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The Princess Alexandra Hospital NHS
NHS Trust

Public Meeting of the Board of Directors

AGENDA

Date and Time: Thursday 7 February 2019 from 09.30 to 12.30
Venue: Boardroom, The Princess Alexandra Hospital, Harlow.

Time	Item	Subject	Action	Lead	Page
01 OPENING ADMINISTRATION					
09.30	**1.1**	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from Meeting on 06.12.18	Approve	Chairman	4
	1.4	Matters Arising and Action Log	Review	All	10
02 STAFF STORY					
09.35	**2.1**	'My Career through PAH'			
03 REPORT FROM CHIEF EXECUTIVE					
10.00	**3.1**	CEO's Report	Discuss/Approve	Chief Executive	11
04 RISK					
10.15	**4.1**	Board Assurance Framework	Approve	Chief Medical Officer	16
05 PATIENTS					
10.25	**5.1**	Mortality Improvement Plan including: • Learning from Deaths (presentation)	Discuss	Chief Medical Officer	32
10.40	**5.2**	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Inform	Director of Nursing and Midwifery	38
10.50	**5.3**	Nursing Establishment Review	Approve	Director of Nursing and Midwifery	50
11.00	**5.4**	Quality Improvement Strategy	Approve	Director of Quality Improvement	62
06 PEOPLE					
11.10	**6.1**	Guardian of Safe Working Annual Report	Discuss	Chief Medical Officer	78
07 PLACES					
11.20	**7.1**	Application for Wave 4 Capital Funds (9.5m)	Note	DoQI	83
08 PERFORMANCE					

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11.30	**8.1**	Integrated Performance Report	Inform	Executives	86
11.40	**8.2**	Operating Plan Update	Inform	Chief Finance Officer /Chief Operating Officer	114
09 GOVERNANCE					
11.50	**9.1**	Reports from Committees: • QSC. 25.01.19 • WFC.28.01.19 • PAF.28.01.19 • CFC. 9.01.19 including Terms of Reference	Inform/ Approve	Chairs of Committees	117 119 120 121
12.00	**9.2**	Report from Senior Management Team	Inform	Chief Executive	125
12.05	**9.3**	Report from ICP Board	Inform	Chief Executive	126
12.10	**9.4**	Report from STP Board	Approve	Chief Executive	129
12.15	**9.5**	Committee Membership	Approve	Chief Executive	138
10 QUESTIONS FROM THE PUBLIC					
12.20	**10.1**	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.	Discuss	Chairman	
11 CLOSING ADMINISTRATION					
	11.1	Summary of Actions and Decisions	-	Chairman/All	
	11.2	New Issues/Risks	Discuss	All	
	11.3	Reflection on Meeting	Discuss	All	
12.30	**11.4**	Any Other Business	Review	All	

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TRUST BOARD 2018/19

Public Board Meeting dates, 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	Steve Clarke	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC)	Vacant	Chief Finance Officer	Trevor Smith
Chair of Quality & Safety Committee (QSC)	Dr. John Hogan	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Andrew Holden (Vice Chairman)	Chief Medical Officer	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 6 December 2018 from 09:00 – 11:30 - Boardroom, Princess Alexandra Hospital

Present:	
Steve Clarke	Trust Chairman (TC)
Pam Court	Non-Executive Director (NED-PC)
Lance McCarthy	Chief Executive Officer (CEO)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
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)
In attendance (Patient Story):	
Jo Ward	Associate Director of Nursing & Therapies
Louise Edwards	Head of Nursing – Cancer Services
Ann Nutt	Chair of Patient Panel
Shahid Sardar	Associate Director – Patient Engagement & Experience Team
Apologies:	
Andrew Holden	Non-Executive Director (NED-AH)
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	Steve Clarke welcomed all to the meeting, his first as the new Trust Chairman (TC).
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 04.10.18 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 PATIENT STORY: Ben's Story (30 minutes)	
2.1	The Chair of the Patient Panel (CoPP) introduced the item and confirmed that the 2018 Patient Panel Conference had been based around cancer and had been a huge success. Three key points which had been highlighted as a result were 1) Patients' concerns about the side effects of medication 2) Young patients' (e.g. students) desire to be treated no differently and 3) A need to review engagement with minority groups.
2.2	Two films had been produced as part of the conference and one of those was then played to Board members. It detailed the pathway followed by a young male from his diagnosis (age 29) through his radiotherapy treatment. It highlighted initial delays in diagnosis, how bad news had been broken reassuringly, the financial stresses of those coping with a serious illness and the support offered by organisations such as Macmillan.
2.3	Members were reminded that the results of the National Cancer Patient Survey had been made public the previous September. The Trust had scored well in most elements but below average in eight, which included care for patients in inpatient areas and the support provided during surgery and on admission with neutropenic sepsis. Ward-based staff were now being supported to address those issues. A Macmillan Recovery Package Manager

	role had been agreed which would include addressing a patient's holistic needs and a Head of Nursing for Cancer Services had also been appointed.
2.4	Non-Executive Director Pam Court (NED-PC) raised a concern around the patient's delay in diagnosis and asked whether that was attributed to the fact that the patient was relatively young. In response it was agreed that the profile of cancer in younger people needed to be raised. The team agreed to share the clip more widely.
2.5	In response to a question raised by NED John Hogan (NED-JH) in relation to cancer services at the Trust, members were informed that whilst the organisation's Oncology Consultants worked elsewhere for part of the week, patients were assigned a CNS and a named keyworker for the duration of their treatment. The Trust had been a victim of its own success in that by continually meeting national cancer standards it then received more referrals.
2.6	The Chief Financial Officer (CFO) highlighted that the patient had stated that the area where he had received his treatment did not feel homely. In response it was confirmed that discussions were already underway around redeveloping the unit or possibly linking in with Macmillan to provide a new unit.
2.7	The TC thanked the team for presenting the story.
03 REPORT FROM CHIEF EXECUTIVE	
3.1 CEO's Report (14 minutes)	
3.1	The CEO presented his report and congratulated Steve Clarke on his appointment as the hospital's new Chairman. Key headlines for the month of November were: • ED performance of 85.2% in October had been the highest for three years. • HSMR (Hospital Standardised Mortality Ratio) continued to be 'higher than expected' but progress had been made in relation to outlier pathways and a Mortality Improvement Board had been established. • The Advisory Appointments Committee (AAC) had recommended the appointment of three Anaesthetists. • The Trust had again won the 'Fab Change 70 Organisation of the Year'. • The consultation on the proposed new collaborative structure of NHSE and NHSI would be launched on 16.11.18. • Paul Burstow had been appointed as the Independent Chair for the STP.
3.2	The Board approved the Consultants appointments made by the AAC.
3.3	The Chief Medical Officer (CMO) added that on 15.11.18 the Anne Robson Trust (who ran the Trust's Butterfly Volunteer Programme) had been chosen as the winner of the Piccalilley Award 2018 (out of 52 schemes) at the FAB NHS Stuff Awards.
3.4	In response to a question from NED-HG it was confirmed there were ongoing daily discussions with Commissioners around the increased volume of ED attendances.
3.5	It was reported that the Trust had received its Provider Information Request (PIR) that week from the CQC ahead of its next inspection. The deadline for submission was 04.01.19.
04 RISK	
4.1 Board Assurance Framework (BAF) (12 minutes)	
4.1	This item was presented by the Head of Corporate Affairs (HoCA). Risks 2.1 and 2.4 had been discussed at the Workforce Committee (WFC) in November and reductions to the risk scores had been agreed and recommended to the Board for approval. The proposed changes were: Risk 2.1 (Workforce Capacity) - from 20 (4x5) to 16 (4x4), target risk of 12. Risk 2.4 (Workforce Capability - from 9 (3x3) to 6 (3x2) = target risk rating.
4.2	In response to a question from NED-JH it was confirmed that the wording of risk 2.1 had changed because it was felt that the capacity issues were specific to certain areas (nursing/medical). 16 was recognised as still high. After discussion it was agreed that the risk would be reviewed again at WFC.28.01.19. in relation to wording and appetite.
ACTION **TB1.06.12.18/11**	**Review BAF Risk 2.1 at WFC.28.01.19 in relation to wording/appetite.** **Lead: Head of Corporate Affairs/Director of People**

4.3	The Board agreed the above two reductions in risk scoring. BAF risk 2.4 would be removed from the BAF as it had achieved the target risk rating.
4.4	Consideration was then given to risks 3.4 (Strategic Change and Organisational Structure Capacity and Capability) and 3.5 (Sustainability of Local Services). Members agreed with the scorings of 12 and 16 respectively.
05 QUALITY	
5.1 Mortality Improvement Plan (25 minutes)	
5.1	This item was presented by the Chief Medical Officer (CMO). He informed members that the Trust had received an interim report from Dr. Foster which was showing the Trust's HSMR at 120, the highest it had been in four years and a poor position both regionally and nationally.
5.2	The CMO continued that extensive discussions had been taking place at the Senior Management Team (SMT) with senior clinical colleagues. A Mortality Strategy and Improvement Plan had now been established.
5.3	The Improvement Plan had been agreed at SMT and the four pillars of work around Getting the Basics Right, Bundles of Care, Hospital @ Night and Reporting & Recording were being progressed supported by the Quality First Team.
5.4	In relation to Reporting & Recording the Trust had now appointed six Medical Examiners and new software. Terms of Reference for the Mortality Surveillance Group were being revised as the forum for overseeing mortality reviews.
5.5	The CMO reminded members that the Mortality Improvement Board (MIB) had been established with Executives sponsoring the key pillars and projects. Regulators and Commissioners were being kept informed
5.6	In response to a question from NED-JH around lines of responsibility it was confirmed the Trust's Associate Medical Directors (AMDs) were fully engaged with all actions in the Improvement Plan as were the Clinical Leads. NED-JH stated it would be critical that the clinicians took ownership of their outcomes and his suggestion would be that mortality data was published by individual. The Board discussed that suggestion. The CEO stated that NED-JH had made a valid point and it might be the means by which a different dialogue could be engendered.
5.7	The TC welcomed the assurance which would be provided by the MIB along with the indications of engagement of key staff. However he cautioned that with the way mortality was reported it would be some time before the impact of improvement was seen in the numbers.
5.8	In response to two questions from Associate NED Helen Howe (ANED-HH) it was confirmed that coding was an implicit part of the plans and also that a specific conversation had taken place at SMT around the phasing of projects proposed in the Improvement Plan.
5.2 Nursing, Midwifery and Care Staff Levels (5 minutes)	
5.9	This item was presented by the Director of Nursing & Midwifery (DoN&M). Key headlines were: • The overall fill rate (RN/RM and HCA) for the ward areas had been 85.1% in September and 87.4% in October so was broadly unchanged. • There had been no significant change to the overall RN/RM workforce numbers (net gain of 1.84 WTE). For Nov/Dec/Jan there were 23 RN, 17 pre-registration and 18 HCA confirmed/predicted starters. • An improved (RN/M) bank/agency fill rate from 57.4% in August to 68.1% in October. • The vacancy position for RNs remained challenging at 25.86% (40.04% for adult wards). A review of the Recruitment & Retention Plan had been commissioned. • There was a plan to develop a Safer Staffing Policy. • Approval for incentives for bank staff through winter.
5.10	The CFO reminded members of the incentives and enhanced rates which had recently been agreed by the Senior Management Team for bank staff, creating a bank pool of staff and the collaboration with the STP to extend and increase the catchment of available staff within the bank.

06 PERFORMANCE	
6.1 Integrated Performance Report (IPR) (14 minutes)	
6.1	This item was introduced by the Chief Operating Officer (COO). Key headlines were: **Executive Summary:** Good performance in infection control, complaints and Friends & Family Test. **Performance:** Continued improvement in ED 4 hour performance in October but had been challenging in November with increased attendances. October had seen the highest level of improvement and achievement since July 2015. Attendances had subsequently continued to increase with the highest for over four years in month. Support from the Emergency Care Intensive Support team continued. The delivery of standards in Diagnostics, Referral to Treatment (Incomplete) and Cancer had been achieved in month. **People:** A continued focus on Recruitment & Retention, Statutory Mandatory training and appraisal. Increased appraisal rates (5% increase in-month). **Pounds:** In month deficit (excluding PSF) £0.1m ahead of plan with increased activity/income compared to financial plan. YTD £0.3m ahead of plan.
6.2	In response to a question from NED-JH it was confirmed that flow could be measured by the number of admissions/discharges per day. The Urgent Care Board used the Pressure Thermometer to demonstrate transit times and flow and there had been improvements over previous weeks particularly in relation to the RAT (Rapid Assessment & Treatment) process. System capacity issues impacted upon achievement of the four hour standard particularly when attendances were exceeding 300 per day. The opening of additional in-patient capacity in the New Year would provide further capacity and support.
07 PLACES	
7.1 Our New Hospital (2 minutes)	
7.1	This item was presented by the Director of Strategy (DoS) who reported that progress remained good with the onsite/offsite decision still scheduled for TB1.07.03.19. The key risks to the programme were the development of the detailed clinical models (in and out of hospital) to ensure the demand management assumptions could be delivered. It was also important that the assumptions developed through the health planning and design phase of work remained coordinated with the Medium Term Financial Plan (MTFP) for the STP.
7.2 New Ward Update (7 minutes)	
7.2	The COO presented this update and was pleased to report that the work was still on track. Handover of the new ward would take place week beginning 17.12.18. 02.01.19 would see the first of the internal ward moves with Tye Green Ward moving into the new area (Charnley Ward). That would unlock other internal ward moves with those due to be completed by 07.01.19. Subject to final nursing sign-off, Nightingale Ward was expected to take patients as of 07.01.19.
7.3	The DoN&M confirmed that nine additional beds would be opened as part of the ward realignments, leaving 17 beds on Nightingale Ward. There were other options for the ward in terms of using it as an overflow area (Mon-Fri) in times of high pressure or when other wards needed to be cleaned.
7.4	The CEO highlighted that a significant amount of hard work had been undertaken to reach the current position, particularly as the capital for the new ward had only been approved that August and that should be recognised.
7.5	In response to a question from ANED-HH around additional medical staff it was confirmed a new consultant had been appointed and had already started, support staff were in place and an experienced Occupational Therapist would join after Christmas.
08 PEOPLE	
8.1 Equality & Inclusion Update (4 minutes)	
8.1	This paper was presented by the DoP and provided assurance to the Board that the Trust was meeting its legal requirements under the Equality Act 2010. It reported on the progress

	made by the Trust on Equality and Inclusion (E&I) objectives as described in its Equality Delivery System 2 (EDS 2). It also summarised key actions for the coming year and would provide an opportunity for the Board to support E&I with new NED appointments coming up.
8.2	In response to a concern raised by NED-PC, the DoP agreed to reflect on E&I training for Board members.
ACTION TB1.06.12.18/12	**Reflect on providing an Equality & Inclusion training session for Board Members. Lead: Director of People**
8.3	NED-HG flagged that the remit of the Freedom to Speak Up Guardians, as detailed in the paper, was broad. In response the DoP confirmed she would review the wording.
ACTION TB1.06.12.18/13	**Review the wording in relation to the remit of the Freedom to Speak Up Guardians (E&I Update). Lead: Director of People**
09 GOVERNANCE	
9.1 University Status (1 minute)	
9.1	The DoP reported that 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 was seeking to become a university hospital.
9.2	The Board approved the Trust's proposal to seek university status
9.2 Well Led Framework (1 minute)	
9.3	The HoCA reminded members that it was recommended that Trusts undertook an annual self-assessment against the Well Led Framework published by CQC in June 2017. The Board had discussed in detail the Trust's self-assessment against the framework at its Development Session on 01.11.18 and the outcomes of the Trust's self-assessment for 2018 were summarised in the paper presented.
9.4	The Board approved the outcomes of the self-assessment.
9.3 Reports from Committees (3 minutes)	
9.5	Quality & Safety Committee - 23.11.18 QSC had discussed mortality, issues/plans in Urology and an increase in complaints on Fleming Ward. It had requested a more detailed report around Caesarean section rates. It had reviewed the CQC 'Must & Should Do' actions. The Board noted the Annual Reports for Safeguarding Adults & Children and Infection Control.
9.6	Workforce Committee – 26.11.18 WFC had discussed the BAF, nurse staffing levels, appraisals and had undertaken a detailed discussion of the results of the GMC Survey.
9.7	Performance & Finance Committee – 26.11.18 The agenda had included the M7 Finance Report, MSK Services, the Fracture Clinic Business Case and IT Strategic Roadmap.
9.4 Report from ICP Board (1 minute)	
9.8	The CEO reminded members that the Board had agreed at its previous meeting to receive an update on the West Essex Integrated Care Programme Delivery Plan. That update was provided in the paper and covered the period 01.08.18 up to 31.03.19.
10 CORPORATE TRUSTEE (1 minute)	
10.1	This item was presented by the Chief Financial Officer (CFO). The purpose of the item was to present the Charity Annual Report and Accounts and associated assurance statements to the Board. Both had been reviewed and recommended to the Board by the Charitable Funds Committee on 03.10.18.
10.2	In line with the recommendation made in the paper the Board (as Corporate Trustee for The Princess Alexandra Hospital NHS Trust Charitable Fund): • Approved the Annual Report and Accounts 2017/18

	• Approved the Letter of Representation, authorising the Chair of the Charitable Funds Committee and Chief Finance Officer sign the Letter. • Authorised that the Chair of the Charitable Fund Committee and the Chief Financial Officer sign the accounts certificates.
11 QUESTIONS FROM THE PUBLIC	
11.1	There were no questions from the Public.
12 CLOSING ADMINISTRATION	
12.1 Summary of Actions and Decisions	
12.1	These are presented in the shaded boxes above.
12.2 New Issues/Risks	
12.2	No new risks or issues were identified.
12.3 Reflections on Meeting	
12.3	Not undertaken at this point.
12.4 Any Other Business (AOB)	
12.4	Members were reminded that the Volunteers' celebration lunch would be taking place the following Monday.

Signed as a correct record of the meeting:	
Date:	07.02.19
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 07.02.19

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.12.18/11	BAF Risk 2.1	Review BAF Risk 2.1 at WFC.28.01.19 in relation to wording/appetite.	HoCA/DoP	TB1.07.02.19	Wording changed to reflect risk as "inability to recruit to critical nursing roles rather than workforce capacity vacancy rate". Remains at a score of 16.	Proposed for closure
TB1.06.12.18/12	Training	Reflect on providing an Equality & Inclusion training session for Board Members.	DoP	TB1.07.02.19	Unconscious bias training to be rolled out to staff and will include Board members.	Proposed for closure.
TB1.06.12.18/13	FTSUGs	Review the wording in relation to the remit of the Freedom to Speak Up Guardians (E&I Update).	DoP	TB1.07.02.19	Remit has been reviewed.	Closed.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board (Public) – 7 February 2019

3.1

Agenda Item:	3.1
Presented by:	Lance McCarthy - CEO
Prepared by:	Lance McCarthy - CEO
Date prepared:	31 January 2019
Subject / Title:	CEO Report

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 updates the Board on key issues since the last public Board meeting: - Performance highlights - Urgent care and flow - Mortality - CQC inspection - Culture change - Regional Director - Long term plan - Media coverage
Recommendation:	The Trust Board is asked to note the CEO report.

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

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

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The Princess Alexandra Hospital NHS
NHS Trust

Chief Executive's Report
Trust Board: Part I – 7 February 2019

3.1

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

(1) Key performance headlines

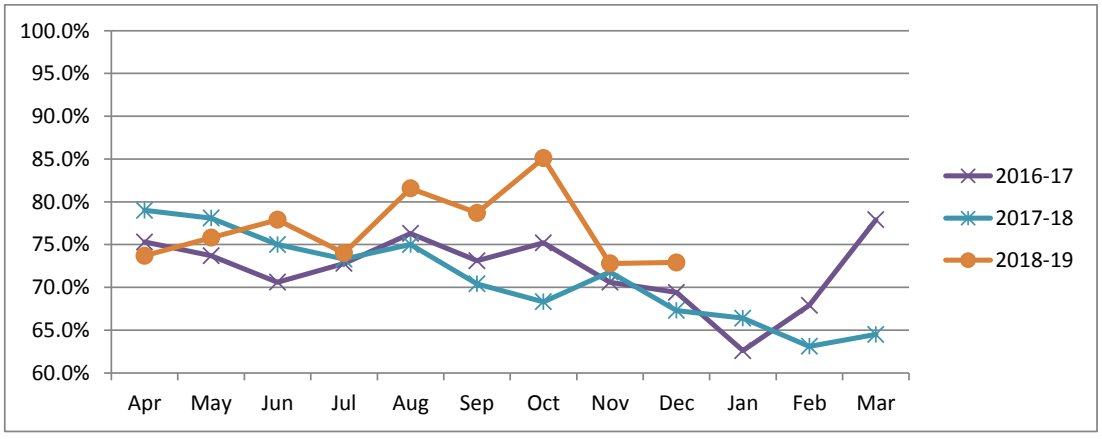
Some key summary performance headlines outlined below for the latest month. More detail on each of these and other key performance indicators are shown in the revised and updated Integrated Performance Report later on the agenda.

Key Performance Indicator	Actual performance for latest month (December)	Comparison to last report
ED 4-hour performance	73.1%	↓ (worse)
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	99.6%	↓ (worse)
Cash balance	£5,048k	↑ (better)
Stat Man training	90.0%	↑ (better)
Vacancy rate	13.4%	↓ (worse)

(2) Urgent care performance and flow

After much stronger performance against the 95% 4-hour access target for urgent care through the end of the summer and the early part of the autumn we have struggled with flow in the last 3 months. Performance remains significantly below where we would wish it to be.

Performance for all months over the last 3 financial years, since April 2016, can be seen in the chart below. Year to date (1 April 2018 – 28 January 2019) we have seen a 5.09% improvement in performance compared with the same period for 2017/18. We have had a 4.02% increase in attendances over the same time period.



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

Our drop in performance in recent months has been due in part to a significant rise in ED attendances: November 2018 was 6.0% higher than November 2017, December 2018 was 6.9% higher than December 2017, and so far January 2019 has seen 8.0% more attendances than January 2018. The acuity of our patients over the last 3 months, as measured by the NEWS2 scores on arrival in ED has also increased significantly.

Month	2016-17	2017-18	2018-19	% change
Apr	8,027	8,164	8,192	0.34%
May	8,931	8,649	8,829	2.08%
Jun	8,461	8,625	8,875	2.90%
Jul	9,108	8,794	9,226	4.91%
Aug	8,312	8,141	8,373	2.85%
Sep	8,385	8,328	8,678	4.20%
Oct	8,691	8,707	8,868	1.85%
Nov	8,533	8,767	9,296	6.03%
Dec	8,432	8,583	9,172	6.86%
Jan	8,076	8,419	9,096	8.04%
Feb	7,459	7,584		-100.00%
Mar	8,737	8,547		-100.00%
TOTAL	**101,152**	**101,308**	**88,605**	
Average	**8,429**	**8,442**	**8,861**	

We are continuing to work closely with primary care, CCG and community services colleagues to understand why we have experienced a sudden increase in pressure of volumes and to maximise the flow of patients out of the hospital and ensure they are receiving care in the most appropriate setting.

We opened our new 27 bedded inpatient ward (Charnley Ward) on 2 January and undertook a complex set of moves and minor ward refurbishments in the following 3 weeks to improve clinical adjacencies and ward environments. The increase in inpatient capacity will help us manage some of the increased demand for urgent care services over the rest of the year.

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

(3) Mortality

Our Hospital Standardised Mortality Ratio (HSMR) continues to be 'higher than expected' despite the good work undertaken to improve both the #NoF (broken hip) and Sepsis pathways, both of which have seen significant improvements.

Our Mortality Improvement Board is meeting fortnightly, set up to oversee a complete set of actions across the organisation including the impact of flow, specific pathway compliance, antibiotic compliance, nursing care and any variations in outcomes. Our Medical Examiners are now fully in post and will from this week be reviewing 100% of deaths in the organisation to maximise any learning. The detail of our plan has been reviewed by Dr Foster and an Imperial College expert in mortality data and has been shared with NHS Improvement.

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

(4) CQC inspection

We received our Provider Information Request (PIR) from the Care Quality Commission (CQC) in mid-December. We completed the return as required by 4 January and have responded in full to the small number of additional information requirements of queries received from the CQC team.

Our Use of Resources inspection date has been set for Tuesday 26 March 2019. We await confirmation of dates for our well-led interviews and confirmation of whether we will have an announced or unannounced inspection. I will update Board members about these as soon as I am made aware.

We continue to play a full part in the helpful and focussed NHS Improvement Good and Beyond events that are being run by Dr Melanie Iles.

(5) Culture change

Our culture change programme continues 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. Executive and Senior Management Team work with TTEF continues to make a positive difference.

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.

By the time of the Board meeting we will have run a Mental Health Awareness Day across the whole of the organisation (31 January) and showcased our free and confidential new Employee Assistance Programme, Health Assured. This service provides a complete support network that offers expert advice and compassionate guidance 24/7 for staff members and their immediate family to help with personal and professional problems that could be affecting either home life, work life, health or general wellbeing.

Our Staff Council will be relaunched on 15 February and we are shortly to start our training programme for all managers in unconscious bias.

We have had our results from the most recent staff survey and Picker have compared these for us with the other organisations that use them to support the process. We are still waiting to see how we compare with all organisations nationally but have already started a series of workshops to build upon our improvements and continue to improve PAHT as a place to work.

I am also delighted to announce that 3 of our up and coming senior leaders (Robbie Ayers, Anne Carey and Darren Hobbs) all successfully completed the local Bedfordshire, Hertfordshire and West Essex Accelerated Director Development Scheme (ADDS) this month.

(6) NHS Improvement and NHS England Regional Director

After a national recruitment process for the joint NHSI and NHSE senior leadership team members, Ann Radmore has been appointed to the Regional Director role for the East of England. Ann has more than 35 years of NHS experience, is currently the Chief Executive of Kingston Hospital and previously the Chief Executive of the London Ambulance Service and NHS South West London. Ann officially starts in post on 1 April and will be visiting PAHT over the spring.

(7) Long Term Plan

The NHS Long Term Plan was launched on 7 January 2019. It is a new plan, building on the 5-year plan, to improve the quality of patient care and health outcomes across the country. The key drivers in the plan are:

- Improving out of hospital care
- Improving maternity safety
- Supporting older people through more personalised care
- Making digital health service mainstream

We have been through the Plan in detail and are aligning our internal transformation programme with the detail in the Plan. We are also working with ICP and STP colleagues to ensure that system wide solutions are developed and aligned.

(8) Media and TV relations

Emma Willis - Delivering Babies, is returning for a second series. W Channel, working with Firecraker, have commissioned a second series, this time 8 episodes, due to air probably in the summer. Emma will start working with us this week building on her skills obtained last year as a Maternity Care Assistant. Thanks to all of our people who will be involved again.

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

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NHS
The Princess Alexandra Hospital
NHS Trust

Trust Board - 7 February 2019

4.1

Agenda Item:	4.1
Presented by:	Chief Medical Officer - Andy Morris
Prepared by:	Head of Corporate Affairs - Heather Schultz
Date prepared:	30 January 2019
Subject / Title:	Board Assurance Framework 2018/19

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Board Assurance Framework 2018/19 is presented for review. Risks, risk ratings and outcomes of Committee reviews in month are summarised (Appendix A) and detailed BAF risks are attached (Appendix B). It is proposed to reduce the risk rating for Risk 1.3 Coding from 16 to 12. The risk was discussed in detail at PAF where it was agreed that the risk rating had improved/reduced, it had not been eliminated and the coding improvement actions must continue. This was informed by a summary of the evidence presented and the outcome is reflected in Appendix A. The wording of Risk 2.1 Nurse Recruitment has been revised and was agreed at WFC. There are no proposed changes to the remaining risk scores.
Recommendation:	The Board is asked to approve the Board Assurance Framework, reduction of the risk score for Risk 1.3 (Coding) from 16 to 12 and revised wording for Risk 2.1 (Nurse Recruitment).

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 31.01.19, PAF.28.01.19, WFC. 28.01.19 and QSC.25.01.19
Risk / links with the BAF:	As reflected in the attached BAF.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with national legislation and regulations and the Code of Governance.
Appendices:	Appendix A - Summary of Residual Risk Ratings Appendix B - Board Assurance Framework 2018/19

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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.25.01.19; 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.28.01.19. 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	**12 (Proposed risk rating)**	PAF Reviewed at PAF.28.01.19. PAF supported the reduction of the risk rating from 16 to 12 following consideration of the following evidence: restructure of the coding team is now complete, two vacancies remain as a result of turnover, SUS FREEZE coding performance has been at 99.9% since April 2018. Mortality data has been analysed by Dr Foster as part of mortality review and feedback is that quality of care is driving the higher than expected mortality rate.
	DoP	2.1 Nurse Recruitment Inability to recruit to critical nursing roles.	**16**	WFC reviewed on 28.01.19 Risk rating confirmed and revised wording of risk agreed.
	DoP	2.3 Internal Engagement Failure to communicate key messages and organisational changes to front line staff.	**9**	WFC reviewed on 28.01.19. Risk rating confirmed.
	DQI	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**20**	PAF Reviewed at PAF.28.01.19. Risk rating confirmed.

	DoS	3.3 Financial and Clinical Sustainability across health and social care system Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system.	**16**	For review by Trust Board on 7.02.19
	DoS	3.4 Strategic Change and Organisational Structure Capacity & capability of senior Trust leaders to influence both internally and externally the required strategic changes.	**12**	For review by Trust Board on 7.02.19
	DoS	3.5 Sustainability of local services Failure to ensure sustainable local services whilst the new hospital plans are in development.	**16**	For review by Trust Board.7.02.19
	DCFO/DQI	4.1 Supporting Functions (including Finance, IT, and Estates and Facilities)** Concerns around the need to modernise the systems, processes, structures, capacity & capability of the business support functions.	**12**	PAF Reviewed at PAF.28.01.19, risk rating confirmed.
	COO	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	**20**	PAF Reviewed at PAF.28.01.19, risk rating confirmed.
	CFO	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	**15**	PAF Reviewed at PAF.28.01.19, and risk rating confirmed.

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2018-19

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Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last**	**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) Unwarranted variation in care ii) System wide flow iii) Inconsistent patient feedback (including PALS) into service improvement and re-design. iv) Failure to achieve sustainable improvements in national survey results v) Poor results in Inpatient Survey with areas for improvement identified	**4 X 5= 20**	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) 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~~ Strategy including dashboard, updates on workstreams and learning from deaths. xxv) ~~Outlier alert process in place~~ xxvi) Introducing '15 steps' walkabouts from January 2019 xxvii) Establishment review xxviii) Safer Staffing policy xxix) Real time patient feeback implemented across all wards xxx) Four domains under the Mortality Improvement Stratgey are: bundles of care, Hospital at night, achieving excellence every time and recording/reporting.	i) National Surveys ii) Cancer Survey iii) CEO Assurance Panels iv) SIG meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings x) PLACE Inspections xi) Medicines Management Committee xii) CCG audits xiii) Monthly QA visits/inspections xiv) End of Life and Mortality Groups xv) AKI and Sepsis merged with Q1st and NED lead xvi) Urgent Care Improvement Board xvii) Mortality Surveillance Group xviii) Mortality 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 viii) Feedback from NHSI and Commissioners on harm reviews (positive) ix) Real time Dr Foster feedback x) Water Safety testing across the Trust (SMH) - normal results xi) GMC Trainee Results Report xii) Integrated Performance Report (IPR) xiii) Outstanding NICU peer review xiv) Clinical Audit report - tiaa xv) Improved and sustained palliative care coding	**4x4=16**	i) Internal/External Comms in development and improving ii) Evolving clinical audit approach- improved local audits and drive to improve collation and input of data for national audits iii) Disparity in local patient experience surveys versus inpatient survey iv) Staffing and site capacity **ACTIONS:** i) Website development ii) Inpatient Survey action plan in place iii) Maxwell Stanley and Dr Foster work commissioned in relation to mortality iv) Software to support medical examiners procured	i) Clinical evidence of improvements made following Compliance with national audits, NICE,NCEPOD. ii) Reporting on Learning from deaths iii) Medical examiners not operational (software in test phase) iv) Reporting to MIB on progress against workstreams identified in Mortality Improvement Strategy.	15/01/2019	**Risk rating not changed.**	4x3 =12 (Target date July 2019 - to ~~achieve 'as expected' for mortality~~ review progress against Mortality Improvement Strategy workstreams and following receipt of inpatient survey results in May)
			Effects: i) Poor reputation ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Recurrent themes in complaints involving communication failure v) Loss of confidence by external stakeholders vi) Higher than expected Mortality rates											

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Extreme Risk		15-25													
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**												
Medium Risk		4-6													
Low Risk		1-3													
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**							
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - continue to improve the quality of care we provide our patients, improving our CQC rating and exiting special measures **Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial targets and control totals**													
BAF 1.2		**EPR** Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes.	Causes: i) Poor engagement with the system, usability, time/skills ii) System fixes	**5 X 4= 20**	Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iii) Performance Mgt Framework in place. iv) Training programme. v) Super users in place to deliver focused support. vi) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability vii) Access Policy viii) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) ix) Development of capacity planning tools/information x) PWC review and actions identified xi) DQ meetings re-structured xii) ICT Newsletter issued xiii) New training process for locums xiv) Link to Quality 1st being discussed. xv) New daily Cambio meetings/roadmap xvi) Internal daily ICT/COSMIC meetings ongoing ~~xvii) 7.7 in development and expected in test environment by end of May 9.02.18~~ xviii) Real time data now available xix) ~~Exec to Exec meetings every 2 weeks~~ ~~xx) Cambio to attend ICT Steering Group~~ xxi) OBS requirements 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~~ out to advert. viii) Compliance with refresher training ~~ix) CDS 011 issue identified with diagnosis qualifier currently in test an requires resolution before 7.7 can go into test environment.~~ ~~x) 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.	Jan-19	Residual Risk rating unchanged	**4x3=12** **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 in progress. vi) Refresher training underway vii) Revised roadmap to incorporate new statutory/legal requirements i.e. GDPR				

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

The Princess Alexandra Hospital Board
Assurance Framework 2018-19

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead	Key Controls	Sources of Assurance	Positive Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
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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~~ vii) Additional codes employed/targeted to areas of risk ix) Weekly Specialty meetings x) CMO monthly meetings with coding re mortality xi) IM&T Programme Board xii) 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) Maxwell Stanley review - quality triangles to optimise coding underway for respiratory and general medicine. Due to increases in activity in Q3 18/19 additional contractor support enagaged.	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 viii) Mortality Improvement Board - workstream for reporting and recording	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 vii) Progress reporting against Mortality workstream on reporting and recording to MIB	~~4 X 4= 16~~ 4 x 3 = 12	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).~~	Jan 2019	Risk rating reduced to 12.	4x3=12 ~~December~~ January 2019 ~~- improvements noted but improvements to be sustained~~)

Risk Key		
Extreme Risk		15-25
High Risk		8-12
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The Princess Alexandra Hospital Board
Assurance Framework 2018-19

