The Princess Alexandra Hospital NHS Trust

Meeting of the Board of Directors

AGENDA

Date and Time: Thursday 7 June 2018 from 10.00 to 13.00
Venue: Boardroom, The Princess Alexandra Hospital, Harlow.

Time	Item	Subject	Action	Lead	Page
01 OPENING ADMINISTRATION					
10.00	**1.1**	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from Meeting on 29.03.18	Approve	Chairman	3
	1.4	Matters Arising and Action Log	Review	All	17
02 PATIENT STORY					
10.10	**2.1**	Staff Story: Freedom to Speak Up Guardians			
03 REPORT FROM CHIEF EXECUTIVE					
10.40	**3.1**	CEO's Report	Discuss	Chief Executive	18
04 RISK					
11.00	**4.1**	Board Assurance Framework	Approve	Head of Corporate Affairs	21
11.15	**4.2**	Significant Risk Register	Discuss	Chief Medical Officer	40
05 PERFORMANCE					
11.30	**5.1**	Integrated Performance Report	Inform	Chief Operating Officer	86
06 QUALITY					
12.00	**6.1**	Nursing, Midwifery and Care Staff Levels	Inform	Chief Nurse	128
12.15	**6.2**	Mortality Update	Discuss	Chief Medical Officer	133
07 GOVERNANCE					
12.30	**7.1**	Reports from Committees: • Audit.24.05.18 • QSC.23.05.18 • WFC.29.05.18 • PAF. 24.05.18	Inform	Chairs of Committees	167 168 170 171
08 QUESTIONS FROM THE PUBLIC					
12.50	**8.1**	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.	Discuss	Chairman	
09 CLOSING ADMINISTRATION					
	9.1	Summary of Actions and Decisions	-	Chairman/All	
	9.2	New Issues/Risks	Discuss	All	
	9.3	Reflection on Meeting	Discuss	All	
13.00	**9.4**	Any Other Business	Review	All	

TRUST BOARD 2018/19

Meetings, Purpose, Membership and Quoracy

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

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

Board Membership and Attendance – 2018/19			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chairman	Alan Burns	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC)	Stephen Bright	Chief Finance Officer	Trevor Smith
Chair of Quality & Safety Committee (QSC)	Dr. John Hogan	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Andrew Holden	Chief Medical Officer	Andy Morris
Chair of the Workforce Committee (WFC)	Pam Court	Chief Nurse	Nancy Fontaine
Chair of Charitable Funds Committee (CFC)	Helen Glenister	**Executive Members of the Board (non-voting)**	
Associate Non-Executive Director	Steve Clarke	Director of Pathways & Partnerships	Marc Davis
Associate Non-Executive Director	(vacant)	Director of People (interim)	Raj Bhamber
		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 29 March 2018 from 10:00 – 13:30
Boardroom, Princess Alexandra Hospital, Harlow

Present (voting members of the Board):

Alan Burns	**Trust Chairman (TC)**
Lance McCarthy	Chief Executive Officer (CEO)
James Anderson	Non-Executive Director (NED-JA)
Stephen Bright	Non- Executive Director (NED-SB)
Pam Court	Non-Executive Director (NED-PC)
Nancy Fontaine	Chief Nurse (CN)
John Hogan	Non-Executive Director (NED-JH)
Andrew Holden	Non-Executive Director (NED-AH)
Stephanie Lawton	Chief Operating Officer (COO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Andy Morris	Chief Medical Officer (CMO)
Trevor Smith	Chief Financial Officer (CFO)

Present (non-voting members of the Board):

Raj Bhamber (non-voting)	Interim Director of People (IDoP)
Steve Clarke (non-voting)	Associate Non-Executive Director (ANED-SC)
Helen Glenister (non-voting)	Associate Non-Executive Director (ANED-HG)

In attendance:

Members of the Public/Observers/Patient Story:

John Dryden	Patient's Father
Josie Dryden	Patient's Mother
Kerry Riches	Head of Patient Experience
Jane Bolton	Matron Critical Care
Naveed Kirmani	Consultant – General Surgery
Anna Mawbey	Ward Manager – Penn Ward
Sarah Lincoln	Head of Nursing - Surgery
Chris Sayer	Quality & Compliance Lead
Pam Humphrey	Associate Director of Nursing - Surgery

Apologies

Suzie Loader	NHSI Improvement Director (NHSI-ID)
Marc Davis (non-voting)	Director of Clinical Pathways & Partnerships (DoPP)

Secretariat:

Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chairman (TC) welcomed members to the meeting.
1.1 Apologies	
1.2	As above.
1.2 Declarations of Interest	
1.3	No declarations were made.
1.3 Minutes of Meeting on 25.01.18	
1.4	The minutes of the meeting held on 25.01.l18 were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	

1.5	There were no matters arising and all actions on the log were closed.
02 PATIENT STORY	
2.1	The Story was introduced by the Head of Nursing for Surgery (HoN-S). She welcomed the patient's family to the meeting and the patient's parents updated the Board on their daughter's journey as follows:
2.2	The patient had attended the Emergency Department (ED) on 25.06.16 experiencing abdominal pain, jaundice and vomiting. She was admitted and treated for presumed biliary sepsis and acute pancreatitis. On 29.06.16 the patient had an ERCP (Endoscopic Retrograde Cholangio-Pancreatography) at UCH and a stent was inserted. She then returned to Princess Alexandra Hospital (PAH) and was admitted to Penn Ward. She developed further abdominal pain and a CT scan showed no perforation but a large amount of free fluid in the abdomen and pelvis. On 05.07.16 the patient's family were called by the ward staff as she had become extremely agitated and asked if they could attend. The family were concerned by how much their daughter's condition had deteriorated. There was a concern that it appeared no doctors or nurses were attending to her. The Critical Care Outreach Team (CCOT) attended and she was intubated, ventilated and transferred to ITU. The family did not have the opportunity to speak with their daughter before she was intubated. Whilst on ITU the patient's condition worsened and a tracheostomy was inserted on 11.07.16. She then developed seizure-like activity on 12.07.16 and a discussion with the neurosurgical team deemed her not for surgical intervention. On 15.07.16 a brain stem test showed no signs of brain stem function and she was pronounced dead at 15:20 on 15.07.16. The patient's father contacted PALs in May 2017 to arrange a meeting as the family had questions regarding their daughter's treatment and care they wanted answered. That meeting took place on 16.01.18. The patient's father felt there was a lack of communication with his daughter and the family regarding her diagnosis and treatment plan. The transfer from Penn to ITU was not handled very compassionately and there was limited communication from ITU regarding his daughter's treatment on ITU with contradictions from two consultants.
2.3	The family wanted to highlight the lack of communication regarding the patient's diagnosis and wanted to know what had been done since to address: • Transfers from Penn to ITU. • Lack of communication between consultants on ITU. • Better experience for families with End of Life (EoL) loved ones on ITU. • Long unacceptable delays in arranging family meetings.
2.4	Following this story the team involved agreed their remit would be to: • Improve communication between clinical teams, patients and families. • Ensure the End of Life (EoL) experience for families was compassionate, honest and above all clear. • Act more promptly in arranging meetings requested by families to discuss the treatment/death of a loved one.
2.5	Aims/Learning Outcomes: • To have an awareness of the impact bad communication has on families • To hear the voice of families • Demonstrate how Values Standards and Behaviours are incorporated every day, every time and in relation to every family.
2.6	Going forward the Healthcare Group (HCG) agreed there needed to be more awareness of the Trust's values: • Respectful – each person's behaviour is strongly influenced by culture, nobody is simply a package of culture. Culture, religion and personality all affect the way an individual does or does not express their feelings. • Caring – listen to concerns, provide support and ensure families are at the heart of everything we do. • Responsible – ensure effective Communication which builds trust - parents who have confidence in the staff and in their judgement and skills are also more likely to feel confident about their own ability to cope.

	• Committed – treat families as individuals and deliver bespoke support and information whilst remembering it is every family's right to have the death of their child properly investigated.
2.7	The Chief Nurse (CN) thanked the patient's parents for speaking very candidly about their very sad and very poor experience. It was only the willingness of families to do that which enabled the organisation to make improvements.
The family and medical team left the room.	
2.8	In response to a question from the TC the Chief Medical Officer (CMO) stated that the Board had previously committed to learn from deaths. The story the Board had just heard was hugely impactful and the Board needed to understand its direction of travel in terms of its learning from deaths.
03 REPORT FROM CHIEF EXECUTIVE	
3.1 CEO's Report	
3.1	The CEO updated on the following: CQC Report Despite the fact the Trust had now exited special measures the CEO highlighted that the story above showed that the organisation was still not getting it right for all patients all of the time and there was still work to be done to ensure that it did. Post CQC report there had been lots of conversations about how to continue improvements for the benefit of patients. He reminded members that the report had been released on 21.03.18 and the organisation had been rated as 'requires improvement' overall with 'good' ratings in the three domains of 'effective', 'caring' and 'well-led'. In relation to the patient story Critical Care had now been rated as 'good', a credit to the team, but with more work still to be done around communication.
3.2	The CEO took the opportunity to thank all of the Trust's amazing people for their hard work, commitment and drive over the last 17 months to improve the quality of care provided to patients. Throughout the report, across all service lines, staff had been described as compassionate, caring and kind. Consistently through the report it was also highlighted that individual patient needs were taken into account and that there was good incident reporting and good learning from incidents. The inspectors also commented a number of times that the organisation had a clear understanding of its current challenges and was committed to improving services.
3.3	Winter Pressures and the Emergency Department (ED) The organisation continued to struggle to achieve the four hour access target although performance had largely been consistent in February and early March. The planned 're-set' had taken place the previous weekend and the organisation had seen three days of a huge step change in performance including for Minors and Paediatrics.
3.4	He reminded members of one of the universal (all acute hospitals) National Emergency Pressures Panel (NEPP) recommendations on 02.01.18 to defer 'all non-urgent inpatient elective care to free up capacity for the sickest patients'. The organisation had maintained the provision of elective surgery for urgent and cancer patients during that period and had restarted its non-urgent elective orthopaedic programme on 26.02.18. Other specialty non-urgent elective surgery was not yet back to baseline levels. That had had an impact on the Trust's financial position (as well as waiting times) which would be discussed later in the meeting.
3.5	Financial Position The Trust's financial position at the end of month 11 was a deficit of £29.7m compared with its gross control total excluding STF monies of £29.1m. The impact of the 02.01.18 NEPP letter regarding the suspension of elective activity and, as a consequence, the organisation's inability to claw back the elective orthopaedic underperformance of earlier in the year had been determined to be £3.7m. Including the impact of the activity suspension the Trust's year-end forecast outturn was £32.6m, £28.9m excluding that. The organisation was close to agreeing its activity and finance contracts for 2018/19 with its two main Commissioners and had submitted its draft Operating Plan for 2018/19 to NHS

	Improvement.
3.6	Consultant Appointments An Advisory Appointments Committee had been held on 14 March for Paediatric Consultants and the AAC was recommending to the Board the appointment of three consultants, two of whom were currently locums within the Trust. The Board approved the above recommendation.
3.7	NHS70 Parliamentary Awards As part of the celebrations for the NHS's 70th birthday in July, the organisation had nominated a number of teams for a Parliamentary Award, created to help celebrate achievements and identify innovative and high quality care. The following nominations had been made against the relevant categories: • Excellence in Cancer Care award – Cancer team • Patient and Public Involvement award – Patient Panel • Person-Centred Care Champion award – Learning Disabilities team • Care & Compassion award – Specialist Palliative Care team • Future NHS award – Research & Development team • Excellence in Urgent & Emergency Care award – Sepsis Pathway team
3.8	In response to a question from Associate NED Steve Clarke (ANED-SC) the CEO confirmed that the late (two weeks) approval by the Board of the consultant appointments above (minute 3.6) had not delayed the recruitment process and was following good governance.
3.2 Strategic Objectives	
3.9	The CEO reminded the Board that it had agreed five Strategic Objectives in June 2017, based around its 5Ps and supporting its ambition to provide outstanding care for its local population. The Board had agreed to maintain the strategic objectives for five years to ensure consistency of direction. Three minor amendments had been made for 2018/19 to reflect the move into the new financial year.
3.10	The objectives and amendments were as follows: 1. Our Patients - continue to improve the quality of care we provide **our patients**, improving our CQC rating ~~and exiting special measures~~ 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 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~~ 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 ~~2017/18~~ 2018/19
3.11	In response to a question from NED James Anderson (NED-JA) and in relation to the amendment to objective 1, the CEO confirmed he did not know when the CQC were likely to revisit. The organisation would, in the meantime, continue to strive towards 'outstanding', and 'good' would be a step towards that should the CQC return in the coming year. The Trust needed to ensure it continued with its own self-assessment aligned to its Quality Improvement (QI) programme. The TC added he would favour another mock inspection, the results of which would be invaluable.
3.12	In relation to objective 3, NED Stephen Bright (NED-SB) raised a concern that the amendment suggested only one part of the strategic area for future focus. In response the CEO acknowledged the point but confirmed that that was the name of the current Integrated Care Alliance (ICA). However the CEO agreed to amend the objective to '…. our local ICA'.
ACTION	**In relation to Strategic Objective 3, amend the wording to "….. aligned with the**

TB1.29.03.18/89	**development of a local Integrated Care Alliance".** **Lead: CEO**
3.13	In response to the above question from NED-JA, the CN stated that an organisation should always be inspection-ready. The Trust would continue to receive support from NHSI after coming out of special measures. There needed to be some further discussion around what the organisation now needed to do to maintain momentum via its quality improvement. Currently four other trusts were being supported by NHSI to participate in a programme of 'what good looks like – how to get to good and beyond' and her recommendation would be to speak to NHSI in relation to being part of a second cohort for that.
04 RISK	
4.1 Board Assurance Framework (BAF)	
4.1	This item was presented by the Head of Corporate Affairs (HoCA). She brought to the Board's attention that risk 2.4 had been completely revised and the revised risk rating was now nine. Risk 2.5 had met its target risk rating of 12. The Board was asked to approve the amendments and agree closure of risk 2.5.
4.2	In response to a question from NED-JA in relation to risk 1.1 the CN stated that the Quality & Safety Committee (QSC) that month had had a very robust discussion about its risks (1.1 and 2.2) and what it would take in order to reduce the rating of those risks. The Acting Committee Chair had requested a summary report outlining the evidence and rationale to support the reduction of the risk scores.
4.3	NED-SC raised a point in relation to risk 1.2 that although the narrative talked positively that actions had been undertaken to address parts of the risk, the target date for completion of actions had been extended. The Chief Financial Officer (CFO) agreed to follow that up.
ACTION **TB1.29.03.18/90**	**Update the Board on risk 1.2 in light of the fact that the target date has been extended despite actions being undertaken to mitigate the risk.** **Lead: Chief Financial Officer**
4.4	NED-SC highlighted there was a similar issue in relation to risk 2.3. In response the HoCA stated that related to a review of the organisation's communication function and the target date had been set to align with completion of that.
4.2 Significant Risk Register (SRR)	
4.5	This paper was presented by the CMO who updated that the top four risks remained unchanged (staffing, infrastructure, performance and finance) and there were no risks scoring 25.
4.6	NED-JA stated it would be useful (and make the register more dynamic) if it could evidence to what extent risks were progressing, how many new risks there were in-month and how many risks had hit their target date. He also had concerns around the issue of GDPR (General Data Protection Regulation) from the narrative provided in the document. In response to the first query the CMO stated that the software could certainly generate new risks in-month but was unsure whether it could provide data around achievement of targets. He agreed to review the register and the previous agreement to provide a front/summary sheet detailing the highest scoring risks.
ACTION **TB1.29.03.18/91**	**Review the Significant Risk Register in terms of providing narrative around progress, number of new risks in-month/hit target date in addition to considering the previous agreement to provide a front/summary sheet detailing the highest scoring risks.** **Lead: Chief Medical Officer**
4.7	In response to the concern around GDPR the CFO confirmed the Reference Group was established and meeting, feeding into the IG Steering Group. The issue would be an agenda item at May Board.
4.8	In response to a concern raised by NED Stephen Bright (NED-SB) in relation to the risks around fire suppression and the door to Grane House, the CFO agreed to update those with target dates.
ACTION **TB1.29.03.18/92**	**Provide target dates for the risks relating to fire suppression and the door to Grane House.** **Lead: Chief Financial Officer**

4.9	In relation to GDPR NED Pam Court (NED-PC) stated (in her capacity as Chair of the Charitable Funds Committee) that she was not assured of the readiness of the Charity, but had been more assured of the readiness of the Breast Unit – she cautioned that the law changed on 05.05.18. In response the CFO stated he would convene a meeting in advance of the May Board meeting to collectively look at the issues.
05 PERFORMANCE	
5.1 Integrated Performance Report (IPR)	
5.1	The Chief Operating Officer (COO) introduced the report in its new format. The report was still work in progress and would look slightly different again the following month but was linked to the organisation's 5P format. She went through the report (in page order) as follows: <u>In-Month</u> In terms of this first section the team had concentrated that month on operational detail but the following month would include quality, patients, workforce, people and places with key headlines for the month. <u>CQC 'Must & Should' Items</u> This section provided relevant progress each month and would link back through QlikView to start the work towards one version of the truth for all reporting. <u>Summary Scorecard</u> The following month this section would evidence the five graphs with the headlines for each of the 5Ps. <u>Performance Overview from the CQC</u> This showed the ratings sheet with the scorecard <u>Executive Summary</u> An update against each of the 5Ps.
5.2	<u>Performance</u> **Cancer** - the COO updated that Cancer performance remained strong and in January the Trust had been second in the country. Throughout 2017 the Trust had remained in the top ten of trusts for Cancer performance and in December had been top. There were some risks going forward in one or two areas but work was underway with clinical teams to mitigate against those. **Referral to Treatment (RTT)** - due to the elective suspension in January the RTT position had not been achieved for the first time since August 2016 and had finished at 89%. Recovery plans were in place with each of the HCGs and she was confident the position would improve over coming months. There had been a small number of 52 week breaches due to the suspension of activity and those patients would be treated as soon as possible. At that stage no harm had been identified. **Delayed Transfers of Care (DToCs)** - the organisation was now below the national average of 3.5% and was currently recording circa 2.3%. Compared to where it had been 18 months previously (seventh worst nationally) it was now amongst the top performing trusts. ED performance continued to be a challenge and there would be further detailed discussion around it that afternoon.
5.3	The COO continued that the new format report included as much bench-marking information as possible although there was further work to do on some of the graphs which had been included to clearly evidence trend lines, targets and trajectories. In terms of non-elective and elective admissions, the graphs showed December performance for non-elective admissions. Looking at the January position that had reduced and further analysis around that would be included the following month. Equally the elective position had also reduced.
5.4	In terms of responsiveness and ED performance she updated that the previous weekend had been a 're-set' weekend around the Trust's Assessment Units. There had been good engagement from six consultants who had come in to support that process in addition to

	those already on shift that weekend. There had also been some strong nursing and operational support. The team had managed to move ENP and GP colleagues into a new location at the front of the hospital with seven new consulting rooms. In terms of the Clinical Decision Unit (CDU) that had been used as an escalation area the previous week however from Saturday onwards (with a couple of exceptions) it had been operational as the Clinical Decision Unit with improvements immediately seen.
5.5	The Surgical Assessment Unit (SAU) had been de-escalated the previous Friday and since then had operated as a SAU with no inpatients. However the biggest improvement had been with the Medical Assessment Unit (MAU) where on Sunday over half the ward had been discharged leaving two clear bays going into Monday morning. There had been further progress throughout the week and as of the previous day there had been eight patients who had been there over 24 hours due to D&V issues which were being worked through that morning – and another four patients who had been there up to 24 hours and were now being placed to other wards. Over the weekend again there had been improvements led by colleagues from the Discharge Team with better discharge planning so the organisation had been able to better forecast leading into the bank holiday weekend.
5.6	In terms of ED itself the COO felt there had been a marked improvement that week – it had been a very positive and proactive department the previous day and there had been a very robust ED huddle attended by both herself and the CFO. Minors performance the previous day had been 94.3% and Paediatrics had been 98% giving an overall performance of 85% - week to date the organisation was at 77.2% and Paediatric week to date was 93.8%. She highlighted that over the previous seven days there had been four days with attendances over 300.
5.7	As a result of the 're-set' weekend further 12 hour trolley breaches had been incurred although no patients had come to harm. Since the previous day there had been no further breaches and the team were working hard to maintain flow.
5.8	NED John Hogan (NED-JH) welcomed the progress as described above but asked whether it was sustainable. In response the COO stated that the coming weekend would be a big test. She had met with key ED team members earlier that morning to talk around the clinical support for the juniors over the next few days. In her view the progress was sustainable unless patients started to back-up. She had seen a shift in attitude over recent days at the front door and in MAU in particular. There had been work done with Social Care and the CCG in relation to opening some extra capacity. Whilst that had not happened it had pushed colleagues to identify alternative capacity. There had been a proposal from EPUT that week to open an additional 18 beds in the system before the end of April – six they felt they could open the following week. There had also been confirmation from Hertfordshire that they would continue to keep open their eight winter beds until the middle of April at least.
5.9	In response to the sustainability question posed above the CEO stated that in terms of ways of working he felt those were sustainable – in terms of MAU and how it worked. Teams were very engaged and the only issue he could foresee would be a backlog in ED which was why outflow was critical. He agreed the organisation would need to continue with its longer term planning on its discharge process but he felt progress was sustainable with the proviso that the extra bed capacity was realised and remained in place. In response to a further question he stated that improvements were not, he felt, due to coming out of the winter period. There had been evidence that week of a huge change in attitude, ownership and belief amongst teams.
5.10	The COO continued that another change she had seen that morning was that the Associate Medical Director in the ED was now starting to look at the data around productivity in terms of performance across the department to facilitate further improvements.
5.11	The Director of Quality Improvement (DoQI) flagged it was important to recognise that each of the Internal Professional Standards (IPSs) over the last week had delivered so a significant improvement at each stage of the process and a reflection of the recent work around culture, behaviour and attitude.
5.12	<u>Patients</u> In relation to Quality the CN continued that from an experience and complaints point of view

	and despite being in special measures, it appeared the organisation would reduce its complaints again for the sixth successive year and with an exponential rise in PALS cases all of which were closed at the point of care within 48 hours – circa 320% improvement. The Friends & Family Test (FFT) in February had seen a greater than 95% achievement. In relation to Infection Control MRSA remained zero for the year. In relation to C-diff it was almost certain the organisation would come in under trajectory (10). The target for the new year was nine. In relation to MSSA the Trust was the top general hospital nationally in terms of MSSA figures which was worth noting and a precursor to MRSA. In relation to Never Events the organisation had been two years without one and also continued to report high levels of incidents with a low level of harm (96%). By year end the Serious Incident (SI) rate would have increased (in a positive way). There had been a slight increase in Grade 2 pressure ulcers which would now go to scrutiny but she felt issues were around the recording of those. Catheter acquired infections were also under scrutiny.
5.13	In relation to Mortality the CMO reported that the numbers in the IPR were different to those in the Dr. Foster report but that was down to timing.
5.14	Associate NED Helen Glenister (ANED-HG) highlighted an increase in avoidable cardiac arrests which mirrored the situation in the previous year. In response the CN stated that related to reporting and more commentary needed to be provided. Avoidable arrests went to SIG but might be about EoL decision-making which would not be known until then. Teams made a preliminary decision at the time of death which could then be subject to change at SIG. The CMO added the increase followed the normal winter pattern but cautioned that numbers were very small.
5.15	<u>People</u> The Interim Director of People (IDoP) stated there were no Staff FFT results that month but once received it would be interesting to see if exiting special measures had had any effect. Data was provided in terms of vacancies, sickness absence, agency and turnover all of which broadly showed a small measure of improvement internally. Her concerns were around maintaining the momentum with statutory/mandatory training and appraisals after exiting special measures.
5.16	<u>Places</u> In relation to Estates & Facilities the DoQI stated the key concern there was to continue to deliver the CIP programme for the year. Training and appraisals were moving in the right direction. The 'First Impressions Count' work-stream was starting to gain momentum with lots of positive feedback from staff and patients alike. There was work to do around data collection on responsiveness and urgency in terms of repairs and maintenance and a new process would be in place shortly around reviewing standards of cleanliness. The team had recently been asked to judge some local art/sculpture designs at the town's college – and had been very impressed. Winners' pieces would soon be on display in the Trust. Artwork from local school children would also soon be displayed.
5.17	The TC thanked the DoQI for the team's remarkable work at the front door over recent weeks and agreed the hospital now felt very different. In response to a question from NED-JA it was confirmed it had been hoped the new front door would open that day but there had been some technical issues. It should open in the next few weeks.
5.18	In response to a question from NED-PC in relation to time to GP appointment being six weeks locally, it was confirmed that conversations around that took place at both the Local Delivery Board and also at the ICA. The CEO stated that the quality of GP referrals was reducing and a spot audit had indicated increasing numbers of patients attending as a referral but without having seen their GP. It was hoped that the new Urgent Treatment Centre and Out of Hours GP service would provide a better response for that cohort of patients.
5.19	<u>Pounds</u> The CFO reported the year-to-date position at Month 11 was £29.7m and outturn of £32.6m including the impact of the elective suspension (£3.7m). The impact was marginally better than had been reported to the Trust's Regulators with the anticipated impact originally estimated to be £4.5m compared to the £3.7m; this was in part due to the management of day case activity. Under-pinning those results was the forecast over-delivery of the CIP

	programme – an £8m target with a forecast delivery of over £9m including the MEA asset revaluation. Agency costs had come down by £2m from the previous year's outturn and the forecast outturn in the current year of £12.6m compared to £13.6m target – included in that were medical locum reductions; the target for which was £0.5m reduction which he believed would now reduce for the year by circa £900k. So over-delivery of medical locum costs from £7m in the previous year to £6.1m in the current. Nurse/agency spend remained relatively static. There were continued discussions at national level around the organisation's eligibility for STF monies which were crucial in terms of the cash settlement that year, the net results for the current year and the control total flexibility for the coming year 2018/19. In terms of capital the organisation was looking to spend its capital resource limit subject to a £250k - £500k underspend and despite late receipt of funds from NHSE (£1.6m) anticipated an external financing limit undershoot of £250k.
5.20	In response to a question from NED-JH in relation to the reduction in the spend on medical locums it was confirmed that was not at the expense of safer staffing. The CMO confirmed all were signed off by him and he had daily meetings around that with HR and there was a very detailed process in place behind it. The CFO also highlighted that rate reductions and costs via direct engagement had also contributed as well as reduced utilisation.
5.2 Operating Plan 2018/19	
5.21	This item was presented by the CFO who highlighted that the report should be read in conjunction with the paper which would be presented to the private session later in the day. The paper focussed on what needed to be done both at local and national level. The detail of the draft annual plan would follow in private session as it was still draft with final submission due on 30.04.18. At the time of writing contract negotiations were still live and but had recently concluded. There remained the issue of the control total for the coming year and eligibility around the flexibility of some £5m subject to the current year's outturn. That was still subject to discussion with NHSI as was the draft plan itself. Once that was concluded their authority would be received to have it placed in the public domain.
5.22	In response to a question from ANED-HG the CFO confirmed that the previous year the organisation had submitted a two year plan so the plan under discussion was year two of that two year plan and was being refreshed under the organisation's 5Ps.
06 QUALITY	
6.1 Nursing, Midwifery and Care Staff Levels	
6.1	This report was presented by the CN and key headlines were: • Actual fill against planned staffing remained above 70% but February had seen the third consecutive month with a reduction in the Trust average fill rate for both registered staff for day and night and unregistered staff for days. • Annual leave was only above compliance on four wards during half term week and Associate Directors of Nursing were driving improvements in annual leave profiling particularly for predicted planned peak periods such as school holidays. • A net gain of 1.0 WTE registered nurse on Safer Staffing Wards. • Little change in the overall Trust RN vacancies from the previous month – a reduction of 0.08 %. • There were currently 192 RN vacancies and 42 HCSW vacancies - that increase had been driven by a skill mix review in theatres and surgery. There were only six vacancies in therapies but with potential recruits in the pipeline. • There had been a net gain of 1.0 WTE RN starter to the 'safer staffing wards' during February. Four RNs plus two international RNS and one midwife had commenced employment in March. There were six confirmed RNs starting in April and four international nurses with five other potential RNs if employment checks were completed. There were delays in Occupational Health clearance which the Interim Director of People was addressing.
6.2	In response to a question from NED-AH the CN agreed, going forward, to provide a table to show the total number of nursing posts versus vacancies.
ACTION	**Hard Truths paper to include a table showing the total number of nursing posts**

TB1.29.03.18/93	**versus current vacancies.** **Lead: Chief Nurse**
6.3	NED-AH raised a second concern that the paper stated that annual leave was only just above compliance on four wards but that PAF had been told earlier that week that of the twelve nurses in the ED only four had been on shift that Monday. In response it was confirmed that was inaccurate and on review the figure was found to be seven.
6.4	The TC highlighted that in summary, the nurse vacancy issue was not diminishing and in his view more needed to be done to resolve the problem. Whatever the reason, other trusts had vacancy rates under 10% compared with the Trust's at just over 22.5%. The CN agreed and voiced a concern that it would be difficult for the Trust to achieve a 'good' rating with so many vacancies. In response the CEO stated that coming out of special measures would have a positive impact and the organisation needed to act quickly on that. The hospital now looked and felt better but his view was that the Trust did not sufficiently promote what it did well or staff benefits. He agreed the recruitment process was improved and he had had conversations with the CN around establishing a greater career structure for higher level nursing posts so that staff felt they could follow a proper career pathway. The CN added that the Trust supported three local universities and had a very strong apprenticeship pipeline and that needed to be promoted on the organisation's website. In summary the Trust needed to be much smarter about its whole offering.
6.5	After a further short discussion it was agreed an update on recruitment/vacancies would be brought to the Board's July meeting.
ACTION **TB1.29.03.18/94**	**Provide an update on Recruitment/Vacancies to July Board.** **Lead: Interim Director of People/Chief Nurse**
6.2 Mortality Update including 3 Year Review	
6.6	This item was presented by the CMO. For clarity he confirmed the correct figure for HSMR (December 2016 to November 2017) was 114.7 and statistically 'higher than expected'. This equated to approximately 130 deaths which had occurred due to something other than chance over the last 12 months. Although missing from the report he confirmed that the stillbirth rate remained very low and well under the national average of 3.5%. However there was now a new requirement for review of stillbirths over 22 weeks gestation and that process had just started in the Trust.
6.7	In relation to the three year review he highlighted the following: • The Trust's mortality did not appear to be related to nursing numbers – nursing vacancies had remained static whilst mortality deteriorated. • The Trust's mortality level was not due to sicker patients which was evidenced by admission data and the hits on the electronic observation system. The Patient Safety Thermometer also did not highlight any particular worrying trend. • What was of interest, and related to operational performance, was that if that was cross-checked with e.g. outlier alerts, the point at which mortality started to slip was Spring 2015 where performance hit the 80s – it then tipped over winter 2016/17 when performance hit the 70s and then picked up again in the Spring of 2017 when performance reached the 80s again. There was no evidence of cause and effect so he was unsure whether one could be attributed to the other but it was a point of interest/concern. He reminded members that international evidence had shown there was a link between mortality and the length of time spent by a patient in the ED. • There was an error in relation to the coding comments – the paper reported that coding had deteriorated but that was an error made by Dr. Foster. The reality was that Trust coding had improved against a national deterioration – he apologised for the error.
6.8	Whilst the organisation had a very good understanding and grip on process, audit and governance, what was actually driving the underlying trend was still very much unclear. For the past seven months in-month HSMR had come down and was 'as expected' so the hope now was that the rolling 12 month HSMR would also move to 'as expected'.
6.9	In terms of improvement actions the CMO continued that any outlier alerts were rigorously

	audited and coding double-checked. Pathways had been reviewed. Clinicians were now more engaging and had data to hand. That week the advert had been issued for the Medical Examiner role and he had had seven applicants in the past 24 hours.
6.10	NED-JA stated that he very much welcomed the internal governance which now existed and also the more stringent response to alerts. NED-JH asked whether if mortality data was made available to the clinical body they would take more ownership of the issue. In response the CMO stated that they already had the data, but their take on it was it was down to 'over-medicalisation'.
6.11	In response to the above the TC stated there needed to be an alternative to the support which had originally been offered (then disappeared) from Public Health England. In response the CMO stated that a Public Health Registrar was about to start with the Trust. It was also highlighted that the Deputy COO had some PHD students joining the Trust in July and they too could be a source of additional support.
07 FINANCE AND WORKFORCE	
7.1 Month 11 Finance Report	
7.1	Already discussed above.
7.2 Staff Survey Report and Action Plan	
7.2	This item was presented by the IDoP who drew members' attention to the appendices at the back of the report which summarised the key findings. The analysis was: • A total of 3233 PAHT staff were sent a questionnaire - 1159 returned a completed survey giving a response rate of 37.1% (compared with 39% in 2016, and 34% in 2015). • The Picker results showed that from a total of 88 questions used in both 2016 and 2017 surveys, the Trust compared to 2016 was significantly better in 23 questions and only worse in two. Comparing the organisation with other Picker Trusts it was significantly better in 11 questions but worse in 23. • The DoH report focused on 32 key areas ('key findings') mainly based on summary scores from groups of questions, which when taken together gave more information about each of the 32 areas of interest. The 32 key findings were presented under nine themes: 1. Appraisals & support for development 2. Equality & diversity 3. Errors & incidents 4. Health & wellbeing 5. Job satisfaction 6. Managers 7. Patient care & experience 8. Violence, harassment and bullying 9. Working patterns • The DoH results showed the Trust had improved in eight of the 32 key findings and declined in none from 2016 to 2017. Just under half of the key findings (15/32) compared the Trust as average to being in the top 20% when compared with benchmarked Trusts. However in 17/32 key findings the Trust was below average when compared to benchmarked Trusts.
7.3	Following analysis of the corporate results the Trust would produce a comprehensive set of action plans to drive further improvements. Work between colleagues in HR and the HCGs would then develop and implement localised action plans specific to each area (and staff group) that could be addressed quickly by the staff involved. Further reports would be presented to the May 2018 Workforce Committee.
7.4	Members agreed there were no surprises from the results and it was reassuring that the negatives were widespread rather than being concentrated in one particular area. The CN highlighted a concern that despite all recent work undertaken around engagement in the organisation, there was still a cohort of staff who felt bullied. It was agreed that data

	needed to be triangulated further with e.g. health and wellbeing data/health and safety incidents.
7.3 Gender Pay Gap Report	
7.5	This item was also presented by the IDoP who stated that the Trust welcomed the new gender pay reporting regulations which had come into effect on 01.04.18. The regulations set out that all public authorities employing more than 250 people must report on gender pay. The position reported was at 31.03.17.
7.6	She highlighted that it was important to note that the gender pay gap was a separate concept from equal pay. Equal pay was concerned with men and women earning equal pay for the same, or similar, work; the gender pay gap is about the difference between men and women's average pay within an organisation.
7.7	The IDoP continued that the gender pay gap measured the difference between mean or median hourly rate of pay of male and female colleagues. The mean pay gap was the difference between average hourly earnings of male and female and the median pay gap was the difference between the midpoints of hourly earnings of male and female. The overall gender split within the Trust's workforce was 78% female and 22% male.
7.8	The organisation's staff survey results showed that the following areas were to be celebrated in relation to gender across the Trust: • KF20 referred to staff experiencing discrimination at work in the last 12 months and showed an improvement of 1% (with a reduction from 13% to 12%).In terms of the gender breakdown, 10% of men and 12% of women responded positively to that line of enquiry. That finding was average when benchmarked with other acute trusts. • KF21 referred to staff believing that the organisation provided equal opportunities for career progression and promotion and also showed an improvement from 80% to 82% from 2016 to 2017. In terms of the gender breakdown, 81% of men and 83% of women responded positively to that line of enquiry. That finding was below average when benchmarked with other acute Trusts – the average was 85%.
7.9	The IDoP confirmed that although the final action plan was still under development it focused on key areas only and would be monitored by the WFC. Following approval of the report by the Board it would be posted on the Trust's website later that day.
7.10	In response to a question from NED-JA it was confirmed that WFC had discussed the report, particularly in relation to female consultants. There were some amendments to be made, not specifically to pay but to access in relation to elements such as posts, opportunities and flexible working.
08 GOVERNANCE – COMMITTEE REPORTS	
8.1	Key headlines were: <u>CFC.12.03.18</u> • Recommendation made to the Committee and to the Board (in relation to the Presidents' Club donation) to keep the donation but not to seek any further donations. <u>AC.15.03.18</u> • Draft note received from Chief Internal Auditor with the likelihood of a reasonable assurance opinion on internal control. • The Committee received the Draft Annual Governance Statement from the CEO as Accountable Officer and noted the statements on internal control. • External Auditors reported on their work to date drawing attention to the change in the basis of asset valuation which they expected to concur with. A question had been raised about 'average life' as future 'average life' was 29 years and may pose an issue in coming years. They would be issuing a S30 letter and a draft had been circulated. • The Committee received a report on Whistleblowing and noted the appointment of two new Freedom to Speak Up Guardians. <u>QSC.21.03.18</u>

	• The Committee had welcomed the attendance of clinical staff for the results of Caesarian Section Audit. • Further updates and assurance had been requested from wards that were non-compliant with high impact interventions/audits. • The Committee had requested assurance that the comments from stakeholders in relation to the Quality Account were addressed. <u>WFC.22.03.18</u> • Whilst the Committee had not received the full report from the GMC Survey it was pleased to note some improvements but equally there were areas of concern e.g. junior doctors not receiving feedback. • A workshop had been held around Strategy. • Advice to Executive team on performance meetings that teams needed to be aware of their staff numbers and appraisal rates etc. • The Committee had felt it was unusual practice for staff to move up an increment when they had not completed their statutory/mandatory training – a point for consideration by the Executive team. <u>PAF.26.03.18</u> • The Committee had had sight of the draft Operating Plan and requested Board agreement for the CFO to be able to access loans up to the value of the deficit. • There had been a presentation from Paediatrics and Minors on performance – the former had been very detailed but with no apparent linkage between actions and hitting targets. The team would update again in May. • OBC – it was agreed that PAF.23.04.18 would be the forum for running through the presentation to NHSI/NHSE on 24.04.18. • New linen contract agreed. • Agreed the scoring on BAF risks would remain unchanged. • Updated provided on M11 Finance Report
09 QUESTIONS FROM THE PUBLIC	
9.1	In response to two questions from a male member of the public the Board responded as follows: *To what extent is PAH making use of partnership working with the voluntary sector in relation to improving palliative care provision?* Following its CQC report 18 months previously where EoL care had been deemed inadequate there had been a concerted effort by the Trust to work more collaboratively with Commissioners, Primary Care and local hospices. Two large groups had become established one with a West Essex focus and the other with an STP focus. Over the last 12 months there had been much progress including work with the voluntary sector. The Trust had linked up recently with the Anne Robson Trust to provide a very successful programme of Butterfly Volunteers in the organisation to care for EoL patients and their families/carers at the bedside. *Although diagnostic performance is good there are clearly challenges in the ED with capacity – is there any work going on in relation to GP referrals to minimise referrals to ED and/or to ensure the quality of any referrals is optimised?* There are a number of areas offering a one-stop and/or seven day service. There does need to be some work on the two week wait cancer pathway. There has been work done in conjunction with the Accountable Care Partnership on three pathways in particular to improve and speed up the patient journey. There has also been work around online clinical portals to enable access to GP records.
10 CLOSING ADMINISTRATION	
10.1 Summary of Actions and Decisions	
10.1	These are presented in the shaded boxes above.

10.2 New Issues/Risks	
10.2	No new risks or issues were identified.
10.3 Reflections on Meeting	
10.3	Not undertaken at this point.
10.4 Any Other Business (AOB)	
10.4	As it was NED-JA's last meeting the TC thanked him for his contribution to the organisation over his term and wished him well in his future endeavours. ANED-HG would be his replacement and the Trust would be out to advert soon to fill the ANED position.

Signed as a correct record of the meeting:	
Date:	07.06.18
Signature:	
Name:	Alan Burns
Title:	Chairman

Trust Board Meeting in Public
Action Log - 07.06.18

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.29.03.18/89	Strategic Objectives	In relation to Strategic Objective 3, amend the wording to "….. aligned with the development of a local Integrated Care Alliance".	CEO	TB 1.07.06.18	Actioned.	Closed
TB1.29.03.18/90	BAF Risk 1.2 (EPR)	Update the Board on risk 1.2 in light of the fact that the target date has been extended despite actions being undertaken to mitigate the risk.	CFO	TB 1.07.06.18	This risk and the actions which will support delivery of the target risk rating have been discussed in detail at PAF and the actions have been clarified in the narrative section of the BAF.	Proposed for closure
TB1.29.03.18/91	Significant Risk Register	Review the Significant Risk Register in terms of providing narrative around progress, number of new risks in-month/hit target date in addition to considering the previous agreement to provide a front/summary sheet detailing the highest scoring risks.	CMO	TB 1.07.06.18	Actioned.	Closed
TB1.29.03.18/92	Fire Suppression /Door to Grane House	Provide target dates for the risks relating to fire suppression and the door to Grane House.	CFO	TB 1.07.06.18	**Fire Suppression**: Capital made available in 17/18 and not spent. New funding request based on the outcome of the formal tender process was agreed at the ICT Programme Board on 22/5/18. Request to quickly undertake a review of the proposal received to ensure that it was 'fit for purpose' before proceeding to order. External evaluation report received 31/5/18 and proceed to order 1/6/18. **Grane House:** Expecting the doors to be available and the work completed mid – end of July 2018.	Proposed for closure
TB1.29.03.18/93	Hard Truths Paper	Hard Truths paper to include a table showing the total number of nursing posts versus current vacancies.	CN	TB 1.07.06.18	Addressed at item 6.1.	Closed
TB1.29.03.18/94	Recruitment/ Vacancies	Provide an update on Recruitment/Vacancies to July Board.	IDoP	TB 1.05.07.18	Item not yet due.	Open

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The Princess Alexandra Hospital NHS Trust

Trust Board Meeting - 7 June 2018

3.1

Agenda Item:	3.1
Presented by:	Chief Executive - Lance McCarthy
Prepared by:	Chief Executive - Lance McCarthy
Date prepared:	1 June 2018
Subject / Title:	Chief Executive's Report

Purpose:	Approval		Decision		Information	x	Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting.
Recommendation:	The Trust Board is asked to note the CEO report and to agree the AACs' recommendations to appoint 2 new consultants.

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:	Links to all 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 June 2018

3.1

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

(1) Key performance headlines

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

Key Performance Indicator	Actual performance for latest month
ED 4-hour performance	75.82%
HSMR	116.4
CDiff numbers	0
MRSA numbers	0
Never Events	0
RTT incomplete	87.2%
Cancer 62 day standard	78.9%
6-week diagnostic standard	99.4%
I&E variance from plan	£75k deficit
Agency expenditure	£995k

(2) Urgent care performance and flow

We continue to struggle to achieve the 95% 4-hour access target, although performance has continued to improve for the last few months. April and May performance were both above their agreed trajectories, as we strive to achieve 90% by September 2018 and 95% by March 2019.

The flow of patients in to, through and out of the hospital has improved significantly since our 'reset' of the hospital on 24 / 25 March. The main aim of this was to be able to get our assessment facilities (Fleming and Melvin) back running as assessment units, rather than inpatient capacity, supporting the quicker diagnosis and treatment of relevant patients. Additional community bed capacity has been put in to place in the immediate term to support patients being discharged more effectively and more timely to an appropriate care environment to best meet their needs and simultaneously reduce inpatient bed occupancy rates. We continue to work closely with our health and care partners to ensure the right community capacity is in place to best meet the needs of our patients, including a system wide point prevalence audit on 25 May.

Recent site visits from Ben Owens (NHSI expert) and Pauline Philip (National Director for Emergency Care) have confirmed that all the recent actions undertaken over the last 9 months are the right ones and are starting to have a positive impact on patient care and experiences. Additional actions recommended by Pauline include ensuring consistent streaming of patients out of ED, in line with our local delivery board plans and additional IP bed capacity on site, in line with our Board discussion last month. Additional actions recommended by Ben include reviewing the timing of all relevant shifts that support the ED and ensure more consistent behaviours and approaches from relevant clinicians, in line with our ongoing work to change the culture of the organisation.

We continue to have an organisational wide weekly urgent care and flow meeting and we remain on regular system wide escalation working closely with NHS England and NHS Improvement to try to reduce blockages in the wider system.

