The Princess Alexandra Hospital NHS Trust

AGENDA

Public Meeting of the Board of Directors

Date and time: Thursday 6 February 2020
09.30 – 11.45

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

	Item	Subject	Action	Lead	
01 Opening Administration					
09.30	1.1	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from Meeting held on 05.12.19	Approve	Chairman	4
	1.4	Matters Arising and Action Log	Review	All	13
02 Staff Story					
09.35	2.1	Staff Story	Inform		14
03 Risk					
10.00	3.1	Significant Risk Register	Review	Chief Medical Officer	24
10.10	3.2	Board Assurance Framework 2019-20	Review	Head of Corporate Affairs	28
04 Chief Executive's Report					
10.15	4.1	CEO's Report	Discuss	Chief Executive	42
05 Patients					
10.30	5.1	Learning from Deaths Presentation (FAWS)	Discuss	Chief Medical Officer	46
10.45	5.2	Learning from Deaths Report	Assure	Chief Medical Officer	51
10.50	5.3	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing & Midwifery	56
06 Performance and Places					
11.00	6.1	Integrated Performance Report (IPR)	Discuss	Executives	65
07 Governance					
11.20	7.1	Reports from Committees: • QSC.24.01.20 • WFC.27.01.20 • PAF.30.01.20	Inform	QSC Chair WFC Chair PAF Chair	110 112 113
11.30	7.2	Report from Senior Management Team meetings: December 2019/January 2020	Inform	Chief Executive	114
08 Questions from the Public					
	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 Risks and Issues Identified	Discuss	All	
	9.3	Any Other Business	Review	All	
11.45	9.4	Reflection on Meeting	Discuss	All	

Public Board Meeting Dates 2020/21

02.04.20	01.10.20
04.06.20	03.12.20
06.08.20	04.02.21

The Princess Alexandra Hospital NHS Trust

Board Purpose:

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

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

The Princess Alexandra Hospital NHS
NHS Trust

1Minutes of the Trust Board Meeting in Public
Thursday 5 December 2019 from 09:30 – 12:30 at
Harlow Leisure Zone, Second Avenue, Harlow CM20 3DT

Present:	
Steve Clarke	**Trust Chairman (TC)**
Lance McCarthy	Chief Executive Officer (CEO)
Pam Court	Non-Executive Director (NED-PC)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Helen Howe (non-voting)	Associate Non-Executive Director (ANED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Andy Morris	Chief Medical Officer (CMO)
Trevor Smith	Chief Financial Officer (CFO)
George Wood	Non-Executive Director (NED)
Patient Story:	
Fiona Lodge	Head of Children's Services & Nursing
James Johnson	Specialist Nurse
Kerry Riches	Head of Patient Experience
Learning from Deaths:	
Julie Matthews	Associate Director of Operations – Surgery
Pam Humphreys	Associate Director of Nursing – Surgery
Observing:	
Dr. Amik Aneja	General Practitioner
Laura Warren	Associate Director of Communications
Members of the Public	
Dean Noble	Harlow Health Centres Trust
Revd Dennis Nadin	Member of Public
Peter Bolton	Epping Forest District Council
Finola Devaney	Director of Clinical Quality & Governance Designate
Apologies:	
Andrew Holden	Non-Executive Director (NED-AH)
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chairman (TC) welcomed all to the meeting particularly Dr. Amik Aneja from West Essex Clinical Commissioning Group (AA-WECCG) who would be observing the Board.
1.1 Apologies	
1.2	As above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Meeting held on 03.10.19	
1.4	These were agreed as a true and accurate record of that meeting with the following amendment: *Minute 5.18:* The Director of Nursing & Midwifery (DoN&M) clarified that bank and agency staff were included in the overall fill rate but not in the movement of staff.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising and no comments on any of the actions.

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02 PATIENT STORY	
2.1 Tate's Story	
2.1	The DoN&M welcomed and introduced the Head of Children's Services & Nursing (HoCS&N) and the HDU Facilitator (HDU-F) who would take members through a young child's journey through Children's Services at the Trust.
2.2	Tate was born on 02.07.18 and seven weeks later was admitted to PAHT having had several seizures – he underwent a number of tests. It was in late September that the Consultant at Addenbrooke's raised concerns about a possible genetic epilepsy disorder diagnosis. Tate then required genetic blood tests to provide a more specific and effective medication. In October 2018 his parents raised a concern as to the length of time it was taking to receive the blood test results, at which time it transpired that bloods had not been sent. Over coming weeks there were many difficult email conversations and at times communication with the family was tense.
2.3	Initially the single point of access for the family had been the HoCS&N but then the HDU Facilitator (HDU-F) took on more of a liaison role which, in hindsight, had been pivotal. There was liaison with GOSH to get the screening completed as quickly as possible (still took three months) and some face-to-face meetings. The HDU-F coordinated Tate's care plan in conjunction with his family and eventually Tate was diagnosed with Dravet Syndrome, a rare form of Epilepsy which can affect a child's overall development.
2.4	The challenges for the family were no single point of access, poor lines of communication, uncertainty and disruption to family plans. The lack of specialist advice for children's epilepsy with a limited offering by West Essex/Hertfordshire.
2.5	As a results of Tate's story the following improvements were made: • Named CNS for all children with a complex diagnosis. • CNS for Epilepsy to start 06.01.20. • Up to date care plan held by parents and the ED team and revised format Patient Passport. • Children's Expert Group to look at joint commissioning and to reduce inequalities across the STP.
2.6	The CEO thanked the team for sharing the story particularly those aspects which the hospital did not get right. The lack of a link with community services in Hertfordshire was concerning to him and needed to be addressed. He agreed to pick that up in future conversations with Hertfordshire Community Trust (HCT).
2.7	NED John Hogan (NED-JH) queried the delay in obtaining the blood test results. In response the HoCS&N confirmed lessons had been learned and at the time there had been operational issues at the tertiary centre. She agreed there needed to be clear communication with families around expected timescales for test results in order that expectations could be appropriately managed.
2.8	In response to a question from NED Pam Court (NED-PC) in terms of referral to hospice the HoCS&N confirmed that Tate had not met the criteria for that. His physical needs could be managed by his parents. She added that should Tate ever require step-down care following an episode in ITU, then Noah's Ark Hospice in Barnet offered that service.
2.9	Associate NED Helen Howe (ANED-HH) queried the procedure should Tate be admitted to the Emergency Department (ED) and the responsibility that placed on his parents. In response it was confirmed that both the ED and also Dolphin Ward (children's ward) had a copy of his 24/7 emergency care plan. In response to a further question it was confirmed that generally only complex patients had that type of care plan. It was noted that the ambulance service used a different algorithm for dealing with seizures so they had a copy too.
2.10	In response to a question from NED Helen Glenister (NED-HG) it was confirmed that in terms of the STP it was unlikely there would be just one-named person across the STP in terms of epilepsy care. Families just needed access to a named healthcare professional in an organisation who could 'unlock' the services they needed.
2.11	The CEO asked whether there were any other specialist areas or pathways where specialist nursing support was required. In response the HoCS&N stated that there were many

	children like Tate who didn't fall into any particular pathway or disease group. Ideally the Trust would have a Complex Needs Nurse who could also manage the transitioning element of care. The CEO suggested that this be discussed further offline.
2.12	The DoN&M thanked the team for their care and stated that the story was a good example of how the organisation had picked up an issue and made changes for the benefit of the patient/family.
03 RISK	
3.1 Significant Risk Register (SRR)	
3.1	This paper was presented by the Chief Medical Officer (CMO). Key points to note were that there were four risks scoring 20 all of which related to Theatres/Theatre Roof leaks. He highlighted there were two new risks (missing from the paper) around issues in the Breast and Hysteroscopy Services.
3.2	In relation to the risks in Theatres and in response to a question from NED-HG, the Director of Strategy (DoS) stated that the Trust had applied for a capital sum (£4.3m) which had been approved and anticipated the roof issue would be addressed by the end of December.
3.3	In relation to the EPMA system ANED-HH was able to provide assurance that an unannounced walk-around requested by the Quality & Safety Committee (QSC) had confirmed that mitigating actions were in place and were working.
3.4	In response to a concern raised by ANED John Keddie (ANED-JK) in relation to the leaking roof in Theatres the CEO and DoS were able to confirm that although it was a significant risk, the number of operations cancelled was small and it was hoped the issue would be resolved by the end of the month.
3.5	In relation to the two new risks mentioned at minute 3.1 above and in response to a question from NED-PC it was confirmed a breast fissure 2 machine had been damaged and a chair in Colposcopy needed to be replaced. Both would be addressed as part of the emergency capital programme.
3.2 Board Assurance Framework (BAF)	
3.6	This item was presented by the Head of Corporate Affairs (HoCA) and was taken as read. Members were asked to consider the recommendation that the finance risk (risk 5.1) be increased from 15 to 20 as had been discussed at the Performance & Finance Committee (PAF).
3.7	The Chief Financial Officer (CFO) clarified that whilst the organisation was seeing an improvement in recruitment, there was a degree of slippage and sickness causing the Trust to be off trajectory in terms of reductions in temporary staffing therefore increasing the risk for delivery of its control total.
3.8	Members approved the BAF and the increase in the rating of risk 5.1 (Finance) from 15 to 20. All other risks were noted and no changes recommended.
04 CHIEF EXECUTIVE'S Report	
4.1 CEO's Report	
4.1	The CEO presented his report. There was little change to key performance indicators (KPIs) since the previous meeting and performance against temporary staffing had been added as requested. He highlighted that the hospital had seen the highest number of patients ever the previous week (2614) in an ED originally built to see 60k annually but over recent years seeing just under 110k annually. Whilst performance was below where it should be, it was consistent, and had been for the whole year.
4.2	Paul Burstow, the Independent Chair of the STP had visited the Trust on 28.11.19 and the CEO thanked colleagues for their support with that visit. It had been agreed to establish a network of NEDs and Lay members across the STP, providing a voice and a route for further organisational development for NED and lay members of the Boards. He updated that the appointment process for the STP CEO post had been deferred into January and the Trust continued to work closely with partners within both STP and ICP across a number of clinical and non-clinical work-streams. A number of joint PAHT and West Essex CCG Executive Team meetings had taken place and a Board to Board meeting with WECCG

	would be held later that afternoon.
4.3	The CEO continued that whilst plans were being worked up for the new hospital, existing risks on the current site needed to be managed to maintain safety. A ward refurbishment programme was underway and Lister Ward had been handed back that week after a very successful revamp. The organisation continued its focus on Equality & Inclusion and had also recently held very successful events to celebrate International Men's Day and Black History Month. In line with the recent funding announcement he was pleased to report that a new CT scanner had been ordered and should be in place by the end of the financial year. As a final point he confirmed the Trust had been shortlisted in three categories of the Annual Nursing Times Awards which was a great recognition of the very high standards of care being provided by specialist teams and volunteers. In addition two patients had been presented with medals to mark more than 50 years of safely and successfully self-managing their diabetes at a special event at the hospital.
4.4	The Director of People (DoP) highlighted there had been 42.8% take-up from staff in responding to the recent Staff Survey which was circa 3% higher than the previous year. In response to a request from the DoP it was agreed to delegate authority to QSC for approval and submission of a Flu Checklist (self-assessment on preparedness) to NHSE/I by the end of December 2019.
ACTION TB1.05.12.19/21	**QSC.20.12.19 to approve submission of the Flu Checklist to NHSI/E by 31.12.19. Lead: Chair of QSC**
4.5	In response to a question from NED-GW it was confirmed compliance with the flu vaccine was currently at 53%, a similar position to the same time the previous year. Resistance to uptake was varied and some benchmarking against other organisations would take place to see if there were any areas of learning.
05 PATIENTS	
5.1 Learning from Deaths (Surgery)	
5.1	The Chief Medical Officer (CMO) welcomed the Associate Director of Nursing for Surgery (ADoN-S) and the Associate Director of Operations for Surgery (ADoOps-S) to the meeting. The ADoOps-S took members through the following patient journey: Jack, a 74 year old male had presented to ED with lower abdominal pain on the morning of 08.11.19. He was referred to the surgeons and a CT of his abdomen was requested. The CT confirmed a leaking infra-renal AAA. Jack became unstable and was transferred to theatre. Jack then underwent a four hour operation during which he lost a lot of blood and was then transferred to ITU. He remained very unwell for the following two days, family visited and a DNACPR order was agreed. A decision was also taken that if there was no improvement in Jack's condition, treatment may be withdrawn. On 12.11.19 the consultant requested a family meeting to discuss withdrawal of treatment. The family agreed with the request (and also a request for organ donation) and were then able to spend some time with Jack before he died later that day.
5.2	A multi-disciplinary team meeting a few days later concluded that: • Decision to admit the patient to ITU was appropriate. • Earlier intervention would not have changed the patient outcome. • No improvements to the patients care during admission would have changed the outcome. • The organ donation team was contacted appropriately for discussion. • No care concerns were identified.
5.3	Areas of good practice were deemed to be: • Regular communication with family through stay and good documentation in the notes. • DNACPR and end of life care made in discussion with the family. • Appropriate referral for organ donation and family present at the time of death. • Information received by family to take away to read later. • Mortality monitoring form completed and the case referred to the coroner as the patient had died within 30 days of abdominal surgery.
5.4	Following review of the patient notes and further discussion it was concluded there was

	nothing different that would have been done. The patient had a good death and the learning would be to share the good practice identified with the team.
5.5	The CMO thanked the team and highlighted that in terms of organ donation over the previous year, it had been found that of six patients who had been appropriate for referral, five had been referred which had led to four going forward for organ donation (OD). The Trust compared very favourably with its peers in terms of OD. He encouraged all members to consider becoming donors and where appropriate for families to be aware. NED-PC agreed and highlighted the need for a whole system approach to increase the numbers of donations made.
5.6	In response to a question from NED-GW it was confirmed the organ donation process was handled by NHSBT (NHS Blood and Transplant) and it was they who communicated with the family concerned, not the Trust. OD was covered by a programme of teaching for doctors, both under and post graduate and also for nursing staff.
5.7	The TC thanked the team for their care.
5.2 Mortality Update	
5.8	This update was presented by the CMO and the paper was taken as read. He reminded Board members that the aim had been to reduce mortality to 'as expected' and to eliminate mortality alerts to zero by December 2020. He was able to update that fractured neck of femur, acute sepsis and COPD were no longer alerting but pneumonia and AKI were. SHMI for the past two months had been 'as expected' as was in-month HSMR. The success of the newly appointed Medical Examiners who were now reviewing 100% of deaths was allowing structured judgement reviews to take place.
5.9	The Director of Quality Improvement (DoQI) drew members' attention to the successful pilot on the use of Procalcitonin for early identification of bacterial infections. Early results from the work had been very encouraging and it was hoped would help to reduce the use of antibiotics across the organisation.
5.10	In response to a question from ANED-HH it was confirmed that there was a mandatory review of certain categories of death (and others would then be added by the hospital). The results of those reviews would be presented to the Trust's Mortality Review Group and any concerns escalated to the Trust Board.
5.11	NED-HG requested assurance of the process to hand projects back to the relevant service once trajectories had been hit. In response the DoQI confirmed there was a project review process in place (which mirrored the CQC process) and reviews would be presented to the Mortality Improvement Board for sign-off. NED-JH confirmed that QSC had also raised the same question and echoed the concerns around COPD/pneumonia.
5.12	In response to a question from ANED-JK the CMO clarified that the graph at appendix 1 showed the long-term trajectory of hospital standardised mortality i.e. observed versus expected number of deaths in hospital. He cautioned that the 12 month rolling position did not provide an accurate picture as it could be up to 12 months before improvements showed in the data. Whilst visually it appeared performance was worse, he cautioned that statistically that was not the case. He accepted it was difficult not to focus solely on the numbers but in terms of relative risk the organisation was above where it should be. The CEO added there would be a continued strong focus on performance against mortality.
5.13	In response to a concern raised by NED-GW the CMO confirmed that performance in relation to acute kidney injury (AKI) had dipped very slightly. ANED-HH provided assurance that she was the NED champion for mortality and as such attended the AKI Group and confirmed there was a huge programme of work underway around mortality and particularly around the deteriorating patient which was key. The ME work would identify variations in care and the deteriorating patient so the reports from the MEs would be critical going forward and she would welcome seeing the outcomes from those. In response the CMO confirmed the software was now in place and the results of reviews should follow in January 2020.
5.3 Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	
5.14	This item was presented by the DoN&M and showed a positive picture. The overseas

	recruitment campaign continued via skype and the Trust would be looking to go out to recruit abroad again early in the next year. Turnover rates had reduced and there had been some new starters from the 'grow our own' cohort. She acknowledged the trajectory was slightly behind where it should be currently but she highlighted that some start dates had been delayed for reasons outside the Trust's control.
5.15	Members acknowledged the good progress.
5.4 Nursing Establishment Review	
5.16	This item was presented by the DoN&M and was the regular six month update on nursing and midwifery staffing levels to assure Boards of the systems in place around setting staffing levels correctly. The paper had been to Workforce Committee (WFC) and PAF the previous week and the recommendation was to uplift some of the medical ward establishments and also maternity. Appendix 5 reflected the nursing workforce intentions for 2020/21 and the recruitment strategy would be reviewed going into the following year. The workforce intentions could offset costs.
5.17	The CEO flagged the importance of having the right nurses with the right skill set to support safety and mortality. He acknowledged the costings set out in the paper were significant and relied on the transformation of the non-nursing element to support the gaps and was part of the on-going Modernisation Programme.
5.18	NED-PC stated that she fully supported the recommendations but cautioned that this would change the vacancies until the posts had been recruited into. The trajectories would change within ongoing recruitment.
5.19	In response to the above NED-GW provided assurance that PAF had discussed the figures in detail and had requested bank/agency costs into April 2020. ANED-HH flagged the issue of skill mix and encouraged the use of Nurse Practitioners and Healthcare Support Workers.
5.20	The Board supported the outcome and recommendations of the July 2019 nursing and midwifery establishment review.
5.5 PAHT Clinical Strategy	
5.21	This paper was presented by the DoS. He noted that the strategy was part of a much wider system strategy and would be important in the move towards an Integrated Care Trust. It was based on the framework of PAHT 2030 i.e. one vision three goals (integrated, modern and outstanding) and the Trust's 5Ps and had been developed bottom up and in conjunction with clinical teams.
5.22	Half of the required workshops had been completed with the aim of having a first draft of the strategy ready in early Spring 2020 for sign-off through to September. Currently work was on track but was time consuming.
5.23	NED-HG stated that she felt assured by the work already undertaken and with the external input into some of the services/areas.
5.24	In response to a question from NED-JH it was confirmed that Primary Care had been involved in some of the discussions.
5.25	The TC thanked the DoS for his update.
5.6 Seven Day Services	
5.26	This item was presented by the CMO and requested retrospective approval (due to the timing of the Trust's Board meeting) of the NHSI/E self-assessment of compliance with the six monthly NHS Clinical Standards for 7 Day services and was the second formal submission. The priority standards which all Trusts were measured against were: Standard 2: **Time to initial consultant review** Standard 5: **Access to diagnostics** Standard 6: **Access to consultant-led interventions** Standard 8: **Ongoing daily consultant-directed review**
5.27	In relation to standard 2 (patient not seen by a consultant within 14 hours of arrival) he cited an example where a patient was admitted to a bed at 09:05 (so missed the consultant round) and was then seen the following day at the end of the consultant round – that would

	flag as over 14 hours. It clearly did not mean the patient wasn't seen, just not within the target set. He highlighted that patients were admitted by a decision maker.
5.28	In response to a concern raised by NED-JH in relation to performance against standard 2 particularly on Tuesdays, it was acknowledged that improving performance against this standard was an area of focus and had been included in the Trust's internal professional standards which had been shared with NED-JH.
5.29	The Board retrospectively approved the Board Assurance Framework for submission to the 7 Day Services Regional Team by the deadline of 29.11.19.
Members took a ten minute break	
06 PEOPLE	
6.1 Freedom to Speak Up Self-Assessment	
6.1	This item was presented by the DoP. She informed members the self-assessment reflected where the Trust had met/partially met or not met the expectations along with the supporting evidence and actions since its last review in May 2019. The partially or not met expectations related largely to ensuring that cases were regularly audited or peer reviewed. Having a positive 'raising concerns culture' did not lie with any single part of the Trust and therefore the self-assessment should be read as part of Trust's overall organisational culture specifically how the trust engaged with and supported its people.
6.2	Both the TC and NED-HG (FTSU NED champion) confirmed they met regularly with the Trust's guardians to ensure they were fully supported in their role.
6.3	The Board approved the self-assessment.
07 PERFORMANCE AND PLACES	
7.1 Integrated Performance Report (IPR) *(28 minutes)*	
7.1	This item was presented by the Chief Operating Officer (COO) and headlines under the organisation's 5Ps were as follows: **Patients:** data remained positive. Complaint response timelines were being revised and the Birthing Unit had reopened following issues with water quality. There had been an equipment fire in the maternity theatre but swift action had been taken by staff. The matter had been discussed at QSC.
7.2	**Performance:** in Diagnostics there were no areas of concern and the national standard was being met. Cancer performance continued to be ahead of trajectory and for the second month the 62 day standard had been achieved closing at 85.2% for the previous month. RTT was slightly behind the national standard but on track in terms of the Trust's internal recovery plan.
7.3	**Emergency Care:** the previous week had seen the highest ever number of attendances at 2614 and teams continued to work under increasing pressure. Support from ECIST continued and plans were on trajectory for the opening of the Urgent Treatment Centre later that month. The new frailty service had gone live that week and work was ongoing with primary care colleagues to identify those GP practices with high ED referrals. Fortnightly performance calls continued with NHSI/E. In terms of length of stay (LoS) performance was improving as it was for stranded patients. In terms of additional capacity once the refurbishment of Ray Ward was complete that would release 18 beds on Nightingale Ward at the end of December (model of care being worked up). Agreed intermediate care beds would come on stream in December/January and discussions were underway with Essex County Council and Commissioners for further additional capacity from January.
7.4	In response to a question from NED-JH it was confirmed that the new appointments in the ED were, in effect, filling existing vacancies. The organisation was working with two recruitment agencies for emergency care in an attempt to fill all vacancies in that area. Once all newly appointed middle grade staff were in post the ED team would be at establishment.
7.5	NED-GW flagged that in a time where the organisation was seeing its highest attendances ever, it was important to point out that compliments had doubled and complaints halved. The DoP flagged an action from a previous Board Development session had been to circulate key messages from the Board and she felt that would be a good one to start with.

ACTION **TB1.05.12.19/22**	**Highlight in staff communications the number of compliments received and reduction in complaints.** **Lead: Director of People**
7.6	In response to a question from the TC it was confirmed that Nightingale Ward was expected to be up and running by 30.12.19 (following completion of the refurbishment of Ray Ward) and following a similar programme of work in ITU/HDU, teams would be ready to move back in around 22.12.19 which would free up capacity on Harvey Ward (general medical).
7.7	**People:** the focus that month had been on temporary staffing. A key area for further review would be time to hire. There had also been a focus on the 'flu campaign.
7.8	**Places:** the Trust had been awarded £4.3m emergency capital to address some of its key estates issues. It should be recognised a significant amount of investment would now be required over the second half of the year. Planned preventative maintenance was being reviewed and a three year programme of work would be put in place for improved oversight. The Catering team had received a compliment from a whole ward area for the quality of its food.
7.9	**Pounds:** financial performance remained a significant concern with the organisation currently £4.1m off plan approaching year-end. There would be a focus on trajectories moving forward, including recruitment plans and associated actions to maximise that improvement and to ensure an entry run rate for delivery of the following year's control total. Capital spend would need to be progressed urgently during the remainder of the year and the Internal Audit of CIPs would be brought forward to Q4 to ensure robust plans were in place for the following year. In response to a question from NED-GW it was confirmed if any additional funding was received before the end of the financial year the organisation would struggle to spend it within the current capital plan.
7.10	The COO reported that circa £390k revenue funding for winter pressures had just been received and had been allocated to schemes. Other discussions were ongoing in relation to additional revenue support for elective capacity and other work streams.
7.11	As a final point the CFO stated that historically the capital plan had been an annual plan but was now moving towards a three to five year plan to better reflect the organisation's needs.
08 GOVERNANCE	
8.1 NED Committee Membership Changes	
8.1	The TC reminded members that at a recent Board Development session it had been agreed to rotate the Chairs of the Board Committees. Proposed changes were detailed in the paper and were to be effective from January 2020.
8.2	NED-PC flagged she had already discussed with NED-AH the chairing of PAF meetings at the beginning of the year due to her inability to make diary changes. The TC agreed the aim would be to have the majority of changes in place six months before the next anticipated CQC visit where possible.
8.3	Members approved the recommended changes.
8.2 Reports from Committees	
8.4	QSC.22.11.19 – Chair NED-JH The Committee had discussed Outpatient Review Lists, the chemotherapy management system and that the Birthing Unit had now re-opened. WFC.25.11.19 – Chair NED-PC The Committee had discussed the possibility of lowering the rating for its risk around nurse recruitment but on reflection had decided to wait a couple of months in light of the good progress currently being made. PAF.28.11.19 – Chair NED-AH There were no additional comments. AC.04.12.19 – Chair NED-GW Internal Audit had given an opinion of limited assurance around PPM but had been content with the robustness of the work plan now in place. It had been agreed to bring the audit of CIPs forward to Q4 and there were some concerns in relation to the new finance system which would come on line in February during the team's move to new premises. There had

	been agreement that the tendering of the Internal Audit contract would be deferred to circa Q2 of 2020/21.
8.3 Report from Senior Management Team Meetings (October/November 2019)	
8.5	This paper was presented by the CEO and key discussions from the last two meetings were noted.
09 QUESTIONS FROM THE PUBLIC	
9.1	Reverend Dennis Nadin (RDN) took the opportunity to inform the Board of his concerns around the Trust's complaints process, with reference to his own personal experience and apparent lack of response from the Trust. NED-JH thanked RDN for bringing his concerns to the attention of the Board and agreed to work directly with the DoN&M to resolve all the issues.
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 issues or risks were identified.
10.3 Any Other Business	
10.3	There were no items of AOB.
10.4 Reflection on Meeting	
10.4	Members agreed there had been issues with the acoustics in the room which would need to be addressed going forward. Members were also reminded of their use of acronyms.

Signed as a correct record of the meeting:	
Date:	06.02.20
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 06.02.20

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.05.12.19/21	NHSE/I Flu Checklist	QSC.20.12.19 to approve submission of the Flu Checklist to NHSI/E by 31.12.19.	Chair of QSC	QSC.20.12.19	Actioned.	Closed
TB1.05.12.19/22	Key Messages to Staff	Highlight in staff communications the number of compliments received and reduction in complaints.	DoP	TB1.06.02.20	Promoting the increase in compliments and decrease in complaints will be highlighted as a full year number at year-end as this gives a complete and solid number that will provide comparison year-on-year. The details will be included as an article in In-Touch magazine and in our annual report, quality account and also included in the *Our year* annual review magazine. We continue to feature compliments in our #FeedbackFriday messaging on our corporate social media platforms and patient compliments are shared within many of the videos we post.	Open

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Hello!

My name is Laura Wood
& this is who I am …..

