The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors (held remotely due to COVID-19)

Date and time: Thursday 7 October 2021 at 9.30 – 11.45
Venue: Microsoft Teams Meeting

	Item	Subject	Action	Lead	
01 Opening administration					
09.30	1.1	Apologies	-		
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	4
	1.4	Matters arising and action log	Review	All	15
09.35	Staff story – Amr's Story				
02 Risk/strategy					
10.00	2.1	CEO's report including: • COVID-19 update • CQC inspections and Section 31 notice	Inform	Chief executive	16
10.15	2.2	Significant risk register	Review	Medical director	23
10.25	2.3	Board assurance framework 2021-22	Review/ Approve	Head of corporate affairs	28
03 Patients					
10.35	3.1	Learning from deaths (Mortality)	Discuss	Medical director	33
10.45	3.2	Maternity SI report	Assure	Director of nursing and midwifery	36
10.55	3.3	Nursing, midwifery and care staff levels including nurse recruitment	Discuss	Director of nursing and midwifery	39
04 People					
11.05	4.1	Annual Report on Medical Revalidation and Compliance Statement	Approve	Medical Director	47
05 Performance/pounds					
11.15	5.1	Integrated performance report	Discuss	Executives	64
06 Governance					
11.30	6.1	Reports from committees: • Audit Committee 06.09.21 including Terms of Reference • Quality & Safety Committee 24.09.21 • New Hospital Committee 27.09.21 • Workforce Committee 27.09.21 • Performance & Finance Committee 30.09.21 • SMT.14.09.21 and 21.09.21	Inform/ Approve	Chairs of committees	132
07 Questions from the public					

	7.1	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
08 Closing administration					
	8.1	Summary of actions and decisions	-	Chair/All	
	8.2	New risks and issues Identified	Discuss	All	
	8.3	Any other business	Review	All	
11.45	8.4	Reflection on meeting	Discuss	All	

The Princess Alexandra Hospital NHS Trust

Public Board Meeting Dates 2021/22

01.04.21	07.10.21
03.06.21	02.12.21
05.08.21	03.02.22

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 2021/22

Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chair	Hattie Llewelyn-Davies	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC) and Senior Independent Director	George Wood	Director of Nursing & Midwifery and Deputy CEO	Sharon McNally
Chair of Quality & Safety Committee (QSC)	Dr. Helen Glenister	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Pam Court	Medical Director	Fay Gilder
Chair of Workforce Committee (WFC)	Helen Howe	Director of Finance	Saba Sadiq
Chair of Charitable Funds Committee (CFC)	Dr. John Keddie	**Executive Members of the Board (non-voting)**	
Non-Executive Director	Dr. John Hogan	Director of Strategy	Michael Meredith
NExT NED	Darshana Bawa	Director of People	Gech Emeadi
Associate NED	Anne Wafula-Strike	Director of Quality Improvement	Jim McLeish
		Chief Information Officer	Phil Holland
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Virtual Trust Board Meeting in Public
Thursday 5 August 2021 from 11:00 to 13:30

Present:	
Helen Glenister	**Acting Trust Chair/Non-Executive Director (ATC)**
Dr. Amik Aneja	General Practitioner (GP-AA), Board Advisor
Darshana Bawa	NExT Non-Executive Director (NNED-DB)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Fay Gilder	Medical Director (MD)
John Hogan	Non-Executive Director (NED-JH)
Helen Howe	Non-Executive Director (NED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Lance McCarthy	Chief Executive Officer (CEO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Saba Sadiq	Director of Finance (DoF)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)
In attendance:	
Kerry Riches (Patient Story)	Head of Patient Experience (HoPE)
Andrew Lofthouse (Patient Story)	Patient Story
Paul and Tara Lofthouse (Patient Story)	Patient Story
Jo Ward (Patient Story)	Associate Director of Nursing - Medicine
Bob Ghosh (Patient Story)	Associate Medical Director - Medicine
Laura Warren	Associate Director - Communications
Members of the Public	
Giles Marcus	Fujitsu
Sharon Brennan	Wilmington Healthcare/HSJ
Jenny Newsom	Pfizer
Apologies:	
Pam Court	Non-Executive Director (NED-PC)
Phil Holland	Chief Information Officer (CIO)
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Acting Trust Chair (ATC) Helen Glenister introduced herself and welcomed all to the meeting, particularly the members of the Lofthouse family who would be sharing their story with Board members. She requested members introduced themselves when speaking for the first time.
1.1 Apologies	
1.2	Apologies were noted as above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of the Meeting held on 11.06.21.	
1.4	These were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.5	The action log was noted and that the one item was closed.
Patient Story: David's Story	

1.6	This item was introduced by the Director of Nursing & Midwifery (DoN&M) and she welcomed Andy, Paul and Tara Lofthouse to the meeting, along with PAHT colleagues who had been involved in the case.
1.7	The details of the story were that the patient (David Lofthouse) had been admitted to the ED in early April 2020 with COVID symptoms during the height of the first wave of the pandemic. Whilst awaiting swab results he had been nursed in a side room on Kingsmoor Ward. At the same time, his wife was critically ill with COVID and deteriorating in ITU. The patient had a history of mental ill-health that was not identified in ED, as not noted in his records, and his anxiety surrounding his wife's illness and his own was not clearly identified as a risk to his own safety. After 48 hours he was found in the side room bathroom, having hung himself. His wife sadly passed away too, two days later.
1.8	The DoN&M reflected that the events had been both tragic, and shocking. They had also had a significant impact on staff (and still did) and it had been important at the time for teams to step back and learn from the experience with a view to improving care for the future. She was grateful for the family's attendance that day and for the way in which they had dealt with the situation which had been with dignity, grace and understanding. She handed over to one of the patient's sons.
1.9	David's son (Paul) then took members through events as they had transpired. He pointed out that at the time, and prior to his admission, the family had been concerned for David's mental health which they had flagged to staff, not realising he also had symptoms of COVID. He felt that a couple of 'red flags' had been missed in terms of his father's assessment. He had not been making eye contact and had been asking for anti-depressants. Since the inquest into his father's death there had been a commitment from the hospital to work on improving cover for mental health patients and he congratulated the Trust on the work undertaken so far.
1.10	At this point in the meeting the Associate Medical Director for Medicine (AMD-M) stated that the team had been devastated by the events of the previous year. He acknowledged that the hospital had been dealing with desperately sick patients at the time, and during a time in which little had been known about COVID. The organisation had taken on board the family's comments on 'red flags' and also how important it was for family members to be kept in touch with each other when they were inpatients at the same time.
1.11	The Associate Director of Nursing for Medicine (ADoN-M) then spoke and confirmed she had been involved directly in David's care. The outcome of events would never leave her, or the team involved in David's care. The team had taken the time to reflect and think about what could have been done differently in the circumstances and particularly on that day from the triggers that David had been exhibiting. David's death, along with his son's strong campaigning for recognition of patients' mental health needs, had encouraged colleagues to re-address the imbalance between the physical and psychological care needs of patients at PAHT. Both colleagues acknowledged how dignified David's family had been through all subsequent contacts following his death and how constructive all their comments had been.
1.12	As a final point Paul commented that all the family now wanted was to ensure no other family had the same experience and he thanked the staff who had provided care to both his parents at the time.
1.13	At this point in the meeting Associate NED Anne Wafula-Strike offered her sincere condolences to the family and thanked them for sharing their story, the outputs of which would now be used to improve patient care.
1.14	The DoN&M reflected that the organisation was now absolutely committed to being in a place where patients' mental health needs were identified as well as their physical health needs, with staff being knowledgeable on the needs of mental health patients. . A Mental Health Quality Forum had been in place for 18 months with mental health partners to drive an holistic view of how to improve care to mental health patients and

	manage acute and mental health care under one roof. Mental Health champions had also been identified.
1.15	The ATC thanked the family, on behalf of the Board for sharing their story that day and for their support in ensuring the Trust could improve care for the future.
02 RISK/STRATEGY	
2.1 CEO's Report	
2.1	The CEO presented his report and key updates were as follows: <u>COVID</u> The CEO stated he would like to take the opportunity to reiterate his thanks to everyone in the organisation for all their hard work and amazing response to the pandemic which remained ongoing. He drew members' attention to the graph on p19 and the rise in new positive COVID inpatients over the previous month. Fortunately the position appeared to have now stabilised with 14 new positive inpatients that week. In line with the numbers of new infections in the community which had fallen day by day for the last 12 days he hoped that position would be mirrored within the hospital.
2.2	He continued there had been recent staffing pressures (as with the first two waves of COVID) and there were currently staff off sick, with and without COVID and a cohort affected by track and trace. Internally the organisation would not be changing its response in terms of process and policies around infection prevention and control so the wearing of face masks was still mandatory along with PPE in clinical areas. Rules around social distancing and hand washing also remained.
2.3	The CEO continued that red ITU had been moved down to a ward on the first floor to ensure there was potential to expand that should there be a need to and to be able to provide support for patients requiring oxygen. Other wards had also required some reconfiguration which had impacted on elective work and COVID recovery. Fortunately teams had responded well to the recovery of non-COVID services whilst at the same time dealing with COVID. The speed of recovery had been excellent and relative to others had been very good, resulting in television appearances for the Chief Operating Officer (COO) and clinical colleagues explaining the current pressures, the organisation's response to those and efforts to reduce patient waits.
2.4	The pressures on staff during the pandemic and currently were acknowledged again and members were informed of a 12 week programme (Back to Better for staff in terms of supporting their health and wellbeing and which had received some very positive feedback.
2.5	In response to a question from NED-GW, the CEO responded that the average age of patients admitted with COVID was much lower than in the previous two waves and the vast majority requiring Critical Care over the last month had not been vaccinated. The DoN&M added there also needed to be a catch-up for those women who had just delivered babies to now access the vaccine where they previously had not.
2.6	<u>CQC Inspection</u> The CEO reminded colleagues that on 07.07.21 the organisation had been notified of a full inspection with well-led interviews to commence on 16.08.21. The new inspection process from the CQC meant that all relevant core service reviews to be completed as part of the inspection, would be completed in advance of the well-led interviews. CQC colleagues had undertaken a core service review of Medicine services on 06/07.07.21 and a core service review of Maternity services on 14.07.21. Other core service reviews were still awaited in advance of 16.08.21.
2.7	Initial written feedback from the Medicine review had been received on 09.07.21 along with 53 information requests which had been received and responded to in full within the 72-hour timeframe requested. The main concern of CQC colleagues had been in relation to the completion and management of the care prevention falls bundle and the ongoing management of patients at risk of falls on Harold ward. The organisation had then conducted its own multi-disciplinary team review which had concluded that all patients

	were assessed as safe and that no direct harm incidents could be identified. In response, the following two key actions were put in to place immediately: • A refreshed safety huddle sheet to provide an 'at a glance' list of patients who were at high risk of falls • An additional healthcare assistant booked for both day and night shifts for Harold Ward to provide headroom over and above required staffing levels.
2.8	Following the Maternity review, 52 information requests had been received and responded to within the 72-hour timeframe requested. Initial written feedback was received on 19.07.21 and responded to. Individual core service draft reports from CQC colleagues were still awaited for both of the above reviews. Given the timing of the well-led interviews clashing with the main holiday period for colleagues, it had been agreed for those to be undertaken over an extended time period. There would now be a presentation to CQC on 11.08.21 with interviews on 16/17/24.08.21 and 07.09.21.
2.9	In response to a comment from the ATC the CEO stated that colleagues had found the MDT review on Harold Ward useful and were now partway through implementing a new set of risk assessments and care packages for those at risk of falling. There were plans for the MDT review process to be repeated in other areas.
2.10	In response to a question from NED-HH in relation to confidence around safety huddles, the CEO stated that the process would depend on the area and was a relatively new concept. In ED there was a huddle every two hours (overseen at times by the COO) and there had been a recent focus on the huddles in Maternity to ensure they were running in line with those across ward areas.
2.11	Non-Executive Director George Wood (NED-GW) asked for clarity around the timeframe for receiving the draft inspection report. In response the CEO stated that the new regime provided six weeks' notice of well-led interview dates then the CQC undertook a range of core service inspections in advance of that, with fewer inspectors but over a longer period of time. The current expectation was that there would be individual reports for each service inspected which would require individual responses from the Trust. It was unclear currently if there would be one final report, and that would need to be addressed with CQC colleagues.
2.12	<u>ICS Boundary Changes</u> A statement had been made that within the East of England there would be no changes to boundaries so the Trust would remain as part of the Herts and West Essex ICS, with ICSs due to become statutory organisations from April 2022.
2.13	<u>New Chair</u> The CEO was pleased to update that Hattie Llewelyn-Davis had been appointed as the new Trust Chair and would join the organisation on 13.09.21. He thanked NED Helen Glenister for stepping into the role during the intervening period.
2.14	<u>New Hospital</u> The organisation continued to work closely with the national New Hospital Programme to develop its OBC. He reminded members the outputs of the current design convergence review would determine the speed at which the OBC could be completed, but he hoped that would be by the end of calendar year/beginning of the new calendar year.
2.15	<u>Awards/Recognition</u> Since the last Board meeting a number of the organisation's amazing people and teams had received awards or recognition for the fantastic work they hadundertaken. Those included: • Mr Ashraf Patel, breast surgeon, had been awarded an MBE for services to funding and research for breast cancer. • The Patient Panel had been presented with their Queen's Award for Voluntary Service by HM The Queen's representative, the Lord Lieutenant of Essex, Jennifer Tolhurst, in a ceremony on 20.07.21.
2.16	<u>Consultant Appointments</u> Following AAC panels in recent weeks the Board ratified the offer of appointments to five new individuals, made through delegated authority to the AAC panels.

2.17	The ATC thanked the CEO for his update. She stated she would like to add her congratulations to the plethora of people receiving awards/recognition and also to staff in general for their continued amazing response to COVID.
2.2 Significant Risk Register	
2.18	This update was presented by the Medical Director (MD) and was a snapshot of risks across the Trust at a specific point and included all items scoring 15 and above. The overall number of significant risks on the register had reduced from 86 to 73 and the main themes for the 13 risks scoring 20 were: • Seven for operational pressures - 3 for referral to treatment standard compliance, 3 for ED standard compliance and 1 for cancer waiting times. • Three for our places - research facility, and theatre roof (2) which despite intensive repairs was still leaking. • Two medical consultant cover - for GI bleed and obstetrics. One new risk had been raised with a score of 15 which related to 'Women waiting greater than four hours to be seen by an obstetrician in MAFU'. The Trust was currently recruiting additional registrars to mitigate this risk.
2.19	In section 2.5.2 she flagged an error in the wording. The Trust was working with Mid and South Essex NHS Foundation Trust in terms of medical cover for GI Bleed (not ENHT).
2.20	The CEO added that in terms of GI bleed (last action from CQC winter assurance visit to ED), that action could now be closed down.
2.21	At this point NED-GW asked whether the issue of stranded patients should be a risk given in the previous month there had been circa 48 over 21 days. In response the MD stated that was an issue (to the Trust and also to the system) rather than a risk because the organisation was aware of it and it was an ongoing issue. She added there was some work underway with colleagues to establish an Issues Register. The COO was able to add that she was working with the DoN&M to scope a work-stream to look at the discharge pathway and how to link that with community and social care partners ahead of winter.
2.22	In response to question from NED John Hogan (NED-JH) in relation to the staffing cover for out-of-hours GI bleed, the MD was able to update that the AMD for Medicine had been leading that work and anticipated having a staffed internal rota by the end of August.
2.3 Board Assurance Framework 2021/22	
2.23	This paper was presented by the Head of Corporate Affairs (HoCA). She informed members the proposal was to increase one risk score that month (Risk 1.0 COVID) from 12 to 16 and to amend the risk descriptions for risk 1.1 Variation in outcomes and risk 4.2 Emergency Department. The risks had been reviewed at Committees in July and QSC had supported the change to the risk score for risk 1.0 and the revised risk description for risk 1.1. Similarly PAF had supported the revised risk description for risk 4.2.
2.24	In line with the recommendation the Board approved the changes to the risk scores and risk descriptions.
2.4 PAHT 2030 and New Values	
2.25	This update was presented by the Director of Strategy (DoS) and the Director of People (DoP) and provided details on the engagement and implementation plan for both the PAHT 2030 strategy campaign and, alongside that, the introduction of the new corporate values. This would culminate with a formal launch of both at September's Event In A Tent.
2.26	The DoP drew colleague's attention to page 67 of the pack and the timeline for Board assurance. She also asked members to note the graphics on page 76 which would be

	used throughout the campaign to ensure all staff were engaged with the strategy and to ensure staff lived the new values.
2.27	The ATC stated she had been involved in both pieces of work and it was good to now see that come together in one engagement piece. She asked whether the engagement plan had been shared yet. In response the DoS confirmed it had been shared at SMT and senior leaders were being challenged to be part of the engagement with their own people and to work with them to develop the action plan for the strategy.
2.28	The ATC commended colleagues for the huge amount of work which had been undertaken and welcomed sight of the timeline with clear visibility of the four phases.
03 PATIENTS	
3.1 Learning from Deaths (Mortality)	
3.1	This update was presented by the MD. Her first good news story was to confirm the appointment of a Deputy Medical Director for Quality & Safety (Joydeep Ghoshdastidar). His start date would be dependent upon COVID critical care demands.
3.2	Her second piece of good news was that ten days previously she had had a conversation with Dr. Foster on the hospital's mortality indices, and was very pleased to update colleagues that for the previous 11 months, HSMR had been recording as 'as expected'. She reminded colleagues that for the previous 36 months it had been performing at 'higher than expected'. This positive change was down to the continued hard work of colleagues from various departments over the previous two and half years.
3.3	In terms of confidence that the trend would be sustained moving forward and that care had improved, she had spoken at length with Dr. Foster colleagues. They had pointed out that during the period August 2017 to July 2018 super-spells had increased, but the death rate had not, which would be expected. The gap therefore between expected and observed deaths was closing and providing assurance that care was improving.
3.4	The MD continued that in terms of comparisons with East of England peer groups, the Trust was now one of six (out of eleven) who was 'as expected' or 'better than expected' for HSMR.
3.5	In terms of COVID deaths, Dr. Foster did not yet know the implications of COVID on their data. However, she drew members' attention to the final slide in the deck which evidenced the disproportionate impact of COVID on PAHT compared nationally, in January 2020 and in April 2020, which would be the likely cause for the hospital's elevated SMR. However, if those COVID deaths were excluded from the data, the organisation's SMR would be 'better than expected'. In terms of SHMI, the Trust's rate was sitting at 'as expected' for those deaths within 30 days of admission to hospital.
3.6	At this point the CEO commented on the news which backed up all the hard work undertaken by many teams over the previous couple of years. He drew members' attention to the graph at the top of p92 which evidenced the impact of COVID on the Trust during the first two waves of the pandemic. Data was also starting to show the same would be true for wave three also.
3.7	In response to the above the DoQI stated the organisation's mortality work was not yet over but the recent good news had clearly re-energised colleagues. It was hugely reassuring to see the early signs of improvement and it would be key moving forward to ensure the positive trend was sustained.
3.8	ANED-JK commented that an outstanding achievement had been delivered. The data was not only showing the trend was genuine, but hopefully sustainable too. He congratulated colleagues on the huge achievement.
3.9	NED-JH also congratulated colleagues but was keen to understand why the Trust in particular had been disproportionately affected by COVID. In response the MD stated that external colleagues felt it related to population demographics (aging/vulnerable) coupled with the size (relatively small) of the hospital's ITU. The hospital really needed red and amber ITUs.

