisions set aside during planning process.
Unforeseen, unquantified cost risk	Potential increase in cost base due to unforeseen or potential cost risks including; Birthrate plus, medical pay award, management of agreed cost pressures.	Business case sign off and additional local CIPs
Assessment /Ed Pricing and Coding	Recovery of income (c£0.6m-£1.5m).	Joint commissioned work with CCG to conclude pricing disputes
Full Recovery of CQUIN	Total CQUIN £2.5m.	Increased focus and accountability on CQUIN. Reinvestment discussions with CCGs.
Delivery of HCG activity plans	Recovery of income.	HCG activity plans signed off. Weekly activity reporting.
Transformation schemes (MSK/COPD)	Potential exposure from proposed contract (TBD).	Contract negotiation, operational management.
Pension Contribution Increase	Shortfall in funding (during/post transitional period). Total estimated additional costs c£6m based on current establishment.	Additional funding and/or CIP requirement.

Pounds

OUR POUNDS

Metric	Annual Plan (Standard)	Latest Month
Agency Spend £s	-£10,292,000	-£1,257,816
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3%	12%
Capital Expenditure	£29,609,000	£400,000
BPPC Volume	95%	87%
BPPC - £s	95%	89%
Cash Balance	£1,000,000	£1,600,000

Commissioning for Quality and Innovation (CQUIN)

2019/20 CQUIN Performance forecast

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

The Princess Alexandra Hospital NHS Trust

Trust Board – 6th June 2019

Agenda Item:	8.1
Presented by:	Trevor Smith, Chief Financial Officer (CFO)
Prepared by:	Tracy Goodacre, Information Governance Manager (IGM)
Date prepared:	May 2019
Subject / Title:	Information Governance Update – Data Security Protection Toolkit (DSPT) Publication 31.03.19.

Purpose:	Approval		Decision		Information	X	Assurance	X

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This summary paper is to provide the Trust Board with the publication scores for the Data Security Protection Toolkit (DSPT) 31.03.19, on behalf of the Information Governance Steering Group (IGSG). The IGSG will continue to report routinely and by exception to Senior Management Team (SMT) when escalation is required in response to queries and progress advancement.
Recommendation:	The Trust Board is asked to note the report.

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

Previously considered by:	IG Steering Group SMT
Risk / links with the BAF:	Information Commissioner's Office (ICO); Data Security Protection Toolkit (DSPT), NHS Standard Contract 2019/2020 General Conditions CG21.2; General Data Protection Regulations (GDPR).
Legislation, regulatory, equality, diversity and dignity implications:	Data Security Protection Toolkit (DSPT) NHS Standard Contract 2019/2020 General Conditions – section CG21.2.
Appendices:	

The Princess Alexandra Hospital NHS
NHS Trust

1.0 PURPOSE

1.1 This summary paper is to provide the Trust Board with the publication scores for the Data Security Protection Toolkit (DSPT) 31.03.19, on behalf of the Information Governance Steering Group (IGSG).

2.0 BACKGROUND

2.1 The DSPT replaced the previous Information Governance Toolkit (IGT) in April 2018.

2.1.1 The DSPT is an online self-assessment tool that enables organisations to measure and publish their performance against the National Data Guardian's ten data security standards.

2.1.2 The Trust was required to publish a 'baseline' assessment by the 31.10.18 and full annual self- assessment using the new toolkit by 31.03.19, both of which took place on time.

3.0 ANALYSIS

3.1 The Trust submitted a critical standards 'not' met publication as of the 31.03.19, but provided its Improvement Plan to NHS Digital (NHSD); the Trust compliance timeline is to 31.07.19. NHSD have still to agree the action plan.

3.0 NEXT STEPS

3.1 Outstanding areas of DSPT compliance are being addressed via the Improvement Plan. Key matters to be completed include 95% compliance rate for Data Security Awareness training, data flow mapping and contract clauses associated with GDPR in line with previous Board agreed timescales.