(3) Consultant appointments

Consultant Advisory Appointments Committees were held on 8 May and 23 May for Trauma and Orthopaedic and Obstetrician and Gynaecologist appointments respectively. The AACs recommend to the Board the appointment of 2 consultants:

- Dimitra Leivadiotu
- Alexander Field

The Board is asked to approve the AACs' recommendation.

(4) NHS Improvement and NHS England changes

On 24 May 2018, there was the first public Board meeting in common of NHS Improvement and NHS England. At this they agreed how they are going to work closer together, including many of their functions moving to single integrated teams reporting to both organisations.

In addition there are proposals for regional teams to be hosted in one of the organisations working on behalf of both in relation to quality, finance and operational performance. The Regional Directors will also support the development and identity of local STPs and ICSs and will report to the two CEOs and be full members of the national NHS Executive Group.

At a national level there will be three national director roles reporting to both CEOs:

- single NHS Medical Director
- single NHS Nursing Director
- single Chief Financial Officer

The senior appointments will be made by the end of the summer.

(5) Executive Director changes

I'd like to take this opportunity to welcome Michael Meredith as our new Director of Strategy. Michael joins us from PwC with a wealth of consultancy experience in the NHS. He started on Monday 4 June 2018.

We have also successfully recruited to our director of People, OD and Communications role on a substantive basis. Ogechi Emeadi will join us on 1 August from Milton Keynes University Hospital NHS Foundation Trust where she has been the Director of Human Resources and Workforce Development for just over 4 years.

I'd also like to take this opportunity to congratulate Nancy Fontaine on her successful appointment to Chief Nurse at Norfolk and Norwich University Hospitals NHS Foundation Trust. Nancy will be leaving us at the end of July / start of August. Her role is currently out to advertisement with a closing date of 11 June and interview date of 29 June 2018.

Author: **Lance McCarthy, Chief Executive**
Date: **31 May 2018**

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The Princess Alexandra Hospital NHS Trust

Trust Board - 7 June 2018

4.1

Agenda Item:	4.1
Presented by:	Head of Corporate Affairs - Heather Schultz
Prepared by:	Head of Corporate Affairs - Heather Schultz
Date prepared:	31 May 2018
Subject / Title:	Board Assurance Framework 2018/19

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Board Assurance Framework 2018/19 is presented for review. The risks, risk ratings and outcomes of Committee reviews in month are summarised in Appendix A and the BAF is attached as Appendix B. Risk 5.1 (finance) was discussed at PAF and the Committee supported the reduction of the risk rating from 20 to 15.
Recommendation:	The Board is asked to approve the Board Assurance Framework and the reduction of the risk score for Risk 5.1 from 20 to 15.

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 in May 2018, QSC on 23 May, Workforce Committee on 29 May and PAF on 24 May 2018.
Risk / links with the BAF:	As reflected in the attached BAF.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with national legislation and regulations and the Code of Governance.
Appendices:	Appendix A - Summary of Residual Risk Ratings Appendix B - Board Assurance Framework 201/18

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5P	Executive Lead	BAF Risks	Current risk score	Designated Committee and outcome of Committee review.
	Chief Nurse/Chief Medial Officer	1.1 Outcomes: Inconsistent outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	16	QSC Reviewed at QSC.23.05.18; rating confirmed.
	Chief Finance Officer/DoI& IT	1.2 EPR Concerns around data quality including misuse and compliance with system and system resilience as well as forward compatibility as Trust moves towards having Integrated Care Records	16	PAF Reviewed at PAF.24.05.18 and actions being taken to support delivery of target risk rating discussed in detail. Risk rating confirmed.
	Chief Finance Officer/DoI& IT	1.3 Coding Risk Coding issues (including clinical) within the Trust impacting on Patient Safety, Finance, Performance and Operational delivery	16	PAF Reviewed at PAF.24.05.18 and actions being taken to support delivery of target risk rating discussed in detail. Risk rating confirmed.
	IDoP	2.1 Workforce Capacity Concerns around staffing capacity to manage workload, deliver services of high quality and maintain national performance requirements.	20	WFC Risk rating confirmed.
	Chief Nurse/Chief Medial Officer	2.2 Clinical Leadership and Engagement Inconsistent Clinical Leadership & Engagement in strategy, operations, performance and delivery which impairs Trusts reputation & sustainability.	16	QSC Reviewed at QSC.23.05.18; discussed reduction of risk rating to 12 and agreed to defer pending outcome of Medical Enagagement Survey.
	IDoP	2.3 Internal Engagement Failure to communicate key messages and organisational changes to front line staff.	9	WFC Risk rating confirmed.
	IDoP	2.4 Workforce Productivity Gaps in staff capability not being consistently addressed through available performance management and development processes	9	WFC Risk rating confirmed.
	DQI	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	PAF Reviewed at PAF.24.05.18, risk rating confirmed.

	DoPP	3.2 Health Economy Stability & Joined up Approach Failure of the Accountable Care Partners to integrate and work effectively as an ACP and deliver demand management, productivity and efficiency targets, undermining both hospital and system sustainability.	**16**	For review by Trust Board.7.06.18.
	DoPP	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.7.06.18.
	DoPP	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.7.06.18.
	DoPP	3.5 Sustainability of local services Failure to ensure sustainable local services.	**16**	For review by Trust Board.7.06.18.
	DCFO/DQI	4.1 Supporting Functions (including Finance, IT, and Estates and Facilities)** Concerns around the need to modernise the systems, processes, structures, capacity & capability of the business support functions. **HR reflected as separate risk in November 2017.	**12**	PAF Reviewed at PAF.24.05.18, risk rating confirmed.
	COO	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	**20**	PAF Reviewed at PAF.24.05.18, risk rating confirmed.
	CFO	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	**15**	**PAF** **Reviewed at PAF.24.05.18, and reduction in risk rating from 20 to 15 supported.**

The Princess Alexandra Hospital NHS
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The Princess Alexandra Hospital Board Assurance Framework

2018-19

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Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2017-18**											
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 **Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
BAF 1.1		Inconsistent outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Inconsistent treatment stratification ii) Failure to incorporate patient feedback (including PALS) into service improvement and re-design. iii) Failure to achieve sustainable improvements in national survey results iv) Poor results in 2016 Inpatient Survey	**4 X 5= 20**	Chief Nurse/ Chief Medical Officer **Quality and Safety Committee**	i) Robust quality and safety governance structures in place including infection control ii) Performance management of unacceptable behaviour. iii) Robust Appraisal/ medical revalidation process which includes patient feedback - 360° feedback and Fitness to Practice process in nursing iv) RCA methodology workshops v) End of Life and deteriorating patient simulation programme for all staff. and Whole System Steering Group vi) Mandated & focused education & training in communication skills such as breaking bad news training. vii) Sharing the Learning Programme viii) Monthly Commissioner reviews of quality and Safety ix)Four 'Big Dots' - AKI, Sepsis, Mortality and End of Life xii) Risk Management Training Programme xiii) Monthly newsletters - Quality Matters, Pharmacy 5 Minutes xiv) Escalation processes for prescribing doctors and processes for non-medical prescribers xv) Electronic handovers and E-Obs xvi) Schwartz Rounds xvii) Redesign of ED xviii) NHSI/NHSE Oversight xix) Red2 Green Board rounds xx) Improved reporting and review process for deaths and establishment of incident management group. xxi) Patient Experience Strategy xxii) NED lead appointed for Mortality	i) National Surveys ii) Cancer Survey iii) CEO Assurance Panels iv) SIG meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings x) PLACE Inspections xi) Medicines Management Committee xii) CCG audits xiii) Monthly QA visits/inspections xiv) End of Life and Mortality Groups xv) Executive Assurance meetings with ED, Critical care, End of Life, Urology and General Surgery. xvi) AKI and Sepsis merged with Q1st and NED lead	i) Improvement in some areas of the National Inpatient Survey ii) CQUIN reports to PAF/QSC iii) CEO Assurance Panels. iv) Reports to QSC on Patient Experience, Serious Incidents, Safer Staffing, Patient Panel, Safeguarding, Infection Control (top quartile) v) Reports to Board from QSC and reports on clinical issues for escalation, Mortality and CN/CMO reports vi) Dr Foster reports, CQC inspection reports and GIRFT reports vii) Increase in Datix reporting and reduced harm over approx. last 18 months viii) Feedback from NHSI and Commissioners on harm reviews (positive) ix) Real time Dr Foster feedback x) Arthoplasty infections (monitoring) xi) Water Safety testing across the Trust (SMH) - normal results xiii) Local Delivery Board (LDB) xiv) GMC Trainee Results Report xv) Integrated Performance Report (IPR) xvi) Mock CQC Inspection Report xvii) Learning from deaths reports and dashboard, Mortality Presentation to Board (Oct 17) and HSMR improved to 114. ~~report to Board November 17 (fourth month of improvement)~~ xviii) ~~Qliview~~ Outstanding NICU peer review xix) Clinical Audit report - tiaa xx) Enable East Review Review (Oct 17) xxi) Improved palliative care coding	**4x4=16**	i) Real time patient safety feedback ii) Internal/External Comms in development iii) Evolving clinical audit approach iv) Real time patient feedback system in procurement phase v) Disparity in local patient experience surveys versus inpatient survey vi) Staffing and site capacity **ACTIONS:** i) Website development ii) Inpatient Survey action plan in place	i) Clinical evidence of improvements made following Compliance with national audits, NICE,NCEPOD.	01/05/2018	**Risk rating not changed.**	**4x3** =12 (Target date ~~March~~ Sept 2018 - to achieve 'as expected' for mortality and for patient experience, 5 personal care indicators in Quality Account in top 20%)
			Effects: i) Poor reputation ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Recurrent themes in complaints involving communication failure v) Loss of confidence by external stakeholders											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2017-18**											
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 **Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial control total for 2018/19**													
BAF 1.2		**EPR** Concerns around data quality including misuse and compliance with system and system resilience as well as forward compatibility as Trust moves towards having Integrated Care Records	Causes: i) Poor engagement with the system, usability, time/skills ii) System fixes	**5 X 4= 20**	Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iii) Performance Mgt Framework in place. iv) Training programme. v) Super users in place to deliver focused support. vi) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability vii) Access Policy viii) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) ix) Development of capacity planning tools/information x) PWC review and actions identified xi) DQ meetings re-structured xii) ICT Newsletter issued xiii) New training process for locums xiv) Link to Quality 1st being discussed. xv) New daily ~~weekly~~ Cambio meetings/roadmap xvi) Internal daily ICT/COSMIC meetings ongoing xvii) 7.7 in development and expected in test environment by end of May ~~9.02.18~~ xviii) Real time data now available xix) Exec to Exec meetings every 2 weeks xx) Cambio to attend ICT Steering Group xxi) OBS requirements being reviewed to assess gaps xxii) Contract review underway xxiii) External Support - PWC	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews	i) Weekly Data Quality reports to Access Board and EDB ii) Internal Audit reports to Audit Committee iii) External Audit reports to Audit Committee on Quality Account Indicators iv) DQ Report to PAF and roadmap report September 2017 v) PWC report and action plan vi) Trust Board workshop April 2017 vii) Cambio roadmap and governance structure reports to PAF	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Executive to raise profile & awareness of implementation/ transformation opportunities with clinical leaders/consultants. vii) CCIO post now vacant viii) Compliance with refresher training ix) CDS 011 issue identified with diagnosis qualifier currently in test an drequires resolution before 7.7 can go into test environment.	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed.	May-18	Residual Risk rating unchanged but version 7.7 includes bug fixes and workflow changes that will have a beneficial impact on DQ hence amended target date for risk to reduce to 12 by ~~March~~ July 2018.)	4x3=12 (~~March~~ Sept 18)
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** i) Ongoing training and support ii) Restructure of IT team (resourcing) iii) Re-establishing realtionship/engagement with Cambio iv) Establishing benefits realisation programme v) Recruitment of new CCIO - in mitigation each ICT Project Board has a clinical member and AMD Q1st engaged in projects. vi) Refresher training underway vii) Revised roadmap to incorporate new statutory/legal requirements i.e. GDPR				

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

The Princess Alexandra Hospital Board
Assurance Framework 2017-18

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead	Key Controls	Sources of Assurance	Positive Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
						Evidence should link to a report from a Committee or Board.								
	Strategic Objective 1: Our Patients - continue to improve the quality of care we provide our patients, improving our CQC rating. **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 control total for 2018/19**													
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 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 within training team	**5 X 4= 20**	Director of IT **Performance and Finance Committee**	i) DQ Improvement Plan ii) Weekly Access Board meetings iii) Data quality dashboards developed iv) MediCode implemented and maintained v) Clinical lead for coding identified vi) Meetings/workshops with clinical leads on coding vii) Clinical coding pilot by clinicians viii) Additional coders employed/targeted to areas of risk ix) Weekly Specialty meetings x) CMO monthly meetings with coding re mortality xi) IM&T Programme Board 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 recieved 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 ~~ex)2 Coders spending time in theatres and ADSU to review and improve coding processes.~~ Mortality validation work underway and linking with Medical Examiners Trainee coders in place Plans underway to relocate off site team members back on site to unify the team	i) Internal Audit (DQ/coding and ED) ii) Annual clinical coding audit for IG Toolkit iii) Dr Foster reports iv) Mortality reviews v) External Audit (Quality Account indicators) vii) PAF meetings	i) Internal Audit reports to Audit Committee ii) External audit report to Audit Committee (Quality Account indicators) iii) DQ Recovery Plan (PAF) iv) Monthly DQ reports (PAF) v) Weekly reports and HG dashboards to EDB and Access Board vi) Maxwell Stanley report on clinical coding	**4 X 4= 16**	i) Need to increase direct clinical coding particularly for outpatients ii) Management and quality of content of medical notes and timely availalbity of notes iii) Continue to develop 'usability' of EPR application to aid users iv) Capacity within operational teams v) Elements of system remain onerous (completion of discharge summaries) vi) External system support vii) Recruitment and retention within coding team and 2 coders on long term sickness absence **ACTIONS:** Recruitment to posts EPR meetings/negotiations Recruitment of CCIO Coding improvement framework following external review and bid to NHSI for funding to support improvements. Guidance for coders updated in respect of co-morbidities from discharge summaries. Coding using electronic systems e.g. radiology, theatres	Current concern around timely completeness of coding has been addressed since April 17 and the focus is shifting to maintain the position and address the secondary issues endorsed by external review. Quality of outsourced coding under review and being monitored with feedback provided to close the loop. (Gaps to be addressed by coding improvement framework)	11/05/2018	No change to risk ratings - ~~External review completed but gaps to be addressed by coding improvement framework.~~	4x3=12 ~~April~~ ~~June~~ August 2018 - embedding actions in Coding Improvement Framework)
			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											

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The Princess Alexandra Hospital Board
Assurance Framework 2017-18

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)
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								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results													
	Strategic Objective 4: Our Performance - meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 2.1		**Workforce Capacity** ~~Concerns around~~ Inadequate staffing capacity to manage workload, deliver services of high quality and meet national performance requirements.	**Causes:** i) National ~~shortage~~ hotspots (Acute physicians, Stroke consultants, ED consultants, Pathologists and Care of elderly staff and registered nurses and midwives). ii) Geographical location of the Trust, close to London but without the HCA weighting. iii) Proximity to teaching hospitals ~~which are attractive to some medical staff —~~ ~~Uncertain future of Trust~~ impacting on retention and attracting new staff iv) ~~Inadequate arrangement/~~ lack of ~~focus on~~ active talent management v) High turnover of nursing, biomedical scientists and AHP staff vi) Rewards currently available for agency working **Effects:** i) Pressure on existing staff to cope with demand leading to overworked staff ii) Low staff morale iii) Shortcuts and failure to follow processes and procedures due to workload and fatigue leading to higher chances of patient safety errors occurring iv) Staff ~~retention and succession planning issues~~ sickness levels/absence and high levels of turnover	**4 X 4 =16**	Interim Director of People **Workforce Committee**	i) National representation to increase international supply through supportive immigration policies. ii) Recruitment prrocesses refreshed (TRAC, benefits package, Vacancy Review Panel, Social Media and Recruitment Campaign) iii) Clear 5P Strategy and direction iv) Succession planning introduced and part of appraisal v) Talent Management Plan features as a component of new People Strategy and Operating Plan 18/19. vi) Turnover of Nursing, Biomedical Scientists and AHPs at 13.3% below STP average of 16%. vii) Agency controls in place and now meeting regulator set target viii) Recruitment and Retention Group introduced initiatives to attract and retain staff.	i)PAF, QSC, WFC, EMT, EMB, Workforce and Board meetings ii) Health Group Boards	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 iv) Positive feedback on People Management	**4 X 5 =20**	Inability to influence supply. Action: Continue to work with HEE to influence national policies	Director of People to review incident and monthly SI reports(ongoing)	22/05/2018	**No change to residual risk rating.**	4x4=16 Oct 2018 (delivery of pillar 2 of People Plan, workforce and resourcing)

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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – support our people to deliver high quality care within a culture that improves, engagement, recruitment and retention and improvements in our staff survey results													
BAF 2.2		**Clinical Leadership and Engagement** Inconsistent Clinical Leadership & Engagement in strategy, operations, performance and delivery which impairs Trusts reputation & sustainability.	**Causes:** i) Capability & capacity to progress change ii) Failure of organisation to transform and consistently achieve performance targets. iii) Perceived lack of listening and response from service leaders & Senior management iv) Low morale of clinicians & staff impacting on more junior staff about numerous/ recurrent changes in senior leadership. v) Perceived non involvement of key clinicians in certain areas. vi) Variable understanding of level of required transformation & efficiencies vii) Sustainable clinical change viii) Lack of OD and clear strategy	**3 X 4= 12**	Chief Nurse/ Chief Medical Officer **QSC**	i) Strong clinical engagement at EMB ii) Use of CQC KLOE for reporting and developing evidence iii) Programme of Sharing the learning for quality iv) Clinician engagement with RCA and Being Open training including Duty of Candour training v) Involving clinicians in listening events (In Your Shoes) and family/Being open meetings vi) Involving clinicians in health group and service reviews vii) Anglia Ruskin Integrated leadership scheme viii) Reporting structure for Quality Governance - Health group risk summits, Quality & Safety panels, PS&Q meetings. ix) Monthly 'Big conversation' with CEO, Board feedback to staff, CQC briefing sessions x) Monthly meeting with CMO/Clinical Leads, AMD for Quality First in post xi) GMC national survey xii) Executive attendance at MAC meetings xiii) CMO adhoc meetings with junior doctors/ registrars & FY leads xiv) Quality First Programme xv) CCIO post now vacant xvi) Junior Doctors Quality Improvement Programme xvii) Medicines Safety Officer appointed xviii) Medical revalidation process and MHPS process xix) Clinical Pathway Leads appointed xx) Deputy CMO appointed (Strategy) xxi) OD Programme and strategy in partnership with ENHT xxii) FFT for staff, Staff Council and Executive Staff Briefings xxiii) Senior Practitioners Forums and action learning sets xxiv) Guardian of Safe Working appointed xxv) CMO Clinical Fellow and PHE trainees xxvi) Schwartz Rounds xxvii) ARHP/UCLP programme for Quality First xxx) Executive Listener xxxi) Buddy arrangements MK and Coventry and Warwick xxxii) Learning from Deaths xxxiii) Clinical engagement workshops led by international experts xxxiii) Multi-professional engagement workshop June 17	i) CQC inspections ii) The National Inpatient and Staff Surveys iii) Trust Board - patient and staff stories iv)Improvement Board Quality First v) EMB Meetings vi) MAC meetings vii) Executive meetings with Junior doctors re industrial action viii) Health Groups Board meetings ix) JLNC meetings x) Junior Doctor meetings xi) Mock CQC Inspection report	i) CQC Reports i) In patient survey improvements with Trust in middle 60%. iii) The National Cancer Patient Experience Survey 2014 improved. iv) Complaints, compliments and PALS reports (reduction in complaints). v) DOPP strategic updates to Board vi) Reports to EMB on pathway work vii) Evaluation of Leadership Programme and 360 feedback viii) NHS Staff Survey results - improvements noted ix) 'Getting it Right First Time' reports x) School of Paeds Trainee Report xi) Deanery Reports xii) Medical Engagement Survey (some positive areas) xiii) Deloitte Review xiv) HEE Report xv) Modern Hospital Report xvi) GMC Trainee Results Report xvii) Cancer performance - top in country xviii) 5P Workshop held (Feb 18) - clinicians in attendance xix) Clinical leadership on Sepsis programme	**4x4=16**	i) Operational vacancies within Health groups creating instability in Governance structures. ii) Operational and clinical pressures precluding attendance at meetings iii) Further development needs for existing/potential junior leaders iv) Allocated budget for OD (pockets of work done) v) Appointment of Senior Nurse information and IT	i) Engagement and internal communications to be embedded. ii) Limited evidence of OD work	01/05/2018	**Risk rating not changed but to be reviewed following receipt of MES.**	**4 x 3 =12 (Target date ~~March~~ Sept 2018 pending outcome of further survey monkey)**
			Effects: i) Impact on workforce morale and negativity ii) Impact on retention, recruitment of high calibre clinicians iii) Lack of cohesive workforce which inhibits quality & safety delivery (e.g. Dementia & Discharge) iv) Ineffective delivery of objectives and targets v) Slow pace of transformation vi) Poor patient experience resulting from hospital and staff communication issues . vii) Adverse Trust reputation viii) Destabilisation particularly with merger of Medicine and ED. ix) Current vacancies at senior levels within Health Groups							**ACTIONS:** i) Ongoing recruitment underway ii) OD programme of support with NHSI Leadership Academy and programme for AMDs			

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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control and Actions**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the**	**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		**Culture of Internal Engagement** Failure to ~~communicate key messages and organisational changes to front line staff,~~ engage frontline staff and celebrate improvements and organisational development.	**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 leadership and communication channels/tools iv) Poor attitude and behaviours v) Competing priorities ~~vi) Collaboration with Lister, development of ACO and uncertainty about STP plan~~ ~~vii) Challenged Provider status~~ viii) Insufficient management time allocated to leadership communication ~~with staff~~ and engagement ix) Leadership style and approach	**4 X 4= 16**	Director of HR **Workforce Committee**	i) Staff awards; ii) CEO weekly blog & 'In Touch'; iii) Staff Briefing sessions iv) Staff, patients and carers involved in creation of values, standards & behaviours to ensure ownership; v) Sharing the Learning events to involve staff in safety improvements, which has included the Being Open/ Duty of Candour. vi) Development and Deployment Strategy vii) Great Leaders Programme viii) Quality Fellows programme ix) National Leadership Programmes for staff x) Staff Survey xi) Schwartz Rounds xii) CQC QIP xiii) Staff Council xiv) Quality Ist Communication Plan and Newsletter xvii) Event in Tent xv) People Strategy ~~in development~~ and plan 2018/19 xvi) Printed magazine (quarterly)	i) PAF and Board meetings ii) QSC meetings iii) Staff Engagement Working Group iv) Workforce Committee	i) Staff survey results. 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. vi) GMC Survey results vii) Leadership/Culture Survey results	**3x3=9**	~~Clarity on timescales for change (SOC approval) and the future of the Trust.~~ Individual feedback mechanisms **Actions:** i) Monthly updates to Board on strategic developments . ii) Sustaining engagement activities following Event in a Tent ~~iii) Recruitment to Head of Communications role~~ iii) Review of Comms function ~~underway~~ complete iv) 360 feedback tools		22/05/2018	**No change to risk rating.**	3x2=6 (~~March~~ July 2018 following ~~review of Comms function and~~ implementation of actions following completion of Comms review. Delivery of Culture and Well being Plan - pillar 1 of People Plan))
			Effects: I) Demoralised staff ii) Disconnect between management and front line staff iii) Changes not embedded as business as usual iv) Poor reputation v) Error omission											

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The Princess Alexandra Hospital Board
Assurance Framework 2017-18

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead	Key Controls	Sources of Assurance	Positive Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
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BAF 2.4		**Workforce Capability** Gaps in staff capability not being consistently addressed through available performance management and development processes	**Causes:** i) Managers not prioritising performance management and development issues ii) Historic lack of management and leadership development training iii) Historic view that appraisals and performance management are not important iv) Lack of a systematic approach to determining organisational, business unit and individual objectives and development plans	**3 X 4 =12**	Interim Director of People	i) Robust people processes and policies (from recruitment to appraisal) ii) People Strategy and plan in place (pillar 3 - leadership and team development) iii) Well established appraisal and PDP process iv) Monthly PRMs to review performance and people metrics (including development plans) v) Bi-monthly Workforce Committee meetings vi) Bi-monthly Board meetings vii) Leadership and Management development framework (key behaviours)	i) Board and WFC meetings	i) Reports to WFC ii) Workforce KPIs and IPR iii) MHPS reports to Board iv) Training and development updates to WFC. V) GMC Survey, Staff NSS and Leadership and Culture Survey results	**3 x 3 = 9**	Talent management framework identifying key roles, individuals and gaps. Actions: i) Talent Management and Succession Planning in development (People Plan 2018/19) ~~ii) Leadership and Management development framework (key behaviours) in development~~ iii) Managers Induction being ~~developed~~ revised.	Confidential staff survey results via staff mobile app and outputs to be included	22/05/2018	No change to risk rating, controls updated.	**3 x 2 = 6 (January 2019 pending results of 2018 Staff Survey and delivery of pillar 3 of People Plan)**
			Effects: i) Impact on ~~staff morale of perceived acceptance of under~~performance ii) Impact on staff ~~retention~~ morale iii) ~~Perpetuating cycle of~~ overworked staff compensating for capability gaps. iv) ~~Potential~~ impacts on workforce productivity ~~and income. efficiency~~ v) ~~Disengaged workforce~~. vi) Reputation											

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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			
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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 3.1		**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.	**5 X 4= 20**	Director of Quality Improvement **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report. iii) Project Board established to review Capital requirements. iv) Potential new build/location of new hospital v) Re-profiled Capital programme - aligned to red rated risks. vi) ~~KPMG Review~~ vii) STP Strategy being developed. viii) Clinical Infrastructure Risk review underway ix) Central returns Steering Committee x) Modernisation Programme for Estates and Facilities xi) ~~Carter Programme Board established.~~ ~~xii) External Water Safety Review~~ xiii) NHSI support and application to NHSI Resources Committee (for funding) xiv) Robust water safety testing processes xv) Annual asbestos survey ~~undertaken (in year actions required - removal of areas of red rag rated areas of risk completed in September and Asbestos Risk Register updated.~~ completed and red risks resolved. xvi) Associate Director of Estates and Facilities appointed xvii) External fire risk assessments completed following Grenfell fire. Action plan being developed. xviii) ~~New kitchen fire alarm installed.~~ xix) ~~Electrical switch replacement completed in September.~~ ~~xx) On track to deliver accelerated Capital Plan.~~	i) PAF and Board meetings ii) EMB Meetings iii) Health and Safety Meetings iv) Capital Planning Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings viii) First Impressions Count project group.	i)Letter from HSE - no regulatory concern raised ii) ~~Quarterly Estates & Facilities report to PAF~~ iii) Reports to EMB iv) Fire Safety report v) Reports on testing for legionella, asbestos vi) Signed Fire Certificate vii) Annual H&S reports to Trust Board and bi-monthly to QSC v) ~~Unannounced visit from Environmental officer - no concerns raised~~ ~~vi) Internal Audit report on H&S~~ ~~vii) KPMG Report~~ ~~viii) STP Report~~ ix) Ventilation audit report x) Water Safety Report (PAH site) xi) Annual and quarterly report to PAF: Estates and Facilities xii) PLACE Assessments	**5x4=20**	ii) Planned Preventative Maintenance Programme (time delay) iii) Ventilation systems iv) Sewage leaks and drainage v) Electrical Safety/Rewiring (gaps) vi) SDMP Plan vii) Maintaining oversight of the volume of action plans associated with compliance. viii) Catering services modernisation ix) Lack of authorised persons within estates and facilities teams. **ACTIONS:** i) Review of Estates and Facilities infrastructure - consultation in Q1. ii) Backlog maintenance review iii) Business cases being developed Combined Heat and Power (in 18/19) iv) Applying for distressed Capital funding to mitigate areas of risk. v) Review of Catering infrastructure/~~menu choice and patient food service~~ Consultation in Q1 vi) SDMP plan to be included in OBC work - draft plan being developed	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 ~~extended~~ tendered.	01/05/2018	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site) and:** **Target rating to be confirmed once the design and technical surveys are completed.**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2017-18**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks			What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
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BAF 3.2		**Health Economy Stability & Joined up Approach** Failure of the Accountable Care Partners to integrate and work effectively as an ACP and deliver demand management, productivity and efficiency targets, undermining both hospital and system sustainability.	**Causes:** i) Lack of clarity re leadership and governance ii) Failure to align incentives and rewards across all partners iii) Poor IT connectivity essential for sharing of clinical information iv) Organisational sovereignty hindering joint workforce arrangements and new ways of working v) System capacity and capability to deploy population health management systems to risk stratify populations	**4 X 4= 16**	DoPP **Trust Board**	i) System Leadership in place ii) CCG proposing new system governance arrangements (ACP within STP footprint which in turn reports to West Essex Partnership Board) iii) Accountable Care Partnership iv) ACP developing project management arrangements v) PAH/CCG propsal for developing a new finacial and contracting model using microsimulation of respiratory services vi) Neighbourhood approach being developed by system vii) CCG reviewing commissioning options for out of hospital services viii) CCG and system agreement on actuarial modelling with Centene and Ribera Salud. ix) CEO chairing ACP Board for next 6 months. x) ACP collaborative agreement signed. xi) Actuarial study completed ~~being undertaken~~ by Milliman (delayed and impacting on OBC). xii) Board to Board held 30.11.17 xiii) CCG reviewing Urgent Care arrangements	i) Outline business case by BCG and KPMG ii) Chairs/ CEO group meetings iii) Accountable Care Provider Board iv) System leadership meetings	i) Minutes and reports from system/partnership meetings/Boards ii) BCG business case and KPMG report iii) Memorandum of Understanding RS/WECCG and PAH iv) STP governance proposals	**4 X 4= 16**	i) STP footprint includes whole of Herts & West Essex therefore potential for lack of focus on West Essex/East Herts system. ii) Underpinning assumptions of STP to be tested. iii) Potential £50m risk across system iv) Lack of demand and capacity modelling at ACP and STP levels **ACTIONS:** Revised governance arrangements Commissioning intentions concerning future provision of out of hospital Role of Integrator being explored STP finance leaders reviewing financial controls to mitigate financial risk Developing new service models and reviewing contracts for MSK, Respiratory and Urgent Care (Completion by OCtober 2018).	None identified.	01/05/2018	**No change to residual risk rating.**	**4x3=12 ~~March~~ October 2018)**
			Effects: i) No clear authority for strategic prioritisation and deployment of system resources ii) Partner organisations seeking approval for decisions from their sovereign organisation iii) Failure of other partners to take on and share risk iv) Fragmentation of provision of care v) Duplication of effort and cost vi) Capacity and capability of already overstretched system workforce not being optimised vii) Hindering introduction of new models of care viii) Potential £50m system-wide STP risk in 2017/18											

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BAF 3.3		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) Limited input from clinicians and other key stakeholders into STP strategy ii) The financial bridge is based on high level assumptions iii) The development of QIPP and CIP programmes for 2017/18 has not followed a Footprint-wide approach iv) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them v) The resources required for delivery at a programme and workstream level have not been defined or secured vi) The current governance structure is under development given the shift in focus from planning to delivery. vii) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoPP **Trust Board**	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP prioritisation under review with workstream leads being nominated. v) STP PMO under development vi) CEO's forum	~~i) PWC review of governance arrangements~~ i) West Essex CCG review of local governance arrangements ii) Feedback from regulators iii) System leadership meetings iv) Proposals made around system dashboards and KPIs	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board iii) PWC report on governance arrangements iv) Presentation to EMB on new STP governance structures	**4 X 4= 16**	Lack of STP demand and capacity modelling. **ACTIONS:** System agreement on governance and programme management System leadership capacity to lead STP-wide transformation Trust to nominate representatives on proposed STP/ACP workstreams Escalation to CEO forum and West Essex actuarial piece to be shared.	Proposed governance structures to be tested.	01/05/2018	**No changes to risk rating.**	**4x3=12 ~~March~~ July 2018)**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) Undermining political support for Capital programme v) More regulatory intervention											

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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) Inability to recruit and retain innovative leaders in the Trust vii) Focus on immediate operational and financial priorities versus the longer term strategic planning viii) Lack of clarity regarding contracting and organisational models in support of ACP ix) Lack of dedicated management resource to drive change and strategy development x) Lack of shared vision and key drivers for change xi) Launched 5Ps at Event in Tent and internal programme for development and implementation of 5P plans. xii) Lack of clarity on capital prioritisation process at national level.	**4 X 4= 16**	DoPP **Trust Board**	i) EMB meetings ii) Clinical specialty meetings iii) Quality 1st Improvement Board iv) Deputy CMO appointed v) Good relationships with key partner organisations vi) CEO chairing ACP leadership team vii) Legal advice taken on potential organisational/contractual models viii) PAH/ENHT Working Group established ix) OBC ~~Strategic Outline Case~~ Steering Group x) Deloitte's Governance review and action plan xi) PWC developing programme with timeline for OBC development and planning advisor working on planning issues xii) CEO attending STP meetings xiii) DoPP actively engaged with Harlow Gilston Garden Town planning xiv) PAH to attend meeting with Centre on 24 April re OBC	i)Workshops with clinical leads ii) ACP and STP meetings including acute and back office workstream meetings iii) OBC Steering Group iv) Harlow/Gilston Garden Town Co-op.	~~i) OD updates to QSC~~ ii) DoPP reports to Board on strategic developments and SOC/OBC eport to PAF. ~~iii) CEO updates to Board~~ ~~iv) KPMG Phase 2 Commissioning Strategy.~~ ~~v) Resource paper submitted to NHSI~~ iii) Report to PAF and Board Feb 18 - resourcing	**4x3=12**	i) Financial analytical support for programme ii) Capacity and capability to develop LEAN process mapping iii) Embedding the programme iv) External training required to develop internal capacity v) Data quality impacting on business intelligence (SLR) **ACTIONS:** ~~CEO chairing ACP leadership team~~ ~~Meetings with Regulators~~ ~~Working group established with ENHT~~ ~~Actions from Deloittes review to be implemented~~ Trust's vision being refreshed and 5P plans - underway	None identified.	01/05/2018	**Risk ratings not changed.**	**4 x 2= 8** ~~March~~ May 2018)
			Effects: i) Poor reputation ii) Imposed strategy not compatible with resources and organisational aim iii) Increased stakeholder and regulator scrutiny iv) Low staff morale v) Threatened stability and sustainability vi) Restructuring fails to achieve goals and outcomes vii) Impact on service delivery and quality of care viii) Poor staff survey ix) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure x) Undermines regulatory confidence to invest in hospital/system solutions												

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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.	**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 Pathways and Partnerships **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) Strategic Outline case for new hospital (June 2017) and meeting scheduled with Centre for 24 April 2018. vii) Estates and Facilities Infrastructure subgroup for West Essex viii) SOC affordability model ix) SOC approved and submitted to NHSI and further financial analysis template submitted to DH x) Planning advisor being engaged and discussions underway with Local Authorities overs site options.	i) PAF and Board meetings ii) EMB Meetings iii) Capital Planning Group iv) Weekly Estates and Facilities meetings v) OBC Steering Group	i) STP reports to Board via CEO Report ii) Reports to EMB iii) KPMG Report iv) STP workplans v) Monthly OBC reports to PAF	**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 Site evaluation work underway Prep for meeting on 24 April 2018. External strategic estates and commercail advice being sought.	i) Strategy not confirmed	01/05/2018	**No change to residual risk rating.**	**4 x 3 =12 ~~March~~ June 2018)**
			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												

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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 / availibility 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 accomodation and facilities to support intergrated working. vii) appetite for change management.	**4x5=20**	**Exec leads** :- Chief Financial Officer, Chief Operating Officer and Director of Quality Improvement. **Committee Lead** :- Performance and Finance Committee	i) continuous priorty reviews and workload planning, ii) business partnering approach and performance reviews, iii) Recruitment exercises - successful reduction in temporay 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 implemenations / upgrades e.g EROS, Qlikview and ledger upgrades, viii) staff surveys / apprasials	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 accomodation.	i) Benefit realisation reviews	01/05/2018		**4x2=8 March 2019**
			Effects: i) Over reliance on manual processes and interventions ii) labour intensive, error prone and time consuming processes iii) Ability to attract skilled staff and retention and morale (leading to relaince on temporary staff), iv) single failure points, v) adequate value for money conclusions.							**ACTIONS:** i) Recruitment plans for areas ii) Market testing iii) ICT re-structure, iv) Alternative office accomodation options v) Income capture processes				

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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 4.2		**4 hour Emergency Department ConstitutionalStandard** Failure to achieve ED standard	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Increased turnover and lack of qualified workforce 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	**4 X 5 = 20**	Chief Operating Officer	i) Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Daily ~~Weekly~~ 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) Executive presence in ED 80% of time~~ ix) Rapid improvement programme supported by Q1st continuing x) Daily specialty response times monitored xi) Weekly meetings with ED team/Q1st and Executive team xii) System reviewing provision of urgent care xiii) Exec attendance at safety huddles daily xiv) Morning briefings in place at 8am xv) ED action plan reported to PAF/Board xvi) CO-location of ENP's, GP's, Out of hours GP'S to support minor injuries xvii) Daily review of Paeds by Clinical Lead and HoN xviii) Assessment capacity work underway	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	i) Daily ED reports to NHSI ii) Twice weekly reports to NHSE on DToCs iii) Escalation reports weekly to NHSE iv) Monthly PRM meetings	**4 x 5 = 20**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) D&D Strategy and recruitment/retention action plan ii) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings iv) Actions being taken in relation to Pauline Phillips letter v) CEO Assurance Panel being held in March to review 12 hour breaches	None noted.	01/05/2018		4x3 =12 ~~March~~ September 2018 (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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								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 5: Our Pounds – manage our pounds effectively to achieve our agreed financial control total for 2018/19													
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 CIP's, iv) workforce shortages v) high levels of unplanned expenditure including maintenance of aging estate, vi) capture and billing of activity.	**5 X 4= 20**	**Exec leads :** All Executives **Committee lead** : Performance and Finance Committee	i) Access to Interim Revenue Support loans ii) Cost Improvement Programme iii) Formal re-conciliation process with CCG iv) Internal and external Agency controls and reporting v) Executive Management Board, PAF and Audit Committee vi) Health Care Group CIP meetings vii) Enhanced Performance Reviews viii) Regular Balance sheet reviews ix) Approved Governance Manual x) Budget sign off process xi) Enhanced financial reporting and controls xii) Regulatory returns required e.g. agency spend xiii) Internal special measures for selected HCG to remain xiv) New medical agency protocol xv) Financial Recovery Plan - Q1 xvi) Demand and Capacity planning	i) Internal Audit & External Audit opinion. **ii)** External reviews iii) NHSI reporting iv) Internal Trust reporting v) Cash Management group	i) Monthly reports including bank balances and cash flow forecasts to PAF and Board ii) CIP Tracker reports iii) IA reports iv) Financial Recovery Plan	**5x3=15**	i) Organisational and Governance compliance e.g waivers ii) Activity and capacity planning iii) CIP reporting and run rate reductions	Service Line Reporting Demand and Capacity planning Workforce planning	01/05/2018		**5x2=10 Sept 2018**
			Effects: i) Ability to meet financial control target ii) Potential delay to payment to creditor/ suppliers iii) Increased performance management iv) Going Concern status v) Risk to recovery of sustainability funding vi) Impact on capital availability vi) Unfavourable audit opinion (VfM,Section 30 Letter) vii) Restrictions on service development viii) Recruitment & retention ix) Increased likelihood of dispute/arbitration processes x) reputational risks xi) increase in agency temp staff costs xii) impact of in year Commissioner QIPP plans							**ACTIONS:** Future Modernisation Demand and Capacity Planning and Modelling Alternative accomodation for corporate staff being sought. Clinical and operational forums in place to review QIPP schemes. Improved FOT process. Review of Capital reporting. Focus on pay and non pay CIPs.				

The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD - 7 JUNE 2018

4.2

Agenda Item:	4.2
Presented by:	Dr Andy Morris – Chief Medical Officer
Prepared by:	Sheila O'Sullivan – Associate Director of Governance & Quality Lisa Flack - Compliance and Clinical Effectiveness Manager
Date prepared:	30 May 2018
Subject / Title:	Significant Risk Register

Purpose:	Approval		Decision		Information	√	Assurance	√

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This paper presents the latest Significant Risk Register (SRR) across the Trust. This was produced from the web based Risk Assure system. There are 62 significant risks (score 15 and above). From the total we have 24 risks scoring 20 (Appendix 1). Six risks are overdue their review period and each lead is asked to provide an update by 5 June 2018, (Appendix 2). Six new risks are raised since 24/4/18 (Appendix 3)
Recommendation:	The Trust Board is asked to i) Note the Significant Risk Register ii) Take assurance from the actions currently in place or planned

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

Previously considered by:	Risk Management Group reviews risk and SRR according to its work plan.
Risk / links with the BAF:	There are no known risks associated with this paper
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	Appendix 1 – Significant Risk Register (Score of 20) Appendix 2 – Risks that are overdue for their reviews Appendix 3 – New risks raised between 26/4/18 to 29/5/18

1.0 INTRODUCTION

This paper details the Significant Risk Register (SRR) across the Trust; it was prepared on 30 May 2018 and produced from the web based Risk Assure system. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks. There is an annual work plan so each area can be reviewed in detail on a rotation.

2.0 CONTEXT

The Significant Risk Register (SRR) is a snap shot of risks across all Health groups and corporate departments at a specific point in time including all items scoring 15 and above. The risk score is arrived at using consequence x likelihood score, with the lowest possible score being 1 and the highest 25.

There are 62 significant risks on our risk register. The breakdown by service is detailed in the table below.

	Risk Score				
	15	16	20	25	Totals
CCCS	4	3	0	0	7
Estates & Facilities	0	1	0	0	1
Information Governance	0	4	0	0	4
IM&T	1	1	2	0	4
Nursing	0	1	0	0	1
Operational	0	0	3	0	3
Patient Safety & Quality	0	1	0	0	1
Workforce	0	1	0	0	1
Child Health	1	1	1	0	3
Safeguarding Adults	0	2	0	0	2
Safeguarding Children	0	1	0	0	1
Women's Health	1	2	1	0	4
Medicine	2	1	16	0	19
Surgery	9	1	1	0	11
Totals	18	20	24	0	62

There are 24 risks with a score of 20; the key areas are detailed below with full details of each risks and controls in place in appendix 1.

- Staffing
- Four hour standard
- IT – requiring fire suppression in computer facilities
- Patients placed in post anaesthetic care unit (overnight)

Most Trust risks are reviewed within the allocated timeframe. There are six risks that are overdue their review date, see appendix 2. For each risk, the responsible manager has been asked to update their register by 5 June 2018; This will be followed up at the Risk Management Committee on 22 June 2018

Six new risks have been raised between 24/4/18 to 29/5/18; these are attached on appendix 3.

As per our current review process our Compliance and Clinical Effectiveness Manager is working with teams to review all new risks, ensure they have fully explained the risk and that

appropriate mitigating actions and controls are detailed. These will all be reviewed as part of the Risk Management group annual work plan.