3.10	In response to the above NED-HH commented the data on HSMR was irrefutable and in addition, the position achieved met one of the organisation's new values – 'Everyday Excellence'.
3.12	At this point the DoS commented that the position in terms of HSMR should be celebrated. There had been significant pressure on the organisation over recent months and the position showed what could be achieved when people worked collaboratively during tough times. He also reflected on the discussion in terms of ITU and the importance of having an acute hospital (and ITU) for the local population. That in turn would reflect on the design of the new hospital. A new ITU would not necessarily need to be bigger, but the design must be flexed to meet future demand.
3.13	In response to the above the ATC recognised the good news in terms of mortality and also the point made around flexible design for the new hospital. As a final point NED-GW stated that performance in terms of mortality was remarkable, and given the health inequalities in the local population, was more than likely significantly better than many other trusts.
3.2 Maternity SI Report	
3.14	This update was presented by the DoN&M. She reminded colleagues the report was a requirement following the Ockenden review and was also presented to QSC where it was discussed in detail. She informed members there had been one new SI in June, and six SIs currently remained open. The new SI had related to an obstetric haemorrhage and there had been a real focus since the event, on the service's response to that. The management of PPH had been a focus for some time and she was pleased to note on p3 of the paper, a significant reduction in the organisation's PPH rate but acknowledged there would need to be some learning from the recent new SI.
3.15	The DoN&M continued there had been a roundtable following the event and she also drew members' attention to the fact that (as stated in the report from QSC), staffing in Maternity through August would be challenging. A new Director of Midwifery had recently joined the team which would be a good opportunity to stand back and take a stock-check of where the service was currently.
3.3 Nursing, Midwifery and Care Staff Levels	
3.16	This update was also presented by the DoN&M and the paper was taken as read. She was pleased to update that the organisation continued to see a healthy fill-rate, currently at 96.4%. Vacancy rates were also significantly down at less than 5% with Band 5 vacancies around 1% which was a hugely positive position for the organisation to be in. Teams would continue to drive forward to reduce vacancies down to zero by the end of the year.
3.17	The DoN&M continued that the staffing position in ED remained challenging, particularly in terms of the COVID footprint being managed in the red ED and the increased establishment and demand template to manage that.
3.18	Colleagues were informed that staffing was managed on a day to day basis to ensure safety and there an establishment review would be presented to the Board in October.
3.19	In response to a comment made by the CEO, members noted the current staffing position in comparison to the 24.5% vacancy rate for registered nurses a few years previously. It also noted the improving position was reflected across the ICS and East of England following investment in recruitment.
3.20	In response to a point made by NED-HH it was confirmed that the increase in Datix reporting related to an increase in pressure ulcers and falls. Work was underway to address that in terms of team dynamics through the recovery from COVID and also in terms of new starters.
3.4 Elective Recovery	
3.21	This update was presented by the COO. She updated that in terms of supporting staff, members were already aware of the Back to Better programme for staff. In terms of

	patients a significant amount of work had been undertaken on modelling and establishing recovery trajectories. There had been some good joint working with clinical and operational teams to support that.
3.22	The COO continued that at no point during any of the COVID waves, had referrals from Primary Care been paused. All had been triaged and patients updated. The Trust had worked hard with the Patient Panel in terms of communications out to patients and that work remained on-going so that patients were kept updated on appointments and dates for surgery.
3.23	There had been some good progress on diagnostic recovery and teams were working well with the ICS to share access to resources and the organisation was on trajectory for diagnostic improvement. Work was also underway with the independent sector to provide capacity and support for patients and it was likely more of that would be seen moving forward. Patient initiated follow-ups (PIFU) continued to be developed.
3.24	In terms of the current position with waiting lists, all patients had been clinically reviewed and risk assessed. With the slight increase currently in COVID admissions there had been a pause in some elements of elective recovery to take stock of those patients who may require ITU/HDU and teams were working hard to minimise disruption to patients and recovery plans.
3.25	In the coming weeks those longer waiting patients would be a focus and some support was now on offer from London hospitals. The Trust was part of a Critical Care cell which was meeting weekly to review access to critical care support for COVID patients and elective recovery to ensure consistency across the region.
3.26	In response to the above NED-GW asked for a figure for current theatre utilisation. In response the COO stated she did not have that but could provide assurance that theatre lists were being maximised on a daily basis, where it was safe.
3.27	In response to a question from the ATC the COO was able to update that recovery was a dynamic process. Clinicians were constantly reviewing their lists, prioritising and keeping the position under constant review. In response to a second question it was confirmed the recent weather had affected theatre capacity in terms of roof leaks, but the Estates team were very responsive and disruption was being kept to a minimum. The recent investment in the hospital's infrastructure, particularly in the theatre rooves, meant the potential for significant disruption had been substantially reduced.
3.28	As a final point the General Practitioner/Board Advisor thanked PAHT colleagues for not turning patient services off during the pandemic.
04 PEOPLE	
4.1 Freedom to Speak Up Guardian (FTSUG) Self-Assessment Tool	
4.1	This item was presented by the DoP. She informed members the self-assessment tool highlighted the current position and the improvement needed to meet the expectation of NHSE/I and the National Guardian's Office to encourage speaking-up. A previous assessment template had last been completed in December 2019. The new template focused on the SMART objectives to support the implementation and the key areas of improvement centred on the Board 'being assured its FTSU culture was healthy and effective'. She was pleased to update the organisation had recently recruited a further five FTSUGs with a clinical background to support the work further.
4.2	The organisation was receiving support from NHSE/I with its work and they had raised the same points in terms of the assessment around the frequency of reporting and using case reviews produced by the National Guardian's Office. NHSE/I had also raised that where there was negative reporting, to seek further assurance to demonstrate improvement.
4.3	NED-HH informed colleagues that the tool had been discussed at WFC. In her view it would be key going forward (and part of the improvements around culture) for staff to be confident that if they spoke up, their concerns were addressed/actioned.
4.4	In line with the recommendation the Board approved the self-assessment tool which it noted would be published on the Trust's website.

05 PERFORMANCE/POUNDS	
5.1 Integrated Performance Report	
5.1	This report was introduced by the COO and the following updates were provided under the organisation's 5Ps: <u>Patients</u> Colleagues were working hard on improving compliance with CTG training for midwives. Of note was that in June the organisation had one detained patient under the Mental Health Act and eleven patients under mental health care. The logging of compliments had recommenced with the volume the highest since February 2020. <u>People</u> In terms of appraisal rates, the organisation was now out of special cause variation and showing continued improvement over the past four months. There had been a small reduction in performance in statutory/mandatory training in June. Sickness absence was in common cause variation with a small increase on May. <u>Performance</u> See above discussions. <u>Places</u> In terms of category 2 responsiveness there had been three months of continued increase in performance seeing it near the upper control limit. <u>Pounds</u> There was a M3 surplus of £83k against a breakeven plan. A significant amount of activity recovery had been achieved during the first quarter with the additional costs of that being matched by additional income provided through the Elective Recovery Fund (ERF).
5.2	NED-JH stated he very much welcomed the summary slide in the revised document and asked whether there were any additional issues members should be aware of. In response the CEO stated the document would now be developed further with the HCGs to align their risks and provide a greater level of assurance on lower level risks to provide more timely oversight. In addition the MD stated that in terms of the organisation's five patient safety priorities there was more work to do in terms of metrics, which in time would be added to the 'Patient' section.
5.3	In response to a concern raised by NED-GW in relation to increased attendances in ED, the COO was able to confirm that conversion rates were being monitored and compared with peer organisations. Teams were maximising the use of the new assessment and frailty facilities and she believed that recent data was showing that admissions were starting to stabilise albeit some additional data points would need to be seen to confirm that. The key focus needed to remain on maximising pathways and working with the system to prevent admissions where appropriate.
5.4	The ATC thanked the COO for her update and advised that QSC had requested an ED deep dive for its September meeting.
06 GOVERNANCE	
6.1 Reports from Committees	
6.1	Updates from Committee Chairs were as follows: <u>New Hospital Committee – 26.07.21</u> Members had no comments/questions. <u>Performance & Finance Committee – 29.07.21</u>

	Members had no comments/questions. <u>Quality & Safety Committee – 30.07.21</u> Members noted that the Executive Summary from the Annual Report on Infection Prevention & Control had been included with the Committee's report to Board. <u>Workforce Committee – 26.07.21</u> NED-HH updated that in relation to the Committee's BAF risk (BAF risk 2.3 Inability to recruit, retain and engage our people – risk score of 12) there had been some discussion following WFC and at SMT in terms of splitting the risk in two. The proposed changes would go through the normal governance processes before being presented to Board. In line with the recommendation the Board approved the changes to the Committee's terms of reference.
6.2	<u>Senior Management Team – 13.07.21 and 20.07.21</u> Members had no comments/questions.
07 CORPORATE TRUSTEE	
7.1 Report from Charitable Funds Committee (CFC)	
7.1	As chair of the CFC, ANED-JK informed colleagues that total fund balances at M2 were £770k (£790k as at 31.03.21). There has been limited activity regarding fundraising other than in some quite specific areas, although that was expected to increase as the year progressed and COVID restrictions were lifted.
7.2	He informed colleagues there had been agreement to proceed to recruit a replacement for the Head of Fundraising and that the focus now would be return on investment on charitable spend, as often the softer benefits outweighed the financial returns.
7.3	In response NED-GW stated his suggestion would be to come up with a top three wish list, for the benefit of either patients or staff. In response ANED-JK stated he agreed and in addition it would be important to ensure people understood the charity was there for their benefit and to come forward with ideas for spend. As a final point he added there were currently many smaller funds dedicated to specific functions so he would very much encourage people to come up with projects so that the money could be spent.
7.2 Policies	
7.4	This item was presented by the DoF. She updated that the Charitable Funds policy covered how the charity was run on a daily basis. She drew members' attention to section three and the changes made to the policy, all of which were fairly insignificant. The second policy, Charitable Funds Investment policy, was work in progress. The discussion at CFC had been the desire to develop the investment policy further so there would be a future iteration. There needed to be more understanding around the risk appetite and what could be done with the funds. The policy would therefore be developed further over the coming six to 12 months.
7.5	In line with the recommendation the Corporate Trustee approved both policies.
08 QUESTIONS FROM THE PUBLIC	
8.1	There were no questions from the public.
09 CLOSING ADMINISTRATION	
9.1 Summary of Actions and Decisions	
9.1	These are presented in the shaded boxes above.
9.2 New Issues/Risks	
9.2	No new risks or issues were identified.
9.3 Any Other Business (AOB)	
9.3	There were no items of AOB.
9.4 Reflection on Meeting	

9.4	The MD reflected on the Patient Story and the Trust's new values. The patient had not been 'at heart' and 'everyday excellence' had not shone through given the national position at the time. However she reflected on the journey a number of people had taken since that day and how teams had come together with the family, to work with them on the organisation's journey towards 'everyday excellence' and 'patient at heart'.
9.5	NED-GW reflected that discussions now needed to take place with mental health partners and local organisations including schools to improve the care that could be offered to patients and to increase capacity in terms of appropriate beds.
9.6	As a final point NED-HH reflected on the good news in terms of mortality rates.

Signed as a correct record of the meeting:	
Date:	07.10.21.
Signature:	
Name:	Helen Glenister
Title:	Interim Trust Chair

Trust Board Meeting in Public
Action Log 07.10.21

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status

No actions recorded at TB1.05.08.21 and no other open actions.

The Princess Alexandra Hospital NHS Trust

2.1

Trust Board (Public) – 7 October 2021

Agenda item:	2.1							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	30.09.21							
Subject / title:	CEO Update							
Purpose:	**Approval**		**Decision**		**Information**	x	**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: - Current pressures - CQC inspection - Welcome to Hattie, our new Chair - New hospital - Event in a Tent - PAHT 2030 / new values launch - COVID booster and flu vaccinations - Consultant appointments							
Recommendation:	The Trust Board is asked to note the CEO report; note the progress made on key items and to ratify the offer of 5 consultant appointments, made through delegated authority to the AAC panels.							

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	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

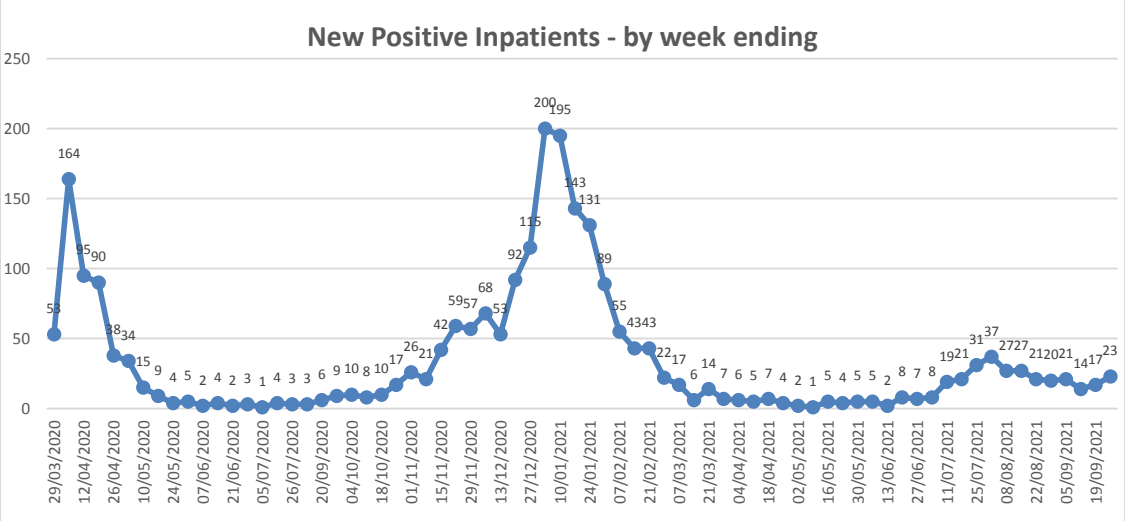
Chief Executive's Report
Trust Board: Part I – 7 October 2021

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

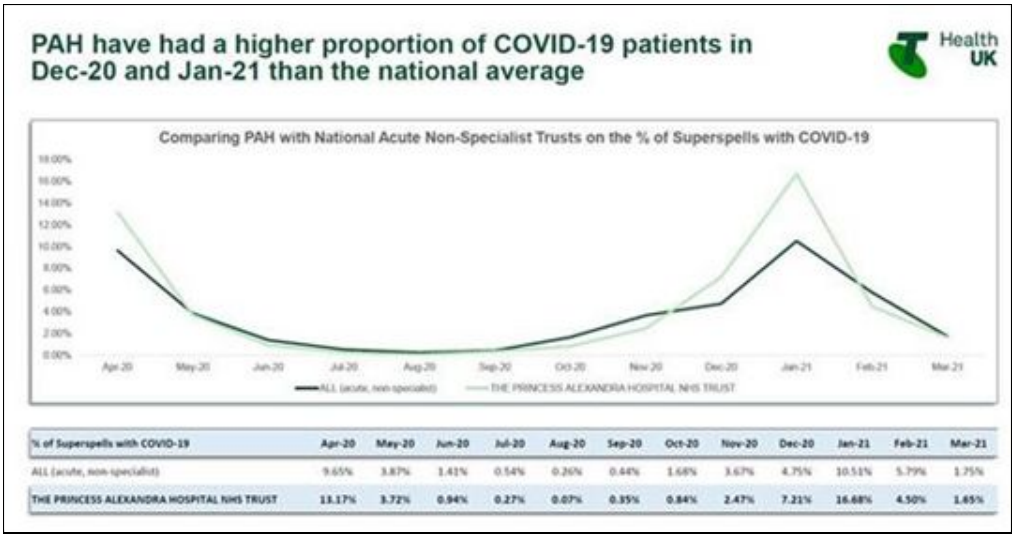
(1) Current pressures

I want to reiterate my thanks to all my colleagues at PAHT for their hard work and amazing response to the COVID-19 pandemic, our recovery of elective activity and our response to the recent unprecedented demand for urgent and emergency care services.