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Content

1. About Me
2. My Roles and Responsibilities
3. Chosen career
4. What I have found most rewarding and challenging
5. Who inspires me
6. Improving quality of patient care
7. Aspirations for the future

About me

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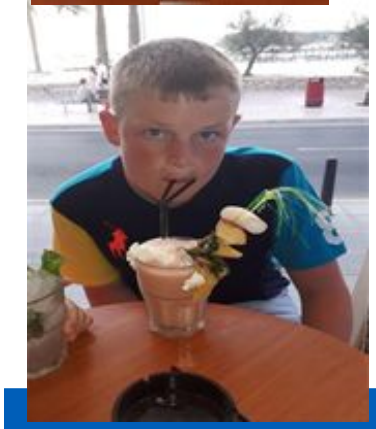

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My Roles and Responsibilities

The Princess Alexandra Hospital NHS Trust

Chosen career

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What I have found most rewarding and challenging

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- Waiting times
- Breaches
- Team work
- Specialities
- Patient journey
- Accident and emergency not anything and everything

Who inspires me

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Improving quality of patient care

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Aspirations for the future

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Thank you

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TRUST BOARD - 6 FEBRUARY 2020

3.1

Agenda item:	3.1
Executive Lead:	Dr Andy Morris – Chief Medical Officer
Prepared by:	Lisa Flack - Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Governance & Quality
Date prepared:	24 January 2020
Subject / title	Significant Risk Registerd

Purpose:	Approval		Decision		Information	√	Assurance	√

Key issues:	This paper presents the Significant Risk Register (SRR) and was produced from the Risk Assure system using the risk registers for all our services. There are a total of 87 risks with a score of greater then 15: • There are no risks with a score of 25 • There are 20 risks with a score of 20, increased from 18 on 25/11/2019. A summary of each risk is detailed within section 2.4-2.8 • 18 risks have a score of 16, the same as previously reported. • 49 risks have a score of 15, increased from 45 in 25/11/2019. Two new risks with a score of 16 have been raised over the last two months: One for a reduction in the size of the research team impacting patients recruited onto trials and the second for long term vacancies of medical consultants. Both have robust mitigation in place. Two new risks with a score of 15 have been raised over the last two months: • A gap in the number of outpatient clinic slots available for new rheumatology referrals • Requirement to provide computerised CTG analysis and growth scans from their first trust attendance, section 3.3.
Recommendation:	Trust board is asked to: i) Note the content of the Significant Risk Register

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

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

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3.1

Significant Risk Register

1.0 INTRODUCTION

This paper details the Significant Risk Register (SRR) across the Trust; the registers were pulled from the web based Risk Assure system on 23 January 2020. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks. There is an annual work plan so each areas register can be reviewed in detail on a rotation.

2.0 CONTEXT

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

2.2 There are 87 significant risks on our risk register which has increased from (81) in the previous paper for December. The breakdown by service is detailed in the table below.

	Risk Score				
	15	16	20	25	Totals
CCCS	12 (11)	4 (5)	2(2)	0 (0)	18 (17)
Estates & Facilities	5(3)	0 (0)	0(0)	0 (0)	5 (3)
Finance	1 (2)	0 (0)	1 (2)	0 (0)	2 (2)
Information Data Quality and Business Intelligence	1(1)	0(0)	0(0)	0(0)	1(1)
Non-Clinical Health & Safety	2(2)	0 (0)	0 (0)	0 (0)	2(2)
Nursing	1 (0)	0 (1)	0 (0)	0 (0)	1 (1)
Operational	1 (1)	0 (0)	4 (4)	0 (0)	5 (5)
Research, Development & Innovation	0(0)	1(1)	0(1)	0(0)	1(1)
Resilience	1 (1)	0(0)	0(0)	0(0)	1 (1)
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Child Health	2(1)	0 (0)	0 (0)	0(0)	2 (1)
Safeguarding Adults	1(1)	0(0)	0 (0)	0 (0)	1 (1)
Safeguarding Children	0	1	0	0	1
Women's Health	5(4)	2(2)	0 (0)	0 (0)	7 (6)
Medicine	4 (4)	5 (6)	9 (8)	0 (0)	18(17)
Surgery	13 (13)	4 (4)	4 (0)	0 (0)	21(17)
Totals	49 (45)	18(18)	20(18)	0 (0)	87 (81)

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

2.3 The Trust has no risks scoring 25.

There are 20 risks with a score of 20; this has increased from 18 reported to Board in the December 2019 summary. A summary of these risks are:-

2.4 Patients

2.4.1 EPMA system

- Dose reductions to be applied as directed by user and not incorrectly interpreted by the EPMA system (CMS/2019/360 on register since January 2019)
- Applying a dose reduction to oral chemotherapy on a different administration days needs to be correctly applied on EPMA (CMS/2019/383 on register since February 2019)

2.4.2 Frailty service

- Operational concerns that will impact on patient safety and experience. (Frail-01 raised March 2019 with score increased in November 2019)

2.4.3 Theatres

Roof over theatre leaks causing an impact on use of theatres during periods of rain resulting in cancellation of planned procedures.

- Theatre 1 roof leaks (THE 006/2019, initially raised on 31/10/19).
- Theatre 6 roof leaks (THE 007/2019, initially raised on 31/10/19).
- Theatre 7 roof leaks (THE 008/2019, initially raised on 31/10/19).
- Roof leaks into the consumable/drape store (THE005/2019 initially raised on 31/10/19, linked to THE 006/2019 and 007/2019).

2.5 People

2.5.1 Nursing staff numbers

- Three clinical areas have insufficient numbers of Registered Nurses – Harold (JS02), Fleming- MAU (03) and Saunders (Saun04) all on the register since July 14),

2.6 Performance

2.6.1 ED performance

- Statutory compliance risk for failure to deliver 4 hour ED standard (001/2017 on register since April 2014).
- Quality and safe care impacted by failure to deliver the 4 hour ED standard, on Medicine teams register (MED57 on register since July 2016).
- Quality and safe care impacted by failure to deliver the 4 hour ED standard, on the Medical teams risk register (ED012 on register since July 2016).
- No patient will spend a journey time greater than 12 hours from arrival in ED to discharge from ED (002/2016 raised July 2016)
- No ED patient to wait for longer than 12 hours to be admitted (003/2016 on register since July 16).

2.6.2 Cancer access standard

- Failure to achieve 85% of all patients referred by GP to receive treatment within the cancer 62 day standard (005/2016 on register since July 2016)

2.6.3 Dermatology Clinic Capacity

- Insufficient clinic capacity to follow up exiting Dermatology patients, on a review list and on high risk drugs. (Derm003 initially raised April 2018 with the score increased in December 2019)

2.7 Places

2.7.1 Endoscopy

- The unit requires an air handling unit as current facilities do not comply with H&S statutory building recommendations (Endo 080719, on register since July 2019)

2.8 Pounds

2.8.1 Income and Expenditure

- Failure to deliver financial control target leading to breach in statutory duty and loss of PSF/FRM monies. (FIN001 initially raised July 2016 but review and risk score increased in December 2019)
- Meeting income target at risk with possible income deficit likely to be 4 million overspend by end of financial year (Med61 initially raised this risk in 27/12/17, the score was increased to 20 on 11/19.

3.0 New Risks on the Significant Risk Register

3.1 In addition to the two new significant risks scoring 20 detailed above (2.6.3 and 2.8.1), the trust has raised the following risks onto the significant risk register since 25 November 2019

3.2 Risk Score of 16

- A reduction in the size of the research team as a result of reduced funding from National Institute for Health Research NIHR, (R&D21.1.20-03).
- High number of Acute Medical consultant vacancies, funded for 7.0 and have 0.7WTE in post (Med070)

3.3 Risk Score of 15

- Trust cannot provide computerised CTG analysis and growth scans from their first trust attendance, this is a requirement of Saving Babies lives care bundle 2, (2019/12/01).
- Dermatology service does not have sufficient outpatient appointments to meet the number of new referrals received (Admin/2010/06)

4.0 RECOMMENDATION

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

The Princess Alexandra Hospital NHS
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Trust Board - 6 February 2020

3.2

Agenda Item:	3.2
Presented by:	Heather Schultz - Head of Corporate Affairs
Prepared by:	Heather Schultz - Head of Corporate Affairs
Date prepared:	29 January 2020
Subject / Title:	Board Assurance Framework 2019/20

Purpose:	Approval	x	Decision		Information		Assurance	

Key Issues:	The BAF risks are presented for review. The risks have been reviewed with Executive leads and discussed at the relevant Committees in January 2020. Appendix A provides an overview of all the risks and the proposed risk ratings. There are no changes to the risk scores this month.
Recommendation:	The Board is asked to approve the Board Assurance Framework.

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

Previously considered by:	WFC 27 January 2020, PAF 30 January and QSC 24 January 2020.
Risk / links with the BAF:	As indicated in the attached BAF
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with the Code of Governance, CQC Well - led Framework.
Appendices:	Appendix A - summary of risks

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

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2019-20

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

The Princess Alexandra Hospital NHS Trust

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, integrating care with our partners and improving our CQC rating													
BAF 1.1		Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Unwarranted variation in care ii) System wide flow	**4 X 5= 20**	Director of Nursing/ Chief Medical Officer **Quality and Safety Committee**	i) Robust quality and safety governance structures in place including infection control ii) Robust Appraisal of medical and nursing ~~revalidation process (3 positive peer reviews) - 360° feedback and Fitness to Practice process in nursing~~ ~~iv) RCA methodology workshops~~ iii) End of Life and deteriorating patient simulation programme for all staff, ICP and ICS iv) ~~Mandated & focused~~ Education & training in communication skills such as breaking bad news training. v) Sharing the Learning Programme vi) Commissioner reviews and engagement in quality and Safety processes vii) Risk Management Training Programme viii) Escalation prescribing processes ix) Electronic handovers, Hospital at Night and E-Obs and observation compliance reports x) Schwartz Rounds xi) NHSI/NHSE Oversight xii) Pres2 Green Board rounds supported by ECIST xiii) Patient Experience Strategy xiv) NED lead appointed for Mortality xv) Mortality Strategy including dashboard, tracker, updates on workstreams and learning from deaths. xvi) ~~Introducing~~ '15 steps' walkabouts ~~from January 2019~~ xvii) Nursing Establishment review (bi-annually) and succesful nursing recruitment campaign xviii) Safer Staffing policy xix) Real time patient feeback implemented across all wards ~~xxi) Robust management of periodic and increased incidences of Infection Control (MRSA/VRE and Pseudomonas)~~ xx) Robust management of variations in neonatal outcomes xxi) Engagement in external reviews MBRRACE,HSIB and LeDeR and Healthcare Safety Investigation Branch (maternity) xxii) Medical examiners (MEs) and Lead ME appointed and Mortality Surveillance Group established xxiii) Complaints workshops held xxiv) Joint GIRFT and Model Hospital quality improvement programme xxv) Patient flow module live xxvi) Electronic fluid prescribing pilot live xxvii) Appointment of medical PS&Q leads xxviii) Complaints process being revised and grading system introduced xxix) Fab Change accreditation	i) National Survey ii) Cancer Survey iii) CEO Assurance Panels iv) SIG meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings, PRMs and Patient Experience meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings/ Vulnerable Patient Group x) PLACE Inspections xi) Medicines Management Committee xii) End of Life and Mortality Surveillance Group xiii) AKI & Sepsis Group xiv) Urgent Care Improvement Board xv) Deteriorating Patient Group xvi) Cardiac arrest review panels xvii) Weekly Long Length of Stay meetings	i) Improvement in some areas of the National Inpatient Survey and NACEL Survey ii) CEO Assurance Panels (as required) iii) Reports to QSC on Patient Experience January 2020, monthly Serious Incidents, monthly Safer Staffing, Patient Panel January 2020, Safeguarding, monthly Infection Control v) Monthly Mortality Improvement report to QSC including updates on ME reviews and monthly IPR report vi) Dr Foster reports, CQC inspection reports (March 18 and draft June 19) and GIRFT reports vii) Real time Dr Foster reports and engagement viii) GMC Survey results (July 2019) and WFC report Nov 2019 ix) Clinical Audit internal audit report 18/19 - tiaa (limited assurance) v) CMO/CFO Coding Meetings and quarterly Coding reports to PAF vi) Positive staff survey outcomes (2019) measuring safety culture and engagement vii) Freedom to Speak Up Guardians quarterly reports to WFC (Nov 19) and Guardian of Safe Working reports to Trust Board (Dec18). viii) Patient stories and learning from deaths presentations to Public Board meetings (bi-monthly) ix) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) x) International Nurse Recruitment business case to SMT/PAF and Board (June/July 19) xi) Presentation to Board on role of Medical Examiner (Jan 2020)	**4x4=16**	Lack of modernisation in some reporting processes including: i) Clinical audit plan developed and to be implemented - improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site footprint and bed constraints iv) Access to Qlikview v) NICE - ~~oversight of guidance that Trust has decided not to implement~~ oversight and management of compliance with guidance vi) Frequency and consistency of approach to mortality reviews **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey action plan in place iii) Ongoing work with Dr Foster in relation to mortality iv) Review of quality/safety and risk leadership structure v) NHS Patient Safety Strategy 2019 published. Trust to review and align to best practice vi) Structured Judgement Review champions being appointed	i) Clinical evidence of improvements made following compliance with national audits, NICE,NCEPOD. ii) Demonstrating an embedded learning programme from Board to ward.	08/01/2020	Risk rating not changed	4x3 =12 (Target date March 2020 - to review progress against Mortality Improvement Strategy workstreams
			Effects: i) Increase in complaints/ claims or litigation ii) Persistent poor results in National Surveys iii) Poor reputation iv) Recurrent themes in complaints involving communication failure v) Loss of confidence by external stakeholders vi) Higher than expected Mortality rates											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, integrating care with our partners and improving our CQC rating **Strategic Objective 5: Our Pounds - we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2019/20 and our local system control total**													
BAF 1.2		**EPR** Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes.	Causes: i) Poor engagement with the system, usability, time/skills ii) Timely system fixes/enhancements	**5 X 4= 20**	Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iv) Performance Mgt Framework in place. v) Training programme. vi) Super users in place to deliver focused support. vii) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability viii) Access Policy ix) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) x) Development of capacity planning tools/information xi) PWC review and actions identified xii) ICT Newsletter issued xiii) Daily ICT/COSMIC meetings ongoing xiv) Real time data now available xv) CDS 011 now live xvi) Maternity MDS configuration completed. xvii) Monthly Contract Performance monitoring meeting with supplier established.	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews vii) Monthly EPR Board to Board meetings viii) Exec to Exec meeting on 25.11.19	i) Weekly Data Quality reports to Access Board and EDB ii) External Audit reports to Audit Committee on Quality Account Indicators (July 19 - adverse conclusion) iii) Monthly DQ reports to PAF and quarterly ICT updates iv) EPR outline business case developed and presented to SMT and PAF September 19.	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Compliance with refresher training vii) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed. Responsiveness and quality of delivery of PFM - testing processes and actions identified by tiaa internal audit (limited assurance).	23.01.20	Risk rating unchanged	**4x3=12 end of March 2020 (subject to monthly review of progress)**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** i) Ongoing training and support ii) Re-establishing relationship/engagement with Cambio iii) Refresher training underway iv) Revised roadmap to incorporate new statutory/legal requirements e.g GDPR				

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

The Princess Alexandra Hospital Board
Assurance Framework 2019-20

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results. **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
BAF 2.1		**Nurse Recruitment** Inability to recruit sufficient numbers of registered nurses.	**Effects:** 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	5 X 4 =20	Director of People and Director of Nursing **Workforce Committee**	i) Participation in local and regional job fairs ii) Targeted overseas recruitment activity and proactive recruitment campaigns iii) Apprenticeships and work experience opportunities iv) Use of new roles in line with national direction v) Use of recruitment and retention premia as necessary vi) Use of TRAC recruitment tool vii) Use of a system to recruit pre-qualification students viii) Working in collaboration with STP and LWAB ix) Lead Nurse for Recruitment and Retention appointed x) Retention plan in place	i) PAF, QSC, WFC, EMT, SMT, Workforce and Board meetings ii) PRMs and Health Group Boards iii) Recruitment and Retention Group iv) People Board	i) Safer Staffing Reports (monthly to QSC, WFC and bi-monthly to Board) ii) Workforce report (progress on recruitment, retention, bank and agency) to WFC 27.01.20 iii) Incident reporting and monthly SI reports to QSC iv) Internal Audit report 18/19 on Recruitment (substantial assurance) v) International Nurse recruitment business case to SMT, PAF (June 2019) and Board (July 2019) vi) Monthly IPR report	4 x 4 = 16	i) Limited ability to influence some of the pre-employment timeframes due to external requirements e.g. NMC registration Actions: Registered nurse vacancy rate to be included in IPR Ongoing monitoring of pre-employment phase of recruitment process to minimise delays	None noted.	14/01/2020	**Risk rating not changed.**	**4 x 3 = 12** ~~**January**~~ **March 2020 (on achieving end year position of less than 10%)**
			Effects: i) Pressure on existing staff to cope with demand leading to overworked staff and increased sickness ii) Low staff morale and impact on engagement iii) Shortcuts and failure to follow processes and procedures due to workload and fatigue leading to higher chances of patient safety errors occurring iv) Lower staff retention rates v) Reduced attendance at training courses vi) Impact on patient experience										

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

The Princess Alexandra Hospital Board
Assurance Framework 2019-20

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results. **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
2.3		**Workforce:** Inability to recruit, retain and engage our people	**Effects:** i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels	**4 X 4 =16**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) Event in a Tent held annually viii) Staff recognition awards held locally and trust wide annually ix) Enhanced controls around temporary staffing x) Line Manager development programme underway xi) Behaviour workshops held xii) New consultant programme launched xiii) Staff engagement groups and Staff Council xiv) International recruitment programme for nurses and ED doctors xv) Medical staffing review underway	i) WFC, QSC, SC, PAF, WFC, SMT, EMT. ii) People board iii) JSCC, JLNC iv) PRMs and health care group boards	i) Workforce KPIs reported to WFC bi-monthly and IPR (monthly) ii) People strategy deliverables iii) Initial Staff survey results 2019 (WFC Jan 2020) iv) Staff friends and family results (WFC Nov 19) v) Medical engagement surveys, action plans and GMC surveys (WFC November 2019)	**4 x3 = 12**	Pulse surveys targeted for all staff Communications strategy Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Roll out of e-rostering to all areas Actions i) Implementation of communication strategy - Q4 ii) Recruitment plans for medical staff - ~~Q2~~ iii) New consultant development programme - Q3 iv) Extranet for staff - Q1 20/21	None identified.	04/11/2019	**Risk score not changed.**	**4 x2 = 8 (at end of 5 year People Strategy but to be reviewed in March 2020)**
			Effects: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.1		**Estates & Infrastructure** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Lack of capital investment, iii) Current financial situation, iv) Inherited aged estate in poor state of disrepair v) No formal assessment of update requirements, vi) Failure to comply with estates refurbishment/ repair programme historically, vii) Under-investment in training of estate management & site development viii) Inability to undertake planned preventative maintenance ix) Lack of decant facility to allow for adequate repair/maintenance particularly in ward areas. x) Key workforce gaps in compliance, energy and engineering.	**5 X 4= 20**	Director of Strategy **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report received (£105m) iii) Potential new build/location of new hospital iv) Capital programme - aligned to red rated risks. v) STP Estate Strategy developed and approved. vi) Modernisation Programme for Estates and Facilities underway vii) Robust water safety testing processes viii) Annual asbestos survey –completed and red risks resolved. ix) Trust's Estate strategy being developed as part of Project Genesis (Our New Hospital) x) Annual fire risk assessment completed and final report received, compliance action plan being developed. xi) New estates and facilities leadership team in place x) Sustainability Manager in post xi) Emergency Capital funding £4.3m	i) PAF and Board meetings ii) SMT Meetings iii) Health and Safety Meetings iv) Capital Working Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings viii) Project Genesis Steering Group	i) Reports to SMT (as required) ii) Signed Fire Certificate iii) Annual H&S reports to Trust Board and quarterly to PAF (Oct 19). v) Ventilation audit report vi) Water Safety Report (PAH site) vii) Annual and quarterly report to PAF- Estates and Facilities (Nov 19) ~~viii) PLACE Assessments (Audit report May 18)~~ ix) IPR monthly x) Sustainability report to PAF (Jan 20) xi) Internal Audit report (Iiaa) - review of PPM (limited assurance report) - Audit Committee Dec 2019, action plan in place	**5x4=20**	i) Planned Preventative Maintenance Programme (time delay) and amber backlog maintenance risks now emerging red risks ii) Ventilation systems iii) Sewage leaks and drainage iv) Electrical Safety/Rewiring (gaps) v) Maintaining oversight of the volume of action plans associated with compliance. viii) Sustainability Management Group to be established **ACTIONS:** i) Backlog maintenance review underway and alignment of capital to identified risks with business cases to support investments. ii) EBME review underway iii) Review of estates function underway iv) Compliance action plan (including PPM) in place	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.	07/01/2020	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iii) The resources required for delivery at a programme and workstream level have not been defined or secured iv) The current governance structure is under development given the shift in focus from planning to delivery. v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS Strategy Committee	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) STP Estates Strategy being developed. viii) STP Clinical Strategy in place ix) STP wide Strategy Group implemented x) Independant STP Chair and independant STP Director of Strategy appointed.	STP CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) STP Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and STP updates iii) STP report to Strategy Committee (Oct 2019) iv) STP lead's presentation to Trust Board (Aug '19).	**4 X 4= 16**	Lack of STP demand and capacity modelling. **ACTIONS:** System agreement on governance and programme management System leadership capacity to lead STP-wide transformation Trust to nominate representatives on proposed STP/ACP workstreams		07/01/2020	**No changes to risk rating.**	**4x3=12 March 2020**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

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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 falling to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we falling to gain evidence that our controls/systems, on which we place reliance, are effective			
						Evidence should link to a report from a Committee or Board.								
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.3		**Strategic Change and Organisational Structure** Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	**Causes:** i) Staff and stakeholders lack of awareness and/or understanding of drivers and issues cross the system ii) Scale, pace and complexity of change required. iii) Infrastructure (IT, buildings) not supportive of change iv) Financial resources lacking to support change v) Focus on immediate operational and financial priorities versus the longer term strategic planning vi) Lack of clarity regarding contracting and organisational models in support of ICP vii) Management resource and team with relevant capability and skills to drive change and strategy development to be developed. viii) Uncertainty around future CCG structure and relationships	**4 X 4= 16**	DoS Strategy Committee	i) Good relationships with key partner organisations ii) CEO chairing ICP Board iii) CEO and Chair attending STP meetings iv) Clinical Strategy being developed. v) Strategy Committee established vi) Development of MSK service and engagement of senior clinicians. vii) One Health and Care Partnership established viii) Financial principles for integrated working developed, allocative contract and due diligence underway ix) NHSE/I assurance process underway x) Legal advice sought on governance and staff transfers xi) Transformation plan in development	i) ICP Board and STP meetings ii) Expert Oversight Groups and workstreams (finance,people, IT) iii) ICP senior leaders meetings iv) Executive to executive meetings and Board to Board meetings (as required)	i) ICP Reports to Strategy Committee ii) CEO report to Board (bi-monthly) iii) ICP update Board development session Jan 2020	**4x3=12**	i) Data quality impacting on business intelligence (SLR) **ACTIONS:** ~~Trust's vision and mission statement being refreshed and 5P plans underway.~~ Strategy team being developed PAH long term strategy being developed	Reporting from EOGs/workstreams to be established Development of governance structures for integration and legislation CCG Accountable Officer process delayed and underway	07/01/2020	**Risk rating not changed.**	4 x 2= 8 **March 2020**
			Effects: i) Poor reputation ii) Increased stakeholder and regulator scrutiny iii) Low staff morale iv) Threatened stability and sustainability v) Restructuring fails to achieve goals and outcomes vi) Impact on service delivery and quality of care vii) Poor staff survey viii) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure ix) Undermines regulatory confidence to invest in hospital/system solutions												

Risk Key														
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High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
edium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance,			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3 : Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
BAF 3.4		**Sustainability of local services** Failure to ensure sustainable local services continue whilst the new hospital plans are in development and funding is being secured.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in backlog maintenance iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) Complexity of STP vii) Insufficient quantity and expertise in workforce capability	**4 X 4= 16**	Director of Strategy **Trust Board**	i) Potential new build/location of new hospital ii) STP Footprint and Estate Strategy developed. iii) Herts & West Essex STP Estates workstream iv) Pathology workstream led by CEO v) Estates and Facilities Infrastructure subgroup for West Essex vi) SOC affordability model vii) SOC approved and submitted to NHSI viii) Detailed analysis of current site option commissioned ix) Master planning work being aligned to Six Facet Survey and Health Planning, phasing of development on PAH site or off site. x) Alignment of strategic capital and tactical capital plans xi) MSK service developments underway xii) Capital funding of £9.5m received xiii) PAH part of HIP 1 funding programme for capital investment xiv) PCBC completed, submitted and reviewed by NHSI	i) PAF, Strategy Committee and Board meetings ii) SMT Meetings iii) Capital Planning Group iv) Weekly Estates and Facilities meetings v) Project genesis steering group	i) STP reports to Strategy Committee (bi-monthly) ii) Reports to SMT iii) STP work plans iv) Our New Hospital reports to Strategy Committee (Oct 2019 and updates to Board (jan 2020). v) PAHT 2030 report to Strategy Committee (Oct 2019) vi) PCBC approved at Trust Board (September 2019) vii) MAU business case approved at Trust Board September 2019	**4 x 4 = 16**	i) Balancing short term investment in the PAH site vs the required long term investment Gaps in Strategy team **ACTIONS:** Strategy being developed and underpinned by 5P plans Phase II work underway	i) Strategy in development	07/01/2020	**No change to residual risk rating.**	**4 x 3 =12** **March 2020**
			Effects: i) Failure to deliver strategy and transformation project and service changes required for service and performance enhancement ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant vii) Poor patient experience, viii)Backlog maintenance ix) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health. x) Lack of integrated approach xi) Increased risk of service failure xii) Impact on throughput of patients												

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.2		**4 hour Emergency Department Constitutional Standard** Failure to achieve ED standard	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Gaps in medical and nursing workforce iv) Lack of public awareness of emergency and urgent care provision in the community. v) Attendances continue to rise annually (5.1% over the last 2 years). vi) Changes to working practice and modernisation of systems and processes vii) Delays in decision making, patient discharges and delays in social care and community impacting on flow viii) Increases in minor attendances	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Escalation calls with NHSI vi) Work in progress to develop new models of care vii) Local Delivery Board in place viii) System reviewing provision of urgent care ix) Exec attendance at safety huddles x) ED action plan reported to PAF/Board xi) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries xii) Protection of assessment capacity work underway xiii) Weekly Urgent Care operational meetings and Urgent Care Board in place xiv) On site support from ECIST and NHSI medical lead xv) Focus on length of stay in ED for all patients xvi) Focus on improving assessment capacity xvii) GP attending weekly length of stay review meetings	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) Fortnightly escalation meetings with NHSI/NHSE vii) Weekly HCG reviews viii) System Operational Group ix) Weekly Length of Stay meetings	i) Daily ED reports to NHSI ii) Monthly escalation reports to NHSE iii) Monthly PRM reports from HCGS iv) Monthly IPR reported to PAF/QSC and Board reflecting ED performance. v) Presentation on ED performance and 'next steps' to PAF and Board (May/June 19)	**4 x 5 = 20**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings and weekly Urgent Care Board review	None noted.	14/01/2020		**4x3 =12 March 2020 (on delivery of standard - 95%)**
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
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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 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2019/20 and our local system control													
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 PSF/FRP ii) CCG affordability, QIPPs, contractual disputes and challenges, iii) ability to deliver recurrent CIPs, iv) workforce shortages and associated temporary staffing usage/costs v) high levels of unplanned expenditure including maintenance of aging estate, vi) Capture and billing of activity. vii) Potential impact of pension changes	**5 X 4= 20**	**Exec leads :** CFO **Committee** : Performance and Finance Committee	i) Access to Interim Revenue Support loans ii) Cost Improvement Programme iii) Formal reconciliation process with CCG iv) Internal and external Agency controls and reporting v) SMT, PAF and Audit Committee vi) Health Care Group PRM 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) Increased frequency of reporting for selected HCGs xiv) Medical agency protocol xv) Financial Recovery Plan - due Sept 2019 xvi) Demand and Capacity planning and HCGs year end forecasts xviii) Use of resources assessment 26.03.19 xxvix) The Trust and CCG are jointly developing revised system financial principles e.g. allocative/block payment or minimum guarantee payment xxx) CCG/STP/Central allocations and support and ongoing system discussions	i) Internal Audit & External Audit opinion. ii) External reviews iii) NHSI/E reporting iv) Internal Trust reporting v) Cash Management group vi) Joint meetings with CCG vii) Delivery Group - weekly viii) Staffing Task Group and CQUIN Group	i) Monthly reports including bank balances and cash flow forecasts to PAF and Board ii) CIP reports iii) Internal Audit reports: Financial Reporting and Budget Monitoring (substantial assurance) Key Financial Systems (substantial assurance) Non-SLA Income (limited assurance) iv) Financial Recovery Plan v) FAM reports monthly vi) PRM packs monthly vii) Recovery plans and trajectories reported to Delivery Group (weekly)	**5 x 4 = 20**	i) Organisational and Governance compliance e.g. waivers ii) Activity and capacity planning iii) CIP delivery iv) CQUIN - risk of recovering full income v) Management of temporary staffing costs	Demand and Capacity Workforce planning	23.01.20		4 x 3 =12 (end March 2020)
			Effects: i) Ability to meet financial control target and loss of £21 PSF/FRF ii) Delay to payment to creditor/ suppliers ii) Increased performance management iv) Going Concern status v) Risk to securing central funds 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							**ACTIONS:** Future_Modernisation Demand and Capacity Planning and Modelling to be regularised Clinical and operational forums in place to review QIPP schemes. Review of Capital reporting and planning for 19/20 underway. Intensive support for job planning, rota and roster management. Focus on Medicine and Surgery HCGs.				