3.0 RECOMMENDATION

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

Detailed Risk Register Report - Ordered by Highest Current Risk

Risk Register (Live)

Corporate Services

Information Management & Technology (IM&T)

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**IT044**	**To provide fire suppression in the two main computer rooms on-site in order to protect patients, visitors, staff, IT servers and core network equipment in the event that a fire broke out in one of the rooms.**	No fire suppression in the PAH computer rooms.		5	4	20	20	05	Furzana Kausar	Stuart Hanlon	12/02/2013		08/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
No controls in place to mitigate this issue.		Furzana Kausar		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
24/05/2018 - Update after ICT Programme Board held on 22 May, one tender received at £87k, majority is to make the rooms ready for gas suppression. Chief Finance Officer requested that a quick review is undertaken of the tender document received in order to revisit suitable options. 07/05/2018 - Tender only received one response. Trust has accepted and will go forward with this proposal so long as ICT Programme Board approve.		Progress Being Made But Overdue On Completion Date	Furzana Kausar	

Detailed Risk Register Report - Ordered by Highest Current Risk

26/03/2018 - Tender has gone out. Deadline for responses is 6 April 2018 after which time they can be evaluated for a preferred supplier. 09/01/2018 - Recommendations received from review. Currently with Health & Safety Officer after review by IT. 30/11/2017 - Mechanical & Engineering Consultant to review computer rooms tomorrow to put technical specification together which can go out to tender. 07/11/2017 - The Trust RMG group requested the risk score to be raised. 01/07/16 - Urgent review of risk and mitigation options. Plan to deal with this years capital fund Trust will deploy suppression or advanced detection systems 11/05/2017 - Waiting to see capital allocation funds for 2017/18 11/07/2017 - Meeting arranged between IT and the Trust Fire Officer to discuss options. 30/09/2017 - Health & Safety Officer has recommended 2 suitable companies and forwarded these to the Fire Safety Officer for a decision.	Heath & Safety Officer leading	Progress Being Made But Overdue On Completion Date	Furzana Kausar	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**IT089**	**To ensure that the front door to Grane House is secure and does not sporadically remain open thus putting at risk patient notes and Service Desk equipment.**	The front door to Grane House is not closing properly. Grane House houses the Service Desk equipment, IT equipment and patient records.	Asked to reduce risk score from 25 to 20 at ICT Programme Board on Fri 15 December 2017.	5	4	20	20	05	Furzana Kausar	Furzana Kausar	25/11/2016		08/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Ask staff to be vigilant and close the front door behind when they enter or exit. This has been reported to Estates as it re-occurs regularly.		Furzana Kausar		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
21/05/2018 - Supplier has received payment. There is an 8 week lead time. Work will start mid July and should complete by end of July. 07/05/2018 - Supplier awaiting 50% of payment before commencing work. Waiting for confirmation that payment was received 4 May.		Action On Track	Sarah Wilcox	
26/03/18 - Order for replacement door has been placed. Delivery date being evaluated. 22/02/18 - Quote has been received by Estates staff to provide an automatic door. This is being progressed by the IT Programme Manager. 15/01/2018 - Communicated with Estates regarding the on-going problem of the front door remaining open. Estates have received a quote for a manual door rather than an automatic one which would suit Coding staff. 19/12/2018 - Met with AD for Estates. Assured that solution will be sought and in the meantime Security will perform regular checks. 15/12/2017 The door is now remaining open. We are reporting it very frequently to Estates but within a day or so of it being fixed it becomes faulty again. There have been discussions regarding replacing the door but this has not progressed. 07/11/17 - The door is now remaining open very frequently. Staff are alerted to remain vigilant about closing the door behind them. Estates staff have mended the door many times but the problem	This risk re-occurs and has to be addressed each time the door fails to close.	Progress Being Made But Overdue On Completion Date	Furzana Kausar	

Operational

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Statutory Compliance	**001/2017**	**To deliver ED 4 hour standard at 95% or above**	Failure to Deliver the ED four hour standard, leading to low performance rating, external scrutiny and potential performance notices and financial penalties.		4	5	20	20	08	Anne Carey	Richard Hammond	01/04/2014		01/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Daily monitoring and review of previous breaches, number/patterns of attendances to facilitate changes in ED pathway to improve or limit detrition in performance	Limited, no sustained reduction in patients exceeding 4 hours.	Richard Hammond	All planning is based on historical data, which does not facilitate Live data	01/06/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
I. Complete the Accountability and Responsibility Grid (ARG) for all roles within and external to the Emergency Department, expanding each area to include clarity and further detail II. Develop a competency model III. For the roles of Nurse in Charge, Consultant in Charge and Operational Lead: i. Clarify of role ii. Develop a daily routine IV. Provide support, guidance and coaching to staff as required V. Assessment of competence of staff VI. Back to basic event to cover: i. the 4 hour standard ii. Internal professional standards iii. ED staff view i.e. what went well, what stops me from doing my role, what would change iv. If I delivered the 4 hour standard for my patients it would mean…….? VII. Development and implementation of daily review of performance against standard and IPS VIII. Improve interaction between site and ED teams		Action On Track	Richard Hammond	29/03/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**002/2016**	**No patient will spend a journey time greater than 12 hours from arrival to discharge from ED**	Patients in ED longer than 12 hours		4	4	16	20	09	Anne Carey	Richard Hammond	27/07/2016		01/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Internal professional standards which articulates at which point a patient should be in their journey through ED.	Standards are measured by Click View and available in real time	Richard Hammond		01/08/2018
Monitoring by the Senior Site Matron to enable identification and escalation of patients that have a long wait in ED with no plan.		Richard Hammond	Lack of assurance on timely and effective response to escalation	01/06/2018

Detailed Risk Register Report - Ordered by Highest Current Risk

Trackers in place to review electronic Tracking System and escalate to Consultant and Nurse in charge if patient is not meeting internal professional standards										Richard Hammond		Roles and accountabilities not clearly defined		01/06/2018
Action in Progress				**Action Commentary**						**Action Rating**		**PS&Q Lead**		**Review Date**
To identify the current system capacity required to support the demand on the urgent care pathway and agree at the Local Delivery Board which Capacity / Demand Model the Trust will be following.										Progress Being Made But Overdue On Completion Date		Richard Hammond		31/03/2018
Domain	**Risk Ref:**	**Objective - What are you trying to achieve**	**Description of Risk - Cause and Effect**	**Risk Comments**	**Consequence**	**Likelihood**	**Initial Risk**	**Current Risk Score**	**Target Risk Score**	**PS&Q Lead**	**Risk Lead**	**Date Risk Raised**	**Date Risk Closed**	**Risk Review Date**
Quality	**003/2016**	**No patient to wait longer than 12 hours from a decision to admit**	Patient in ED waiting longer than 12 hours from a decision to admit		4	4	16	20	09	Anne Carey	Richard Hammond	28/07/2016		01/06/2018
Risk Mitigation/Controls				**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**						**PS&Q Lead**		**Gaps in Control**		**Review Date**
Internal professional standards which articulates at which point a patient should be in their journey through ED.				Standards are measured by Click View and available in real time						Richard Hammond				01/08/2018
Monitoring by the Senior Site Matron to enable identification and escalation of patients that have a long wait in ED with no plan.				Lack of assurance on timely and effective response to escalation						Richard Hammond				01/06/2018
Trackers in place to review electronic Tracking System and escalate to Consultant and Nurse in charge if patient is not meeting internal professional standards										Richard Hammond		Roles and accountabilities not clearly defined		01/06/2018
Action in Progress				**Action Commentary**						**Action Rating**		**PS&Q Lead**		**Review Date**
To identify the current system capacity required to support the demand on the urgent care pathway and agree at the Local Delivery Board which Capacity / Demand Model the Trust will be following.										Progress Being Made But Overdue On Completion Date		Richard Hammond		30/03/2018

Family & Womens Services

Child Health

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**NICU ROP Outpatient**	**Ophthalmology Retinopathy (ROP) Outpatient Follow up Clinic to be held in the eye Unit rather than the Neonatal Unit**	A weekly ROP Outpatient follow up clinic is undertaken on The Neonatal Unit. This increases the risk of Infection due to babies being brought back to the Neonatal Unit from the community. Due to the strict security access for the neonatal unit, having a clinic without knowing the attendance list, poses a risk to security for both the safety of patients and staff on the unit Poor patient experience , feedback from parent , raised "sitting room felt like a waiting room , rather than a relaxing space"	25/04/2018 Email has been sent to Ophthalmologist team, suggesting that the babies returning under 40 weeks go to PAU. A meeting has been set up for the 3rd May to discuss 24/05/2018 Meeting not held Plan to start clinic in PAU in June following a few weeks training with PAU nursing team with Opthalmology team. Date not set	4	5	20	20	01	Claire Jakes	Janelle Gardner			18/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Extra staff from the Neonatal Unit booked on follow up clinic days to support Opthalmology		Claire Jakes		
List of weekly attendees received Ward Clerk contacts The Eye Unit and obtains information from Cosmic This is to ensure that staff are aware of which patients are attending the clinic for security reasons		Claire Jakes	Attendee list not always received Cosmic not always completed with patient details	
There are Infection control /hand hygiene posters up in the Neonatal Unit from the entrance for all visitors, parents and staff to heed	Hand Hygiene audit	Claire Jakes	The risk of a family coming on to the Neonatal Unit, who have been in contact with infection such as D&V, chicken pox etc is difficault to monitor	

Detailed Risk Register Report - Ordered by Highest Current Risk

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Ophthalmology needs to recruit Paediatric Ophthalmologist and follow up outpatient clinic to be held away from the Neonatal Unit	19/01/2018 ophthalmology consultant has been recruited. Awaiting HR checks and start date. MDT meeting requested with all stakeholders to discuss the ROP clinic and staffing. 22/02/2018 Email sent to Assistant Service Manager, General Surgery by C Jakes requesting update on new Paediatric Ophthalmologist and enquire about the booking of Outpatient Appointments away from the Neonatal Unit. 27.03.2018 New Paediatric Ophthalmologist commencing in post in Sept 2018 Meeting still not been held to discuss outpatient clinics being held in Eye clinic and not within the neonatal unit for ROP follow ups	Progress Being Made But Overdue On Completion Date	Claire Jakes	

Womens Health

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**Womens 24**	**To maintain a high standard of care for women receiving treatment on Nightingale and to increase the Staffing Numbers and morale**	Insufficient number of registered nurses on Nightingale Ward to provide safe and effective care. Staff on the ward are often agency staff so do not have the gynaecology competencies to be able to undertake certain duties.	Reviewed 16/01/18, Current vacancy rate is 12.99WTE for registered nurses, 7.8WTE for health care assistants. Job Vacancy has just closed with no interest. 2 nurses will be interviewed end of January who telephoned following closure of the advert. 10 HCAs have been shortlisted for interview. 15.05.18 Current establishment on Nightingale is: Unqualified nursing band 2 10.30 Generic ward HCA/Ward Clerk band 3 1.00 RN band 5 14:00 band 6 4.00 Ward Manager band 7 1.00 Ward Clerk band 2 1.00 Gynae Ward Matron Band 8A 1.00 Total staff 32.30	5	4	20	20	06	Erin Harrison	Jacqui Featherstone	04/12/2017		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Currently lines of work agency staff are available to cover shifts, interviews for staff across the bands are taking place over January.	Less agency covering shifts and substantive employment of both registered nurses and health care assistants.	Erin Harrison	Job vacancy closed with no interest. still relying heavily on Agency staff.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Advertisement for health care assistants for Nightingale Ward Schedule interviews from shortlist of applicants	Interviews have been successfully completed and Nightingale should be at full establishment for HCAs if all applicants start as planned	Action On Track	Erin Harrison	
Job roles advertised on NHS jobs for Registered nurses and Healthcare assistants.	Job Advert closed for Registered Nurses with no interest March 2018 - continue to advertise roles within nightingale ward. 1 x RN employed	Progress Being Made But Overdue On Completion Date	Erin Harrison	

Detailed Risk Register Report - Ordered by Highest Current Risk

Recruitment of band 5 nurses to Nightingale Ward. Advertisement has been published Interviews to be scheduled for shortlist of applicants Plan to re advertise for nursing posts again in June 2018	One band 5 nurse for interview in W/B 7th May 2018 Advertisement to be republished in one month - June 2018	Action On Track	Erin Harrison	
Regular Agency staff are used who know the ward and the daily routines to create a better working environment. The Lines of Agency staff are able to administer Intravenous Drugs, use cosmic and access the Trust Guidelines.	Substantive jobs are available and staff across the Trust have been encouraged to apply.	Action Fully Implemented	Erin Harrison	

Medicine Healthcare Group (MHCG)

Accident & Emergency (A&E)

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**ED Staff 01**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high number of Band 5 vacancies across the MHC. The potential impact is that: *Patients may not receive consistent standards of care. *Decrease in staff morale and increased level of sickness. *Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Reviewed 13/4/2018 Vacancy Factor Band 5 - 13 WTE - Risk score remains the same	4	5	20	20	08	Lesley Chandler	Victoria Barnes	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
*Agency staff used to support numbers. These staff are regular workers and now complete an induction pack and competencies similar to permanent staff	Daily review by Senior ED team and escalation to Senior Medical Health Group team	Lesley Chandler		31/07/2018
Daily use of safe care		Lesley Chandler		31/07/2018
ENP team supporting RAT process and ED staffing when required	Daily review and escalation of requirements	Lesley Chandler		31/07/2018
Safety checklist and new patient documentation has been introduced	Audit of documentation to be undertaken	Lesley Chandler		31/07/2018
Safety huddles		Lesley Chandler		31/07/2018
Staffing monitored on a shift by shift basis	Daily review and escalation	Lesley Chandler		31/07/2018
Working closely with Workforce in relation to recruitment and retention	Monthly HR reports Staffing reports	Lesley Chandler		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Agency Paramedics currently being utilised on a daily basis. Plans are to recruit to these posts substantively		Action On Track	Lesley Chandler	31/07/2018
Support from ITU and Matron team. Working in ED Resus 1 shift per week		Action On Track	Lesley Chandler	31/07/2018

Detailed Risk Register Report - Ordered by Highest Current Risk

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**ED012**	**To ensure the Trust is able to deliver the National Emergency Department (ED) 4 hour standard whilst ensuring safe, quality care is provided to patient's within the department**	There is potential risk to: *Patient safety due to the impact on patient flow and associated risk of crowding within the department *The ability to complete ambulance offload and handover in a timely manner *Financial penalties against KPI's that are not achieved	21/5/18 Month to date March - 60.66% Month to date April - 73.77% Year to date performance 73.99%	4	5	20	20	04	Lesley Chandler	Curtis Emordi	01/07/2016		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Ambulance Escalation and offload SOP in place		Lesley Chandler		31/07/2018
Daily monitoring and reporting of ED 4 hour performance by Information Team and shared with Health Group and Executive team	Monitroing of 4 hour performance figures	Lesley Chandler		31/07/2018
ED manager of the day	Non elective pathway, steering group and board. Reporting to Senior Management Team. Medical Healthcare Board and ED PSQ meetings	Lesley Chandler		31/07/2018
ED trialed the Rapid Assessment and Treatment (RAT) process is now fully implemented. RAT is model is a structured approach to the way that patients are received and assessed within the Emergency Department. It is a senior decision maker-led approach to ensuring patients are assessed and initial care plan requirements quickly put in place also a way of ensuring those patients with immediate / acuity care needs are promptly assessed. RAT Standard Operating Procedure (SOP)in place.		Lesley Chandler	IT maintain a record of daily performance RAT SOP in draft, peer reviewed and agreed, awaiting noting at Trust Policy Group	31/07/2018
Monitoring of compliance with escalation triggers through floor walkers and Patient Journey Trackers	Non elective pathway, steering group and board. Reporting to Senior Management Team. Medical Healthcare Board and ED PSQ meetings	Lesley Chandler		31/07/2018
RCA reports to be completed to review any failures in the patient journey and identify the learning		Lesley Chandler		31/07/2018
Reopening of Clinical Decisions Unit on the 8th December 2017 has allowed for movement of patients awaiting diagnostics results from the ED thus creating capacity within the department		Lesley Chandler	Patients referred to specialty can be delayed due to delays in clinicians attending ED within the agreed Internal Professional Standards	31/07/2018
Safety Round SOP in place	Non elective pathway, steering group and board. Reporting to Senior Management Team. Medical Healthcare Board and ED PSQ meetings	Lesley Chandler	Safety round protocols constantly under review, therefore reducing the risk of staff not understanding the need for change and adopting safety round processes in line with changes - ongoing education with staff	31/07/2018

The Trusts transforming our care programme has seen an improvement in discharges across all wards. This has in turn supported patient flow which allows for patients with decisions to admit to be transferred to the wards		Lesley Chandler		31/07/2018
There is a revised escalation policy with clear triggers for escalation and actions to be taken which is supported by a review of daily operational functions within the Trust	Daily review meetings held	Lesley Chandler		22/07/2018
There is an ED remedial action plan in place which supports the non elective pathway		Lesley Chandler		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Daily monitoring and reporting of ED 4 hour performance by Information team and shared with the Health Group and Executive Team		Action Fully Implemented	Lesley Chandler	22/07/2018

Endoscopy

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Endo - 04**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment.**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards.	Reviewed 13/04/18 Vacancy Factor Band 5 - 8 WTE - 2 WTE starting in May 2018.	4	5	20	20	08	Claire McClements	Leanne Summersell	01/07/2017		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Claire McClements		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lauren Springham		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lauren Springham		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff.	Monthly HR reports staffing reports.	Lauren Springham		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. Datix.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lauren Springham	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff	This is an ongoing action for the trust.	Action On Track	Lauren Springham	31/07/2018

Gibberd Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Gibberd01**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Vacancy Factor Band 5 - March 2018 =16 WTE April 2018 = 15.76 WTE	4	5	20	20	08	Lesley Chandler	Michelle Ashman	20/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lesley Chandler		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lesley Chandler		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lesley Chandler		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Lesley Chandler		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. DATIX.	Lesley Chandler		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lesley Chandler	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff	This is an ongoing action for the trust.	Action On Track	Claire McClements	31/07/2018

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Harold Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Harold02**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Band 5 vacancy factor March 2018 = 9 WTE April 2018 = 10.24 WTE April 2018 6 x Staffing incidents reported	4	5	20	20	08	Lauren Springham	Helen Webber	20/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lauren Springham		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lesley Chandler		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate.	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lauren Springham		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Lauren Springham		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. Datix.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lauren Springham	31/07/2018
Rolling recruitment programme, alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing satff	This is an ongoing action for the trust.	Action On Track	Lauren Springham	31/07/2018

Harvey Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	HARV01	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	April 2018 Vacancy Factor Band 5 - 11.1 WTE	4	5	20	20	08	Lesley Chandler	Jill Holden	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3x Daily meetings	Lesley Chandler		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lesley Chandler		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lesley Chandler		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Lesley Chandler		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. DATIX.	Lauren Springham	Capped on NHSP and Agency. Ward often has high acuity patients. Non arrival of bank and agency staff.	13/12/2017

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lesley Chandler	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff	This is an ongoing action for the trust.	Action On Track	Claire McClements	31/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date

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Quality	**HARV04**	**Ensure all patients admitted to the acute medical wards are assessed and care plans put in place to minimize the risk of falls.**	Patients in hospital are at particular risk of falling and injuring themselves because of intercurrent illness, general frailty, confusion and the effects of the hospital environment.	All patients have a falls risk assessment completed on admission and appropriate plans put in place to reduce the risk of falls.	3	3	9	09	06	June Barnard	Jill Holden	01/01/2013		31/03/2018

Risk Mitigation/Controls	**Source of Assurance on Control Effectiveness eg. How would you know your control is working?**	**PS&Q Lead**	**Gaps in Control**	**Review Date**
All staff are trained on new Morse Tool to efficiently calculate risk of falls, and instigate appropriate mitigations to minimise avoidable falls.	Evidence of reduction of the severity of falls and that any fall occurring is unavoidable. This will be monitored through incident report and Essential Care Scrutiny panels, which are highlighted through to Trust PS&QC.	Jill Holden		31/01/2018
Processes are described within the falls policy as a control.	Evidence of reduction of the severity of falls and that any fall occurring is unavoidable. This will be monitored through incident report and Essential Care Scrutiny panels, which are highlighted through to Trust PS&QC.	Jill Holden		31/01/2018

Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**
High risk fallers are identified and assessed for low rise bed, bed rails, confusion and other co-morbidities.	Patients meeting the criteria are nursed in an observable bed. Encourage carers and relatives to sit with the patients Night light left on Falls risk assessments completed on admission and escalated to specialist falls nurse if required. Medication review. Blood pressure assessment. Line and standing BP	Action On Track	Lauren Springham	14/05/2018

John Snow Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**JS 02**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Vacancy Factor Band 5 March 2018 - 9 WTE April 2018 - 9.77 WTE April 2018 = 0 Staffing incidents reported	4	5	20	20	08	Lauren Springham	Peter Robinson	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lauren Springham		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lauren Springham		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate.	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting.	Lauren Springham		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Lauren Springham		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. Datix.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lauren Springham	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff	This is an ongoing action for the trust.	Action On Track	Lauren Springham	31/07/2018

Detailed Risk Register Report - Ordered by Highest Current Risk

Lister Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**List 02**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Vacancy Factor Band 5 March 2018 - 12 WTE April 2018 - 11.31 WTE	4	5	20	20	08	Lesley Chandler	June Barnard	20/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lesley Chandler		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lesley Chandler		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lesley Chandler		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Lesley Chandler		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. DATIX.	Lesley Chandler		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE	This is an ongoing action for the trust	Action On Track	Lesley Chandler	
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.	This is an ongoing action for the trust.	Action On Track	Lauren Springham	31/07/2018

Locke Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**LOCK01**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Vacancy Factor Band 5 March 2018 = 11 WTE April 2018 = 13.24 WTE	4	5	20	20	06	Lesley Chandler	Valerie Paddick	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lesley Chandler		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lesley Chandler		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lesley Chandler		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Lesley Chandler		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. DATIX.	Lauren Springham	Capped on NHSP and Agency. Ward often has high acuity patients. Non arrival of bank and agency staff.	31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lesley Chandler	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.	This is an ongoing action for the trust.	Action On Track	Claire McClements	31/07/2018

Detailed Risk Register Report - Ordered by Highest Current Risk

Medical Assessment Unit - Fleming

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**MAU FLEM-03**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Reviewed 13/04/18 Vacancy Factor Band 5 - 22 WTE No staffing incidents reported for April 2018	4	5	20	20	08	Lauren Springham	Louise Barnes	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lauren Springham		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lauren Springham		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lauren Springham		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. Datix.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lauren Springham	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.	This is an ongoing action for the trust.	Action On Track	Lauren Springham	31/07/2018

Medical Short Stay Saunders

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Saun 04**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	April 2018 = 7 staffing incidents reported	4	5	20	20	08	Lauren Springham	Johncy John	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lauren Springham		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lauren Springham		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting.	Lauren Springham		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff.	monthly HR reports staffing reports.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lauren Springham	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.	This is an ongoing action for the trust	Action On Track	Lauren Springham	31/07/2018

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Medicine - Operational

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**MED04**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment.**	There are currently high numbers of Band 5 vacancies across MHCG. Patients may not receive consistent standards of care. Staff morale may be decreased with increased levels of sickness. Reduced ability to comply with the requirements of clinical effectiveness and assurance and safety standards.	18/04/2018 - 130 WTE vacancies	4	5	20	20	08	June Barnard	June Barnard	23/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety.	3 x daily meetings	June Barnard		31/07/2018
Associate Director of Nursing for MHCG facilitating career clinics. Head facilitating itchy feet		June Barnard		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	June Barnard		31/07/2018
Provision of staff development through secondment/work experience in other clinical areas	Appraisals and 1:1 meetings	June Barnard		31/07/2018
Weekly meetings with recruitment to understand progress of international recruits and ensuring contact is maintained so that staff do not loose interest in joining the Trust.	Weekly meetings	June Barnard		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Anglia Ruskin University Open Days		Action On Track	June Barnard	31/07/2018
Recruitment open days. Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.		Action On Track	June Barnard	31/07/2018
Relaunch exit interview process and analyse data to inform initiatives		Action On Track	June Barnard	31/07/2018
Rolling adverts on NHS jobs.	Application and interviews monitored and arranged by HR	Action On Track	June Barnard	31/07/2018
Utilising social media when advertising posts and to engage current and potential workforce.	Communications monitor social media activity levels. Senior staff members on social media.	Action On Track	June Barnard	31/07/2018

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**MED57**	**To ensure the Trust is able deliver the national Emergency Department (ED) 4 hour standard whilst ensuring safe, quality care is provided to patients within the department.**	The trust has not been able to deliver performance against the 4 hour standard for a significant period of time. This is a potential risk to : -Patient safety -Patient flow -Crowding This has a significant impact on our ability to : -Complete ambulance offload and handover in a timely manner -Meet KPI's which in turn may incur Financial penalties	22.05.18 Month to date April - 73.77% Year to date performance 73.99%	4	5	20	20	04	June Barnard	Curtis Emordi	01/07/2016		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Ambulance Escalation and Offload SOP in place		June Barnard		30/06/2018
Daily monitoring and reporting of ED 4 hour performance by Information team and shared with the Health Group and the Executive team.	Monitoring of 4 hour performance figures	Lesley Chandler		31/07/2018
ED manager of the day	Non elective pathway, steering group and board. Reporting to Senior Management Team, Medical Healthcare Board, Emergency Department PSQ meeting.	Lesley Chandler		31/07/2018
ED trialed the Rapid Assessment and Treatment (RAT) process is now fully implemented. RAT is model is a structured approach to the way that patients are received and assessed within the Emergency Department. It is a senior decision maker-led approach to ensuring patients are assessed and initial care plan requirements quickly put in place also a way of ensuring those patients with immediate / acuity care needs are promptly assessed. RAT Standard Operating Procedure (SOP)in place.	IT maintain a record of daily performance. Datix reports.	Lesley Chandler	RAT SOP currently in draft - peer reviewed and agreed however requires noting at Trust Policy Group.	19/06/2018
Monitor compliance with Escalation triggers through ED Floor Walkers and Patient Journey Tracker.	Non elective pathway, steering group and board. Reporting to Senior Management Team, Medical Healthcare board, ED Patient Safety & Quality meeting.	Lesley Chandler		19/06/2018
Reopening of Clinical Decisions Unit on 8th December 2017 has allowed for the movement of patients who are awaiting diagnostic results to be moved from the ED thus creating capacity within the department		June Barnard	Patients referred to specialty can be delayed due to delays in clinicians attending ED within the agreed internal professional guidance.	30/06/2018
Root Cause Analysis reports are completed to review any failures in the patient journey and identify the learning		June Barnard		30/06/2018

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Safety round Standard Operating Procedure in place.	Non elective pathway, steering group and board. Reporting to Senior Management Team, Medical Healthcare board, ED Patient Safety & Quality meeting	Lesley Chandler	Safety round protocols constantly under review, therefore having the risk of staff not understanding the need for change and adapting safety round processed in line with changes - ongoing education with staff.	30/06/2018
The Trust transforming our care programme has seen an improvement in discharges across all wards. This has in turn supported patient flow which allows for patients with decisions to admit to get to the wards.		June Barnard		30/06/2018
There is a revised escalation policy with clear triggers for escalation and actions to be taken which is supported by a review of daily operational functions within the Trust	Daily review meetings are held	June Barnard		30/06/2018
There is an ED remedial action plan in place which supports the non elective pathway		June Barnard		30/06/2018
Trust Escalation processes in place to identify Trust-wide and external stakeholder support i.e. Ambulance Trust and Community Services.	Non elective pathway, steering group and board. Reporting to Senior Management Team, Medical Healthcare Board, ED Patient Safety & Quality meeting	Lesley Chandler		30/06/2018
Action in Progress	**Action Commentary**	**Action Rating**	**PS&Q Lead**	**Review Date**

Patient at Home

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**08/17.01**	**Full establishment of Staff Recruitment to maintain safety and viability of the service provision. This includes both Medical and Nursing recruitment**	Unexpected loss of 3 agency doctors effective 10/07/17 and the last doctor left as planned 09/10/17. Inability to maintain set trajectory safely and at high risk of service closure. Financial loss to Trust. Only able to recruit up to 15 patients/consultant as per original business case at present	Currently we have recruited new Locum doctors until we recruit to substantive staff We have 2 locum SHO Monday - Friday, one GP working 3 days a week and 1 Consultant working weekends Clinical lead working 4 days a week, on-call weekends. Nursing establishment is currently an issue due to recent leavers. We currently have 12 WTE nursing posts against a plan of 19.31 WTE.	4	4	16	20	02	Tal Heymann	Tal Heymann	10/08/2017		31/05/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Recruitment Plan to detail interim workforce solution by use of locum and agency staff	We recruit to fixed term appointment to allow enough time for business continuity whilst substantive staff commence employment. Check KPIs to see activity increase	Tal Heymann		17/05/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Clinical Service Manager on long term sick Recruitment of Band 6 and 7. New vacancy request uploaded on TRAC has been achieved. Advert on NHS jobs until 16/05/17	Once advert closes for Band 6 and 7 16/05/18. Shortlisting thereafter and recruit to vacant posts	Progress Being Made But Overdue On Completion Date	Tal Heymann	29/06/2018
Recruitment of locum / agency staff to bridge the gap until substantive recruitment is complete	Medical Staffing Team have assisted to book suitable agency doctors. Currently we have enough locum medical staff and we will continue to maintain this staff until we achieve substantive recruitment.	Progress Being Made But Overdue On Completion Date	Tal Heymann	17/05/2018
Substantive job descriptions agreed by Royal College for Acute Consultant post SHO posts out to advert on NHS jobs. Progression on recruiting medical posts currently on hold until the service gains clarity on supportive substantive nursing posts and direction of the service.	Team supported by Clinical lead. Locum medical support remains. Acute General Clinician JD and person spec agreed with Royal College. SHO job advert on NHS jobs. Current workforce 2 full time SHO Bank 1 part time GP Bank Leadership - Clinical lead The service needs recruitment plan clarity regarding nursing vacancies, until this is clarified the substantive medical recruitment will be on hold and the service will continue to reduce its ability to increase activity numbers.	No Progress Made	Tal Heymann	22/05/2018

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Ray Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**RAY01**	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Vacancy Factor Band 5 - March 2018 = 12 WTE April 2018 = 9.97 WTE April 2018 7 x staffing incidents reported	4	5	20	20	08	Lauren Springham	Jiji Phillip	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lauren Springham		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lauren Springham		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate.	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting.	Lauren Springham		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff.	monthly HR reports staffing reports.	Lauren Springham		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lauren Springham	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.	This is an ongoing action for the trust	Action On Track	Lauren Springham	31/07/2018

Winter Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	WINT01	**Ensure all patients receive safe, quality care within a safely staffed clinical environment**	There are currently high numbers of Band 5 vacancies across MHCG. The potential impact is that: -Patients may not receive consistent standards of care. -Decrease in staff morale and increase level of sickness. -Reduced ability to comply with the requirements of clinical effectiveness, assurance and safety standards	Vacancy Factor Band 5 March 2018 - 8 WTE April 2018 - 4.77 WTE April 2018 Staffing incidents reported x 1	4	5	20	20	08	Lesley Chandler	Madhavi Saikumar	01/07/2014		31/07/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
3 x daily review of staffing by Matrons to ensure each area is appropriately staffed to ensure patient safety. Daily use of "Safe Care"	3 x daily meetings	Lesley Chandler		31/07/2018
MHCG working closely with HR to review recruitment and retention processes.	Monthly HR reports. Staffing reports.	Lesley Chandler		31/07/2018
Monitoring of all incidents reported daily with the Patient Safety and Quality team and the Matrons. Incidents escalated where appropriate	Near Miss, Moderate and Severe Incidents discussed daily at the Incident Oversight meeting	Lesley Chandler		31/07/2018
Regular agency staff workers now complete an induction pack and competencies similar to permanent staff	monthly HR reports staffing reports	Lesley Chandler		31/07/2018
Use of NHSP and agency staff to ensure safety on the ward.	Audit compliance. Workforce report. Exception report. DATIX.	Lesley Chandler		31/07/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Cohort of pre-reg nurses working towards OSCE		Action On Track	Lesley Chandler	31/07/2018
Rolling recruitment programme. Alternate monthly schedule of recruitment open days throughout 2018 aimed at nursing staff.	This is an ongoing action for the trust.	Action On Track	Claire McClements	31/07/2018

Surgery & Critical Care

PACU

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	PACU001/2018	**For all patients requiring inpatient stay to be allocated an appropriate bed on a ward to eliminate the need to ward patients in PACU**	Patients remaining in Post Anaesthetic Care Unit (PACU) due to the lack of in patient beds. Impact – •Lack of capacity to accept post anaesthetic patients from theatres following surgery •Delay in sending for patients once PACU full potentially causing cancellations due to lack of theatre time/overrunning of lists •Need to book additional staff (bank/agency) to care for this patient group in the day and night •If unable to locate staff to fill the shift potentially would cause emergency provision to cease as staff rostered caring for patient in PACU •Breach of Eliminating Mixed Sex Accommodation (EMSA) guidance	23/05/18 YET TO BE APPROVED BY HG	4	5	20	20	06	Gail De Souza	Maxine Priest	22/05/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
•Patients who have been identified to stay overnight in PACU are segregated using curtains and cohorted into one area of PACU •Patients are recovered in theatres when there is no capacity in PACU •Patients cancelled on the day before or on the day of surgery due to lack of capacity		Gail De Souza		

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Daily/Weekly monitoring of theatre schedules and trust bed status		Action On Track	Gail De Souza	

Detailed Risk Register Report - Ordered by Highest Current Risk

Risk Register (Live)

Cancer Cardiology & Clinical Support Services

Cancer

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Finance	**Canc/2017/02**	**For the Williams Day Unit building to provide sufficient resources to deliver all required clinical activity to patients.**	Inadequate environmental resources Poor quality poor patient experience poor staff experience potential PALS, Complaints & Incidents lack of opportunities to develop the service	Feb 2018 - Risk updated	3	5	15	15	04	Nicola Tikasingh	Bernadette Roach	04/05/2017		31/03/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Additional chairs provided from the treatment area if available to accommodate standing patients. Tea and coffee machine purchased through charitable funds to create a more patient friendly environment.	CWT records Reduction or no negative PALS and complaints Reduction or no Incidents reported	Tina Smith		31/03/2018
Heating Issues: Hot drinks and blankets provided to the patients. Administrative staff wearing winter coats during the colder months.	CWT records Reduction or no negative PALS and complaints Reduction or no Incidents reported	Tina Smith	Heating issues to be audited during the colder months to ensure that we meeting health and safety requirements.	31/03/2018
Mobile screens used in phlebotomy area to aid privacy and dignity. Phlebotomy/storage area cleared daily to enhance access to resuscitation trolley when patients present.	CWT records Reduction or no negative PALS and complaints Reduction or no Incidents reported	Tina Smith		31/03/2018
Substantive clinics are still being run with inadequate clinic rooms. Hand washing is sought from another clinic room when available or from the staff wash room facilities. Request for a sink made to estates. Job No: 43355. Consideration has been given to relocating clinics but there is not enough sufficient capacity elsewhere There are no controls in place for pursuing new service development.	CWT records Reduction or no negative PALS and complaints Reduction or no Incidents reported	Tina Smith		31/03/2018
Treatment chair removed from Blue Area to allow access to fire exit (impacts capacity). Consideration has been given to the removal of more chairs but this will impact further on service delivery. To accommodate inpatients who require a bed, chemotherapy will be given on the ward. However, this impacts on WDU workforce capacity (2 chemotherapy trained nurses anything from 1-6 hours).	CWT records Reduction or no negative PALS and complaints Reduction or no Incidents reported	Tina Smith		31/03/2018

Detailed Risk Register Report - Ordered by Highest Current Risk

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
"Space" Workshop to be held to review service needs jointly with the estates department. Consideration could be given to reutilisation of space		Action On Track	Tina Smith	31/03/2018

Therapies

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**ther/2017/03**	**1. 80% urgent referrals to Paeds Dietitian O/P clinics to be seen in 4 weeks 2. 80% of routine referrals to be seen in 8 weeks**	increased number of referrals to Dietitian Paeds Outpatient clinics leading to an increase in waiting times for appointments to over 5 months, leading to an increase in concerns raised parents, increase in phone-calls from parents and reduction in quality of dietitetic service	Feb 2018 - this risk has been updated in the action point	3	4	12	15	04	Susan Fullen	Susan Fullen	29/08/2017	31/07/2018	03/03/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
1. Providing a few extra clinics 2. Providing advice over the telephone	1. Length of time patients are waiting for appointments- KPI 2. Complaints 3. Incidents	Susan Fullen		29/09/2017

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Business Case submitted Option1: Only see PAH consultant referrals, and discontinue seeing CDC referrals Option 2: Secure funding for 0.3 band 6 DT to provide 1.5 clinics per week	Business Case presented at Budget meeting. Further information required regarding income and activity. Income information provided. Feb 2018 - Option 1 route is being followed through. Plans in place for next meeting 8th Feb 2018.	Action On Track	Susan Fullen	03/03/2018

Detailed Risk Register Report - Ordered by Highest Current Risk

Corporate Services

Workforce - Human Resources

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Workforce and Organisational Development	**WPOD01**	**To ensure the Trust has effective workforce planning processes, supported by equally effective recruitment and selection processes, to further ensure delivery of safe, effective patient care.**	A lack of effective workforce planning presents a risk that the workforce may not be fully fit for purpose to deliver services now and in the future. Currently workforce planning tends to be cost-driven rather than service driven; with the current service redesign plans, the Trust has an opportunity to address the skills it needs to deliver in the coming years.		4	4	16	16	08	Ellie Manlove	Ellie Manlove	15/06/2017		03/05/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Cost is an essential part of current workforce planning and therefore is a partial control, BUT consideration needs to be given to aligning skills to services.	Recruitment KPI's Turnover and Stability data	Ellie Manlove	Need to improve the way we align skills to services; workforce implications of service design and redesign to be an essential consideration.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
HR forms for Appointment/Change/termination are realigned to new establishment process	New establishment control process in place for any changes to pay and establishment	Action Fully Implemented	Ellie Manlove	30/04/2018
ESR is aligned to financial ledger		Action On Track	Ellie Manlove	31/05/2018
HR senior Team to produce a high level workforce plan based on trust data which can then be aligned to the People strategy and 5p plans	It is recognized that this will be a longer-term piece of work with 18/19 plans being developed and reviewed in September 2018 for 19/20 and beyond	Action On Track	Ellie Manlove	04/05/2018
HR Team review people risk on each HCG Risk register.		Action On Track	Ellie Manlove	29/06/2018
Workforce planning using data to inform part of the resourcing plan as outlined in the People Strategy and work plan, which is then linked to educational plans Daily recruitment summits focusing on highest vacancies. Increased use on social media for advertising. Streamlined recruitment processes with KPI's reported at PRM's		Action On Track	Ellie Manlove	04/05/2018

Family & Womens Services

Safeguarding Adults

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Adult SG Mental Capacity 06/17**	**To improve staff knowledge and application of The Mental Capacity Act and understanding of DoLS in relation to planning of care for Patients**	The Trust is not following the legislation and guidance on the mental capacity act 2005, and the Deprivation of Liberty Safeguards. This could lead to where care and treatment is not provided in line with peoples decisions about consent. Applications to authorized DoLS are not made appropriately in a timely way.	24/04/2018 Team recruited a Band 7 who started on 28th March 2018. Once induction complete, the MCAs will be audited	4	4	16	16	04	Fiona Lodge	Fiona Lodge	13/06/2017		21/05/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Specific training package developed on MCA and DoLS for staff. Key professionals are being identified to receive this training A flow chart has been devised for staff guidance.	Staff compliance on training An audit has been devised to collect qualitative data. 3/10/2017 audits have been completed which have demonstrated in improvement in the completion of best interest decision The DNACPR form has been updated with the MCA form as part of this	Fiona Lodge	Staff being released for training Safeguarding time to train.	02/01/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
Audit required on training undertaken over last 12 weeks	25/08/17 MCA training occurring for 12 weeks 22/02/2018 MCA training is included as part of safe gurading training, there is a specific training for staff regarding MCA. Training compliance remains an issue across the Trust. Level 2- 72%	Action On Track	Fiona Lodge	

Detailed Risk Register Report - Ordered by Highest Current Risk

Womens Health

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Womens 9**	**Initiatives to reduce LSCS rate. Women transferred to main theatre if maternity theatre in use. Business case put forward to trust board for maternity rebuild to include a second theatre.**	One maternity theatre inadequate for increasing birth rate, and caesarean section rate. Leading to delay in perineal repairs and delays in delivery. Approx 4 reported patient safety incidents per week.	Plans for a prefabricated maternity theatre to be placed on site are under discussion. Business case already underway. 05.06.2017 risk score amended to 16 as increase in datix reporting due to delays and the use of main theatre. Non compliance with national standards.	4	4	16	16	04	Erin Harrison	Alison Steele	22/11/2011		30/04/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Business case put forward to trust board for maternity rebuild to include a second theatre.	by the approval of a second theatre for maternity	Erin Harrison	if the business plan is rejected.	
Initiatives to reduce LSCS rate.	to see a gradual decrease in the LSCS rate.	Erin Harrison	Due to some emergency situations not all LSCS are avoidable, this may mean that the rate fluctuates.	
Women transferred to main theatre if maternity theatre in use.	The safe transfer to main theatre for delivery, no SI's due to no operating theatre being available.	Erin Harrison	There may be a time when main theatre is busy so emergency cases have to be prioritized accordingly.	

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
04.01.17 No change to risk. The current Theatre refurbishment is planned for later this year. 3 incidents in december for delays in transfer.	October 2017 - Work has begun on new theatre and recovery area Business plan submitted. awaiting date for commencement of build 25/08/2017 building work due to commence in October 2017 for second maternity theatre. March 2018- work is continuing on labour ward theatre. currently behind schedule	Progress Being Made But Overdue On Completion Date	Erin Harrison	
18.7.2014 Maternity expansion plan has been submitted to the TDA-awaitng decsion.	March 2018- work is continuing on labour ward theatre. currently behind schedule	Progress Being Made But Overdue On Completion Date	Erin Harrison	
26.1.15 No change with plans, however now on CCG radar following their visit in Dec14	October 2017 - work has begun on new theatre and recovery area 25/08/2017 - business plan accepted and building work due to start October 2017 March 2018- work is continuing on labour ward theatre. currently behind schedule	Progress Being Made But Overdue On Completion Date	Erin Harrison	

Elective LSCS moved to main theatre. Awaiting outcome of proposed maternity refurb, plans and business proposal submitted to trust board.	October 2017 - Work has begun on new theatre and recovery area. ELLSCS proposed to move from ADSU to new theatre once the works are completed. 25/08/2017 - building work confirmed to commence October 2017 March 2018- work is continuing on labour ward theatre. currently behind schedule	Progress Being Made But Overdue On Completion Date	Erin Harrison	

Medicine Healthcare Group (MHCG)

Harvey Ward

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Risk Comments	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**HARV04**	**Ensure all patients admitted to the acute medical wards are assessed and care plans put in place to minimize the risk of falls.**	Patients in hospital are at particular risk of falling and injuring themselves because of intercurrent illness, general frailty, confusion and the effects of the hospital environment.	All patients have a falls risk assessment completed on admission and appropriate plans put in place to reduce the risk of falls.	3	3	9	09	06	June Barnard	Jill Holden	01/01/2013		31/03/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
All staff are trained on new Morse Tool to efficiently calculate risk of falls, and instigate appropriate mitigations to minimise avoidable falls.	Evidence of reduction of the severity of falls and that any fall occurring is unavoidable. This will be monitored through incident report and Essential Care Scrutiny panels, which are highlighted through to Trust PS&QC.	Jill Holden		31/01/2018
Processes are described within the falls policy as a control.	Evidence of reduction of the severity of falls and that any fall occurring is unavoidable. This will be monitored through incident report and Essential Care Scrutiny panels, which are highlighted through to Trust PS&QC.	Jill Holden		31/01/2018

Action in Progress	Action Commentary	Action Rating	PS&Q Lead	Review Date
High risk fallers are identified and assessed for low rise bed, bed rails, confusion and other co-morbidities.	Patients meeting the criteria are nursed in an observable bed. Encourage carers and relatives to sit with the patients Night light left on Falls risk assessments completed on admission and escalated to specialist falls nurse if required. Medication review. Blood pressure assessment. Line and standing BP	Action On Track	Lauren Springham	14/05/2018

Detailed Risk Register Report - Ordered by Highest Current Risk with Parameters for Current Risk Score

The Princess Alexandra Hospital NHS Trust

Risk Register (Live)

Cancer Cardiology & Clinical Support Services

Cancer

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**Canc2018/03**	**The role of the MDT coordinator and tracking team is to manage the cancer patient tracking lists, and the MDT, this involves preparing for MDTs, capturing outcomes and actions as well as expediting them to support delivery of the cancer pathways.**	• Increase in number of "new" patients to be tracked on the patient tracking list by 600 – 700 patients per week (1500 approximately). • 4 New team members in the last 8 months. • Difficulty finding strong calibre band 4's through recruitment. • Increased data items to be collected through new cancer waiting times guidance, audits and COSD8 (Cancer Outcomes and Services Data Set) • Tracking intensified to support CWT delivery. • Poor discharge profile from specialties such as Lower GI and Urology have caused highest increases affecting pathway management. • Increase number of errors identified on weekly basis through patient tracking list meetings. • Datix's raised particularly in Urology (SI's included) • Reoccurrence list has additional 187 patients across all specialties • The team used to offer surveillance monitoring for patients post cancer who require repetitive planned diagnostics, this worked well but service suspended as not sustainable	4	4	16	12	04 (2x2)	Tina Smith	Bernadette Roach	26/05/2018		31/08/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Key individuals have been restricted from specific tasks that have been causing errors. Further support and training being given.	Reduction in incident	Tina Smith	Staff are overloaded with work and this may increase the risk for error and oversight of individual patients pathways	31/08/2018

Detailed Risk Register Report - Ordered by Highest Current Risk with Parameters for Current Risk Score

The surveillance monitoring pathways have been suspended	Reduction of patients discussed at PTL meetings	Tina Smith	Patients on surveillance pathways will not be monitored potentially posing a risk to patients that require discussion or missing patients who need to be placed onto the cancer pathway	31/08/2018
Action in Progress	**Action Commentary**		**PS&Q Lead**	**Review Date**
Actively recruiting into MDT coordinator posts	May 2018 - positions yet to be filled		Tina Smith	31/08/2018
Review and amend the surveillance monitoring pathways and consider timely reintroduction	May 2018 - pathways yet to be reviewed		Tina Smith	31/08/2018

Corporate Services

Information Management & Technology (IM&T)

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**IT102**	**A stable and resilient Trust Integration Engine**	The current Trust Integration Engine (TIE) feeds patient registration data as well as admissions, discharges and transfer data to many critical downstream systems. This single server was under scoped when it was built for Cosmic. The server needs to be re-provisioned and redundancy built into the design as well as an increased amount of disk space.	4	3	12	12	04 (04x01)	Furzana Kausar	Lynne Fenwick	04/05/2018		08/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
The TIE has a support and maintenance contract and is monitored 24x7x365. Staff are alerted if the server is idle for any length of time signifying that there may be a problem.	The TIE has been stable for a long period of time. IT systems continue to receive the data they require to operate effectively.	Furzana Kausar	The TIE is a single point of failure as it resides on one server which could fail. The software on the TIE also requires upgrading as it is a few versions out of sync with the most current version.	

