The Princess Alexandra Hospital NHS Trust

Public Meeting of the Board of Directors

AGENDA

Date and Time: Thursday 6 December 2018 August 2018 from 09.00 to 11.30
Venue: Boardroom, The Princess Alexandra Hospital, Harlow.

Time	Item	Subject	Action	Lead	Page
01 OPENING ADMINISTRATION					
09.00	**1.1**	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from Meeting on 04.10.18	Approve	Chairman	3
	1.4	Matters Arising and Action Log	Review	All	15
02 STAFF STORY					
09.05	**2.1**	Patient Story: Ben's Story			
03 REPORT FROM CHIEF EXECUTIVE					
09.30	**3.1**	CEO's Report	Discuss/Approve	Chief Executive	16
04 RISK					
09.40	**4.1**	Board Assurance Framework	Approve	Head of Corporate Affairs	20
05 QUALITY					
09.50	**5.1**	Mortality Improvement Plan	Discuss	Chief Medical Officer	37
10.00	**5.2**	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Inform	Director of Nursing and Midwifery	39
06 PERFORMANCE					
10.10	**6.1**	Integrated Performance Report	Inform	Executives	49
07 PLACES					
10.30	**7.1**	Our New Hospital	Discuss	Director of Strategy	85
10.40	**7.2**	New Ward Update	Inform	Chief Operating Officer	Verbal
08 PEOPLE					
10.50	**8.1**	Equality & Inclusion Update	Inform	Director of People	88
09 GOVERNANCE					
11.00	**9.1**	University Status	Approve	Director of People	95
11.05	**9.2**	Well Led Framework	Approve	Head of Corporate Affairs	98
11.10	**9.3**	Reports from Committees: • QSC.23.11.18 including Annual reports:	Inform/ Approve	Chairs of Committees	101

		- Safeguarding Children & Adults Annual Report - Infection Control Annual Report • WFC.26.11.18 • PAF.26.11.18			103 144 219 220
11.15	**9.4**	Report from ICP Board	Inform	Chief Executive	221
10 CORPORATE TRUSTEE					
11.20	**10.1**	Charitable Funds Annual Report and Accounts	Approve	Chief Financial Officer	232
	10.2	Letter of Representation	Approve	Chief Financial Officer	251
11 QUESTIONS FROM THE PUBLIC					
	11.1	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.	Discuss	Chairman	
12 CLOSING ADMINISTRATION					
	12.1	Summary of Actions and Decisions	-	Chairman/All	
	12.2	New Issues/Risks	Discuss	All	
	12.3	Reflection on Meeting	Discuss	All	
11.30	**12.4**	Any Other Business	Review	All	

TRUST BOARD 2018/19

Meetings, Purpose, Membership and Quoracy

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

Board Purpose
The purpose of the Trust Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care. It determines strategy and monitors performance of the Trust, ensuring it meets its statutory obligations and provides the best possible service to patients, within the resources available.
Board Quoracy
One third of voting members, to include at least one Executive and one Non-Executive (excluding the Chair). Each member shall have one vote and in the event of votes being equal, the Chairman shall have the casting vote.

Board Membership and Attendance – 2018/19			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chairman	Vacant	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC)	Steve Clarke	Chief Finance Officer	Trevor Smith
Chair of Quality & Safety Committee (QSC)	Dr. John Hogan	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Andrew Holden (Vice Chairman)	Chief Medical Officer	Andy Morris
Chair of the Workforce Committee (WFC)	Pam Court	Director of Nursing & Midwifery	Sharon McNally
Chair of Charitable Funds Committee (CFC)	Helen Glenister	**Executive Members of the Board (non-voting)**	
Associate Non-Executive Director (non voting)	Helen Howe	Director of Strategy	Michael Meredith
		Director of People	Gech Emeadi
		Director of Quality Improvement	Jim McLeish
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public
Thursday 4 October 2018 from 10:00 – 13:30
Boardroom, Princess Alexandra Hospital, Harlow

Present:

Alan Burns	Trust Chairman (TC)
Pam Court	Non-Executive Director (NED-PC)
Lance McCarthy	Chief Executive Officer (CEO)
Steve Clarke (non-voting)	Associate Non-Executive Director (ANED-SC)
Ogechi Emeadi (non-voting)	Director of People
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan (late arrival)	Non-Executive Director (NED-JH)
Andrew Holden (late arrival)	Non-Executive Director
Helen Howe (non-voting)	Associate Non-Executive Director (ANED-HH)
Stephanie Lawton	Chief Operating Officer (COO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Andy Morris	Chief Medical Officer (CMO)
Trevor Smith	Chief Financial Officer (CFO)

Members of the Public/Observers

Beverley Watkins	Incoming Deputy Director of People
Dominic Brown (item 2.1)	Junior Doctor
James Roach (item 9.1)	Programme Director for Integrated Care

Apologies
(None)

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 Sharon McNally the Trust's new Director of Nursing & Midwifery (DoN&M) and Beverley Watkins, the incoming Deputy Director of People (DDoP) who would join the organisation on 29.10.18 and was observing the meeting.
1.1 Apologies	
1.2	As above.
1.2 Declarations of Interest	
1.3	No declarations were made.
1.3 Minutes of Meeting on 02.08.18	
1.4	The minutes of the meeting held on 02.08.18 were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no comments on the action log and no matters arising.
02 STAFF STORY	
2.1	Dominic Brown, an FY3 (DB-FY3) in the Trust introduced himself to members and talked about his current role (three days in Surgery and one day in Medical Education). He had undertaken his foundation year 2 training at the Trust and had applied for core surgical training to start the following year. Rather than taking some time out before that training began he had agreed a role of three days on the Surgical SHO rota (General and Vascular Surgery) including on-calls and one day per week in the Medical Education Department as

	a Clinical Teaching Fellow (organising and delivering under-graduate Education for medical students from St. Mary's). In addition he was also Deputy Clinical Lead for Sepsis Awareness. Discussions were now underway with the MEM and the Consultant General and Vascular Surgeon/Clinical Tutor (CGVS-CT) in relation to rolling out a similar type of role to others.
2.4	Non-Executive Director Helen Glenister (NED-HG) asked whether similar roles were available at other trusts. In response DB-FY3 stated that a couple of colleagues were undertaking similar roles (with more teaching) in London but generally no.
2.5	DB-FY3 confirmed he had been seconded to an area which was of particular interest to him (General Surgery) but would be seeking to enquire later in the year whether or not he could switch to another area of interest e.g. Urology.
2.6	The Chief Medical Officer (CMO) highlighted that 40% of junior doctors dropped out of the system at FY2 level. Roles like Dominic's, tailored to individual needs, were clearly the way forward for both the individual and the trust. His involvement in Sepsis Awareness (a big dot item agreed by the Board) only emphasised that.
2.7	NED Pam Court (NED-PC) introduced herself as the Chair of the Trust's Workforce Committee (WFC) and would very much welcome DB-FY3's attendance at that Committee to discuss the same. DB-FY3 agreed.
2.8	The TC asked about the mix of any future roles. In response DB-FY3 confirmed that those would need to align with any existing gaps in the organisation. In addition he highlighted that the education side of the role had been beneficial all round and cautioned any future roles should not push too far towards service provision.
03 REPORT FROM CHIEF EXECUTIVE	
3.1 CEO's Report	
3.1	The CEO presented his update. In relation to key performance metrics he drew members' attention to the addition of two new metrics since the previous report i.e. cash balance and vacancy rate. Of the eight reported in August, three had improved, three had remained the same and two were worse. The six week diagnostic standard had fallen by 0.4% (but remained high at 99.2%) and the Hospital Standardised Mortality Ratio (HSMR) had risen slightly by 1.9.
3.2	In relation to ED performance the Trust's position continued to improve against the 95% 4-hour access target although performance levels remained significantly below where they should be. August's performance had been 81.56% and was the first time since December 2015 that performance had been better than 80%. September's performance had finished at 78.9% which had been a good recovery following a significant increase in Paediatric and Older People's attendances in the month.
3.3	The CEO continued that good progress was being made with the building of the new 27 bedded inpatient ward. The foundations and the building of the new facility was on track for handover on 17.12.18 to support flow through the winter months. Recruitment for the new facility was underway as were plans to relocate other services within the hospital to maximise the benefit of having the right and most productive clinical adjacencies. The Trust continued to work closely with heath and care partners to ensure the right amount of the right type of capacity was available in the community for winter. He flagged that £240 million of extra monies had been announced that week for social care with a proportion of that to be allocated locally.
3.4	Building on the success of the previous year, the hospital had again run a very successful three day 'Event in a Tent' between 25-27.09.18 to celebrate, support and recognise its staff and their achievements. More than 1,000 people had visited the tent over the three days and the feedback had been universally positive. This would now be run as an annual event. On Day 1 there had been a fantastic poster celebration displaying 70 of the most inspiring and innovative quality improvement and research and development programmes in place within the organisation over the last 12 months. The Chairman's Quality Improvement Fund had also been launched and was an opportunity for colleagues to bid for up to £50k to support further improvements and innovations.
3.5	The other two days had been themed, Day 2 for staff health and wellbeing and Day 3 for

	recruitment and community engagement. Within those a number of initiatives to support staff had been launched including a Behaviour Charter, a staff app (my PAHT), a new employee assistance programme (including legal/mental health) and the relaunch of the Staff Council and Equality & Inclusion Programme.
3.6	The CEO continued that during August the Consultant Advisory Appointments Committee had recommended the appointment of an Oncoplastic Breast Surgeon. In response the Board approved that appointment.
3.7	Members' attention was drawn to the new UK Corporate Governance Code which would come into effect on 01.01.19
3.8	A copy of the latest STP Leader's Update was attached for information and was noted.
3.9	The CEO extended his thanks to Sharon Cullen who had pushed back her retirement to act into the role of Chief Nurse during August and September to provide the organisation with continuity. As it was Chairman's last Board meeting in public he also took the opportunity to thank Alan Burns on behalf of the Board for his energy, passion and commitment to the Trust over the previous two years and his clear direction and drive for improvements to the care and experiences of patients. The recruitment process for a new Chairman, led by NHS Improvement (NHSI), was in train.
3.10	NED-PC stated that she very much welcomed the Behaviour Charter and reminded members that at its launch it had been agreed to cascade it in a manner other than by email. In response the CEO confirmed that the cascade had happened. He suggested that the Charter could be used in conjunction with appraisal training.
3.11	In response to a concern raised by NED-PC the CEO confirmed that nursing staff had attended the Event in a Tent although he agreed he did not know whether those staff had come from all areas.
3.12	Associate NED Helen Howe (ANED-HH) commended the display of posters (from the Event in a Tent) in the Board Room. As those had been barcoded she suggested it would be useful to collate them into groups as many related to the CQC key lines of enquiry and could be used as evidence. The CEO agreed.
3.13	NED John Hogan flagged the Quality & Safety's Committee's concerns around ED performance and the suggestion that poor flow in the department was leading to raised HSMR. In response the CEO agreed that the trajectories for August and September had been missed but highlighted that the organisation was now seeing improved and sustained ED performance. A robust Urgent Care Improvement Board took place on a weekly basis and one of the issues it had flagged was insufficient inpatient capacity. This would be addressed with the opening of the additional capacity by Christmas. He agreed the trajectory profile would need to be re-set but confirmed the aim was still to reach over 90% by the end of March 2019.
3.14	The TC highlighted that more often 90% plus was achieved for Minors and Paediatrics the more obvious it became that the issues related to admitted patients and the potential impact on HSMR. The Board would discuss that further at item 5.1 and again that afternoon in the private session.
3.15	Picking up on the Trust's AGM the Chief Financial Officer (CFO) stated how well attended the event had been which had seen an excellent presentation on Frailty Developments and the Frailty Unit. Figures were showing that often 40-50% of that cohort of patients did not require admission. The team were keen to expand the service which would also benefit the system as a whole.
3.16	The Director of People (DoP) added that at the Nurse Recruitment Event during EIAT, eight nurses (with PINs) had been recruited.
3.17	The TC agreed the EIAT had been very successful, particularly the Staff Awards and AGM attendance.
(Five minute break for coffee)	
04 RISK	
4.1 Board Assurance Framework (BAF)	
4.1	This item was presented by the Head of Corporate Affairs (HoCA). No changes were proposed to any of the risk ratings other than to risk 3.2 (Integrated Care Partnership – ICP)

	Health Economy Stability and Joined Up Approach. It was proposed to reduce the risk rating from 16 to 12. She asked the Director of Strategy (DoS) to provide some of the rationale for reducing the risk rating. In response the DoS stated that over recent months the ICP Board had started to make progress, with members working more collaboratively and evidence of alignment with the CCG. Expert Oversight Groups were in place and working well.
4.2	NED Steve Clarke (NED-SC) asked whether exernal partners would share his view in relation to the risk. In response the DoS stated he had not discussed that directly with partners however, partner attendance and vocal support at the Trust's recent AGM was evidence of improved (and possibly the best ever) level of collaborative working.
4.3	In response to a question from NED-JH about the exact detail of the risk, the CEO stated that the risk talked about failure of the ICP to deliver demand management, productivity and efficiency targets which would undermine both hospital and system sustainability and as an example, the risk of having an outlier such as COPD would thereby be diminished. The CFO cautioned that the risk had not gone away and there were still issues that required resolution however the sense was that the risk had reduced. In conclusion the Board agreed to reduce the risk rating to the target risk score of 12 and noted that the risk would be removed from the BAF.
4.2 Significant Risk Register (SRR)	
4.4	This item was presented by the CMO. He highlighted that there were no new risks but he cautioned there was one risk in relation to Urology staffing which was now scoring 25 (an increase from 20 in August).
4.5	He emphasised that the Trust's Risk Management Group's (RMG) role was not to review risks in terms of review dates but to encourage relevant areas to deal with that themselves. He acknowledged the target date on some risks had expired but assured members the RMG would continue with its efforts around that.
4.6	In relation to the Urology risk the COO was able to update that three appointments had been made to the posts of Consultant Urologist – two substantive and one fixed term appointment. Unfortunately two of the appointees had withdrawn. The one remaining (substantive) candidate was due to start on 15.12.18. In the meantime a further three long-term locum consultants had been secured for an initial period of three months with potential for that period to be extended. The remaining two posts had been re-advertised and one had been made the Lead for the MDT which it was hoped would be more attractive. The relationship with UCLH continued in relation to the securing of two Fellows and that had now been extended. Collaboration with Addenbrooke's also continued in relation to the Paediatric Urology Service which it was hoped to make more permanent. In summary the position was more positive, the Executive were meeting with the team on a regular basis and patients on the waiting list were being reviewed on a weekly basis (both Cancer and 18 week pathway).
4.8	NED Steve Clarke (NED-SC) raised a concern in relation to the risks where target dates had expired and asked the CMO for assurance that this would be addressed. In response the CMO confirmed that the RMG had representation from all clinical and corporate areas and he could provide assurance that conversations did take place at the meeting in relation to target dates. In addition he could provide absolute assurance that each local risk register was reviewed (in rotation) on a line-by-line basis.
05 QUALITY	
5.1 Mortality Update	
5.1	This item was presented by the CMO who updated that HSMR remained a concern for the organisation. He reported on some key headlines which the Board may want to discuss further at its session that afternoon.
5.2	In summary it was now the 17th consecutive month that HSMR had been 'higher than expected'. The most recent report which had been received two days previously showed a slightly improved position with HSMR at 115.3. In summary the Trust was in a plateau, if not slowly descending, phase of its rolling HSMR.

5.3	In relation to in-month HSMR this was more real time and showed it had been 'as expected' for eight of the last 12 months.
5.4	On the positive side Palliative Care Coding which had been a recent concern was now in a more robust position with a sustained and high reporting rate of almost national average. He felt that reflected the work of the newly appointed End of Life Clinical Nurse Specialist and Consultant. Also to note was that in relation to fractured neck of femur (which had featured for many months) this had now finally dropped off the rolling HSMR data and in his view, related to flow for that cohort of patients.
5.6	Moving away from the data/report the CMO said in his view there was a link between flow (not just in the ED) and mortality. It was clear the Trust's ED performance had been challenging over recent years. Some background to what contributors to that might have been were that in November 2012 the Urgent Care Centre had moved in Minors and had then closed (April 2013) – he felt that was a significant point. In December 2013 the ED at Chase Farm had closed and in October 2014 the same had happened at Queen Elizabeth II at Welwyn. In-month annual ED attendances had risen from 60k to 90k and then to circa 100k. There had been an impact on PAH with the wider system ED closures. In March 2016 the Trust's HSMR then started to rise. He emphasised that the medical and nursing workforce during that time had not changed and changes to the infrastructure had only happened a lot later. The department therefore had not been equipped to deal with that increased volume of attendances.
5.7	The CMO noted some other aspects which were under consideration including the mortality rates for patients from Hertfordshire and Essex and the socio-economic factors for the four boroughs of the Trust's catchment.
5.8	The CMO continued that an external review of coding had been undertaken and the Executive had agreed an additional piece of work with a focus on 'frequent fliers for the HRG codes', sepsis being one of those. Further areas for review included sepsis, COPD, pneumonia and intestinal obstruction. Over-medicalisation of patients and 'admissions over the age of 75 with high frailty scores' would be reviewed as well.
5.10	A procurement exercise was underway for the purchase of some mortality software and a mortality dashboard was being developed. He felt once that was established oversight of mortality and learning from deaths would be clearer.
5.11	The CMO went on to say that another piece of work which would be useful would be around DToCs/LoS/occupancy/stranded and super-stranded patients (over three years) to provide more evidence around the case that mortality was linked to patient flow both internally and within the system.
5.12	The CFO updated that he felt progress was being made with the team from Dr. Foster as they started to examine data in greater detail. However, there was still more to be done and further sessions to arrange. The other work undertaken by external teams then needed to be triangulated with Dr. Foster outcomes.
5.13	NED-AH queried whether the closure of external facilities would also have had a knock-on effect in relation to others' HSMR. In response the CMO stated that what Dr. Foster had done was to try and identify other hospitals with poor ED performance but better HSMR with the nearest of those being Hillingdon. The CMO had arranged to meet their CMO to discuss potential lessons to be learned.
5.14	In response to a question from NED Pam Court (NED-PC) the CMO confirmed that the objective was to bring HSMR back to 'as expected'. Oversight of mortality was led by the Trust's Mortality Surveillance Group whose initial remit had been to establish a robust governance process – that was now fully embedded.
5.15	The TC stated that in his view there needed to be clarity around what was real and what was statistical. The factors driving the 'expected' rate needed to be understood and palliative care coding was one of those. The other part was morbidity (deprivation) element.
5.16	In response to a question from ANED-HH the CMO confirmed that clinicians were engaged with the issue. As assurance he confirmed the Trust's process for the review of outlier alerts was robust but often uncovered discrepancies in coding (coder/clinician).
5.17	The TC thanked the CMO for his update and confirmed next steps would be discussed that afternoon in the private session.

5.2 Nursing, Midwifery and Care Staff Levels	
5.18	This item was presented by the Director of Nursing & Midwifery (DoN&M). She drew members' attention to the fact that in August the night fill rate for RNs/Midwives had been less than 80% and bank/agency fill for July had seen a request for around 4000 shifts with a fill rate of only 60%. She had agreed with the DoP to undertake a full establishment review across the organisation and anticipated reporting back on the results of that review in two months. The CFO requested that the scope of that review ensured it was sufficiently broad and linked with roster management. The DoN&M confirmed that it would.
5.19	In relation to staffing of the new ward inpatient facility she confirmed she would be working with the Chief Operating Officer (COO) and DoP to ensure it was safely staffed.
5.21	The CEO highlighted the organisation's aim to ensure that recruitment was ambitious and would like to increase 'hands on' time for nursing staff to support patient experience. Model Hospital data suggested the organisation was spending more on its nursing staff than its peers but maybe at the wrong levels and any establishment review would be vital in evidencing if that was the case.
06 PERFORMANCE	
6.1 Integrated Performance Report	
6.1	This item was introduced by the COO. The CQC 'must and shoulds' were now a key focus of all HCG and corporate area Performance Reviews and Executive Walkabouts would begin that week supporting the Triumvirates. Other key headlines were: <u>Patients</u> • DNACPR audit – poor performance but the audit had been repeated and compliance was now at 81%. • C-difficile – ten cases reported with three successfully challenged so seven cases reported for the year.
6.2	<u>Performance</u> • Overnight bed moves – audit to begin shortly. • Red to Green – standardised process now on each ward with Executive support in four areas so good progress. • New Ward – agreement that week for a weekly MDT working group meeting leading up to the opening of the new ward. • RTT – continued delivery of the standard at 92% • Cancer performance – improvement in month but remaining fragile. Trajectory to return to delivery of national standard was September. • Diagnostics – performance remained strong with 99% achieved in month. • ED – improved start to performance in October. Minors and Paediatrics continued to perform well. Opening hours of Paediatric Ambulatory Unit extended till 22:00 on weekdays and now open Sunday. • Frailty Service – going from strength to strength with a very engaged Lead. • Outpatients – focus required and an Improvement Board and Modernisation project agreed to lead into the organisation's clinical strategy work.
6.3	In response to a concern raised by NED-JH in relation to endoscopy washers the COO confirmed that an additional washer had already been purchased and a vanguard unit would be coming on stream to address the backlog. Two additional washers were now going through the procurement process.
6.4	<u>People</u> • Statutory/mandatory training – compliance remained a concern particularly in relation to Information Governance and Fire but the drive for improvement continued. • Appraisal – issues with on-line system now being addressed. • Time to hire - delays in short-listing were being addressed.
6.5	<u>Places</u>

	• PLACE Assessment – good news story with significant progress seen in all but one domain. • Backlog maintenance – most issues now out to market with the majority of work to take place over the next six months.
6.6	Pounds • Operating Investment & Expenditure - on target in M5 and year-to-date. • Activity and income - lower than planned in month but offset by lower bank costs and remained on target to deliver the gross control total and CIP target and agency cost target for the year. • Capital – schemes still to commence so back-end loaded but on target to maximise the capital resource limit. • Cash – remained positive and closely monitored and managed. Detailed work now underway around forecast outturn (FOT) internally and externally with a focus on activity levels over the winter period. On track to deliver all year-end targets. • Provider Sustainability Funds (PSF) – in relation to ED those for Q1/Q2 would be lost.
6.7	In response to a question from NED-SC in relation to the Trust's performance against Public Sector Payment Policy the CFO confirmed that had shown a slight improvement and agreed to provide details of that to PAF along with a trajectory.
ACTION **TB1.04.10.18/09**	**Provide details and trajectory on Public Sector Payment Policy to PAF.26.11.18.** **Lead: Chief Financial Officer**
07 PLACES	
7.1 Our New Hospital	
7.1	This item was presented by the DoS. He reminded members that three site options were being considered. Two were offsite; one was near the new junction 7A of the M11 and one in Gilston Village. The third option was the redevelopment of the current site. The intention had been to agree the offsite option that day but following a request from Essex County Council for further micro-modelling on the traffic survey (which would take five to six weeks) and the fact that significant work was about to start on the feasibility of the current site, a decision had been taken to delay the decision on a site until the Trust's March 2019 Board meeting.
7.2	In response to a question from NED-JH the DoS confirmed that an external company were advising on the sizing of a new hospital and the Trust's clinicians were involved.
7.3	The TC emphasised the need for open and engaged work prior to March to properly inform any decision around a site. The CEO agreed saying that going forward communication with stakeholders, particularly the public, would be key moving forward. In response to a question from NED-HG the DoS confirmed that he had already been in discussion with the DoP around lines of communication and had recently attended a Patient Panel meeting and engaged with the PALS team. He had met local authority leads the previous week and there was strong representation from all stakeholders on the organisation's Steering Group. Unified political support had also been obtained.
7.2 Hertfordshire and West Essex STP Estates Plan	
7.7	This item was presented by the Director of Quality Improvement (DoQI). He requested members note the contents of what was an extensive document which had culminated in the agreement of changes to how the NHS would access capital funds in future, aligned to STP priorities and strategy. He felt it was the first time there had been a comprehensive overview of the scale of the challenge for the STP which included the elements of a new hospital at both West Hertfordshire and in Harlow.
7.8	The DoQI continued that the purpose of the document was to provide an idea of requirements and prioritisation for capital funding over the next five years. The Trust had played a significant role in ensuring it was at the forefront of that and indeed had submitted over ten schemes for its medium to long term strategy. The Trust's scheme for additional capacity for winter had been included in the prioritised list. As a final point he drew member's attention to the roadmap and future actions in order to deliver the strategy.

7.10	In line with the recommendation in the paper the Board approved the Hertfordshire and West Essex STP Estates Plan.
08 PEOPLE	
8.1 Training and Continued Professional Development (CPD) Funding 2018/19	
8.1	This item was presented by the DoP. She informed members that over the previous two years funding had reduced by a quarter. That year a sum of £57k had been received against a request for £0.5m.
8.2	Given that training was one of the organisation's biggest opportunities in relation to recruitment and retention, ways to supplement the £57k had been sought. Other funding streams had been reviewed and a small additional amount had been gleaned.
8.3	Health Education England's (HEE) comment had been that funding had been reduced in favour of the Apprenticeship Levy and after a review, it had transpired that as of next year and going forward that Levy could be used.
8.4	The TC asked what percentage of the Levy the organisation recouped. In response it was confirmed it was less than one third. The organisation should currently have 80 apprentices but only had 20.
8.5	The DoP continued that from the Staff Survey it was evident that access to and quality of statutory/mandatory training needed to improve. Going forward a decision had been taken to set up a mirco-site and highlight the benefits of that, along with the App. HEE had allocated £0.5m to the STP but organisations would need to bid against that which made the process somewhat protracted.
8.6	As a final point the DoP confirmed she had been appointed Senior Responsible Officer (SRO) for Attraction & Retention in the STP.
(12:15 CMO left the meeting)	
8.7	The TC highlighted that it was for the Trust to fund the CPD of its staff and to agree where those funds came from. The Apprenticeship Levy was a considerable sum (£700k) and every effort should be made to recoup that where possible. As a final point the CFO confirmed that the in-year residual issue would be addressed via the FOT sign-off.
8.2 Healthcare Worker Flu Vaccination: Self-Assessment	
8.8	The DoP presented this item and reminded members that in September that year national clinical and staff side professional leaders had written to CEOs requesting that the best practice management checklist for healthcare worker vaccination be completed. It was a requirement that the self-assessment against those measures be published in Trust Board papers before the end of 2018 for public assurance.
8.10	In line with guidance the TC urged the Board to consider a review and possible redeployment of staff who had not been vaccinated, particularly in high risk areas. In addition (and in line with a previous hand-washing campaign) he would encourage patients to establish whether or not the clinician treating them had been vaccinated. In response the DoP confirmed that data on individuals and areas was being collated and would continue to be reported on a weekly basis
8.11	The Board approved the Self-Assessment.
9.2 Annual Report on Emergency Preparedness and Business Continuity and Forward Plan	
9.1	This item was presented by the COO who confirmed that substantial assurance had been received following discussions with NHSE and Commissioners.
9.2	A question raised regularly at the Trust's Performance & Finance Committee was around how emergency plans were tested. She was able to confirm a desktop exercise would take place the following day ahead of winter and in addition two live exercises were planned during the winter period. In response to a question from the TC it was confirmed cyber security would be included in the testing exercise.
9.3	The Board approved the submission of the Core Standards to the Local Health Resilience Partnership.
9.3 Reports from Committees	

9.4	Audit Committee (AC) There were no comments on the report. The Board approved the Committee's Terms of Reference for 2018/19.
9.5	Charitable Funds Committee (CFC) The Committee had met the previous day and key highlights (reported verbally) were: • Income less than budget and less than M5 the previous year – partly due to a reduction in donations and to the staging of the breast screening fund-raising activity (roughly 82% of total charity income). • Charity's Annual Report & Accounts for 2017/18 were approved following review of the report from the Independent Examiner – to be presented to the Corporate Trustee in December. • Reserves to the value of £200k agreed (as per previous years). • Concern raised by CFC around fund-raising stewardship which presented a risk. After discussion the Board agreed that oversight of fundraising would now become part of the remit of the Committee in addition to its role for overseeing the financial governance of the funds.
9.6	Quality & Safety Committee (QSC) The report and key escalations were noted.
9.7	In response to the Committee's ToR and a question raised by the COO it was agreed that HCGs' quarterly deep dives would be presented by the appropriate Triumvirate rather than just the ADoN and AMD. The Board approved the Committee's ToR for 2018/19 as recommended by QSC.
9.8	Workforce Committee (WFC) The report was noted, the Terms of Reference were approved and the Annual Review of the Committee was noted.
9.9	NED-HG highlighted that as Volunteers and Communications were included under the Committee's remit, the Committee could change its name to the People Committee. The Board noted the suggestion and NED-PC suggested that this be discussed at the next WFC meeting.
9.10	Performance & Finance Committee (PAF) The paper was taken as read. Points to note were: • Alternate PAF meetings would focus on the medium term financial plan and other strategic financial planning items. • PAF agreed its ToR for 2018/19 which included the removal of the DoP from its membership. • In relation to the New Ward and under delegated authority from the Board, PAF had considered and approved the additional capacity to support emergency flow over winter.
9.11	The Board agreed the PAF ToR for 2018/19.
09 GOVERNANCE	
9.1 West Essex Integrated Care Partnership (ICP) Governance Model	
9.12	In the absence of the ICP Programme Director the CEO introduced the paper. He drew members' attention to the following: • The ten principles by which members would work together to improve the quality of care and pathways. • The process to implement the change to the governance structure over the coming four months. • The realignment of other groups/meetings that worked across the ICP for example the nationally mandated Local Delivery Board for Urgent Care. • The key decision-making and proposal to delegate to the ICP Board rather than to individual boards.
9.13	There was no specific impact on the Trust Board and the CCG Board had already approved the model.
9.14	In response to a question raised by NED-AH in relation to the award of contracts it was

	confirmed that for example in the case of MSK, the ICP would make recommendations on how those services were provided, for member Board approval. In response to a question from the TC the CEO confirmed the membership of the ICP was as to be expected i.e. the Trust, WECCG, EPUT, Essex County Council, Stellar Healthcare.
At this point in the meeting the Programme Director for Integrated Care(PD-IC) arrived.	
9.15	In response to a question from NED-PC the CEO agreed there was the potential for conflicts of interest but as the partnership continued to develop he would expect that would diminish as all services would be provided in collaboration (i.e. no conflict in terms of competition). He agreed there had been no discussions around NED involvement in the Partnership at which point the PD-IC added that in relation to making decisions as a system he felt there might be a requirement for a Chair's Oversight Group which could be expanded to include NEDs.
9.16	In relation to governance and delegation NED-SC stated that there needed to be clarity on what was being delegated and to whom.
9.17	In response the PD-IC confirmed a Memorandum of Understanding would be drafted to brief the partnership and would include NED involvement, how decisions were made and how recommendations were made to other Boards. The CEO stated that a regular report from the ICP should be made to each Board and that should be added to the framework.
ACTION **TB1.04.10.18/10**	**A regular report from the ICP to be presented to each member Board and to be included in the governance framework.** **Lead: CEO**
9.18	The CFO added that national guidance was being developed which would also need to be presented to the Board to support the framework. The PD-IC added that the role of the CCG would change as the ICP developed and the guidance around that would be incorporated.
9.19	The TC summarised by saying that it would be important that going forward the ICP worked well as it would be the vehicle for delivering integrated care pathways within a strategic commissioning framework. The Trust itself was committed to the ICP and to making it work but in line with the comments above, there were clearly some changes to be made to the framework. He requested the CEO ensure those changes were made. Board members were content with the proposal subject to the changes noted above being made by the PD-IC/CEO.
10 QUESTIONS FROM THE PUBLIC	
10.1	There were no questions from the Public.
11 CLOSING ADMINISTRATION	
11.1 Summary of Actions and Decisions	
11.1	These are presented in the shaded boxes above.
11.2 New Issues/Risks	
11.2	No new risks or issues were identified.
11.3 Reflections on Meeting	
11.3	Not undertaken at this point.
11.4 Any Other Business (AOB)	
11.4	There were no items of AOB.

Signed as a correct record of the meeting:	
Date:	06.12.18
Signature:	
Name:	

The Princess Alexandra Hospital NHS
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Title:	Chairman

Trust Board Meeting in Public
Action Log - 06.12.18

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.02.08.18/07	Nurse Recruitment	Re-open the discussion around nurse recruitment at October Board.	The Board	~~TB1.04.10.18~~ BD.01.11.18	Addressed at item 5.2	Closed.
TB1.04.10.18/09	Public Sector Payment Policy	Provide details and trajectory on Public Sector Payment Policy to PAF.26.11.18.	CFO	PAF.26.11.18	Covered in PAF Finance Assurance Pack October 2018.	Closed
TB1.04.10.18/10	Report from ICP	A regular report from the ICP to be presented to each member Board and to be included in the governance framework.	CEO	TB1.06.12.18	Addressed at item 9.4.	Closed.

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TRUST BOARD
29 March 2018

3.1

Agenda Item:	3.1
Presented by:	Lance McCarthy
Prepared by:	Lance McCarthy
Date prepared:	27 November 2018
Subject / Title:	CEO Report

Purpose:	Approval	X	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting: - Performance highlights - Urgent care and flow - Mortality - Culture change - Consultant appointments - Chairman recruitment - Awards and media coverage - Regular closer collaboration - STP Independent Chair
Recommendation:	The Trust Board is asked to note the CEO report and to agree the AACs' recommendations to appoint 3 new consultant anaesthetists.

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

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

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The Princess Alexandra Hospital NHS
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Chief Executive's Report
Trust Board: Part I – 6 December 2018

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

(1) Key performance headlines

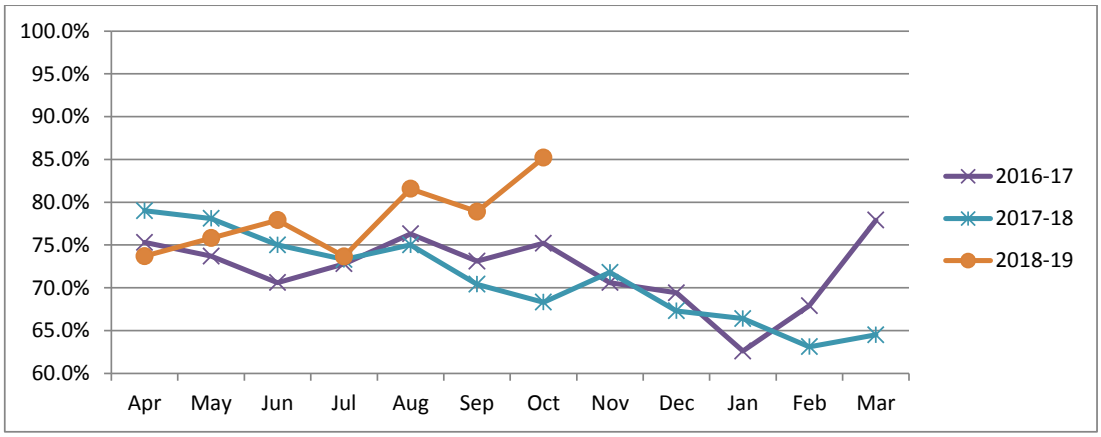
Some key summary performance headlines outlined below for the latest month. More detail on each of these and other key performance indicators are shown in the revised and updated Integrated Performance Report later on the agenda.

Key Performance Indicator	Actual performance for latest month (October)	Comparison to last report
ED 4-hour performance	85.2%	↑ (better)
HSMR	116.7 (Jun 17 – May 18)	→ (NB: same data as last report)
CDiff numbers	1	→
MRSA numbers	0	→
Never Events	0	→
RTT incomplete	92.5%	↑ (better)
6-week diagnostic standard	99.7%	↑ (better)
Cash balance	£703k	↓ (worse)
Vacancy rate	12.4%	↑ (better)

(2) Urgent care performance and flow

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

October's performance was 85.2%, the first time since July 2015 that performance has been better than 85%. Performance for all months over the last 3 financial years, since April 2016, can be seen in the chart below, showing improvements over the last 7 months.



As at 27 November, performance for the month however was 73.9%. We have seen a significant rise in ED attendances this month, up 4.7% on November 2017 and up 3.6% on October 2018, with a significant increase in paediatric and older people with complex conditions. We have also had more days with more than 300 attendances in the month (19) than ever before, putting added strain on the

department. We are working closely with primary care, CCG and community services colleagues to understand why we have experienced a sudden increase in pressure of volumes.

More detail on actions to support our urgent care patients, the progress with the building of a new 27 bedded inpatient ward to increase capacity and our preparations for winter will be picked up later in the agenda.

(3) Mortality

Our Hospital Standardised Mortality Ratio (HSMR) continues to be 'higher than expected' despite concerted efforts and good progress made in our outlier pathways over the last 12 months.

We have set up a Mortality Improvement Board to oversee an increased set of actions to bring this back to 'as expected' and eventually to 'lower than expected'. In addition our Medical Examiners will be functional from early December, reviewing every death in the hospital to ensure we maximise our learning from deaths.

More detail on this is provided in the mortality item on the agenda.

(4) Culture change and trust

Our culture change programme continues at pace throughout the organisation, improving the level of openness and honesty and the respectful challenge of colleagues, as we continue to improve the care provided to all of our patients. Working with The Trusted Executive Foundation (TTEF), we have put 'trust' at the heart of what we do and aligned the TTEF habits of 'trust' with our organisational values. Our Behaviour Charter, launched at our Event in a Tent in September is becoming embedded and we continue to see increasing use of our Freedom to Speak up Guardians.

(5) Consultant appointments

We held a Consultant Advisory Appointments Committee during August for 3 anaesthetics, one to predominately support critical care and the other two to support obstetrics. The AAC recommends to the Board the appointment of:

- Dagmar Holmquist
- Suzanne Bell
- Dinesh Das

The Board is asked to approve the AACs' recommendations.

(6) Chairman recruitment

The recruitment process for the Chairman, led by NHS Improvement, has been completed. There were 5 applicants shortlisted, who were interviewed on 14 November 2018. At the time of writing the report, the announcement had not been made as to who the successful candidate is.

(7) Awards and media coverage

The NHS 'Academy of Fab Stuff', a social movement for sharing health and social care ideas, headed up by Roy Lilley, held its annual awards in London on 15 November. With a 'Fab 70' theme, in recognition of 70 years of the NHS, PAHT won the 'Fab Change 70 Organisation of the Year', a second consecutive victory in this category. The award was given to the organisation whose 'energy, leadership and vision has empowered staff to put their ideas into action and have embedded QI

(Quality Improvement) as 'the norm' throughout their organisation'. This is great recognition of all the ongoing quality improvements that our people are making across the hospital for the benfit of our patients. A team of our people went to the awards ceremony and were presented with the trophy by Simon Stevens, Chief Executive of NHS England.

Emma Willis - Delivering Babies, reached its conclusion with the 6th and final episode shown on W Channel on Monday 25 November 2018. The series followed Emma working as a Maternity Care Assistant in our 'outstanding' rated maternity department for 10 weeks over the summer. It was viewed by more than 0.5 million people and showed the fantastic services we provide and the amazing people that we have working in maternity services. Thanks to all of our people who were involved, to the production team and to Emma herself.

(8) NHS England and NHS Improvement closer collaboration

The speed of change with closer collaboration between NHS England and NHS Improvement is increasing. The consultation on their proposed new structure was launched to their teams on 16 November and the announcement of the 7 new combined Regional Directors is due imminently. PAHT will be in the East of England region, a region spanning from Norfolk across to Milton Keynes and over to South Essex.

(9) STP Independent Chair

After a thorough recruitment process, Paul Burstow has been appointed as the Independent Chair for our STP. An ex-Minister of State for the Department of Health and the Chair of Tavistock and Portman NHS Foundation Trust, Paul will bring a wealth of health experience with him as we continue to work more closely with commissioner and provider colleagues across Hertfordshire and West Essex.

Author: **Lance McCarthy, Chief Executive**
Date: **27 November 2018**

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Trust Board - 6 December 2018

4.1

Agenda Item:	4.1								
Presented by:	Head of Corporate Affairs - Heather Schultz								
Prepared by:	Head of Corporate Affairs - Heather Schultz								
Date prepared:	26 November 2018								
Subject / Title:	Board Assurance Framework 2018/19								
Purpose:	Approval	x	Decision		Information		Assurance		
Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Board Assurance Framework 2018/19 is presented for review. The risks, risk ratings and outcomes of Committee reviews in month are summarised in Appendix A and the detailed BAF risks are attached as Appendix B. Risks 2.1 and 2.4 were discussed at Workforce Committee in November and reductions in the risk scores were agreed and recommended to the Board for approval. The proposed risk scores are: Risk 2.1 - reduced from 20 (4x5) to 16 (4x4) Risk 2.4 - reduced from 9 (3x3) to 6 (3x2) which is the target risk rating.								
Recommendation:	The Board is asked to approve the Board Assurance Framework and the reduction of the risk scores for Risks 2.1 and 2.4.								

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 29.11.18, PAF.26.11.18, WFC. 26.11.18 and QSC.23.11.18
Risk / links with the BAF:	As reflected in the attached BAF.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with national legislation and regulations and the Code of Governance.
Appendices:	Appendix A - Summary of Residual Risk Ratings Appendix B - Board Assurance Framework 201/18

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5P	Executive Lead	BAF Risks	Current risk score	Designated Committee and outcome of Committee review.
	Chief Nurse/Chief Medical Officer	1.1 Outcomes: Inconsistent outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	**16**	QSC Reviewed at QSC.23.11.18; risk rating confirmed.
	Chief Finance Officer/DoI&IT	1.2 EPR Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes	**16**	PAF Reviewed at PAF.26.11.18. Risk rating confirmed.
	Chief Finance Officer/DoI&IT	1.3 Coding Risk Coding issues (including clinical) within the Trust impacting on Patient Safety, Finance, Performance and Operational delivery	**16**	PAF Reviewed at PAF.26.11.18. Risk rating confirmed.
	DoP	2.1 Workforce Capacity Concerns around staffing capacity *in some areas* to manage workload, deliver services of high quality and maintain national performance requirements.	**16**	**WFC reviewed on 26.11.18 Risk rating reduced from 20 to 16.**
	DoP	2.3 Internal Engagement Failure to communicate key messages and organisational changes to front line staff.	**9**	WFC reviewed on 26.11.18. Risk rating confirmed.
	DoP	2.4 Workforce Productivity Gaps in staff capability not being consistently addressed through available performance management and development processes	**6**	**WFC reviewed on 26.11.18. Risk rating reduced from 9 to 6 (target risk rating).**
	DQI	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**20**	PAF Reviewed at PAF.26.11.18. Risk rating confirmed.

	DoS	3.3 Financial and Clinical Sustainability across health and social care system Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system.	**16**	For review by Trust Board.6.12.18.
	DoS	3.4 Strategic Change and Organisational Structure Capacity & capability of senior Trust leaders to influence both internally and externally the required strategic changes.	**12**	For review by Trust Board.6.12.18.
	DoS	3.5 Sustainability of local services Failure to ensure sustainable local services whilst the new hospital plans are in development.	**16**	For review by Trust Board.6.12.18.
	DCFO/DQI	4.1 Supporting Functions (including Finance, IT, and Estates and Facilities)** Concerns around the need to modernise the systems, processes, structures, capacity & capability of the business support functions.	**12**	PAF Reviewed at PAF.26.11.18, risk rating confirmed.
	COO	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	**20**	PAF Reviewed at PAF.26.11.18, risk rating confirmed.
	CFO	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	**15**	PAF Reviewed at PAF.26.11.18, and risk rating confirmed.

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The Princess Alexandra Hospital Board Assurance Framework

2018-19

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Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures **Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
BAF 1.1		Inconsistent outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Inconsistent treatment stratification ii) ~~Failure to incorporate~~ Inconsistent patient feedback (including PALS) into service improvement and re-design. iii) Failure to achieve sustainable improvements in national survey results iv) Poor results in ~~2016~~ Inpatient Survey with areas for improvement identified v) Unwarranted variation in care	**4 X 5= 20**	Chief Nurse/ Chief Medical Officer **Quality and Safety Committee**	i) Robust quality and safety governance structures in place including infection control ii) Performance management of unacceptable behaviour. iii) Robust Appraisal/ medical revalidation process which includes patient feedback - 360° feedback and Fitness to Practice process in nursing iv) RCA methodology workshops v) End of Life and deteriorating patient simulation programme for all staff, and Whole System Steering Group vi) Mandated & focused education & training in communication skills such as breaking bad news training. vii) Sharing the Learning Programme viii) Monthly Commissioner reviews of quality and Safety xi)Four 'Big Dots' - AKI, Sepsis, Mortality and End of Life xii) Risk Management Training Programme xiii) Monthly newsletters - Quality Matters, Pharmacy 5 Minutes xiv) Escalation processes for prescribing doctors and processes for non-medical prescribers xv) Electronic handovers and E-Obs xvi) Schwartz Rounds ~~xvii) Redesign of ED~~ xviii) NHSI/NHSE Oversight xix) Red2 Green Board rounds xx) Improved reporting and review process for deaths and establishment of incident management group. xxi) Patient Experience Strategy xxii) NED lead appointed for Mortality xxiii) Bundles of Care being implemented - Pneumonia xxiv) Mortality Improvement Plan xxv) Outlier alert process in place xxvi) Introducing '15 steps' walkabouts xxvii) Establishment review xxviii) Safer Staffing policy xxix) Real time patient feeback implemented across all wards	i) National Surveys ii) Cancer Survey iii) CEO Assurance Panels iv) SIG meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings x) PLACE Inspections xi) Medicines Management Committee xii) CCG audits xiii) Monthly QA visits/inspections xiv) End of Life and Mortality Groups ~~xv) Executive Assurance meetings with ED, Critical care, End of Life, Urology and General Surgery.~~ xvi) AKI and Sepsis merged with Q1st and NED lead xvii) Urgent Care Improvement Board	i) Improvement in some areas of the National Inpatient Survey ii) CQUIN reports to PAF/QSC iii) CEO Assurance Panels. iv) Reports to QSC on Patient Experience, Serious Incidents, Safer Staffing, Patient Panel, Safeguarding, Infection Control (top quartile) v) Reports to Board from QSC and reports on clinical issues for escalation, Mortality and CN/CMO reports vi) Dr Foster reports, CQC inspection reports and GiRFT reports vii) Sustained Increase in Datix reporting and reduced harm~~ over approx. last 18 months~~ viii) Feedback from NHSI and Commissioners on harm reviews (positive) ix) Real time Dr Foster feedback ~~x) Arthoplasty Infections (monitoring)~~ xi) Water Safety testing across the Trust (SMH) - normal results ~~xiii) Local Delivery Board (LDB)~~ xiv) GMC Trainee Results Report xv) Integrated Performance Report (IPR) ~~xvi) Mock CQC Inspection Report~~ xvii) Learning from deaths reports and dashboard, Mortality Presentation to Board (Oct 17) and HSMR improved to 114. xviii) Outstanding NICU peer review xix) Clinical Audit report - tiaa ~~xx) Enable East Review (Oct 17)~~ xxi) Improved and sustained palliative care coding	**4x4=16**	~~i) Real time patient safety feedback.~~ ii) Internal/External Comms in development and improving iii) Evolving clinical audit approach- improved local audits and drive to improve collation and input of data for national audits iv) ~~Real time patient feedback system in procurement phase~~ v) Disparity in local patient experience surveys versus inpatient survey vi) Staffing and site capacity **ACTIONS:** i) Website development ii) Inpatient Survey action plan in place ~~iii) Medical Examiners being appointed - implementation September 2018~~ ~~iv) Real time patient feedback (anonymised) live in 11 area - roll out scheduled for completion by October 2018.~~ iii) Maxwell Stanley and Dr Foster work commissioned in relation to mortality iv) Software to support medical examiners being procured	i) Clinical evidence of improvements made following Compliance with national audits, NICE,NCEPOD. ii) Reporting on Learning from deaths	08/11/2018	**Risk rating not changed.**	~~4~~x3 =12 (Target date ~~May~~ July 2019 - to achieve 'as expected' for mortality and following receipt of inpatient survey results in May)
			Effects: i) Poor reputation ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Recurrent themes in complaints involving communication failure v) Loss of confidence by external stakeholders vi) Higher than expected Mortality rates											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
						Evidence should link to a report from a Committee or Board.								
	Strategic Objective 1: Our Patients - continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures **Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial targets and control totals**													
BAF 1.2		**EPR** Concerns around availability of functionality for innovative operational processes together with data quality ~~including misuse~~ and compliance with system processes ~~and system resilience as well as forward compatibility as Trust moves towards having Integrated Care Records~~	Causes: i) Poor engagement with the system, usability, time/skills ii) System fixes	**5 X 4= 20**	Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iii) Performance Mgt Framework in place. iv) Training programme. v) Super users in place to deliver focused support. vi) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability vii) Access Policy viii) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) ix) Development of capacity planning tools/information x) PWC review and actions identified xi) DQ meetings re-structured xii) ICT Newsletter issued xiii) New training process for locums xiv) Link to Quality 1st being discussed. xv) New daily Cambio meetings/roadmap xvi) Internal daily ICT/COSMIC meetings ongoing ~~xvii) 7.7 in development and expected in test environment by end of May 5.02.18~~ xviii) Real time data now available xix) ~~Exec to Exec meetings every 2 weeks.~~ xx) Cambio to attend ICT Steering Group xxi) OBS requirements being reviewed to assess gaps xxii) Contract review completed xxiii) CDS 011 now live	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews	i) Weekly Data Quality reports to Access Board and EDB ii) Internal Audit reports to Audit Committee iii) External Audit reports to Audit Committee on Quality Account Indicators iv) DQ Report to PAF and roadmap report September 2017 v) PWC report and action plan vi) Trust Board workshop April 2017 vii) Cambio roadmap and governance structure reports to PAF	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Executive to raise profile & awareness of implementation/ transformation opportunities with clinical leaders/consultants. vii) CCIO post now vacant viii) Compliance with refresher training ~~x) CDS 011 issue identified with diagnosis qualifier currently in test an requires resolution before 7.7 can go into test environment.~~ ix) Cambio delivery schedule slippage. 7.4 HF04 and HF05 to go Live 19/09/18, then PFM to go into Test by ~~28/09/2018~~ January 2019.	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed. Quality of delivery of PFM - testing processes and actions identified by tiaa internal audit. Internal Audit reporting on testing, limited assurance.	Nov-18	Residual Risk rating unchanged	**4x3=12** ~~December~~ **March 2019**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** i) Ongoing training and support ii) Restructure of IT team (resourcing) iii) Re-establishing relationship/engagement with Cambio iv) Establishing benefits realisation programme v) Recruitment of new CCIO - JD developed and recruitment to commence. ~~- in mitigation each ICT Project Board has a clinical member and AMD Q1st engaged in projects.~~ vi) Refresher training underway vii) Revised roadmap to incorporate new statutory/legal requirements i.e. GDPR				

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

The Princess Alexandra Hospital Board Assurance Framework 2018-19

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead	Key Controls	Sources of Assurance	Positive Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
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	Strategic Objective 1: Our Patients - continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures **Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators** **Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial targets and control totals**													
BAF 1.3		**Coding Risk** Coding issues (including clinical) within the Trust impacting on Patient Safety, Finance, Performance and Operational delivery	**Causes:** ~~i) Clinical staff not fully, accurately capturing information required in a timely manner~~ i) Liaison and education between coders and clinicians not optimal. ii) Failure to capture and code activity by national submission deadlines such as flex and freeze dates. iii) EPR issues - clinical engagement with COSMIC iv) Inconsistent engagement by HGs in addressing data completeness and clinical coding issues v) Poor notes and record keeping vi) Human element with some junior doctors not providing definitive diagnosis to facilitate coding vii) Ongoing COSMIC development/fixes viii) SOPs not in place and inconsistent compliance ix) Maintaining alignment with information systems to ongoing changes in operating models x) Capacity and capability within training team **Effects**: i) Loss of income ii) Incorrect triggering in external reports such as Dr Foster and impact on HSMR and SHMI iii) Negative impact on reputation iv) Potential safety issues v) Capacity planning and operational performance vi) Pathway and Collaboration implications vii) Costs for overtime and agency staff	**5 X 4= 20**	Director of IT **Performance and Finance Committee**	i) DQ Improvement Plan ii) Weekly Access Board meetings iii) Data quality dashboards developed iv) MediCode implemented and maintained v) Clinical lead for coding identified vi) Meetings/workshops with clinical leads on coding vii) Clinical coding pilot by clinicians viii) Additional coders employed/targeted to areas of risk ix) Weekly Specialty meetings x) CMO monthly meetings with coding re mortality xi) IM&T Programme Board xiii) Coding action plan xiv) Presentations to CWG and MAC xv) Business case for additional resource now approved xvi) Outsourcing to improve coding backlog and percentage coded by flex date. xvii) External review completed and final report received and presented to EMT; further actions identified and to be incorporated into coding improvement framework. xviii) Recruiting to new structure (ongoing) xix) Weekly clinical coding quality audit for the insourced/outsourced coding resource xx) Mortality validation work underway and linking with Medical Examiners Trainee coders in place ~~xxi) Plans underway to relocate off site team members back on site to unify the team.~~ xxii) Further Maxwell Stanley review commissioned - quality triangles to optimise coding	i) Internal Audit (DQ/coding and ED) ii) Annual clinical coding audit for IG Toolkit iii) Dr Foster reports iv) Mortality reviews v) External Audit (Quality Account indicators) vii) PAF meetings	i) Internal Audit reports to Audit Committee ii) External audit report to Audit Committee (Quality Account indicators) iii) DQ Recovery Plan (PAF) iv) Monthly DQ reports (PAF) v) Weekly reports and HG dashboards to EDB and Access Board vi) Maxwell Stanley report on clinical coding	**4 X 4= 16**	i) Need to increase direct clinical coding particularly for outpatients ii) Management and quality of content of medical notes and timely availability of notes iii) Continue to develop 'usability' of EPR application to aid users iv) Capacity within operational teams v) Elements of system remain onerous (completion of discharge summaries) ~~vi) External system support~~ vii) Recruitment and retention within coding team - 2 vacancies ~~and 2 coders on long term sickness absence~~ **ACTIONS:** Recruitment to posts EPR meetings/negotiations Recruitment of CCIO Coding improvement framework following external review ~~and bid to NHSI for funding to support improvements.~~ Guidance for coders updated in respect of co-morbidities from discharge summaries. Coding using electronic systems e.g. radiology, theatres ~~Maxwell Stanley project launching in August.~~	~~Current concern around timely completeness of coding has been addressed since April 17 and the focus is shifting to maintain the position and address the secondary issues endorsed by external review.~~ Quality of outsourced coding under review and being monitored with feedback provided to close the loop. (NOTE: Outsourcing concluded end of November 18)	08/11/2018	No change to risk ratings.	4x3=12 ~~December~~ January 2019 - improvements noted but improvements to be sustained)

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

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	Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 2.1		**Workforce Capacity** Concerns around staffing capacity in some areas to manage workload, deliver services of high quality and maintain national performance requirements.	**Causes:** i) National hotspots (Acute physicians, ~~Stroke consultants~~, ED consultants, ~~Pathologists and Care of elderly staff,~~ Urology and registered nurses ~~and midwives~~). ii) Geographical location of the Trust, close to London but without the HCA weighting. iii) Proximity to teaching hospitals which are attractive to some staff iv) Lack of focus on active talent management v) High turnover of nursing, biomedical scientists and AHP staff vi) Rewards currently available for agency working	**4 X 4 =16**	Director of People **Workforce Committee**	i) National representation to increase international supply and supportive immigration policies. Ii) Recruitment processes refreshed (TRAC, benefits package, Vacancy Review Panel, Social Media and Recruitment Campaign) iii) Clear 5P Strategy and direction iv) Succession planning introduced and part of appraisal v) Talent Management Plan features as a component of new People Strategy and Operating Plan 18/19. vi) Turnover of Nursing, Biomedical Scientists and AHPs ~~at 13.3%~~ below STP average of 16%. vii) Agency controls in place having met regulator set target in 17/18 and improved use of bank.. viii) Improved use of technology and monitoring of time to hire KPIs ix) Leadership and Development Programmes underway x) New roles in place e.g. physician associates, FY3 roles, training nurse associates xi) Recruitment mico-site xii) Improved focus on education and learning	i) PAF, QSC, WFC, EMT, EMB, Workforce and Board meetings ii) Health Group Boards iii) Internal Audit report on Recruitment (substantial assurance)	i) Safer Staffing Reports (monthly to QSC and Board) ii) Workforce reports (progress on recruitment, retention, bank and agency) to PAF iii) Incident reporting and monthly SI reports to QSC	**~~4 X 5 =20~~** **4 x 4 = 16**	Inability to influence supply. Gap in CPD funding Action: Continue to work with HEE to influence national policies Implement a workforce planning cycle Establishment review to be undertaken (Dec 2019) CPD funding gap being addressed by improving governance around allocation, apprenticeship levies and other sources of funding	~~Director of People to review incidents and monthly SI reports.~~	09/11/2018	**Proposed to reduce risk rating from 20 to 16**	**~~4x4=16 December 2018~~** **4 x 3 = 12 Nov 2019**
			Effects: i) Pressure on existing staff to cope with demand leading to overworked staff ii) Low staff morale iii) Shortcuts and failure to follow processes and procedures due to workload and fatigue leading to higher chances of patient safety errors occurring iv) Staff retention ~~and succession planning issues~~											

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BAF 2.3		**Internal Communication** Failure to communicate key messages and organisational changes to front line staff.	**Causes:** i) Change fatigue and 'regulation fatigue' ii) Increasing demand versus reducing resources iii) Lack of awareness around the organisation of strategic direction due to poor communication channels/tools iv) Poor attitude and behaviours v) Competing priorities ~~vi) Collaboration with Lister, development of ACO and uncertainly about STP plan~~ vii) Challenged Provider status viii) Insufficient management time allocated to communication with staff	**4 X 4= 16**	Director of People **Workforce Committee**	i) Staff awards; ii) CEO ~~weekly~~ blog & 'In Touch'; Ask Lance iii) Staff Briefing sessions iv) Staff, patients and carers involved in creation of values, standards & behaviours to ensure ownership; v) Sharing the Learning events to involve staff in safety improvements, which has included the Being Open/ Duty of Candour. viii) Quality Fellows programme ix) National Leadership Programmes for staff x) Staff Survey xi) Schwartz Rounds xii) Staff Council (being relaunched at EIAT) xiii) Quality Ist Communication Plan and Newsletter xiv) Event in Tent xv) People Strategy in development xvi) Printed magazine (quarterly) xvi) The Trusted Executive work in progress xvii) Associate Director of Comms appointed	i) PAF and Board meetings ii) QSC meetings iii) Staff Engagement Working Group iv) Workforce Committee	i) Staff survey results - showing signs of improvement ii) FFT for staff - improvements iii) Workforce reports to PAF and Workforce Committee iv) IPR to PAF and Board v) OD reports to WFC vi) Learning and Development reports to WFC.	**3x3=9**	Clarity on timescales for change (FCBC, SOC approval). ~~and the future of the Trust.~~ **Actions:** ~~i) Monthly updates to Board on strategic developments -~~ ~~ii) Sustaining engagement activities following Event in a Tent~~ ~~iii) Recruitment to Associate Director of Communications role. Structure of Comms team and recruitment pending – awaiting start of new DoP and Comms~~ iv) Review of Comms function completed and implementation to follow. v) Relaunch of website vi) Staff app being developed		09/11/2018	**No change to risk rating.**	3x2=6 (~~November 2018~~ June 2019 re-structure of Comms team and function
			Effects: i) Error omission ii) Poor reputation iii) Demoralised staff iv) Impact on sustainability v) Changes not embedded as business as usual vi) Disconnect between management and front line staff											

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BAF 2.4		**Workforce Capability** Gaps in staff capability not being consistently addressed through available performance management and development processes	**Causes:** i) Managers not prioritising performance management and development issues ii) Historic lack of management and leadership development training iii) Historic view that appraisals and performance management are not important iv) Lack of a systematic approach to determining organisational, business unit and individual objectives and development plans	**3 X 4 =12**	Director of People Workforce Committee	i) Capability Policy in place ii) Training for Managers, Band 5, 6 and 7 leadership training programmes including 'Leading difficult conversations' sessions. External funding in place. iii) HR support for managers in managing underperformance iv) Leadership development and action learning sets in place v) People Strategy vi) New appraisal system vii) Data on Informal Dispute Resolution viii) NHS Staff Survey and action plan ix) Manager training workshops in progress. x) Medical appraisals and revalidation processes xi) GMC referrals and MHPS process xii) GMC Survey	i) Board and WFC meetings	i) Employee Relations reports to WFC ii) Workforce KPIs and IPR iii) MHPS reports to Board iv) Training and development updates to WFC.	~~**3 x 3 = 9**~~ **3 x 2 = 6**	Talent management framework identifying key roles, individuals and gaps. Actions: i) Talent Management and Succession Planning in development ii) Leadership and Management development framework (key behaviours) in development iii) Managers Induction being developed	Confidential staff survey results via staff mobile app and outputs to be included	09/11/2018	Proposed to reduce the risk rating from 9 to 6	**3 x 2 = 6 (January 2019 pending results of 2018 Staff Survey/ Organisational design review)**
			Effects: i) Impact on staff morale of perceived acceptance of underperformance ii) Impact on staff retention iii) Perpetuating cycle of overworked staff compensating for capability gaps. iv) Potential impacts on workforce productivity and income. v) Disengaged workforce.											