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Positive Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results													
	Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 2.1		**Nurse Recruitment** ~~Concerns around staffing capacity in some areas to manage workload, deliver services of high quality and maintain national performance requirements.~~ Inability to recruit to critical nursing roles.	**Causes:** National shortages of appropriately qualified staff Competition from neighbouring hospitals National drive to increase nursing number leaving market shortfall (demand outstrips supply) **Effects:** i) Pressure on existing staff to cope with demand leading to overworked staff and increased sickness ii) Low staff morale iii) Shortcuts and failure to follow processes and procedures due to workload and fatigue leading to higher chances of patient safety errors occurring iv) Lower staff retention rates v) Reduced attendance at training courses	**4 X 4 =16**	Director of People **Workforce Committee**	i) Participation in local and regional job fairs ii) Targeted overseas recruitment activity iii) Apprenticeships and work experience opportunities iv) Use of new roles to bridge gaps v) Use of recruitment and retnetion premia as necessary vi) Use of TRAC recruitment tool vii) Use of a system to recruit pre-qualification students viii) Use of enhanced adverts, social media and recruitment days	i) PAF, QSC, WFC, EMT, EMB, Workforce and Board meetings ii) Health Group Boards iii) Internal Audit report on Recruitment (substantial assurance) iv) Recruitment and Retention Group	i) Safer Staffing Reports (monthly to QSC and Board) ii) Workforce reports (progress on recruitment, retention, bank and agency) to PAF iii) Incident reporting and monthly SI reports to QSC	**4 x 4 = 16**	i) Dedicated nurse recruiter ii) Detailed pipeline and trajectory iii) Career escalator	None noted.	23/01/2019	**Risk rating not changed.**	**4 x 3 = 12 Nov 2019**

Risk Key														
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		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control and Actions**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
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	Strategic Objective 2: Our People – support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results													
BAF 2.3		**Internal Communication** Failure to communicate key messages and organisational changes to front line staff.	**Causes:** i) Change fatigue and 'regulation fatigue' ii) Increasing demand versus reducing resources iii) Lack of awareness around the organisation of strategic direction due to poor communication channels/tools iv) Poor attitude and behaviours v) Competing priorities vi) Challenged Provider status vii) Insufficient management time allocated to communication with staff	**4 X 4= 16**	Director of People **Workforce Committee**	i) Staff awards; ii) CEO blog & 'In Touch'; Ask Lance iii) Staff Briefing sessions iv) Staff, patients and carers involved in creation of values, standards & behaviours to ensure ownership; v) Sharing the Learning events to involve staff in safety improvements, which has included the Being Open/ Duty of Candour. viii) Quality Fellows programme ix) National Leadership Programmes for staff x) Staff Survey xi) Schwartz Rounds xii) Staff Council (being relaunched at EIAT) xiii) Quality Ist Communication Plan and Newsletter xiv) Event in Tent xv) People Strategy in development xvi) Printed magazine (quarterly) xvi) The Trusted Executive work in progress xvii) Associate Director of Comms appointed	i) PAF and Board meetings ii) QSC meetings iii) Staff Engagement Working Group iv) Workforce Committee	i) Staff survey results - showing signs of improvement ii) FFT for staff - improvements iii) Workforce reports to PAF and Workforce Committee iv) IPR to PAF and Board v) OD reports to WFC vi) Learning and Development reports to WFC.	**3x3=9**	Clarity on timescales for change (PCBC, SOC approval). **Actions:** i) Review of Comms function completed and implementation to follow. ii) Relaunch of website iii) Staff app being developed		15/01/2019	**No change to risk rating.**	3x2=6 June 2019 (re-structure of Comms team and function)
			Effects: i) Error omission ii) Poor reputation iii) Demoralised staff iv) Impact on sustainability v) Changes not embedded as business as usual vi) Disconnect between management and front line staff											

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Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the development of a West Essex and East Hertfordshire Accountable Care Partnership													
BAF 3.1		**Estates & Infrastructure** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in team and structure iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) No formal assessment of update requirements, vii) Failure to comply with estates refurbishment/ repair programme historically, viii) Under-investment in training of estate management & site development ix) Inability to undertake planned preventative maintenance x) Lack of decant facility to allow for adequate repair/maintenance particularly in wards areas. xi) Key workforce gaps in compliance, energy and engineering.	**5 X 4= 20**	Director of Quality Improvement **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report received (£105m) ~~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 Estate Strategy ~~being~~ developed and approved. ~~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 underway ~~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~~ xvi) Annual fire risk assessment completed and factual accuracy check underway.	i) PAF and Board meetings ii) EMB Meetings iii) Health and Safety Meetings iv) Capital Working Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings viii) First Impressions Count project group. ix) Project Genesis Steering Group	i) ~~Letter from HSE – no regulatory concern raised~~ ii) Reports to SMT ~~iii) Fire Safety report~~ iv) Reports on testing for legionella, asbestos v) Signed Fire Certificate vi) Annual H&S reports to Trust Board and quarterly to PAF. ~~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. x) Sustainability Management Group to be established and Sustainability manager to be recruited. **ACTIONS:** ~~i) Review of Estates and Facilities infrastructure – consultation in Q1.~~ i) Backlog maintenance review and Six Facet Survey completed. ~~ii) Business cases being developed. Combined Heat and Power (in 18/19)~~ ~~iv) Applying for distressed Capital funding to mitigate areas of risk.~~ ii) Recruitment of Sustainability Manager underway	i) Estates Strategy /Place Strategy developing within STP ii) Compliance with data collection and reporting iii) PPM data not as robust as required iv) PAM assurance not robustly updated. ~~Design phase for sewage and plumbing work tendered.~~	15/01/2019	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2018-19**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
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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 3.3		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The development of QIPP and CIP programmes for 2017/18 has not followed a Footprint-wide approach iii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iv) The resources required for delivery at a programme and workstream level have not been defined or secured v) The current governance structure is under development given the shift in focus from planning to delivery. vi) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS **Trust Board**	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) STP PMO under development vi) CEO's forum vii) Integrated Clinical Strategy in development ~~viii)~~ STP Estates Strategy being developed. ix) MSK contract being developed with system partners and due diligence submission (9.01.19) x) STP Clinical Strategy in place xi) STP wide Strategy Group implemented	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	**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.~~	15/01/2019	**No changes to risk rating.**	**4x3=12** **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 SP 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) Data quality impacting on business intelligence (SLR) **ACTIONS:** Trust's vision and mission statement being refreshed and 5P plans underway as part of Clinical Strategy work. Establishment of a 'Strategy Committee. ~~Clinical Strategy underway.~~ Strategy team being developed New chair of PAH ~~to be~~ appointed.	None identified.	15/01/2019	**Risk rating not changed.**	**4 x 2= 8** **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 tactical 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) STP work plans iv) Monthly Our New Hospital reports to PAF and updates to Board.	**4 x 4 = 16**	i) Balancing short term investment in the PAH site vs the required long term investment **ACTIONS:** Strategy being developed and underpinned by 5P plans Phase II work underway Capital Plan submission for PAH prioritised. PCBC work commissioned Regular meetings held with regulators. Establishing a Strategy Committee	i) Strategy in development	15/01/2019	**No change to residual risk rating.**	**4 x 3 =12 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**											
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Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
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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 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) Existing finance systems provider has novated to SBS and SBS advised Trust that upgrades and improvements to current system will not be supported beyond contract expiry 2020.	**4x5=20**	**Exec leads** :- Chief Financial Officer, Chief Operating Officer and Director of Quality Improvement. **Committee:** Performance and Finance Committee	i) Continuous priority reviews and workload planning, ii) business partnering approach and performance reviews, iii) Recruitment exercises - successful reduction in temporary costs, iv) increase involvement in collaborative work e.g. STP, v) review of staffing structures and consultation / market testing, vi) modernisation groups and use of benchmarking to identify improvements e.g. Qlikview, EROS, Carter, GIRFT, model hospital, vii) system implementations / upgrades e.g. EROS, Qlikview and ledger upgrades, viii) staff surveys / appraisals ix) Mitre lease extended for 18 months. x) Procurement strategy scheduled for PAF approval Jan 19.	i) Internal and external Audit reports ii) PAF and Board meetings iii) NHSI reviews/reports iv) Business case approved for ICT restructure. v) ICT Programme Board vi) Audit Committee vii) NHSI review/visit re estate	i) Outputs from NHSI deep dives ii) Internal Audit and External Audit reports including Head of Internal Audit Opinion and VFM conclusion. iii) Estates Governance review reported to Audit Committee iv) Staff survey outcomes	**4x3=12**	i) Recruitment and retention. ii) Enhanced plans to realise full benefits of system implementation / upgrades. iii) Re-location of Corporate Staff to alternative office accommodation. iv) Trust will need to undertake an options appraisal to review finance systems.	i) Benefit realisation reviews	22/01/2019		**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) iii) Income capture processes under review iv) Trust obtaining support from external supplier.					

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								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.2		**4 hour Emergency Department Constitutional Standard** Failure to achieve ED standard	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Gaps in medical and nursing workforce iv) Lack of public awareness of emergency and urgent care provision in the community. vi Attendances continue to rise annually (5.1% over the last 2 years). viii) Changes to working practice and modernisation of systems and processes viii) Attitude and behaviour challenges ix) Delays in decision making, patient discharges and delays in social care and community	**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 handed over in December 2018~~ xvii) Additional capacity handed over 20.12.18 xviii) Additional winter funding for social care xix) Weekly Urgent Care Board meetings xx) On site support from ECIST	i) Access Board meetings ii) Board, PAF and EMB meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) Daily system executive teleconference vii) Fortnightly escalation meetings with NHSI/NHSE viii) Weekly HCG reviews ix) System Operational Group	i) Daily ED reports to NHSI ~~ii) Twice weekly reports to NHSE on DToCs~~ iii) Monthly 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.	21/01/2019		4x3 =12 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											

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	Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial targets and control totals													
BAF 5.1		**Finance** Concerns around failure to meet financial plan including cash shortfall.	Causes: i) Operational performance impacting on financial performance including recovery of STF e.g. ED target, ii) CCG affordability and contractual disputes and challenges, iii) ability to deliver recurrent CIPs, iv) workforce shortages v) high levels of unplanned expenditure including maintenance of aging estate, vi) Capture and billing of activity. vii) Potential impact of pay settlement	5 X 4= 20	**Exec leads :** CFO/All Executives **Committee** : Performance and Finance Committee	i) Access to Interim Revenue Support loans ii) Cost Improvement Programme iii) Formal re-conciliation process with CCG iv) Internal and external Agency controls and reporting v) Executive Management Board, PAF and Audit Committee vi) Health Care Group CIP meetings vii) Enhanced Performance Reviews viii) Regular Balance sheet reviews ix) Approved Governance Manual x) Budget sign off process xi) Enhanced financial reporting and controls xii) Regulatory returns required e.g. agency spend xiii) Internal special measures for selected HCG to remain xiv) New medical agency protocol xv) Financial Recovery Plan - Q1 xvi) Demand and Capacity planning xvii) Revised forecast meetings with HCGs and SMT. HCG's that are off trajectory are required to ensure full mitigation. xviii) Use of resources assessment 26.03.19 iixx) The Trust and CCG are jointly discussing a potential year end settlement for 18/19.	i) Internal Audit & External Audit opinion. ii) External reviews iii) NHSI reporting iv) Internal Trust reporting v) Cash Management group vi) Pay award steering group vii) Joint meetings with CCG	i) Monthly reports including bank balances and cash flow forecasts to PAF and Board ii) CIP Tracker reports iii) IA reports iv) Financial Recovery Plan	5x3=15	i) Organisational and Governance compliance e.g. waivers ii) Activity and capacity planning iii) CIP reporting and run rate reductions	PLICs Demand and Capacity planning regularisation Workforce planning	22/01/2019	**Risk rating not changed.**	**5x2=10 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 Clinical and operational forums in place to review QIPP schemes. Review of Capital reporting and planning for 19/20 underway. Focus on pay and non pay CIPs.Medical pay award being assessed. CCG triangulation. Model Hospital data 2017/18 under review. Trust reviewing 19/20 control total and impact assessment of tariff.				

The Princess Alexandra Hospital NHS Trust

TRUST BOARD - 7 February 2019

5.1

Agenda Item:	5.1
Presented by:	Andy Morris – Chief Medical Officer
Prepared by:	Andy Morris – Chief Medical Officer
Date prepared:	25/01/19
Subject / Title:	Mortality Improvement 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]	The validated12 month rolling HSMR for December 2017 to November 2018 is 127.18 and statistically "higher than expected" and there are 6 diagnostic outliers. A summary of the progress made by the Mortality Improvement Board is detailed in the paper.
Recommendation:	The Board is asked to note the report and progress made to date by the mortality improvement programme.

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 on 25 January 2019.
Risk / links with the BAF:	BAF risk 1.1 Inconsistent outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality (C x L=16)
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	N/A

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The Princess Alexandra Hospital NHS Trust

Mortality Improvement Update

1. Introduction

The Trust's mortality markers remain a concern.

A summary of the progress made by the workstreams reporting into the newly established Mortality Improvement Board are included in the paper.

The mortality dashboard is being developed and Learning from deaths will be presented to the Trust Board as part of a rolling programme of presentations from the HCGs. The software to support the Medical Examiners has been tested and will be implemented in February which will support reporting on learning from deaths.

2. Mortality Rates

The validated 12 month rolling HSMR for December 2017 to November 2018 is 127.18 and statistically "higher than expected"'.

There are 6 diagnostic outliers:

1) Septicaemia

2) Fluids and electrolytes

3) Aspiration pneumonitis

4) Fractured neck of femur

5) COPD

6) Complication of device, implant of graft

3. Progress made so far

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

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

The Mortality Improvement Board programme and project structure and supporting governance have been agreed (outlined in the terms of reference – see appendix 1). Meeting and reporting frequencies have been set and scheduled. Programme sponsors are executive directors and programme senior leadership teams consist of Associate Medical Directors, Associate Directors of Nursing and Associate Directors of Operations (Programme Triumvirates).

Programme Triumvirates, with a Quality First Triumvirate in attendance, have met with Quality First project managers to agree project leads and begin to define project 'aims' and 'success measures'. Once these are established, the project teams will be supporting the Programme Triumvirates in agreeing ideas for change and running PDSA cycles as per our quality improvement methodology (model for improvement):

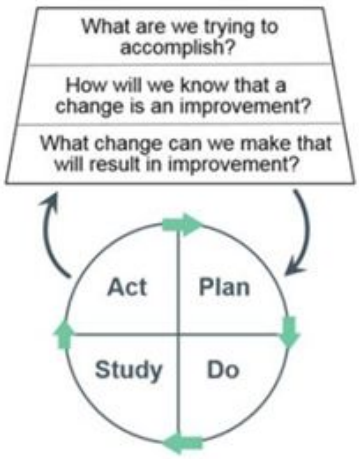


Image 1: Model for Improvement – PDSA Cycle

Executive Sponsors will be signing these off by 5th February 2019. Following this all supporting project documentation will then be completed by members of the Quality First Team by 19th February 2019.

Dr. Foster[1] and our internal Information team have provided support with analytics to ensure our programme of work is focused on areas where improvement against mortality rates are targeted to ensure greatest benefit possible for our patient outcomes.

Driver diagrams will be a tool used to identify specific change ideas by working backwards from the project 'aims' and 'success measures'.

[1] https://my.drfoster.co.uk/users/account/accessdenied?ReturnUrl=%2F

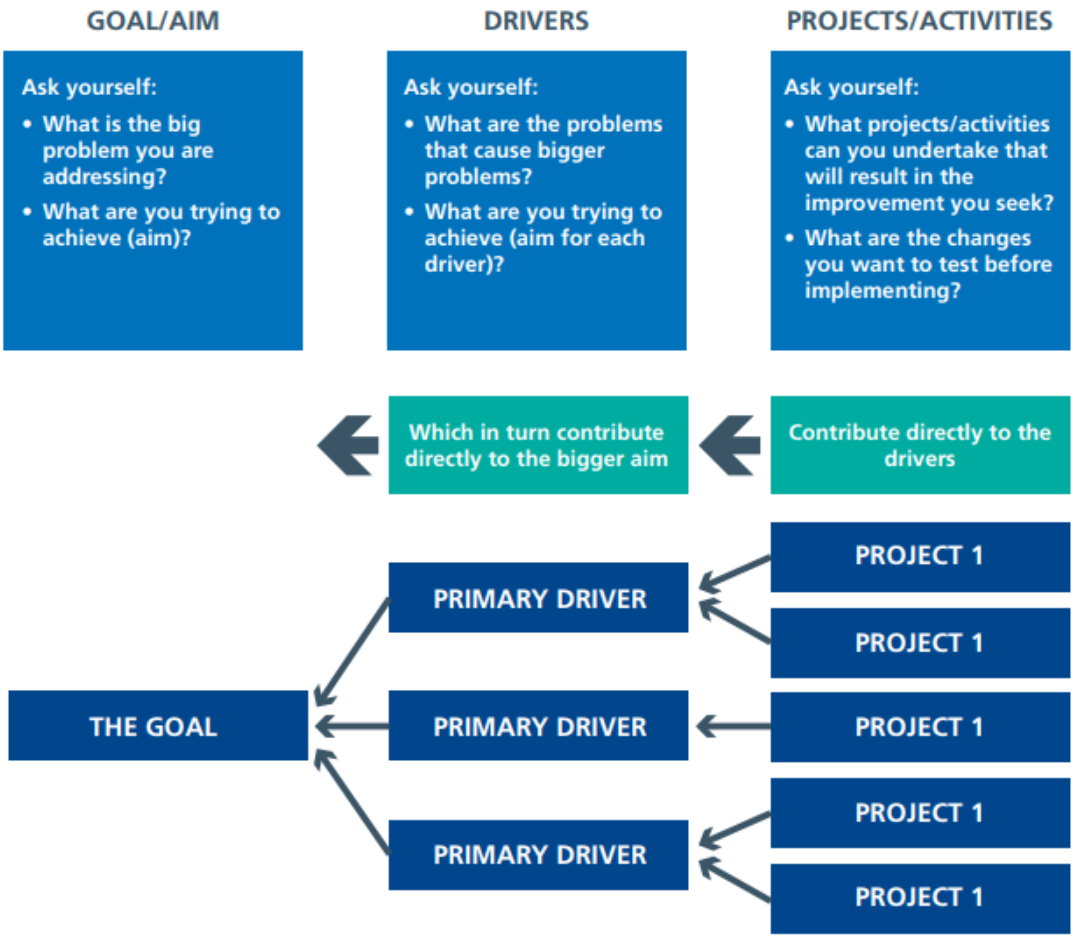


Image 2: Principle of Driver Diagrams

4. Notable deliverables achieved so far

Area of focus	Actions delivered	Measurable impact
Mortality Improvement Programme Governance structure	• 5 workstreams agreed • Executive leads agreed for the 5 workstreams (Care Bundles, Excellence every time A+B, Reporting and recording, H@N • Triumvirates agreed for 4 of the 5 workstreams which are based on skills and interests rather than health care group.(H@N not) • Individual Workstream Project managers identified • Time of weekly triumvirate	

	meetings supported by project managers agreed for 3/5 programmes • 4 of the 5 triumvirates have had their first scoping meeting • All 5 Project leads identified for Care Bundles Programme. In other programmes most project leads are being identified.	
Medical Examiners	• Mortality dashboard created. • 5 Medical Examiners have been identified, and one has received training. • Clinical testing by medical examiners needed. • Time to be scheduled in job plans to support the review of deaths work.	Learning captured record and shared.
Antibiotic prescribing	• Process mapping of antibiotic prescribing. • Qualitative survey of 17 junior doctors identifying reasons of non-compliance with antibiotic prescribing policy.	Improved compliance with antibiotic stewardship leading to reduction in Length of stay
Patient observations	• Vital Sign observation SOP developed and ratified. • Review of available hardware to record e-obs identified significant amount of ward based hardware not in use or broken • Weekly and monthly reporting templates shared with all areas that use e-obs. • Trajectory for improvement agreed. • Training to all senior nursing teams for cascading taking place throughout January 19	Improved compliance with timeliness of observations (target of 95% by June 2019) leading to early detection and escalation of deteriorating patients
Fluid Management	• Baseline audit of compliance with completion of fluid balance chart on 2 wards identified very poor compliance • Fluid balance chart PDSA cycles commenced on one medical and one surgical ward on 16.1.19 • Baseline audit of 50 sets of patient notes of paper fluid prescription charts (green chart) identified only 22% of patients received all prescribed fluids. • EPMA team working with the AKI clinical team to introduce prescribing of IV fluids on JAC. Plan to go live with upgrade of	Improved compliance with accurate fluid balance record to inform effective clinical decision making.

	JAC to 2016 version. • Commenced scoping of requirements and systems interfacing required for submission of AKI data from PAH lab to UK Renal Register	
Sepsis	• Implementation and embedding into practice, of the sepsis 6 care bundle. • Over 15 Sepsis Champions have attended training • Clinical Lead Consultant for sepsis in ED has been identified. • Deputy Trust junior clinical lead for sepsis appointed. • Air conditioning unit request has been sent to procurement. • Funding identified for air conditioning unit. • Blood culture analyser has passed IG assessment and once contract is signed (expected by 18/01/19) no further IG concerns	Aim to reduce death from sepsis by 25% by 31st March 2019 – Achieved and performance being sustained Sepsis mortality continues to improve (the mortality rate for sepsis has improved from 22% (October 2017 - May 2018) to 13% (May 2018 – October 2018).

5. Recommendation:

The Board is asked to note:

- The current Mortality markers.
- The progress made by the Mortality Improvement Board
- The development of the dashboard.

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

Date: **25 January 2019**

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 7 February 2019

5.2

Agenda Item:	5.2
Presented by:	Sharon McNally - 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:	11.01.19
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 November and December (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 84.3% in November and 83.62% in December. • The nursing vacancy position remains broadly unchanged. The overall combined RN/M rate is 22.67% (21.79% last month). The forecast band 5 RN vacancy rate is forecast at 31% for January 2019. • There is a drive and focus to significantly improve the vacancy position over 2019. • An exception report detailing the analysis of the rota fill, any impact on quality and actions is included in appendix.2.
Recommendation:	The Board is asked to note the information within this report.

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

Previously considered by:	SMT.22.01.19 QSC.25.01.19 WFC.28.01.19
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	Appendix 1: Ward level fill rates Appendix 2: Ward staffing exception reports

The Princess Alexandra Hospital NHS Trust

5.2

1.0 PURPOSE

To update and inform the Committee on actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff in November and December 2018. To provide an update to the nursing vacancy rate, that the plans to further reduce the vacancy rate over 2019.

2.0 BACKGROUND

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

3.0 ANALYSIS

3.1 This report provides an analysis based on the planned versus actual coverage in hours for the calendar months of November and December 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.

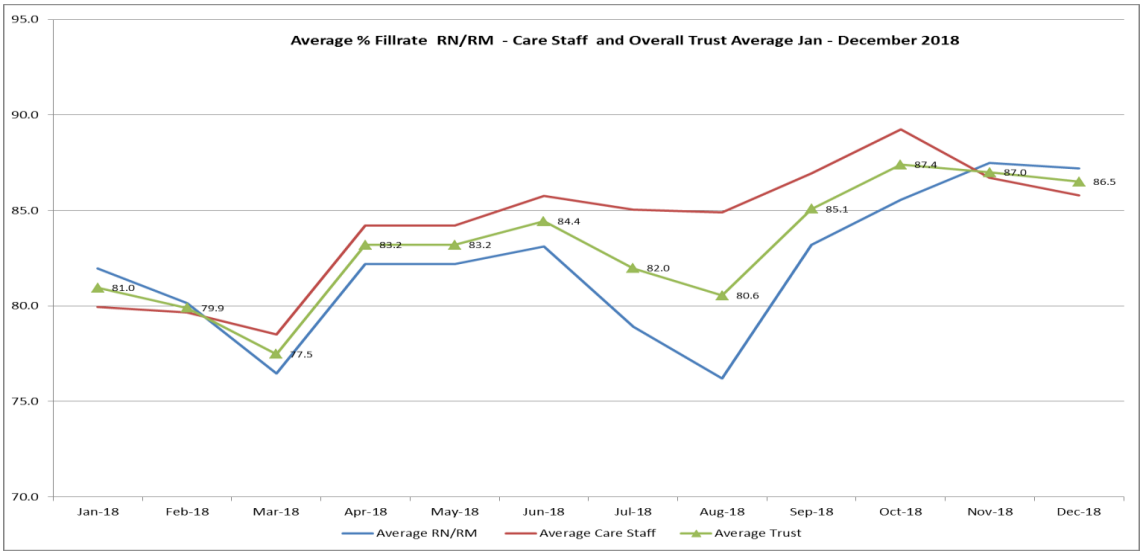
3.3 Care Hours per Patient Day* (CHPPD) has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018). From September 2018, publication of CHPPD replaced the actual v's fill dataset on My NHS and NHS Choices. CHPPD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

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

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Av RM/RN	Av care staff	Av ALL staff
Trust average	75% (74.9%)	75.2% (77.2%)	88.7% (88.5%)	95.2% (96.6%)	81.85 (81.7%)	85.2% (86.9%)	83.62% (84.3%)
Change	↑ 0.1%	↓ 2%	↑ 0.2%	↓ 1.4%	↑ 0.15%	↓ 1.7%	↓0.68%

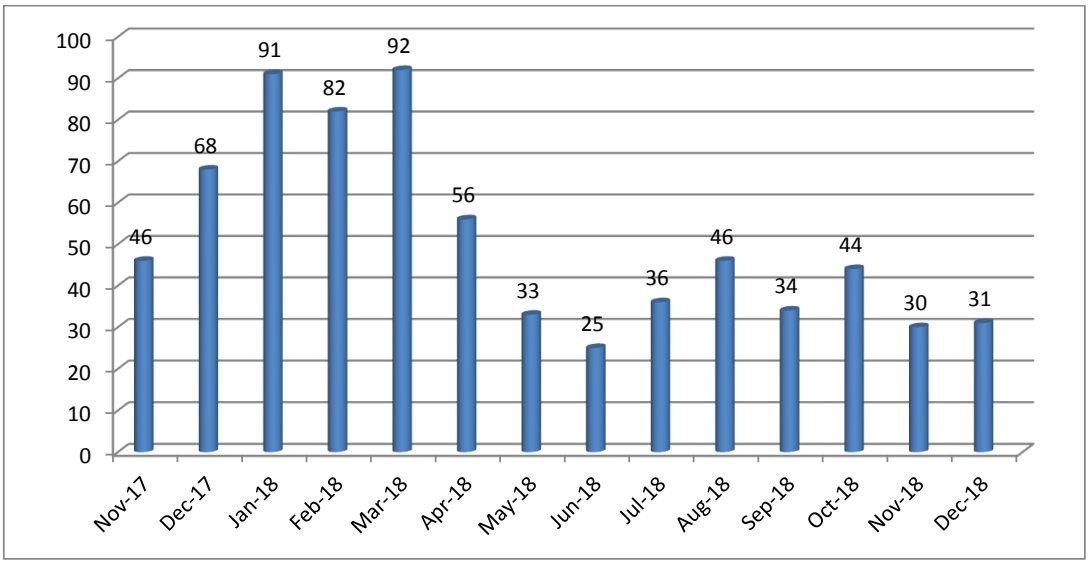
* *CHPPD is the total number of hours worked on the roster (clinical staff), divided by the bed state captured at 23.59 each day. For the purposes of reporting, this is aggregated into a monthly position.*

3.5 Fill rate: the rolling 12 month data is included in the table below: the flattening of the fill rate in December may in part be due to a reduction in the agency fill over the festive period.



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

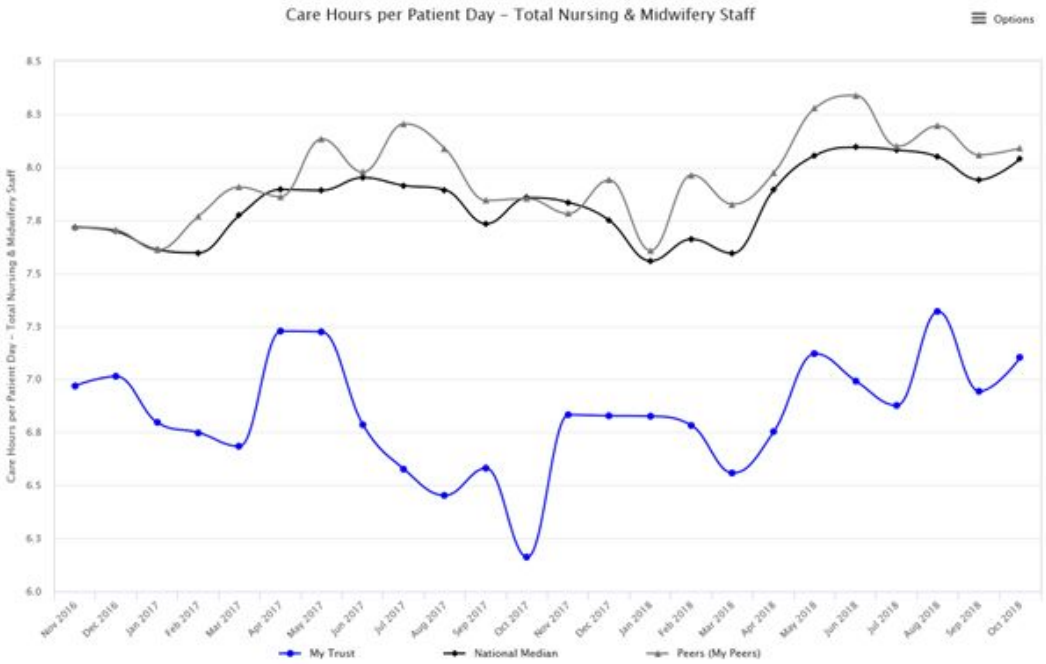
3.7 Datix reports: The trend in reports completed in relation to nursing and midwifery staffing is included below. All incidents continue to the reviewed by the safety and quality review process.
Recorded staffing incidents December 17 – December 18



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

Table 3	October 2018 data	Variance against national median
CHPPD Total	7.1 (8.0)	↓ 0.9
CHPPD RN	4.2 (4.8)	↓ 0.6
CHPPD HCA	2.9 (3.2)	↓ 0.3

The graph below shows Care Hours per Patient Day (total Nursing and Midwifery Staff) taken from the Model Hospital site (data updated October 2018) showing PAH against the national median and NHSI selected peers. A CHPPD of 7.1 and 4.2 is in the lowest quartile nationally. An reduction in the vacancy rate would have a positive impact on the CHPPD.



3.9 Quality & Safety

During 2019, the Trust will be moving to holding monthly nursing workforce meetings, which will provide an opportunity to review the shift templates, vacancies, skill mix, roster KPIs and nurse sensitive indicators including red flags. There will also be a corresponding move to undertake 'deep dives' in areas where there is concern, and provide a summary position in this report.

There were no beds closed as a result of staffing concerns during December 2018.

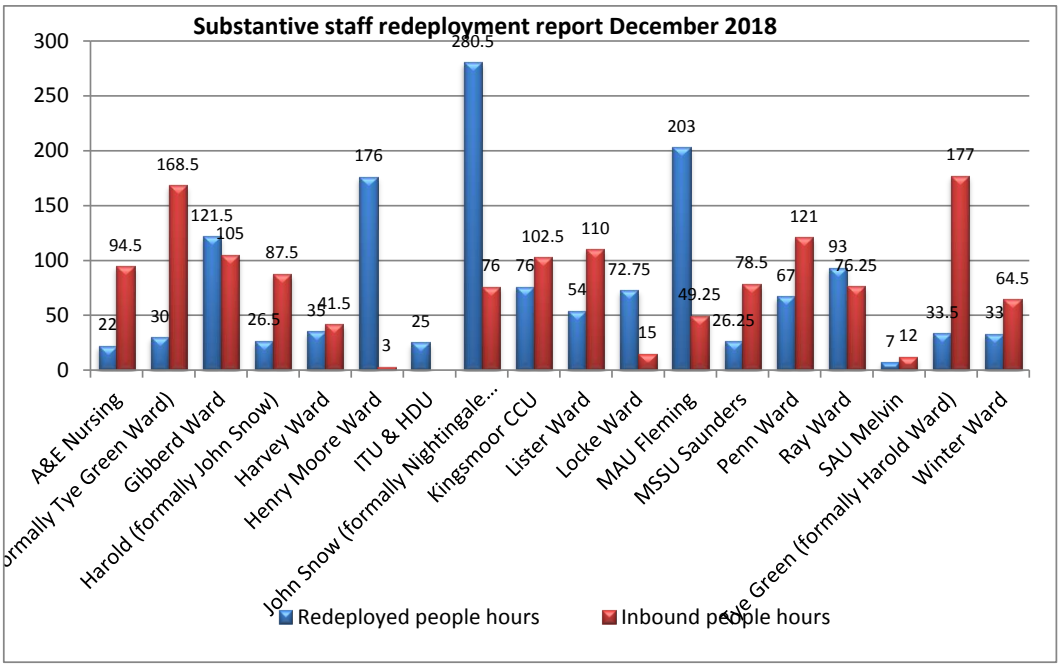
3.10 Mitigation

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. The policy is due to be ratified in February 2019.

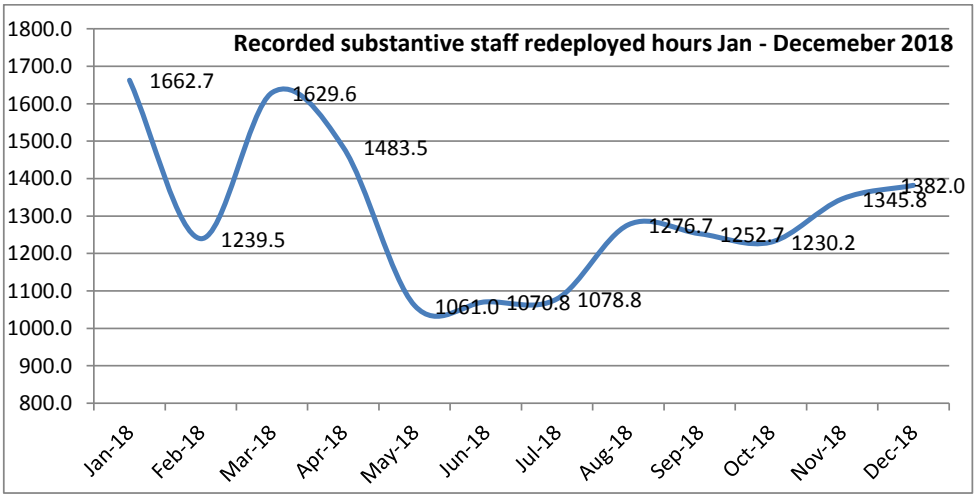
The Trust is in the process of establishing a "specialist pool" of HCAs to be used when vulnerable patients require close observation (patients with dementia, learning disabilities or those at high risk of falling).

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 following graph shows the number of recorded redeployed hours for substantive staff (excluding maternity)



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

3.12 Bank and Agency fill rates:

The use of NHSP continues to support the clinical areas to maximise safer staffing. The Trust has worked with NHSP to increase the availability of resource, and are working in partnership to improve this further. The table below demonstrates a flattening of the RN % fill rate in December may in part be due to a reduction in the agency fill over the festive period.
The HCSW % fill rate has remained broadly unchanged between September and December.

RN/M temporary staffing demand and fill rates:

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
August 2018	3,929	1,443	36.7 %	897	22.8 %	59.6 %	1,589	40.4 %
September 2018	3,958	1,530	38.7 %	920	23.2 %	61.9 %	1,508	38.1 %
October 2018	3,853	1,570	40.7 %	1,007	26.1 %	66.9 %	1,276	33.1 %
November 2018	3,524	1,496	42.5 %	1,060	30.1 %	72.5 %	968	27.5 %
December 2018	3,622	1,490	41.1 %	982	27.1 %	68.2 %	1,150	31.8 %
December 2017	4,139	1,263	30.5 %	1,122	27.1 %	57.6 %	1,754	42.4 %

HCA temporary staffing demand and fill rates:

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
August 2018	2,234	1,532	68.6 %	0	0.0 %	68.6 %	702	31.4 %
September 2018	2,061	1,488	72.2 %	0	0.0 %	72.2 %	573	27.8 %
October 2018	2,100	1,479	70.4 %	0	0.0 %	70.4 %	621	29.6 %
November 2018	2,029	1,455	71.7 %	0	0.0 %	71.7 %	574	28.3 %
December 2018	2,099	1,528	72.8 %	0	0.0 %	72.8 %	571	27.2 %
December 2017	1,848	1,100	59.5 %	2	0.1 %	59.6 %	746	40.4 %

In order to support safe staffing, in December the Trust launched an initiative aimed at increasing the bank fill rates.