Action in Progress	Action Commentary	PS&Q Lead	Review Date
04/05/2018 The TIE requires to be rebuilt onto new hardware and the software needs to be upgraded. Work is taking placing with Suppliers to produce a project plan for a phased implementation.		Furzana Kausar	
29/05/2018 A plan has been formulated for upgrading the TIE in a safe manner with the assistance of the supplier. The supplier has stated that they can perform the upgrade in June. However Cosmic hotfixes need to be completed before the upgrade can be done.		Furzana Kausar	

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Projects and Business Continuity	**IT103**	**Safely move services which currently run on Vodafone ISDN lines away and onto an alternative provider**	PAH currently use Vodafone's ISDN lines for our direct dial numbers (DDI) which is any extension number beginning with a 7 which can be dialled directly 01279 82 7xxx. We have 910 DDI numbers. We will need to move this service to an alternative provider before the end of June as Vodafone will cease the service on 30 June 2018.	4	3	12	12	0 (0x0)	Furzana Kausar	Stuart Hanlon	21/05/2018		22/06/2018

Risk Mitigation/Controls	Source of Assurance on Control	PS&Q Lead	Gaps in Control	Review Date

Detailed Risk Register Report - Ordered by Highest Current Risk with Parameters for Current Risk Score

Risk Mitigation/Controls	Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Action in Progress	**Action Commentary**		**PS&Q Lead**	**Review Date**
An alternative contract has been procured and action is to commence which will port the connections to this new provider.			Furzana Kausar	

Surgery & Critical Care

All Surgery

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Finance	**S&CC002/2018**	**To achieve Financial balance for the year 2018-19 for income and expenditure meeting the planned contribution rate.**	Operational pressures (beds, staffing levels) may lead to the level of income not being to the planned level. Elective bed capacity may lead to elective cancellations leading to reduced income. Medical staffing gaps may impact on pay rate if agency is not controlled to within plan. Month 1 provisional budget headlines. Contribution £379 below plan. Expenditure £41K below draft budget. Income £420K below plan. (Budget £4,780K actual £4,360) variance 8.78% variance of budget	5	5	25	15	12 (4x3)	Julie Matthews	Julie Matthews	21/05/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
• Daily and weekly monitoring of income performance, agency use. • Senior sign off for purchase. • Weekly challenge meetings with Execs. • Monthly budget review with all budget holders. • Grip and control for theatre bookings and utilisation of theatres implemented.	• Increase in activity over plan as monitored via Finance order book. • Budget statements provided monthly. • Reduction in agency as monitored weekly by agency specialist.	Heather Keoghoe	• Delays in reporting of Finance which is monthly however mitigated by Senior sign off and weekly monitoring of agency and income	30/06/2018

Action in Progress	Action Commentary	PS&Q Lead	Review Date
Daily and weekly monitoring to continue.		Heather Keoghoe	

Detailed Risk Register Report - Ordered by Highest Current Risk with Parameters for Current Risk Score

PACU

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**PACU001/2018**	**For all patients requiring inpatient stay to be allocated an appropriate bed on a ward to eliminate the need to ward patients in PACU**	Patients remaining in Post Anaesthetic Care Unit (PACU) due to the lack of in patient beds. Impact – •Lack of capacity to accept post anaesthetic patients from theatres following surgery •Delay in sending for patients once PACU full potentially causing cancellations due to lack of theatre time/overrunning of lists •Need to book additional staff (bank/agency) to care for this patient group in the day and night •If unable to locate staff to fill the shift potentially would cause emergency provision to cease as staff rostered caring for patient in PACU •Breach of Eliminating Mixed Sex Accommodation (EMSA) guidance	4	5	20	20	06 (2x3)	Gail De Souza	Maxine Priest	22/05/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
•Patients who have been identified to stay overnight in PACU are segregated using curtains and cohorted into one area of PACU •Patients are recovered in theatres when there is no capacity in PACU •Patients cancelled on the day before or on the day of surgery due to lack of capacity		Gail De Souza		

Action in Progress	Action Commentary	PS&Q Lead	Review Date
Daily/Weekly monitoring of theatre schedules and trust bed status		Gail De Souza	

Urology

Domain	Risk Ref:	Objective - What are you trying to achieve	Description of Risk - Cause and Effect	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	PS&Q Lead	Risk Lead	Date Risk Raised	Date Risk Closed	Risk Review Date
Quality	**URO001/ 2018**	**This is to inform the directorate that the BK Ultrasound Machine (Oak Unit) life span expired in 2014 and that the ultrasound probe is now broken with electric wires exposed.**	The BK ultrasound Machine and the probe are used for taking prostate biopsy samples for detection of cancer cells, ultrasound scanning of the prostate and bladder. (Breakdown will lead uncontrolled breaches of cancer patients and delay in prostate cancer diagnosis).	4	3	12	12	06 (2x3)	Kirstie Heys	Ajay Sooknah	16/05/2018		30/06/2018

Risk Mitigation/Controls	Source of Assurance on Control Effectiveness eg. How would you know your control is working?	PS&Q Lead	Gaps in Control	Review Date
Action in Progress	**Action Commentary**		**PS&Q Lead**	**Review Date**
To purchase a new machine	The new machine would cost £56,000		Ajay Sooknah	

NHS
The Princess Alexandra Hospital
NHS Trust

Integrated Performance Report

April 2018

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

Your **future** | Our **hospital**

Contact:

Lance McCarthy, Chief Executive Officer

Andy Morris, Chief Medical Officer

Nancy Fontaine, Deputy CEO & Chief Nurse

Trevor Smith, Deputy CEO & Chief Financial Officer

Stephanie Lawton, Chief Operating Officer

Jim McLeish, Director of Business Delivery

Raj Bhamber, Interim Director of People

respectful | caring | responsible | committed

In this month

NHS
The Princess Alexandra Hospital
NHS Trust

Perfomance:

We received:

Referrals from GPs	4745
Urgent cancer referrals	894

We treated:

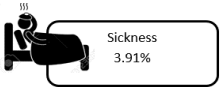
A&E attendances	8547
Non-elective admissions	2458
Outpatient attendances	7361
Day cases	1834
Elective inpatients	327

Patients:

Compliments	33
Complaints	23
FFT Inpatients	96%
FFT Outpatients	96%
FFT A&E	95%
FFT Maternity	100%

People:

Starters	64
Leavers	32



Places:

Priority 1 Response	100%
Catering Patient Satisfaction	87%
Meals served	40,683
Food Waste	7.4%

Pounds:

YTD Deficit	-£3,234,000
Agency Target £s	-£995,000
Nursing Agency Target	9%
Capital Expenditure	£189,000
BPPC Volume	63%
BPPC - £s	85%
Cash Balance	£1,841,000
Income & Expenditure: In month	-£3,234,000
Income & Expenditure: YTD	-£3,234,000
Income & Expenditure: FOT	-£3,158,500

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Navigation

Our Patients
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Our Performance
Our Places

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Key

The table below identifies the 2018/19 KPI target, current performance and then sets a trajectory for the year. The different coloured boxes indicate the individual month's trajectory and in which month the target will be met as follows:
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		Executive LEAD	MUST / SHOULD	2018 / 19 Target	Compliance Data Source	Current performance (Feb 18)	Trajectory April 18	Trajectory May 18	Trajectory June 18	Trajectory July 18	Trajectory Aug 18	Trajectory Sept 18	Trajectory Oct 18	Trajectory Nov 18	Trajectory Dec 18	Trajectory Jan 19	Trajectory Feb 19	Trajectory March 19
Patients	**Review DNARCPR forms to ensure completed fully in line with Trust Guidelines and National Policy**	Nancy Fontaine	MUST	95%	Audit of DNARCPR forms	82% Dec 17	84%	86%	88%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	Review MCA & DOLS and how this is documented within patient notes	Nancy Fontaine	MUST	90%	Audit of medical records every 2 months			80%		85%		85%		90%		90%		90%
	Fridge temperatures are regularly checked and acted upon if temperatures are outside the normal range	Nancy Fontaine	MUST	98%	Ward Accreditation Audit	95%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	(Urgent Care) Medical records contain a complete and contemporaneous record in respect of each patient and that appropriate risk assessments are completed and documented	Nancy Fontaine	MUST	90%	ED Documentation audit	NA	Implement new ED documentation	Embed ED documentation	Embed ED documentation	90%	90%	90%	90%	90%	90%	90%	90%	90%
	(Paeds) Improve transition arrangements for adolescent patients	Nancy Fontaine	MUST	Transition arrangements in place & embedded	Transition audit / Patient Survey	Limited arrangements in place	Transition Policy approved	Transition Policy implemented	Transition Policy implemented	Transition Policy embedded	Transition Policy embedded	Transition Lead in post		Transition policy fully embedded	Transition policy fully embedded	Transition policy fully embedded	Transition policy fully embedded	Transition policy fully embedded
	The Trust must continue to ensure that bottles of liquid medications are dated, signed on opening and do not exceed the expiry date	Nancy Fontaine	SHOULD	90%	Pharmacy Audit & Clinical Wednesday Audit	80%	80%	82%	84%	86%	88%	90%	90%	90%	90%	90%	90%	90%
	(CCCS) Ensure there is a planned preventative maintenance programme in place for all the equipment in the Mortuary	Nancy Fontaine	SHOULD	100%	Evidence of appropriate documentation	Improved documentation of maintenance commenced Feb 18	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	(Urgent Care) Conduct regular Care Rounds	Nancy Fontaine	SHOULD	95%	Audit documentation	NA	Care rounds implemented	Care rounds implemented	Care rounds implemented	Care rounds implemented	Care rounds implemented	Care rounds implemented	Care rounds implemented	Care rounds implemented	Care rounds implemented	Care rounds implemented	Care rounds implemented	Care rounds implemented
	(Urgent Care) Conduct Emergency Care Safety Checklists	Nancy Fontaine	SHOULD	90%	Weekly audit in ED		Implement new ED documentation	Embed ED documentation	Embed ED documentation	90%	90%	90%	90%	90%	90%	90%	90%	90%
	(Critical Care) Introduce disposable washing bowls for patients	Nancy Fontaine	SHOULD	100%	Evidence of disposable bowls in use in Critical Care	None	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	(Paeds) Consent should be consistently documented	Nancy Fontaine	SHOULD	90%	Documentation & notes audit	Not audited	Align with GDPR process	Align with GDPR process	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	(Paeds) Enhance communication with patients to ensure they have all the information they need	Nancy Fontaine	SHOULD	100% leaflets reviewed	NA	Review in progress	79%	80%	85%	90%	100%	100%	100%	100%	100%	100%	100%	100%
	(Paeds) Ensure records are complete and comprehensive, in particular the documentation of conversations with parents	Nancy Fontaine	SHOULD	90%	Documentation & notes audit	ED document being revised	ED documentation revised	Me First work shops for staff	Me First work shops for staff	Me First work shops for staff	Me First work shops for staff	90%	90%	90%	90%	90%	90%	90%
People	**Appraisals**	Raj Bhamber	MUST	90%	Appraisal records	86%	87%	88%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	Stat/Man Training (inc: safeguarding, Fire, Infection Control, Hospital Life Support)	Raj Bhamber	MUST	90%	Training records	84%	85%	86%	87%	88%	89%	90%	90%	90%	90%	90%	90%	90%
	Paediatric Life Support Training Compliance	Raj Bhamber	MUST	90%	Training records	80%	85%	87%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%
	Adult Life Support Training (level 2)	Raj Bhamber	MUST	90%	Training records	77%	70%	74%	78%	82%	86%	90%	90%	90%	90%	90%	90%	90%
	Adult Safeguarding Training (Levels 1 & 2)	Raj Bhamber	MUST	90%	Training records	L1 - 92% L2 - 78%	L1 - 93% L2 - 78%	L1 - 93% L2 - 80%	L1 - 93% L2 - 82%	L1 - 93% L2 - 84%	L1 - 93% L2 - 86%	L1 - 93% L2 - 90%	L1 - 93% L2 - 90%	L1 - 93% L2 - 90%	L1 - 93% L2 - 90%	L1 - 93% L2 - 90%	L1 - 93% L2 - 90%	L1 - 93% L2 - 90%
	Paediatric Safeguarding Training (levels 1, 2 & 3)	Raj Bhamber	MUST	90%	Training records	L1 - 92% L2 - 85% L3 - 62%	L1 - 92% fL2 - 87% L3 - 70%	L1 - 92% L2 - 88% L3 - 74%	L1 - 92% L2 - 90% L3 - 78%	L1 - 92% L2 - 90% L3 - 82%	L1 - 92% L2 - 90% L3 - 85%	L1 - 92% L2 - 90% L3 - 88%	L1 - 92% L2 - 90% L3 - 90%	L1 - 92% L2 - 90% L3 - 90%	L1 - 92% L2 - 90% L3 - 90%	L1 - 92% L2 - 90% L3 - 90%	L1 - 92% L2 - 90% L3 - 90%	L1 - 92% L2 - 90% L3 - 90%
	(Urgent Care) Staff are competent including: Fire, Safeguarding & Infection Control	Raj Bhamber	MUST	90%	Training records	81% (medical HCG)	85%	86%	87%	88%	89%	90%	90%	90%	90%	90%	90%	90%
	(Surgery) There must be a Paediatric trained nurse in theatres at all times	Raj Bhamber	MUST	100%	Staff Roster	0%	0%	0%	0%	50%	50%	50%	50%	50%	50%	100%	100%	100%
	(Paeds) Recruit Registered Paediatric Nurses to ensure compliance with RCN standards regarding staffing & competences on Dolphin Ward	Raj Bhamber	MUST	14%	Staff Roster / Shelford Acuity Model & Safer Staffing	22.9%	22%	22%	18%	18%	18%	15%	15%	15%	15%	15%	15%	14%

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	Recruit Registered Nurses (RNs) to ensure adequate numbers of RN's in line with national guidance	**Raj Bhamber**	**SHOULD**	18%	Vacancy Data	24.0%	22%	21.5%	21%	20.5%	20%	20.0%	19.5%	19.5%	19%	19%	18.5%	18%

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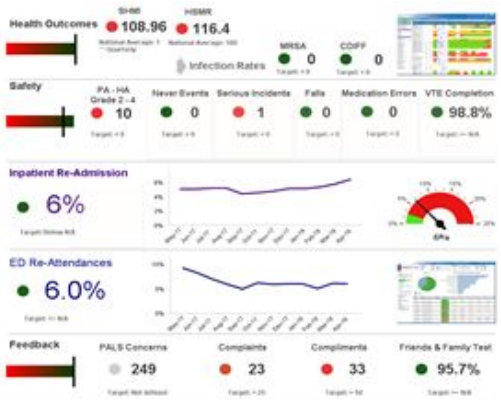
Performance	(HDU) Reduce the number of mixed sex breaches	Steph Lawton	MUST	Zero	IPR	5	2	2	2	1	1	1	0	0	0	0	0	0
	Ambulance patients are appropriately assessed & triaged in a timely manner in accordance with RCEM guidelines	Steph Lawton	MUST	<30mins - 80% 30-60mins - 20%	IPR	<30mins - 66% 30-60mins - 26% >60mins - 8%	<30 - 65% 30-60 - 31.5% >60 - 3.5%	<30 - 68% 30-60 - 29% >60 - 3%	<30 - 70% 30-60 - 27.5% >60 - 2.5%	<30 - 74% 30-60 - 24% >60 - 2%	<30 - 77% 30-60 - 28.5% >60 - 1.5%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%	<30 - 80% 30-60 - 20%
	Reduce the number of late discharges (22.00-08.00hrs)	Steph Lawton	SHOULD	Zero	IPR	3.0%	4.0%	4.0%	3.5%	3.5%	3.0%	3.0%	2.5%	2.0%	1.5%	1.0%	0.5%	0%
	Reduce the number of bed moves between (22.00-08.00hrs)	Steph Lawton	SHOULD	Zero	IPR	3.0%	4.0%	4.0%	3.5%	3.5%	3.0%	3.0%	2.5%	2.0%	1.5%	1.0%	0.5%	0%
	Reduce the number of delayed discharges from HDU to the wards	Steph Lawton	SHOULD	4-24hrs=12 >24hrs = 2	IPR	4-24hrs=21 >25hrs=12	4-24hrs=23 >24hr=24	4-24hrs=22 >2hr4=22	4-24hrs =21 >24hr=20	4-24hrs=20 >24hr=18	4-24hrs=19 >24hr=16	4-24hrs=18 >24hr=14	4-24hrs=17 >24hr=12	4-24hrs=16 >24hr=10	4-24hrs=15 >24hr=8	4-24hrs=14 >24hr=6	4-24hrs=13 >24hr=4	4-24hrs=12 >24hr=2
	(Surgery) Reduce the use of PACU for inappropriate patients (DSU etc.) late at Night	Steph Lawton	SHOULD	Extend DSU opening hours to 22.00hrs / Zero	IPR	DSU closes at 18.00hrs	Recruit additional staff	Recruit additional staff	Recruit additional staff	Extend opening to 22.00hrs. ZeroDSU pts in PACU	Extend opening to 22.00hrs. ZeroDSU pts in PACU	Extend opening to 22.00hrs. ZeroDSU pts in PACU	Extend opening to 22.00hrs. ZeroDSU pts in PACU	Extend opening to 22.00hrs. ZeroDSU pts in PACU	Extend opening to 22.00hrs. ZeroDSU pts in PACU	Extend opening to 22.00hrs. ZeroDSU pts in PACU	Extend opening to 22.00hrs. ZeroDSU pts in PACU	Extend opening to 22.00hrs. ZeroDSU pts in PACU
	The Trust needs to monitor trends in delayed discharges to identify trends / areas for improvement	Steph Lawton	SHOULD	Trends monitored & acted upon	Audit data	Trends not monitored	Trends not monitored	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon	Trends monitored and acted upon
Places	(HDU) When refurbishing, consider the position of the sink area in HDU, moving it so that staff do not have to pass through a bed area to wash their hands	Marc Davis	SHOULD	Review space & identify a new design. Submit business case.	NA	NA	Review space	Review space	Submit business case for approval	If approved go out to tender	If approved go out to tender	Start building work	Complete building work	New HDU	New HDU	New HDU	New HDU	New HDU
	(HDU) When refurbishing, consider the space required to provide safe movement around bed spaces	Marc Davis	SHOULD	Review space & identify a new design. Submit business case.	NA	NA	Review space	Review space	Submit business case for approval	If approved go out to tender	If approved go out to tender	Start building work	Complete building work	New HDU	New HDU	New HDU	New HDU	New HDU
	(CCCS) Ensure there is a planned preventative maintenance programme in place for all the equipment in the Mortuary	Marc Davis	SHOULD	100%	NA	Improved documentation of maintenance commenced Feb 18	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Summary Scorecard

NHS
The Princess Alexandra Hospital
NHS Trust

We will measure our performance across these areas each & every month to enable us to take corrective action where necessary, expedite innovation, celebrate successes or learn from our areas where we can improve whilst also identifying any trends or themes.

Our Patients



Our Performance

Performance Overview

External views of the Trust

The Princess Alexandra Hospital NHS Trust

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

Care Quality Commission

NHS Choices

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

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

Stars - maximum 5

OK = Within expected range

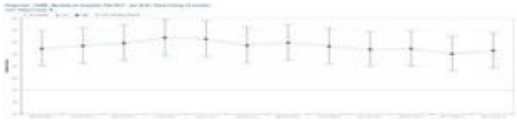
✓ = Among the best (top 20%)

! = Among the worst

Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

HSMR/Mortality: The provisional 12 month rolling HSMR for February 2017 to January 2017 is 116.4 and statistically "higher than expected"'. Last month's figure, also 116.4, has corrected to 115.1 with complete data migration. This is the 13th consecutive month of reporting for a "higher than expected".



The corrected in-month HSMR was "as expected" for the 7 of the previous 12 months but is now "higher than expected". In the 12 month period there are a total of 138 deaths over and above those expected. This is essentially unchanged from last month.

There are 5 diagnostic outliers:

1) Fracture of neck of femur
2) Pneumonia
3) Septicaemia
4) Intestinal obstruction without hernia

Safety: In April there was 6 serious incidents (SI) raised. A total of 757 incidents were reported. Of the PAH incidents, 718 (approx. 95% were 'no and minor harm' incidents while moderate harm incidents were 31 (4 %) and severe harm incidents were 3 (0.39 %) and 5 deaths (0.66%).

The moderate, severe and death incidents have all been reviewed and/or discussed at the oversight and Serious Incident Group. The grading of some of these incidents is subject to change. Data is correct at 9 May 2018.

Safety Thermometer: Harm free care rate was 94.88% (n=408/430) reported as No Harm.

22 patients are recorded as having 1 or more harm. The data shows 7 patients were recorded as having hospital acquired harm.

The main themes from the audit show 12 pressure ulcers, with 3 hospital acquired and 9 community acquired.

Catheter & Urinary Tract Infection, 7 of which 1 was hospital acquired and 6 community/catheter acquired.

Falls with harm are 3.

VTE hospital acquired 0.

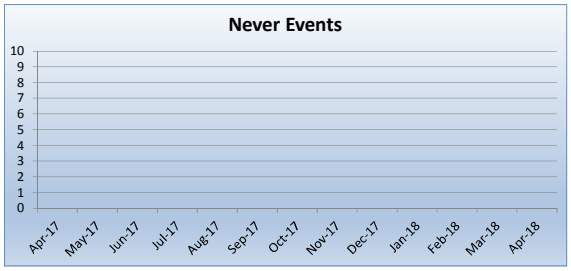
1 Our Patients Summary 1.1 Patient Safety - incident reporting

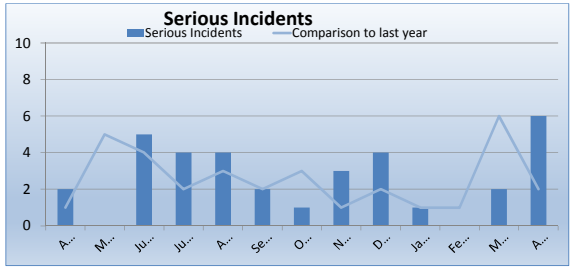
The Princess Alexandra Hospital NHS Trust

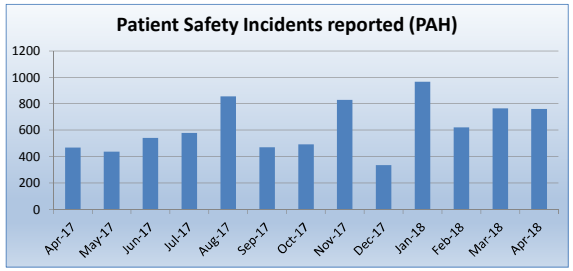
Patient Safety & Serious Incidents: There were a total of 896 incidents reported with 760 of these being PAH. In the year we have raised a total of 9580 safety incidents & overall over the year this has increased by 3.11%.
Of the PAH incidents, approx. 95 % were 'no harm' or 'minor harm' incidents while 5% rated as moderate, severe harm & death. The moderate & severe incidents have been reviewed and/or discussed at oversight and/or Serious Incident Group & grading may be subject to change. Data is correct as at 1st May 2018.
During April 2018 there were 6 Serious Incidents:

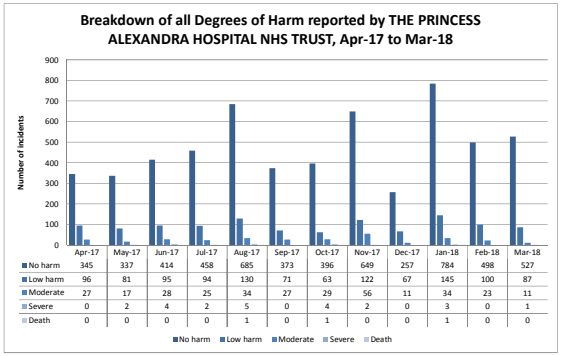
1. Maternity/ Obstetric Incident meeting SI criteria: Mother and Baby. Intrapartum stillbirth – no immediate care or service delivery concerns identified.
2. Maternity/ Obstetric Incident meeting SI criteria: Baby only. Baby born via emergency C-Section in poor condition requiring cooling and transfer to tertiary centre.
3. Treatment delay meeting SI criteria. Patient was advised to stop Warfarin prior to receiving chemotherapy. No further anticoagulation prescribed. Patient developed bilateral Pulmonary Emboli
4. Suboptimal Care of the Deteriorating Patient. Unwell patient in Emergency Department. Blood tests taken but not acted upon. Patient deteriorated and died
5. Actual / Alleged Abuse. Patient under DOLs and wearing mittens on the ward. One of the patients' hands was tied to the bedrails with gauze by a substantive registered nurse to prevent self-removal of cannula
6. Apparent/actual/suspected self-inflicted harm meeting SI criteria. Patient received care and treatment at the Trust 24 hours before taking their own life - no immediate care or service delivery concerns identified

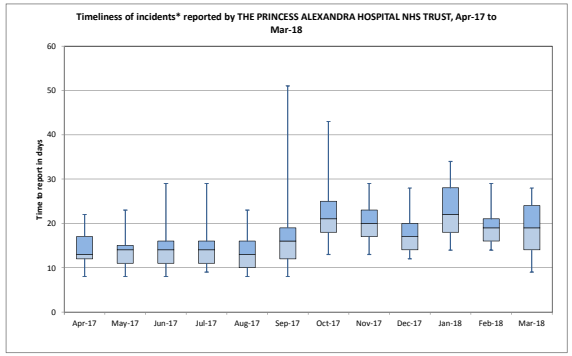
Safety Thermometer for April 2018
94.88% of the incidents reviewed were reported as no harm, 22 patients are recorded as having 1 or more harm. The data shows that of these patients 7 were recorded as having hospital acquired harms NB: The information collected during the Monthly Patient Safety Thermometer is a point prevalence audit and as such only provides us with snap shot of information relating to all inpatients on the one audit day of the month

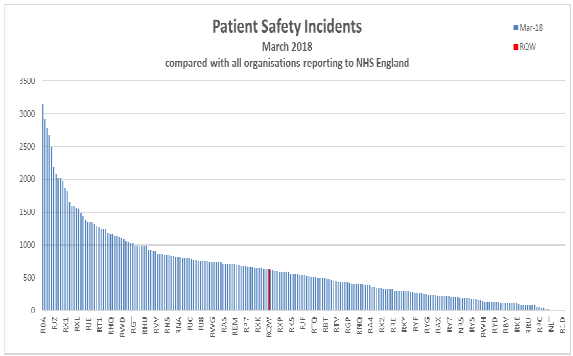












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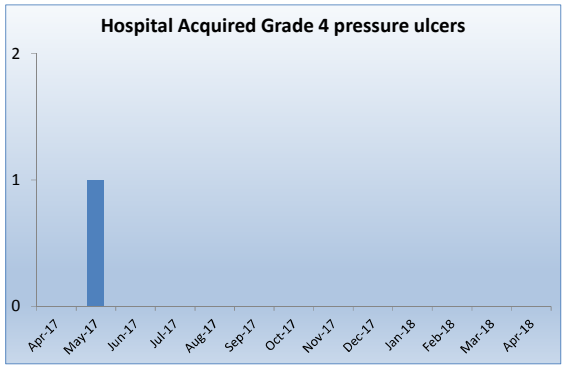
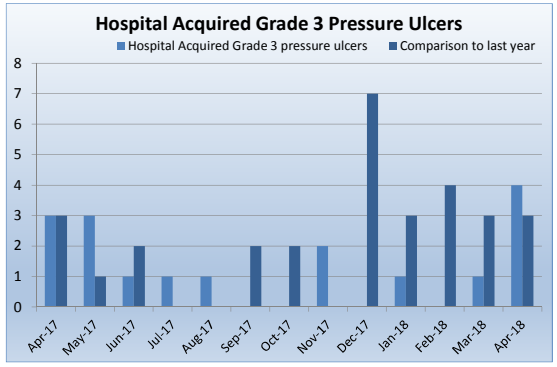
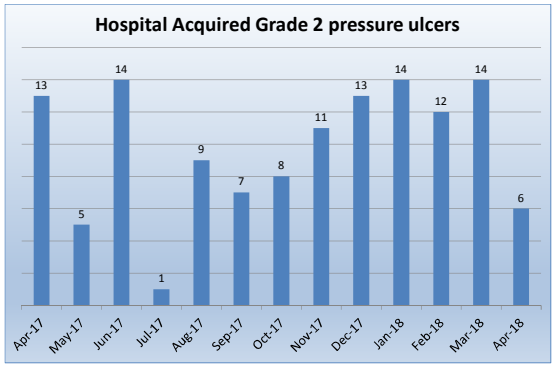
None of these cases have yet been presented at scrutiny panel. Feedback with regards to root causes or themes, whether avoidable or non-avoidable, will be provided once this has occurred.



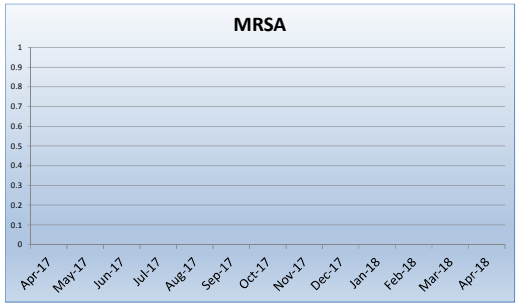


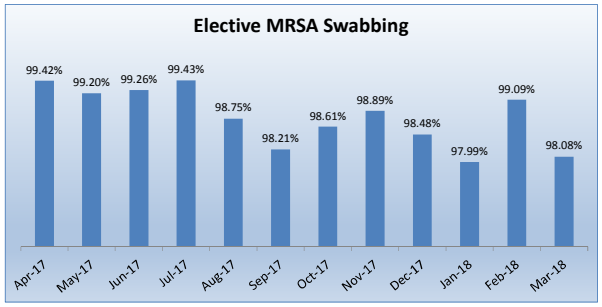


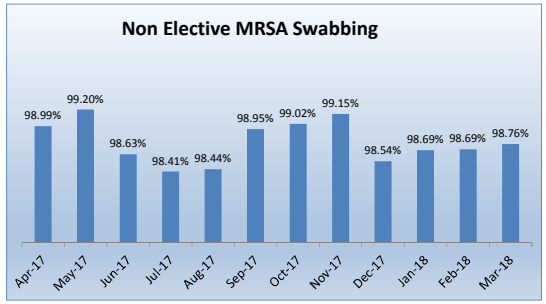
1 Our Patients Summary 1.3 Infection Control

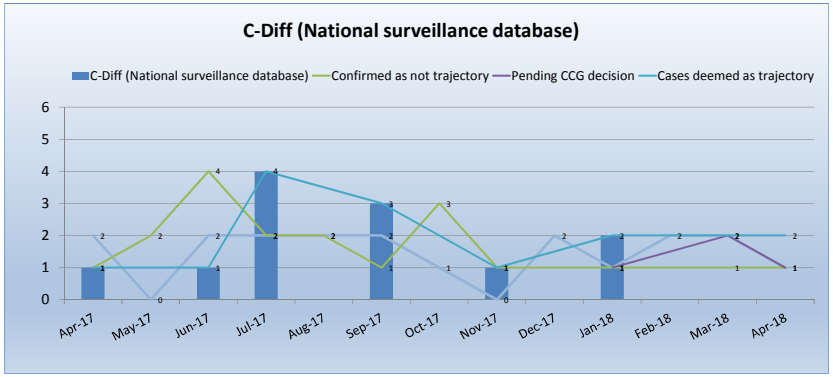
The Princess Alexandra Hospital NHS Trust

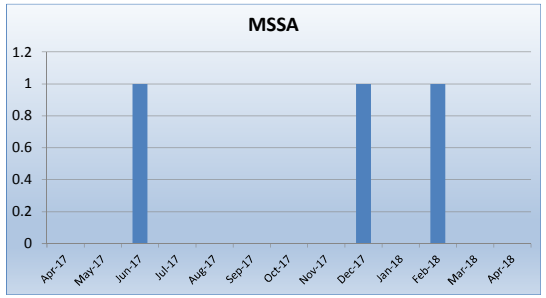
MRSA bacteraemia: There have been no cases of Trust-apportioned MRSA to date for 2018-19
Clostridium difficile: The trajectory for 2018-19 is nine cases for the year. There were two cases of C.difficile in April; of these, the RCA for one case has been held, the other will be happening in May. Under the new Sustainability and transformation programme (STP), cases will now go the East Herts C.diff Appeals Panel. Unfortunately we are unable to appeal the first case because there was inappropriate antibiotic usage on patient admission (discussed at the RCA with the clinical team).
Update on 2017-2018 appeals: It was reported the Trust ended the year with a total of 14 Trust apportioned cases; five of these have been successful appeals, placing our end of year position at nine cases. However, we have since had another successful appeal from 2017/18 cases, meaning the position is now eight Trust-apportioned cases and six successful appeals. There are still potentially a further three cases going through the appeals process.
MSSA: There were no Trust apportioned cases in April. There is no trajectory in place for MSSA, but we continue to monitor and report cases.
MRSA Screening: Over 98% compliance was achieved for both elective & non-elective screening in April.











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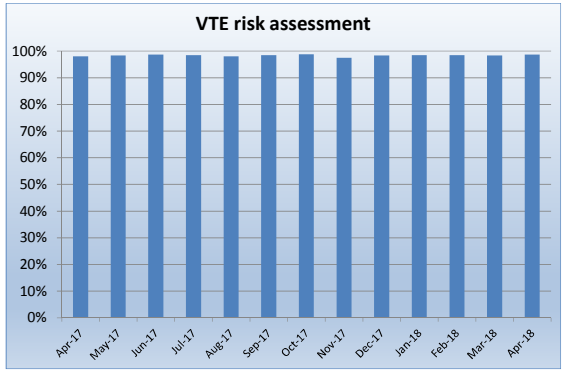
1 Our Patients Summary 1.4 Screening on admission

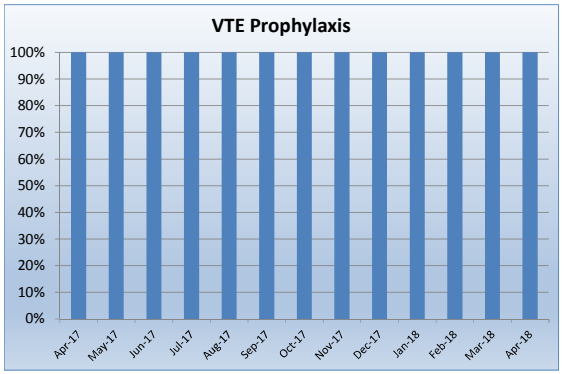
The Princess Alexandra Hospital NHS Trust

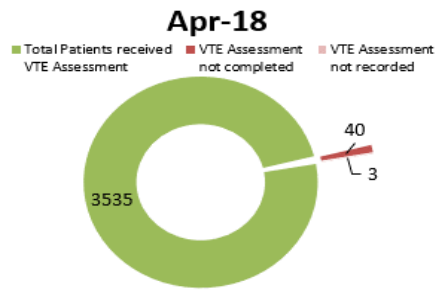
VTE: All doses missed are escalated immediately to the Nurse in charge and patient receives prescribed anticoagulation.

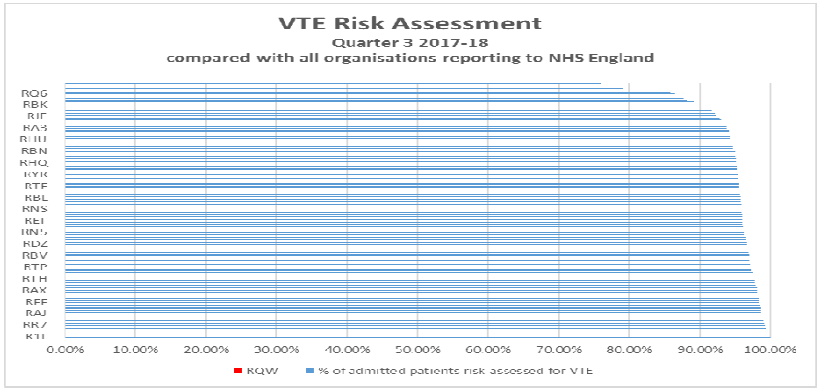
All non-compliant VTE assessments are scrutinised by the VTE leads and reported monthly through PSQ.

Any incidents are recorded on DATIX and are reported through the daily incident group.









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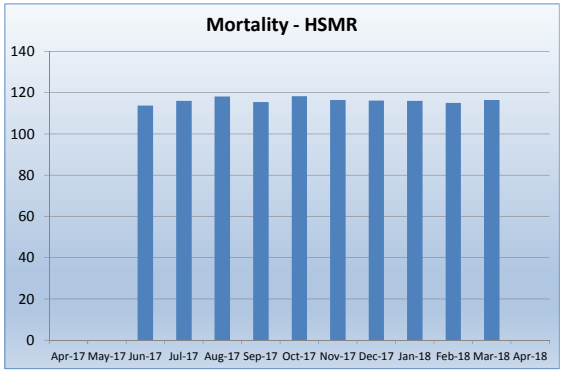
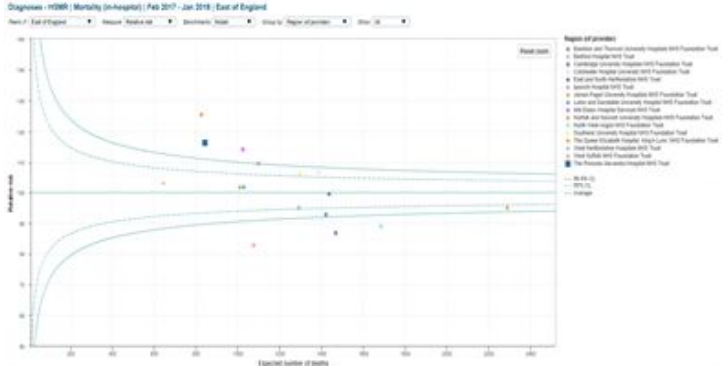
1 Our Patients Summary 1.5 Mortality indicators

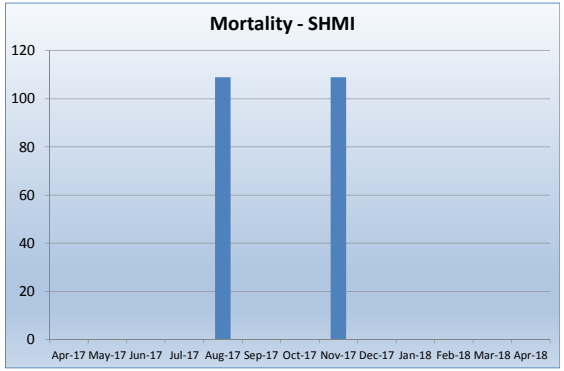
The Princess Alexandra Hospital NHS Trust

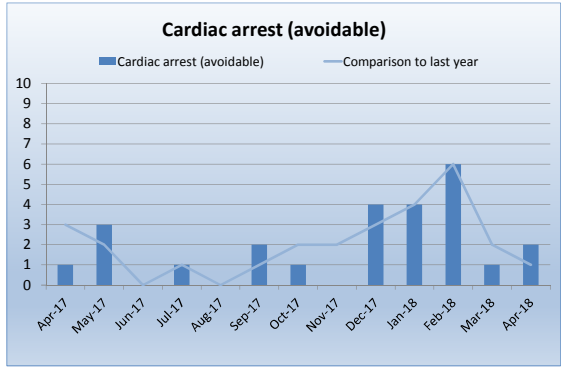
The provisional 12 month rolling HSMR for February 2017 to January 2018 is 116.4 and statistically "higher than expected". Last month's figure, also 116.4, has corrected to 115.1 with complete data migration. This is the 13th consecutive month of reporting for a "higher than expected". There are 5 diagnostic outlier alerts: #NOF, COPD, Septicaemia, Gastrointestinal obstruction and Pneumonia. SMR is 114.9 and statistically "higher than expected". There are 5 diagnostic outliers: #NOF, Pneumonia, Cancer of head and neck, Septicaemia and COPD. SHMI for October 2016 to September 2017 was 108.96 and is "as expected".

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









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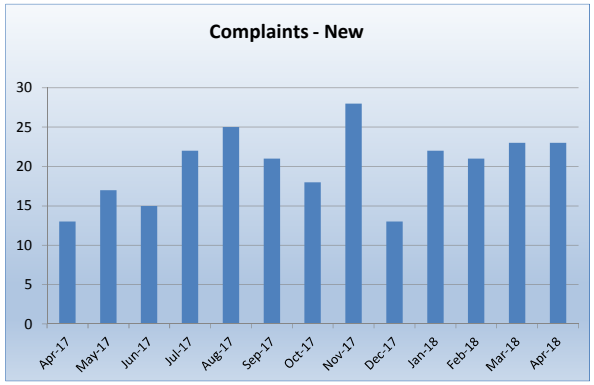
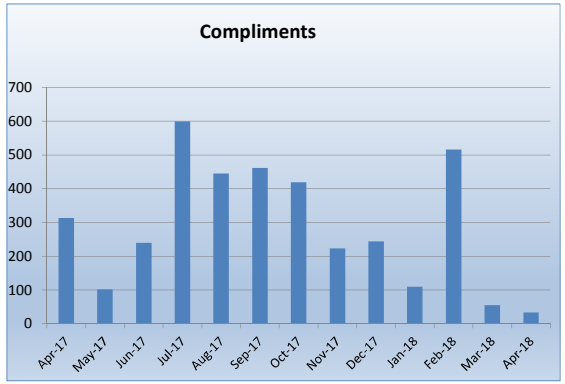
1 Our Patients Summary 1.6 Complaints & Compliments

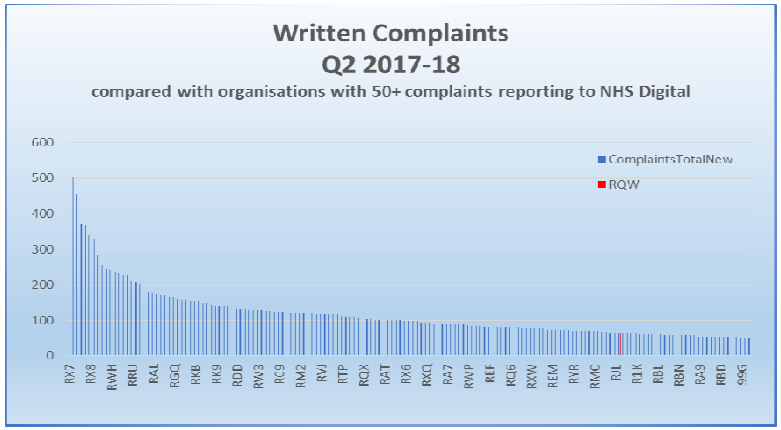
The Princess Alexandra Hospital NHS Trust

Complaints: Winter impacts on the patient experience have had a long tail this year with continued elevated levels of complaints received, but distributed equally between medical care, nursing and communication issues.

Compliments: Numbers at this low are clearly the result of recording effects and on 15 May, the numbers had changed and were at 115 with more being added as we overcome our staffing capacity issues which should be resolved in the coming months.