The number of new COVID positive patients continues to fluctuate by week, averaging just over 3 new positive patients per day for the last 3 months. We continue to run a separate 'red ED' and 'red ITU' to manage patients appropriately. The average age of admissions is lower than in the first or second wave.



The graph below, from Dr Foster colleagues, shows the relative additional pressure that we were under in April 2020, December 2020 and January 2021 in terms of the number of COVID spells, compared with other acute non-specialist Trusts in the country. . In April 2020, PAHT had 36% more spells with COVID-19 than peer organisations. In December 2020 and January 2021, PAHT had 52% and 59% more spells respectively than peer organisations.



All of our teams are continuing to work hard at recovering our non-covid services, significantly affected over the last year. Our backlog of elective cases and cancer activity is reducing and we are continuing to work closely with NHSEI colleagues, ICS colleagues and the other acute providers across the ICS, local cancer alliance and our local independent sector colleagues to maximise every opportunity for our longest waiting and most urgent waiters to receive the interventions they require in a timely manner. We are on track to ensure there are no patients waiting for more than 104 weeks by the end of this year.

Despite the easing of national lockdown measures, we have not changed any of our policies or ways of working within the hospital settings; maintaining high levels of vigilance within the hospital including strong compliance with the NHS IPC guidelines related to wearing masks at all times, maintaining 2m social distancing where possible and complying with good handwashing and ventilation.

We continue to enhance our health and wellbeing support for all colleagues who continue to remain under considerable strain and pressures. The impact of the pandemic and the pressures and anxieties experienced by colleagues over the last 18 months cannot be underestimated. These are not subsiding with the ongoing drive for us to recover our services and meet the increase in demand for UEC whilst still managing duplicate pathways to support the safety of our patients and our people. This has led to an increased rate of sickness absence and a reduction in fill rates for shifts put out to bank and agency.

(2) CQC formal inspection

As Board members will be aware, we were formally inspected by our CQC colleagues between 6 July 2021 and 6 September.

We are awaiting the reports from CQC colleagues, expected within the next few weeks, after which there will be a short period for us to check their factual accuracy before the final consolidated report will be published, likely to be in November.

Key headlines from each of the core service inspections and well-led interviews is outlined below:

2.1 Medicine core service review

- CQC colleagues undertook a core service review of our medicine services on 6 and 7 July.
- Initial written feedback from the medicine review was received on 9 July, with 53 information requests received on 12 July and responded to in full on 15 July, within the 72-hour timeframe requested.
- Concerns were raised informally and in the written feedback about timely and complete risk assessment for falls and the implementation of relevant care plans aligned to the output of the risk assessments. We undertook an immediate multi-disciplinary review of all patients on Harold ward in regard to the completion of falls risk assessments and associated care plans and were assured that no patients were at increased risk or unsafe as a result of our assessments and care. The review found some concerns which were addressed straight away and HCSW staffing on the ward was enhanced for the immediate period to support colleagues with the ongoing roll out of the new assessment process. Board members have seen all the associated correspondence and discussed the medicine core service review at the Board meeting on 5 August 2021. We have not received any further correspondence and any additional raising of concerns in relation to the medicine core service review to date.

2.2 Maternity core service review

- CQC colleagues undertook a core service review of our maternity services on 14 July.
- 52 information requests following the maternity review were received on 16 July and responded to in full on 21 July, within the 72-hour timeframe requested. Initial written feedback from the maternity review was received on 19 July.

- Concerns were raised informally and in the written feedback about consistent staffing levels of consultant obstetricians, burn out of midwifery staff, ECG machine lead issue, full completion of patient records and robust feedback from incidents. Board members have seen all the associated correspondence and discussed the maternity core service review at the Board meeting on 5 August 2021. We have not received any further correspondence and any additional raising of concerns in relation to the maternity core service review to date.

2.3 Urgent and Emergency Care core service review

- CQC colleagues undertook a core service review of our urgent and emergency care services on 10 August.
- A large number of information requests following the review were received on 11 August and responded to in full on 16 August, within the 72-hour timeframe requested.
- On 12 August we received a letter from CQC colleagues in regard to potential urgent enforcement action due to concerns with risk assessment completion / action; timeliness of observations; streaming and triage process; number of nursing staff.
- My response of 13 August to the concerns did not fully assure the CQC of the complete mitigation of all the risks identified to patient safety and areas of concern, so I was formally served with a notice under Section 31 of the Health and Social Care Act 2008 on 16 August, imposing conditions on the registration as a service provider.
- The following conditions have been imposed on us:
  - To ensure there are sufficient numbers of suitably qualified, skilled, competent and experienced nursing staff at all times to meet the needs of patients within the ED
  - To operate an effective system which will ensure that every patient attending the ED has an initial assessment of their condition to identify the most clinically urgent patients
  - To undertake a review of current and future patients clinical risk assessments, care planning and physiological observations and ensure that the level of patients' needs are individualised, recorded and acted upon
  - To ensure that we implement an effective system for all patient observations to be completed within 15 minutes of arrival

  (Note: the Section 31 notice itself has not been included in the public board papers because it contains patient identifiable information)

- We are required to provide monthly progress reports and updates to the CQC to show how we are improving and meeting the requirements and a range of weekly data returns.
- Board members have seen all of the associated correspondence and have had a number of discussions about the content of the section 31 notice and the next steps.
- CCG, ICS, LA, MP and regional colleagues have been made aware of the section notice.
- I have written to all colleagues at PAHT to inform them also
- The Urgent and Emergency care team have clear plans for improving these items as well as continuing their transformation work to ensure we provide safe, effective and responsive care to all of our patients.
- This however is not just an ED issue. Continuing to improve the flow of patients out of the ED, through SDEC or AAU, in to and through the IP wards and safely out of the hospital is needed to continue to reduce the pressure in the ED department. To support both the Section 31 notice concerns but also the unprecedented increase in demand for our UEC services being experienced currently, the key focus of everyone in the Trust currently is on the safe management and care of our local population requiring urgent and emergency care.
- In addition to the internal focus, the current pressures on UEC being experienced require a whole system approach including our health and care partners outside of PAHT. We continue to work with our system partners to address the increasing demand for our services and the support for safe and effective discharge and the management of suitable patients in the community.
- Our internal governance and oversight process for UEC will remain in place and we will continue to report progress formally through QSC. In addition, we have agreed with ICS and Regional NHSEI colleagues to have a monthly oversight group to track progress and gain assurance of improvement, the first of which is scheduled for 4 October.

2.4 Well-led interviews

- I made a presentation to the team on 11 August and formal interviews were held on 16, 17 and 24 August and 6 September.

(3) Welcome to Hattie

I'm delighted to welcome Hattie Llewelyn-Davies OBE on behalf of everyone on the Board to her first Board meeting as the new Chair of the Trust. Hattie was appointed by NHSEI following an interview process on 13 and 14 July, and started with the Trust on 13 September.

Hattie has extensive experience as chair of NHS organisations, having chaired Hertfordshire Partnership NHS Foundation Trust (HPFT) for many years before spending the last seven years as chair at Buckinghamshire Health NHS Trust, where she will continue to remain the Chair until March 2022.

Before joining the NHS, Hattie had a number of chief executive and senior management roles in the housing and homelessness sector; and was awarded an OBE for services to homeless people in 2004. Hattie was also recognised by the Sunday Times as Non-Executive for the Public and Not for Profit Sector in 2019 and is a Trustee on the board of NHS Providers.

I'd like to thank Helen Glenister, as the vice-Chair, for stepping into the interim Chair role for the last 3 months.

(4) New hospital

We continue to work at pace with the development of the new Princess Alexandra Hospital in conjunction with the national New Hospital Programme (NHP). Our Outline Business Case is continuing to be developed and we are expecting to be able to submit this in March 2022.

(5) Event in a Tent – annual staff celebration and engagement event

Our annual engagement event for everyone at PAHT, Event in a Tent, to celebrate, support and recognise all of our people was a fantastic set of events run from 14th to 16th September this year. After running the whole event virtually last year, we ran all of this year's events both physically in the Tent, with reduced numbers, and simultaneously live streamed.

We had some great external speakers across the 3 days on topics ranging from the impact in healthcare of human factors, to the art of being brilliant and how to be positive, take control and develop self-awareness, to how we can better support each other and colleagues and a look at different personalities and how we can better embrace all of our differences to work together more effectively.

We launched our new strategy, PAHT 2030 and our 3 new values, both developed with the input from more than 500 colleagues. Our new behaviour framework, This is us, which underpins our values and how we are going to deliver our ambitious PAHT 2030 plans, was also launched and well received.

We heard some very powerful first hand personal stories and reflections of the pressures over the last 18 months from a range of clinical colleagues in our COVID-19 Schwartz round, and separately from a range of teams across the Trust about their proudest moments over the last year, with some very creative and entertaining ways to explain this.

We also had some great discussions on how to continue to support and enhance equality, diversity and inclusion across the Trust and how we can continue to develop and strengthen the experiences that our patients have.
Thanks also to everyone who attended our Annual General Meeting both physically and online to hear about our challenges and achievements over the last year and our ambitions for service improvements and developments this year.

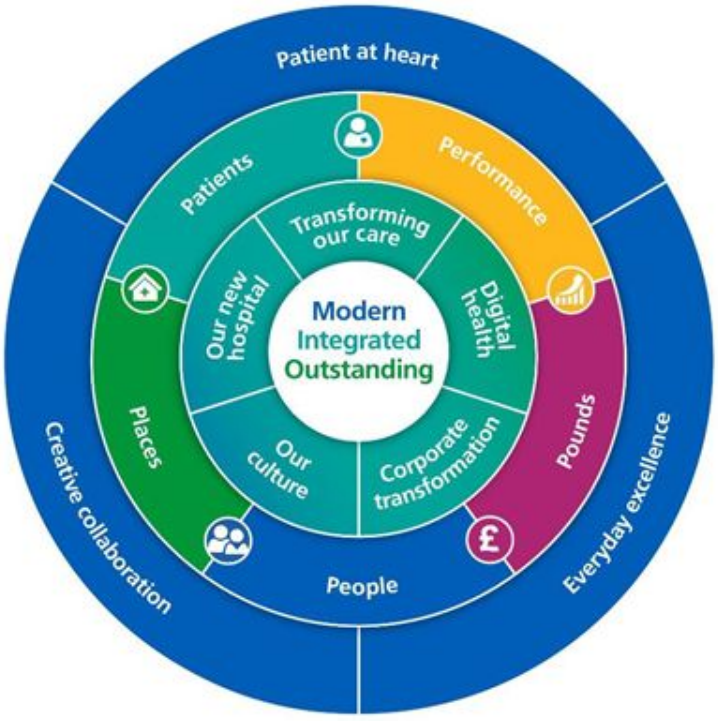
As always though, the highlights for me of the three days were being able to thank and to celebrate all of our long service award colleagues and all of our people who won one of this year's Our Amazing People Awards. It is always humbling to speak to colleagues who have committed so much of their working life and career to supporting patients in the local population. This year there are 66 colleagues who have just reached their 20th anniversary and 27 colleagues who have reached their 25th anniversary, an astonishing combined number of years worked in the organisation of 1,995. I cannot begin to imagine the number of patients who will have benefitted directly as a result of those 1,995 years of PAHT service between them. I was truly humbled however and in awe of all of our people who stepped on to the stage on 15th September though to receive an award, nominated by their colleagues, the most amazing form of recognition anyone can receive. The citations for our highly commended colleagues were astonishing and the 3 words that best described to me the qualities of all of the winners on the night were humility, dedication and compassion. It was an enormous pleasure and privilege for me and my Executive Director colleagues to be part of the evening and to share the celebrations with our winners and I'd like again to say well done to all winners and thank you to all colleagues who took the time to nominate them.

Finally thank you to the communications, people and learning and OD teams who worked tirelessly in the run up to the Event in a Tent and throughout the three days to ensure that it was the success that it was to celebrate, support and recognise all of our people.

(6) PAHT 2030 / New organisational values launch

As planned, following the soft launch of PAHT 2030 and our 3 new values at the start of August, they were both formally launched at The Event in a Tent. The engagement sessions during August enabled us to further enhance and develop the detailed actions for the first 2 years of the strategy under each of our 5 priorities:

- Our Culture
- Transforming our Care
- Digital Health
- Corporate Transformation
- Our New Hospital



Good progress is being made with the creation of a PMO to support our QI and OD teams in driving the transformation with all of our colleagues. There have also been a large number of good conversations across the Trust about the new values, what they mean, what poor behaviours may be and what and how these can be changed so that behaviours align with the values. Our This is us booklet will be distributed to all colleagues.

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

(7) COVID booster and flu vaccinations

Our annual flu vaccination programme for all colleagues across the Trust starts on Monday 4 October.

This year we will be running it in conjunction with the provision of the COVID-19 booster vaccination for all appropriate colleagues (must have had both original doses and have had the second of these >6 months before the booster vaccination).

For colleagues who choose to have both vaccinations, it will be possible for them to have them at the same. I will keep the Board updated about the uptake from colleagues of both vaccinations and I, the Executive team and the SHaW team will continue to promote the availability of the vaccinations to everyone.

Thank to everyone who has coordinated the programme or volunteered to be a vaccinator.

(8) Consultant appointments

Following an AAC panel on 23 September, an offer of appointment as a consultant at PAHT has been made to:

- AAC on 23 September – Dr Sarah Babatunde; consultant anaesthetist with an interest in obstetrics

The Board is asked to ratify the offer of this appointment, made through delegated authority to the AAC panel.

Author: **Lance McCarthy, Chief Executive**
Date: **30 September 2021**

The Princess Alexandra Hospital NHS Trust

2.2

TRUST BOARD - 7 OCTOBER 2021

Agenda item:	2.2							
Presented by:	Fay Gilder - Medical Director							
Prepared by:	Lisa Flack – Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Quality Governance							
Date prepared:	20 September 2021							
Subject / title	Significant Risk Register							
Purpose:	Approval		Decision		Information	√	Assurance	√
Key issues:	This paper presents the Significant Risk Register (SRR) for all our services. The Significant Risk Register (SRR) is a snapshot of risks across the Trust at a specific point and includes all items scoring 15 and above. The overall number of significant risks on the register has reduced from 73 to 69 (section 2.1). The main themes for 14 risks scoring 20 on the SRR are: • Six for operational pressures: two ED access standard compliance, two referral to treatment standard compliance, one Cancer-waiting times, one bed pressures in medicine on Covid-19 register. • Three for our patients covering: equipment for Dolphin ward, electronic storage of maternal CTG reports and delays for medical review in same day admissions unit • Two for our places - concerning the theatre roofs • Two medical consultant cover - for GI bleed rota and obstetrics. Actions taken and mitigations are detailed in sections 2.4 to 2.7 Four new risks scoring 15 and 16 raised since 1 July 2021: Two under our people, one our patients and one our pounds. Actions taken and mitigations are detailed in section 3							
Recommendation:	Trust board is asked to review the contents of the Significant Risk Register							
Trust strategic objectives:	Patients	People	Performance	Places	Pounds			
	√	√	√	√	√			

Previously considered by:	Risk Management Group reviews risks on a rotation; each service is monitored quarterly as per annual work plan. This paper was reviewed by Senior Managers Team on 14 September 2021
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

1.0 INTRODUCTION

1.1 This paper details the Significant Risk Register (SRR) across the Trust; the registers were taken from the web based Risk Assure system on 2 September 2021. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

There is an annual work plan (AWP) to ensure each areas register has a review in detail and on rotation. During Covid-19 wave 2, meetings focused on significant risks, new and emerging risks.

2.0 CONTEXT

2.1 The Significant Risk Register (SRR) is a snapshot of risks across the Trust 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.
In line with the new quality governance structure we are reviewing how risk is managed as an organisation with additional training been provided to staff on how we to manage risks at a local level.

2.2 There are 69 significant risks on the risk register, decreased from 73 in the paper discussed in August Trust Board. The breakdown by service is detailed in the table below.

	Risk Score				
	15	16	20	25	Totals
Covid-19	1 (2)	0 (1)	1 (0)	0 (0)	**2 (3)**
Cancer, Cardiology & Clinical Support	2 (4)	8 (8)	0 (0)	0 (0)	**10 (12)**
Communications	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Estates & Facilities	0 (1)	3 (2)	0 (0)	0 (0)	**3 (3)**
Finance	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Health Safety and Resilience **(formerly Non-Clinical Health & Safety)**	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Information Data Quality and Business Intelligence	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
IM&T	1 (1)	2 (2)	0 (0)	0 (0)	**3 (3)**
Integrated Hospital Discharge Team	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Learning from deaths	0 (0)	1 (2)	0 (0)	0 (0)	**1 (2)**
Nursing	1 (2)	0 (0)	0 (0)	0 (0)	**1 (2)**
Operational	2 (2)	1 (1)	4 (4)	0 (0)	**7 (7)**
Research, Development & Innovation	0 (0)	1 (1)	0 (1)	0 (0)	**1 (2)**
Resilience	0 (1)	0 (0)	0 (0)	0 (0)	**0 (1)**
Workforce	0 (0)	0 (1)	0 (0)	0 (0)	**0 (1)**
FAWs Child Health	3 (3)	0 (0)	1 (1)	0 (0)	**4 (4)**
FAWs Women's Health	5 (6)	3 (3)	2 (2)	(0)	**10 (11)**
Safeguarding Adults	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Medicine	3 (3)	(0)	1 (1)	(0)	**4 (4)**
Surgery	3 (3)	3 (2)	4 (4)	0 (0)	**10 (9)**
Urgent & Emergency Care	1 (1)	4 (1)	1 (0)	0 (0)	**6 (1)**
Totals	**24 (31)**	**31 (29)**	**14 (13)**	**0 (0)**	**69 (73)**

(The scores from paper presented at SMT in July and Trust Board in August 2021 are detailed in brackets)

2.3 There are 14 risks with a score of 20: increasing by one from the previous paper. A summary of these risks is below and all new risks are detailed:-

2.4 Our Patients

2.4.1 Baby cots for paediatrics

- The Favero 300 cots used on Dolphin do not lower enough to allow staff below 5ft 5in to reach a child to perform CPR (Dolph01/2021 risk raised February 2021, score increased end of June 21 following Datix incidents and receiving a government alert regarding expected surge in respiratory viruses affecting babies and toddlers within the UK). The head of the cot makes intubation awkward, as procedure needs to be completed from the side rather than above the head.
  Action: Ten Tomtom 2 cots have been purchased and awaiting delivery, expect delivery by end October 21. Mitigation is the ward have five cots and can borrow additional cots from NICU as needed, and for instances requiring intubation, the child will be placed on an adult bed for this procedure.