4.0 RECOMMENDATION

4.1 The Trust Board is asked to note the report.

Author: **Tracy Goodacre – Data Protection Officer / Information Governance Manager**
Date: **May 2019**

Your future | Our hospital

The Princess Alexandra Hospital NHS Trust

Trust Board - 6 June 2019

Agenda Item:	8.2
Presented by:	Chief Executive - Lance McCarthy
Prepared by:	Head of Corporate Affairs - Heather Schultz
Date prepared:	30 May 2019
Subject / Title:	NHS Provider Licence Self Certification - Condition FT4

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]	NHS trusts are required to self-certify against the NHS Provider Licence. The Single Oversight Framework (SOF) bases its oversight on the NHS Provider Licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions. The Trust is required to self certify ('confirmed' or 'not confirmed') against Condition FT4 by 30 June 2019.
Recommendation:	The Board is asked to consider and approve a declaration of 'confirmed' in relation to Condition FT4.

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

Previously considered by:	EMT on 24 May 2019
Risk / links with the BAF:	All BAF Risks and compliance with the NHS Provider Licence.
Legislation, regulatory, equality, diversity and dignity implications:	N/A
Appendices:	Appendix 1: Condition FT4 Template for self certification

8.2

respectful | caring | responsible | committed

The Princess Alexandra Hospital NHS
NHS Trust

NHS Provider Licence Self Certification (Condition FT4) - Trust Board 6 June 2019

1.0 Context

NHS trusts are required to self-certify against the NHS Provider Licence. Under directions from the Secretary of State NHSI are required to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate.

The Single Oversight Framework (SOF) bases its oversight on the NHS provider Licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.

The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. Compliance with the licence is routinely monitored through the Single Oversight Framework but, on an annual basis, the licence requires NHS providers to self-certify as to whether they have:

- Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6 (3)) by 31 May 2019.
  This self-certification was approved by the Board on 2 May 2019 and the template has been published on the Trust's website.

- Complied with required governance arrangements (Condition FT4) by 30 June 2019.

  The attached template, Appendix 1 reflects the requirements for condition FT4 and the proposed declaration of 'confirmed' in relation to each of the six statements for Condition FT4. A brief commentary against each of the statements is also included.

  In relation to statement 6: The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence - the risk relating to the Trust's registered nurse vacancy rate has been noted along with the mitigating actions that are in place.

2.0 Recommendation

The Board is asked to approve:

• A declaration of 'confirmed' in relation to Condition FT4 as reflected on Appendix 1.

Author: Heather Schultz - Head of Corporate Affairs

Date: 30 May 2019

respectful | caring | responsible | committed

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2018-19** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	No material risks identified: The Trust's Annual Governance Statement with the Head of Internal Audit Opinion (Reasonable assurance) provides assurance on the Trust's system of control and assurance framework.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	No material risks identified: Arrangements are in place for the Trust to receive guidance and there are established links with NHS Providers and the Good Governance Institute. #REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	No material risks identified: The Trust's Annual Governance Statement with the Head of Internal Audit Opinion (Reasonable assurance) provides assurance on the Trust's system of control and assurance framework. NHSI observed the Trust Board and Committees in 2018/19 and the Trust has self assessed compliance aginst the Well Led Framework. Reports following the CQC core services and Well Led inspection undertaken in March and April 2019 are awaited. #REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	No material risks identified: a) Annual report and accounts process and External Audit Opinion reported to Audit Committee and Trust Board. Monthly monitoring and scrutiny by Performance and Finance Committee. Use of resources assessment undertaken by NHSI/CQC in April 2019 and report awaited. b) Integrated Performance Report and Accountability Framework c) Quality and Saferty Committee reviews compliance, Quality 1st team supports compliance with CQC standards and quality improvements. d) Annual reports and accounts process and External Audit Opinion (unqualified opinion for 2018/19) e) Integrated Performance Report and Accountability Framework. f) Board Assurance Framework, Significant Risk Register and aligned risk registers (supported by a Risk Management Strategy) in place to identify and manage risks. g) Annual Business planning processes (Operating Plan and budget sign off) in place with oversight by SMT, Performance and Finance Committee and Board. h) Legal Services team in place. Reviews by Internal/External Audit with reporting to Audit Committee and Board. #REF!