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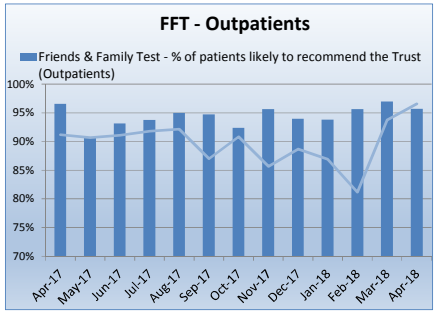
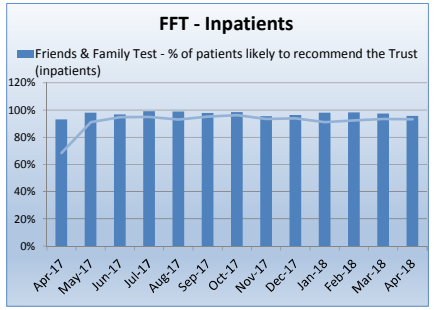
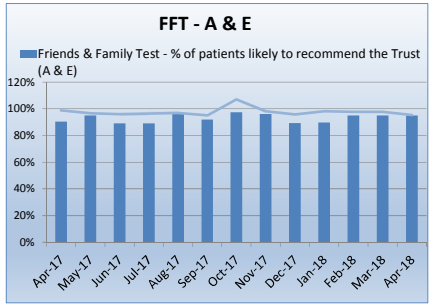
1 Our Patients Summary 1.7 Friends & Family Test

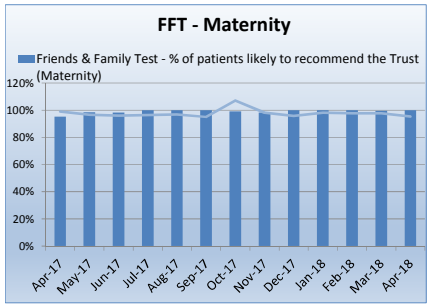
The Princess Alexandra Hospital NHS Trust

FFT and the planned switch to an Electronic Feedback System is to be phased in over June and July and should see some change in scoring and sampling. The PE team will be providing support throughout the switch over which begins with briefings on 18 May.









Friends & Family Test Results		Positive & Negative Response Total						Total Responses								
Friends & Family Test Return		Likely	%	Unlikely	%	Neither / Don't Know	%	Extremely Likely	Likely	Neither	Unlikely	Extremely Unlikely	Don't Know	Total Responses	Total Eligible Patients	Response Rate
Maternity	Q1 Antenatal Care	18	100.00%	0	-	0	-	18	0	0	0	0	0	18	-	-
	Q2 Birth	175	100.00%	0	0.00%	0	0.00%	175	0	0	0	0	0	175	318	55.03%
	Q3 Care on postnatal ward	175	100.00%	0	0.00%	0	0.00%	175	0	0	0	0	0	175	313	55.91%
	Q4 Postnatal community provision	33	100.00%	0	0.00%	0	0.00%	33	0	0	0	0	0	33	304	10.86%
	Total excluding Q3	226	100.00%	0	0.00%	0	0.00%	226	0	0	0	0	0	226	622	36.33%
A&E		1100	95.07%	22	1.90%	35	3.03%	904	196	33	11	11	2	1157	3881	29.81%
Acute Inpatients		717	95.86%	16	2.14%	15	2.01%	655	62	4	6	10	11	748	1649	45.36%
Total excl. Outpatients		**2043**	**95.87%**	**38**	**1.78%**	**50**	**2.35%**	**1785**	**258**	**37**	**17**	**21**	**13**	**2131**	**6152**	**34.64%**
Outpatients		2058	95.72%	40	1.86%	52	2.42%	1656	402	42	20	20	10	2150	25355	8.48%
Total Incl. Outpatients		**4101**	**95.80%**	**78**	**1.82%**	**102**	**2.38%**	**3441**	**660**	**79**	**37**	**41**	**23**	**4281**	**31507**	**13.59%**

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Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

RTT performance - the RTT recovery plan is underway to get back to the national standard for the incomplete performance. The challenge in month has been maintaining surgical performance through the bed base as well as providing the capacity for first appointments to accommodate a large number of ASIs.
The trajectory is to achieve 89% for April as indicated in the graph increasing to 92% from Q2, the Healthcare Groups have
• Trajectories in place at speciality level
• Backlog clearance delivery plans in place for all surgical specialities, supported by theatres with additional capacity focused on key risk areas
• GooRoo capacity & demand model used to review the sustainable capacity required
• Workforce and Job Plans to be reviewed to support sustainable delivery
• Pathways and LOS to be reviewed to reduce demand on inpatient beds in line with best practice

52 weeks breaches – 17 (one in Trauma & Orthopaedics and 16 in Paediatric Urology). Paediatric Urology Clinics are being provided from the end of June for by Addenbrookes Consultants, who will review all patients in outreach clinics at PAH to confirm management plans before offering surgical dates at Addenbrookes.

Cancer performance - the 62 day standard for March has not been achieved due largely to the challenges facing the Urology service which remains a performance risk until substantive staff can be appointed. The fortnightly reviews of activity, workforce and patient flow will continue.

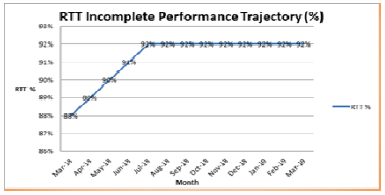
Diagnostic performance - performance remains consistent with the 6 week target achieved for the month. Endoscopy is receiving additional support from CCCS Healthcare Group and capacity is due to be increased by moving to 7 day working.

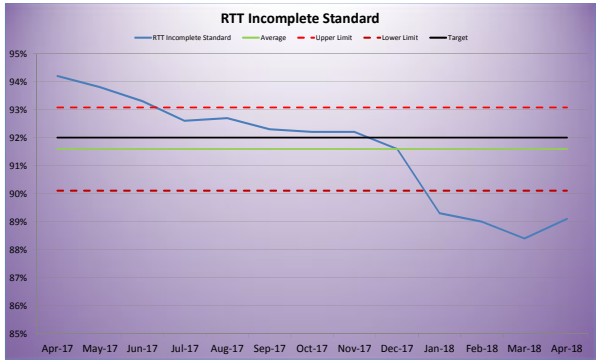
Emergency performance - this remains challenging. Performance for April was 73.67% which is slightly above the trajectory at this stage. The re-establishment of the assessment capacity in March has aided this, but challenges were faced in terms of winter pressures, over crowding and staffing shortfalls in ED evidenced by the large number of 12hour breaches.
In addition, patient flow through the hospital was constrained due to ward closures due to norovirus.

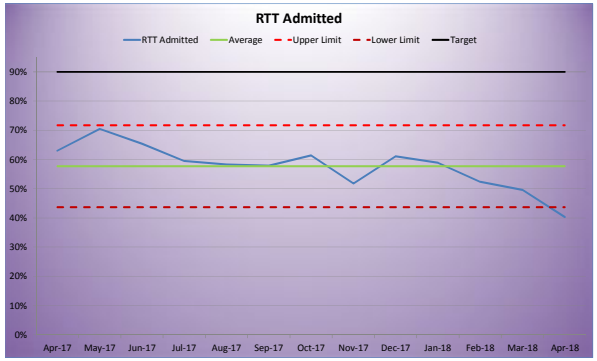
2 Our Performance Summary — 2.1 Responsive - RTT

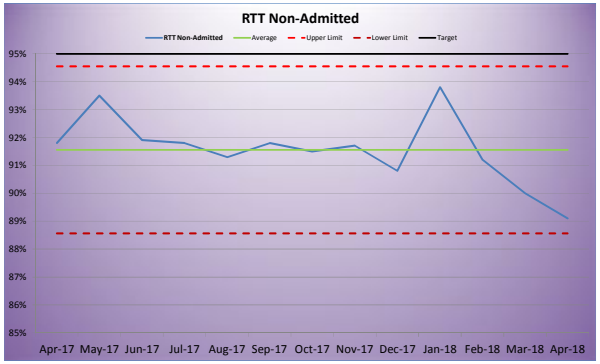
The Princess Alexandra Hospital NHS Trust

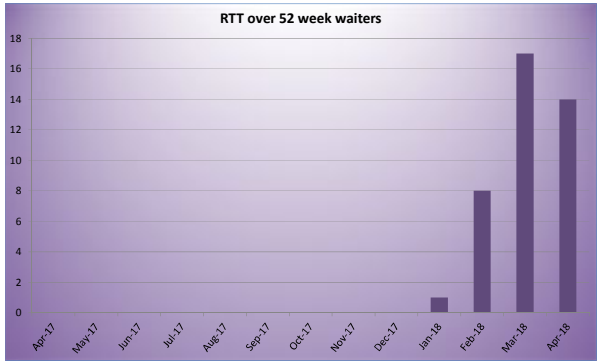
The RTT recovery delivery is on track against the trajectory and all teams are working towards achievement of the 92% incomplete standard. The April target of 89% was achieved.











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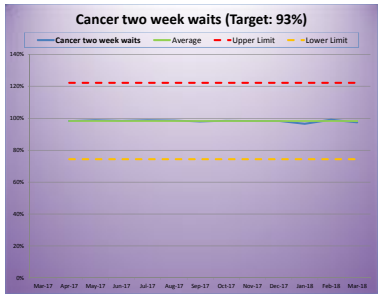
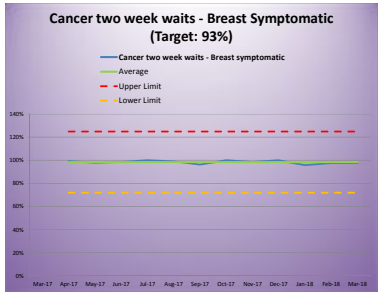
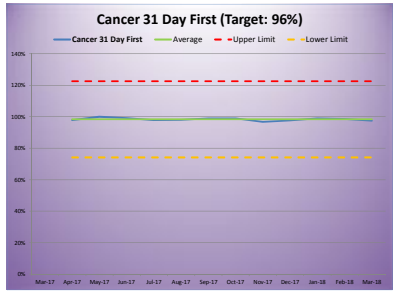
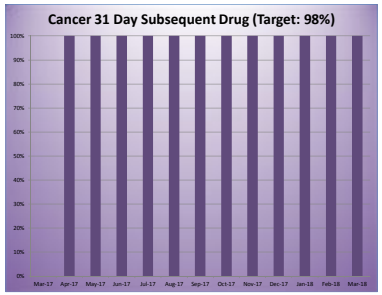
Cancer 62 day standard: Multiple themes over 17 breaches of the standard. Urology (9 breaches) included delays in first OPA, histology and diagnostics at PAH driven by medical staffing levels. Other tumour groups (8 breaches) included delays to bringing to MDT, histology delays and delays in treatment capacity at other Trusts .
31 day rare: One breach, capacity issues meant patient could not be offered TCI in date.

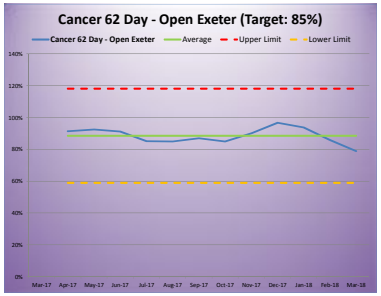
The COO held performance recovery meetings with all specialities to review their position and recovery trajectories

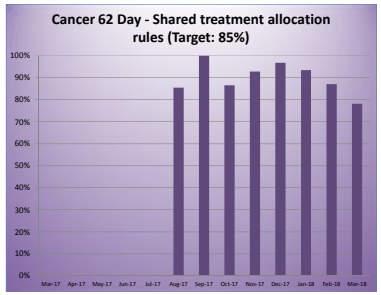


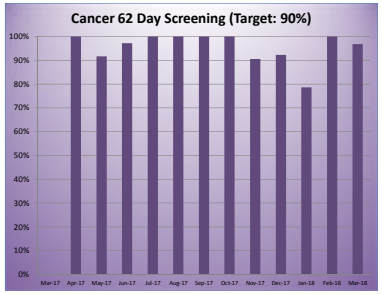


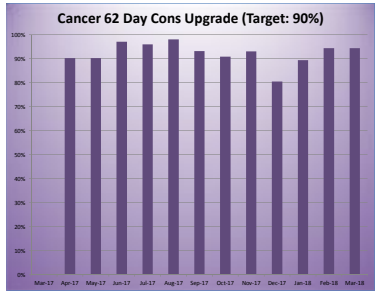






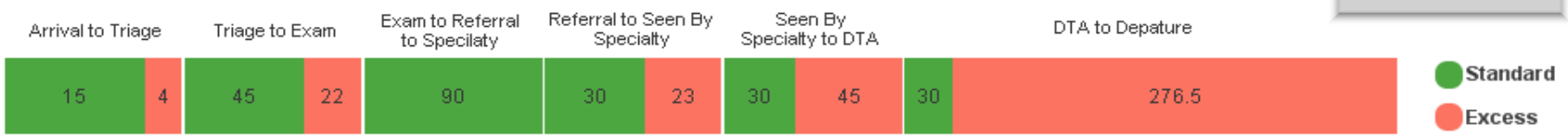


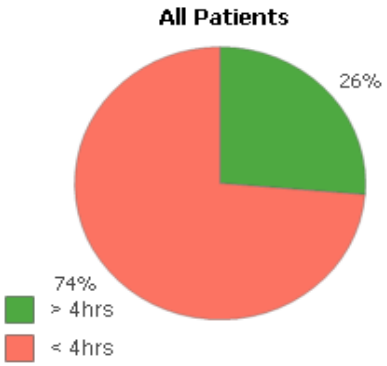




Median timeline for breach patients showing excess minutes over the standard.

Show hr of breach





Measure	Standard	Median	Excess	Patients with Timestamp	Patients Who Breached	% Breached	Patients Who Breached Rank
Arrival to Triage	00:15:00	00:19:00	00:04:00	8,082	4,568	57%	
Triage to Exam	00:45:00	01:07:00	00:22:00	7,292	3,674	50%	
Exam to Referral to Specialty	01:30:00	01:01:00	00:00:00	2,559	509	20%	
Referral to Seen by Specialty	00:30:00	00:53:00	00:23:00	2,656	1,722	65%	
Seen by Specialty to DTA	00:30:00	01:15:00	00:45:00	1,482	818	55%	
DTA to Depature	00:30:00	05:06:30	04:36:30	1,723	1,061	62%	

2 Our Performance Summary — 2.4 Responsive - Ambulance & ED

The Princess Alexandra Hospital NHS Trust

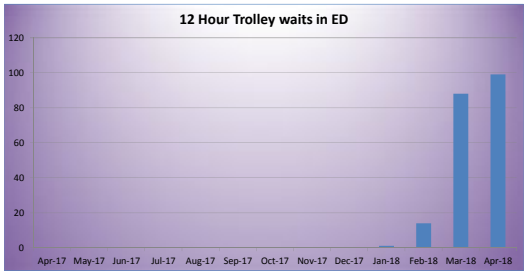
Progress towards achieving the national 4 hour access standard continues to be a major risk & challenge to the Trust. Overall performance for the month of April '18 was 73.67%. However, it is recognised that this performance is a >8% improvement on March '18 & is partly attributable to the re-calibration event that took place in March.

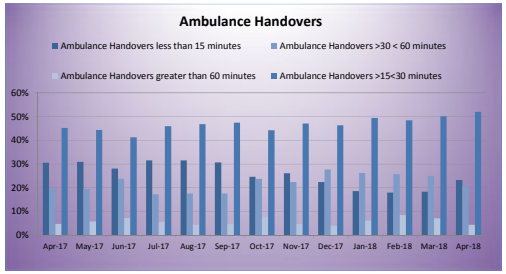
12 hour trolley waits continued as the organisational challenges continue around flow & overcrowding within the ED. Subsequently DTAs continued to be managed within the ED whilst awaiting for ward discharges.

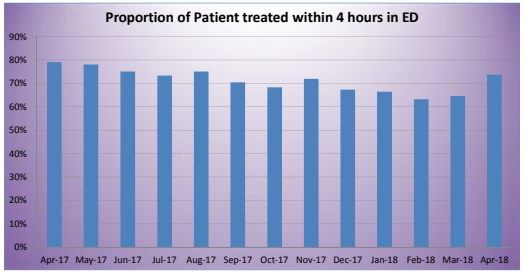
A blueprint for success - identifying the next steps has been drafted and agreed with the CEO & COO. It has been presented at Trust Access Board and now need wider distribution and next level planning. This blueprint supports & enhances the Integrated Urgent care work that is being developed with stakeholders & external partners.

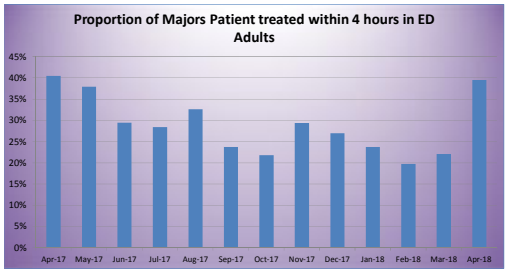
Ambulance handover times continued to show improvement. An action plan has been created & signed off following the report from independent auditors (tiaa). Priorities have been defined & assigned to senior ED staff to ensure recommendations are implemented.

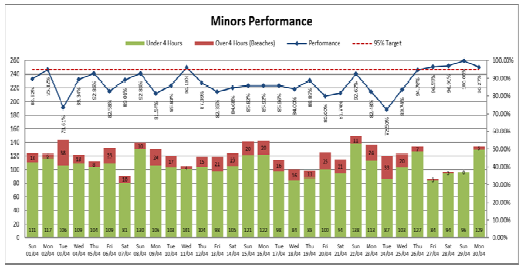
A full capacity protocol policy has been written & submitted for comments & should be signed off in readiness for implementation within next couple of weeks.

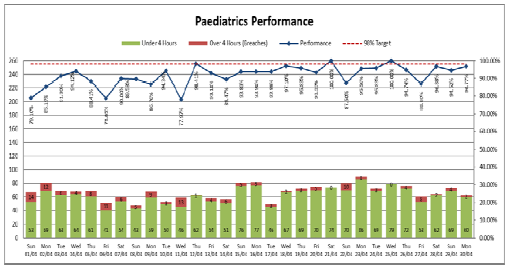












Ambulance Handovers 17/18

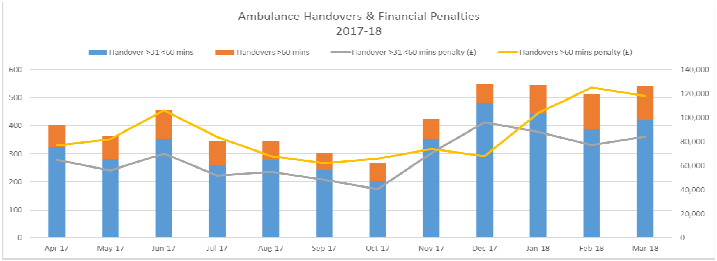
Suspended as part of Sustainability and Transformation Fund, but previously penalised as per contract ref E.B.S.7a/b (pg65)

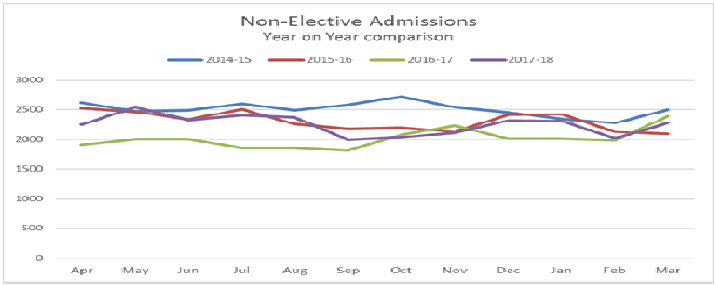
Ambulance handovers should be within 15 minutes with none waiting more than 30 minutes

£200 per service user waiting over 30 minutes and £1,000 waiting over 60 minutes (in total, not aggregated with 30 minutes penalty)

Handover figures provided by Information

	Penalty per SU	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	YTD
Handover >31 <60 mins		324	280	351	260	276	242	203	352	482	440	386	422	4018
Handovers >60 mins		77	82	106	84	68	62	66	74	68	104	125	118	1034
Handover >31 <60 mins penalty (£)	200	64,800	56,000	70,200	52,000	55,200	48,400	40,600	70,400	96,400	88,000	77,200	84,400	803,600
Handovers >60 mins penalty (£)	1,000	77,000	82,000	106,000	84,000	68,000	62,000	66,000	74,000	68,000	104,000	125,000	118,000	1,034,000
Total Penalties (£)		141,800	138,000	176,200	136,000	123,200	110,400	106,600	144,400	164,400	192,000	202,200	202,400	1,837,600





2 Our Performance Summary — 2.5 Responsive - Diagnostics, Readmissions, Caesarean Sections

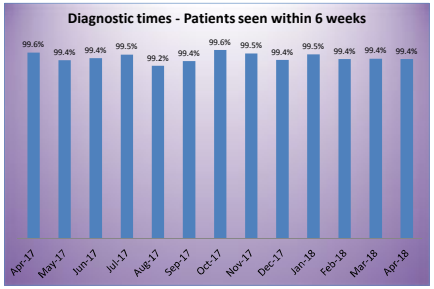
The Princess Alexandra Hospital NHS Trust

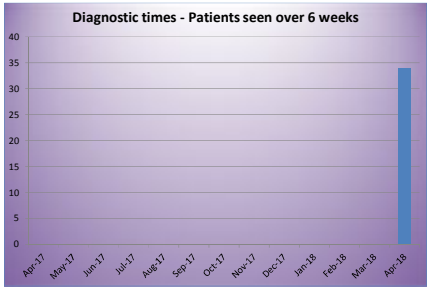
Total planned & Unscheduled Caesarean Sections: This is above our target but represents an improvement compared to previous months (average rate Jan to March 2018 was 31.6%). Action: Analysis of trends continues to enable the FAWS team to identify areas for further improvement. Statistics are now collected on the rates within three different groups of C Section i.e. category 1, 2 and 3. These categories reflect the perceived urgency of the C Sections

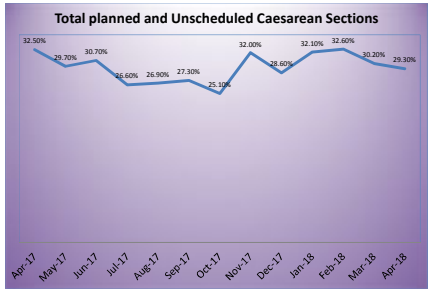
Midwife to Birth ratio: Comment: target achieved. Action: To continue to monitor the numbers of midwives compared to births, antenatal and postnatal pathway numbers.

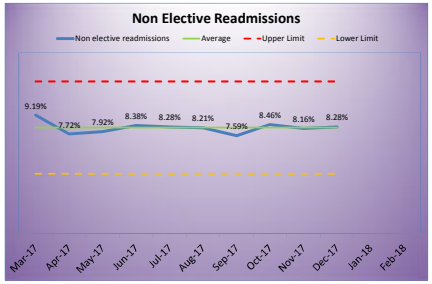
1:1 care in labour: 100% target achieved. Action: Staff are moved from other areas such as community midwifery to Labour ward and Birthing Unit and Midwife Managers work clinically to ensure this target is achieved.

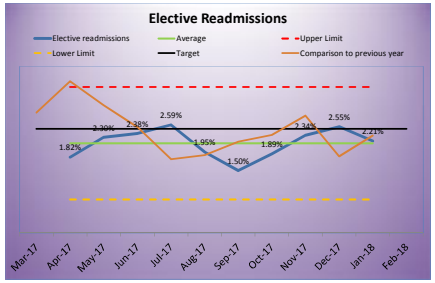
Still Births: The still birth rate for April 2017 to March 2018 is 1.71 per 1000 births adjusted for termination of pregnancy. Including termination of pregnancy over 24 weeks gestation the rate is 2.93 per 1000 births. The national rate is 3.87 per 1000.



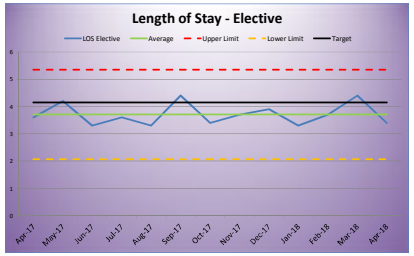


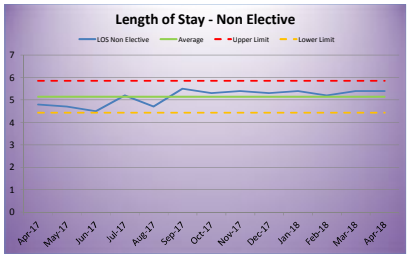


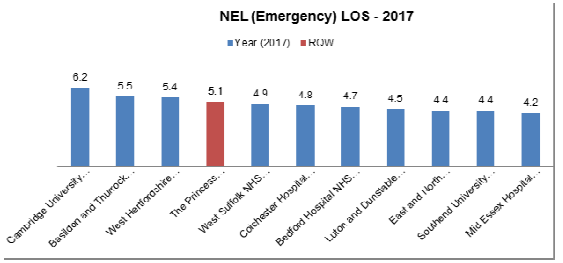


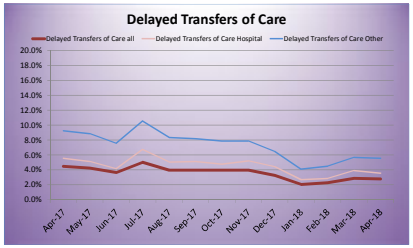


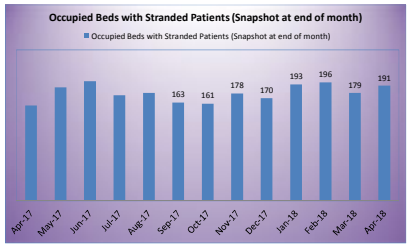
The Elective LOS continues to drop. However the Non-elective LOS is consistent with last month. It is recognised that a focused project is required and is underway to bring together all the elements which contribute to LOS - readmissions, stranded patients, 23 hours surgical model and HSMR.

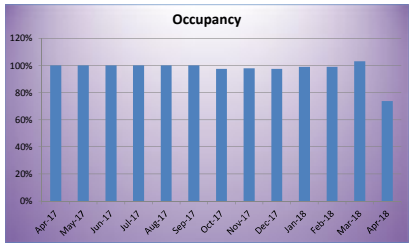


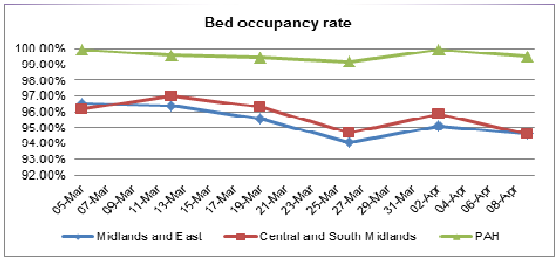












5.1

2 Our Performance Summary — 2.7 Outpatient Management

The Princess Alexandra Hospital NHS Trust

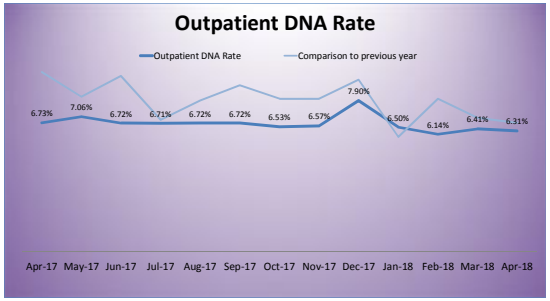
Outpatients: Outpatient DNA rates remain constant under 7% which is below the national average – this places the Trust near the upper quartile of all Trusts in England.
Outpatient new to follow rates remain constant & in line with contractual requirements.

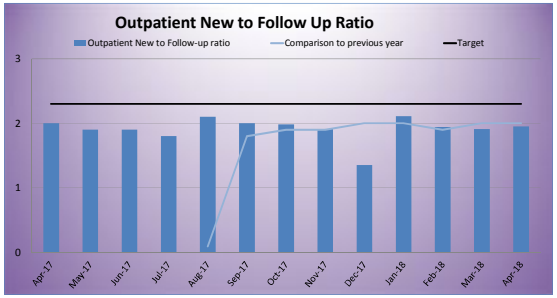
Short Notice Outpatient Hospital Clinic Cancellations: The number of Outpatient Clinics cancelled at short notice remained the same as month of March, but the number of patients affected reduced in April by 118 from March figures. Themes for cancellations are predominantly due to annual leave and training cancellations being notified under six weeks (36%) and changes to rotas or staff shortages (20%). This means that 56% of cancellations or reductions are avoidable. Careful monitoring is carried out weekly with escalation to Access Board and then to the Executive Management board. All cancellations must be verified and authorised by a senior member of the HCG management team.
EMB have requested some focused work to at the processes in place, determine the key drivers and identify some process improvements to manage the clinic cancellations is clinical safe and operationally sustainable.
Since May 2017 389 clinics have been cancelled and 206 reduced resulting in 5897 patient appointments being cancelled.

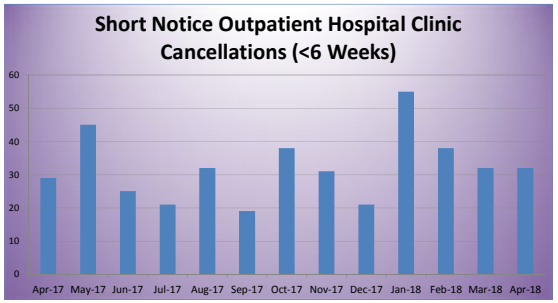
For the month of April 45 Clinics were cancelled or reduced affecting 384 patients, please see page 3 for a detailed breakdown of cancellations/reductions.

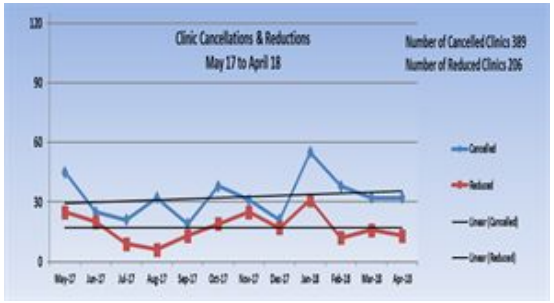
Capacity has not been provided to re-book any patients.

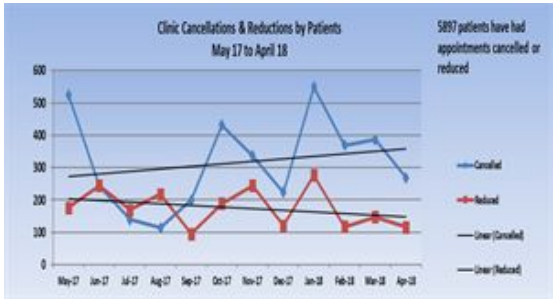
The cost of cancelled clinics to date is £81,724.64.











Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

With the exception of appraisal and agency spend, the vast majority of people metrics have remained stable.

However, in comparison with our benchmark STP providers, our performance is unfavourable for the following metrics:
Statutory/mandatory training at 85% in comparison with the average for the STP which is 89%.
Appraisal at 78% in comparison with the average for the STP which is 85%.
Sickness absence at 3.9% in comparison with the average for the STP which is 3.5%.
Agency at 8.1% in comparison with the average for the STP which is 5.6%.

The following metrics compare favourably in comparison with our STP providers:
Voluntary turnover at 13.02% in comparison with the average for the STP which 16.221%.
Vacancy factor at 10.62% in comparison with the average for the STP which 12%.
Stability at 88.12% in comparison with the average for the STP which 83%.

We continue to monitor performance and action plans at the HCG performance review meetings and the People Board sub committee.

3 Our People Summary — 3.1 Well Led - Workforce Indicators - Summary

The Princess Alexandra Hospital NHS Trust

Agency Spend £994,971
Bank Spend £989,667

Head Count
3328.49 WTE

Training
85%

Vacancy Rate
11%

Sickness
3.91%

Medical
99.57%
Non-Medical
78%

Turnover
13.02%

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NHS The Princess Alexandra Hospital NHS Trust

	Trust Target	Herts & West Essex STP average benchmarking data March 2018	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	HR Workforce	Finance
Funded Establishment- WTE			3364.31	832.19	463.6	810.49	669.42	271.53	130.77	53.36	132.95
Vacancy Rate	8.0%	12.0%	10.62%↑	3.8%↑	9%↑	18.8%↓	15.5%↑	9.3%↓	-7.4%	8.3%↓	6.5%↑
Agency % of paybill		5.6%	8.1%↑	4.4%↑	6%↑	12.7%↑	9.3%↑	9.7%↑	5.8%↓	0%↔	6%↓
Bank Usage - Cost	n/a		£989,567	£59,917	£103,934	£611,728	£228,337	£95	£10,985	£19,586	£33,779
Agency Usage -Cost	£858,000		£994,970	£125,545	£105,862	£404,307	£252,589	£55,642	£23,715	-£2,666	£29,976
Sickness Absence	3.5%	3.5%	3.9%↔	3.5%↓	3.2%↓	4.0%↔	3.3%↑	6.3%↓	4.5%↑	5.2%↓	5.4%↑
Long Term Sickness			2.0%	1.8%	1.3%	1.6%	1.3%	4.6%	3.3%	4.0%	3.1%
Short Term Sickness			1.8%	1.6%	1.8%	2.4%	1.9%	1.7%	1.4%	1.2%	2.2%
Turnover (voluntary)	12%	16%	13%↓	12.5%↓	12.4%↓	14.5%↓	12.2%↑	10.5%↓	9.9%↓	20.7%↓	20.3%↑
Stability	90%	83%	88.1%↔	91%↑	90%↑	83.4%↔	90%↓	82.3%↓	88%↓	97.5%↑	87%↔
Statutory & Mandatory Training	90%	89%	85%↑	91%↔	77%↑	81%↑	80%↔	90%↑	94%↔	98%↑	98%↑
Appraisal	90%	85%	78%↓	87%↓	70%↓	67%↓	81%↓	93%↑	86%↓	72%↓	64%↓
FFT (care of treatment) Q3	70%		58.0%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FFT (place to work) Q3	70%		48.0%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Flu Vaccination	70%		70.8%	22.7%	20.0%	23.6%	21.0%	8.9%	3.8%	n/a	n/a
Active Job Plans	100%							n/a	n/a	n/a	n/a
Electronic Rosters (clinical staff)	100%		91%↑	100%↔	100%↔	100%↔	71%↑	n/a	n/a	n/a	n/a
Exception Reports (junior doctors)	3		4↓	0↔	1↔	1↓	2↔	n/a	n/a	n/a	n/a
Time to hire (Advert to formal offer made)	31Days									n/a	n/a

Above target
Exceeding or below target
underachieving target

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

	Trust Target	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical & Dental	Nursing Registered	Midwifery Registered
Funded Establishment - WTE		91.77	566.56	687.8	129.39	290.42	93.15	481.3	880.86	143.06
Vacancy Rate	8.0%	5%↑	6.7%↑	3.3%↓	8%↑	6.2%↓	12.5%↓	7.1%↑	25.6%↑	-5.2%
Bank Usage - Cost	n/a	£10,481	£177,690	£95,532	£0	£1,527	£0	£319,811	£384,527	£0
Agency Usage -Cost		£156,384	£14	£93,021	£0	£45,313	£0	£364,523	£335,715	£0
Sickness Absence	3.5%	2.1%↑	7.1%↑	4%↑	3.4%↓	5.4%↓	6.5%↑	0.2%↓	3.2%↓	3%↓
Long Term Sickness		0.0%	3.9%	2.5%	2.7%	3.3%	4.3%	0.0%	0.9%	1.4%
Short Term Sickness		2.1%	3.2%	1.5%	0.7%	2.1%	2.2%	0.2%	2.3%	1.5%
Turnover (voluntary)	12%	8.5%↑	14%↔	13.7%↔	20.9%↑	8%↓	11%↓	8.5%↑	17%↓	9.2%↓
Stability	90%	74.%↑	90.3%↓	91.2%↑	84.7%↑	86.6%↓	85.7%↓	88.5%↑	83.4%↓	90.9%↑
Statutory & Mandatory Training	90%	92%↑	85%↑	96%↔	89%↓	90%↑	95%↑	64%↑	84%↑	
Appraisal	90%	95%↑	76%↓	73%↓	90%↔	92%↑	84%↓	97.2%↓	74%↓	
Flu Vaccination	70%	36.2%	43.7%	18.4%	36.2%	26.1%	4.4%	62.2%	76.5%	

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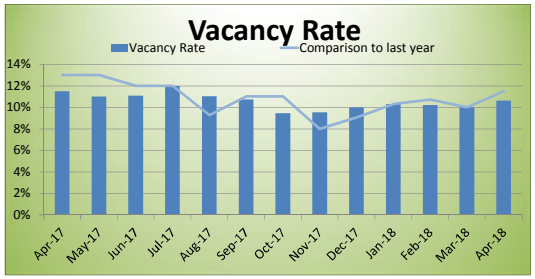
3 Our People Summary — 3.3 Well Led - Workforce Indicators (a)

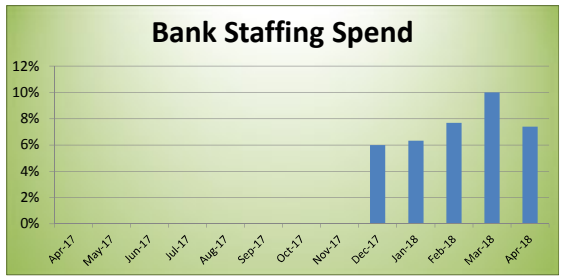
The Princess Alexandra Hospital NHS Trust

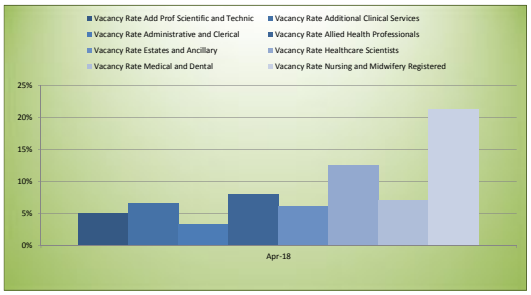
Vacancy Rate: The overall vacancy rate remains above target (8%) at 10.6% with the highest vacancies in nursing (21%) which has incremented slightly from last month's position (20.2%). A number of recruitment initiatives are underway which will assist in reducing the vacancy rate, these include; monthly recruitment days, weekly nursing interviews and on-going international recruitment. The current focus is to recruit UK based registered nurses via agency, which will yield results in the coming months as candidates start in post.

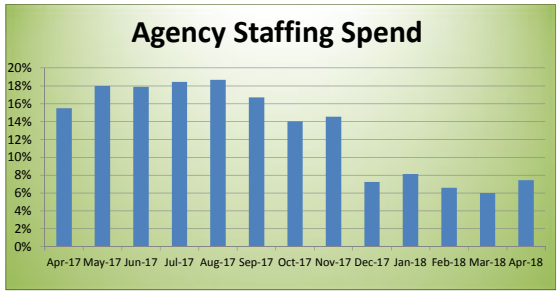
Agency Staffing Spend: Our % of agency has increased slightly, although it is still below the % threshold. Spend continues to be monitored with medical and AHP supply authorised and reviewed daily between CMO and Contingent Labour Manager. Nursing continues to be authorised by Chief Nurse and Deputy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

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









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

The Princess Alexandra Hospital NHS Trust

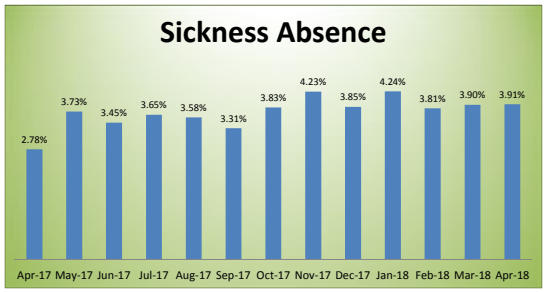
Sickness Absence: There has been a minimal increase in sickness in month. As part of the people plan the Health and Wellbeing focus for Q1 relates to Mental Health first aid and Physical activity, the expected output and measure for this is a 0.5 reduction in overall sickness absence with associated health benefits for staff undertaking new activities/cessation courses.

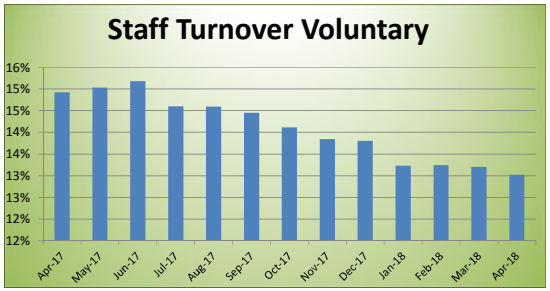
Staff Voluntary Turnover: Overall Voluntary turnover has continued to decrease month on month and it's the lowest in the last 12 months. The decrease was seen in all staff grouped except within AHP a slight increase due to two leavers.

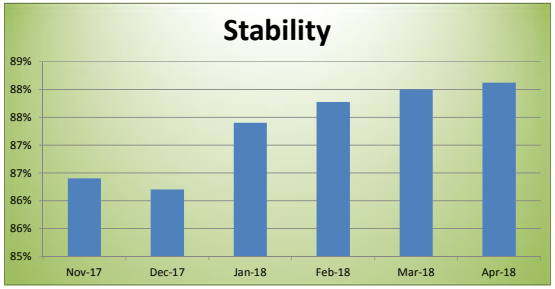
Stability: Overall stability has remained relatively the same since last month.

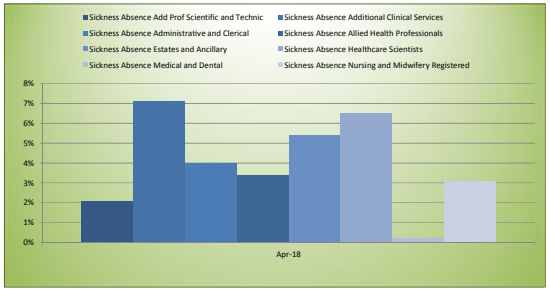
Contracted Staff in Post: These include all current employed staff on a permanent and fixed term contract.

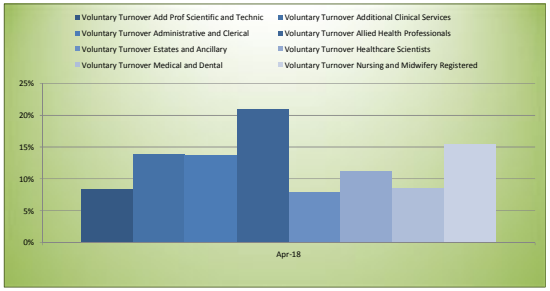
Temporary Staff in Post: These are all employees on a fixed term contract mostly trainee doctors.

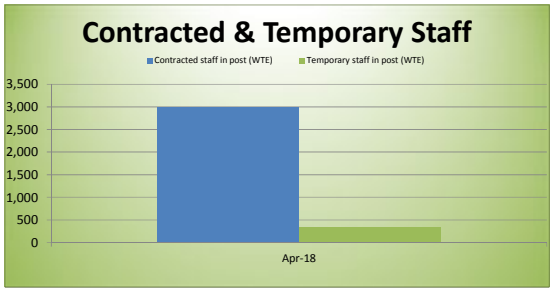












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3 Our People Summary — 3.5 Well Led - Workforce Indicators (c)

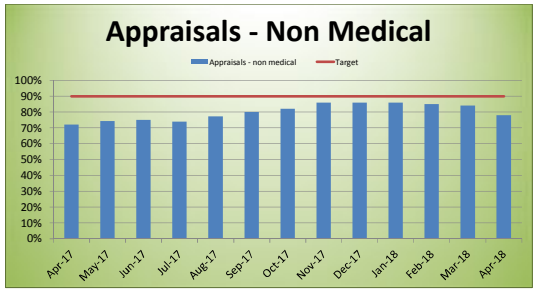
The Princess Alexandra Hospital NHS Trust

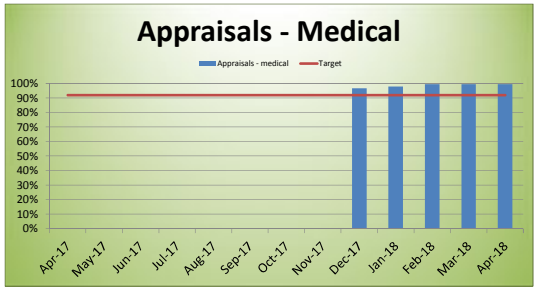
Appraisals - non medical: A 6% drop in compliance this month is largely due to the high proportion of whole teams that were appraised this time (March/April) last year, and subsequently, managers not planning for the high volume of appraisals that would need to be completed this March/April. A number of managers have been advised to implement phased recovery plans in order to improve their compliance over the next 3 months to ensure they do not continue to have the same issue in 2019 onwards. Admin & Clerical staff are disproportionately non-compliant in comparison to the proportion this staff group contributes to the total workforce. Actions taken to address compliance:
- Reminder emails sent to outstanding staff.
- Reminder emails sent to staff due appraisals within the next 2 months.
- 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.