The Princess Alexandra Hospital NHS Trust

4.1

Trust Board – 6 February 2020

Agenda Item:	4.1							
Presented by:	Lance McCarthy – CEO							
Prepared by:	Lance McCarthy – CEO							
Date prepared:	29 January 2020							
Subject / Title:	CEO Update							
Purpose:	Approval		Decision		Information		Assurance	
Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting: - Performance highlights - New hospital - Development of Integrated Care Provider - Chief Technical Officer - Pathology reconfiguration - Other items of note							
Recommendation:	The Trust Board is asked to note the CEO report.							

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

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

Chief Executive's Report
Trust Board: Part I – 6 February 2020

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

(1) Key performance headlines

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

Key Performance Indicator	Actual performance for latest month (December)	Comparison to last report
ED 4-hour performance	68.2%	↓ (worse); target = 95%
SHMI	111.6 (Sep 18 – Aug 19)	↑ (better); higher than expected
C. Diff (hospital onset)	4	↑ (worse)
MRSA	0	↓ (better)
Never Events	0	→
Incidents reported	824	↓ (better)
No harm / minor harm incidents	97.7%	↑ (better)
Falls / 1,000 bed days	9.0	↑ (worse)
6-week diagnostic standard	98.4%	↓ (worse); target = 99%
Stat Man training	93.0%	→
Agency % of pay bill	5.1%	↑ (worse)
Temporary staff % of pay bill	16.3%	New indicator
Front line staff 'flu vaccination	73.3%	New indicator; target = 80%

(2) New hospital

Following the announcement made by the Prime Minister and the Secretary of State for Health on Sunday 29 September that we would receive the capital funding for a new hospital in Harlow, we have continued to work closely with our NHS regional and national colleagues and our local and national political colleagues to make this a reality.

Our preferred way forward, agreed by the Trust Board in March 2019, is to build a new hospital on a greenfield site next to the new junction 7a on the M11. Before we can break ground we need to develop, and have approved, detailed business cases and to undertake the detailed design of a new facility. We are expecting to have completed an Outline Business Case in early 2021 and the Full Business Case in early 2022. This will enable us to have commissioned a new hospital by the end of 2025. As part of the process to support this, we are meeting with David Williams, Director General of Finance and Group Operations at DHSC, and other national colleagues on 12 February.

The new hospital is a vital part of our local clinical strategy, transformation and modernisation plans as well as a vital part of the local West Essex integrated care plans. The new hospital will support our ability to work much more at a 'place' level, with a wider focus on the health of the local population as a whole.

In addition, as the largest employer in Harlow and the surrounding towns, we are also an anchor organisation to all of our local council's ambitions and our preferred way forward is key to and included in their local area plans. Our transformation, service provision and success are fundamental to the opportunity, ambition and pride of the local population and achieving the transformation of Harlow as a place.

(3) Development of West Essex Integrated Care Provider (ICP) – One Health and Care Partnership

We continue to work at pace and closely with our West Essex health and care colleagues to develop more system wide clinical pathways for the benefit of our patients.

Our 5-year Alliance contract with Essex Partnership University Trust (EPUT) for the provision of integrated musculoskeletal services for the local population is developing well, with further changes to the clinical model being discussed by the MSK Expert Oversight Group.

We are continuing to develop further plans for taking on the Lead Provider role for other services and pathways for the population of West Essex from April 2020 and are currently having our plans reviewed as part of an assurance process with NHS England Regional colleagues.

The expansion of the Lead Provider role will help all provider organisations in the local system to continue to build on the integrated work to date to continue to better transform and modernise care pathways across all local health and care organisations to improve patient outcomes and experiences and the local population's health generally. The provision of different models of care, increased out of hospital care and radically transformed outpatient care are also all integral to the plans for a new hospital and the wider development and regeneration of the local area and aligned with the NHS Long Term Plan.

Our plans are also aligned with the Hertfordshire and West Essex STP's medium term financial plans and the drive for the STP to become an Integrated Care System (ICS).

(4) Chief Technical Officer

Maximising the benefits for our patients and our people of a new hospital and working in a much more coordinated and integrated way with our local health and care partners will only be possible if they are combined with and supported by a seismic shift in our technology and digital infrastructure. This needs to align with the adoption of more modern practices and technologies to support our patients and our people.

Consequently, the Trust Board recently approved the creation of a Chief Technology Officer (CTO) role that is currently out to recruitment. The postholder will be a member of the Executive team with responsibilities for the IT and digital agenda of the Trust and who will work closely with our Chief Clinical Information Officer (CCIO) and all clinicians to ensure we invest in the right technology for our patients.

At the heart of this is the need to upgrade / replace our patient administration system to ensure we have an effective Electronic Patient Record from which decisions can then be made about the need for other clinical systems that communicate effectively with those used by our primary care and community care colleagues. The post holder will also be instrumental in driving a much broader digital strategy for clinical and non-clinical departments, supporting the transformation and modernisation of the services aligned with their local strategies.

(5) Pathology reconfiguration update

In line with the national drive to create pathology networks across the country, the Hertfordshire and West Essex STP-wide procurement of a 3rd party to provide pathology services across the 3 acute Trusts and for primary care colleagues within the 3 CCGs remains on track with plan.

An Invitation to Participate in Dialogue (ITPD) was issued to all bidders on 17th December 2019, who have until 10th February 2020 to issue a draft response. Dialogue sessions are scheduled for March and April with a request for a Best and Final Offer (BAFO) expected to be issued in late May.

A preferred supplier is expected to be chosen in the summer with a Full Business Case coming to the Board (and those of the other 5 organisations) in the autumn for final approval before the contract is issued.

(6) Other items of note

Key other items of note for the Board include:

- Performance against the 4-hour standard slipped in December to 68.2% (PAH) / 69.7% (PAH and H&EH). This was the 3rd lowest performance of the 15 East of England hospital sites on current reporting. Our Q3 performance of 73.3% was the 4th lowest (12th out of 15) and our Year to Date performance of 75.7% remains the 3rd lowest. At the time of writing the report, January performance had improved to 73.7%. Compared with 2018/19 our year to date attendances have increased by 7.75% and our year to date performance has fallen by 3.8 percentage points. Our relative performance reduction is the 6th best across the region. More information is available in the Integrated Performance Report and our ongoing service improvements and developments to support urgent care will be discussed as part of that item.

- Our income and expenditure position in December was £0.2m better than plan. Year to date, we are £4.9m worse than plan, but within our year end control total. The key driver for the deficit remains the higher use of temporary staff compared with plan, which will continue to reduce as a result of our successful international nurse recruitment campaign (153 new starters since April 2019). More information is available in the Integrated Performance Report and our ongoing mitigation for the deficit will be discussed as part of that item.

- We have just launched our nursing degree apprenticeship scheme with Anglia Ruskin University providing a new pathway in to nursing. We interviewed for the 10 places at the end of January and the successful applicants will start in March.

- PAHT has become the second hospital in the country to be accredited by the Academy of Fabulous NHS Stuff, run by Roy Lilley, for our quality improvement (QI) approach and work.

- Our in-house mortality rate for Septicaemia has fallen by nearly 30% over the last 6 months as a result of our focussed QI programme on sepsis management across the Trust.

- As part of our modernisation and transformation programme for our non-clinical services, we remain on track to exit our lease for the Mitre Buildings by the end of March and move into fantastic new accommodation in Kao Park. The new facilities will be a significant improvement for the people, finance, information and procurement teams, enabling them to work in bright, functional and modern office space that will support the modernisation of their services and the associated efficiencies and waste and cost reductions.

Author: **Lance McCarthy, Chief Executive**
Date: **29 January 2020**

The Princess Alexandra Hospital NHS Trust

Learning from Deaths

Family & Women's Health Care Group

6th February 2020

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Overview

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- 65yr old female
- Generic flag on Cosmic that patient has a learning disability
- Admitted 05/04/18 for Lefort procedure (vagina prolapse repair with obliteration of vagina)
- Post operatively patient was hypotensive and required prolonged stay in PACU, transferred to Nightingale Ward 07/04/18 at 20.40hrs
- Spent 5 days on ward where she was treated for hospital acquired pneumonia
- Discharged 12/04/18
- Found unresponsive by carers the following morning and transferred into Emergency Department
- CT angiogram pulmonary performed and reported bilateral pulmonary emboli
- CT head reported as no significant intracranial abnormality
- 15/04/18 repeat CT head requested as patient had become increasingly drowsy with National Early Warning Score (NEWS) at 8 and ?Stroke
- CT head reported as multifocal subacute ischaemic infarcts, likely cause was a stroke
- 15/04/18 @ 21.30 end of life pathway commenced
- 16/04/18 @ 13.10 patient died

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NHS
The Princess Alexandra Hospital
NHS Trust

What Went Well

- Remained in Post Anaesthetic Care Unit until stable and fit for transfer
- Initial prompt escalation and comprehensive SHO review
- Evidence of multidisciplinary team work between Pharmacy and ward staff to discourage patient's self-discharge
- Regular Critical Care Outreach Team physical reviews
- Prescribed prophylaxis enoxaparin post surgery and on discharge

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What didn't work well

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- No evidence of consultant obstetric review following surgery
- Referral to medical team but no physical review
- No further consideration to revisit initial diagnosis when not responding to treatment
- DOCUMENTATION
- Minimal evidence of effective awareness of clinical wellbeing of the patient or acknowledgement of deterioration
- Red flag on Cosmic was not clear
- No robust documented plan for discharge and care plan for community care

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Lessons learned

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- An allocated consultant everyday to cover gynae inpatients. All gynae inpatients to be reviewed daily by a clinician of at least Registrar grade
- Gynae patients to be discussed in FAWS morning handover and agreement as to which senior clinician will review
- When a referral to another speciality is made it must be clearly documented and verbalised that a physical review is required. Any delays in review must be escalated to On-Call Consultant
- If a post operative patient fails to recover as expected following surgery the operating surgeon should be informed and asked to review
- A review of the process in adding a generic Learning Disabilities flag to COSMIC to be carried out by the Learning Disabilities team
- To incorporate specific NHS guidance on gaining consent from people with LD into Trust consent policy
- All staff to accurately assess and document AVPU scores

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The Princess Alexandra Hospital NHS Trust

Trust Board Meeting

5.2

Agenda item:	
Presented by:	Jo Howard – Deputy Chief Medical Officer
Prepared by:	Nicola Tikasingh - Matron for Mortality and Quality Jo Howard – Deputy Chief Medical Officer
Date prepared:	28th January 2020
Subject / title:	Learning From Deaths Report

Purpose:	Approval		Decision		Information		Assurance	x

Key issues:	Medical examiners are currently scrutinising 100% of all deaths at PAHT. The 'structured judgement review' process commenced November 2019. The Matron for Mortality and Quality commenced in post in January 2020. Consultant Structured judgement review champions have been identified in all healthcare groups and are beginning to undertake mortality reviews. A Mortality Review Group has been established to collate themes and learning from the structured judgement reviews. An independent 'Learning from Deaths Panel' is being established to review any cases identified by structured judgement review as having evidence of 'poor care'.
Recommendation:	To note the report.

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

Previously considered by:	None
Risk / links with the BAF:	BAF Risk 1.1 Inconsistent clinical outcomes
Legislation, regulatory, equality, diversity and dignity implications:	*'Learning from Deaths'* - National Quality Board, March 2017
Appendices:	None

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The Princess Alexandra Hospital NHS Trust

5.2

1.0 Purpose

The purpose of this paper is to provide an update around 'Learning from deaths' at PAHT.

2.0 Background

The National Learning from Deaths framework (National Quality Board Recommendations) informs the requirement to scrutinise all deaths within provider trusts by a Medical Examiner (ME). The ME process started at the PAHT over a year ago. The PAHT are now achieving 100% of ME death reviews.

Approximately 25% of all deaths should be reviewed through Structured Judgement Review (SJR) to ensure learning from deaths can be understood and embedded across the healthcare system.

Initiation of the SJR process commenced from 13th November 2019. The process requires assessment of the quality of care during the hospital spell and is broken down into phases of care. Any phase of care identified as 'poor care' will be independently reviewed by a second panel of senior clinicians (Learning from Deaths panel) to consider the probability of avoidable death. The new patient safety Matron for Mortality and Quality commenced full time 1/1/2020 and she will help facilitate this process.

SJR champions have now been identified within the healthcare groups and they are beginning to undertake the mortality reviews within their clinical areas. Learning themes will be identified and shared at the newly established mortality review group on a monthly basis. This new process will continue to be imbedded into practice and the organisation.

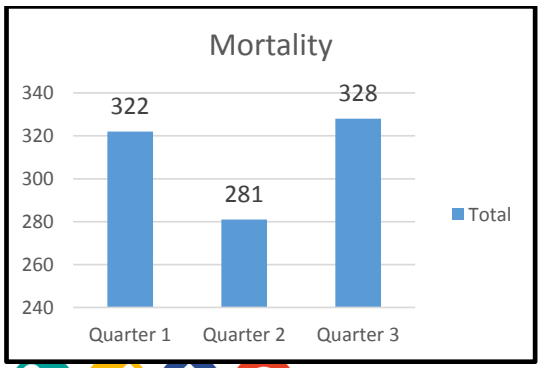
Dr Foster Intelligence is a provider of healthcare information in the United Kingdom, monitoring the performance of the National Health Service and providing information to the public. It was launched in February 2006 and is owned by Telstra. Dr Foster aims to improve the quality and efficiency of health and social care.

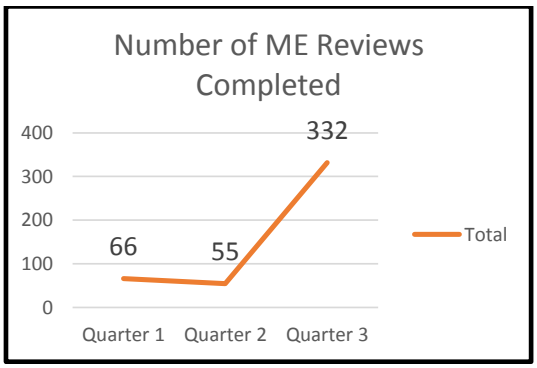
The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect.

Dr Foster Intelligence also reports on the SHMI (Summary Hospital–level Mortality Indicator). The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged.

3.0 Analysis

Annual mortality review by quarter (financial year):





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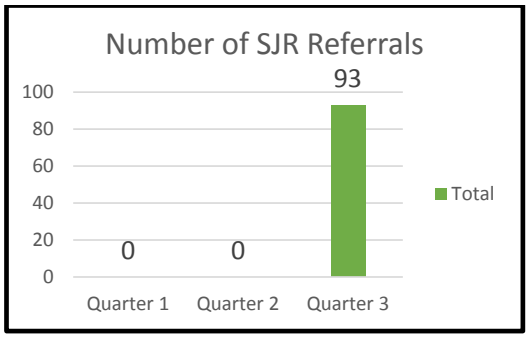
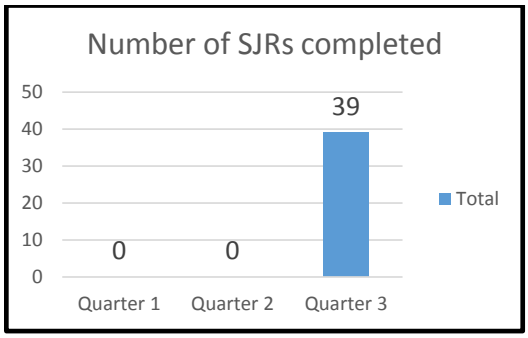
In Quarter 3, the trust had 328 deaths.
328 (100%) reviewed by a medical examiner





(Note: SJR's commenced mid November 2019)

93 cases referred for a structured judgement review in Quarter 3 (39 in Nov, 54 in Dec). This currently exceeds the 25% requirement.

In Quarter 3: 18 SJR's were undertaken in Nov; and 21 in Dec. The SJRs identified no deaths as likely to have been caused by errors in healthcare with no evidence of 'avoidability'. Two SJR's identified poor care (family raised concerns in these cases).These cases will be reviewed by the independent 'Learning from Deaths Panel' (due to start at end of January 2020).

Dr Foster report: January 2020 (reporting data for September – October 2019)
HSMR: 120.6 (statistically significantly high).
PAH is 1 of 6 Trusts within the peer group of 15 that sit within the 'higher expected'.

5 outlying groups:

- Pneumonia
- Urinary tract infections
- Aspiration pneumonitis
- Acute and Unspecified Renal Failure
- Cardiac dysrhythmias

SHMI: 116.3 (as expected).
There are 6 key outlying groups (significantly higher than expected deaths)

- Pneumonia
- Urinary Tract Infection
- Cardiac Dysrhythmias
- Aspiration pneumonitis
- Respiratory Failure
- Acute Cerebrovascular Disease

Comorbidity Coding: The Trust retains a high proportion of admitted patient spells with no comorbidity compared to nationally.
Comorbidity profile changes as the LOS increases.
A Quality improvement project is currently underway to improve admission documentation of co-morbidities.

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4.0 Mortality Review Group (MRG) Update

The MRG has now had two meetings (November 2019 & January 2020). This is a clinically led group with multi-professional membership including input from: Clinical coders, ME's Learning Disability Lead Nurse, Information Technology, SJR Champions, Non-Executive Director, Chief Medical Officer, Deputy Chief Medical Officer, Matron for Mortality and Quality. Links are being established with Hertfordshire Community Trust – invited to attend from February.

The group will agree the cases to be identified by the MEs for further scrutiny by SJR. Currently this includes all mandatory reviews and patients within the outlier groups. Themes of learning from these case reviews will be shared within the group and quality improvement initiatives will be undertaken to resolve any issues.

East of England Regional Examiner meeting is being held in Harlow in March 2020

5.2

Author: Nicola Tikasingh, Matron for Mortality and Quality, Dr Jo Howard Deputy CMO
Date: 29th January 2020

The Princess Alexandra Hospital NHS Trust

Trust Board Meeting – 6/2/2020

5.3

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

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	This paper sets out the regular nursing and midwifery retrospective staffing report for the month of December 2019 (part A), and provides an update to the workforce position (part B). Headlines: • Overall fill rate in month was 96% with an RN/M fill rate of 95.4%. For the 3rd month in succession no ward rated 'red' for RN fill. • The overall nursing vacancy position reduced again in December to 13.4% and the Band 5 rate to 15.8%. While slightly behind original forecast vacancy rate this is a significant achievement as over 100 additional nurses have joined the Trust YTD. The RAG rating remains green as the number of confirmed starters for the remainder of the year is on track to achieve an overall vacancy of less than 10% based on a strong profile of domestic recruitment activity, reduced turnover rates and overseas pipeline.
Recommendation:	The Board is asked to note the information within this report

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

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

The Princess Alexandra Hospital NHS Trust

5.3

1.0 PURPOSE

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

2.0 BACKGROUND

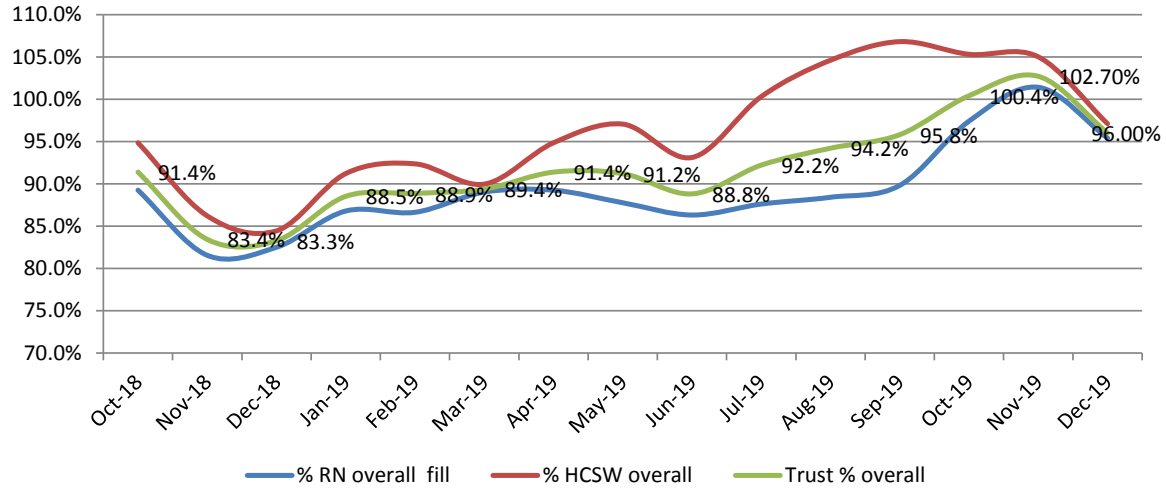
The report is collated in line with The National Quality Board recommendations (June, 2016).

3.0 ANALYSIS

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

3.2 The summary position for the Trust Safer Staffing Fill rates for December 2019 is included in the table below with a comparison with November 2019. First cut of the data which required further validation is that the fill rate has decreased slightly for overall RN/RM in month to 96% which is a decrease of 6.7% however taking into adjustment for the high number of overseas nurses on the wards in October and November where additional support was required to ensure patient safety this is in line with a steady increase in fill rates over the last 12 months which is in line with our successful recruitment programme.

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
Trust average December	102%	92.9%	93.1%	103.2%	95.4%	97.1%	96%
Trust average November	102%	99%	100.7%	113.8%	101.4%	105%	102.7%
Change against November	-	↓6.1%	↓7.6%	↓10.5%	↓6%	↓7.9%	↓6.7%



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

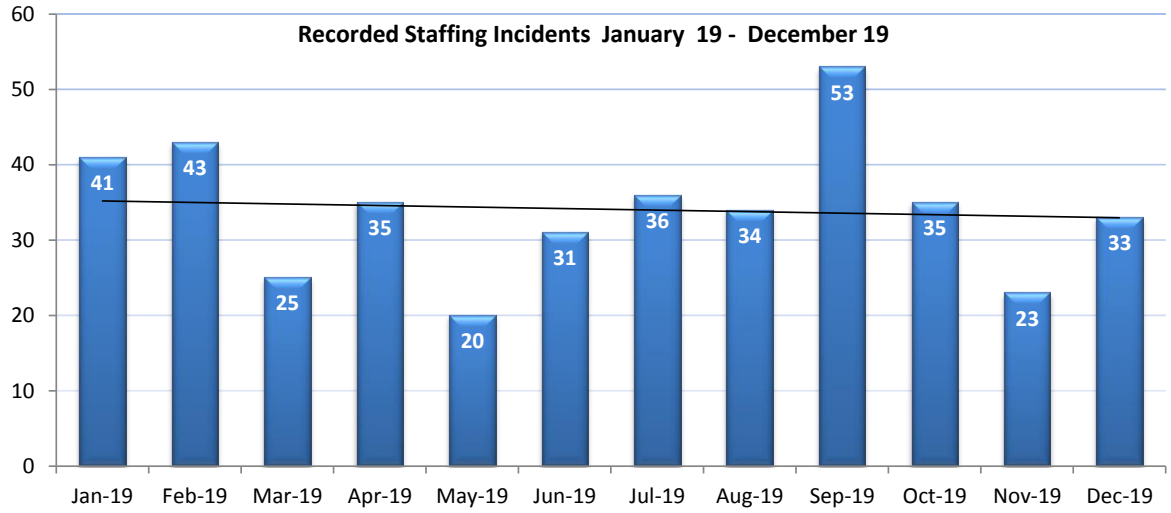
Red <75%	Amber 75 – 95%	Green >95%

3.4.1 National reporting is for inpatient areas, and therefore does not include areas including the emergency department or day units. To ensure the Board is sighted to the staffing in these areas, the data for these areas is included below using the same methodology as the full UNIFY report.

	Day		Night	
October 2019	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
A&E Nursing	93.3%	90.1%	92.0%	96.2%
PAH Theatres	tbc	tbc	tbc	tbc
Endoscopy Nursing	tbc	tbc	-	-

NB Over the Holiday period the demand template for theatres and endoscopy was lower than in other months however adjustments to the demand have been unable to be made in time for this report.

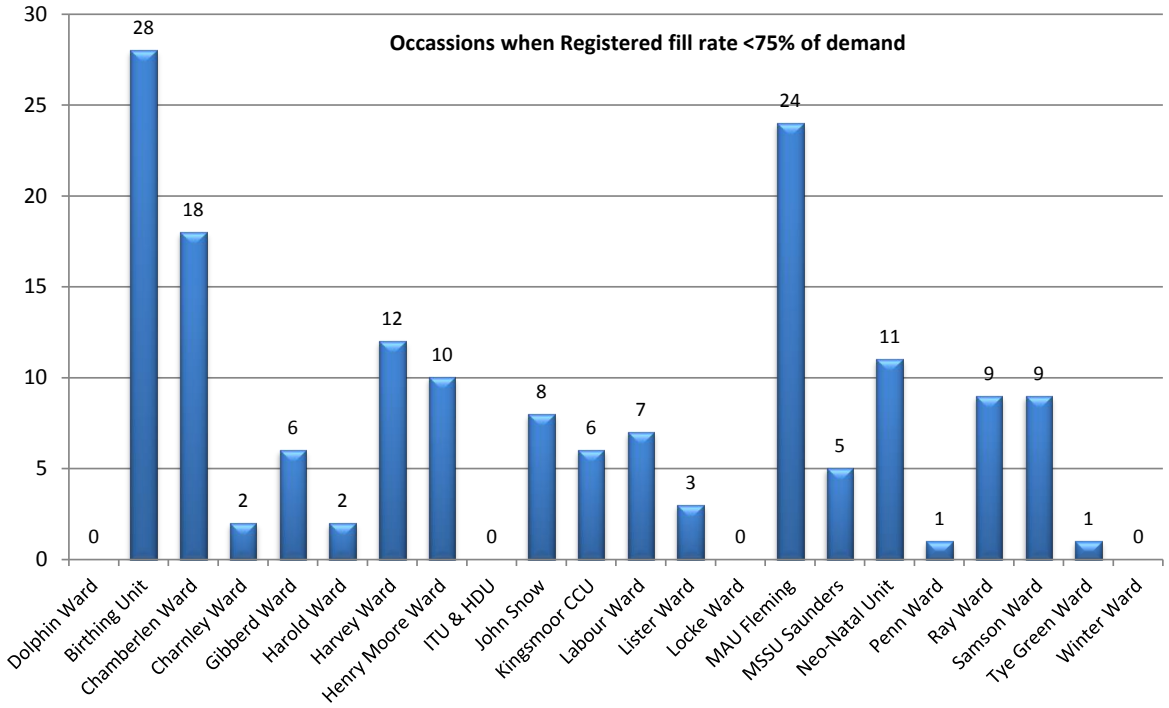
3.5 Datix reports: The trend in reports completed in relation to nursing and midwifery staffing is included below and shows an increase in December. All incidents continue to be reviewed by the safety and quality review process.



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

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

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



3.8 Care Hours per Patient Day* (CHPPD) has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018). The table below shows the Trust data from the Model Hospital. Current model hospital data for national median is based on latest available data. This shows the Trust and National data from October 2019, this shows that the Trust has exceeded the National median for Registered CHPPD.