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BAF 3.1		**Estates & Infrastructure** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in team and structure iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) No formal assessment of update requirements, vii) Failure to comply with estates refurbishment/ repair programme historically, viii) Under-investment in training of estate management & site development ix) Inability to undertake planned preventative maintenance x) Lack of decant facility to allow for adequate repair/maintenance particularly in wards areas. xi) Key workforce gaps in compliance, energy and engineering.	**5 X 4= 20**	Director of Quality Improvement **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report. iii) Project Board established to review Capital requirements. iv) Potential new build/location of new hospital v) Re-profiled Capital programme - aligned to red rated risks. vi) STP Strategy being developed and being submitted to Board in October 2018 vii) Clinical Infrastructure Risk review underway viii) Central returns Steering Committee ix) Modernisation Programme for Estates and Facilities x) NHSI support and application to NHSI Resources Committee (for funding) xi) Robust water safety testing processes xii) Annual asbestos survey -completed and red risks resolved. xiii) Associate Director of Estates and Facilities appointed xiv) External fire risk assessments completed following Grenfell fire. Action plan developed. xv) Trust's Estate strategy being developed as part of Project Genesis (Our New Hospital) xvi) SDMP plan approved at Board in August 2018	i) PAF and Board meetings ii) EMB Meetings iii) Health and Safety Meetings iv) Capital Planning Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings viii) First Impressions Count project group.	i)Letter from HSE - no regulatory concern raised ii) Reports to EMB iii) Fire Safety report iv) Reports on testing for legionella, asbestos v) Signed Fire Certificate vi) Annual H&S reports to Trust Board and bi-monthly to QSC vii) Ventilation audit report viii) Water Safety Report (PAH site) ix) Annual and quarterly report to PAF: Estates and Facilities x) PLACE Assessments	**5x4=20**	ii) Planned Preventative Maintenance Programme (time delay) and amber backlog maintenance risks now emerging red risks iii) Ventilation systems iv) Sewage leaks and drainage v) Electrical Safety/Rewiring (gaps) vi) SDMP Plan vii) Maintaining oversight of the volume of action plans associated with compliance. viii) Catering services modernisation ix) Lack of authorised persons within estates and facilities teams. **ACTIONS:** i) Review of Estates and Facilities infrastructure - consultation in Q1. ii) Backlog maintenance review and Six Facet Survey underway iii) Business cases being developed Combined Heat and Power (in 18/19) iv) Applying for distressed Capital funding to mitigate areas of risk. v) ~~Review of Catering infrastructure - Consultation in Q1~~ ~~vi) SDMP plan to be included in OBC work.~~ vii) Estates and facilities management re-structure ~~viii) Capital Programme realigned to address red risks~~	i) Estates Strategy /Place Strategy developing within STP ii) Compliance with data collection and reporting iii) PPM data not as robust as required iv) PAM assurance not robustly updated. Design phase for sewage and plumbing work tendered.	08/11/2018	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site) and:** **Target rating to be confirmed once the design and technical surveys are completed.**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

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BAF 3.3		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** ~~i) Limited input from clinicians and other key stakeholders into STP strategy~~ ii) The financial bridge is based on high level assumptions iii) The development of QIPP and CIP programmes for 2017/18 has not followed a Footprint-wide approach iv) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them v) The resources required for delivery at a programme and workstream level have not been defined or secured vi) The current governance structure is under development given the shift in focus from planning to delivery. vii) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS **Trust Board**	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) ~~STP prioritisation under review with workstream leads being nominated.~~ STP priorities developed and aligned across the system v) STP PMO under development vi) CEO's forum vii) Integrated Clinical Strategy in development viii) STP Estates Strategy being developed. ix) MSK contract being developed with system partners	i) West Essex CCG review of local governance arrangements ii) Feedback from regulators iii) System leadership meetings iv) Proposals made around system dashboards and KPIs	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board ~~iii) PWC report on governance arrangements~~ ~~iv) Presentation to EMB on new STP governance structures~~ ~~v) STP paper on system working~~	**4 X 4= 16**	Lack of STP demand and capacity modelling. STP Clinical Strategy being developed and demand assumptions to be considered to ensure achievable cost savings **ACTIONS:** System agreement on governance and programme management System leadership capacity to lead STP-wide transformation Trust to nominate representatives on proposed STP/ACP workstreams Escalation to CEO forum and West Essex actuarial piece to be shared.	Proposed governance structures to be tested.	08/11/2018	**No changes to risk rating.**	**4x3=12** **~~Sept 2018~~** **March 2019**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

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BAF 3.4		**Strategic Change and Organisational Structure** Capacity & capability of senior Trust leaders to influence both internally and externally the required strategic changes.	**Causes:** i) Staff and stakeholders lack of awareness and/or understanding of drivers and issues cross the system ii) Change fatigue and continuous change in leadership iii) Scale, pace and complexity of change required. iv) Infrastructure (IT, buildings) not supportive of change v) Financial resources lacking to support change vi) Focus on immediate operational and financial priorities versus the longer term strategic planning vii) Lack of clarity regarding contracting and organisational models in support of ICP viii) Management resource and team to drive change and strategy development being built. ix) Lack of shared vision and key drivers for change xi) Internal programme for development and implementation of 5P plans.	**4 X 4= 16**	DoS **Trust Board**	i) SMT meetings ii) Clinical specialty meetings iii) Good relationships with key partner organisations iv) CEO chairing ICP Board v) SOC Steering Group vi) CEO attending STP meetings vii) Director of Strategy appointed. viii) Programme plan in place - health planners engaged, transport study, strategic estates advisors engaged. ix) Clinical Strategy being developed. x) Strategy Committee being established.	i)Workshops with clinical leads ii) ICP and STP meetings including acute and back office workstream meetings iii) SOC Steering Group iv) Harlow/Gilston Garden Town Co-op.	i) Reports to Board on strategic developments and Our New Hospital reports to PAF/Board. ii) Board workshop sessions held in September: site options and clinical strategy. iii) System workshop held on new hospital design (Nov 18) iv) Well led rating assigned by CQC - good	**4x3=12**	i) ~~Financial analytical support for programme~~ ii) Capacity and capability to develop LEAN process mapping ~~iii) Embedding the programme~~ ~~iv) External training required to develop internal capacity~~ v) Data quality impacting on business intelligence (SLR) **ACTIONS:** Trust's vision and mission statement being refreshed and 5P plans underway. Establishment of a 'Strategy Committee. Clinical Strategy underway. Strategy team being developed New chair of PAH to be appointed.	None identified.	08/11/2018	**Risk rating not changed.**	**4 x 2= 8** ~~**Dec 2018**~~ **March 2019** for engagement process with level of management below Board
			Effects: i) Poor reputation ii) Increased stakeholder and regulator scrutiny iii) Low staff morale iv) Threatened stability and sustainability v) Restructuring fails to achieve goals and outcomes vi) Impact on service delivery and quality of care vii) Poor staff survey viii) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure ix) Undermines regulatory confidence to invest in hospital/system solutions											

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	Strategic Objective 3 : Our Places – maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the development of a West Essex and East Hertfordshire Accountable Care Partnership													
BAF 3.5		**Estate** Failure to ensure sustainable local services continue whilst the new hospital plans are in development	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in backlog maintenance iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) Complexity of STP vii) Insufficient quantity and expertise in workforce capability	**4 X 4= 16**	Director of Strategy **Trust Board**	i) Potential new build/location of new hospital ii) KPMG Review iii) STP Footprint and Estate Strategy ~~being~~ developed. iv) Herts & West Essex STP Estates workstream v) Clinical Support Service workstream led by CEO vi) Estates and Facilities Infrastructure subgroup for West Essex vii) SOC affordability model viii) SOC approved and submitted to NHSI and further financial analysis template submitted to DH ix) Site analysis Phase I complete x) Detailed analysis of current site option commissioned xi) Director of Strategy appointed xii) Master planning work being aligned to Six Facet Survey and Health Planning, phasing of development on PAH site or off site. xiii) Alignment of strategic capital and capital plans	i) PAF and Board meetings ii) SMT Meetings iii) Capital Planning Group iv) Weekly Estates and Facilities meetings v) SOC Steering Group	i) STP reports to Board via CEO Report ii) Reports to EMB ~~iii) KPMG Report~~ iv) STP work plans v) Monthly Our New Hospital reports to PAF and updates to Board.	**4 x 4 = 16**	i) Balancing short term investment in the PAH site vs the required long term investment **ACTIONS:** Strategy being developed and underpinned by 5P plans Phase II work underway Capital Plan submission for PAH prioritised. PCBC work commissioned Regular meetings held with regulators. Establishing a Strategy Committee	i) Strategy in development	08/11/2018	**No change to residual risk rating.**	**4 x 3 =12** **~~December 2018~~ March 2019 timeframe for completion of master planning work)**
			Effects: i) Failure to deliver strategy and transformation project and service changes required for service and performance enhancement ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant vii) Poor patient experience, viii)Backlog maintenance ix) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health. x) Lack of integrated approach xi) Increased risk of service failure xii) Impact on throughput of patients												

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.1		**Supporting Functions (including Finance, IT and Estates and Facilities)** Capacity & capability of the business support functions including a requirement to continue to modernise systems, processes and structures.	Causes: i) High volume of internal, regulatory and STP information requirements, ii) shortage of skill sets / specialist staff, iii) limited investment / availability of resources iv) reliance on outsourced contractors / systems and inflexible systems, v) historical systems which are not fully integrated (vi physical space and poor office accommodation and facilities to support integrated working. vii) Appetite for change management. ~~viii) Trust has been given notice to vacate Mitre Buildings by November 2018 and this is a risk to continuity. The Trust has received a verbal offer to extend this period for a short period and is negotiating the length of this period although discussions have not yet concluded.~~ viii) Mitre lease extended for 18 months ix) Automation options appraisal underway x) Procurement Strategy drafted	**4x5=20**	**Exec leads** :- Chief Financial Officer, Chief Operating Officer and Director of Quality Improvement. **Committee:** Performance and Finance Committee	i) Continuous priority reviews and workload planning, ii) business partnering approach and performance reviews, iii) Recruitment exercises - successful reduction in temporary costs, iv) increase involvement in collaborative work e.g. STP, v) review of staffing structures and consultation / market testing, vi) modernisation groups and use of benchmarking to identify improvements e.g. Qlikview, EROS, Carter, GIRFT, model hospital, vii) system implementations / upgrades e.g. EROS, Qlikview and ledger upgrades, viii) staff surveys / appraisals	i) Internal and external Audit reports ii) PAF and Board meetings iii) NHSI reviews/reports iv) Business case approved for ICT restructure. v) ICT Programme Board vi) Audit Committee vii) NHSI review/visit re estate	i) Outputs from NHSI deep dives ii) Internal Audit and External Audit reports including Head of Internal Audit Opinion and VFM conclusion. iii) Estates Governance review reported to Audit Committee iv) Staff survey outcomes	**4x3=12**	i) Recruitment and retention. ii) Enhanced plans to realise full benefits of system implementation / upgrades. iii) ~~Re-~~location of Corporate Staff to alternative office accommodation.	i) Benefit realisation reviews	09/11/2018		**4x2=8 March 2019**
			Effects: i) Over reliance on manual processes and interventions ii) labour intensive, error prone and time consuming processes iii) Ability to attract skilled staff and retention and morale (leading to reliance on temporary staff), iv) single failure points, v) adequate value for money conclusions.							**ACTIONS:** i) Recruitment plans for areas ii) Market testing iii) ~~ICT re-structure, iv) Alternative office accommodation options.~~ v) Income capture processes under review				

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.2		**4 hour Emergency Department Constitutional Standard** Failure to achieve ED standard	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Gaps in medical and nursing workforce iv) Lack of public awareness of emergency and urgent care provision in the community. vi Attendances continue to rise annually (5.1% over the last 2 years). viii) Changes to working practice and modernisation of systems and processes viii) Attitude and behaviour challenges ~~ix) Poor flow out of ED~~ x) Delays in decision making, patient discharges and delays in social care and community	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Daily call with NHSI/ CCG/NHSE, daily report on performance. vii) Work in progress to develop new models of care viii) Local Delivery Board established ix) Daily specialty response times monitored x) Weekly meetings with ED team and all HCGs xi) System reviewing provision of urgent care xii) Exec attendance at safety huddles daily xiii) ED action plan reported to PAF/Board xiv) CO-location of ENP's, GP's, Out of hours GP'S to support minor injuries xv) Daily review of Paeds by Clinical Lead and HoN xvi) Protection of assessment capacity work underway xvii) Establishment of Urgent Care team xviii) Development of additional capacity to support flow - new ward handover in December 2018 xix) Additional winter funding for social care	i) Access Board meetings ii) Board, PAF and EMB meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) Daily system executive teleconference vii) Fortnightly escalation meetings with NHSI/NHSE viii) Weekly HCG reviews ix) System Operational Group	i) Daily ED reports to NHSI ii) Twice weekly reports to NHSE on DToCs iii) Escalation reports weekly to NHSE iv) Monthly PRM meetings	**4 x 5 = 20**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings	None noted.	08/11/2018		4x3 =12 ~~September 2018~~ March 2019 (on delivery of standard - 95%)
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels												

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial targets and control totals													
BAF 5.1		**Finance** Concerns around failure to meet financial plan including cash shortfall.	Causes: i) Operational performance impacting on financial performance including recovery of STF e.g. ED target, ii) CCG affordability and contractual disputes and challenges, iii) ability to deliver recurrent CIPs, iv) workforce shortages v) high levels of unplanned expenditure including maintenance of aging estate, vi) Capture and billing of activity. vii) Potential impact of pay settlement	5 X 4= 20	**Exec leads :** CFO/All Executives **Committee** : Performance and Finance Committee	i) Access to Interim Revenue Support loans ii) Cost Improvement Programme iii) Formal re-conciliation process with CCG iv) Internal and external Agency controls and reporting v) Executive Management Board, PAF and Audit Committee vi) Health Care Group CIP meetings vii) Enhanced Performance Reviews viii) Regular Balance sheet reviews ix) Approved Governance Manual x) Budget sign off process xi) Enhanced financial reporting and controls xii) Regulatory returns required e.g. agency spend xiii) Internal special measures for selected HCG to remain xiv) New medical agency protocol xv) Financial Recovery Plan - Q1 xvi) Demand and Capacity planning xvii) Revised forecast meetings with HCGs and SMT xviii) Use of resources assessment undertaken	i) Internal Audit & External Audit opinion. ii) External reviews iii) NHSI reporting iv) Internal Trust reporting v) Cash Management group vi) Pay award steering group	i) Monthly reports including bank balances and cash flow forecasts to PAF and Board ii) CIP Tracker reports iii) IA reports iv) Financial Recovery Plan	5x3=15	i) Organisational and Governance compliance e.g. waivers ii) Activity and capacity planning iii) CIP reporting and run rate reductions	PLICs Demand and Capacity planning regularisation Workforce planning	09/11/2018	**Risk rating not changed.**	**5x2=10 ~~Dec~~ March 2019**
			Effects: i) Ability to meet financial control target ii) Potential delay to payment to creditor/ suppliers ii) Increased performance management iv) Going Concern status v) Risk to recovery of sustainability funding vi) Impact on capital availability vi) Unfavourable audit opinion (VfM,Section 30 Letter) vii) Restrictions on service development viii) Recruitment & retention ix) Increased likelihood of dispute/arbitration processes x)Reputational risks xi) Increase in agency temp staff costs xii) Impact of in year Commissioner QIPP plans							**ACTIONS:** Future Modernisation Demand and Capacity Planning and Modelling to be regularised ~~Alternative accomodation for corporate staff being sought.~~ Clinical and operational forums in place to review QIPP schemes. ~~Improved FOT process.~~ Review of Capital reporting and planning for 19/20 underway. Focus on pay and non pay CIPs.Medical pay award being assessed. CCG triangulation Model Hospital 2017/18				

The Princess Alexandra Hospital NHS Trust

TRUST BOARD 6.12.18

5.1

Agenda Item:	5.1
Presented by:	Andy Morris – Chief Medical Officer
Prepared by:	Andy Morris – Chief Medical Officer
Date prepared:	28.11.18
Subject / Title:	**Mortality Update**

Purpose:	Approval	x	Decision		Information	x	Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	Our Hospital Standardised Mortality Ratio (HSMR) continues to be 'higher than expected' despite concerted efforts and good progress made in our outlier pathways over the last 12 months. We have set up a Mortality Improvement Board to oversee an increased set of actions to bring this back to 'as expected' and eventually to 'lower than expected'. In addition our Medical Examiners will be functional from early December, reviewing every death in the hospital to ensure we maximise our learning from deaths.
Recommendation:	Board is asked to note the concerns and the plan for improvement.

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

Previously considered by:	QSC 23.11.18 SMT 21.11.18 EMT 22.11.18
Risk / links with the BAF:	BAF risk 1.1 Inconsistent outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality (CxL=20)
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	Mortality Improvement Plan

PROPOSED MORTALITY IMPROVEMENT PLAN NOVEMBER 2018 v1 Andy Morris

The Princess Alexandra Hospital NHS Trust

FLOW

VARIATION IN CARE

Mortality Improvement strategy by Q3 2018

Evidence of Board level learning by Q4 18-19

HSMR as expected by Q1 20-21

Outlier alerts eliminated by Q3 20-21

Improved oversight at all levels by Q4 20-21

- Getting the basics right
  - NEWS 2
  - Fluids
  - Antibiotics
  - DNACPR, EOL and TEP decision making
  - Improved documentation
- Bundles of care
  - Sepsis
  - Pneumonia
  - COPD
  - Acute abdomens
- Hospital @ Night
- Reporting & Recording
  - MEs & software
  - Compliance KPIs
  - Right place, right time, first time
  - Time to theatre NOFs
  - Laparotomy dashboard
  - Mortality Improvement Board
  - Refreshed Mortality surveillance Group

Your future | Our hospital

The Princess Alexandra Hospital NHS Trust

Workforce Committee – 26.11.2018

5.2

Agenda Item:	2.3
Presented by:	Director of Nursing and Midwifery
Prepared by:	Andy Dixon Matron for Quality Improvement Sharon McNally, Director of Nursing and Midwifery
Executive Director Sponsor	Sharon McNally, Director of Nursing and Midwifery
Date prepared:	9th November 2018
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 months of September and October (part A), and provides an update to the workforce position (part B). Headlines: • The overall fill rate (RN/M and HCA) for the ward areas was 85.1% in September and 87.4% in October, this has remained broadly unchanged. • There has been no significant change to the overall RN/M workforce numbers (net gain of 1.84 WTE). For November December 2018 and January 2019 there are 23 RN, 17 pre-registration and 18 HCA confirmed or predicted starters: • The vacancy position for RNs remains challenging at 25.86%. (40.04% for adult wards). The Director of Nursing and Director of People have commissioned a review of the recruitment and retention plan to ensure a robust improvement in the trajectory • To note the plan to develop a safer staffing policy to support day: day and prospective decision making
Recommendation:	The Committee 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.

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:	N/A
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: Deep dive Penn and Saunders wards

The Princess Alexandra Hospital NHS Trust

5.2

1.0 PURPOSE

To update and inform the Trust Quality and Safety Committee on actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff in September and October 2018.

2.0 BACKGROUND

The report is collated in line with The National Quality Board recommendations (July, 2016) and has been benchmarked against reports published by comparable Trusts.

3.0 ANALYSIS

3.1 This report provides an analysis based on the planned versus actual coverage in hours for the calendar months of September and October 2018

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 (specialling). 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.

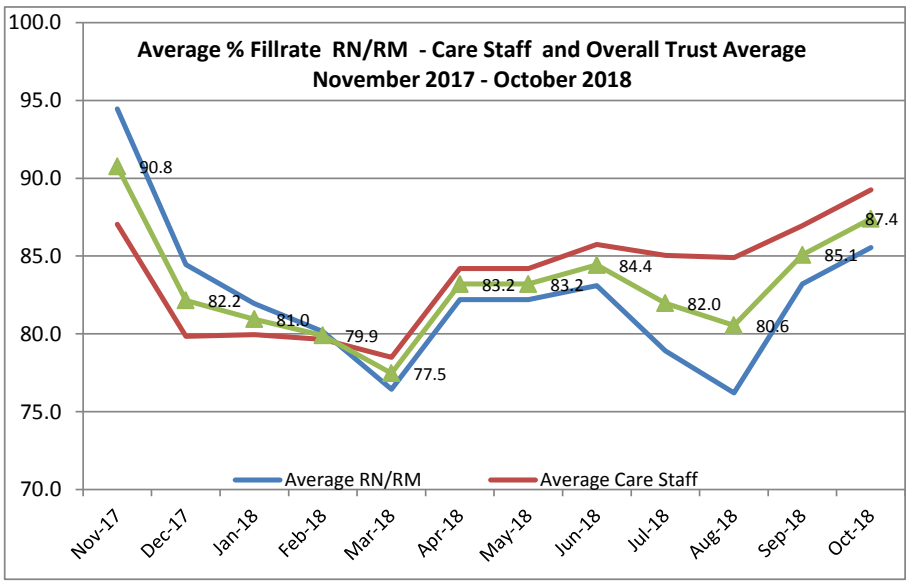
3.3 Care Hours per Patient Day* (CHPPD) has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018). From September 2018, publication of CHPPD replaced the actual v's fill dataset on My NHS and NHS Choices. CHPPD is reported under section 3.9.

3.4 The summary position for the Trust Safer Staffing Fill rates for October is included in the table below:

	Days - registered nurses / midwives (%)	Days - Average fill rate - care staff (%)	Nights - registered nurses / midwives (%)	Nights - Average fill rate - care staff (%)	Average RN/RM (%)	Average Care Staff (%)	Average Trust All Staff (%)
Trust Average	77% (72.6%)	83.3% (81.5%)	94.1% (85.3%)	95.2% (91.9%)	85.5% (83.2%)	89.2% (86.9%)	87.4% (85.1)
Change	↑4.4%	↑1.8%	↑8.8%	↑3.3%	↑2.3%	↑2.3%	↑2.3%

* *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 The rolling 12 month data is included in the table below, and demonstrates an improving trajectory in the overall fill rate position. :



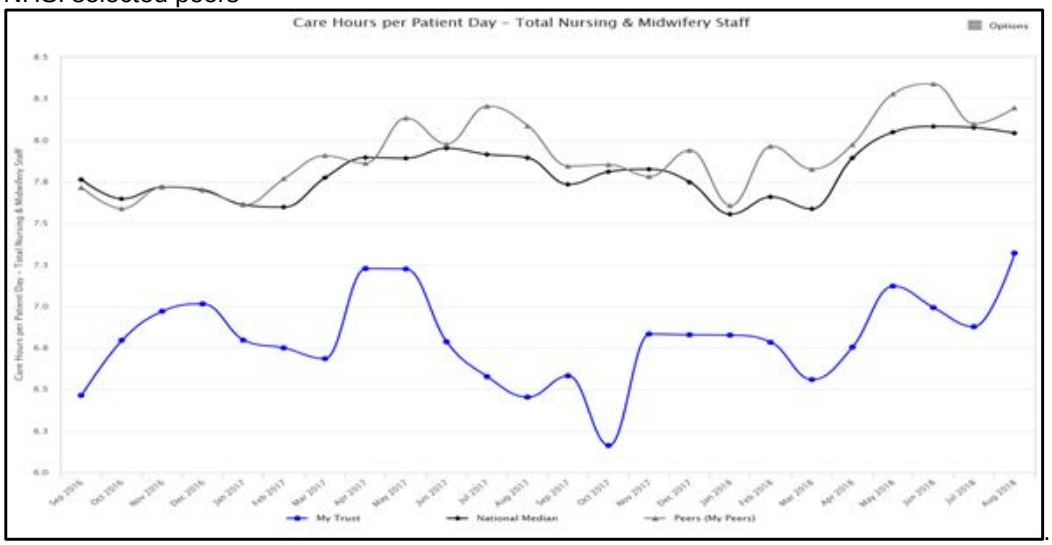
3.6 Exception reporting: future reports will include an exception report for wards, the report will include an analysis of the position, note any impact on quality, safety or experience and detail any actions in place to mitigate and improve the position where safe staffing is of concern.

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.

3.8 Care Hours Per Patient Days (CHPPD): Data from the Model Hospital Dashboard (updated August 2018 data). National median in brackets:

Table 3	August 2018 data	Variance against national median
CHPPD Total	7.3 (8.0)	↓ 1.3
CHPPD RN	4.3 (4.7)	↓ 0.4
CHPPD HCA	3.0 (3.2)	↓ 0.2

The graph below shows Care Hours per Patient Day (total Nursing and Midwifery Staff) taken from the Model Hospital site (data updated August 2018) showing PAH against the national median and NHSI selected peers



3.9 Quality & Safety Metrics - summary for month

Patient experience feedback for October 2018:
242 new PALs issues (total 343 open)
32 new complaints (total 73 open)
110 compliments

Falls: for October we have seen an average number of reported falls which is in line with previous years' October reporting levels. 100 falls were reported which is a <3% increase on the 97 falls that were reported in September but 4% lower than the same period for last year in October. Trust wide the level of harm remains low with 96% no harm or minor harm events with 4% or less suffering moderate/severe harm which is in line with national benchmarks.

Analysis of the falls and incident reports suggests that there are no glaring omissions of care that are common place across the board. An improvement action relating to Lying/standing Blood Pressure monitoring continues to be embedded which may proactively identify syncope and prevent some falls.

Pressure Ulcers: October saw an increase in hospital acquired Pressure Ulcers (PU) of 11 to 24(18 category 2 and 2 category 3 and 4 unstageable). Following the new NHSI pressure ulcer guidance that was published in June 2018 we are now reporting unstageable pressure ulcers (historically these would have been graded as category 3's). The new guidance also includes the removal of the 72 hour rule; however this was only attributable to one incident during October. Further information relating to the trend in PU reporting and actions can be found in the Integrated Performance Report.

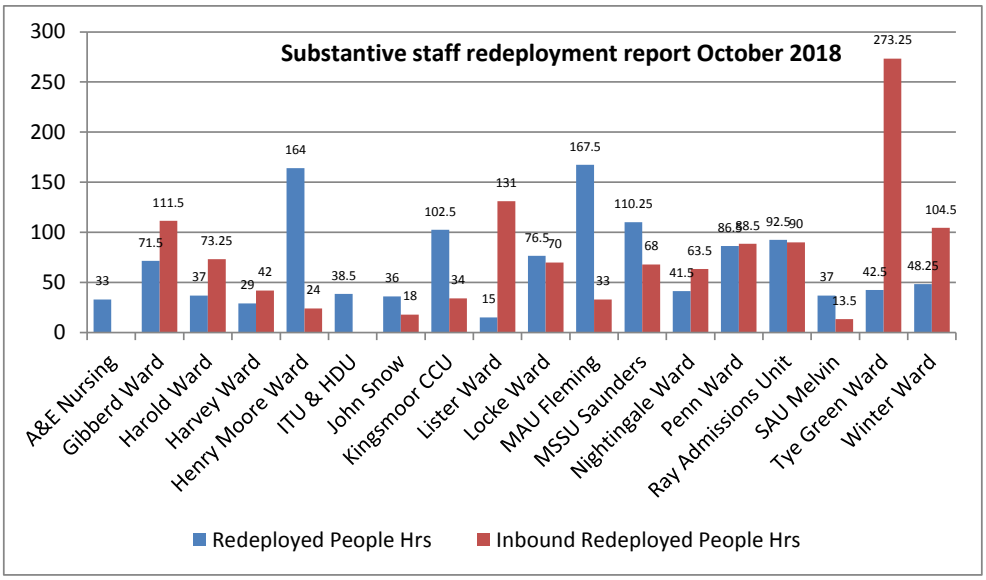
A deep dive to Penn Ward and Saunders Ward, providing an analysis of workforce and quality is included in appendix. 2.

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. Maintaining safe staffing continues to compromise the ward manager ability to work in a supervisory capacity.

In order to support safer staffing processes further, the Director of Nursing has requested the senior nursing team develop a safer staffing policy to guide day: day and prospective decision making.

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



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

The accuracy of this report 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 tables below demonstrate an improvement (RN/M) from 57.4% fill in August to 68.1% in October, it is anticipated that this improved position will be sustained and further improvement made. The HCSW % fill rate has remained broadly unchanged; however more shifts are being filled each month since July 2018 (c. 150 more).

RN/M temporary staffing demand and fill rates:

Current YTD Month & Year	Net Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
July 2018	4,186	1,397	33.4 %	1,007	24.1 %	57.4 %	1,782	42.6 %
Aug 2018	3,930	1,445	36.8 %	897	22.8 %	59.6 %	1,588	40.4 %
Sept 2018	3,900	1,548	39.7 %	924	23.7 %	63.4 %	1,428	36.6 %
Oct 2018	3,813	1,587	41.6 %	1,009	26.5 %	68.1 %	1,217	31.9 %
Oct 2017	4,063	1,374	33.8 %	985	24.2 %	58.1 %	1,704	41.9 %

HCA temporary staffing demand and fill rates:

Current YTD Month & Year	Net Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
July 2018	2,072	1,334	64.4 %	0	0.0 %	64.4 %	738	35.6 %
Aug 2018	2,234	1,532	68.6 %	0	0.0 %	68.6 %	702	31.4 %
Sept 2018	1,989	1,487	74.8 %	0	0.0 %	74.8 %	502	25.2 %
Oct 2018	2,033	1,481	72.8 %	0	0.0 %	72.8 %	552	27.2 %
Oct 2017	2,083	1,217	58.4 %	2	0.1 %	58.5 %	864	41.5 %

3.13 The risks associated with registered nurse vacancy and turnover have been assessed both from a corporate perspective and at individual health group level; these are entered on the Risk Assure system and regularly reviewed through the Trust Risk Management Group.

Part B:
Workforce:

At present the Trust is challenged by a 25.8% vacancy rate, the number of vacancies has declined monthly since August 2018 where the vacancy rate peaked at 28.2%.

Given the lack of supply locally and nationally the trust has employed an increased focus towards international recruitment and is highly successful in converting internationally trained nurses to UK Registered; over July, August and September all OSCE candidates passed their practical exam first time, our 100% pass rate far exceeds the 73% national average over the same period.

The recruitment a retention plan is being reviewed by the Director of Nursing and the Director of people to ensure that all routes for nursing staff are optimised, and we maximise opportunities to drive down the vacancy rate. Any additional resource requirement for any additional planned capacity also needs to be factored into the forecast and plan. In addition, the Director of Nursing has commenced an establishment review which will report in February 2019.

The table below provides a 6 month forward view of local and international recruitment with provisional start dates;

	Nov	Dec	Jan 19	Feb 19	Mar 19	Apr 19
Trust Recruitment						
RNs	11	4	13	4	-	1
Newly Qualified	1	-	-	5	1	-
International Recruitment						
Weekly Skype	-	4	10	6	6	6
India Campaign	-	-	4	4	3	4
Total	**12**	**8**	**27**	**19**	**10**	**11**

Based on the current pipeline we will have 87 new nursing starters over the next 6 months.

This will be bolstered by;

- The remaining 26 nurses from the India campaign, who will be set start dates into Summer 2019 once exam and NMC requirement are met
- A further 80 nurses whom we aim to appoint following a recruitment tour to India in December 2018. We anticipate that deployment for this cohort will begin during Summer 2019

- Additional overseas campaigns are planned, and a trajectory to significantly reduce the vacancy rate for autumn 2019 is being set.

In addition, the following workstreams are being reviewed, refreshed and given momentum to support the nursing and midwifery workforce position:

Retention:

- The nursing and midwifery workforce retention plan is being refreshed through the Recruitment and Retention Group to ensure that all actions are delivering or embedded, and that new ideas and initiatives are captured. The Director of Nursing will be undertaking the chair of the group to ensure focus and pace. To include:
    - Retention diagnostics e.g. on-boarding data, exit data, demographic data etc
    - Bespoke rotation programmes
    - Career clinics
    - Learning beyond registration support
    - flexible working and return to practice
    - the professional nurse and midwifery advocate programme

Effective rostering and efficient use of resources:

- The rostering policy is under review to ensure this is aligned to NHSI e-rostering good practice guide (2018)
- Rota KPIs will be agreed in line with national guidance
- 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).
- Establishing an e-rostering group

4.0 RECOMMENDATION

The Committee 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,
Sharon McNally, Director or Nursing and Midwifery

Date: **16th November 2018**

The Princess Alexandra Hospital NHS Trust

5.2

Appendix 1.

Ward level data: fill rates October 2018.

Ward name	DAY				NIGHT			
	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff	
	Average fill rate	ind	Average fill rate	ind	Average fill rate	ind	Average fill rate	ind
Dolphin Ward	63.9%	▼	63.7%	▼	90.0%	▼	130.9%	▼
Kingsmoor Cardiac Care Unit prev Fleming Ward	69.4%	▼	73.9%	▼	90.3%	▲	106.6%	▲
Medical Assessment Unit Fleming prev. Kingsmoor	55.3%	▼	67.8%	▼	59.4%	▲	81.9%	▲
Harold Ward	65.3%	▼	103.3%	▲	90.9%	▼	104.3%	▲
Harvey Ward	77.5%	▲	104.1%	▼	107.2%	▲	97.3%	▲
ITU & HDU	92.4%	▲	23.0%	▼	89.9%	▲	-	▶
Nightingale Ward	79.4%	▲	95.8%	▲	92.8%	▲	85.7%	▲
Tye Green Ward	64.4%	▲	75.7%	▼	101.0%	▲	100.0%	▲
Lister Ward	91.4%	▲	69.0%	▼	104.8%	▼	112.7%	▲
Locke Ward	74.3%	▲	111.3%	▼	99.1%	▲	151.5%	▲
Neo-Natal Unit	81.1%	▼	51.3%	▲	74.3%	▼	56.5%	▲
Penn Ward	60.9%	▼	132.4%	▲	101.9%	▼	102.1%	▼
Ray Admissions Unit	86.1%	▼	78.1%	▼	114.6%	▼	90.6%	▼
Medical Short-Stay Unit Saunders prev. Saunders Ward	87.5%	▼	110.4%	▲	142.1%	▲	101.2%	▲
John Snow Unit (formerly Stroke Unit (B40))	56.4%	▼	112.0%	▲	101.6%	▲	95.7%	▼
Henry Moore Ward prev. OSU	84.5%	▲	42.2%	▲	89.3%	▲	85.5%	▼
Gibberd Ward	64.5%	▼	74.1%	▼	58.5%	▲	103.2%	▲
Winter Ward	65.4%	▼	86.5%	▼	112.7%	▲	107.3%	▲
Chamberlen Ward	87.2%	▼	73.8%	▼	87.3%	▲	65.6%	▲
Labour Ward	86.2%	▲	87.4%	▼	73.1%	▼	87.4%	▲
Birthing Unit	95.8%	▼	108.3%	▲	96.6%	▲	74.2%	▲
Samson Ward	103.0%	▼	88.5%	▲	93.7%	▲	58.1%	▼
TRUST	77%	▲	83.3%	▲	94.1%	▲	95.2%	▲

Appendix. 2.

Deep dive – Penn Ward

- **Average fill rates for the ward (past 3 months)**

RN days	63.5%
RN night	101.8%
HCSW day	115.8%
HCSW night	103.2%

- Current vacancy rates: RNs 44.37%, HCSW -39.22%
- Sickness rates: RNs 0.56%, HCSW 0.91%

Penn only reported three falls for the October period, and reporting practices on Penn are regarded as being sound therefore under-reporting is not suspected. Rather Penn does not have such a large concentration of mainly frail older patients like other clinical areas and so tends to report fewer falls than other wards. Over the 3 months from August to October they reported 13 falls, which is about average for this area. The majority of falls occur at the patients' bedside with no distinct patterns which would suggest omissions in care.

- The ward has reported 1 pressure ulcer (grade 3) in the last 3 months which was identified following an admission of a patient from another ward to Penn ward.
- The ward has had 15 medication errors in the past three months. Of these 8 were due to incorrect prescription, 5 due to administration errors and 2 due to TTA dispensing errors. Work is underway with the ward pharmacist to ensure that learning from these incidents is shared.
- All incidents are followed up under the HealthCare Group governance arrangements
- The ward has received 1 complaint in the past three months.
- A review of SafeCare for October shows that the ward does not consistently meet the number of care hours required to meet the patients' needs. Recommendations following the establishment review undertaken during November 2018 will be reported to Board in February 2019.

Deep dive - Saunders ward

- **Average fill rates for the ward (past 3 months)**
- RN days 89.263%
- RN night 132.96%
- HCSW day 96.66%
- HCSW night 96.36%

- Current vacancy rates: RNs 52.84%, HCSW 26.14%
- Sickness rates: RNs 0.81%, HCSW 5.12%
- Saunders reported 23 falls for the 3 month period from August to October. This is about average for the area with between 6 and 8 occurring each month. The falls reported did not display any recurrent themes and each occurred due to differing events. Whilst the patient cohort on Saunders Ward does not tend to be the chronically deconditioned patients who fall recurrently, it should be noted that the patient LoS is an improving picture as the LoS has reduced from 4.7 to 3.8 days. The high turnover of patients, and acute nature of their presentation does increase the falls rate.

- The ward has received 6 complaints in the past 3 months. There are no themes identified.
- The ward has recorded 1 pressure ulcer in the last 3 months (Grade 2).
- There have been 17 medication incidents reported during the three months which cover a number of themes, the most common of which are prescription incidents.
- All incidents are followed up under the HealthCare Group governance arrangements.
- A review of SafeCare for October shows that the ward does not consistently meet the number of care hours required to meet the patients' needs. Recommendations following the establishment review undertaken during November 2018 will be reported to Board in February 2019.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board 6 December 2018

Agenda Item:	6.1							
Presented by:	Executive Directors							
Prepared by:	Information Team, HealthCare Groups & Corporate Teams							
Date prepared:	November 2018							
Subject / Title:	Integrated Performance Report (October)							
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:** Continued good performance on all areas of infection control. Complaints in line with previous years. Positive Friends and Family Test results. A review of the QIPP and associated actions is underway across all healthcare teams (overseen by QSC). **Performance:** ED October improved to 86%, the highest since July 2015. November attendance numbers and performance challenging. Support from ECIST in place. Reducing variation continues to be targeted. RTT, Diagnostics and Cancer all achieved in month. The number of 52 week breaches remain static with ongoing discussions **People:** Continued focus on recruitment and retention, in particular registered nursing; also statutory/mandatory training and appraisals. **Pounds**: YTD deficit £17.3m, £0.3m ahead of plan (£0.1m ahead in-month). **Places**: Additional capacity modular in place and on trajectory.							
Recommendation:	The Board is asked to discuss the report, noting the current position and further action being taken in areas below agreed standards.							
Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]	Patients	People	Performance	Places	Pounds			
	x	x	x		x			
Previously considered by:	Senior Management Team, November Quality & Safety Committee, November Performance & Finance Committee, November							
Risk / links with the BAF:	In full							
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.							
Appendices:	IPR							

6.1

NHS
The Princess Alexandra Hospital
NHS Trust

Integrated Performance Report

October 2018

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

Contact:

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

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Trust Objectives

NHS
The Princess Alexandra Hospital
NHS Trust

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

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

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

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

Our Pounds
Manage **our pounds** effectively to achieve our agreed financial control total for 2018/19.

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In this month

The Princess Alexandra Hospital NHS Trust

Perfomance:	
Proportion of Patient treated within 4 hours in ED	85.14%
RTT Incomplete Standard	92.5%
Delayed Transfers of Care all	1.53%
Diagnostic times - Patients seen within 6 weeks	99.66%
Cancer two week waits	97.60%

People:	
Starters	43.41
Leavers	38.17
Vacancy	12.4%
Turnover	14%
Stat Mand	88%
FFT (Care & Treatment)	N/A
FFT (Place to Work)	N/A

Places:	
Priority 1 Response	99%
Catering Patient Satisfication	86%
Meals served	46544
Food Waste	1%
PLACES Score	90%

Patients:	
Compliments	110
Complaints	32
FFT Inpatients	97.02%
FFT Outpatients	93.33%
FFT A&E	95.39%
FFT Maternity	98.10%

Pounds:	
YTD Deficit	-£17,464,785
Agency Target £s	-£5,386,087
Nursing Agency Target	7%
Capital Expenditure	£2,768,800
BPPC Volume	59%
BPPC - £s	72%
Cash Balance	£703,000
Income & Expenditure: In month	£1,456,750

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Navigation Appendix 1

Our Patients
Our People
Our Performance
Our Places

Your future | Our hospital

Key

The table below identifies the 2018/19 KPI target, current performance and then sets a trajectory for the year. The different coloured boxes indicate the individual month's trajectory and in which month the target will be met as follows:
RED: Starting point
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IPR = Integrated Performance Report (the trust wide dashboard)

		Executive LEAD	MUST / SHOULD	2018 / 19 Target	Compliance Data Source	Baseline performance (Feb 2018)	Expected Monthly Performance (Sept 18)	Performance in April 18	Performance in May 18	Performance June 18	Performance July 18	Performance Aug 18	Performance Sept 18	Performance Oct 18	Trajectory Nov 18	Trajectory Dec 18	Trajectory Jan 19	Trajectory Feb 19	Trajectory March 19
Patients	** (Trust) Review DNARCPR forms to ensure completed fully in line with Trust Guidelines and National Policy	Director of Nursing	MUST	95%	Audit of DNARCPR forms	82% Dec 17	80%	52%		44%	44%	56%	81%	88%	90%	90%	90%	90%	90%
	** (Trust) Review MCA & DOLS and how this is documented within patient notes	Director of Nursing	MUST	90%	Audit of medical records every 2 months		85%		55%		87%	63%	100%	100%	85%		90%		90%
	(Trust) Fridge temperatures are regularly checked and acted upon if temperatures are outside the normal range	Director of Nursing	MUST	98%	Ward Accreditation Audit	95%	98%	99%	87%	97%	99%	96%	98%	100%	98%	98%	98%	98%	98%
	** (Trust) must ensure that bottles of liquid medications are dated, signed on opening and do not exceed the expiry date	Director of Nursing	SHOULD	90%	Pharmacy Audit & Clinical Wednesday Audit	80%	90%	Planned audit 4/4 not completed	Planned audit 2/5 not completed. Changed to DOLS	25%	70%	65%	55%	76%	90%	90%	90%	90%	90%
	** (Urgent Care) Medical records contain a complete and contemporaneous record in respect of each patient and that appropriate risk assessments are completed and documented	Director of Nursing	MUST	90%	ED Documentation audit	NA	90%	Embed ED documentation	Embed ED documentation	Embed ED documentation	20%	20%	13%	33%	90%	90%	90%	90%	90%
	(Urgent Care) Conduct hourly comfort round observations	Director of Nursing	SHOULD	95%	Audit documentation	NA	Care rounds implemented 95%	Care rounds being implemented	Care rounds implemented	Care rounds implemented	Care rounds implemented, 82%	Care rounds implemented 90%	Care rounds implemented 97%	Care rounds implemented 79%	Care rounds implemented 95%	Care rounds implemented 95%	Care rounds implemented 95%	Care rounds implemented 95%	Care rounds implemented 95%
	** (Urgent Care) Conduct Emergency Care Safety Checklists / EWS Observations	Director of Nursing	SHOULD	90%	Weekly audit in ED		90%	Implement new documentation	Embed ED documentation	Embed ED documentation Audit Results: 78%	98%	100%	94%	100%					
	(CCCS) Ensure there is a planned preventative maintenance programme in place for all the equipment in the Mortuary	Director of Nursing	SHOULD	100%	Evidence of appropriate documentation	Improved documentation of maintenance commenced Feb 18	100%	100%	100%	100%	100%	100%	100%						
	(Critical Care) Introduce disposable washing bowls for patients	Director of Nursing	SHOULD	100%	Evidence of disposable bowls in use in Critical Care	None	100%	100%	100%	100%	100%	100%	100%						
	** (Paediatrics) Improve transition arrangements for adolescent patients	Director of Nursing	MUST	Transition arrangements in place & embedded	Transition audit / Patient Survey	Limited arrangements in place	Transition policy to be embedded	Transition Policy being developed	Transition Policy consultation in progress	Transition policy for further amendment after consultation	Transition policy has been delayed. Will be discussed at TPG in September	Transition policy requires more work for October submission	Transition policy requires more work Expected to be completed by November	Transition policy requires more work	Transition Lead in post	Transition policy fully embedded	Transition policy fully embedded	Transition policy fully embedded	Transition policy fully embedded
	** (Paeds) Consent should be consistently documented	Director of Nursing	SHOULD	90%	Documentation & notes audit	Not audited	80%	Align with GDPR process	Align with GDPR process Audit planned end June	Audit tool developed First audit to be completed July	40%	60%	80%	80%	90%	90%	90%	90%	90%
	** (Paeds) Enhance communication with patients to ensure they have all the information they need (give ward leaflet to all children)	Director of Nursing	SHOULD	100% leaflets given to patient and parents	NA	Review in progress	80%	Audit to be developed	Audit to be developed	Audit tool developed First audit to be completed July	40%	40%	60%	40%	90%	95%	100%	100%	100%
	** (Paeds) Ensure records are complete and comprehensive, in particular the documentation of conversations with parents	Director of Nursing	SHOULD	90%	Documentation & notes audit	ED document being revised	Rollout of Me First Workshop to staff 80%	Audit to be developed	Audit to be developed	Audit tool completed and first audit will be completed in July	80%	80%	3 Staff attended Me First Workshop Audit: 80%	Rollout of Me First Workshop to staff Audit: 100%	90%	90%	90%	90%	90%
People	** (Trust) Appraisals	Director of People	MUST	90%	Appraisal records	86%	90%	78%	77%	76%	83%	81%	80%	85%	90%	90%	90%	90%	90%
	** (Trust) Stat/Man Training (inc: safeguarding, Fire, Infection Control, Life Support - Core 8 Topics)	Director of People	MUST	90%	Training records	84%	90%	84%	86%	86%	89%	88%	88%	88%	90%	90%	90%	90%	90%
	** (Trust) Paediatric Life Support Training Compliance	Director of People	MUST	90%	Training records	80%	88%	75%	78%	80%	97%	92%	94%	79%	90%	90%	90%	90%	90%
	** (Trust) Adult Life Support Training (level 2)	Director of People	MUST	90%	Training records	77%	78%	65%	65%	68%	69%	73%	75%	74%	80%	84%	88%	90%	90%

Key

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	** (Trust) Adult Safeguarding Training (Levels 1 & 2)	Director of People	MUST	90%	Training records	L1 - 92% L2 - 78%	L1 - 90% L2 - 90%	L1 - 93% L2 - 79%	L1 - 94% L2 - 83%	L1 - 94% L2 - 84%	L1 - 95% L2 - 88%	L1 - 96% L2 - 86%	L1 - 96% L2 - 86%	L1 - 97% L2 - 88%	L1 - 90% L2 - 90%	L1 - 90% L2 - 90%	L1 - 90% L2 - 90%	L1 - 90% L2 - 90%	L1 - 90% L2 - 90%
	** (Trust) Safeguarding Children Training (levels 1, 2 & 3)	Director of People	MUST	90%	Training records	L1 - 92% L2 - 85% L3 - 62%	L1 - 90% L2 - 90% L3 - 85%	L1 - 92% L2 - 85% L3 - 63%	L1 - 93% L2 - 87% L3 - 70%	L1 - 94% L2 - 87% L3 - 72%	L1 - 94% L2 - 90% L3 - 77%	L1 - 95% L2 - 87% L3 - 76%	L1 - 95% L2 - 86% L3 - 79%	L1 - 96% L2 - 87% L3 - 78%	L1 - 90% L2 - 90% L3 - 90%	L1 - 90% L2 - 90% L3 - 90%	L1 - 90% L2 - 90% L3 - 90%	L1 - 90% L2 - 90% L3 - 90%	L1 - 90 % L2 - 90% L3 - 90%
	** (Trust) Recruit Registered Nurses (RNs) to ensure adequate numbers of RN's in line with national guidance	Director of People	SHOULD	18%	Vacancy Data	24.0%	20%	26%	25%	26%	26%	28%	28%	28%	19.5%	19%	19%	18.5%	18%
	** (Urgent Care) Staff are competent including: Fire Safeguarding L.2 / 3 Infection Control L2	Director of People	MUST	90%	Training records	81% (medical HCG)	89%	F: 74% SA: 77% SC-2: 83% SC-3: 61% IC: 74%	F: 81% S.A: 86 % S.C-2: 91% SC-3: 63% IC: 77%	F: 90% S.A2: 86% S.C.2: 96% S.C.3: 78% IC: 73%	F: 94% SA2: 89% SC2: 91% SC3: 76% IC:78%	FI: 94% SA: 87% SC2: 80% SC3: 75% IC 84%	Fire: 94% SA: 84% SC2: 84% SC3: 83% IC: 76%	Fire: 96% SA: 88% SC2: 90% SC3: 83% IC: 80%	90%	90%	90%	90%	90%
	** (Surgery) There must be a Paediatric trained nurse in theatres at all times - Working with FAWS	Director of People	MUST	100%	Staff Roster	0%	25%	0%	0%	0%	0%	0%	0%	0%	50%	75%	100%	100%	100%
	** (Paeds) Recruit Registered Paediatric Nurses to ensure compliance with RCN standards regarding staffing & competences on Dolphin Ward	Director of People	MUST	14%	Staff Roster / Shelford Acuity Model & Safer Staffing	22.9%	26%		RN: 68% Establishment filled 32% Vacant	RN: 68% Establishment filled 32% Vacant	RN: 71% Establishment 29% Vacancy	RN: 71% Establishment 29% Vacancy	RN in Post: 83% 17% Vacancy	RN in Post: 87% 13% Vacancy	24%	22%	20%	18%	16%
	(Urgent Care) Ambulance patients are appropriately assessed & triaged in a timely manner in accordance with RCEM guidelines	Chief Operating Officer	MUST	<30mins - 80% 30-60mins - 20%	IPR	<30mins - 66% 30-60mins - 26% >60mins - 8%	<30: 80% 30-60: 20%	<30: 75% 30-60 min: 21% >60: 4.2%	<30: 83% 30-60: 16% >60: 1%	<30: 76.7% 30-60: 22.3% >60: 1%	<30: 70.1% 30-60: 26% >60: 4.3%	<30: 82.2% 30-60: 16.9% >60: 0.9%	<30: 79% 30-60: 20% >60: 1%	<30: 79% 30-60: 19% >60: 1%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%
	(Trust) Reduce the number of late discharges (22.00-08.00hrs)	Chief Operating Officer	SHOULD	Zero	IPR	3.0%	3%	4.8%	5.2%	9.7%	8.3%	6.5%	6.8%	6.0%	2.0%	1.5%	1.0%	0.5%	0%
	** (Trust) Reduce the number of bed moves between (22.00-08.00hrs)	Chief Operating Officer	SHOULD	Zero	IPR	3.0%	5.0%	Concerns about data quality 17.7%	Concerns about data quality 17.9%	Concerns about data quality 17.5%	Concerns about data quality 20.8%	Concerns about data quality 16.71%	Concerns about data quality 7 non clinical transfers 16.4%	Concerns about data quality 14 non clinical transfers 19.5%	3.0%	1.5%	1.0%	0.5%	0%
	(Trust) Reduce the number of delayed discharges from HDU to the wards	Chief Operating Officer	SHOULD	4-24hrs=12 >24hrs = 2	IPR	4-24hrs=21 >25hrs=12	4-24hrs:17 >24hr: 12	4-24hrs: 23 >24hr: 17	4-24hrs: 21 >24 hr: 10	4-24hrs: 18 >24hr: 11	4-24hrs: 16 >24hr= 13	4-24hrs=22 >24hr=16	4-24hrs: 23 >24hr: 19	4-24hrs: 15 >24hr: 4	4-24hrs=16 >24hr=10	4-24hrs=15 >24hr=8	4-24hrs=14 >24hr=6	4-24hrs=13 >24hr=4	4-24hrs=12 >24hr=2
	(Trust) To monitor trends in delayed discharges to identify trends / areas for improvement	Chief Operating Officer	SHOULD	Trends monitored & acted upon	Audit data	Trends not monitored	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon						
	(Surgery) Reduce the use of PACU for inappropriate patients (DSU etc.) late at Night	Chief Operating Officer	SHOULD	Extend DSU opening hours to 22.00hrs / Zero	IPR	DSU closes at 18.00hrs	Extend opening to 22.00 Zero DSU pts in PACU	Recruit additional staff	Recruit additional staff	Recruit additional staff	Extend opening to 21.00hrs. 5 pts moved to PACU	Extend opening to 21.00hrs. 1 DSU pts moved to PACU	Day unit open to 21.00hrs. 4 DSU pts moved to PACU	Day unit open to 21.00hrs 14 DSU pts in PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU	Extend opening to 22.00hrs. Zero DSU pts in PACU
	** (HDU) Reduce the number of mixed sex breaches	Chief Operating Officer	MUST	Zero	IPR	5	1	8	2	5	4	8	3	8	0	0	0	0	0
Places	(HDU) When refurbishing, consider the position of the sink area in HDU, moving it so that staff do not have to pass through a bed area to wash their hands	Director of Strategy	SHOULD	Review space & identify a new design. Submit business case.	NA	NA	If approved go out to tender	not in capital plan 18/19	not in capital plan 18/19	not in capital plan 18/19	not in capital plan 18/19	not in capital plan 18/19	not in capital plan 18/19	not in capital plan 18/19					

Key

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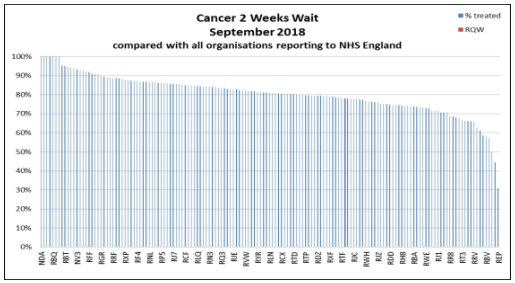
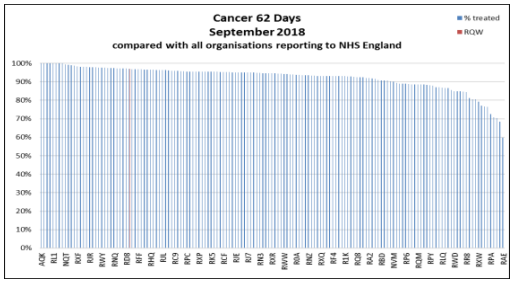
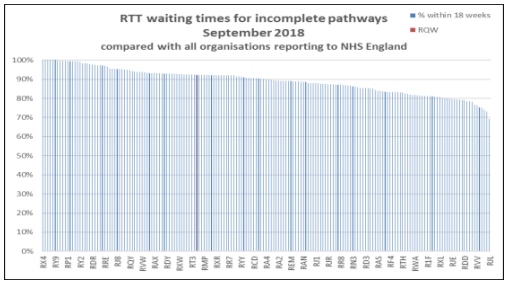
(HDU) When refurbishing, consider the space required to provide safe movement around bed spaces	Director of Strategy	SHOULD	Review space & identify a new design. Submit business case.	NA	NA	**If approved go out to tender**	**not in capital plan 18/19**	**not in capital plan 18/19**	**not in capital plan 18/19**	**not in capital plan 18/19**	**not in capital plan 18/19**	**not in capital plan 18/19**	**not in capital plan 18/19**					
(CCCS) Ensure there is a planned preventative maintenance programme in place for all the equipment in the Mortuary	Director of Strategy	SHOULD	100%	NA	Improved documentation of maintenance commenced Feb 18	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**						

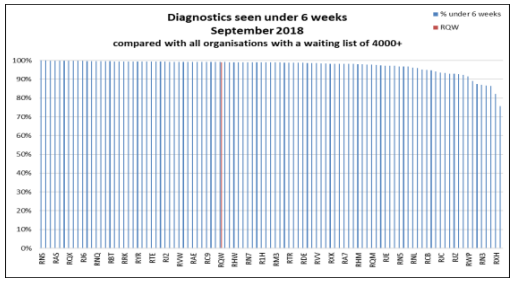
National Benchmarking
Compared with all organisations reporting to NHS England

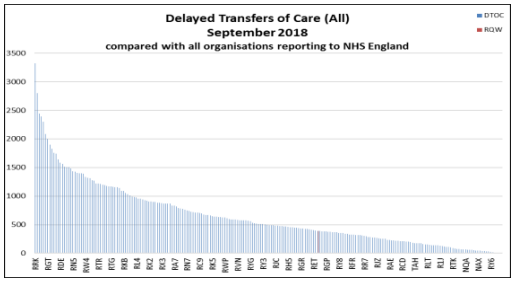
NHS
The Princess Alexandra Hospital
NHS Trust

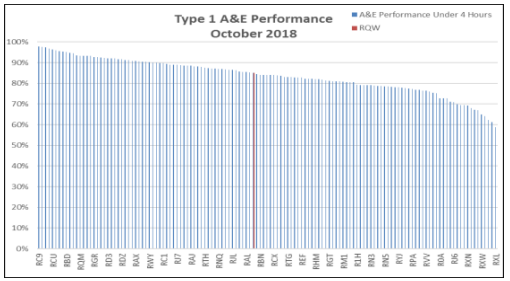


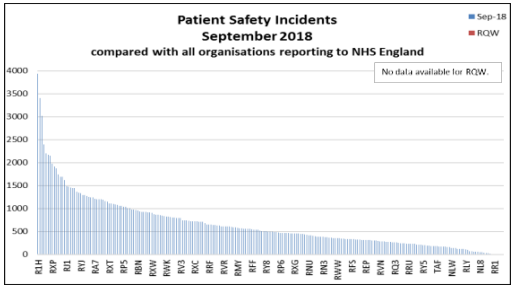


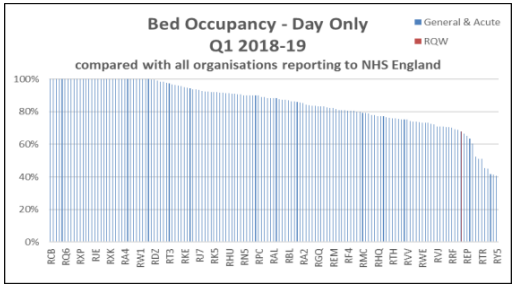


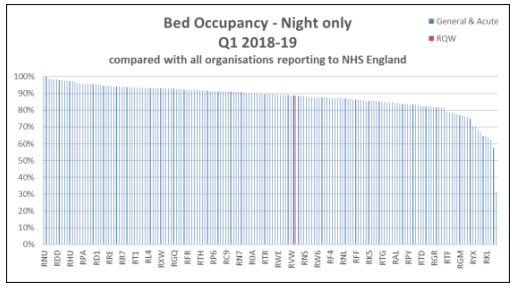












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Data Source: NHS England Statistics/Public Health England/Dr Foster

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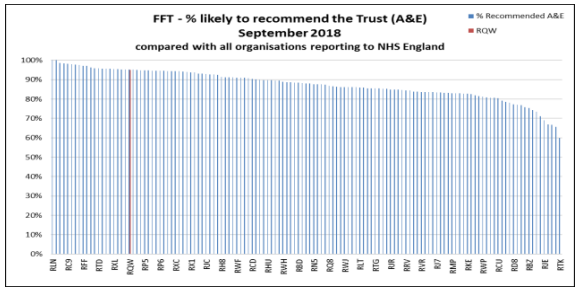
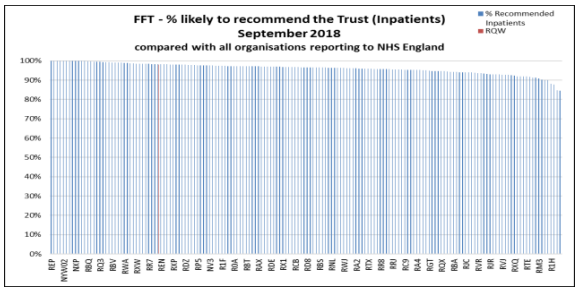
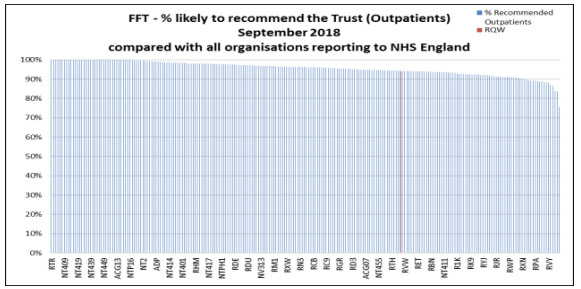
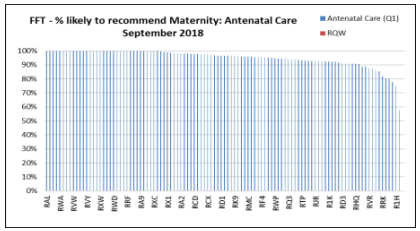
National Benchmarking
Compared with all organisations reporting to NHS England

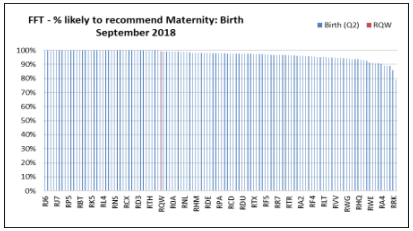
NHS
The Princess Alexandra Hospital
NHS Trust

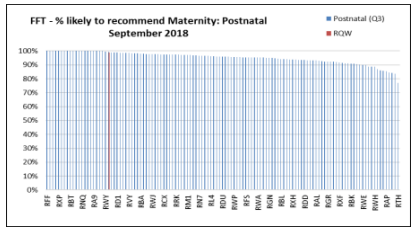


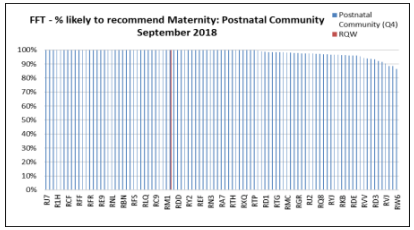


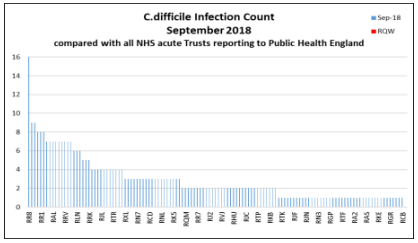


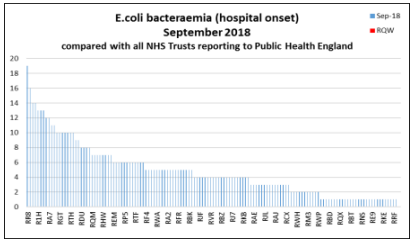


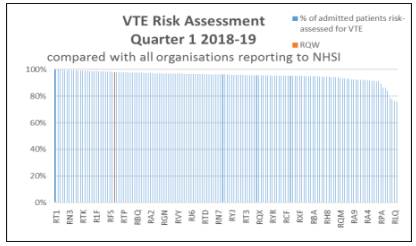


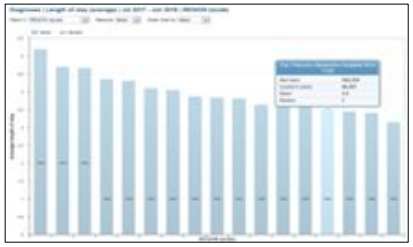












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Data Source: NHS England Statistics

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Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

Performance has improved in month, with objectives that were non-compliant for several months having delivered an improvement.

From the 13 objectives in the QIPP (Our Patients) 3 (23%) are achieved, 5 (38.5%) objectives have either exceeded or achieved their planned monthly trajectory. 5 objectives (38.5%) have not achieved the expected monthly trajectory standard.

Expiry of liquid medications: An improvement in compliance in month is noted. Six (reduced from 10) clinical areas were non-compliant and five wards did not submit data in month. This is being addressed with the change in role of matrons pver the next 6 months.

Urgent Care Medical Records audit of complete and contemporaneous notes: Mitigating actions are:
• During October the method of documentation was a mix between electronic and paper. Continuing to move all ED doctors' documentation to the electronic system (Cosmic) will continue. This will ensure improvement in seven out of the eight core standards automatically. The final item that will need to be typed for each patient is the medical management plan; the team have met this standard consistently.
• The nursing team will support the doctors in their audited and convert it to daily (rather than the current retrospective audit), to allow staff to be given feedback on poor documentation on the day the patient attends the department
To improve the Emergency Care teams compliance with care round the team will
• Discussed daily at safety huddle to ensure everyone is aware this is vital for safety in dept.
• One additional team member is planned to focus on additional teaching in the department to ensure good practice is shared and poor documentation is highlighted to individuals concerned.
• The team are confident this was a single month dip in performance.

Paediatric Transition Policy: The policy was reviewed by the Trust Policy Group in November and requires further amendments. A mitigating action is that since May the Transition group meet monthly to deliver the practical outputs of transition for young people moving to adult services.

Audit monitoring improved communication with patients: Mitigating actions are:
• Leaflet has been developed with a plan to strengthen the distribution by placing a copy at each bed space and laminating a copy to be placed in parent's room.

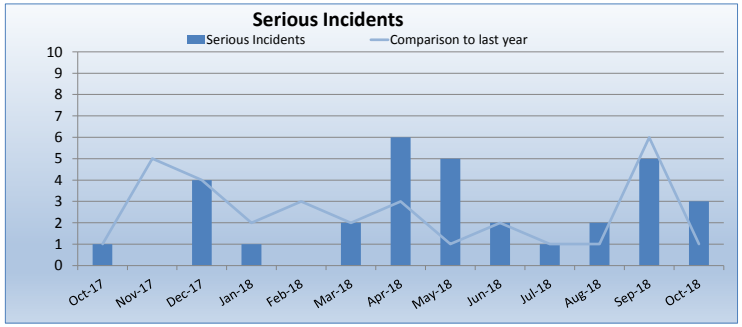
1 Our Patients Summary 1.1 Patient Safety - incident reporting

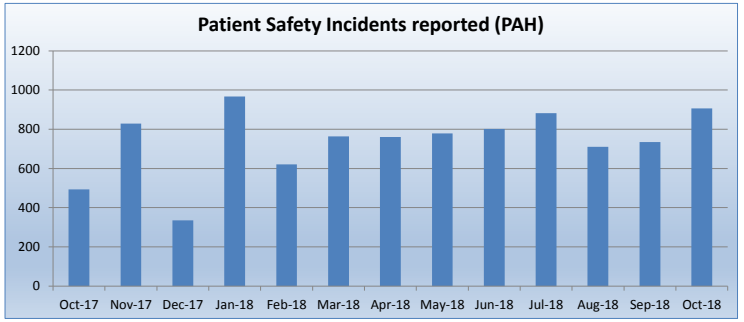
NHS The Princess Alexandra Hospital NHS Trust

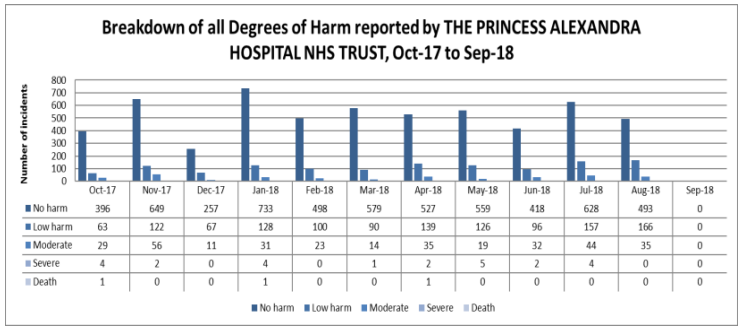
Incidents:
There were a total of 1094 incidents reported in October 2018 with 907 of these being PAH. Of the PAH incidents during October 2018, approx. 96% were 'no harm' or 'minor harm' incidents while 4% rated as moderate, severe harm & death. The moderate & severe incidents have been reviewed and/or discussed at oversight and/or Serious Incident Group & grading may be subject to change. The number of incidents reported month on month has increased overall in comparison to when the paper based system was in place.