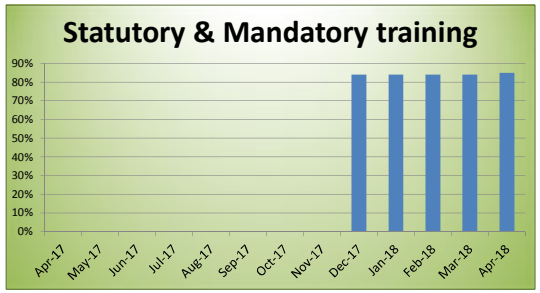
Appraisals - medical: One appraisal that was not complete in May was due to delay as appraisal was on hold due to investigation.

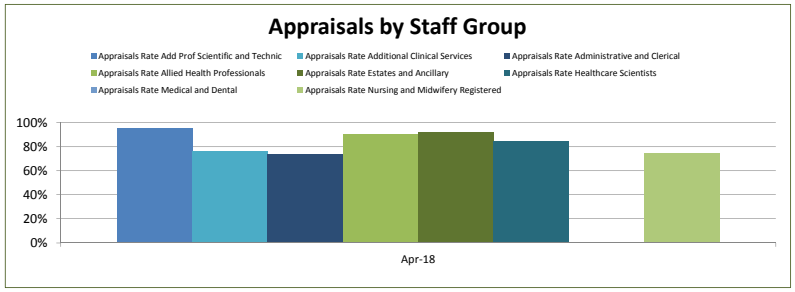
Stat & Mand training: Overall compliance for April is at 85%. This month we have seen a percentage increase in the overall compliance with a 5% variance to achieve our organisational CQC target of 90% by July 2018. Attendance at classroom sessions continues to be patchy, however, enrolment, last minute staff cancellations, DNAs on booked sessions & session cancellations due to operational pressures still causing concern.

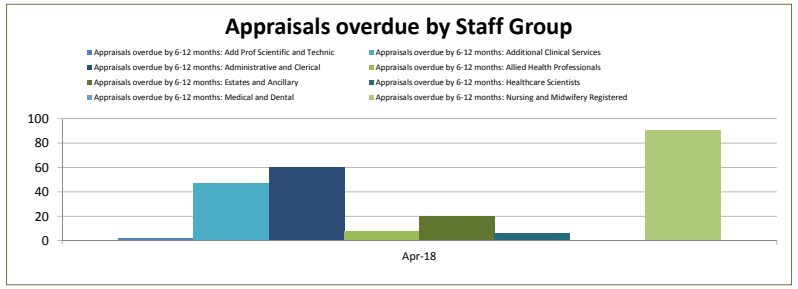
Actions:
- Additional Classroom sessions are being provided each month for individual topics at various time slots including out of hours and weekends.
- Mobile sessions continue to be offered at other venues and in clinical areas.
- Working with HCGs and Departments, carrying out 'deep dives', to ensure data accuracy and that each staff competency profile is accurate.
- Regular reminders are issued when staff are approaching renewal and after compliance has lapsed.
- Reminders are sent to all staff who are non-compliant in certain areas to remind them to complete all outstanding training.
- Regularly review & update our staff competency profiles with managers & Subject Matter Experts to ensure that all staff are allocated the right topics/levels of Training for their role.











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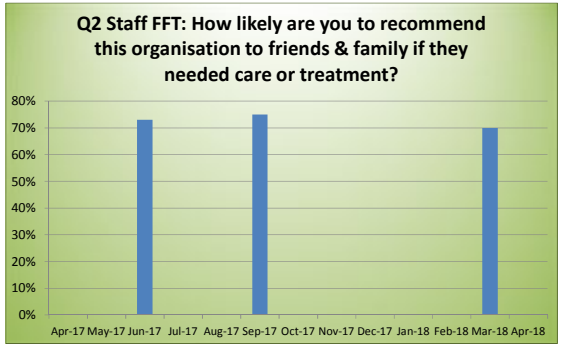
3 Our People Summary — 3.6 Well Led - Staff Experience

NHS The Princess Alexandra Hospital NHS Trust

Q1: This is a 1% fall from the quarter 2 (July to September 2017) response to this question, and a 7% improvement from a similar question asked as part of the National Staff Survey (October to December 2017).

Q2: This is a 5% fall from the quarter 2 (July to September 2017) response to this question, and a 12% improvement from a similar question asked as part of the National Staff Survey (October to December 2017).

SFFT action plans, combined with National Staff Survey, GMC and the local Culture survey, are in development for the Trust and HCGs to address areas of concern.



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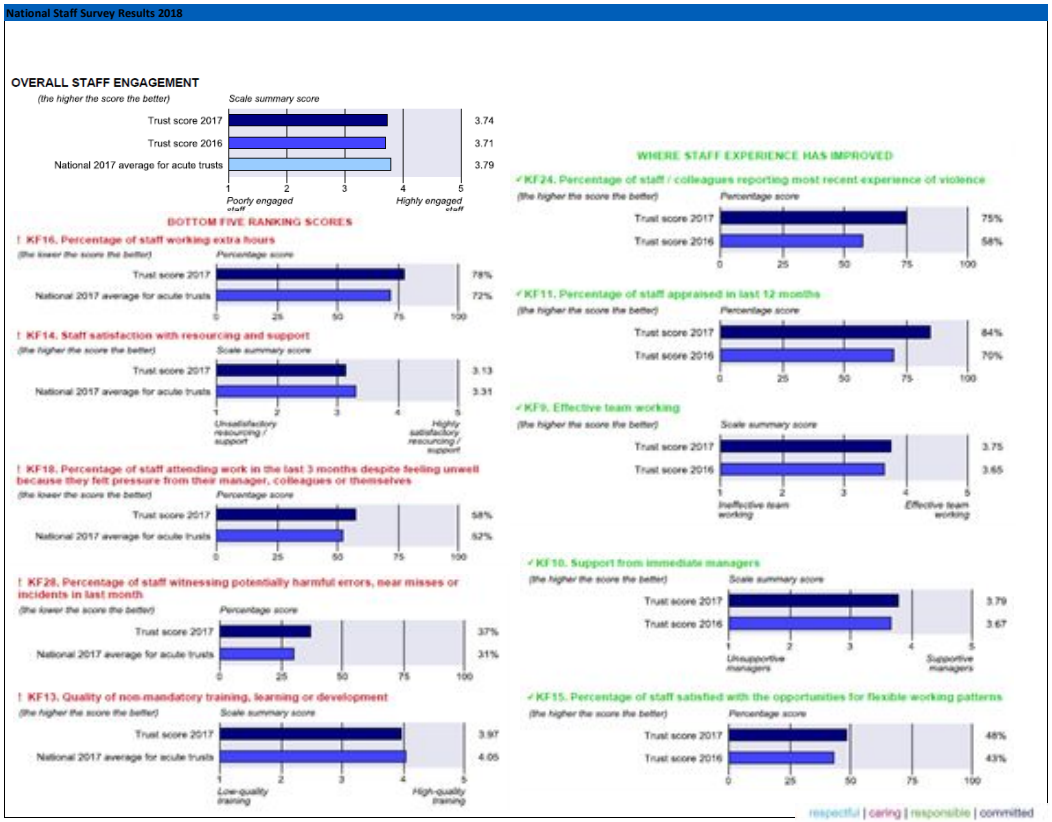

Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

April 2018 saw the realisation of a number of patient related initiatives, including the main entrance, with the introduction of the 7 day week presence, addressing patient anxiety from the onset of their clinical pathway or visiting the hospital and the catering transformation, which has seen patient satisfaction increase from 54% to over 85% in a matter of weeks, and regularly averaging 90%. The opening of the Costa Coffee and Marks and Spencer 'simply food' store In March 2018 has been well received by our patients, visitors and staff, with a consistent over performance in trading.

The team is actively preparing for a comprehensive and challenging cost improvement programme, which is promising to realise not only significant reoccurring savings, but improvements to our core services, targeting domestic services, estates maintenance, car parking and electrical and biomedical engineering (EBME). Each of these initiatives has been developed to address anomalies highlighted within the model hospital charging data.

The 2018 PLACE assessment (Patient Led Assessment of the Care Environment) will be conducted on 3rd May 2018. This year's assessment will only be conducted by patient representatives. In previous years, the assessors were made up of staff and patient representatives, often with conflicting aims and objectives. This approach will be the first known PLACE assessment to be conducted in this manner.

This period has seen significant improvements to our appraisal and statutory mandatory training compliance, in all cases exceeding the Trust targets.

4 Our Places Summary — 4.1 Cleanliness

The Princess Alexandra Hospital NHS Trust

April 2018 saw the realisation of a number of patient related initiatives, including the main entrance, with the introduction of the 7 day week presence, addressing patient anxiety from the onset of their clinical pathway or visiting the hospital and the catering transformation, which has seen patient satisfaction increase from 54% to over 85% in a matter of weeks, and regularly averaging 90%. The opening of the Costa Coffee and Marks and Spencer 'simply food' store In March 2018 has been well received by our patients, visitors and staff, with a consistent over performance in trading.

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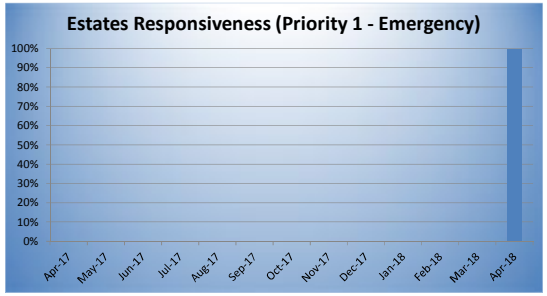

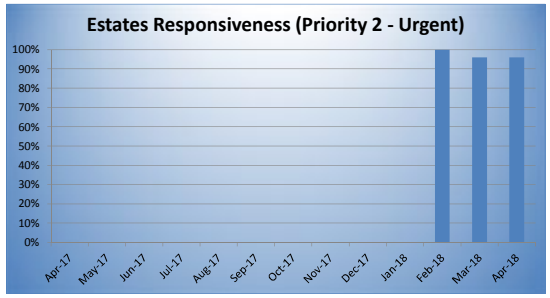

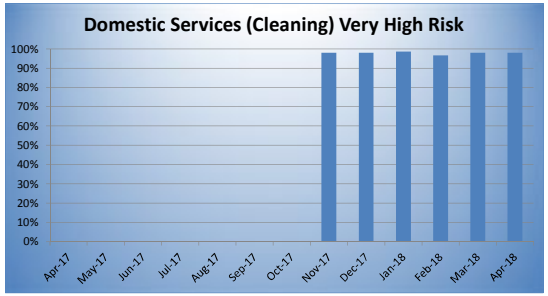

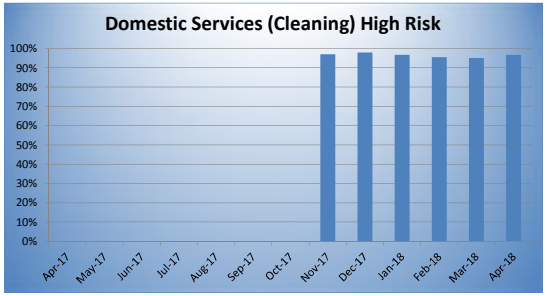

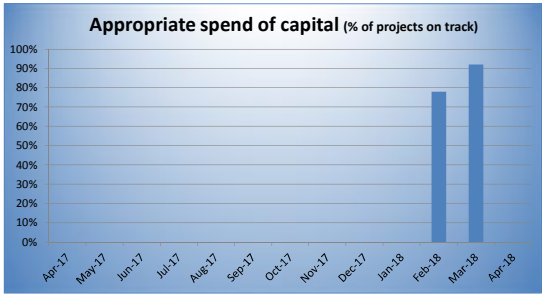

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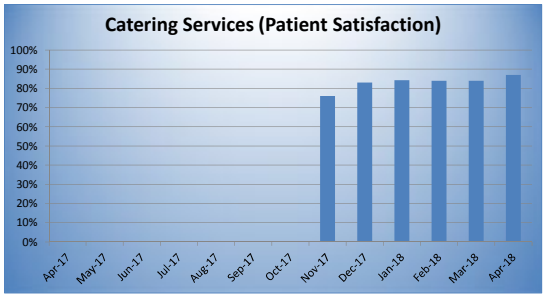
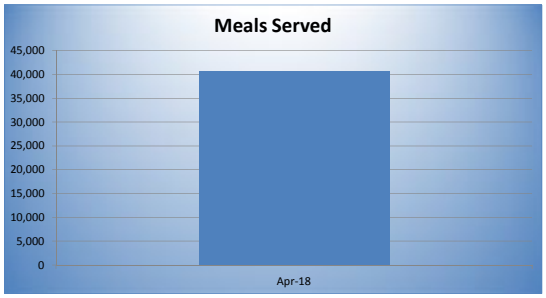

Catering Services (Patient Satisfaction)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18


Meals Served
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Apr-18


Catering Food Waste
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
Feb-18
Mar-18
Apr-18

Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

The Month 01 deficit is £3.2m, £0.1m worse than plan (£0.4m including PSF).
Income has underperformed by £1.2m, of which £0.3m relates to PSF funding and £0.9m relating to Patient Treatment income underperformance including lower levels of activity through assessment areas and less outpatient activity. This under-performance has been offset by pay and non pay under spends although agency costs have increased from previous levels of expenditure with Month 01 actuals of £1m compared to £0.9m plan.

Key risks to the plan include:-

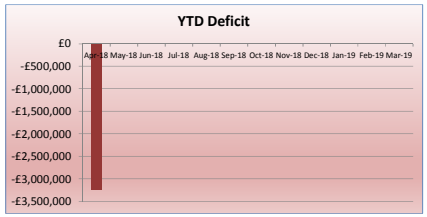
1. Delivery of CIPs
2. Commissioner QIPP schemes of £4m, and
3. Delivery of agency target

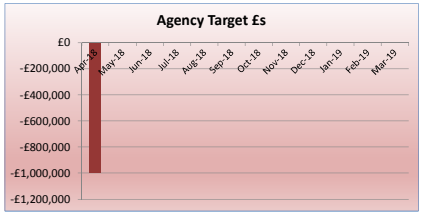
5 Our Pounds Summary — 5.1 Overall financial position

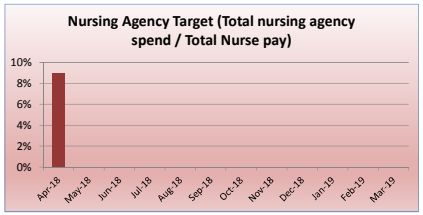
The Princess Alexandra Hospital NHS Trust

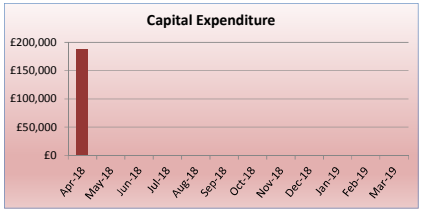
OUR POUNDS

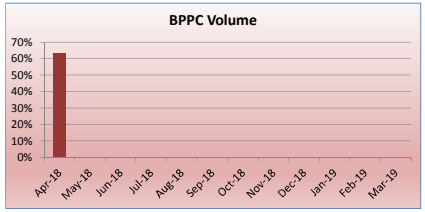
Metric	Annual Plan (Standard)	Previous Month	Latest Month
YTD Deficit	-£28,471,000	-£1,967,126	-£3,234,000
Agency Target £s	£10,300,000	£789,221	£995,000
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3%	8%	9%
Capital Expenditure	£12,834,000	£4,368,000	£189,000
BPPC Volume	95%	38%	63%
BPPC - £s	95%	47%	85%
Cash Balance	£1,000,000	£1,262,000	£1,841,000

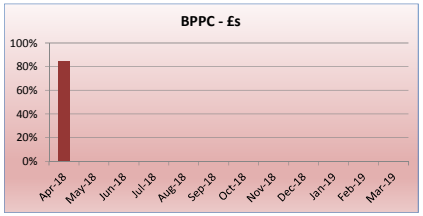


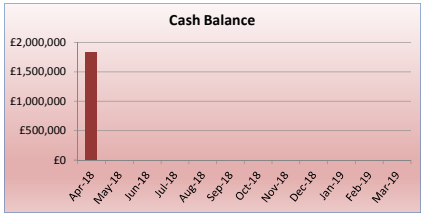












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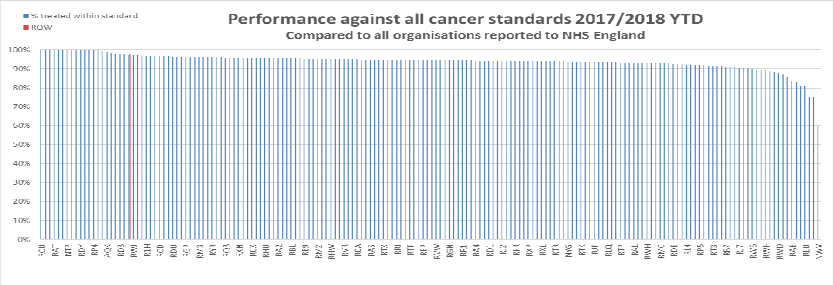
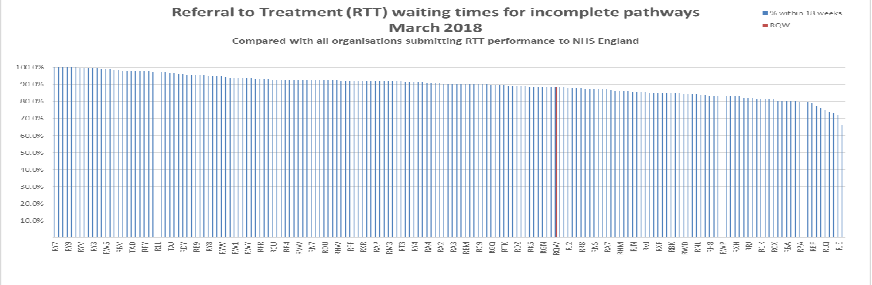
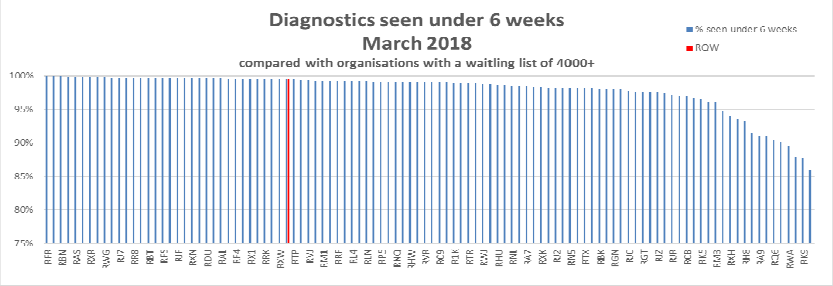
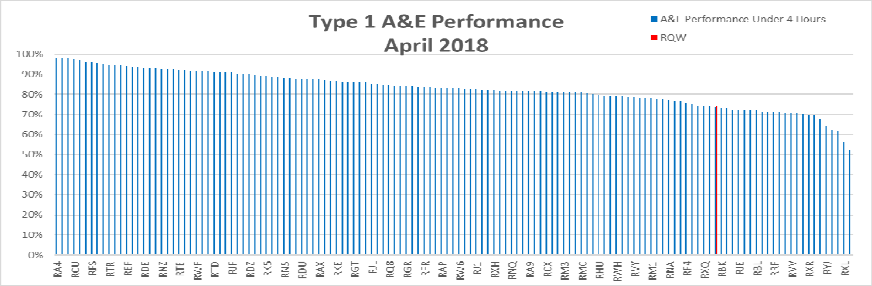
National Benchmarking
Compared with all organisations reporting to NHS England

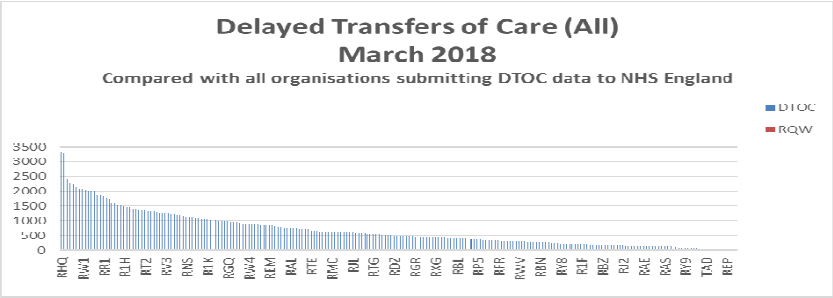
NHS
The Princess Alexandra Hospital
NHS Trust











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Data Source: NHS England Statistics

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Health Care Group Management Priorities

HCG: Surgery & Critical Care

	Our Patients	Our People	Our Performance	Our Assets	Our Finances
Key Management Priorities 2018-2019	Achieve a minimum of a 'Good Rating' at the next CQC inspection for all metrics within SCC	Achieve a minimum of a 'Good Rating' at the next CQC inspection for all metrics within SCC	To achieve and maintain all constitutional standards as a HCG	To ensure the safety of all areas within the HCG and to improve the environment where possible	To deliver financial balance for 2018-19

Quality Dashboard Performance	The surgery HCG continue to maintain Zero pressure ulcers. The HCG reduced the number of overdue SIs in April'18 4 closed with 10 outstanding.
Concerns	Current bed base for Surgery and the consistent number of medical outliers.
	To reduce the use of PACU overnight as an escalation area
	Reduce the number of mixed sex breaches in HDU and to reduce the number of delayed discharges from critical care to the wards
	Reduce the number of inappropriate late discharges (22.00-08.00hrs)
	To continue to ensure that bottles of liquid medications are dated, signed on opening and do not exceed the expiry date.
	Urology medical staffing and service capacity.
	Environment - Penn ward and HDU require refurbishment.
	Recruitment and retention of staff primarily nursing.
	Fridge temperatures are regularly checked and acted upon if temperatures are outside the normal range.

	Issue	Action Required	Who by	Domain List
Requires Support	Repatriation of medical patients into the most appropriate wards & the protection of the surgical bed base in times of increased pressure.	Medical HCG to submit plan for repatriation.		
	Support from procurement to maximise STP opportunities.	Procurement to identify an STP lead.		
	Disaggregation of pre assessment & same day admissions requires a clinical environment to be identified which will enhance the patient experience.	Identification of clinical space.		

	Item	Actions Completed/Outstanding
Action Log from previous months		

HCG: Cancer, Cardiology & Clinical Support Services

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

Quality Dashboard Performance

Getting the basics right: 98% compliance with Resus Trolley checks, 100% Compliance with CD checks, 100% Compliance with Fridge Temperature checks across CCCS.
Agency Nurse Checklist: 85% compliance with agency nurse checklist on Kingsmoor Ward this is an improvement.
Nurse/AHP Vacancy: 11% RN on Kingsmoor Ward with active recruitment on going. WDU has 10% RN vacancy and it has proved difficult to recruit competent chemotherapy trained nurses. Recruitment in therapies has significantly improved the vacancy rate.
PALS and Complaints: 2 new complaint in April. 4 ongoing complaints but all within timeframe of with agreed extensions. 26 PALS received aim for local resolution of PALS within 48hrs.
Incident Reporting: 110 incidents reported (reduction due to re-allocation of incidents to the correct departments). 2 moderate harm.1 Serious Incident and 1 ongoing Red incident investigation.
Mortality Meetings: All specialities holding regular mortality reviews and cardiology moving towards morbidity review meetings.
Clinical Effectiveness: Results from local and national audits including MINAP and the NHFA to be shared at CCCS PS&Q with updated action plans. CCCS are review all local and national audits undertaken by the HCG and are monitoring the results and action plans to ensure they are effective.
Infection Control: Hand hygiene audits > 95% across most areas. Any areas falling below this standard have an action plan in place. 0 MRSA Transmissions, 0 C.Diff cases across the HCG in February.
DNACPR: Maintained compliance with DNACPR Audit.
Pharmacy: Medical Gasses Training for designated nursing officers commenced. Electronic prescribing system planned for roll out in June and July.
Regular Heads of Nursing meeting with Chief Pharmacist to ensure communication of medications safety agenda with agreed actions.
End of Life Care: 6 day service has maintained 100% of patients being seen within 24 hours of referral to SPCT.

Concerns

Cancer: The lack of capacity across specialties such as Urology, Lower GI and Breast have caused the Trust to fail the Cancer Target for April and the May position looks tenuous as well. Focused recovery meetings have been held with each HCG and tumour site leads.

Pathology: There are a number of managed service contracts that are due for renewal throughout the 2018/19 financial year. Due to the guidance from NHSI regarding future Pathology services, it becomes very unclear over the rules on extending contracts against going out to tender for new providers. Many Companies are offering large discounts to simply extend these contracts in uncertain times which would fit with NHSI guidance but this has to be balanced against procurement laws and fair competition.

Requires Support

Issue	Action Required	Who by	Domain List
Pathology: There are a number of managed service contracts that are due for renewal throughout the 2018/19 financial year. Due to the guidance from NHSI regarding future Pathology services, it becomes very unclear over the rules on extending contracts against going out to tender for new providers. Many Companies are offering large discounts to simply extend these contracts in uncertain times which would fit with NHSI guidance but this has to be balanced against procurement laws and fair competition.	Procurement Team to give strong guidance and leadership on all Pathology contract renewals.	Procurement	Business Constraints
Cancer: The lack of capacity across specialties such as Urology, Lower GI and Breast have caused the Trust to fail the Cancer Target for April and the May position looks tenuous as well. Focused recovery meetings have been held with each HCG and tumour site leads.	Every healthcare Group and Tumour suite lead to focus on capacity and process issues that are affecting their cancer pathways.	All HCGs	Patient Safety

Action Log from previous months

Item	Actions Completed/Outstanding
Pathology: There are a number of managed service contracts that are due for renewal throughout the 2018/19 financial year. Due to the guidance from NHSI regarding future Pathology services, it becomes very unclear over the rules on extending contracts against going out to tender for new providers. Many Companies are offering large discounts to simply extend these contracts in uncertain times which would fit with NHSI guidance but this has to be balanced against procurement laws and fair competition.	Discussed with Deputy Director of Finance who has given guidance on process. The potential savings and routes for each MSC will be discussed with Execs as the renewals arise so that guidance can be given.
Cancer: The lack of resources and clinical support in urology has led to lengthy delays and a high number of potential cancer breaches.	Discussions with UCLH and the London Cancer Vanguard have taken place to arrange some support for Urology.

HCG: Family & Women Services

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

Quality Dashboard Performance	**Missing outcomes codes:** FAWS have 20 missing outcome codes which is within the target to keep the number of outstanding to <30. Daily e mails sent of all outstanding appointments to named clinic Consultant to continue. Community Midwives don't always have computer access to outcome all their appointments on same day. **Invalid Source of Referral**: Modest reduction from 178 to 175 outstanding. Significant number of corrections but continuing new errors. Plan for May 2018 is to identify & reduce ongoing errors. Highest numbers are Dolphin ward & EPU referrals from A&E. **Missing or incomplete discharge summaries**: FAWS have a total of 372 missing discharge summaries (with no subsequent hospital same speciality activity) since April 2016 to date. 10% of all these FAWS missing discharge summaries have been audited. A total of 51 of these relate to January 2018 to 9th May 2018. An ongoing audit of a rolling 3 month period are presented and discussed at every FAWS Board Meeting and work is ongoing to put new Processes in place. **National & Access Target Performance:** FAWS delivered against all Cancer and RTT national targets. **Patients unarrived or DNA list**: There are 29 outstanding for FAWS. This is within our target to maintain the number of outstanding to <30.
Concerns	Medical, midwifery & nursing staff shortages & the difficulty with recruiting to these posts.
	Colposcopy QA on 28 March 17, full report received with various recommendations & action plans to be worked through by the HG along with CCCS HG.
	Contract issues but in negotiations to validate EH Maternity Antenatal Lead provider status correctly going forward for 2018/2019.
	LSCS - 29.3% in March 2018. This is above our target but represents an improvement (average rate Jan to March 2018 was 31.6%).
	Paediatric ambulatory unit build completed, but not yet operational due to staffing.
	Achieving the 95% national target for paediatric ED
	Medical staffing, out of hours
	Transitional care on the postnatal ward – increased workload and prolonged LOS in hospital for mother and baby
	Labour ward theatre does not meet National Operating Standards & there is only 1 theatre when there is a requirement for 2 labour ward theatres.

	Issue	Action Required	Who by	Domain List
Requires Support	Labour Ward Theatre not meeting Capacity & National Standard.	**High Impact** - Business case has been approved by EMB for new Maternity theatres that meet National standards - this is now approved by the Trust Board as a key priority for 2017/2018.	Capital Board	Project & Business Constraints
	Medical staffing, out of hours not compliant with statutory recommendation.	**High Impact** - Business case to be approved by EMB for additional junior medical staff to ensure adequate staff that meet National standards Business case completed, under review	HG Lead, EMB	Statutory Compliance, Operational Development
	Ventilation in room 9 now turned off but no heating available.	**High Impact -** The ventilation system was due to be renewed at same time as the new theatre H54 refurbishment but is now being considered by the Trust board for 2017/2018.	Capital Board	Project & Business Constraints
	Location for the development of a Paeds Assessment & Ambulatory Unit - subject to full business case & commissioner approval for the activity.	**High Impact** - Identify suitable location for the Paeds ambulatory/Assessment area. On-going discussion on identified suitable area, to be assigned by the Trust.	Trust Executive, HG Leads	Statutory Compliance
	Melvin Ward transition to Gynaecology ward	**High Impact** - Exec Board has approved transition of Melvin ward to be the Gynaecology emergency, elective & non-elective inpatients ward. Cost centre now transferred to FAWS - Recruitment of substantive staff planned.	HG Leads & Corporate services (HR & Finance)	Statutory Compliance, Operational Development
	Continued difficulty in recruitment of specialist staff throughout the HG.	**High Impact** - Recruitment systems & processes being streamlined to meet Health Group requirements.	HR, HG Leads	Workforce & Operational Development
	The need for a second clinical room and couch for Women's Health OP i.e. Hysteroscopy, Colposcopy, Myosure services	**Medium Impact** - To review current services and offices co-located in this area and come up with the business/service plan to create a second clinical room to allow for increase in activities in Gynae oncology	HG Leads, Capital Board	Project & Business Constraints
	Space to increase our ANC bookings	**Medium Impact** - To review use of HEH & SMH.	HG Leads	Project & Business Constraints

	Item	Actions Completed/Outstanding
Action Log from previous months	Recruitment of Nursing staff for Melvin ward transition to Gynae ward	Outstanding - on-going recruitment.
	Maternity theatres build bid agreed. Work to commence in October.	Outstanding - Build programme agreed, building works have commenced
	Recruitment & Staffing	Outstanding - on-going recruitment.
	Data Quality & Maternity Pathway inconsistencies.	Outstanding - on-going work to improve DQ, DQ Manager working with HG & Information team

HCG: Medicine

	Our Patients	Our People	Our Performance	Our Places	Our Pounds
Key Management Priorities 2018-2019	Improve patient safety, outcomes & experience.	Improve staff wellbeing, engagement & involvement.	Achieve greater grip on performance including the ED 4 hour performance.	Redevelop the Emergency Depart to allow streaming at the front door following a successful capital bid to NHSE for £952K.	Achieve greater grip on aspects of finance, management of budgets and income against plan.
	Achieve greater integration, which for us means patient centred, well coordinated & sustainable care.	Recruitment & retention of medical & nursing staff across key specialties & wards.	Improving patient flow, reducing patient delays, reducing ED crowding, removing exit block from ED & improvement against the four hour standard.	Development of Medical Assessment space, to take patients directly from ED Streaming & RAT.	Delivery CIP savings and a sustainable reduction in temporary staff expenditure
	Non Invasive Ventilation (NIV) Service to start on Locke Ward.	Develop strategy based upon staff feedback from quality framework analysis (enablers) & performance captured in our balanced scorecard (results).	Start streaming the Rapid Access & Treatment process in the new ED Build.	Open & operate the new End of Life & Dementia service on Gibberd Ward.	Delivery of agreed forecast out turn

Quality Dashboard Performance

Safe:

Risk Register April 2018
The top risks for the HCG are:
A&E 4 hour target (20)
Band 5 vacancies across the healthcare group (20)
Medical Staff Vacancies within ED (20)
MHCG Financial Position (20)

Incidents April 2018
Serious Incidents
New: 2
(+ 1 joint ED with Radiology, Radiology leading)
Closed: 0
Open: 5 at month end.

Internal Reds
New: 0
Closed: 0

Quality Audits April 2018
96.3% Compliance with Pressure Ulcer Standards
100% Compliance with Vital Sign Observation
93.7% Compliance with Falls Standards
94.2% Compliance with Hand Hygiene
98.4% Compliance with Medicines Management
94.3% Compliance with Oral Hygiene Standards
100% Compliance with Pain Standard

CAS Alerts
1 new PSA received in April 2018 regarding Resources To Support The Safe Adoption Of The Revised National Early Warning Score (News2).

Currently awaiting confirmation as to which HCG will be leading on this PSA

2 open and on target.

NICE Guidance (All)
15 received in April l2018

45 outstanding
20 overdue
6 Mostly Implemented
16 under review - oldest dated Feb 2016
23 require assessment

Caring:

Complaints
10 complaints received in April 2018.
5 Complaints closed in April 2018.
40 open complaints at month end.
Top themes : Nursing care, communication and medical care.

PHSO
0 new PHSO enquiry received in April 2018.

7218 – await advice from Legal Services
38731 – Medical records and file with PHSO – await decision
8868 – Medical records and file with PHSO – await

PALS April 2018
75 received.
66 PALS closed .
165 PALS open at month end.

CQC enquiry
0 received for April 2018.

Compliments
13 compliments received within the Healthcare Group (not accurate data)

Patient Experience:
Work is on-going to renovate the ground floor meeting room in Arendal House which is often used for Complaints Resolution meetings.
New chairs have been purchased (self funded by MHCG PSQ Facilitators) and new carpet has been laid.
Currently awaiting for the painters at attend.

Responsive

Well- Led:
Vacancy position **130 WTE** Band 5
Turnover rate **15.84%**
Sickness **4.0%** , last month **3.6%**
Appraisal rates central data in **75%** compliance

Concerns

ED current performance against national target. ED - Need to improve streaming processes at the front door and ambulance handover times.

The number of ongoing medical and nursing vacancies and the impact that this has on retention, staff morale, reliance on temporary workforce. Recruitment open day on 27th Jan did not yield the numbers expected despite the new advertising campaign.

Rheumatology review lists, although local plan is in place. Dermatology capacity related to the number of patients requiring review on high risk drugs, no capacity list and fast track capacity

Requires Support

Issue	Action Required	Who by	Domain List
Medical staffing - ongoing number of consultant vacancies in ED which is being mirrored nationally is impacting on the ability to deliver & sustain performance.	Exploration of alternative recruitment initiatives to assist in the appointment of suitably qualified staff to support delivery of the service. Consultant, Middle Grade and junior post to be advertised.	Recruitment	Workforce & Operational Development

Action Log from previous months

Item	Actions Completed/Outstanding

CQUIN

CQUIN schemes 2017-2019

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

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

The national CQUIN schemes are:

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

Monitoring arrangements:

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

Reporting process:

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

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

The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD 7 JUNE 2018

Agenda Item:	6.1
Presented by:	Professor Nancy Fontaine Chief Nurse and Deputy CEO
Prepared by:	Sharon Cullen Deputy Chief Nurse
Date prepared:	25 May 2018
Subject / Title:	Report on Nursing, Midwifery and care staff levels

Purpose:	Approval		Decision		Information	✓	Assurance	✓

Executive Summary:	In April there was an improved fill rate for day and night for both registered and unregistered staff. A review of annual leave profiling for the Safer Staffing wards confirmed that all wards were compliant with the agreed percentage. The monthly requests for bank and agency shifts have been scrutinised to nullify the risk of double counting the demand for temporary staff. This has resulted in a reduced registered staff demand and increase in fill rate. Although unregistered bank demand has reduced, the percentage fill rate remains static. The net gain for the organisation for the rolling year is currently 18.3 WTE RNs/RMs Registered nurse and midwifery vacancy for the organisation is currently 25.6%; the rise is related to newly agreed funded establishments when compared to 2017/18; the areas being Nightingale, MAU and PAU.
Recommendation:	The Trust Board is asked to receive the summary of information related to national submission of nursing, midwifery and care staff data alongside the current vacancy challenges and recruitment and retention plans.

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

Previously considered by:	The detailed monthly report of Nursing, Midwifery and Care staff levels (hard Truths) was presented to the Quality and Safety Committee on 23 May 2018.
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	This report to the Trust Board meets the national recommendations from the National Quality Board (July 2016).
Appendices:	

6.1

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The Princess Alexandra Hospital NHS
NHS Trust

TRUST BOARD 07 JUNE 2018
NURSING, MIDWIFERY AND CARE STAFF LEVELS

1.0 PURPOSE

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

1.2 To demonstrate that actions taken to address gaps in planned levels of nursing, midwifery and care staff are mitigating risk for patients and staff.

2.0 BACKGROUND

2.1 This summary report is provided to the Trust Board in line with the National Quality Board (NQB) recommendations (updated in July 2016). A detailed Safer Staffing report is provided to the Trust Quality and Safety Committee on a monthly basis.

2.2 Information related to nurse, midwifery and care staff vacancies, recruitment and retention approaches are included. Appendix A shows the total number of nursing posts versus vacancies for April 2018 by clinical area and by health care group.

6.1

3.0 ANALYSIS

3.1 Safer Staffing data submission

Planned and actual nurse, midwifery and care staff levels have been successfully submitted to the NHS database (Unify) on a monthly basis.

3.2 Fill Rates

Table 1 shows Safer Staffing Fill rates for April 2018 with March 2018 in brackets.

Table 1	Days - registered nurses / midwives (%)	Days - Average fill rate - care staff (%)	Nights - registered nurses / midwives (%)	Nights - Average fill rate - care staff (%)
Trust Average	72.7% (69.2%)	79.3% (74.2%)	91.7% (88.1%)	89.1% (86.9%)
Change	↑3.5%	↑5.1%	↑3.6%	↑2.2%

3.21 In April there was an increased fill rate for day and night, both registered and unregistered staff. A review of annual leave profiling for the Safer Staffing wards confirmed that all were compliant with the agreed percentage.

The monthly requests for bank and agency shifts has been scrutinised to nullify the risk of double counting the demand for temporary staff. The results from this work, coupled with the improved leave profiling are shown in Tables 2a and 2b; a reduction in registered staff demand and an increase in fill rate. Although unregistered bank demand has reduced, the percentage fill rate remains static.

Table 2a: Registered demand and fill

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
January 2018	4,445	1,415	31.8 %	1,106	24.9 %	56.7 %	1,924	43.3 %
February 2018	4,311	1,342	31.1 %	1,049	24.3 %	55.5 %	1,920	44.5 %
March 2018	4,972	1,646	33.1 %	1,068	21.5 %	54.6 %	2,258	45.4 %
April 2018	3,970*	1,320	33.2 %	986	24.8 %	58.1 %	1,664	41.9 %
April 2017	3,628	1,222	33.7 %	1,057	29.1 %	62.8 %	1,349	37.2 %

**600 shifts have been removed from the registered demand due to recalculating the Rapid Response Pool demand to avoid double counting.*

Table 2 b: Unregistered demand and fill

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
January 2018	2,025	1,196	59.1 %	4	0.2 %	59.3 %	825	40.7 %
February 2018	1,982	1,162	58.6 %	0	0.0 %	58.6 %	820	41.4 %
March 2018	2,398	1,401	58.4 %	1	0.0 %	58.5 %	996	41.5 %
April 2018	2,047	1,187	58.0 %	0	0.0 %	58.0 %	860	42.0 %
April 2017	1,823	1,185	65.0 %	0	0.0 %	65.0 %	638	35.0 %

3.3 Recruitment and turnover

3.31 The rolling 12 month position shows there is a net gain of 18.3WTE registered nurses and midwives across the Trust. Areas of particular success up to the end of April 2018 have been maternity services, operating theatres and Ray and Winter wards. Appendix A highlights funded establishment by clinical area (and healthcare group) and actual whole-time equivalents in post. Table 3 shows the comparison between March and April 2018 in terms of funded and actual staff in post by professional group.

Table 3	31.3.2018				30.4.2018				Vacancy
	Funded FTE	SIP FTE	Vacancies FTE	Vacancies %	Funded FTE	SIP FTE	Vacancies FTE	Vacancies %	March /April
RN	866.46	653.4	213.06	24.59%	880.86	655.04	225.82	25.64%	12.76
RM	143.06	151.99	-8.93	-6.24%	143.06	150.49	-7.43	-5.19%	1.5
HCA	414.21	382.43	31.78	7.67%	431.03	390.23	40.8	9.47%	9.02
Therapies Division	56.54	48.33	8.21	14.52%	56.54	46.48	10.06	17.79%	1.85

3.32 The percentage vacancy for registered nurses, midwives and healthcare support staff by health care group is provided in Table 4.

Table 4: Percentage vacancy by HealthCare Group April 2018

Health Care Group	RN (% vacancy)	RM (% vacancy)	HCSW (% vacancy)
Medicine	36.6%	-	15.4%
Surgery & C. Care	25%		12%
Maternity **Children's services** **Nightingale**	53.5% 25.5% 68%	4.3%	8.3% 35% 12%
Cancer, Cardiology and Clinical Support	**To follow**		

3.33 Maternity services have been striving to improve the midwife to birth ratio with great success up to the end of April 2018. May has, however seen an increased number of leavers; retirement, relocation and commencement of midwifery studies have been the main drivers. The healthcare group are predicting a positive outcome to the recruitment of newly qualified midwives in September (14 headcount).

3.34 The Paediatric vacancy position includes the additional posts agreed for the opening of 24 hour ambulatory care services for children and the uplift required for the newly refurbished ED.

3.34 There are a number of confirmed and predicted starters in the pipeline described in Table 5. Recruitment campaigns include specific speciality focused advertisements, open days for health care groups and international initiatives in both India and the Philippines. A monthly pipeline of 4 to 6 international nurses joining the Trust to undertake the OSCE process is now embedded.

Table 5: New starters pipeline (external recruits).

	Family and Women		Medicine		Surgery and Critical care		Cancer, Cardiology & Clinical Support	
	Reg	**CSW**	**Reg**	**CSW**	**Reg**	**CSW**	**Reg**	**CSW**
May 2018	-	1	4	3	1	1	-	1
June 2018	3	-	2	4	4	1	2	1
July 2018	-	4	4	18	1	2	1	-
August 2018	1	-	1	-	1	-	-	-
September 2018	17	-	8	-	5	-	-	-
October 2018	1	-	-	-	-	-	-	-
Total	**22**	**5**	**19**	**25**	**12**	**4**	**3**	**2**

3.34 Improved retention remains a primary focus; the introduction of the senior staff nurse role in 2017 with an accompanying development programme has proved to be particularly successful. 40% of those appointed have now achieved promotion to band 6 roles in the Trust, the remaining senior staff nurses are all still working in the Trust.

3.35 April data shows the Trust gaining 9.94WTE more than it recruited left in month, which is the first positive balance after two successive months of negative balance. The rolling 12 month position shows there is a net gain of 18.3 WTE registered nurses and midwives across the Trust. From a ward based perspective; there is a net gain of 4.4 WTE to the wards, which remain the Trusts areas of greatest risk.

3.36 The areas of focus for retention in 2018 are provision of career clinics and advancing opportunities for expanding skillsets through taster sessions, shadowing, placements, secondments and leadership development programmes.