	Trust October 2019 data	National Median (Oct 2019)	Variance against national median
CHPPD Total	7.8	8.0	↓0.2
CHPPD RN	4.8	4.7	↑0.1
CHPPD HCA	3.0	3.2	↓0.2

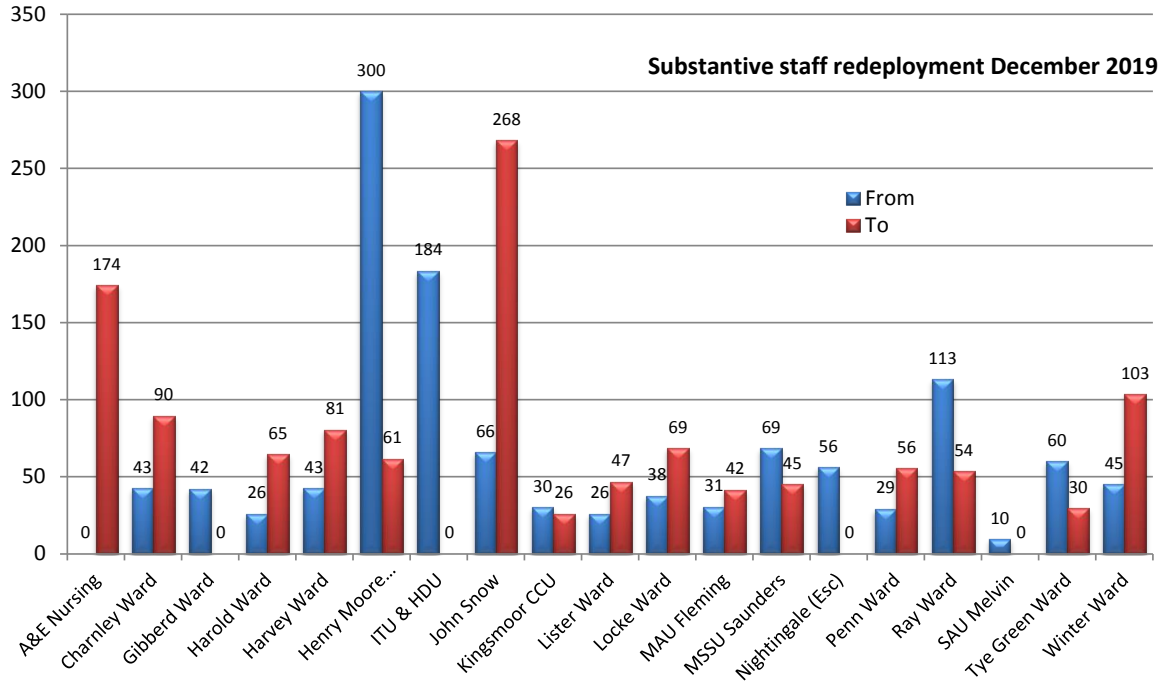
3.9 Mitigation:

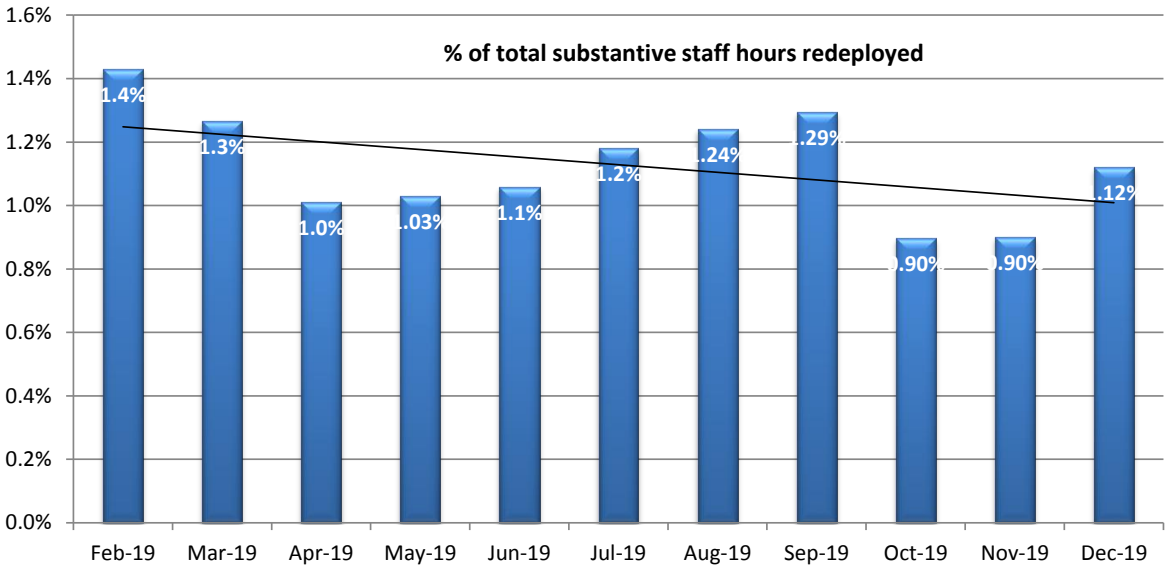
The day to day management of safer staffing across the organisation is managed through the daily staffing huddles and information from SafeCare to ensure support is directed on a shift: shift basis as required in line with actual patient acuity and activity demands. Ward managers support safe staffing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

3.10 Redeployment of staff:

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

The first graph shows the number of hours of staff redeployed from and to the adult inpatient ward to support safe staffing while the second graph shows the percentage of the total number of staff hours that are redeployed which has shown a small increase against the previous month.





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

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

3.11 Bank and Agency fill rates:

The use of NHSP continues to support the clinical areas to maximise safer staffing. The Trust has worked with NHSP to increase the availability of resource, and are working in partnership to improve this further. The table below shows that there was a reduction in registered demand (↓344 shifts) in

December in response to reduced substantive vacancy rates. There was a slight decrease in NHSP fill and increase in agency fill for RN, resulting in an overall increase fill rate for RNs (0.2%) in month.

The HCSW demand shows an increase (↑95 shifts) with the overall fill rate down by 3.7% against November.

RN temporary staffing demand and fill rates:

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
September 19	4,348	1,770	40.7%	1031	23.7%	64.4%	1547	35.6%
October 19	4,156	1,777	42.8%	1029	24.8%	67.5%	1350	32.5%
November 19	4,185	1,888	45.1%	1043	24.9%	70.0%	1254	30.0%
December 19	3,891	1,703	42.3%	1,020	27.9%	70.2%	1,168	29.8%
December 18	3603	1502	41.7%	983	27.3%	69.0%	1118	31.0%

HCA temporary staffing demand and fill rates:

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
September 19	2,613	1,956	74.9%	0	0%	74.9%	657	25.1%
October 19	2,533	1,874	74.0%	0	0%	74.0%	659	26.0%
November 19	2,594	1,872	72.2%	0	0%	72.2%	722	27.8%
December 19	2,689	1,805	68.5%	0	0%	68.5%	884	31.5%
December 18	2073	1526	73.6%	0	0%	73.6%	547	26.4%

B: Workforce:

Nursing Recruitment Pipeline

The nurse vacancy rate continues to fall steadily. The overall nursing vacancy rate in December fell to 13.4 %. Although this is slightly behind the forecast rate of 10.8% the Trust remains on track to achieve the overall target of <10% by March 2020.

Band 5 posts continue to make up the bulk of the vacancy rate and in December the vacancy rate fell further 4.9% in month to 15.8% slightly behind the forecast rate of 9.8%. The trajectory remains green as the number of starters planned for Q4 will keep us on track to meet forecast outturn position. The recruitment pipeline has over 100 nurses who are holding offers of employment and there is confidence that sufficient number of offer holders will convert into starters by the end of March to achieve the trajectory. The pipeline is supplemented with a better than expected domestic recruitment

The Recruitment and Retention Nurse is working with the DDoN to develop the pipeline for 2020/21 and target Band 6 and above vacancies which mow make up equivalent WTE vacancies as Band 5's The following table shows confirmed recruitment figures (in green) against the planned trajectory and turnover rate falling from 15.06% to 10.13% over the last 12 months.

Establishment V Staff in Post												
Funded Establishment WTE	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61
Staff in Post WTE	704	710.00	711.00	716.00	737.00	759.00	774.00	796.00	816.00	829.00	847.00	859.00
Vacancy WTE	238.61	232.61	231.61	226.61	205.61	183.61	168.61	146.61	126.61	113.61	95.61	83.61
Actual RN Vacancy Rate	25.3%	24.7%	24.6%	24.0%	21.8%	19.5%	17.9%	15.6%	13.4%	12.1%	10.1%	8.9%
Forcast Vacancy Rate in Business Plan	26.8%	26.9%	25.4%	24.0%	22.7%	19.3%	16.2%	13.1%	10.8%	9.7%	9.4%	9.3%

Band 5 Establisment V Staff in Post												
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Funded Band 5 Establisment WTE	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93
Band 5 Staff in Post WTE	289	294	296	302	322	347	364	387	411	426	435	449
Band 5 Starters	9	7	7	8	22	29	20	28	27	21	15	20
Vacancy Band 5 WTE	198.93	193.93	191.93	185.93	165.93	140.93	123.93	100.93	76.93	61.93	52.93	38.93
Actual Band 5 Vacancy Rate	40.8%	39.7%	39.3%	38.1%	34.0%	28.9%	25.4%	20.7%	15.8%	12.7%	10.8%	8.0%
Forcast Vacancy Rate in Business Plan	40.8%	41.0%	38.1%	35.4%	32.8%	26.2%	20.3%	14.3%	9.8%	7.8%	7.2%	7%

Projected Starters Pipeline												
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RNs (not Band 5)	1	1	2	2	4	1	2	3	1	1	1	1
Band 5 Newly Qualified + Local	3	2	0	1	1	3	7	3	4	1	11	0
Band 5 International Recruitment	6	5	7	7	21	26	13	25	23	20	15	20
Band 5 Starters	**9**	**7**	**7**	**8**	**22**	**29**	**20**	**28**	**27**	**21**	**26**	**20**
Total Starters	10	8	9	10	26	30	22	31	28	22	27	21

Projected Leavers WTE												
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RNs (not Band 5) Leavers	2	3	3	3	3	4	4	4	5	3	3	3
Band 5 Leavers	3	2	5	2	2	4	3	5	3	6	6	6
Total Leavers	**5**	**5**	**8**	**5**	**5**	**8**	**7**	**9**	**8**	**9**	**9**	**9**
Nursing turnover %	15.06%	14.86%	14.79%	13.41%	12.13%	12.22%	11.83%	11.09%	10.13%			

4.0 RECOMMENDATION

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

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

Date: 17th January 2020

The Princess Alexandra Hospital NHS Trust

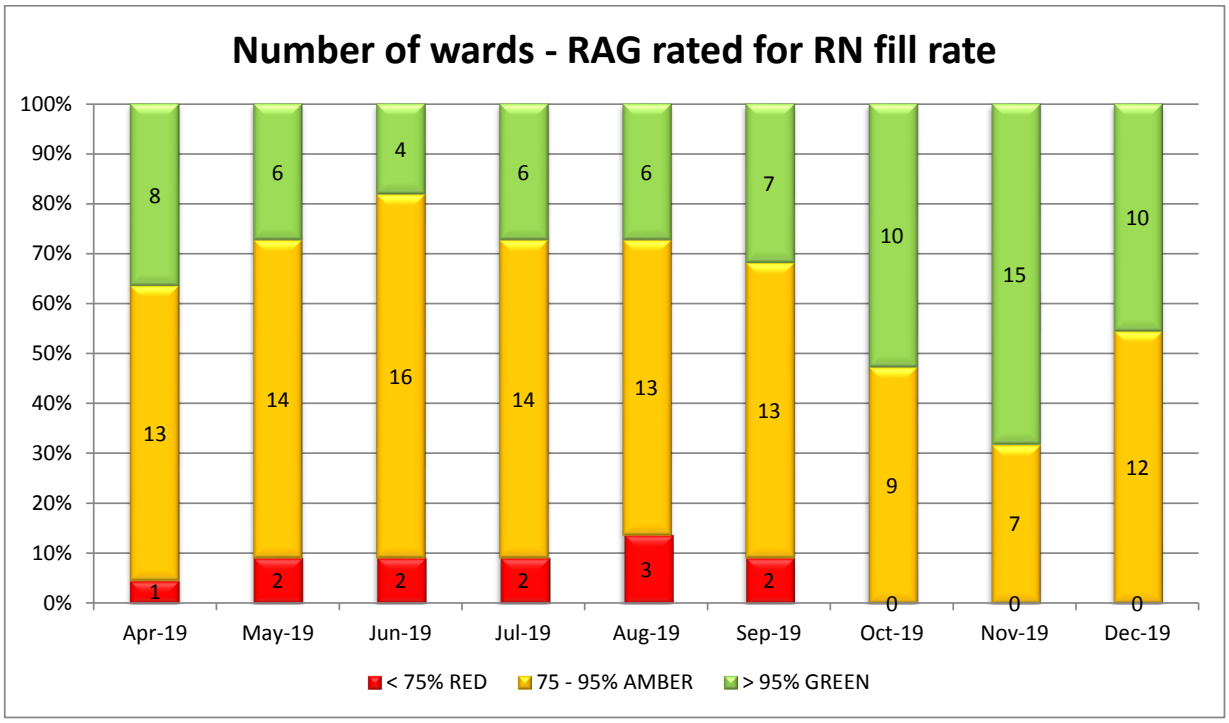
Appendix 1.

Ward level data: fill rates December 2019.

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
Dolphin Ward	110.6%	105.0%	93.5%	112.6%	103.0%	107.5%	104.1%
Kingsmoor CCU	86.4%	105.0%	100.0%	111.0%	92.1%	107.3%	97.6%
MAU Fleming	98.3%	121.5%	91.7%	90.3%	95.4%	106.6%	100.1%
Tye Green Ward	104.8%	90.8%	95.6%	111.0%	100.9%	99.0%	100.1%
Harvey Ward	86.5%	79.9%	90.3%	74.0%	88.0%	77.1%	83.0%
ITU & HDU	89.1%	115.2%	89.7%	104.5%	89.4%	110.1%	91.5%
John Snow	101.4%	85.9%	95.6%	105.0%	99.1%	93.1%	96.6%
Charnley Ward	92.4%	101.9%	115.5%	108.1%	100.6%	104.2%	102.0%
Lister Ward	95.4%	93.6%	87.3%	137.3%	91.7%	107.4%	98.5%
Locke Ward	108.6%	87.3%	105.6%	108.0%	107.3%	95.2%	103.0%
Neo-Natal Unit	82.4%	63.0%	79.1%	130.7%	80.8%	85.6%	81.9%
Penn Ward	104.3%	115.3%	89.5%	129.7%	98.1%	120.8%	106.2%
Ray Ward	83.7%	72.1%	80.3%	116.4%	82.2%	86.1%	83.8%
MSSU Saunders	84.5%	90.3%	88.0%	94.1%	86.0%	91.9%	88.6%
Harold Ward	91.4%	110.2%	93.8%	106.3%	92.4%	108.6%	99.5%
Henry Moore Ward	81.0%	59.0%	100.3%	56.5%	88.1%	58.2%	76.7%
Gibberd Ward	113.2%	100.0%	111.4%	101.7%	112.5%	100.8%	106.3%
Winter Ward	105.8%	95.6%	113.9%	163.7%	108.7%	121.4%	113.6%
Chamberlen Ward	91.5%	69.8%	86.1%	41.9%	89.0%	56.5%	80.8%
Labour Ward	118.6%	76.2%	92.8%	77.4%	106.3%	76.8%	99.7%
Samson Ward	113.5%	77.8%	95.6%	82.8%	104.9%	79.7%	93.4%
Birthing Unit	82.3%	82.7%	72.7%	83.1%	77.6%	82.9%	78.9%
Trust total	102.0%	92.9%	93.1%	103.2%	95.4%	97.1%	96.0%

The Princess Alexandra Hospital NHS Trust

Appendix 2



5.3

The Princess Alexandra Hospital NHS Trust

Appendix 3

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

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

Trust Board – 06.02.20

Agenda Item:	6.1
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Information Team, Executive Directors
Date prepared:	22.01.2020
Subject / Title:	Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	✓	Assurance	✓
Key Issues:	To be highlighted at the meeting.							
Recommendation:	The Board is asked to discuss the report and note the current position and further action being taken in areas below agreed standards.							

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

Previously considered by:	QSC.24.01.20 PAF.30.01.20
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	

6.1

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report

December 2019

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

Contact:

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

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Trust Objectives

NHS
The Princess Alexandra Hospital
NHS Trust

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

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

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

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

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

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5Ps

In this month

The Princess Alexandra Hospital NHS Trust

Patients

Performance

People

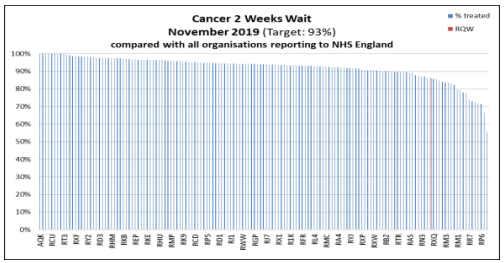
Pounds

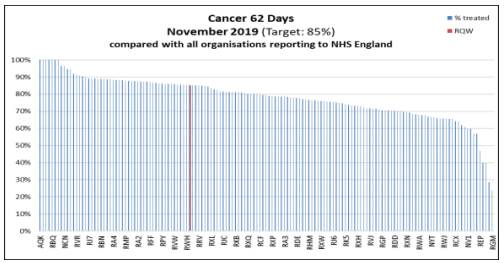
Places

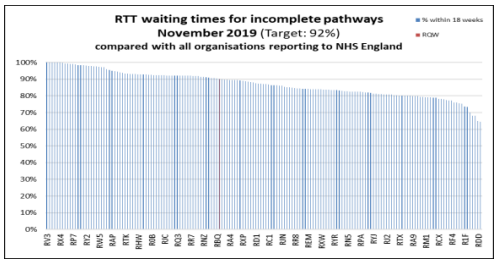
6.1

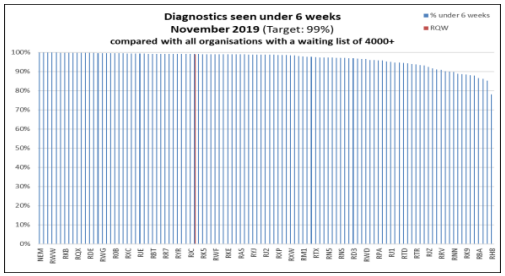
National Benchmarking
Compared with all organisations reporting to NHS England

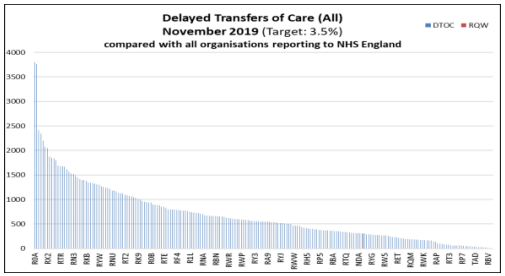
NHS
The Princess Alexandra Hospital
NHS Trust

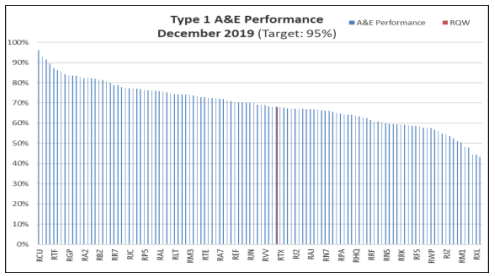


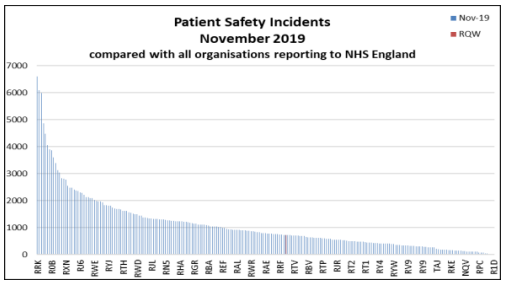


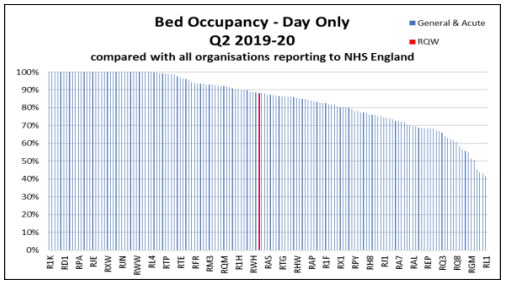


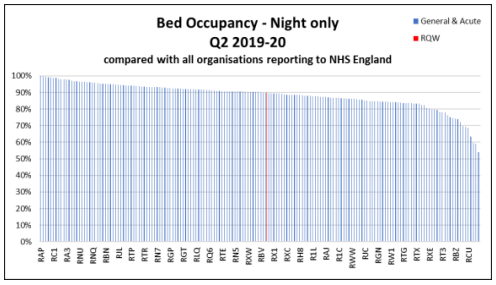












Your future Our hospital

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

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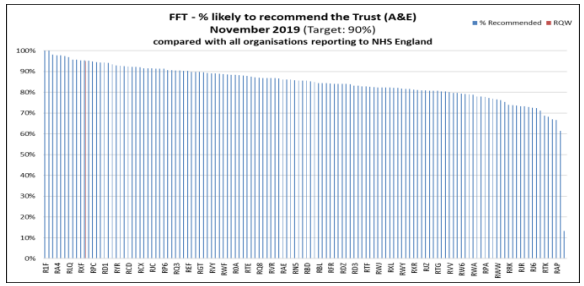
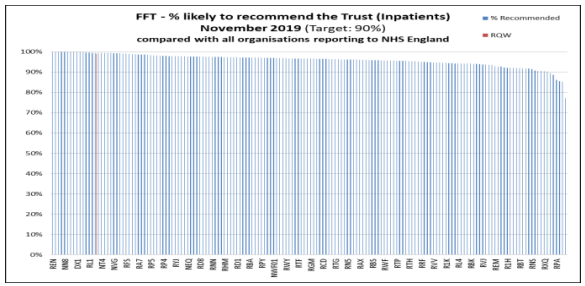
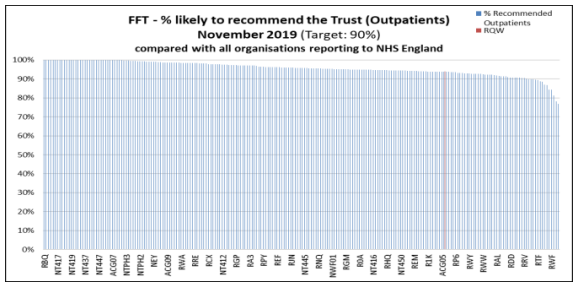
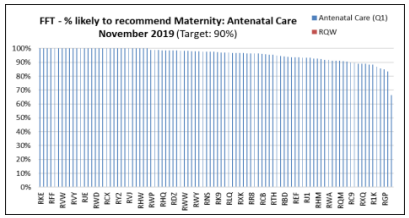
National Benchmarking
Compared with all organisations reporting to NHS England

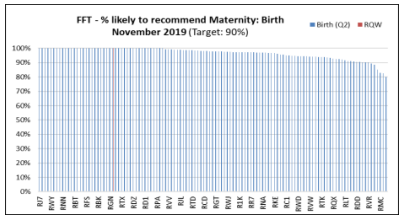
NHS
The Princess Alexandra Hospital
NHS Trust

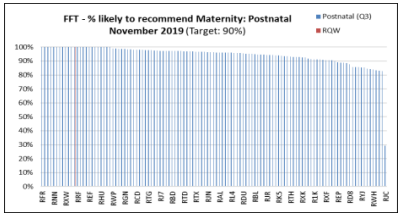


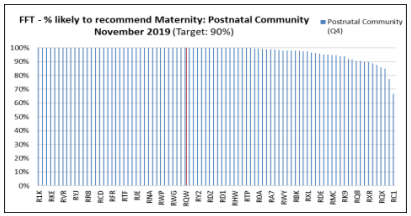


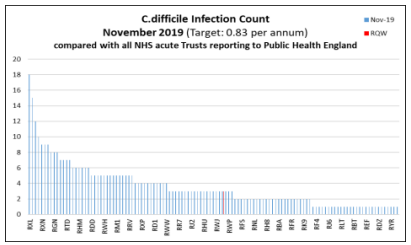


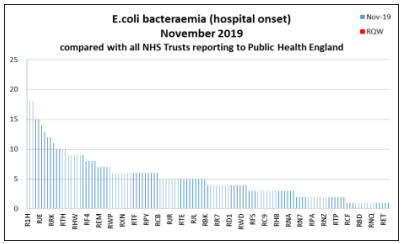


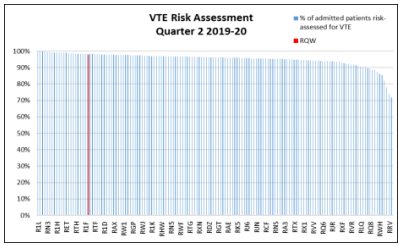


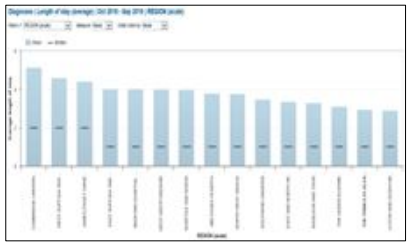












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Data Source: NHS England Statistics/Public Health England/Dr Foster

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Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

Patient Experience: To note the complaint and PALS trends and the work underway to further improve our responsiveness. Benchmark against the national complaint rate is favourable. External funding has been secured to enhance the volunteering services, which is focused on supporting sustainability and winter pressures.

Patient Safety: There were 1065 incidents reported in December 2019 of which 824 incidents were PAH, comprising of 601 no harm, 204 minor harm (97.7%) for both of these.
18 moderate harm (2.2%), 1 severe harm (0.1%).The percentage spread is consistent with previous months.

Infection Control: MRSA - No MRSA bacteraemia cases in December. Total of two cases for the year. C.difficile - There have been a total of 18 cases year to date; under new definitions these are classified as 14 hospital onset cases and four community onset cases. There were four (hospital) cases in December. Of the 18 cases we have had, eight have been successfully appealed, a further five cases are due to be appealed. Gram Negative Blood Stream Infections (GNBSIs) - The Trust remains in a good position when compared nationally with other hospitals (in the top performing quarter).

Harm free care: Pressure Ulcers - there were a total of 37 pressure ulcers in December which is the same as last month. The Pressure Ulcer Prevention plan continues to focus on reducing pressure ulcers to the feet/heels, device related pressure ulcers and improving the quality of repositioning.

Falls: The overall number of falls rate was 122 an increase on previous months. The falls with harm rate was 30% which is in line with total overall harm rate for the last 12 months (30%). A Trustwide Falls Prevention strategy is being developed to take forward the improvements which include reviewing the risk assessment process and introducing a care bundle to guide nursing care of high risk fallers to reduce the number of unwitnessed falls with harm.

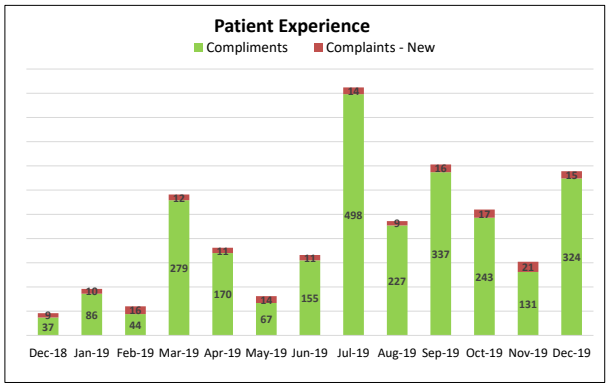
Maternity: Note the maintenance of compliance with CTG training, and the favourable PAH Stillbirth Rate of 2.27 per thousand (2019) compared to the latest available MBRRACE National Rate, from 2015, of 3.93 per thousand.