- Establishment of a bank “pool” for both RNs and HCAs – which gives a premium rate of pay to the RNs (with the proviso that they would be moved to any ward which needs cover).
- For RNs there is a £25 per shift premium – which will be continued until the end of March. Currently, it is too early to be able to measure the impact of these initiatives but the outcomes are being monitored.
- Lottery for RN’s working shifts between 24/12/2018 and 31/03/2019 with 6 RN’s chosen at random to receive cash prizes of £500 providing they work a bank shift in that time period.
- NHSP paid for national initiative to all N&M staff who work a bank shift between 01/12/2018 and 31/01/2019 whereby they could win a prize drawn amount of £200.

The initiative is being tracked weekly and is hoped to impact the number of RN shifts filled by NHSP during January.
.

3.13 The risks associated with registered nurse vacancy and turnover has 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:

Nursing Recruitment Pipeline

There continues to be a positive improvement in the nurse vacancy rate. However, there continues to be areas with a higher vacancy rate, and this is particularly challenging across adult inpatient areas where the rate is c. 38%.
The dataset below has been developed to gain greater oversight, and enable a focused drive to significantly reduce the vacancy rate. The data includes a forecast of *all* registered nurse vacancies, and the band 5 staff nurse position.

RN Establishment V Staff in Post												
	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Funded Establishment WTE	919.88	919.88	919.88	919.88	919.88	919.88	919.88	919.88	919.88	919.88	919.88	919.88
Staff in Post WTE	676.07	679.57	682.07	689.57	694.07	694.57	695.07	696.57	698.07	699.57	701.07	704.57
Vacancy WTE	243.81	240.31	237.81	230.31	225.81	225.31	224.81	223.31	221.81	220.31	218.81	215.31
Forecast RN Vacancy Rate	26.5%	26.1%	25.9%	25.0%	24.5%	24.5%	24.4%	24.3%	24.1%	23.9%	23.8%	23.4%
Funded Band 5 Establisment WTE	486.19	486.19	486.19	486.19	486.19	486.19	486.19	486.19	486.19	486.19	486.19	486.19
Band 5 Staff in Post WTE	305.33	308.83	311.33	318.83	323.33	323.83	324.33	325.83	327.33	328.83	330.33	333.83
Vacancy Band 5 WTE	180.86	177.36	174.86	167.36	162.86	162.36	161.86	160.36	158.86	157.36	155.86	152.36
Forecast Band 5 Vacancy Rate	37.2%	36.5%	36.0%	34.4%	33.5%	33.4%	33.3%	33.0%	32.7%	32.4%	32.1%	31.3%

Starters Pipeline												
	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
RNs	7	2	2	2	2	2	2	2	2	2	2	2
Newly Qualified/ Pre Reg Nurses	0	1	3	-	-	-	-	-	6	-	-	-
International Recruitment												
Weekly Skype	2	6	7	10	6	5	4	5	6	5	4	5
India Campaign (July 18)	1	6	5	7	6	3	3	3	2	2	2	2
Philipines Campaign (Dec 18)		-	-	-	2	2	3	3	3	4	5	6
Provisional Starters	**10**	**15**	**14**	**19**	**16**	**12**	**12**	**13**	**13**	**13**	**13**	**15**
Confirmed Starters	**10**											

Average Leavers WTE												
	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Projected RN Leavers	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.5
Confirmed RN Leavers												
Total												

The current trajectory sees the forecast overall vacancy rate reducing to c. 23% for December 2019; this is exclusive of any additional capacity in the 2019/20 winter plan. However, the forecast band 5 staff nurse position is 31% for December 2019. There is a commitment and drive to significantly reduce the vacancy rate further by December 2019, and we are looking at additional campaigns during spring to achieve this. In addition:

- Two recent international campaigns to both India (July 2018) and the Philippines (December 2018) resulted in just over 100 offers of employment, from which we expect 70 starters to be deployed throughout 2019

- We are in consultation with a number of recruitment agencies to intensify our skype recruitment programme. We currently interview via skype weekly, and seek to double the number of interviews as we receive additional CVs from our new agencies.
- From the above, we average approximately 11.5WTE leavers a month; work will continue to embed the nursing retention plan to reduce this figure.

Attraction & Retention

- Revamp and promotion of staff benefits and the attraction package for provisional recruits, appropriately articulating the 'sell' of PAH & living/working in Harlow
- Bi-monthly nursing recruitment open days throughout 2019, with varied promotion on social media, new trust website & nursing microsite and radio campaigns
- Improvements are being made to international Nurse Starter packs – in a bid to meet their immediate needs of navigating the Harlow area, bus and train information, sim cards etc. This will improve the overall induction experience and impression of our new recruits – particularly when coming from overseas.
- Analysis of trends from exit interview data will be used to inform training & development/career options for our staff

- Periodic 'post induction check-ins' for our recent starters (held at 3, 6, 9 months) and for any themes raised to inform initiatives and plans to aid retention;
    - International recruitment buddies/network, to formalise the integration of our international recruits with existing overseas nurses.
    - Thinking of you/ trust update letters to those on long term sick/mat leave

- Short Pulse surveys to be conducted on ward areas to enable insights into staff motivations and challenges at work.

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), which will include rota KPIs 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).

4.0 RECOMMENDATION

The Board is asked to note the information within the report.

Author: Andy Dixon. Matron for Quality Improvement,
Sharon McNally, Director or Nursing and Midwifery
Date: **11.01.19**

The Princess Alexandra Hospital NHS Trust

Appendix 1.

Ward level data: fill rates December 2018.

*Please note: the fill rates for Dolphin ward have not been submitted nationally due to data quality concerns.

	Day		Night	
Ward name	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
Kingsmoor Cardiac Care Unit	75.8%	82.8%	91.1%	101.7%
Medical Assessment Unit Fleming	58.2%	69.4%	61.7%	85.8%
Tye Green Ward (formaly known as Harold)	77.7%	89.9%	110.3%	110.1%
Harvey Ward	75.7%	96.0%	104.9%	95.6%
ITU & HDU	80.3%	26.3%	86.7%	-
John Snow (formally known as Nighingale)	61.7%	79.1%	82.2%	75.6%
Charnley Ward (formally known as Tye Green)	71.9%	86.0%	98.2%	94.6%
Lister Ward	86.4%	79.7%	118.8%	102.2%
Locke Ward	86.2%	83.5%	100.0%	149.5%
Neo-Natal Unit	97.3%	71.6%	80.1%	64.5%
Penn Ward	80.9%	89.0%	129.1%	96.8%
Ray Admissions Unit	92.7%	80.7%	127.6%	87.1%
Medical Short-Stay Unit Saunders	91.9%	95.7%	142.4%	96.8%
Harold Ward (formally known as John Snow)	59.7%	90.6%	101.8%	102.2%
Henry Moore Ward	60.8%	39.3%	58.6%	76.9%
Gibberd Ward	67.3%	91.9%	52.9%	97.8%
Winter Ward	68.3%	89.2%	111.5%	109.7%
Chamberlen Ward	82.5%	75.4%	88.2%	76.5%
Labour Ward	84.6%	64.0%	77.5%	79.0%
Samson Ward	124.6%	73.3%	96.8%	67.2%
Birthing Unit	92.2%	82.6%	92.1%	80.6%

The Princess Alexandra Hospital NHS Trust

Ward staffing exception reports

Reported where fill is < 85%, or where the ADoN has concerns re: impact on quality/ outcomes.

Appendix 2

Dec.18

				Report from the Associate Director of Nursing for the HCG		
	%fill RN/M	% Care Staff	% overall fill	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Fleming	59.5%	77.45%	68.47%	Establishment incorporates assessment beds but currently these beds are used for longer length of stay patients up to 72hrs which requires different rota coverage. Staff are moved to support other areas as can be seen under section 3.11	1 PALS; 4 complaints; Of the incident reported: 1 staffing incidents; 9 falls (7 no harm, 2 minor) ; 1 pressure ulcer (grade 1); no SIs or reds classified incidents.	Recruitment and retention plan in place with monthly recruitment events. On-going focus to ensure the patient flow for the short stay assessment facility is supported.
Ray		82.9%		Bd 5 3.17 WTE vacancy. 0.46 WTE over established on Bd 6 support junior staff	2 PALS; 0 complaints; 5 staffing incidents; 3 pressure ulcers (1 DTI, 2 Grade 2); 10 falls (9 no harm, 1 minor); no SIs or reds classified incidents.	x1 pre-reg nurse awaiting OSCE. Daily review of staffing levels and skill mix which is mitigated across Trust x3/day.
JSU	80.45%			Bd 5 7.7 WTE vacancy, compounded by x1 WTE on long term sick leave and x1 WTE due for maternity leave. Senior Bd 5 supports junior staff on nights with Bd 6 also rotating to nights to promote safety	No PALS; no complaints; 1 staffing incident; 5 pressure ulcers (2 grade 2, 2 grade 1, 1 DTI); 6 Falls (1 no harm, 3 minor, 1 severe harm (pending review) no SIs or reds classified incidents.	Daily review of staffing levels and skill mix which is mitigated across Trust x3/day. Ongoing advert for staff of all grades within Frailty Unit
Gibberd	58.3%		76.57%	Bd 5 12.03 WTE vacancy	4 PALS concerns raised; 1 complaint; 1 staffing incident, 3 pressure ulcers (3 DTI, 1 grade 2) 6 falls (6 minor)	Daily review of staffing levels and skill mix which is mitigated across Trust x3/day. X3 agency staff provided long lines of work to sustain skillmix and offer continuity within the Unit. X2 Bd 5 provides senior support for most nights. Rapid response pool used and regular staff allocated by Site Team

Winter	83.05%			Bd 5 5.5WTE vacancy.	4 PALS, 0 complaints; 1 staffing incident, 2 pressure ulcers (1 grade 1, 1 grade 2); 5 falls (4 no harm, 1 minor); no SIs or reds classified incidents.	Review to increase bd 6 establishment. X3 Bd 5 only do NOT have shift manager competency. Daily review of staffing levels and skill mix which is mitigated across Trust x3/day
ITU/HDU	83.5%	13.15%	64.4%	Registered nurse vacancy at 9% Unregistered vacancy at 41%. 1 WTE band 7 on secondment.	29 incidents reported – 1 staffing incident. 5 pressure ulcer reports. 0 PALS 0 complaints 0 falls 0 SI .	Twice daily shift review of staffing levels and skill mix. 1 NHSP on a line of Nights able to be in charge (ex CCOT nurse). Agency staffs have been utilised. Flexing of critical care beds to accommodate care levels of patients. Active recruitment on going.
Henry Moore	57.95%	58.1%	58%	Registered Nurse vacancy 4.1 WTE. None registered vacancy 4.2 WTE. Ward closed over Christmas period and staff utilised in the surgical health group. Low fill rate reflects the flexible activity in the ward, and the movement of staff to support other areas as detailed under section 3.11	3 incidents reported.	Roster reviewed and adjusted appropriately.
Kingsmoor	83.85%			The overall fill rate for RNs has fallen in month but this has been mitigated by increasing the number of care staff hours and by the ward manager working clinically on the ward.	There were no reported adverse events on Kingsmoor Ward over the month of December. There were incidents relating to reduced staffing levels.	The roster is reviewed daily by the senior nursing team to ensure patient safety is prioritised.
Dolphin	71.95%		83.95%	This Figure includes the specialist nurses OPD staff and PAU	No concerns noted re quality	Process in place to correct the roster
Nightingale	71.6%	77.2%	74.4%	Ward closed over Christmas which has affected the fil rate. Staffing has improved with 2 new RNs	No concerns noted re quality	Active recruitment ongoing, ward to move to John Snow in January
NICU		68.05%	78.37%	Long term sickness in care staff, the community neonatal team also	No concerns noted re	Recruitment on going

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				support this rota.	quality
Chamberlen		75.95%	80.65	Maternity staffing is reviewed as a whole as we move to where the acuity is, long term Sickness and maternity leave for RMs and MCAs across the unit although high for Health Group is improving	Maternity training compliance improved although below 95% Formal meetings continue with regard to sickness absence with matrons and HR
Labour ward	81.05%	71.5%	76.27%		
Samson		70.25%			
Birthing unit		81.6%			

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Trust Board – 7 February 2019

5.3

Agenda Item:	5.3
Presented by:	Director of Nursing, Midwifery and AHPs
Prepared by:	Associate Directors of Nursing , Medicine, Surgery, Cancer Cardiology and Clinical Support, Family and Women's
Date prepared:	17 January 2019
Subject / Title:	Nursing and Midwifery Establishment Review

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The establishment review was undertaken in November 2018 in line with national best evidence. The review recommends uplift in the establishment of 16.46 wte band 5 registered nurses (RNs) and 22.49 wte clinical support workers (CSW). Of this, 12.27 wte RNs and 18.2 wte CSW reflect unsubstantiated changes in rotas as a result of activity changes and pathway changes already implemented. A summary of the proposed changes can be reviewed under section 4.
Recommendation:	The Board is asked to note the methodology used to inform the establishment review process, in line with national best evidence and to approve the recommendations detailed in the paper.

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

Previously considered by:	EMT 24/1/19. WFC on 28/01/19
Risk / links with the BAF:	BAR Risk 2.1 Nurse Recruitment
Legislation, regulatory, equality, diversity and dignity implications:	As outlined in the paper.
Appendices:	Nil

1.0 PURPOSE

This report provides assurance that mechanisms are in place to review nursing and midwifery establishments in line with regulatory requirements. It details the outcome and recommendations following the review of establishments undertaken in November 2018.

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

2.0 BACKGROUND and NATIONAL CONTEXT

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

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

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

The data collection for this nursing and midwifery establishment review was commenced in November 2018 utilising the Safer Nursing Care Tool (SNCT) for adult ward areas and the Baseline Emergency Staffing Tool (BEST) for the Emergency department. The Safer Nursing Care Tool (SNCT) is a nationally recommended tool for measuring the acuity and dependency of patients in adult ward areas to determine establishments (NICE, 2014). This tool is widely accepted by Chief Nurses as the tool of choice used to inform ward establishment requirements. BEST has been designed by the Royal College of Emergency Medicine to demonstrate Emergency Department (ED) nursing workload based on a combination of the number of patients attending the department, a measure of the patients nursing dependency and length of stay. Nationally agreed guidelines and standards have been applied in areas where these are recommended such as Critical Care and Theatres.

Whilst the establishment reviews focus on the acuity/dependency results, these are not reviewed in isolation. Experience and best practice identifies that a wider suite of quality indicators must be considered to allow more informed approaches in respect of assuring the Trust that staff are in place to provide high quality, safe and compassionate care. A review of the nurse sensitive indicators are included under section 2.1. The quality indicators were reviewed when considering the SNCT findings. Additional local information related to the ward layout, and professional judgement supplements the outcome of the SNCT findings.

Nursing Red Flags (NICE, 2014) should also be analysed, to understand the frequency and incidence within the clinical areas. A refresh of Nursing Red Flags in line with national

guidance will be undertaken to inform safe staffing and future establishment reviews. Red flags would include:

- Omitted medicines
- Delay in providing pain relief for over 30 minutes
- Omission or delay in undertaking comfort rounds
- Shortfall of 25% or 8 hours (whichever is reached first) in RN availability on a shift
- Less than 2 RNs on a shift.

The SNCT calculation is based upon a funded headroom allowance of 22% (leave allowance including annual, study, sickness etc.), our trust allowance is currently 20%, it should be noted that the Royal College of Nursing (RCN) recommends 25%. The Ward Manager role has 22.5hours per week supernumerary time built in however achievement of compliance with supernumerary time is inconsistent across all areas due to the vacancy rate.

2.1 Summary of Nurse Sensitive Indicators for each in-patient area

HCG	Ward	PALS (inc bereavement / GP queries)	PALS Queries referred to Complaints	Open PALS at month end	Compliments	New Complaints	Open complaints at month end	Pressure Ulcers (all category 2)	Falls	SI	Staffing levels	Medication errors
MHCG	A&E	17		24	10	4	9		4	1	2	3
	Fleming (Medical Assessment Unit)	2		2	3		5	1	5			1
	Gibberd	3		11			4	5	6		2	4
	Harold			1			1		4		6	1
	Harvey	2		5	1		1		6			3
	Jon Snow	2		2	10	1	3		8			
	Lister	2		4	4				2			6
	Locke	5		4			2		1			10
	Ray	1	1	4		1	2	2	18		3	2
	Saunders (Medical Short Stay)	6		9		1	4	3	8	1		
	Winter			6		1	3		11		1	12
SHCG	Penn	4		18	4		2		2		2	
	HDU/ITU	2		9				1	1			6
	Henry Moore (OSU)			2	1				2			
	Tye	8	1	10		1	3		6		3	4
CCCS	Kingsmoor (Cardiac Care)	6		6		1	1		2		1	4
FAWS	NICU	1					1					
	Nightingale (Obs & gynae)	3	1	4		2	1		1			1
	Samson	1		1								
	Birthing Unit											
	Chamberlen						1					
	Dolphin	3							1		3	5

3.0 Additional Information

In response to changes in nurse education and the ongoing nursing vacancy position across the trust, a number of roles have been implemented to support nursing teams to focus on delivery care. These roles have been funded from vacancy in ward establishments:

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

- Ward Assistants – unregistered clinical role working under the supervision of nursing staff which is a hybrid of portering, housekeeping and care delivery role.
- Assistant Practitioners – unregistered clinical role working under the supervision of nursing staff responsible for a group of patients, staff may develop to Nursing Associates or Apprentice routes.

Nationally, the following role has been developed to support the RN workforce:

- Nursing Associates – A stand-alone clinical role regulated by the NMC which supports the delivery of clinical care and may progress into graduate level nursing.

Exclusions

Due to recent service changes in the acute pathway areas the following areas have been excluded and remain under review (Fleming, Ambulatory Care Unit and Saunders). The ADoN for the MHCG is confident that the current funded establishment does not require any immediate change.

The Birth Rate + establishment review for Maternity services is being undertaken across the Local Maternity Systems, and is due to report its findings in February 2019. It is recommended that the outcome of the Birth Rate +, alongside an overview and update to the maternity services are reported to Board in spring 2019.

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4.0 Summary table of findings:

HCG	Ward	Tool	Recommendation	Cost (FYE)
Medicine	ED	BEST	To substantiate the increase the establishment in line with increase in activity, new pathways and increased opening hours of CDU 4.27 WTE band 5 13.53 WTE CSW	£176,974 £396,578 **Total: £573,552**
	Tye Green	SNCT	Increase in RN x 1 on each day shift – in line with opening of 4 additional beds in January 2019. 4.29 WTE band 5	**Total: £177,803**
Surgery	John Snow	SNCT	Increase in CSW x 1 on each day shift – in line with opening of 4 additional beds in January 2019. 4.29 WTE CSW	**Total: £125,744**
	ITU/HDU	GPICS	To introduce the Associate Critical Care Practitioner role (band 4)	Cost neutral
	Theatres	AfPP	To substantiate the additional staff required to open the second maternity theatre, and additional staff required for increase in theatre sessions / activity 4 WTE band 5 4.67 wte CSW	£165,783 £136,882 **Total: £302,665**
	PACU (recovery)	AfPP / BARNA	To substantiate the RN requirement for overnight within PACU 4 WTE band 5	**Total: £165,783**
CCCS			No changes	

FAWS			No changes	
			Total Investment Required	**£1,345,547**

It should be noted that the current vacancy rate for RNs across the organisation is c. 27% and there is an increased focus and drive to significantly reduce the vacancy factor throughout 2019. Uplift to the RN establishments is unlikely to result in achieving full establishment in 2019/20 and therefore will not reach full year effect (FYE) cost. Implementing the establishment changes will enable the shift coverage template to change to support the staffing levels, and enable to use of temporary staffing solutions where available. It is therefore recommended that any increase to the RN establishment should be phased over 2019/20.

The vacancy factor for CSW is significantly less challenged than the RN position, with a healthy temporary staff fill to support any vacancies, Additional CSW establishment is likely to achieve full recruitment throughout 2019/20.

Summary of ward/ department reviews.

Medicine Health Care Group including Urgent and Emergency Services

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

20 bedded Gastroenterology/Haematology Ward which has 10 individual side rooms. This ward has one of the largest compliments of side rooms, one of which is larger and is used to accommodate bariatric patients and equipment and because on the increased number of side rooms is also the ward of choice for patients with special needs such as learning disabilities. Recommendation:

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

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

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

28 bedded Complex Care of the Elderly Ward which has achieved the Quality Mark for the delivery of Elder Friendly Care. This ward has four individual side rooms. The SNCT data identified a requirement to increase the RN establishment however, the SNCT trend to capture variation needs to be available. In addition, the current RN establishment has not been achieved the recommendation is to monitor the dependency and acuity data on a daily basis, making appropriate changes to workforce to ensure patient safety and complete a SNCT establishment review in a further six months.

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

27 bedded Respiratory Ward which in September 2018 as part of service improvements opened a three bedded Acute Respiratory Unit (ARU). Locke Ward has had their establishment increased to open the Non Invasive Ventilation (NIV) service which is currently

being used for the increased clinical acuity in ARU. Further plans are in place to repatriate the NIV service from Critical Care to Medicine in the early part of 2019 which will impact on the clinical acuity and essential care needs of the ward. The recommendation of the SNCT establishment review is not to make any further changes to the establishment and complete a further review in six months in line with future service developments.

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

28 bedded Complex Care of the Elderly Ward which has achieved the Quality Mark for the delivery of Elder Friendly Care. This ward has four individual side rooms. Based on SNCT data an increase in establishment is not required at present.

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

This ward is the specialist Frailty ward with an expected patient length of stay up to 72 hours. Until the ward realignment in January 2019, the ward had 22 inpatient beds. As part of the ward realignment the Ward has moved from the first floor to the ground floor (improving clinical adjacency to ED) increasing the bed base by 5 from 22 to 27 beds. Future developments in the rapid access frailty service assessment will focus on increasing the use of frailty assessment admission avoidance and admission for up to 72 hour length of stay. There will be an amalgamation of the frailty team and the ward based team. The SCNT establishment review which was based on previous capacity prior to the move recommended no further increase to that establishment. Based on the SNCT findings amalgamation of teams and service developments the recommendation is not to change the current establishment and to complete a further review in 6 months which will incorporate future business plans once developed.

Tye Green
Recommendation: Increase in the band 5 establishment 4.29 WTE, cost £177,803

This ward is the specialist Fractured Neck of Femur ward, which until the ward realignment in January 2019 had 26 inpatient beds and 1 assessment bed. Following the ward realignment the bed base has increased by 4 beds to 30 inpatient beds with 1 assessment bed. The SNCT establishment review was based on previous capacity prior to the move and the outcome recommended no further increase to that establishment. Given the increase in capacity by 4 beds the recommendation is to increase the establishment by 1 RN on every shift during the day and complete a further review in 6 months.

Emergency Department
Recommendation: 4.27 WTE band 5, 13.53 WTE CSW, cost £573,552

Additional investment requested should be phased in line with the recruitment pipeline, however the recommendation is that this is front loaded for Q1 to enable recruitment to come on line for Q4.

The last skill mix review was completed following the refurbishment of the Emergency department in January/February 2018, the results of which brought about an increase in the current nursing establishment to 16 RN and 4 CSW for day and 14 RN and 5 CSW for the night shift. However since then there has been a 7.6% increase in the number of attendances to the department with an associated increase in patient acuity. On a daily basis the ED has seen higher than planned attendances, with c300 attendances a day, which is expected to continue into 2019/20. This increase in activity along with a number of changes and redesign to pathways were not reflected in the last BEST audit. Examples of these changes are

- Increased number of Rapid Assessment and Treatment Teams (RAT) from 2 to 4 impacting on patient safety and achievement of key performance indicators. This change is recommended following external review by NHS Improvement
- A 7.6% increase in the number of attendances to ED
- A requirement to support the Resuscitation area with a CSW
- A requirement to support the Streaming pathway with a CSW
- A requirement to support the Clinical Decision Unit (CDU) with a CSW. It should be noted that this area during the last audit was budgeted to be opened from 10:00 till 02:00 and is now open 24 hours per day seven days per week.

Analysis of the BEST audit recommends the following changes and reflects peak times of activity across the 24 hour period

- Increasing the day shift template to 17 RN +10 CSW, this will include introduction of a middle shift from 10:00-22:00 for 1 RN, increasing the ability to run 4 RAT teams in response peak activity times and will ensure that CDU is open 24 hours per day.
- Additional CSW to be allocated to the Resuscitation area
- Additional CSW to be allocated to Streaming pathway
- Increasing the night shift template to 16 RN+9 CSW

The total cost of these changes is £573,552, given that there is a current vacancy factor of 46% the HCG recommends introduction of the changes phased throughout 2019/20 in the budget setting process.
The recommendations should be overseen within the Urgent Care Board to ensure that any further changes impacting on pathways are taken into account.
It should be noted that these recommendations take into consideration current changes to pathways and increased actively already realised but does not consider future activity increases, this position will be reviewed as part of the next BEST audit in May 2019.

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

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

Areas Excluded:

Fleming Ward & Ambulatory Care Unit

A medical assessment ward with mixed capacity for beds chairs and trolleys up to a maximum of 26 patients. The staffing establishment for this area includes staff for the Ambulatory Care Unit which is open 7 days a week 08.00 to 20.00 and sees on average 40 patients per day. The operational model for Fleming is rapid assessment, discharge or admission with a length of stay no longer than 24 hours. As a result of the ward realignment last year this area has already had an increase in establishment to support the operational model. Consequently the decision was made to exclude the SNCT data for this establishment review period whilst process are being developed and implemented.

Saunders Ward

28 bedded short stay admission ward aiming to have a length of stay up to 72 hours. This operational model is linked to developments on Fleming and Ambulatory Care and is currently in the initial stages of implementation. As a result the SNCT establishment review is not reflective of the current operational model and therefore the decision has been made to

exclude the data obtained from the review on this occasion. A further review will be completed in 6 months.

Surgery and Critical Care Health Care Group

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

19 bedded elective orthopaedic surgical ward which cares for patient's pre and post-operative from elective care bad patients who are having planned trauma surgery. The ward was realigned 12 months ago and the establishment amended at that time. The wards patient capacity fluctuates at times and as such this and the SNCT data, a change in establishment is not required at present. However this will be reviewed in 6 months once the ward maintains full patient capacity.

John Snow Ward (currently Nightingale)
Recommendation: Increase in the CSW establishment 4.29 WTE, cost £125,744

This ward is the female gynaecology and surgical ward, which until the ward realignment in January 2019 had 18 inpatient beds. Following the ward realignment the bed base will increase to 22 inpatient beds. The SNCT establishment review was based on previous capacity prior to the move and the outcome recommended no further increase to that establishment. Given the increase in capacity by 4 beds the recommendation is to increase the establishment by 1 CSW on every shift and complete a further review in 6 months.

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

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

Charnley Ward

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

This ward is a new build 27 bedded ward and was opened on the 2nd January 2019. The ward moved from Tye Green where it had 31 beds and the SNCT establishment review which was based on previous capacity prior to the move. This data recommended no changes to that establishment. The recommendation is not to change the current establishment and to complete a further review in 6 months. This will allow consideration of the changes to the ward layout and the reduction of 4 beds.

Intensive care unit / High Dependency Unit (Critical Care)

Recommendation: change to the ICU establishment to introduce the Associate Critical Care Practitioner (no additional cost)

This is 10 bedded unit (5 ITU and 5 HDU beds). The Intensive Care Society Guidelines for Provision of Intensive Care Services (GPICS) were applied in the review of the establishment within critical care. These ensure that level 3 patients are nursed on a 1:1 basis, level 2 patients on a 1:2 basis and provide a supernumerary nurse in charge with a dedicated Clinical Nurse Educator. There is a recommendation of a change in skill mix within the unregistered staff to develop roles as associate critical care practitioner. This change is within the financial envelope of the current unit establishment. This role will support the ability to adapt to any

changes in the number of patients within the unit requiring level 2 or 3 care without the need to acquire additional a staff for short episodes of time.

Theatres

Recommendation: Increase in the band 5 establishment by 4 WTE, and CSW by 4.67 WTE, cost £302,665

The standards from the Association of Perioperative Practice (AfPP) were applied in reviewing the theatre establishment. This was based on the current theatres schedules where there is a known gap in theatre workforce. This is currently managed through the use of agency and temporary staff and carries the risk that if these are unfilled there will be a cessation of list and a reduction in planned activity for the service. This review also incorporates the known staffing cost pressures (unfunded) following the recent build of the maternity theatre. The recommendations are for an increase in establishment of a total of 8.67 WTE.

Recovery (PACU)

Recommendation: Increase in the band 5 establishment by 4 WTE, cost £165,783

The standards from the Association of Perioperative Practice (AfPP) and British Anaesthetic & Recovery Nurses Association (BARNA) were applied in reviewing this establishment. This was based on current theatre schedules and incorporates the need for night shift registered nurse for the recovery area. This is currently an unfunded role within the recovery department and is covered with agency and temporary staff costing cira £120,000PA. The recommendations are for an increase in the establishment of 4WTE at registered nurse level.

The recommendations for both theatres and PACU should be phased throughout 2019/20 within the budget setting process, and the implementation overseen by the surgery performance review meetings with the executive team.

Day Stay Unit (ADSU)
Recommendation: no change to establishment.

This service underwent a review 12 months ago with an increase in the establishment to facilitate later opening times and weekend working. There was an increase in the staffing establishment at this time. This will be reviewed in line with service needs as required.

Oak Unit
Recommendation: no change to establishment.

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

Eye Unit
Recommendation: no change to establishment, but note intention to include additional establishment requirements in line with any future business plan.

This service will be undergoing a review in the next 3 months following recent changes to the types of services delivered in the Eye Unit. Any changes to the staffing establishment will be reviewed at this point and managed through business planning.

Family and Women services Health Group

Dolphin Ward

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

16 bedded children's ward. The Shelford Acuity Tool has to be used in conjunction with the RCN guidelines for Paediatric Staffing. The report from National Quality Board June 2018 further evaluates methods for calculating staffing levels versus activity.
Current establishment is compliant with National Guidelines, however we are in the process of reviewing our bed capacity and high dependency provision. Any recommendation will inform the next establishment review.

Paediatric Emergency Department and Paediatric Ambulatory Unit (PAU)

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

The Children's Emergency Department and PAU relocated and opened co-located in December 2017 with an accompanying staffing uplift reflecting this change. The staff are utilised flexibly to meet nursing and activity demand. The department have recruited to the additional posts, but have been carrying significant maternity leave - despite this have we successfully continued to staff the department at all times with children trained staff only.

Maternity Services

Excluded from current review.

Consultant led high risk labour ward with 9 delivery rooms and 1 maternity theatre with the second theatre just waiting to be handed over following completion, plus a three bedded recovery room. Antenatal inpatient services include a 15 bedded ward with 1 bereavement suite. The postnatal inpatient ward has 22 beds.
There is a co-located birthing unit for low risk women to access midwifery led care. The birthing unit has 3 delivery rooms all with the provision for water births, there are 12 post natal beds on the birthing unit.
The SNCT is not utilised within maternity, the workforce tool used is Birthrate plus which is currently the only midwifery specific national tool that gives the insight and aptitude needed to be able to model midwifery numbers, skill mix and deployment. Working alongside individual trusts Birthrate plus can calculate an indivdual ratio of clincial midwives to births for maternity services
Data collection for Birthrate plus is being collected during December and January with results planned by February 2019 as it being coordianted with the Local Maternity System (LMS)

Cancer, Cardiology and Clinical Support, Health Care Group

Kingsmoor Ward

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

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

Outpatients

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

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

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

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

William's Day Unit
Recommendation: based on Professional Judgement and activity templates, no change to establishment

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

4.1 Staffing Template Number Summary Post Review

It should be noted that although there has been considerable national debate on the subject of skill mix and nurse to patient ratio, to date no national standards for staffing levels in inpatient areas have been mandated in England, although a minimum Registered Nurse to patient ratio of 1:8 in the day and 1:11 at night is supported by professional organisations such as the Royal College of Nursing and the Safe Staffing Alliance. The table below shows the funded nurse to patient ratio at PAH with the proposed establishment changes incorporated. All daytime ratios are within the 1:8, and at night within 1:11.

Ward/Department	Early		Late		Night		Number of beds	Day		Night	
	RN	HCA	RN	HCA	RN	HCA		Patient to RN ratio	Patient to all staff ratio	Patient to RN ratio	Patient to all staff ratio
Fleming	10	6	10	6	7	4	26	2.6	1.6	3.7	2.4
Gibberd	4	4	4	4	3	4	27	6.8	3.4	9	3.9
Tye Green	5	4	5	3	4	3	31	6.2	3.4	7.8	4.4
Harvey	4	3	4	3	3	2	20	5	2.9	6.7	4
Henry Moore	3	2	3	2	2	1	19	6.3	3.8	9.5	6.3
Lister	4	4	4	4	3	2	28	7	3.5	9.3	5.6
Locke	5	3	5	3	4	2	27	5.4	3.4	6.8	4.5
Harold	5	3	5	3	3	2	27	5.4	3.4	9	5.4
Kingsmoor	5	3	5	3	4	2	30	6	3.8	7.5	5
John Snow	4	3	4	3	3	2	22	5.5	3.1	7.3	4.4
Ray	4	4	4	4	3	2	28	7	3.5	9.3	5.6
Penn	5	3	5	3	3	2	28	5.6	3.5	9.3	5.6
Saunders	5	4	5	4	4	3	28	5.6	3.1	7	4
Charnley	5	3	5	3	3	2	27	5.4	3.4	9	5.4
Winter	5	3	5	3	3	2	28	5.6	3.5	9.3	5.6
ITU/HDU	9	1	9	1	9	1	10	1.1	1	1.1	1
Emergency Department	15	8	15	8	15	6	NA	NA	NA	NA	NA
Endoscopy	10	3	10	3	NA	NA	NA	NA	NA	NA	NA

5.0 RECOMMENDATIONS

- To note the recommendations within this report, and the methodology used to inform the establishment setting process.
- The total financial recommendation for RN and CSW establishment uplift across the trust is **£1,345,547**. Given the current underspend in nursing this may be proved in a phased approach in line with recruitment but should be included in the next budget setting round and phased throughout 2019/20.
- Medicine HCG will increase the establishment for Tye Green by 1 RN 24 hours equating to 4.29 WTE. Total cost £177,803.
- Increase the ED staffing template in line with BEST recommendations by 4.27 WTE RN's s and 13.53 WTE CSW. Total cost £573,552. Review the impact of pathway changes by repeating the BEST audit in 6 months.
- Surgery and Critical Care will increase the establishment within theatres and PACU (recovery) equating to 12.67 WTE. Total cost £468,448.
- Surgery HCG will increase the establishment for John Snow by 4.29 WTE CSW. Total cost £125,744.
- The changes to the Eye Unit establishment will be reviewed through a business case process and will be funded from the increased activity and income this service will achieve.
- 3 times per day Safe Care review will review to support the redeployment of staff in line with clinical acuity and dependency information.
- Nurse Sensitive Indicators will be reviewed by exception reports on a monthly basis to ensure safe staffing levels.
- Nursing Red Flags will be refreshed and implemented.
- A further establishment review will be completed in May 2019, and reported to Board in September.