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	No material risks identified: Well Led Framework reviewed annually and CQC inspection under Well Led undertaken in April 2019 (report awaited). Quality information is included in: Monthly Integrated Performance Report to PAF,QSC and Trust Board In line with the Committee's workplan, QSC receives reports on patient safety, quality and experience and the Committee reports to Board after each meeting.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Risks/Mitigations identified: the registered nurse vacancy rate remains one of the Trust's top risks and is reflected in Health Care Group risk registers, SRR and the BAF. Nursing and Midwifery Staffing levels are reviewed monthly (QSC/Workforce Committee and Trust Board). Trust wide workforce monitored by the Workforce Committee.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name **Name**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1 The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Please Respond

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	**Signature**
Name	**Name**
Capacity [job title here]	**Capacity** [job title here]
Date	**Date**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06/06/19 **AGENDA ITEM NO: 8.3**

REPORT TO THE BOARD FROM: Workforce Committee

REPORT FROM: Pam Court – Committee Chair

DATE OF COMMITTEE MEETING: 20/05/019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• Statutory and mandatory training compliance and appraisal rates continue to be above 90%. • Agency spend has increased in April 2019 and steps are being taken to address this. • Unconscious bias training has commenced. • The Freedom to Speak Up Guardians presented their Q4 update, themes were noted and will be discussed further with HCG's at their Staff Experience Groups. • CPD funding - PAHT will receive £78,550.90 (£118,121.65 minus STP top slice of 33.5%) and plans for investment have to be submitted by 20th May. Funding is being allocated to HCG's and Corporate departments based on the numbers of staff. • Staff survey action plans were reviewed. • Unison's domestic services members voted 98.6% in favour of strike action on a 83.5% turnout
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), Communications update, Temporary Staffing, Safer Staffing, Training and Education, STP 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.

8.3

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: **06/06/2019** **AGENDA ITEM NO:** **8.3**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: Andrew Holden – Chair of Audit Committee (interim)

DATE OF COMMITTEE MEETING: 23/05/2019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
In relation to the Annual Accounts and Financial Statements 2018-19; the Audit Committee: - Confirmed that there were no post balance sheet events or adjustments. - Confirmed that the 2018/19 Annual Accounts and Financial Statements had been prepared on a Going Concern Basis. - Reviewed the Letter of Representation and recommended it to the Extraordinary Board for approval. - Approved the 2018/19 Annual Accounts and Financial Statements and recommended that the Board adopt them, and that the associated statements are signed on behalf of the Trust. The Annual Report and Annual Governance Statement were reviewed and recommended to the Extraordinary Board for approval. The Head of Internal Audit Opinion was confirmed with a reasonable assurance opinion and the annual Internal Audit report was noted. A draft of the Quality Account was reviewed. The committee also received the following reports: 1. LCFS Annual Report 2. Legal Services Annual Report 3. Waivers, Losses and Special Payments
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee's progress against its Annual Work Plan is set out below:
The AC is making good progress against its annual work plan.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 6 June 2019 **AGENDA ITEM NO: 8.3**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Andrew Holden - PAF Chairman
DATE OF COMMITTEE MEETING: 23.05.19

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **M1 results:** These were reported as £763k behind plan which could result in a £1,057k loss of PSF/FRF funds. The focus going forward would be around reducing temporary staffing spend and delivering on activity.
- **ED Performance:** Adult ED performance was at 73% (as of 23.05.19) with stabilising numbers of attendances. Key actions moving forward would be to extend medical assessment space, to fill vacancies and to continue the work around length of stay. Expectations were that from June 2019 Paediatric ED performance would start to consistently deliver performance at 90% or above now that the team was once again fully established.
- **Financial Outturn 2018/19:** The report evidenced that all key financial targets had been delivered including income and expenditure, capital (CRL), cash (External Financing Limit, EFL) and agency target. A full set of the draft Accounts 2018/19, including a written report outlining key matters from the preparation of accounts and financial performance would be considered that day by the Trust's Audit Committee.
- **MSK** (clinical transformation and associated contract and payment reform): A detailed presentation was received. In relation to the Lead Contract, next steps would be 1) to agree a five year indicative activity plan with the CCG 2) continued dialogue to resolve key contract issues and 3) escalation plan to be developed.
- **Deep Dive Ophthalmology**: A detailed report was presented by the HCG and discussions focussed on numbers of cancellations, levels of temporary staffing, variability of patient numbers and case mix. It was agreed a further update would be presented in November with a focus on service line reporting.
- **Trust's Sustainable Development Management Plan/Carbon Reduction and Sustainability Strategy Annual Report:** PAF noted the significant improvement in performance against carbon reduction. Whilst the Trust was on track to deliver against the 2020 target there would still be challenges to overcome particularly in relation to new legislation around air pollutants, waste management and recycling.