2.4.2 Electronic storage of Cardiotocography (CTG) for obstetrics

- The Trust needs electronic storage of CTG to cover antenatal and intrapartum care, (20202/06 raised in June 2020, score adjusted as software programme requires investment.
  Action: Currently all notes are available in paper and the team make copies where there is a known outcome that the CTG will be required for a review post-delivery. The team are awaiting an update to the server to ensure that all CTGs can be stored centrally.

2.4.3 Delays to assessment in Same Day Emergency Care unit

- **SCORE INCREASED:** Patients are having lengthy delays waiting for a medical review in SDEC. There are two doctors to review 40 to 45 patients (SDEC-120721, raised in April 21 with score increased in August due to increasing waiting times)
  Action: Where possible additional doctors are allocated to the unit. To complete a detailed review of the service, mapping and benchmarking against other trusts by end October 2021

2.5 Our People

2.5.1 Consultant cover in obstetrics

- Consultant cover achieves 82 hours per week including the extra four hours at the weekend associated with extra ward rounds as recommended in the Ockenden report, against the national requirement for availability at 98 hours a week for units with 4,000-5,000 deliveries per annum. There is a high potential for obstetric consultants needing to be called into the trust (2020/10/01 December 2020). Our unit delivers approx. 3,800 per annum, which means we should have 60 hours of cover, but we are aspiring to be better than the minimum.
  Action: All consultant job plans were reviewed. Recruitment is planned for two new WTE substantive roles, staff are due to come off the on call rota for health reasons, so we are unlikely to be at 98 hours in the short term. Once the new Clinical Director is in post, the intention is to complete a work force review as part of the work on the Maternity Strategy. A hot week consultant role is in place, to ensure there are twice daily ward rounds on labour ward as per Ockenden recommendations.

2.5.2 Medical cover for GI bleed out of hours

- Trust does not have an out of hours GI bleed rota (Endo 08 initially raised October 2016, score amended after discussion within September Medicine Board meeting and increased to 20 in September 2020).

Action: Completed the upper GI bleed proforma and policy. From 9 June 2021, trust has a GI bleed advisory service, with Consultant lead available 24/7 to provide advice and support to teams managing a patient during out of hour's period. Working towards an out of hours GI bleed service by end of Q2 2021/2.

2.6 Our Performance

2.6.1 ED performance

Two risks regarding achieving the four-hour Emergency Department access standard

- Compliance with the statutory standard for the Emergency department (ED) (001/2017 on operations team register since April 2014)
- Achieving the standard of patients being in ED for less than 12 hours (002/2016 raised July 2016 on operational team register)
  Actions: Comprehensive ward bed plan and forecasts by speciality level demand and capacity in place. Internal professional standards agreed and trackers review compliance. Rapid assessment and treatment process monitoring flow through department. Increasing consultant presence in ED until 22.00 hours, opening of the new acute admissions unit to facilitate admissions, actions taken on safety rounds, timely escalation with clear trigger and daily patient tracking of discharges. PRISM team supporting ED with flow and processes.

2.6.2 Cancer access standard

- Not achieving 85% of all patients referred by GP to receive treatment within the cancer 62 day standard (005/2016 on register since July 2016)
  Actions: Patient target list has granular information for oversight of individual patients on cancer pathway to monitor against escalation triggers. Recovery plan in place and trajectory monitored.

2.6.3 Referral to treatment standard

Two risks associated with performance against the national standard

- Risk of 52-week breaches because of the pandemic, pauses to OPD clinics and elective surgical activity. The numbers of patients waiting between 40 to 52 weeks is monitored (Nil over 52 weeks) and tracked by operational teams (Operational register 006/2017 and S&CC004/2020B)
  Action: Working with STP partners to manage paediatric urology, patients booked in order of clinical priority, monitoring of PTL continues weekly. Continue with use of independent sector. Cancer PTL reviewed daily, weekly for remainder of specialities. Monthly performance boards review performance and planned elective work.

- Achieve SCC 92% RTT standard, risk of non-compliance (S&CC002/2015 raised 2015 with score amended in March 21 due to worsening position)
  Action: patients are risk stratified as per NHSI guidance. Elective programme recommenced March 21.

2.6.4 Bed pressures in Medicine

- **SCORE INCREASED:** Significant pressure on medical beds due to Covid-19 and ongoing increased non Covid-19 emergency demand (C19-058 on Covid-19 register).
  Action: Close forecasting of Covid demand and cancelling of elective surgery has enabled the Trust to have adequate capacity. However, if elective activity recommences the risk of insufficient beds increases

2.7 Our Places

2.7.1 Environment: Surgery

- **Two risks for Theatres:**
  Water ingress in theatre 1 and theatre 7 due to structure of the roof and rainwater ingress affecting the use of theatres for surgery. (THE 006/2019 and THE 008/2019, initially raised on 31/10/19, score increased on 22/6/21 as result of new roof leaks).

Action: Weather forecast checked prior to commencing surgery, staff are vigilant; lists are moved to another theatre if possible or not commenced.

2.8 Our Pounds: Nil

3.0 NEW RISKS – raised or scores amended since 1 July 2021

3.1 Our Patients

3.1.1 Delays to assessment in Same Day Emergency Care unit – Score 16

- Patients are having lengthy delays waiting for a surgical speciality review in SDEC affecting timely assessment and care (SDEC300721-02 raised 30 July 2021).
  Action: Expected urology patients are given appointments for the afternoon period. Senior surgical nurses coordinate role to support patient flow (weekdays) and escalation to senior doctors for issues of long waits. Looking to have a dedicated on call surgical doctor by end of November 2021.

3.2 Our People

3.2.1 Mammography gaps due to vacancy and sickness absence – Score 16

- The service requires four WTE radiology staff to deliver the mammography screening service (RAD2021/03 raised July 2021)
  Action: Breast imaging assistant recently started in post, out to advert for a postgraduate staff member and locum roles.

3.3 Nurse staffing on Kingsmoor ward – Score 15

To provide safe quality care with 9.3% nursing vacancies (KINGS01 raised June 2021 and score increased in August as a result of staffing incidents reported)
Action: Five registered nurses have been re-allocated to the ward. Thrice daily staffing reviews by matrons using safe care to ensure staffing meets acuity of patients. Using NHSP and agency staff to cover the ward safety

3.3 Our Pounds

- **Financial cost to undertake refurbishment of Parndon Hall – Score 16**
  Trust to undertake remedial works to Parndon Hall to deliver compliance with building regulations (FMEST-01- 2021 raised in February and score increased at end of July when staff had to be relocated out of the building)
  Action: accredited air safety and structural integrity tests both passed. Have restricted access to authorised members of staff.

4.0 RECOMMENDATION

Trust Board is asked to review the contents of the Significant Risk Register.

The Princess Alexandra Hospital NHS Trust

2.3

Trust Board – 7 October 2021

Agenda item:									
Presented by:	Heather Schultz – Head of Corporate Affairs								
Prepared by:	Heather Schultz – Head of Corporate Affairs								
Date prepared:	30 September 2021								
Subject / title:	Board Assurance Framework 2021/22 – October update								
Purpose:	**Approval**		**Decision**		**Information**		**Assurance**		
Key issues:	The Board Assurance Framework is presented for review and approval. The risks have been reviewed at the relevant committees during September and it is proposed to increase the score for two risks: BAF risk 2.3 Inability to recruit, retain and engage (lead executive – Director of People): risk score to increase from 12 to 16 BAF risk 4.2 Four Hour Emergency Department Constitutional Standard (lead executive – Chief Operating Officer): risk score to increase from 16 to 20. WFC and PAF reviewed and supported the increases in scores; actions in progress are detailed in the summary paper. An overview of all the risks is included in Appendix B and the full BAF is attached as Appendix C.								
Recommendation:	Review and approve the changes to the BAF and the two risk scores.								
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:	NHC, QSC, WFC, PAF and EMT in September 2021.
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance.
Appendices:	Appendix A – summary paper Appendix B – BAF dashboard Appendix C – BAF October 2021

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

Trust Board – 7 October 2021

Board Assurance Framework 2021/22 – October update

1.0 Purpose/Issue

The Board Assurance Framework (BAF) is presented for review with proposed changes, as discussed at Committees during September 2021, summarised below. Appendix 1 provides a summary of the risks and changes in risk scores to date.

2.0 Key changes

It is recommended that the risk scores for the two risks below are increased and the remaining scores remain unchanged following review and scrutiny at the relevant committees in September.

2.1 BAF risk 2.3 Inability to recruit, retain and engage (lead executive – Director of People):

The risk has been reviewed and in light of the results of the staff survey, pulse survey, Deloitte survey and the GMC survey it is recommended that the residual score is increased from 12 to 16 and the target date for achieving the target risk score is revised to March 2023.

The following actions are in progress:

- Develop workforce plans for medical staff by January 2022
- Extranet for staff - Q3 21/22
- Staff survey action plan
- Review of raising concerns (increase in FTSUGs - completed, lead FTSUG to be appointed in Q3, and senior inclusion lead Q3)
- NHSE/I Health and wellbeing framework assessment - Q3
- Review of management and leadership development provision - Q3
- Deloitte well-led review actions - Q3 to 2022/23 Q2
- EDI actions from WDES, WRES, EDS2 and gender pay gap – ongoing.

Lead Committee: Workforce committee reviewed the risk on 27.09.21 and supported the increase in score.

2.2 BAF risk 4.2 Four Hour Emergency Department Constitutional Standard (lead executive – Chief Operating Officer)

The risk has been reviewed and in light of the current pressures in urgent and emergency care and the increase in the volume of patients attending A&E, it is recommended that the score is increased from 16 to 20.

The following actions are in progress:

- Review of capacity in Urgent Treatment Centre and SDEC to support attendance and walk in patients through ED
- Review of weekly medical and nursing staffing
- Capacity through inpatient wards and application of red to green oversight in place
- Daily review and panel of pathway zero patients and simple discharges
- Executive oversight daily
- Attendance from senior clinicians at the ED safety huddles and real time escalation of all specialty delays.

Lead Committee: Performance and Finance Committee reviewed the risk on 30.09.21 and supported the increase in score.

3.0 Recommendation:

The Board is asked to:

- Review and approve the changes to the risk scores detailed above

Heather Schultz, Head of Corporate Affairs

Board Assurance Framework Summary 2021.22

Ref.	Risk description	Year- end score (Apr 21)	June 21	August 21	Oct 21	Dec 21	Feb 22	Year-end score (Apr 22)	Trend	Executive lead
Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population										
1.0	COVID-19: Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered.	16	12	*16 Increased score	16				↔	CEO/ DoN&M
1.1	Variation in outcomes resulting in an adverse impact on clinical quality, safety, patient experience and 'higher than expected' mortality.	16	16	16	16				↔	DoN&M/ MD
1.2	EPR: The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	16	16	16	16				↔	DoIMT/ CIO
Strategic Objective 2: Our People – we will support **our people** to deliver high quality care within a compassionate and inclusive culture that continues to improve how we attract, recruit and retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.										
2.3	Workforce: Inability to recruit, retain and engage our people	12	12	12	16* Increased score				↑	DoP
Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.										
3.1	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20	20				↔	DoS
3.2	Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	16	16	16	16				↔	DoS
3.5	There is a risk that the new hospital will not be delivered to time and within the available capital funding.	16	16	16	16				↔	DoS
Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators										
4.2	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	16	16	16	20* Increased score				↑	COO
Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.										
5.1	Revenue: The Trust has established an indicative annual breakeven budget for 21/22. For the first half of the financial year (H1) income allocations are new and are linked to System envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement. For the second half of the year (H2) the national finance regime is under development and therefore allocations available to the Trust are uncertain.	New risk	12	12	12				↔	DoF
5.2	Capital: In year delivery of the Trust's Capital programme within the Capital Resource Limit and ICS allocations.	New risk	12	12	12				↔	DoF

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2021-22

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
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/negative 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 Objectives 1-5													
BAF 1.0		**COVID-19:** Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on staffing levels, staff health and wellbeing, operational performance and patient outcomes.	Causes: i) Highly infectious disease with emerging new variants ii)Human Factors: Failure of public to adhere to Public Health messages and increasing Covid demand iii) Sustainability of supply chains during peak covid periods iv) Limitation and configuration of PAHT estate v) Vacancy and absence rates vi) Public perceptions around accessing services as normal	5 X 5= 25	Chief Executive /Deputy Chief Executive supported by Executive team QSC	i) Level 4 national incident declared by NHS England reduced to level 3 March 21st 2021 ii) PAHT incident co-ordination centre and incident management team established iii) COVID-19 incident management governance structure in place iv) Compliance with national directives v) Ongoing engagement with ICS and Local Resilience Forum, Local Delivery Board re-instated vi) COVID-19 patient pathways instigated vii) Staff being redeployed to provide additional support ix) Daily executive oversight of incident management x) Recovery and restoration planning (PAHT/ICP and ICS) xi) Separation of hospital into Covid and Covid free areas xii) Use of independant sector for elective patients xiii) Staff vaccination programme xiv) Engagement with critical care network xv) Back to Better Campaign launched xvi) Staff health and wellbeing initiatives introduced xvii) Nosocomial death review process in place	i) Incident Management Team Meeting ii) Strategic Incident Management Cell iii) IPC Cell and Infection Control Committee iv) Site Management Cell v) Communications Cell vi) People Cell viii) Clinical Cell ix) Incident management group	i) Incident management action and decision logs ii) QSC updates monthly from (March 2020 to September 2021) iii) Trust Board updates (March, to September 2021) iv) Recovery Plans and submissions (Recovery paper to Board August 21) v) Covid risk register	4x4=16	~~i) Loss of staff with key skills and training due to virus; shielding/isolating or sickness - cross out~~ ii) Adaptability and configuration opportunity of clinical areas		Sep-21	Score to remain at 16.	3x3=9 ~~September~~ February 2022
			Effects: i) Increased numbers of patients and acuity levels ii) Shortages of staff, staff shielding and increased sickness; **staff fatigue and reduced resilience** iii) Shortages of equipment, medicines and other supplies iv) Lack of system capacity v) Staff concerns regarding safety and well-being vi) Changing national messaging vii) Potential for patient harm due to cancellation of elective surgery							Actions: i) Critical network support ii) Surge planning: red ITU moving to Henry Moore iii) Second Covid ward being prepared iv) Maximising elective daycases				