The Princess Alexandra Hospital NHS Trust

Trust Board – 7 February 2019

5.4

Agenda Item:	5.4
Presented by:	Jim McLeish Director for Quality Improvement
Prepared by:	Quality First Triumvirate
Date prepared:	30th January 2019
Subject / Title:	Quality Improvement Strategy 2019-2022

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]	Quality improvement at PAHT has strengthened and developed over time by engaging with patients, staff and the wider community, which has resulted in an approach that is widely adopted and supported in the organisation which in turn has led to sustainable improvements being made. The Princess Alexandra Hospital NHS Trust Quality Improvement Strategy aims to communicate the areas of Quality Improvement focus (what we will do) and the Quality Improvement methodology used (how we will do it).
Recommendation:	That the Trust Board supports and approves the Quality Improvement Strategy.

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:	Executive Management Team 20th December 2018 Quality and Safety Committee 25th January 2019
Risk / links with the BAF:	Quality Improvement has the potentially support the mitigation of a number of risks in the organisation, but to highlight two specifically: 3.4 Strategic Change and Organisational Structure 1.1 Inconsistent Outcomes
Legislation, regulatory, equality, diversity and dignity implications:	CQC should view the presence of a visible and consistent approach to quality improvement as a positive finding. If it is present in an organisation that provides services that we have rated as good or outstanding, it might contribute to a rating of outstanding for well-led at provider level - link.
Appendices:	

NHS
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5.4

Quality Improvement Strategy

2019-2022

Your future | Our hospital

PAHT QI st IMPROVEMENT PARTNER

The Princess Alexandra Hospital NHS Trust

Foreword by Ann & Lance

As chair of the Patient Panel here at the Princess Alexandra Hospital NHS Trust I am proud to provide an independent voice and advocate on behalf of patients and their families. Furthermore we are champions of patient co-production, which is how we should all be working – doing with and not for, or to, people – not just sometimes, but all the time.

I am pleased to say that when it comes to quality improvement there are many examples of the patient's perspective directing and informing change at PAHT. I look forward to seeing this collaborative working approach go from strength to strength over the life time of this Quality Improvement Strategy.

Ann Nutt | Chair of the Patient Panel

Putting quality first in everything that we do remains our Trust mission as we strive to deliver outstanding healthcare to our local community.

At PAHT we have seen so many members of staff embrace quality improvement as a way to continuously raise standards and improve outcomes for our patients. The need to improve care is especially important here in Harlow as each improvement made is a positive step to delivering our new hospital.

Lance McCarthy | Chief Executive Officer

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The Princess Alexandra Hospital NHS Trust

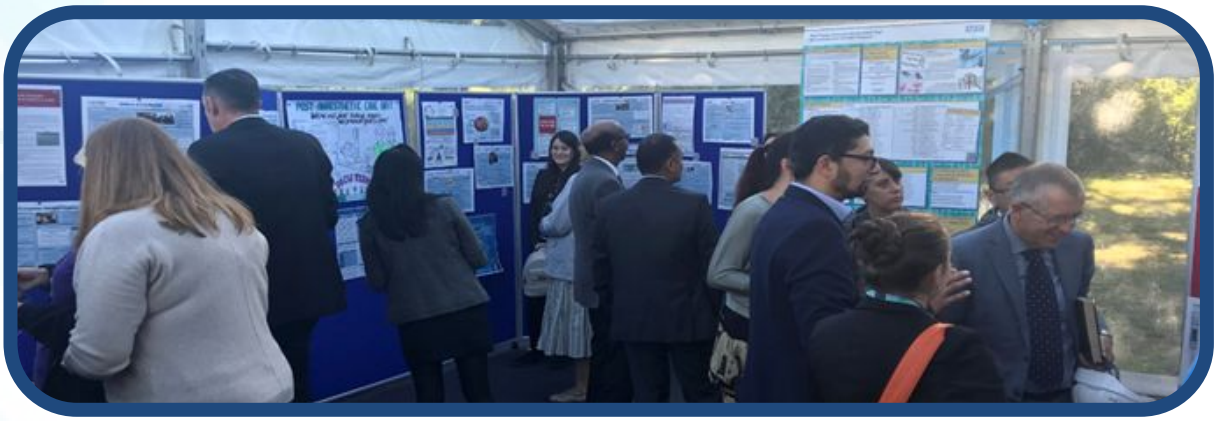
Quality Improvement Strategy Summary

The Strategy highlights the Princess Alexandra Hospital NHS Trust's quality improvement approach. This includes:

- The Model for Improvement is the methodology used
- The Quality Improvement (QI) approach for the Trust is called "Quality First"
- There is a central Quality Improvement Team
- The Trust has developed a QI education and development programme which includes Leading Change and Leading Projects
- The five enablers for success are
  - Technology
  - Safe care and reducing harm
  - Leadership and culture
  - Pathways and models of care
  - Collaborative working
- The core measures demonstrating success of the QI strategy will be significant improvements by 31 March 2022 will be:
  - Reduction in mortality
  - Reduction in length of stay including reduction time spent in urgent care
  - Improvement patient experience
  - Reduction in harm incidents

Contents

The Princess Alexandra Hospital NHS Trust



Framing our strategy

The Princess Alexandra Hospital NHS Trust

Aim of the quality improvement strategy

The Princess Alexandra Hospital NHS Trust (PAHT) quality improvement (QI) strategy (2019 –2022) aims to communicate both our areas of focus (what we will do) as well our QI methodology (how we do QI).

Background

To achieve the Trust's vision 'to deliver truly outstanding healthcare to our local community' the Board has agreed five strategic objectives:

1. Our **Patients** - continue to improve the quality of care we provide to our patients, improving our CQC rating.
2. Our **People** – support our people to deliver high quality care within a culture that improves, with engagement, recruitment and retention and improvements in our staff survey results.
3. Our **Places** – maintain the safety of and improve the quality and look of our places and work with our partners to develop an Outline Business Case (OBC) for a new build, aligned with the development of our local Integrated Care Alliance.
4. Our **Performance** - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators.
5. Our **Pounds** – manage our pounds effectively to achieve our agreed financial control total for 2018/19.

Introduction to Quality Improvement

Since October 2016, when the trust received a Care Quality Commission (CQC) rating of inadequate, the clear strategic direction to improve from this rating has been for a trust wide quality improvement approach. This approach has been named "QUALITY FIRST". An initial document, called "Quality First Our Improvement Plan 2016-2021" has since been refreshed and advanced into this "Quality Improvement Strategy 2019-2022". This reflects the progress made in the objectives and development of the Quality First Team.

Since then the hospital has developed a whole system approach to quality improvement. The Quality First team works alongside the Patient Safety and Quality department which is aligned to corporate governance and patient safety. Putting 'quality first' is the underpinning principal to this Quality Improvement Strategy and our methodology to quality improvement. We define quality improvement as 'working together in partnership to make the sustainable changes that will lead to excellence for our patients, people, places, performance and pounds.'

Framing our strategy

The Princess Alexandra Hospital NHS Trust

Case for change

'Boards must put quality at the heart of all they do (i.e.) patient safety, effectiveness of care and patient experience'

National Leadership Council (NLC), 2010, the Healthy NHS Board

The CQC visit of 2015 resulted in activity that addressed some of the concerns to good effect, but with others there was no change and even deterioration. Key areas were overlooked or neglected and overall the Trust position moved from 'Requires improvement' to 'Inadequate' in 2016. A different approach was required to not only support the Trust out of "Special Measures" but also on our journey going forward. There was a growing need to improve the quality and safety of healthcare, not only by regulation or quality control, but by also improving our culture. Improvement and innovation needs to be a driving force, leading to best practice for the benefit of our patients, staff and wider community.

Our mission, 'Putting quality first will be our approach in everything we do as we strive for excellence' will be instilled within our organisation, teams (including the Trust Board) and individuals. This cannot be achieved by reactive fire-fighting responses, which are not sustained and have a limited focus.

There is now a need for an overarching strategy to describe our Quality Improvement journey that identifies all the enablers. Quality improvement at PAHT has strengthened and developed over time by engaging with patients, staff and the wider community, which has resulted in an approach that is widely adopted and supported in the organisation leading to sustainable improvements being made.

Celebrating success

For two consecutive years PAHT have won Champion Organisation at the annual Academy of Fabulous Stuff national awards. At the awards in November 2018, the chief executive of the NHS, Simon Stevens said 'this award is presented to the trust whose energy, leadership and vision has empowered staff to put their ideas into action and have embedded quality improvement as 'the norm' throughout their organisation'.

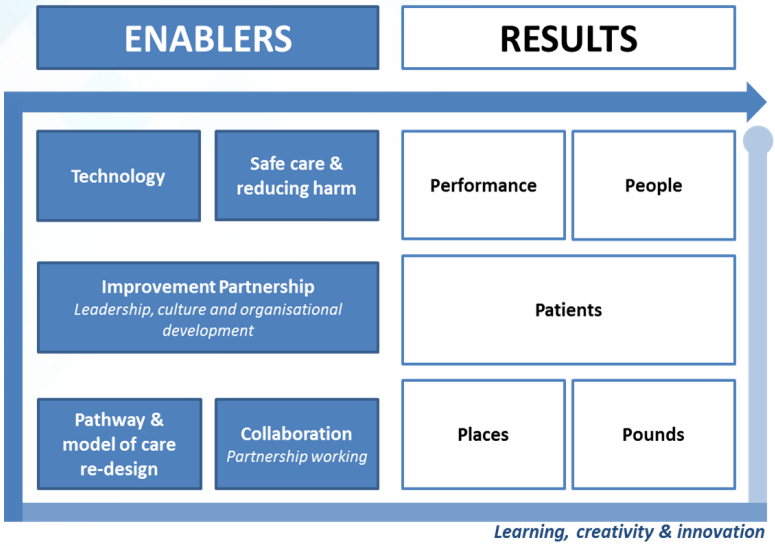
Our Focus *(what we do)*

The Princess Alexandra Hospital NHS Trust

Enablers to successful quality improvement at PAH

Five key 'enablers' have been identified to help focus quality improvement activity to achieve continuous improvement across our five Ps (patients, people, performance, places and pounds). The five enablers are explain in more detail in appendix1.

Throughout the lifetime of this strategy (2019-2022) progress and performance will be tracked via the Trust's Integrated Performance Report that is reviewed in the Trust Board's three sub-committee meetings as well as the Board of Directors meetings on a monthly basis. This creates a feedback loop for our quality improvement efforts allowing us to live a learning culture throughout the lifetime of our quality improvement strategy.



Results (success measures)

The following four measures have been identified as key determining factors for 'success criteria' against the quality improvement strategy i.e. if the goals are achieved, the strategy will have been a success. It is recognised and understood that the delivery of healthcare can be complex and multifactorial, and the work associated with delivering the quality improvement strategy will not be the only factors that dictate success. Details on specific projects and actions to ensure the delivery of these success measures will be outlined in annual work plans agreed with Executive Management Team.

ID	Description	Source	Goal
1	Mortality rates (HSMR)	Dr Foster HSMR	Achieve 'as expected' across all specialities, with no more than two outlier alerts over a 12 month rolling period by March 2021 and to be sustained.
2	Length of Stay	Dr Foster average non-elective length of stay for each specialty	Achieve national average (or better) across each of the specialities by March 2021 and to be sustained.
3	Annual Patient experience survey	Survey Results, Q68 – Overall Experience (in patient, out patient and A&E)	Achieve top quartile by March 2022.
4	Harm	Information team	Achieve top quartile against National Reporting Learning System (NRLS) March 2022 .

Dr Foster, Model Hospital and GIRFT tools and analysis will be used to benchmark throughout life time of QI Strategy

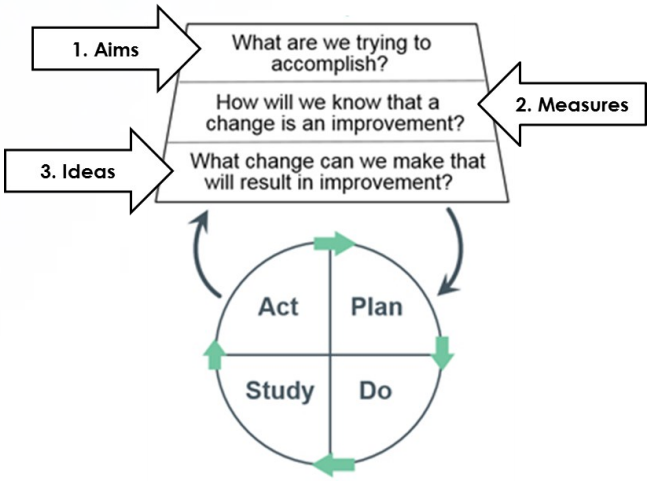
QI methodology (how we do QI)

The Princess Alexandra Hospital NHS Trust

Model for Improvement

The **Model for Improvement** is the Princess Alexandra Hospitals NHS Trust's quality improvement methodology of choice. The Model for Improvement, developed by Associates in Process Improvement, provides an intuitive framework for developing, testing and implementing changes that can better ensure improvement.

1. The model firsts asks you to define a SMART (specific, measurable, achievable, realistic and time bound) **aim**.
2. The second question asks you to identify what you will **measure** to understand whether a change leads to an improvement.
3. The final question asks you to develop change **ideas** that would lead to a measurable improvement.



The model then combines with the Plan Do Study Act (PDSA) cycle to test changes on a small scale before scaling up.

Our quality improvement methodology is spread throughout the trust and further strengthened by learning and development gained via the **Leading Change** and **Leading Projects** learning and development sessions, which are facilitated by the Quality First team.

QI methodology (how we do QI)

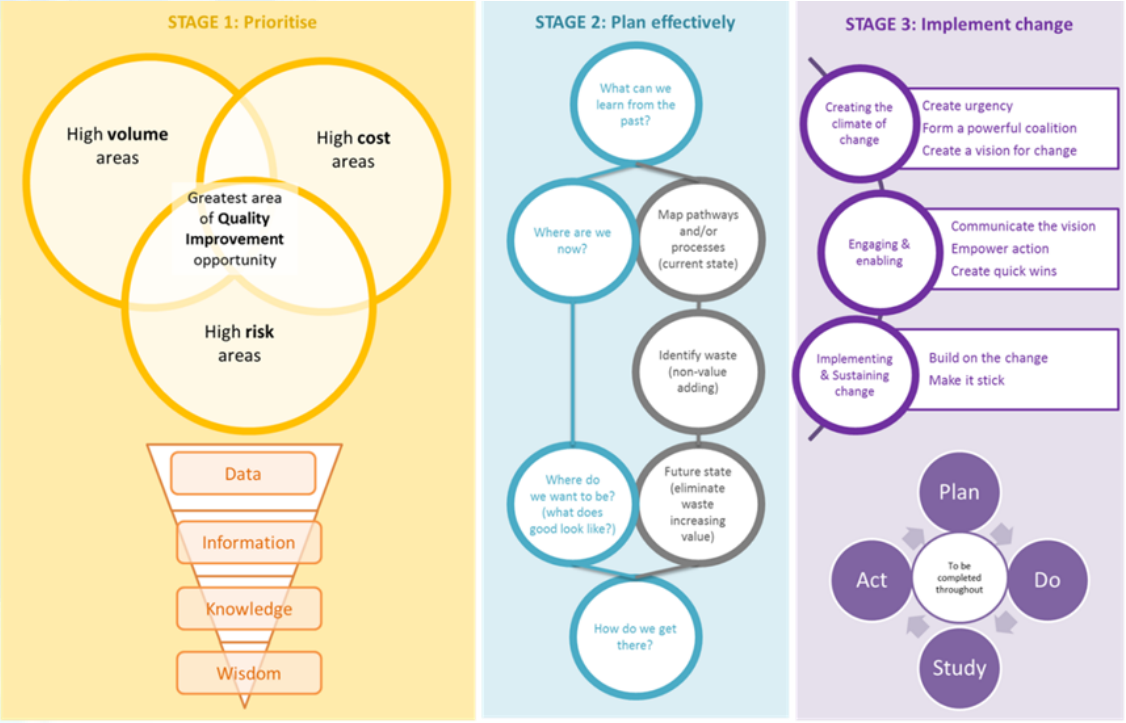
The Princess Alexandra Hospital NHS Trust

Leading Change

Our model for leading change has three stages:

1. Prioritise
2. Plan effectively
3. Implement change

During the supporting learning and development sessions, the importance of putting the customer (usually patient) at the centre of the changes is emphasised.



'Those who fail to appreciate their impact on others squander talent and potential every day'.

Professor Beverly Alimo-Metcalfe, 2001

Every stage of the leading change model is underpinned by the following five leadership practices:

- Model the way
- Inspire a shared vision
- Challenge the process
- Enable others to act
- Encourage the heart

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QI methodology (how we do QI)

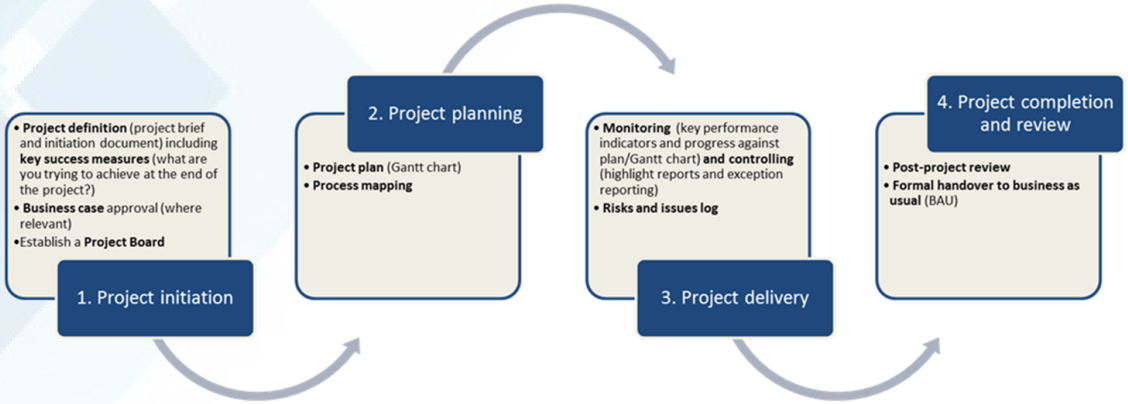
The Princess Alexandra Hospital NHS Trust

Leading Projects

Project management is a discipline that involves planning, organising and monitoring within the constraints of time, budget and resources allocated for it. Projects begin by defining a goal based on a demonstrated need, and conclude with demonstrating that the need has been effectively met by the project, and the goal achieved. Internally, we have Leading Projects learning and development sessions that support the use of a project workbook that utilises the best practice elements from a number of project management methodologies such as Prince 2.

We have developed a best practice approach to project management to avoid individuals, teams and ultimately patients being exposed to chaotic management, lack of governance and risk management, unclear objectives, unmet expectations, a lack of resources, unrealistic planning, poor quality deliverables, projects going over budget and delivered late.

When it comes project management we have defined four stages from starting (project initiation) to completing (project completion and review) a project. These four stages are:



The Improvement Partnership

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

The Improvement Partnership as an enabler addresses the leadership, culture and organisational development required to embed quality improvement at PAHT.

QI methodology (how we do QI)

The Princess Alexandra Hospital NHS Trust

Patient co-production

Our patients are most important partners. 'Co-production means that we are there at the beginning, we are sitting at the table as an equal, and we will contribute to the decision about whether something is needed or not' (Ann Nutt, Chair of Patient Panel). We will embed co-production into our QI approach by adopting the five values and seven steps in NHS England's 'Co-production Model' as outlined below.

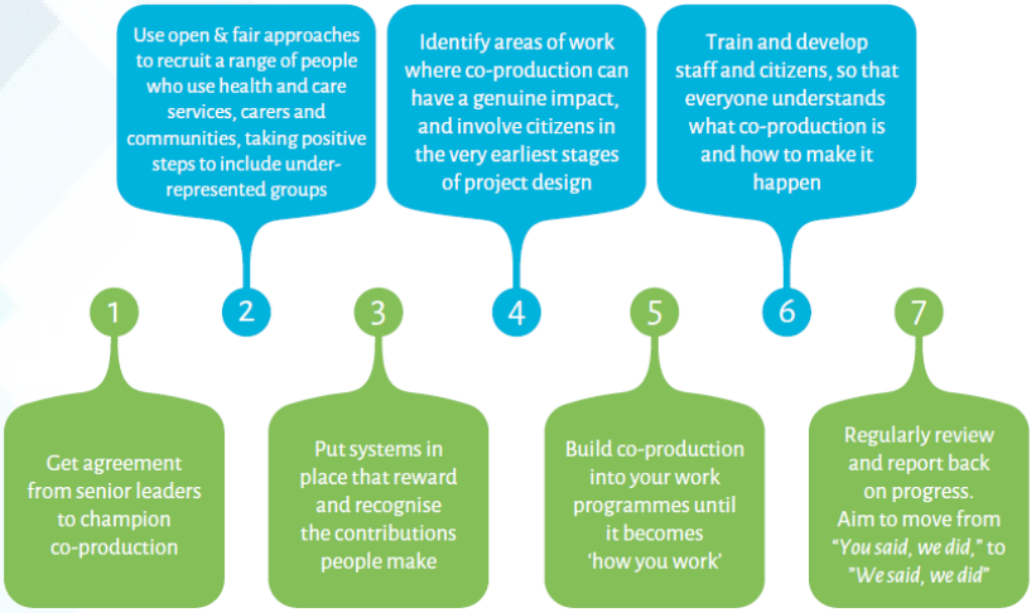
Values and behaviours

For co-production to become part of the way we work, we will create a culture where the following values and behaviours are the norm:

- Ownership, understanding and support of co-production by all
- A culture of openness and honesty
- A commitment to sharing power and decision making with patients, families and community
- Clear communication in plain English
- A culture in which people are valued and respected

How to do it?

Seven practical steps to make co-production happen in reality:



QI methodology (how we do QI)

The Princess Alexandra Hospital NHS Trust

Quality First Team

One of the signs of quality improvement being embedded across an organisation is the 'presence of a central team that leads the provider's quality improvement approach' (Care Quality Commission). PAHT's central team is the Quality First Team, which is led by a senior doctor, nurse and manager. The team work alongside our staff, patients and wider partners in health and social care.

This multidisciplinary team's key functions are:

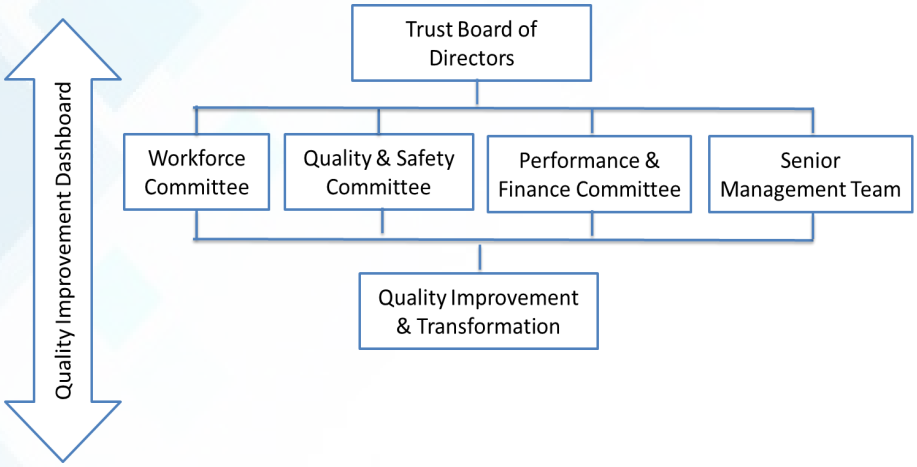
- to centrally coordinate the delivery of quality improvement initiatives that deliver greater efficiency and productivity as well as reducing unwarranted variation.
- to support the delivery and realisation of our long term plan (Your future, our hospital (five P's), Clinical Strategy and QI Strategy).
- to lead quality improvement and organisational development to prepare the Trust for our future health and social care campus.
- to support the strategic realisation of the clinical strategy.

QI methodology (how we do QI)

The Princess Alexandra Hospital NHS Trust

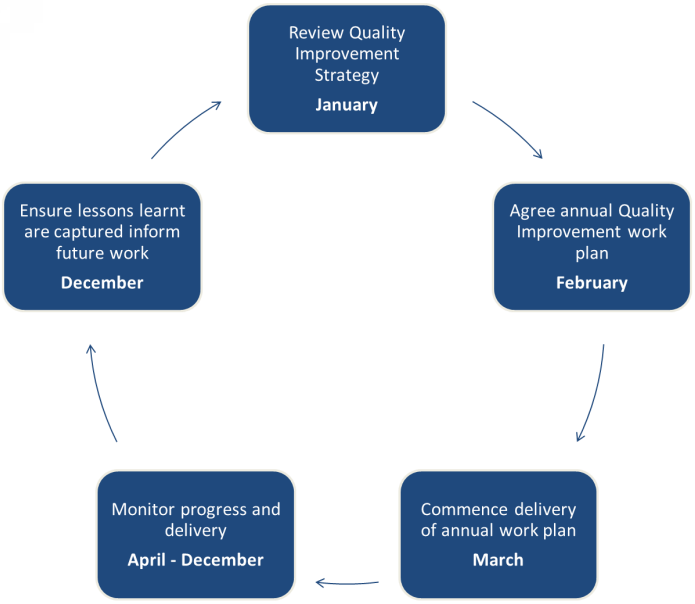
Governance and reporting

There will be a high focus on 'mortality improvement' and 'service transformation', although there will continue to be many other projects supported by the quality improvement team in line with our philosophy of embedding a quality improvement ethos from ward to board. The reporting structure outlines how areas of focus will feed to and from the Board of Directors.



The process for ratification of the QI Strategy has included a discussion at the Senior Management Team, followed by the Quality & Safety Committee before final approval at Trust Board.

Annual Quality Improvement Strategy review cycle



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Appendix

The Princess Alexandra Hospital NHS Trust

Appendix 1 : *Enablers explained in more detail*

Five key 'enablers' (**technology, safe care and reducing harm, Improvement Partnership, pathway and model of care re-design and collaboration**) have identified to help focus quality improvement activity to achieve continuous improvement across our five Ps (patients, people, performance, places and pounds). Throughout the lifetime of this strategy (2019-2022) progress and performance will be tracked across the five Ps via the Trust's Integrated Performance Report that is reviewed in the Trust's three committee meetings as well as the Board of Directors meetings on a monthly basis. This creates a feedback loop for our quality improvement efforts allowing us to live a learning culture throughout the lifetime of our quality improvement strategy.

Technology

Technology can be a great tool to support efforts to reduce unwarranted variation in care; however unless a quality improvement approach is taken during implementation then benefits will often remain unrealised.

Safe care and reducing harm

Our patients have a right to be safe and not experience harm in our care, which is why it will be at the forefront of our minds when making quality improvements at PAHT.

Improvement Partnership

The Improvement Partnership (page 8) as an enabler addresses the leadership, culture and organisational development required to embed quality improvement at PAHT. In partnership with internal teams such as Research, Library and Information Team staff are supported in their innovation and research efforts further strengthening the delivery of quality improvement.

Pathway and model of care redesign

Process mapping is our tool of choice when creating a visual picture of how pathways currently works, capturing the reality of the process, exposing areas of duplication, unwarranted variation and unnecessary steps. By involving a range of people (including the patient) from across the pathway, everyone can agree the actual steps taken through the journey/pathway before agreeing the changes needed to improve and transform pathways and models of care.

Collaboration (partnership working)

Collaboration, as an enabler, will be a part of our quality improvement efforts as we recognise that as an acute hospital we work in a wider health and social care system, which is important in the context of our efforts to move from an Integrated Care Partnership (ICP) to an Integrated Care Alliance (ICA). We also see opportunities to collaborate with regulators, national bodies, education, industry and global partners in finding common values and objectives, which will help us achieve quality improvement in a sustainable and potentially innovative manner.

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Trust Board (Public) - 7 February 2019

6.1

Agenda Item:	6.1
Presented by:	Andy Morris – Chief Medical Officer
Prepared by:	Kamilia El-Farra (Guardian of Safe Working) Victoria Allan – Medical Staffing and Rostering Team Lead
Date prepared:	17.01.19
Subject / Title:	Annual Report on Safe Working Hours for Doctors & Dentists in Training (October 2017 – September 2018)

Purpose:	Approval		Decision		Information	X	Assurance	X

Executive Summary:]	The report's purpose is to provide the Board with a summary of the Guardian's quarterly reports over the previous 12 months. This report will represent the period of 1st October 2017 to 30th September 2018. Moving forward, this will be a quarterly return. This is the second report and it demonstrates improved compliance with the GOSW process, speedier resolution of concerns, few concerns in total and no cases of fines being required. There are improved satisfaction reports from the Junior Doctors Committee and the LNC. There have been no episodes of patient or staff harm.
Recommendation:	For noting 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

Previously considered by:	n/a
Risk / links with the BAF:	BAF Risk 1.1
Legislation, regulatory, equality, diversity and dignity implications:	This is a statutory requirement for the new Junior Doctor contract.
Appendices:	Annual Report

The Princess Alexandra Hospital NHS
NHS Trust

1.0 PURPOSE

The annual report's purpose is to provide the Board with a summary of the Guardian's quarterly reports over the previous 12 months. This report will represent the period of 1st October 2017 to 30th September 2018.

The doctors in training receive full and continuing support from the HR and Recruitment team, Medical Education team and Clinical and Educational Supervisors to seek to minimise concerns and maintain safe and effective care.

All trainees would have transitioned on to the new terms & conditions by November 2017.

Number of doctors / dentists in training (total):	162
Number of doctors / dentists in training on 2016 TCS (total):	162
Annual vacancy rate among this staff group:	10.41%

Any immediate safety concerns (ISCs) that have been raised on exception reports have been addressed by the guardian of safe working.

None of the ISCs raised were related to any harm caused to a patient or staff member.

The guardian of safe working attends the junior doctors' forum, held monthly, to listen to any concerns raised by the junior doctors and feedback and escalate where appropriate.

2.0 CONTEXT

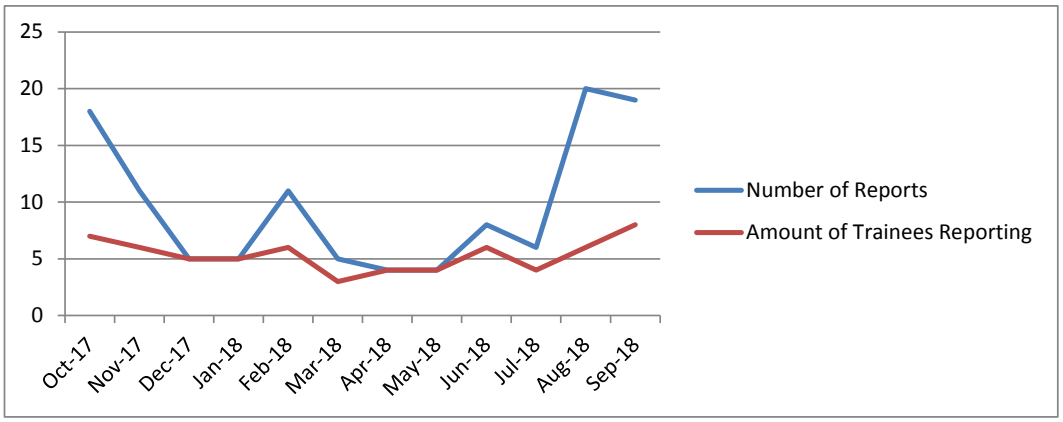
Doctors in training are expected to electronically submit exception reports if they work beyond their contracted hours, miss breaks, have insufficient support or are unable to attend educational opportunities.

These reports should be submitted soon after the event so that prompt steps can be taken to prevent recurrence. The reports should be handled by clinical supervisors.

We are pleased to see the reporting system in use throughout the year with 116 reports received with 147 separate episodes. The majority of our exceptions have come from junior trainees, but we have seen that some higher grade ST doctors have embraced the system since they transitioned.

Overall, ~24% of current trainees have submitted a report. Speaking to the junior doctors in the junior doctors' forum it would appear that overworking is likely more common than this, but some trainees are reluctant to report their extra hours. The trainees are regularly encouraged to raise exception reports and advised that we have no clear way of addressing their problems until we know what they are.

Whilst we have seen the number of exception reports vary month on month over the last year, the amount of junior doctors raising these individual reports on a monthly basis has remained quite consistent.



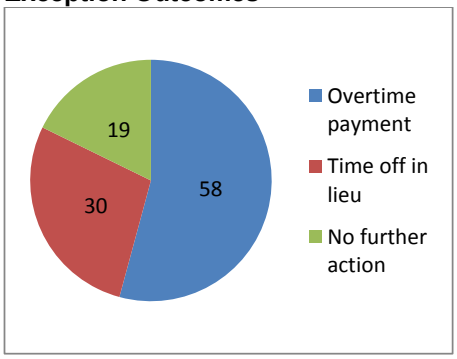
Over the year, the average time taken to close an exception report is 22 days, but this has improved in the last quarter with exceptions only taking an average of 11 days to close in the period July to September.

Since August, we have implemented a new process that means exception reports that are relating to hours that go >30 days overdue are now closed by the GOSW administrator and the doctor is paid for their time via Payroll.

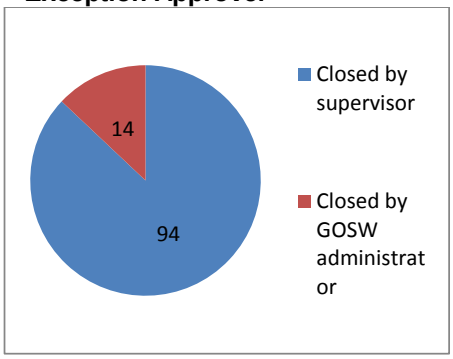
3.0 ANALYSIS

Of the 107 exceptions that were closed, the majority were paid for their time, although we did see an increase in paid exceptions towards the end of July/beginning of August due to not having the time to give the doctors lieu hours before they rotated out of the Trust.

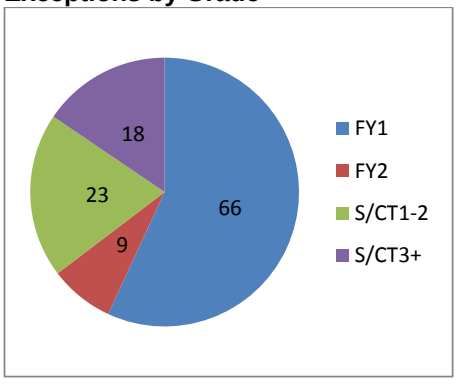
Exception Outcomes



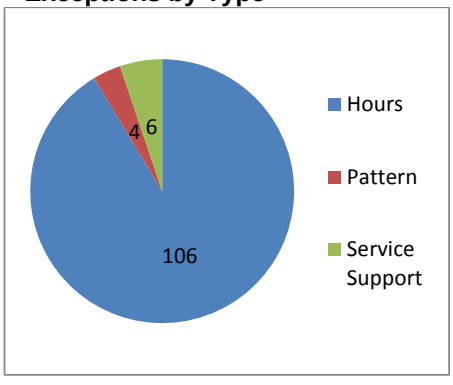
Exception Approver



Exceptions by Grade



Exceptions by Type



Annual Data Summary

Specialty	Grade	Quarter 1 (Oct - Dec)	Quarter 2 (Jan - Mar)	Quarter 3 (Apr - Jun)	Quarter 4 (Jul - Sep)
Obs & Gynae	FY2 - ST2	0	3	4	3
Obs & Gynae	ST3+	4	1	2	0
Medicine	FY1	0	3	3	10
Medicine	FY2 - ST2	0	3	0	11
MAU/ED Split	FY2	1	0	0	0
Cardiology	FY1	7	6	0	7
Cardiology	FY2 - ST2	1	0	0	3
General Surgery	FY1	11	3	6	10
General Surgery	FY2 - ST2	0	1	0	1
General Surgery	ST3+	0	0	1	0
Orthopaedics	ST3+	10	1	0	0
Total		**34**	**21**	**16**	**45**

There have been **no exception reports** from any doctors working in any of the following areas:

Cancer, Cardiology & Clinical Support Services

- Haematology (SHO)
- Histopathology (SHO and Reg)
- Radiology (SHO and Reg)

Family & Womens' Services

- Paediatrics (FY1, SHO and Reg)

Medicine

- A&E (SHO and Reg)

Surgery

- Anaesthetics (SHO and Reg)
- ENT (SHO)
- Ophthalmology (SHO)
- Oral Surgery (SHO)
- Trauma & Orthopaedics (FY1 and SHO)
- Urology

Safety Concerns

Any immediate safety concerns (ISCs) that have been raised on exception reports have been addressed by the guardian of safe working. None of the ISCs raised were related to any harm caused to a patient or staff member.