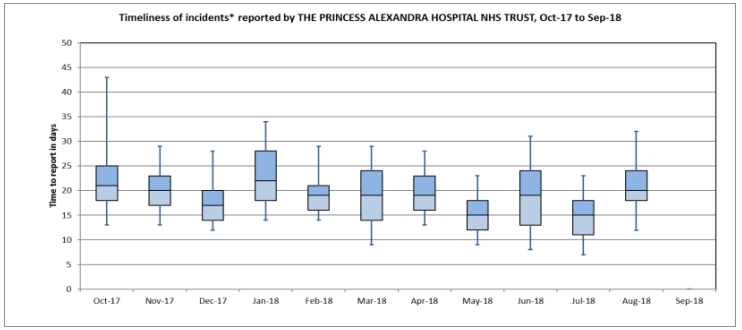
During October 2018 there were 3 Serious Incidents:
Treatment delay meeting SI criteria: Medicine Health Group
VTE meeting SI Criteria: FAWS health group
Treatment delay meeting SI criteria: CCCS Health Group

Safety Thermometer:
Harm Free Care was 93.36% (422/452) 30 patients are recorded as having 1 or more harm. The data shows that of these patients 18 were recorded as having hospital acquired harms. NB: The information collected during the Monthly Patient Safety Thermometer is a point prevalence audit and as such only provides us with snap shot of information relating to all inpatients on the one audit day of the month.
The accuracy cannot be completely validated in each case – this is currently being reviewed as to how best we can be confident of the accuracy of this element in the survey.









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

The Princess Alexandra Hospital NHS Trust

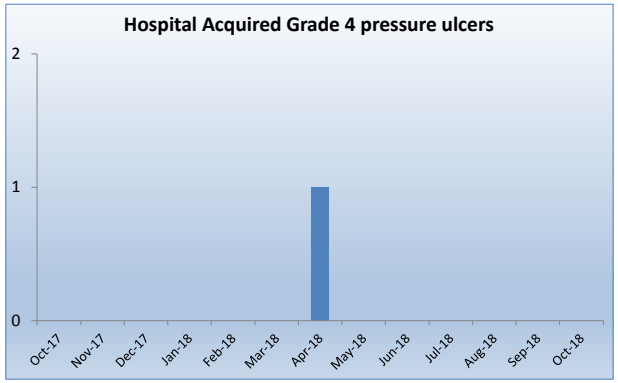
There has been an increase in the number of hospital acquired pressure ulcers in October. This equates to 1.49 per 1000 bed days.

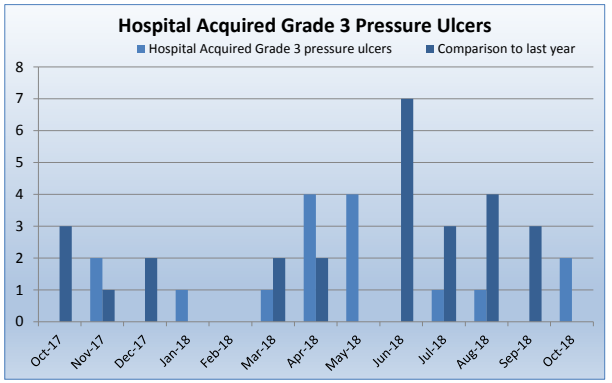
Analysis:

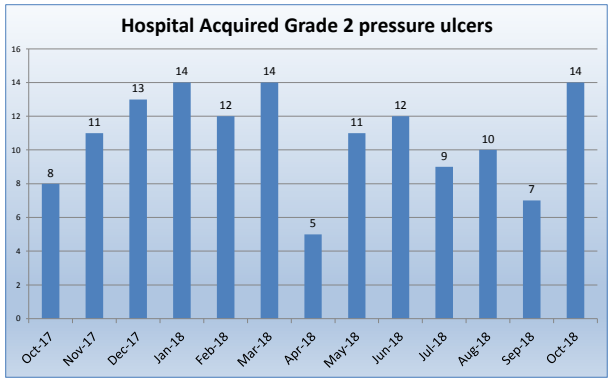
Additional training and education has already been provided to wards where there have been increases in the number of pressure ulcers.

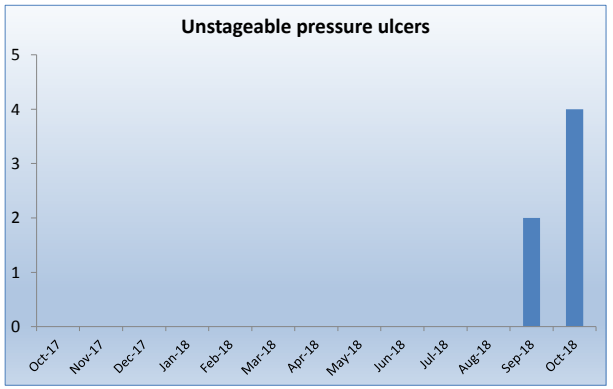
Following investigation of incidents, learning identified goes back to the ward teams for dissemination. This has included ensuring patients are regularly repositioned.

The trust is very proud to continue to deliver a very successful link nurse programme (Agents for Nutrition and Tissue Viability) where nurses are trained in all aspects of tissue viability including pressure ulcer prevention. Investing in our staff through this programme has shown to benefit patient care through the excellent projects that have been carried out as part of this course. The wards identified as having increases have been encouraged to apply for places on the upcoming ANT's programme.









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1 Our Patients Summary 1.3 Infection Control

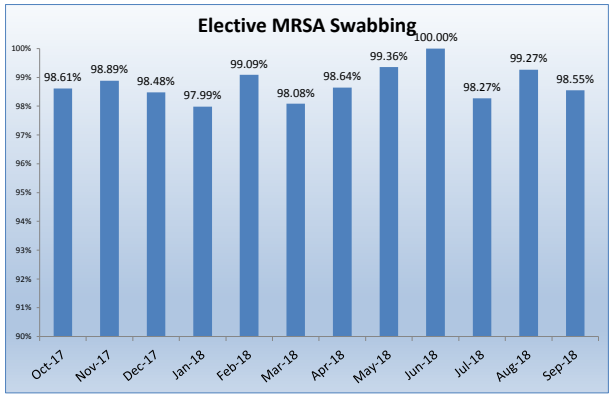
NHS The Princess Alexandra Hospital NHS Trust

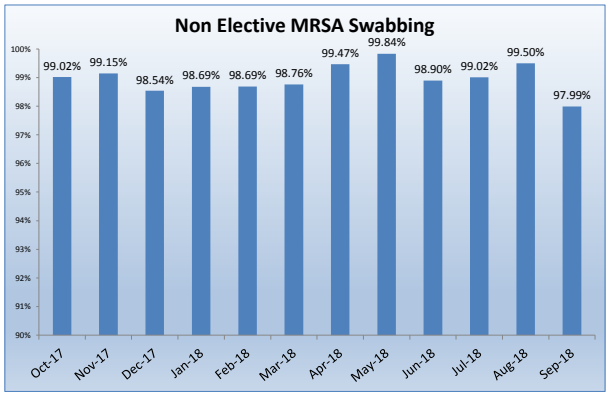
MRSA bacteraemia: There have been no cases of Trust-apportioned MRSA to date for 2018-19

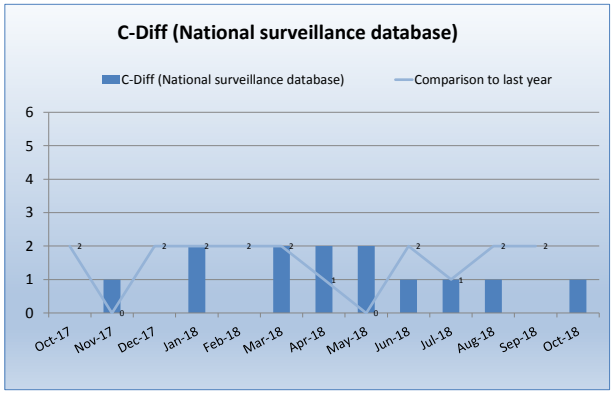
MRSA Screening: Over 97% compliance was achieved for both elective & non-elective screening in September (reporting 2 months in arrears).

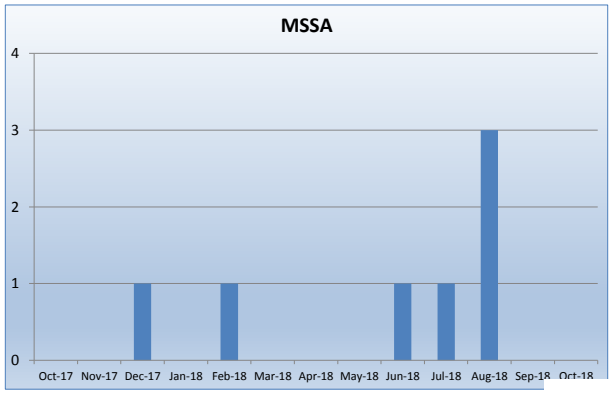
Clostridium difficile: The trajectory for 2018-19 is nine cases for the year. There was one case of C.difficile in October

MSSA: There were no cases in October. There is no trajectory in place for MSSA, but we continue to monitor and report cases.









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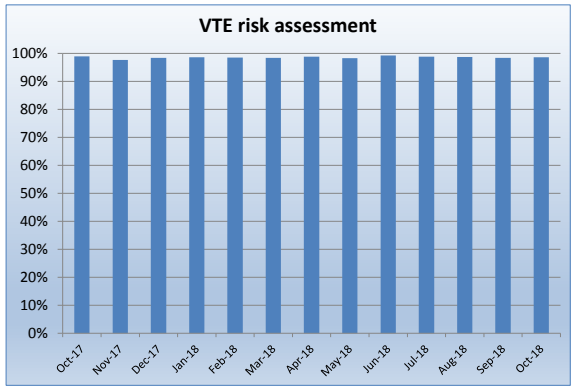
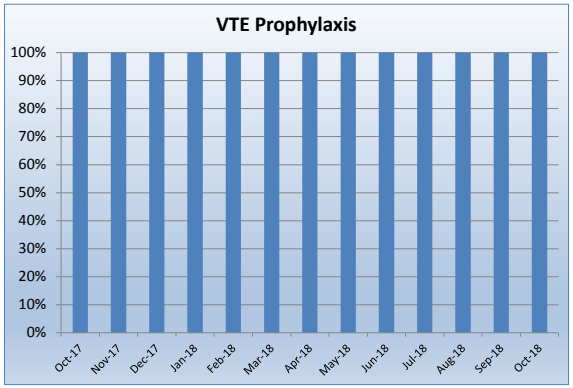
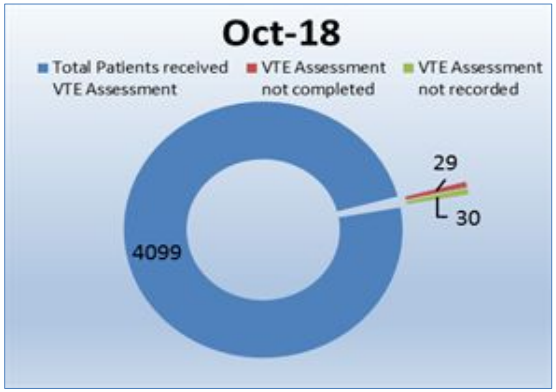
1 Our Patients Summary 1.4 Screening on admission

The Princess Alexandra Hospital NHS Trust

The Trust is currently above target for VTE Assessments for October as at 15th November 2018.
All non-compliant VTE assessments are scrutinised by the VTE leads and reported monthly through PSQ. Any incidents are recorded on DATIX and are reported through the daily incident group. All prophylaxis doses missed are escalated immediately to the Nurse in charge and the patient receives prescribed anticoagulation.







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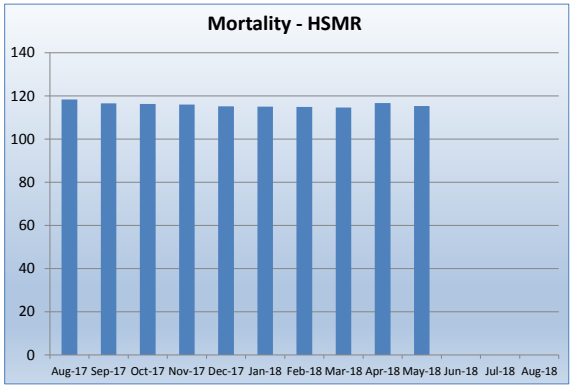

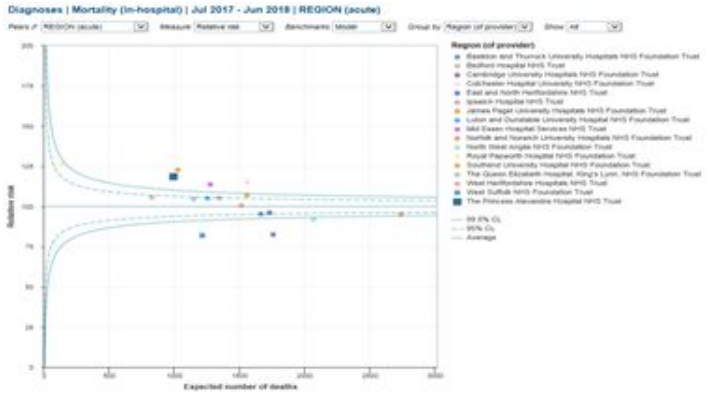

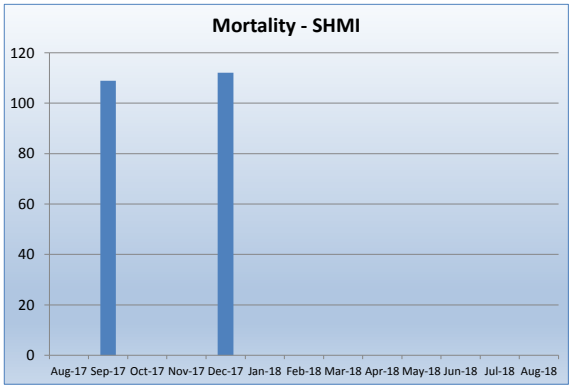

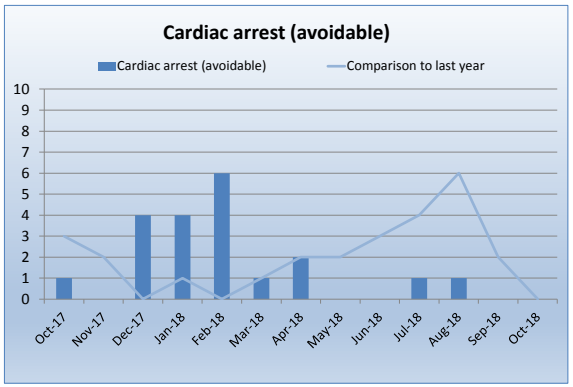

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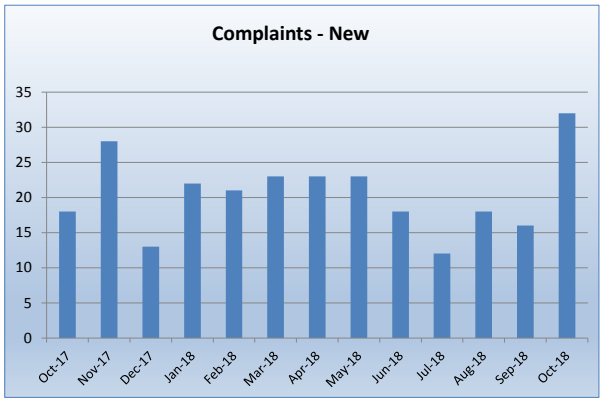
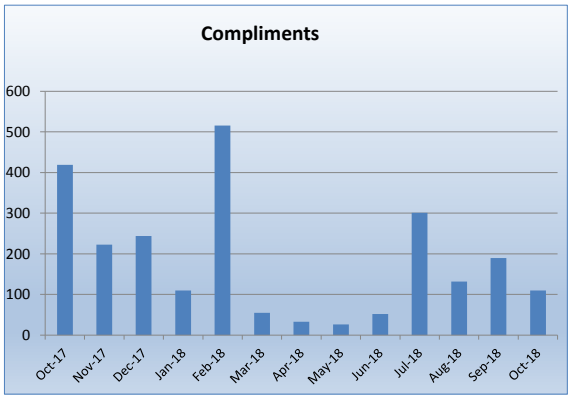
1 Our Patients Summary 1.6 Complaints & Compliments

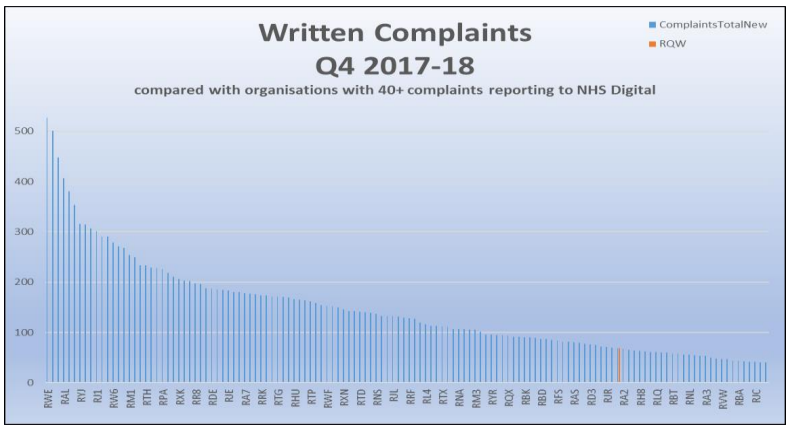
NHS The Princess Alexandra Hospital NHS Trust

This increase in complaints in the closing months of the year is consistent with increases in previous years:

Themes relate to medical care expectations (12) & communication (7) with three cases reported under the sub heading of end of life care. These cases have been reported to the End of Life Steering group & are being reviewed separately. The dominant themes are consistent with evidence based research on complaints* & synopses for October 2018 have been circulated to partners across the health & care system.
*Reader and Gillespie 2016







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Executive Summary Our Performance

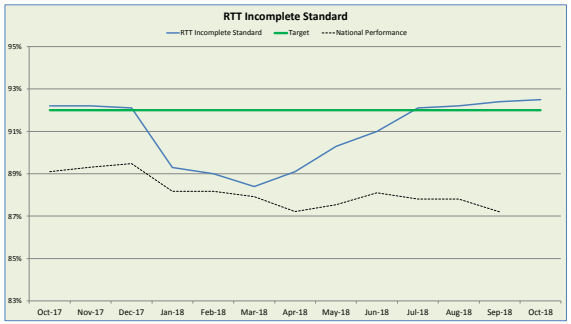
The Princess Alexandra Hospital NHS Trust

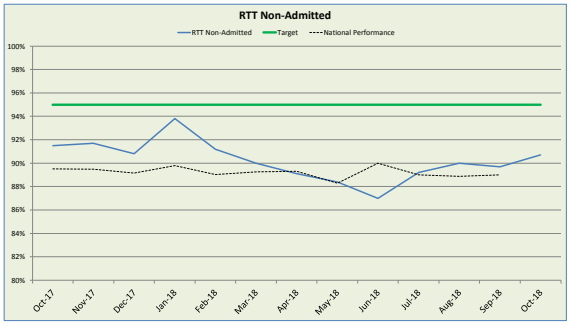
The delivery of constitutional standards in Diagnostics, Referral to Treatment (Incomplete) and Cancer has been achieved in month. Continued improvement in delivery of the ED 4 hour performance was demonstrated in October although at the start of November the numbers of attendees and performance has proved difficult and challenging. October saw seen the highest level of improvement and achievement since July 2015. Attendance numbers have continued to increase with the highest for over 4 years in month. Support from the Emergency Care Intensive Support team continues in ED on the Non-Admitted pathway and ambulance handovers. Action to improve length of stay and stranded patients is underway with dedicated LOS reviews led by AMDs in Medicine and Surgery every Thursday. Matrons have been reallocated to support patient experience, compliance and standards together with flow across all inpatient areas from now until the end of March.

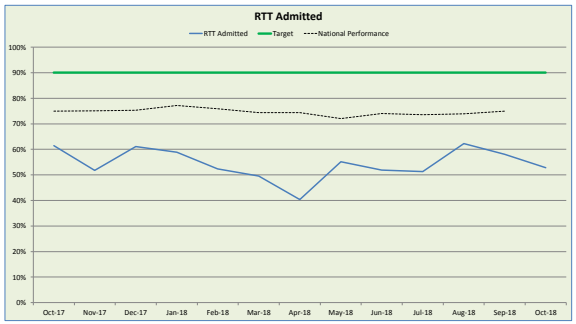
2 Our Performance Summary — 2.1 Responsive - RTT

The Princess Alexandra Hospital NHS Trust

Incomplete standard achieved. No issues to report in month. Work continues on the admitted and non admitted pathways with clear trajectories in place for all specialities. A review of the patients on "review lists" and actions to address are in place.







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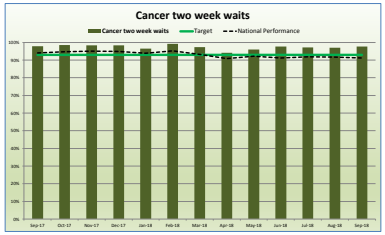
2 Our Performance Summary — 2.2 Responsive - Cancer performance

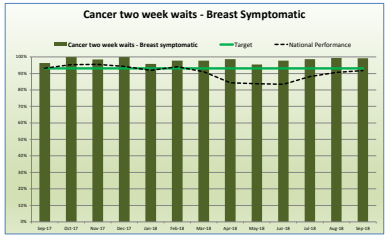
The Princess Alexandra Hospital NHS Trust

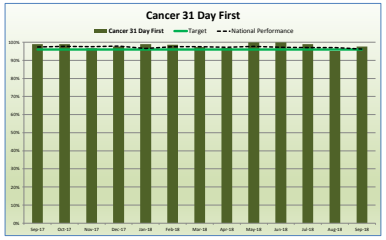
Cancer Performance:
Work is ongoing to clear the backlog of patients and ensure performance improves to meet national and local targets:
• Three additional trackers employed on a temporary basis to reduce the patient tracking list and promote expediting treatments. • Urology locums are in place to keep the waiting lists under control. Work is ongoing with both UCLH and Queens Romford to create joint posts • Micro management of trigger points to ensure patients hit pathway targets (first seen in 7 days, first diagnostic in 14, diagnostic results in 21 days, confirmation of cancer in 28 days, discussion at MDT in 31 days and ITR sent in 36 days).
Part of this work saw The Trust achieve September 62 day standard performance for the first time since February although more work is needed to achieve continuous success.

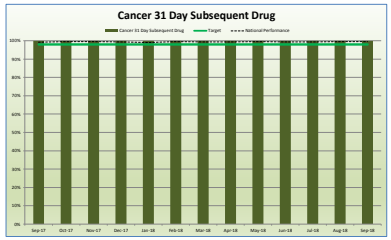
Breach analysis 62 day Screening:
Breast – 1 complex patient, multiple diagnostics and MDT discussions needed. The other two patients were at Broomfield's for 66 and 67 days, delayed due to capacity issues in Plastics, these were both preventable (but not by PAH).

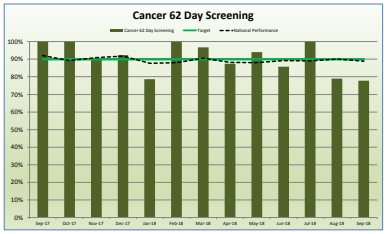
Breach analysis 62 day Consultant Upgrade:
Breast – 1 patient was at Broomfield's for 60 days, delayed due to capacity issues in Plastics(ITR sent day 23). Preventable, but not by PAH.
Head & neck - 1 patient very complex with multiple cancers which needed treating first – not preventable, should be within 10% tolerance.
Lung - ITR sent on day 36, treatment at UCLH on day 75 could not be brought forward by Trust. Preventable but not at PAH.
Upper GI – 1 Patient first considered for surgery but inoperable, could not be started on Palliative Care until returned from holiday. Patient choice, not preventable by PAH.
Urology – 1 Patient poor capacity at PAH. 1 Patient confusion over which Trust was to start Active Monitoring (PAH or RFH). Both preventable.

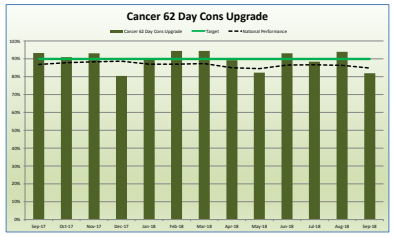


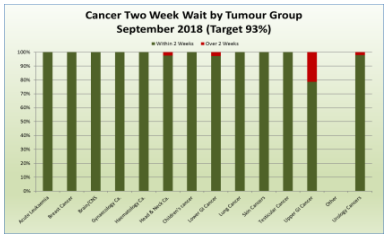








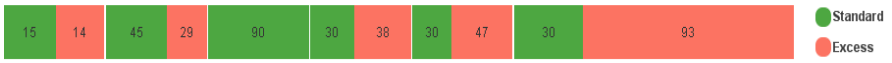


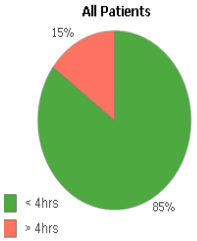


Target Wait Group	14 day target performance %	31d day first seen performance %	62 day standard performance %	62 day Screening performance %	62d CU performance %	31d day subsequent drugs performance %	31d day subsequent surgery performance %
Acute Leukaemia	100.0%						
Breast Cancer	100.0%	95.8%	84.2%	77.8%	66.7%	100.0%	100.0%
Brain/CNS	100.0%						
Gynaecology Ca.	100.0%	100.0%	100.0%		100.0%		
Haematology Ca.	100.0%	100.0%	100.0%		100.0%		
Head & Neck Ca.	97.6%		100.0%		0.0%		
Children's cancer	100.0%				100.0%		
Lower GI Cancer	97.3%	90.0%	100.0%		100.0%	100.0%	
Lung Cancer	100.0%	100.0%	100.0%		92.3%	100.0%	
Skin Cancers	100.0%	100.0%	100.0%		100.0%		
Testicular Cancer	100.0%						
Upper GI Cancer	78.6%	100.0%	66.7%		77.8%		
Other		100.0%					
Urology Cancers	97.8%	100.0%	70.0%		55.6%	100.0%	100.0%
Total performance	97.6%	97.7%	88.2%	77.8%	82.0%	100.0%	100.0%
Symptomatic Breast	99.2%						

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

Show hr of breach





Measure	Standard	Average	Excess	Patients with Timestamp	Patients Who Breached	% Breached	Patients Who Breached Rank
Arrival to Triage	15	29	14	8,770	5,167	59%	
Triage to Exam	45	74	29	8,081	3,957	49%	
Exam to Referral to Specialty	90	72	0	2,603	416	16%	
Referral to Seen by Specialty	30	68	38	2,751	1,779	65%	
Seen by Specialty to DTA	30	77	47	1,751	852	49%	
DTA to Depature	30	123	93	2,463	1,103	45%	

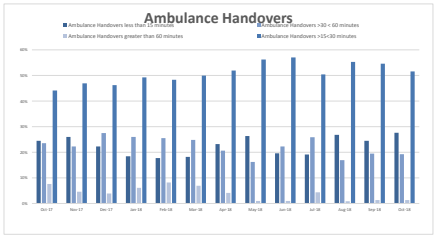
ED Internal Professional Standards

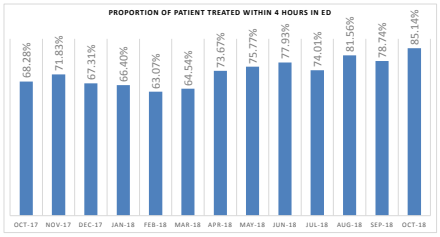
	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Arrival to Triage - Average Wait (Minutes)	31	28	33	33	35	37	31	32	32	32	28	31	29
Triage to Exam - Average Wait (Minutes)	95	95	96	103	111	111	100	92	98	98	79	82	74
Exam to Referral to Specialty - Average Wait (Minutes)	94	93	92	97	99	99	87	82	75	79	74	78	72
Referral to Seen by Specialty - Average Wait (Minutes)	73	72	83	89	85	83	79	69	66	74	70	69	68
Seen by Specialty to DTA - Average Wait (Minutes)	113	110	118	123	132	121	105	91	87	91	77	86	77
DTA to Departure - Average Wait (Minutes)	275	284	309	328	391	416	381	219	160	201	119	161	123

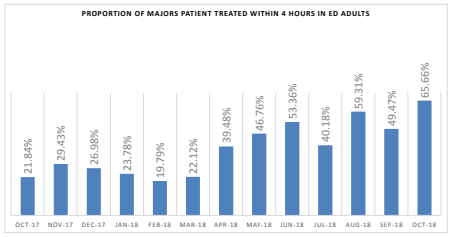
2 Our Performance Summary | 2.4 Responsive - Ambulance & ED | The Princess Alexandra Hospital NHS Trust

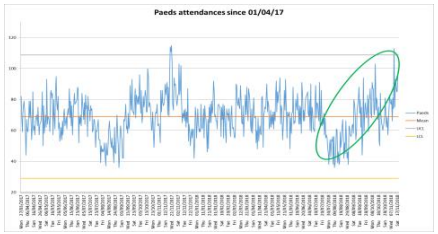
We saw a 2% increase in attendances compared to October 2017
We saw over 85% of attendees in under 4 hours for the first time since July 2015
Our CDU usage was the highest it has been since it opened
Our wait to be seen by a clinician was the shortest it has been for over two years.

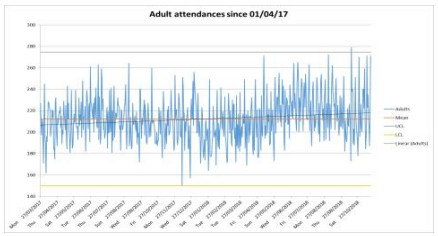
There was no real improvement on Ambulance delays >30 minutes and >60 minutes, however handovers within 15 minutes increased from 394 (September) to 447 (October).

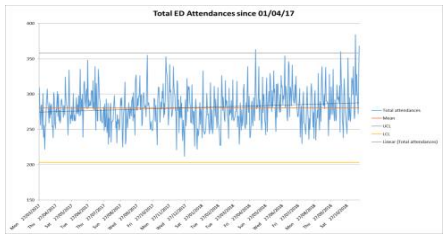


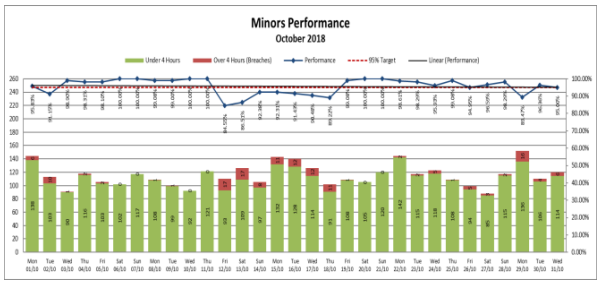


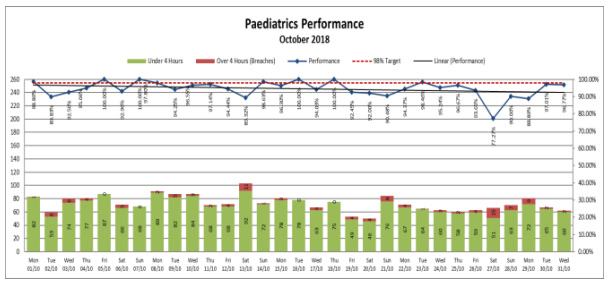


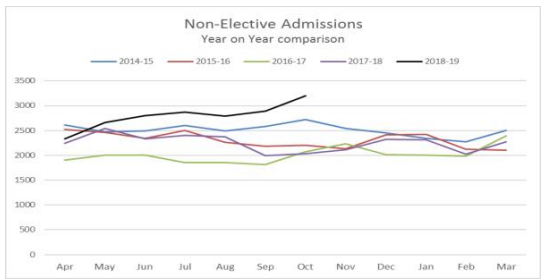












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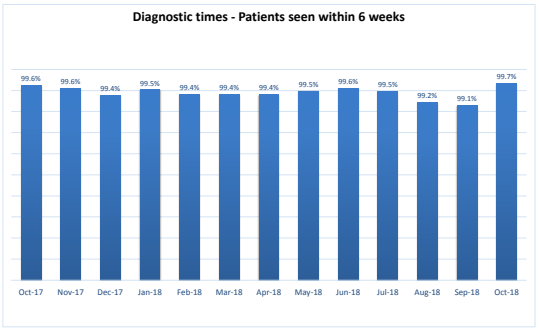
6.1

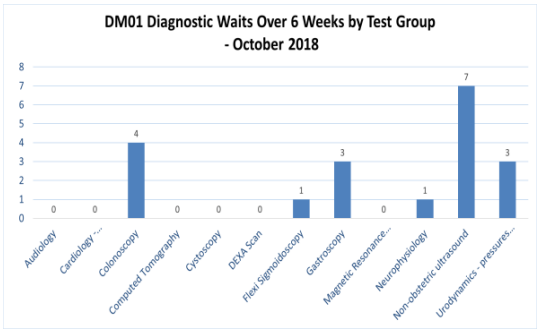
2 Our Performance Summary

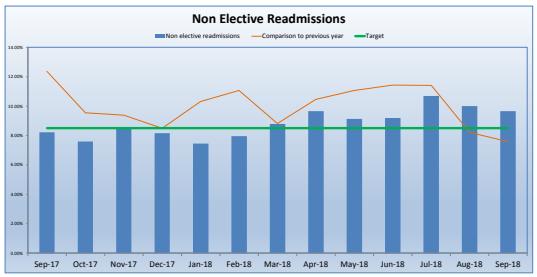
2.5 Responsive - Diagnostics, Readmissions

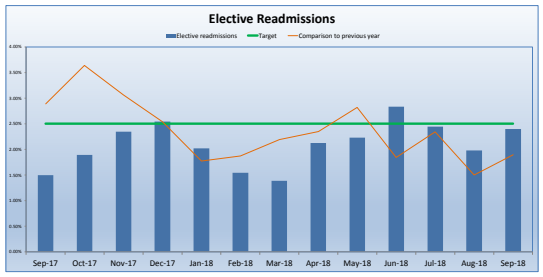
The Princess Alexandra Hospital NHS Trust

Diagnostics: Patients seen within 6 weeks: We have achieved this target every month for the last 3 and a half years with an average performance of 99.4% over the last 12 months. Nationally, the UK have not met this target for over 2 and a half years with an average performance of 97.2%. Below is the graph to show the month on month performance when compared to the national position. The October performance of 99.66% is the highest performance for 2 years.
Patients seen over 6 weeks: The number of 6 week breaches fluctuates by month but is predictable year on year with the number increasing in the three key periods of Easter, summer and Christmas. The threshold for breaches for PAH is dependent on activity but is circa 50 breaches per month tolerance. PAH average around 28 breaches per month so have an adequate buffer to allow for unexpected scanner breakdowns, etc.
Over 6 weeks by Test: The graph below shows the breakdown per test over the last 6 months. Yellow areas are where the performance is below the required 99%, but the total numbers performed are relatively low that it is accepted (both locally and nationally) that it is extremely difficult to achieve 99% in those specialties and the numbers of breaches are not a concern.









Test	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Magnetic Resonance Imaging (MRI)	99%	99.31%	99.82%	99.72%	100.00%	100.00%	100.00%	100.00%
Computed Tomography (CT)	99%	99.37%	99.22%	99.41%	100.00%	99.84%	99.84%	100.00%
Non-Obstetric Ultrasound (Non-Obs US)	99%	99.82%	99.81%	99.96%	99.96%	99.92%	99.92%	99.71%
DEXA	99%	97.06%	100.00%	100.00%	99.28%	100.00%	100.00%	100.00%
Audiology - Audiology Assessments	99%	99.16%	99.25%	98.70%	100.00%	100.00%	100.00%	100.00%
Cardiology - Echocardiography	99%	99.32%	99.85%	100.00%	98.48%	95.01%	98.30%	100.00%
Neurophysiology	99%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	93.55%
Urodynamics	99%	100.00%	95.65%	100.00%	88.89%	96.36%	94.47%	92.68%
Colonoscopy	99%	96.52%	97.66%	98.53%	94.97%	97.87%	89.16%	97.35%
Flexi Sigmoidoscopy	99%	97.37%	96.36%	100.00%	100.00%	95.12%	97.37%	96.97%
Cystoscopy	99%	77.78%	95.45%	66.67%	75.00%	100.00%	96.30%	100.00%
Gastroscopy	99%	91.75%	95.36%	96.40%	96.47%	94.87%	95.19%	97.41%
PAH PERFORMANCE	99%	99.40%	99.48%	99.60%	99.45%	99.22%	99.34%	99.66%
NATIONAL PERFORMANCE	99%	97.50%	97.30%	97.10%	97.20%	96.90%	97.30%	

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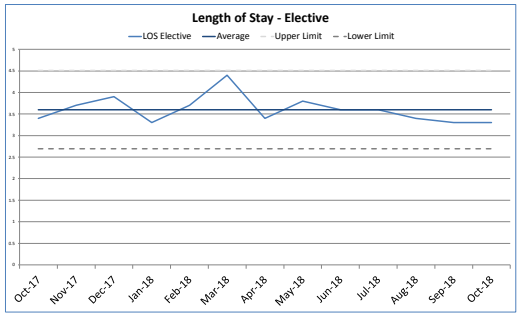
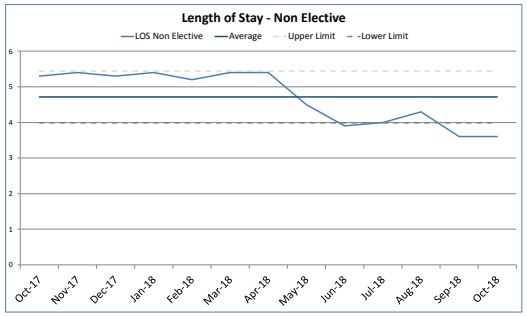
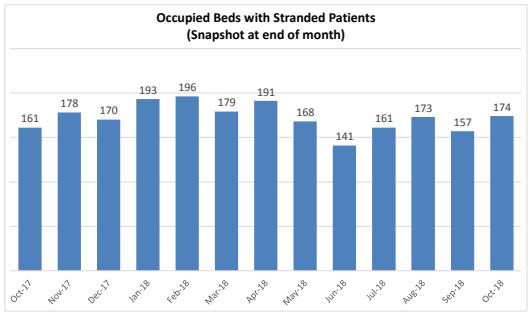
2 Our Performance Summary — 2.6 Bed Capacity & Management

The Princess Alexandra Hospital NHS Trust

LOS - Elective: The elective length of stay continues to be within the target of 4.15 days. There was a slight improvement in length of stay for T & O and General Surgery for October discharges which are the highest volume specialties.







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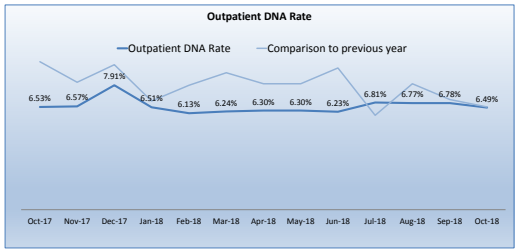
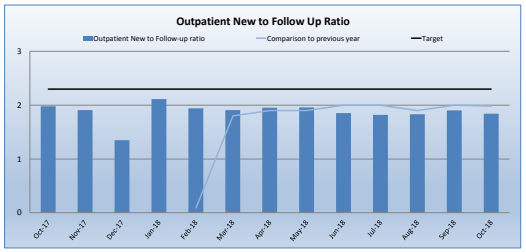
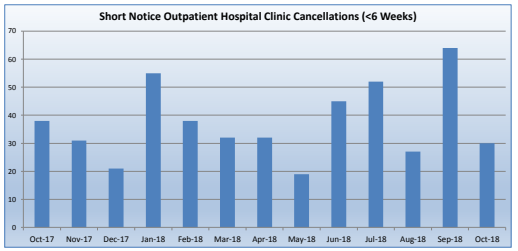
2 Our Performance Summary — 2.7 Outpatient Management

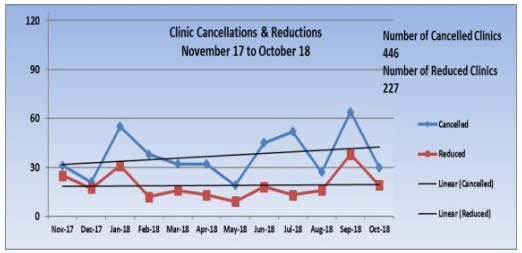
The Princess Alexandra Hospital NHS Trust

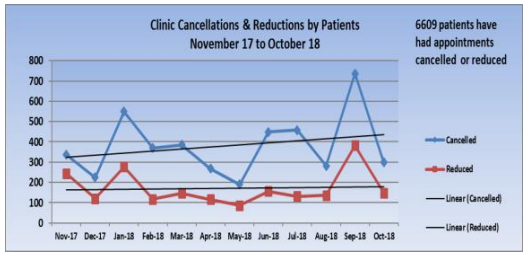
Outpatients: Outpatient DNA rates remain constant under 7% which is below the national average, however a review across all specialities with opportunity for further improvement is underway. The use of technology to support patient experience and performance within outpatients is underway. The launch of an Improvement Board for all Outpatient work will take place in December. **Short Notice Outpatient Hospital Clinic Cancellations:** The number of Outpatient Clinics cancelled at short notice for October has decreased since September, with numbers of patients affected significantly lower. Themes for cancellations and reductions continue to be mainly due to Sickness (29%), Locum unavailability (23%) and Rota/Staffing issues (21%) predominantly in the specialities of Urology, Gastroenterology and Ophthalmology. There is considerable focus in Urology and Ophthalmology to address longer term solutions to medical staff shortages including securing sufficient consultant locum cover to minimise patient cancellations. Operational teams are adhering to local short notice cancellation process to clinically prioritise available capacity to fast track, urgent and clinically vulnerable patients and this may create ongoing cancellations for patients who fall outside of this criteria. Careful weekly monitoring continues to be carried out with escalation to Access Board and then to the Executive Management board. All cancellations must be verified and authorised by a senior member of the HCG management team.











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Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

Actions taken in month to support improvement in performance for Our peope include:
• Individuals with the most outstanding numbers of statutory mandatory training or who have the longest duration of non-compliance will be asked to attend one to one meetings with the Director for People.
• Strengthening use of e-roster to block study leave if staff are not compliant with statutory mandatory training
• Providing additional support for staff to access and use e-learning modules
• Looking to reintroduce the single day for statutory mandatory training updates
• Developing pre-induction support for new starters
• Streamlining the approach to carrying forward training undertaken at other NHS organisations

Urgent Care training: The compliance for the nursing team members meets the Trust standard for all but one topic of statuary mandatory training with poor compliance for the medical staff. The practice development lead is taking over responsibility for the organisation of medical staff training, with 15 drop in sessions taking place from 5 October to 5 December to increase compliance. The team anticipate compliance by early next year.

Trust Registered Nurse (RN) vacancy rate does not achieving the trajectory planned:
The mitigating actions are:
• Registered Nurse recruitment remains an ongoing priority, with rolling adverts for RN band 5 and HCA
• Bespoke recruitment for specific clinical areas and in month focus for Medicine with the highest number of vacancies.
• International Recruitment continues with weekly Skype interviews for candidates to keep pipeline going.
• Scoping international recruitment to Philippines and India with our system partners in the New Year.
• The Trust is attending external events at local Schools, Colleges, Universities – not only to get our name as a Trust in the public but also plan for long term recruitment, as well as immediate. We have an upcoming Event at Harlow College with all the students to showcase what we have to offer, a local Jobs fair at the Leisure zone.
• The nursing retention plan continues and key measures are now embedded. We have increased the promotion of staff health and wellbeing through the use of our app to detail the employee assistance programme and are promoting staff benefits. This was promoted using the Trusts Event in a Tent
• Developing a plan for non-nursing clinical roles to include Nurse Associates, Physicians Assistants and FY3 doctors.
A Child's Trained Nurses in Recovery (PACU): The mitigating actions are:-
• Trust has ensured the recovery staff has the appropriate skills to care for children immediately after an anaesthetic; all qualified staff have completed Paediatric Life Support (PILs) which has a component of assessment and competency of airway management.
• The PACU staff have completed Safeguarding Children level 3 training.
• The Matron for PACU working with the Head of Nursing for Children's will develop competencies to ensure the PACU staff can correctly assess and interpret Paediatric Early Warning Score (PEWS) and can apply knowledge of a child's stage of development to the care they deliver in the recovery area. There will be a taught component to cover the physiological differences between children and adults.
• All paediatric nurses who are being orientated to the Trust will have part of their orientation in theatres so they can have training on airway management and will spend some time in recovery
• A surgical champion on Dolphin ward will be the first point of contact for the theatre team to help facilitate any care issues.

Agency Spend 5.55%
Bank Spend 12.43%

Staff In Post
3039
(WTE)

Training
88%

Vacancy Rate
12.4%

Sickness
3.8%

Turnover
14%

Medical 93%
Non-Medical 85%

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Workforce Measures as at 31st Octoober 2018	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3483.13	839.9	483.92	871.85	692.31	270.53	123.51	54.16	146.95
Vacancy Rate	8.0%	12.4%	3.7%	10.4%	22.9%	15.3%	7.8%	0.0%	6.7%	16.8%
Agency % of paybill	7.0%	5.5%	3.8%	3.9%	7.3%	9.4%	0.0%	0.1%	4.4%	3.3%
Bank Usage - Cost	n/a	£1,761,113	£82,377	£192,971	£925,995	£436,417	£47,306	£11,534	£7,190	£56,597
Agency Usage -Cost	£858,000	£782,605	£113,186	£77,110	£270,119	£296,930	£219	£1,010	£8,327	£17,726
Sickness Absence	3.5%	3.8%	2.7%	4.8%	4.2%	3.1%	7.5%	1.7%	4.6%	3.8%
Long Term Sickness	1.75%	1.9%	1.40%	1.8%	1.5%	1.3%	6.4%	0.8%	1.6%	1.8%
Short Term Sickness	1.75%	2.0%	1.3%	3.0%	2.7%	1.8%	1.2%	1.0%	3.0%	2.1%
Turnover (voluntary)	12%	14.0%	13.5%	14.2%	16.5%	13.5%	8.5%	13.1%	14.7%	17.6%
Stability	90%	87.9%	91.0%	90.1%	83.1%	87.8%	83.8%	86.9%	98.0%	91.0%
Statutory & Mandatory Training	90%	88%	94%	85%	84%	83%	91%	95%	99%	97%
Appraisal	90%	85%	91%	80%	88%	80%	81%	89%	88%	67%
FFT (care of treatment) Q2	70%	76%	tbc	tbc	tbc	tbc	tbc	tbc	n/a	n/a
FFT (place to work) Q2	61%	61%	tbc	tbc	tbc	tbc	tbc	tbc	n/a	n/a
Active Job Plans (first sign off)	90%	64%	55%	69%	63%	70%	n/a	n/a	n/a	n/a
Electronic Rosters (Medical staff)	100%	85%	39%	100%	100%	100%	n/a	n/a	n/a	n/a
Exception Reports (junior doctors)	3	18	0	1	8	9	n/a	n/a	n/a	n/a
Time to hire (Advert to formal offer made)	31Days								n/a	n/a

Above target	
Exceeding or below target	
underachieving target	

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3 Our People Summary

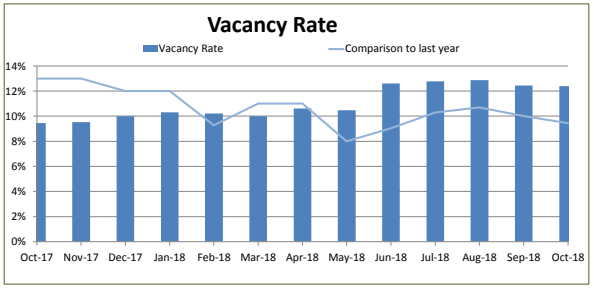
3.3 Well Led - Workforce Indicators (a)

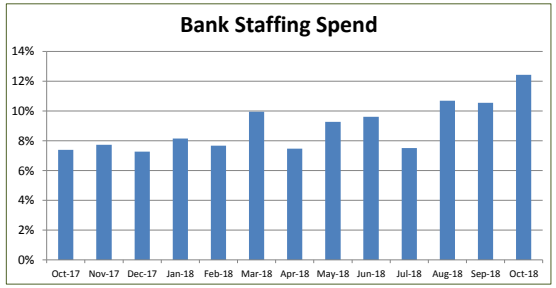
NHS
The Princess Alexandra Hospital
NHS Trust

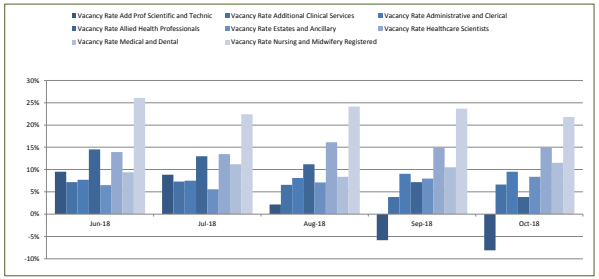
Agency Staffing Spend: Our % of agency has increased from the previous month and is still below the % threshold. Spend continues to be monitored with medical and AHP supply authorised and reviewed daily between CMO and Contingent Labour Manager. Nursing continues to be filtered through the agency pool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

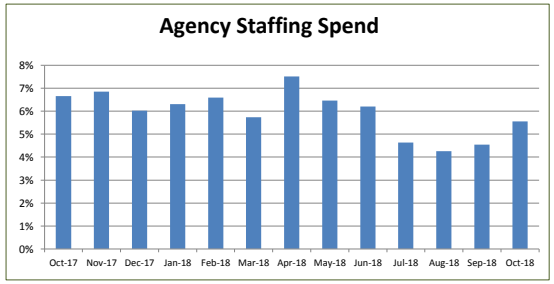
Bank Staffing Spend: Bank spend has increased from the previous month. Bank usage continues to be in line and monitored against the new NHSP contract. The ongoing effort is to increase bank fill rates and reduce agency spend. Nurses and doctors who are not on bank have been written to individually by the Trust, highlighting the benefits of working shifts via NHSP. It is hoped this will capture staff who have not worked shifts recently. Ward walks will also take place by NHSP to the areas with the biggest unfilled rates and work with the teams to try and increase these by agency migration. External bank recruitment is ongoing and qualified nursing fill has peaked at 41% (9% increase from April 2018) under the new contract.

Vacancy Rate: The Trust vacancy rate has reduced for the second successive month, down to 12.4% which is a reduction of 0.44% from the month prior.
The continued reduction has been mirrored with the nursing and midwifery staff group which has decreased from 27.6% in October down to 25.8% which is the lowest rate since June 2018. We expect maintain the reduction over the next few months as we welcome circa 36 new nurses over December and January; a mixture of pre-reg and registered nurses. Our recruitment campaign to the Philippines in on track for early December as we aim to make 80 WTE appointment, with further recruitment tours being reviewed for Jan/Feb 2019.









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3 Our People Summary

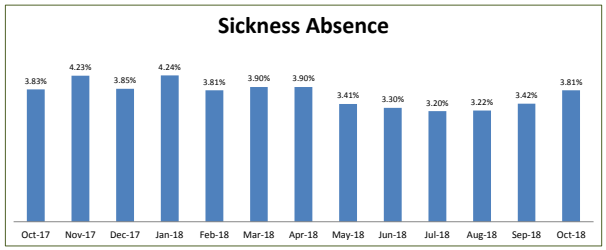
3.4 Well Led - Workforce Indicators (b)

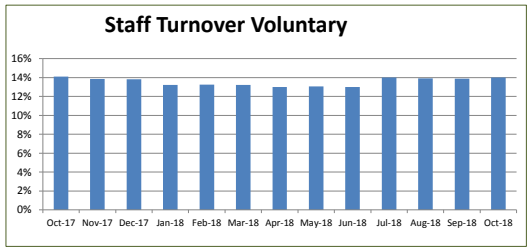
The Princess Alexandra Hospital NHS Trust

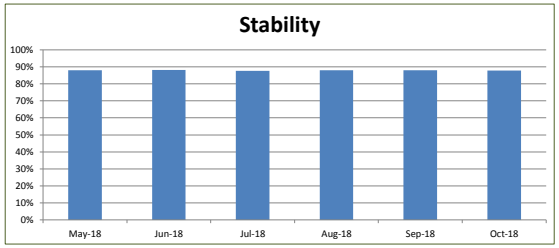
Sickness Absence: Action taken to reduce Sickness Absence:
- Continual promotion of EAP service.
- Encouragement for all staff to have flu jab by promoting myth busting and senior leadership buy in.
- Ongoing HR support for line managers and individuals.

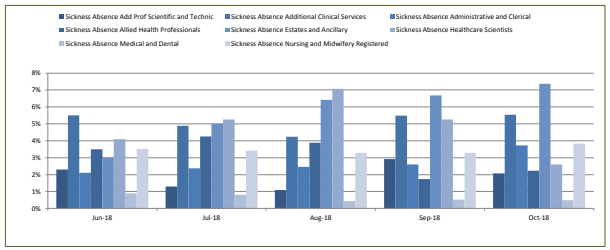
Staff Turnover Voluntary: Actions to reduce voluntary turnover:
- Introduction of values based recruitment – Hire the right person.
- Promotion of flexible working policy.
- Full integration of exit questionnaires will inform initiatives going forward.
- Key Focus on retention practice within the healthcare group and Services with higher than usual turnover.
- Review of our on boarding process with a three and six months check-in for new starters.

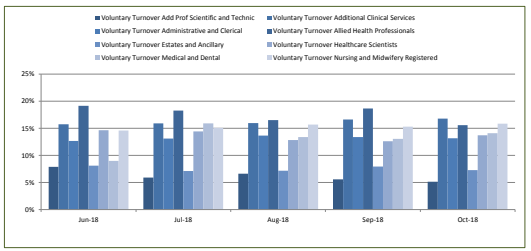
Stability: Overall Stability has remained stable indicating the Trust is retaining its experience workforce.











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3 Our People Summary — 3.5 Well Led - Workforce Indicators (c)

The Princess Alexandra Hospital NHS Trust

Appraisals - Non Medical: A positive move for appraisals this month – up 5% to 85%. Medicine & CCCS HCGs have made significant improvements.

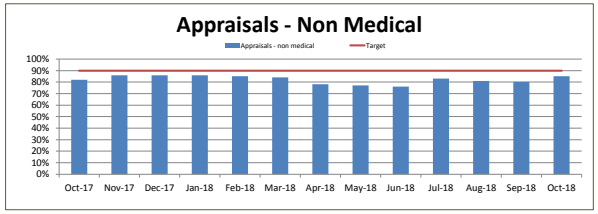
Managers will continue to receive their reports detailing future appraisal dates and those who are out of date. We have also highlighted those who will be falling out of date over the next quarter to allow for better planning. We will continue to support managers to improve use of ESR self service and support managers to engage with the Workforce team to make data corrections. Individuals who are more than 6 months out of date will be sent an individual email and the managers with the most number out of date and the longest out of date appraisals will meet with our Director of People to address their performance.

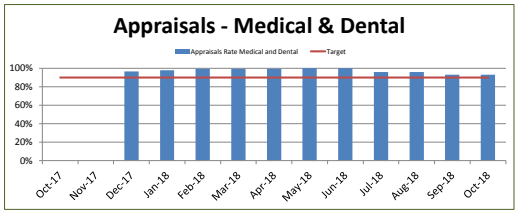
Although we saw a 5% improvement this month, that level of improvement is unusual and therefore it is unlikely we will achieve 90% next month without significant work from FAWs and Surgery. To achieve 90% we would need 116 of the outstanding appraisals to be completed as well as the 170 appraisals due in November.

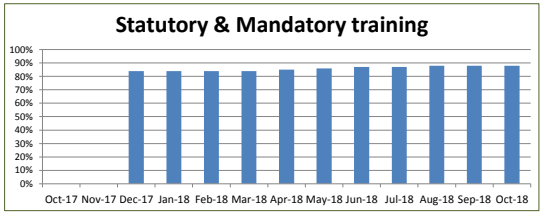
Statutory & /Mandatory Training:
Highlights for this month:
- Overall Trust core training compliance remained at 88% as in previous month.
- Compliance for Fire continues to be a concern with over 200 compliances expiring this month.
- Compliance for Information Governance has also increased slightly by 2%.
- Overall % compliance in Medicine saw one percent increase from the previous month with FAWS and Surgery remaining the same.
- Overall % compliance in Estates & Facilities have increased from 88% previous month to 91% this month.
- Overall % compliance in most of the staff group improved significantly but the Medical & Dental which remain same as the previous month.
- In all areas there has been a significant drop in compliance between 10 – 21% for Information Governance.

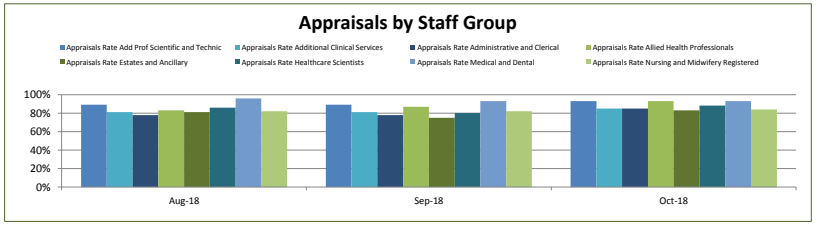
In the months of July – November there will be sharp drop in compliance in Fire, Infection Prevention & Control L2, Safeguarding Children Level 3, Adult Basic Life Support Level 2 and Introduction to Information Governance. These topics are yearly renewals and are, as a result of the additional classes held last year including the introduction of the Core Training booklet prior to the CQC inspections in 2017.

Actions taken
- We recognise that to move through this compliance trajectory in the time available is challenging for the whole organisation. As such it continues to be a major organisational focus over the past and coming months.
- In preparation for the dip in compliance, we have auto enrolled all staff that are non-compliant with Level 2 Training in Safeguarding Adults, Safeguarding Children and Infection Prevention & Control and sent out communication by individual email to staff requesting that only need to simply log on and complete the outstanding training.
- We have reviewed the workbook for Information Governance Training and updated a Fire Training information Sheet for all non-clinical staff. This information has been sent via email to all staff whose compliance have either expired or expiring soon and followed up weekly.
- This month we have over 200 Fire competency expiring and have sent reminder email to all clinical staff, to remind them that they can now update their competency by simply reading the Fire information sheet or via eLearning including scheduled weekly classes. Clinical staff can only update their learning via the leaflet or eLearning if they have completed Fire training in the previous year (2017 only) in a face to face session.
- All staff completing training via the booklet or the information sheets are required to complete and sign a Compliance Declaration From for updating ESR.
- Whilst the responsibility to ensure that staff participate in training falls to all staff, their managers and Executive Directors, the Training team have a responsibility to ensure the provision of adequate training sessions and flexible delivery options including improved monitoring and reporting and have continued to provide these. However, enrolment and attendance at these sessions in general continues to be a concern. This month we had 262 staff that enrolled onto a class but did not attend on the day.









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Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

Award and Recognition - The following members of our Estates and Facilities team are recognised for their significant contribution to the Trust and awarded with Long Service Award - Maureen Cast, Wendy Hill, Sarah Burgess, Sue Brett, Joan Jones, Sue Vanbeck.

Capital Projects – Infrastructural works on the new 27 bed in-patient facility (Charnley Ward) is progressing as planned for a completion on 20th December 2018. The Estates and Facilitates team are fully prepared to mobilise this newly built facility, ready for occupation in the New Year on 2nd January 2019. Contract to remedy essential works on Air Handling Unit/ Basement-Fire-stopping, Chillers replacement and Antenatal MAFU is awarded this month with plans for completion in Jan 2018. Capital committee is progressing with allocating funds for the essential maintenance works, due to begin shortly on the Lister ward. Tender on the Corporate Training Facility is released to market and closing on 14th December 2018. Williams Day tender is now closed with plans to mobilise services in March 2019. Installation on new generator is expected to be completed by March 2019. Tender on Fracture Clinic is expected to release this month with plans to fully mobilise by March 2019.

Catering Consultation – Consultation has now concluded and the outcome letters will be released to staff on Monday, 19th November 2018. The recruitment process has already begun and the date to go live will be confirmed as soon as we are able to fully resource, enabling staff to go on set internal rotation, which is designed around business needs. The implementation will ensure new ways of working (e.g., sustainable, cost-effective and productive services aligning to Model Hospital efficiencies).

Portering Consultation – We have begun consultation with Estates and Facilities porter's team on 14th November 2018, at present we are reviewing terms with individual staff on a case by case basis, and will confirm an outcome on 21-12-2018. It is expected that the confirmed proposal will go live from 1st February 2019, ensuring that resources are effectively aligned and based on patients and business needs.

Bed Management Contract – This tender combines range of pressure area care products and services and is developed to provide significant support to clinical & technical teams enabling RFID (live equipment tracking), access to specialist products (e.g., kinetic rotational therapy surfaces), Hybrid mattresses and dedicated tissue viability support together with standard beds and patient-bedside furniture. Besides being substantial on added value services, the tender will help minimise costs and increase standards for patients' quality of care. Response for tender closed on Friday, 16th November, clinical teams will begin assessment in line with timeframe for a call-off in Jan 2019.

Soft FM & Total Waste Management Contract – Aligning to Model Hospital efficiencies, range of Soft FM services including total waste management are being put together as a robust specification, which fits well with London Procurement Partnership Framework for fully managed service for soft facilities management services. The completed proposal is with East of England Procurement Hub to support with release over the next 3-4 weeks and supports full recovery on VAT costs. In line with confirmed timelines, the award is scheduled for a call-off, latest by mid-March 2019. Besides being cost-effective, the proposal will also bring innovations to help minimise costs, embrace sustainability and will help to progress technological breakthrough within the service provision.

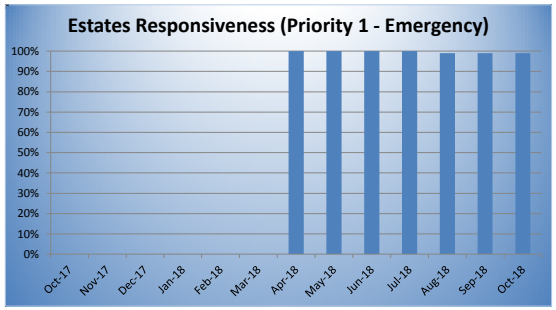
4 Our Places Summary — 4.1 Cleanliness

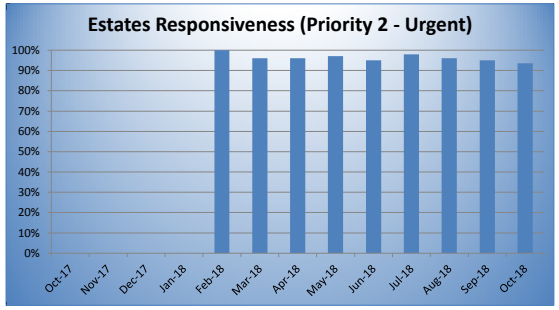
NHS
The Princess Alexandra Hospital
NHS Trust

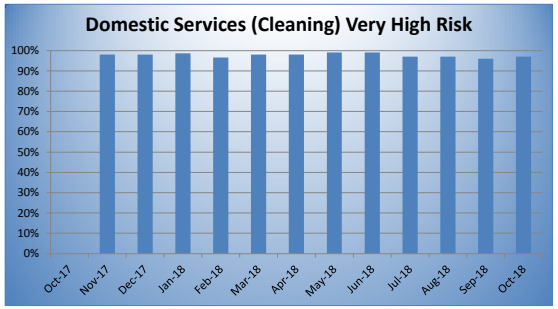
Estates Responsiveness (Priority 2 - Urgent): Reduction in rate is due to unusual delays with receiving parts, increasing lead time on job closures.

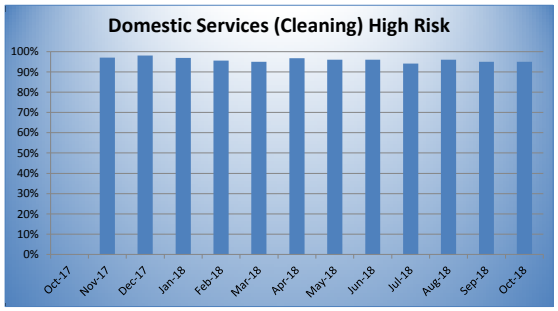
Domestic Services (Cleaning) Very High Risk: We are in process to implement PAS 5748:2014 (revised standard that will exist alongside National Standards of Cleanliness) to provide additional means of demonstrating compliance. As the implementation is time intensive, in the interim we have enabled increased scrutiny resulting in lower scores across very high risk areas.

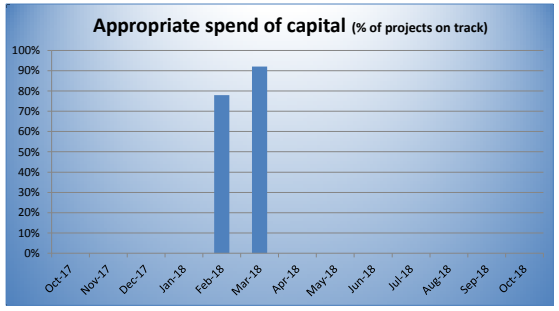
PLACE: Scores are awarded annually based on patient-led assessment of the care environment and benchmarked against national average for each domain separately.