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
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/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
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								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, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population													
BAF 1.1		Variation in outcomes resulting in poor clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Unwarranted variation in care ii) System wide flow iii) Workforce gaps	**4 X 5 = 20**	Director of Nursing/ Medical Director **Quality and Safety Committee**	i) Quality and safety governance structures in place ii) Robust Appraisal/ medical and nursing iii) End of Life and deteriorating patient simulation programme for all staff, across ICP and ICS (suspended due to Covid) iv) 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 and refresh of the risk management strategy 2021/22 viii) FTSUG's and 5 clinical FTSUG's appointed ix) Electronic handovers, Hospital at Night and E-Obs and observation compliance reports x) Schwartz Rounds xi) NHSI/NHSE Oversight xii) Patient Experience Strategy xiii) NED lead appointed for Mortality xiv) Mortality Strategy including dashboard in development , tracker, updates on work streams and learning from deaths, SMART software database implemented in July 21 xv) '15 steps' walkabouts (on hold over Covid and starting August 2021)- appreciate enquiry to commence August 21 xvi) Nursing Establishment review (bi-annually) and successful nursing recruitment campaign xvii) Safer Staffing policy and use of SafeCare to inform daily staffing xviii) Real time patient feedback implemented across all wards xix) Robust management of variations in neonatal outcomes xx) Engagement in external reviews MBRRACE,HSIB and LeDeR and Healthcare Safety Investigation Branch (maternity) xxi) Medical examiners (MEs) and Lead ME appointed and Strategic Learning from Deaths–established xxii) Complaints workshops held and development of PE strategy as part of Quality strategy (Sept 21) xxiii) Joint GIRFT and Model Hospital quality improvement programme xxvi) Appointment of medical PS&Q leads underway (July 21) xxvii) Complaints process being revised and grading system introduced xxix) Quality peer review process in place xxxi Covid-19 governance structure/meetings in place xxxii) HCG restructure consultation xxxiv) Appointment of DMD (quality)	i) National Surveys and audits, national quality audits ii) Cancer Survey iii) CEO Assurance Panels iv) Incident Management Group meetings, SIAP 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 Optimisation Group xii) End of Life xiii) AKI & Sepsis Group xiv) Urgent Care Board xv) Deteriorating Patient Group xvi) Cardiac arrest review panels xvii) Twice weekly Long Length of Stay meetings xviii) Quality Compliance Improvement Group, Clinical Compliance Group	i) CEO Assurance Panels (as required) ii) Reports to QSC on Patient Experience (bi-monthly), monthly Serious Incidents, monthly Safer Staffing, Patient Panel (bi-monthly) , Safeguarding, monthly Infection Control and Covid-19 updates Quality and safety data in the Integrated Performance Report iii) Monthly Mortality Improvement report to QSC including updates on ME reviews and monthly IPR report iv) ~~Dr Foster reports~~, CQC inspection reports (ED inspection report April 21, Section 31 notice issued and IRMER May 21 and GIRFT reports) v) Dr Foster reports and engagement vi) Quarterly Coding reports to PAF vii) Freedom to Speak Up Guardians quarterly reports to WFC viii) Patient stories and learning from deaths reports to Public Board meetings (bi-monthly) ix) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) x) TARN review (March 21) xi) Current HSMR 104.27	**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) NICE oversight and management of compliance with guidance v) Frequency and consistency of approach to M & M meetings vi) Clinical documentation not supported by existing infrastructure **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey 2020/21 action plan in place and (Sept 2021) iii) Ongoing work with Dr Foster in relation to mortality iv) EPR development and OBC to PAF/Board September 2021 - approved v) Developing PAHT Quality Strategy vi) Medical records Committee leading programme of work to improve documentation vii) Review of Mortality Strategy viii) Review of departmental clinical governance meetings - agenda, attendance and frequency ix) QiS metrics to be included in PRMs x) Raising awareness of 5 patient safety priorities HCG governance structures and IPR reporting x) Prism working with UEC to improve safety and quality for patients	i) Demonstrating an embedded learning programme from Board to ward. ii) Inconsistent re-audit iii) Lack of data to support information on progress with some patient safety metrics.	20/09/2021	**Risk rating to remain at 16.**	**4x3=12 October 2021**
			Effects: i) Higher than expected Mortality rates ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Poor reputation and low staff morale v) Patient harm vi) Loss of confidence by external stakeholders											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
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								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, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population **Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way**													
BAF 1.2		**EPR** The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	Causes: i) Poor clinical engagement with the system, due to lack of usability and limited functionality. ii) Timely system fixes/enhancements iii) Static functionality	**5 X 4= 20**	Chief Information Officer/Chief Operating Officer **Performance and Finance Committee**	i) Fortnightly DQ meetings held at ADO level ii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iii) Performance Mgt Framework in place. iv) User Training programme. v) Super users in place to deliver focused support. vi) Access Policy vii) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) viii) Development of capacity planning tools/information ix) Weekly ICT/COSMIC meetings ongoing x) New EPR Board established – chaired by CEO xi) EPR replacement programme established xii) EPR SOC developed and benefits realisation with link to HIMSS xiii) EPR OBC developed and to be presented to Board 10/09	i) Access Board ii) EPR Programme Board (to be chaired by CIO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews	i) Weekly Data Quality reports to Access Board and daily DQ reports to organisation ii) Quarterly DQ reports to PAF and quarterly ICT updates to PAF (August21) iii) Reports to EPR Programme Board iv) EPR SOC approved by SMT, PAF and Board (March to April 21 and May 21 Trust Board). Regional team approval received to proceed straight to OBC. v) EPR OBC approved by SMT (02/09), to be considered by PAF and Board (08/09 and 10/09)	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams to ensure completeness of data quality 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. Supplier requests to remove contractual requirement to comply with national standards e.g. ISNs - 2 risks associated 1) exposes PAH to technical compliance issue as supplier not compelled to comply and 2) financial risk – assurance PAH have declined supplier request on advice from NHSD.	Sep-21	Risk rating unchanged	**4x3=12** **end of 2022**
			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:** SOC approved and OBC developed to procure new EPR solution. Ongoing user training programme underway.				

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 2021-22

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/negative 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 our people to deliver high quality care within a within a compassionate and inclusive 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	**Causes:** 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 viii) Covid -19 **Effects**: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation. Covid-19 effects - delays in workforceplanning, recruitment programmes and additional health and wellbeing pressures on teams	**5 X 4 =20**	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 development programme launched xiii) Staff engagement groups and Staff Council xiv) International recruitment programme for nurses and ED doctors xv) Medical staffing review underway (Medical Safer Staffing) xvi) Additional recruitment ('Bring back staff') during Covid xvii) Provision of Health and Well-being support during Covid-19 including psychological support and absence line.Back to Better campaign launched March 21 xviii) Communications Strategy approved June 2020 xix) NHS People Plan and ICS People Plan xx) Webinars during Covid (BAME, Vaccination)	i) WFC, QSC, SC, PAF, SMT, EMT. ii) People board iii) JSCC, JLNC iv) PRMs and health care group boards v) People Cell established (Covid-19)	i) Workforce KPIs reported to WFC bi-monthly and inluded in IPR (monthly) ii) People strategy deliverables iii) Staff survey results 2020 (reported March 2021) iv) GMC survey (March 21) v) WRES and WDES reports 2021 (WFC and Board) vi) OD Framework approved (WFC June 2020) vii) Medical workforce plan update to WFC November 2020 and June 2021 viii) Dignity at Work report January 2021 ix) Culture and values refresh (July 21) x) Compassionate and inclusive leadership session (Board development session March 21) xi)Here to hear listening event and survey xi Deloitte well-led review survey xiii) NHSE/I pulse survey xiv) NHSE/I FTSU assessment	**4 x4 = 16**	Pulse surveys targeted for all staff Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Roll out of e-rostering to all areas Safer Medical Staffing plan in development CV19 staff vaccination implementation plan Actions i) ~~workforce~~ plans for medical staff Jan '22 ii) Extranet for staff - Q3 21/22 iii) Staff survey action plan iv) Review of raising concerns (increase in FTSUGs - completed, lead FTSUG Q3, senior inclusion lead Q3) vi CV19 staff booster implementation plan - Q3 vi) NHSE/I Health and wellbeing framework assessment - Q3 vii) Allocate rostering system review assessment and plans - Q2 vii) Review of management and leadership development provision - Q3 viii) Deloitte well-led review actions - Q3 to 2022/23 Q2	None identified.	20/09/2021	**Risk score increased from 12 to 16**	**4 x2 = 8** **March 2023**

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
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/negative 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 will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.1		**Estates & Infrastructure** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) 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) Inability to undertake planned preventative maintenance viii) Lack of decant facility to allow for adequate repair/maintenance particularly in ward areas.	5 X 5= 25	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 x) Annual fire risk assessment completed and final report received, compliance action plan being developed. xi) New estates and facilities leadership team in place with authorised persons in posts x) Sustainability Manager in post xi) Emergency Capital funding £4.3m xii) Compliance Manager appointed xiii) Significant capital programme for year c.£40m	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) Monthy Estates Board meeting	i) Reports to SMT (as required) ii) Signed Fire Certificate iii) H&S reports quarterly to PAF. iv) Ventilation assurance report v) Annual and quarterly report to PAF: Estates and Facilities quarterly report) vi) IPR monthly ix) Annual Sustainability report to PAF (May 2021 and update to PAF Sept 21) x) Capital projects report (PAF May 2021, Trust Board April 2021 and weekly updates at EMT)	5x4=20	i) Planned Preventative Maintenance Programme (time delay) ii) Sewage leaks and drainage iii) Electrical Safety/Rewiring (gaps - power failure March 21) iv) Maintaining oversight of the volume of action plans associated with compliance. **ACTIONS:** i) EBME review underway ii) HSE inspection in October 2021 - preparations underway	i) Estates Strategy /Place Strategy developing within ICS ii) Compliance with data collection and reporting iii) PPM data not as robust as required	01/09/2021	**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 2021-22**											
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/negative 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 – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
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 Trust Board	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) 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. xi) System agreement on governance and programme management xii) New ICS governance and structure meetings set up woth PAH attending task-finish groups ICS meetings focussing on management of Covid-19	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 (CEO report August and Development sessions in October/November 2020)	**4 X 4= 16**	Lack of ICS demand and capacity modelling. Implications of white paper and statutory changes. **ACTIONS:** System leadership capacity to lead ICS -wide transformation		21/05/2021	**No changes to risk rating.**	**4x3=12** **July 2021**
			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											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
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/negative 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 will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership													
BAF 3.5		**New Hospital:** There is a risk that the new hospital will not be delivered to time and within the available Capital funding.	Causes: ii) Funding is not made available for the preferred way forward ii) enabling works are delayed iv) there is a delay to approval of the business case v) the required SoA can not be delivered within the agreed affordability envelope vi) the land purchase is not completed successfully and in a timely manner vi) Development of new standards and programme approach by NHP may delay OBC Effects i) Hospital remains on existing site ii) Unable to deliver service transformation iii) Unable to manage system demand due to lack of transformation iv) Digital transformation not complete v) Poor staff retention due to failing infrastructure vi) Unable to reach outstanding service provision due to failing infrastructure vii) New hospital, if delayed, will be undersized because demand management is delayed viii) Loss of clinical engagement	**5 X 4= 20**	Director of Strategy New Hospital Committee	i) Detailed programme of work ii) Monthly meetings with national cash and capital team iii) Weekly meetings with regional team iv) Weekly meetings with landowners v) New national team appointed to provide transaction support vi) detailed review of proposed solution to ensure it is deliverable within the available funding envelope vii) National Programme design convergence review initiated	i) New Hospital Committee ii) Trust Board iii) External advisory meetings as required.	i) Monthly reports to Trust Board and New Hospital Committee. (November 2020) Ii) Letters of support received from JIC. iii) confirmation received that programme management structure is appropriate. Iv) Expert advice received on procurement strategy. v) Landowners have accepted offer in principle vi) Positive technical review feedback	**4x4=16**	Negotiations with landowners Delay to the DCR NHP Commercial strategy not agreed Actions i) Support national team with Design Convergence Review ii) Develop Heads of Terms for land transaction iii) Complete clinical review of 1:200 drawings	None.	Sep-21	**Risk score not changed.**	**3x3=9** **December 2021**

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive/negative 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 resulting in increased risk to patient safety and poor patient experience.	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Changes to working practice and modernisation of systems and processes iv) Delays in decision making, patient discharges and impacting on flow v) Lack of assesment and short stay capacity, lack of CDU space vi) Increase in volume of patients presenting to ED vii) Volume of ambulance patients and delays offloading patients	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) Revised Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Developing new models of care vii) Local Delivery Board in place ix) ED action plan reported to PAF/Board x) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries xi) Weekly Urgent Care operational meetings and Urgent Care Board in place xii) Focus on length of stay in ED for all patients xii) Think 111 First ~~xiii) Paeds ED now relocated back into ED with Executive oversight meeting weekly~~	i) Access Board meetings ii) Board, PAF and SMT meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) System Operational Group vii Weekly Length of Stay meetings viii) Urgent Care Board	i) Daily ED reports to NHSI ii) Monthly PRM reports from HCGS iii) Monthly IPR reported to PAF/QSC and Board reflecting ED performance (PAF, QSC Sept 21) iv) UEC deep dive presentation QSC Sept 21	~~4x4=16~~ **4x5=20**	i) Staffing (Trust wide) and site capacity ii) System capacity and demand pressures iii) Leadership issues Actions: 1. All trust consultant escalations and awareness of current pressures 2. Review of capacity in UTC and SDEC to support attendance and walk in patients through ED 3. Review of weekly medical and nursing staffing 4. Capacity through inpatient wards and and application of red to green oversight in place 5. Daily review and panel of pathway zero patients and simple discharges 6. Executive oversight daily 7. Attendance from senior clinicans at the ED safety huddles and real time escalation of all specialty delays	None noted.	01/09/2021	**Risk score increased to reflect current pressures on the organisation and the system.**	**4x3 =12** **March 2022** **(on consistent 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 2021-22**											
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)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.													
BAF 5.1		**Finance :** The Trust has established an indicative annual breakeven budget for 21/22. For the first half of the financial year (H1) income allocations are know and are linked to System envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement. For the second half of the year (H2) the national finance regime is under development and therefore allocations available to the Trust are uncertain.	**Causes:** The main causes of risk are : (i) The current financial regime operates under 'block contract' arrangements. There is limited capacity for Commissioner contracts to be varied. (ii) There is uncertainty of the financial regime to be operated in H2. (iii) Financial plans include a requirement to deliver CIPs with a step change in delivery required in H2 - the ability to control costs and the deliverability of CIPs will be influenced by COVID, restore and recover. (iv) The Trust has a number of cost pressures that will require mitigation. (v) Although the Trust has improved its vacancy rates it remains over reliant on temporary staffing which attracts premium costs - continued improvements in substantive recruitment is required. (vi)The CIP ask in H2 will be increased. This increases the potential for non-delivery of the CIP (vii) Elective Recovery Funding activity levels have been increased from M4. Therefore the system may not achieve the required activity levels. Consequently, this may put the reimbursement of ERF in jeopardy.	**4 X 4= 16**	**Exec leads:** DoF **Committee** : Performance and Finance Committee	**Key Controls include :** (i) Agreed H1 financial envelopes including continued levels of COVID funding. (ii) Health Care Group / Corporate performance review meetings are in place where performance is being monitored. (iii) Exec led vacancy control group. (iv) Oversight of the Trust's financial performance by the EMT, SMT, PAF, Workforce and Audit Committee. (v) Monthly monitoring of financial performance by NHSE/I through the submission of financial returns. (vi) Strengthening of financial control and governance including an improved governance process for business case investmentusiness case approval process. (vii) Development of CIP workshops and plans. (vii) Temporary staffing audit underway and focus on reduction in temporary staffing.	**Sources of Assurance :** (i) Performance review meetings - monitoring against plan and forecast (ii) Internal audit reports / Head of Internal Audit Opinion (iii) External audit opinion (iv) Cash management monitoring and adequate cash balances (v) CIP tracking (vi) Reduction in run rate spend on temporary staffing	**Positive Assurances :** (i) Delivery against YTD and forecasted plans. (ii) CIP delivery and forecast to plan. (iii) Substantial rating on internal audit reports. (iv) Unqualified value for money opinion	**4x3=12**	**Gaps in Control** : (i) Instances of non-compliance across the organisation in relation to SFIs i.e. non compliant waivers (ii) Activity and demand and capacity planning. (iii) CIP delivery (iv) Embedding management of temporary staffing costs (v) Existence of manual processes across the Trust	**Gaps in Assurance :** (i) National H2 Financial regime is under development and therefore uncertainty over allocations in H2. (ii) Fully integrated business and operational planning including demand and capacity plans. (iii) Business case benefits realisation process	21/09/2021	**Residual risk score not changed.**	**4 x 2 = 8 (Q4 2021/22)**
			Effects: (i) Challenges to meet financial control targets, including delivery of our CIP (ii) Delivery of revenue position may impact on future capital availability.							**ACTIONS:** (i) Transformational and modernisation work plans. (ii) Demand and capacity planning and modelling to be regularised. (iii) Consideration being given to the introduction of a PMO. (iv) Review of Governance Manual				

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
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)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way													
BAF 5.2		Finance : In year delivery of the Trust's Capital programme within the Capital Resource Limit and ICS allocations.	**Causes:** The main causes of risk to delivery are (i) An over-subscribed capital programme. (ii) Operational pressures that may constrain the delivery of a capital scheme. (iii) Confirmation of external funding sources within a timeframe to allow projects to be completed including adequate planning and procurement preparation. (iv) Incomplete and/or untimely production of business cases that do not facilitate required approvals. (v) Single year funding settlements that do not support development of longer term / 5 year plans and management of a plan over financial years. (vi) As the ICS takes on increasing responsibilities for capital planning the Trust will be competing for capital resource across the ICS. (vii) The development of the New Hospital will continue to be a significant programme of work. (viii) Costs for building projects are increasing therefore adding pressure to the capital programme. (ix) The capital programme has an overplanning margin wich increases the risk of breaching the CRL if all projects deliver.	**4 X4 = 16**	**Exec leads:** DoF **Groups:** Capital Working Group, SMT, EMT and Performance and Finance Committee, New Hospital Committee	**Key Controls:** (i) The Trust has developed a 'Risk based' prioritised capital programme which is agreed through the capital working group, SMT, PAF and the Board. The CWG meets monthly to monitor progress on pre agreed schemes. (ii) The Risk Management Committee detail all risk that require capital investment. (iii) The Trust undertakes a six facet survey which informs of all backlog maintenance risks and how this element of capital is spent. (iv) Business cases are required for all capital investment. (v) All capital projects have a senior responsible officer and project lead and report into HCG/Corporate areas. (vi) Application of external funding for additional, ad hoc capital. (vii) Discussion with system partners to ensure that the Trust does not breach its CRL as capital allocations can be moved across the system.	**Sources of Assurance :** (i) Frontloaded capital trajectories that monitor expected performance against plans, including cashflow forecasts. (ii) YTD and forecast reports detailing progress. (including New Hospital) (iii) Internal audit reports. (iv) A prioritised capital programme that allows for flexibility and longer term planning. (vi) Business case review process verifies investments are strategic/operational and meet the Trust's requirements to achieve its objectives.	**Positive Assurances :** (i) Delivery against YTD and forecasted plans. (ii) Business cases approved timely. (iii) Substantial internal audit reports. (iv) Reduction in non-compliant waivers. (v) Approval of external funding and receipt of PDC/MoU	**4x3=12**	**Gaps in Control**: (i) Compliance to business case and approval process as this is a new process and is currently being embedded within the organisation.	**Gaps in Assurance:** (i) Improvements in forecasting trajectories and development of longer term capital programme.	21/09/2021	**Residual risk score not changed.**	**4 x 2 =8 (Q4 2021/22)**
			Effects: (i) Risk to under/overshoot of CRL.							**ACTIONS:** (i) Business Development Group is being initiated in line with the revised Capital and Revenue investment guidance				

The Princess Alexandra Hospital NHS Trust

Trust Board 7 October 2021

3.1

Agenda item:	3.1							
Presented by:	Dr Fay Gilder, Medical Director							
Prepared by:	Dr Fay Gilder, Medical Director							
Date prepared:	30 September 2021							
Subject / title:	Learning from deaths update							
Purpose:	**Approval**		**Decision**		**Information**	**x**	**Assurance**	x
Key issues: please don't expand this cell; additional information should be included in the main body of the report	No update from Dr Foster provided due to a failure in their data quality. Dr Foster intend to provide the most recent mortality indices 1 October 2021 and a verbal update will be presented to Board as a consequence.							
Recommendation:	For noting and debate							

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:	Verbal report to QSC
Risk / links with the BAF:	BAF 1.1 Variation in outcomes in clinical quality, safety, patient experience and "higher than expected mortality"
Legislation, regulatory, equality, diversity and dignity implications:	*'Learning from Deaths'* - National Quality Board, March 2017
Appendices:	

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

1.0 Purpose

The purpose of this paper is to provide assurance on the implementation of the learning from death process, to highlight key pieces of learning and to provide progress updates on the current programme of work to improve clinical practice.