The guardian of safe working attends the junior doctors' forum, held monthly, to listen to any concerns raised by the junior doctors and feedback and escalate where appropriate.

Work Schedules

Most rotas were redesigned prior to the new contract going live in August 2016 to be brought in line with the new contract rules. We continue to edit/redesign these rotas were appropriate to ensure that they fit the needs of the service, whilst remaining safe for the junior doctors that work them.

NHS Employers recommend that doctors in training should be made aware of their next placement 12 weeks before commencement. They should receive information about their upcoming post (including their work schedules) 8 weeks prior to commencement so that they can request annual leave in advance. Finalised rotas should be made available to them 6 weeks prior to commencement. These guidelines exist to address uncertainties that contribute to low morale and stress in the trainee workforce.

Most trainees that arrived in the Trust in the last year received their work schedules and rotas on time. Those that were sent late were due to incorrect information from the Deanery (email addresses etc.) or late notice of trainee names.

The work schedules seem to be well understood by the trainees, however we are unsure if they are being used to their full capacity with regards to documenting and meeting each individuals training needs etc.

Author: Miss Victoria Allan
Date: 15th October 2018

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 7 February 2019

Agenda Item:	7.1
Presented by:	Jim McLeish – Director of Quality Improvement
Prepared by:	Executive Team
Date prepared:	22nd January 2019
Subject / Title:	**Application for Wave 4 Capital Funds**

Purpose:	Approval		Decision		Information	x	Assurance	x

Executive Summary:	Following the Trust's successful bid for capital funding support from Sustainability and Transformation Plans (£9.5m), the Trust has returned the required information request form as attached. The initial application was submitted as part of the wave 4 process. The bid detailed the Trust's need to build additional capacity to support our emergency pathway and further enhance our assessment facilities.
Recommendation:	The Board is asked to note the information submission in line with national guidelines.

Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	x	x	x	x	x

Previously considered by:	Executive Management Team PAF 28.01.19
Risk / links with the BAF:	Section 2 of the Health and Social Care Act Regulation 1 sets fundamental standards for the provision of services by Trusts. These require that the provision of premises and equipment must be safe, clean, and secure. Section 15(1)2 of the Regulations require that users of premises are protected against the risks associated with unsafe or unsuitable premises by means of adequate maintenance and proper operation of the premises. The outcome expected is that people are in safe, accessible surroundings that are being adequately maintained and that comply with any legal requirements relating to the premises.

7.1

Legislation, regulatory, equality, diversity and dignity implications:	• Health & Safety Legislation • Fire Safety Legislation • NHS Estate code (HBN 00-08) – Strategic Framework for the Efficient Management of Healthcare Estates and Facilities. • Regulations 12 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • Health Technical Memorandum (HTM 00) • Sustainability Regulatory Frameworks • PAS 5748 (2014): Specification for the planning, measurement and review of cleanliness services in hospitals.
Appendices:	NHSI STP Wave 4 Information Request

NHS Improvement

Appendix 1 Information request

Please return by 31 January 2019 to NHSI.CapitalCashQueries@nhs.net

Information Request		Response
Public Consultation		
1	Is public consultation required for this scheme?	No
2	If yes (a) If consultation has already taken place, please provide the dates and outcome (b) has this been agreed with commissioners and the local authority? (c) Please provide the date of the anticipated public consultation	
3	Expected FBC Trust Board approval	April 2019
4	Expected FBC submission to NHS Improvement	April 2019
Expected capital expenditure profile		
5	Please provide an updated capital expenditure profile for the scheme	

	£'000
2018/19	
2019/20	7,500
2020/21	2,000
2021/22	
2022/23	
Total	9,500

Ministerial Milestones (estimated dates)		
6	Construction start date	September 2019
7	Half-way construction date	January 2020
8	Site opening date	July 2020
STP Estates Strategy		
9	Please confirm that the STP estates strategy and disposal plan for surplus land is up to date.	Yes

7.1

Trust Board – 7 February 2019

Agenda Item:	8.1
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Information Team/Executive Directors
Date prepared:	7th February 2019
Subject / Title:	Integrated Quality and Performance Report (December)

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:** The quality & safety markers remain stable despite increasing activity and organisational pressure. **Performance:** All planned care standards – Diagnostic, Cancer and RTT – have been delivered and performance remains strong. Increase in ED attendances continues **People:** Nursing vacancy rate remains the most challenged area. Flu compliance has improved. Appraisal and Statutory Mandatory Training plans are in place to meet agreed trajectories **Pounds**: In month deficit (excluding PSF) is on plan. YTD deficit £22.5m, £0.1m ahead of plan **Places**: The new ward opened was handed over on 20th December. Ward opened with patients on the 2nd January. Significant progress has been made on the annual capital backlog programme.
Recommendation:	The Board is asked to discuss the report and note the current position and further action being taken in areas below agreed standards.

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

Previously considered by:	Executive Management Team Senior Management Team
Risk / links with the BAF:	The IPR links to all BAF Risks.
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	IPR

The Princess Alexandra Hospital NHS Trust

Integrated Quality & Performance Report

December 2018

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

Your future | Our hospital

Contact:

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

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Trust Objectives

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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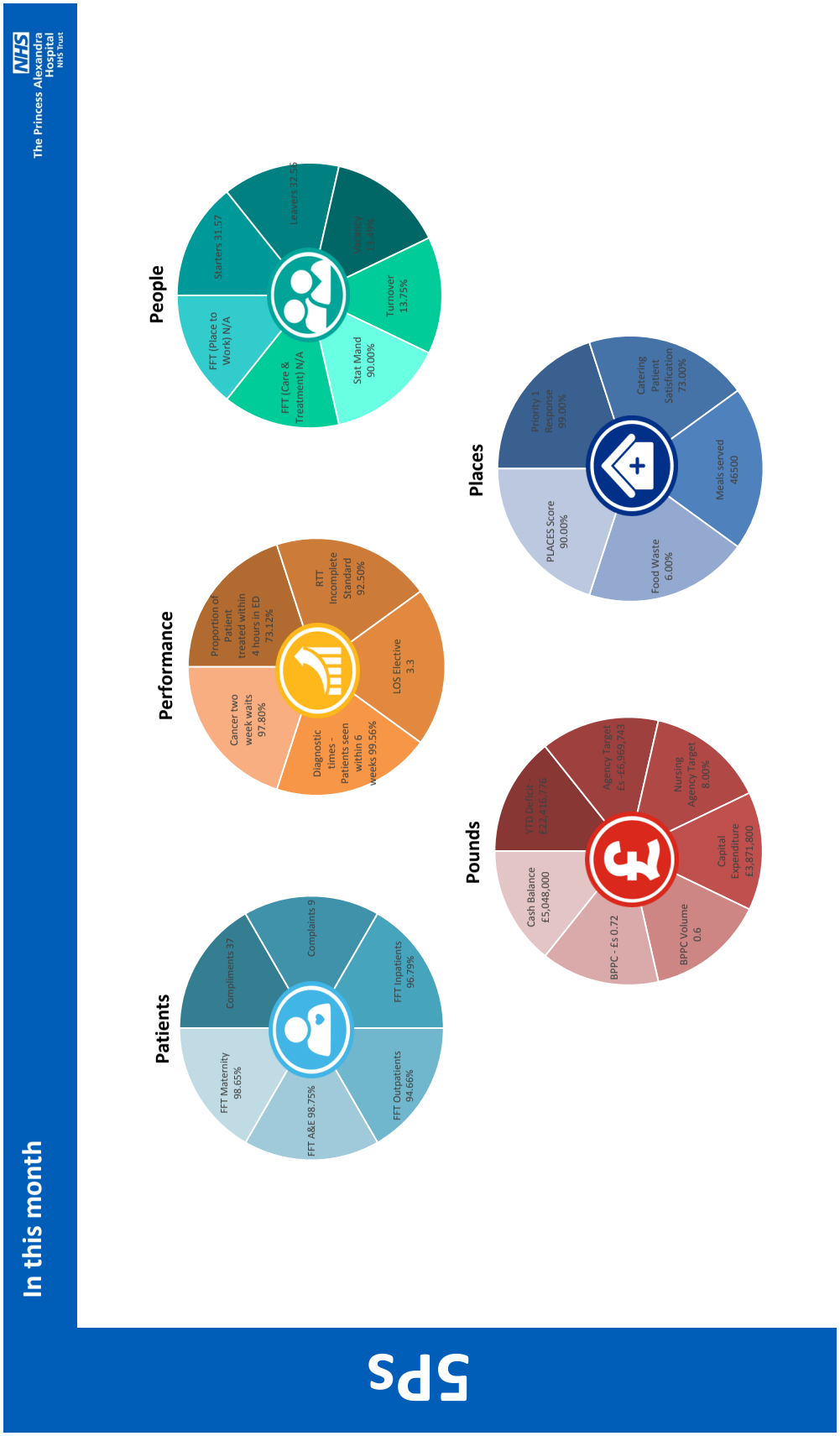
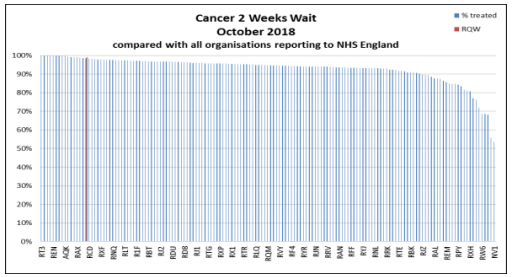
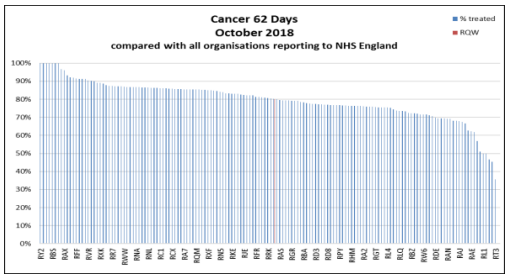

5Ps
In this month
The Princess Alexandra Hospital NHS Trust
People
Starters 31.57
Leavers 32.15
Vacancy 14.24%
Turnover 13.75%
Stat Mand 90.00%
FFT (Care & Treatment) N/A
FFT (Place to Work) N/A
Performance
RTT Incomplete Standard 92.50%
LOS Elective 3.3
Diagnostic times - Patients seen within 6 weeks 99.56%
Cancer two week waits 97.80%
Proportion of Patient treated within 4 hours in ED 73.12%
Places
Catering Patient Satisfaction 73.00%
Meals served 46500
Food Waste 6.00%
PLACES Score 90.00%
Priority 1 Response 99.00%
Pounds
Nursing Agency Target 8.00%
Capital Expenditure £3,871,800
BPPC Volume 0.6
BPPC - £s 0.72
Cash Balance £5,048,000
YTD Deficit - £22,416,776
Agency Target £s -£6,969,743
Patients
FFT Inpatients 96.79%
FFT Outpatients 94.66%
FFT A&E 98.75%
FFT Maternity 98.65%
Compliments 37
Complaints 9

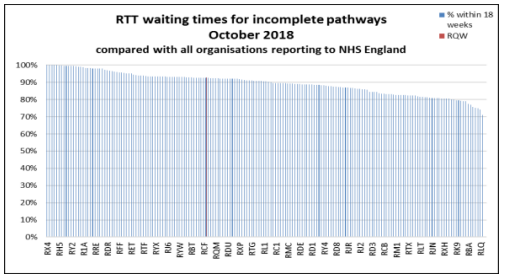
8.1

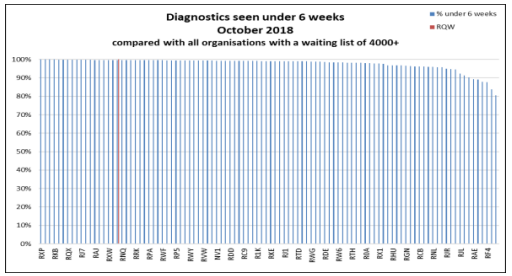
National Benchmarking
Compared with all organisations reporting to NHS England

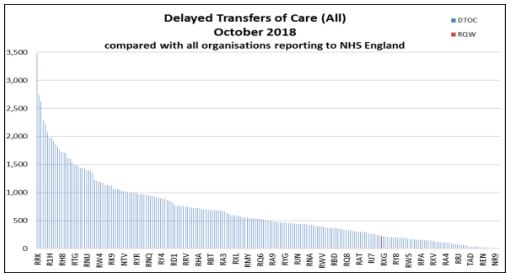
NHS
The Princess Alexandra Hospital
NHS Trust

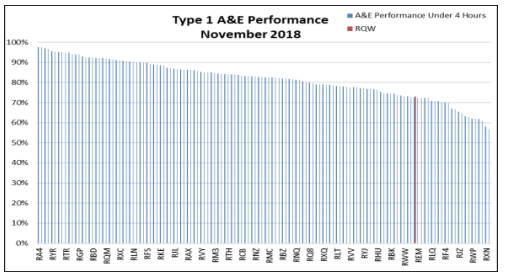


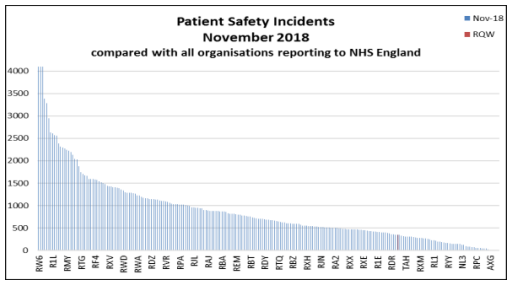


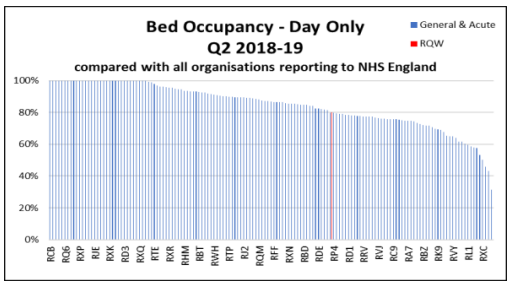


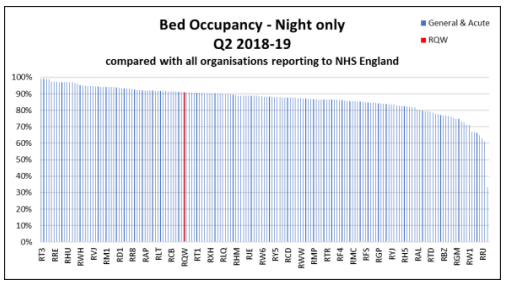












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Data Source: NHS England Statistics/Public Health England/Dr Foster

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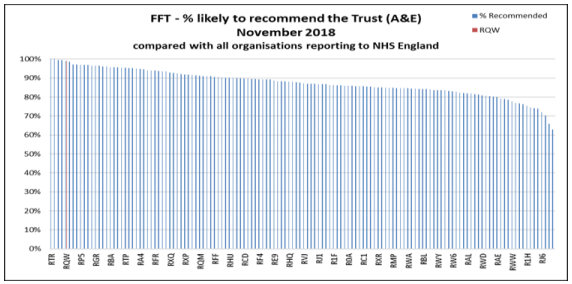
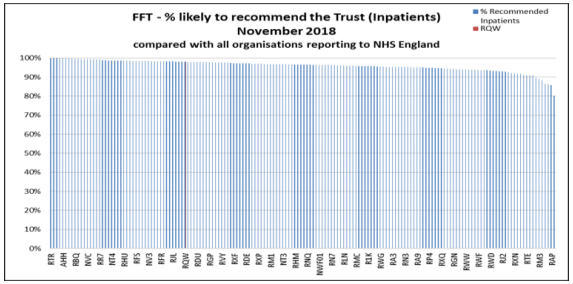
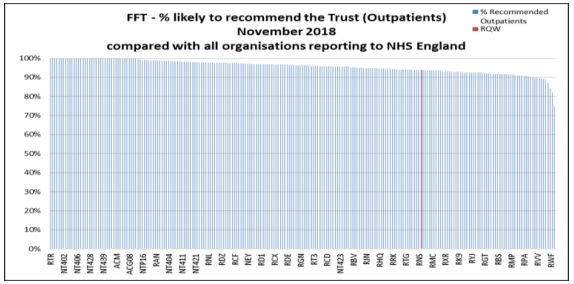
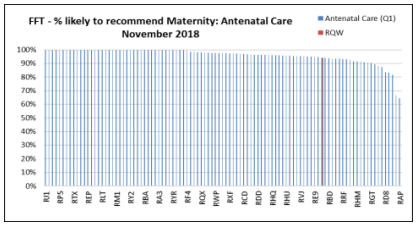
National Benchmarking
Compared with all organisations reporting to NHS England

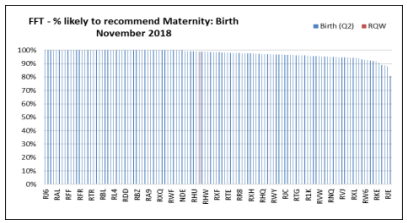
NHS
The Princess Alexandra Hospital
NHS Trust

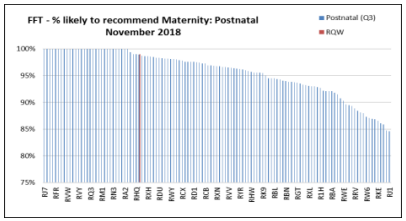


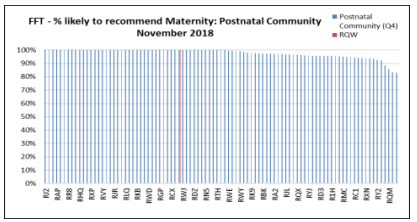


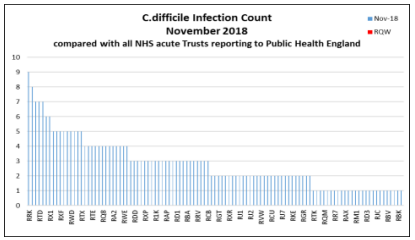


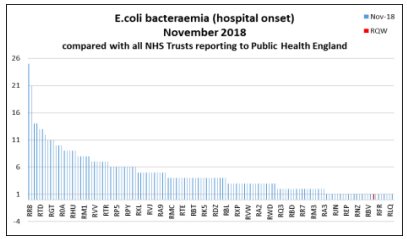


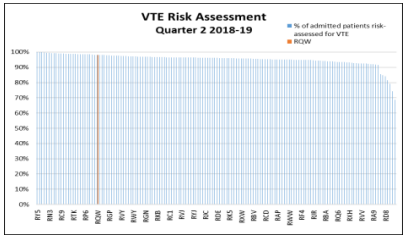


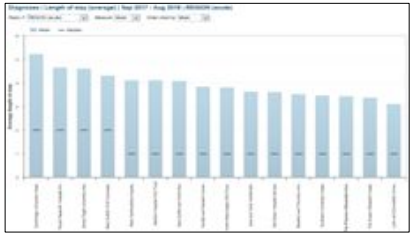












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Data Source: NHS England Statistics

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Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

The quality and safety markers remain broadly stable this month despite the increasing activity and organisation pressure.

Friends and Family Test continues to have a positive position across all domains, and there was a reduction in the amount of complaints received in the month of December.
The patient metrics are now inclusive of the number of patient falls in the organisation, which is considered to be a nurse sensitive indicator. The number of patient falls should be reviewed in context with the deconditioning agenda 'more patients moving more often', and it should be noted that whilst we have high levels of reporting, we have a lower percentage of falls resulting in 'Severe' or 'Moderate' harm when compared to recognised national figures (NHSI).

In relation to the QIP, performance has improved in month, with objectives that were non-compliant for the last few months delivering an improvement and meeting their trajectory. 4 objectives (31%) have not achieved the expected monthly trajectory standard.

Actions in place to further improve performance include:
Monitoring of fridge temperature:
• Results shared with all senior nursing staff to ensure teams focus on making an improvement
• Matrons to reinforce the expected standard at the ward safety huddles

Expiry of liquid medications: This is embedded in practice for 83% of clinical areas who demonstrate they are not using liquid medications beyond their expiry date. 70% of areas are compliant in the application of labels on opened liquid medicine bottles.
The actions to be undertaken are the practice development team have been asked to lead the implementation of an action plan to address this with actions including:
• Share examples of wards demonstrating good practice with those that are non-compliant
• Embed a teaching programme through: Preceptorship, Bands 6 & 7 development, trust induction.
• Discussion will take place at Senior Practitioner forum on 20/12/18 to confirm the standard expected.
• Information has been developed that will be laminated and placed on every medication trolley.
• Matrons and Heads of Nursing are responsible for delivery and improvement across all clinical areas.

Urgent Care Medical Records audit of complete and contemporaneous notes: Mitigating actions are:
• Since October the method of documentation is gradually changing from paper notes to use of Cosmic. The exception is obviously cases where a patient is being admitted and their notes are made up quickly.
• By utilising Cosmic this will ensure compliance with seven of the eight core standards measured.

To improve the Emergency Care team's compliance with patient comfort rounds the team will:
• Discuss at safety huddle
• One additional team member is planned to focus on teaching in the department to ensure good practice is shared and poor practice to be highlighted to individuals concerned.
• The team are confident that the progress made this month will ensure delivery for December.

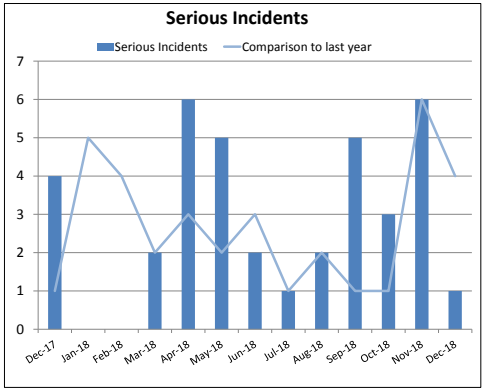
Severe Harm Incidents in December 2018:
2 severe harm incidents reported
• Following review and investigation - one has been downgraded to a no harm incident, the second relates to a patient fall / collapse and is pending the outcome of a comprehensive investigation.

Patient Safety & Experience

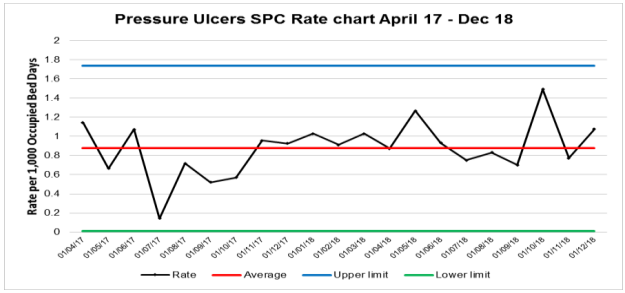
1 Our Patients Summary 1.1

The Princess Alexandra Hospital NHS Trust

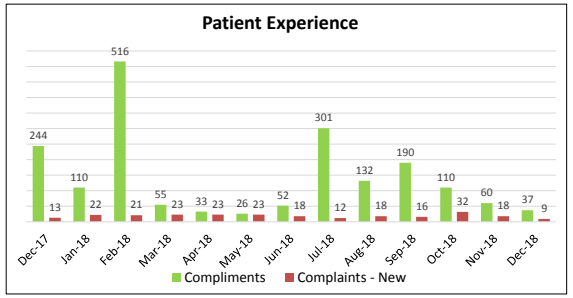
Serious Incidents



Pressure Ulcers SPC Rate chart April 17 - Dec 18



Patient Experience



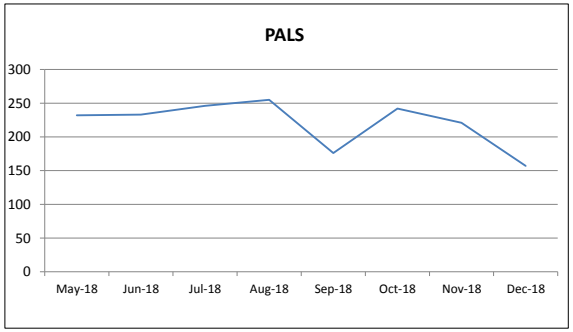
Unstageable pressure ulcers

Nov-18	0
Dec-18	1

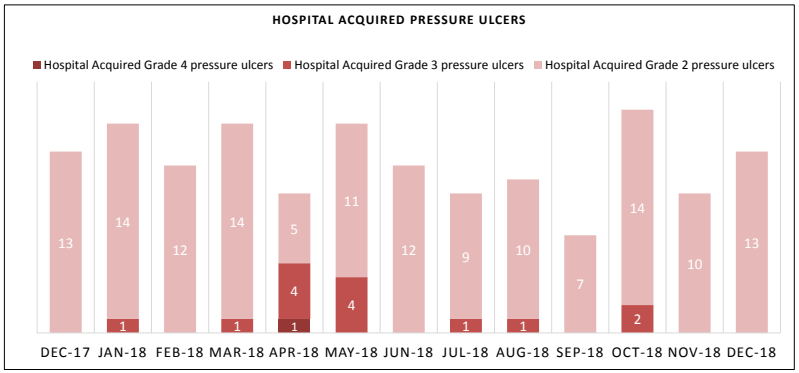
PALS converted to Complaints

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

PALS

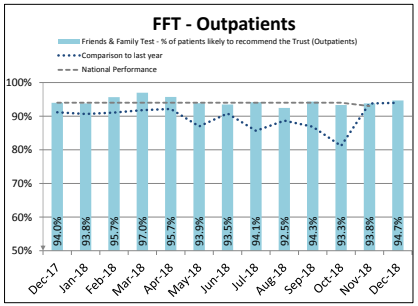


HOSPITAL ACQUIRED PRESSURE ULCERS

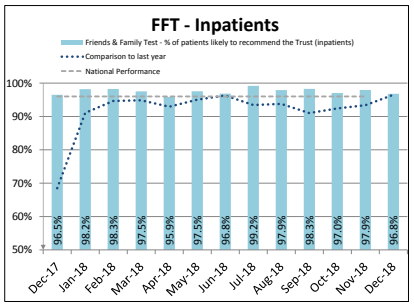


Complaints by Theme	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Complaints - Care & Treatment	32	11	6	0	0	0
Complaints - Staff Attitude & Behaviour	0	0	0	0	0	0

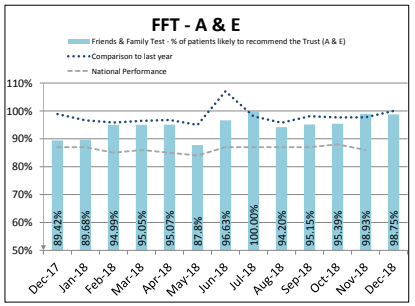
FFT - Outpatients



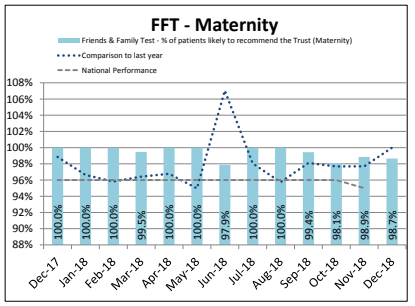
FFT - Inpatients



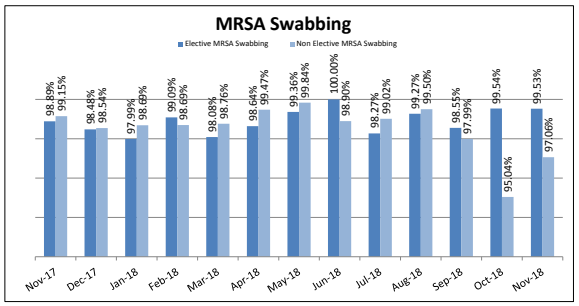
FFT - A & E



FFT - Maternity



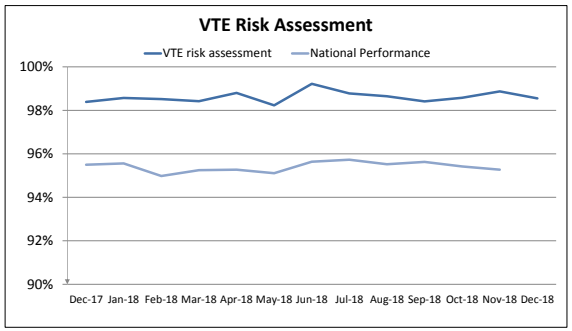
Infection Control, VTE & Mortality

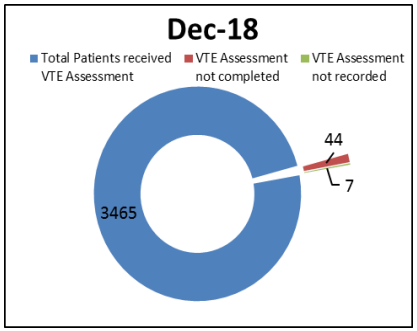


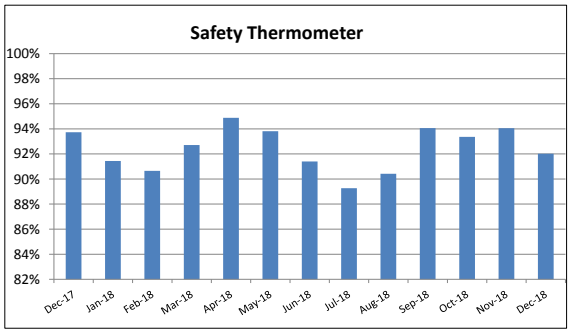
MSSA	
Feb-18	1
Mar-18	0
Apr-18	0
May-18	0
Jun-18	1
Jul-18	1
Aug-18	3
Sep-18	0
Oct-18	0
Nov-18	0
Dec-18	0

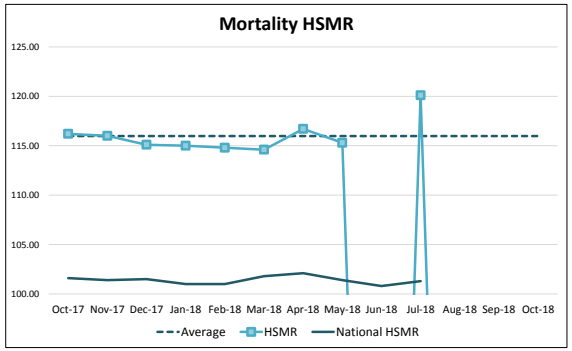
C-Diff (National surveillance database)	
Dec-17	0
Jan-18	2
Feb-18	0
Mar-18	2
Apr-18	2
May-18	2
Jun-18	1
Jul-18	1
Aug-18	1
Sep-18	0
Oct-18	1
Nov-18	0
Dec-18	1

E Coli	
Dec-17	0
Jan-18	0
Feb-18	0
Mar-18	0
Apr-18	3
May-18	0
Jun-18	1
Jul-18	2
Aug-18	1
Sep-18	1
Oct-18	1
Nov-18	1
Dec-18	1





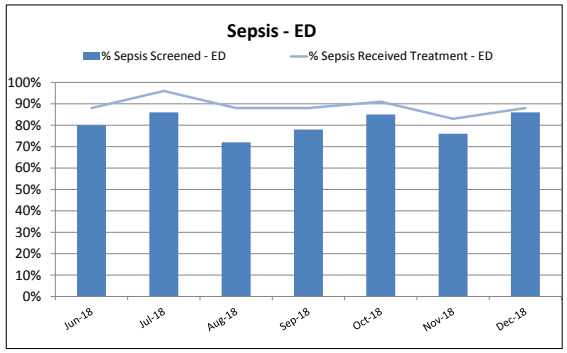


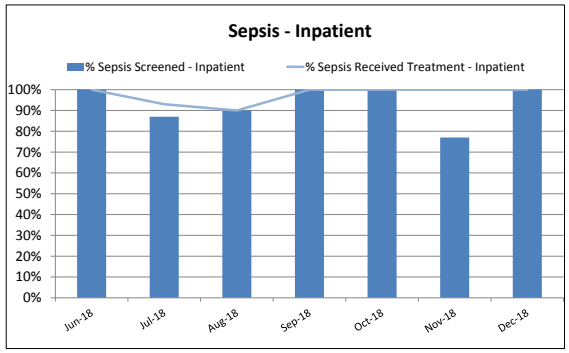


Mortality SHMI	
Oct-17	
Nov-17	
Dec-17	112.1
Jan-18	
Feb-18	
Mar-18	113.7
Apr-18	
May-18	
Jun-18	
Jul-18	
Aug-18	
Sep-18	
Oct-18	

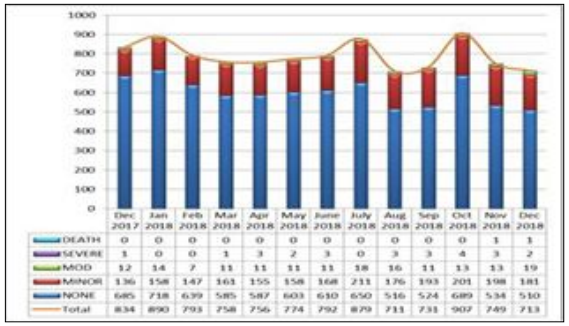
Mortality Outlier Alerts	
Jun-18	5
Jul-18	3
Aug-18	No data
Sep-18	4
Oct-18	4
Nov-18	No data
Dec-18	6

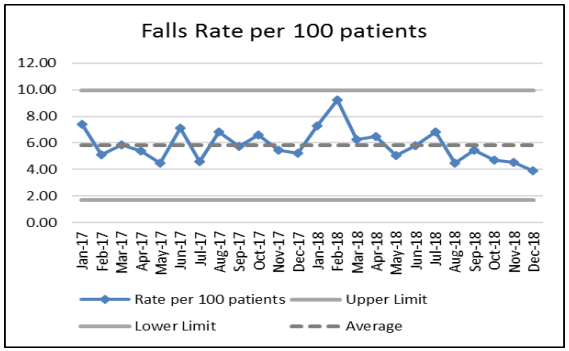
Sepsis, Harm & Deaths

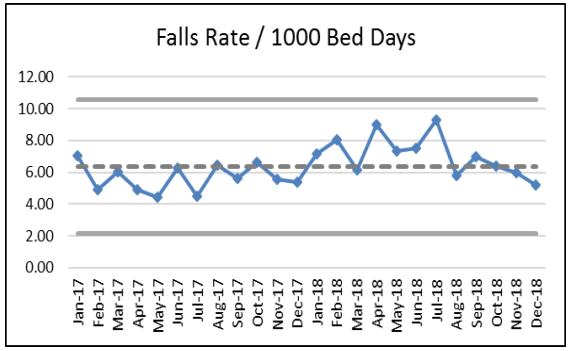




Severity of reported Incidents on Datix (Dec 17 – Dec 18)







Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

Key Performance Indicators (by exception)

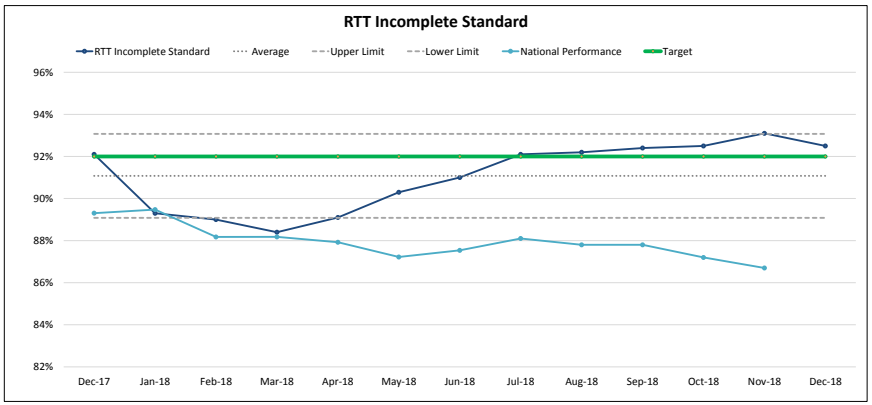
Operational delivery of RTT

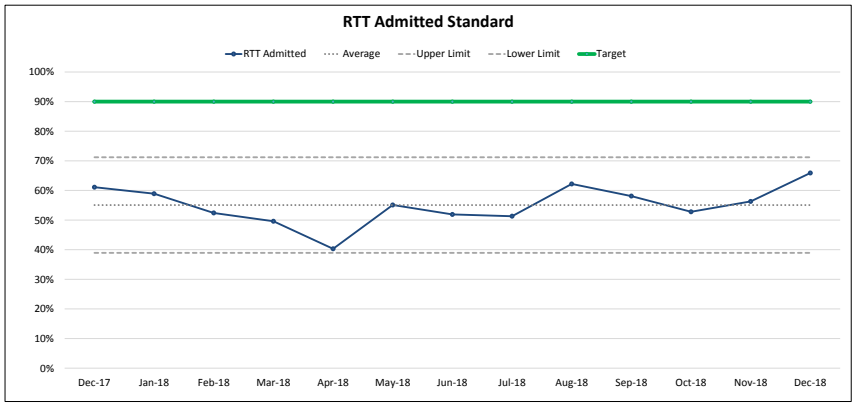
18 Weeks, Diagnostics and Cancer standards all remain strong.