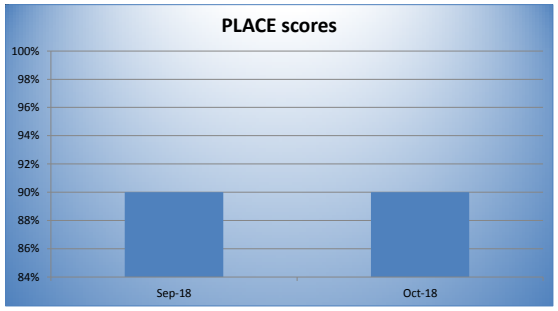












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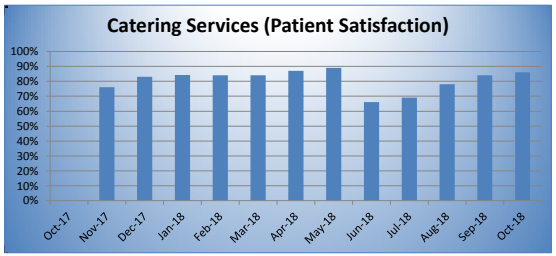
4 Our Places Summary — 4.2 Catering

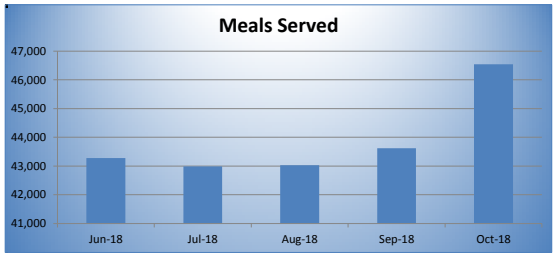
NHS The Princess Alexandra Hospital NHS Trust

Catering Services (Patient Satisfaction): Scores represents a small sample size, and we are working to improve our internal processes to capture wider response and accuracy.

Meals Served: There are some anomalies identified with our internal process to capture this data accurately, where we have made some improvements resulting in large variance as compared to previous reports.

Catering Food Waste: For the month of Oct, we have reported 3299 surplus meals to actual bed capacity (7.62% more), in response to increased demand. Previously, we reported surplus meals in place of wastage and this is now rectified. The figures now reported represent 'Whole Plate Waste' against meals supplied outside the protected meal times and gets recorded through our tills.





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Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

In month deficit (excluding PSF) £0.1m ahead of plan with increased activity/income compared to financial plan. YTD deficit £17.3m, £0.3m ahead of plan. The Trust has performed a comprehensive mid year review including financial forecasts signed off by all HCGs and Corporate Directorates. In order to finalise the Forecast Outturn (FOT) position the Trust is triangulating its income expectations with Commissioners. On conclusion of this exercise the Trust will finalise its position and any proposal to submit a re-forecast outturn to NHSI. The Trust continues to seek to deliver a deficit position better than its control target.

Key risks to delivery of financial plan:

a) Potential impact of Commissioner QIPP/FOT.
b) Temporary staff costs. The Trust is currently delivering the agency target and must sustain delivery through the winter period.
c) Potential under-performance against CQUIN and increase in the level of financial deductions.
d) Delivery of ED Trajectories to secure PSF funding.
e) Potential pressure associated with winter including temporary ward facilities and/or any impact of a required downturn in elective activity to support emergency capacity.
f) Impact of pay settlement.
g) Pricing Challanges associated with Assessment space.

Other key matters include:

- Final conclusion of Maternity Pathway disputes with other NHS providers.
- Full and recurrent delivery of cost improvement programmes with continued focus on cost control and continuous improvement.

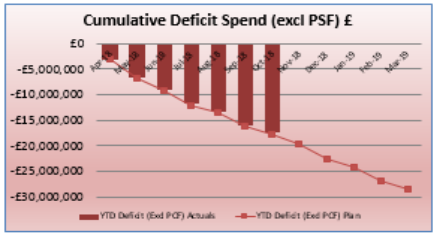
Capital and cash positions remain subject to close scrutiny to ensure resources are maximised and liquidity maintained and managed appropriately.

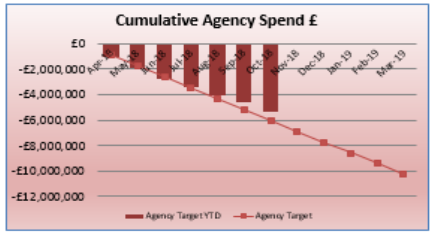
£ Our Pounds Summary — 5.1 Overall financial position

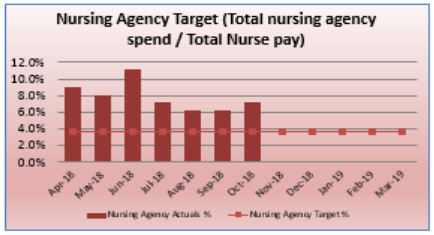
NHS The Princess Alexandra Hospital NHS Trust

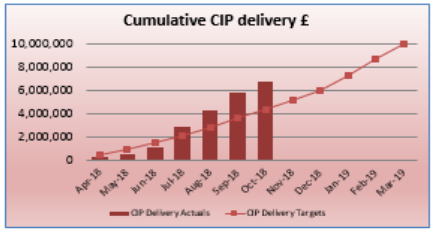
OUR POUNDS

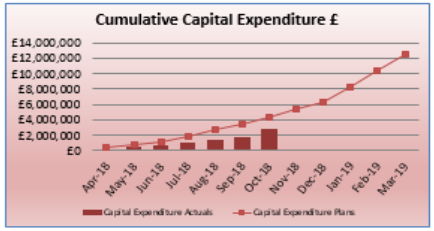
Metric	Annual Plan (Standard)	Previous Month	Latest Month
YTD Deficit (Excl. PSF)	-£28,471,000	-£16,008,035	-£17,464,785
Cumulative Agency Spend £s	£10,300,000	£4,600,482	£5,386,087
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3%	6%	7%
Cumulative Capital Expenditure	£12,834,000	£1,718,600	£2,768,800
BPPC Volume	95%	60%	59%
BPPC - £s	95%	73%	72%
Cash Balance	£1,000,000	£2,687,000	£703,000

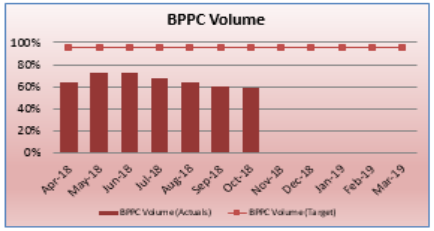


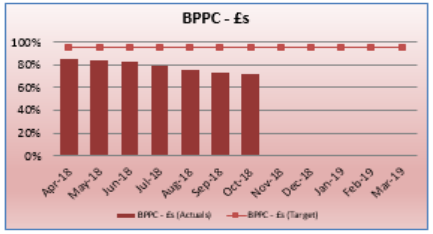


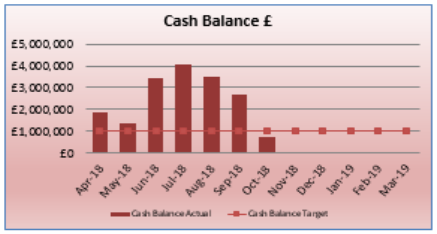












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CQUIN

CQUIN schemes 2017-2019

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

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

The national CQUIN schemes are:

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

Monitoring arrangements:

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

Reporting process:

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

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

Your future | Our hospital

The Princess Alexandra Hospital NHS Trust

Trust Board - 06.12.18

Agenda Item:	7.1
Presented by:	Director of Strategy
Prepared by:	Director of Strategy
Date prepared:	28 November 2018
Subject / Title:	Our New Hospital Update

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]	Project Genesis is still on track to enable a decision on a preferred site option in March 2019. Fortnightly delivery meetings have been scheduled with the CCG's to track the progress of the Pre-consultation Business Case (PCBC) and a Clinical Senate has been held to stress test the in-hospital model of care. The key risks to the programme are the development of the detailed clinical models (in and out of hospital) to ensure the demand management assumptions can be delivered and the assumptions developed through the health planning and design phase of work become out of sync with those of the Medium Term Financial Plan (MTFP) for the STP. These risks are being managed through the programme.
Recommendation:	This report aims to update the Performance and Finance Committee on the progress of Project Genesis.

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:	Performance and Finance Committee
Risk / links with the BAF:	This programme mainly pertains to BAF 3.3: Estates & Infrastructure - Concerns about potential failure of the Trust's estate & infrastructure and consequences for service delivery
Legislation, regulatory, equality, diversity and dignity implications:	All stages of the business case for Our New Hospital need to be approved by NHS Improvement and DH
Appendices:	

The Princess Alexandra Hospital NHS
NHS Trust

Our New Hospital Update
Trust Board 6 December 2018

1. PURPOSE

This paper is to update the Committee on the progress of Our New Hospital programme (Project Genesis).

2. UPDATE

Programme of work

Work continues at pace. The key deliverables are the on-site/off-site decision to be made at March Board and the development of the PCBC and SOC refresh. Key dates and deliverables are outlined in the table below:

Deliverable	Target date	Progress	Risk
Patient Panel	14-10-2018	Completed	
Clinical Senate	27-10-2018	Complete	
Alignment of tactical capital investment and strategic capital investment	29-10-2018	Site phasing and sale options in development. Six facet survey commissioned and near completion	• Six facet survey not complete • Phase plan not complete
HOSC update	5-12-2018	On track	
Public engagement	Dec 18 to Feb 19	Planning underway	• Plan not in place • Engagement before site known my cause public concern
Construction costing and comparator. Including outline HOT and funding structure	31-01-2019	Wilmot Dixon engaged with team of 10 to develop costing model. Early site review complete. Meetings with health planners and master planners scheduled.	• Reliant on the output of health planners • Funding models and asset classes not confirmed • Partnership model not agreed • Financial advisors not appointed
Site planning complete	8-02-2019	Health planners on site workshops underway. Mater planners first 'fit-to-site' complete	• Short notice has delayed workshops and clinical engagement
HOSC on preferred site	03-03-2019		
SOC and PCBC drafting	Jan 18 to April 19	Skeleton documents and gap analysis complete	• Limited writing resource available
Trust Board site decision	7-03-2019		
Trust board SOC/PCBC approval	2-05-2019		
NHSE Assurance panel	06-05-2019		
PCBC/SOC Submission	27-05-2019		

7.1

3. Summary

Good progress has been made and the programme is still on track to deliver the on-site/off-site decision at March Board.

The Trust presented the in-hospital model of care to the Clinical Senate on 27th November 2018. The model was stress tested by a broad range of clinicians and commissioners from acute community and mental health services. The model was well received and written feedback from the Senate is due in December 2018.

The key risks to the programme are the development of the detailed clinical models (in and out of hospital) to ensure the demand management assumptions can be delivered. There is an additional risk that assumptions developed through the health planning and design phase of work become out of sync with those of the Medium Term Financial Plan (MTFP) for the STP (i.e. the granularity required to design and scope the hospital challenges the high level assumptions used for the STP MTFP)..

To manage these risks the following mitigations have been put in place:

- Agreed with all Directors of Finance that the MTFP will be the starting point for all activity based assumptions
- The Health Planners with fully document any changes to demand assumptions based on evidenced best practice from other systems
- SOC and PCBC assumptions to be agreed at STP Directors of Finance meeting
- NHSE/NHSI meeting in place to agree approach to activity and financial modelling
- Regular update meetings with NHSI and NHSE agreed

4. RECOMMENDATION

Trust Board is assured programme is on track and reasonable mitigating strategies are in place.

Author: Michael Meredith Director of Strategy
Date: 28/11/2018

The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD – 6TH DECEMBER 2018

Agenda Item:	8.1
Presented by:	Ogechi Emeadi, Director of People, OD and Communications
Prepared by:	Nathaniel Williams, Workforce Information & Systems Manager and Equality Workforce Lead
Sponsor:	Ogechi Emeadi, Director of People, OD and Communications
Subject / Title:	Equality and Inclusion Update

Purpose:	Approval		Decision		Information		Assurance	X

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	• Provide assurance to the Board that the Trust is meeting its legal requirements under the Equality Act 2010. • Report the progress made by the Trust on Equality and Inclusion (E&I) objectives as described in its Equality Delivery System 2 (EDS 2). • Summarise key action for the next year.
Recommendation:	The Trust Board is asked to: • Note and approve the contents of this report; • Endorse further progress on the Trust's Equality, Inclusion Action Plan; • Consider how best we can continue to demonstrate support and leadership for improving E&I related events.

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:	
Risk / links with the BAF:	BAF 2.1 Workforce capacity BAF 2.3 Internal engagement BAF 2.4 Workforce capability
Legislation, regulatory, equality, diversity and dignity implications:	Equality Act 2010 Public Sector Equality Duty CQC well led framework Equality Delivery System 2 Workforce Race Equality Standard
Appendices:	Appendix 1: Equality and Inclusion Charter

8.1

The Princess Alexandra Hospital NHS
NHS Trust

Equality and Inclusion Update

1.0 PURPOSE

Provide assurance to the Board that the Trust is meeting its legal requirements under the Equality Act 2010.
Report the progress made by the Trust on Equality and Inclusion (E&I) objectives as described in its Equality Delivery System 2 (EDS 2).
Summarise key action for the next year.

2.0 CONTEXT

2.1 The Trust has statutory obligations under the Equality Act 2010 protecting the equality, diversity and inclusion of its staff and patients. The public sector equality duty (PSED) is the requirement that public sector bodies have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and any other conduct that is prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

2.2 The Equality Act requires public sector bodies to publish relevant information to demonstrate their compliance with the PSED.

2.3 In January 2018 the Trust Board approved the ED 2 which highlights key actions to achieve its E&I objectives. The Workforce Race Equality Standard (WRES) action plan was approved in September 2018 by the Workforce Committee. Both are available on the Trust's website.

2.4 The Workforce Committee receives regular reports on the E&I action from EDS2, WRES, staff survey etc. However, it was agreed at the January 2018 Trust Board that a progress updates on the equality and inclusion should Diversity and Inclusion Action Plan would be seen at six-monthly intervals..

3.0 SUMMARY OF PROGRESS AGAINST THE EQUALITY AND INCLUSION ACTIONS

3.1 The Trust established an equality and inclusion steering group (EISG) in April 2017 which has met monthly.

3.2 The EISG works 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
- Co-ordination of a Black History Month celebration (2x)
- Contribution and publication to the Workforce Race Equality Standards (WRES) action plan
- Contribution and publication of the Gender Pay Gap Report – March 2018
- Production of an equality and Inclusion calendar – to make reference and observer were necessary religious and diversity events to represent our diverse workforce
- Contribution and support E&I action in relation to the staff survey
- Appointed equality & inclusion champions against for all nine protected characteristics
- Launch of the Lesbian, Gay Bisexual and Transgender, Queer or Questioning) plus (LGBTQ+) network
- Launch of the Black, Asian and Minority Ethnic (BAME) network

4.0 OUR COMMITMENT

4.1 Inclusion Charter
The Trust' Equality and Inclusion Charter highlights the Trust's commitment to E&I Appendix 1

4.2 EISG
The equality and inclusion group will continue to be an integral vehicle on our journey to improve even further and will report into our Workforce Committee, as a sub- committee of the Board, to ensure visibility and scrutiny of all interventions.

The Trust Intranet has a dedicated page for equality and inclusion to be updated with photos of our champions and equality and monitoring information

4.3 Partnerships and networking
Relationships have been built with other Trusts in order to share best practice and collaborate to solve complex problems relating to E&I. As part of this network building, the Trust is part of the East of England Leadership Academy's Inclusion Network.

There have also been efforts to learn from other Trust's in developing approaches to E&I work. Representatives from EISG have visited Essex Partnership University Trust (EPUT) to gain insight into how they operate their staff networks.

4.4 Training
Several of the E&I champions and other EISG members have completed ILM Level 4 Award Accredited Programme for Diversity and Inclusion Leads.

4.5 Freedom to Speak Up Lead Guardians (F2SUG)
F2GUGs who are members of EISG have a role in monitoring bullying and harassment within the Trust and developing strategies and interventions to address any issues identified.

5.0 ACTIONS FOR IMPROVEMENT AND OBJECTIVES 2019/20

5.1 An annual update report will be presented to Workforce committee in January 2019 to focus on our equality and inclusion objectives around of 5Ps for 2019/20 Items will include:

- Reverse Mentoring on E&I for executive directors
- Implementation of the Workforce Disability Equality Standards (WDES) including joining the Disability Confident Scheme to achieve 'Disability Confident Employer' status.
- Staff Networks – to develop a disability network and women's network.
- Unconscious Bias Training especially to support recruitment and selection
- Gender Pay Gap Reporting March 2019
- A refreshed Equality and Delivery System (EDS2)
- Consideration as to how to increase the diversity of the Trust Board

6.0 CONCLUSION

6.1 We are proud of the achievements we have made so far and are looking forward to building on these in 2019/20. 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 we are confident that the Trust will continue to be able to demonstrate its commitment to learning and therefore be an employer of choice.

7.0 RECOMMENDATION

7.1 The Trust Board is asked to:

7.1.1 Note and approve the contents of this report;

7.1.2 Endorse further progress on the Trust's Equality, Inclusion Action Plan;

7.1.3 Consider how best we can continue to demonstrate support and leadership for improving E&I related events.

Author: **Nathaniel Williams, Workforce information and systems manager and Workforce equality lead**

Date: **28th November 2018**

The Princess Alexandra Hospital NHS
NHS Trust

APPENDIX 1

The Princess Alexandra Hospital NHS Trust

EQUALITY AND INCLUSION CHARTER

Promoting equality, diversity and encouraging inclusion

respectful | caring | responsible | committed

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Our commitment

At Princess Alexandra Hospital NHS Trust we understand that equality means the equal treatment of everyone regardless of race, religion, gender, age, disability, ethnicity or sexual orientation. Diversity is key to successful and healthy communities and we will always promote the values of equality, diversity and inclusion in all aspects of the organisation in line with the Equality Act 2010.

To achieve this, we recognise that we must use our resources and act in a way which enables the inclusion of people from different backgrounds with an emphasis on co-operative working and mutual respect across the organisation regardless of whether they are staff, volunteers, patients or visitors.

Our people are empowered to challenge inappropriate behaviour and will be treated with dignity and respect, while being expected to provide the same treatment to others. This charter is our commitment which will support us to deliver our outstanding care to our community and provide an inclusive working environment.

Our aims

- Provide a supportive and nurturing environment within the organisation, where it is safe to explore negative behaviours and enable the positive development of all of our people.
- Ensure our services will be accessible to more people, with consistent quality that meets the needs of all staff, volunteers, patients, and visitors.
- Ensure that all staff, volunteers, patients, and visitors will have access to the information they need to make the most of the services provided within the Trust.
- Improve the accessibility of our infrastructure to enable everyone to access the Trust (physically, emotionally, developmentally, and virtually).
- Ensure that our services promote and improve the health and wellbeing of staff, volunteers, patients, and visitors
- Achieve a workforce which is reflective and representative of the diversity of our community.
- Ensure all future and current staff and volunteers are supported to make the most of their skills and talents
- Create a more inclusive culture where all staff, volunteers, patients and visitors feel engaged
- Encourage our partner organisations and suppliers to acknowledge and support our commitment to diversity as a core value
- Engage with more of our diverse communities to effectively inform, develop and deliver our strategies, services and initiatives.
- Engage with our senior leaders to ensure that equality and inclusion is a central trait of the organisation
- Champion the concept of zero tolerance to the fear of violence, abuse, harassment and intolerance.
- Champion and enable all of our staff, volunteers, patients, and visitors to have the freedom to speak up.

If you have any questions, comments or want to raise any concerns related to equality, diversity and inclusion you can contact equalityandinclusion@pah.nhs.uk

The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD – 6TH DECEMBER 2018

Agenda Item:	9.1
Presented by:	Ogechi Emeadi, Director of People, OD and Communications
Prepared by:	Ogechi Emeadi, Director of People, OD and Communications
Sponsor:	Lance McCarthy, Chief Executive Officer and Andy Morris, Medical Director
Subject / Title:	University Status

Purpose:	Approval	X	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	In recognition of the Trust's status and commitment to medical education; as well as its continued commitment to the education and development of nursing, midwifery and other professional groups, the Trust is seeking to become a university hospital.
Recommendation:	To approve the Trust in seeking to gain university status

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

Previously considered by:	N/A
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	CQC Well led
Appendices:	

9.1

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The Princess Alexandra Hospital NHS
NHS Trust

UNIVERSITY STATUS

1.0 PURPOSE

1.1 In recognition of the Trust's status and commitment to medical education; as well as its continued commitment to the education and development of nursing, midwifery and other professional groups, the Trust is seeking to become a university hospital.

2.0 CONTEXT

2.1 The title of 'university hospital', also known as a teaching hospital, is bestowed by the Department of Health. The criteria for receiving this title requires significant interests in teaching and/or research and, strong links with a university.

3.0 PROCESS

3.1 Ultimately, it is the Department of Health and Social Care who will approve the Trust's change of title. This process is managed by the NHS Identity Management Team part of NHS England. Details of the process is provided in the link below.

https://www.england.nhs.uk/nhsidentity/identity-guidelines/naming-principles/

3.2 The steps to take before that are:

- Letter of support from the sponsoring university - This is normally from the dean of school or vice chancellor. The Trust has had an initial discussion with Queen Mary University London (QMUL)
- Consultation with NHS Improvement delivery and improvement director and NHS England regional director

4.0 OTHER CONSIDERATIONS

4.1 Once approved the Trust will need to appoint an associate non-executive director from the appropriate university.

4.2 Whilst it is the NHS Identity team who will advise the Trust on its new name, it is envisaged that the Trust will change its name to The Princess Alexandra University Hospital NHS Trust.

5.0 RESOURCES REQUIRED

5.1 Legal advice may be required but this is expected to be minimal. Other trusts have sought advice on whether formal consultation is required.

5.2 There will be no cost to make name changes to online publications. Changes to physical signs other than the main entrances will occur when practical and over time eg name badges with the new logo will be issued to new starters.

6.0 NEXT STEPS AND TIMELINE

6.1 If approved by the Trust Board, the Trust will provide further details including timelines having formally consulted with the NHS Identity team including appropriate engagement events for its people and patients.

7.0 RECOMMENDATION

7.1 The Board is asked to approve the Trust's proposal to seek university status.

Author: **Ogechi Emeadi, DPODC**
Date: **28th November 2018**

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Trust Board - 6 December 2018

Agenda Item:	
Presented by:	Head of Corporate Affairs - Heather Schultz
Prepared by:	Head of Corporate Affairs - Heather Schultz
Date prepared:	7 November 2018
Subject / Title:	Well Led Framework - Self Assessment 2018

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]	It is recommended that Trusts undertake annual self-assessments against the Well Led Framework published by CQC in June, 2017. The Board discussed the Trust's self-assessment against the framework at its Development Session on 1.11.18. The outcomes of the Trust's self-assessment for 2018 are summarised in the attached paper.
Recommendation:	The outcomes of the self-assessment are presented for formal approval by the Board.

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

Previously considered by:	EMT meetings, Trust Board II 4.10.18 and Board Development Session 1.11.18.
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with CQC requirements, national legislation and regulations.
Appendices:	Well Led Framework Self Assessment 2018

9.2

respectful | caring | responsible | committed

Well Led Framework-Self Assessment 2018

1.0 Purpose

It is recommended that Trusts undertake annual self-assessments against the Well Led Framework published by CQC in June, 2017.

The Trust's self-assessment for 2018 was discussed at the Board Development session on 1 November 2018.

The outcome of that assessment is presented to the Board for formal approval.

2.0 Background

The Well Led Framework is structured around eight key lines of enquiry (KLOEs):

3.0 Outcome

The Trust Board reviewed all 47 of the detailed questions underpinning the eight key lines of enquiry in the well-led framework.

A summary of the ratings is detailed below and an overall rating of 'Good' has been assigned; this aligns with the CQC assessment of the Trust when last inspected in December 2017.

Below is the summary of well-led at KLOE level:

CQC KLOE	Exec team self-assessment	CQC KLOE	Exec team self-assessment
W1 – Leadership capacity and capability	GOOD	W5 – Clear and effective risk management	GOOD
W2 – Vision and strategy	GOOD	W6 – Appropriate and accurate information	GOOD

W3 – Culture of high quality care	REQUIRES IMPROVEMENT	W7 – User engagement	GOOD
W4 – Clear responsibilities	REQUIRES IMPROVEMENT	W8 – Robust systems for learning	REQUIRES IMPROVEMENT GOOD

4.0 Next steps

The following actions have been agreed and progress will be monitored by the Executive team and reported to Trust Board as indicated below:

ACTION	LEAD	TIME
1. Complete data and evidence collection to underpin the scores	Head of Corporate Affairs	End of December
2. Undertake the same KLOE evaluation process on a regular basis for the other 4 CQC domains with the Executive team.	Head of Corporate Affairs	Rolling from November
3. Action plan for all well-led questions with 'RI' answers (to get to good or outstanding)	Relevant Exec	End of November
4. Action plan for all well-led questions with 'Good' answers (to get to outstanding)	Relevant Exec	Mid-January
5. Action plan for all the other domains	Relevant Exec	End of February
6. Regular progress review at Trust Board	Chief Executive/Head of Corporate Affairs	February onwards

5.0 Recommendation

The Trust Board is asked to formally approve the Trust's self-assessment.

Authors:

Lance McCarthy, Chief Executive

Heather Schultz, Head of Corporate Affairs

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 6 December 2018 **AGENDA ITEM NO: 9.3**

REPORT TO THE BOARD FROM: Quality & Safety Committee

REPORT FROM: John Hogan

DATE OF COMMITTEE MEETING: 23 November 2018

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

Items for escalation to the Board:

- **Mortality:** There was no formal written report this month due to data issues between the Trust and Dr. Foster however early signs are that HSMR has increased again. A Mortality Reduction & Improvement Plan has now been drawn up and a Mortality Improvement Board will be established with its inaugural meeting to take place on 04.12.18 and a second two weeks subsequently. The Committee fully supported the Improvement Plan.
- **Urology Performance:** The organisation's Cancer target is at risk again for October due to delays in Urology but the Committee was reassured that the Cancer Services Team are working hard to review and support pathways. A new consultant will join the Trust in December and two long-term locums have been secured. Discussions continue with UCL and Addenbrooke's in relation to Paediatric Urology. There have been no patient cancellations to date.
- **Patient Experience Report:** There had been five new complaints relating to Fleming Ward in October. An update/analysis would be provided to the next meeting.
- **NICE Guidelines and Status** – The update showed that Trust compliance against NICE guidance shows 202 (36%) implemented fully/fully partially, 32 (6%) partially implemented, 63 (11%) under review and 12 (2%) not assessed & not implemented with 249 (45%) not applicable. The Committee noted the improvement in the compliance trajectory but requested an update the following month when it hopes to see an improvement.
- **Virtual Dementia Tour (reported via PSQ Group)**: This has been operational for three years at the Trust. The Service Evaluation has been reviewed by the Faculty of Health's Ethics Committee at the University of Essex at PAH who have reported that the Trust has an established VDT training programme with over 500 NHS staff completing the VDT training.
- **C-section:** A revised report was requested by the Committee to include additional elements pertaining to national practice/thresholds and data around avoidable/non-avoidable events.
- **Pressure Ulcers:** There has been an increase in October of hospital acquired PUs (equating to 1.49 per 1000 bed days) and the Committee requested an update for December's meeting.
- **CQC Preparation:** 19 (57%) of the 'must and shoulds' are not achieving the monthly planned trajectory. The Committee will await the next update in December.
- **NurseStaffing:** The overall fill rate (RN/M and HCA) for the ward areas has been 85.1% in September and 87.4% in October. There have been no significant change to the overall RN/M workforce numbers (net gain of 1.84 WTE). For November, December 2018 and January 2019 there are 23 RN, 17 Pre-registration and 18 HCA confirmed or predicted starters. The vacancy position for RNs remains challenging at 25.86%. (40.04% for adult wards).

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

Attached for Information:

- Infection Control Annual Report
- Safeguarding Children & Adults Annual Report

Other items discussed:

- NHSI Observation Feedback from the Committee's meeting on 26.10.18.
- Integrated Performance Report
- Healthcare Group Performance Report – Surgery
- Update from Patient Panel
- Learning Disability Update
- Infection Control Monthly Report
- Review of BAF Risks allocated to the Committee
- Annual Report from Clinical Ethics Committee
- Monthly Quality, Safety & Effectiveness Report

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

The Committee is making good progress against its work plan.

The Princess Alexandra Hospital NHS
NHS Trust

Safeguarding Adults/Children Annual Report 2017/18

9.3

Sarah Cowley – Lead Nurse Safeguarding Adults
Nicole Anderson – Named Nurse Safeguarding Children
Caroline Loake – Senior Safeguarding Children Nurse

The Princess Alexandra Hospital NHS
NHS Trust

ANNUAL REPORT SAFEGUARDING ADULTS AND CHILDREN
April 2017 – March 2018

1. Introduction

1.1 This is the 4th Princess Alexandra Hospital NHS Trust's joint Safeguarding Adult/Children and Young People (Adult/CYP) Annual Report. It sets out the Trust's compliance with its legal duties for safeguarding children and adults and the work plan for the coming year 2017/18.

1.2 The purpose of this paper is to present to the Trust Board an annual report for safeguarding Adults/CYP in the period April 2017 – March 2018. The paper outlines our key joint achievements and challenges within the service with an overview of training for both specialties. The paper reports adult and child safeguarding progress and performance respectively.

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

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

1.5 Trust policies and procedures all adhere to the 'Working Together to Safeguard Children' (2015) document which is the pivotal national guidance for quality and standards for safeguarding CYP and the work plan reflects the Essex Safeguarding Children Board's (ESCB) business plan.

2.0 Trust Safeguarding Leads

Name	Role
Professor Nancy Fontaine	Chief Nurse and Executive for Safeguarding Children/Adults
Dr Than Soe	Consultant Paediatrician and Named Dr – Safeguarding Children
Mrs Sarah Cowley	Safeguarding Adult Lead
Mrs Nicole Anderson	Named Nurse – Safeguarding Children/Young People
Mrs Christine Curtis	Named Midwife for Safeguarding

2.1 The Deputy Chief Executive/Chief Nurse is the Executive Lead for safeguarding Adults/CYP.

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

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

3.0 Summary of Compliance

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

3.2 Safeguarding children services seek to promote the welfare of children and prevents them from harm. Children and Young People (CYP) are defined as children from 0-17 years up to their 18th birthday.

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

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

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

3.5 In March 2015, the new 'Working Together to Safeguard Children' guidance was published. This document provides pivotal statutory guidance for all professionals working with CYP and their parents/carers. The new 'Working Together' is expected at any time and will be reflected in all services offered to Children/Young people when published in 2018.

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

4.0 Risk and Quality Assurance

4.1 The Deputy Chief Executive/Chief Nurse is responsible for safeguarding. She presents the Annual CYP Protection Report to the Trust Board and chairs the Trust Joint Safeguarding Steering Group.

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

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

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

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

5.0 Risk Register

5.1 There were four risks relating to safeguarding Adults/CYP on the risk register for 2017/18

- Percentage levels of safeguarding CYP training compliance – the Trust has not consistently met the compliance levels (90%) set by the CCG
- The Deprivation of Liberty applications made to the supervisory body are not reviewed in the time frame by them
- An inability to meet the target levels for supervision due to the lack of appropriately trained supervisors across the Trust to support the supervision strategy.
- A lack of administrative support to the Team in response to the increasing safeguarding awareness within maternity services in particular, and across the Trust for Adults and Children/Young people
- Vacancy in the adult safeguarding team and difficulty in recruitment of this post
- Child Protection Alerts system not robust, timely or safe in its current form
- MCA- To improve staff knowledge and application of The Mental Capacity Act and understanding of DoLS in relation to planning of care for Patients

6.0 Serious Case Reviews/Partnership Reviews

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

6.2 There were three SCR's in 2017/18 undertaken by the Hertfordshire and Essex local Safeguarding Children Boards where PAH were involved either directly or indirectly. Information was provided and participation by PAH staff in the discussions held during the course of the reviews. There were no Serious Incidents in 2017/18 which compared to four in the previous year 2016/17 is reassuring. The safeguarding children team were called for four cases to be heard at the significant incident group.

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

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

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

7.0 Complaints

7.1 The Trust received one safeguarding related complaint during the year 2017/18. The complaint was made by a parent expressing dissatisfaction with the child protection process undertaken by PAH NHS Trust, Children Services and the Police. Whilst we acknowledged the need to review our process around consent for a Child Protection medical, the Child Protection process had been appropriately followed with the child's best interests being considered at all times.

8.0 Performance

8.1 In December 2017 The Care Quality Commission undertook a comprehensive follow up inspection at the Princess Alexandra Hospital NHS Trust (PAH). The inspection was carried out to assess if improvements had been made in all core services following the previous inspection conducted in June 2016. The outcome of the inspection was published by the CQC in March 2018.

8.2 The latest CQC report reflected the many positive changes made throughout the Trust since the previous CQC report was published in October 2016. As a result, we are now rated as 'Good' for Effective, 'Good' for 'Caring', and 'Good' for Well-led. Our Trust's overall rating has risen from 'Inadequate' to 'Requires Improvement', which reflects the programme of quality improvement underway.

8.3 Findings in relation to safeguarding are as follows:

- Review how MCA/Dols is documented in the medical records
- Continue the drive in achieving compliance on safeguarding Adult and Children's training
- ***'All staff we spoke with understood their role concerning keeping patients safe and reporting any potential safeguarding issues. Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse'.***

9.1 Training

9.2 Training compliance remains a key issue for the safeguarding team. The West Essex Clinical Commissioning Group (CCG) set a 90% compliance target for all levels of safeguarding children training. The Trust has not met this target and despite the message that the safeguarding children/young people/adults training must be attended we continue to fall short of the target.

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

9.4 The 'No Secrets' document (DoH, 2000) is clear that agencies should provide training for staff and volunteers on the safeguarding policy, procedures and professional practices that are in place locally, commensurate with their responsibilities in the adult protection process.

Therefore all staff, encompassing both clinical and non-clinical, have basic awareness training (Level 1) for safeguarding.
See **appendix 3** for compliance

9.5 Since the introduction of the Care Act in April 2015 – the safeguarding adults training has incorporated the changes, including the definition of abuse and the categories. Training has been introduced for all clinical staff on induction to the Trust and on the clinical refresher day held every 3 years. This programme incorporates Safeguarding Adults/Children – Level 2, Domestic Abuse, PREVENT and Conflict Resolution. This training is for all clinical staff and is held on a 3 yearly cycle. At the end 2017/18, 60% of staff had attended this. It is expected that by **December 2018** a trajectory for achieving 95% of staff compliance with this training will be achieved

9.6 The adult safeguarding training will be reviewed in line with the Adult Intercollegiate document once this becomes available in 2018

9.7 For staff working directly with Children/Young People and their Parents/Carers, a mandatory annual level 3 training is delivered. This reflects the guidance of the 2014, Intercollegiate Document - Safeguarding Children/Young People: Roles and Competences for Health Care Staff. This negates the need for this group of staff to undertake the level 2 training on the clinical refresher day. At the end of 2017/18 a compliance rate of 63% was achieved. It is expected that by December 2018 a trajectory for achieving 95% of staff compliant with this training can be achieved providing staff are mandated to attend by the health groups.

10.0 SAFEGUARDING ADULTS PERFORMANCE 2016/17

10.1 Deprivation of Liberties Safeguards (DoLS)

10.2 The Trust continues to see a maintained approach in the DoLS applications (table 2), primarily due to increased awareness in this area, specifically since the Supreme Court ruling in March 2014. There has been an increase of 9% in this financial year in applications made

10.3 As a result of this increase nationally, this has elongated the time frame that the external supervisory body is taking to process the high number of applications. Although this is an issue external to the Trust, it has been placed on the risk register as DoLS timeframes are being exceeded. Assurance can be given that all applications have been approved or appropriately managed and each CQC notification is validated and approved by the Director of Nursing. The Trust has reflected this in our internal process to ensure compliance is met. At present, the Department of Health and the Law Society are working to identify how the DoLS legislation will be amended, as it is recognised that the current situation is presenting significant difficulties

Table 2: Safeguarding Adults Activity 2011-2018

Safeguarding Adults activity	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018
Number of DOLS completed	21	38	83	197	160	196	213
Number of SetSaf completed by PAH	104	107	99	120	112	116	255
Number of SetSaf against PAH	21	15	23	32	36	58	49
Number of MCA's completed	75	183	198	159	183	228	269
Adult Safeguarding Training completed	61%	87%	95%	93%	91%	71%	93%
Level 2 training						65%	79%
Consultations				204	329	572	465

Table 3: Safeguarding Adults Activity 2017/18

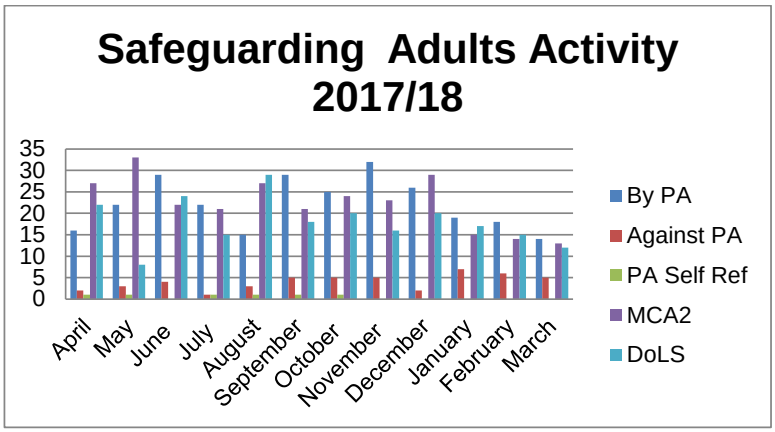
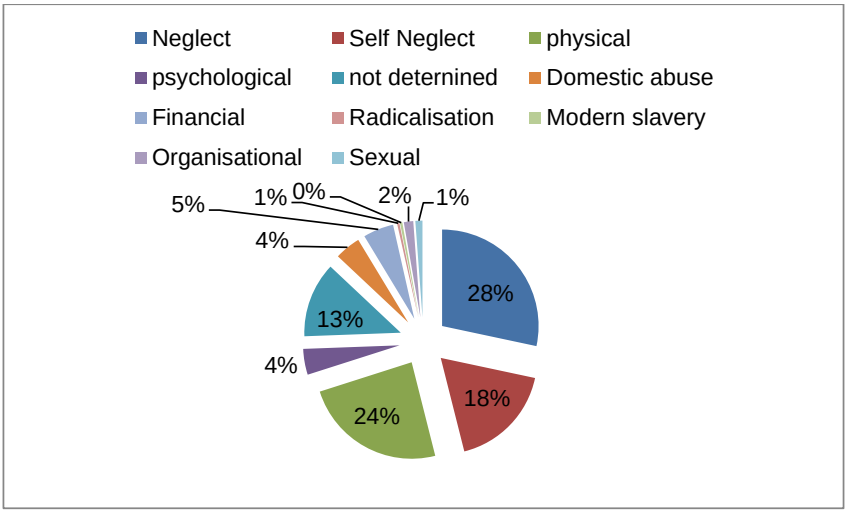


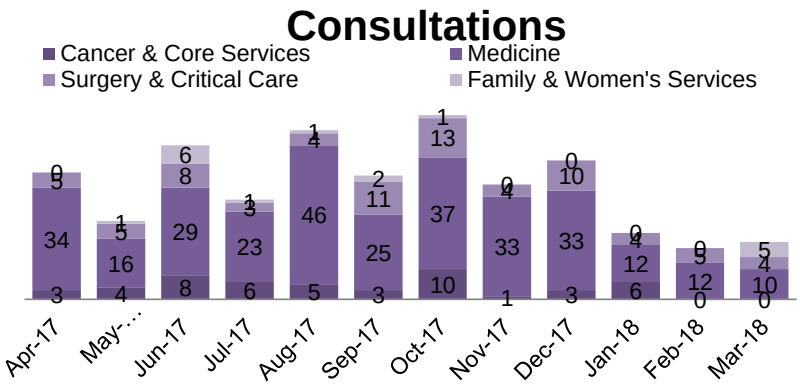
Table 3: Safeguarding Adults Themes 2017/18

The safeguarding adults team record the data of themes of referrals made by the organisation in order to anayse recurrent safeguarding themes seen during presentations to the PAH NHS Trust and share this data as part of training.
We have identified 28% of referrals are related to neglect whilst 24% are deemed to be physical injuries cases, this can include referals for patients attending with pressure injuries form both their own home and care providers. Some of the catogories overlap in both neglect ,physical and psychological and we have to consider one catogary does not always fit all cases.
Some cases the referrer does not state the catogary and tick the box not detemined.
In relation to the self neglect cases the outcome of these generally are case managed, and do not progress down the safeguarding route as the capcity and wishes of the patients are considered in actions taken by the LA



11.0 Safeguarding Adult Consultations

11.1 During 2016/17 the Safeguarding Adults Team undertook a total of 465 consultations for safeguarding concerns compared to 573 in the period 2016/17, this demonstrating a 20% decrease in consultations compared to the same period in the previous year .To note there was staff vacancy in the team for the period of September to April, which will account of the reduction in only 1 member of staff undertaking consultations from staff compared to 2 the previous year. These cover a wide range of areas including advice on potential safeguarding concerns to completion of mental capacity assessments and those patients who may meet the Deprivation of Liberty safeguards



12.0 Safeguarding Adult Referrals (Table 2/3)

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

12.2 All cases are investigated by the Local Authority and the Trust works closely with partnership agencies, including the police and social services to ensure a safe discharge for these patients into the correct placement. There has been an increase of referrals made by the Trust of 120% compared to 2017/2017

12.3 In relation to safeguarding referrals raised against the organisation, the number has decreased in the last year by 16% compared to 2016/2017 This includes 7 self-raised against the Trust, which can be about staff related incidents, or where deemed avoidable harm to a patient whilst in the Trust.

- 49 have been raised by other agencies However in total; only 4 have been substantiated against the Trust. (See table below)
- Some have still not been finalised by the local authority and this is a constant, in chasing this up with the local authority and has been escalated to the Local Authority, Adult Head of Safeguarding in these delays

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

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

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

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

- The 4 cases substantiated raised by other providers, were related to discharge of the patient's lack of communication on aspects of their care to the other provider,

which includes medication and plan of care, and concerns related to lack of information on discharge relating to pressure injuries

- 1 of the case's was substantiated, as the notes could not be obtained to complete the investigation – this was also reported as an IG Breach when identified by the health group. The Trust is still waiting on the outcome on the 22 cases which have been submitted to the local authorities

- Subsequently, directorate action plans and shared learning has been instigated from each incident. Key themes from these incidents have been verbal and written communication on discharge of patients.

Table 4: Safeguarding Adult Referrals 2016/17

	Substantiated	Partially Substantiated	Unsubstantiated	On-going cases	Submitted LA Await outcome
Self-Raised	0	0	6	0	1
Raised by other provider	4	0	13	7	23

13.0 Mental Capacity Assessments (MCA) in Adults

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

13.2 There has been an increase in MCA's of 18% over the last year received by the safeguarding team. This is highlighted on training for staff that forms should be sent for audit to the safeguarding team.

13.3 To support this agenda the Trust introduced an amended consent form (consent form 4) which incorporates the MCA within the document. This is in the process of being updated and a proof is currently awaited for review by the safeguarding team

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

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

13.5 The Trust uses the Southend Essex Thurrock (SET) Mental Capacity assessment form**.** Key themes on completion since the introduction of the new form in 2016 are again basic generic details of the patient and completion of the communication which took place, how this took place and the best interest decision, and the plan of care for the patient.

13.6 New training was introduced for clinical staff, which was more focused on the actual completion of the form and the documentation required to evidence discussion which had

taken place. The feedback from this has been positive as staff have had the opportunity to go over the completion of the assessment and discuss scenarios

13.7 The safeguarding team are aware that not all forms are received to quality check and review and this reiterated in staff training and at given opportunities within the clinical areas that forms should be sent to the team for this purpose

13.8 It has been recognised further training has been required and the funding has been secured by the Safeguarding Adult team from NHS England to commission an external trainer. Further training has been provided; by commissioning a law firm to offer a different angle to this subject, in September 2017.This was attended by 20 staff despite being publicized across the organisation for all staff to attend.

14.0 Safeguarding Adult Audit

14.1 Safeguarding adults are undertaken as part of the Quality assurance inspections and feedback has been given directly to the ward/clinical areas at this time .As a result of these audits, the training has changed in respect of Mental Capacity to make this more practical focused in completion of these

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

15.0 Domestic Abuse

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

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

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

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

15.5 Initial findings from a preliminary report in February 2018 was that victims referred to the Health IDVA's appeared to represent more vulnerable persons: from the data we have available, they are more likely to be pregnant, to have dependents, and to have accessed emergency services in the past. The service is also capturing a younger demographic,

similar to other domestic abuse programmes, but older users are also captured: at least one of these older users had been in receipt of abuse for many years. More than half of users have dependents, with the possibility that the abuse they are experiencing is affecting other vulnerable people. Essex County Council stated that this would need to explore this aspect further: data has been collected on the support provided to the dependents of HIDVA service users.

15.6 The project is due to end in July 2018, there has been no identified funding for this to continue and this risk has been raised at the Health Executive Forum, and the CCG.

An action from the safeguarding steering group has been that the HON write a business case for this proposed service to continue

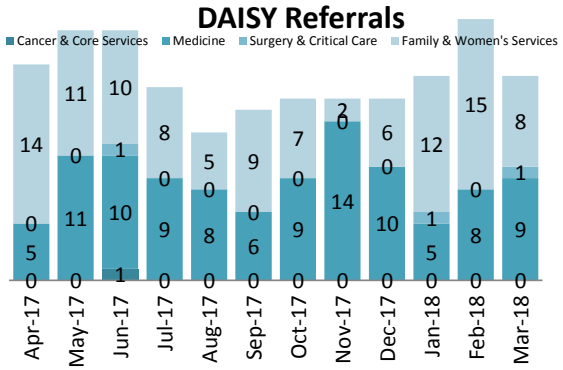
There has been close working with safer places and the Trust to see how this service can continue if in a somewhat different guise to continue to provide a service to the organisation. During this period there has been continued inconsistency in the DAISY team, in that it has been under established and a frequent turnover of staff. This aspect in managed by Safer Places who have updated the Trust in their recruitment plans and cover for the service

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

15.8 Staff at each J9 contact point have been trained to signpost, advise and spot the signs of domestic abuse. Each venue has a safe place where victims can access information and use a phone. 59 PAH staff members have been trained in this period in relation to J9 .From July 2018 this training will be accessed through the Safer Harlow Partnership due to the forthcoming changes in the health IDVA service

15.9 NICE guidance in relation to domestic abuse was issued in February 2014. Owing to the introduction of the Daisy project and Safer Places, the Trust continues to be virtually compliant on all the relevant criteria within this guidance. The only outstanding area is to demonstrate working in partnership to support the perpetrators of abuse, which does not sit within the gift of the Trust.

Table 5: Daisy referrals by month and department 2017/2018



16.0 Adult Safeguarding Supervision

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

16.2 The Trust is compliant with the KPI as deems that all named safeguarding professionals will receive 1:1 supervision, this is either in the format of peer supervision or individual supervision.

9.3

17.0 CQC Outcome 7: Safeguarding Vulnerable People Who Use Services (including the PREVENT agenda)

17.1 CQC standards are monitored at the Joint Safeguarding Steering Group and although previously there has been inconsistent attendance the group is now well attended. The format has been modified to allow for guest speakers and training to increase the knowledge and awareness of the safeguarding agenda for the CQC leads for outcome 7. The steering group will report back to the senior practitioner forum on the safeguarding agenda on a bi-monthly basis, identifying key themes and learning from reviews and incidents.

17.2 The Adult Essex Safeguarding Adults/Children's Board Audit was undertaken in December 2016.The results demonstrated that key areas of concern were: strategies for FGM and forced marriage, human slavery, PREVENT and implementing the findings of the positive and proactive care – report and supervision in relation to safeguarding.

17.3 PREVENT

The PREVENT Strategy is a cross-government policy that forms one of the four strands of CONTEST: The United Kingdom's Strategy for Counter Terrorism. It includes anti-radicalisation of vulnerable adults and children.

The Trust delivers its PREVENT Training via a number of means to enable the Trust to meets its obligations for PREVENT Training.

The NHS England – Prevent Training and Competencies Framework outlines the minimum requirements for training of staff in PREVENT.

The training requirements fall in to 3 board categories

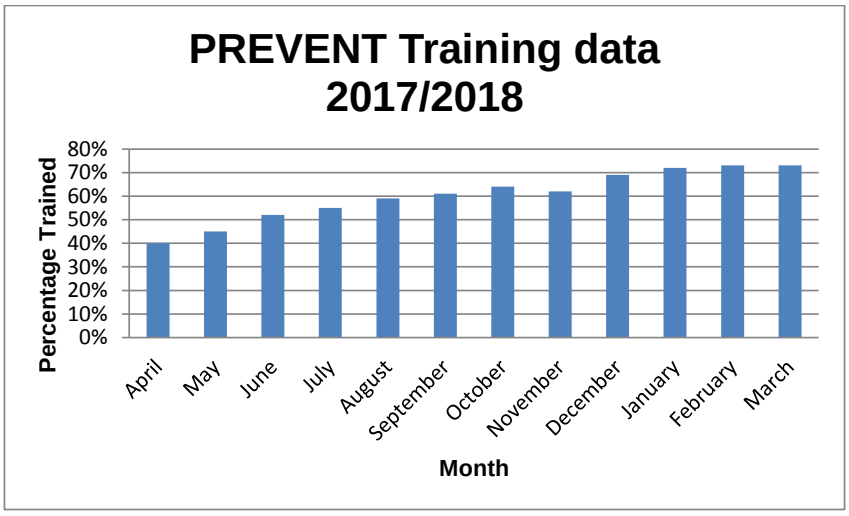
- Basic Prevent Awareness Training – Level 1 and 2
- PREVENT Awareness Training – Level 3, 4 & 5
- Competency Level for Organisational PREVENT Leads

The Trust has been delivering HealthWRAP training as required for Level 3, 4, & 5 staff as part of the Vulnerable Patient Study Day since June 2015.

In addition to the Vulnerable Patient Study Day there are Drop In sessions held, advertised via InTouch and the Training Department, to enable staff to undertaken their HealthWRAP sessions outside of the planned Vulnerable Patient Study Days. Additionally, these sessions can be used for non-clinical staff, as the Trust recognises the importance of the training of all staff, and would like to work beyond the NHS England Framework and train all staff in HealthWRAP

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

Table 7. Prevent HealthWRAP compliance figures



9.3

18.0 Serious Adult Reviews/Multi-Agency Serious Incident Reviews

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

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

18.3 The purpose of an SAR is to:

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

18.4 The Trust has been actively involved in 1 SAR in the period April 2017 to March 2018. This was commissioned by the Hertfordshire Safeguarding Adults Board .An IMR and chronology has been submitted on behalf of the Trust and this case is still ongoing. Any Learning from SARS is published on the intranet and referenced in training to share the learning from this.

19.0 Domestic Homicide Reviews (DHR)

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

19.2 The Trust has been involved in 2 DHR's within the West Essex Area and both these are ongoing cases.

- The first case an initial scoping request has been submitted on hospital attendance's of the victim to the Essex DHR Panel – no further information has been requested
- The second case a chronology has been submitted on the victim after the initial scoping was submitted and further information was requested.

20.0 2017/18 Safeguarding Adults Work Plan

Continuation of Mental Capacity Training for clinical staff

- Introduction of Safeguarding champions across the Trust
- Ratification of Trust Supervision policy to ensure Safeguarding Adults supervision is incorporated into this
- Scope for access to further courses for more supervisors to attend to support the supervision agenda
- Identify and train further supervisors for Adult supervision to support the Lead nurse in this role
- Explore the business case for increase admin support for safeguarding adults team in line with safeguarding children team
- Continued development of Safeguarding nurse to meet the needs of the service and support the Lead nurse Safeguarding Adults
- Review the MCA training to meet needs of staff
- Continue to work with ESAB and NHS England on projects and attend Safeguarding forums and subgroups
- Maintain the J9 Training to support the Domestic abuse agenda with support of Safer places and Safer Harlow partnership
- Ratification of Deprivation of Liberty Policy which has been reviewed

- Embedding of the Safeguarding Scrutiny panel across the health groups, to review all safeguarding cases raised against the Trust to ensure completed in a timely manner.
- Sustained Implementation training for Medical staff on Mental Capacity Act
- Work with end of life team in relation to DNACPR form and capacity assessments being evidenced as part of this process
- Work with Quality First team and information department in having safeguarding audit as part of the Patient safety and Quality Audit which the ward /clinical areas complete
- Review the RCN intercollegiate document for Adults and review training needs in relation to this

21.0 Safeguarding Children Performance

21.1 The Safeguarding Children Team have experienced considerable increase in activity within the Paediatric and Adult Emergency services, Maternity Services and in fact across the Trust generally. It is considered that this increased activity is attributable to the provision of mandatory safeguarding children training, particularly the Level 3 which is now delivered annually alongside targeted supervision.

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

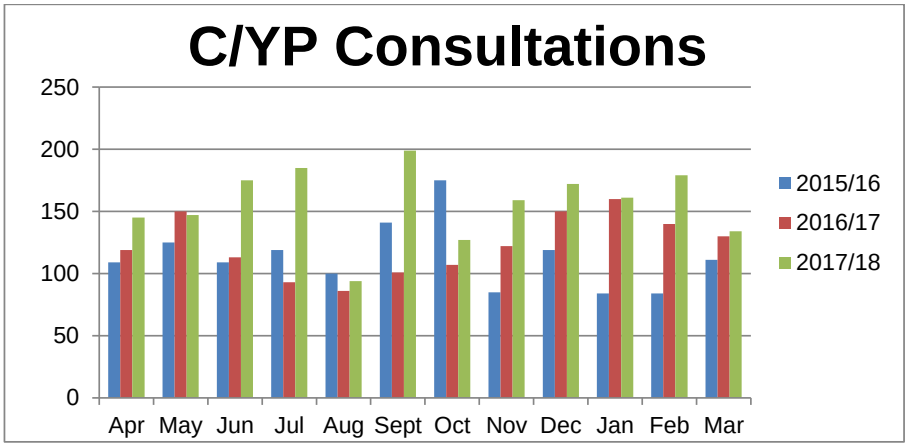
- The number of referrals made to children's social care
- The number of unborn babies/children and young people with a CP plan
- Figures for supervision and training
- CSE, FGM and LAC presentations to PAH NHS Trust
- 16/17 year olds that present to the Trust and admitted to adult wards
- Presentation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

21.3 The Trust has implemented mandatory reporting of all women/children who are seen with FGM. All but one FGM cases have identified within maternity services. 2017/18 saw eight cases of FGM.

22.0 Safeguarding Children Consultations

22.1 When a concern for a Child or Young Person (CYP) is identified a copy of the health record is stamped for the attention of the safeguarding children team. They are kept for collection by the Safeguarding Children Team (SCT) on a daily basis. Once collected the record is scrutinised by the SCT to ensure appropriate action has been taken, the data is stored for statistical evidence and outcomes for children completed. In addition to this the SCT receive numerous calls from staff and these consultations or Ad-Hoc supervision details are also recorded. During the course of 2017/18 a total of 1877 consultations were received and risk assessed by the SCT, showing an increase of 192 **(**11%) from 2016/17 with a consistent increase month on month. These increases are illustrated in Table 5 and are attributed to a wider understanding of safeguarding concerns for children by PAH Trust staff.

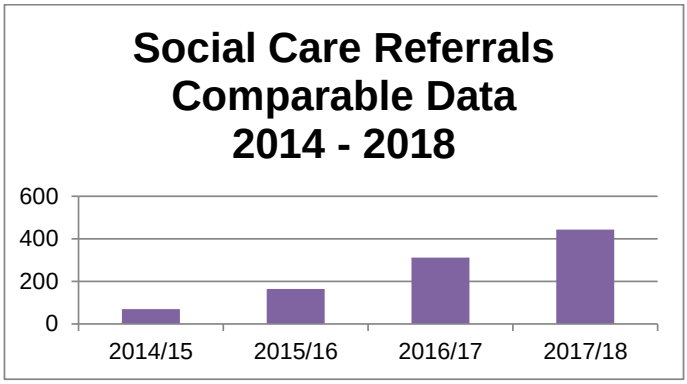
Table 5 Comparable Consultations by Month for 2015/16, 2016/17 and 2017/18



23.0 Safeguarding Children Referrals

23.1 Referrals are made to Children's Services when a professional considers a child or unborn baby to be at risk of significant harm. If a safeguarding referral is made a datix report is also completed. The number of children safeguarding referrals made to social care from the Trust has increased by 42% from 312 referrals in 2016/17 to 443 referrals in 2017/18. This sustained increase in responses from PAH staff indicates that many more staff members are now routinely recognising concerns and responding appropriately to initiate on-going services for their patients outside the Trust. This clearly demonstrates the responsibility for safeguarding children/young and vulnerable people is becoming more widely accepted by staff as part of their practice. The SCT have continued to extend the level 3 training to a wider audience partly in response to our recent CQC inspection but also since young people, 16/17 year olds in particular, are very much included in the safeguarding children agenda.

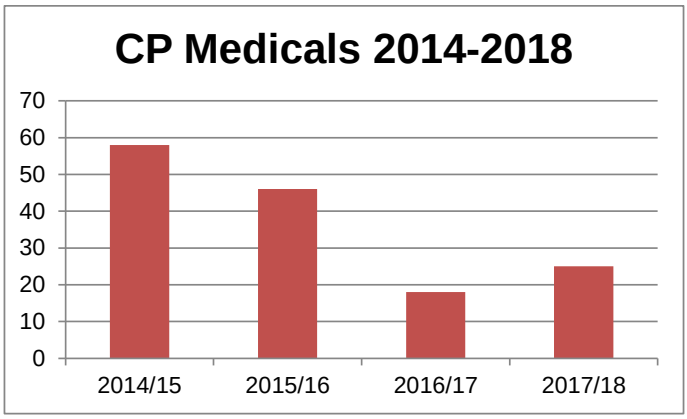
Table 6: Comparable Referrals by Year 2014-2018



24.0 Child Protection Medicals

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

Table 7. Comparable Figures for CP Medical undertaken in 2014-2017



24.2 The safeguarding children team have continued to raise concern about the low number of requests for CP medicals from Social Services. Comparison with neighbouring Trusts shows discrepancies between local authorities with some conducting as many as 200 CP medicals per year compared to others in Essex conducting only 9. The PAH NHS Trust have undertaken 25 CP Medicals in 2017/18 demonstrating a 39% increase in numbers (7) compared to 2016/17 when just 18 CP Medicals were conducted. Concerns about the low numbers of requests for CP medicals have been escalated by the Executive Lead for Safeguarding within the Trust and to the Designate Team within the West Essex CCG. The Executive Lead for the Trust has also raised this as a concern within the West Essex Health Executive Forum (HEF) and multi-agency community strategy discussions.

25.0 CP Plans

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

25.2 The Safeguarding Children team are notified by Essex and Hertfordshire Social Care about children with a CP plan. The team administrator puts an alert on the child's electronic record for staff to see when a child presents to the Trust. It is recognised that this is not a failsafe way of working but currently has been the only option. This has been raised as a concern to the risk register.

25.3 The Safeguarding team were approached in November 2017 by the Essex STP project group to begin work towards the implemetation of the national Child Protection – Information Sharing (CP-IS) project. CP-IS is an NHS project that is helping health and children's social care staff to share information and better protect society's most vulnerable children. It works in unscheduled healthcare settings only and applies to the following unscheduled healthcare settings only:

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

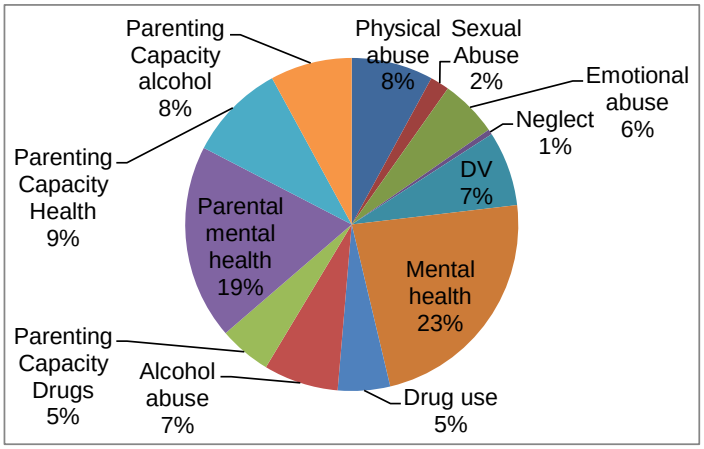
- ambulance services

25.4 CP-IS is not for use in scheduled care settings such as outpatients, as this will result in notifications being sent to local authorities that they are not prepared for. The information that CP-IS provides comes from local authorities that have statutory responsibility for children's services only. Once a child is made subject to a child protection plan or becomes a Looked After child a child care alert is placed on the NHS spine by the local authority responsible for them. The NHS spine is checked against every child/young person/UBB presenting to the organisation for unscheduled services. In line with the Trust policy health professsionals are expected to inform the local authority of the attendance. Work has been undertaken to support the CP-IS implementation in April 2018.

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

25.6 We have identified that 43% of the consultations recieved by the safeguarding team are made up of parent related issues that impact negatively on children. Drug and alcohol issues account for 13% of all consultations with parental mental health such as deliberate self-harm and overdose accounting for 19% of consultations. Domestic Abuse accounts for 7% of the consultations which are often seen in association with issues such as drug, alcohol and mental health problems. 9% of parental problems are related to health issues and include cancer, sepsis, flu, diabetes and multiple sclerosis. Whilst some of the health issues are not the specific reason for safeguarding concerns it is the parents capacity to manage their children when they become ill. There are occassions when the illness leads to death and the bereavement needs of the child require exploration. Other difficulties experianced are that there is no extended family member who can look after children when a parent becomes unwell.

Table 8. Safeguarding Themes 2017/2018



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

25.8 In respect of the four categories of abuse for children 8% experience physical abuse, 2% sexual abuse, 6% emotional abuse and 1% for neglect. There is often overlap for the differing categories of abuse and consider that we are currently not linking up the mental health, drug and alcohol issues with child sexual exploitation/sexual abuse.

25.9 Child Sexual Exploitation (CSE) is an area that is fully covered in the level 3 training and discussed at levels 1 and 2. We have a CSE risk assessment tool and staff appear to have an understanding of the issues, howver this is not reflected in our data. We only actually recorded 3 cases of CSE in 2017/18 which seems a low figure considering what we know about CSE. We are concerned that CSE is hidden by the presenting concern and recognise further work to raise awareness in this area. We have started this by undertaking a CSE awareness day in November 2017 by holding a stall promoting information, literature and advice around this topic. CSE posters are also displayed across the Trust and via our communications team on the electronic information screens that are also available to the public attending the organsiation.

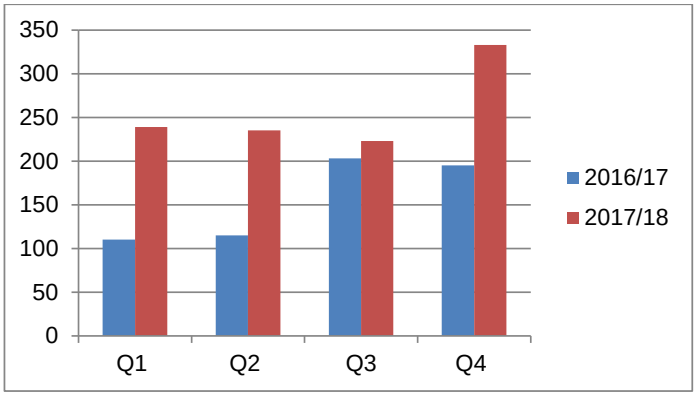
26.0 Maternity Safeguarding

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

26.2 From January 2016 information sharing was brought into the safeguarding team for dissemination to our community health colleagues. This change was brought about following the publication of Serious Case Review 'John' (SCR) in November 2015. The SCR identified serious failings in respect of information sharing about vulnerable pregnant women between maternity services both internally and externally, GP's and Health Visitors. The Safeguarding Children Team opted to take responsibility for the dissemination of information to our health partners once it was identified a more robust process was required.