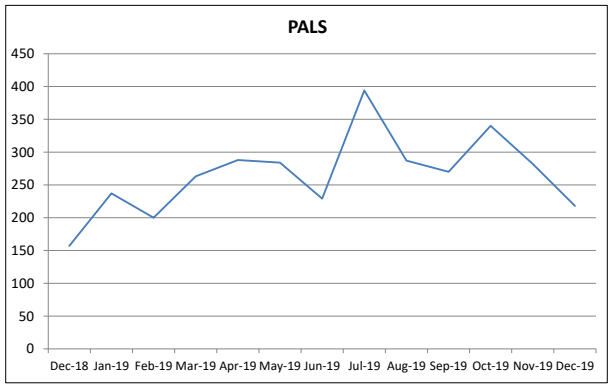
Patient Experience

1 Our Patients Summary 1.1 Patient Experience

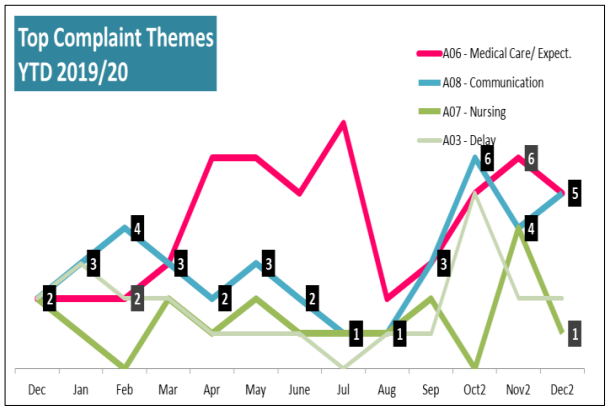
The Princess Alexandra Hospital NHS Trust

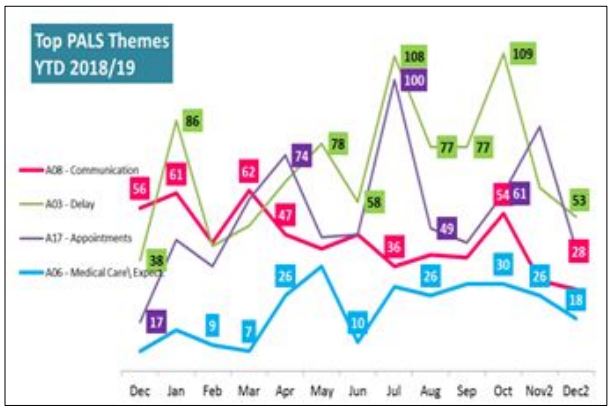
The PALS service responded to 3310 cases in 2019 (the highest ever recorded), of these cases 387 are open with HCG level teams working to respond and the patient experience team pressing for completion through evidence of actions taken. The Trust received 164 total complaints in 2019, 71 are open, 28 were reported out of time at the end of December, as this has been raised through the Patient Safety and Quality forum and escalated to triumvirates. There is a increase in the number of PALS cases becoming complaints but this may be seasonal variation which we will continue to track and escalate. Compliments data is reported with Medicine Healthcare Group, including the Emergency Department followed by Lister, Penn and Charnley receiving the highest number of compliments in December 2019. Improvement work is ongoing, funding has been secured via NHSIE to grow and develop volunteering, beginning with winter pressures and ED, the establishment of a carers working group to address communication challenges and support STP and CCG level patient engagement.

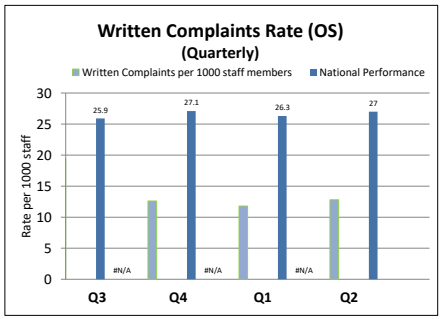




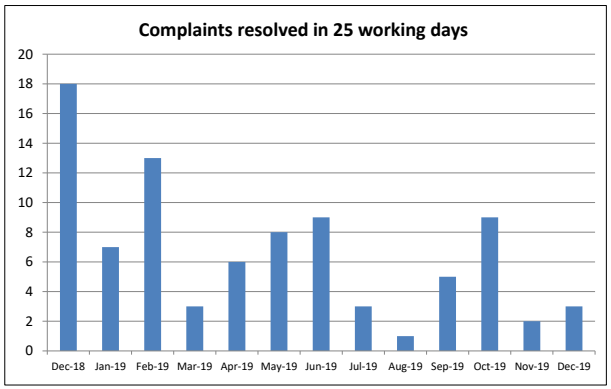
PALS converted to Complaints	
Dec-18	1
Jan-19	2
Feb-19	2
Mar-19	0
Apr-19	1
May-19	2
Jun-19	2
Jul-19	1
Aug-19	1
Sep-19	4
Oct-19	2
Nov-19	3
Dec-19	4

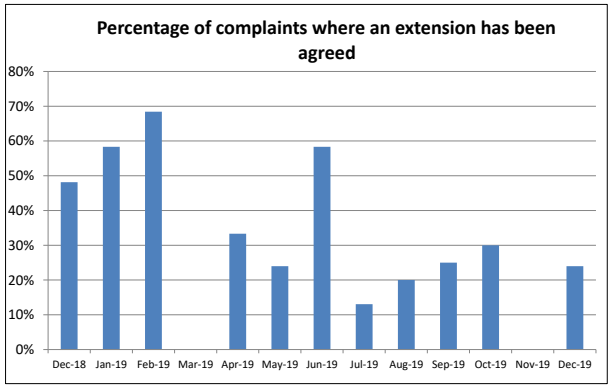


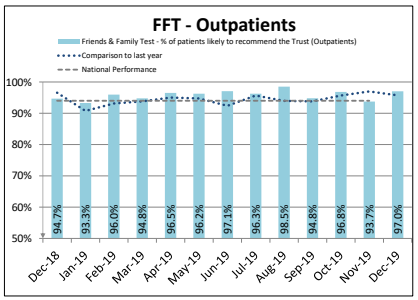


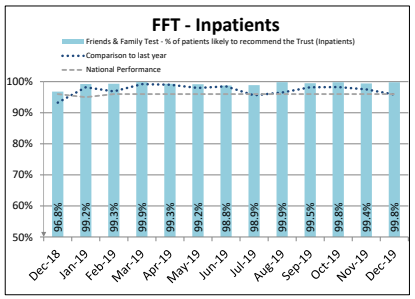


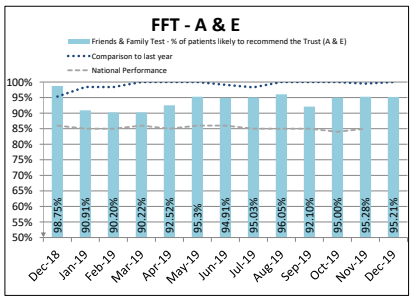
Patient Experience

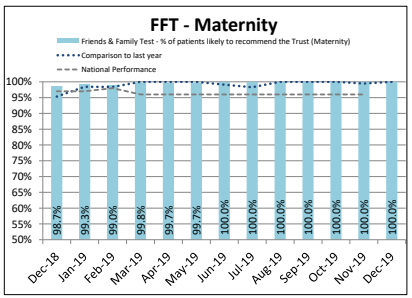












Patient Safety

1 Our Patients Summary 1.3 Patient Safety

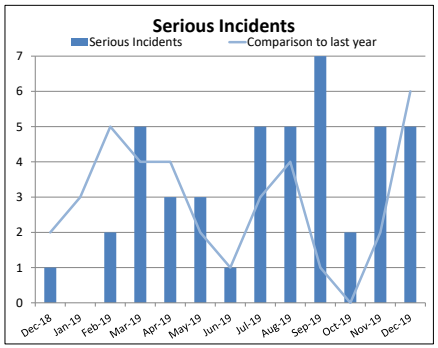
NHS The Princess Alexandra Hospital NHS Trust

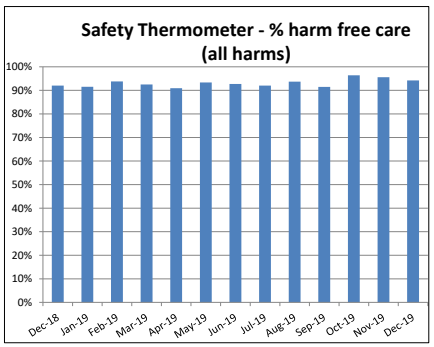
There were 1065 incidents reported in December 2019 of which 824 incidents were PAH, comprising of 601 no harm, 204 minor harm (97.7%) for both of these.
18 moderate harm (2.2%), 1 severe harm (0.1%).The percentage spread is consistent with previous months.

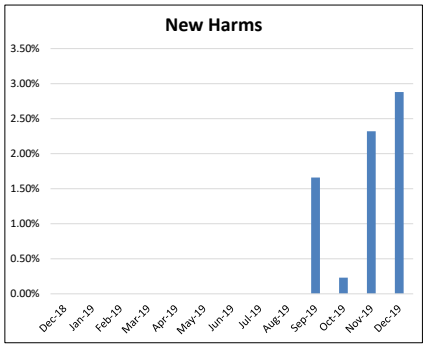
There were 5 incidents meeting the Serious Incident criteria & were declared externally in December 2019:
- Delay in diagnosis of an incidental finding on a CT scan (in 2017). Patient died of cholangiocarcinoma in 2019 (this incident occurred in July but was established from review undertaken in December).
- 2 patients died following an unwitnessed falls (1 incident graded as severe and 1 graded as moderate).
- Patient sustained a sub-arachnoid haemorrhage and a fractured neck of femur following an unwitnessed fall (moderate harm).
- Patient who presented to Emergency Department (ED) with a hernia and was discharged home. Returning 48 hours later with an incarcirated hernia. Patient deteriorated and the decision was made to not operate and to make the patient end of life (incident occurred in November).

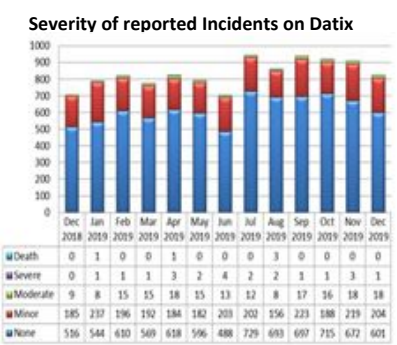
For all incidents the final grading will be confirmed upon conclusion of the investigations.

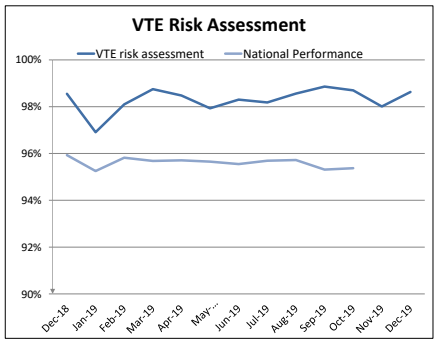
National Reporting and Learning System (NRLS)
We reported in previous months that there was a variation of 10.7% (144 incidents) in incidents recorded on PAH Datix system in comparison with NRLS.
After completing a subsequent upload to NRLS in December, the data the variance is now 0.62% which is 21 incidents. The discrepancy of 21 incidents is likely to be due to changes made on Datix by the incident handlers as Datix is a dynamic system and handlers are reviewing incidents on a daily basis.

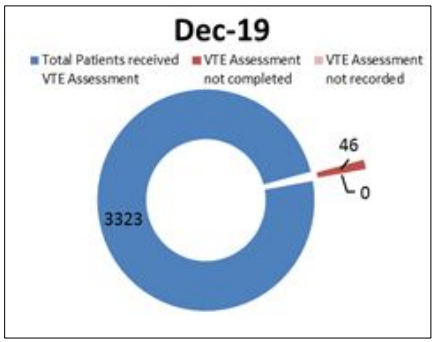


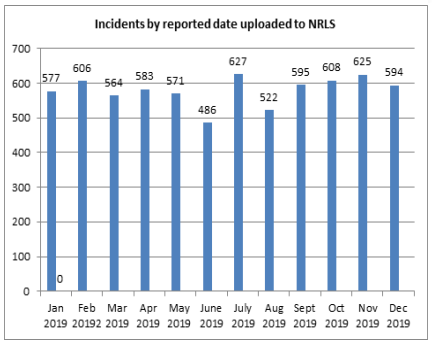


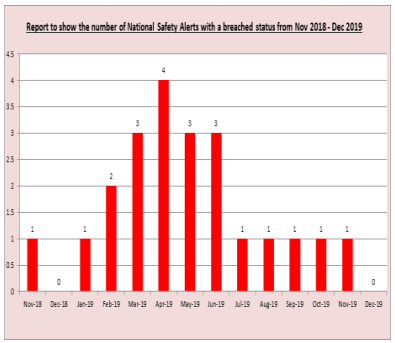












Infection Control

1 Our Patients Summary 1.4 Infection Control

The Princess Alexandra Hospital NHS Trust

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

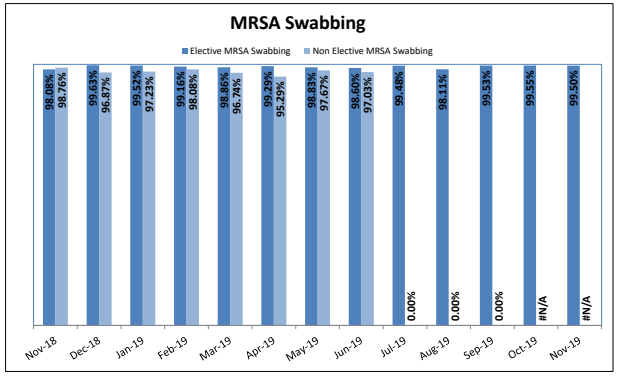
MSSA - The Trust continues to have low numbers of MSSA bacteraemia and remains in the top quarter of best performing hospitals nationally. There were no Trust cases of MSSA during December.

C.difficile - There have been a total of 18 cases year to date; under new definitions these are classified as 14 hospital onset cases and four community onset cases. There were four (hospital) cases in December (Harvey ward, Kingsmoor ward, Penn ward and John Snow). Of the 18 cases we have had, eight have been successfully appealed. The next Appeals Panel (chaired by the CCG) has been organised for 23/01/2020, where five further cases will be appealed.

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

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

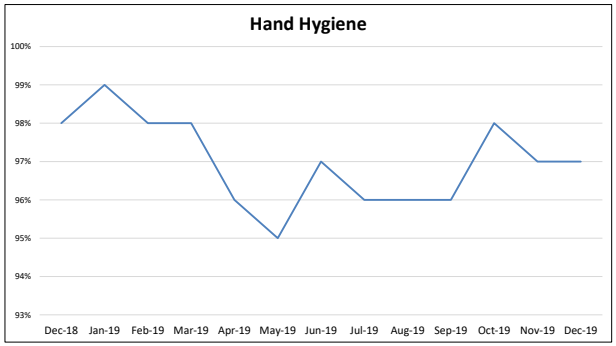
Hand Hygiene Audits – All wards/clinical department are expected to participate in monthly audits and these are undertaken as 'cross-over' audits, meaning staff do not audit themselves. The expectation is that 100% of clinical areas participate and the performance standard is 95% compliance. During December,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



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

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

C-DIFF (New categories including community from April 2019)					
Month	Hospital Responsible		Community Responsible		Total
	Hospital onset healthcare associated	Community onset healthcare associated (Acute Admission within last 4 wks)	Community onset indeterminate association (Acute Admission within last 12 wks)	Community onset community associated (No acute contact within 12 wks)	
Apr-19	2	1	1	0	4
May-19	1	1	1	0	3
Jun-19	0	1	0	2	3
Jul-19	1	0	0	5	6
Aug-19	0	0	1	2	3
Sep-19	1	1	0	0	2
Oct-19	1	0	1	2	4
Nov-19	3	0	0	1	4
Dec-19	4	0	3	0	7



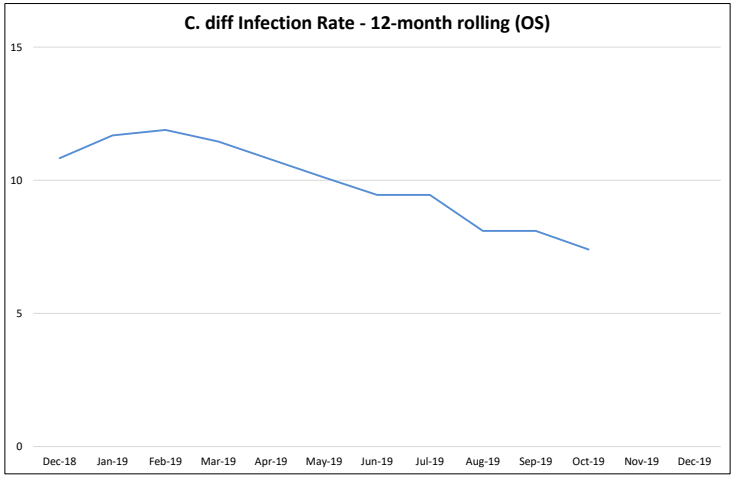
E Coli	
Dec-18	1
Jan-19	1
Feb-19	2
Mar-19	1
Apr-19	2
May-19	1
Jun-19	2
Jul-19	0
Aug-19	2
Sep-19	3
Oct-19	0
Nov-19	0
Dec-19	1

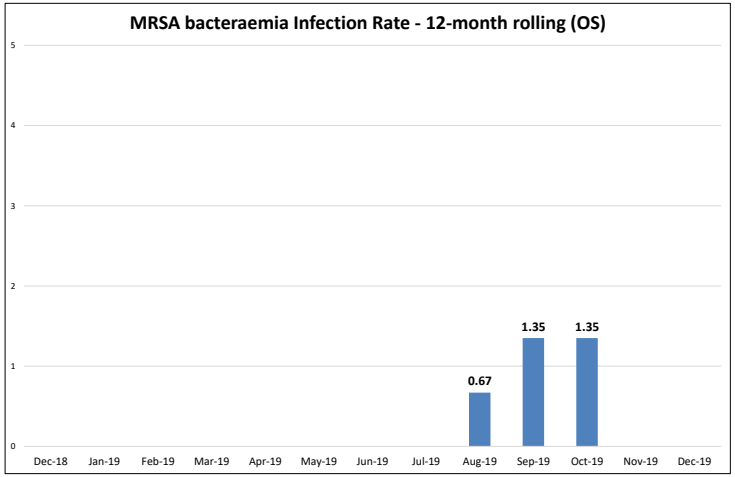
Klebsiella	
Dec-18	1
Jan-19	2
Feb-19	0
Mar-19	0
Apr-19	0
May-19	0
Jun-19	1
Jul-19	0
Aug-19	0
Sep-19	0
Oct-19	0
Nov-19	0
Dec-19	1

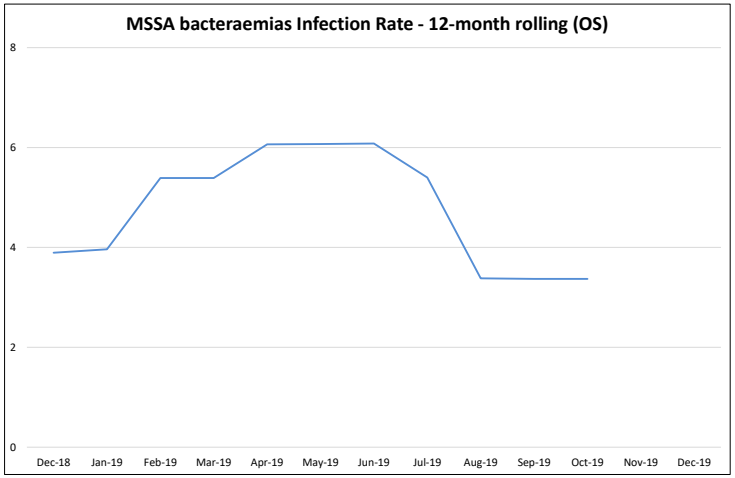
Pseudomonas	
Dec-18	0
Jan-19	0
Feb-19	0
Mar-19	0
Apr-19	0
May-19	0
Jun-19	0
Jul-19	0
Aug-19	0
Sep-19	1
Oct-19	2
Nov-19	0
Dec-19	0

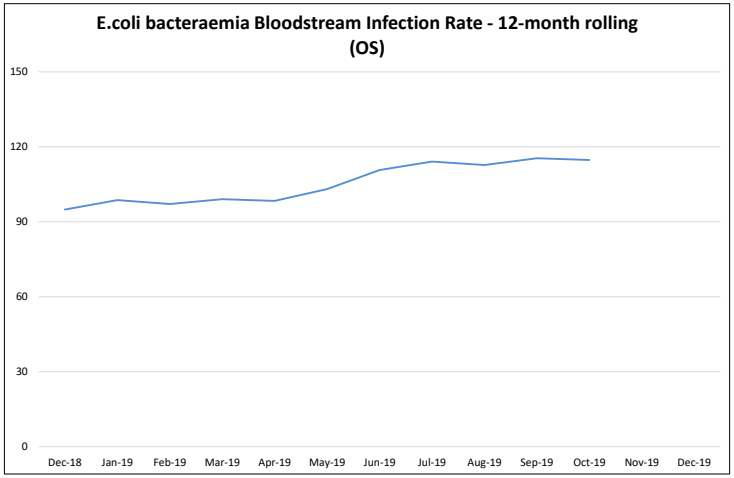
Infection Control

The following are the latest published data available.









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

Pressure Ulcers

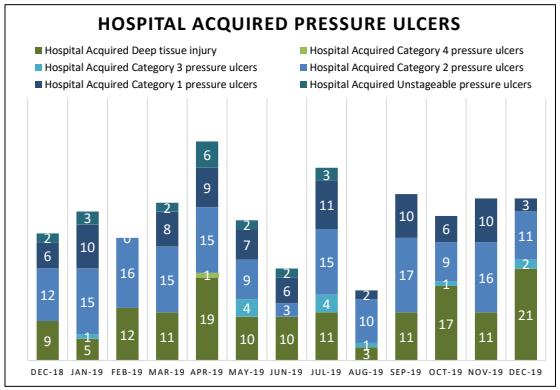
There were a total of 37 pressure ulcers in December which is the same as last month. In terms of severity, there were 0 unstageable/ 0 Category 4 pressure ulcers and 2 Category 3 pressure ulcers.

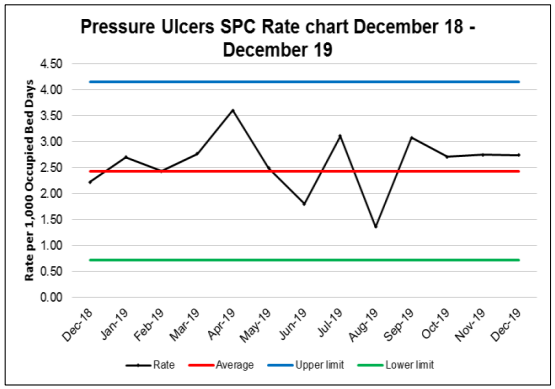
Six of the PUs were medical device related, 5 from oxygen devices. Two patients developed pressure ulcers related to end of life skin failure, with no omissions in care identified. It is worth noting that several pressure ulcers this month developed due to patient's poor clinical condition including CPR administered on the floor and patients needing inotropes, 1 patient acquiring 3 pressure ulcers in ITU due to this reason.

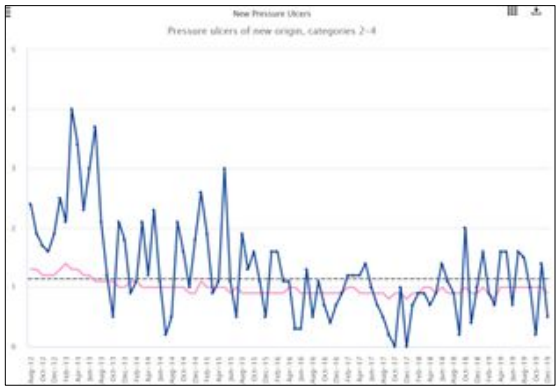
This month the highest number of hospital acquired pressure ulcers were Tye Green with 6 followed by ITU and Gibberd both with 5 pressure ulcers. The Pressure Ulcer Prevention plan continues to focus on reducing pressure ulcers to the feet/heels, device related pressure ulcers and improving the quality of repositioning.

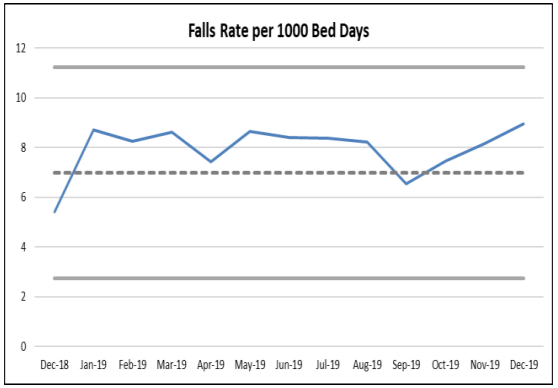
Falls

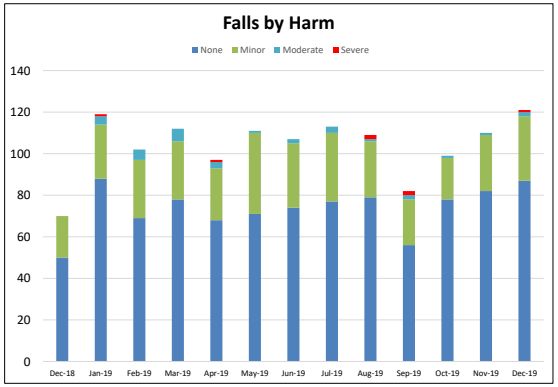
The overall number of falls rate was 122 an increase on previous months. The falls with harm rate was 30% which is in line with total overall harm rate for the last 12 months (30%). There are a number of ongoing RCA investigations into the falls with severe harm and a round table is being held with the CCG to undertake a thematic review of the root causes. A Trustwide Falls Prevention strategy is being developed to take forward the improvements which include reviewing the risk assessment process and introducing a care bundle to guide nursing care of high risk fallers to reduce the number of unwitnessed falls with harm.

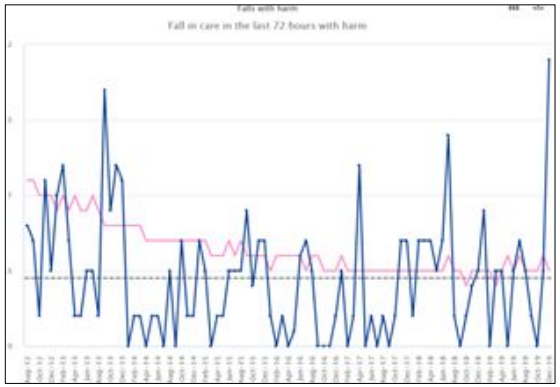










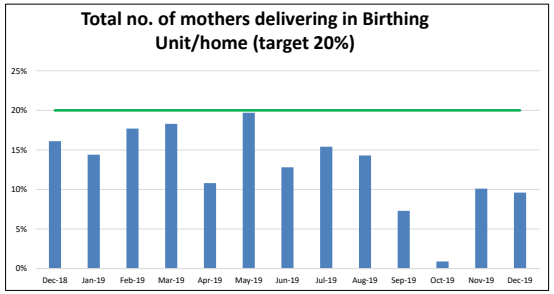


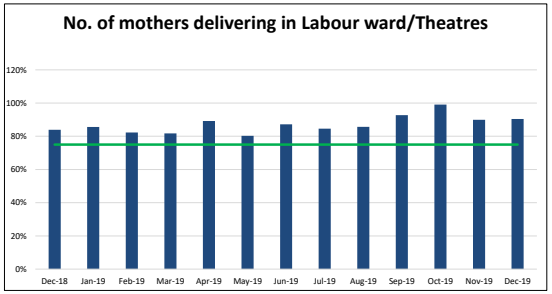
Family & Women's Service

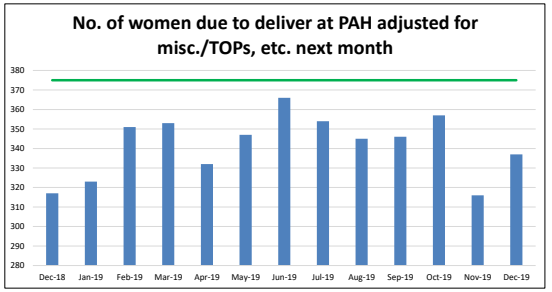
2 Our Patients Summary 1.7 Family & Women's Service

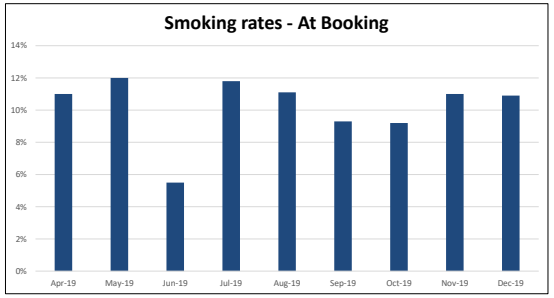
The Princess Alexandra Hospital NHS Trust

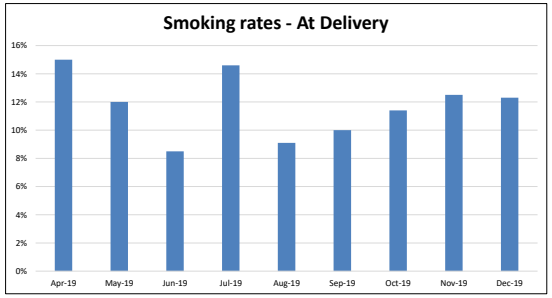
The Doctors CTG training has steadily improved over the last three months and now stands at 93%.
The overall C Section rate for December was 33.8%, which was higher than usual. This was mainly due to the proportion of planned C Sections being higher than expected, at 16.9% of all deliveries. The Antenatal Clinic keeps a record of the indications for every C Section.
An audit of all the reasons for the planned C Sections in December will be conducted and presented at the next available FAWS Audit Meeting.
PAH Stillbirth Rate for 2019 was 2.27 per thousand compared to the latest available MBRRACE National Rate, from 2015, of 3.93 per thousand.