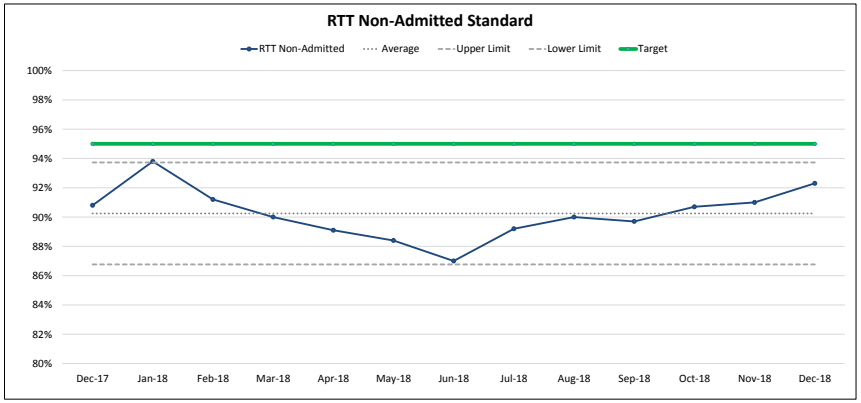
Delivery of the 4 hour Emergency Standard remains challenging. The increase in attendances has continued throughout December with circa 7% increase compared to December 2017. Work to review progress against each of the internal professional standards continues with the support from ECIST. The ECIST report received in December identifies a marked improvement from their previous work in 2017. ECIST have committed to working with the Trust over the next 12 months with dedicated onsite presence every week to support further work across both the emergency and inpatient areas. Through the Trust's Urgent Care Board, progress on each of the internal pathways will be monitored with representation from clinical, operational and support staff in attendance. Paediatric Emergency Care have introduced a GP into the team initially at the weekends and Monday. This will be evaluated with the potential to roll out across the week. The GP Clinical Lead for Urgent Care will commence at the beginning of January 2019. The ambulance service have agreed to support a HALO in the department at least 2-3 days a week with a plan to increase to 7 day coverage from March/April. The Trust saw an increase in the number of ambulance conveyances in December which together with the increase in attendances has contributed to the decline in handover performance, however close working with the ED team and EEAST continues to be very positive. Analysis of data from nerve centre has shown an increase in those patients with a NEWS score of 5 or above at the time of admission has increased by approx 25% from November to December. It is expected that this will show further increases into January.

Following completion of the additional inpatient capacity, the Trust received handover of Charnley Ward on the 20th December 2018. A series of ward moves to ensure optimum clinical adjacencies has been completed. Work on improving patient flow, early discharge rounds and weekend working is well underway with consultant ward rounds on short stay, elderly care and assessment taking place across 6 days. Work to improve Length of Stay, reduce stranded patient numbers and continue to maintain DTOC rates is working well. The focus for January is to continue to work on improvements in the emergency care pathways and to ensure flow in, through and out of the Trust is maxmised.

RTT

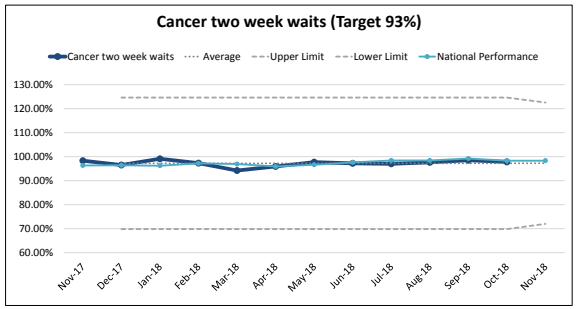

RTT Incomplete Standard
RTT Incomplete Standard
Average
Upper Limit
Lower Limit
National Performance
Target
96%
94%
92%
90%
88%
86%
84%
82%
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18

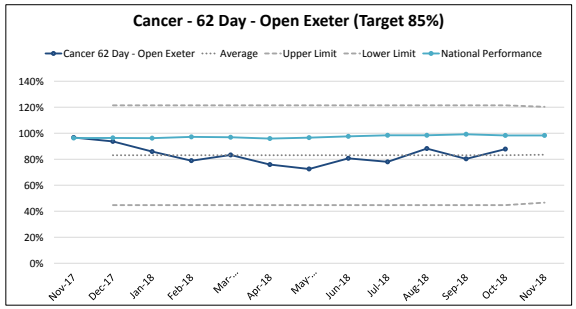

RTT Admitted Standard
RTT Admitted
Average
Upper Limit
Lower Limit
Target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


RTT Non-Admitted Standard
RTT Non-Admitted
Average
Upper Limit
Lower Limit
Target
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18

	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Nov-17	98.50%	96.70%	100.00%	100.00%
Dec-17	100.00%	97.70%	100.00%	100.00%
Jan-18	95.80%	98.90%	100.00%	100.00%
Feb-18	97.70%	98.60%	100.00%	100.00%
Mar-18	97.70%	97.40%	100.00%	100.00%
Apr-18	98.60%	96.80%	100.00%	100.00%
May-18	95.50%	100.00%	100.00%	100.00%
Jun-18	97.70%	100.00%	100.00%	100.00%
Jul-18	98.70%	98.90%	100.00%	N/A
Aug-18	99.40%	95.20%	100.00%	100.00%
Sep-18	99.20%	97.70%	100.00%	100.00%
Oct-18	98.80%	96.70%	100.00%	100.00%
Nov-18	97.30%	96.70%	100.00%	100.00%

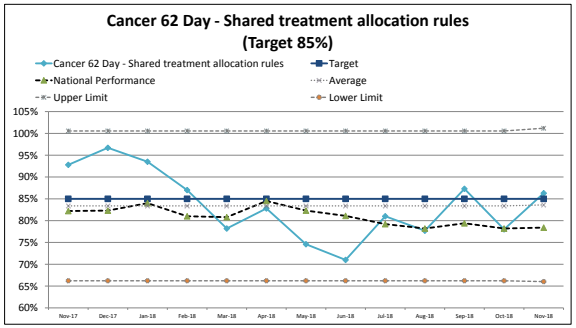
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

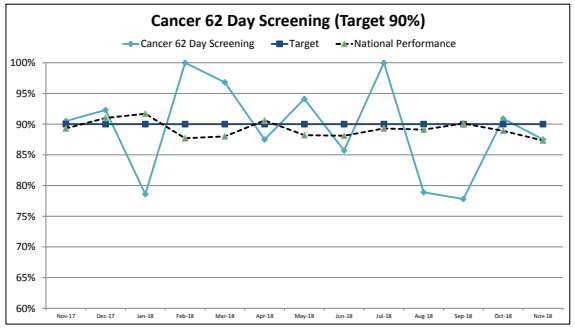


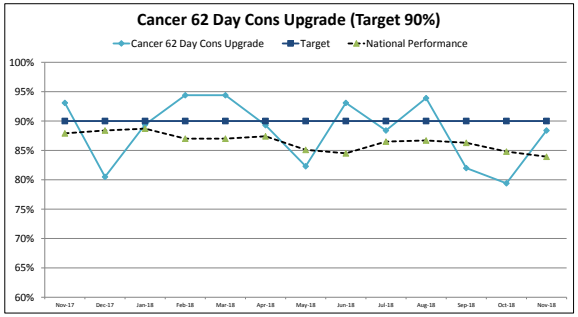


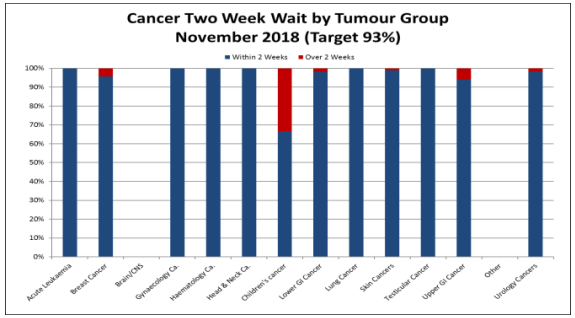
November performance by tumour group

Target Wait Group	14 day target performance %	31d day first seen performance %	62 day standard performance %	62 day Screening performance %	62d CU performance %	31d day subsequent drugs performance %	31d day subsequent surgery performance %
Acute Leukaemia	100.0%						
Breast Cancer	95.7%	94.4%	100.0%	86.7%	100.0%		
Brain/CNS							
Gynaecology Ca.	100.0%	100.0%	100.0%		80.0%		
Haematology Ca.	100.0%	100.0%	66.7%		100.0%		
Head & Neck Ca.	100.0%	100.0%			100.0%		
Children's cancer	66.7%						
Lower GI Cancer	98.1%	91.7%	70.6%	100.0%	100.0%		
Lung Cancer	100.0%	100.0%	100.0%		90.9%		
Skin Cancers	98.9%	100.0%	96.8%		100.0%		
Testicular Cancer	100.0%						
Upper GI Cancer	94.0%	100.0%	100.0%		100.0%		
Other		100.0%			100.0%		
Urology Cancers	98.3%	95.5%	82.5%		62.5%	100.0%	100.0%
Total performance	97.8%	96.7%	87.8%	87.5%	88.4%	100.0%	100.0%
Symptomatic Breast	97.3%						

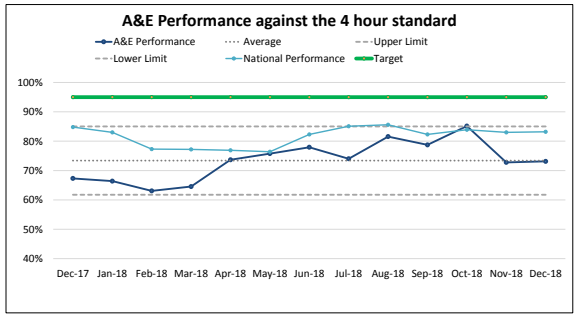


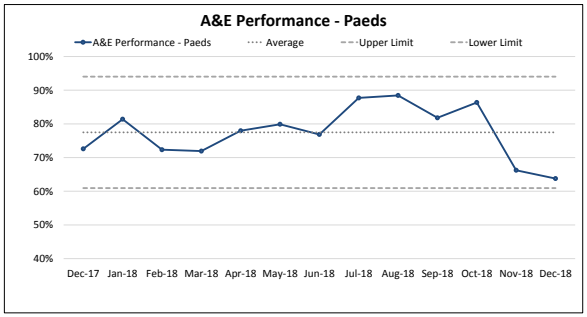


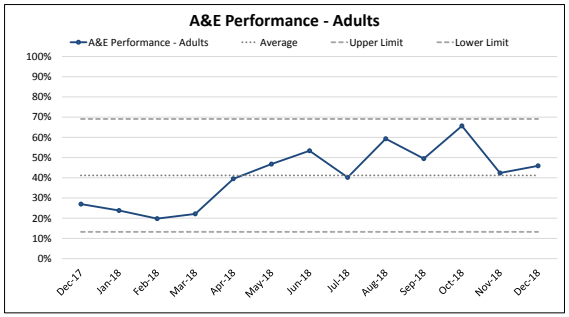


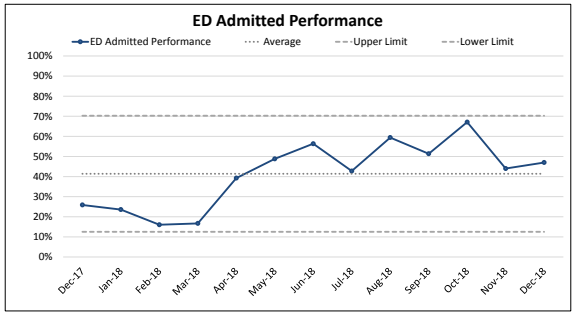


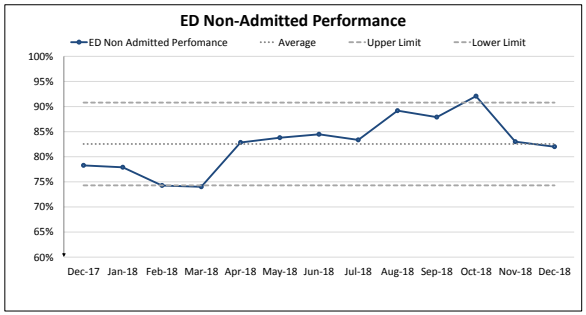
ED

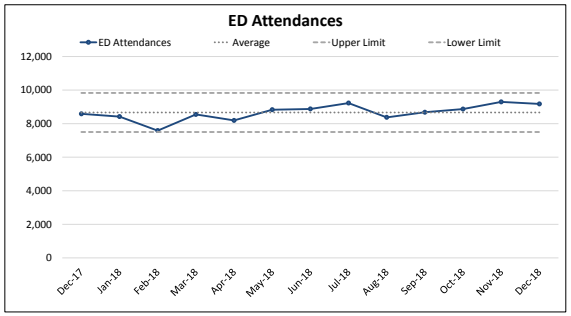






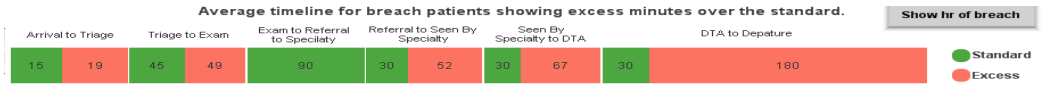


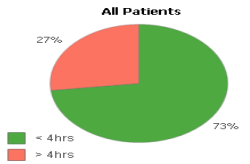




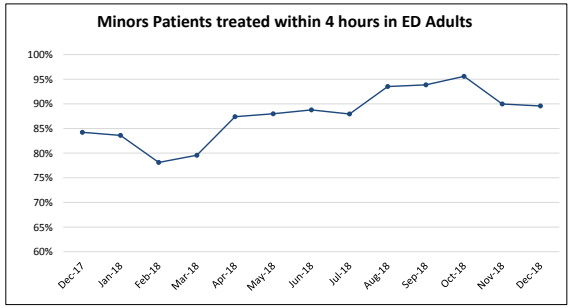
ED Internal Professional Standards

	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Arrival to Triage - Average Wait (Minutes)	33	33	35	37	31	32	32	32	28	31	29	36	34
Triage to Exam - Average Wait (Minutes)	96	103	111	111	100	92	98	98	79	82	74	91	94
Exam to Referral to Specialty - Average Wait (Minutes)	92	97	99	99	87	82	75	79	74	78	72	80	83
Referral to Seen by Specialty - Average Wait (Minutes)	83	89	85	83	79	69	66	74	70	69	68	83	82
Seen by Specialty to DTA - Average Wait (Minutes)	118	123	132	121	105	91	87	91	77	86	77	94	97
DTA to Departure - Average Wait (Minutes)	309	328	391	416	381	219	160	201	119	161	123	223	209

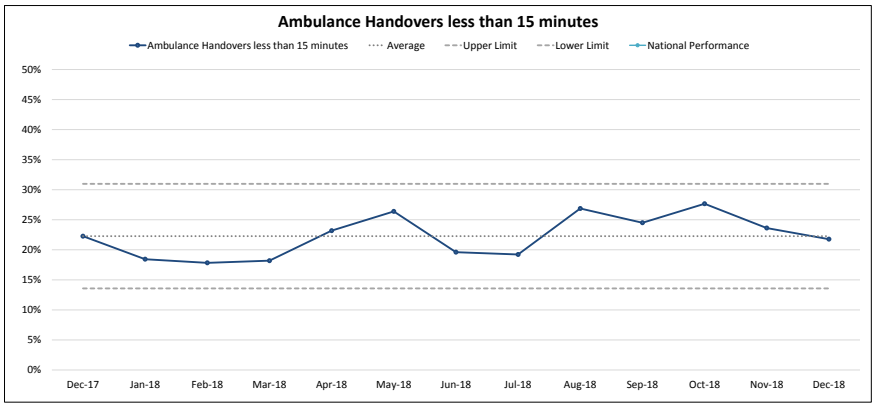


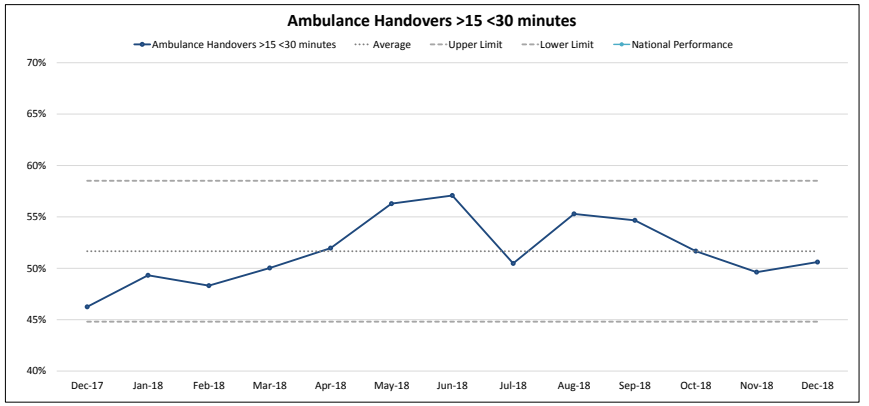


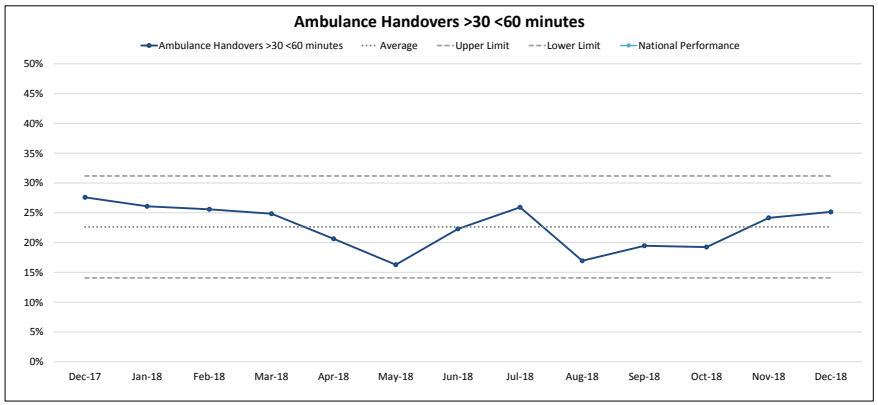
Measure	Standard	Average	Excess	Patients with Timestamp	Patients Who Breached	% Breached	Patients Who Breached Rank
Arrival to Triage	15	34	19	9,041	5,725	63%	
Triage to Exam	45	94	49	8,183	4,548	56%	
Exam to Referral to Specialty	90	83	0	2,771	502	18%	
Referral to Seen by Specialty	30	82	52	2,923	2,094	72%	
Seen by Specialty to DTA	30	97	67	1,659	889	54%	
DTA to Depature	30	210	180	2,351	1,294	55%	



Ambulance


Ambulance Handovers less than 15 minutes
Ambulance Handovers less than 15 minutes
Average
Upper Limit
Lower Limit
National Performance
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
National Performance
70%
65%
60%
55%
50%
45%
40%
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
National Performance
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
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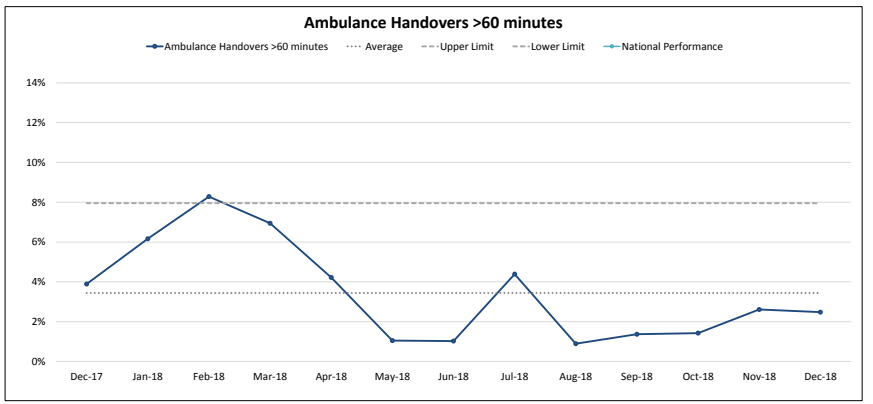
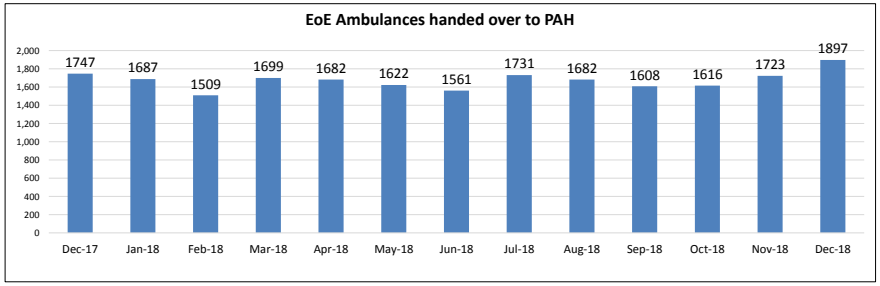
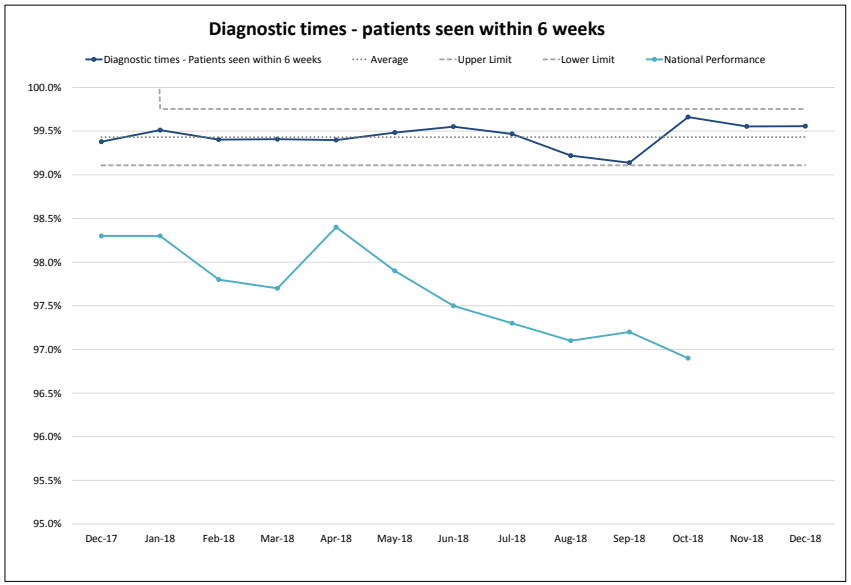
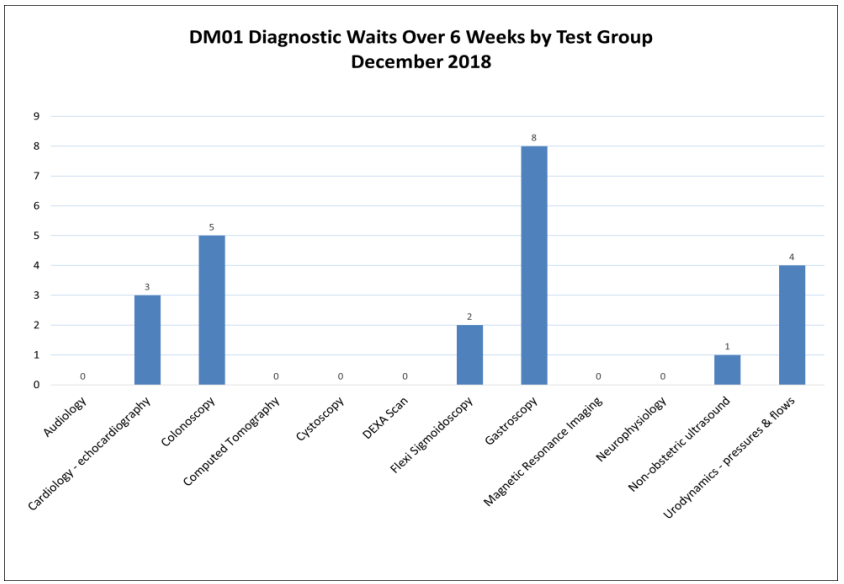
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


Ambulance Handovers >60 minutes
Ambulance Handovers >60 minutes
Average
Upper Limit
Lower Limit
National Performance
14%
12%
10%
8%
6%
4%
2%
0%
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


EoE Ambulances handed over to PAH
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1747
1687
1509
1699
1682
1622
1561
1731
1682
1608
1616
1723
1897
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18

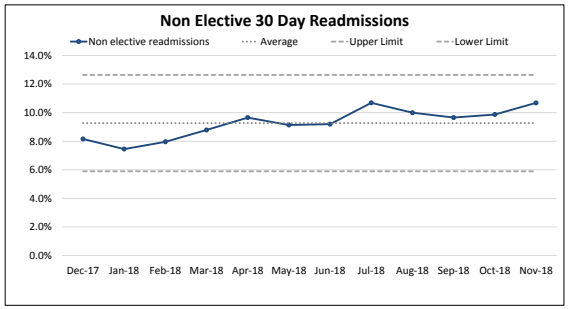
Diagnostics

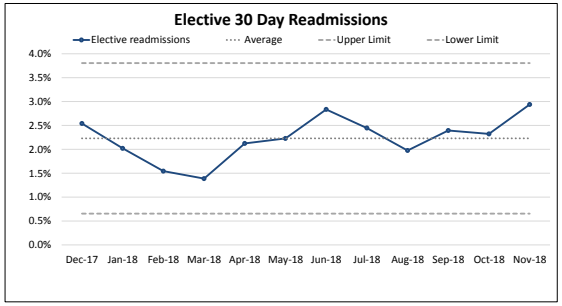


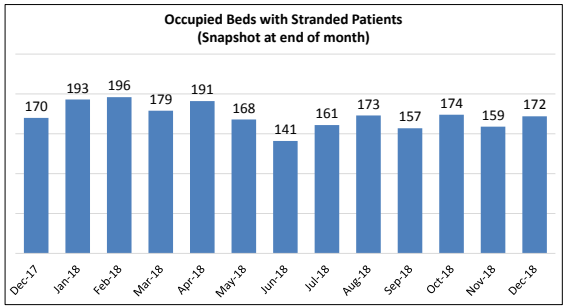


Test	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Magnetic Resonance Imaging (MRI)	99.91%	99.82%	99.72%	100%	100%	100%	100%	100%	100%			
Computed Tomography (CT)	99.37%	99.22%	99.41%	100%	99.84%	99.84%	100%	100%	100%			
Non-Obstetric Ultrasound	99.92%	99.81%	99.96%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

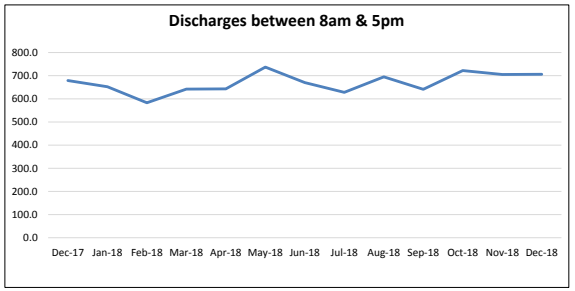
Readmissions & Stranded Patients

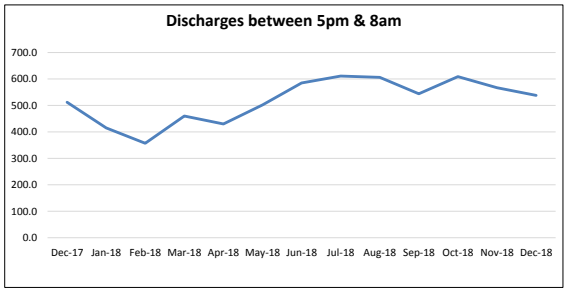


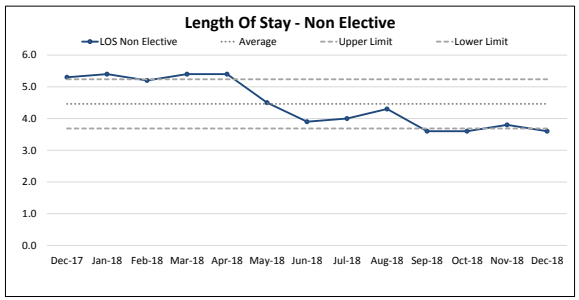


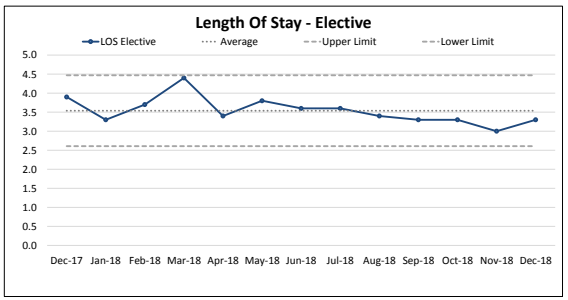


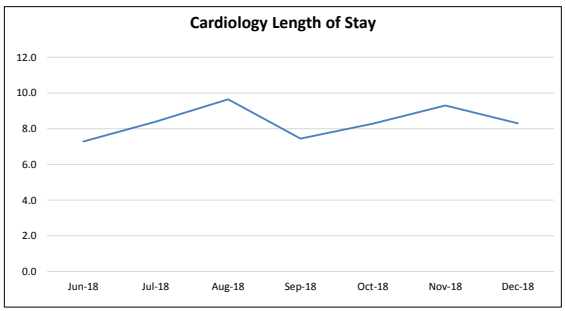
Discharges & LOS

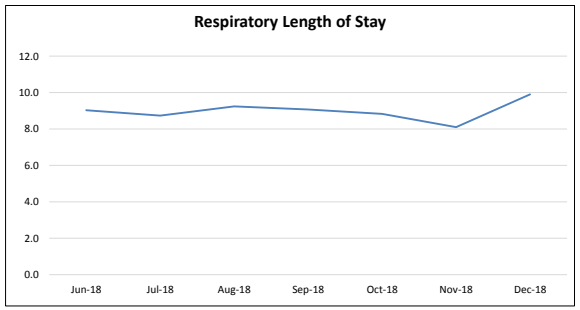


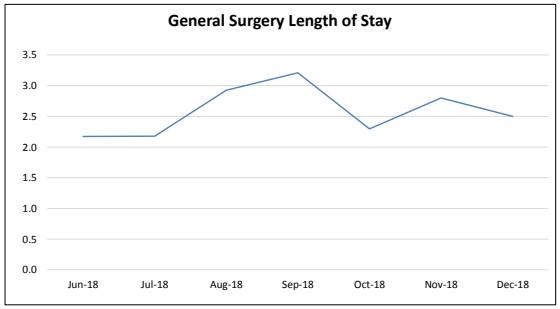




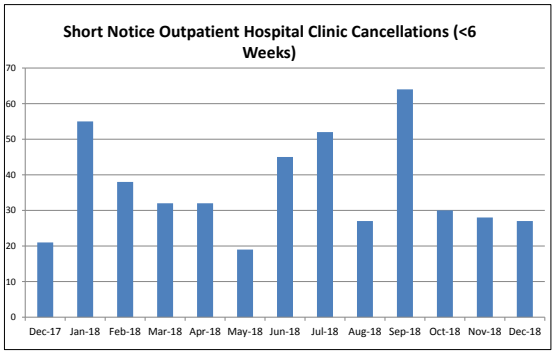


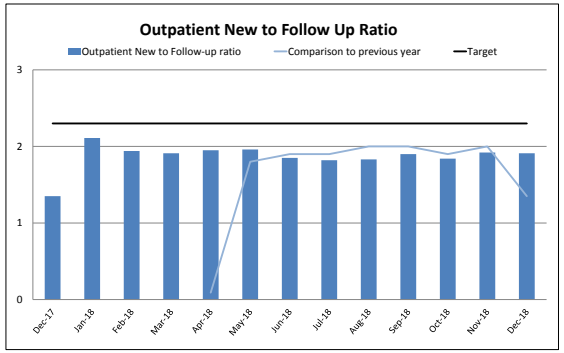


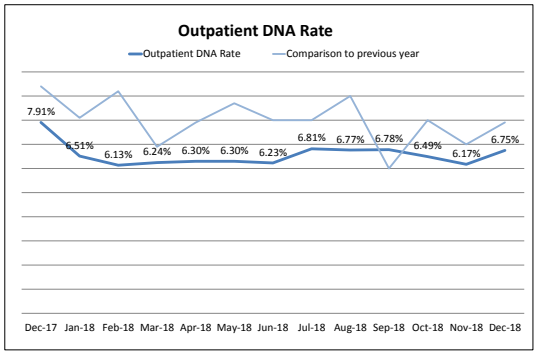


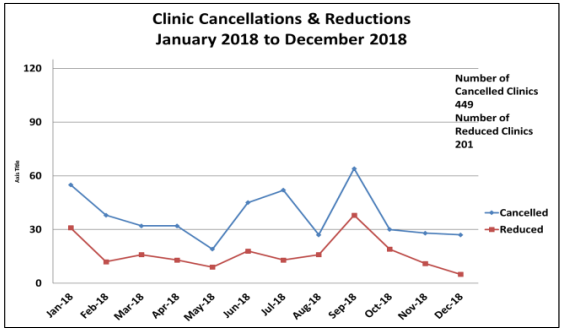


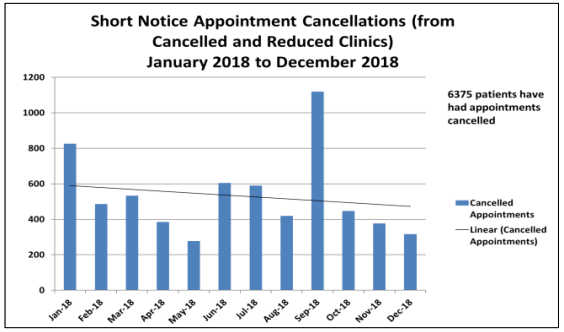
Outpatients & Cancelled Operations

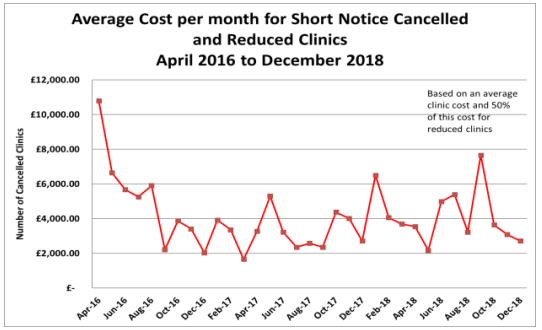












Cancelled Operations	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Cancelled Operations for Non Clinical reasons	30	16	18	41	61	27	7	22	17	21	14	8	29
Cancelled Operations - breach of 28 day standard	0	2	3	5	2	1	0	0	0	1	2	0	0
Urgent operations cancelled (Non Medical)	0	0	0	0	0	2	1	5	0	0	1	0	0
Urgent operations cancelled for a second or more time (Non medical)	0	0	0	0	0	0	0	0	0	0	0	0	0

Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

Key Performance Indicators (Reporting by Exception)

Sickness

There has been a slight increase in sickness for the month of December however as rolling year this equates to 3.84%. Staff are still being encourage to have the Influenza immunisation and currently this is reported at 69% for front line workers. Detailed sickness discussions continue to take with HCG and Divisions to ensure that our people are managed and supported in a proactive way.