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

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

- Data Quality
- M1 IPR

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

The Committee continues to make progress against the 2019/20 workplan with a deep dive approach on specific areas on alternate months.

8.3

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 6 June 2019 **AGENDA ITEM NO: 8.3**

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

REPORT FROM: Helen Glenister

DATE OF COMMITTEE MEETING: 24 May 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: **Infection Control (Measles):** The Trust has had two confirmed (unrelated) measles incidences (one in ED in April and a second case in the maternity department in May). This is not surprising given the low vaccination uptake and reduced immunity within the UK population. The IPC team and EHMS have been involved in contact tracing and following up patients and staff who were in contact with the cases. **Intrapartum Deaths:** (update to be provided in the private Board session). **Urological Stents:** The issue surrounding monitoring and tracking of patients following stent insertion had been declared as a Serious Incident. Assurance was provided around identification of missed patients, the undertaking of harm reviews and that outpatient appointments had been booked where required. All stents inserted from February 2019 were now monitored via a log (reviewed daily) and discussions were underway to join the national registry. A SOP for wait list procedures and a junior doctor handover guide had been implemented. **2018/19 Quality Account:** The draft account was presented to the Committee for review and delegated authority would be requested of the Board for final sign-off by the Committee/Committee members prior to the deadline for publication (28.06.19). **Open Incidents:** A deep dive would be undertaken by the Patient Safety & Quality Group.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
Other items discussed: QSC also received the following reports: Quarterly Performance Report (FAWS), M1 Integrated Performance Report, Mortality Improvement Programme, report on Nursing, Midwifery and Care Staff Levels, Monthly Quality, Safety & Effectiveness Report, Monthly Report from Patient Safety & Quality Group, Quality Compliance Readiness 2018/19, CQC Insight Report, Anticoagulant Audit Data, Bowel Cancer Services, Sharing the Learning Annual Report, Patient Experience Report, Update from Patient Panel, Surgical Site Infection Update.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee is making good progress against its work plan.

8.3

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06/06/19 **AGENDA ITEM NO: 8.3**

REPORT TO THE BOARD FROM:	Strategy Committee
REPORT FROM:	Steve Clarke – Committee Chair
DATE OF COMMITTEE MEETING:	24/05/019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• The inaugural meeting of the Committee took place on 24 May 2019; the terms of reference were reviewed and recommended to the Board for approval (attached as **Appendix 1**). • PAHT 2030 - staff engagement events will be held during June with key messages from those informing discussions which will take place at the leadership event in July 2019. Following this PAHT 2030 will be launched at Event in a Tent in September 2019. The Committee asked for more detail on patient engagement to be included in the plan. • Clinical Strategy - an update following workshops with HCGs was received and a detailed update will be presented to the next meeting. • Our New Hospital - the committee received an update on the outcome of a meeting with NHSE/I and this is being discussed in the private Board session.
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: • ICP/ICS Update
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee's progress against its Annual Work Plan is set out below:
The Committee workplan is being developed.