3.4 Patient Safety Incidents

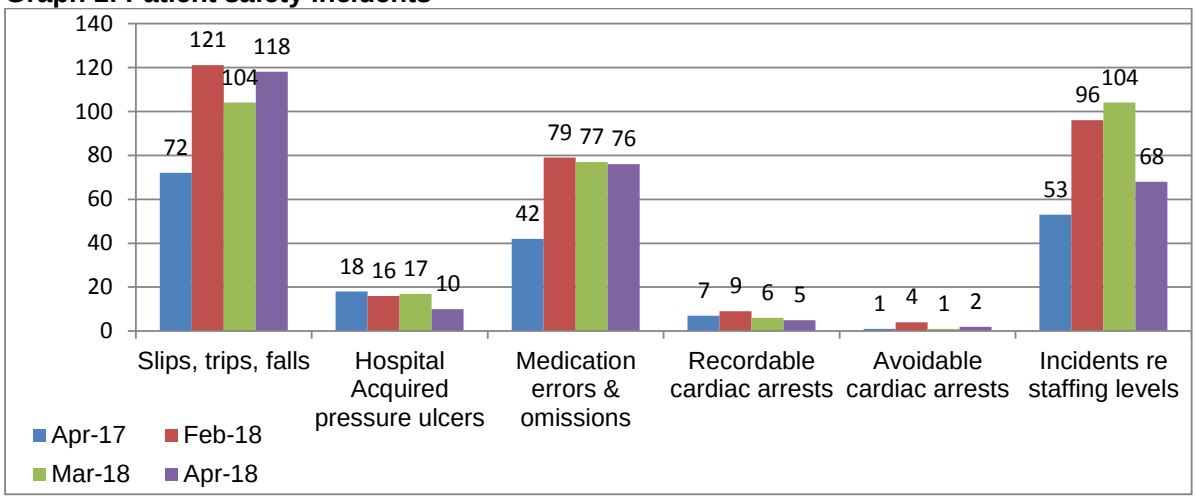
Graph 1 shows the trend in terms of numbers of key safety incidents reported for the wards included in the safer staffing monthly returns.

3.41 Whilst the number of hospital acquired pressure ulcers appear little changed from 12 months ago; the consistency with which the pressure ulcers are managed remains good with less than 20% deteriorating to grade 3 ulcers.

3.42 The increased number of cardiac arrests assessed and potentially avoidable in February 2018 was directly attributable to missed opportunities to discuss Do Not Attempt Resuscitation with patients and their families.

3.43 The number of slips trips and falls has risen in 2018; reported falls at night have decreased slightly whilst reported falls during day increased slightly. An explanation may be that as the Trust has been promoting the #EndPJparalysis message over the month of April; more patients are up and about during the day. This would lead to an expectation of an increase in reported falls. This would not be unusual and as patients become more mobile during the day they may be more settled at night, thereby reducing night time falls. Our focus is prevention of harm rather than prevention of falls; harm levels remain low.

Graph 1: Patient safety incidents



4.0 RECOMMENDATION

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

Author: Sharon Cullen, Deputy Chief Nurse
Reviewed; Professor Nancy Fontaine, Chief Nurse
Date: 31 May 2018

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 07.06.18

Agenda Item:	6.2
Presented by:	Andy Morris – Chief Medical Officer
Prepared by:	Andy Morris – Chief Medical Officer
Date prepared:	01.06.18
Subject / Title:	**Mortality Update**

Purpose:	Approval		Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The provisional and un-validated 12 month rolling HSMR for March 2017 to February 2018 is 116.4 and statistically "higher than expected"'. Only 50% of spells have been returned to date. Last month's figure, also 116.4, has corrected to 115.0 with complete data migration. This is the 14th consecutive month of reporting for a "higher than expected".
Recommendation:	The Trust Board is asked to note the update.

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

Previously considered by:	
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	Appendix 1 - Dr Foster Mortality Summary Report

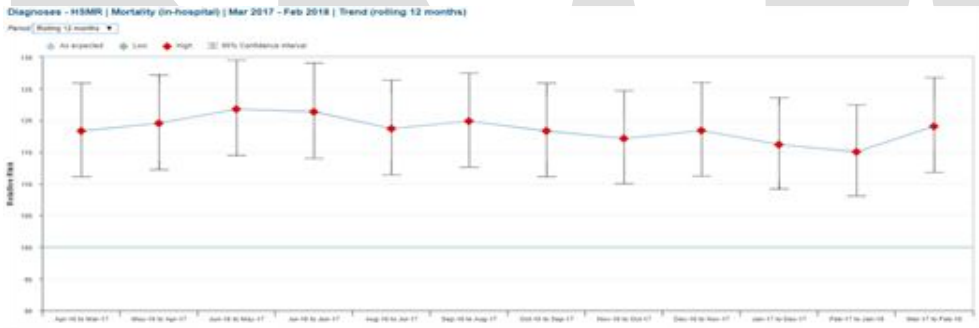
6.2

Guidance for Trust and Boards
https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

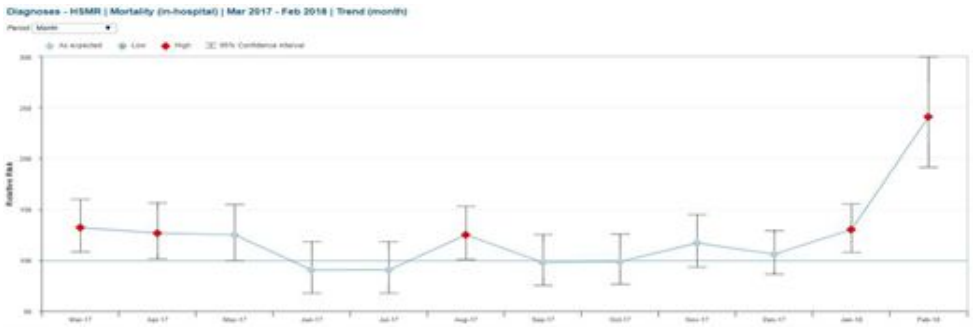
https://improvement.nhs.uk/uploads/documents/170720_Implementing_LfD_-_information_for_boards_proofed_v2.pdf

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

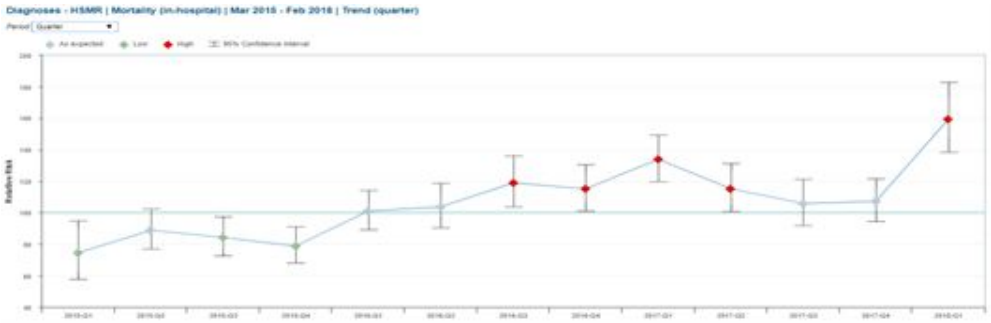
HSMR
The provisional and un-validated 12 month rolling HSMR for March 2017 to February 2018 is 116.4 and statistically "higher than expected"'. Only 50% of spells have been returned to date. Last month's figure, also 116.4, has corrected to 115.0 with complete data migration. This is the 14th consecutive month of reporting for a "higher than expected".

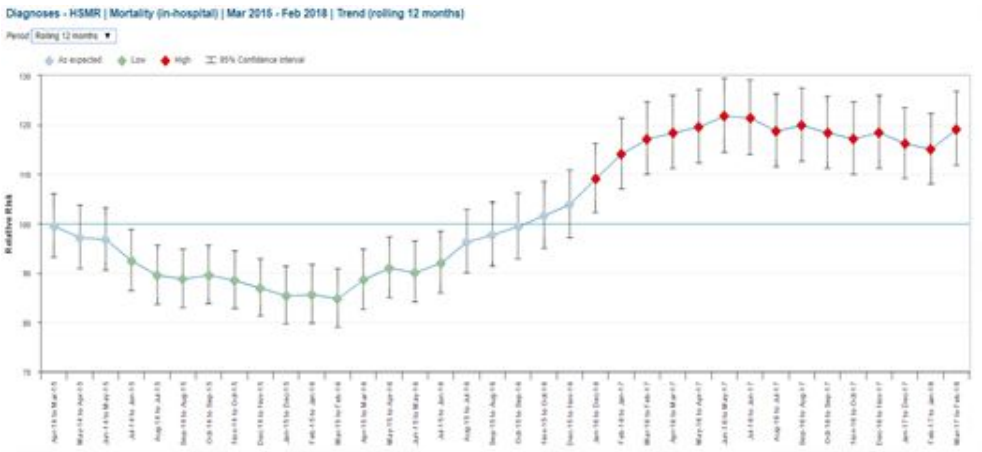


The corrected in-month HSMR has been "higher than expected" for the last 2 months:

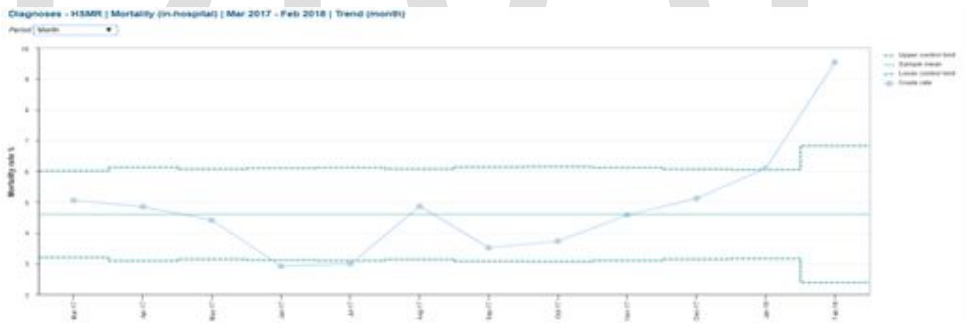


The following graphs show the 3 year trends:





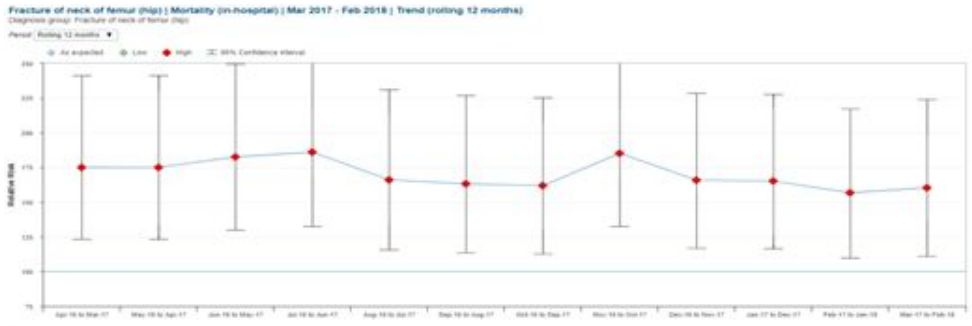
The 12 month rolling crude death rate within the HSMR basket has risen for the last 5 months:



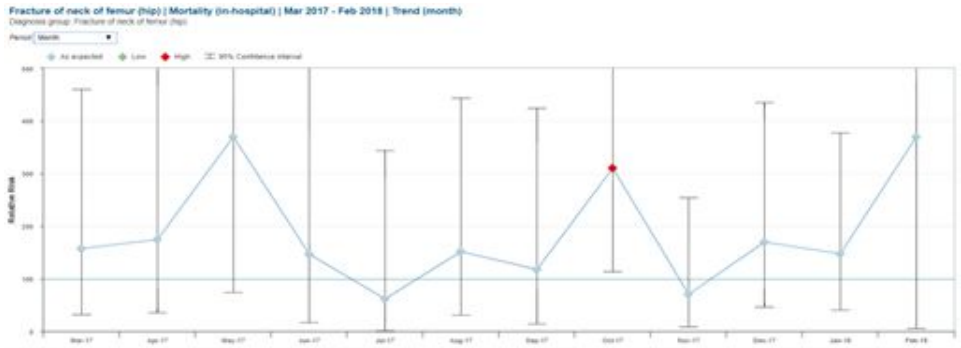
In the 12 month period there are a total of 159 deaths over and above those expected. This has increased from last month.

There are 5 diagnostic outliers:

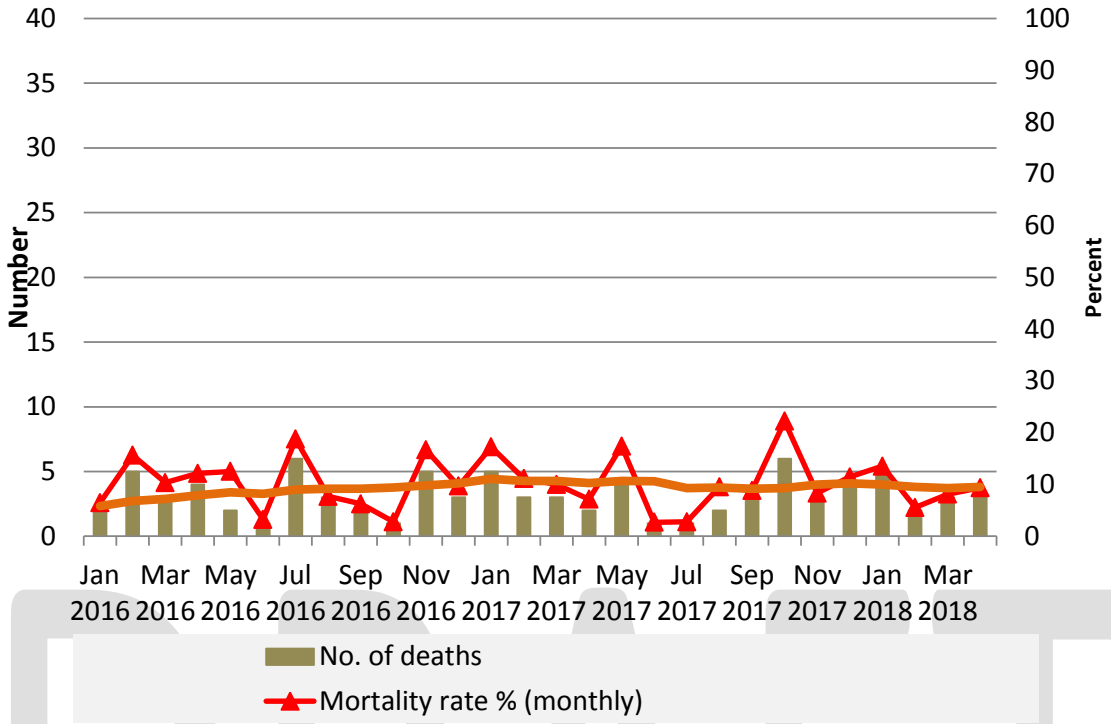
1) Fracture of neck of femur, 34 deaths vs. 21 expected.
The 12 month rolling HSMR is higher than expected:



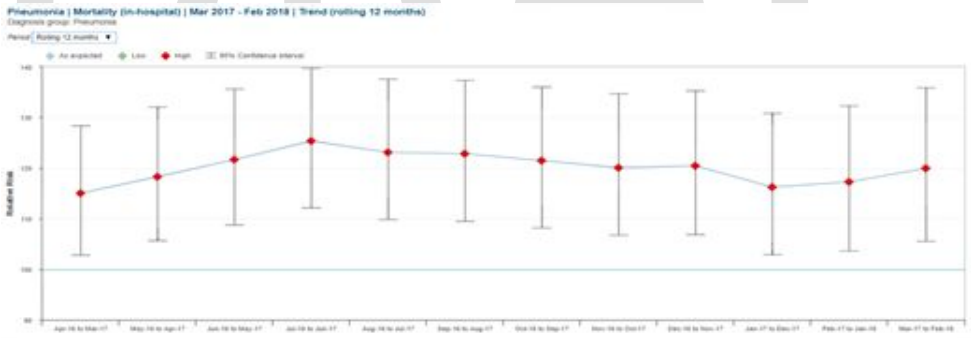
The monthly trend shows a more favourable picture:



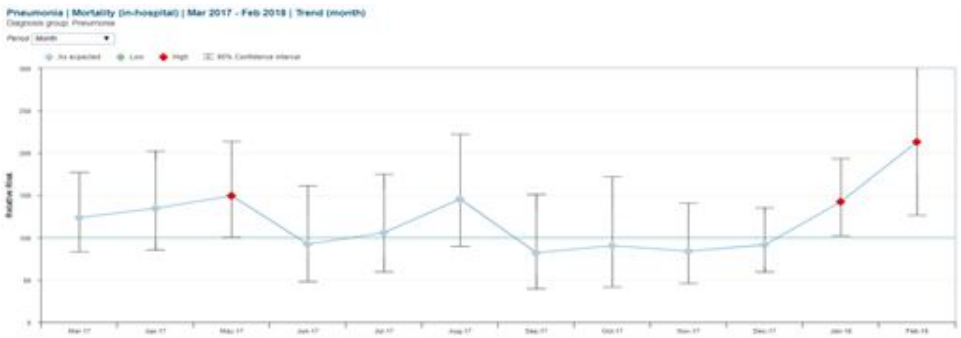
The Dr Foster crude mortality data does not match the monthly Trust data. The Dr Foster data suggests an annual mortality of 9.9% whereas the Trust data equates to 9.5%. This correlation is closer than in previous months.



2) Pneumonia, 248 deaths vs. 2206 expected.
The 12 month rolling trend shows a higher than expected mortality for the last 13 months:

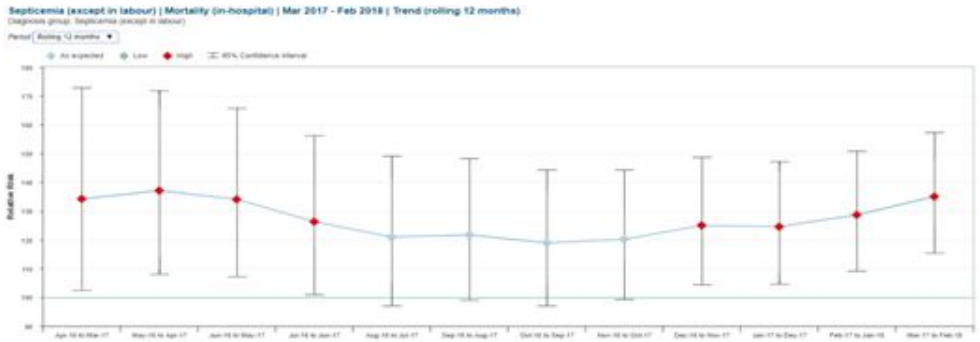


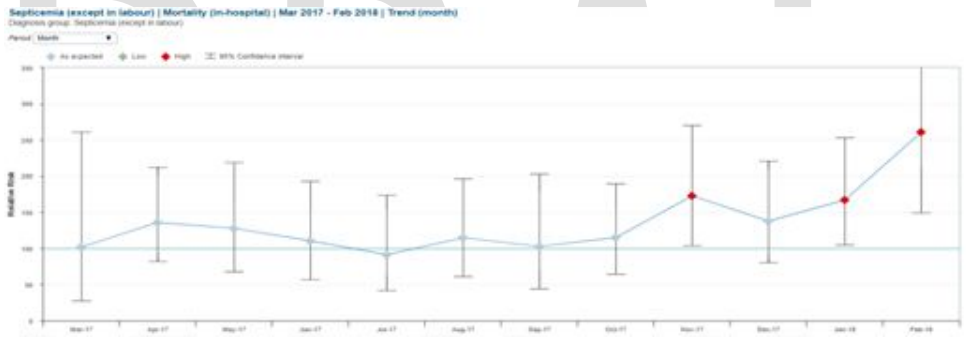
The in-month HSMR has been higher than expected for the last 2 months:



This has been audited and a pneumonia pathway has been introduced. This now needs to be audited fort complaince.

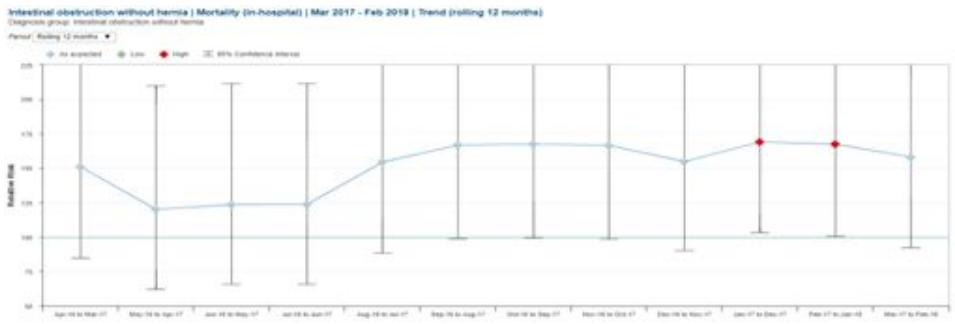
3) Septicaemia, 167 deaths vs. 123 expected.
The rolling 12 month and in-month HSMR are higher than expected:





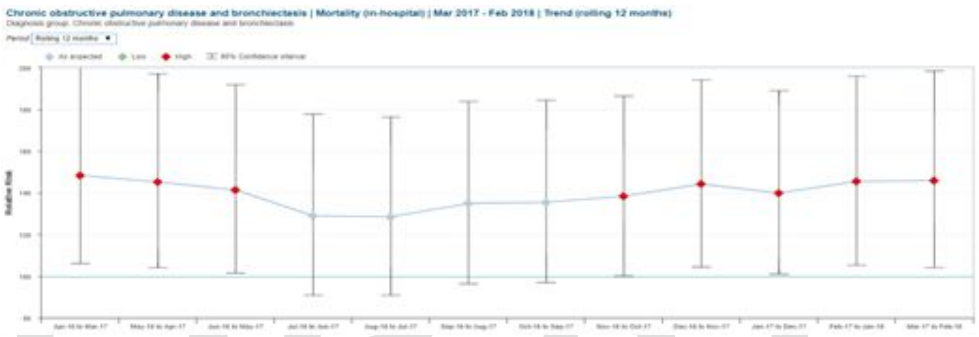
The Sepsis programme remains very active with over 400 frontline staff trained on recognising and acting on the Sepsis 6.

4) Intestinal obstruction without hernia, 17 deaths vs. 10 expected.
The 12 month rolling HSMR has improved to as expected:

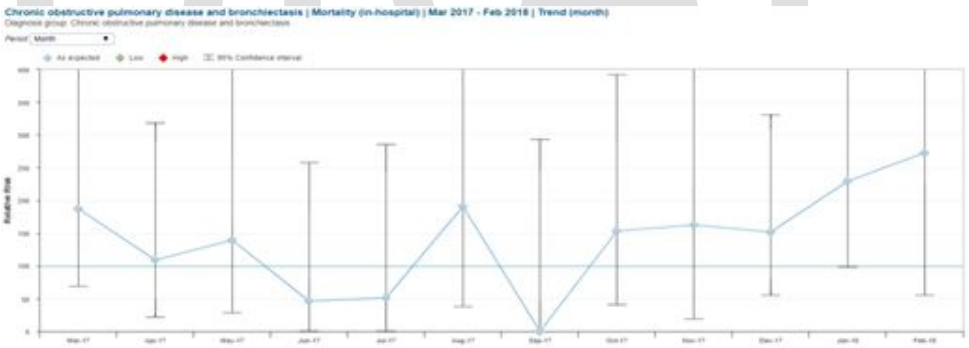


The in-month HSMR is as expcted and has improved:

5) COPD and bronchiectasis, 40 deaths vs. 27 expected.
The 12 month rolling HSMR is higher than expected:



The in-month HSMR is as expected:



Weekday and weekend admissions
There is no significant difference for weekday and weekend admissions. Both are “higher than expected”

Palliative care coding
The palliative care coding rate is 3.27% versus the national rate of 4.07%. This has plateaued.

Co-morbidity coding (upper quartile)
25.1% of spells are coded as within the Charlson co-morbidity upper quartile.

SMR
All diagnosis SMR for March 2017 to February 2018 was 115.5 and statistically "higher than expected". This has plateaued:

There are 7 diagnostic outliers:
1) Fracture neck of femur
2) Pneumonia
3) Cancer of head and neck
4) Septicaemia
5) COPD
6) Cancer of ovary (new alert)
7) Other diseases of kidney and ureter (new alert)

CUSUM alerts
There is 1 alert this month:
Septicaemia

SHMI
The new SHMI for October 2016 to September 2017 was 108.96 and is "as expected".

Stillbirths
The stillbirth rate for May 2017 to April 2018 is 1.95 per 1000 births adjusted for termination of pregnancy. Including termination of pregnancy over 24 weeks gestation the rate is 2.93 per 1000 births. The national rate is 3.87 per 1000.

Matters to note:
- HSMR and SMR remain higher than expected
- The Medical Examiner role is being rolled out with 8 applicants now starting their training

Summary
The statistical markers for mortality remain a significant concern.

MORTALITY SUMMARY REPORT

THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST

TRUST LEVEL – JUNE 2018

Report Date	28th May 2018
Healthcare Intelligence Specialist	Marianne Tankard
Area	East of England
Contact details	07738 028 185
Data Period	March 2017 to February 2018

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Data Period: March 2017 to February 2018

Metric	Result
HSMR	**116.4** 'higher than expected' range
HSMR position vs. peers	PAH is 1 of 6 Trusts within the peer group of 16 that sit within the 'higher expected' range
HSMR outlying groups	There are 5 outlying groups attracting significantly higher than expected deaths (0 new groups this month): • Fracture of neck of femur (hip) – continues to alert • Septicaemia (except in labour) – continues to alert • Chronic obstructive pulmonary disease and bronchiectasis – continues to alert • Pneumonia - continues to alert • Intestinal obstruction without hernia – continues to alert
Coding analysis	• The Trust has a palliative care coding rate of 3.27% vs. national rate of 4.07% • The Trust codes 25.1% of spells within the upper quartile Charlson co-morbidity vs. 25% nationally
All Diagnosis SMR	All Diagnosis SMR is **115.5** 'higher than expected' range There are 5 outlying groups attracting significantly higher than expected deaths. 2 new alerts this month: • Cancer of head and neck – continues to alert • Septicaemia (except in labour) – continues to alert • Cancer of ovary – NEW ALERT THIS MONTH • Fracture of neck of femur (hip) – continues to alert • Other diseases of kidney and ureters – NEW ALERT THIS MONTH • Pneumonia – continues to alert • Chronic obstructive pulmonary disease and bronchiectasis – continues to alert
New CUSUM alerts this month	There is 1 new CUSUM alerts this month: • Septicaemia (except in labour) – new alert triggered Feb 18, total of 2 alerts over last 12 months)

SHMI (Oct 16 to Sep 17)	SHMI = 108.96 ‘as expected’ (band 2)

REPORT OUTLINE

Background

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

Methods

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

HOSPITAL STANDARDISED MORTALITY RATIOS (HSMR) ANALYSIS

Key Highlights:

- HSMR = **119.1** 'higher than expected' range *(Last month = **116.4** at time of report, now 115.0 with updated data)*
- Crude rate within HSMR basket = 4.5% (Peer group rate = 3.6%)
- There are 5 outlying groups attracting significantly higher than expected deaths (0 new groups this month):
  - Fracture of neck of femur (hip) – continues to alert
  - Septicaemia (except in labour) – continues to alert
  - Chronic obstructive pulmonary disease and bronchiectasis – continues to alert
  - Pneumonia - continues to alert
  - Intestinal obstruction without hernia – continues to alert

Figure 1 – HSMR Monthly Trend

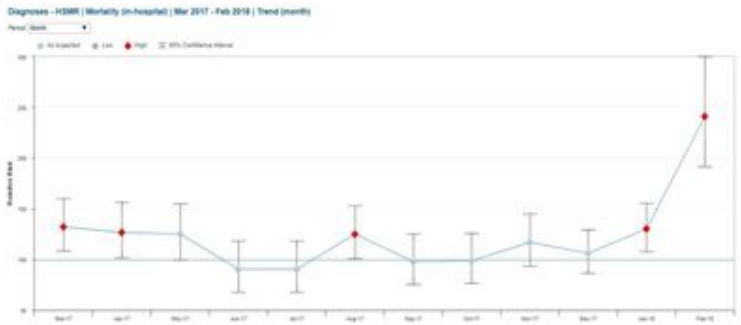
HSMR = **116.4** 'higher than expected' range.

Diagnoses - HSMR | Mortality (in-hospital) | Mar 2017 - Feb 2018 | Trend (month)

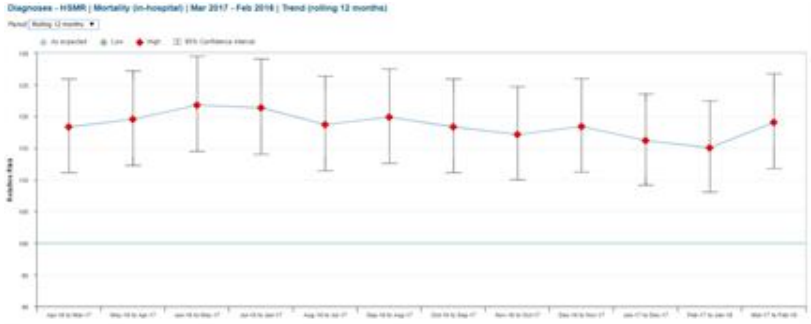
Period: Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	21,480	100.0%	21,530	989	4.6%	830.7	3.9%	158.3	119.1	111.8	126.7
Mar-17	2,099	9.8%	2,101	106	5.1%	80.2	3.8%	25.8	132.1	108.2	159.8
Apr-17	1,795	8.4%	1,798	87	4.8%	68.7	3.8%	18.3	126.6	101.4	156.2
May-17	1,930	9.0%	1,935	85	4.4%	68.0	3.5%	17.0	125.0	99.8	154.5
Jun-17	1,854	8.6%	1,860	54	2.9%	59.8	3.2%	-5.8	90.4	67.9	117.9
Jul-17	1,807	8.4%	1,814	54	3.0%	59.7	3.3%	-5.7	90.5	67.9	118.0
Aug-17	1,914	8.9%	1,916	93	4.9%	74.4	3.9%	18.6	124.9	100.8	153.1
Sep-17	1,767	8.2%	1,773	62	3.5%	63.4	3.6%	-1.4	97.8	75.0	125.3
Oct-17	1,744	8.1%	1,749	65	3.7%	65.9	3.8%	-0.9	98.7	76.2	125.8
Nov-17	1,813	8.4%	1,814	83	4.6%	71.0	3.9%	12.0	116.9	93.1	144.9
Dec-17	1,934	9.0%	1,940	99	5.1%	93.4	4.8%	5.6	106.0	86.1	129.0
Jan-18	1,985	9.2%	1,989	121	6.1%	93.0	4.7%	28.0	130.1	108.0	155.5
Feb-18	838	3.9%	841	80	9.5%	33.2	4.0%	46.8	240.9	191.0	299.9

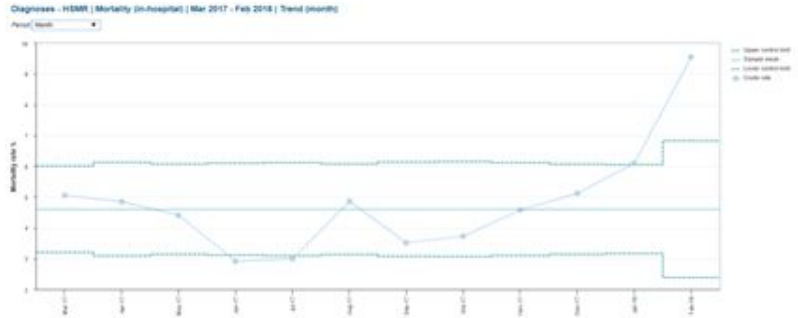
HSMR Trend (month)



HSMR Trend (rolling 12 months)



Crude rate Trend (month) - HSMR Basket



Crude rate Trend (rolling 12 months) - HSMR Basket

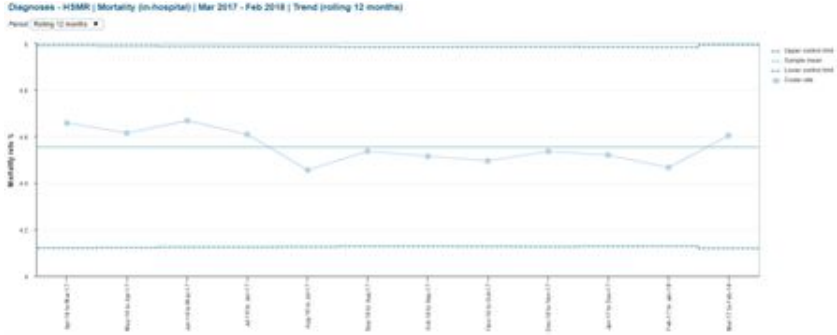


Figure 2 – HSMR 12 Month's Peer Comparison

The Trust is 1 of 7 Trusts (within the peer group of 16) with an HSMR within the 'higher expected' range. The crude rate is 4.50% (vs 3.6% for the peer group).

Diagnoses - HSMR | Mortality (in-hospital) | Feb-17 to Jan-18 | REGION (acute)

Peers // REGION (acute) ▼ Measure Relative risk ▼ Show All ▼

REGION (acute)	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		567,725	100.0%	574,456	20,159	3.6%	19996.0	3.5%	163.0	100.8	99.4	102.2
James Paget University Hospitals NHS Foundation Trust	RGP	19,722	3.5%	19,824	1,065	5.4%	845.2	4.3%	219.8	**126.0**	118.5	133.8
Papworth Hospital NHS Foundation Trust	RGN	12,192	2.1%	14,168	152	1.2%	113.7	0.9%	38.3	**133.7**	113.3	156.7
Mid Essex Hospital Services NHS Trust	RQ8	30,054	5.3%	30,210	1,174	3.9%	1018.1	3.4%	155.9	**115.3**	108.8	122.1
The Princess Alexandra Hospital NHS Trust	RQW	22,387	3.9%	22,437	1,000	4.5%	869.3	3.9%	130.7	**115.0**	108.0	122.4
Colchester Hospital University NHS Foundation Trust	RDE	35,577	6.3%	35,721	1,489	4.2%	1379.2	3.9%	109.8	**108.0**	102.5	113.6
Ipswich Hospital NHS Trust	RGQ	36,386	6.4%	36,532	1,219	3.4%	1125.5	3.1%	93.5	**108.3**	102.3	114.6
Southend University Hospital NHS Foundation Trust	RAJ	40,301	7.1%	40,386	1,377	3.4%	1286.8	3.2%	90.2	**107.0**	101.4	112.8
Luton and Dunstable University Hospital NHS Foundation Trust	RC9	32,489	5.7%	32,591	1,067	3.3%	1037.0	3.2%	30.0	102.9	96.8	109.3
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	RCX	29,062	5.1%	29,196	1,029	3.5%	998.9	3.4%	30.1	103.0	96.8	109.5
Bedford Hospital NHS Trust	RC1	18,371	3.2%	18,542	690	3.8%	663.8	3.6%	26.2	103.9	96.3	112.0
East and North Hertfordshire NHS Trust	RWH	40,907	7.2%	41,340	1,441	3.5%	1449.7	3.5%	-8.7	99.4	94.3	104.7
Norfolk and Norwich University Hospitals NHS Foundation Trust	RM1	68,603	12.1%	69,376	2,173	3.2%	2271.0	3.3%	-98.0	**95.7**	91.7	99.8
West Hertfordshire Hospitals NHS Trust	RWG	29,527	5.2%	29,653	1,236	4.2%	1286.4	4.4%	-50.4	96.1	90.8	101.6
Basildon and Thurrock University Hospitals NHS Foundation Trust	RDD	33,477	5.9%	34,519	1,347	4.0%	1434.9	4.3%	-87.9	**93.9**	88.9	99.0
North West Anglia NHS Foundation Trust	RGN	44,821	7.9%	45,111	1,534	3.4%	1699.6	3.8%	-165.6	**90.3**	85.8	94.9
Cambridge University Hospitals NHS Foundation Trust	RGT	53,132	9.4%	53,951	1,275	2.4%	1453.1	2.7%	-178.1	**87.7**	83.0	92.7
West Suffolk NHS Foundation Trust	RGR	20,717	3.6%	20,899	891	4.3%	1063.5	5.1%	-172.5	**83.8**	78.4	89.5

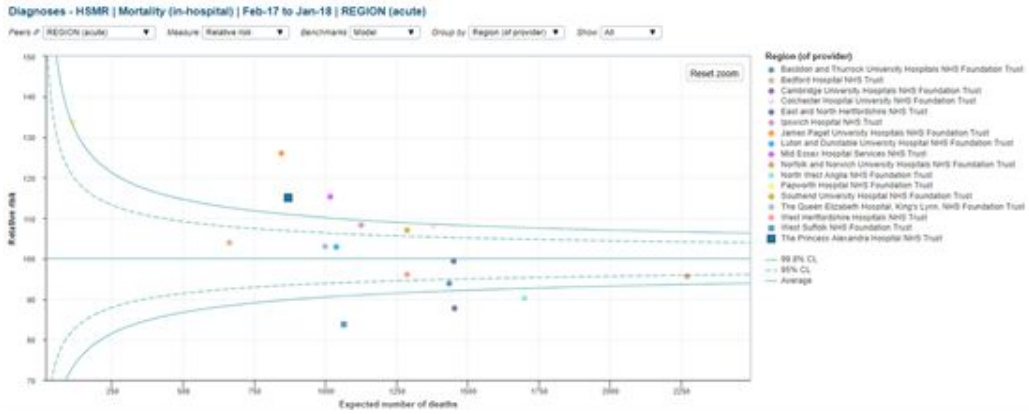


Figure 3 – HSMR by diagnosis group

There are 5 outlying groups - 0 new alert this month, which it would be prudent to investigate further:

- Fracture of neck of femur (hip) – continues to alert
- Septicaemia (except in labour) – continues to alert
- Chronic obstructive pulmonary disease and bronchiectasis – continues to alert
- Pneumonia - continues to alert
- Intestinal obstruction without hernia – continues to alert

Diagnoses - HSMR | Mortality (in-hospital) | Feb-17 to Jan-18 | Diagnosis group

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

Diagnosis group	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	22,387	100.0%	22,437	1,000	4.5%	869.3	3.9%	130.7	115.0	108.0	122.4
Fracture of neck of femur (hip)	363	1.6%	363	36	9.9%	23.0	6.3%	13.0	156.7	109.7	216.9
Septicemia (except in labour)	722	3.2%	726	153	21.2%	118.8	16.5%	34.2	128.8	109.2	150.8
Chronic obstructive pulmonary disease and bronchiectasis	644	2.9%	644	43	6.7%	29.6	4.6%	13.4	145.4	105.3	195.9
Pneumonia	1,575	7.0%	1,582	263	16.7%	225.2	14.3%	37.8	116.8	103.1	131.8
Intestinal obstruction without hernia	170	0.8%	170	19	11.2%	11.4	6.7%	7.6	167.4	100.7	261.4
Aspiration pneumonitis, food/vomitus	185	0.8%	191	69	37.3%	57.5	31.1%	11.5	120.0	93.4	151.9
Fluid and electrolyte disorders	202	0.9%	203	14	6.9%	8.2	4.1%	5.8	170.8	93.3	286.6
Urinary tract infections	1,024	4.6%	1,027	37	3.6%	29.1	2.8%	7.9	127.3	89.6	175.5
Congestive heart failure, nonhypertensive	393	1.8%	395	54	13.7%	45.0	11.7%	8.0	117.5	88.2	153.3
Cancer of pancreas	146	0.7%	146	9	6.2%	4.8	3.3%	4.2	185.8	84.8	352.7

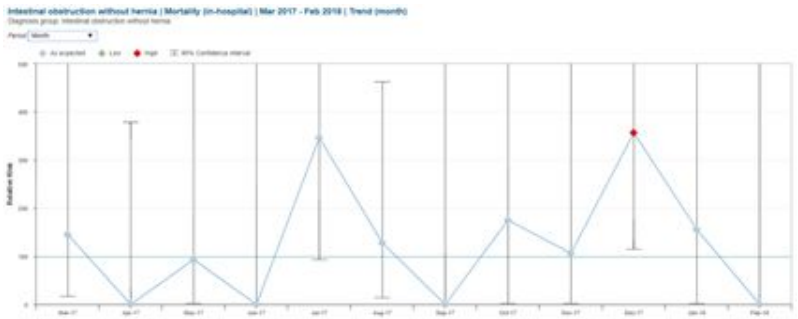
Figure 3.1 – Tracking of outlying groups: **Intestinal obstruction without hernia**

Intestinal obstruction without hernia | Mortality (in-hospital) | Mar 2017 - Feb 2018 | Trend (month)

Diagnosis group: Intestinal obstruction without hernia

Period Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	156	100.0%	156	17	10.9%	10.8	6.9%	6.2	158.0	92.0	253.0
Mar-17	17	10.9%	17	2	11.8%	1.4	8.1%	0.6	145.1	16.3	524.1
Apr-17	13	8.3%	13	0	0.0%	1.0	7.5%	-1.0	0.0	0.0	378.7
May-17	24	15.4%	24	1	4.2%	1.1	4.5%	-0.1	92.9	1.2	517.1
Jun-17	10	6.4%	10	0	0.0%	0.4	4.4%	-0.4	0.0	0.0	826.8
Jul-17	17	10.9%	17	4	23.5%	1.2	6.8%	2.8	346.2	93.2	886.5
Aug-17	14	9.0%	14	2	14.3%	1.6	11.2%	0.4	127.9	14.4	461.9
Sep-17	9	5.8%	9	0	0.0%	0.5	6.0%	-0.5	0.0	0.0	679.0
Oct-17	6	3.8%	6	1	16.7%	0.6	9.5%	0.4	174.9	2.3	973.1
Nov-17	15	9.6%	15	1	6.7%	0.9	6.3%	0.1	106.4	1.4	591.8
Dec-17	20	12.8%	20	5	25.0%	1.4	7.0%	3.6	**356.7**	115.0	832.4
Jan-18	9	5.8%	9	1	11.1%	0.6	7.1%	0.4	155.8	2.0	867.0
Feb-18	2	1.3%	2	0	0.0%	0.1	3.9%	-0.1	0.0	0.0	4688.1



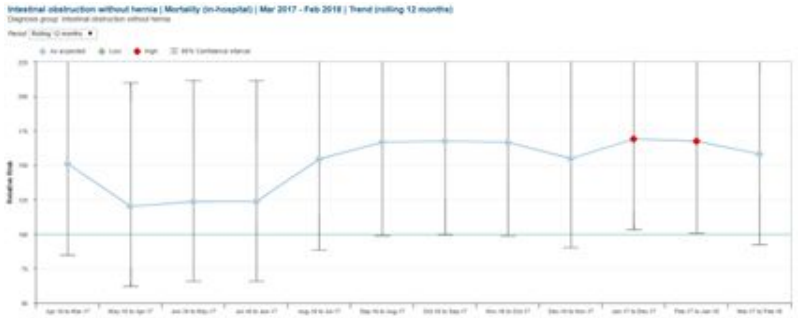


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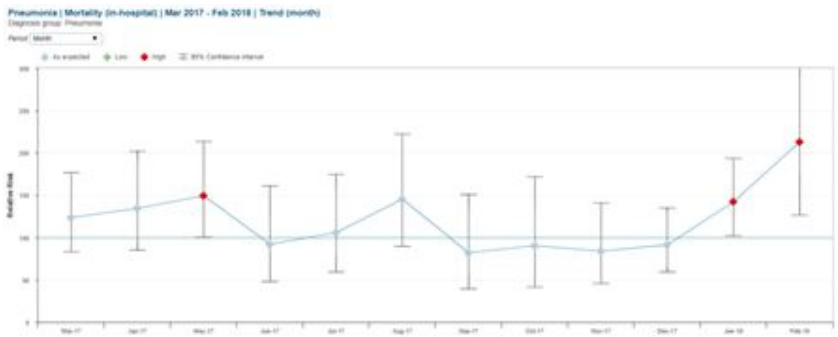
Figure 3.2 Tracking of outlying groups: **Pneumonia**

Pneumonia | Mortality (in-hospital) | Mar 2017 - Feb 2018 | Trend (month)

Diagnosis group: Pneumonia

Period: Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	1,435	100.0%	1,439	248	17.3%	206.7	14.4%	41.3	120.0	105.5	135.8
Mar-17	145	10.1%	145	30	20.7%	24.3	16.7%	5.7	123.5	83.3	176.4
Apr-17	129	9.0%	129	23	17.8%	17.1	13.3%	5.9	134.4	85.2	201.6
May-17	141	9.8%	141	30	21.3%	20.1	14.3%	9.9	149.2	100.7	213.0
Jun-17	99	6.9%	100	12	12.1%	13.0	13.2%	-1.0	92.0	47.5	160.8
Jul-17	111	7.7%	111	15	13.5%	14.2	12.8%	0.8	105.8	59.1	174.4
Aug-17	86	6.0%	86	21	24.4%	14.5	16.8%	6.5	145.2	89.9	222.0
Sep-17	83	5.8%	85	10	12.0%	12.2	14.7%	-2.2	82.0	39.3	150.8
Oct-17	79	5.5%	79	9	11.4%	10.0	12.6%	-1.0	90.3	41.2	171.4
Nov-17	118	8.2%	118	14	11.9%	16.7	14.1%	-2.7	83.9	45.8	140.7
Dec-17	179	12.5%	179	25	14.0%	27.4	15.3%	-2.4	91.3	59.1	134.8
Jan-18	222	15.5%	223	41	18.5%	28.8	13.0%	12.2	142.1	102.0	192.8
Feb-18	43	3.0%	43	18	41.9%	8.5	19.7%	9.5	212.7	126.0	336.2