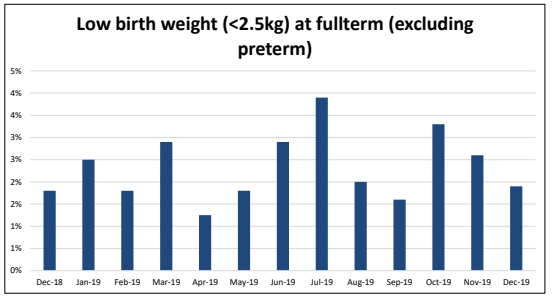


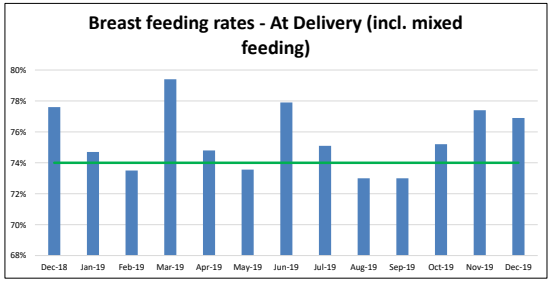


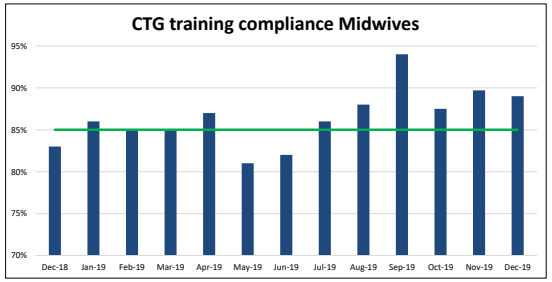


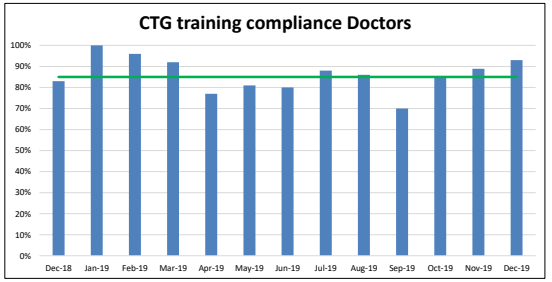




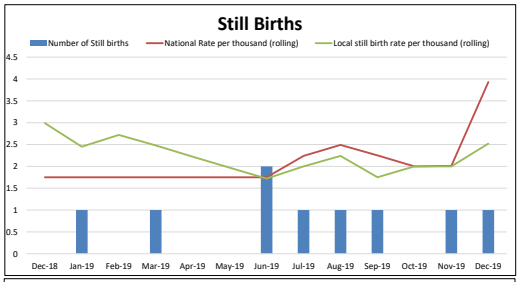


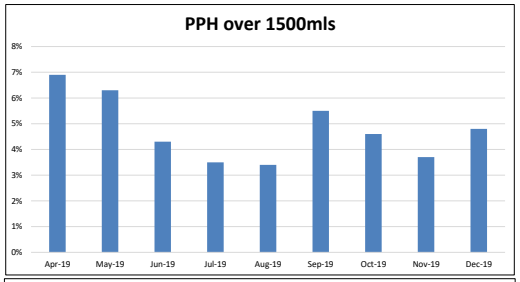


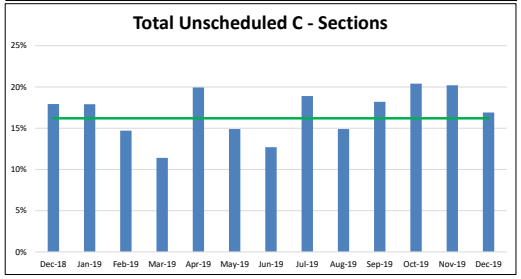


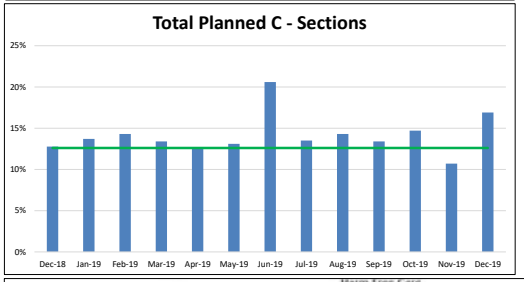


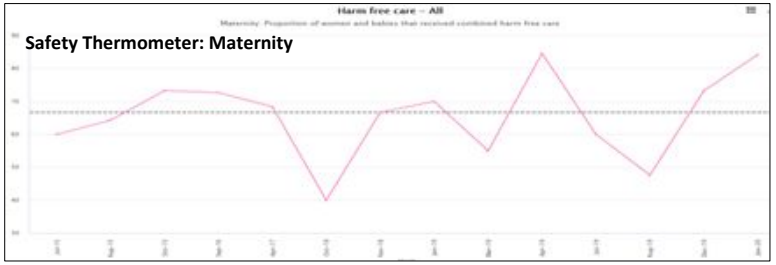
Family & Women's Service









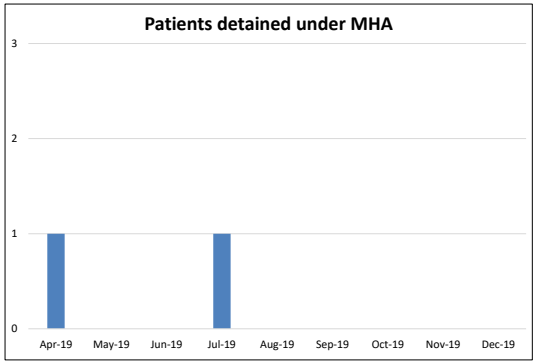


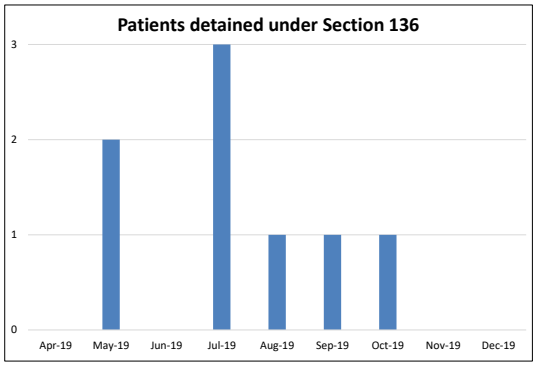
Mental Health

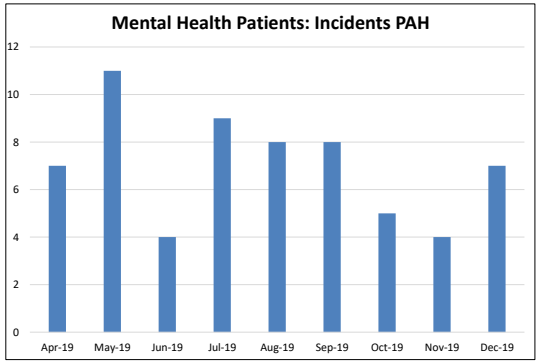
1 Our Patients Summary 1.9 Mental Health

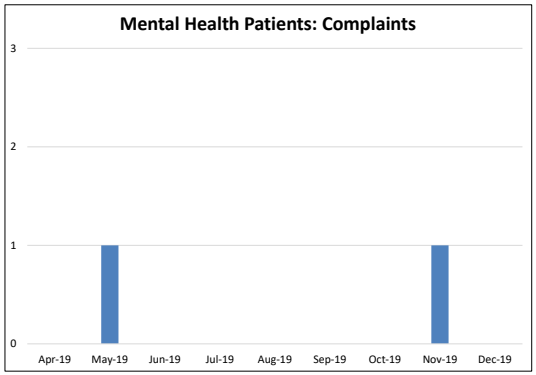
The Princess Alexandra Hospital NHS Trust

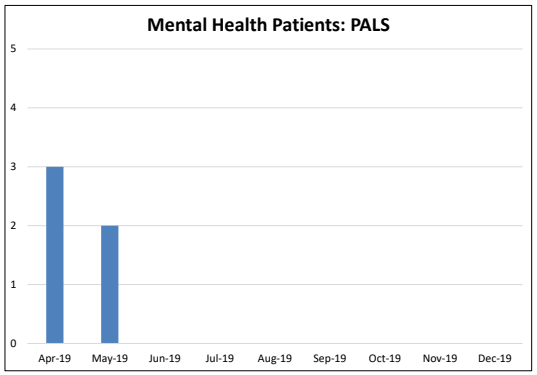
This page notes the number of patients detained under the Mental Health Act to PAH, and the number of incidents and complaints in relation to mental health. Quality improvement work, and joint work with our mental health partners continues through the Mental Health Quality Forum.

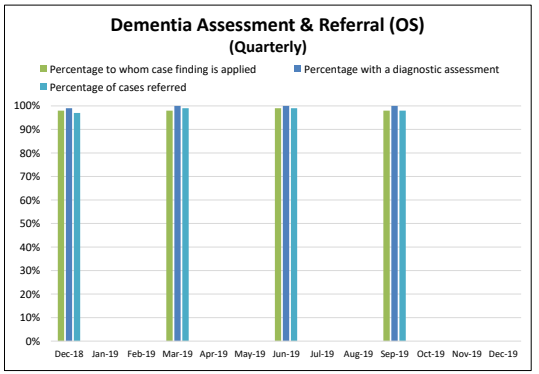




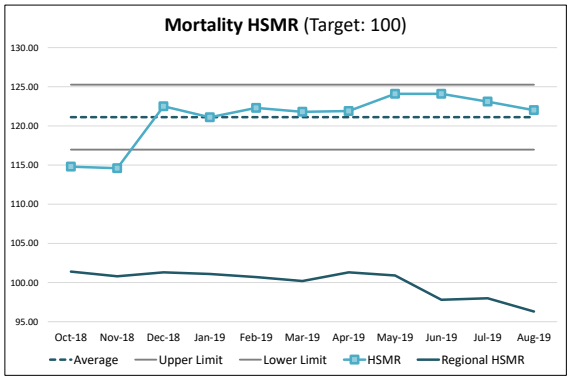


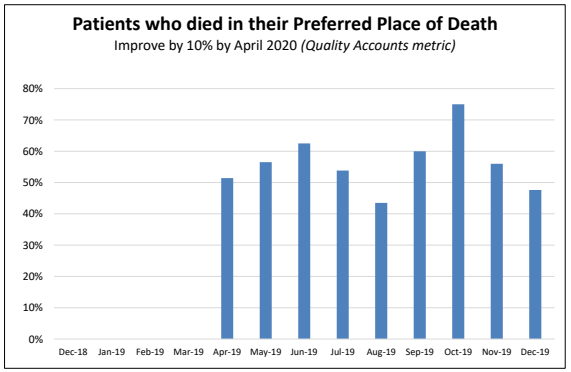






Mortality





Mortality SHMI	
Dec-18	
Jan-19	114.3
Feb-19	113.6
Mar-19	
Apr-19	113.0
May-19	111.4
Jun-19	111.8
Jul-19	112.1
Aug-19	111.6
Sep-19	
Oct-19	
Nov-19	
Dec-19	

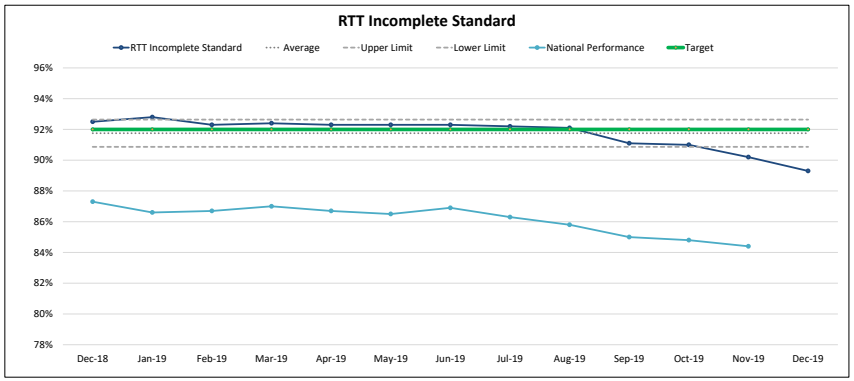
Mortality Outlier Alerts (QA)	
May 17 - Apr 18	4
Jun 17 - May 18	4
Jul 17 - Jun 18	4
Aug 17 - Jul 18	6
Sep 17-Aug 18	6
Oct 17 - Sep 18	9
Nov 17 - Oct 18	8
Jan 18 - Dec 18	7
Feb 18 - Jan 19	6
Mar 18 - Feb 19	7
Jul 18 - Jun 19	7
Aug 18 - Jul 19	6
Sep 18 - Aug 19	5

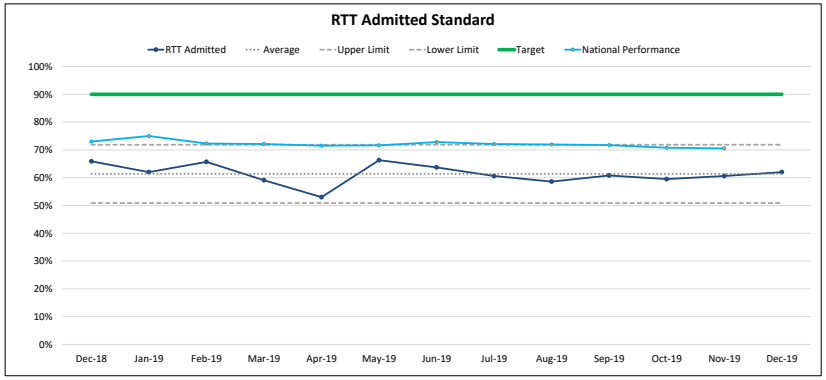
Executive Summary Our Performance

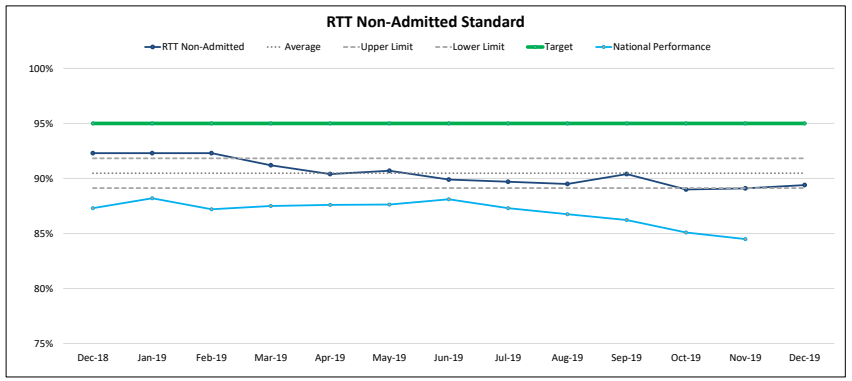
The Princess Alexandra Hospital NHS Trust

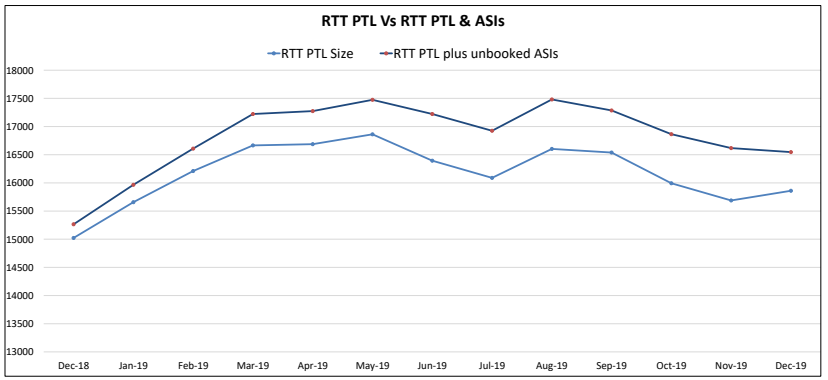
Constitutional standards in Cancer were achieved with consistent improvement in pathway management of patients. RTT continued to perform below national standards, however recovery trajectories are in place and monitored on a weekly basis. Full demand and capacity work is underway ahead of operational planning and contracts for 2020/21. Additional senior operational support is in place to assist the medical specialties with good clinical engagement in place. Diagnostics narrowly missed the national standard in month, however will return to national performance levels in January. The expected winter pressures continued in December with high level of attendances and demand compared to the same period in 2018. Minors increased by 10% with a slight increase in majors at just over 1%. Ambulance conveyances were consistent throughout the month. Following negotiations through the Local Delivery Board, the Trust now has a 7 day Hospital Ambulance Liaison Officer (HALO) cover in place 12 hours per day. Demand management schemes agreed with CCG and system partners are all in place and monitored through the weekly operational teams. Additional capacity in primary care is in place with 3200 more appointments available for patients. The Trust went live with the Urgent Treatment Centre on the 31st December, which means the urgent care team can now direct book appointments into primary care. All additional hospital winter capacity is now in place and open in line with agreed plans. Additional intermediate care beds will open mid January, with additional spot purchase arrangements in place in the interim period. Length of stay increased in December with a spike in patients staying over 20 days in the Trust. There are weekly reviews in place across the Trust which now include GP and Community colleagues to ensure robust discharge plans are in place.

RTT


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


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

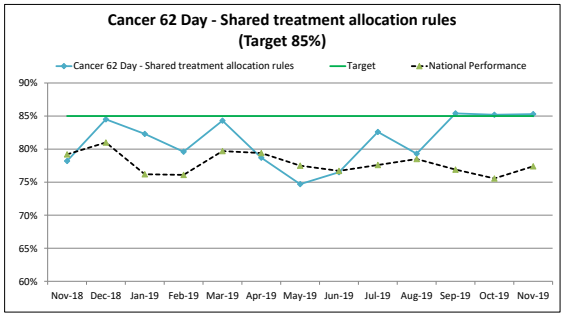

RTT Non-Admitted Standard
RTT Non-Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
95%
90%
85%
80%
75%
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19

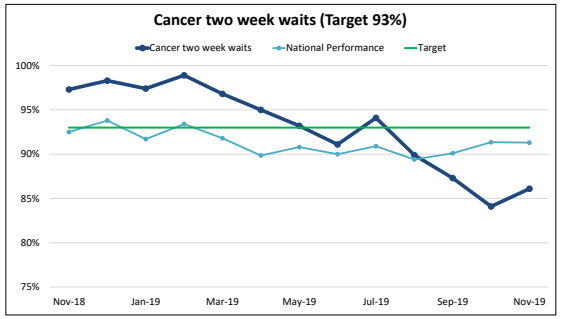

RTT PTL Vs RTT PTL & ASIs
RTT PTL Size
RTT PTL plus unbooked ASIs
18000
17500
17000
16500
16000
15500
15000
14500
14000
13500
13000
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19

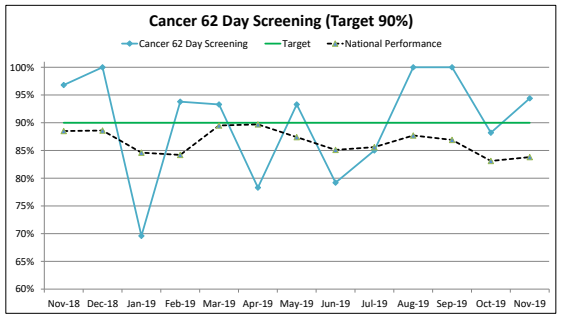
Cancer

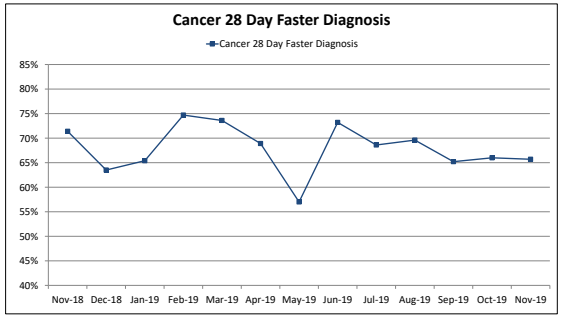
	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Nov-18	97.70%	97.40%	100.00%	100.00%
Dec-18	96.90%	100.00%	100.00%	100.00%
Jan-19	97.40%	97.00%	100.00%	100.00%
Feb-19	96.70%	97.30%	100.00%	100.00%
Mar-19	86.90%	96.90%	100.00%	100.00%
Apr-19	91.00%	100.00%	100.00%	100.00%
May-19	92.60%	97.80%	92.90%	75.00%
Jun-19	76.10%	98.10%	100.00%	100.00%
Jul-19	95.70%	99.00%	100.00%	100.00%
Aug-19	97.50%	98.90%	100.00%	100.00%
Sep-19	99.10%	99.10%	100.00%	100.00%
Oct-19	99.10%	100.00%	100.00%	100.00%
Nov-19	97.60%	100.00%	100.00%	100.00%

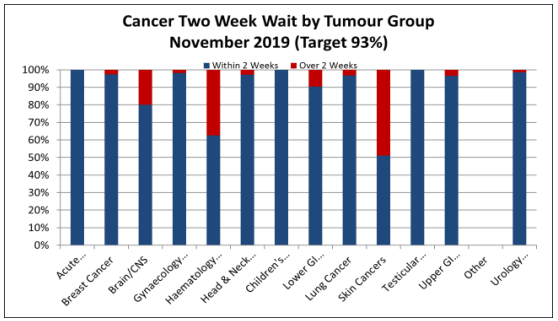
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

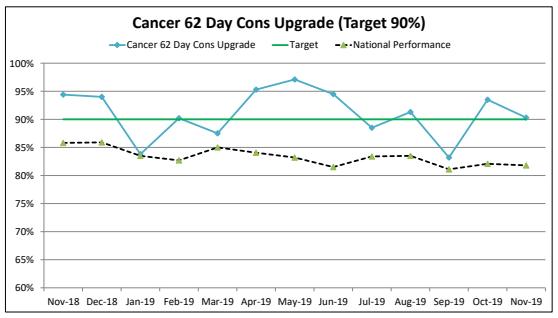




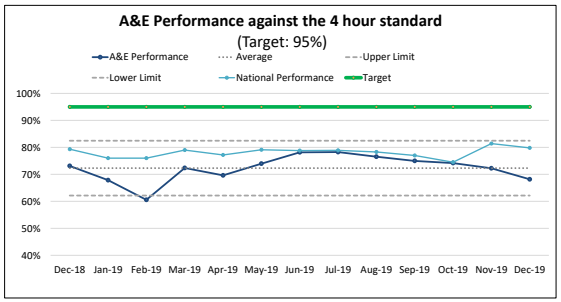


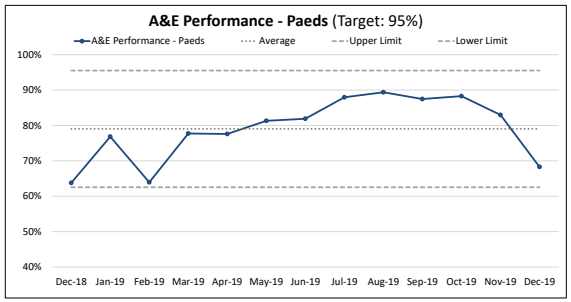


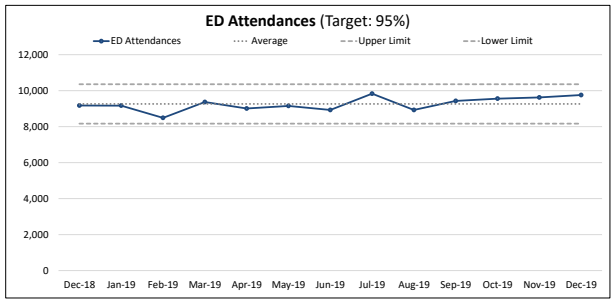


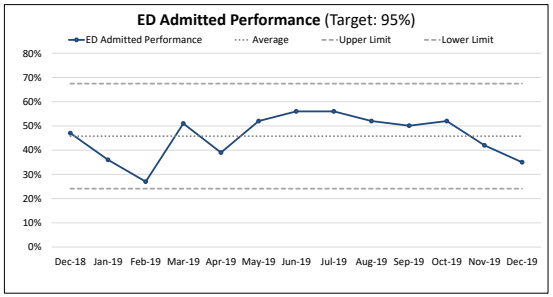


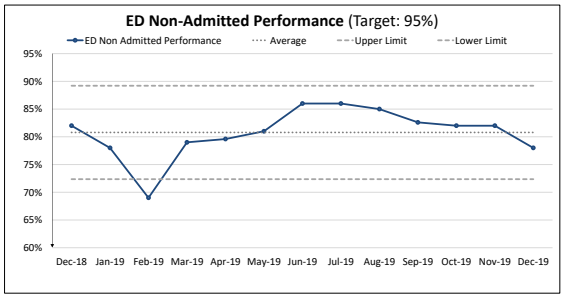
ED





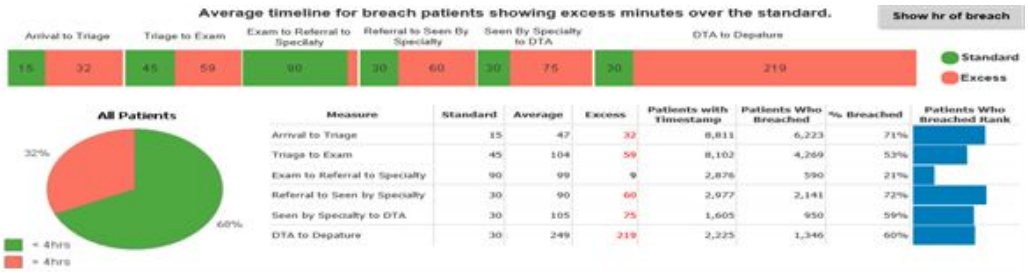




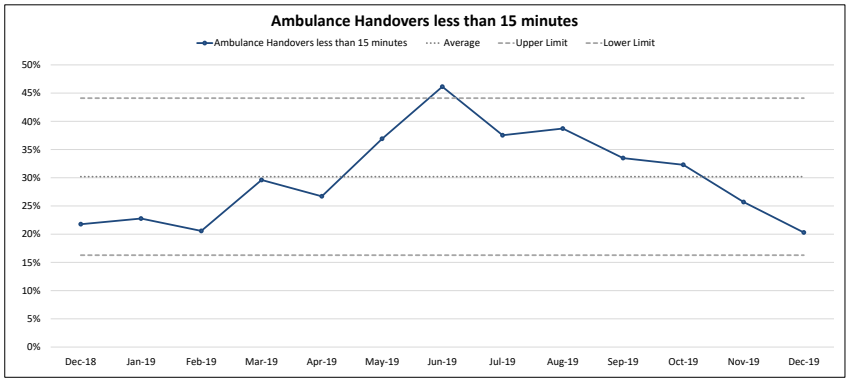


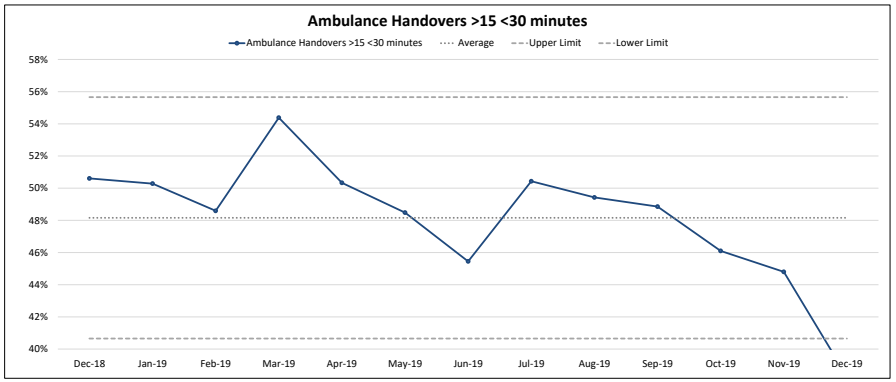
ED Internal Professional Standards

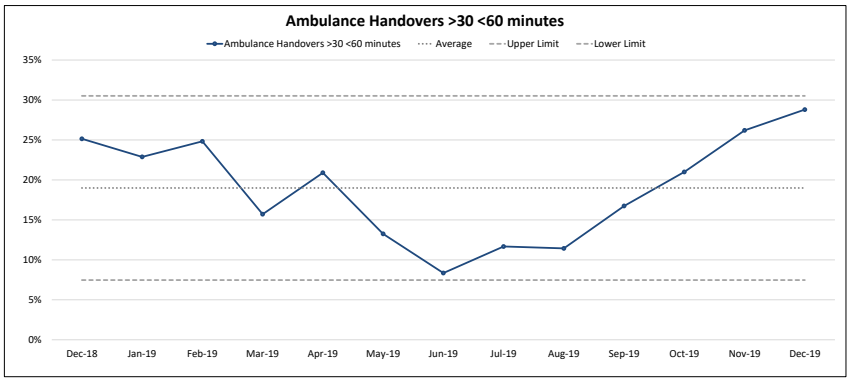
	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Arrival to Triage - Average Wait (Minutes)	34	37	43	35	38	33	26	46	34	39	35	38.63	46
Triage to Exam - Average Wait (Minutes)	94	106	118	106	99	99	91	90	93	102	108	102	104
Exam to Referral to Specialty - Average Wait (Minutes)	83	85	97	81	82	80	82	81	83	84	88	96	99
Referral to Seen by Specialty - Average Wait (Minutes)	82	84	85	73	75	69	67	65	79	70	78	98	90
Seen by Specialty to DTA - Average Wait (Minutes)	97	105	109	82	93	72	78	73	74	84	87	96	105
DTA to Departure - Average Wait (Minutes)	209	312	308	171	197	147	120	115	108	120	116	217	249