26.3 A joint audit to monitor the effectiveness of the new information sharing process between maternity, health visiting and GP services was conducted and concluded in July 2017. The findings have been shared within maternity services, to the local GP's and health visitors. An audit report and action plan was devised and can be read in **Appendix 4**

Table 8: Maternity Information Sharing Forms

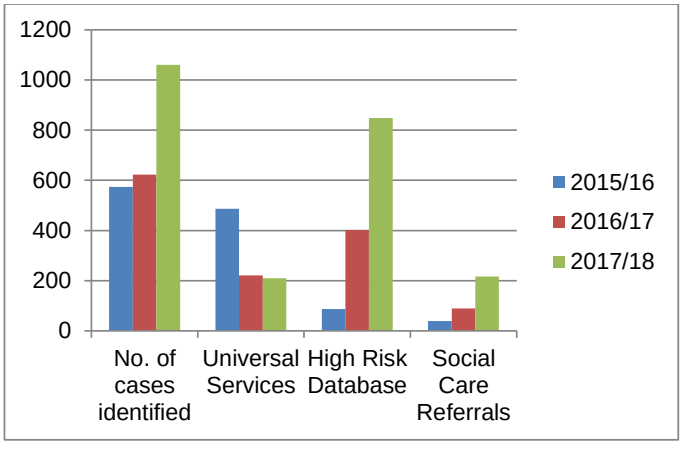


26.4 The new information sharing process also included a new information sharing form (ISF) which has been utilised well within the process. The information received is now stored in individual files on a maternity database. Any additional information that is generated from strategy meetings, professionals meetings, child protection conference minutes, core group minutes and pre-birth plans are also stored in the individual file to be accessed by any midwife, at any time of the day in any area within the maternity service. The IT Team have arrangements in place to ensure midwives to have 'Read only' access. This is to ensure that current information about vulnerable pregnant women and their unborn babies is accurate. Table 8 illustrates maternity activity in 2016/17 – 2017/18

26.5 During 2017/18, 1060 pregnant women were identified as having a level of need that would indicate vulnerability compared to 623. This was an increase of 65% (407) of vulnerable cases compared to 2016/17 equating to approximately 25% of all pregnancies booked at PAH NHS Trust during the year 2017/18. This is an increase of 10% from 2016/17. All the cases are risk assessed with 20% (21) being returned to universal services compared to 35% in the year 2016/17. Although we have seen a drop in ISF being returned to universal services we believe this is related to the increase in ISF's being submitted to the team and that midwives are recognising and escalating vulnerable pregnancies, rather than a lowered threshold for concern. 75% (848) of cases were entered onto the high risk maternity database with a recommended plan for the CMW, GP and Health Visitor to consider the need for on-going safeguarding monitoring. This compares to 65% of cases entered onto the maternity database in 2016/17. Maternity figures kept through 2017/18 show that 217 cases were referred to social services, an increase of 143% from 2016/17 and 15% more than 2016/17.The PAH maternity services supported the delivery of 4200 babies in 2017/18, 7.4% of those babies were referred to social services. Table 9 illustrates the maternity activity and comparable data during 2017/18.

26.6 During 2017/18, 34 Unborn Babies (UBB) had a Child Protection Plan implemented during pregnancy. This would indicate that the Essex and Hertfordshire Pre-Birth Protocol are being reflected in practice and that early intervention to meet the needs of UBB's is effective. This in turn has an impact on maternity services as the Community Midwife has to provide a child protection report, attend the Child Protection Conference and the regular Core Group meetings and work with partner agencies to support families and ensure a clear pre/post-birth plan is developed. Hospital midwives organise a discharge planning meeting to include the social worker, health visitor, community midwife and parents so that appropriate plan for monitoring and support is in place prior to discharge.

Table 9: Maternity Safeguarding Activity



27.0 FGM

27.1 A joint approach to FGM training for midwives as part of the annual Skills & Drills' updates was implemented in January 2017. Collaboration with the National FGM Centre during the training has underpinned the Trust's FGM policy and encouraged the referral of women to the specialist family support workers from the National FGM Centre. The PAH NHS Trust identified 8 women who had FGM and all cases were detected via maternity services. We have not seen any children identified who has experienced FGM.

27.2 FGM – RIS is a national IT system that supports the early intervention and ongoing safeguarding of girls, under the age of 18, who are potentially at risk of female genital mutilation (FGM). Launched by the Department of Health (DH) and NHS England at the Girl Summit in July 2014, the FGM RIS provides a national IT system for healthcare professionals and administrative staff to record the potential risk of FGM on girl's health record. Work to implement FGM-RIS was initiated during November 2017

28.0 Learning Disability

28.1 A learning disability pathway is being devised to support expectant parents with a learning disability and this will be launched in June 2018. This is a joint initiative between the community midwifery team, the Named Midwife, the learning disability team and the obstetric consultant. The Essex and the Hertfordshire Pre-Birth Protocol highlights that the that the most successful preventative action is taken if these children are identified pre-birth. This early warning system can only operate in a meaningful way if there is an agreed inter-agency commitment to the importance of this area of child protection, and that professional's work together to assess and manage the response to this high-risk group.The need for early assessment and possible intervention where significant concerns about parental ability to self-care and/or to care for a child e.g. unsupported, young or learning disabled mother (SET Procedures Part B, chapter 41.3, Parents with Learning Difficulties) or a parent has mild, moderate or severe learning disabilities (HSCB Safeguarding Procedures, Chapter 6.9, Pre Birth Assessment and Guidance) cannot be emphasised enough. The safeguarding Midwifery team will report on the progress of this initiative in the 2018/19 report.

29.0 Perinatal Mental Health Service

29.1 The EPUT Perinatal Mental Health Service is an Essex-wide specialist service and was launched at PAH NHS Trust in October 2017. The service assesses and treats women with serious mental illness or complex disorders. The perinatal period starts at conception through to one year after birth and high risk groups such as patients with affective psychosis and severe depressive illness, drug misuse are among the high risk group at risk of exacebating mental problems during the perinatal period. Suicide rates are highest during 6 weeks before birth and 12 weeks postnatal. 60% of suicides occur in the perinatal period (Knight et all Oats, Cantwell, 2015). New onset conditions arising after 28 weeks and before 6 weeks postpartum have the potential to be serious so urgency of assessment should be established within 2 days. (Perinatal Community Mental Health Standards CCQI 2016). Admission to a mother and baby unit will always be considered where a woman has any of the following:

- Rapidly changing mental state
- Suicidal ideation (particularly of a violent nature)
- Pervasive guilt or hopelessness
- Significant estrangement from the infant
- New or persistent beliefs of inadequacy as a mother
- Evidence of psychosis.

29.2 The following are 'red flag' signs for severe maternal mental illness and require urgent psychiatric assessment:

- recent significant change in mental state or emergence of new symptoms
- new thoughts or acts of violent self-harm
- new and persistent expressions of incompetency as a mother or estrangement from the infant.

29.3 The safeguarding team are collating data for this service and will present this in the next annual report

30.0 Supervision and Peer Review

30.1 The Working Together document (2015) acknowledges the importance of safeguarding supervision for staff who work directly with child and their parent/carers to enable reflection learn from case discussions and obtain support for the emotional aspects associated with the work. It is known that attendance at supervision increases staff knowledge, skills, and supports emotional consequences of face to face contact with child protection cases.

30.2 From April 2014, safeguarding supervision was included in the Trust's key performance indicators (KPI) with a target of 80%. The Trust has struggled to reach compliance with this requirement due to a lack of individuals with the supervisory skill to provide safeguarding supervision. Opportunities became available via NHS England for access to the NSPCC Supervision Knowledge and Skills course in 2017/18 and one additional safeguarding team member completed the course with the Named Nurse and Safeguarding also completing the course as an update. There are no more planned NHS England funded places on the horizon.

30.3 It is recommended that safeguarding supervision be delivered on a three monthly basis for all staff who work directly with children or their parents/carers. The target areas for 2017/18 were the PAH NHS paediatric nursing staff, specialist community nurses, paediatricians, neo-natal staff, and community midwives. This was delivered as a combination of individual and group sessions as well as ad-hoc supervision on a needs basis. All supervision is recorded on a newly developed supervision database with support from the Information Team. This enables any themes to be considered, monitors supervisee discussions, solutions reached and can provide information if required for serious incidents.

30.4 The Safeguarding Team have recognised that there is not the resource within the current arrangements to be able to meet the KPI for supervision so are looking to secure funding for an in-house supervision training to be commissioned to equip additional supervisors across the adult, paediatric and maternity services. This is planned for 2018.

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

31.0 Looked After Children (LAC)

31.1 The national average for children who are 'Looked After' is 60 per 10,000 children, in West Essex that figure is approximately 12/13 per 10000 children. Harlow has the highest number of children within West Essex who are 'Looked After' 45 per 10,000 children. This has a significant impact on our Trust as it is imperative that the key worker from social services is made aware of any presentation to PAH NHS Trust. Unlike CP plans we do not receive a list of children who are 'Looked After' and rely on questioning on presentation or contact from partner agencies to inform us. Again this is not a failsafe system and needs review.

31.2 Child Protection – Information Sharing (CP-IS) is a national projected underway to improve information sharing in respect of those children that have a CP plan or who are 'Looked After'. Working jointly, health and social care have created a means to input information about children on the national spine. When the NHS number is accessed an alert is seen indicating if the child has a CP plan or is 'Looked After' with contact details for the responsible authority. A child can be from anywhere in the country. It is envisaged that this facility will in place at PAH in April 2018.

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

32.0 2018/19 Safeguarding Children Work Plan

1. The application for funding and commissioning for an in-house safeguarding supervision course to enable a cohort of additional supervisors across adult, maternity and paediatric services who can support the 'Hub and Spoke' approach to supervision.
2. To continue offering safeguarding supervision to all staff who work directly with children or who have contact with their parents/carers (to include Dolphin ward, paediatric ED and maternity services)
3. Safeguarding midwifery supervision figures to be recorded and reviewed monthly to ensure compliance and early escalation to midwifery managers if midwives do not attend.
4. To re-audit the maternity safeguarding information sharing process from September 2018 against the action plan devised after the 2017 audit
5. To continue feeding back the findings from the information sharing audit to HV's and GP's across West Essex
6. To improve and forge good communication processes between community midwives and the GP's by attendance to the GP neighborhood meetings.
7. To update the annual level 3 training programme to reflect the latest national guidance, local needs and ensuring the intercollegiate core competencies continue to be met
8. To continue the development of CSE Champions in all paediatric areas, ED and Sexual health services to raise the awareness of CSE, promote the use of a tool to assist in identifying CSE and offering support to victims of CSE
9. Continue to review and report monthly safeguarding children training figures, contacting staff and their managers who do not attend
10. Safeguarding Team to undertake and evaluate an audit of the quality of safeguarding supervision
11. To review the CP medical arrangements and implement a dedicated contact number for referrers, to be negotiated via the CP Team in working hours and to monitor, record and report on categories for the medicals
12. Contribute to key projects and audits for the ESCB/CCG as required.
13. To continue the implementation of CP-IS to maternity services with a 'go live' deadline of July 2018
14. To maintain the current band 6 safeguarding midwifery post to a substantive WTE position within the team
15. To continue the drive for the expansion of the administrative support available within the safeguarding children team.
16. To take forward a collaborative initiative with the Police, Essex Social Care and the CCG for a multi-agency conference about fabricated/induced Illness planned for December 2018.
17. To report data for referrals to perinatal mental health
18. To launch maternity learning disability pathway.

33.0 Recommendations

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

Authors: Sarah Kent Leybourn - Lead Nurse for Adult Safeguarding,Nicole Anderson - Named Nurse for Child Safeguarding and Caroline Loake- Senior Safeguarding Children's Nurse

Reviewed by:

Appendix 1: Adult Safeguarding Arrangements: National and Local

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

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

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

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

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

Main Changes to Note

The Care Act does not give a definition of a "vulnerable adult" but instead states that safeguarding duties apply to an adult who

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing or is at risk of abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Categories of abuse

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

- **Physical Abuse** – including assault, hitting, slapping, pushing, and misuse of medication, restraint or inappropriate physical sanctions.
- **Domestic Violence** – including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.

- **Sexual Abuse** – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.
- **Psychological Abuse** – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
- **Financial or Material Abuse** – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
- **Modern Slavery** – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
- **Discriminatory Abuse –** including forms of harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion.
- **Organisational Abuse** – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.
- **Neglect and Acts of Omission –** including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
- **Self-Neglect** – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

The Care Act also requires that each local authority must:

- Make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so by whom
- Set up a Safeguarding Adults Board (SAB). As you are aware Essex already has an established Safeguarding Adults Board
- Arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has `substantial difficulty` in being involved in the process and where there is no other suitable person to represent and support them
- Co-operate with each of its statutory partners in order to protect the adult. In their turn each relevant partner must also co-operate with their local authority

Appendix 2: Child Safeguarding arrangements: National and Local

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

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

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

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

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

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

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

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

Appendix 3: Safeguarding Children's Training Report Month by Month 2017/18

% of staff compliant with safeguarding children's training

Meets CCG requirement of 95% staff trained

Between 85 -94% of staff meeting requirement

Less than 85% of staff meeting requirement

Competence Name	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Level 1		72	72	76	77	82	88	95	92	86	92	92
Level 2		68	76	77	78	80	83	85	85	86	85	85
Level 3				75	75	75	70	76	67	65	62	63

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

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Appendix 4:

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Clinical Audit Report

Audit Title : An Audit of the Maternity Information Sharing Pathway

Clinical audit tool to promote quality for better health services

Clinical Audit Report written by Nicole Anderson Dec 2017

The Princess Alexandra Hospital NHS Trust

Patient Safety and Quality
The Princess Alexandra Hospital NHS Trust

Business Unit : FAWS

Audit Title: An Audit of the Maternity Information Sharing Pathway

Audit No:

Specialty: Maternity

Project Team	
Name	**Title**
Nicole Anderson	**Named Nurse – Safeguarding Children, PAH NHS Trust**
Christeen Bartlett	**Practice Development Lead for HV's – Virgin Care**
Sue Humphries	**Named GP**

Clinical Audit Report written by Nicole Anderson Dec 2017

The Princess Alexandra Hospital NHS
NHS Trust

1.0 Background / Rationale

1.1 A Child ('John') Serious Case Review was adopted by Essex Safeguarding Children Board (ESCB) on 24th March 2015. This was following the admission to hospital of a 10 week old baby suffering from fits. Investigations indicated he had suffered a brain injury and that the likely cause was non-accidental injury received in unknown circumstances while in the care of one or other of his parents. At the time of the injury, the baby was subject to a Child Protection Plan under the category of neglect.

1.2 Significant concerns were present about the background of both parents who both had other children either known to social care or who were being 'Looked After' by social care. The findings from the SCR indicated that the injuries to the baby were not predictable but were preventable if all the information known about his family had been assessed in pregnancy that could have resulted in a decision to remove him from his parents care at birth.

1.3 The recommendations for health agencies following the SCR focused on information sharing processes and stated that all health service commissioners and providers in Essex should re-evaluate current methods and expectations of sharing information (both internally and externally), regarding children for which there are Child Protection or Child in Need concerns. In addition, NHS England Area Team, Clinical Commissioning Group and NHS England Public Health (Essex) together as commissioners should act on these findings to advise, alert or commission (as appropriate) revisions to these methods to ensure that the deficiencies in existing IT systems supporting information sharing do not hinder the sharing of information between professionals which is essential to keeping children safe.

1.4 In response to this, the PAH NHS Trust reviewed their own information sharing processes between maternity services (MW's), the health visiting service (HV's) and GP's in respect of vulnerable pregnant women and found them to be inconsistent and not robust. In January 2016 a revised electronic information sharing process was devised and implemented to improve maternity information sharing at an earlier point between GP's, MW's and HV's to ensure early responses were initiated by all services once concerns were recognised.

2.0 Aim

2.1 The aim of the audit was to demonstrate that the new maternity information process ensured that all health services involved in the care of vulnerable pregnant women were aware at the earliest opportunity in pregnancy of any concerns that would have a potential negative impact on vulnerable pregnant women, an unborn baby (UBB) or families. Actions would be clearly formulated to reduce risks posed to vulnerable pregnant woman and her UBB with a lead health professional (usually the midwife) assigned to ensure actions are completed.

2.2 The audit involved tracking the pathway of an Information Sharing Form (ISF) from its generation, usually by a midwife at booking, the sharing of it with community staff and GPs, and the required actions undertaken as a result of a risk assessment undertaken by the safeguarding team or community midwife. The purpose of this was to assess the effectiveness of the information sharing process, ensure a risk assessment had been

undertaken and that action plans were implemented to provide positive outcomes for vulnerable pregnant women and their UBB's. The audit involved three services - the Princess Alexandra midwifery team, the West Essex Health Visiting service and West Essex General Practice. The safeguarding children team randomly selected 20 cases where an ISF had been generated and reviewed the involvement undertaken by midwives, the health visiting service and general practice in these cases.

3.0 Objectives

- To improve the information process between GP's, HV's and MW's
- To provide and share accurate information between all three services
- To enable a joined up way of monitoring and supporting vulnerable pregnant women and their unborn babies (UBB's) in pregnancy and the post-natal period

- To ensure good quality referrals with accurate information are made to our social care partners
- To ensure actions were completed so that good outcomes could be achieved for vulnerable pregnant women and their babies

4.0 Findings

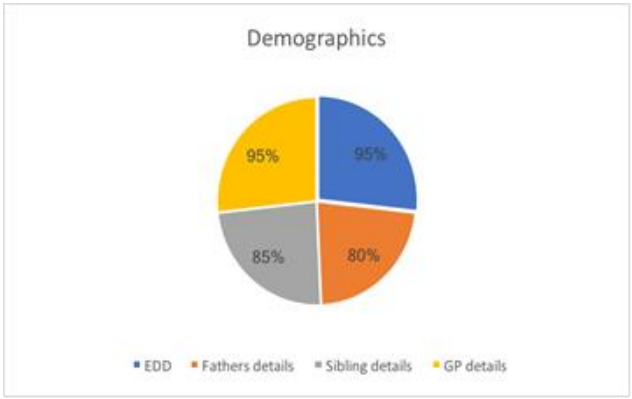
4.1 The audit tool was designed to reflect the objectives for each of the services and to determine if the process promoted a more joined-up approach to care. In general practice it was established which surgeries the 20 cases were registered with and found to involve ten practices (i.e. some practices had more than one case to review). In the maternity and health visiting service all 20 cases were reviewed, however for the GP's part of the audit there were three cases where the practices stated they were unable to provide any information as the women were no longer registered there. There was one case where there was no response from the practice despite several reminders. This meant that the GP element of the audit process involved reviewing the records of 16 cases. The audit had three elements to the report and will begin by analysing the outcomes from the maternity services.

4.2 The audit asked from which service the ISF's originated from. As predicted it was established that the ISF's were completed in all cases (100%) by the community midwife. Whilst this was not unexpected there are occasions when HV's or GP's may be made aware of a pregnancy before the midwife. Should the pregnancy have social complexity or vulnerability all health partners need to be aware that anyone can complete the ISF. The ISF had replaced a previously used 'significant events' form so the audit wanted to determine that the new ISF had been launched effectively and all midwives were aware of its use. We found that in 95% cases referred to the safeguarding children team were done so using the new ISF.

4.3 It is essential that all personal information related to the pregnancy is documented so Q3 explored if four particular areas, Estimated Date of Delivery (EDD), father's details, existing children details and GP details were completed. Historically, there were many cases where these details had not all been recorded. There are situations when social care referrals are required and such information is pivotal for gathering further information, determining risk and planning care. The Southend Essex and Thurrock 2015 (SET) procedures in the Multi-Agency Pre-Birth assessment state that the

unborn baby's father and mother's current partner (if different) should be included in a pre-birth assessment so this information on the ISF is essential. Not having this information can impede the progress of an assessment and may impact negatively on outcomes for babies and their siblings.

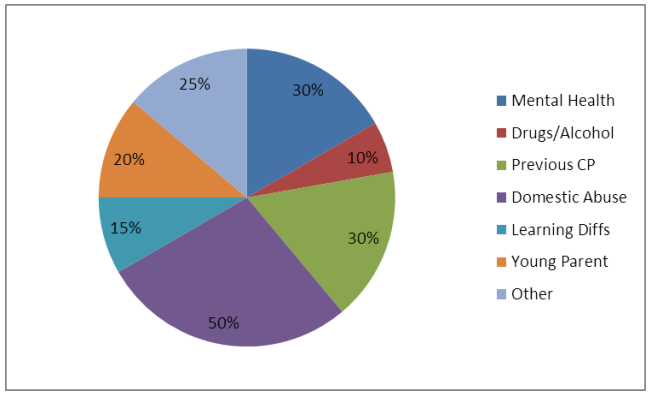
Table 1. Figures related to the key demographics



4.4 The audit wanted to demonstrate the level of complexity and vulnerability being managed by health services in pregnancy and the need for a joined-up approach to ensure needs can be met through safe monitoring of vulnerable pregnant women and their UBB's and good information sharing practices. The audit tool specifically asked about the identification of concerns associated with pregnant women and their UBB's. Not only does the audit demonstrate that midwives recognised negative impacts on pregnancy and babies but we are able to see some of the themes that affect this group within the particular area of West Essex. The PAH NHS Trust has a delivery rate of approximately 4200 babies per year and approximately 9% of this group experience social complexity and vulnerability. This audit has highlighted some of the major issues being dealt with by health professionals in West Essex.

4.5 There were numerous cases where more than one theme was recorded. An example of this was in the cases where domestic abuse was identified, 50% of cases featured significant mental health problems.

Table 2 Social complexity and vulnerability themes identified in pregnancy



4.6 During the booking process midwives are expected to gain consent from women to share information with other agencies especially when concerns are identified. Information can only be shared without consent where there are safeguarding concerns (The Children Act 1989) and then it is always good practice to inform a parent of this unless to do so would put a child at risk of significant harm. Often in the early stages of pregnancy it may be difficult to determine the level of risk and only by sharing information with other agencies can a risk be adequately assessed. It is therefore essential that this is explicitly requested when completing an ISF. Only 50% of cases had consent gained been recorded on the ISF – this is an area to be addressed with the midwives as the issue of consent, if not obtained, may hinder any work required by other agencies such as social services and may prevent the safety and well-being of a child being supported.

4.7 The audit wanted to look at the recognition of concerns by midwives, the triage/risk assessment made by the safeguarding children team and to see if the actions recommended by the team had been actioned by the midwives. In 50% (10) of cases a safeguarding concern had been identified by the referrer and 50% (10) had been completed for information sharing purposes or for further guidance, In 55% (11) of cases a social care referral had already been made and 10% (2) were already open cases to social services. The remaining 35% (7) required prompting for a social services referral to be made. The safeguarding children team make recommendations other than social care referrals that may include signposting to other agencies such as the Domestic Abuse, Drug and Alcohol services and local children centres for those cases where support is required but thresholds are not met for social care. In 75% of cases such recommendations were not followed.

4.8 This report will now consider the findings of the audit in respect of the Health Visiting (HV) and GP services. Secure e-mail addresses were sought for both GP practices and the West Essex Health Visiting services (formerly known as SEPT) with support from the West Essex CCG designated nurse. An appointed lead within SEPT was responsible for receiving and disseminating the ISF to the appropriate HV team. The HV audit reviewed all 20 cases selected and identified that health visitors received an ISF in 60% (12) of cases with GP's receiving 69% (11 out of 16). Whilst a disappointing

result, it is recognised that some cases selected were from the implementation stage of the new process with information about the new process only being presented to a Health Visiting forum in April 2016.

4.9 It is expected that the ISF is reviewed by the safeguarding team and returned to the original referrer, community midwifery team, HV and GP within 10days of receipt. This was achieved in 55% (11) of the HV audit and just 36% (4) of the GP audit. The GP audit recorded that of the 'no' responses, 45% (3) were received within two weeks, 9% (1) within one month and 9% (1) after 5 months. It is possible that the 9% (3) received within two weeks actually equate to 10 working days and therefore do fulfil the required time scale. There were two 'unsure' responses, in one case the patient had registered at the surgery when mid-trimester and the surgery was unable to comment.

4.10 It is recommended that on receipt of an ISF there would be liaison between CMW, HV and GP during the course of a vulnerable pregnancy and this is an action point recorded by the safeguarding team in every case. Of the 20 cases reviewed there was clear evidence in 80% of cases that some liaison had occurred between CMW and HV. This is a positive result, however, in the 69% (11) of GP cases the information sharing process has not been so successful achieving liaison in just 50% (8) of cases. Of the eight 'yes' responses, five cases had been discussed with the HV with one practice reporting a formal meeting with the HV and MW – this is an example of excellent practice. One case was called in to see a GP and two cases were referred to the Child and Family Wellbeing Service. This is an area that requires further exploration as a joined up approach in such cases as identified in SCR 'John' (2012) is expected.

4.11 The majority of GP practices in West Essex use the SystmOne electronic patient record. It is recommended that the ISF be attached to the pregnant mother's record so that information is available, on a need to know basis, by practitioners involved in their care. In all the cases (60%) where an ISF was received by the HV service it was attached to the maternal record, however only 35% (8) resulted in an alert being applied to the record. Of the 69% (11) of cases received by GP services just 63% (7) attached the ISF or recorded an alert to the maternal record. 36% (4) of the 'yes' responses added an alert to the patient's record recording the vulnerability or receipt of the ISF. Two practices felt that 'Domestic Abuse' codes already on the records were sufficient and one practice had already highlighted the patient's vulnerable status prior to receiving the ISF.

4.12 The audit asked if HV's or GP's were contacted by social care partners for S17/S47 (Children Act 1989) information where a referral had been made. Of all the cases referred to Social Services HV's recorded requests for information in 20% (4) of cases 10% (2) cases were already open to social services indicating that contact had not been made by social services to HV's in 70% of cases. The GP's also were contacted in just 20% (4) cases for information relating to cases. This low figure may be the result of the quality of referrals or a decision made to not action further made by children social care.

4.13 Of the 20 ISF forwarded to HV's all were risk assessed according to the HV criteria. 10% (2) were involved with the Family Nurse Partnership programme (FNP) so were already receiving an enhanced package of care. 10% (2) cases were assessed as requiring MESCH, an HV intervention and system that is
delivered within universal services and based on the core health visiting principles to support and improve transition to parenting by supporting mothers through pregnancy. 25% (5) receiving enhanced HV care and were open to Social Services as 'Child in Need' and 15% managed as 'Child Protection

with the UBB having a CP plan. 40% (8) cases remained in universal services. System One allows HV's to join up children, siblings and parents so that any family vulnerability is reflected in all associated records. 95% (19) of the ISF forwarded to the HV services were recorded in the 'Groups and Relationships' tab and a care plan formulated.

4.14 An ISF can be completed by any health professional coming into contact with a vulnerable pregnant woman. GP's were asked if they knew of who could complete an ISF. Of the nine practices involved in the audit, three were aware that any health professional can complete an ISF and six practices were unaware indicating a need for further education in this area.

5.0 Observations

5.1 The audit was an example of joined up working by safeguarding professionals within the three services offering health care to vulnerable pregnant women and their UBB's. It has become evident that on balance the process is becoming embedded in most areas of practice and has been a useful information sharing tool particularly between HV and midwifery services. It is evident that the ISF process was not adequately rolled out to GP's and this was reflected in the lack of knowledge identified within GP practices. This is being corrected currently by supporting GP's to use the ISF and sharing the findings of the audit at the safeguarding GP forum.

5.2 The audit has highlighted some areas of excellent practice such as the calling of a multi-disciplinary health meeting to discuss vulnerable cases and to monitor the progress in pregnancy. This enables good communication so that all are working towards good outcomes for vulnerable pregnant women and their UBB's. Also recognising and responding at the earliest opportunity if a case is not progressing in an expected way.

6.0 Recommendations

Incorporate SMART (Specific Measurable Achievable Realistic Timely) principles in all recommendations.

1. Produce a flow chart for receipt and actions required by all relevant organisations (PAH/ GP/ Virgin Care) on receipt of an ISF liaison, highlighting records

2. Encourage GP practices to hold a regular children's multidisciplinary team meeting, with attendance from Community Midwives and have the ISF as a standing agenda item.

3. Ensure GPs know how to generate an ISF when identifying vulnerable pregnant woman

4. Feedback to GPs any relevant learning points from the other two sections of the audit

5. To ensure Alerts are applied to the SystmOne maternal record

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6. To ensure midwives gain consent from all women to share information

7. To ensure midwives are aware of their safeguarding responsibilities and are able to make safeguarding referrals when indicated and in accordance with ESCB guidance at the earliest opportunity ensuring improve outcomes for vulnerable women and their babies

8. To monitor audit liaison between GP, HV's and CMW to ensure vulnerable pregnant women are appropriately supported, monitored and receiving joined up care in pregnancy and the PN period

The Princess Alexandra Hospital NHS
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Trust action plan for Information Sharing forms
Completed by: Nicole Anderson

No.	Recommendations	Evidence	Action required	Expected completion date	Actual completion date	Person Responsible
1.	Produce a flow chart for receipt and actions required by all relevant organisations (PAH/ GP/ Virgin Care) on receipt of an ISF liaison, highlighting records	Audit and monitor compliance	1. Safeguarding midwifery team to triage ISF's within 10 working days 2. HV Professional lead to review current process 3. Cascade updated pathway to HV teams to ensure compliance with receipt of ISF's onward process.	Feb 18	Feb 18	HV Lead
2.	Community midwives to attend GP practice multidisciplinary team meeting and to have the ISF as a standing agenda item.	Record of attendance and feedback to safeguarding team.	Named midwife to share dates of meetings with community midwifery team leaders to ensure attendance.	Aug 18		Named Midwife for Safeguarding
3.	Ensure GPs know how to generate an ISF	Blank ISF emailed to	• To discuss at	Aug 18		Named Midwife

Clinical Audit Report – N. Anderson, C.Curtis, C.Bartlett & S.Humphries

The Princess Alexandra Hospital NHS
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No.	Recommendations	Evidence	Action required	Expected completion date	Actual completion date	Person Responsible
	when identifying vulnerable pregnant woman	all GP's with a summary of how to complete and secure email details.	GP neighbourhood meetings			for Safeguarding
4.	Feedback to all professionals the relevant learning points from the all sections of the audit.	Presentation – copy of email shared to all midwives.	Arrange presentation at peer review, PS&Q, Named Professional meeting and all midwifery staff.	Feb 18		Safeguarding Team
5.	To ensure Alerts are applied on the SystmOne maternal record	Repeat of ISF audit to ensure alerts applied to antenatal record	To review S1 / Electronic record to see if a status marker is put onto the record during the ante natal period	Feb 18		HV Lead
6.	To ensure midwives gain consent from all women to share information via the ISF	Repeat of ISF audit to ensure consent requirements are met.	1. To reinforce requirement in training and supervision of midwives 2. To cascade the findings from the audit at midwifery team meetings	Feb 18		Named Midwife
7.	For all midwives to be compliant with mandatory safeguarding training and safeguarding supervision to ensure they are aware of their safeguarding responsibilities and are able to make safeguarding referrals when indicated and in accordance with ESCB	• Training attendance of midwives • Supervision of	Audit & monitor compliance figures from the training department and Safeguarding supervision compliance	Ongoing		Safeguarding Team

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No.	Recommendations	Evidence	Action required	Expected completion date	Actual completion date	Person Responsible
	guidance at the earliest opportunity ensuring improve outcomes for vulnerable women and their babies	community midwives	from the supervision database.			
8.	To audit the completion of actions from the triaged ISF.	Audit of ISF's	Repeat of ISF audit to ensure actions are being carried out	Nov 18		Named Midwife

Standards / Guidelines / Evidence Base

- The Essex Multi-Agency Pre-Birth Protocol
- The Hertfordshire Multi-Agency Pre-Birth Protocol
- Working Together to Safeguard Children 2015
- ESCB - Southend, Essex and Thurrock safeguarding procedures
- HSCB - Hertfordshire safeguarding procedures
- The PAH NHS Trust Safeguarding Children/Young People Policy

The Princess Alexandra Hospital NHS
NHS Trust

	Quality and Safety Committee **26th October 2018**
Agenda Item:	3.2
Presented by:	Dr Shico Visuvanathan, Consultant Microbiologist and Director of Infection Prevention and Control Jenny Kirsh, Head of Infection Prevention and Control
Prepared by:	Jenny Kirsh, Head of Infection Prevention and Control Dr Shico Visuvanathan, Consultant Microbiologist and Director of Infection Prevention and Control
Date prepared:	August 2018
Subject / Title:	Infection Prevention and Control Annual Report 2017-2018

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 report outlines Infection Prevention and Control activity at PAH NHS Trust from 1st April 2017 – 31st March 2018. It includes the Infection Prevention and Control Annual Work Programme, and Audit Programme for the period 1st April 2018- 31st March 2019. A detailed Executive summary is included in the main report.
Recommendation:	The Quality and Safety Committee are asked to consider and note the attached 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:	N/A
Risk / links with the BAF:	Patient safety is at risk if good infection control practice is not adhered to. Poor practice will lead to an increase in Health Care Associated Infections, putting patients at risk. The Trust is liable for financial penalties if we breach our *C difficile* and MRSA bacteraemia targets.
Legislation, regulatory, equality, diversity and dignity implications:	The Trust has a duty to ensure compliance with the Health and Social Care Act 2008 (updated 2010), which contains Statutory guidance about compliance with Infection Prevention and Control Standards.
Appendices:	Three appendices attached – see contents page

9.3

The Princess Alexandra Hospital NHS
NHS Trust

Infection Prevention and Control

Annual Report

1st April 2017 – 31st March 2018

Including the Infection Prevention and Control Annual Work Programme and Audit Programme 1st April 2018- 31st March 2019

Authors:

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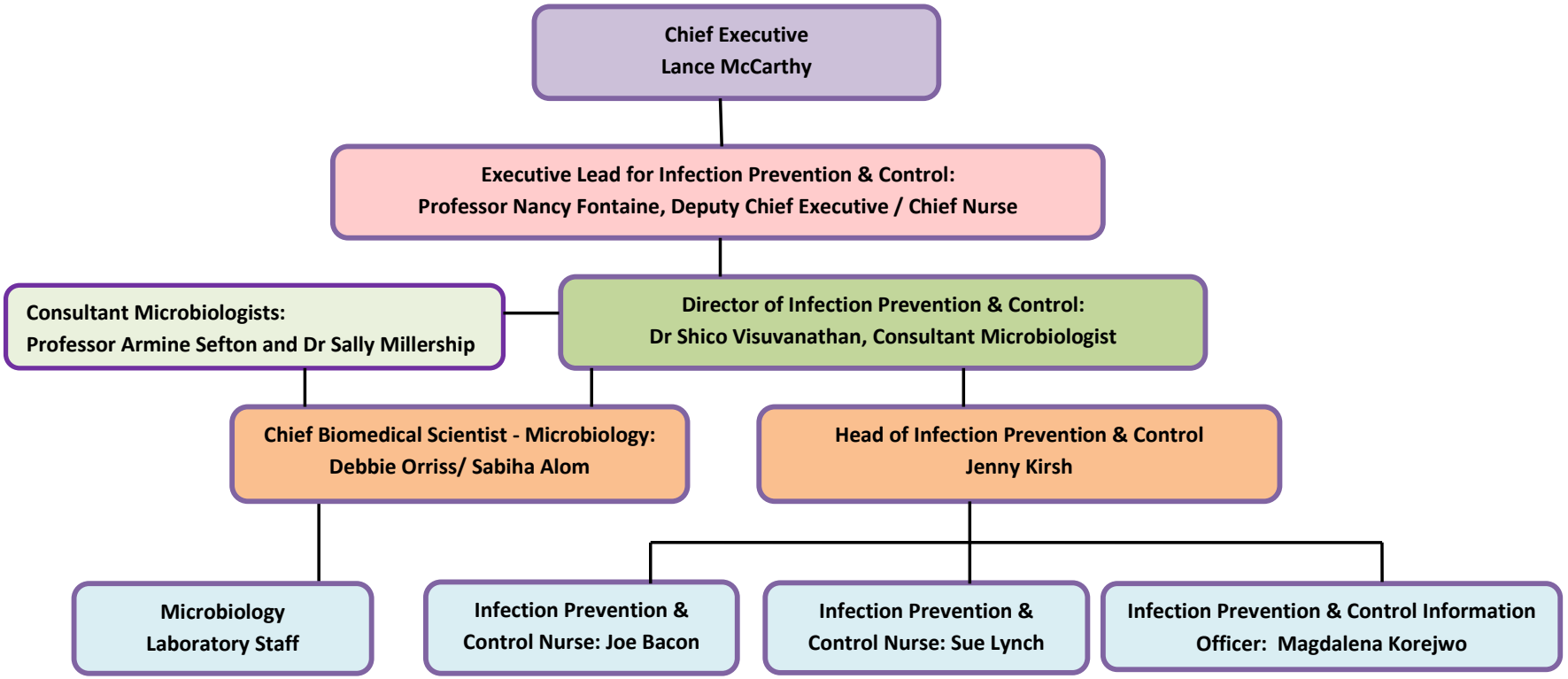
Contents

Abbreviations used in this Document.

ADON	Associate Director of Nursing
A & E	Accident and Emergency Department
CCDC	Consultant in Communicable Disease Control
CCG	Clinical Commissioning Group
C.difficile	*Clostridium difficile*
CEO	Chief Executive
CMO	Chief Medical Officer
CPE/CPO	Carbapenemase-producing *Enterobacteriaceae*/organisms
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
DOH	Department of Health
DPH	Director of Public Health
E.coli	*Escherichia Coli*
ESBL	Extended Spectrum Beta Lactamase producing organisms
GDH	Glutamate Dehydrogenase
HCAI	Health Care Associated Infection
HCG	Health Care Group
HPA	Health Protection Agency. To be replaced with Public Health England
HOIPC	Head of Infection Prevention and Control
HON	Head of Nursing
IPCN(s)	Infection Prevention and Control Nurse(s)
IPCT	Infection Prevention and Control Team
IPC	Infection Prevention and Control
MRSA	Methicillin (or Meticillin) resistant *staphylococcus aureus*
MSSA	Methicillin (or Meticillin) sensitive *staphylococcus aureus*
NHSLA	NHS Litigation Authority
NICE	National Institute of Clinical Excellence
NTDA	Nation Health Service Trust Development Authority
PAH	Princess Alexandra Hospital
PCR	Polymerase Chain Reaction
PHE	Public Health England
SSI	Surgical Site Infection
SUI/SI	Serious Untoward Incident/ Serious incident
RCA	Root Cause Analysis
VRE / GRE	Vancomycin Resistant *Enterococci* / Glycopeptide Resistant *Enterococcus*

1.0 Trust Organisational Structure and Reporting of Infection Prevention and Control



2.0 Executive Summary:

2.1 The Trust has a duty to ensure compliance with the Health and Social Care Act 2008 (updated 2010), which contains statutory guidance about compliance with Infection Prevention and Control (IPC) standards. The IPC annual report reflects arrangements in place for management and monitoring IPC at the PAH NHS Trust, and provides an overview of IPC activity in the financial year 2017 /18. There is a separate IPC work programme and audit programme for 2018 /2019.

2.2 There is a trajectory of zero tolerance of MRSA bacteraemia across the NHS. During 2017-18, there were zero cases of MRSA at PAH NHS Trust. PAH has not had a Trust apportioned MRSA bacteraemia case since July 2014.

2.3 In total, there were 14 cases of Trust apportioned *Clostridium difficile* (*C.difficile*) reported in the 2017-18 period. This was against another challenging trajectory assigned to the Trust of just ten cases for the year. However, eight of the 14 cases were successfully appealed at the North Essex Quality Collaborative Serious Incident and Never Event Panel; thus the Trust only had six cases that were 'considered' to be Trust-apportioned in terms of CCG contractual agreements. As a result of this, there will not be any financial penalties imposed on the Trust and would be a cost saving of approximately £ 40,000.

2.4 Trust apportioned cases of Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia has remained very low at four cases for the year. National benchmarking demonstrates the Trust has continued to control these infections year on year. This has ensured we have remained in the top quarter of best performing Trusts for low rates of MSSA infections.

2.5 National benchmarking shows our health care economy in a favourable position, in the top quarter, for total numbers of Escherichia coli (*E. coli*) blood stream infections (BSI or bacteraemia). During this financial year, 20 of the 175 cases of E .coli BSIs were Trust-apportioned, which is 11.4% of cases.

2.6 It is noted that although the number of patients presenting with ESBL bacteraemia remains small, these multi-resistant organisms, like many multi-resistant organisms across the UK, are slowly rising year on year. However there is no national information to compare our figures.

2.7 There is a national gram negative blood stream infection (BSI) ambition (since April 2017), to halve the numbers of healthcare associated Gram-negative BSIs by 2021. For 2017/18 the focus was on reducing healthcare associated *E. coli* BSIs, because they represent 55% of all Gram-negative BSIs. Clinical commissioning groups (CCGs) are leading on achieving the Quality Premium from April 2017 for two years, aiming to reduce all E. coli BSIs by 10% in Year 1. From April 2017 we also began collecting data for *Klebsiella sp* and *Pseudomonas aeruginosa* cases.

2.8 During 2017-18 there 41 isolates (all sites) of Vancomycin Resistant *Enterococcus*. These were colonised cases as opposed to clinical infection.

2.9 There were no cases of Carbapenemase-producing *Enterobacteriaceae* (CPE) in the Trust this year.

2.10 A programme of IPC inspections has continued in clinical areas, with a multi-disciplinary team.

2.11 Monthly cross over audit results for hand hygiene compliance over the year shows the Trust average overall compliance to be good. Performance was 92% for the Medicine Health Care Group (HCG), 93% for the Surgery and Critical Care HCG, 99% for the Family and Women HCG, and 98% for the Cancer, Cardiology and Clinical support HCG.

2.12 Norovirus outbreaks at PAH occurred from August 2017 until March 2018 (and continued until May 2018, past the period covered in this report). In total there were six outbreaks (involving multiple wards). The Trust has robust systems in place for the management of outbreaks with daily meetings for the duration.

2.13 Our hospital based Tuberculosis (TB) multi-disciplinary team (MDT) has significantly improved the diagnosis and management of TB across the health care setting. PAH are able to demonstrate that we meet national standards in TB diagnosis and management, including standards outlined in the Collaborative Tuberculosis Strategy for England 2015 to 2020.

2.14 SHAW (Staff Health and Well-being) have led again on the Influenza vaccination programme in the Trust this year, vaccinating staff across the organisation. The target of 70% of staff vaccination was met.

2.15 The Patient Panel Representative attending the ICC since early 2014 provides a lay person's perspective to IPC. The patient representative has been extremely helpful and supportive of the ICC and ICT.

2.16 Since January 2018 there has been no Trust HIV or sexual health Consultant input for in – patients. Staff members who require Post exposure prophylaxis (PEP) for a needlestick injury receive initial support from ED, and then from SHAW (Staff Health and Wellbeing). However there is no support from a Consultant HIV physician.

This has been placed on the risk register for the Medicine Health Care group.

3.0 Introduction

3.1 The purpose of this report is to provide assurance that the Princess Alexandra Hospital (PAH) NHS Trust has safe and robust IPC measures in place which are effective in controlling healthcare associated infections (HCAIs). Additionally, it aims to afford the Trust's compliance against the Code of Practice on the Prevention and Control of Infections (under The Health and Social Care Act 2008), by which it has a duty to provide safe and effective care. This annual report covers the period 1st April 2017 to 31st March 2018 and reference to the 'year' or '2017/18' refers to these dates. The annual work programme and annual audit programme for 2018/19 are also included as appendices to this report.

3.2 The Trust demonstrates leadership in IPC at Board level by the Executive lead for IPC (Chief Nurse), and from the IPC Team (IPCT) by the Director of Infection Prevention and Control (DIPC), who is a Consultant Microbiologist, and the Head of Infection Prevention and Control (HOIPC), who is the Lead IPC Nurse. The IPCT is supported by a Trust wide team, and strives to ensure a culture of continuous quality improvement to minimise IPC

risks to patients, people visiting the hospital, and staff. Patients and visitors can expect all Trust staff from Board to ward level to take responsibility for the control of health care associated infections (HCAIs), including outbreaks of infection.

3.3 Staff in all HCGs demonstrate clinical ownership, and ward-based medical and nursing staff attend IPC related root cause analysis (RCA) meetings and outbreak meetings. Patient Panel representatives on the Trust IPC Committee and Quality and Safety Committee ensures patient experiences of HCAIs are used to inform IPC reviews and investigations.

4.0 Acknowledgments

4.1 All staff have made great efforts to ensure IPC remains 'everybody's business' at PAH. We thank them all for helping us continually improve and maintain IPC standards across the Trust.

4.2 Additionally the IPCT wish to acknowledge and thank all those that have contributed to the writing of this report, including; Debbie Oriss (Chief BMS, Microbiology Laboratory), Alison Morris (Health and Safety Manager /Acting Estates Manager), Richard Hammond (previous Deputy Chief Operating Officer and Decontamination Lead), Shayi Shali (Antimicrobial Pharmacist), Chris Goulding (Joint Replacement Nurse), Mandy Kerr (Practice Development Midwife), Andy Hare (TB Nurse Specialist), Polly Ridgwell-Cook (Information Department), Alexandra Anyanwu (Head of Core Training and Development) and Kathryn Court (SHAW Nurse).

5.0 Infection Prevention and Control Service and Arrangements

5.1 The IPC department provide a service for the Princess Alexandra Hospital NHS Trust and the out-patient departments of St. Margaret's Hospital in Epping and the Herts and Essex Hospital in Hertfordshire.

5.2 A fully constituted IPCT are in place in the Trust; the team are responsible for the delivery of the infection prevention and control service across the organisation. The function of the team is to provide an advisory service to all members of staff, to provide training and education for clinical and non-clinical staff; to undertake proactive work to reduce the incidence of infection and reactive work in response to incidents and outbreaks. Additionally the team are responsible for the development of the core IPC policies, overseeing and undertaking of audits, surveillance and outbreak management.

5.3 The IPC nursing team establishment is currently funded as:

- 1.0 WTE Head of Infection Prevention and Control
- 2.0 WTE Infection Prevention and Control Nurses
- 1.0 WTE Infection Prevention and Control Information Officer

5.4 The IPC nursing team are led by the DIPC. The line management of the HOIPC is with the Associate Director of Nursing (ADON) for Cancer, Cardiology and Clinical Support

(CC&CS) and directly to the Chief Nurse as the Executive Lead for IPC. Professionally, the HOIPC is accountable to the DIPC. The HOIPC has line management responsibility for the IPC nursing team and the Information Officer.

5.5 The Chief Nurse is also the Executive Lead for Infection Prevention and Control at the Trust.

5.6 There are two other Consultant Microbiologists, one WTE and one part time, who provide support to the IPC team.

5.7 Additionally, the IPC team have close working relationships with the Microbiology laboratory staff, the Antimicrobial Pharmacist, and Staff Health and Wellbeing (SHAW).

5.8 The IPCT provides an on-call service outside of normal working hours.

6.0 Infection Prevention and Control Team Networks

6.1 The expectation of the Care Quality Commission (CQC) is that the Trust will have effective management systems in place for the prevention and control of HCAI, informed by risk assessments and analysis of infection incidents.

6.2 The IPC networks ensure that the Trust Board and senior staff are kept informed and that surveillance, audit and risk assessments are undertaken and lessons learnt are acted on.

6.3 The HOIPC submits monthly reports detailing activity to the Quality and Safety Committee (Q&SC), Service Performance and Quality Review Group (SPQRG), Trust Integrated Performance Report (IPR), monthly performance reports for each of the four health care groups (HCGs).

7.0 Microbiology Services

7.1 PAH is one of the current NHS pathology providers in the East of England

7.2 Pathology services across the East of England have been consolidated over the last few years with laboratories at Norwich (Eastern Pathology Alliance), Cambridge (The Pathology Partnership) and Basildon/ Southend (Integrated Pathology Partnerships) as well as two standalone Pathology laboratories at PAH and MEHT

7.3 Across England, NHS and social care organisations have been encouraged by NHS England to work closely together to deliver more effective, joined-up and affordable services that can continue to meet the needs of the population now and in the future. With this in mind Pathology services have initiated preliminary talks with our local STP partners. The Trust is also involved with NHS Improvement who have identified 29 potential pathology networks, allowing for the transformation of pathology services into a series of networks across the country.

7.4 The Microbiology Department endeavours to provide a modern, relevant microbiological service in an accurate, comprehensive and timely manner. This service includes laboratory diagnosis of, and advice on treatment of infections, advice on

immunisation, and the provision of control of infection advice in hospitals. It employs analytical and interpretive skills to aid in the prevention, diagnosis and treatment of disease.

7.5 Services are continually reviewed to ensure the development of services to meet future demands and implementation of new technologies to improve patient safety and efficiencies. The Trust has been supportive in the implementation of these technologies which has enabled us to improve our turnaround times and the quality of results provided. Maintaining an on–site Microbiology service is of great importance in supporting our highly reactive IPC service.

7.6 The laboratory is fully accredited under the new UKAS standard ISO 15189:2012 and is awaiting a response from UKAS with regard to maintaining this accreditation following a recent annual inspection.

8.0 Committees and other meetings:

8.1 Infection Control Committee

8.1.1. The Infection Control Committee (ICC) is chaired by the DIPC. The committee usually meets on a quarterly basis. It is expected that there is representation from each HCG (medical and nursing), as well as departments such as Facilities and Estates, SHAW and Pharmacy. The Committee is a productive forum, but increased representation from the HCGs and Clinicians would be beneficial. This year there has not been representation from all HCGs. The need for increased medical representation has been previously highlighted. The attendance is monitored by the DIPC.

Public Health England (PHE) is represented at the ICC; the Consultant in Communicable Disease Control (CCDC) has a dual role and also works at the Trust part time as a Consultant Microbiologist. The IPCT continue to inform and liaise with PHE when there are public health concerns or any communicable diseases to notify.

8.2 Trust Board, Governance and relationships including with other Committees

8.2.1 The HOIPC submits monthly reports to the Q&SC and attends the meeting to present the report. The DIPC attends as required and will also report to the Trust Board at least once a year. The HOIPC also submits monthly reports to the SPQRG and will attend as required.

8.3 Meetings with Clinical Commissioning Group (CCG)

8.4 Monthly RCA Scrutiny Panel

8.4.1. Up until January 2018 a memorandum of understanding (MOU) was in place across the three North Essex CCGs for the provision of IPC oversight and assurance, and within this MOU, Mid Essex CCG hosted the CCG IPCT . The HOIPC attended the monthly North Essex HCAI Scrutiny Panel meetings chaired by the CCG IPC Nurse, to discuss all cases of *C. difficile* and relevant HCAIs. The purpose of the meetings was to provide a second line of assurance, with expert oversight of the quality of investigations of relevant HCAIs, across NHS North Essex locality, and to ensure sharing of the learning identified from such investigation, providing assurance to the CCGs and provider organisations.

8.4.2. The panel was responsible for deciding if Trust apportioned *C. difficile* cases met the criteria for appealing against. The presenting Trust provided a full overview of each case to the Scrutiny Panel representatives and a decision is reached as to whether it is a suitable case to be taken forward by the CCG Lead IPCN to the Serious Incident Assurance Panel for final sign off.

8.4.3. In January 2018, the MOU ended as a consequence of the three CCGs being aligned to different sustainability and transformation partnerships (STPs) footprints. Following the ending of the MOU, West Essex CCG (WECCG) has joined the IPC meeting which is held in common with the Hertfordshire CCG's and reporting of data from both PAHT and Essex Partnership University trust (EPUT) is now reviewed in common with our STP partners. This is not a formally constituted Committee as an STP Governance structure has not yet been agreed.

8.4.4. The CCG Director of Nursing and Quality have been in discussion with the Chief Nurse from PAHT and the possibility of a local system IPC function which would strengthen local oversight and support to commissioned services whilst also ensuring a greater degree of assurance to the WECCG Board in relation to IPC Matters.

9.0 Standards

9.1 Regulation 12 of the Health and Social Care Act 2008 *Code of Practice on the prevention and control of infections and related guidance* reviewed 2010 (regulated activities), requires acute Trusts to be compliant with all elements of the regulation; this is monitored by the Care Quality Commissioners (CQC) The Trust is registered with the CQC without conditions.

9.2 The Trust should also demonstrate compliance with best practice guidance such as National Institute of Clinical Excellence (NICE).

10.0 Summary of Infection Prevention and Control Performance 2017-18

10.1 Mandatory surveillance

10.1.1 Mandatory surveillance and monitoring is a requirement for all Trusts on the following:
All bacteraemias caused by:

- Meticillin Resistant *Staphylococcus Aureus* (MRSA)
- Meticillin Sensitive *Staphylococcus Aureus* (MSSA)
- Glycopeptide Resistant *Enterococcus* (GRE) - also referred to as Vancomycin Resistant Enterococcus (VRE)
- *Escherichia Coli* (E-coli)
- *Klebsiella spp.*
- *Pseudomonas aeruginosa*
- *Clostridium difficile* infections in patients over the age of two years old.

and

- Surgical Site Surveillance - all NHS Trusts where orthopaedic surgery is performed are expected to carry out a minimum of three months surveillance per year (1 April to 31 March) in at least one of the four orthopaedic categories:

- Hip replacements
- Knee replacements
- Repair of neck of femur
- Reduction of long bone fracture

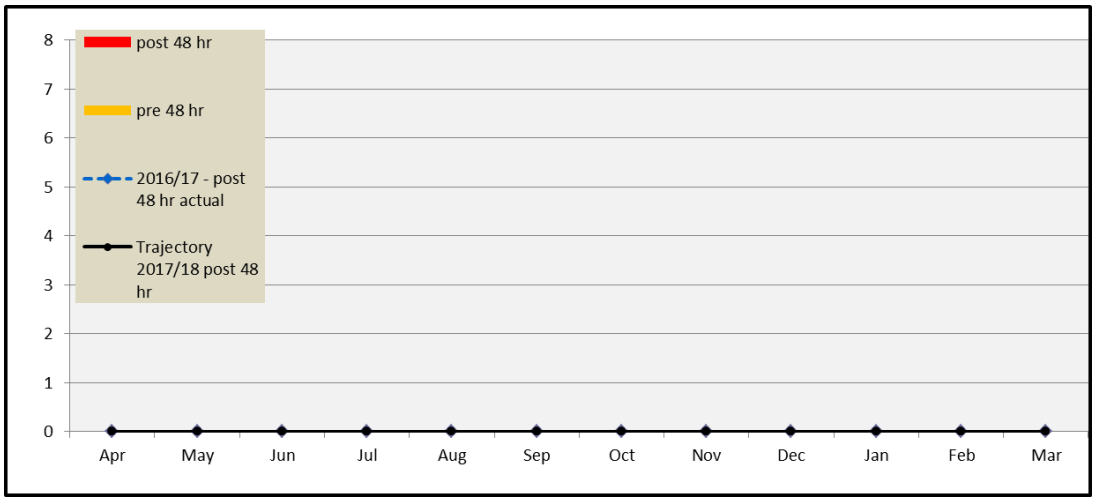
10.2 MRSA bacteraemia

10.2.1. The Trust is proud of its continued low rate of MRSA bacteraemia and has maintained its position in the top third of best performing Trusts nationally. There have been no Trust apportioned cases since July 2014.

10.2.2. Whilst our national position is favourable, it is important that staff do not become complacent. It is therefore essential that there is compliance with IPC standards amongst all staff to reduce the risk of susceptible/colonised patients developing an MRSA bacteraemia.

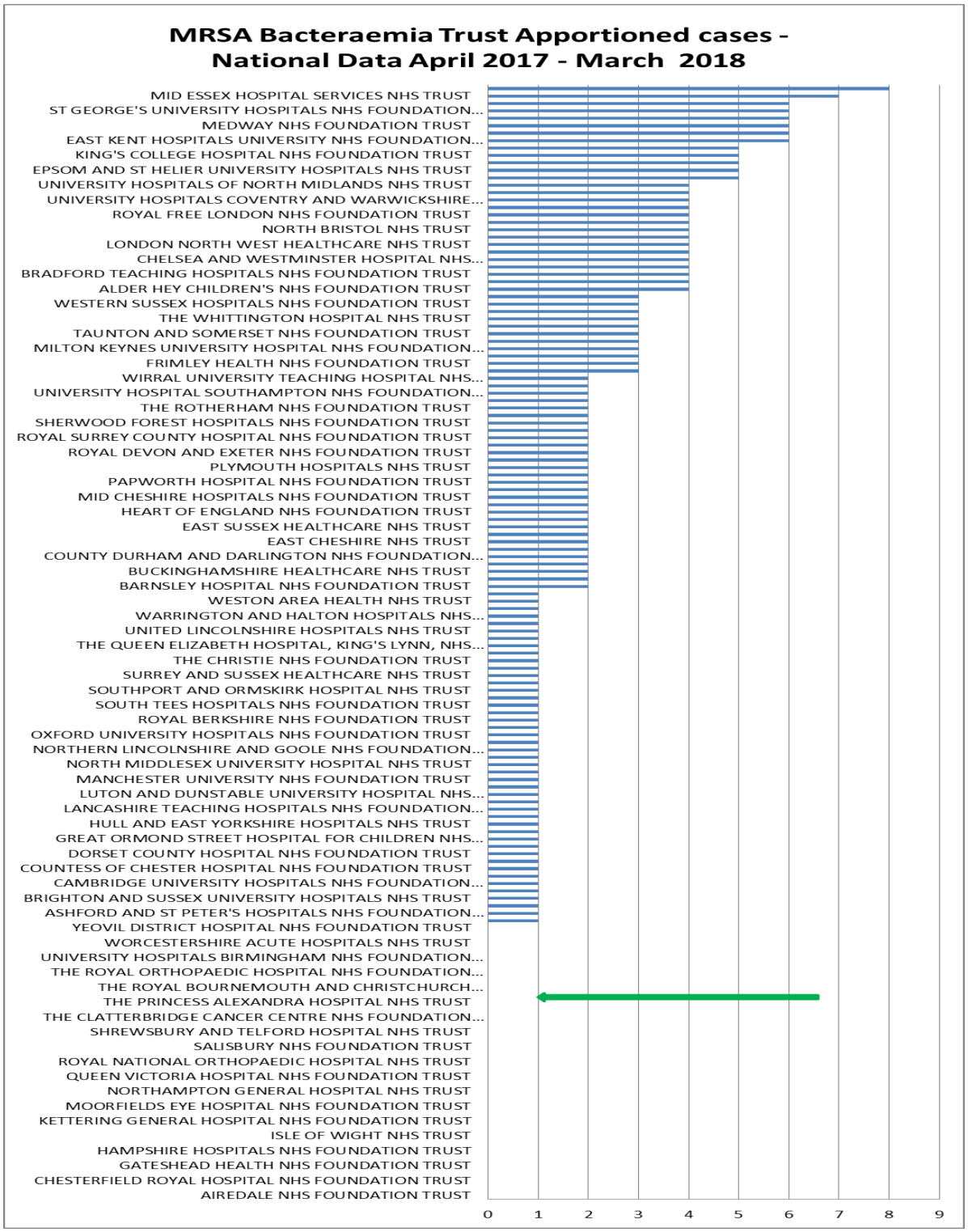
10.2.3. In the graph below (**Figure1**) the Trust trajectory of zero for 2017 /2018 is shown in black (a target of zero tolerance has been set by the DoH for all NHS hospitals).

Figure 1: Cumulative data at PAH NHS Trust, for Trust apportioned and non-apportioned MRSA bacteraemia cases in 2017/2018



The Trust's position against all acute Trust's in England can be seen in **Figure 2** below:

Figure 2: MRSA Bacteraemia Trust Apportioned Cases – Acute Trusts in England 2017-2018



10.3 *Clostridium difficile*

10.3.1. The PAH infection prevention and control strategy means we have performed extremely well over the years, placing us in the top third of best performing Trusts nationally for 2017-18. We have achieved this through commitment and effort from all staff at the Trust who have remained vigilant and engaged in infection control procedures throughout the year. We have a robust Root Cause Analysis (RCA) process in place which is significant in contributing to shared learning amongst staff. Our success reflects our compliance with IPC and antimicrobial prescribing policies. This is despite the challenges of PAH being an old hospital with many Estates issues and coming through another difficult winter with many elderly patients, many of who are 80 + and norovirus outbreaks.

10.3.2. It should also be noted that PAH had a significantly lower trajectory than our neighbouring Trusts; this reflects our excellent rates in previous years, but means we face a more challenging trajectory than many others. The trajectories set for PAH have been similar to those assigned to paediatric and specialist hospitals such as orthopaedic and maternity hospitals (where a low rate of *C.difficile* would be expected).

10.3.3. There were 14 cases reported by us for 2017-18 (four less than the previous year) on the national HCAI data capture system, but the CCG (via the North Essex HCAI Scrutiny Panel) are considering only six (of 14) cases to be Trust-apportioned. This is because *C difficile* is recognised as an unfortunate consequence of the use of antibiotics (which often can be life -saving) and there were no lapses in care associated with eight of our 14 cases; these were therefore deemed to be 'unavoidable' cases.

10.3.4. In cases where Trusts go above their trajectory, financial penalties are imposed by the CCG. This therefore means that due to the successfully appealed cases, we are below trajectory; not only is this significant for the Trust's reputation and patient safety, it also means there has been a cost avoidance in penalty fines to the Trust of around £40,000.

10.3.5. Root Cause Analysis (RCA) meetings were held for all cases chaired by the DIPC / Consultant Microbiologist, and included representation from the Consultants (or deputies) caring for the patients, Ward Managers (or Deputy), Matrons, IPCN(s) and the Antimicrobial Pharmacist.

10.3.6. Key themes identified in the investigations included delays in isolation or unclear documentation relating to this (where appropriate escalation was made, this did not stop cases winning appeals), some delays in specimen collection and the need for improved communication e.g. it was not always identified in the hand-over of patients to the clinical site team or admitting clinical area that the patient was having diarrhoea. The positive themes included overall good compliance with antimicrobial prescribing and good hand hygiene and environmental audit scores.

10.3.7. The Trust has continued to implement its strategy for the prevention and control of *C.difficile* management which has included;

- Continued use of the SIGHT model (**S**uspect, **I**solate, **G**loves/aprons, **H**and washing, **T**est samples)
- Use of the antimicrobial prescribing Smart phone app

- Undertaking of IPC inspections in clinical areas with a team of multidisciplinary staff to evaluate the environment (cleaning and estates) and general IPC practices.
- Antimicrobial stewardship; the formation of an antimicrobial stewardship group in December 2017, antibiotic ward rounds with Antibiotic Pharmacist/Consultant Microbiologist and the antimicrobial audits
- Teaching and education
- Hydrogen Peroxide Vaporiser for the decontamination of the environment (on discharge of all cases of patients with C.*difficile)*
- Root Cause Analysis of all cases where learning is shared
- Appeals process in place for unavoidable cases.

10.3.8. The graph below (**Figure 3**) demonstrates the cumulative total of *C. difficile* from 1 April 2017 – 31 March 2018. All cases, including Trust apportioned cases (shown in red and labelled as post 72 hour cases) and non-Trust attributable (in yellow, referred to as pre 72 hour cases) are shown. The Trust trajectory for 2017-18 is shown in black, and the blue dotted line shows actual Trust-attributable *C. difficile* cases last year, in 2016 -17. The green bars show *C. difficile* toxin *negative* (Glutamate Dehydrogenase) cases which although being monitored and managed by the IPCT, are not required to be reported to the DoH and PHE. Toxin positivity is required for *C. difficile* disease.