Early interventions are being put into place for staff that report stress and anxiety as a reason for absence and are being monitored on a monthly basis.

Detailed analysis is being undertaken in relation to MSK/Back problems with the internal process for early interventions being reviewed by a multi-disciplinary team.

Vacancies

The vacancy rate for nursing staff is the highest rate across all staff groups with 22% for December. This staff group continues to be our most challenging to recruit area, our highest vacancy rates being within Medicine and Surgery.

A number of steps are being taken to address this, we are reviewing the nursing recruitment pipeline to ensure opportunities to recruit are being maximised, we are commissioning additional agencies to add to our existing pipeline and increasing the number of international nursing candidates interviewed weekly via skype. We are also reviewing the reintroduction of “refer a friend” scheme

In addition to this the recruitment team are reviewing our attraction package when advertising and increasing the use of social media.

Corporate vacancy figures, in part are being attributed to review of establishment rather than inability to recruit.

Non-Medical Appraisal

. Compliance has remained at 83%. Over a busy time with many staff taking annual leave, this should not be seen as a negative outcome - remaining static still requires a large number of appraisals to be completed.

Actions taken to address compliance:

- Reminder emails sent to outstanding staff
- Continued targeted compliance emails to leadership teams highlighting areas below trajectory - including new data format
- 1-1 support offered to managers to work through appraisal compliance figures if discrepancies between central and local data are reported
- Continued offer of training including in local departments
- Director of People to meet with managers of low-performing teams

Turnover

We are working with our staff side colleagues to capture true and accurate reasons for why staff choose to leave the organisation with a view to understanding what the Trust can do to support retention.

In November we launched a new exit questionnaire, as we collect intelligence from these we will utilise this to inform our recruitment and retention strategy and where appropriate avoid cases where we lose staff unnecessarily.

As part of the retention strategy, the recruitment team are also identifying the reasons staff enjoy working at PAHT and what benefits appeal to them. In addition to the above we continue to work in partnership with staff council to identify further recruitment and retention initiatives

Workforce Indicators Summary

Agency Spend 5.78%
Bank Spend 12.60%

Staff In Post
3026
WTE

Training
90%

Sickness
4.2%

13.5%

Turnover
14%

Medical 95%
Non-Medical 83%

Scorecard

Workforce Measures as at 31st December 2018	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3497.97	845.8	484.92	872.83	696.27	270.53	122.51	54.16	150.95
Vacancy Rate	8.0%	13.2%	5.3%	11.3%	23.3%	15.5%	8.7%	0.0%	11.5%	17.0%
Agency % of paybill	7.0%	5.8%	2.9%	3.5%	9.1%	8.4%	4.3%	3.0%	0.0%	0.0%
Bank Usage - Cost	n/a	£1,775,795	£100,032	£196,007	£938,334	£410,391	£44,449	£12,997	£10,135	£62,383
Agency Usage -Cost	£858,000	£814,140	£87,373	£69,159	£348,202	£273,101	£27,617	£8,687	£0	£0
Sickness Absence	3.5%	4.2%	3.0%	5.5%	4.3%	3.6%	8.7%	2.4%	1.7%	3.9%
Long Term Sickness	1.75%	2.1%	1.4%	2.7%	2.1%	1.8%	5.1%	0.0%	0.0%	2.3%
Short Term Sickness	1.75%	2.2%	1.7%	2.8%	2.2%	1.8%	3.6%	2.4%	1.7%	1.7%
Turnover (voluntary)	12%	14%	13.5%	14.9%	15.5%	12.8%	7.4%	14.0%	14.6%	19.0%
Stability	90%	88%	90%	89.1%	85.5%	88.9%	84.5%	87.9%	97.7%	89.4%
Statutory & Mandatory Training	90%	90%	95%	87%	87%	86%	94%	96%	99%	97%
Appraisal	90%	83%	87%	75%	83%	76%	89%	97%	68%	75%
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
Staff Survey 2018		36.7%	39.9%	30.9%	26.6%	30.5%	33.3%	78.0%	79.2%	67.7%
Flu Vaccination(Front Line)	75%	68%	58.4%	59.2%	62.0%	60.4%	62.8%	64.4%	81.8%	n/a
Active Job Plans (first sign off)	90%						n/a	n/a	n/a	n/a
Electronic Rosters (Medical staff)	100%	91%	64%	100%	100%	100%	n/a	n/a	n/a	n/a
Exception Reports (junior doctors)	3	6	0	0	4	2	n/a	n/a	n/a	n/a
Time to hire (Advert to formal offer made)	31Days	49	33	28	64	50	n/a	49	n/a	n/a

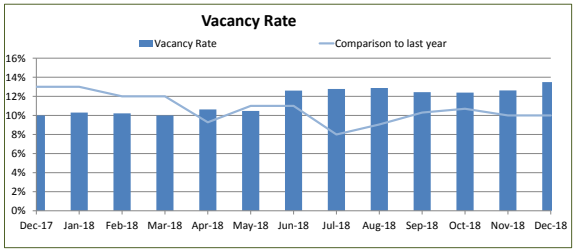
Above target	
Exceeding or below target	
underachieving target	

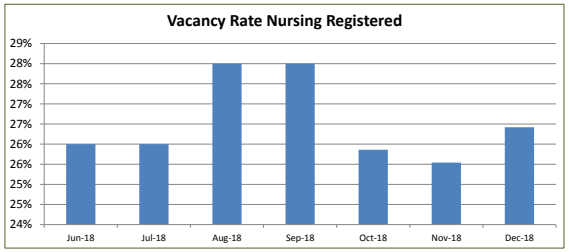
Workforce Indicators

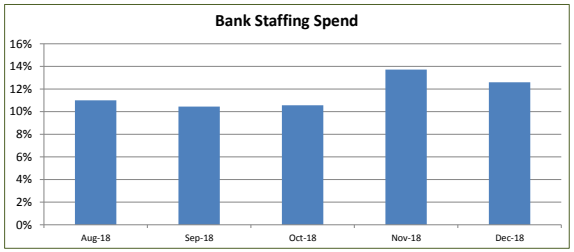
3 Our People Summary

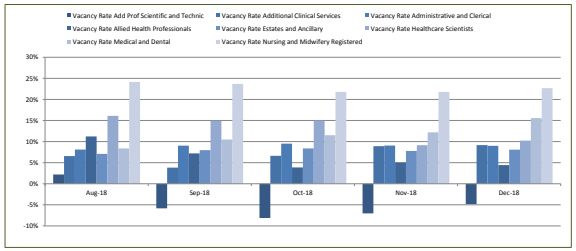
3.3 Well Led

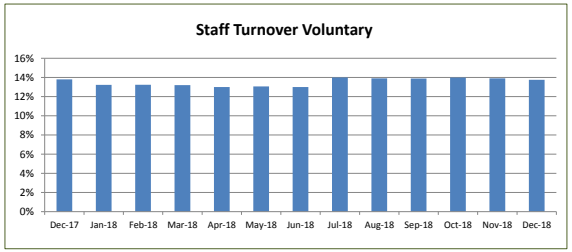
The Princess Alexandra Hospital NHS Trust

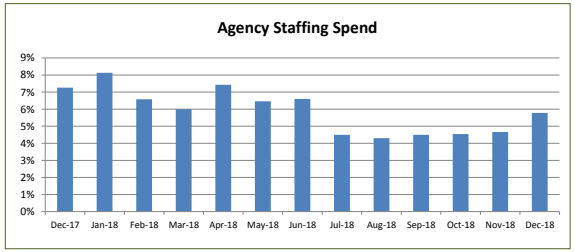


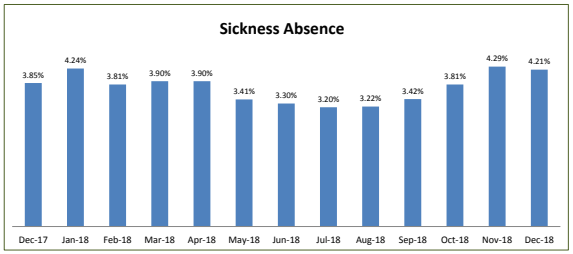


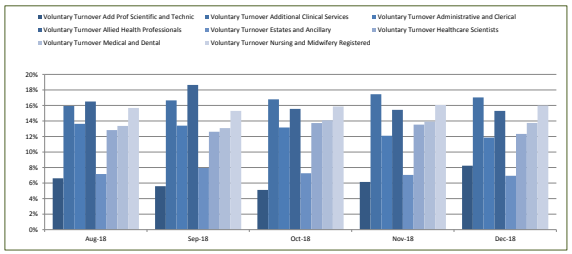


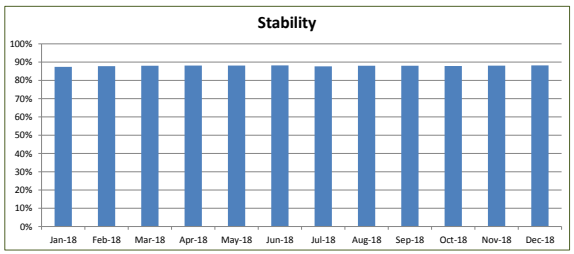


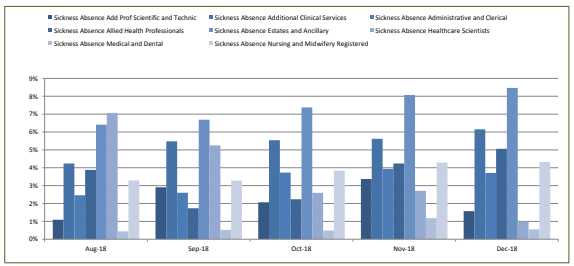


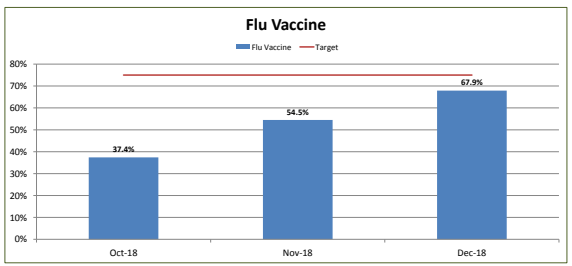




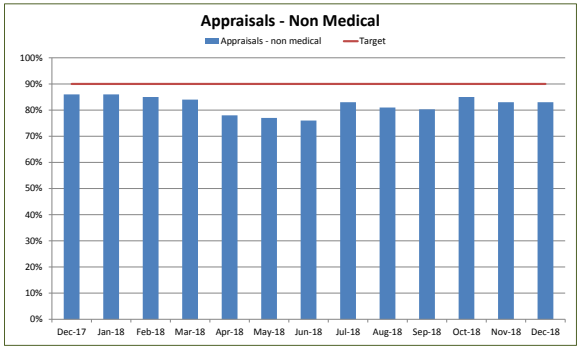


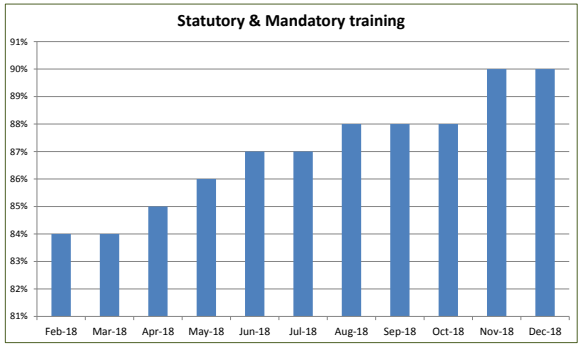


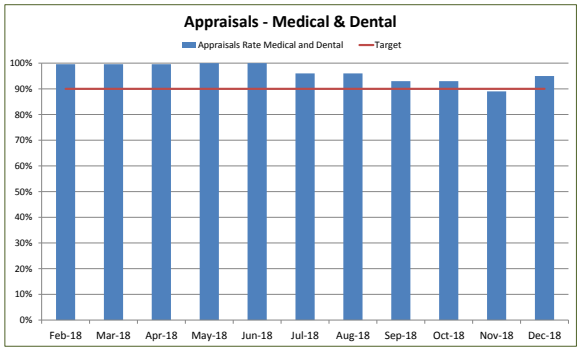


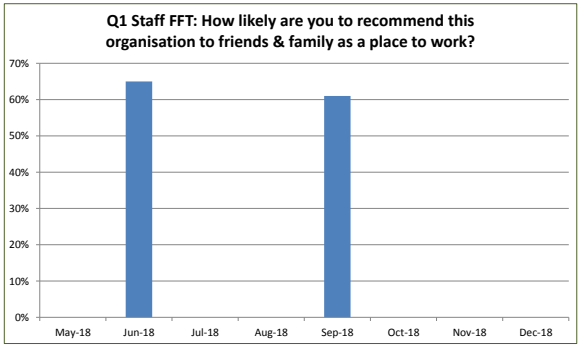


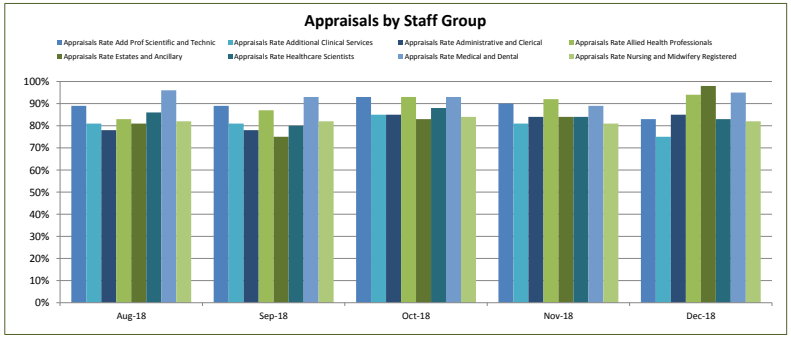
Workforce Indicators

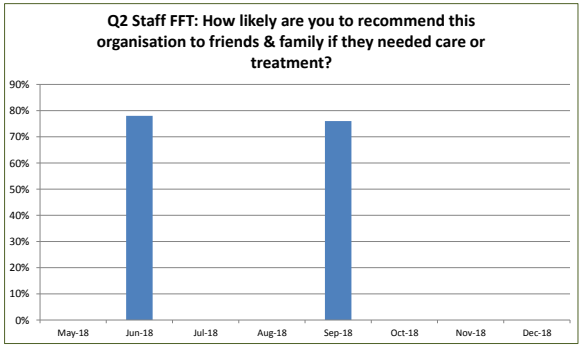












Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

Key Performance Indicators (Reporting by Exception)

Patient satisfaction (Catering Services) has fallen in month, primarily to the comments relating to appetite due to the inconsistency in presentation and the deviation from the menu design. Our catering management team supported by the patient panel have held a workshop to promote the importance of patient food, the actions from this workshop will act as a catalyst for change, and in January 2019 it is expected that the level of satisfaction will improve.

Catering whole plate food waste has dropped to 6%, however, there is a high proportion of food waste from patient meals, which is reported at 30%, an engagement exercise is taking place at ward level to encourage and support patients to eat their meals. This initiative is being led by Ann Nutt (Patient Panel) and Andreas Wingert (Catering Improvement Lead)

Estates and Facilities Team – The team have been able to maintain mandatory training compliance for three consecutive months, in November achieving compliance of 94%. This is reflective of a collaborative approach with our corporate teams in providing additional training sessions for out of hours staff and improvements in accurate and timely reporting. Staff appraisals has also shown an improvement, now showing as just below the trust target however this has now increased to above the target.

Catering Consultation – There has been a slight delay in the catering consultation however we are now working on implementation of the new rota and the recruitment of the new staff required.

Market Testing of Services – The output specifications to enable the market testing of the domestics and estates services are complete and subject to initiating informal consultation in early 2019, the process will commence. The domestic services will be subject to a mini competition under the East of England framework and estates and grounds and gardens within a 'direct award' framework, against competitively tendered rates. The process is expected to take 3 months to complete and Board approval papers expected in June 2019.

Capital Projects – Significant progress on the annual capital backlog programme, with over 76% of the schemes at implementation stage after a competitive tender process. The schemes will commence in December with the majority completed in February 2019.

The backlog maintenance (eleven in total) will address some of the Trusts highest estates risks, including, drainage, the refurbishment of the Williams Day unit.

The water ingress into Harvey and Lister ward has now beeen addressed with the areas concerned sealed and new windows due to be fitted.

The CCTV project is in the scoping stage.

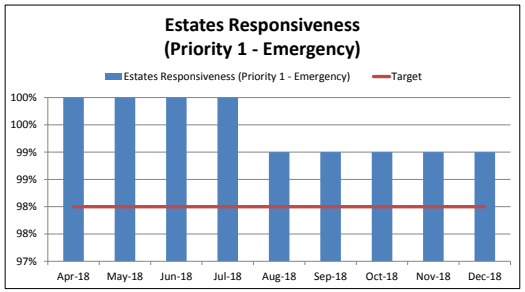
Theatre Temperature control is at the contract mobilisation stage.

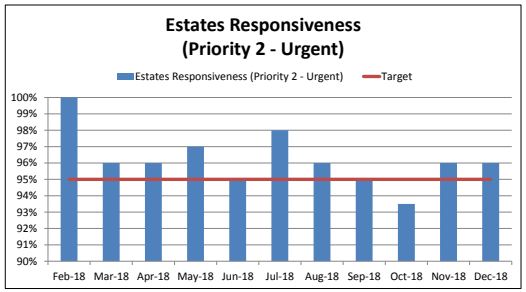
Lift refurbishment we are in negotiation with suppliers.

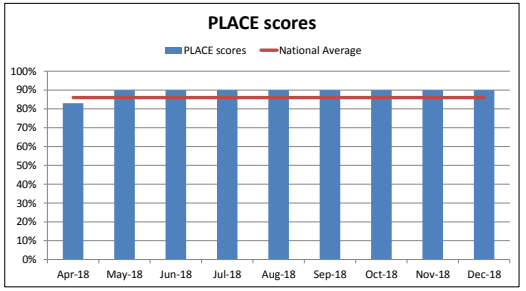
The repatriation of the fracture clinic is being managed by consultants , Artelia. The tender process has been extended until 25th January 2019.

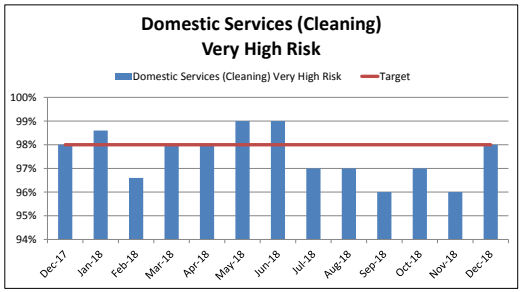
The corporate training centre development has achieved RIBA level 2, the tenders have been returned and evaluated and are awaiting board approval.

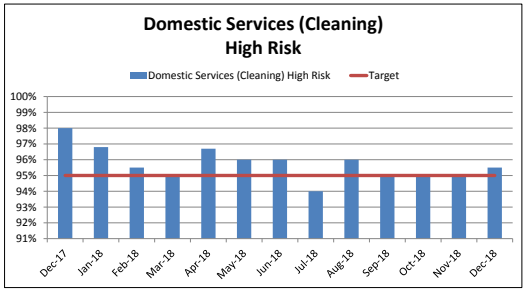
Charnley Ward was successfully completed and handed over to the Trust on Thursday 20th December. Given the complexity of this major project, this is a tremendous achievement and defines the expectations going forward for other hospital schemes. The new ward will officially open on Wednesday 2nd January 2019.

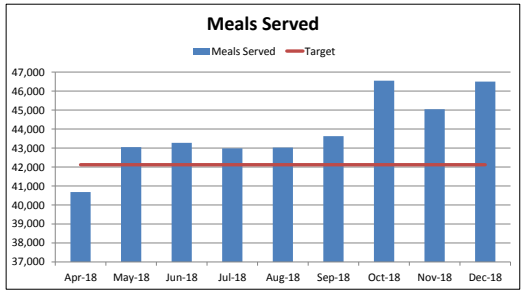

Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target
100%
100%
99%
99%
98%
98%
97%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18

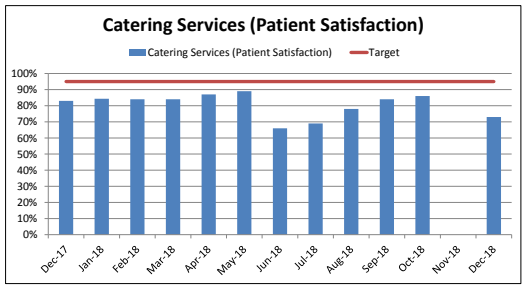

Estates Responsiveness (Priority 2 - Urgent)
Estates Responsiveness (Priority 2 - Urgent)
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


PLACE scores
PLACE scores
National Average
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


Domestic Services (Cleaning) Very High Risk
Domestic Services (Cleaning) Very High Risk
Target
100%
99%
98%
97%
96%
95%
94%
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


Domestic Services (Cleaning) High Risk
Domestic Services (Cleaning) High Risk
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


Meals Served
Meals Served
Target
47,000
46,000
45,000
44,000
43,000
42,000
41,000
40,000
39,000
38,000
37,000
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18


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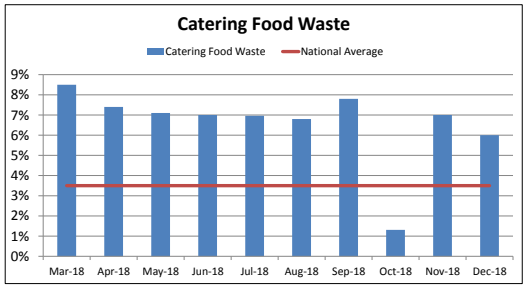

Catering Food Waste
Catering Food Waste
National Average
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18

Executive Summary Our Pounds

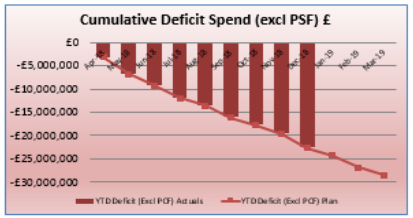
The Princess Alexandra Hospital NHS Trust

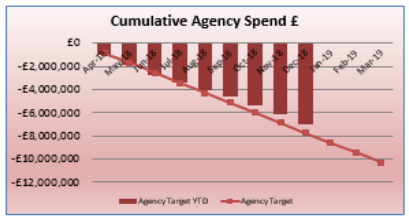
In month deficit c£3m (excluding PSF) on plan. YTD deficit £22.5m, £0.2m ahead of plan. The Trust needs to deliver an average monthly deficit of £2m per month in order to meet its year end control target (£28.5m). Key risks are CCG commissioning outturn forecasts and continued increased levels of bank/temporary staffing (c£2.6m in month, c£31m annualised). The Trust continues to work with commisioners on year end forecasts to support delivery of the control total. The back end loading of the Capital Investment Programme is being carefully managed to ensure resources are maximised and Capital Resource Limit achieved. Full detail of Financial performance can be found within PAF papers in Diligent.

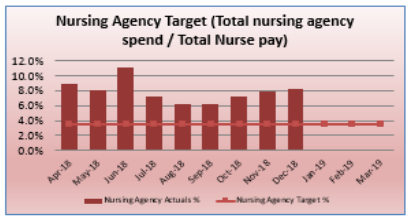
Pounds

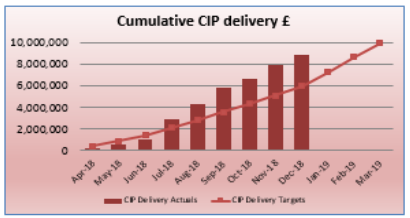
OUR POUNDS

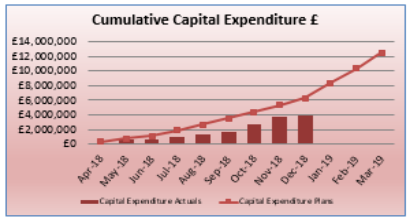
Metric	Annual Plan (Standard)	Previous Month	Latest Month
YTD Deficit (Excl. PSF)	-£28,471,000	-£19,447,636	-£22,416,776
Cumulative Agency Spend £s	£10,300,000	£6,155,603	£6,969,743
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3%	8%	8%
Cumulative Capital Expenditure	£12,834,000	£3,305,300	£3,871,800
BPPC Volume	95%	59%	60%
BPPC - £s	95%	73%	72%
Cash Balance	£1,000,000	£3,744,000	£5,048,000

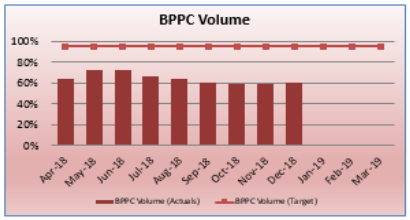


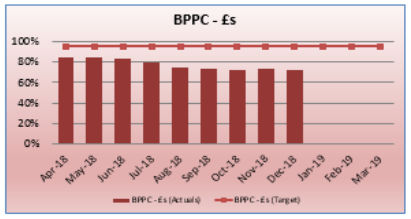


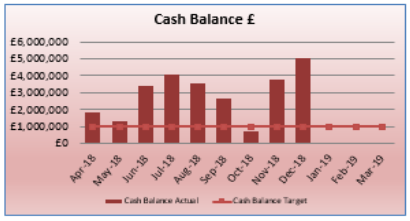












The Princess Alexandra Hospital NHS Trust

Trust Board (Public) - 7 February 2019

Agenda Item:	8.2
Presented by:	Trevor Smith – Chief Financial Officer Stephanie Lawton – Chief Operating Officer
Prepared by:	Nick Ryan – Deputy Chief Financial Officer
Date prepared:	29.01.19
Subject / Title:	Operating Plan Update

Purpose:	Approval		Decision		Information	x	Assurance	

Executive Summary:	The report provides an update on the annual planning process FY1920: • Draft submission due 12th February, final submission 4th April. • Financial Control Total received for consideration. • Key matters being worked through include activity, workforce and financial plans, performance trajectories and quality improvements. Technical matters include national tariff changes, national contract consultation and System planning requirements. The development of the Plan is being co-ordinated through SMT with oversight by Performance & Finance Committee. Further detail will be presented and discussed in Board Part 2 agenda.
Recommendation:	The Board are asked to note the development of the Operating Plan.

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

Previously considered by:	PAF.21.12.18 and PAF.28.01.19 SMT: December 2018, January 2019.
Risk / links with the BAF:	All
Legislation, regulatory, equality, diversity and dignity implications:	National Constitutional Standards. Statutory duty to breakeven. Capital Resource Limit.
Appendices:	1. Key Dates 2. Key Planning Headlines Note: Diligent includes planning documents from NHSI/E and briefing from NHS Providers.

8.2

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Key Dates

The Princess Alexandra Hospital NHS Trust

Item	Deadline
Initial operational planning guidance released (received)	Mid December 2019
Initial activity submission to NHSI (completed)	14th Jan 2019
Tariff consultation starts	17th Jan 2019
Draft 2019/20 operating plans to NHSI	12th Feb 2019
Aggregate system operating plan submission to NHSI	19th Feb 2019
2019/20 Standard contract published	22nd Feb 2019
2019/20 Contract / plan submission alignment submission	5th March 2019
2019/20 Final tariff published	11th March 2019
Deadline for Contract signature	21st March 2019
Organisational approval of 2019/20 budgets	By 29th March 2019
Final 2019/20 plan submission	4th April 2019
Final 2019/20 system operating plan submission	11th April 2019

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Key Planning Headlines

The Princess Alexandra Hospital NHS Trust

- Greater focus on aligned system plans with system control totals.
- Tariff proposals include blended payments system for urgent care, transfer of £1bn PSF into core prices and top-slicing tariff to fund centralised procurement.
- Impact of assessment and ambulatory care activity on blended payments to be considered.
- National tariff uplift 3.8% (excluding PSF, CQUINN and pension change).
- Changes to the pension scheme not included in uplift, to be resourced from separate additional funding.
- Providers to deliver 1.1% efficiency over the next five years utilising Carter reviews.
- Financial Recovery Fund (FRF) established for providers in deficit linked to additional 0.5% efficiency.
- MRET / Readmissions abolished.
- Maternity Incentive Scheme continues.
- Updated Market Forces Factor, phased in over 5 years.
- CQUIN values reduce by 50%, funds into core tariff.
- Same Day Emergency Care model to increase proportion of acute admissions discharged on day of attendance from c20% to c33%.

- Performance trajectories to be agreed.
- Triangulation of activity, workforce and financial plans.
- Alignment of Medium Term Financial Plan including QIPP assumptions and recovery plans.
- MSK lead provider contract and associated sub-contracts being developed.
- System use of NHS RightCare programme to implement national priorities for cardiovascular and respiratory conditions.
- Revised CCG allocation formulae and Control Totals; running cost reduction in 2020/21.
- Increased mental health investment.
- Capital funding announcements, Spending Review 2019.
- Updated 5 year plans, Autumn 2019.
- Clinical Standards review to be published spring 2019 and tested for implementation from October 2019.
- Trusts signing up to Control Totals exempt from most contract sanctions; sign up to be agreed by Trust Board.

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The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 7 February 2019 **AGENDA ITEM NO: 9.1**

REPORT TO THE BOARD FROM:	Quality & Safety Committee
REPORT FROM:	John Hogan
DATE OF COMMITTEE MEETING:	25 January 2019

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

Items for escalation to the Board:

- **Mortality:** this remained a concern with the latest report showing HSMR up to November 2018 at 120. The Medical Examiner process would go live as of 05.02.19. QSC requested a matrix of KPIs and progress against each item.

- **Stillbirths:** the committee were informed of increased scrutiny in relation to the incidence in the numbers of stillbirths/perinatal deaths reported over the last 12 months. Regulators have been informed and we have asked NHSI to undertake a review to ensure transparency and learning. A CEO Scrutiny Panel will take place on 12.03.19.

- **Quality compliance:** The newly established Quality Compliance Improvement Group will scrutinise progress to meet compliance requirements as identified in the monthly report to QSC. In response to the CQC PIR process undertaken in January 2019 the group will also focus on areas requiring additional support to strengthen evidence of compliance.

- **Quality Improvement Strategy:** QSC supported and recommended the Strategy (with a request for a summary of key bullet points to be added at the start) to the Board.

- **Infection Control:**
  Five patients on ITU have had multi-resistant gram positive organism - Vancomycin Resistant *Enterococcus* (VRE) isolated. The patients were colonised with VRE, however two of the five patients were treated with antibiotics as a precaution. Control of VRE is by way of a combination of good environmental and equipment cleaning, isolation, hand hygiene and control of antibiotic use; appropriate actions are being taken.

- **BAF Risk 1.1:** (*inconsistent outcomes in clinical quality, safety, patient experience and higher than expected mortality*): it was agreed the risk rating would remain at 16.

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

Other items discussed:

- Infection Control - routine water sampling has detected Legionella pneumophila serogroup 1 in an unused outlet in the MRI department. Actions are being taken to address this.
- Review List Update (all specialties)
- Healthcare Group Quarterly Performance Report (FAWS)
- M9 Integrated Performance Report
- Sharing the Learning Report
- Patient Experience Report (including Q3 Complaints Report)
- Patient Panel Update
- Report on Nursing, Midwifery and Care Staff Levels (Hard Truths)

• Monthly Quality, Safety & Effectiveness Report • Monthly Report from Patient Safety & Quality Group • Quality Compliance Readiness 2018/19 • CQC Insight Report
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee is making good progress against its work plan and agreed to receive a six monthly report on the 15 Steps Programme as well as a report on the Trust's compliance with its obligations under the Mental Health Act.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 07/02/19 **AGENDA ITEM NO: 9.3**

REPORT TO THE BOARD FROM:	Workforce Committee
REPORT FROM:	**Pam Court – Committee Chair**
DATE OF COMMITTEE MEETING:	**28/01/2019**

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- The committee received the Nursing Establishment Review and commended the paper to the Board.
- The committee supported an amendment to the wording for BAF risk 2.1, which was amended to reflect an inability to recruit to critical nursing roles.
- It was noted there was an increase in bank and agency staff expenditure, however this remained below the Trust target and was being monitored closely.
- The fill rate for Nursing and Midwifery staffing was 84.3% in November and 83.62% in December. The vacancy position showed a slightly improving trajectory, with a focus on launching a major overseas nursing campaign to attract individuals throughout 2019. Other incentives were also being pursued including 'refer a friend' initiatives.
- The trust target of 90% for statutory and mandatory training had been achieved for 2 months successively and continues to be monitored to ensure this is maintained.
- The draft staff survey results were received; some improvements noted and the final report to be considered at the next meeting.

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

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

Freedom to Speak Up Report: The committee received the Freedom to Speak Up Guardian report and noted the themes identified in the report.

Draft People Strategy and Plan: The committee received the draft People Strategy and Plan which was being reviewed by stakeholders and would be approved at the March committee.

Fit and Proper Persons Report: The committee received the Fit and Proper Persons Report and noted 100% compliance.

The committee also received the following reports:
Workforce Report (Targets and Performance) 2018/19, Temporary Staffing Report Discuss, Nursing Establishment Review, Annual Report and Assessment on Equality and Diversity, Staff Survey and FFT Results, Communications Update, Training and Education Update, Implementation of AfC New Pay deal, Action Plan: Medical Engagement Survey, People Board Report and NHSI Workforce Committee Observation.

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: 7 February 2019 **AGENDA ITEM NO: 9.1**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Andrew Holden - PAF Chairman
DATE OF COMMITTEE MEETING: 28.01.19

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

Month 9 Finance Report: In-month deficit £3m, on plan. Year-to-date deficit £22.4m, £0.2m ahead of plan. Outturn deficit of £28.4m will require maximum £2m deficit per month, Trust working extensively with Commissioners to secure satisfactory year-end settlement. Capital investment subject to continued close monitoring and management, clarity being sought for STP ICT funds phasing this year/next.