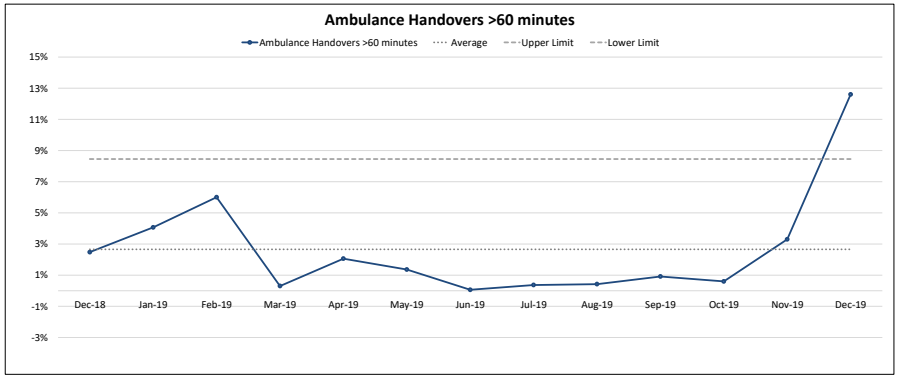


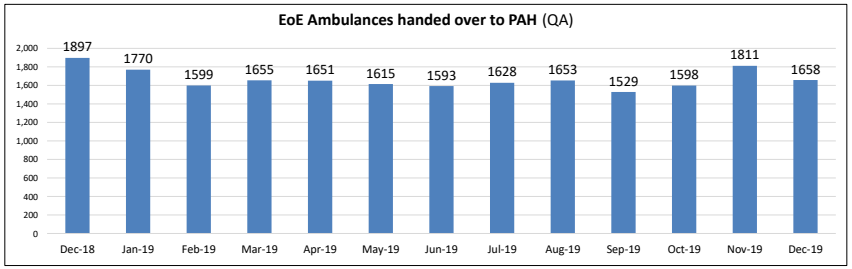
Measure	Standard	Average	Excess	Patients with Timestamp	Patients Who Breached	% Breached	Patients Who Breached Rank
Arrival to Triage	15	47	32	8,811	6,223	71%	
Triage to Exam	45	104	59	8,102	4,269	53%	
Exam to Referral to Specialty	90	99	9	2,876	590	21%	
Referral to Seen by Specialty	30	90	60	2,977	2,141	72%	
Seen by Specialty to DTA	30	105	75	1,605	950	59%	
DTA to Depature	30	249	219	2,225	1,346	60%	


Ambulance Handovers less than 15 minutes
Ambulance Handovers less than 15 minutes
Average
Upper Limit
Lower Limit
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19

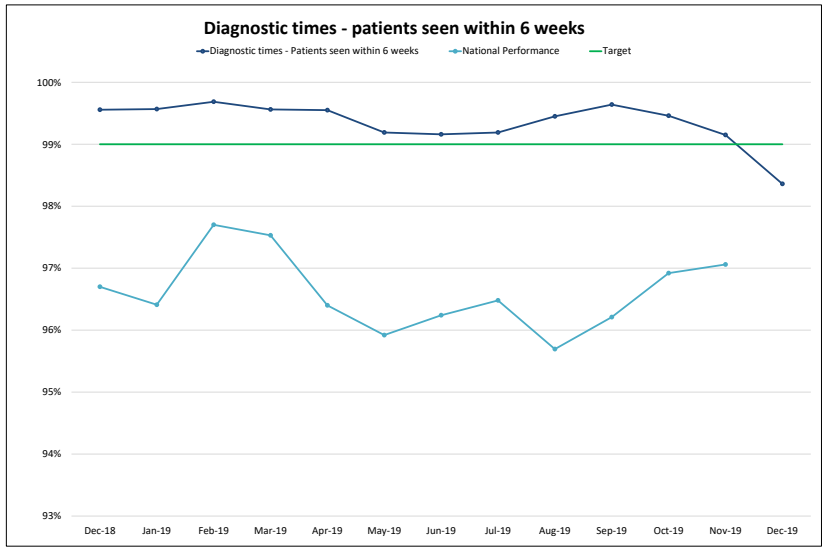

Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
58%
56%
54%
52%
50%
48%
46%
44%
42%
40%
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19

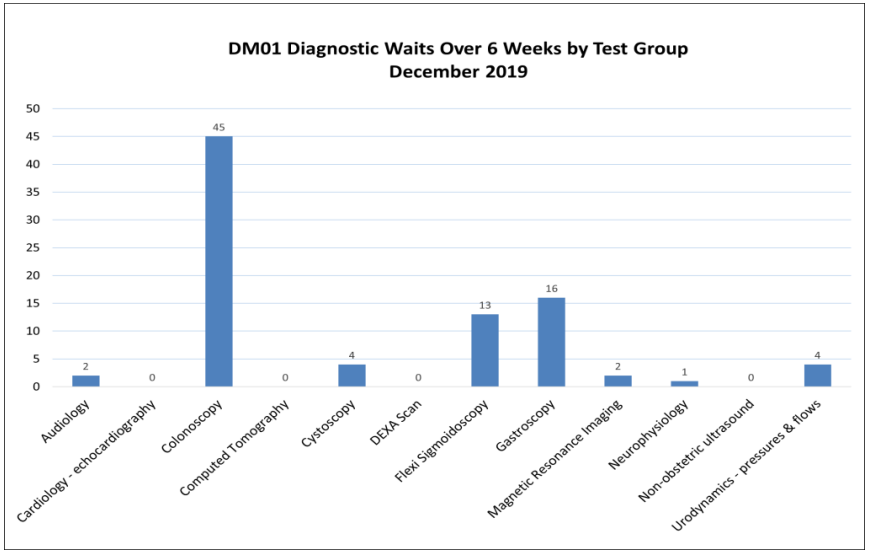

Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
35%
30%
25%
20%
15%
10%
5%
0%
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19


Ambulance Handovers >60 minutes
Ambulance Handovers >60 minutes
Average
Upper Limit
Lower Limit
15%
13%
11%
9%
7%
5%
3%
1%
-1%
-3%
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19

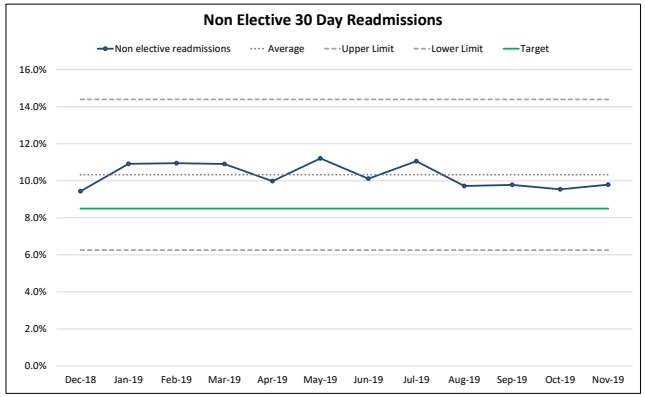

EoE Ambulances handed over to PAH (QA)
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1897
1770
1599
1655
1651
1615
1593
1628
1653
1529
1598
1811
1658
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19

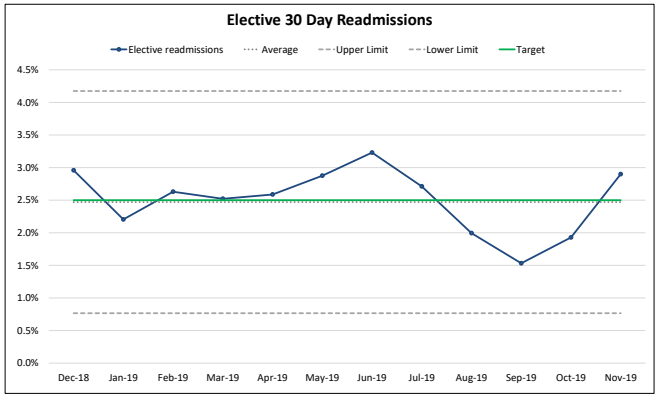
Diagnostics

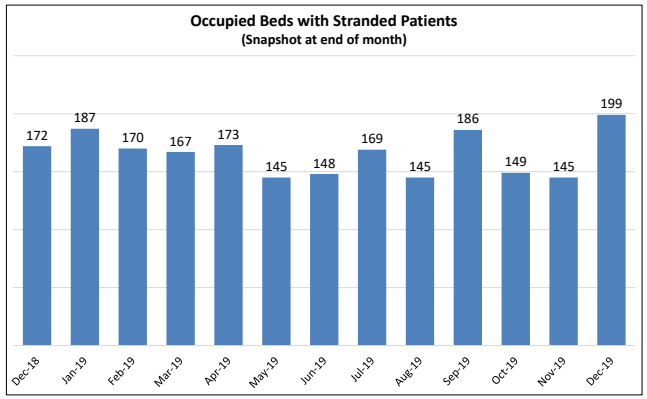


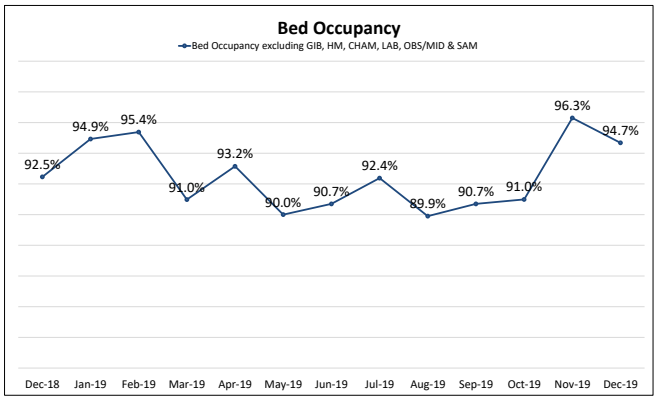


Test	% of Total Cohort - Dec 19	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Magnetic Resonance Imaging (MRI)	24.3%	100.00%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	99.86%	99.79%	99.84%
Computed Tomography (CT)	10.8%	100.00%	100%	99.70%	99.85%	100%	99%	100%	100.00%	99.09%	99.83%	100.00%	99.81%	100.00%
Non-Obstetric Ultrasound	38.2%	99.96%	99.84%	99.66%	100.00%	99.76%	100%	100%	100.00%	99.86%	99.96%	99.92%	99.92%	100.00%
DEXA	0.7%	100%	100.00%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Audiology - Audiology Asessments	3.0%	100.00%	98%	99%	98%	100%	99%	99%	100.00%	99.51%	100.00%	100.00%	100.00%	98.76%
Cardiology - Echocardiography	15.2%	100%	100.00%	100.00%	100.00%	100%	100%	100%	100.00%	99.86%	99.74%	98.34%	100.00%	100.00%
Neurophysiology	0.7%	100%	100%	100%	100%	100.00%	100%	83%	50%	67%	67%	86%	93%	97.22%
Urodynamics	0.7%	80%	70.37%	82.35%	90.00%	86.84%	90%	93%	90.00%	95.24%	94.74%	89.19%	92.00%	88.57%
Colonoscopy	3.4%	95.93%	98.45%	98.16%	95.24%	96.76%	91%	88%	84.62%	94.81%	99.24%	98.68%	89.14%	74.72%
Flexi Sigmoidoscopy	0.8%	96%	97%	100.00%	90.91%	97.67%	90%	93%	89.66%	92.86%	100.00%	94.29%	94.59%	69.05%
Cystoscopy	0.5%	100.00%	100.00%	100%	94.74%	100%	91%	92%	95.65%	93.55%	100.00%	96.30%	92.00%	86.21%
Gastroscopy	1.8%	92.38%	98.51%	100.00%	95.00%	95.35%	93%	88%	88.79%	96.83%	98.81%	99.07%	89.57%	83.16%

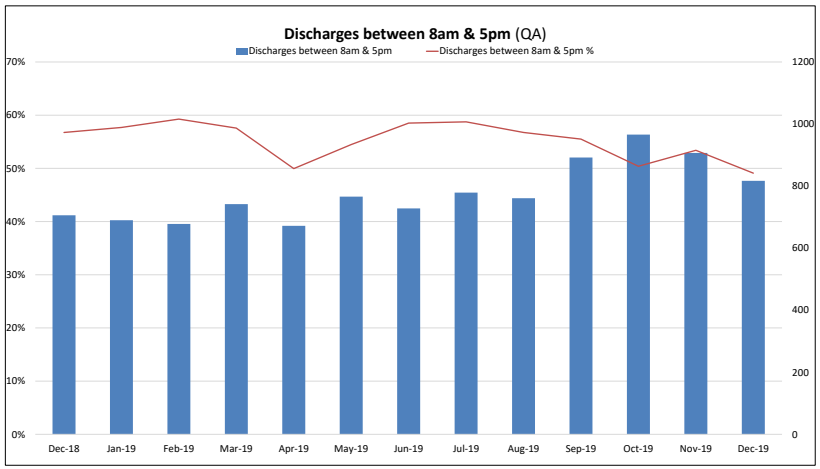

Non Elective 30 Day Readmissions
Non elective readmissions
Average
Upper Limit
Lower Limit
Target
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19

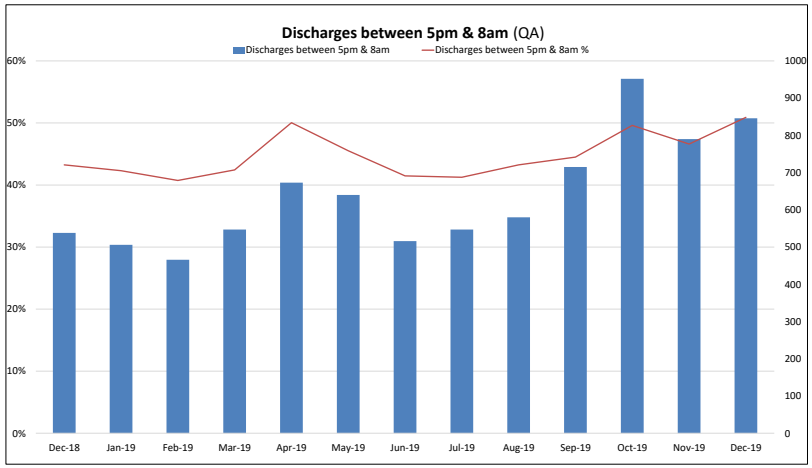

Elective 30 Day Readmissions
Elective readmissions
Average
Upper Limit
Lower Limit
Target
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19

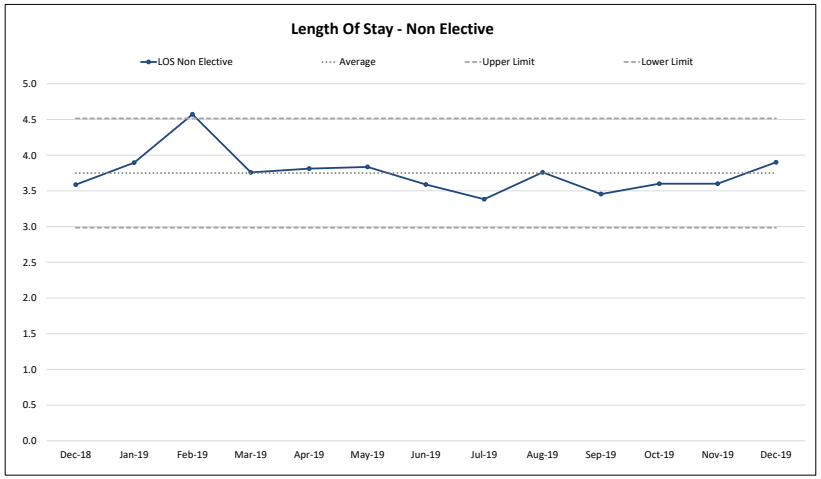

Occupied Beds with Stranded Patients
(Snapshot at end of month)
172
187
170
167
173
145
148
169
145
186
149
145
199
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19

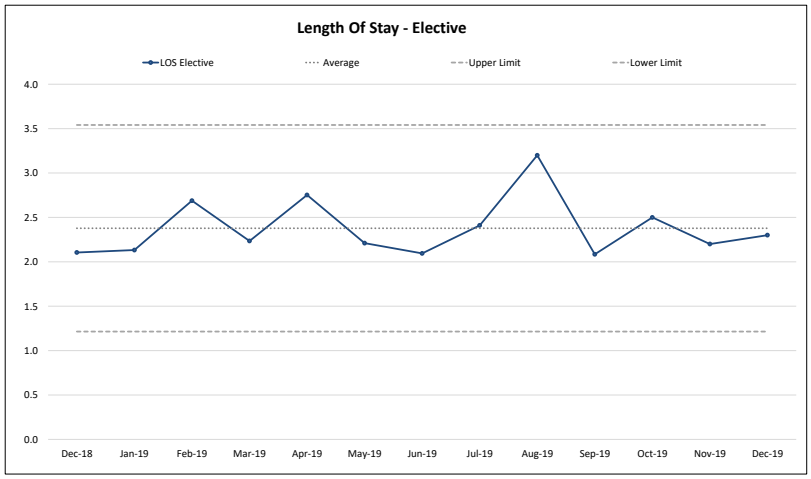

Bed Occupancy
Bed Occupancy excluding GIB, HM, CHAM, LAB, OBS/MID & SAM
92.5%
94.9%
95.4%
91.0%
93.2%
90.0%
90.7%
92.4%
89.9%
90.7%
91.0%
96.3%
94.7%
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19

Discharges & LOS

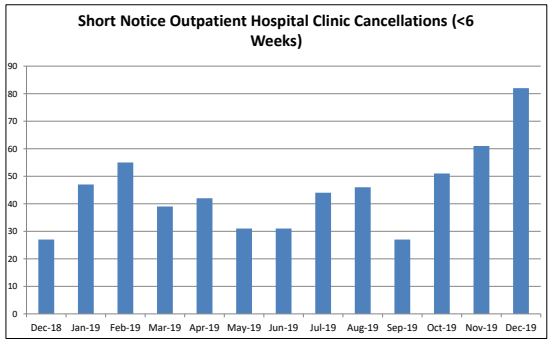


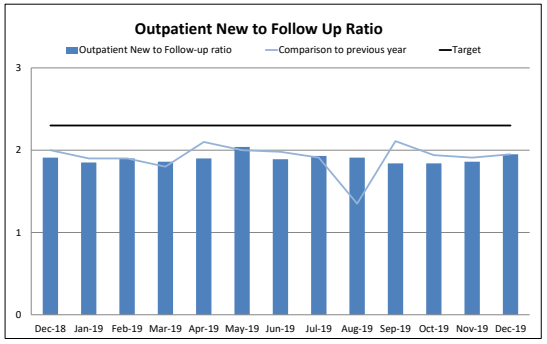


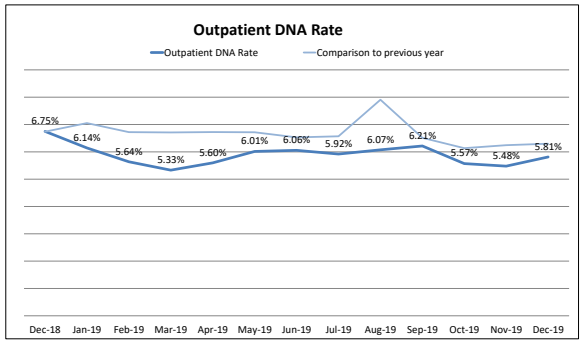


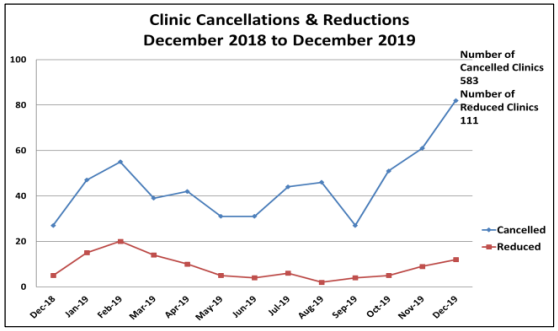


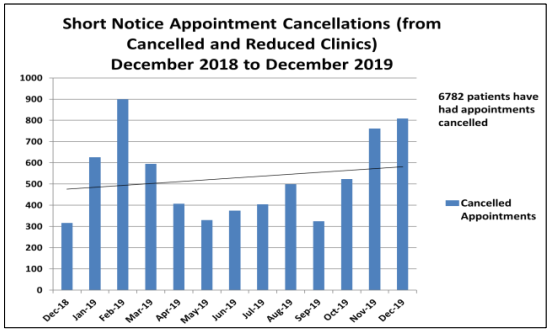
Outpatients & Cancelled Operations

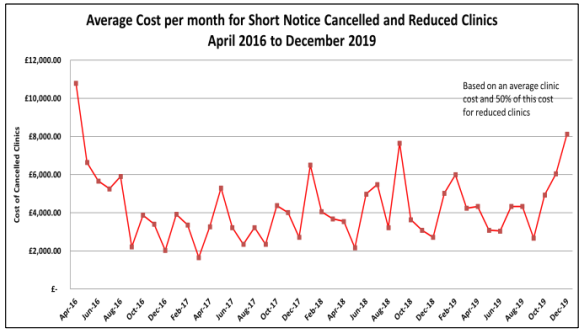












DNA Rate for Follow Up Appointments per Specialty for December

Specialty & Performing Unit	AHP Episode	Anticoagulant Service	Breast Surgery	Cardiology	Chemical Pathology	Clinical Haematology	Clinical Oncology	Colorectal Surgery	Community Midwifery	Dermatology	Diabetic Medicine	Dietetics	Endocrinology	ENT	Gastroenterology	General Medicine	General Surgery	Gynaecology	Haematology	Medical Oncology	Medicine for the Elderly	Neonatology	Neurology	Obstetrics	Ophthalmology	Optometry	Oral Surgery	Orthoptics	Paediatric Diabetic Medicine	Paediatrics	Physiotherapy	Respiratory Medicine	Rheumatology	Trauma & Orthopaedics	Urology	Vascular Surgery	Well Baby	Total
DNA Rate	0.0%	11.4%	6.4%	4.2%	21.6%	14.3%	0.5%	1.7%	5.7%	6.7%	5.2%	7.7%	2.3%	5.8%	6.4%	0.4%	5.7%	4.5%	3.9%	0.5%	0.0%	0.0%	4.9%	3.7%	9.3%	4.5%	7.5%	16.2%	13.8%	6.6%	9.9%	7.9%	5.0%	6.6%	4.3%	3.1%	5.4%	5.4%

Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

People measures

• The overall trust vacancy rate is 10.3%. The trust's largest vacancy rate continues to be within nursing, specifically at Band 5. This vacancy rate has improved considerably over this financial year, reducing from 40% less than 20% as of November 2019.
• The trust continues with its successful programme of overseas recruitment for both Nursing and Medical staff.
• The appraisal rate for December is 87%, sitting just below the trust KPI of 90%. Meetings continue to take place with the HCGs to support action plans to improve compliance. The trust is seeing improvements in some areas.
• Statutory and Mandatory compliance for the trust is 93%. Monitoring and support is given to HCGs to ensure compliance remains above the KPI
• Friends and Family test responses are above the trust KPI:
- Place to work 61% (KPI 65%)
- Care of treatment 78% (KPI 67%)
• Flu vaccination – Frontline staff 70%, all staff 64%.
• Improvements to temporary staffing spend, bi-weekly executive led meetings taking place to review governance and cost.

People development

• Second managers' induction programme took place in December, topics covered recruitment and selection, sickness absence, performance management with positive feedback being given by delegates. Further sessions booked for Jan and Feb.
• Unwrapping unconscious bias training sessions will continue until March 2020. 66% of managers have attended so far.
• PAHT will be leading on "Step into Work" programmes in conjunction with the STP.
• Preparations for the first cohort of the PAHT talent management programme in conjunction with Silvermaple have commenced.