Figure 3: Cumulative data for Trust apportioned and non-apportioned *C difficile* and GDH cases in 2017/2018

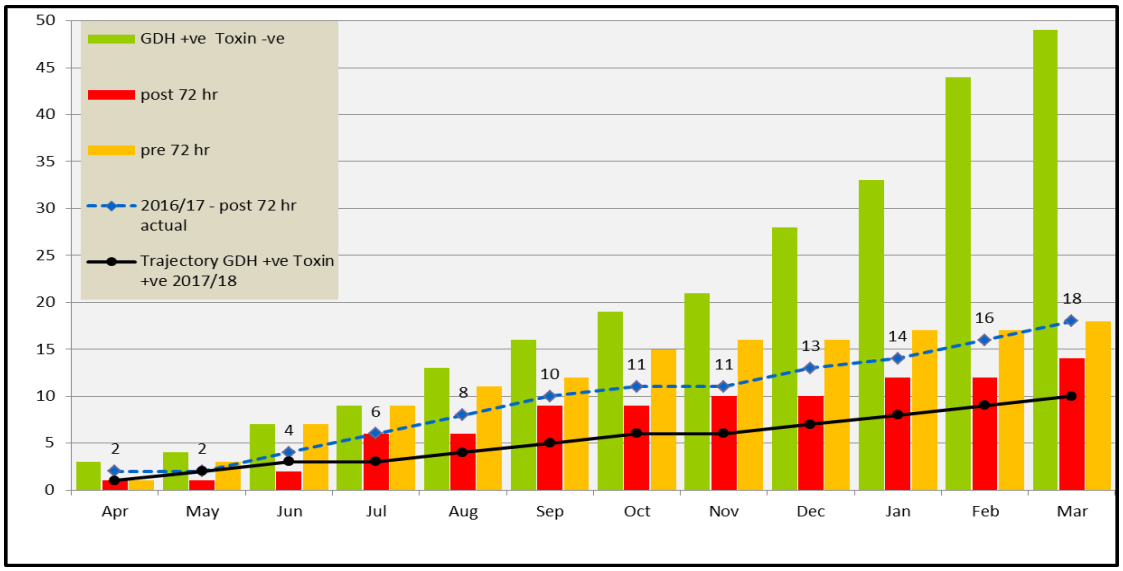
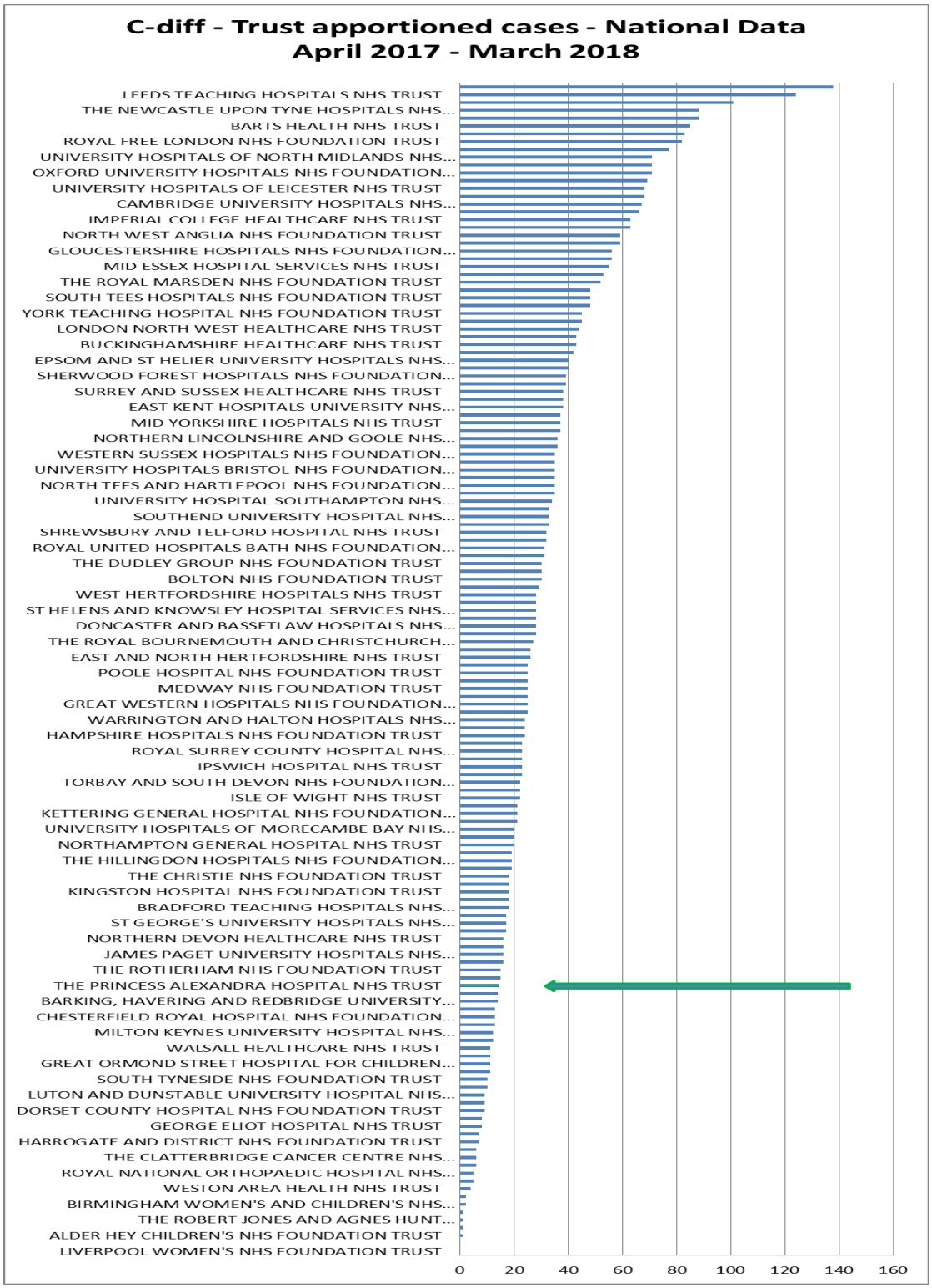
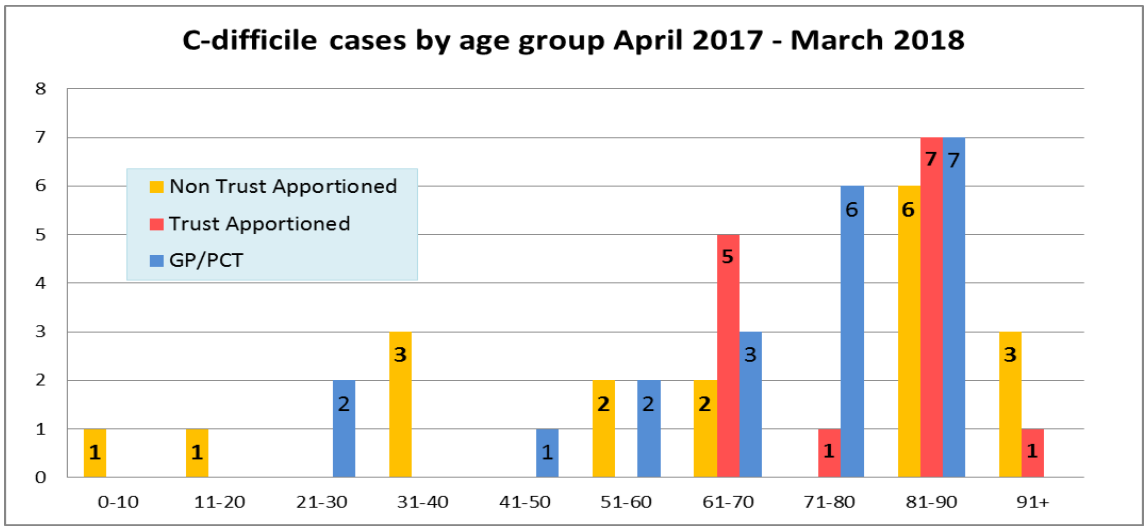


Figure 4: The Princess Alexandra Hospital's position against all acute Trust's in England for *C difficile* for the period of April 2017 – March 2018.



10.3.9. The total number of cases (both Trust apportioned and non-Trust apportioned) categorised by age groups is demonstrated in **Figure 5,** with the highest numbers being in the 81-90 years age group for both Trust-apportioned and non-Trust apportioned cases.

Figure 5: *C.difficile* categorised by age group (all cases)



10.4 Glutamate Dehydrogenase (GDH) Testing

10.4.1. GDH is the first test of a two-step a screening test and was introduced at PAH NHS Trust in July 2012 to comply with the DoH guideline on diagnosis of *C.difficile* infection (Updated Guidance on the Diagnosis and Report of Clostridium Difficile, Department of Health, March 2012). It detects *C. difficile* antigen and is undertaken on all specimens that meet the criteria for *C.difficile* testing. If positive, this would be followed by a test for toxin detection (indicative of *C.difficile* disease). If GDH was negative, the toxin test would not be performed.

10.4.2. All GDH positive, toxin negative cases are managed in the same way as toxin positive cases, in terms of infection control precautions, isolation and environmental decontamination (as patients still carry the *C.difficile* organism and may pose a risk to others). Treatment is considered on an individual basis.

10.5 Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia

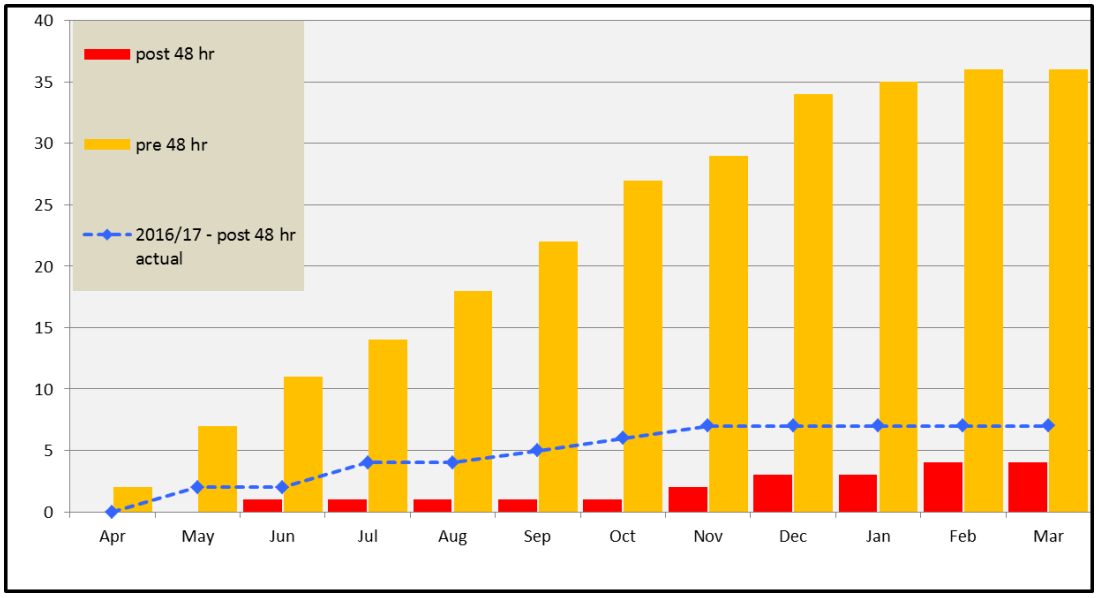
10.5.1. MSSA is the normal *staphylococcus aureus* strain that many patients carry in the anterior nares of the nose as part of their 'normal' flora. When MSSA is isolated in the blood stream this is referred to as an 'MSSA bacteraemia' and is potentially a serious condition, which, in some cases, causes mortality. MSSA strains can be treated with Flucloxacillin, a narrow spectrum antibiotic, which cannot be used in *MRSA* treatment, as MRSA is by definition Flucloxacillin resistant.

10.5.2. In the cumulative MSSA graph below (**Figure 6**), there is no black trajectory line, as the DoH has not set Trust targets for MSSA. However the IPCT continue to monitor cases and

work with clinical teams to reduce Trust attributable cases. A reduction of cases can be seen in the graph from the previous year (from seven cases then to four cases in 2017/18); however even in 2016/17 numbers were still low and some variation is expected. **Figure 7** demonstrates our favourable national position as one of the best performing Trusts.

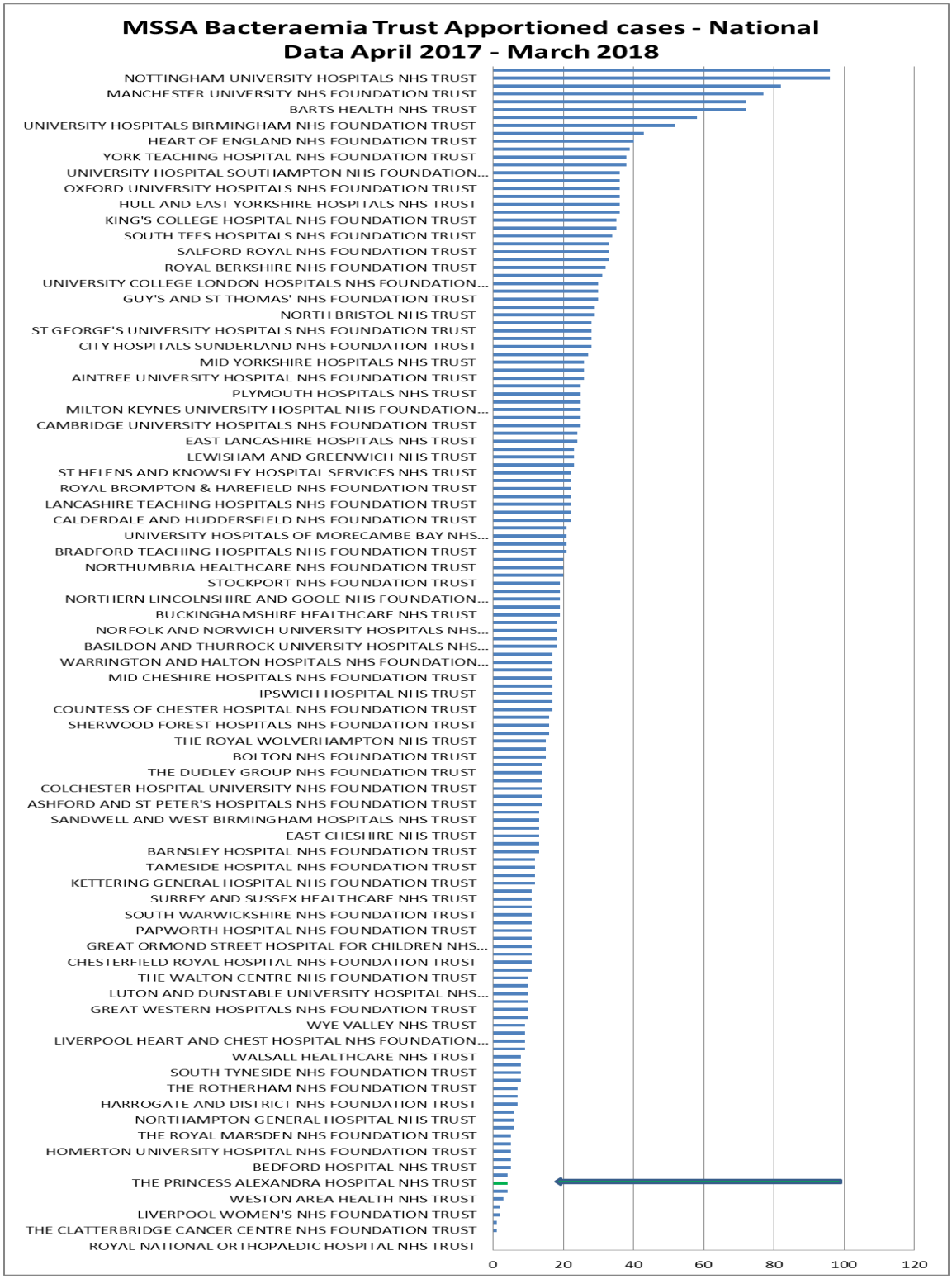
10.5.3. Our success has been achieved by multiple measures such as strict adherence to the aseptic insertion of cannulas, monitoring of phlebitis scores using the 'body map', and by monitoring the use and early removal, when possible, of cannulas and other invasive devices. Additionally all in-patients are provided with an antimicrobial wash to use for the duration of their stay which has been found to reduce the risk of MSSA bacteraemia following a study undertaken in the Trust some years ago. Many measures used to control MRSA also control MSSA. The intravenous (IV) to oral switch of antibiotics also helps control MSSA bacteraemia indirectly by enabling cannulas to be removed early in a large group of patients, as at any one time 25 -30% of hospital patients receive an antibiotic, often intravenously.

Figure 6: Cumulative MSSA Bacteraemia at PAH NHS Trust April 2017 – March 2018



9.3

Figure 7: The Princess Alexandra Hospital's position against all acute Trusts in England:



10.6 Gram negative blood stream infections (GNBSIs)

10.6.1. In England, BSIs caused by Escherichia coli and Klebsiella pneumoniae increased by 15.6% and 20.8% respectively, from 2010 to 2014. These two bacteria also cause the greatest burden of antibiotic resistant infections. Introduction of a national GNBSI target followed to reduce GNBSIs by 50% by FY 2020 /2021 as a whole health care economy, as did mandatory reporting of Klebsiella sp. and Pseudomonas aeruginosa bacteraemia. Collaborative working between CCG and hospital teams is on-going to identify common themes. However more and more surveillance information is being gathered locally and CCG IPC nursing support is required to take this work forward.

10.6.2. In 2017 / 2018: GNBSI total was 239, of which 38 were Trust apportioned

10.6.3. *Escherichia coli* (*E.coli*) bacteraemia

During the year 2017/2018, there were 155 non Trust apportioned cases and 20 Trust apportioned (post 48 hour) cases. It is reassuring that the numbers are no higher than 2016/2017.
The number of community attributable cases is far higher than hospital attributable, with the majority of positive blood cultures taken within 48 hours of admission, usually in the emergency department. In a significant number of the Trust apportioned cases, it is likely that these were not acquired on admission, but timing of the blood cultures means they are assigned as attributable to the Trust. This cumulative data is displayed in **Figure 8** below.

The urinary tract is the most common primary source of *E.coli* bacteraemia, accounting for almost two thirds (60%) of all cases in 2017-18; this compares to 62% of cases at PAH NHS Trust in 2016 -17 and 45% nationally in 2015 -2016 being associated with the urinary tract.

The urinary tract as a primary source is followed by respiratory (15% of cases), hepato-biliary (11% of cases), gastro-intestinal (6% of cases). The primary sources of all cases of *E.coli* bacteraemia can be seen in **Figure 14**.

10.6.4. Of those patients where the urinary tract was the source of gram negative blood stream infection, 29 % had a urinary catheter. The figures from previous years for % of patients with catheters when a urinary source was identified as the cause of the gram negative BSI were: 26% in 2016-17, 17% in 2015-16, 23% in 2014-15, 43% in 2013-14. These trends will continue to be monitored.

10.6.5. **Figure 15** demonstrates the Trust's position for E.coli BSIs, against all acute Trusts in England during the 2017-18 period. PAH is in a favourable position in the top third of best performing Trusts nationally.

Cases of ESBL bacteraemia are also monitored by the IPCT, and are discussed in detail in section 11 below. There is currently no national information available to compare our figures.

10.6.6. In 2017/2018, the focus at PAH NHS Trust was agreed to be on patients with uro-sepsis.

10.6.7. As the new gram negative BSI trajectory requires detailed RCAs and analyses, there has been a significant impact on the IPCT. This is being addressed for the coming year by the

Head of IPC. Although it is recommended nationally that the CCG lead on this target, the Trust IPCT will carry out much of the investigation, as all patients with BSIs will be in-patients at the point when blood cultures are taken.

10.6.8. Link with AMR (antimicrobial resistance): The fourth PHE annual report from the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) was published in 2017. ESPAUR was established to disseminate robust data on AMR, enable use of this data across healthcare settings through feedback on the PHE Fingertips platform and to measure the impact of interventions.

10.6.9. The report highlighted that AMR was common in the more than 1 million UTIs identified in NHS laboratories in 2016. This reflects our current recommendation that urine samples be sent to the laboratory from those with clinical treatment failure, frequent or recurrent UTIs or who have a likelihood of a resistant infection. The trimethoprim resistance rate of 34% reported nationally and the current recommended first line treatment nitrofurantoin with a resistance rate of 3%, reflects almost exactly our local resistance rates.
Treating UTIs optimally in General Practice and in hospital may have had controlled our E.coli BSIs, so the figures were no higher than last year. However it is too early to firmly conclude this and we will need to look at data in the coming year to see if this downward trend continues.

10.6.10. In April 2017 we have also collected data on Klebsiella sp. and Pseudomonas aeruginosa BSIs. This is because nationally, E. coli, Pseudomonas aeruginosa and Klebsiella spp. account for 72% of all Gram-negative BSIs.

Klebsiella sp.: During the year 2017/2018, there were six Trust apportioned (post 48 hour) cases.
Pseudomonas aeruginosa: During the year 2017/2018, there were 10 Trust apportioned (post 48 hour) cases.

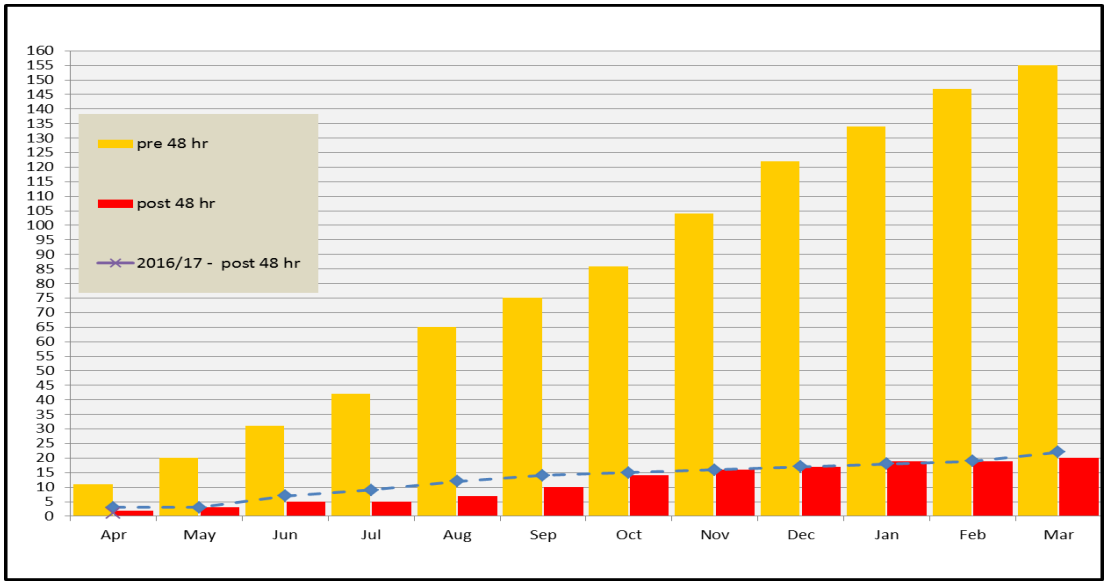
It is of concern that when compared nationally, our Pseudomonas bacteraemia numbers are high (**Figure 10**). Although total case numbers are small, the national trend is not similar to E.coli and Klebsiella BSIs. With the latter two organisms our Trust compares favourably.

Non Trust apportioned GNBSIs show similar trends, with Pseudomonas BSIs appearing in higher numbers than expected.

RCAs are planned for Trust apportioned Pseudomonas BSIs in the coming months. As pseudomonas UTIs can be associated with catheterisation, it is hoped that the catheter associated UTI reduction group established in the Trust will help address this problem.

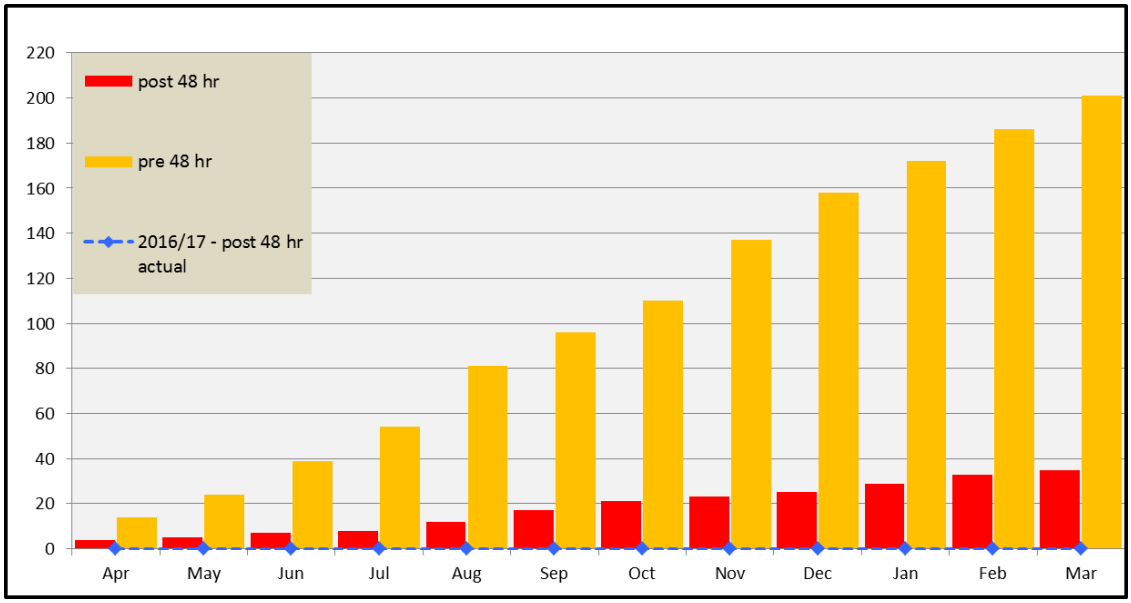
Cases of ESBL *bacteraemia* are also monitored by the IPCT, and are discussed in detail in section 12.1 below. There is currently no national information available to compare our figures.

Figure 9: Cumulative *E.coli* Bacteraemia cases 2017-2018



The total number of GNBSIs (*E.Coli, Klebsiella spp* and *Pseudomonas aeruginosa*) are shown in below.

Figure 10: Cumulative total of Gram-negative Bloodstream Bacteraemia for 2017-18



9.3

Figure 11: Cumulative *E.coli* Bacteraemia cases 2014- 2018 at PAH NHS Trust

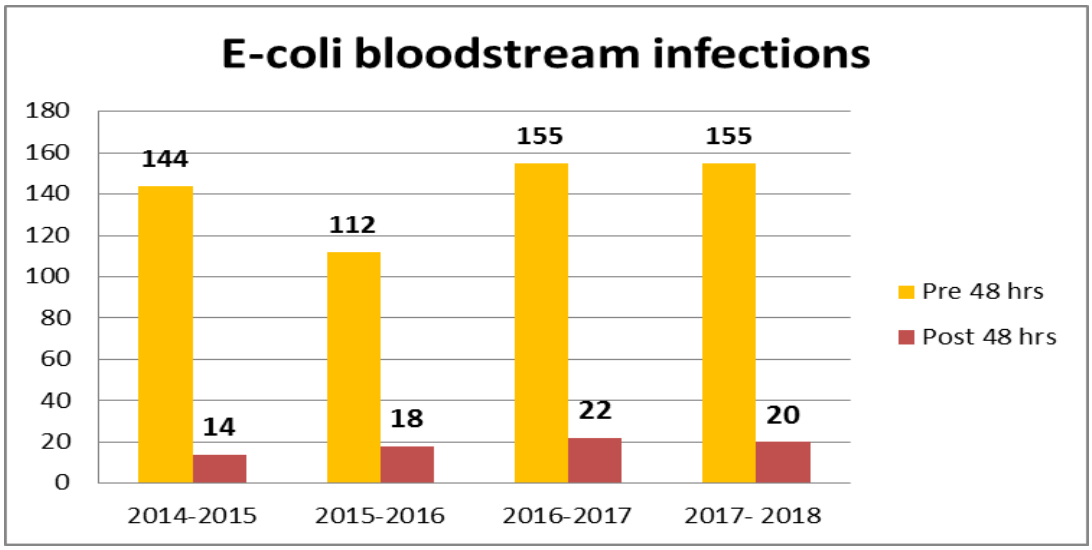
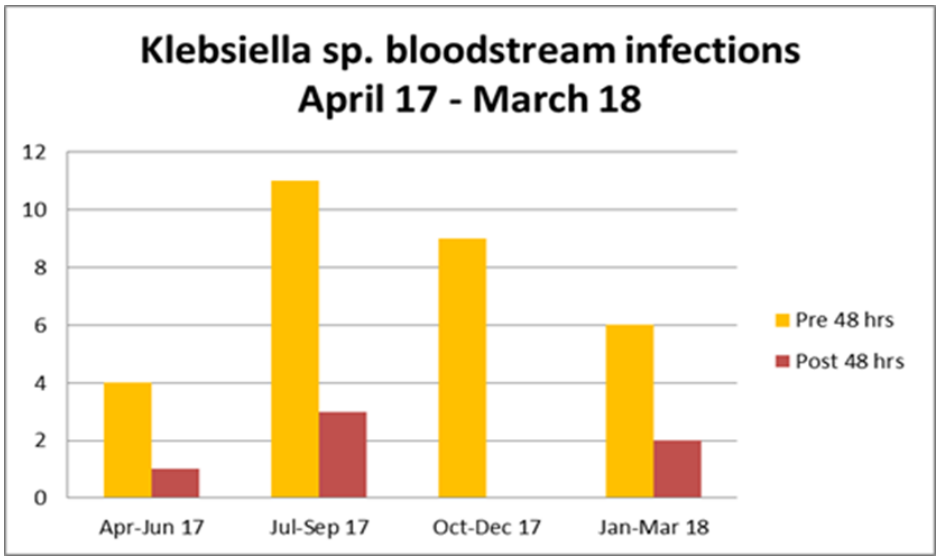


Figure 12: Cumulative *Klebsiella sp.* bacteraemia cases



9.3

Figure 13: Cumulative *Pseudomonas aeruginosa* bacteraemia cases

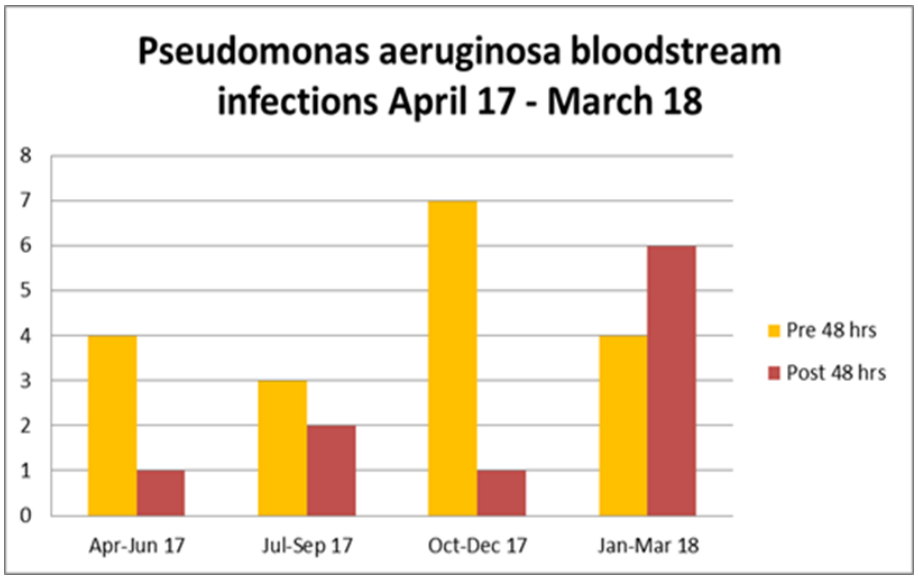
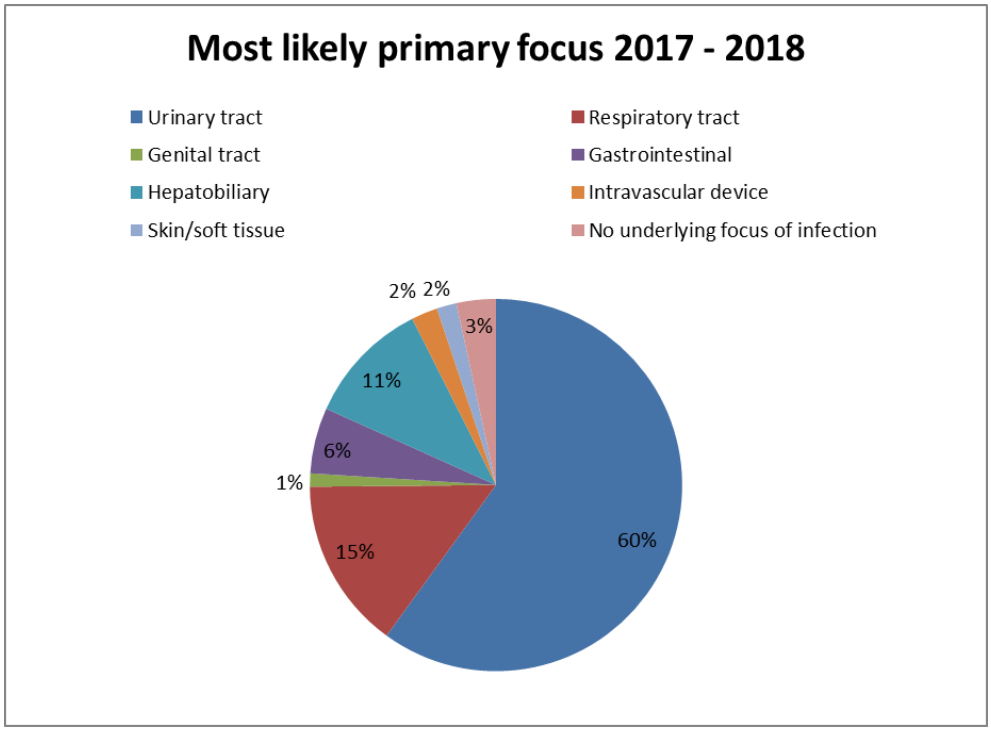
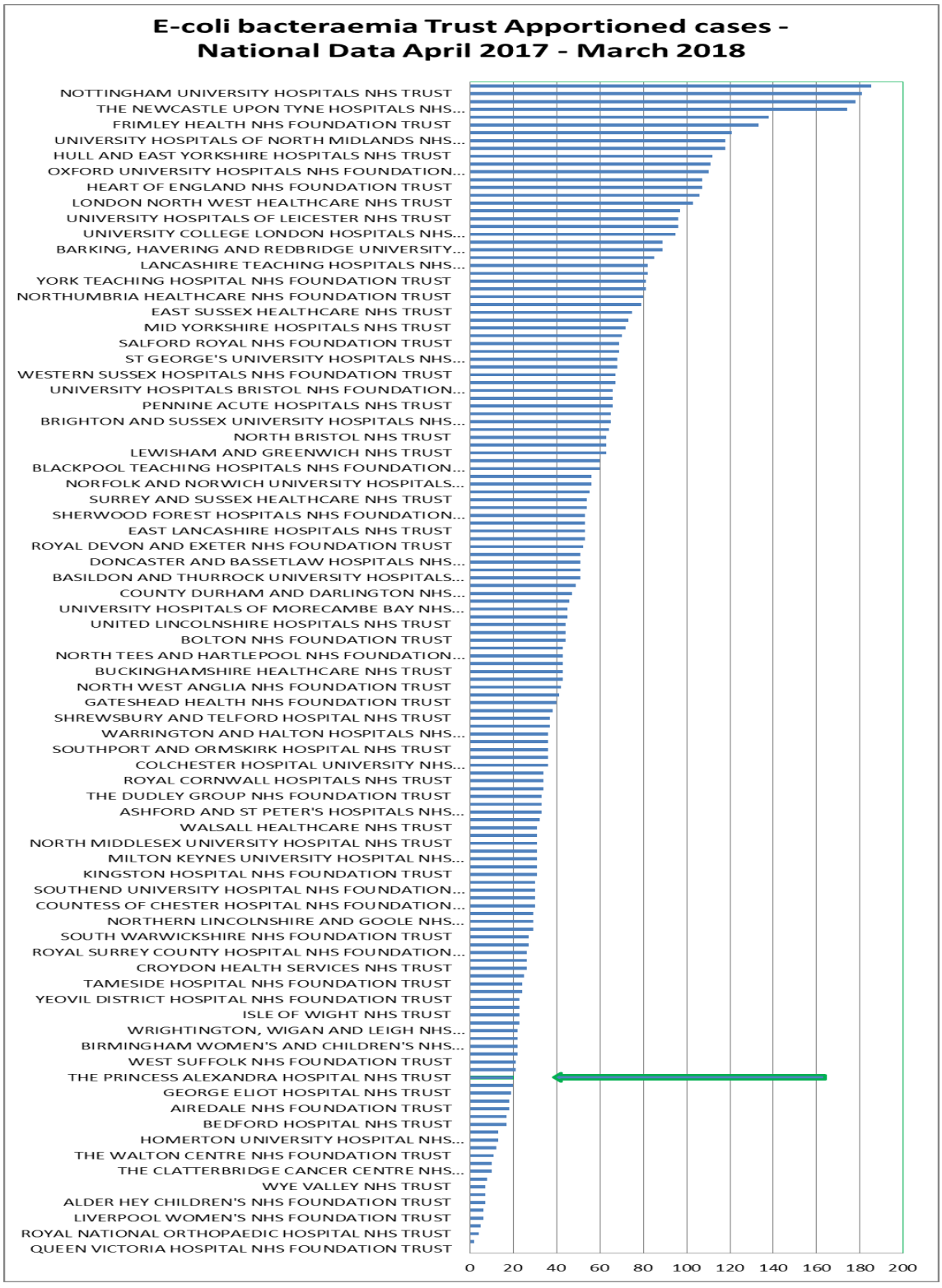


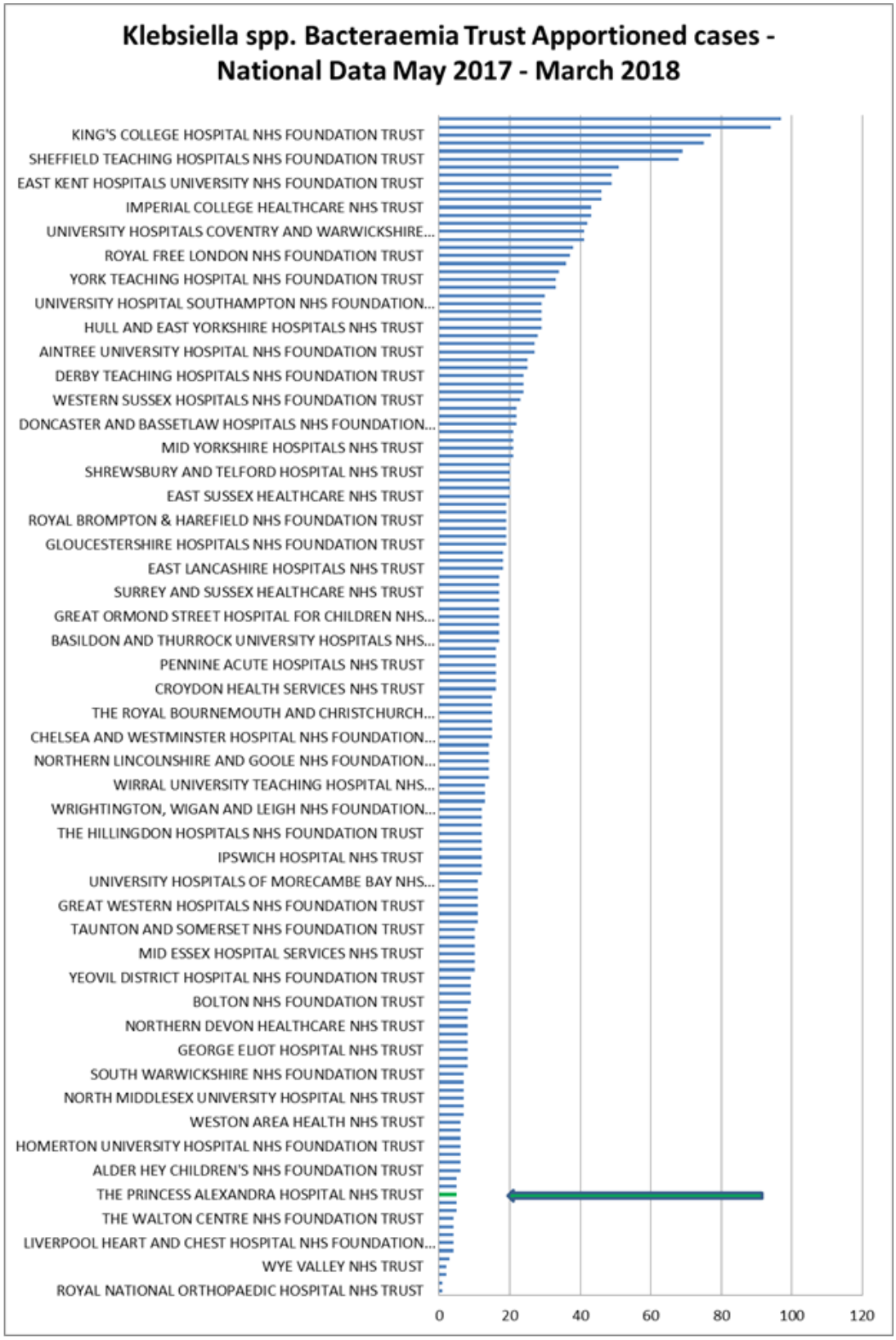
Figure 14: Likely Sources of Primary Infection 2017 – 2018 for cases of *E. coli* bacteraemia at PAH NHS Trust



9.3

Figure 15: The Princess Alexandra Hospital's position against all acute Trusts in England:




Klebsiella spp. Bacteraemia Trust Apportioned cases - National Data May 2017 - March 2018
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
IMPERIAL COLLEGE HEALTHCARE NHS TRUST
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE...
ROYAL FREE LONDON NHS FOUNDATION TRUST
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION...
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION...
MID YORKSHIRE HOSPITALS NHS TRUST
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
EAST SUSSEX HEALTHCARE NHS TRUST
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
EAST LANCASHIRE HOSPITALS NHS TRUST
SURREY AND SUSSEX HEALTHCARE NHS TRUST
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS...
BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS...
PENNINE ACUTE HOSPITALS NHS TRUST
CROYDON HEALTH SERVICES NHS TRUST
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH...
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION...
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION...
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS...
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION...
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST
IPSWICH HOSPITAL NHS TRUST
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS...
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST
TAUNTON AND SOMERSET NHS FOUNDATION TRUST
MID ESSEX HOSPITAL SERVICES NHS TRUST
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST
BOLTON NHS FOUNDATION TRUST
NORTHERN DEVON HEALTHCARE NHS TRUST
GEORGE ELIOT HOSPITAL NHS TRUST
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
WESTON AREA HEALTH NHS TRUST
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST
THE WALTON CENTRE NHS FOUNDATION TRUST
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION...
WYE VALLEY NHS TRUST
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
0
20
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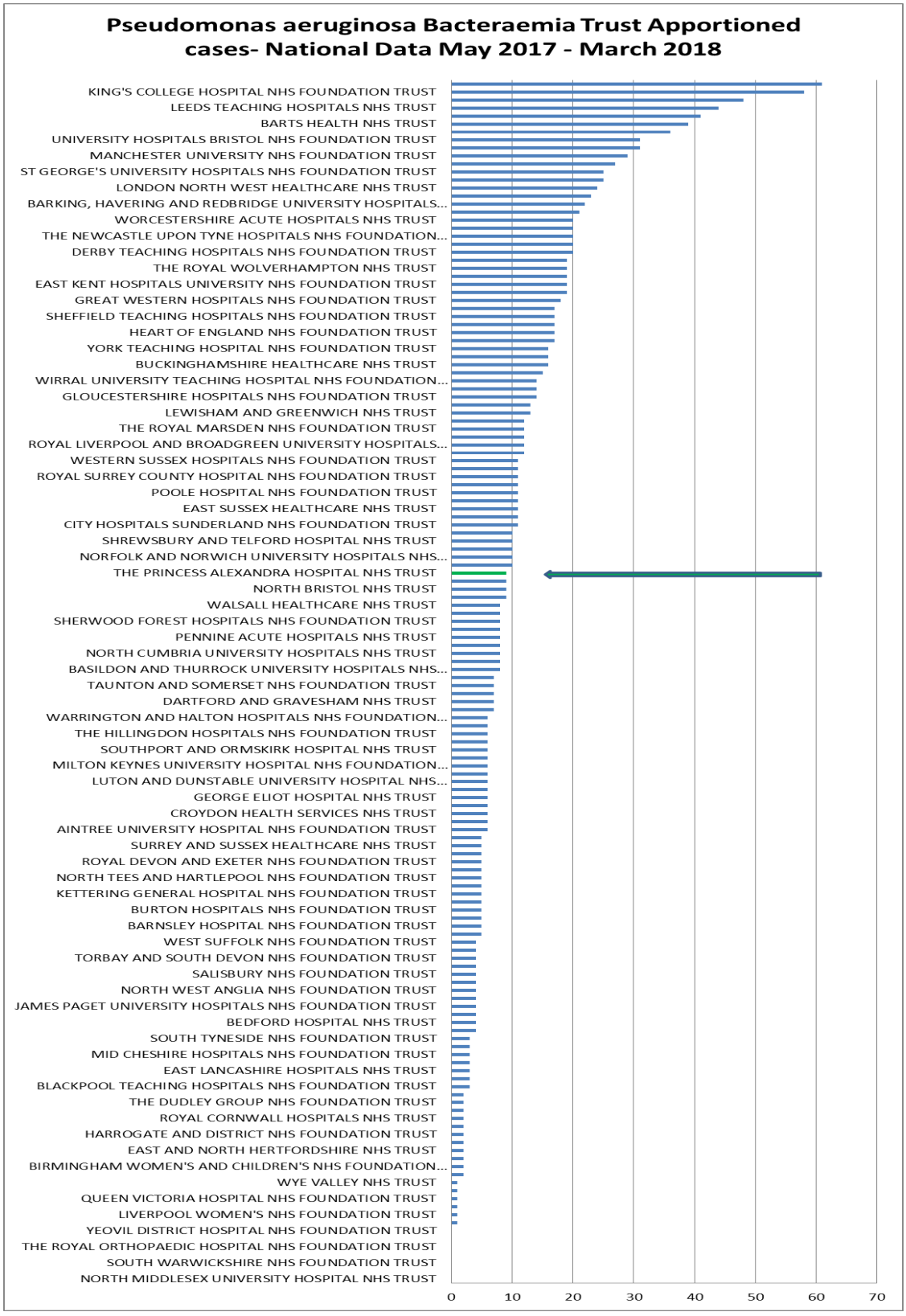
80
100
120


Pseudomonas aeruginosa Bacteraemia Trust Apportioned cases- National Data May 2017 - March 2018
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST
LEEDS TEACHING HOSPITALS NHS TRUST
BARTS HEALTH NHS TRUST
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST
ST GEORGE'S UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
LONDON NORTH WEST HEALTHCARE NHS TRUST
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS...
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION...
DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST
THE ROYAL WOLVERHAMPTON NHS TRUST
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST
HEART OF ENGLAND NHS FOUNDATION TRUST
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION...
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
LEWISHAM AND GREENWICH NHS TRUST
THE ROYAL MARSDEN NHS FOUNDATION TRUST
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS...
WESTERN SUSSEX HOSPITALS NHS FOUNDATION TRUST
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST
POOLE HOSPITAL NHS FOUNDATION TRUST
EAST SUSSEX HEALTHCARE NHS TRUST
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS...
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST
NORTH BRISTOL NHS TRUST
WALSALL HEALTHCARE NHS TRUST
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST
PENNINE ACUTE HOSPITALS NHS TRUST
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST
BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS...
TAUNTON AND SOMERSET NHS FOUNDATION TRUST
DARTFORD AND GRAVESHAM NHS TRUST
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION...
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST
MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION...
LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS...
GEORGE ELIOT HOSPITAL NHS TRUST
CROYDON HEALTH SERVICES NHS TRUST
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
SURREY AND SUSSEX HEALTHCARE NHS TRUST
ROYAL DEVON AND EXETER NHS FOUNDATION TRUST
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST
BURTON HOSPITALS NHS FOUNDATION TRUST
BARNSLEY HOSPITAL NHS FOUNDATION TRUST
WEST SUFFOLK NHS FOUNDATION TRUST
TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST
SALISBURY NHS FOUNDATION TRUST
NORTH WEST ANGLIA NHS FOUNDATION TRUST
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
BEDFORD HOSPITAL NHS TRUST
SOUTH TYNESIDE NHS FOUNDATION TRUST
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST
EAST LANCASHIRE HOSPITALS NHS TRUST
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST
THE DUDLEY GROUP NHS FOUNDATION TRUST
ROYAL CORNWALL HOSPITALS NHS TRUST
HARROGATE AND DISTRICT NHS FOUNDATION TRUST
EAST AND NORTH HERTFORDSHIRE NHS TRUST
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION...
WYE VALLEY NHS TRUST
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
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10.7 Glycopeptide (Vancomycin) Resistant *Enterococcus* bacteraemia (GRE / VRE)

10.7.1. It can be seen in **Figure 16** that numbers of VRE isolates (all sites, not just bacteraemia) have been steadily increasing since 2010 to date.

10.7.2. During the year 2017/2018, there were 41 VRE isolates (all sites, not just bacteraemia)

10.7.3. VRE bacteraemia remains unusual in our hospital setting (two cases this year). Most patients are colonised with VRE, rather than infected. The IPCT has noted that VRE has increasingly been isolated from wound swabs as well as urine samples.

10.7.4. Oral vancomycin is used as second line treatment for C difficile infection, in accordance with DoH recommendations. It is recognised that low dose oral vancomycin is a risk factor for the development of VRE. The DIPC has reiterated the need to follow Trust antibiotic guidance for the treatment of C difficile; metronidazole remains first line treatment for C difficile.

Figure 16: VRE isolates from clinical samples: 2009 and 2018

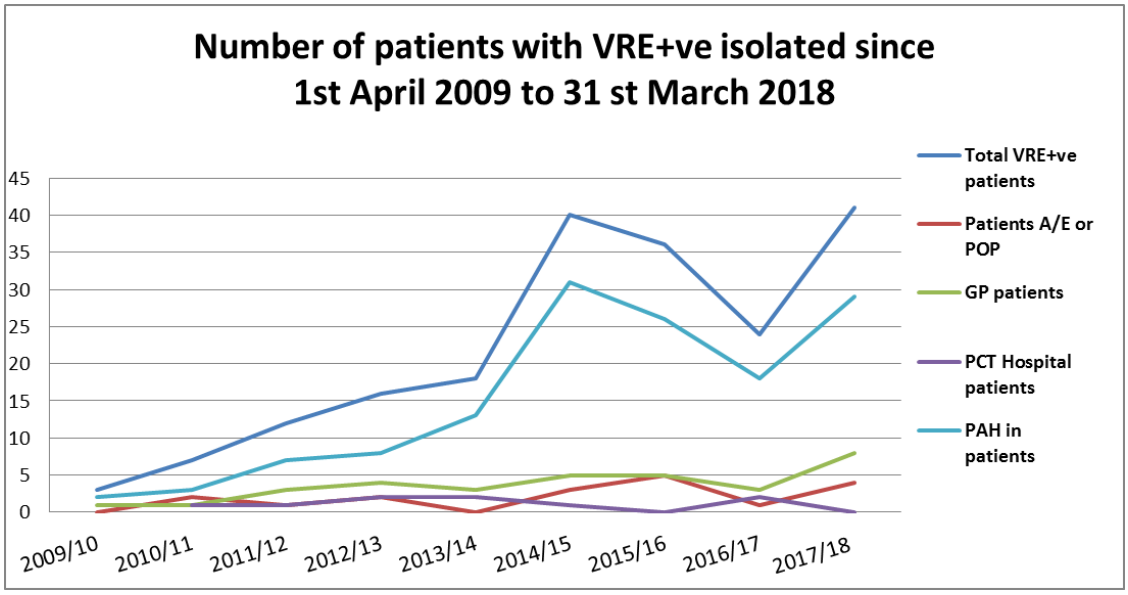
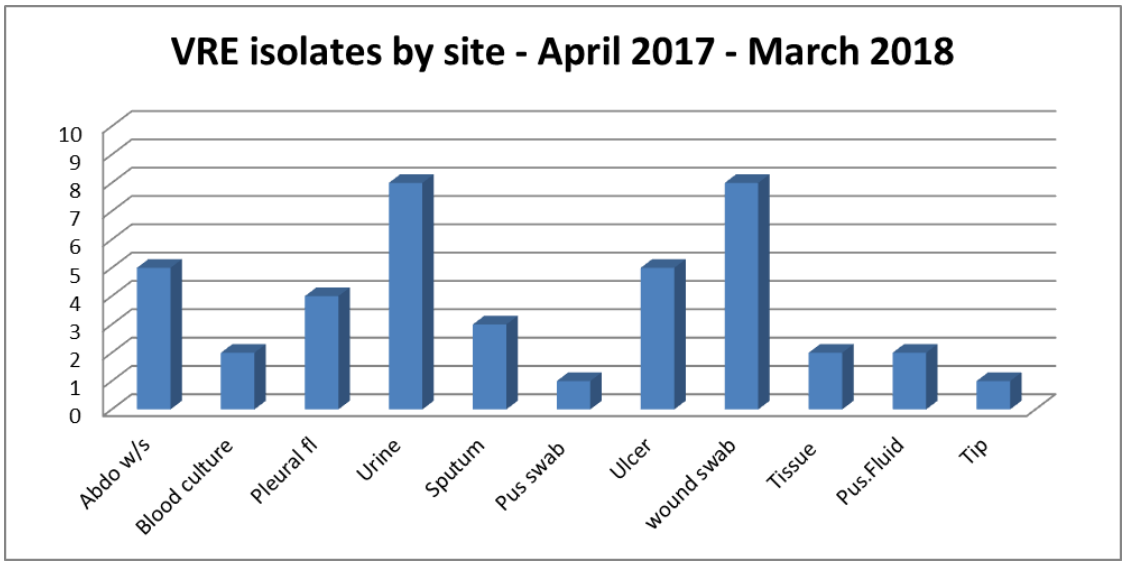


Figure 17: VRE isolates by site – PAH Microbiology Laboratory



11.0 Other Organisms Under Surveillance

11.1 Extended-Spectrum Beta Lactamase producing organisms (ESBL)

11.1.1. The Trust had four Trust-apportioned (post 48 hour) cases of ESBL bacteraemia this year (**Figure 18**). This is an upward trend, however numbers are small.

11.1.2. There were a total of 18 patients admitted with ESBL bacteraemia; this compares with 21 in 2016-17 and 17 in 2015-16. Cases have more than doubled since 2014-15, however, numbers are still small and it is difficult to know the significance of this.

11.1.3. Urine specimens continue to account for almost 86% first isolates that are positive for ESBL producing organisms, with wound, blood, respiratory and other isolates all being very small in numbers in comparison (**Figure 19**).

11.1.4. ESBLs are multi-resistant organisms and are entered on the patient's data base under the risk factor section, in the same section as penicillin allergy or MRSA. This is in order that clinicians can use optimal antibiotic treatment (Meropenem) to treat patients who present with serious ESBL infection. Approximately 50% of strains are resistant to Gentamicin and Ciprofloxacin as well as all the beta lactam antibiotics (penicillins and cephalosporins), and Nitrofurantoin resistance is now over 10%.

Figure 18: Cumulative ESBL Bacteraemia in blood culture

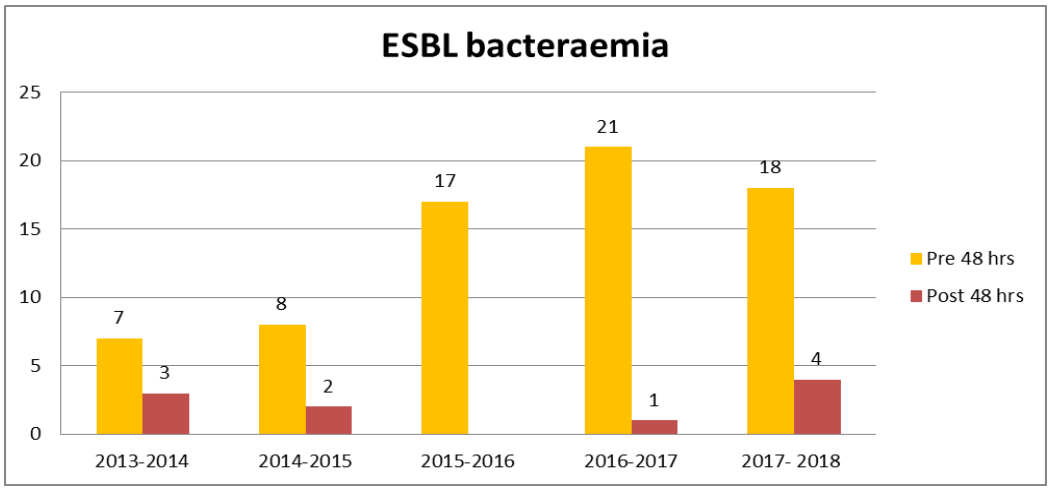
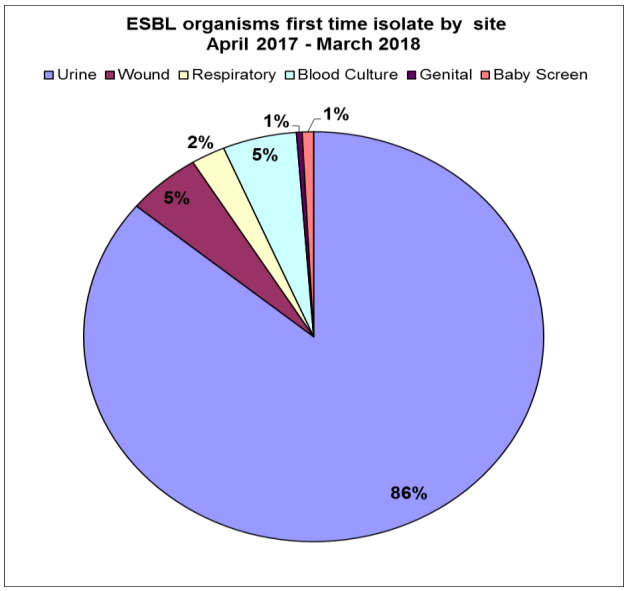


Figure 19: ESBL Isolates by site (first isolate only) – April 2017 – March 2018



11.2 Carbapenemase- Producing Organisms (CPO)

The CPO group of organisms includes CPE (Carbapenemase-producing Enterobacteriaceae) and, Carbapenemase producing *Pseudomonas* sp. and *Acinetobacter* sp.

11.2.1. Carbapenems include Meropenem and Imipenem; these are third line antibiotics for serious infection. Organisms that destroy Carbapenemase have potentially serious consequences.

11.2.2. Carbapenem resistance remains low in blood culture isolates of E. coli and Klebsiella spp. in England. Such resistance is however considered a significant threat to healthcare, as data from other countries such as Italy, have shown that this type of resistance can increase dramatically over short time periods.

11.2.3. The epidemiology of carbapenem resistance is complex, as it commonly involves both spread of resistant bacterial strains and inter-strain (including inter-species) spread of plasmids containing genes encoding carbapenemases.

11.2.4. Awareness, education, antibiotic control and preventing cross infection are key to controlling CPO. Our normal IPC procedures will control CPO, but they must be implemented at all times.

11.2.5. CPE outbreaks can be controlled by early detection of cases, isolation of patients, patient/staff cohorting and enhanced hygiene measures (hand hygiene and environmental cleaning).
Antimicrobial stewardship may also play an important role in preventing outbreaks of drug-resistant infections (not only CPE).

11.2.6. Most CPE are resistant not only to the carbapenems, but to most other antibiotic classes. Only colistin remained effective against >90% of all CPE. However colistin resistance has started emerging.

11.2.7. A local Trust policy for CPO has been written and updated. This includes rectal screening of high risk patients, as screening is the most common method of detecting CPO.

11.2.8. During 2017-18, we submitted 18 isolates to the reference laboratory for analysis; none were confirmed as CPO positive.

11.2.9. In 2017-18 an audit to monitor compliance with the CPO policy and screening was undertaken by the IPCT. Results of the audit showed that many patients were not actually being asked if they had been to hospitals abroad. More education and training is required for the programme to become as successful as the Trust MRSA screening programme.

12.0 Mandatory Surveillance

12.1 Orthopaedic Surgical Site Infections (SSI) 2016-2017

At Princess Alexandra we began an orthopaedic surveillance programme in 2005 reporting only on knee replacement for the mandatory one quarter annually. However, since the last quarter in 2012, we have been reporting for the whole year on both hip and knee replacements. Whilst this category of surgery is mandatory, it is not mandatory to undertake the surveillance for all four quarters of the year, but the Trust have opted to do this. The data is submitted to PHE and quarterly reports are produced from this.

This data enables the Trust to understand its infection rates year to year, provides scope to benchmark accurately against other hospitals that participate in the surgical site surveillance programme. All data is collated by the Joint Replacement Nurse Practitioner and reported to the ICC.

The unit reported an increase in clinical infections from December 2016 until March 2017, both deep and superficial, associated with hip and knee joint replacement surgery. These infections were reported up to one month post- surgery. Due to the rise in SSIs to a rate of about 6% (5 times the average), the Orthopaedic surgical unit for the first time required temporary closure in March 2017. After improvements to the pre-operative, intra-operative and post-operative orthopaedic pathway, the unit was re-opened in July 2018. There have been no infections since that date.
Please see Appendix 1.

12.2 Caesarean Section Surgical Site surveillance

12.2.1. A surveillance programme for caesarean section was launched in the Trust in June 2016.

12.2.2. Caesarean section rates have increased globally during the past three decades. SSI following caesarean sections is a common cause of morbidity with reported rates of between 3-15%, averaging at just under 10% (British Medical Journal, 2016).

12.2.3. Undertaking surveillance of women having caesarean sections will facilitate the Trust in understanding whether there are any concerns pertaining to wound infections in this category of patients, and if there are, to what extent. One of the advantages of undertaking surveillance in caesarean sections is that women are followed up by community midwives once discharged from the hospital; this allows the surveillance to continue post discharge.

12.2.4. As caesarean section surveillance is not yet one of Public Health England's (PHE) formal surveillance categories (it was previously a national pilot project, but to date, has not been funded to enable it to be a recognised category of surveillance); For this reason (and unlike other categories of surveillance), the information for caesarean section cannot, as yet, be entered onto the PHE surveillance database for bench marking (which allow formal reports to be produced on behalf of the Trust). Data collection and analysis will there be managed and reported internally by the Family and Women Health Care Group (FAWs HCG).

12.2.5. Data collection is on-going, but numbers are still small; it is therefore difficult to interpret overall results and may not give an accurate insight of a true infection rate. Measures have been implemented to improve compliance, but further work must be implemented by the FAWs team to ensure a more robust process whereby all women are captured.

12.2.6. **Steps taken to improve compliance**:

- Forms were being printed on coloured paper so they stood out and were sent home in baby's red developmental book as it was hoped this would make makes it more visible, however since the introduction of collating the information from the birth register, this is now of less importance.
- The Surveillance process is discussed at mandatory update days in record keeping, skills and drills and tissue viability sessions
- On the agenda at all team co-ordinator meetings

- Since January 2018 details of all women having a Caesarean Section are taken from the birth register and added to a database held on the trust X Drive under the maternity Helpline folder. This is a much more accurate way of monitoring all women who have a Caesarean Section, and improves the numbers contacted. The numbers are now much more accurate, although the problem of being able to contact some women is still present.

Table 1: Current figures April 2017 - March 2018

	Apr -17	May -17	Jun -17	Jul-17	Aug -17	Sep -17	Oct-17	Nov -17	Dec -17	Jan -18	Feb -18	Mar -18	Total
Number of C/S	94	97	106	91	95	102	97	136	90	110	90	86	1194
Number of forms received	5	8	14	16	37	9	20	30	13	N/A	N/A	N/A	152
Women not contacted	0	0	0	7	20	0	10	17	4	33	23	20	134
Women with Post-operative concerns	3	6	9	1	8	0	3	5	3	22	18	13	91
No post C/S problems	3	1	5	8	9	1	7	8	6	55	49	54	206
Readmissions	0	0	0	0	0	1	1	0	0	4	3	4	13
Swabs taken	0	1	0	0	2	1	3	1	1	14	2	9	34
Antibiotic therapy	3	5	8	1	5	1	2	4	2	21	7	11	70

NB these figures are not accurate as April to December 2017 of this report we did not have sufficient forms returned to represent the true caesarean section rate.

Currently this is reported on monthly at local Patient Safety and Quality Forums, the patient safety and quality teams monitor and investigate all readmissions for wound infections. Additionally it is presented at the Quality and Safety Committee on a quarterly basis.

13.0 MRSA Screening and Transmissions

13.1 Non Elective Screening

13.1.1. In 2014, the DoH published guidance (Implementation of modified admission MRSA screening guidance for NHS (2014) Department of Health expert advisory committee on Antimicrobial Resistance and Healthcare Associated Infection), recommending Trust's

should consider reverting to the previous risk assessment based screening. However, following a review of the document and consultation with medical and nursing colleagues PAH made a decision to continue to screen all patients. The Trust has an excellent record for control of MRSA bacteraemia and we were concerned risk-based screening may compromise this.

13.1.2. The Information Team are responsible for collecting the data and reporting on compliance. The target for screening patients with MRSA is 95%. Those patients that are attending the Emergency Department and having treatment, but not being admitted i.e. zero day's length of stay (LOS) are excluded.

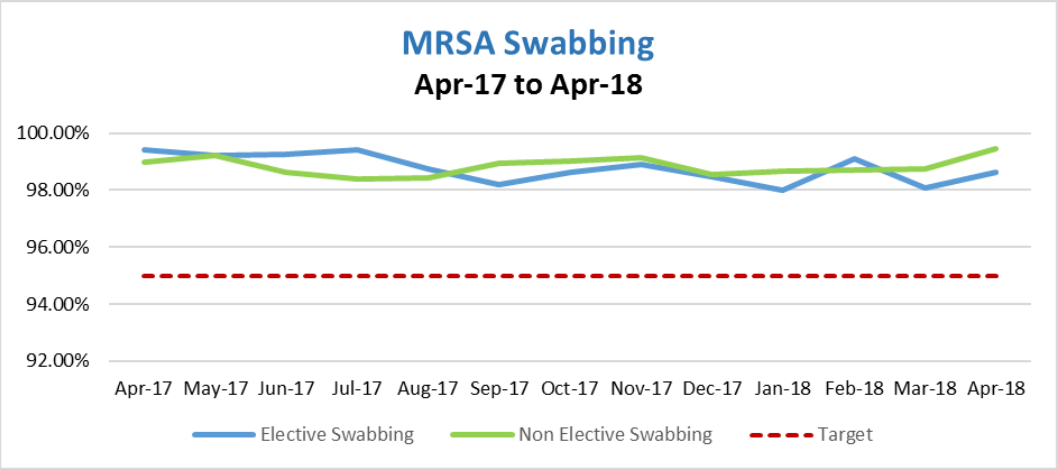
13.2 Elective Screening

13.2.1. All elective patients must be screened as part of the pre-assessment process, with the exception of the exclusion categories outlined in the 2010 DoH publication; MRSA screening - operational guidance 3. Additionally, whilst not mandatory, the Trust has taken the decision to screen patients attending oncology and haematology as day cases; this is because of the potential serious consequences of developing an MRSA infection in this group of patients and because of shared learning from other Trusts.