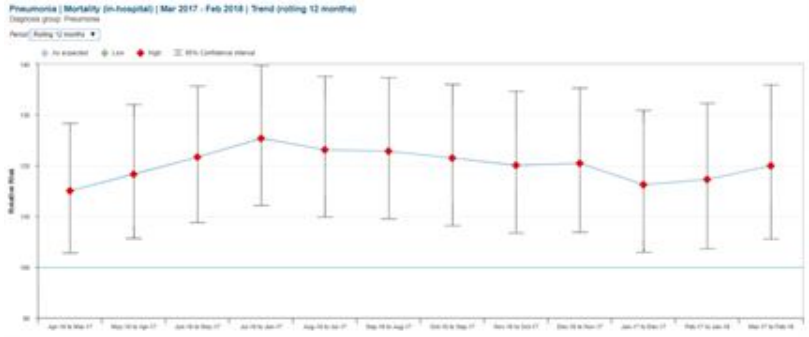


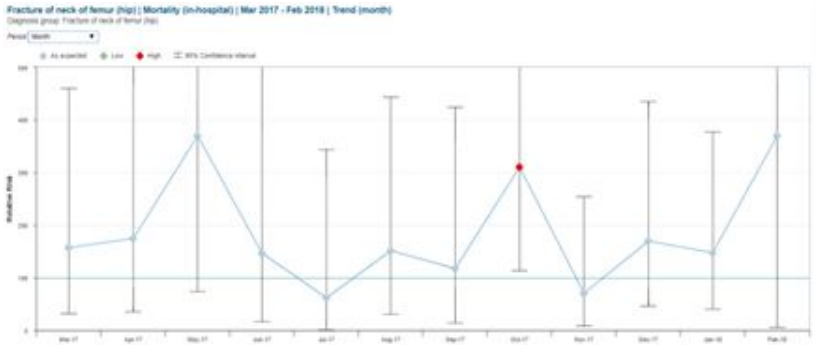
Figure 3.3 – Tracking of outlying groups: **Fracture of neck of femur**

Fracture of neck of femur (hip) | Mortality (in-hospital) | Mar 2017 - Feb 2018 | Trend (month)

Diagnosis group: Fracture of neck of femur (hip)

Period: Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	343	100.0%	343	34	9.9%	21.2	6.2%	12.8	160.2	111.0	223.9
Mar-17	28	8.2%	28	3	10.7%	1.9	6.8%	1.1	157.4	31.6	459.9
Apr-17	27	7.9%	27	3	11.1%	1.7	6.4%	1.3	174.5	35.1	509.8
May-17	20	5.8%	20	3	15.0%	0.8	4.1%	2.2	369.7	74.3	1080.1
Jun-17	37	10.8%	37	2	5.4%	1.4	3.7%	0.6	146.6	16.5	529.5
Jul-17	33	9.6%	33	1	3.0%	1.6	4.9%	-0.6	61.8	0.8	343.7
Aug-17	25	7.3%	25	3	12.0%	2.0	7.9%	1.0	151.5	30.5	442.7
Sep-17	32	9.3%	32	2	6.3%	1.7	5.3%	0.3	117.5	13.2	424.3
Oct-17	30	8.7%	30	6	20.0%	1.9	6.4%	4.1	310.2	113.3	675.2
Nov-17	36	10.5%	36	2	5.6%	2.8	7.9%	-0.8	70.4	7.9	254.1
Dec-17	34	9.9%	34	4	11.8%	2.4	6.9%	1.6	169.7	45.6	434.4
Jan-18	36	10.5%	36	4	11.1%	2.7	7.5%	1.3	147.5	39.7	377.6
Feb-18	5	1.5%	5	1	20.0%	0.3	5.4%	0.7	369.6	4.8	2056.4



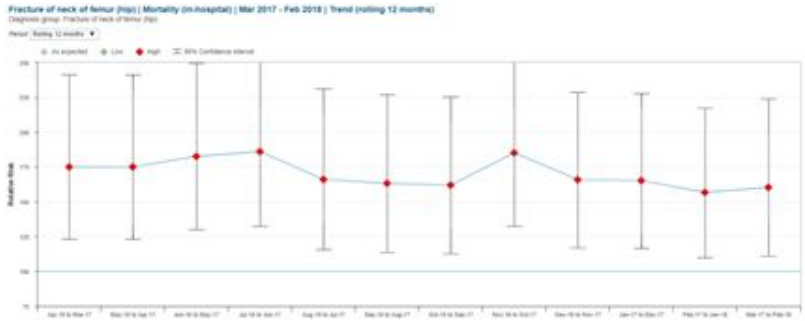


Figure 3.4 Tracking of outlying groups: **Septicaemia (except in labour)**

Septicemia (except in labour) | Mortality (in-hospital) | Mar 2017 - Feb 2018 | Trend (month)

Diagnosis group: Septicemia (except in labour)

Period: Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	735	100.0%	735	167	22.7%	123.7	16.8%	43.3	135.0	115.3	157.1
Mar-17	26	3.5%	26	4	15.4%	3.9	15.1%	0.1	101.8	27.4	260.7
Apr-17	76	10.3%	76	19	25.0%	14.0	18.4%	5.0	135.8	81.7	212.1
May-17	69	9.4%	69	13	18.8%	10.2	14.8%	2.8	127.7	67.9	218.4
Jun-17	66	9.0%	66	12	18.2%	10.9	16.5%	1.1	110.4	57.0	192.9
Jul-17	71	9.7%	71	9	12.7%	9.9	13.9%	-0.9	91.2	41.6	173.2
Aug-17	70	9.5%	70	13	18.6%	11.3	16.2%	1.7	114.7	61.0	196.1
Sep-17	68	9.3%	68	8	11.8%	7.8	11.5%	0.2	102.7	44.2	202.4
Oct-17	68	9.3%	68	15	22.1%	13.1	19.2%	1.9	114.9	64.3	189.5
Nov-17	58	7.9%	58	19	32.8%	11.0	19.0%	8.0	172.6	103.9	269.6
Dec-17	69	9.4%	69	17	24.6%	12.3	17.9%	4.7	137.7	80.2	220.4
Jan-18	67	9.1%	67	22	32.8%	13.2	19.7%	8.8	166.9	104.6	252.7
Feb-18	27	3.7%	27	16	59.3%	6.1	22.7%	9.9	260.8	149.0	423.5

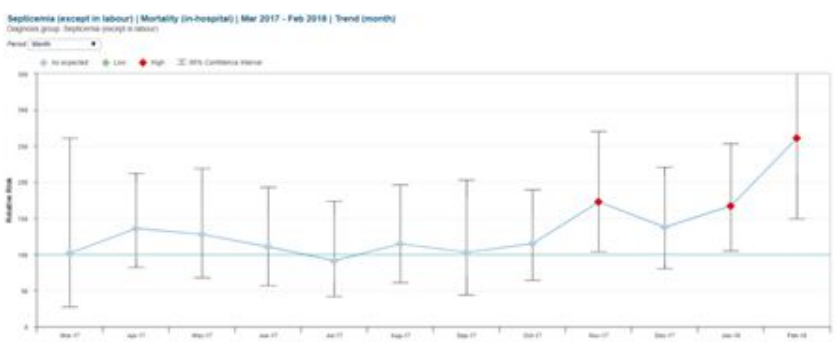


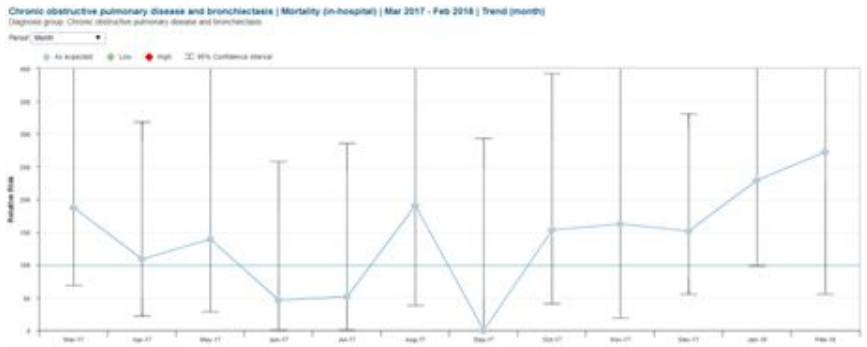
Figure 3.4 Tracking of outlying groups: **Chronic obstructive pulmonary disease and bronchiectasis:**

Chronic obstructive pulmonary disease and bronchiectasis | Mortality (in-hospital) | Mar 2017 - Feb 2018 | Trend (month)

Diagnosis group: Chronic obstructive pulmonary disease and bronchiectasis

Period: Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	596	100.0%	596	40	6.7%	27.4	4.6%	12.6	145.8	104.1	196.5
Mar-17	68	11.4%	68	6	8.8%	3.2	4.7%	2.8	187.1	68.3	407.3
Apr-17	49	8.2%	49	3	6.1%	2.8	5.6%	0.2	108.9	21.9	318.2
May-17	53	8.9%	53	3	5.7%	2.2	4.1%	0.8	139.3	28.0	407.0
Jun-17	50	8.4%	50	1	2.0%	2.2	4.3%	-1.2	46.2	0.6	257.2
Jul-17	47	7.9%	47	1	2.1%	2.0	4.2%	-1.0	51.2	0.7	285.1
Aug-17	47	7.9%	47	3	6.4%	1.6	3.3%	1.4	190.7	38.3	557.3
Sep-17	40	6.7%	40	0	0.0%	1.3	3.1%	-1.3	0.0	0.0	293.0
Oct-17	45	7.6%	45	4	8.9%	2.6	5.8%	1.4	153.2	41.2	392.3
Nov-17	33	5.5%	33	2	6.1%	1.2	3.7%	0.8	162.6	18.3	587.0
Dec-17	76	12.8%	76	6	7.9%	4.0	5.2%	2.0	151.7	55.4	330.2
Jan-18	73	12.2%	73	8	11.0%	3.5	4.8%	4.5	229.3	98.7	451.8
Feb-18	15	2.5%	15	3	20.0%	1.1	7.3%	1.9	272.5	54.8	796.2



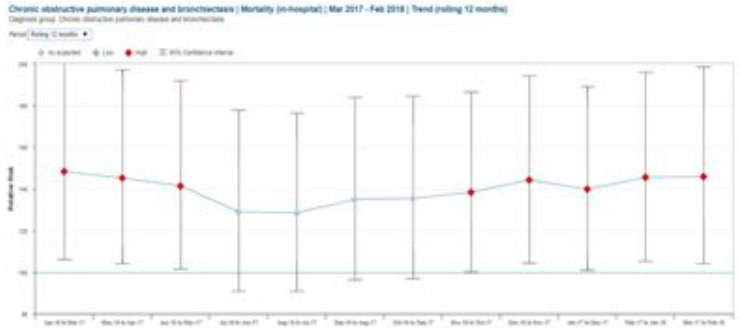
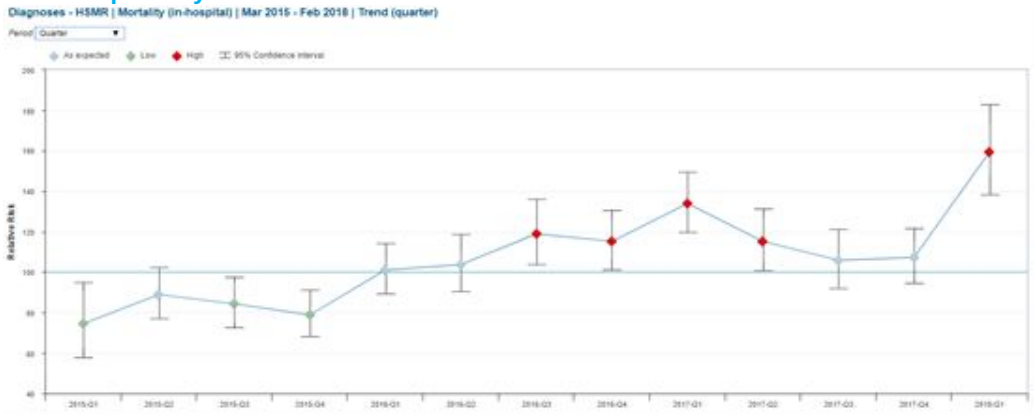
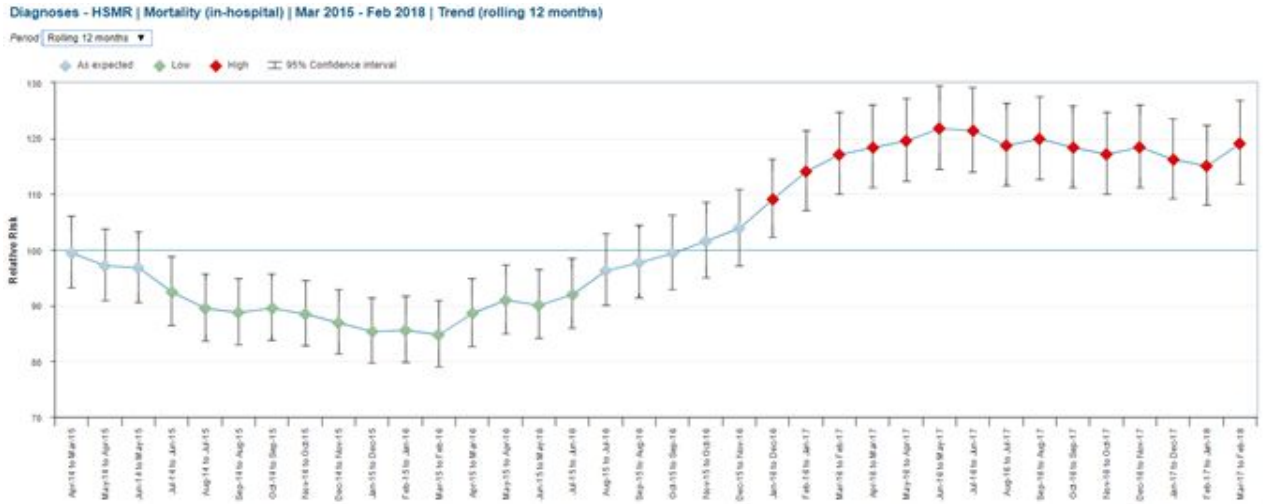


Figure 4 – HSMR trend over last 3 years

HSMR – quarterly trend



HSMR – Rolling 12 month trend



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TRENDS IN CODING

Key Highlights:

- The Trust has a palliative care coding rate of 3.27% vs. national rate of 4.07%
- The Trust codes 25.1% of spells within the upper quartile Charlson co-morbidity vs. 25% nationally

Figure 7 – Palliative Care Coding Rate Vs National (HSMR Basket)

Palliative Care Profile

Organisation: **The Princess Alexandra Hospital NHS Trust** *Report Date:* **28 May 2018**

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

Trend (Financial Year)	Non-elective spells	Palliative care	Rate	National Rate	Peer Group Rate
2014/15	13,585	239	1.76%	3.57%	3.63%
2015/16	13,176	269	2.04%	3.79%	3.63%
2016/17	12,277	340	2.77%	4.03%	3.97%
2017/18	11,294	369	3.27%	4.07%	4.11%

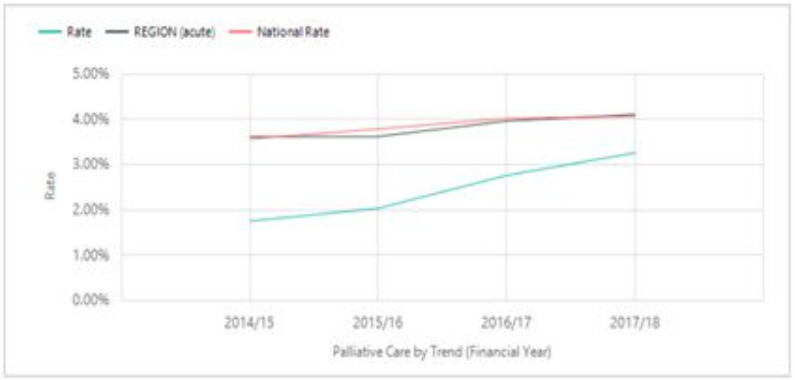


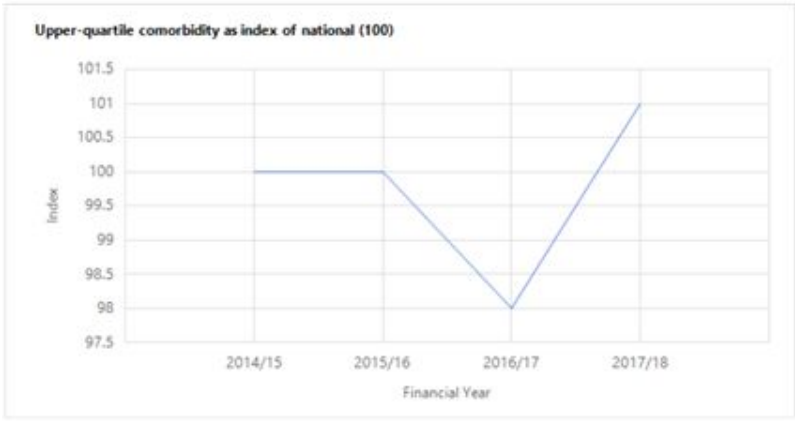
Figure 8 – Charlson Index Co-morbidity Coding Rates Vs National

Comorbidity Profile

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

Report Date: **28 May 2018**

	2014/15	2015/16	2016/17	2017/18
Upper-quartile comorbidity	25.0%	24.9%	24.4%	25.1%
as index of national (100)	100	100	98	101



SMR ALL DIAGNOSIS ANALYSIS

Key Highlights:

- All diagnosis SMR = **115.5** 'higher expected' range
- There are 7 outlying groups attracting significantly higher than expected deaths (2 new alerts this month)
  - Cancer of head and neck – continues to alert
  - Septicaemia (except in labour) – continues to alert
  - Cancer of ovary – NEW ALERT THIS MONTH
  - Fracture of neck of femur (hip) – continues to alert
  - Other diseases of kidney and ureters – NEW ALERT THIS MONTH
  - Pneumonia – continues to alert
  - Chronic obstructive pulmonary disease and bronchiectasis – continues to alert

Figure 9 – SMR All Diagnosis trend month: All diagnosis SMR = 115.5 'higher than expected' range
(Last month SMR = **114.9**'higher than expected)

Diagnoses | Mortality (in-hospital) | Mar 2017 - Feb 2018 | Trend (month)

Period Month

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	67,435	100.0%	67,559	1,144	1.7%	990.4	1.5%	153.6	115.5	108.9	122.4
Mar-17	6,155	9.1%	6,159	114	1.9%	90.7	1.5%	23.3	125.7	103.7	151.1
Apr-17	5,291	7.8%	5,297	96	1.8%	76.4	1.4%	19.6	125.6	101.8	153.4
May-17	6,073	9.0%	6,088	93	1.5%	78.4	1.3%	14.6	118.6	95.7	145.3
Jun-17	5,784	8.6%	5,796	70	1.2%	68.0	1.2%	2.0	102.9	80.2	130.0
Jul-17	5,802	8.6%	5,818	62	1.1%	71.3	1.2%	-9.3	87.0	66.7	111.5
Aug-17	5,858	8.7%	5,869	104	1.8%	83.8	1.4%	20.2	124.1	101.4	150.4
Sep-17	5,463	8.1%	5,477	78	1.4%	74.8	1.4%	3.2	104.2	82.4	130.1
Oct-17	5,601	8.3%	5,613	72	1.3%	75.6	1.4%	-3.6	95.2	74.5	119.9
Nov-17	5,563	8.2%	5,571	94	1.7%	82.8	1.5%	11.2	113.6	91.8	139.0
Dec-17	5,257	7.8%	5,265	118	2.2%	106.1	2.0%	11.9	111.2	92.0	133.2
Jan-18	5,665	8.4%	5,674	135	2.4%	107.4	1.9%	27.6	125.7	105.4	148.8
Feb-18	4,923	7.3%	4,932	108	2.2%	75.0	1.5%	33.0	143.9	118.1	173.8

Figure 10 – All diagnosis SMR crude rate trend

All diagnosis basket crude over the 36 months vs. East of England average (monthly trend)

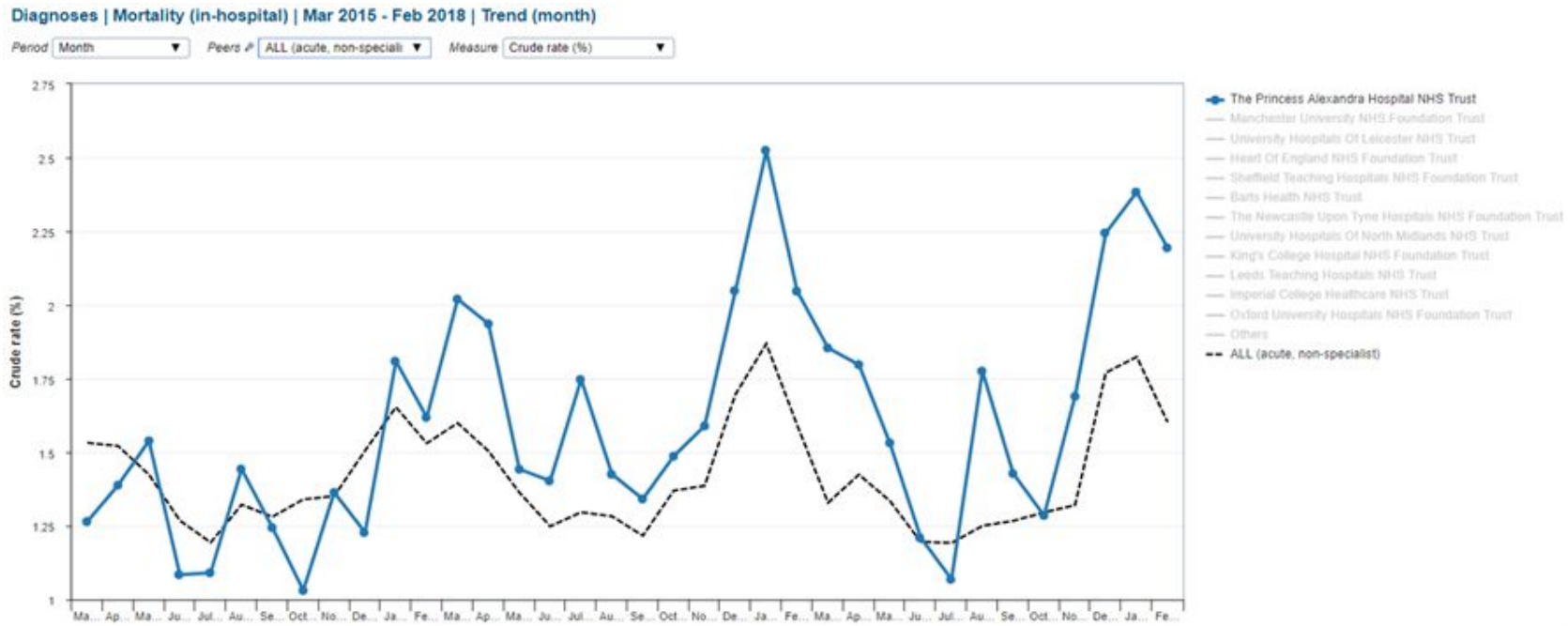


Figure 11 – All diagnosis SMR diagnosis group

There are 7 outlying groups attracting significantly higher than expected deaths which it would be prudent to investigate further: 2 new alerts this month

- Cancer of head and neck – continues to alert
- Septicaemia (except in labour) – continues to alert
- Cancer of ovary – NEW ALERT THIS MONTH (https://one.drfoster.com/Query/?id=816483)
- Fracture of neck of femur (hip) – continues to alert
- Other diseases of kidney and ureters – NEW ALERT THIS MONTH (https://one.drfoster.com/Query/?id=816486)
- Pneumonia – continues to alert
- Chronic obstructive pulmonary disease and bronchiectasis – continues to alert

Diagnoses | Mortality (in-hospital) | Mar 2017 - Feb 2018 | Diagnosis group

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

Diagnosis group	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	67,435	100.0%	67,559	1,144	1.7%	990.4	1.5%	153.6	115.5	108.9	122.4
Cancer of head and neck	23	0.0%	23	3	13.0%	0.4	1.9%	2.6	691.3	138.9	2019.8
Septicemia (except in labour)	730	1.1%	735	166	22.7%	122.5	16.8%	43.5	135.5	115.7	157.8
Cancer of ovary	9	0.0%	9	3	33.3%	0.5	5.8%	2.5	573.9	115.3	1676.9
Fracture of neck of femur (hip)	343	0.5%	343	34	9.9%	21.2	6.2%	12.8	160.2	111.0	223.9
Other diseases of kidney and ureters	294	0.4%	295	6	2.0%	2.0	0.7%	4.0	293.2	107.1	638.2
Pneumonia	1,428	2.1%	1,439	246	17.2%	205.2	14.4%	40.8	119.9	105.4	135.8
Chronic obstructive pulmonary disease and bronchi...	596	0.9%	596	40	6.7%	27.4	4.6%	12.6	145.8	104.1	198.5
Aspiration pneumonitis, food/vomitus	175	0.3%	183	69	39.4%	55.6	31.8%	13.4	124.1	96.5	157.1
Congestive heart failure, nonhypertensive	380	0.6%	383	57	15.0%	45.1	11.9%	11.9	126.5	95.8	163.9
Fluid and electrolyte disorders	196	0.3%	198	14	7.1%	8.1	4.1%	5.9	173.4	94.7	291.0

CUSUM ALERTS

Key Highlights:

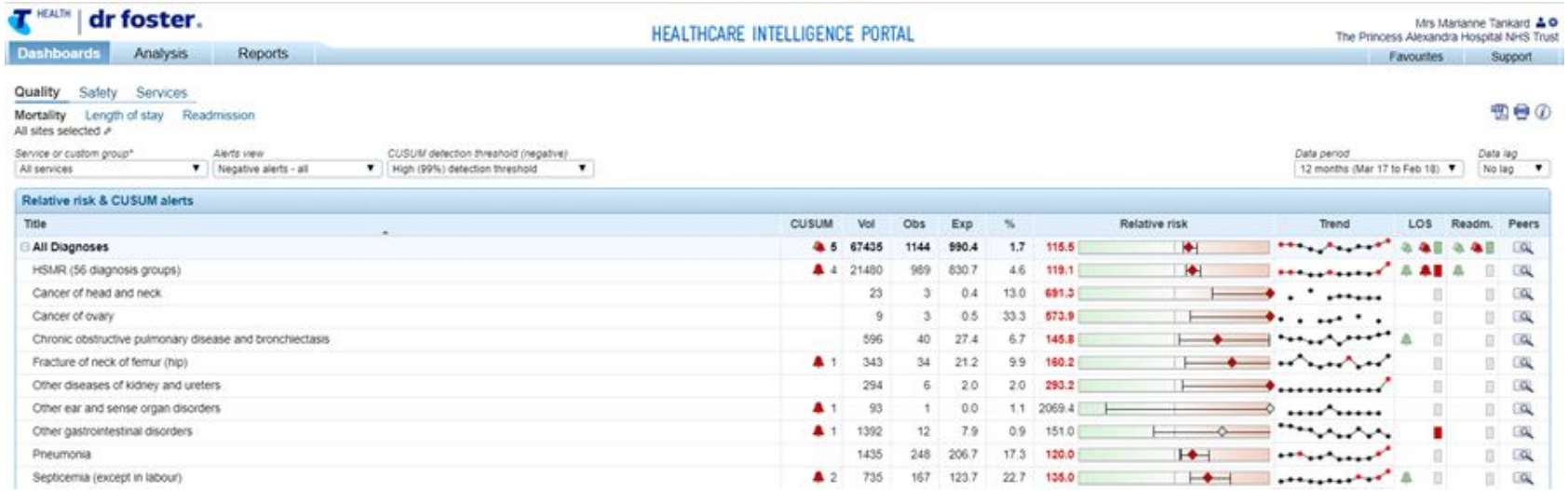
1 new CUSUM diagnosis groups alerts this month

- **Septicaemia (except in labour) – new alert triggered Feb 18, total of 2 alerts over last 12 months)**

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

- Fracture of neck of femur (hip) – 1st alert triggered Jan 17, 2nd alert triggered Jul 17 – see chart below
- Other ear and sense organ disorders – alert triggered Aug 17
- Other gastrointestinal disorders – alert triggered Jul 17
- Septicaemia (except in labour) – triggered Jan 18

Figure 12 – Relative Risk and CUSUM Alerts



Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	5	67435	1144	990.4	1.7	115.5				
HSMR (56 diagnosis groups)	4	21480	989	830.7	4.6	119.1				
Cancer of head and neck		23	3	0.4	13.0	691.3				
Cancer of ovary		9	3	0.5	33.3	673.9				
Chronic obstructive pulmonary disease and bronchiectasis		596	40	27.4	6.7	145.8				
Fracture of neck of femur (hip)	1	343	34	21.2	9.9	160.2				
Other diseases of kidney and ureters		294	6	2.0	2.0	293.2				
Other ear and sense organ disorders	1	93	1	0.0	1.1	2069.4				
Other gastrointestinal disorders	1	1392	12	7.9	0.9	151.0				
Pneumonia		1435	248	206.7	17.3	120.0				
Septicemia (except in labour)	2	735	167	123.7	22.7	135.0				

Septicaemia (except in labour) CUSUM – additional details

Link to patient records (deaths in Jan & Feb 18): https://one.drfoster.com/Query/?id=816497

SHMI (DATA PERIOD: (OCT 16 TO SEPT 17)

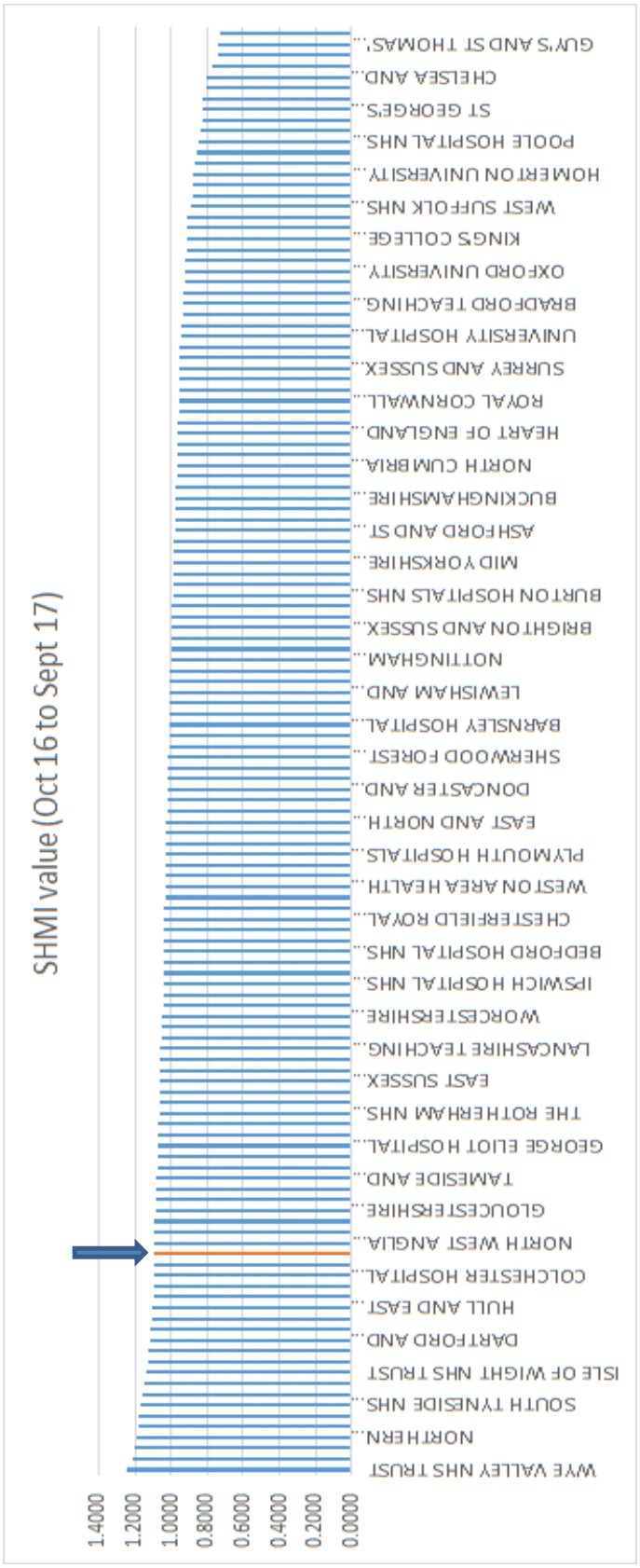
Key Highlights:

- SHMI = 108.96 ‘as expected’ (band 2)

Figure 13 – SHMI value

Provider code	Provider name	SHMI value	SHMI banding	Number of spells	Observed deaths	Expected deaths	99.8% Poisson lower control limit	99.8% Poisson upper control limit	95% over-dispersion lower control limit	95% over-dispersion upper control limit
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	1.0896	2	47,809	1,572	1,442.7581	0.9206	1.0841	0.8921	1.1209

Figure 14 – SHMI position vs. peers


SHMI value (Oct 16 to Sept 17)
1.4000
1.2000
1.0000
0.8000
0.6000
0.4000
0.2000
0.0000
WYE VALLEY NHS TRUST
NORTHERN...
SOUTH TYNESIDE NHS...
ISLE OF WIGHT NHS TRUST
DARTFORD AND...
HULL AND EAST...
COLCHESTER HOSPITAL...
NORTH WEST ANGLIA...
GLOUCESTERSHIRE...
TAMESIDE AND...
GEORGE ELIOT HOSPITAL...
THE ROTHERHAM NHS...
EAST SUSSEX...
LANCASHIRE TEACHING...
WORCESTERSHIRE...
IPSWICH HOSPITAL NHS...
BEDFORD HOSPITAL NHS...
CHESTERFIELD ROYAL...
WESTON AREA HEALTH...
PLYMOUTH HOSPITALS...
EAST AND NORTH...
DONCASTER AND...
SHERWOOD FOREST...
BARNSLEY HOSPITAL...
LEWISHAM AND...
NOTTINGHAM...
BRIGHTON AND SUSSEX...
BURTON HOSPITALS NHS...
MID YORKSHIRE...
ASHFORD AND ST...
BUCKINGHAMSHIRE...
NORTH CUMBRIA...
HEART OF ENGLAND...
ROYAL CORNWALL...
SURREY AND SUSSEX...
UNIVERSITY HOSPITAL...
BRADFORD TEACHING...
OXFORD UNIVERSITY...
KING'S COLLEGE...
WEST SUFFOLK NHS...
HOMERTON UNIVERSITY...
POOLE HOSPITAL NHS...
ST GEORGE'S...
CHELSEA AND...
GUY'S AND ST THOMAS'...

REFERENCES

SMR

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

HSMR

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

Benchmark

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

CUSUM

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

HSMR Comparison

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

Charlson Index of Comorbidities

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

Charlson Upper-Quartile Rate

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

Palliative Care Coding Rate

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

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 07/06/2018 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: Stephen Bright – Chair of Audit Committee

DATE OF COMMITTEE MEETING: 24/05/2018

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

The Audit Committee met on Thursday 24 May 2018 – a private session was held with internal and external audit and no concerns were raised.

The committee raises the following to the attention of the board.

1. The committee received the annual accounts which were submitted ahead of time. The move to a Modern Equivalent Asset valuation of land and buildings equated to a reduction of asset value by £40 million, to £103 million. There were no post balance sheet events. The following was recommended to Board for approval:
   i. Letter of Representation
   ii. Annual Accounts and Financial statements
   iii. Going Concern was recommended to Board with a minor technical amendment at the request of auditors.
2. There would be a referral under S30 as the Trust had not broken even.
3. Subject to some minor amendments, the Annual Report and Annual Governance Statement were recommended to Board for approval.
4. The Deputy CFO report of Waivers Losses and special payments detailed the following: Cumulative losses: £93.3k, Waivers - March 18: £826k, £3.7m year to date. Waivers were reported in performance reviews with a focus on reducing waivers for recurrent suppliers.
5. Internal audit had conducted a review of **ED standards** which received limited assurance and the review of the **IG toolkit** was assigned a reasonable assurance rating.
6. The Head of Internal Audit Opinion was confirmed with a reasonable assurance opinion.
7. Three new counter fraud referrals had been received since the last committee.
8. Subject to a number of amendments the Quality Accounts were approved and recommended to Board.

The committee also received the following reports:

1. LCFS Annual Report
2. Legal Services Annual Report

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

The Committee's progress against its Annual Work Plan is set out below:

The AC is making good progress against its annual work plan and meets again on Wednesday 05.09.18.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 7 June 2018 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee

REPORT FROM: John Hogan

DATE OF COMMITTEE MEETING: 23 May 2018

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

Items for escalation to the Board:

Mortality: the Chief Medical Officer reported the ongoing concern that HSMR was still higher than expected although may have plateaued to a degree. Coding remained a concern and there needed to be an improved dialogue between clinicians and coders. He was pleased to report that for the last three months coders were now meeting with the appropriate clinician the day after death to agree both the admission code and the death code. It was hoped the move to bring in Medical Examiners would further improve the issue with any death reviews of concern then taken to immediately to SIG.

ED Performance: the Committee Chair voiced his concerns about ED performance and asked for assurance that the department was safe. It was felt that on days when the flow to MAU and SAU was working well then performance was good – but currently that was not consistent. The other concern was the lack of consistency in the way consultants worked however performance metrics were now being discussed amongst clinicians. On a day-to-day basis it was felt the department was safe, but there were some concerns around the link between flow though the department and . mortality levels. The Committee Chair stated he would be looking to see an improvement in performance very soon.

62 Day Cancer Wait Pathway: the target had not been achieved in March 2018 and was unlikely to be achieved in April. Issues related to Urology and Lower GI Pathways and Urology staffing. Support had been requested from both Addenbrooke's and UCLH and availability of staff was currently being worked through. It was flagged that six or seven patients had deviated from the pathway and at least two or three of those had come to harm and there had been one death. The root cause was now fully understood and had been addressed however there would now need to be a look back at other potential cases of which, it was felt, there could be circa 250.

New Ambition to Reduce Gram Negative Blood Stream Infections (GNBSIs): the Committee was informed of the new NHS ambition to halve GNBSIs by 50% by 2020 /2021 as a health care economy approach. The ambition would require leadership from CCG Infection Prevention & Control teams and the Trust's team to work with CCG colleagues across the whole health and social care sector. GNBSI numbers were rising across the UK by 10% a year.

BAF Risks 1.1 (Clinical Outcomes) and 2.2 (Clinical Engagement): risk 1.1 remained unchanged and the recommendation to reduce the risk t rating for 2.2 from 16 to 12 was supported in principal but deferred until the June meeting. This would allow for the results of the Medical Engagement Survey to be received.

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

QSC received reports on the following items:

- Infection Control Monthly Update
- Quality Compliance Readiness 2018/19
- Quality & Safety Performance Report – CCCS

- Monthly Healthcare Group Update on Achievements, Performance and Risks (with mitigation) against each of the CQC Domains
- Report on Nursing, Midwifery and Care Staff Levels (Hard Truths)
- Monthly Serious Incident Report
- Mortality Report
- Quality Account Priorities
- Patient Experience Report
- Significant Risk Register
- Review of Risks Allocated to QSC
- Results of Ward Based Pharmacy Pilot (verbal)
- Plan for the Transition from Child to Adult Care
- Early Information on the Rollout of Criteria Led Discharge (verbal)
- Quality & Safety Dashboard
- Health & Safety Update
- Sharing the Learning Report
- CQUIN Update

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

The Committee is making good progress against its work plan.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 07/06/18 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM: Workforce Committee

REPORT FROM: **Pam Court – Committee Chair**

DATE OF COMMITTEE MEETING: **29/05/2018**

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• There were no changes to the BAF risks with workforce capacity remaining the most significant risk, with a rating of 20. The committee noted the workforce resourcing plan and safer staffing report in response to this risk. • As compliance with statutory and mandatory training (85% as at April 2018) remains of concern, it was agreed to establish a task and finish group, reporting to the WFC. The group will review training requirements and compliance by subject area and agree a rolling calendar of presentations by SMEs to the WFC. • Whilst sickness absence rates within the corporate functions were above target, there was an improvement from the previous month for most areas. Voluntary turnover was above target in two of the corporate functions although there was an improvement in the HR function. • The committee received its first ever report on volunteers and it was agreed to align this to the workforce report to provide visibility of the extended team by HCG and department. • The National Staff Survey results (which showed an improvement in 8 of the 32 key findings and no deterioration from the previous year) have now been analysed by the 9 protected characteristics to identify themes and actions (for example staff over the age of 51 were less positive about their experience and the under 30s reported more stress and anxiety). The HCGs and departments have developed action plans in response to both the positive findings and areas for development.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
The following are highlighted for the Board's awareness and/or assurance:
Workforce submission to NHSI – The final workforce plan for 2018/19 was submitted to NHSI and HEE at the end of April 2018. **Report on Staffing Levels** – Nurse vacancies had increased to 25.64% related to an increased establishment. There were 225.82 registered nurse vacancies. The committee also received the following reports: People Strategy and Plan 2018/19, NHSP Contract Update, Employee Relations Overview, NHS Terms and Conditions and Provisional Framework agreement.
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 is being developed and was discussed at the meeting; further refinements were suggested and the workplan will continue to be developed.

7.1

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 07.06.18 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM: Performance and Finance Committee
REPORT FROM: Andrew Holden - PAF Chairman
DATE OF COMMITTEE MEETING: 24.05.18

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

Annual Work Plan: the Committee would now start to receive:

1) A quarterly report on Board Members' expenses which, as of that month, would also be posted monthly onto the Trust's website
2) A quarterly review of the new Bank Staff contract with NHS Professionals.

OBC Update: a verbal update was provided in addition to a tabled timeline of the 100 Day Plan from PCBC to Public Engagement (May 2018 to March 2019). The Chairman raised concerns that the timeline was insufficient and requested it be revised and resubmitted the following month to pick up clear stages with confirmation of resourcing and provide key milestones (with dates).

Performance:

- **Paediatric ED:** the team attended to provide an update on performance since their presentation to the Committee. The Paediatric Assessment Unit (PAU) had been open five days per week since 24.04.18. Staffing and performance were slowly improving with an achievement of 100% that weekend. The team were congratulated for the progress made to date but it was acknowledged there was still more to be done.
- **Emergency Department:** performance remained challenging with an achievement of 73.67% for April, slightly above trajectory. Main pressures were overcrowding and staffing shortfalls evidenced by the large number of 12 hour breaches which are all being reviewed and to date no harm has been identified. Attitudes and behaviours were improving and it was felt the organisation was approximately 6-8 weeks off achieving consistent performance in the 80%-89% range.
- **RTT:** the Trust was still on its recovery trajectory and had achieved the agreed milestones for April and would repeat that in May.
- **Cancer:** the 62 Day Standard had not been achieved in March and was unlikely to be achieved in April mainly due to challenges in Urology. The view was that performance would recover by May.
- **Diagnostics:** performance remained strong.

Operational Data Quality: generally good progress being made with a couple of concerns in relation to discharge summaries/backlog and missing outpatient outcomes at freeze point. Work ongoing with the HCGs to address that.

CQUIN Update: The Trust has received formal agreement from West Essex CCG colleagues on the forecast outturn position for CQUIN: 85% payment of the 1.5% element and 100% of the 1% element of CQUIN, this equates to £2,299,384. PAF requested further assurance in relation to continued oversight of CQUIN performance and also around maximising income.

2017/18 Financial Outturn: an adjusted retained deficit of £28.4m.

Month 1 Finance Report: a £3.2m deficit against a planned deficit of £3.1m.

Coding: staffing vacancies in the team were adding to the pressure to hit flex and freeze dates. A case taken to EMB to increase resources but an intention now to recruit additional Band 4s and 'grow our own'.

BAF Risks: PAF reviewed BAF Risks 1.2 (EPR), 1.3 (Coding), 3.1 (Estate), 4.1 (Supporting Functions), 4.2 (ED) and 5.1 (finance). PAF supported the reduction of the risk rating for Risk 5.1 Finance from 20 to 15. The other risk ratings remained unchanged.

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

PAF received reports on the following agenda items:

- OBC Update
- Integrated Performance Report
- Paediatric ED
- Operational Data Quality
- CQUIN Update
- Outturn 2017/18 and Audit of Accounts
- M1 Finance Report
- Workforce Update
- Carter Progress Report

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

The Committee is making good progress against its work plan.