2.0 Context

BAF 1.1 Variation in outcomes in clinical quality, safety, patient experience and "higher than expected mortality".

3.0 Key Points

3.1 Dr Foster (now known as Telestra) update

Due to a failure of confidence in data transfer from HES to Telestra through their secure portal, the mortality indices for M2 and M3 are not available. The data will be made available 1 October 2021 and a verbal update will be given to Board.

3.2 Mortality Improvement Programmes (cyclical 3 monthly updates)

Sepsis – 6 month audit of ED compliance with sepsis 6 showed 94% of patients with sepsis are receiving antibiotics within one hour and 90% of patients are receiving all six elements of the Sepsis 6 bundle. Work continues on improving compliance further
COPD/Pneumonia – From Mid September a comprehensive 24/7 non invasive ventilation service is now being offered on Locke Ward. Clinical effectiveness of the service is being audited.

3.3 SMR outlier deep dives

Case record reviews of all cases that triggered the SMR outliers (January 2021-March 2021) have been completed. Opportunities to improve care identified – specifically earlier referral to the specialist palliative care team and early referral to the oncology specialty team. This

learning has been fed back to the SPCT and the CCCS healthcare group. Opportunities to improve coding were also identified and the learning shared with the clinical coding team.

3.4 Medical Examiner Service

To meet the requirement (which becomes statutory in April 2022) for all community deaths to undergo a medical examiner scrutiny - 3 new medical examiner posts are being recruited to. The interviews are in October.

4.0 Next steps

The healthcare group restructure offers us the opportunity to embed the learning from deaths into service and divisional patient quality and safety governance and learning. This opportunity will be realised as part of the work of the Deputy Medical Director for Quality and Safety (in post November 2021), the Deputy Chief Nurse for Quality and the divisional patient safety and quality leads (medical and nursing).

SMART mortality software has now been in use for 3 months. A dashboard is being refined and the data will be used to support this report going forward.

The Princess Alexandra Hospital NHS Trust

3.1

5.0 Recommendation

For the Board to provide feedback on the contents of the paper to ensure a dynamic discussion and challenge of the information provided.

Author: Dr Fay Gilder, Medical Director
Date: 30 September 2021

The Princess Alexandra Hospital NHS Trust

Trust Board – 07.10.2021

3.2

Agenda item:	3.2
Presented by:	Sharon McNally, Director of Nursing, Midwifery and AHPs
Prepared by:	Erin Harrison, Lead Governance Midwife
Date prepared:	7th September 2021
Subject / title:	Overview of Serious Incidents within maternity services

Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**	**X**
Key issues:	Following the Ockenden report published in December 2020, an essential action from enhanced safety was that all Maternity Serious Incidents (SIs) with a summary of key issues must be sent to the Trust Board and at the same time to the local LMNS for scrutiny oversight and transparency. There were 2 new Obstetric incidents declared since the last report which are both current HSIB cases. There were 2 Obstetric incidents closed since the last report, with 6 previously declared SIs under investigation.							
Recommendation:	To note the report and the ongoing work with the investigation process, thematic learning and improvement actions.							

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

Previously considered by:	Patient Safety Group Sept 21 QSC Sept 21 (paper for Board abridged, with the removal of patient sensitive information)
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the recent Ockenden report that was published in December 2020 with recommendations for maternity services.
Appendices:	

The Princess Alexandra Hospital NHS Trust

3.2

1.0 Purpose

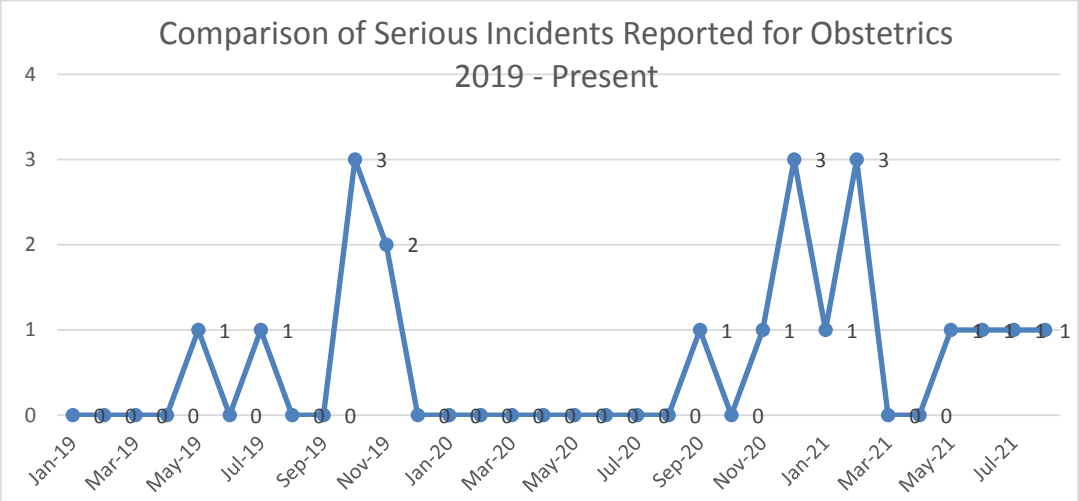
This paper outlines the open SI's within Women's Health (Obstetrics and Gynaecology) with concerns, areas of good practice and shared learning identified.

2.0 Background

Following the Ockenden report published in December 2020, an essential action from enhanced safety was that all Maternity SI's with a summary of key issues must be sent to the Trust Board and to the local LMNS for scrutiny, oversight and transparency.

3.0 Analysis

Table 1. Serious and Internal Incidents



3. Overview of Incidents

Obstetrics currently have 6 Serious Incidents (SI's) under investigation, the detail can be found in Appendix 1. Gynaecology currently have 2 Serious Incidents (SI's) under investigation, the detail can be found in Appendix 1.

The 2 new Serious Incidents declared in July and August 2021 meet the Healthcare Safety Investigation Branch* (HSIB) criteria and will be investigated through HSIB.

*HSIB: hosted by NHSEI and part of the national action plan to make maternity care safer, the HSIB investigate cases in term labour (at least 37 weeks gestation) where there is an intrapartum death, early neonatal death (0-6 days), potential severe brain injury (diagnosed within first 7 days), direct or indirect maternal deaths (within 42 days of end of pregnancy)

Paweb102303 / HSIB: Early Neonatal Death - baby born via category 1 caesarean section for bradycardia, required resuscitation and admission to neonatal unit.

<u>Immediate learning:</u>
Need to strengthen documentation regarding CTG interpretation and record keeping standards.
Review of practice re pulse oximeter use.
Fetal Scalp Electrode removed before spinal.

PAweb101460 /HSIB: HIE Cooling Baby delivered with Apgars 2 at 1. 7 at 5 min and 7 at 10 minutes. Neonatal resuscitation given and baby transferred to tertiary unit for 72 hours of cooling.

Immediate Learning:
Need to strengthen documentation regarding CTG interpretation.

Update from HSIB: (20.8.21):
MRI report normal and therefore outside of HSIB criteria, however HSIB will continue to investigate following discussion with the family.

Quarterly review meetings are being undertaken with the regional lead for HSIB and the Healthcare Group. Weekly update reports received from HSIB. Since 2019, the Trust has had 10 cases referred to HSIB for investigation, 4 cases have been rejected and 4 final reports have been received and shared with the families.

4.0 Themes

There has been learning surrounding CTG interpretation which was identified through the referred cases to HSIB and this has been recognised by both the governance team and the fetal monitoring team. Debriefs have been held with the teams involved and immediate learning was shared. A Fetal Monitoring training programme is in place and all midwifery and obstetric staffing are allocated to attend an annual update and competency assessment. This is also a requirement for Year 4 of the Maternity Incentive Scheme. There will be an implementation from the Governance team of 'message of the month' and fetal monitoring will be one of the key topics for learning and development.

5.0 Oversight

All highlighted concerns have been escalated at Health group board. All incidents are discussed at the Health Group Patient Safety and Quality Group and Trust Incident Management Group and escalated where relevant for further investigation. There has been good transparency and openness from the service relating to a cluster of maternity incidents which are currently under external review. This has been discussed at Trust level, CCG, CQC, NHSI/E and with the Regional Chief Midwifery Officer.

6.0 Recommendation

To note the report and the ongoing work with the investigation process, thematic learning and improvement actions.

Author: Erin Harrison, Lead Governance Midwife
Sharon McNally, Director of Nursing, Midwifery and AHPs
Date: 30th September 2021

The Princess Alexandra Hospital NHS Trust

Trust Board – 7th October 2021

3.3

Agenda item:	3.3							
Presented by:	Sharon McNally – Director of Nursing & Midwifery							
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery							
Date prepared:	10.9.2021							
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels and an update to Nursing and Midwifery Workforce Position – Hard Truths Report							
Purpose:	Approval		Decision		Information	x	Assurance	x
Key issues:	Staffing risk rating in month: GREEN The fill rate for overall RN/RM in month 93.3% Registered nurse temporary staff demand has reduced in line with increased recruitment however HCSW demand has increased due to static vacancy rate and increased demand to support enhanced care for patients higher care demand than the staff template are unable to support. There has been an increased use of RMN specials due to the higher than normal number of patients with mental health needs being in our care The overall nursing vacancy rate is 3.1%. The report details our pipeline of starters and summarises international recruitment activity which is supported by additional investment from NHSE.							
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 27th September 2021
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	Appendix 1: Registered fill rates by month against adjusted standard planned template. RAG rated. Appendix 2: Ward staffing exception reports.

The Princess Alexandra Hospital NHS Trust

3.3

1.0 PURPOSE

To update and inform the Committee on actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff in August 2021. To provide an update on plans to reduce the nursing vacancy rate over 2020/21

2.0 BACKGROUND

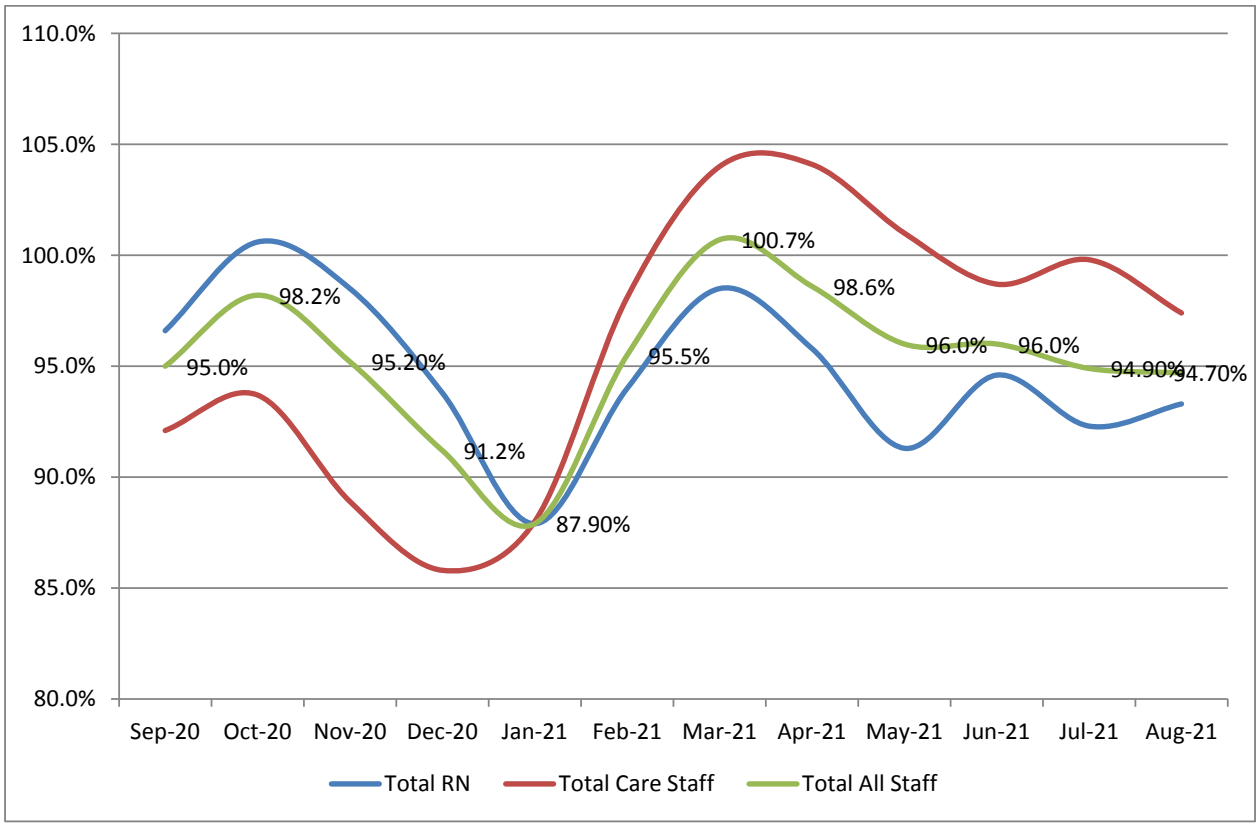
The report is collated in line with The National Quality Board recommendations (June 2016).

3.0 ANALYSIS

3.1 The Trust Safer Staffing Fill rates for August 2021 against the standard templates for overall RN/RM in month has increased to 93.3%, which is an increase of 1.0% against July 2021.

3.2 Fill rates continued to be supported in month by redeployment of nurses .Ward level breakdown of fill rate data is included in Appendix 1; the accuracy of this continues to be dependent on all staff moves being captured on Health Roster

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
In Patient Ward average August 21	88.6%	90.6%	100.6%	107.1%	93.3%	97.4%	94.7%
In Patient Ward average July 21	87.9%	92.6%	98.2%	110%	92.3%	99.8%	94.9%
Variance August 21 – July 21	↑0.7%	↓2.0%	↑2.4%	↓2.9%	↑1.0%	↓2.4%	↓0.2%



National reporting is for inpatient areas, and therefore does not include areas including the emergency department. 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

Benchmarking in line with other acute Trusts in the STP the threshold for the RAG rating is a below.

Red <75%	Amber 75 – 95%	Green >95%

	Day		Night	
A&E Nursing	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
June 2021	85.3%	96.2%	107.5%	74.1%
July 2021	90.3%	91.1%	99.5%	82.2%
August 2021	93.1%	77.8%	94.3%	81.9%

There has been an increase in registered staffing levels within ED although availability of skilled and experienced senior ED RN's remained a risk despite additional actions that have been taken to increase temporary staffing cover. Monitoring of risk and the potential impact on patient safety continues by the Urgent and Emergency Care team supported by the Executive Team.

3.5 Fill rates by ward

Fill rates by ward have been produced against the standard planned templates (Appendix 1). 1 ward reported average fill rates below 75% for registered nurses against the standard planned template during August. This does not reflect the fluctuating patient numbers on these wards over the month due to bed closures and changes in patient acuity against the norm for these areas following change of use.

3.6 Datix reports:

The trend in reports completed in relation to nursing and midwifery staffing is included below and shows that the number of incidents recorded decreased in month to 26 total (↓19), though Tye Green (14) remains the main ward raising Datix reports in relation to staffing levels. Staff on Tye Green are being supported to analyse and report where care has been affected by safe staffing rather than when below template/ Triangulation with patient safety incidents raised has not identified any patient safety issues as a direct result of the staffing concerns however close monitoring of trends in patient safety issues is identifying an increase in month of incidents relating to essential care e.g. pressure ulcers, falls with harm etc.

3.9 Bank and Agency fill rates

The day-to-day management of safer staffing across the organisation is managed through the twice daily staffing huddles using information from SafeCare to ensure support is directed on a shift: by shift basis as required in line with actual patient acuity and activity demands

The use of NHSP continues to support the clinical areas to maximise safer staffing. The need for temporary staff is reviewed daily at the Safe Staffing daily meeting, staff redeployment along with a greater challenge continues and all shifts not required continue to be cancelled.

In August there was a decrease in registered requirements, the main areas utilising agency staff continued to be A&E Nursing and critical care where specialist skills are required. There was a decrease in registered demand (↓207 shifts) in August compared to July. August also shows a decrease in agency usage (↓74 shifts). The overall fill rate increased from 82.2% to 89.5%

RN temporary staffing demand and fill rates*: (August 2021 data supplied by NHSP 8.9.2021)*

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
March 2021	3294	1892	69.0%	380	11.05%	69%	1022	31%
April 2021	2666	1642	61.6%	340	12.08%	74.3%	684	25.07%
May 2021	2787	1885	67.6%	310	11.01%	78.8%	592	21.2%
June 2021	2688	1761	65.5%	400	14.9%	80.4%	527	19.6%
July 2021	2792	1809	64.8%	498	17.4%	82.2%	498	17.8%
August 2021	**2585**	**1880**	**72.7%**	**424**	**16.8%**	**89.5%**	**271**	**10.5%**
August 2020	2271	1619	71.3%	217	9.6%	80.8%	435	8.7%

The HCSW demand shows a continued increase in unregistered demand (↑54 shifts), there was an increase in fill rate from 85.2% in July to 88.7% in August. The increased demand is being driven by additional beds being open, enhanced care demand and continued vacancy rates. There continued to be zero agency HCA filled shifts in August demonstrating the impact of HCSW recruitment.