13.2.2. Data is reported on a monthly basis via the Information Team to the ADONs/Matrons, Senior Managers and the IPCT**.** Each month, a preliminary compliance figure is calculated, but usually includes data on a number of patients with missing screens; therefore the compliance rate at this point is lower. Nominated individuals within each HCG follow up on, and validate patients with missing screens. Once this information is received, the Information Team provide a final figure after adjustments are made.

13.2.3. Performance for both elective and non-elective swabbing has remained well above the 95% target for the whole year.

Figure 20: Elective and Non-Elective MRSA Swabbing: April 2017 – April 2018 (provided by Informatics Team).



13.3 MRSA: New Cases, Colonisation and Transmission.

13.3.1. The IPCT monitor new cases of MRSA colonisation and transmission and are responsible for communicating results to the clinical areas.

13.3.2. All patients admitted to the hospital (regardless of their MRSA status) are commenced on decolonisation treatment (a wash preparation); this is to reduce the risk of both colonisation and transmission of MRSA (and MSSA), which could potentially lead to a bacteraemia developing in susceptible patients.

13.3.3. There were 267 new isolates this year, compared with 258 the previous year, therefore little variance. Of the 267 cases, 12% (32 cases) were possible transmissions, compared with 14% in 2016-17. See **Table 2**

13.3.4. The Trust continues to screen in-patients for MRSA on a weekly basis. This is not a national requirement, but the Trust made this decision locally as it was felt this was beneficial to the control of MRSA and therefore optimises patient safety.

13.3.5. A process is in place for monitoring transmission cases which includes a review with the Ward Manager; factors that may have contributed to the transmission, for example, other patients on the ward with MRSA, risk factors, hand hygiene and environmental audit results are addressed. The Information Officer undertakes ward mapping to establish whether there has been any commonalities or links with other patients on the ward who may have had MRSA. If there are deemed to be particular areas of concern, or multiple cases, a meeting will be held with the wider team including Matron/HoN/ADON and ward Consultant.

13.3.6. As with most years, we have observed clusters of patients with MRSA in some wards. Gibberd ward appeared to have a higher than expected number of patients that became colonised with MRSA. During the period of May – December 2017, there were a total of nine cases (one or two each month with exception of September when there were no cases).

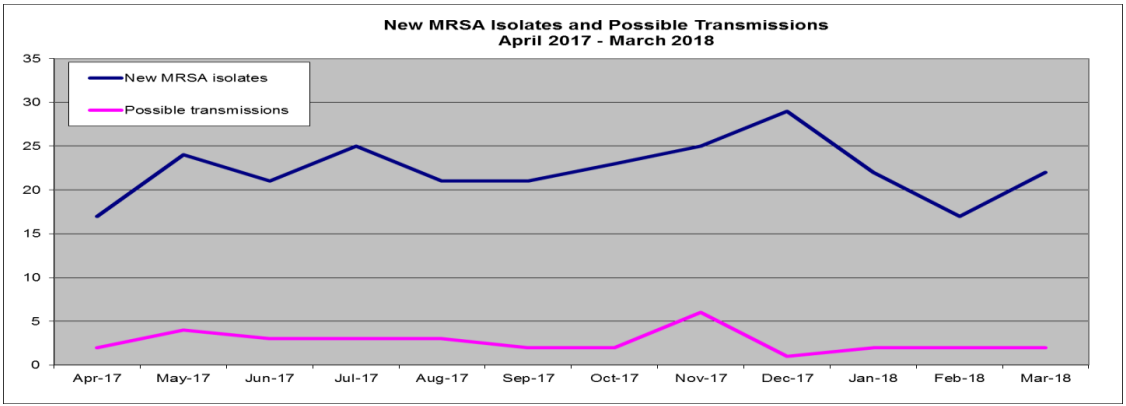
13.3.7. On investigation, it was identified that there was no correlation between the locations of the patients. There appeared to be multiple in-patient movement in the ward during single stay which could contribute to transmissions being more likely. Additionally, the End of Life patients were prioritised for single side rooms over patients with infection control needs.

13.3.8. The IPCT worked with the ward, undertaking observations of practice and the environment. Risk assessments in conjunction with the IPCT were made to review patient placement and side room priorities. Following these actions, there were no further cases in the remainder of the year.

Table 2: New MRSA Isolates and Possible MRSA Transmissions by Month

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
New MRSA isolates	17	24	21	25	21	21	23	25	29	22	17	22
Possible transmissions	2	4	3	3	3	2	2	6	1	2	2	2
% of possible transmissions from new isolates	12%	17%	14%	12%	14%	10%	9%	24%	3%	9%	12%	9%

Figure 21: New MRSA and Possible Transmissions across the Trust April 2017 - March 2018



14.0 Tuberculosis (TB)

The incidence of tuberculosis in England is higher than most other Western European countries, and more than four times as high as in the US. TB has been identified as a priority, and indicators of TB incidence and TB treatment outcomes are included in the Public Health Outcomes Framework.

Public Health England (PHE) and NHS England believe that action, supported by national expertise, can reduce the suffering and harm caused by TB, meet the WHO End TB Strategy milestone of reducing TB incidence by 50% by 2025, and contribute eventually to the elimination of TB.

14.1 The TB Nursing Service

14.1.1. The TB nursing service is an essential part of the diagnosis and management of TB. The TB specialist nurses work closely with the Chest Physicians to provide the clinical TB service managing patients and their contacts. Only very few patients with TB are in-patients at PAH, most patients are managed as out-patients.
The TB specialist nurses are employed and managed by Essex Partnership University Trust (EPUT). The Service has been commissioned 19 hours per week. The Royal College of Nursing (RCN) recommends 1 WTE for 40 standard TB cases and 1 WTE for 20 enhanced management TB cases. The lead for PAH is Andrew Hare.

14.2 TB cases in Harlow

14.2.1. TB patients in and outside hospital are managed by the TB MDT, comprising the TB specialist nurses (EPUT), the Trust chest physicians, the DIPC / Consultant Microbiologist, Chief Biomedical scientist Microbiology, the Consultant in Communicable Disease Control who is the TB Lead Public Health England (Anglia & Essex) based at the Essex Health Protection unit, a public health nurse, and a Consultant Radiologist (Chest), with input from the IPCN staff as required. The MDT meets once a month.

Hospital teams must remain vigilant and refer any suspected cases early to the nominated Consultant Chest Physician who is the Lead for TB in the Trust.

14.2.2. In 2017 (January to December) there were 26 active cases of TB and 34 latent cases of TB.

Measures were put in place at the PAH NHS Trust in 2014 to improve the clinical, radiological and microbiological diagnosis of TB. Standardised protocols were used for all patients, and all suspected or proven TB cases were discussed at the MDT. The results of a comprehensive clinical audit carried out by the MDT (TB) are presented below. The team reviewed clinic letters, pathology, biochemistry and radiology using the 'SystmOne' Electronic record system held by the TB nurse specialists. Medical notes and laboratory results were also reviewed.

Table 3:

PAH	2012	2013	2014	2015	2016	2017
Total TB notifications	39	25	17	18	14	26
Culture confirmed	11	13	9	11	7	10
Clinically probable	20	8	8	7	7	16
Diagnosed incorrectly and notified as active TB (but were actually latent TB)	6	2	0	0	0	0
Not TB – diagnosed incorrectly	2	2	0	0	0	0

Table 4:

	National standard PHE, 2015	PAH 2014	PAH 2015	PAH 2016	PAH 2017
Proportion of culture confirmed TB cases	58-61%	53% Standard not met	61% Required standard achieved	58% (2 were excluded as diagnosed overseas)	48% (5 excluded as diagnosed outside PAH)
Culture confirmed Pulmonary TB cases	72%	42% Standard not met	70% Required standard achieved	75%	50% (9 from 18 cases)
Culture confirmed Extra-pulmonary cases	47%	80% Very high	50% Required standard achieved	25%	33% (1 from 3 cases)

Our audit had showed significant and sustained improvements with the measures introduced at PAH NHS Trust in 2014 However 2017 has shown an upturn in cases of TB. This is partly due to one case of PTB identifying via contact screening a further 9 cases of active TB.

- The total number of cases diagnosed as TB had reduced from 39 in 2012, to 17 in 2014, 18 in 2015 and 14 in 2016 but now 26 in 2017. All notified cases of TB were either clinically highly probable or proven by culture.
- There were no cases notified as TB that were subsequently thought to have been latent infections or incorrectly diagnosed infections.
- The TB service and Microbiology are currently reviewing the low numbers of culture confirmed MTB for 2017. It is in part due to the type of Pulmonary TB we are seeing. A majority of PTB cases have been from Pleural or Intrathoracic Lymph Node sites which are typically Paucibacillary thereby making culture confirmation less likely.

15.0 SHAW (Staff Health and Well Being)

15.1 Staff Influenza Vaccination Programme

The vaccination programme for staff began in October 2017 and all staff were required to have a face to face consultation with a member of the Influenza (flu) team. The programme was planned in order to control the risk of flu transmission in the event of a local or national outbreak.

Regular communication during the campaign and the Trust's 'InTouch' magazine was used as a means of communication, and to advertise the campaign and update on progress via screen savers.

Final PAH figures concluded that 756 of Healthcare workers were vaccinated, that have direct contact with patients.

The table below **Table 5** provides information on the numbers of vaccinations administered to different staff groups between October 2017 and March 2018.

Flu champions on the ward areas are commended for their support and continuing with vaccination during difficult times.

Influenza Vaccines administered October 2017 – March 2018

Table: 5

Staff Group	Number of vaccines administered
Doctors - Anaesthetists, all grades of Doctors, Medical Students	**271 out of 436 =62.2%**
Nurses/Midwives - Ward Managers, Matrons, Specialist Nurses	**639 out of 830 =76.9%**
Support staff- Health care Assistant, Maternity Care Assistants, Operating Department Practitioners, Trainees, pre-registered Nurses, Nursery Nurses, Students, Assistants, Domestics, Porters, Ward clerks	**756 out of 868 =87.1%**
Allied Healthcare Professionals - Audiology, Technicians, Pharmacy, Pathology, Radiology, ATO's, IM&T, Physiotherapy, EBME, Scientists, In Patient Therapies	**162 out of 447 =36.2%**
Target was set to have 70% of healthcare workers vaccinated for PAH From the total number of 2581 staff	**Achieved**

15.2 **Inoculation Injuries**

The report on inoculation injuries for 2017-18 shows that in total 72 injuries and body fluid splashes occur in that time and out of 72, 55 sharps injuries were noted.

Table 6: Where these Occurred

Cardiac Cancer and Diagnostics Health Group	13
Family and Women's service	8
Medical health group	31
Surgical Health Group	20

Table 7: Staff Designation

Consultant	6
Junior Doctor	25
HCA	9
Nurses	16
Phlebotomist	2
Student	2
Technician	1
Domestic	1
Midwife	6
Other	4

Table 8: Equipment involved in the Injury

Blood gas syringe with needle	5
Cannulation Inducer	5
Disposable syringe with needle	7
Hollow needle	21
Scalpel	3
Suture needle	10
Insulin Needle	9
Vacutainer needle	8
Other	4

Staff members who require Post exposure prophylaxis (PEP) for a needlestick injury receive initial support from ED, and then from SHAW (Staff Health and Wellbeing). However there is no support from a Consultant HIV physician. This has been placed on the risk register for the Medicine Health Care group.

16.0 Cleanliness and the Environment

16.1 Monitoring of Cleaning Standards

16.1.1. In addition to good hand hygiene, prompt isolation and antimicrobial control measures, the cleanliness and condition of the patient environment and estate is an integral part of the control and reduction of infection.

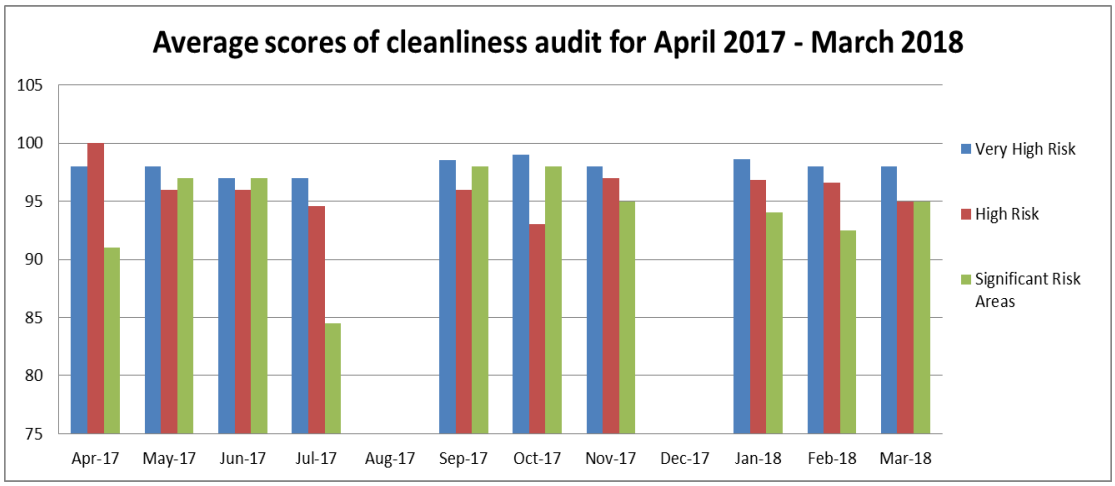
16.1.2. The Facilities Team undertake environmental hygiene audits on a regular basis and the Domestic Supervisors have responsibility for these. As with the previous year, staff shortages in the Facilities Team has resulted in some areas not being audited monthly; however, where any non-compliances have been identified, the Facilities Team have provided assurance that action plans were implemented immediately and the areas re-audited.

16.1.3. The 'pass' marks for the audits are:

- Very High Risk areas – 98%
- High Risk areas – 95%
- Significant Risk areas – now 90%

16.1.4. The graph below (**Figure 22**) provides the average scores achieved within the 2016-17 period.

Figure 22: Environmental Hygiene Audit Scores – 2017-2018 (data was not available for August and December 2017 due to staff sickness)



16.2 Deep Cleaning and Hydrogen Peroxide Vaporiser (HPV) Decontamination

16.2.1. Deep cleans are undertaken in clinical areas in situations where a more intense level of cleaning is required, for example after an outbreak situation. Hydrogen Peroxide Vaporiser (HPV) decontamination is an additional measure which can be used after an area has been

deep cleaned. All side rooms occupied by patients with *C.difficile* must be decontaminated with HPV following discharge. To facilitate this process, the IPCT work closely with the Clinical Site Team and Facilities Teams on a daily basis, communicating rooms which will require HPV decontamination via the isolation list.

16.2.2. Areas of the main ward requiring HPV decontamination must be unoccupied (from all personnel) and sealed off for a number of hours. This does have limitations as capacity in the Trust is usually running at a high level and there is not a 'decant' area available. Meticulous planning is therefore required to enable decanting of these wards to other areas in order to facilitate the deep cleaning and HPV decontamination.

16.3 Clinical and Environmental Inspections

16.3.1. The purpose of undertaking Clinical and Environmental Inspections is to undertake unannounced 'spot checks' of the clinical environment and IPC activity. The focus is to ensure clinical areas meet the requirements of the Hygiene Code, and are compliant with IPC standards, and where not compliant, make recommendations. Clinical practice, cleaning standards and estates/environment issues are all included in the audits.

16.3.2. The inspections are co-ordinated and facilitated by the IPCT, and where possible, the Estates and Facilities teams join the IPCT. The location of the inspection is not identified in advance of the audit.

16.3.3. Following the inspections, a report is collated by the IPCT and circulated to the relevant staff. Ward Managers, Estates and Facilities are expected to take immediate action at the time of the inspection if appropriate, and to implement an action plan for issues that will require longer term planning.

16.3.4. If there are significant concerns following an inspection, a re-visit of the area will take place.

16.3.5. During 2017-18, the IPCT, in conjunction with the Informatics department, developed an electronic audit tool, the purpose of which was to make the process smoother and sleeker with the ability to produce reports more quickly. Whilst this is in place, there are limitations to it and it is hoped that the introduction of 'Perfect Ward' will provide the IPCT with an audit tool that can capture all of the aspects required. Additionally we will be reviewing audit tools in conjunction with the Facilities team to ensure a more collaborative approach.

17.0 Infection Control Incidents and Outbreaks

17.1 Norovirus Outbreaks

17.1.1. The Trust experienced an increased period of gastroenteritis outbreaks this year; there were six outbreaks in 2017-18, three involved multiple wards and three were single ward outbreaks. Norovirus PCR confirmed cases in four of the outbreaks. See **Figure 23** below for affected wards; the green bars indicate PCR positive results.

17.1.2. The increase in outbreaks reflected the national position; the number of hospital beds taken out of service due to norovirus outbreaks reached its highest level in five years this year. The average number of bed closures each week this winter in the UK was 5,722,

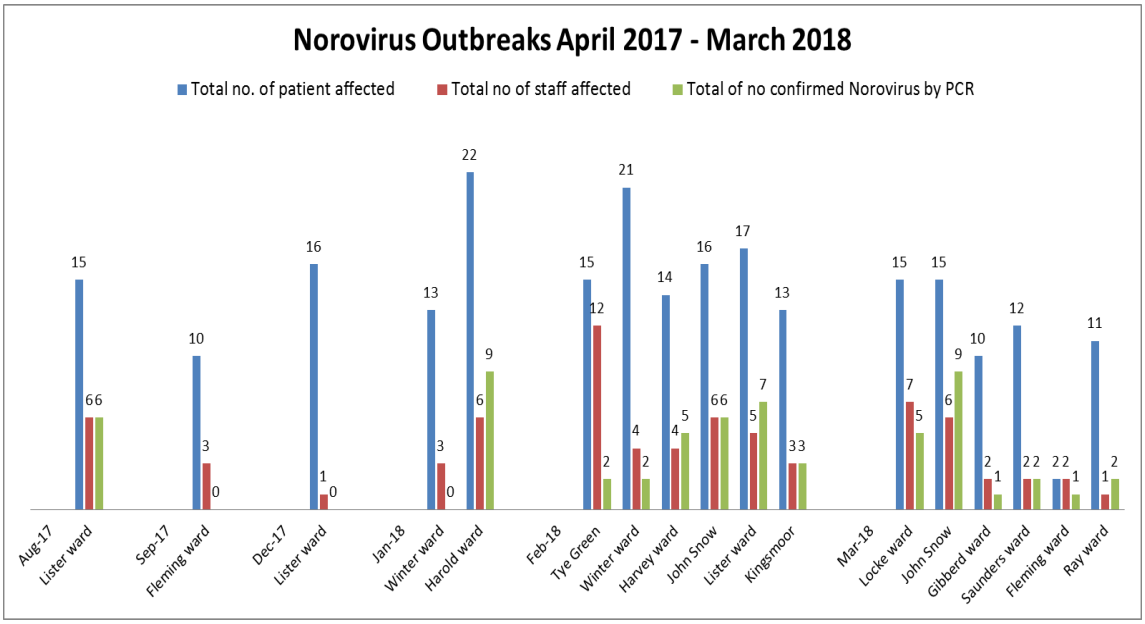
32% higher than the average of the previous four winter. On the single worst-affected day, over 1,200 beds had to be taken out of service.

17.1.3. During this period 12 wards at PAH were affected (some more than once). There were just over 200 patients (55 confirmed norovirus cases), over 70 staff members affected and more than 350 bed days lost.

17.1.4. Our infection control management and associated processes have demonstrated that we have been able to ensure that the affected wards became fully operational as soon as possible (after closure), by taking necessary steps such as managing wards bay by bay, isolating and co-horting within the ward (as per national norovirus guidelines).

17.1.5. Outbreak meetings were held daily, led by the IPCT, and supported by the Chief Nurse / Deputy Chief Nurse. Additionally the Deputy Director of Nursing from West Essex CCG attended several of the meetings to offer support to the Trust. Some wards took longer than other recover; however, there were multi-factorial reasons for this. There were situations where it was necessary to admit new patients with vomiting / diarrhoea to affected wards to avoid compromising patient safety. This contributed to wards remaining closed for longer. All wards were fully operational by 19th March in the 2017-18 period; however the Trust did experience further outbreaks in April and May.

Figure 23: Norovirus Outbreaks April 2017 – March 2018



18.0 Deaths Associated with HCAI

All deaths relating to HCAI should initiate a discussion between the DIPC or a Consultant Microbiologist, and the clinical teams. This provides assurance that deaths due to HCAI are accurately recorded on death certificates. It also enables the impact of HCAI associated mortality to be monitored.

18.1 There were no deaths this year where MRSA were cited on death certificates.
There was only two deaths associated with *C difficile* in last financial year recorded on the death certificate; one as Part 1c (a non-Trust apportioned case) and the other was Part 2 (a Trust apportioned case).

19.0 Audits

19.1 Audit Programme 2017-18

19.1.1 Audits have been undertaken throughout the year; a variety of clinical areas were involved in the audit programme. The audits undertaken in this period were:

- Hand hygiene compliance (cross over validation audits)
- Surgical site infection (*Saving Lives* audit)
- Ventilated associated pneumonia (*Saving Lives* audit)
- Peripheral line insertion (*Saving Lives* audit)
- Peripheral line on-going care (*Saving Lives* audit)
- Urinary catheter insertion (*Saving Lives* audit)
- Urinary catheter on-going care (*Saving Lives* audit)
- Unannounced Clinical and Environmental audits
- Isolation Policy compliance audit
- CPO Policy and screening log
- Patient Safety Thermometer (Urinary Sepsis)
- Antimicrobial compliance

19.2 Hand Hygiene Compliance Audits

19.2.1. Training and education on hand hygiene remains an integral part of all teaching sessions provided by the IPCT for all groups of staff.

19.2.2. Compliance with hand hygiene is monitored through the monthly hand hygiene audits which are a mandatory requirement for all clinical areas. The purpose of the audit is to capture staff compliance with hand hygiene before and after direct contact with patients' and with their environment. Additionally it monitors compliance with the Trust dress/uniform code.

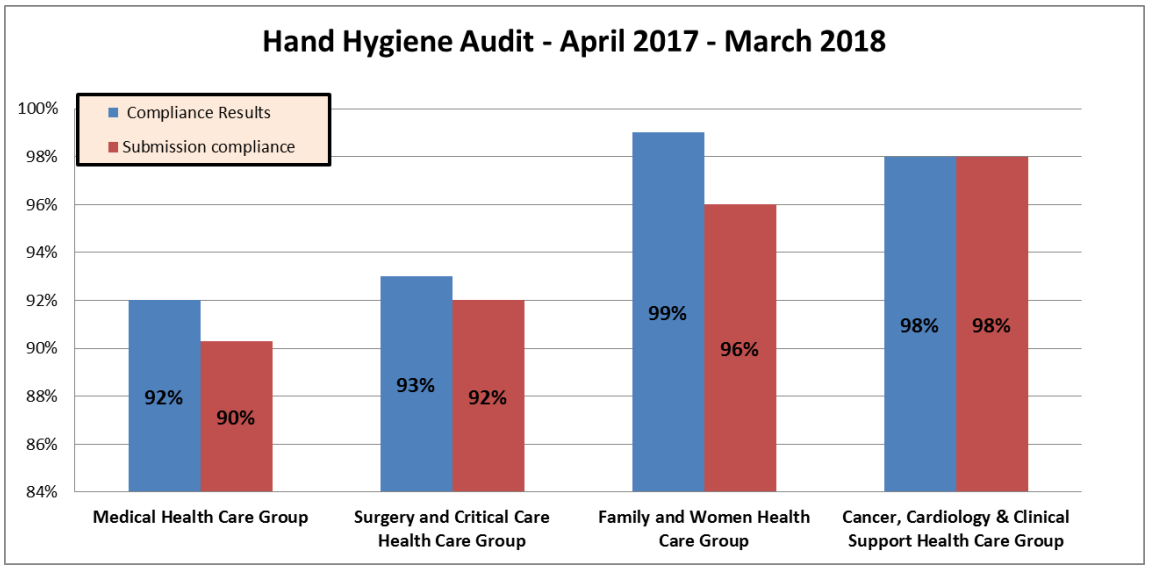
19.2.3. All clinical wards/departments undertake 'cross over' (peer review) audit rather than auditing their own area. The expectation is for each clinical area to observe 20 opportunities for hand hygiene each month and the expected standard of compliance is 95%.

19.2.4. The results of the audits are collated by the IPC Information Officer and widely distributed each month in several reports. The results are also discussed as a standing agenda at the ICC meetings and Quality and Safety meetings. Additionally it is the expectation that these are discussed, and the appropriate actions implemented, in the local Health Group PS&Q meetings.

19.2.5. An average score (by Health Care Group) for the year in terms of both submission of audits and performance can be seen in **Figure 24**. This shows that two HCGs were above the expected standard in both submitting and performance, and two were slightly under.

19.2.6. The individual monthly breakdown by ward/department is shown in **Table 9**.

Figure 24: Hand hygiene audit compliance by Health Group – 2017 - 2018



The Princess Alexandra Hospital NHS
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Table 9: Hand hygiene audits – monthly by ward/department – 2017 - 2018

Area	Monthly average	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
A&E	76%	71%	90%	61%	80%	53%	Not audited by Kingsmoor	68%	84%	Not audited by Fleming ward	79%	92%	84%
Fleming/MAU	80%	99%	81%	51%	64%	77%	82%	94%	94%	Not audited by A&E	Not audited by A&E	Not audited by A&E	83%
Harvey	99%	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Harold	96%	61%	93%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Gibberd ward	98%	99%	100%	100%	98%	100%	98%	100%	100%	93%	91%	98%	100%
Winter Ward	91%	96%	91%	100%	85%	70%	87%	97%	93%	100%	Not audited by Lister ward	98%	89%
Ray	96%	100%	100%	92%	94%	91%	95%	88%	Not audited by Locke ward	96%	100%	Not audited by Locke ward	100%
Lister	86%	Not audited by Ray ward	96%	100%	100%	93%	69%	75%	94%	95%	92%	63%	65%
Locke	90%	99%	88%	100%	93%	85%	94%	100%	94%	90%	100%	56%	83%
John Snow Unit	99%	99%	100%	100%	97%	100%	100%	98%	Not audited by Harold ward	100%	100%	100%	100%
Saunders	95%	86%	100%	100%	98%	95%	98%	Not audited by Gibberd ward	Not audited by Gibberd ward	Not audited by Gibberd ward	88%	Not audited by Gibberd ward	99%
Endoscopy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Penn ward	95%	Not audited by PACU	100%	98%	80%	100%	96%	98%	Not audited by Melvin ward	100%	86%	97%	95%
Henry Moore	99%	98%	100%	98%	100%	100%	100%	100%	91%	100%	100%	100%	100%
ICU/HDU	98%	Not audited by Main Theatres	95%	100%	98%	95%	100%	100%	100%	96%	Not audited by Penn ward	100%	100%
Tye Green	99%	98%	96%	100%	100%	100%	100%	100%	100%	100%	Not audited by Henry Moore	100%	100%
PACU	84%	86%	95%	78%	65%	82%	92%	75%	91%	88%	91%	86%	Not audited by Main Theatres
Main Theatres	78%	100%	100%	50%	80%	77%	78%	71%	77%	73%	76%	78%	80%
Alexandra Day Stay Unit	91%	91%	84%	95%	84%	89%	87%	96%	92%	93%	84%	95%	99%
Eye Unit	92%	100%	81%	91%	100%	92%	76%	96%	100%	74%	98%	100%	100%
Melvin ward	96%	start from May	91%	93%	Not audited by ITU/HDU	100%	93%	100%	96%	ward closed	ward closed	ward closed	Not audited
A&E/Paeds	98%	100%	100%	98%	100%	98%	92%	100%	100%	Not audited by Dolphin ward	100%	98%	94%
Dolphin	99%	96%	100%	100%	92%	100%	100%	97%	100%	100%	100%	98%	100%
NICU	97%	100%	100%	97%	100%	97%	98%	97%	78%	100%	94%	100%	100%
Samson	97%	100%	99%	92%	98%	93%	92%	96%	100%	98%	100%	100%	Not audited by Nightingale
Chamberlain	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Labour ward	100%	100%	100%	100%	100%	Not audited	100%	100%	100%	100%	100%	100%	100%
Birth Unit	100%	100%	100%	100%	100%	100%	Not audited	100%	100%	100%	100%	100%	96%
Nightingale	95%	start from May	91%	93%	Not audited by ITU/HDU	100%	93%	100%	96%	95%	91%	97%	96%
MFAU	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
ANC	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Kingsmoor/CCU	97%	100%	100%	97%	98%	87%	91%	100%	100%	93%	100%	100%	100%
Cardiac Angiography	95%			90%	Not audited	88%	96%	91%	96%	100%	93%	100%	100%
OPD PAH	98%	100%	94%	95%	100%	94%	98%	98%	100%	100%	100%	100%	100%
Williams Day Unit	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%
Radiology	96%	Not audited by Fleming ward	89%	100%	100%	92%	97%	96%	100%	100%	93%	95%	97%
Bevan Oral	99%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Oak Unit	99%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	95%	100%
OPD H&E	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	99%
OPD SMH	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

9.3

19.3 High Impact Intervention Audits

19.3.1. The High Impact Interventions (HIIs) were introduced as part of the 'Saving Lives: reducing infection, delivering clean and safe care' programme (DoH 2007). The purpose is to incorporate care bundles based on best practice and care process / actions associated with quality patient care. They are used as a tool to help address particular practice or care process issues. By auditing HII there is a constant review, and process for improvement of care. The tool reinforces the actions that are required on a continuous basis to reduce infection and to reduce unwarranted variation in care delivery. Each element of the audit is evidence based and has been proven to have a benefit in reducing health care associated Infections.

19.3.2. The HII audits undertaken in 2017-18 were:

- Preventing peripheral line infection (insertion)
- Preventing peripheral line infection (on-going care)
- Preventing urinary catheter infection (insertion)
- Preventing urinary catheter infection (on-going care)
- Ventilated Associated Pneumonia (VAP-ITU)
- Surgical Site Infection (SSIs – Theatres)

19.3.3. All clinical areas involved in the care of patients with peripheral lines or urinary catheters, are expected to undertake the audits on a monthly basis. As with the hand hygiene audits, the HII audits are reported on monthly by the IPCT in the HCG Performance reports, at the Quality Safety Committee. Results should also be discussed in the local HCG PS&Q forums, with actions taken by the ward/department manager as appropriate.

19.3.4. This year there has been a focus on increasing compliance in the undertaking and submission of the HII audits. There has been a significant improvement in this, with most areas undertaking them and a process in places with the HoNs for following up wards/ departments that do not submit. During December there were not any ventilated patients on ITU on the day of the audit, hence there is no data recorded for this month (Table 10).

19.3.5. **Table 10** shows the monthly performance scores for

Table 10: Compliance of HII audits (SSI and VAP) for 2017-18

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Jan-18	Feb-18	Mar-18
The Ventilated Associated Pneumonia (VAP)	94%	100%	100%	n/s	100%	100%	100%	100%	n/s	100%	100%
Preventing Surgical Site Infection SSI	n/s	100%	n/s	100%	98%	96%	100%	98%	100%	100%	93%

Table 11: Average Compliance for Submission and Performance for 2017-2018

	Preventing Peripheral Lines Infection - Insertion Performance%	Preventing Peripheral Lines Infection - Insertion Compliance%	Preventing Peripheral Lines Infection - Ongoing Care Performance%	Preventing Peripheral Lines Infection - Ongoing Care Compliance%	Preventing Urinary Catheter Infection - Insertion Performance%	Preventing Urinary Catheter Infection - Insertion Compliance%	Preventing Urinary Catheter Infection - Ongoing Care Performance%	Preventing Urinary Catheter Infection - Ongoing Care Compliance%
Medical Health Care Group	**98**	**62**	**88**	**68**	**100**	**67**	**98**	**69**
Surgery and Critical Care Health Group	**97**	**64**	**88**	**80**	**100**	**77**	**99**	**77**
Women and Family Health Group	**99**	**83**	**91**	**77**	**92**	**83**	**92**	**83**
Cancer, Cardiology & Clinical Support Services Health Group	**88**	**86**	**83**	**92**	**100**	**92**	**100**	**92**

Table 12: Monthly Performance Scores 2017-2018

HII 2. Preventing Peripheral Lines Infection (Insertion)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Medical Health Care Group	99%	97%	98%	91%	100%	99%	100%	100%	98%	100%	95%	98%
Surgery and Critical Care Health Care Group	90%	99%	98%	94%	99%	96%	97%	99%	96%	99%	96%	99%
Family and Women Health Care Group	99%	99%	100%	97%	100%	98%	94%	100%	98%	99%	99%	99%
Cancer, Cardiology & Clinical Support Health Care Group	93%	0%	95%	96%	95%	94%	97%	93%	98%	99%	99%	99%

HII 2. Preventing Peripheral Lines Infection (Ongoing Care)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Medical Health Care Group	96%	97%	94%	96%	96%	90%	95%	98%	93%	96%	96%	97%
Surgery and Critical Care Health Care Group	92%	99%	98%	96%	94%	95%	97%	98%	96%	94%	93%	94%
Family and Women Health Care Group	99%	99%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%
Cancer, Cardiology & Clinical Support Health Care Group	100%	100%	100%	100%	100%	100%	100%	0%	100%	100%	100%	100%

HII 6. Preventing Urinary Catheter Infection (Insertion)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Medical Health Care Group	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Surgery and Critical Care Health Care Group	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	97%	100%
Family and Women Health Care Group	100%	100%	100%	100%	0%	100%	100%	100%	100%	100%	100%	100%
Cancer, Cardiology & Clinical Support Health Care Group	100%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

HII 6. Preventing Urinary Catheter Infection (Ongoing Care)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Medical Health Care Group	97%	98%	97%	98%	99%	98%	97%	99%	99%	99%	100%	99%
Surgery and Critical Care Health Care Group	100%	100%	99%	100%	100%	100%	99%	98%	97%	100%	99%	98%
Family and Women Health Care Group	100%	100%	100%	0%	100%	100%	100%	100%	100%	100%	100%	100%
Cancer, Cardiology & Clinical Support Health Care Group	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

20.0 Antimicrobial Prescribing Compliance

20.1 Increasingly stringent, Department of Health set targets for Trusts for healthcare-associated infections (HCAIs) and developing resistance of micro-organisms indicates that there is a clear need to optimise the use of antimicrobial agents within the NHS Trusts. As shown by antimicrobials prescribing audits, a high percentage of antimicrobials prescriptions do not follow our Empiric Treatment of Infection Guidelines, creating an increased potential for:

- Antibiotic-associated healthcare-acquired infections; e.g. Clostridium difficile infection and MRSA bacteraemias.
- Colonisation with resistant strains of bacteria, which results in:

  - Higher morbidity and mortality
  - Increased length of hospital stay
  - More difficulty in treating infections
  - Adverse effects to antimicrobials

20.2 The Code of Practice on the prevention and control of infections (Health and Social Care Act 2008) requires registered healthcare providers to have and adhere to policies that will help to prevent and control infections.

20.3 **Aim**

Address areas of sub-optimal antimicrobials prescribing within the Trust, to optimise the management of primary infections, whilst minimising the incidence of HCAIs and the development of resistant organisms.

20.4 **Actions**

20.4.1. **Compliance with NICE NG15 – Antimicrobials Stewardship**

Establishing Antimicrobial Stewardship Group to review issues relating to antimicrobial stewardship, non-compliance with local guidelines, including the review of incident reports relating to antimicrobials and identify actions to address these if necessary. This Group aims to ensure the optimum use of antimicrobials, particularly to minimise the risk of causing healthcare-associated infections (HCAIs) and minimising antimicrobial related adverse effects and the development of antimicrobial resistance whilst maximising their cost effectiveness and clinical therapeutic effectiveness.

20.4.2. **Improve monitoring of and intervention with antimicrobials prescribing.**

- Pharmacy staff will clinically check antibiotics prescriptions to see if they comply with antibiotic guidelines, make sure that choice and usage are clinically appropriate before signing and dating scripts and clinically intervene as necessary, recording any interventions on the Pharmacy Department interventions form.
- Prescriptions must include; the name of the antibiotic, the clinical indication, a duration or review-date, dose, route, times of administration and suitable identification of the prescriber (name in capitals and bleep number) under his/her signature. For antimicrobials with use restricted to microbiologist authorisation only, the authorising microbiologist must be included in the medical notes.
- For those prescriptions which do not comply with antibiotic guidelines, a pharmacist will speak to the prescriber to highlight the deficiencies and provide advice for change.
- If the prescriber continues to deviate from antibiotic guidelines, action will be escalated to the Antimicrobial Stewardship Group.
- Regular audits (minimum of twice yearly; more frequently if with specific agreement and available resource) of antimicrobials prescribing practice.

20.4.3. **Electronic Prescribing**

Integrate best practice in antimicrobials prescribing into (EPMA) electronic prescribing system, through consultation with the Trust's antimicrobials team, the Pharmacy Department and the Project Team developing the e-prescribing system.

20.4.4. **AMR CQUIN**

Data will be collected and submitted by the CCOT nurses and the antimicrobial pharmacist.

20.4.5. **Education and Training**

The Antimicrobial Stewardship Group will ensure that a robust, antimicrobial education and training strategy is in place for all relevant Trust staffs at an appropriate level.

21.0 Training and Education Programme

21.1 The Infection Prevention and Control team continues to support the Trust achieve one of its key clinical priorities to protect patient, visitors and staff from the risk of healthcare associated infections caused by germs. The team continues to achieve this by its contribution to both our monthly corporate inductions and core training refresher update sessions for all staffs. The training sessions are aimed at different staff groups and levels dedicated to supporting staff to prevent and control cross – infections.

21.2 Furthermore, the team provides training sessions for overseas nurses, student nurses, health care support workers and at doctors' inductions. The training varies from regular face-to-face sessions, online learning and provides ad-hoc training for individuals areas/ groups of staff where requested. The sessions have received very positive attendee

feedback ratings with overall staff satisfaction rating of 8/10 and above with higher ratings received for "the ability to apply the learning into practice".

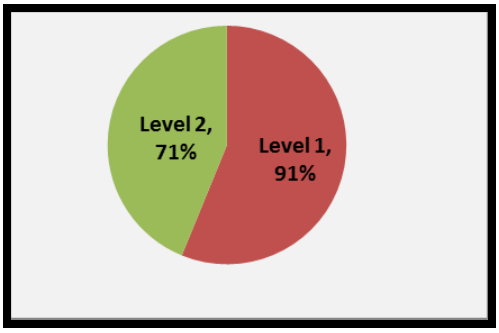
21.3 The training provided by the team is aligned to the UK Core skills Training Framework therefore covers all of the learning outcomes as stipulated by Skills for Health. Including, the fundamentals of hand hygiene, waste management, PPE, sharps safety, Health and Social Care Act, Role of the Infection Control team, The Chain of infection, Health Care Associated Infections (HCAIs), cleaning and cleanliness and standard precautions.

21.4 Following the completion of a 'Risk Based Training Needs Analysis' to ensure training is proportioned to local risks and also considers the actual evidence based risk and whether training is the best mitigation intervention; the Trust now has a locally customised eLearning content available to all staff and accessible on small electronic devices as a key driver for its desire for continuous improvement in training. The eLearning content supports the provision of core training compliance and the prudent management of healthcare associated infections.

21.5 Benefits derived from the continuous improvement to training are predominately in the form of opportunity cost but can have a positive effect on the patient safety and experience agenda, risk and staff engagement.

21.6 In the last year, PAH has made a steady improvement on IPC compliance rate and is keen to drive an upward trajectory. The Learning and Development team produces monthly reports with overall compliance for Infection Prevention & Control Level 2 for clinical staff currently at 71% and Level 1 for non-clinical staff at 91% *(figures taken from end of month core training report March 2018)*. The rapid increase in Level 1 compliance can be attributed to the introduction of a new Core Training booklet in Sept 2017 covering all basic level training. The training team and managers are working in collaboration to ensure that all clinical staff achieve and sustain 90% compliance by September 2018.

Infection Prevention and Control compliance as at 30th March 2018 for Levels 1 & 2



Actions to improve compliance rates:

- Support staff in the use of our Local eLearning option, extending its usage.
- Non-compliant staff are formally notified of their non-compliance in writing by a Trust Exec and given a period to rectify the non-compliance.

- We have ensured that our monthly classroom offerings exceed our maximum requirements (to help take into account of our DNA/late cancellation rates), and a monthly trajectory improvement target has been agreed.
- Interventions to ensure coverage of staff who work permanent nights and weekends.
- Smarter use of bank staff to cover permanent staff on training.
- Individual managers are informed when their staff DNA from any core training, and follow up actions advised.
- We proactively engage with areas on low compliance to provide help and support on how to address the issues.

22.0 Water Services Management (report from Estates)

22.1 Estates activities

During this time period the Estates department provided a reactive and proactive maintenance service across the Trust to include issues relating to infection prevention and control. This includes:

- Ventilation maintenance and monitoring
- Water quality monitoring
- Minor repairs to fabric of buildings

22.2 Drainage

This year saw a further increase in the amount of blocked drains causing flooding and damage to the hospital fabric. The root cause for approximately 80% of drain blockages was patient dry wipes and other objects that had been disposed of inappropriately. This issue along with the narrowing of drains due to age has caused serious infection control issues along with substantial damage to building fabric. The infection Prevention and control team along with the health and safety team has carried out awareness training with ward areas on the correct disposal of patient dry wipes, but this has had little positive effect. Due to the increase in risk around this issue, a capital project for 2018/19 has been developed to reline the drainage pipework to alleviate the issue.

22.3 Water safety management

Water monitoring continues across the Trust in line with HTM requirements. Samples taken from various areas of the Trust have highlighted high risk organisms, the main areas being SCBU, Gibbered ward and the campus block. Works have been carried out to remove or repair problem outlets, which has solved some issues. In other areas, water system repairs and adjustments along with an increased flushing regime were required to remedy the issues. Escalation of water safety issues and immediate actions were effective in some areas, emergency meetings of the water safety group and further works were required in others. These issues are expected due to the age and complexity of water systems across the Trust, and it is evident that the monitoring regimes in place detect and resolve the issues in a safe and timely manner. The water safety issues experienced by the Trust are similar to other organisations with an infrastructure that is not indifferent to the Trust. Other organisations have requested advice from the Trust in managing their water issues due to the successful management processes we have shared with other organisations.

22.4 Flooring and fabric

Where areas were identified as being difficult to clean due to poor quality flooring or walls coverings, remedial works have been undertaken on a programme based on risk by both internal estates and contractors. The have been no ward refurbishments programmed for 2018/19 but there is a plan to begin ward refurbishments when a suitable decant facility is in place in 2019/20.

22.5 Capital projects

22.5.1. Maternity Theatres

One of the highest risks to the Trust was addressed in the 2018/19 capital programme to refurbish maternity theatres providing a new HTM complaint ventilation system and theatre fabric to ensure infection risks are reduced as far as is reasonably practicable. The project has suffered delays, and is due for final completion in Aug 2018.

22.5.2. Day stay roof

Leaks from the roof in day stay were causing a significant infection risk and have now ceased following the replacement of various roof sections.

Henry Moore refurbishment

Following increased infection rates in OSU, the decision was taken to relocate OSU to Henry Moore ward in order to increase proximity to theatres, limiting patient journey and therefore decreasing infection risks. The ward was structured in accordance with best practice guidance with regards to bed spaces to reduce infection further, and all fabric of the ward was replaced or repaired in order to prevent infection and enable suitable and sufficient cleaning.

22.5.3. ED Streaming

The ED was refurbished in order to improve patient flow, along with reducing infection risks by upgrading the fabric of the area and including surfaces that can be easily cleaned.

Domestic pipework upgrades and redundant pipework removal

Works have been carried out to improve the flow of water in the domestic hot water system in order to reduce the risk of microbial growth. This has included pump and valve replacement, removal of redundant pipework, replacement of sinks and taps and pipework redirection.

23.0 Decontamination (report from Decontamination Lead)

The decontamination group meets on a bi monthly basis to review, resolve issues and plan support developments for decontamination with the Trust

New Authorised Engineer for decontamination [AED] was appointed during 2017/18

23.1 **CSSD**

- Washer disinfectors were replaced during March 2017
- A Reverse Osmosis (R.O) plant was installed in February 2018
- During the past year a number of orthopaedic patients were identified as having surgical site infections. An extensive investigation was undertaken as a result CSSD was not identified as the source of infection. However a number of actions were

undertaken in CSSD to improve processes and techniques used in the instrument sterilisation.
- ISO inspection May 2017 – no issues were identified and the service retaine its accreditation.

23.2 Endoscope decontamination

23.2.1. Colposcopy

Reverse Osmosis Unit
- Working well, no issues reported during the year.

Scope washers
- Washer working well, no issues identified
- The decontamination room is now compliant, after a refurbishment of the area.

23.2.2. Endoscopy
- This year there have been no issues with the water testing results.
- JAG accreditation has been granted for a further year.

23.2.3. Oak Unit
- PFE washers are at end of life and now have been decommissioned.
- Service is maintained with the use scopes which use single use sheaths.

23.3 Trust Decontamination Group

Table 13: A report of the current level of compliance to National Standards

Decontamination 2017-2018 Compliance with COSHH HTM01-05 CQC Outcome 8 and Outcome 11			
Standard	Controls in place	Evidence	Are requirements met?
COSHH:			
As per the Trust COSHH policy all departments are responsible for ensuring compliance with COSHH regulations.	This includes risk assessment, storage and use of substances hazardous to health.	Held centrally on the X Drive.	YES
Theatres:			
Annual checks & maintenance on all AHU's are up-to-date.	The Trust policy 'Management of Ventilation Systems'.	Details held by Estates.	YES
Theatres 1-5 Laminar flow systems are performance measured and validated on an annual basis by company called 'CAMFIL'.	Theatres hold the records for this following recent audit.	Held in Theatres.	YES
A PPM is in place to carry out theatre shutdowns periodically, during which an overhaul and deep clean of the ventilation systems occurs, along with a programme of other maintenance tasks.	Updated, as required.	Details held by Estates.	YES

The Management of Ventilations Systems Policy is written to comply with standards set out in relevant HTMs.	Updated, as required.	Details held by Estates. Policy held on central system.	YES
Endoscopy:			
JAG Accreditation	Updated as required	The Trust retains accreditation	YES
CSSD:			
ISO 9001 and ISO 13485 accreditation is maintained. It was agreed that the department would no longer be certificated to ISO 9001 as this is now included as part of ISO 13485	This is audited annually with recertification happening every 3 years.	ISO inspection	YES
Outpatients:			
Cleansing of Nasal Endoscopes must meet local decontamination standard.	Recording process in place for each use and regular audits undertaken as spot checks.	Details held locally in Outpatients.	YES
ISO accreditation is maintained.	This is audited every 6 months the recertification happens every 3 years.		YES
Outpatients:			
Cleansing of Nasal Endoscopes must meet local decontamination standard.	Recording process in place for each use and regular audits undertaken as spot checks.	Details held locally in Outpatients.	YES

24.0 Conclusion

24.1 2017-2018 has been challenging especially due to the continuing tight *C difficile* target, and the introduction of the new gram negative BSI (GNBSI) target without any further resource(s).

24.2 The *C. difficile* trajectory for next year is again low at 9 cases. Trust clinicians, pharmacists, facilities staff and the entire hospital team remain committed to *C difficile* control. The continuing low numbers of C difficile is a real achievement year on year at the Trust. Our in-house Facilities Team continue to play a vital role in maintaining high standards of cleanliness and use hydrogen peroxide vapour to further decontaminate ward environments, including providing out of hours support.

24.3 Introduction of the GNBSI target with mandatory reporting of E.coli, Klebsiella sp. and Pseudomonas aeruginosa bacteraemia has meant more and more information being gathered locally. Collaborative working between CCG and hospital teams is required to identify common themes. CCG IPC nursing support is required to take this work forward.

24.4 A Trust wide programme to reduce catheter associated urinary tract infections has been agreed locally as another step towards reducing GNBSIs.

24.5 An NHS objective is to improve population health through reduced antimicrobial resistance (AMR). Good antimicrobial stewardship has been strengthened due to the establishment of an antimicrobial stewardship committee in the Trust in November 2017. This has been one of the most significant developments in the Trust this year. This committee has received support from senior Consultants and junior doctors, and has established strong relationships with the

Microbiology team, anti-microbial pharmacy team and ward pharmacists. The Trust antibiotic policy has been updated taking into consideration local resistance patterns, and ensures the antibiotic management of infection and sepsis is optimal.

24.6 The on-site Microbiology laboratory team report antimicrobial resistance as real time information to the IPCT, who then take the necessary actions. We have an active surveillance programme of antibiotic resistance as well as antibiotic use. Our CQUIN information however still shows a high consumption of antibiotics, including some broad spectrum antibiotics. As there is good understanding across the Trust about AMR and a willingness to use antibiotics correctly, it may be that antibiotics are duplicated often, such as co-amoxiclav and metronidazole for anaerobe cover. Education and training will continue to address these issues. The Microbiology team also supports the Patient at home service, as many patients are treated for infection by this service.

24.7 Resistance to antibiotics in gram negatives is increasing in our Trust, and reflects national trends closely. For example, for E.coli in blood cultures, the resistance rate in 2017 was just over 14% for gentamicin, one of our broad spectrum antibiotics. Some other hospitals have needed to change to the antibiotic Amikacin due to increasing gentamicin resistance. This may need to be considered at PAH NHS Trust in the next few years if gentamicin resistance continues.

24.8 Carbapenemase producing Enterobacteriaceae (CPE) continue to be monitored, although this organism group have so far not caused concerns at PAH NHS Trust. Rectal screening in patients who present to PAH from hospitals where CPE is common is still not well established. This will require more education and training of front line staff.

24.9 The main hospital outbreaks this year have been due to Norovirus. This virus which causes acute onset diarrhoea and vomiting has impacted more than usual as outbreaks have been more frequent.

24.10 There was no outbreak of Influenza this year at PAH NHS Trust. SHAW received support from the wider hospital team and the Trust achieved high rates of staff vaccination for Influenza.

24.11 Our highly reputed elective orthopaedic unit had an increase in surgical site infections relating to hip and knee joint replacement surgery in early 2017. Improvements were made throughout the patient journey, and SSIs are now satisfactory and down to the usual low rates.

24.12 The IPCT continue to receive engagement and support from all levels of Trust staff. The local (Essex) Health Protection Unit have offered support for public health matters. Teaching and training in IPC including microteaching, has been on going throughout the year and the IPC Audit programme has been actively supported. The Executive Team, Consultants and Matrons continue to ensure IPC is an essential quality standard, and part of our Trust safety culture.

Authors:
Dr Shico Visuvanathan (DIPC/Consultant Microbiologist) and Ms Jenny Kirsh (Head of IPC)
September 2018

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Appendix 1. Surgical Site Infection Surveillance Annual Report

April 2017- March 2018

A national surveillance system for surgical site surveillance was established in England in 1997 as part of the PHLS Nosocomial Infection National Surveillance Scheme. This early scheme evolved into the Health Protection Agency Surgical Site Infection Surveillance Service (SSISS), now co-ordinated by Public Health England. The prevention of healthcare-associated infection has been highlighted as a priority for action by successive Chief Medical Officers. From April 2004 surveillance of surgical site infections in orthopaedic surgery became mandatory for all English NHS Trusts.

The aim of Surgical Site Infection Surveillance is to enhance the quality of patient care by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a benchmark rate, and to use this information to review and drive improvements in clinical practice.

At Princess Alexandra the surveillance programme began in 2005 reporting for the mandatory one quarter in knee replacement. From the last quarter in 2012, the hospital participates in all four quarters of the year for both hip and knee replacement. Recognising the importance of infection prevention and control, the orthopaedic team continues to undertake surveillance of surgical wounds for elective hip and knee replacement.

KNEE REPLACEMENT

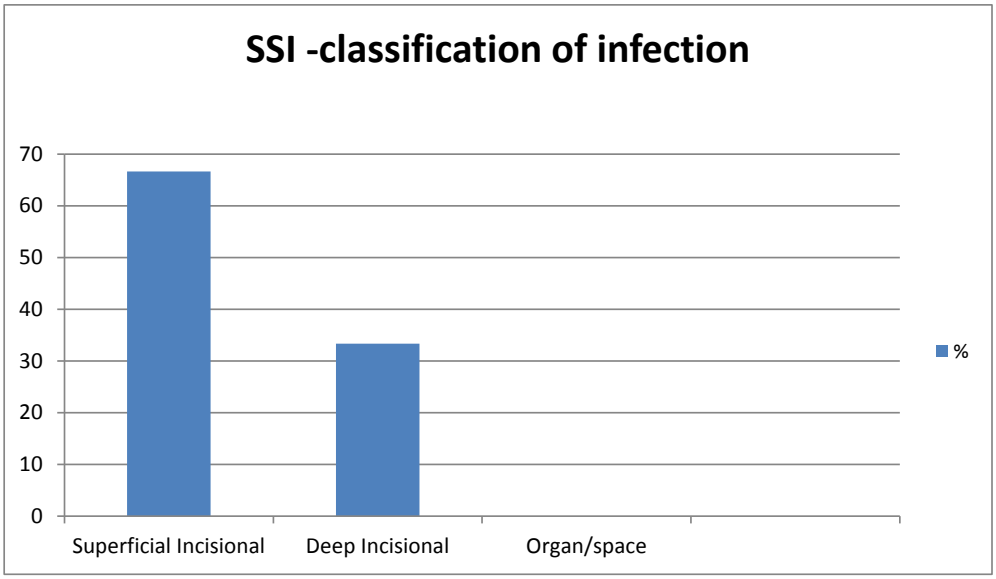
Rate of SSI

Figure One

Year & Period	No. operations	Inpatient & readmissions No. %	Post discharge confirmed No. %	Patient reported No. %	All SSI No. %
2017 Q2	65	1 1.5	0 0.0	0 0.0	1 1.5
2017 Q3	69	0 0.0	0 0.0	0 0.0	0 0.0
2017 Q4	86	1 1.2	0 0.0	0 0.0	1 1.2
2018 Q1	55	0 0.0	1 1.8	0 0.0	1 1.8
Total	**275**	**2** **0.7**	**1** **0.3**	**0** **0.0**	**3** **1.1**

The above table summarises surveillance for knee replacement in all quarters for the year 2017/18 at Princess Alexandra Hospital.

Figure Two



The chart above shows these infections were classified as one deep incisional and two superficial infections.

Comparative data benchmarked against other hospitals previous 5 years (Apr-Jun 2013 to Jan-Mar 2018 (last four periods)

This data enables the Trust to gain a true picture of its infection rates year to year, and gives the ability to benchmark accurately against other hospitals that participate in the surgical site surveillance programme.

Figure Three

	No. operations	Inpatient & readmissions No. %	Post discharge confirmed No. %	Patient reported No. %	All SSI No. %
PAH	275	2 **0.7**	1 **0.4**	0 **0.0**	3 **1.1**
All hospitals	328286	1237 0.4	991 0.3	2117 0.6	4345 1.3

HIP REPLACEMENT

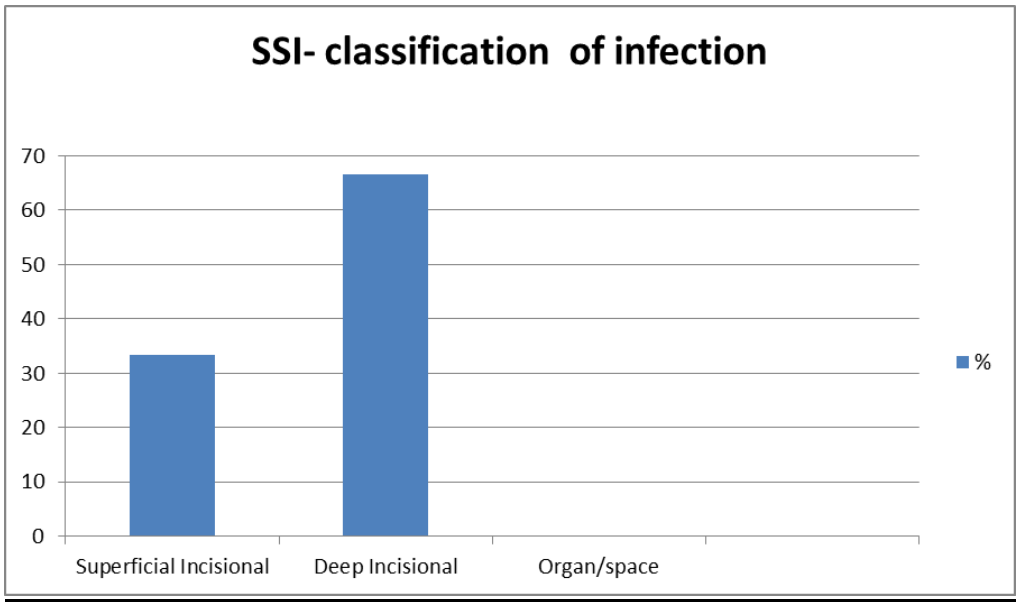
Rate of SSI

Figure Four

Year & Period	No. operations	Inpatient & readmissions No. %	Post discharge confirmed No. %	Patient reported No. %	All SSI No. %
2017 Q2	73	2 2.7	0 0.0	0 0.0	2 2.7
2017 Q3	51	0 0.0	0 0.0	0 0.0	0 0.0
2017 Q4	84	1 1.2	0 0.0	0 0.0	1 1.2
2018 Q1	33	0 0.0	0 0.0	0 0.0	0 0.0
Total	**241**	**3** **1.2**	**0** **0.0**	**0** **0.0**	**3** **1.2**

The above table summarises the surveillance for hip replacement in all quarters of 2017/18 at Princess Alexandra Hospital.

Figure Five



The chart above shows these infections were classified as two deep incisional and one superficial infection.

Comparative data benchmarked against other hospitals previous 5 years (Apr-Jun 2013 to Jan-Mar 2018 (last four periods)

This data enables the Trust to gain a true picture of its infection rates year to year, and gives the ability to benchmark accurately against other hospitals that participate in the surgical site surveillance programme.

Figure Six

	No. operations	Inpatient & readmissions No. %	Post discharge confirmed No. %	Patient reported No. %	All SSI No. %
PAH	241	3 **1.2**	0 **0.0**	0 **0.0**	3 **1.2**
All hospitals	304859	1340 0.4	648 0.2	907 0.3	2895 0.9

Findings/ Discussion

There has been a much improved overall performance since the incidence of increased surgical site infections. The orthopaedic elective ward moved to Henry Moore in winter 2017 and opened to patients on 28-Nov-2017. This may be coincidence, but performance has improved dramatically.

However, the team are fully aware not to become complacent and will be launching the 'One Together Assessment Toolkit'- a quality improvement collaborative with the aim of promoting and supporting the adoption of best practice to reduce the risk of surgical site infection throughout the patient's surgical journey. Unfortunately this was delayed due to the national problem with emergency admissions and the dictate from NHS England in the cessation of all non- urgent elective surgery. However, this had been planned to commence in May 2018, but still has not been undertaken- this has now become a priority for the team to implement in the coming months.

We will continue to participate in the surgical site surveillance programme as we recognise the importance of regular performance review and audit.

The Trust has also signed up for a QIST study (Quality Improvement for Surgical Teams) which begins later this year. This emphasises the Trust's commitment and drive to improving our services and outcomes to patients. Below is a brief overview/ explanation of the study with its positive benefits.

What is this study about?

Each participating NHS Trust is treated as a cluster, and are randomised 1:1 using minimisation by number of hip and knee replacement procedures performed and the traffic light indicators in the Learning From Mistakes league table. Trusts in both arms in the trial receive the intervention, i.e. training in the Breakthrough Series Collaborative. Trusts are randomised to receive either training on MSSA to control post-surgery infection (20 hospitals) or training on the anaemia optimisation programme (20 hospitals). None of the participating Trusts will have implemented either protocol prior to acceptance into the trial. Therefore, the control group for the anaemia optimisation quality improvement initiative are the other 20 hospitals who continue with their usual practice for anaemia and vice versa, the control group for MSSA are the other 20 hospitals who continue with their usual practice for MSSA screening. Hospitals are given the opportunity to be trained in the quality improvement initiative they have not received after the evaluation period is over.

What are the possible benefits and risks of participating?
The potential benefit for participating Trusts is the prospect of improved care and costs. These are a reduction in anaemia related blood transfusions, critical care, length of hospital stay and readmission rates leading to a potential saving of £160 per patient; and a reduction in surgical site MSSA related infections. Participating trusts are expected to save the NHS £6.3M per year, based on the experience at the Chief Investigator's own Trust. There are no perceived risks to Trusts or the teams from participating Trusts.