Emergency Department 4 Hour Performance: Delivery of the standard remains challenging with increased attendances continuing throughout December (circa 7% increase compared to December 2017). The 3 most key areas currently: 1) Assessment facilities – insufficient space due to increased demand and further work on systems and processes 2) Culture/ behaviours, progress being made and supported with ECIST colleagues and 3) Work on discharge management/length of stay linked to system capacity and improved patient flow. PAF was informed that proposed extra community capacity at Sydenham House was not progressing and that the Local Delivery Board would be discussing alternative options.

Operating Plan 2019/20: The Committee noted the plan and key elements. It was agreed further work would be required around potential pension increases, pay awards and CIPs. The Financial Control Total offer was considered. First draft submission due 12.02.19, therefore delegated authority to be requested from Board.

Contracts: PAF noted that the contract for Transport of Non-Emergency patients had been let for an initial 6 month term (circa £102k) and also Endoscopy Washers circa £350k. The contract for Bed Management will require Board approval but points of clarification are still being worked through. Tendering for Fracture Clinic capital works now closed.

New Hospital: Good progress sustained and on track for a decision on the site preference at TB1.07.03.19.

BAF Risk 1.3 (Coding): PAF discussed and agreed with the recommendation to reduce the risk from 16 to 12 with evidence received in support of the recommendation from Director of IMT; it was noted that the risk rating had improved/reduced, it had not been eliminated and the coding improvement actions must continue.

Use of Resources: PAF received a briefing on the forthcoming Use of Resources Assessment. The initial return is to be submitted by 12.02.19 with the full assessment scheduled for 26.03.19.

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

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

- MSK Contract
- Data Quality Update
- Carter Work Stream Update
- Capital: Appendix 1 due to be submitted 31.1.2019 for successful STP Wave 4 bid (£9.5m)
- Estates and Facilities

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

The Committee is making good progress against its work plan which is being reviewed to enable deeper focus on specific areas on alternate months (Feb: ICT Roadmap and Op Plan 1920 incl. MSK).

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 07.02.19 **AGENDA ITEM NO: 9.1**

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

REPORT FROM: Helen Glenister

DATE OF COMMITTEE MEETING: 09.01.19

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
The committee escalated the following to the Boards attention: • The committee discussed the future of fundraising and agreed that the current approach to general fundraising would continue. The committee also discussed further assurance related to the governance of general fundraising. • The committee reviewed and agreed the Terms of Reference (Appendix 1) which had been updated to include oversight of fundraising and some membership changes. These are recommended to Board for approval. Executive lead for the committee has transferred from Trevor Smith, CFO to Ogechi Emeadi, Director of People. The following was also noted: • Future annual reports for the charity would include an overview of research activities funded by the Charity and the impact of charitable activities. This is in line with requirements of the Charity Commission and is an opportunity to celebrate and to promote the charity. • The committee agreed the timeframe to obtain financial plans for the 2019/20 year. • M8 Finance report: income: £427,000, expenditure: £452,000, net reduction: £25,000 • Fundraising Update: A number of events had been planned and the committee sought clarification on some of the detail of the events. • An update was received from the Breast Fund and the committee noted the success of patient focussed initiatives such as the Fabulous and Beautiful programme. The Great Chef's Dinner (2020) was approved by the committee.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE (To include an update on delivery of each performance trajectory – ED, RTT, Cancer, 30 Day Re-admissions, 52 week breaches and Stroke)
The following are highlighted for the Board's awareness and/or assurance:
Section 2 is not applicable to the Charitable Funds Committee
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The CFC is making good progress against its annual work plan.

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CHARITABLE FUNDS COMMITTEE
2018/19

TERMS OF REFERENCE

CONSTITUTION: The Princess Alexandra Hospital NHS Trust ("the Trust") appointed as Corporate Trustee of the Trust's charitable funds by virtue of SI 2001 (2271), hereby resolves to establish a Committee to the Board to be known as the Charitable Funds Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

PURPOSE: The Charitable Funds Committee ("the Committee") has been established by the Board to make and monitor arrangements for the control and management of the Trust's charitable funds and fundraising activities.

SCOPE AND DUTIES:

1. Within the budget, priorities and spending criteria determined by the Trust as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) seek assurance that charitable funds have been managed and spent in accordance with their respective governing documents and in line with the Standing Financial Instructions.
2. To ensure that the Trust's policies and procedures for charitable funds investments are followed. To make decisions involving the sound investment of charitable funds in a way that both preserves their capital value and produces a proper return consistent with prudent investment and ensuring compliance with:
   - Trustee Act 2000
   - Charities Act 1993
   - Charities Act 2006
   - **Charities Act 2011**
   - Terms of the funds' governing documents
3. On behalf of the Board, review the accounts of the Charity and receive the external auditor's report and commend the accounts to the Board once considered by the Committee.
4. To develop, monitor and review progress against ~~approve~~ the Trust's Charitable Funds Strategy, agree any new appeals to be supported by the Trust and monitor the progress of these appeals.
5. To appoint investment advisors (where appropriate) and agree their terms of appointment and monitor investment progress.
6. To receive regular reports on fund balances and performance.
7. To approve any arrangements for the day-to-day running of the Trust's charity.
8. To review and approve the acceptance of restricted funds
9. To approve charitable fund expenditure over £10000; if approval is required between meetings the Chair and CFO can approve the request with ratification by the Committee at the next meeting.
10. To maintain oversight of and receive regular reports on fundraising activities.

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ACCOUNTABLE TO: Trust Board.

REPORTING ARRANGEMENTS: A regular report from the Committee shall be produced for the Board of Directors by the Committee Chairman and Lead Executive.

CHAIRMAN: Non-Executive Director.

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COMPOSITION OF MEMBERSHIP:	Committee Chairman, ~~another~~ another Non-Executive Director, Director of People, OD and Communications, Director of Strategy, Deputy Chief Financial Officer, Head of Financial Services.
ATTENDANCE:	Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee meetings within each reporting year. An attendance record shall be taken at each meeting and an annual register of attendance will be included in the Committee's annual report to the Board. ~~If any substantive member is unable to attend, a nominated deputy should be in attendance at the committee meetings and should have delegated authority from the executive member.~~
INVITED TO ATTEND:	In addition to the members of the Committee, the following may be invited to attend the Committee to provide advice, support and information: • Charitable Funds & Income Assistant • ~~Head of Financial Services~~ • Fundraising Coordinator • Fund Raisers/Managers within the Trust/representative from the Breast Fund • External Audit (as required). • Investment Advisors (as required). • ~~One fund-raiser to attend each meeting.~~
DEPUTISING ARRANGEMENTS:	In the absence of the Chairman of the Committee, another Non-Executive Director member shall chair the meeting. If any substantive member is unable to attend, a nominated deputy should be in attendance at the committee meetings and should have delegated authority from the executive member
QUORUM:	The quorum for any meeting of the Committee shall be two members, one of whom shall be the Lead Executive and the other shall be a Non-Executive Director.
DECLARATION OF INTERESTS:	All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.
LEAD EXECUTIVE:	~~Chief Finance Officer~~ Director of People, OD and Communications
MEETING FREQUENCY:	Meetings shall be held not less than three times per year.
MEETING ORGANISATION:	• Meetings of the Committee shall be set before the start of the financial year. • The meeting shall be closed and not open to the public. • The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee. • A draft agenda shall be developed by the Head of Corporate Affairs and the Lead Executive and agreed by the Committee Chairman at least ten clear days* before the next Committee meeting. • All final Committee reports must be submitted six clear days* before the meeting. • The agenda and supporting papers shall be forwarded to each member

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of the committee and planned attendees five clear days* before the date of the meeting and not less than three clear days* before the date of the meeting.

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

AUTHORITY: The Committee is empowered with the responsibility for the day to day management of investments of the charitable funds in line with Trust, regulatory and statutory procedures and appropriate professional advice. The Committee shall also have the power to appoint an investment manager to advise it on investment matters and may delegate day to day management of some or all of the investments to that investment manager.

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

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

DATE APPROVED: By Charitable Funds Committee: ~~4 July 2018~~ xx
By Trust Board: xxx

NEXT REVIEW DATE: July 2019

Membership and Those in Attendance	
Members	
Chairman - Non-Executive Director	Helen Glenister
Non-Executive Director	Pam Court
~~Non - Executive Director~~	~~Helen Howe~~
Director of People, OD and Communications	Ogechi Emeadi
Deputy Chief Finance Officer	~~Trevor Smith~~ Simon Covill
Head of Financial Services	Colin Forsyth
In Attendance/Invited as Required	
Charitable Funds & Income Assistant	Lorraine Keast
Fund Raisers/Managers within the Trust	~~TBC~~As identified
Charitable Funds Co-ordinator	Graham Norcott
Representative of Breast Fund (Associate Specialist Surgeon)	Ashraf Patel
Secretariat	
Head of Corporate Affairs	Heather Schultz
Committee Secretary	Esther Kingsmill

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The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 07.02.19 **AGENDA ITEM NO: 9.2**

REPORT TO THE BOARD FROM: Senior Management Team
REPORT FROM: Lance McCarthy - Chairman
DATE OF COMMITTEE MEETING: 22.01.19

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
SMT reviewed and recommended the Bed Contract award to PAF and Board. SMT reviewed and recommended the Quality Improvement Strategy to QSC and Board for approval. The Cost Improvement Programme Policy was approved.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
In addition to the above, SMT received reports on the following agenda items: • CQC Preparedness and PIR Update • Short Notice Clinic Cancellations • Review Lists • Finance/General Update – Month 9/FOT • Procurement Strategy • Operating Plan Update • Cost Improvement Programme Policy • Use of Resources • National Staff Survey 2018 – PAH Results • Hard Truths Report • Integrated Performance Report (IPR) • Expert Oversight Group Updates including Urgent care and MSK

9.2

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 7 February 2019

Agenda Item:	10.3
Presented by:	Lance McCarthy - CEO
Prepared by:	Lance McCarthy - CEO
Date prepared:	31.01.19
Subject / Title:	Report from the ICP Board

Purpose:	Approval	x	Decision		Information		Assurance	

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

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

Previously considered by:	N/A
Risk / links with the BAF:	1.1 outcomes 3.3 financial and clinical sustainability across the health and care system 3.5 sustainability of local services
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	None

9.3

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The Princess Alexandra Hospital NHS
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Report from the ICP Board
Trust Board: Part I – 7 February 2019

This report updates the Board on progress being made across the Integrated Care Partnership (ICP).

(1) Background

The West Essex ICP is a partnership of all health and care organisations across West Essex. Its aim is to integrate care and care pathways across all providers for the benefit of the residents of West Essex.

Real progress and tangible actions have been delivered in the last 12 months with a revision to the structure, with a transformation board and a range of clinician-led Expert Oversight Groups reporting to an overarching ICP Board.

(2) New contractual forms

New contractual forms are proposed to be in place for MSK, COPD and our integrated urgent care service from 1 April 2019. The detail of each will be presented to the Board for approval in March, prior to the start of the new financial year.

All 3 services will be contracted on a lead provider basis, with PAHT as the lead, sub-contracting with other providers in the system for the whole of the relevant pathways.

The Integrated urgent care service was implemented in 2018/19 to support better flow for our urgent care patients, integrating GP, specialist nurse, streaming and minors services at the front of ED. This is having a positive impact on the flow of patients in to the right service and taking pressure of the main ED for those in need of more complex urgent care.

Significant progress has been in 2018/19 with the provision of an integrated COPD service across the local system. Better identification of patients with COPD and better access to spirometry in the community have been supported with specialist nurse input across the pathway and in ED to help to minimise admissions and support patients with COPD with self-management and confidence in their condition. The contractual form change will further support the integrated approach and the value and activity levels will be determined by the evidence of changes made this year.

The Expert Oversight Group for MSK services have developed a range of improved and integrated pathways to better support timely and appropriate intervention for patients with MSK conditions. A new acute back pain service has been implemented and a new central referral system will be introduced in the next few months.

Good partnership working between all providers in the local system has enabled these significant developments for our patients to be made.

(3) Pipeline of activity

Building on the success of the 3 pathways outlined above, the ICP transformation group has agreed a pipeline of improvement activity for 2019/20. The conditions that will be focussed on first are:

- Diabetes
- Heart failure
- Frailty

There is a workplan being developed for each, to include the key clinicians in each of the providers through Expert Oversight Groups, supported with operational and financial input.

(4) Transition to population health and formalisation of the ICP

The pathway specific work has and will see significant improvements in the care and outcomes of relevant patients. The next big step to run in parallel with the pipeline transformation is to start to transition to a more population health based model of care across the system, increasing the level of genuine personalised care and better supporting patients with many conditions / co-morbidities.

To facilitate this we are in discussion with all health and care partners in the ICP about what an ICP looks like in the future as a delivery vehicle of the Hertfordshire and West Essex Integrated Care System, ensuring we align the direction of travel for the ICP with the NHS Long Term Plan. A proposal will be discussed with the Board over the next few months before being more widely discussed within the STP governance structure.

The Trust Board is asked to note progress and developments in the Integrated Care Partnership.

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

The Princess Alexandra Hospital NHS Trust

Trust Board – 7 February 2019

Agenda Item:	9.4
Presented by:	Lance McCarthy – CEO
Prepared by:	Lance McCarthy – CEO
Date prepared:	31.01.19
Subject / Title:	Report from the STP Board

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	Attached is the updated Integrated Heath and Care Strategy for the Hertfordshire and West Essex STP, supporting the delivery of a healthier future for the local population. It has been developed by clinicians from across the STP and has been approved by the STP CEOs and STP Chairs groups.
Recommendation:	The Trust Board is asked to: - discuss and endorse the Strategy - discuss and note the 4 next steps including confirmation of PAHT's commitment to them

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

Previously considered by:	n/a
Risk / links with the BAF:	1.1 outcomes 3.3 financial and clinical sustainability across the health and care system 3.5 sustainability of local services
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	None

9.4

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Hertfordshire and West Essex STP, Integrated Health and Care Strategy

This strategy is a blueprint for delivering a healthier future for the population of Hertfordshire and West Essex.

It is designed to guide our health and care organisations, staff, the voluntary sector and our population to work in partnership.

Our approach is based on the principles of population health management. This is a way of targeting our collective resources where they will have the greatest impact, improving the quality of care through improved, affordable services. Our key priorities are:

- Meeting people's health and social care needs in a joined-up way in their local neighbourhoods, whenever that's in their best interests - saving time and cutting out unnecessary tests and appointments. Health and care services will support people to live as independently for as long as possible. We will provide care and support to keep people as healthy as possible, rather than reacting when they are in crisis.
- Adopting a shared approach to treating people when they are ill and prioritising those with the highest levels of need, reducing the variations in care which currently exist. Support and treatment will be delivered compassionately, effectively and efficiently, in partnership with people and their families and carers.
- Placing equal value and emphasis on people's mental and physical health and wellbeing in all we do. Improved mental health care and support for people with disabilities is a core pillar of our strategy and people's psychological and emotional wellbeing will be supported while their physical health and social care needs are being met.
- Driving the cultural and behavioural change necessary to achieve personalised care delivering the improvements we need. Care professionals, service users, families and carers will understand the role they have to play in creating a healthier future. Staff will be empowered to drive change throughout the system. We will all be supported and encouraged to take greater responsibility for our own health and wellbeing.
- Ensuring that we have the integrated workforce, technology, contracting and payment mechanisms combining social care and health in place to support our strategy, delivering health and care support efficiently, effectively and across organisational boundaries.

All of the STP's organisations are committed to working together to implement this strategy, so that we can make rapid improvements to the health and wellbeing of our population and the sustainability of our health and care system.

3. Background

1.1 This paper provides an overview of the development to date of the Hertfordshire and west Essex Integrated Health and Care Strategy. The strategy sets out a blueprint for how we will deliver a healthier future for our population through high quality, personalised proactive care which is better joined up, to deliver a healthier future for our population and our services.

1.2 The strategy has been co-designed with health and care professionals and representatives of the area's community and voluntary organisations within our STP footprint and will act as a guiding framework for health and care organisations, professionals, service users, and our population.

1.3 The Hertfordshire and West Essex health and care system is unsustainable if we carry on as we are and do nothing differently. We can only resolve this by working together as a single system, with a single budget approach at greater scale and in a more integrated way.

1.4 What's wrong now?

- We focus on what people can't do
- Resources are not targeted effectively
- Care is built around organisational boundaries or individual illnesses and conditions, rather than taking into account the whole person
- Too many people are treated in hospital
- Care is often only provided when things go wrong
- Mental health and the health of people with learning disabilities is not routinely prioritised
- Health and care professionals take different approaches, leading to varied care and treatment for our population
- Organisations and staff are not united by a common approach

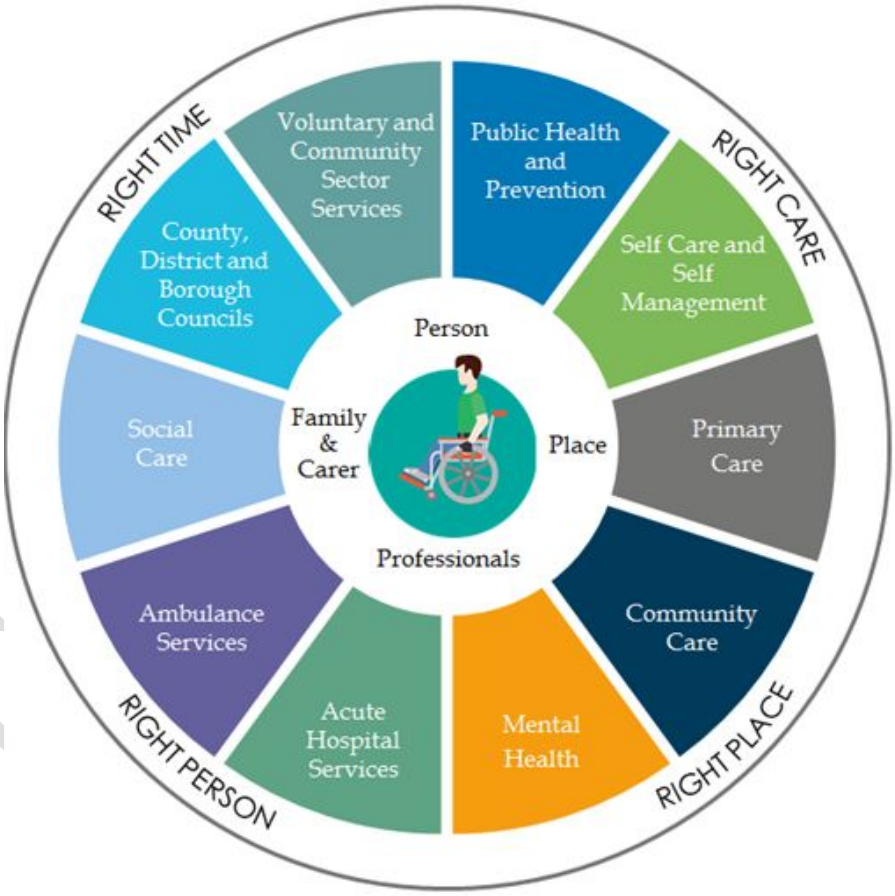
1.5 What will we do differently?

- Our staff and population will be encouraged to work together to make the most of our strengths
- We will use evidence to target resources, using a population health management approach
- Health and care needs will be met in a joined-up way, based on each person's needs
- Care will be provided as close to home as possible. High quality specialist hospital treatment will be there when it's really needed
- Care will be proactive and better coordinated to help people to stay healthy and independent
- We will place equal value and emphasis on the mental and physical health or all of our population
- We will develop care pathways for everyone to follow, to reduce variation in outcomes and promote best practice
- Each organisation and professional will understand their role in delivering this strategy

1.6 Strategic and operational planning guidance was issued by NHS England (NSHE) on the 16th October 2018. It sets out the expectation that all STPs and NHS organisations prepare for local implementation of the National NHS Long Term Plan which is due to be issued in December 2018. Our strategy and Medium Term Financial Plan are fully in line with this direction of travel.

2. What does the strategy cover?

2.1 Our Integrated Health and Care Strategy has been written for service users, patients, their families and carers and everyone who supports them. It covers the range of health and care services that our population of 1,520,500 use.



2.2 The strategy builds on the foundation of our 'Healthier Future' summary plan published in 2016. It takes into account ongoing improvements to health and care services including local strategies developed by our Health and Wellbeing Boards, County and District Councils, CCGs, and Trusts.

2.3 This strategy is supported by the STP's:

- developing population health management plan
- medium term financial plan and
- workforce strategy.

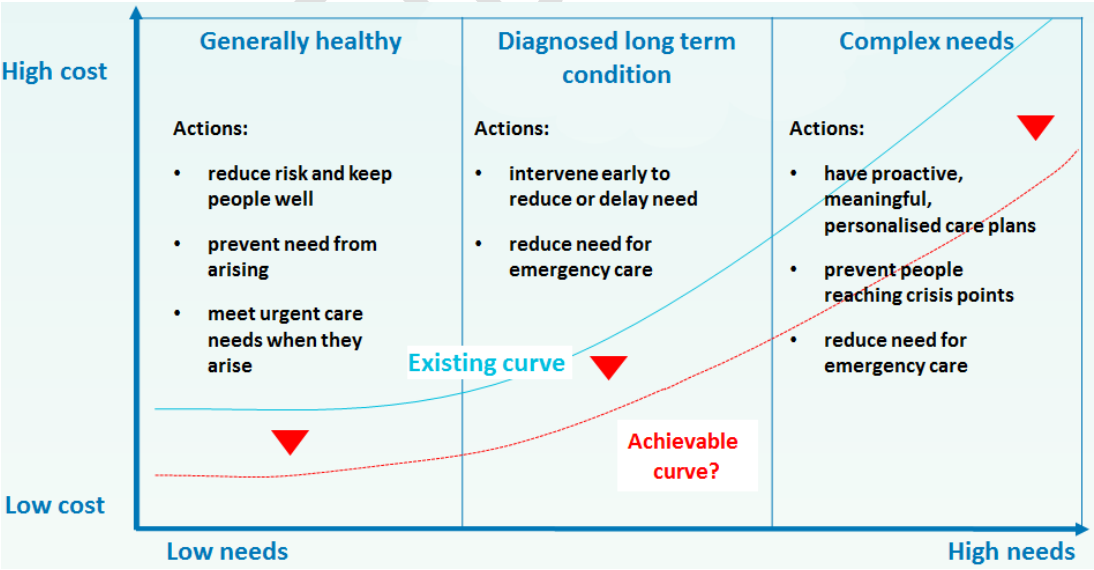
It will inform our area's neighbourhood strategies and places individuals at the heart of an improved, cohesive health and care system.

2.4 A 'population health management' approach

'Population health management' is an approach which will enable our STP to target our collective resources where evidence shows that they will have the greatest impact.

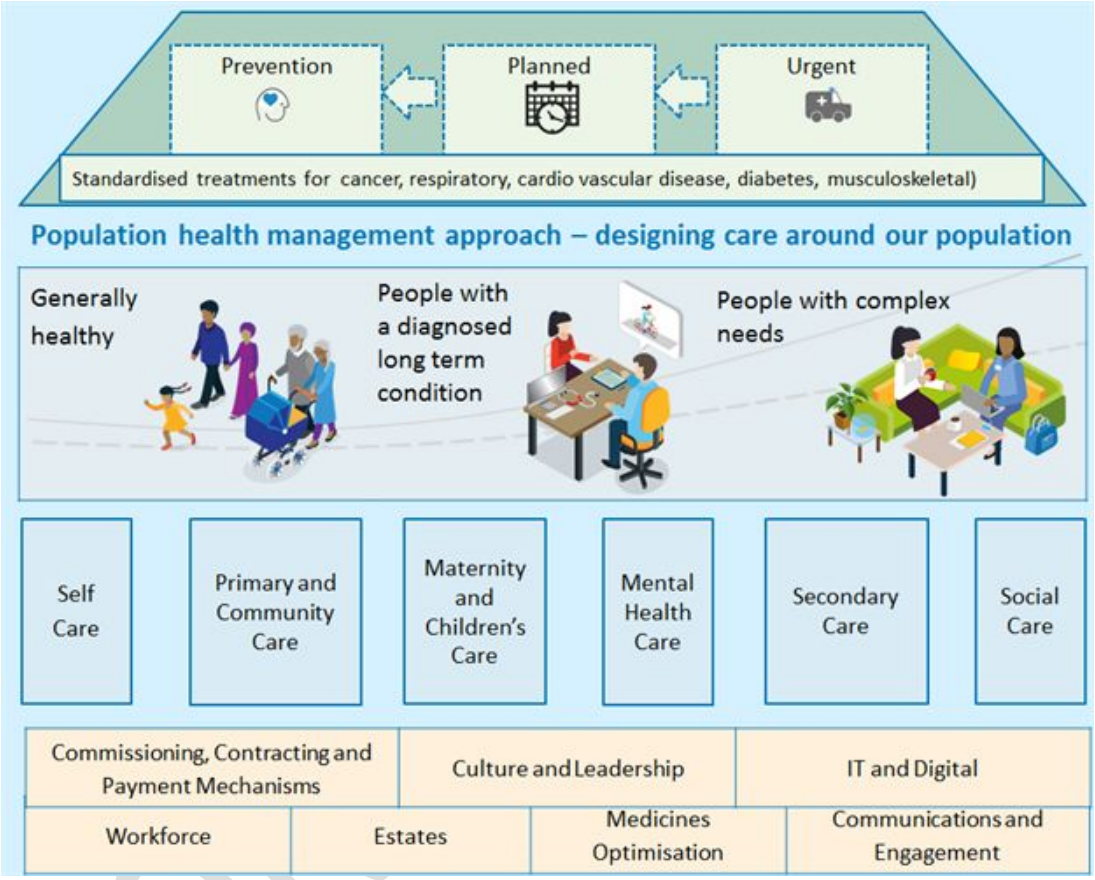
Social care and health organisations, supported by the community and voluntary sector, will work closely together to deliver joined-up services to defined groups of the population. In this way, we will prevent, reduce, or delay need before it escalates; and prevent people with complex needs from reaching crisis points.

This graph demonstrates the way in which the population of our area can be placed into three main groups, according to their level of health and care needs. It shows the potential impact that targeted actions can have on maintaining good health, thereby reducing the cost of care.



9.4

2.5 The 'house' of integrated care diagram outlines our strategic approach:



Using this model, the STP will:

- Develop integrated, person- centred models of care, designed to meet the needs of our population, delivered in local neighbourhoods wherever possible.
- Ensure that effective and efficient health and care is delivered in the right place, by the right person, at the right time.
- Shift care from reactive to proactive when possible, and standardise our approach to treatments.
- Agree the improvements we want to see and report back on their success.
- Transform key pillars of our health and care system, to ensure they are sustainable, resilient, and deliver integrated care.
- Put in place the staff, culture and systems we need to support the transformation we need.

2.6 What we want the strategy to achieve for our population:

- Reduce the difference in healthy life expectancy between people with and without mental illness and learning disabilities
- Minimise the risk of developing long-term conditions (especially cancer, cardiovascular disease, respiratory disease, and diabetes)
- Ensure people with disabilities lead an independent life as citizens of their local community
- Optimally manage every individual with a diagnosed long-term condition/need
- Halve the number of people developing more than one long term condition within 10 years
- Increase the proportion of people who are cared for at home or in their local community, as opposed to in hospital
- Increase the number of people who die in their place of choice, according to their wishes, free from avoidable distress and suffering

2.7 What we want the strategy to achieve for our staff:

- Increase the proportion of staff who feel they are motivated, have the right skills, and are empowered to use them
- All staff understand our vision and their role in delivering
- Attract and retain the required number of staff with the right skills and values
- Be innovative and efficient in changing our skill mix and work together in multi-agency and multi-disciplinary teams of people who die in their place of choice, according their wishes, free from avoidable distress and suffering. people who die in their place choice, according to their Close the funding and efficiency

2.8 What we want for our system:

- Close the funding gap and improve efficiency
- Reduce unwarranted clinical or care variation across our system
- Reduce unplanned hospital admissions and A&E attendances by c.20-25%*
- Reduce planned hospital activity by 20 %*
- Reduce occupied bed days*
- Reduce the number of people being permanently admitted to care homes
- Meet all national performance targets e.g. A+E performance, RTT, cancer targets

*Against the projected position set out in the medium term financial plan which illustrates what will happen if we do not take action to work differently.

2.9 To deliver a population health management model of care effectively in our area, the commissioning and delivery of integrated care will be as follows:

An Integrated Care System (ICS), serving the whole population

- Responsible for delivering the Integrated Health and Care strategy – improving the health of the population
- Strategic commissioning based on need, identified through a population health management approach
- Provides professional leadership for system
- Works in a cross-organisational way

- Oversees planning assumptions, sets financial principles and budgets
- Is responsible for delivering a sustainable system that delivers services that meet national standards
- Ensures we have the workforce, culture and systems we need to support the transformation we need.

Three Integrated Care Alliances (ICAs)

- Responsible for joint and 'place based' commissioning
- Organisations that provide health and care services working together collaboratively
- Shared transformation programmes to improve services
- Local risk and reward mechanisms, alignment of incentives, and new contractual forms.

Several localities serving 100-150,000 people

- Enabling staff across organisations to work together in an integrated way to meet the needs of the population
- Development of integrated care hubs
- Single multi-agency and multi-disciplinary operating policies and procedures

A number of 'neighbourhoods' serving 30-50,000 people

- With integrated multi-disciplinary teams of health and care staff providing joined-up care
- Establish Primary Care Home networks linking GP practices with other local integrated serevices
- Social prescribing and support, with provision for continuing health care, nursing and care homes

Next Steps

3.1 Programme design/governance

- Boards of STP organisations to sign-off the final draft strategy alongside the medium term financial plan by the end of January 2019
- Review and reset current STP workstreams to deliver the changes set out in this strategy by January 2019
- Revise the design of the programme to reflect new priorities end December 2019
- Expand membership of the STP's clinical oversight group to include care professionals and a wider range of clinical expertise by January 2019
- Continue to engage stakeholders, professionals, third sector organisations and the public in the strategy during January to March 2019
- Continue to refine the strategy after the NHS Long Term Plan in December 2018

3.2 Model the impact of our plans

- Agree baseline and resource proposal by March 2019
- Undertake detailed modelling work to quantify the impact of the interventions set out in this strategy by March 2019

- Review the modelling outputs in light of the activity and financial assumptions set out in the medium term financial plan by January 2019
- Iterate delivery plans for each workstream by March 2019
- Quantify targets for outcomes and objectives by March 2019

3.3 Develop detailed delivery plans

- Establish an integrated, system wide transformation and implementation methodology by January 2019
- Co-produce detailed delivery plans with care professionals across the system
- Agree what will be delivered in the next 1,3, and 5 years by June 2019
- Develop implementation plan on a page by March 2019

3.4 Implementation

- Adopt a robust portfolio management approach to manage implementation and realise benefits by March 2019
- Regular reporting against delivery plan milestones and benefits throughout 2019/20
- Regular programme reviews to ensure work continues to be aligned with objectives and outcomes reporting to each key stakeholder during 2019/20

Recommendations

1) Discuss and endorse the HWE I H & C strategy.

2) Discuss and note the 4 areas of next steps including confirmation of commitment to play our role in each step.

The CEOs agreed the strategy and we have tried to make it more easy to understand and change the language to less NHS focused.

The CEOs agreed to take it through their Boards during December and January and we welcome any feedback as well as offer senior STP leads to come and present or listen to feedback.

Align this strategy with the MTFP also going through stakeholders Boards.

Authors:
- **Deborah Fielding, Chief Executive Officer, STP**
- **Harper Brown, Director of Strategy, STP**
- **Alison Gilbert, Director of Delivery and Partnerships, STP**

The Princess Alexandra Hospital NHS Trust

Trust Board – 7 February 2019

Agenda Item:	9.5
Presented by:	Lance McCarthy - CEO
Prepared by:	Lance McCarthy - CEO
Date prepared:	31.01.19
Subject / Title:	Committee Membership

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This report provides an update of the proposed changes to Board Committee membership as part of an annual review and to ensure: - reduce the variation in membership - ensure representation is aligned with the standing of each Committee - reduce the variation in individuals' Committee attendance - agree the membership of the new Strategy Committeee - ensure Non-Exec Director membership of Committees supports a read across between key Committees
Recommendation:	The Trust Board is asked to approve the proposed changes and the next steps.

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

Previously considered by:	Executive Management Team
Risk / links with the BAF:	The Committee membership supports and links with all the BAF risks
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	Proposed Committee Membership

9.5

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Committee Membership
Trust Board: Part I – 7 February 2019

This report provides an update of the proposed changes to Board Committee membership. The proposed attendance of Executive and Non-Executive Directors is shown in the attached sheet, with the changes from the current membership highlighted in yellow. All changes have been discussed with everyone.

(1) Rationale

We committed to review the membership of all Board committees on an annual basis to ensure there is appropriate representation across each. In addition we have had a number of changes to Executive Director appointments in the last year, a change of Chair, vacant NED and Associate NED roles and have agreed the need for a Strategy Committee to support the Trust's strategic direction and the development of a new hospital.

(2) What are we trying to achieve?

The proposed changes are attempting to address a number of issues / principles:

- Reduce the variation in numbers of Exec and Non-Exec Directors at each Committee that has developed over time and ensure representation is aligned with the standing of each Committee.
- Reduce the variation in individuals' Committee attendance
- Agree the membership of the new Strategy Committee
- Ensure the CEO and Chair are not regular members of any Committee but attend all of them on a rotational basis
- Ensure Non-Exec Director membership of Committees supports a read across between key Committees (Audit and PAF / QSC and PAF, QSC and Workforce respectively)

9.5

(3) Headline proposed changes

The headline proposed changes are:
- Changes to almost all Committees
- Reduction in Exec Director membership at PAF, with an increase in Exec Director membership at both QSC and Workforce Committees
- With the new NED and Associate NED roles filled, an increase in Non-Exec Director membership at all Committees with the exception of Charitable Funds Committee
- Exec lead for QSC to be the Director of Nursing
- Exec lead for Charitable Funds to move from the Finance Director to the Director of People

(4) Next steps

The next steps are:
- Trust Board to agree the proposed changes (7 February)
- All changes to be made from now for the 2019/20 financial year (7 February)
- Strategy Committee ToRs to be completed by Director of Strategy (March end)
- Committee dates to be confirmed for the next 12 months by the Head of Corporate Affairs (February end)

The Trust Board is asked to approve the proposed changes and the next steps.

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

Whole Board - Revised / proposed Committee membership (changes in yellow):

Committee	PAF	QSC	Workforce	Audit	Charitable Funds	Strategy
Chair	NED-AH	NED - JH	NED - PC	NED (vacant)	NED - HG	TC
Exec Lead	CFO	DoN	DoP	CFO	DoP	DoS
Regularity	Monthly	Monthly	Bi-monthly	4 per year	Quarterly	Bi-monthly
Meetings / annum	12	12	6	4	3	6

Trust Chairman	50%	50%	50%	50%	50%	Y
NED - AH	Y			Y		
NED -JH		Y				Y
NED - PC			Y		Y	Y
NED - HG		Y			Y	
ANED - HH		Y	Y	Y		
NED (vacant)	Y		Y	Y		
ANED (vacant)	Y					Y
NED TOTAL	3	3	3	3	2	4
NED mtgs / annum	42	42	21	14	7.5	24

CEO	50%	50%	50%	Y	50%	Y
CFO	Y			Y	1	
DoN		Y	Y	as required		
CMO		Y		Y		
COO	Y	Y	Y	as required		
DoP			Y	as required	Y	
DoS	Y			as required	Y	Y
DQI		Y		as required		Y
EXEC TOTAL	3	4	3	3	2	3
Exec mtgs / annum	42	54	21	12	8.5	18

TOTAL	6	7	6	6	4	7
TOTAL mtgs / annum	84	96	42	26	16	42