HCA temporary staffing demand and fill rates: ***(August 2021 data supplied by NHSP 8.9.2021)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
March 2021	1635	911	55.7%	131	8.0%	63.7%	593	36.6%
April 2021	1397	1007	72.01%	33	2.04%	74.04%	357	25.06%
May 2021	1385	1170	84.5%	0	0	84.5%	215	15.5%
June 2021	1334	1143	85.7%	0	0	85.7%	191	14.3%
July 2021	1588	1353	85.3%	0	0	85.2%	235	14.8%
August 2021	**1642**	**1456**	**88.7%**	**0**	**0**	**88.7%**	**186**	**11.3%**
August 2020	1352	1040	76.9%	0	0	76.9%	312	23.1%

B: Workforce:

Nursing Recruitment Pipeline

The overall clinical nursing vacancy rate in August was 3.1% a reduction of 0.1% from July The vacancy rate for Band 5 RN's was 0.5% (0.4% July). The table below includes projections of starter including international nurses who are in the pipeline, nursing apprenticeships due to qualify and student nurses who have accepted offers of employment with the Trust. The vacancy rate is against funded

establishment for clinical nursing posts and does not include additional posts required for support service or midwifery or those required to support Covid additional demand.

Nursing Establishment v Staff in post												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Funded Establishment WTE	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25
Staff in Post WTE	915.00	920.00	922.00	937.00	936.00	938.00	960.00	978.00	972.00	966.00	960.00	954.00
Vacancy WTE	51.25	46.25	44.25	29.25	30.25	28.25	6.25	-11.75	-5.75	0.25	6.25	12.25
Actual RN Vacancy Rate	5.3%	4.8%	4.6%	3.0%	3.1%	2.9%	0.6%	-1.2%	-0.6%	0.0%	0.6%	1.3%
Forcast Vacancy Rate in Business Plan												

Band 5 Establisment V Staff in Post												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Funded Band 5 Establisment WTE	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2
Band 5 Staff in Post WTE	498	502	516	520	525	547	565	559	553	547	541	535
Band 5 Starters	12	16	16	8	13	29	25	1	1	1	1	1
Vacancy Band 5 WTE	24.2	20.2	6.2	2.2	-2.8	-24.8	-42.8	-36.8	-30.8	-24.8	-18.8	-12.8
Actual Vacancy Rate	4.6%	3.9%	1.2%	0.4%	-0.5%	-4.7%	-8.2%	-7.0%	-5.9%	-4.7%	-3.6%	-2.5%
Forcast Vacancy Rate in Business Plan												

Actual/Projected Starters Pipeline												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
RNs (not Band 5)	3	2	3	1	4	7	7	7	7	7	7	7
Band 5 Newly Qualified + Local	1	0	3	0	3	16	12	1	1	1	1	1
Band 5 International Recruitment	11	16	13	8	10	13	13					
Band 5 Starters	**12**	**16**	**16**	**8**	**13**	**29**	**25**	**1**	**1**	**1**	**1**	**1**
Total Starters	15	18	19	9	17	36	32	8	8	8	8	8

Projected Leavers WTE												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
RNs (not Band 5) Leavers	4	4	2	6	7	7	7	7	7	7	7	7
Band 5 Leavers	6	12	2	4	8	7	7	7	7	7	7	7
Total Leavers	**10**	**16**	**4**	**10**	**15**	**14**	**14**	**14**	**14**	**14**	**14**	**14**
N&M Turnover %	8.65%	10.83%	10.43%	10.80%	11.51%							

The Trust receive support for recruitment of healthcare support workers from NHSE/I. The table below provides the pipeline and recruitment trajectory for HCSW. The vacancy rate has remained static at 12% since April despite the recruitment team working closely with the practice development team, department leads in supporting the recruitment and on boarding of this group of staff. Sustained increase in posts is proving problematic due to high turnover but it should be noted that some of the turnover is driven by HCSW commencing apprenticeship pathways to foundation degree and nursing degrees as part of a pathway to becoming a registered nurse. The DDoN will be working with the new nurse recruitment lead and recruitment team to refresh the selection and on boarding process to ensure the right staff are recruited.

Establishment V Staff in Post												
	Apr-21	May-21	Jun-21	Jul-21	Aug-20	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Funded Establishment WTE	419	419	419	419	419	419	419	419	419	419	419	419
Staff in Post WTE	366.00	375.00	376.00	368.00	365.00	375.00	385.00	385.00	385.00	385.00	385.00	385.00
Vacancy WTE	53	44	43	51	54	44	34	34	34	34	34	34
Actual B2/B3 Vacancy Rate	12.6%	10.5%	10.3%	12.2%	12.9%	10.5%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%
Forcast Vacancy Rate in Business Plan												

Actual/Projected Starters Pipeline												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Band 2 Starters	**0**	**19**	**9**	**3**	**9**	**20**	**20**	**10**	**10**	**10**	**10**	**10**
Total Starters	0	**19**	**9**	**3**	**9**	**20**	**20**	**10**	**10**	**10**	**10**	**10**

Projected Leavers WTE												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total Band 2/3 Leavers	**0**	**10**	**8**	**11**	**12**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
HCSW Turnover %	11.59%	12.23%	12.45%	16.86%	15.98%							

The Trust has a new Recruitment and Retention Nurse joined the Trust next month.

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: Sarah Webb, Deputy Director of Nursing and Midwifery

Date 10.9. 2021

Appendix 1

Ward level data: fill rates August 2021. ***(Adjusted Standard Planned Ward Demand)***

Appendix 1 has captured the fill rate at ward level, the accuracy of this data is dependent on all ward / staff moves and redeployment being captured and recorded accurately in Health Roster.
Chamberlen Ward, Labour Ward, Samson Ward and Birthing Unit ward level data has been collated and reported as Maternity; this is gives a more accurate picture and reflects the way Maternity works.

	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
ITU & HDU	96.0%	90.0%	99.0%	66.1%	97.5%	78.1%	94.7%
John Snow Ward	92.9%	144.1%	101.6%	116.9%	97.0%	131.1%	105.0%
Henry Moore Ward	74.1%	101.1%	102.8%	69.2%	85.0%	91.1%	86.9%
Harvey Ward	84.2%	73.5%	102.2%	89.2%	91.5%	81.0%	86.7%
Lister Ward	92.9%	95.7%	99.3%	108.4%	95.6%	100.9%	97.9%
Locke Ward	97.2%	95.2%	108.9%	136.2%	102.1%	110.7%	105.2%
Ray Ward	91.4%	78.3%	122.2%	130.3%	103.0%	94.6%	99.5%
Saunders Unit	89.7%	113.1%	118.6%	166.1%	86.8%	133.2%	103.4%
Nightingale Ward	100.8%	94.5%	130.1%	148.5%	112.7%	115.0%	113.7%
Tye Green Ward	85.8%	85.1%	100.1%	132.3%	91.8%	104.3%	97.3%
Charnley Ward	84.4%	89.7%	102.5%	97.8%	92.0%	93.0%	92.5%
AAU	87.3%	94.1%	89.4%	109.5%	88.3%	101.5%	92.2%
Kingsmoor Red	103.6%	142.8%	179.4%	261.3%	132.3%	180.0%	150.3%
Penn	113.3%	101.7%	102.5%	77.3%	108.5%	90.8%	101.4%
Fleming Ward	83.7%	95.5%	100.8%	118.4%	91.0%	104.2%	95.7%
Harold Ward	100.5%	73.4%	126.0%	110.6%	111.3%	88.5%	101.3%
Neo-Natal Unit	92.5%	122.6%	101.5%	77.6%	97.0%	100.1%	97.5%
Dolphin Ward	65.7%	75.9%	93.5%	98.7%	78.1%	83.5%	79.5%
Maternity	98.5%	101.6%	86.4%	74.3%	92.7%	88.6%	91.4%

Total	**88.6%**	**90.6%**	**100.6%**	**107.1%**	**93.3%**	**97.4%**	**94.7%**

The Princess Alexandra Hospital NHS Trust

Appendix 2

Ward staffing exception reports
Reported where the overall 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

The Princess Alexandra Hospital NHS Trust

Trust Board – 07.10.21

4.1

Agenda item:	4.1								
Presented by:	Fay Gilder – Medical Director								
Prepared by:	Jane Bryan - Medical Resourcing Manager								
Date prepared:	September 2021								
Subject / title:	Annual Board report and statement of compliance								
Purpose:	**Approval**	**x**	**Decision**		**Information**	**x**	**Assurance**		
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The report gives a summary of Appraisal & Revalidation and relates to the completed round of appraisals for 2020/21 for the permanent medical staff of The Princess Alexandra Hospital NHS Trust (PAHT). The paper sets out a summary of the process for the annual appraisal, compliance data and how this is monitored and assessed to ensure it is quality assured.								
Recommendation:	For information and sign-off of statement of compliance								

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		

Previously considered by:	Workforce Committee 27th September 2021
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Princess Alexandra Hospital NHS Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes Action from last year: None Comments: Dr Fay Gilder, Responsible Officer (R.O) /Dr Jeff Phillips Deputy Responsible Officer Action for next year: Dr Fiona Hikmet to be appointed to Responsible Officer later this year, R.O training is complete

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: None Comments: None Action for next year: None

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes Action from last year: None Comments: None Action for next year: None

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes -Action from last year: Appraisal and Revalidation Policy/Responding to concerns policy were to be reviewed

Comments: Actioned/both policies reviewed/agreed Action for next year: Medical Appraisal and Revalidation policy to be further reviewed in June 2022 (agreed for an interim period in June 2021 for a period of 1 year at the request of JLNC

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Yes- a peer review was carried out by Mid Essex Hospital Services NHS Trust in 2016. A Higher Level Responsible Officer visit was also carried out in 2018

Actions from last year: None

Comments: The report following the Higher Level Responsible Officer visit confirmed satisfaction that the actions and recommendations from the previous visit had been carried out and that PAHT continued to deliver good practice in relation to professional standards work

Action for next year: None

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Yes – the 2020 Appraisal model was adopted this year and incorporated into our Clarity software system. The new model received positive feedback and the incorporation of a stronger focus relating to health and wellbeing was welcomed

Action from last year: None

Comments: Following the suspension of appraisals there have been some challenges with some doctors re-engaging with the process for timely appraisals resulting in a decrease in the compliance rate compared to previous years

Action for next year: to increase completion rate to previous level

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A

Comments: N/A

Action for next year: N/A

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

Action from last year: To review the Medical Appraisal and Revalidation policy

Comments: This policy has been reviewed and agreed for an Interim period of 1 year at the request of the JLNC

Action for next year: To further review this policy in June 2022

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes

Action from last year: None

Comments: None

Action for next year: None

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal

network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Yes

Appraisers attend a monthly appraisers forum, and participate in annual refresher training. In addition there is an appraisers What's app group where queries may be discussed/raised.

There is a quality assurance process in place.

The Deputy RO quality assures the last five appraisals of all doctors undergoing revalidation each year (approx. 20%) of the appraisees. Any themes are raised with appraisers at meetings. The Clarity system ensures that the minimum standard of quality assurance is met as the appraisals cannot be 'completed' otherwise. This is not the same for some of the non-electronic systems used in other organisations.

Anonymous feedback forms are completed by Appraisees as part of the trust process for individual appraisers and the process carried out, this is discussed at the Appraisers forum and reviewed where necessary

Action from last year: None

Comments: The forums were temporarily suspended during suspension of appraisals but then resumed in September 2020.

Action for next year: None

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Comments: The Quality Assurance forms are sent to the Medical Director/RO

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Princess Alexandra Hospital NHS Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	225
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	176
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	49
Total number of agreed exceptions	19

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes

Action from last year: None

Comments: None

Action for next year: None

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes Action from last year: None Comments: None Action for next year: None

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes Action from last year: None Comments: None Action for next year: None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes Action from last year: None Comments: None Action for next year: None

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes -

Action from last year: To review the current Responding to concerns policy

Comments: This has been reviewed and agreed

Action for next year: None

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: None

Comments: The Workforce Committee is provided with data relating to any formal cases, which includes doctors. The Board is provided with statistical analysis annually including formal cases with analysis including protected characteristics.

Action for next year: None

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Yes

Action from last year: None

Comments: Includes all information requested and received via the Medical Practitioner Information transfer forms

Action for next year: None

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes Action from last year: None Comments: None Action for next year: None

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes Action from last year: None Comments: None Action for next year: None

Section 6 – Summary of comments, and overall conclusion

The current appraisal completion rate as at 31st March 2021 was 78%

Since the last Board report, the impact of Covid and temporary suspension of Appraisals resulted in the overall completion rate reducing to 78% as at 31st March 2021, compared to 99% completion in the previous year.

- New Actions:
- New Responsible Officer, Dr Fiona Hikmet will be appointed to the role later this year
- The Medical Appraisal and Revalidation policy will be further reviewed in June 2022

Section 7 – Statement of Compliance:

The Board of Princess Alexandra Hospital NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive

Official name of designated body: Princess Alexandra Hospital NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
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London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 07.10.21

5.1

Agenda item:	5.1
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	23 September 2021
Subject / title:	M5 2021/22 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:

Patients		
Patients	**Dementia Patient Falls**	Seven consecutive months below the mean showing performance in improving special cause variation. This improvement has been supported by the Essential Care Strategy to reduce falls
	Smoking Rates at Delivery	Nine consecutive months below the mean showing improving special cause variation, down from 14% in April 2019.
People		
People	**Appraisals**	Now out of special cause variation and showing continued improvement. This has been as a result of four months of continued improvement between March and June, but has plateaued since then
	Statutory and Mandatory Training	Whilst still not in special cause variation, it remains consistent at 88%, and below the target of 90%
	Sickness Absence	In common cause variation but still performing at or in excess of the target
Performance		
Performance	**RTT**	Performance remains in special cause variation, but recovery actions are in place, with patients being treated in clinical priority
	Cancer 2 week wait	Whilst performance remains in common cause variation performance has deteriorated due to a mismatch of capacity and demand, after being back at target for March
	Cancer 62 day pathway	Performance remains in common cause variation despire detoriation in July
	Four hour standard	Has returned to special cause variation for under performance with a number of indicators still flagging. We have continued to see attendances at the upper control limit for the last three months
	Diagnostics	Still in special cause variation with performance plateauing over the last four months
	52 week waits	Still is special cause variation, with an increase in patients waiting in July and August compared to June
	Bed Occupancy	Bed occupancy remains at a high level. Although it has dropped below the upper control limit for July and August the three months previous have been higher than any level seen since December 2019
Pounds		
Pounds	**Year to Date**	The Trust has achieved, at August (month 5), a year-to-date surplus of £109k against a break-even plan. There is a focus on ensuring that the Trust delivers it CIP target of £2.2m for H1 (April to September 2021) to ensure that the overall financial plan is delivered. The Trust has revised its capital profile following discussion with NHSE/I. Year-to-date capital spend is £7.8m against a capital plan of £7.9m. The Trust continues to have a healthy cash balance of £53.2m. There is a push to reduce aged payables and improve the Trust's performance against the Better Payment Practice Code. NHSE/I will be publishing planning guidance shortly which will form the basis of H2 and 2022/23 financial planning
Places		
Places	Category 2 Responsiveness	Domestic services cleaning very high risk remains in improving special cause variation with eight months above the mean

The Princess Alexandra Hospital NHS Trust

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 five Ps is relevant to the subject of the report	Patients	People	Performance	Places	Pounds
	x	x	x	x	x

Previously considered by:	QSC.24.09.21 and PAF.30.09.21.
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	

5.1

NHS
The Princess Alexandra Hospital
NHS Trust

Integrated Performance Report for August 2021

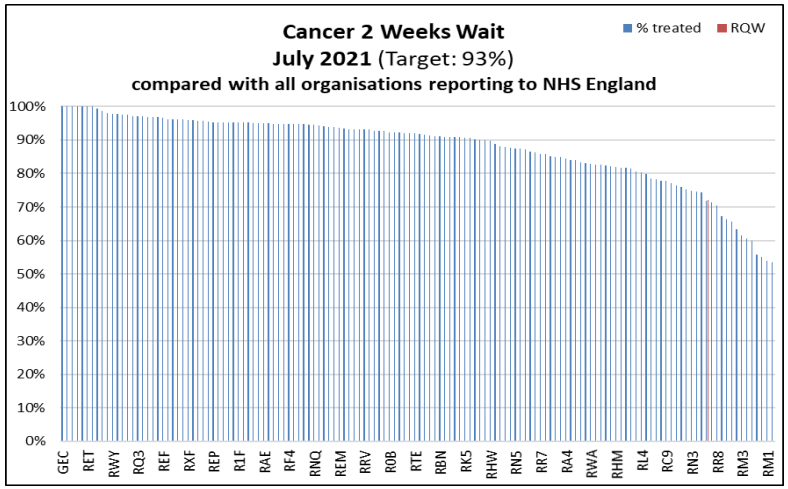
respectful • caring • responsible • committed