Christopher Goulding

Joint Replacement Nurse

04-July-2018

Appendix 2: Infection Prevention and Control Annual Work Programme 1st April 2018 – 31st March 2019

	Objective	Actions Required	Designated Lead	Timescale	Progress
1	**Provision and Delivery of an Infection Prevention and Control Service** An infection control service is required to deliver safe patient care and reduce the risk of incidents and outbreaks of infection	1.Delivery of a proactive and reactive infection control advisory service, accessible to all clinical and non-clinical staff across the Trust to minimise health care associated infections and deliver safe patient care. 2.The provision of a proactive/reactive IPC nursing team service Monday to Friday, and an on call service out of hours. 3.Clinical Microbiology advice available from the Microbiology Consultants in normal working hours and via the on call Microbiologist Consultant outside of working hours/weekends/Public Holidays. 4.Incidents and outbreaks of significance will be reported through the correct channels and these are discussed in team meetings, reported on at committees (ICC, Quality Safety Committee, Health Group PSQ forums, Senior Practitioner Forums, Band 6/7 Forums, Link Practitioner Meetings), Executive Team and communicated to the commissioners, NHSI and PHE as required. 5.Monthly performance reports submitted to QSC and SPQRG, detailing IP&C activity and any incidents/outbreaks of importance. 6. Root Cause Analyses (RCA's) are undertaken for significant incidents and the lessons learned are shared with clinical teams. 7.The IPC nursing team have allocated areas that they are responsible for providing expert support and advice to.	1.DIPC/IPCT 2.IPCT 3.Consultant Microbiologists 4.DIPC/Head of IPC 5. Head of IPC 6..DIPC/Head of IPC 7. Head of IPC	1.4.18 – 31.3.19 1.4.18 – 31.3.19 1.4.18 –31.3.19 -Weekly/monthly IPCT meetings -Monthly committees/ forums -Monthly reports to QSC, IPR SPQRG and each HCG. Notify Executive Team (in particular CMO / Chief Nurse) when significant outbreak / incident occurs. Monthly Within 14 days of incidents occurring Daily (the two IPCN's will rotate)	.
2.	**Hygiene Code Compliance**	1.Review on a regular basis and continue to ensure that any gaps are identified and actions put in place to address concerns	1.Head of IPC 2.DIPC/Head of	November 2018 and March 2019	

	Objective	Actions Required	Designated Lead	Timescale	Progress
	Compliance with the Health and Social Care Act 2008 *Code of Practice on the prevention and control of infections and related guidance (*updated 2010 & 2015)	2.Ensure that IPC risks are identified and included on the IPC risk register and HCG risk registers.	IPC/ADONs/ Heads of Departments/ Service Leads/ PSQ Facilitators/ Matrons		
3	**Surveillance and Reduction of HCAI** Continue to undertake mandatory surveillance on alert organisms as per national requirements	**MRSA Bacteraemia:** DoH Trajectory for 2018-19 - zero tolerance 1. Report monthly to PHE via HCAI Data Capture System 2. Local RCA to be undertaken and develop delivery plans for any case of Trust apportioned MRSA bacteraemia (The Trust is not required to undertake a PIR this year due to our good performance) 3. Disseminate dashboard to Managers and Clinicians (includes CCG) at least weekly	1.DIPC/IPC Information Officer 2.DIPC/Microbiologist/IPCT with relevant Consultant/Medical Team and Ward Manager or Nursing Team member, Matron/ADON and Chief Nurse/Deputy Chief Nurse Ownership: Health Group 3.IPC Information Officer	1.4.18 – 31.3.19	

	Objective	Actions Required	Designated Lead	Timescale	Progress
		Clostridium difficile: DoH Trajectory for 2018-19 = 9 1. Report monthly to PHE via HCAI Data Capture System **2.** RCA undertaken for all Trust apportioned cases **3.** RCA Scrutiny Panel meetings (now chaired by NHS Herts Valleys CCG and NHS East & North Hertfordshire CCG) **4.** Disseminate dashboard for all cases of *C.difficile* to Managers and Clinicians (including CCG) at least weekly	1.DIPC/IPC Information Officer 2.DIPC/Microbiologist/IPCT with relevant Consultant/Medical Team and Ward Manager or Nursing Team member and Matron/ADON and Antibiotic Pharmacist Ownership: Health Group 3.CCG Lead IPC Nurse 4. IPC Information Officer	1.4.18– 31.3.19 (as cases occur) Internal RCA Panel Review must be held within 14 working days of a new case occurring External RCA Panel: Cases discussed monthly at the North Essex CCG Scrutiny Panel. Cases for appeal must reach the panel at the earliest opportunity after the internal RCA review, but must take place within three months.	
		***E.coli* bacteraemia:** DoH ambition (came into effect from 1.4.17): Reduce the numbers of healthcare associated Gram-negative		1.4.18 – 31.3.19	

	Objective	Actions Required	Designated Lead	Timescale	Progress
		bloodstream infections (BSIs) by 50% by the year 2021 1. Report monthly to PHE via HCAI Data Capture System 2. RCA undertaken for Trust apportioned cases 3. Focus will be on those patients with an *E.coli* bacteraemia associated uro-sepsis and Pseudomonas for 2018-19 - RCA meeting to be held. 4. Set up a Catheter-associated UTI (CAUTI) working group to support the Trust with the DoH ambition. 5. Update Trust antibiotic guidance to control urinary and other infections, thereby preventing onset of various bacteraemias; use of antibiotics is monitored by the Antimicrobial stewardship group. 6. Disseminate dashboard to Manager and Clinicians (including CCG) at least weekly to provide feedback	1.DIPC/IPC Information Officer 2.Consultant Microbiologist /IPCT 3.Consultant Microbiologist /IPCT with relevant Consultant/Medical Team and Ward Manager or Nursing Team member and Matron/ADON Ownership: Health Group 4. Quality First Project manager/Contienence nurse/IPCT/DIPC 5. DIPC and Antimicrobial pharmacist 6. IPC Information Officer		
		Vancomycin/ Glycopeptide Resistant Enterococcus (VRE/GRE) Positive Blood Cultures No DoH trajectory has been set 1. Report quarterly to PHE via HCAI Data Capture System	DIPC/Consultant	1.4.18– 31.3.19	

	Objective	Actions Required	Designated Lead	Timescale	Progress
		2. Continue to monitor trends in both blood cultures and isolates, and raise awareness amongst clinicians	Microbiologist/ IPCT and Lead BMS		
		Carbapenemase Producing Organisms (CPO) **1.** Continue to promote policy; raise awareness and educate clinical staff **2.** Continue to work with the Emergency Department/ward staff to implement screening of patients that fulfil the criteria as set out in the policy **3.** Raise awareness of standard infection control precautions (hand hygiene, environmental hygiene) **4.** Monitor adherence to antimicrobial policy **5.** Initiate management plan and contact tracing actions as per CPO policy/algorithm if cases occur **6.** Audit screening log to determine compliance.	1,2,3,4,5,6 DIPC/Microbiologist /IPCT 4.Antimicrobial pharmacist	1.4.18 – 31.3.19	
4	**Antibiotic Stewardship**	1. Monitor compliance with antimicrobial policy bi-annually. Audits to be disseminated to Clinical Leads, Executive team and to ICC. Use of antibiotics is monitored by the Antimicrobial Stewardship Committee which was started in November 2017. Antibiotic policies for the Trust for adults, children, patient-at-home, and palliative care will be updated by March 2019. 2. To promote responsible use of antibiotics across the Trust and health care setting 3. Provide telephone and ward support for prescribers in choice and use of antibiotics; choices need to be compliant with Start Smart then Focus 2011 (DoH) ,the UK 5 Year Antimicrobial Resistance Strategy 2013 – 2018 and updated Trust antibiotic guidance	1.DIPC, Antimicrobial Pharmacist and Consultant Microbiologists 2.Consultant Microbiologists and all ward pharmacists Consultant Microbiologists	May and November 2018 On-going	

	Objective	Actions Required	Designated Lead	Timescale	Progress
		4. To progress Antibiotic CQUIN (2018 - 2019) Part 2c – Antibiotic review: documented durations or review dates must now be stated either in the medical notes or on the prescription. Part 2d - The Trust needs to follow the three AWaRe antibiotic categories recommended by WHO. The three AWaRe categories divide antibiotics as follows: a. Reserve – Antibiotics that need to be reserved due to antimicrobial resistance. b. Watch – Second-line agents. c. Access – Key antibiotics which are narrow spectrum and used as first-line treatment options.	Antimicrobial pharmacist /DIPC CQUIN Trust lead (Deputy Chief Nurse), and Contracts Manager responsible for CQUIN	Quarterly returns with progression for maximal compliance by 31 March 2019	
6	**Development and review of IP&C Policies** Programme of core and key policies requiring development and updating	1. Regular review and updating of Policy Review Programme 2. Key policies to be written or updated this year (list not exhaustive): - Control of Carbapenemase Producing Organisms - Management of Meningitis Policy - Management of Scabies, Lice and Infestation - Notification of Infectious Diseases Polices - Infection Prevention and Control Team Roles Responsibilities and Assurance Framework Policy - MRSA Policy - Management of Clostridium Difficile Policy - Control of Viral Haemorrhagic Fevers Policy - Management of Invasive Devices Policy - Prevention and Management of Chickenpox and Shingles Guideline - Decontaminating with Hydrogen Peroxide	Head of IPC oversees policy review programme	1.4.18 – 31.3.19	

	Objective	Actions Required	Designated Lead	Timescale	Progress
7	**Provision of Education and Training to all grades of clinical and non-clinical staff**	1. The IPCT will continue to be responsible for delivery of infection prevention and control training for all grades of staff across the organisation. This will be in the form of structured sessions and ad hoc events 2. The IPCT will continue to update and review presentations 3. Focus on developing and strengthening the role of the IP&C Link Practitioner (IPCLP) and the educational programme, to improve communication and engagement. 4. IPC to facilitate an Annual IP&C Conference	IPCT IPCT PCT (with support from Ward Managers) IPCT	1.4.18 – 31.3.19 Four per year: June 18, October 18 (Conference), January 19, March/April 19	
8	**Development of the IPC Intranet Page**	1. The IPCT will continue developing the IPC page to ensure staff have access to a variety of current IPC information: 2. New information as required, for example seasonal information such as Norovirus information 3. All new policies/information leaflets 4. Information on upcoming study days e.g. Link Practitioners 5. Information and guidance on audits (and audit tools) that clinical staff undertake i.e. HII audits 6. Master copies of IPC related documents/forms for clinical staff 7. IPC Newsletter	IPC Nursing Team and IPC Information Officer	2. As required 3.Policies as ratified 4.As required 5.As required 6. As required 7. Monthly	
9	**Hand Hygiene Compliance** Maintain compliance and increase in areas	1. Training and education to continue (formal sessions, plus ad hoc events, extra training in areas where concerns are identified) 2. Plan participation in 'Hand Hygiene Awareness week	IPCT IPCT	1.4.18 – 31.3.19	

	Objective	Actions Required	Designated Lead	Timescale	Progress
	requiring support	3. Continue with 'cross over' (peer review) audit programme in all clinical areas	Head of IPC to oversee programme; ownership with HCG leads.	October/November 2018 Monthly	
10	**Surgical Site Surveillance**	1. Caesarean section SSI surveillance to continue and develop into a more robust process 2. Mandatory Hip/Knee joint replacement SSI surveillance to continue	Caesarean section surveillance: HoN and Practice Development Miwife for FAWS HCG (supported by Head of IPC). CNS for Joint Replacement	Quarterly (all quarters) Quarterly (all quarters)	
11	**MRSA Screening** Achieve screening compliance for elective and emergency admissions	1. Work with Information Analyst to review monthly screening data and with the clinical areas that have non-compliances in MRSA screening 2. Undertake sample screening checks across in- patient areas to gain assurance of compliance with weekly screens.	Information Analyst for CC&CS Head of IPC supported by ADONs /HCG Dept/Service Leads IPC Information officer	1.4.18 - 31.3.19 - monthly Commence August 2018	
12	**Implementation of the IPC Audit Programme**	Refer to separate audit programme	Head of IPC	1.4.18-31.3.19	Refer to audit programme (circulated separately)
13	**Cleanliness and Environmental Hygiene**	1. To work with the Facilities Team on any work/projects/trials/ requiring IPC input/advice 2. To continue to lead on the IPC audit programme with	Head of IPC and Facilities Manager	1.4.18 - 31.3.19 IPC environmental audits two	

	Objective	Actions Required	Designated Lead	Timescale	Progress
	Support Facilities Team in compliance with national guidance on cleanliness standards	input from the Facilities Team. 3. Review Audit tool for cleaning with Facilities Team		per month. November 2018	
14	**Building Projects and Facilities** Provision of expert advice on all matters pertaining to planning, building, estates work	• The IPCT will continue to work closely with the Estates and Facilities departments in all matters relating to building work, water safety and cleaning where IPC advice/input is required	Head of Estates/Head of Capital projects/Health and Safety Manager Head of IPC Nurse Head of Facilities	1.4.18 – 31.3.19	

The Princess Alexandra Hospital NHS
NHS Trust

Appendix 3 : Infection Prevention & Control Annual Audit Programme 1st April 2017 – 31st March 2018

	Audits	Monitoring / Audit method	Lead	Responsible Person	Audit Frequency	Proposed Date(s)	Date of Completion	To which committee was outcome and action plans reported to (inc date)	Audit Registration Number
1	CPO Policy and screening log	Internal audit tool	Head of IPC	IPC Nurses	Annual	17th January 2019			TBC
2	Isolation Policy Compliance	Internal audit tool	Head of IPC	IPC Nurses	Annual (but also included in annual ward and department environmental audit)	6th December 2018			TBC
3	MRSA Weekly Screening	Internal audit tool	Head of IPC	IPC Information Officer	Monthly	1st August 2018 – 31st March 2019			
4	Hand Hygiene Policy	Internal audit tool (Peer review 'cross over' audits)	Head of IPC	Ward Managers	Monthly	1.4.18 – 31.3.19			TBC
5	Environmental and IPC ward/Departmental Annual Audit	Internal audit tool (based on the Infection Prevention and Control Society Improvement Tools)	Head of IPC	IPC Nurses with support from Estates and Facilities	Annually in every clinical department	1.4.18 – 31.3.19 separate programme of dates			TBC

	Audits	Monitoring / Audit method	Lead	Responsible Person	Audit Frequency	Proposed Date(s)	Date of Completion	To which committee was outcome and action plans reported to (inc date)	Audit Registration Number
6	Antimicrobial Prescribing Compliance Audits	Internal audit tool	Antimicrobial Pharmacist	Junior Doctors/ Antimicrobial Pharmacist/ Microbiology Consultants	Bi Annually	1.4.18 – 31.3.19			TBC
7	Sharps Safety (External company)	Sharps Smart audit tool	Head of IPC	Sharps Smart	Monthly	Monthly			
8	Hand Hygiene Compliance (External company)	Deb Cutan audit tool	Head of IPC	Deb Cutan Rep	Annual	TBC			
Saving Lives High Impact Intervention									
9	Prevention of Ventilated Associated Pneumonia (VAP)	Saving Lives audit tool	Intensive Care Unit Manger	Intensive Care Unit Nurses	Monthly	1.4.18 – 31.3.19			TBC
10	Surgical Site Infection (SSI)	Saving Lives audit tool	Theatre Matron	Theatre Nurses	Monthly	1.4.18 – 31.3.19			TBC
11	Peripheral Line	Saving Lives audit	Head of IPC	Ward/Departm	Monthly	1.4.18 – 31.3.19			TBC

	Audits	Monitoring / Audit method	Lead	Responsible Person	Audit Frequency	Proposed Date(s)	Date of Completion	To which committee was outcome and action plans reported to (inc date)	Audit Registration Number
	Insertion and Continuing Care	tool		ent Managers (all relevant clinical areas – see Scorecard)					
12	Urinary Catheter Insertion and Continuing Care	Saving Lives audit tool	Head of IPC	Ward Managers	Monthly	1.4.18 – 31.3.19			TBC
13	Central Venous Access Device Insertion and Continuing Care	Saving Lives audit tool	Head of IPC	Ward Managers	Monthly	TBC			TBC

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06/12/18 **AGENDA ITEM NO: 9.3**

REPORT TO THE BOARD FROM:	Workforce Committee
REPORT FROM:	**Pam Court – Committee Chair**
DATE OF COMMITTEE MEETING:	**26/11/2018**

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- The Committee supported two changes to the BAF risk ratings. It was recommended risk 2.1, workforce capacity, reduce from a score of 20 to 16. This was based on the rationale that workforce capacity had improved in a number of areas and although nursing employment remained a concern midwifery posts were fully established. It was further recommended that risk 2.4, workforce capability, reduce from a score of 9 to 6 due to consistent improvements in staff survey results since the issue was raised. There were no proposed changes to the risk score for risk 2.3, internal communications however the target date was updated to June 2019.
- The fill rate for Nursing and Midwifery staffing remained static at 87.4%.Overall fill rates had improved which was associated with the revised NHSP contract. Schemes were being investigated to address the staffing gap, including the potential for additional incentives for bank staff and a review of how alternative staffing structures could be utilised. A full review of vacancies is underway and will report to Board in February.
- The committee received the GMC action plan following the GMC survey results. When benchmarked against other trusts PAH was generally performing slightly above average. Areas of concern included paediatrics, anaesthetics and GP trainees. An action plan had been developed to address these areas. A number of other areas, such as Surgery and Urology demonstrated significant improvement when compared to the previous survey.
- Appraisal compliance had increased by 5% when compared to the previous reporting period, although it remained 5% below target.

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

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

Temporary Staffing: temporary staff utilisation was below the trust target by £600,000, whilst bank usage had increased. This remained under review to ensure a continued downward trend.

Succession Planning: A talent management strategy and plan is being developed to assist in succession planning to support the attraction, recruitment and retention of staff.

The committee also received the following reports:
Workforce Report; Draft People Strategy and Plan; Training and Education Update, Workforce Plan for the New Capacity Ward; Health and Wellbeing Update; Trusted Executive Foundation Update; Voluntary Services Quarterly Report; Communications Update; Local Workforce Action Board; People, OD and Communications Governance Structure and discussed the NHSI Observation Report from QSC.

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

The Committee's progress against its Annual Work Plan is set out below:

The Committee work plan was agreed with some minor amendments.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06.12.18 **AGENDA ITEM NO: 9.3**

REPORT TO THE BOARD FROM: Performance and Finance Committee
REPORT FROM: Andrew Holden - PAF Chairman
DATE OF COMMITTEE MEETING: 26.11.18

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
Fracture Clinic Business Case: The Committee considered the case and investment required to move the Fracture Clinic back from Herts & Essex Hospital onto the PAH Harlow site. The Committee supported and recommended the case to Board for approval (subject to the additional requirements on use of existing buildings). **Month 7 Finance Report:** In-month deficit £1.5m, £0.1m behind plan. Year-to-date deficit £17.5m, £0.3m ahead of plan. **MSK Update:** Commissioners are seeking a lead provider to manage the entire MSK pathway. Detailed proposals will come to PAF in December and Board in January as part of the consideration and approval of the response to the CCG Due Diligence Exercise during January. **IT Roadmap:** PAF discussed the current position and roadmap towards a new digitally enabled hospital for the future.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
In addition to the above, PAF received reports on the following agenda items: • Costing/SLR Update • BAF Risks • Data Quality • Coding • New Hospital • Procurement (quarterly report)
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee is making good progress against its work plan. It has agreed to focus on MSK in December and SLR, reference costs, model hospital and Get it Right First Time (GRFT) in February.

The Princess Alexandra Hospital NHS Trust

Trust Board
6 December 2018

Agenda Item:	9.4
Presented by:	Chief Executive - Lance McCarthy
Prepared by:	James Roach - Programme Director ICP
Date prepared:	30 November 2018
Subject / Title:	ICP Update

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]	An update on the West Essex Integrated Care Programme Delivery Plan August 1st – 31st March 2019 is attached.
Recommendation:	The Board is asked to note the update.

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

Previously considered by:	N/A
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	N/A
Appendices:	N/A

9.6

respectful | caring | responsible | committed

West Essex Integrated Care Programme

Delivery Plan August 1st – 31st March 2019.

Section 1 - Overview

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

This paper includes an overview of

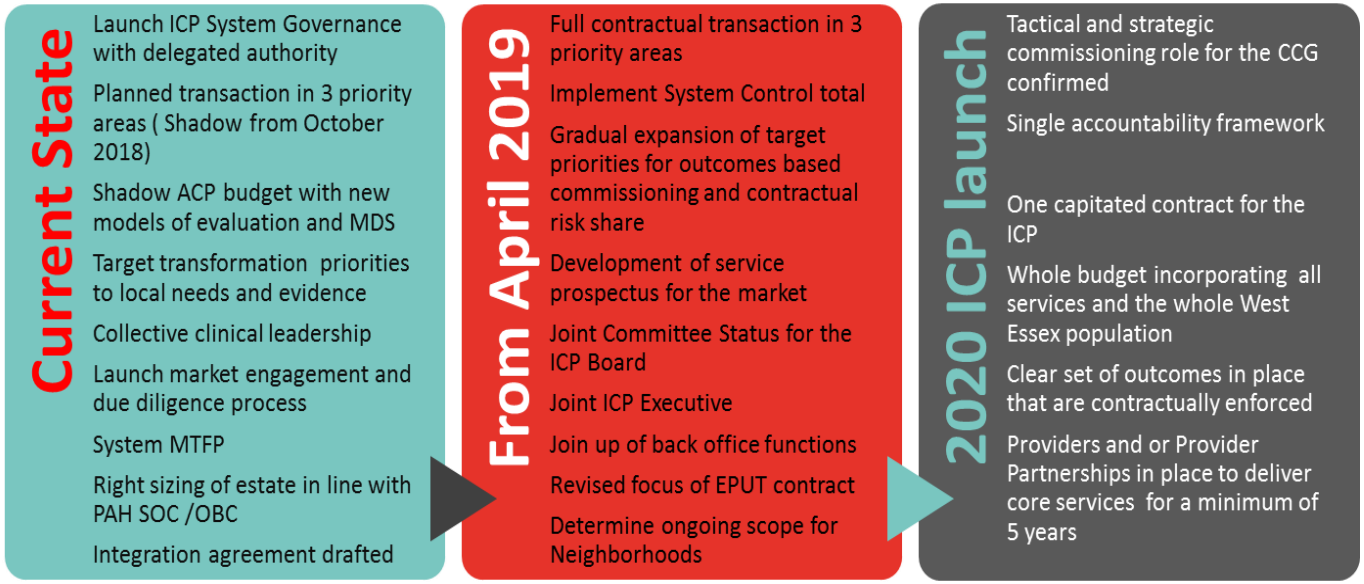
- Key strategic priorities
- Key delivery actions
- The proposed due diligence Process for MSK and COPD services
- Proposed levels of delegated authority for the ICP Programme

Section 2- Key strategic priorities

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

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

Section 3 - Delivery strategy



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Section 4 - Action plan 2018/19

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

Reference	Key area of focus	Start date	End Date	On track
1	**Pre mobilisation**			
1.1	Gain approval from ICP Board for service specifications (COPD and MSK)	1st August	18th August	**Delivered**
1.2	Finalise legal and procurement position (received)	18th August	31st August	**Delivered**
1.3	Commence ICP Provider Due diligence process for MSK and COPD	1st September	30th October	**Started 17/09/18**
1.4	Draft Commissioning Intentions for ICP	1ST October	31st October	**Finalised at 08/10/18 planning event**
1.5	Establish and launch the Shadow Periods for MSK ,COPD and Urgent Care (this will include completion of contractual variations and schedules and evaluation programme)	1st November	31st March 2019	**Signed off by providers**

Reference	**Key area of focus**	**Start date**	**End Date**	**On track**
2.	**Establish Programme Governance and Leadership**			
2.1	Sign off ICP governance model and with associated levels of delegated authority (all aspects of the governance model)	24th July	1st September	**On track – item on Governing Bodies (PAH/EPUT/CCG)**
2.2	Governance model to be approved by individual Governing Bodies in September	1st September	30th September	**Completed**
2.3	Current contract review /take stock	1st September	31st October January 2019	**Completed**
2.4	Draft Formal Integration Agreement (all partners) for date effective launch of 1st April 2019. Potentially will need Governing Body sign off in January and then shadow implementation to the end of March 2019	1st August		**On track**
2.5	Develop Communication and lead Stakeholder Engagement Plan	1st September 2018	1st December 2019	**CCG comms strategy Approved /widen to ICP. Commas summit in Dec**

2.6	Agree resources necessary for ICP Programme mobilisation 2019/20	1st October	31st March 2019	**Paper for approval for Dec ICP Board**
2.7	Development of contracting intentions for the system /ICP and develop and begin the implementation of ICP Intentions	1st January 2019	31st March 2019	**In line with planning timetable**
2.8	Development of the Medium Term Financial Plan for the West Essex system and put in place a supporting delivery and assurance mechanism	1st October	31st March 2019	**On track**
2.9	Develop and Implement a Single Accountability Framework for the ICP	1st October	31st March 2019	**Work has commenced**

Reference	Key area of focus	Start date	End Date	On track
3.	**Launching local care models**			
3.1	Front Door Model (Shadow with agreed MDS and payment terms)	1st August	31st/3/2019	**Framework now agreed**
3.2	MSK service launch (shadow with agreed MDS and payment terms)	1st October	31st/3/2019	**Due diligence process has commenced**
3.3	COPD service launch (Shadow with agreed MDS and payment terms)	1st October	31st /3/2019	**As above**
3.4	Development of contractual mechanisms and relevant variations, associated legal frameworks with gain/risk sharing agreement and financial incentives for impact from April 1st 2019	1st September	31st October	
3.5	Transformation Board (working in partnership with Expert Oversight Groups) to recommend new clinical target areas for ICP	1st October	1st October	**3 areas identified at system planning event**
3.6	Develop an outline Clinical Strategy for the system and Prioritise clinical work plans	1st October	1st December	

3.7	Work with Professional Leaders Group and Clinical Senate to develop new areas for clinical integration and an Innovation Pipeline for 2019/20	Ongoing	30th November	**Ongoing**
3.8	Develop a ICP prospectus of future service delivery/commissioning intentions Market engagement in identified areas	1st December	31st March 2019	**Strategy and intentions being drafted**
Reference	**Key area of focus**	**Start date**	**End Date**	**On track**
4.	**Developing the outcomes framework**			
4.1	Commence monitoring of revised outcome measures for MSK/COPD and Front Door Model	1st October	31 / 3/ 19	**Outcomes drafted**
4.2	Design and approve ICP Reporting Architecture	1st September	1st November	**November ICP Board**
4.3	Launch system wide Population Health Framework	1st October	1st December	**Launched**

5.	**Developing the contractual and financial framework**			
5.1	Define and agree via System FDS a detailed contracting strategy for 2019/20 and 2020/21 to include budget modelling, scenarios and the framework approach for risk and gain share.	**1st September**	**1st November**	**In progress – looking to join up baseline planning**
5.2	Develop financial report and templates to support the revised contract model	**1st September**	**1st November**	**On track and in line with local planning framework**
Reference	**Key area of focus**	**Start date**	**End Date**	**On track**
6.	**Workforce and system development**			
6.1	Develop a workforce strategy following local needs analysis	**1st August**	**1st Nov**	
6.2	Engaging OD support for the transformation model	**From 1st October**		
6.3	Launch Integrated Care System KLOE review	**September**		**In progress**
6.4	Confirm approaches in relation to strategic and tactical commissioning			**Board seminar October**
7.	**Communications and engagement**			
7.1	Produce Patient Engagement Plan	**3rd September**		**Commenced**

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

James Roach

Programme Director ICP

November 2018

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board
6 December 2018

Agenda Item:	10.1							
Presented by:	Trevor Smith – Chief Finance Officer							
Prepared by:	Colin Forsyth – Head of Financial Services							
Date prepared:	24 November 2018							
Subject / Title:	PAH Charity Annual Report and Accounts 2017/18							
Purpose:	Approval	✓	Decision	✓	Information		Assurance	
Executive Summary:	The purpose of this report is to present the Charity Annual Report and Accounts and associated assurance statements to the Trust Board. The Annual Report and Accounts were reviewed and recommended to the Board by the Charitable Funds Committee 3 October 2018.							
Recommendation:	The Trust Board (as Corporate Trustee) for The Princess Alexandra Hospital NHS Trust Charitable Fund is asked to approve: • The Annual Report and Accounts 2017/18 and • The Letter of Representation, authorising the Chair of the Charitable Funds Committee and Chief Finance Officer sign the Letter. • Authorise that the Chair of the Charitable Fund Committee and the Chief Finance Officer sign the accounts certificates.							

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

Previously considered by:	Charitable Funds Committee 3 October 2018
Risk / links with the BAF:	Failure to comply with Charity Commission requirements, insufficient funds to meet liabilities, reputational damage from lack of financial control over charitable funds.
Legislation, regulatory, equality, diversity and dignity implications:	As a condition of its registration, the Charity is required to comply with Charity Commission guidance and reporting requirements.
Appendices:	Appendix 1 – Annual Report and Accounts 2017/18 Appendix 2 – Letter of Representation

The Princess Alexandra Hospital NHS
NHS Trust

1.0 PURPOSE

The purpose of this report is to present, and request approval of the Charitable Fund Annual Report and Accounts 2017/18 and associated assurance statements.

2.0 CONTEXT

The Annual Report and Accounts were reviewed and agreed by the Charitable Funds Committee on the 3 October 2018.

The Charity is not required to submit a full set of Charity Accounts to NHS Improvement. However, a submission of an annual report and accounts does need to be made to the Charity Commission on an annual basis.

The Annual Report and Accounts for 2017/18 (Appendix 1) are presented for approval by the Corporate Trustee prior to submission to the Charity Commission.

The Accounts do not require a full audit. Charity Commission guidance (CC31, Independent examination of charity accounts: trustees, June 2015) is that:

For financial years ending on or after 31 March 2015, trustees may opt for an independent examination instead of an audit provided their charity's gross income is not more than £1m, or where gross income exceeds £250,000, its gross assets are not more than £3.26 million

The 2017/18 Annual Accounts have now been reviewed by the appointed independent examiner Ernst & Young LLP. The report of the independent examiner is included within the Annual Report and Accounts (Page 6).

3.0 KEY POINTS TO NOTE ON THE BASIS OF THE PREPARATION OF THE ACCOUNTS

- The Trust submitted its draft accounts and working papers for review to the independent examiner as per the agreed local timetable.

- There have been no independent examiner initiated changes to the Annual Report and Accounts that impact on the overall financial position reported in the draft Accounts. Minor presentational and disclosure changes within the accounting notes were agreed during the independent examination (see section 5).

- The financial statements have been prepared under the historic cost convention and in accordance with the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland (FRS102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

- The Trust Board (as Corporate Trustee) consider that the Charity is a going concern and consider that there are no material uncertainties about The Princess Alexandra Hospital NHS Trust Charitable Fund and its ability to continue as a going concern. There are no material uncertainties affecting the current year accounts.

The Annual Report and Accounts 2017/18 can be found at Appendix 1.

The Princess Alexandra Hospital NHS
NHS Trust

4.0 KEY FINANCIAL HEADLINES

The summary financial position for the charity is:

	2017/18 Total Funds £000	2016/17 Total Funds £000
Income and endowments from:		
Donations and legacies	211.0	289.0
Other trading activities	535.0	634.0
Investments	1.0	1.0
Total	**747.0**	**924.0**
Expenditure on:		
Raising funds	(297.6)	(255.0)
Charitable activities		
- Contributions to the Trust	(311.0)	(260.0)
- Medical Research	(165.0)	(171.0)
- Patient welfare and amenities	(69.0)	(87.0)
- Staff welfare and amenities	(37.0)	(6.0)
Total	**(879.6)**	**(779.0)**
Net (expenditure)/income	**(132.6)**	**145.0**
Fund Balances		
Total funds brought forward	602.0	457.0
Total funds carried forward	**469.4**	**602.0**

The reduction in fund balances is primarily attributable to a general reduction in-year from donations of £78k and the net contribution from the Breast Unit fund reducing by £158k (£387k in 2016/17 to £247k in 2017/18)

10.1

5.0 ADJUSTMENTS TO DRAFT ACCOUNTS

There have been no independent examiner initiated changes to the Annual Accounts and Financial Statements that impact on the overall financial position reported in the draft Accounts. The Trust has made some changes within notes where appropriate. In particular:

- **Cash and Cash Equivalents, and Creditors Balances** – The Trust has two "linked" Barclays bank account balances that should be reported as a single “Cash and Cash Equivalents” figure, rather than reporting un-cleared cheques as a separate balance within creditors. The 2016/17 balance for Cash and Cash Equivalents has been restated (a reduction of £10k), with an equivalent movement in creditors (a decrease of £10k) to reflect the linked nature of the Barclays accounts.

- **Contingent Asset additional disclosure (Note 19)** – The Charity has been notified of a potential legacy for the ophthalmology unit. The legacy could be in the region of £60k for the Trust, however this value remains uncertain, and therefore it has not been recognised in the 2017/18 Statement of Financial Activities.

The Princess Alexandra Hospital NHS
NHS Trust

6.0 LETTER OF REPRESENTATION TO EXTERNAL INDEPENDENT EXAMINER

As part of the review process the Corporate Trustees are required to formally present a Letter of Representation to the independent reviewer confirming the basis upon which the accounts have been prepared. The draft letter of Representation (Appendix 2), once approved, requires signing by both the Chair of the Charitable Funds Committee and the Chief Finance Officer.

The letter of representation provides assurance to the Trust's independent examiners on matters within the Annual Report and Accounts 2017/18 presented to them for the review. The draft letter is included at Appendix 2. This letter is required by the independent examiner prior to them signing the Independent Examiner's report.

7.0 RECOMMENDATION

It is recommended that the Trust Board (as Corporate trustee) for The Princess Alexandra Hospital NHS Trust Charitable Fund approve:

- The Annual Report and Accounts 2017/18 and
- The Letter of Representation, authorising the Chair of the Charitable Funds Committee and the Chief Financial Officer to sign the letter.
- Authorise that the Chair of the Charitable Fund Committee and the Chief Finance Officer sign the accounts certificates.

Author: Colin Forsyth, Head of Financial Services
24 November 2018

10.1

The Princess Alexandra Hospital NHS Trust Charitable Fund

Annual Report and Accounts 2017/18

10.1

THE PRINCESS ALEXANDRA HOSPITALS NHS TRUST CHARITABLE FUND
ANNUAL REPORT AND ACCOUNTS 2017/18

OUR BACKGROUND

The Princess Alexandra Hospital NHS Trust Charitable Fund (the "Charity"), was formed under a trust deed dated 21 March 1996 and is registered with the Charity Commission, registration number 1054745.

The Princess Alexandra Hospital NHS Trust Charitable Fund is registered as an Umbrella Fund which encompasses three unrestricted special funds; The Princess Alexandra Hospital General Fund, The St Margaret's Hospital General Fund and The Herts and Essex Hospital General Fund.

The Trustee of the Charity is The Princess Alexandra Hospital NHS Trust (the "Trust"), a Body Corporate. This responsibility is managed by the Board members, with voting rights, of the Trust.

Charitable Funds received by the charity are accepted and held and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990 and these funds are held on trust by the corporate body.

The beneficiaries of the Charity are the patients, staff and visitors of The Princess Alexandra Hospital NHS Trust.

OUR OBJECTIVES

Through fundraising activities, events and appeals we will further improve the provision of high quality patient care at the cutting edge of technology throughout the Trust, focusing on areas not covered or fully supported by central NHS funds. The Trust Board confirm that they have referred to the guidance contained in the Charity Commission's general guidance on public benefit when reviewing the Charity's activities and objectives and in planning future activities.

The Trust Board shall hold the Charitable Fund, and apply the income where applicable, and at their discretion the capital for any charitable purposes or purposes relating to the National Health Service. Within the single registered charity there are a number of funds for the Trust, each managed by a fund manager. There is specific criteria documented and funds should be spent in line with the purposes of the fund. This criteria is for internal guidance only and has no legal standing. However, expenditure from funds given by the general public must be seen as being appropriate and in line with their wishes. The receipt given for donations is in line with Charity Commission guidelines and states that the funds will be used 'for the general purposes of (the) charity, and I desire they use such sum to …' This means that the Charity will try to spend the cash in accordance with the donor's wishes, but retains the right to use discretion. Unless raised for a specific object, Charitable Funds should be spent within a three year time period for the purposes of the fund and should not be built up for future years.

OUR ACTIVITIES, ACHIEVEMENTS AND PERFORMANCE

During the year, the funds continued to support a wide range of charitable and health related activities benefiting both patients and staff. In general they are used to purchase the very varied additional goods and services that the NHS is unable to provide. Charitable funds were used to purchase much needed medical equipment, for example, a Microtome for the Pathology Department, a Phototherapy System for the Neonatal Unit and a Junior Optiflow System for Dolphin Ward.

Case Study - Microtome (Pathology)

Following a number of events to support the Cancer & Diagnostics service, it was decided to buy a "Microtome" machine for the cellular pathology department. This machine costs £7,500 and can take very thin sections (just 1 cell thick) of tissue, which can then be reviewed by consultant pathologists. Sections can be taken from the lung, breast or colon, and the process, undertaken by trained laboratory staff, is used in routine diagnostics of both benign conditions, as well as cancer specimens. It was the dedication of the consultant pathologist and supporters who helped raise the funds needed for this purchase.

The ward charitable funds receive many donations specifically given to thank the nursing staff and these are used for charitable activities that will benefit staff. The charitable funds also enable consultants and other medical staff to attend courses, not funded by the NHS, which will update them on the new ideas and modern techniques in their specialities.

The charity makes available funds to sponsor non commercial research in areas where the Trust has considerable expertise with a view to developing new therapies for treating and caring for patients. This peer reviewed programme, which is approved by the NHS Trust Research Ethics Committee, is supported by way of fundraising events (see note 7).

The Princess Alexandra Hospital General Purpose Fund receives donations and legacies that can be used for the benefit of all staff and patients of The Princess Alexandra Hospital NHS Trust.

Fundraising events and appeals continued to be held during 2017/18 and are proving to be very successful. A Shooting Day, which took place in May 2017 generated income of £84,051. A dinner held at the Savoy Hotel in London generated income of £86,163. The Improving Cancer Services Appeal has raised a net of £4,945 as at 31 March 2018.

Case Study - Royal Parks Half Marathon

The Breast Unit is one of the largest breast cancer clinical trials facilities in Hertfordshire, Essex and North London and has raised over £3 million, which has been used to purchase specialist equipment, introduce new initiatives and fund further research into the breast cancer. One of the fundraising events that took place in 2017, was participation in the Royal Parks Half Marathon, where approximately 75 runners took part in raising around £36,000 for the fund. The event was promoted on Facebook, Twitter and Instagram and all 75 places available were quickly filled by supporters keen to raise as much as possible for the charity. A space was booked in a marquee at the event to allow runners, families, friends and supporters to meet, and was a great opportunity to say thank you and to raise awareness and provide further information about the work of the Breast Unit fund. We continue to raise money for breast cancer clinical trials in order that we can improve understanding and help find new ways to prevent, diagnose and treat different kinds of breast cancer, and will be holding this event again in 2018.

FUTURE PLANS

Mindful of the many changes in the NHS the future direction of the charity will be shaped by those changes. The reconfiguration of services and the plans for redesigning patient care to meet the needs of the future will influence the priorities for spending charitable funds. However, the Charity will continue to meet its objectives in the future.

A Fundraising Co-Ordinator has now been appointed to implement the fundraising strategy for the Charity as a whole and implement ways to generate more funds to allow the objectives of the Charity to be achieved.

FINANCIAL REVIEW

These financial statements have been prepared under the historic cost convention and in accordance with the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland (FRS102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015. These can be found on pages 7-14 of this report.

The Charity is constituted of 104 individual funds as at 31 March 2018 (114 in 2016/17).

Income

The Charity received income for the year totalling £747,000, an decrease of £177,000 compared to 2016/17.

This income is comprised of donations of £211,000 (decreased from £271,000 in 2016/17), the majority of which were made by patients and visitors (in excess of 1000 donations).

The charity received no legacies in 2017/18. Of the amount of £17,600 received for ITU in 2016/17, £4,797 has been utilised to purchase equipment and furniture for the unit with £12,803 yet to be used.

The Charity received investment income of £1,000 (£1,000 in 2016/17).

Income from activities for generating funds totalling £535,000 (£634,000 in 2016/17) has been received into the Charity. Of this income, £517,200 was raised for the purposes of research, £1,300 for the Water Ball event, £5,300 for the ED/ITU Ball event, £500 for the Gauntlet Games event, £1,500 for the My Life Memory Software Appeal, £8,000 for the Improving Cancer Services Appeal and £1,200 for the ITU Equipment Appeal.

Expenditure

During the year the Charity provided support in the form of education and training, and the supply of medical equipment and expended resources totalling £550,000 (£492,000 in 2016/17).

These comprised contributions to The Princess Alexandra Hospital NHS Trust of £444,000 (£399,000 in 2016/17), of which the majority were for medical equipment, computer hardware and software and furniture for the wards. Expenditure of £37,000 (£6,000 in 2016/17) was made for staff welfare and amenities and £69,000 (£87,000 in 2016/17) for patient welfare and amenities.

Investments

Investments held by the Charity have been acquired in accordance with the powers available to the Trust Board. The policy for the current investments is to hold cash funds in secure interest bearing bank accounts.

The investments realised a slightly increased level of income in 2017/18 to those received in 2016/17, due to an increase in the Bank of England interest rate during the financial year, which increased interest earned on the cash investments held.

Reserves Policy

The Charitable Fund looks to maintain fund balances to allow for a minimum of 6 months of operating costs (administrative and fundraising) and does not hold designated reserves. The Trust Board confirms that the Charity's assets are available and adequate to fulfil the obligations of the Charity.

STRUCTURE, GOVERNANCE AND MANAGEMENT

The Princess Alexandra Hospital NHS Trust Charitable Fund was formed under a trust deed dated 21 March 1996 and is registered with the Charity Commission, registration number 1054745.

The responsibility for the identification, implementation and monitoring of the strategic direction of the Charity is performed by the Trust Board of Directors. This is made up of a Chairperson, eight Executive Directors (three non-voting), including the Chief Executive, five Non-Executive Directors and two Associate Non-Executive Directors. The Executive Directors are responsible for the day-to-day running of the Charity. The Non-Executive Directors are appointed by the Secretary of State for Health or independently by the Board for their specialist expertise and/or local knowledge.

Appointments to Executive Director posts, including that of the Chief Executive, follow a common process. Posts are normally advertised nationally and short-listed candidates meet with senior Trust and local health economy staff prior to formal interview. The final decision on appointments is made by an interview panel, chaired by the Trust Chair, which includes executive level staff from NHS Improvement and local Clinical Commissioning Groups (CCG's), other Trust Non-Executive Directors and an external assessor.

There are no formal training procedures in place for all members of the Trust Board relating specifically to the Charity. However, the Non-Executive Directors who are members of the Charitable Funds Committee regularly attend sessions provided by the Association of NHS Charities where topics including GDPR, Innovation in the NHS and Investment and Charity Policies are discussed. Briefings from the Association are included in the papers for each meeting of the Charitable Funds Committee.

The Trust Board have adopted policies which achieve the objects stated by ensuring funds are used for the purpose for which the donor intended and are not accumulated unless part of a greater project or fund raising scheme.

STRUCTURE, GOVERNANCE AND MANAGEMENT (CONTINUED)

Risk Management

The Trust Board have the overall responsibility for ensuring that the charity has an appropriate system of controls, financial and otherwise. The systems of financial control are designed to provide reasonable, but not absolute, assurance against material misstatement or loss. They include:

- regular consideration by the Charitable Funds Committee of financial results;
- delegation of authority and segregation of duties; and
- identification and management of risks.

The Trust Board will continue to monitor risks and set up or amend formal policies to mitigate them. There is a formal, Trust wide risk management process in place, detailed in the Trusts' Governance and Risk Management Strategy and it is the intention of the Trust Board to perform a review of the following categories of risk; governance and management, operational, external factors and compliance with laws and regulations. The Trust Board will identify the primary risks applicable to the Trust in each category and develop action plans to mitigate the risks identified.

REFERENCE AND ADMINISTRATIVE DETAILS

The Princess Alexandra Hospital NHS Trust Charitable Fund is registered with the Charity Commission, registration number 1054745. It's working name is The Princess Alexandra Hospitals Charity.

The Princess Alexandra Hospital NHS Trust Charitable Fund is registered as an Umbrella Fund which encompasses three unrestricted special funds whose names and objects are as follows:

The Princess Alexandra Hospital General Fund
For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by The Princess Alexandra Hospital.

The St. Margaret's Hospital General Fund
For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by The St. Margaret's Hospital.

The Herts & Essex Hospital General Fund
For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by The Herts & Essex Hospital.

The purposes of the unrestricted funds are to support any charitable purpose relating to the NHS; 103 particular designated funds and 1 unrestricted fund have been created to reflect the non binding wishes of donors (114 in 2016/17).

The Charity's assets consist of cash investments, which are available and adequate to fulfil the obligations of all the above funds.

The Charity has no paid or unpaid volunteers, and no paid employees, but is supported in its activities by The Princess Alexandra Hospital NHS Trust. The administrative function is performed by the Finance Department of The Princess Alexandra Hospital NHS Trust, the services of which are reimbursed by the Charity.

For day to day operations the Charitable Funds adhere to the Standing Orders and Standing Financial Instructions of the Corporate body (The Princess Alexandra Hospital NHS Trust).

Our Principal Office
The Princess Alexandra Hospital NHS Trust Charitable Fund
Hamstel Road
Harlow
Essex
CM20 1QX

Trustees
The Trustee of the Charity is The Princess Alexandra Hospital NHS Trust governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011. This responsibility is managed by the Board members, with voting rights, of the Trust.

Board members for the period 1 April 2017 to 31 March 2018 are listed below:

Chairman
Alan Burns

Executive Directors

Lance McCarthy	Chief Executive Office (from 03 May 2017)
Trevor Smith	Acting Chief Executive Officer (to 31 May 2017)
Trevor Smith	Chief Financial Officer (from 1 June 2017)
Simon Covill	Acting Chief Financial Officer (to 31 May 2017)
Andy Morris	Chief Medical Officer
Nancy Fontaine	Chief Nurse
Jim McLeish	Director of Quality Improvement (non-voting)
Marc Davis	Director of Pathways and Partnerships (non-voting)
Stephanie Lawton	Chief Operating Officer
Liz Booth	Director of HR (non-voting) (to 17 November 2017)
Raj Bhamber	Director of People (non-voting) (from 20 November 2017)

THE PRINCESS ALEXANDRA HOSPITALS NHS TRUST CHARITABLE FUND
ANNUAL REPORT AND ACCOUNTS 2017/18

REFERENCE AND ADMINISTRATIVE DETAILS (CONTINUED)

Non Executive Directors

Steven Bright	
John Hogan	(from 01 August 2017)
Andrew Holden	
Pam Court	
James Anderson	
Helen Glenister	Associate Non-Executive Director (from 01 August 2017)
Steve Clarke	Associate Non-Executive Director (from 01 August 2017)

The Trustees are assisted in their work by a number of professional advisors, as detailed below:

Independent Examiners

Ernst & Young LLP
400 Capability Green
Luton
LU1 3LU

Bankers

Barclays Bank PLC	RBS
Water Gardens	280 Bishopsgate
Harlow	London
Essex	EC2M 4RB
CM20 1AN	

PARTNERSHIP WORKING AND NETWORKS

The Princess Alexandra Hospital NHS Trust Charitable Fund is one of 129 NHS linked charities in England and Wales who are eligible to join the Association of NHS Charities. As a member charity, we have the opportunity to discuss matters of common concern and exchange information and experiences and to participate in conferences and seminars which offer support and education for our trustees.

We remain indebted to the work of the volunteers of the Harlow League of Hospital Friends who raise substantial amounts each year through a range of fundraising events including coffee mornings and hospital fetes, and the WRVS who support us at St Margaret's Hospital.

HAVING READ ALL ABOUT US, PLEASE CONSIDER SUPPORTING OUR WORK

There are many ways in which the staff and public can help to raise funds for the Charity, these include:

Making a donation – donations can be made by cash or cheque, and these donations can be received by the ward or department concerned, via the Cashier's office within Princess Alexandra Hospital or by post to the Finance Department. Donations can also be made online through www.justgiving.com/pahnhs.

Holding or taking part in a fundraising event – everything from a cake sale to a sponsored silence at school or a quiz, trek or running event.

Setting up a regular donation by completing a standing order form.

Leaving a gift to the Charitable Fund in your will.

Please contact the Fundraising Team (fundraising@pah.nhs.uk) at The Princess Alexandra Hospitals Charity for more ideas on how you could help.

THANK YOU

On behalf of the staff and patients who have benefited from improved services due to donations and legacies, the Corporate Trustee would like to thank all patients, relatives and staff who have made charitable donations.

THE PRINCESS ALEXANDRA HOSPITALS NHS TRUST CHARITABLE FUND
ANNUAL REPORT AND ACCOUNTS 2017/18

TRUSTEE STATEMENTS

Statement of Trust Board's Responsibilities in respect of the financial statements.

Under charity law, the Trust Board are responsible for preparing the Trustee's Annual Report and Accounts for each financial year which show a true and fair view of the state of affairs of the charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice requires that the Board of Directors:

- Select suitable accounting policies and then apply them consistently
- Make judgements and estimates that are reasonable and prudent
- State whether the recommendations of SORP have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue its activites.

The Trust Board are required to act in accordance with the Trust Deed and the rules of the charity within the framework of trust law. The Trust Board are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the Trust Board to ensure that, where any statements of accounts are prepared by the Trust Board under section 132(1) of the Charities Act 2011, those Directors have general responsibility for taking such steps as are reasonably open to the Trust Board to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The Trust Board confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 7 to 14 attached have been compiled from and are in accordance with the financial records maintained by the Trust Board.

By Order of the Trust Board

Helen Glenister
Non-Executive Director
6 December 2018

Trevor Smith
Chief Finance Officer
6 December 2018

THE PRINCESS ALEXANDRA HOSPITALS NHS TRUST CHARITABLE FUND
ANNUAL REPORT AND ACCOUNTS 2017/18

Independent examiner's report to the trustee of The Princess Alexandra Hospital NHS Trust – Charitable Fund

I report on the accounts of The Princess Alexandra Hospital NHS Trust – Charitable Fund for the year ended 31 March 2018, which are set out on pages 7 to 14.

Respective responsibilities of trustee and independent examiner

The charity's trustee is responsible for the preparation of the accounts. The trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no material matters have come to my attention which gives me cause to believe that in, any material respect:

- the accounting records were not kept in accordance with section 130 of the Charities Act; or
- the accounts did not accord with the accounting records; or
- the accounts did not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give 'true and fair' view which is not a matter considered as part of an independent examination.

I have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Use of our report

This report is made solely to the trustee, as a body, in accordance with our engagement letter dated 16 April 2018. The examination has been undertaken so that we might state to the trustee those matters that are required to be stated in an examiner's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the trustee as a body, for this examination, for this report, or for the statements made.

Name: Debbie Hanson
For and on behalf of Ernst & Young LLP
Relevant professional qualification or body: CIPFA
Address: 400 Capability Green, Luton, LU1 3LU
Date:

THE PRINCESS ALEXANDRA HOSPITALS NHS TRUST CHARITABLE FUND
ANNUAL REPORT AND ACCOUNTS 2017/18

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDING 31 MARCH 2018

	Note	2017/18				2016/17
		Unrestricted Funds	Designated funds	Endowment Funds	Total Funds	Total Funds
		£000	£000	£000	£000	£000
Income and endowments from:						
Donations and legacies	3	12	199	0	**211**	289
Other trading activities	4	0	535	0	**535**	634
Investments	5	0	1	0	**1**	1
Total		**12**	**735**	**0**	**747**	**924**
Expenditure on:						
Raising funds	1g/6	0	(298)	0	**(298)**	(255)
Charitable activities						
- Contributions to the Trust	7	(26)	(285)	0	**(311)**	(260)
- Medical Research	7	0	(165)	0	**(165)**	(171)
- Patient welfare and amenities	7	0	(69)	0	**(69)**	(87)
- Staff welfare and amenities	7	0	(37)	0	**(37)**	(6)
Total		**(26)**	**(854)**	**0**	**(880)**	**(779)**
Net (expenditure)/income		(14)	(119)	0	**(133)**	145
Transfers between funds		0	0	0	**0**	0
Net movement in funds		**(14)**	**(119)**	**0**	**(133)**	**145**
Reconciliation of funds:						
Total funds brought forward	18	28	574	0	**602**	457
Total funds carried forward		**14**	**455**	**0**	**469**	**602**

THE PRINCESS ALEXANDRA HOSPITALS NHS TRUST CHARITABLE FUND
ANNUAL REPORT AND ACCOUNTS 2017/18

BALANCE SHEET AS AT 31 MARCH 2018

	Note	2017/18	2016/17[1]
		£000	£000
Current assets:			
Debtors	13	90	114
Cash and cash equivalents	14	458	581
Total current assets		**548**	**695**
Liabilities:			
Creditors: Amounts falling due within one year	15	(79)	(90)
Net current assets		**469**	**605**
Creditors: Amounts falling due after more than one year	15	0	(3)
Total net assets		**469**	**602**
The funds of the charity:			
Endowment funds	18	0	0
Unrestricted funds	18	14	28
Designated funds	18	455	574
Total charity funds		**469**	**602**

Note 1: 2016/17 balance for cash and cash equivalents and creditors restated as per note 1 (m)

10.1

THE PRINCESS ALEXANDRA HOSPITALS NHS TRUST CHARITABLE FUND
ANNUAL REPORT AND ACCOUNTS 2017/18

STATEMENT OF CASH FLOWS AS AT 31 MARCH 2018

	Note	2017/18 Total Funds	2016/17[1] Total Funds
		£000	£000
Cash flows from operating activities:			
Net cash (used in)/provided by operating activities	16 / 1(m)	(124)	81
Cash flows from investing activites:			
Dividends, interest and rents from investments	5	1	1
Purchase of investments		0	0
Net cash provided by investing activities		**1**	**1**
Change in cash and cash equivalents in the reporting period		**(123)**	**82**
Cash and cash equivalents at the beginning of the reporting period	14 / 1(m)	581	499
Cash and cash equivalents at the end of the reporting period	14 / 1(m)	**458**	**581**

Note 1: 2016/17 balance for Cash and Cash Equivalents and Creditors restated as per Accounting Policies note 1 (m)

These financial statements were approved by the Trust Board on 6 December 2018 and signed on their behalf

Helen Glenister
Non-Executive Director
6 December 2018

Trevor Smith
Chief Finance Officer
6 December 2018

10.1

THE PRINCESS ALEXANDRA HOSPITALS NHS TRUST CHARITABLE FUND
ANNUAL REPORT AND ACCOUNTS 2017/18

NOTES TO THE ACCOUNTS

1. Accounting Policies

(a) Basis of Preparation

These financial statements have been prepared under the historic cost convention and in accordance with the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland (FRS102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

Going concern:

The Trust Board consider that the Charity is a going concern. Fund balances are stable, with growth predicted for the future year. The Trust Board consider that there are no material uncertainties about The Princess Alexandra Hospital NHS Trust Charitable Fund and its ability to continue as a going concern. There are no material uncertainties affecting the current year accounts.

(b) Funds structure

The Princess Alexandra Hospital NHS Trust Charitable Fund is registered as an Umbrella Fund encompassing three unrestricted special funds whose names and objects are:

The Princess Alexandra Hospital General Fund

For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by The Princess Alexandra Hospital.

The St. Margaret's Hospital General Fund

For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by The St Margaret's Hospital.

The Herts & Essex Hospital General Fund

For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by The Herts and Essex Hospital.

The purposes of the unrestricted funds are to support any charitable purpose relating to the NHS; 103 particular designated funds and 1 unrestricted fund have been created to reflect the non-binding wishes of donors (114 in 2016/17).

(c) Incoming Resources

Cash donations, gifts, legacies, investment income and income from fund raising events are included in the full statement of financial activities as soon as the conditions for receipt have been met and there is reasonable assurance of receipt.

The Charity received no gifts in kind.

(d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is virtually certain; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled

(e) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(f) Allocation of overhead and support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration and internal and external examination/audit costs. Support costs have been apportioned between fundraising costs and charitable activities on the basis of fund balances.

(g) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the Charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 9.

NOTES TO THE ACCOUNTS

1. Accounting Policies (continued)

(h) Debtors

Debtors are amounts owed to the Charity. They are measured on the basis of their recoverable amount.

(i) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments in interest bearing savings accounts.

(j) Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

Amounts which are owed in more than a year are shown as creditors: amounts falling due after more than one year.

(k) Realised gains and losses

There are no realised gains or losses in 2017/18 (nil in 2016/17).

(l) Events after the end of the reporting period

No events (either adjusting or non-adjusting) occurred after the end of the reporting period for 2017/18 (nil in 2016/17).

(m) Restatement of 2016/17 Cash and Cash Equivalents, and Creditors Balances

The 2016/17 balance for Cash and Cash Equivalents has been restated (a reduction of £10k), with an equivalent movement in creditors (a decrease of £10k). This is to reflect "linked" bank account balances that are reported as a single Cash and Cash Equivalent figure, rather than reporting uncleared cheques as a seperate balance within creditors..

2. Related Party Transactions

The Princess Alexandra Hospital NHS Trust Charitable Fund is managed by The Princess Alexandra Hospital NHS Trust, a corporate body established by order of the Secretary of State for Health. As such, the Trust is the ultimate controlling party and the Trust Board of the Charity are the Directors of the Trust as detailed in page 3 of this Annual Report and Accounts.

Details of The Princess Alexandra Hospital NHS Trust are:

	2017/18		2016/17	
	Turnover	**Net Outflow**	Turnover	Net Outflow
	£000	**£000**	£000	£000
Nature of business				
Provision of healthcare	213,231	(31,642)	209,742	(27,019)

Unqualified audit reports have been issued in both 2016/17 and 2017/18 on the accounts of The Princess Alexandra Hospital NHS Trust.
The Trust Board received no remuneration or re-imbursement of expenses from the Charitable Fund during 2017/18 (nil in 2016/17).

The main beneficiaries of the charity are the patients and staff of The Princess Alexandra Hospital NHS Trust. The Charity has provided grant funding for items purchased on behalf of these beneficiaries totalling £550,000 as detailed in notes 7 and 8 of these accounts.

Expenditure of the charity is considered to be a grant to The Princess Alexandra Hospital NHS Trust, as the staff, patients and visitors of the Trust are the ultimate beneficiaries of the purchase.

3. Income from donations and legacies

	Unrestricted Funds	**Designated Funds**	**Total 2017/18**	**Total 2016/17**
	£000	**£000**	**£000**	**£000**
Donations	12	199	211	271
Legacies	0	0	0	18
Total	**12**	**199**	**211**	**289**

THE PRINCESS ALEXANDRA HOSPITALS NHS TRUST CHARITABLE FUND
ANNUAL REPORT AND ACCOUNTS 2017/18

4. Income from other trading activities

Trading income relates to funds received from fundraising events (and where VAT is not chargeable), rather than from the sale of merchandise.

	Unrestricted Funds	Designated Funds	Total 2017/18	Total 2016/17
	£000	£000	£000	£000
Water Ball 2016	0	1	1	3
Long Live Liver Appeal	0	0	0	0
Gauntlet Games	0	1	1	0
My Life Memory Software Appeal	0	1	1	0
ED/ITU Ball	0	5	5	3
Improving Cancer Services	0	8	8	8
ITU Equipment Appeal	0	1	1	12
Events organised by the Breast Unit Fundraising Team	0	518	518	608
Total	**0**	**535**	**535**	**634**

5. Investment income

	Unrestricted Funds	Designated Funds	Total 2017/18	Total 2016/17
	£000	£000	£000	£000
Short term investments and deposits and cash on deposit	0	1	1	1
Total	**0**	**1**	**1**	**1**

6. Expenditure on raising funds

	Unrestricted Funds	Designated Funds	Total 2017/18	Total 2016/17
	£000	£000	£000	£000
Skydive 2016	0	0	0	2
It's a Knockout	0	0	0	2
Water Ball	0	0	0	0
Long Live Liver Appeal	0	0	0	0
My Life Memory Software Appeal	0	0	0	0
Gauntlet Games	0	1	1	1
Improving Cancer Services	0	0	0	0
ITU Equipment Appeal	0	5	5	5
PAH Cancer and Diagnostic Services	0	0	0	0
Events organised by the Breast Unit fundraising team	0	288	288	233
Support costs	0	4	4	11
Total	**0**	**299**	**299**	**255**

7. Charitable expenditure

The charity pursued its charitable activities by making grants. Support costs have been apportioned across the categories of charitable expenditure on the basis of fund balances at the 31 March 2017. 2016/17 totals include support costs.

	Grant funded activity	Support Costs	Total 2017/18	Total 2016/17
	£000	£000	£000	£000
Contributions to the Trust	279	32	311	260
Medical research	165	0	165	171
Patient welfare and amenities	69	0	69	87
Staff welfare and amenities	37	0	37	6
Total	**550**	**32**	**582**	**524**

8. Analysis of grants

There were no grants made payable to individuals during 2017/18 (nil in 2016/17). All grants are made to The Princess Alexandra Hospital NHS Trust to provide for the care of NHS patients, and the welfare of it's staff and visitors. The total cost of making grants, including support costs is disclosed on the Statement of Financial Activities and the actual funds spent on each category of charitable activity is disclosed in note 7.

Institution receiving grant support	Number of Grants paid	Total 2016/17	Total 2016/17
		£000	£000
The Princess Alexandra Hospital NHS Trust	1	582	524
Total	**1**	**582**	**524**

9. Allocation of support costs and overheads

The financial administration costs have been allocated between governance and charitable activity on the basis of staff time. External audit costs were wholly allocated to governance. The basis of the apportionment of support costs is disclosed in note 1f.

Net incoming resources for the year are stated after charging:

	Raising funds £000	Charitable Activities £000	Total 2017/18 £000	Total 2016/17 £000
Charitable activity				
Administration - staff costs	3	29	32	38
Other - bank charges	0	1	1	1
Governance				
External examination	1	2	3	3
Fundraising Regulator levy charge	0	1	1	1
Total	**4**	**32**	**36**	**43**

10. Trustees' remuneration, benefits and expenses.

The Trust Board give their time freely and receive no remuneration for the work that they undertake as trustees.

11. Analysis of staff costs

The Charity does not employ any staff.

12. Independent Examiners remuneration

The independent examiners remuneration of £3,200 (£3,200 in 2016/17) related solely to the independent examination carried out in 2017/18, with no other additional work undertaken.

13. Analysis of current debtors

Debtors under 1 year

	Total 2017/18	Total 2016/17
	£000	£000
Trade debtors	5	0
Debtors (host trust)	34	27
Accrued income	10	1
Prepayments	41	86
Total	**90**	**114**

14. Analysis of cash and cash equivalents

	Total 2017/18	Total 2016/17[1]
	£000	£000
Cash held as short term investments and deposits	458	574
Cash at bank and in hand	0	7
Total	**458**	**581**

Note 1: 2016/17 balance for Cash and Cash Equivalents and Creditors restated as per note 1 (m)

15. Analysis of liabilities

Creditors due within 1 year

	Total 2017/18	Total 2016/17[1]
	£000	£000
Other creditors	42	76
Creditors (host trust)	37	14
Total	**79**	**90**

Creditors due after more than 1 year

	Total 2017/18	Total 2016/17
	£000	£000
Other creditors	0	3
Total	**0**	**3**

Note 1: 2016/17 balance for Cash and Cash Equivalents and Creditors restated as per note 1 (m)

16. Reconciliation of net income/(expenditure) to net cash flow from operating activites

	Total 2017/18	Total 2016/17[1]
	£000	£000
Net (expenditure)/income for 2017/18 (as per the statement of financial acitivities	(133)	145
Adjustments for:		
(Gains)/losses on investments	0	0
Dividends, interest and rents from investments	(1)	(1)
Decrease/(increase) in debtors	24	(31)
(Decrease) in creditors	(14)	(32)
Net cash (used in)/used by operating activites	**(124)**	**81**

Note 1: 2016/17 balance for Cash and Cash Equivalents and Creditors restated as per Accounting Policies note 1 (m)

17. Transfers between funds

There were no transfers between accounts in 2017/18 (nil in 2016/17).

18. Analysis of unrestricted and designated fund movements

	Balance 1 April 2017	Income	Expenditure	Transfers	Balance 31 March 2018
	£000	£000	£000	£000	£000
Unresticted Funds					
Herts & Essex Hospital	0	0	0	0	0
Princess Alexandra Hospital	(28)	(12)	26	0	(14)
St Margarets Hospital	0	0	0	0	0
Total	**(28)**	**(12)**	**26**	**0**	**(14)**
Designated Funds					
Herts & Essex Hospital	(1)	(0)	0	0	(1)
Princess Alexandra Hospital	(311)	(110)	141	0	(280)
St Margarets Hospital	(262)	(625)	713	0	(174)
Total	**(574)**	**(735)**	**854**	**0**	**(455)**
Total Unrestricted and Designated Funds	**(602)**	**(747)**	**880**	**0**	**(469)**

The Charity does not hold any Endowment Funds.

19. Contingent Assets

The Charity has been notified of a potential legacy for the opthalmology unit. The legacy could be in the region of £60k for the Trust, however this value is uncertain, and therefore it has not been recognised in the 2017/18 Statement of Financial Activities.

The Princess Alexandra Hospital NHS
NHS Trust

Hamstel Road
Harlow
Essex
CM20 1QX

Ernst & Young LLP
400 Capability Green
Luton
LU1 3LU

6th December 2018

Dear Sirs

This representation letter is provided in connection with your examination of the financial statements of The Princess Alexandra Hospital NHS Trust Charitable Fund ("the Charity") for the year ended 31 March 2018. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to complete your examination as to whether there are matters to which attention should be drawn to enable a proper understanding of the financial statements to be reached.

We understand that the purpose of your examination of our financial statements is to report whether any matter has come to your attention:

which gives you reasonable cause to believe that in any material respect the requirements:

- to keep accounting records in accordance with section 130 of the 2011 Act;

and

- to prepare accounts which accord with the accounting records, comply with the accounting requirements of the 2011 Act have not been met; or

to which attention should be drawn in order to enable a proper understanding of the accounts to be reached.

We understand that this examination is substantially less than an audit and involves an examination of the accounting records and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor necessarily be expected to disclose – all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

A. Financial Statements and Financial Records

1. The Directors of the Trustee consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

2. We have fulfilled our responsibilities, as set out in the engagement letter, for the preparation of the financial statements in accordance with the Charities SORP and UK Generally Accepted Accounting Practice.

3. We acknowledge, as directors of the Trustee of the Charity, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position, financial performance and cash flows of the Charity in accordance with UK GAAP, and are free of material misstatements, including omissions. We have approved the financial statements.

4. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.

B. Fraud

1. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.

2. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

3. We have no knowledge of any fraud or suspected fraud involving management or other employees who have a significant role in the Charity's internal controls over financial reporting. In addition, we have no knowledge of any fraud or suspected fraud involving other employees in which the fraud could have a material effect on the financial statements. We have no knowledge of any allegations of financial improprieties, including fraud or suspected fraud, (regardless of the source or form and including without limitation, any allegations by "whistleblowers") which could result in a misstatement of the financial statements or otherwise affect the financial reporting of the Charity.

C. Compliance with Laws and Regulations

1. We have disclosed to you all known actual or suspected non compliance with laws and regulations whose effects should be considered when preparing the financial statements.

D. Information Provided and Completeness of Information and Transactions

1. We have provided you with:

    - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters.

    - Additional information that you have requested from us for the purpose of the examination and

    - Unrestricted access to persons within the entity from whom you determined it necessary to obtain evidence.

2. All material transactions have been recorded in the accounting records and are reflected in the financial statements.

3. We have made available to you all minutes of the meetings of trustee or subcommittees of trustee (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the period to the most recent meeting on the following date: last meeting: 3rd October 2018.

4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Charity's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related

balances due to or from such parties at the year end. These transactions have been appropriately accounted for and disclosed in the financial statements.

5. We have disclosed to you, and the Charity has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

E. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.

2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal advisers.

3. We have recorded and/or disclosed, as appropriate, all liabilities related litigation and claims, both actual and contingent, and have not given any guarantees to third parties.

F. Subsequent Events

1. There have been no events subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

G. Other information

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises the Annual Report.

2. We confirm that the content contained within the other information is consistent with the financial statements.

H. Reporting to regulators

1. We confirm that we have reviewed all correspondence with regulators, in England and Wales, which has also been made available to you, and the serious incident report guidelines issued by the Charity Commission (updated in 2017). We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the signing of the balance sheet.

Yours faithfully

Helen Glenister
Chair of the Charitable Funds Committee

Trevor Smith
Chief Finance Officer