Workforce Indicators Summary

Agency Spend 5.13%
Bank Spend 11.20%

Staff In Post
3238
WTE

Training
93%

Sickness
4.1%

10.4%

Turnover
11%

Medical 99%
Non-Medical 87%

Scorecard

People Measures as at 31st December 2019	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3639.25	890.87	467.17	890.41	770.24	278.18	131.75	54.68	155.95
Vacancy Rate	8.0%	10.39%	6.46%	12.04%	14.36%	15.73%	9.45%	0.00%	4.04%	9.48%
Agency % of paybill	7.0%	5.1%	2.2%	3.1%	10.5%	6.1%	0.0%	0.0%	0.0%	0.0%
Bank Usage - wte	n/a	342.35	35.48	33.55	168.19	69.31	15.63	9.10	0.51	10.55
Agency Usage -wte	n/a	109.58	12.24	5.95	51.44	27.81	0.00	12.14	0.00	0.00
November 2019 Sickness Absence	3.7%	4.1%	3.5%	3.7%	4.1%	3.5%	9.3%	3.6%	0.8%	4.6%
Short Term Sickness	1.85%	2.1%	1.9%	2.1%	2.2%	1.8%	3.4%	2.1%	0.8%	2.0%
Long Term Sickness	1.85%	2.0%	1.6%	1.6%	1.8%	1.8%	5.9%	1.5%	0.0%	2.6%
Rolling Turnover (voluntary)	12%	10.6%	9.8%	10.1%	11.3%	11.1%	10.7%	9.7%	12.5%	10.4%
Statutory & Mandatory Training	90%	93%	97%	89%	91%	89%	96%	97%	96%	99%
Appraisal	90%	87%	90%	85%	84%	85%	82%	89%	88%	91%
FFT (care of treatment) Q2	67%	78%	76%	84%	83%	78%	61%	75%	68%	82%
FFT (place to work) Q2	61%	65%	56%	72%	69%	62%	45%	75%	60%	67%
Flu Vaccination 19/20	100%	62%	59%	61%	55%	59%	47%	80%	50.0%	42.1%
% of Rosters Approve on Time	100%	60%	100%	60%	48%	80%				
Starters (wte)		47.07	7.94	1.80	3.84	5.00	5.64	21.85	0.00	1.00
Leavers (wte)		20.08	5.27	5.40	4.53	2.80	1.08	0.00	0.00	1.00
Time to hire (Advert to formal offer made)	31Days									

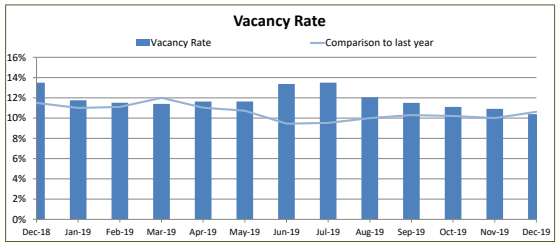
Above target
Improvement from last month/above or below target
Underachieving target

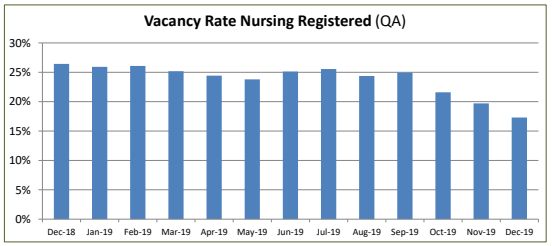
3 Our People Summary

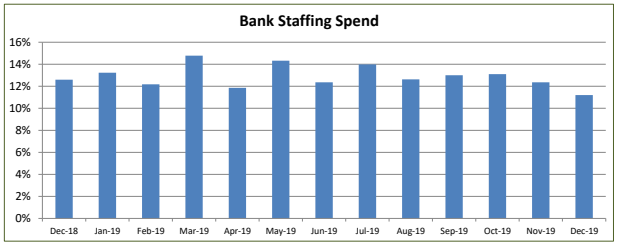
3.3 Well Led

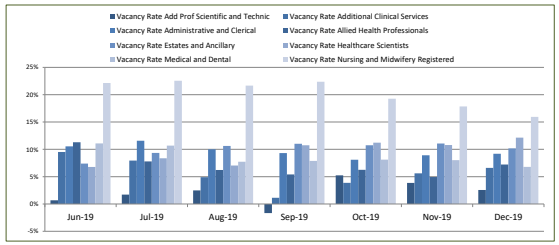
The Princess Alexandra Hospital NHS Trust

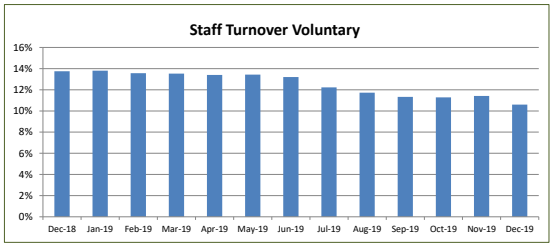
Workforce Indicators

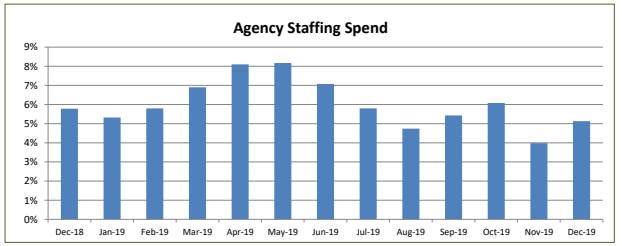


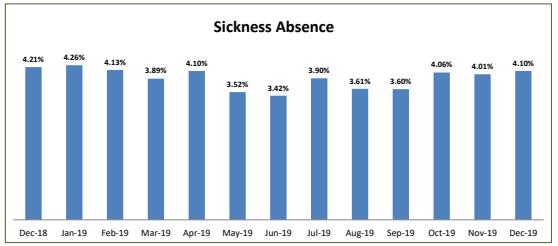


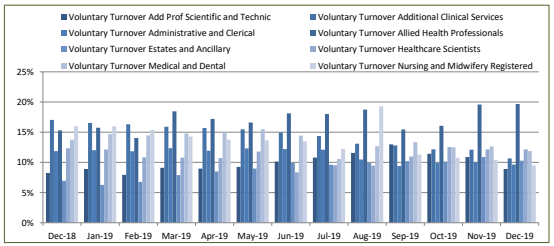


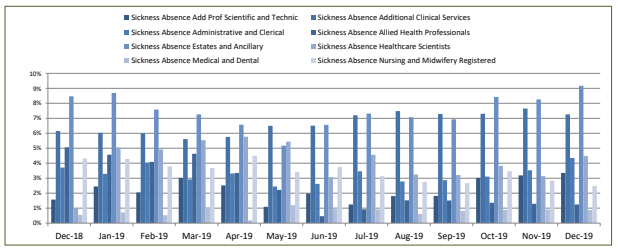


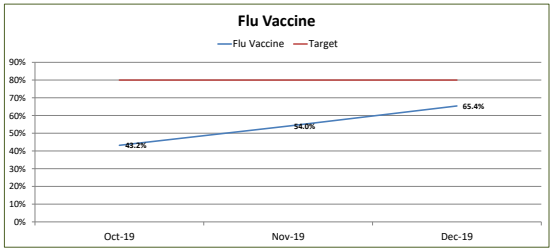




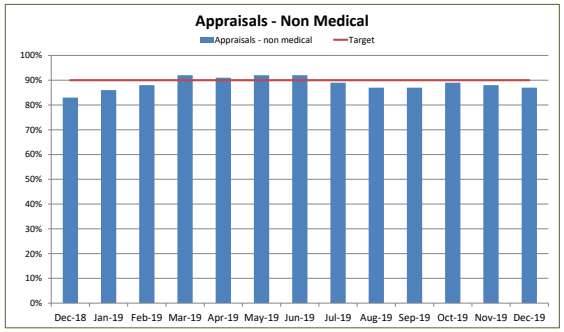


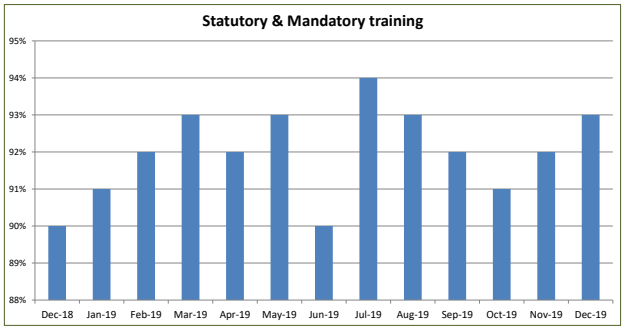


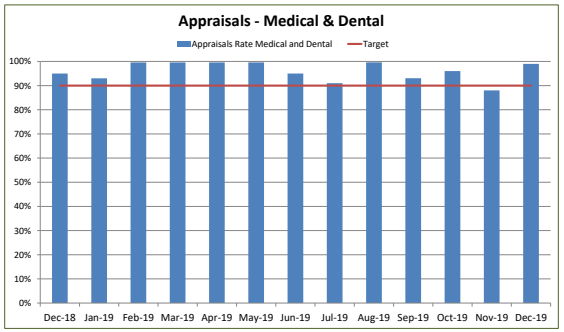


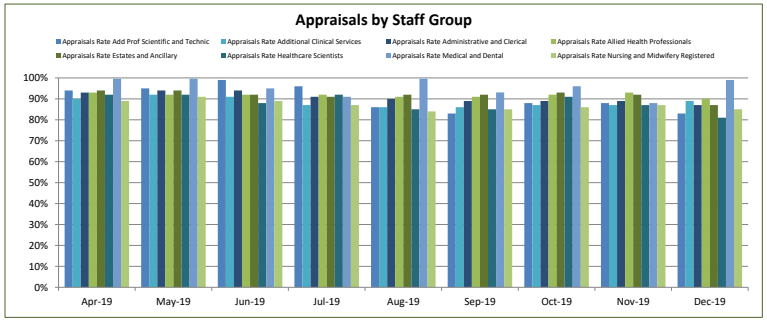


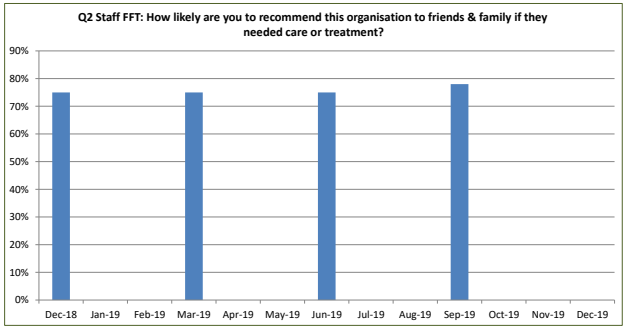
Workforce Indicators











Workforce Indicators

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

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

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

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

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

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

Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

Estates The Estates department showed a slight increase in the number of urgent jobs completed. The increase in backlog maintenance continues. Estates is continuing to work closely with the Capital team identifying backlog maintenance which requires capital funding.

Domestic Services There is an increase from last month in both the High Risk & the Very High Risk scores. The Domestic transformation project is nearing its end; reports & findingS are being prepared for discussion. PLACE scores are yet to be realised.

Catering Services The number of meals prepared & served to patients increased this month due to the increase in patient activity across the trust. The Volunteer Christmas meal & the staffs Christmas dinners were a huge success with the Catering team excelling in the food produced.

Capital Services Capital Estates Team have produced a 5 yearly Capital plan based around Business as Usual from the Trust Estates Risk Register targeting the High & Significant risk items & has obtained Trust approval allowing risk mitigation during the current financial year via a robust resourcing plan using Government Framework options for both Design Team members & Suppliers for the required works to meet end of March 2020 timescale.

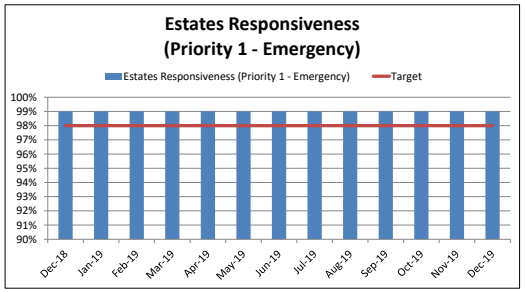
Full NHSI funding has now been received by the Trust for £4.98M over 2 years & finance codes set up for orders to be raised for Design Team members required on projects & quotations from SBS Framework suppliers for £4.28M current in year spend.

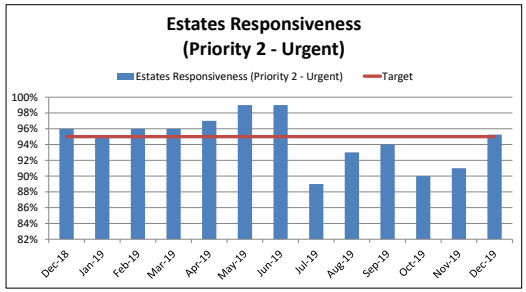
Orders being placed for required additional Project & Programme Management, Contract Administrator/Cost Consultant, Principal Designer (H&S) & Services Consultant to support & design various projects to obtain costings & deliver the 2019/20 spend profile. Orders now raised for site mobilisation for support team accommodation & SBS suppliers for enabling works packages on early projects to remove risk to Trust.
Works due on site from late January 2020 through to end of March 2020 with full site engagement and governance processes to handover.

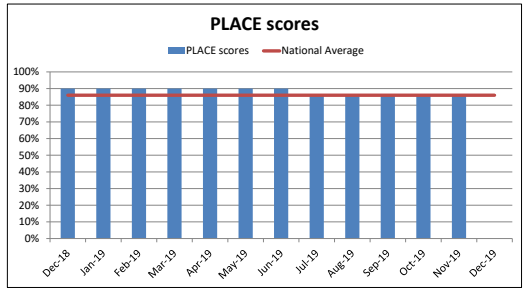
Below the line projects have also been produced for due consideration by the project governance board at fortnightly progress meetings.
Capital Team are producing a list of projects for financial year 2020-21 for due consideration at Capital Working Group meetings to plan for early 2020 start after formal approval.

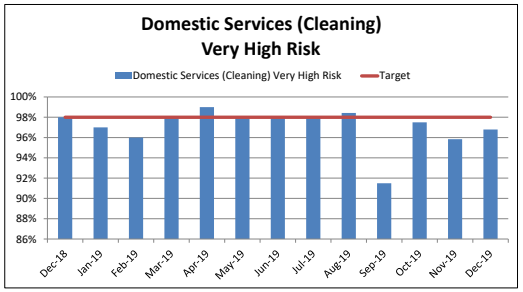
Mandatory Training & Appraisals Appraisal compliance dropped to 82% this month which equates to 44 out of the 250 staff. Five departments within the directorate are compliant. The management team are booking in all non-compliant staff in for their appraisals & booking in staff who are due soon. Mandatory training increased again this month to 96% with Fire training now compliant at 92% above the trust target . IG stayed static & unfortunatley is still below the trust target of 90%.

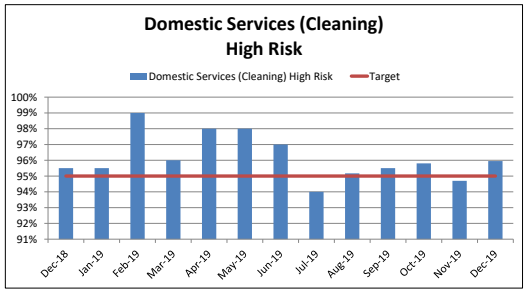
Places

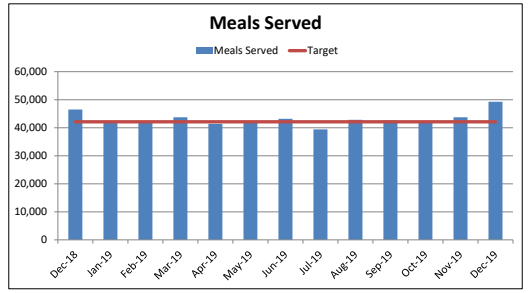

Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19

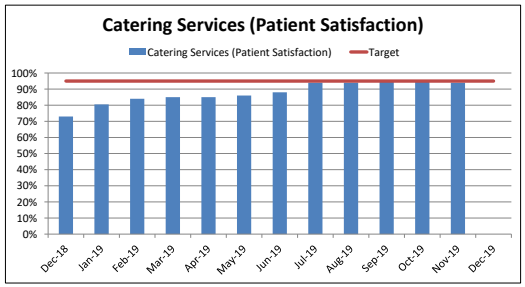

Estates Responsiveness (Priority 2 - Urgent)
Estates Responsiveness (Priority 2 - Urgent)
Target
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19


PLACE scores
PLACE scores
National Average
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19


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


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


Meals Served
Meals Served
Target
60,000
50,000
40,000
30,000
20,000
10,000
0
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19


Catering Services (Patient Satisfaction)
Catering Services (Patient Satisfaction)
Target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Dec-18
Jan-19
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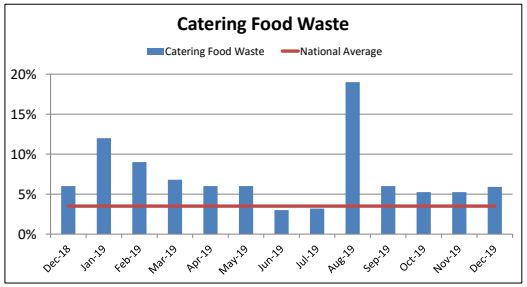
Dec-19


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

Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

In-month deficit £2.8m, £0.2m better than plan.
Income and non-pay were better than plan and included additional non-recurrent funding. Adverse variances remain pay related.
Temporary staffing totalled £2.5m consistent with M8. Nursing spend reduced by £0.2m. This was equally offset by medical costs in ED over Christmas.
The cumulative deficit is £26.1m, £4.9m behind plan; no PSF/FRF (£13.1m) eligible to date. The year end Control Total (CT) is £26.9m i.e. £0.8m higher than YTD actuals with three months remaining. Delivery of the CT remains dependent on both reduced costs in Q4 and additional revenue.
YTD Capital spend is £6.1m leaving a residual £10.5m of capital spend between now and year end, including recently approved £4.3m emergency capital schemes. Weekly updates on capital spend will form part of the Delivery Group.

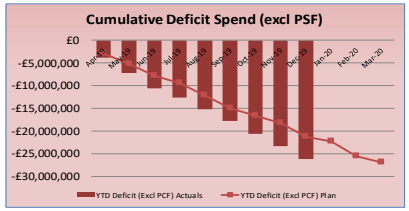
Pounds

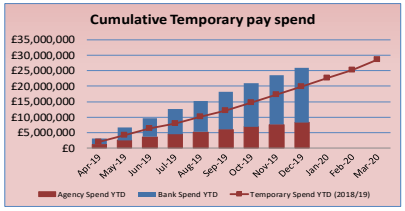
5 Our Pounds Summary

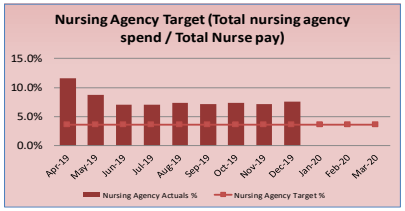
5.1 Overall financial position

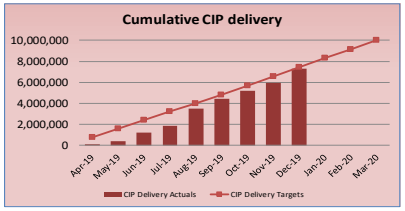
The Princess Alexandra Hospital NHS Trust

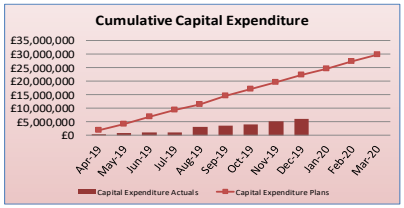
OUR POUNDS		
Metric	Annual Plan (Standard)	Latest Month
YTD Deficit (Excl. PSF)	-£26,942,000	-£26,119,116
Cumulative Agency Spend £s	-£10,292,000	-£8,329,640
Cumulative Bank Spend £s	N/A	-£17,665,072
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3%	8%
Cumulative Capital Expenditure	-£29,714,000	-£6,103,000
BPPC Volume	95%	90%
BPPC - £s	95%	85%
Cash Balance	£1,000,000	£4,951,000

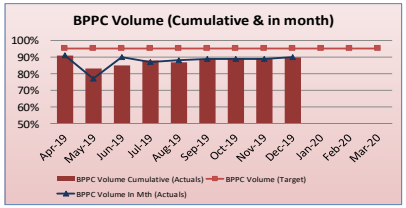


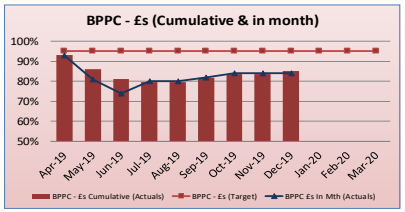


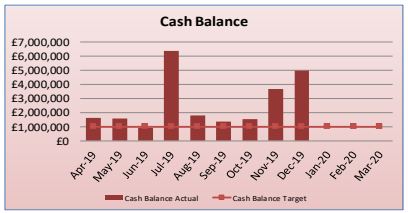












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CQC Rating

CQC

The Princess Alexandra Hospital NHS Trust

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

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

CQC Inpatient Survey (OS)

20 June 2019

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

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

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Commissioning for Quality and Innovation

2019/20 CQUIN Forecast

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

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

THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST

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

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

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

MUST Recommendations

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

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

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

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

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

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

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

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

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 6 February 2020 **AGENDA ITEM NO: 7.1**

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

REPORT FROM: Helen Glenister - Committee Chair

DATE OF COMMITTEE MEETING: 24 January 2020

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 - Improvements in mortality were noted; the Board will be updated under Board agenda item 5.2. Structured judgement review champions have now been appointed.

- Cervical screening - Turnaround times had previously been escalated to QSC as a concern and noted on the HCG's risk register. In September 2019 samples were converted to the HPV primary screening pathway and administration times have improved. The risk has now been removed from the register. The service moved to Norfolk & Norwich University Trust (NNUH) in January 2020 following an STP procurement process.

- Postpartum Haemorrhage (PPH) - QSC received an update on the results of two audits that have taken place within Maternity. The audits showed there could be some over-estimation of the blood loss however a further review of the notes is to take place and QSC will receive a further update from the FAWS healthcare group next month.

- QSC received assurance on the Trust's protocol for major obstetric haemorrhage following a recent case reported in the media. No incidents of non-compliance with the protocol have been recorded. Assurance was also received regarding the use of meshes for hernia repairs and the information provided to patients around the risk of chronic pain.

- Emergency Department Safety/Corridor care - the AMD for Urgent Care and ADoN, Medicine provided comprehensive assurance on corridor care and patient safety in ED with a review of December's data. A post winter review focussing on patient safety will be presented to QSC in April 2020.

- National Emergency Laparotomy Audit (NELA) & Best Practice Tariff - NELA looks at structure, process and outcome measures for the quality of care received by patients undergoing emergency laparotomies. QSC received a presentation on the audit which took place from December 2018 to November 2019 and noted the improvements in compliance, performance and patient outcomes since January 2019 when the Trust was not meeting the requirements for payment of the best practice tariff. (The enhanced tariff will be paid if 80% of high risk patients have a consultant surgeon and consultant anaesthetist present during surgery and are admitted to critical care.)

- 15 Steps - QSC received the six monthly summary of 15 Steps visits and requested Board members to ensure they provide feedback on their visits and any suggestions for visits in the year ahead.

- Corona virus - QSC received assurance on the Trust's preparedness for managing patients with suspected symptoms of the virus.

- BAF risk 1.1 - the risk was reviewed and the rating confirmed at 16.

The Princess Alexandra Hospital NHS
NHS Trust

SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
Other items discussed: QSC also received the following reports: Medical Healthcare Group Quarterly Performance Report, M8 Integrated Performance Report, , Patient Experience Update, Update from Patient Panel, Audit Update, Monthly Quality, Safety & Effectiveness Report, Monthly Report from Patient Safety & Quality Group, Monthly Update on Nursing, Midwifery and Care Staff Levels, Clinical Compliance Readiness 2019/20, Care Quality Commission Insight Report, Infection Control 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 Trust

BOARD OF DIRECTORS

MEETING DATE: 06/02/20 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM:	Workforce Committee
REPORT FROM:	Helen Howe – Committee Chair
DATE OF COMMITTEE MEETING:	27/01/20

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• BAF risks 2.1 and 2.3 were discussed and WFC noted improvements in the indicators for both but agreed that pending further review at WFC in March 2020, the risk ratings should remain at 12 and 16 respectively. • The successful nurse recruitment programme continues. • The initial (embargoed) report on the staff survey was discussed and the Committee expressed disappointment at the findings. Improvement plans are being put in place and progress will be monitored at future meetings.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
The following are highlighted for the Board's awareness and/or assurance:
The committee also received the following reports: Workforce Report (Targets and Performance), Temporary Staffing, Safer Staffing, Training and Education, STP update, Communications update and a report from the People Board.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee's progress against its Annual Work Plan is set out below:
The Committee is making good progress against the work plan.

7.1

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06.02.20 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Andrew Holden - PAF Chairman
DATE OF COMMITTEE MEETING: 30.01.20

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
Finance Month 9 - in-month deficit was £2.8m, £0.2m better than plan. Year-to-date deficit was £26.1m, £4.9m off plan and £0.8m from year-end control total with no PSF/FRF (£13.1m) eligible to date. The year-end control total remained dependent upon both additional financial payments and cost reductions in Q4, in particular temporary staffing reductions. In-month income and non-pay were better than planned, that included additional non-recurrent winter and activity funding. Adverse variances remained pay-related, in particular temporary staff which totalled £2.5m. Whilst nursing spend reduced by £0.2m it was offset by increased ED medical costs over the Christmas period. Members were also updated on other financial matters including Board expenses. It was agreed to escalate to the Board the Committee concerns on the revenue position going into the new financial year and the importance of delivery in Q4 of the current year in order to start the new year in the best possible position. **Capital** - YTD spend was £6.1m leaving a residual balance of £10.5m (excluding Interoperability and MAU business case which were subject to Regulator approval). The remaining £10.5m included: Emergency Backlog £4.3m, Fracture Clinic £1.0m, Corporate accommodation £0.8m (it was noted cost estimates had increased on this and were currently being considered by the Executive), ICT/HSLI £2.1m, LED lighting £0.5m and medical equipment £1.1m. Weekly performance reports were being provided to Delivery Group and EMT to ensure delivery of the programme. SMT members had confirmed their expenditure profiles Jan to March and the careful management of capital investment to year end. It was agreed to escalate to the Board the importance of 'front-loading' the programme going forward. **Maternity Deep Dive** - 2018/19 draft reference costs showed the Trust's annual cost for Maternity services was £20m, £6.7m lower than the national average of £26.8m. CNST premium was set to rise by £3m in 2020/21 (from 5.7m to 8.7m for maternity). Lower birth numbers since the beginning of the year were impacting NICU activity with income under-performance on the NHSE contract mitigated by NICU pricing improvements. There were CIP shortfalls and expenditure associated with non-lead maternity pathway charges which were being addressed. **Nurse Recruitment** – the Deputy Director of Nursing & Midwifery updated on the intention to set the nursing vacancy factor for 2020/21 at less than 1%. Concerns now focussed on the shortage of Band 6 nurses (who could not be recruited directly from overseas). It was therefore agreed to look into establishing nursing accelerator programmes for both current Band 5 post holders and future international recruits, to fill the gap. It was also agreed that the recruitment trajectory for the coming year would be reviewed in an attempt to accelerate it towards the start of the year, albeit that would need to recognise the associated increase in 'starter' costs.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
In addition to the above, PAF received reports on the following agenda items: • BAF risks allocated to the Committee (Finance, ED 4 hour standard, EPR and Estate & Infrastructure). • Draft Annual Operating Plan Assumptions • M9 Integrated Performance Report • Quarterly Procurement Update • Quarterly Report on the Trust's Sustainable Development Management Plan
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee continues to make good progress against the workplan.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06.02.20 **AGENDA ITEM NO: 7.2**

REPORT TO THE BOARD FROM: Senior Management Team
REPORT FROM: Lance McCarthy - Chairman
DATES OF MEETINGS (Fortnightly): 3 and 17 December 2019, and 21 January 2020

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at the meetings:

03.12.2019:

- Deep Dive on Dermatology
- Update on Ward Refurbishments Project
- Annual SIRO Report
- Finance Updates
- Month 7 Final Position / Month 8 highlights
- Temporary Staffing Deep Dive
- Integrated Performance Report (IPR

17.12.2019.

- TIAA Internal Audit: Audit priorities for 2020/21
- Information Governance Update
- Handover / Hospital@night
- Nine Principals of Effective Emergency Care (presentation)
- Mobile Phone Contract
- Revised Complaints Process Proposal

21.01.2020.

- Modernisation: ICT High Level Programme including, demonstration of My Care Record Demo and an options appraisal of PATHWEB (to support storage of legacy data going forward)
- Maternity Deep Dive (presentation to PAF in January 2020).
- Planned changes to access standards
- STP Vascular Network Update
- Medicines Management CMS Project and Risks Update
- Finance - Month 8 Final Position / Month 9 highlights
- Staff Survey results
- Risk Management Group Escalation Report

7.2