8.3

The Princess Alexandra Hospital NHS
NHS Trust

STRATEGY COMMITTEE
2019/20

TERMS OF REFERENCE

PURPOSE:	The Strategy Committee ("the Committee") is responsible for overseeing the development of the strategy to deliver the Board's vision of PAH being an excellent provider of integrated acute care services. The purpose of the Committee is to establish a sustainable vehicle and model for acute care services in West Essex and East Hertfordshire and maintain oversight of its delivery and the Trust's contribution to the system wide strategy as well as the trusts strategic ambition of delivery of a new hospital.
DUTIES:	1. To maintain oversight of system integration in relation to clinical services and pathways. 2. To maintain oversight of the development of the new PAHT hospital and the underpinning programme of work. 3. To maintain oversight of the development and delivery of the clinical strategy and review/ratify other Trust strategies as they are developed. 4. Provide assurance to the Board on deliverability of strategic programmes at the outset and during the delivery process. 5. To review and monitor the development and delivery of the Trust's *five* year strategy/PAHT 2030. 6. To keep under review the Trust's strategic objectives, mission and vision statements and monitor their delivery. 7. Monitor the Trust's alignment with national and local policies and directives, ensuring alignment with the system and Integrated Care Partnership/Alliance (ICP). 8. Maintain oversight of the risks and mitigations associated with these programmes of work, review the associated Board Assurance Framework risks and provide assurance to the Board on the management of these risks
ACCOUNTABLE TO:	Trust Board.
REPORTING ARRANGEMENTS:	Following each meeting of the Committee a report shall be produced for the Board of Directors by the Committee Chairman and Lead Executive.
CHAIRMAN:	Non-Executive Director
COMPOSITION OF MEMBERSHIP:	Two further Non-Executive Directors, the Chief Executive, Director of Strategy and Director of Quality Improvement.
ATTENDANCE:	Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee meetings within each reporting year. An attendance record shall be taken at each meeting. In addition to the members of the Committee , the following shall be expected to attend each meeting: • Deputy Chief Medical Officer • Deputy Director of Strategy • Deputy Chief Operating Officer
INVITED TO ATTEND:	The Committee may invite internal and external attendees to attend the Committee to provide advice, support and information.

8.3

The Princess Alexandra Hospital NHS
NHS Trust

DEPUTISING ARRANGEMENTS:	In the absence of the Chairman of the Committee, another Non-Executive Director member shall chair the meeting.
QUORUM:	The quorum for any meeting of the Committee shall be two members, one of which must be a Non-Executive member and the other an Executive member.
DECLARATION OF INTERESTS:	All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.
LEAD EXECUTIVE:	Director of Strategy
MEETING FREQUENCY:	Meetings shall be held bi-monthly
MEETING ORGANISATION:	• The meeting shall be closed and not open to the public. • The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee. • A draft agenda shall be developed by the Head of Corporate affairs and the Lead Executive and agreed by the Committee Chairman at least ten clear days* • All final Committee reports must be submitted six clear days* before the meeting. • The agenda and supporting papers shall be forwarded to each member of the committee and planned attendees five clear days* before the date of the meeting and not less than three clear days* before the date of the meeting. *'clear day' means any day which is not a Saturday or Sunday or a public or bank holiday.
AUTHORITY:	The Committee is constituted as a Committee of the Trust Board. Its constitution and terms of reference shall be as set out above, subject to amendment by the Board as necessary. The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from inside or outside the Trust with relevant experience and expertise if it considers this necessary
TERMS OF REFERENCE:	The terms of reference of the Committee shall be reviewed annually and approved by the Trust Board.
DATE APPROVED:	By Committee: 24 May 2019 By Trust Board:

The Princess Alexandra Hospital NHS
NHS Trust

Strategy Committee Membership	
Members	
Trust Chairman & Committee Chair	Steve Clarke
Non-Executive Director	John Hogan
Non-Executive Director	Pam Court
Chief Executive Officer	Lance McCarthy
Director of Strategy (Lead Exec)	Mike Meredith
Director of Quality Improvement	Jim McLeish
Attendees	
Deputy Director of Strategy	Georgina King
Deputy Chief Medical Officer	Marcelle Michael
Deputy Chief Operating Officer	Anne Carey
Secretariat	
Heather Schultz	Head of Corporate Affairs
Lynne Marriott	Board & Committee Secretary

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06.06.19 **AGENDA ITEM NO: 8.4**

REPORT TO THE BOARD FROM: Senior Management Team
REPORT FROM: Lance McCarthy - Chairman
DATES OF MEETINGS: 7th and 21st May 2019.

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
SMT meetings took place on 7 and 21 May 2019. The following items were discussed at the meetings: 7 May 2019: • Well Led Inspection Update • Short Notice Clinic Cancellations – Monthly Report • Financial Year 18/19 Key Results • CIP Sign off • CQUIN Update • Operational Data Quality update • Integrated Performance Report (IPR) • Capital Working Group (CWG) Terms of reference (approved). 21 May 2019: • Ophthalmology presentation - SLR and reference costs. • STP/ICP Work Streams / Expert Oversight Group Updates. • Capital Update • Information Governance Quarterly Update • Advanced Clinical Practitioner (ACP) - implementation of the role including overcoming key challenges (presentation).

8.4