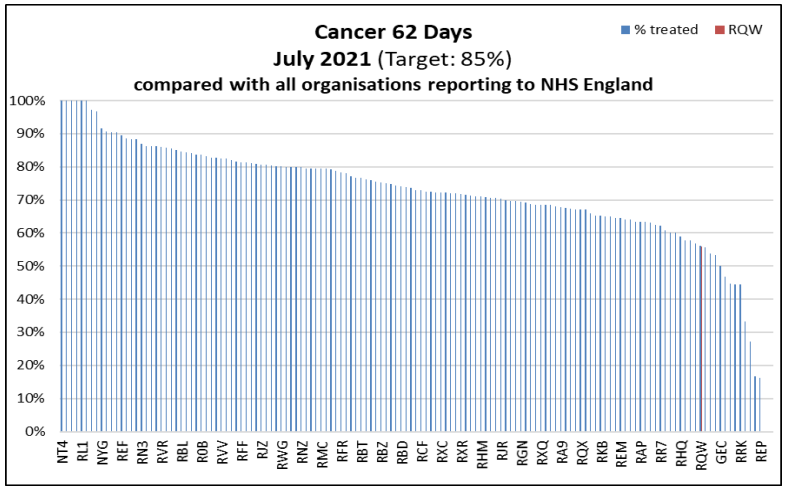
Performance Summary

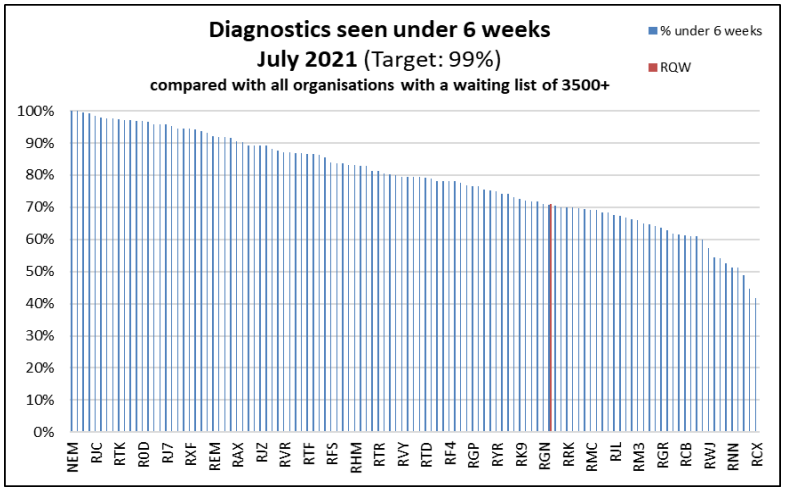
Patients		
Patients	**Dementia Patient Falls**	Seven consecutive months below the mean showing performance in improving special cause variation. This improvement has been supported by the Essential Care Strategy to reduce falls
Patients	**Smoking Rates at Delivery**	Nine consecutive months below the mean showing improving special cause variation, down from 14% in April 2019.
Pounds		
Pounds	**Year to Date**	The Trust has achieved, at August (month 5), a year-to-date surplus of £109k against a break-even plan. There is a focus on ensuring that the Trust delivers it CIP target of £2.2m for H1 (April to September 2021) to ensure that the overall financial plan is delivered. The Trust has revised its capital profile following discussion with NHSE/I. Year-to-date capital spend is £7.8m against a capital plan of £7.9m. The Trust continues to have a healthy cash balance of £53.2m. There is a push to reduce aged payables and improve the Trust's performance against the Better Payment Practice Code. NHSE/I will be publishing planning guidance shortly which will form the basis of H2 and 2022/23 financial planning.
Places		
Places	Domestic Services Cleaning - Very High Risk	Domestic services cleaning very high risk remains in improving special cause variation with eight months above the mean

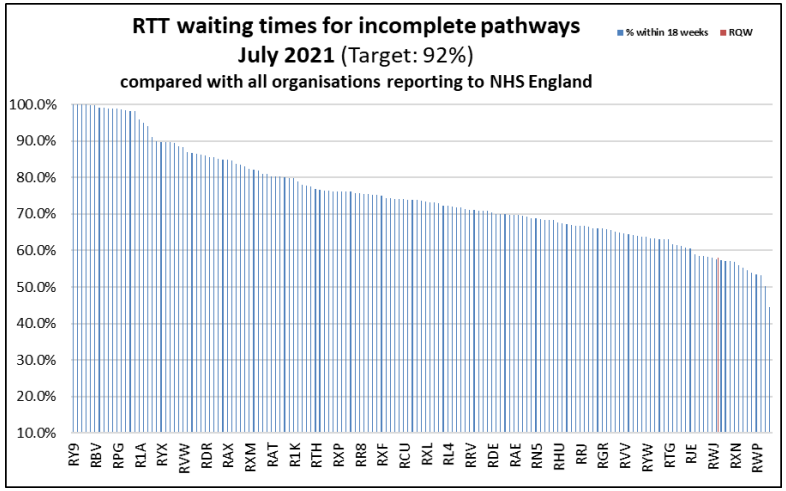
People		
People	**Appraisals**	Now out of special cause variation and showing continued improvement. This has been as a result of four months of continued improvement between March and June, but has plateaued since then
People	**Statutory and Mandatory Training**	Whilst still not in special cause variation, it remains consistent at 88%, and below the target of 90%
People	**Sickness Absence**	In common cause variation but still performing at or in excess of the target
Performance		
Performance	**RTT**	Performance remains in special cause variation, but recovery actions are in place, with patients being treated in clinical priority
Performance	**Cancer 2 week wait**	Whilst performance remains in common cause variation performance has deteriorated due to a mismatch of capacity and demand, after being back at target for March
Performance	**Cancer 62 day pathway**	Performance remains in common cause variation despite detoriation in July
Performance	**Four hour standard**	Has returned to special cause variation for under performance with a number of indicators still flagging. We have continued to see attendances at the upper control limit for the last three months
Performance	**Diagnostics**	Still in special cause variation with performance plateauing over the last four months
Performance	**52 week waits**	Still is special cause variation, with an increase in patients waiting in July and August compared to June
Performance	**Bed Occupancy**	Bed occupancy remains at a high level. Although it has dropped below the upper control limit for July and August the three months previous have been higher than any level seen since December 2019

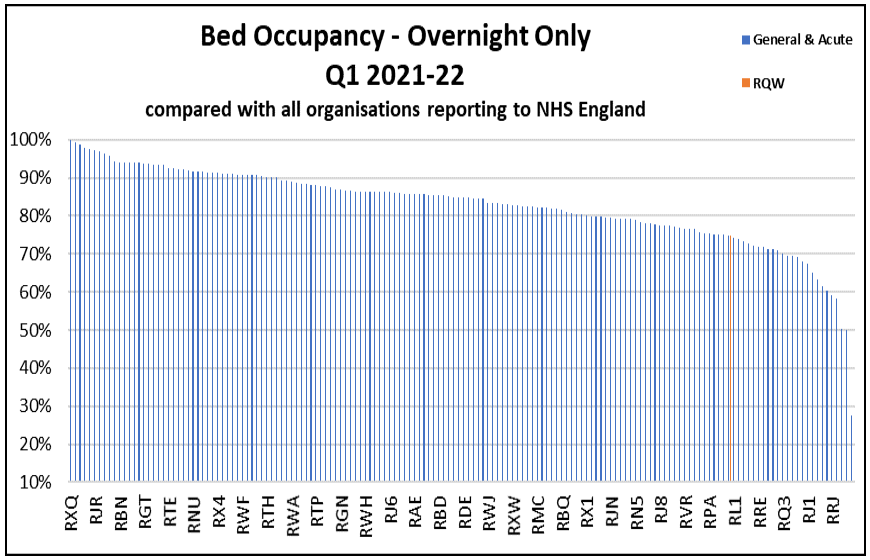
National Benchmarking

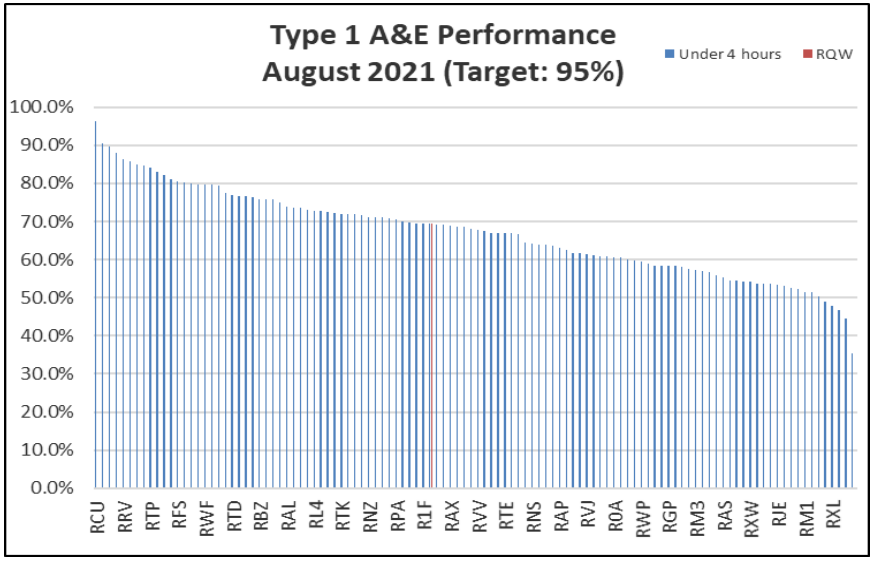


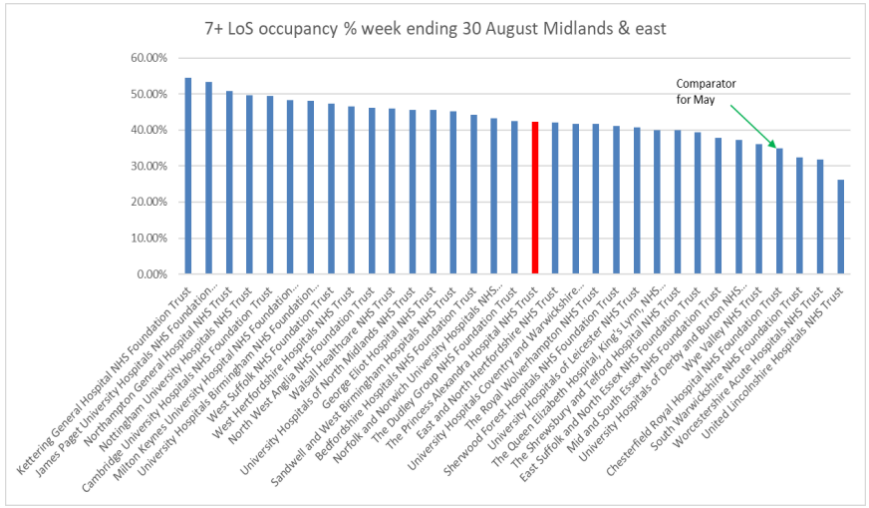


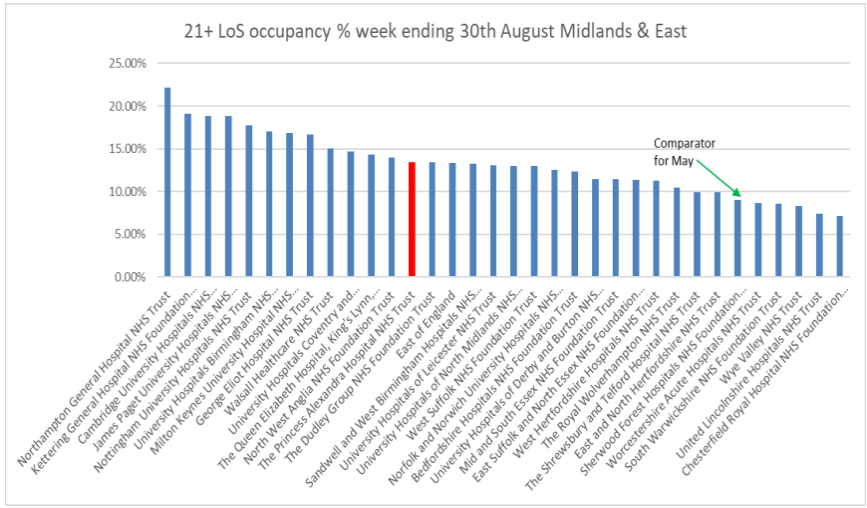





Bed Occupancy - Overnight Only
Q1 2021-22
compared with all organisations reporting to NHS England
General & Acute
RQW
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
RXQ RJR RBN RGT RTE RNU RX4 RWF RTH RWA RTP RGN RWH RJ6 RAE RBD RDE RWJ RXW RMC RBQ RX1 RJN RN5 RJ8 RVR RPA RL1 RRE RQ3 RJ1 RRJ


Type 1 A&E Performance
August 2021 (Target: 95%)
Under 4 hours
RQW
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
RCU RRV RTP RFS RWF RTD RBZ RAL RL4 RTK RN2 RPA R1F RAX RVV RTE RNS RAP RVJ R0A RWP RGP RM3 RAS RXW RJE RM1 RXL


7+ LoS occupancy % week ending 30 August Midlands & east
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Comparator for May


21+ LoS occupancy % week ending 30th August Midlands & East
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Comparator for May


Benchmarking

Patients

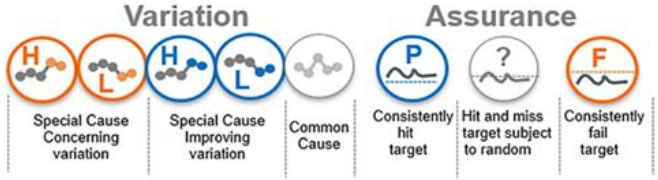
*We will continue to improve the quality of care, outcomes & experiences that we provide **our patients**, integrating care with our partners & reducing health inequity in our local population*

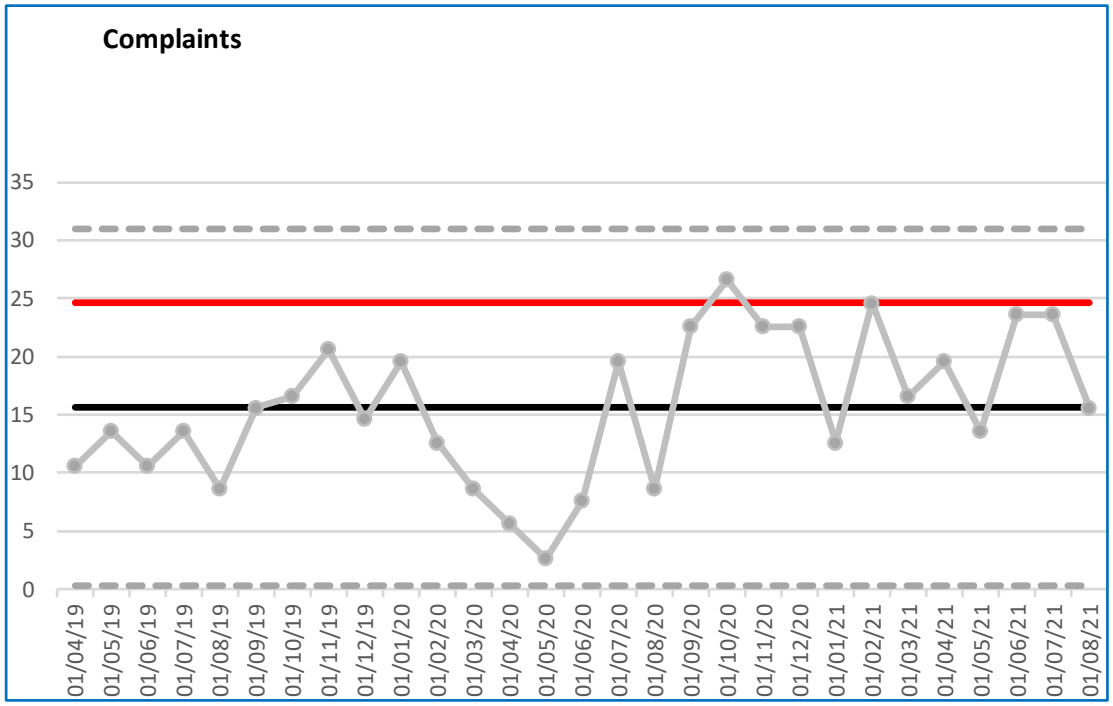
Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Dementia Patient Falls	Seven consecutive months below the mean showing performance in improving special cause variation. This improvement has been supported by the Essential Care Strategy to reduce falls	For recognition	N/A
Smoking Rates at Delivery	Nine consecutive months below the mean showing improving special cause variation, down from 14% in April 2019.	For recognition	N/A

KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
Complaints	Aug 21	16	25			16	1	31
Compliments	Aug 21	75	50			142	-108	392
PALS	Aug 21	359	none			285	146	424
Complaints closed within target	Aug 21	4	none			5	-4	14
% of complaints where an extension has been agreed	Aug 21	51%	none			41%	2%	81%
Mixed Sex Accommodation Breach	Aug 21	1	0			8	-5	20
Serious Incidents	Aug 21	1	none			5	-5	16
MSSA	Aug 21	2	none			1	-1	3
CDIFF	Aug 21	10	none			6	-2	13
Hand Hygiene	May 21	99%	none			90%	68%	112%
eColi	Aug 21	3	none			1	-2	4
Klebsiella	Aug 21	0	none			0	-1	2
Pseudomonas	Aug 21	1	none			0	-1	1
Falls per 1000 bed days	Aug 21	7.0	none			8.8	6.1	11.6
Falls by Harm - None	Aug 21	63	none			77	45	108
Falls by Harm - Minor	Aug 21	20	none			25	11	40
Falls by Harm - Moderate	Aug 21	3	none			2	-2	5
Falls by Harm - Severe	Aug 21	1	none			1	-2	3
Total number of mothers delivering in birthing unit/home	Aug 21	5%	20%			12%	0%	23%
Number of mothers delivering in Labour Ward/Theatres	Aug 21	95%	75%			88%	76%	100%
Number of women due to deliver at PAH adjusted for misc/TOPs	Aug 21	346	375			332	280	385
Smoking rates at booking	Aug 21	8%	none			9%	4%	14%
Smoking rates at delivery	Aug 21	10%	6%			10%	6%	15%
Breast feeding rates at delivery	Aug 21	72%	74%			75%	65%	86%
Total Planned C-Sections	Aug 21	17%	none			15%	8%	22%

Patients

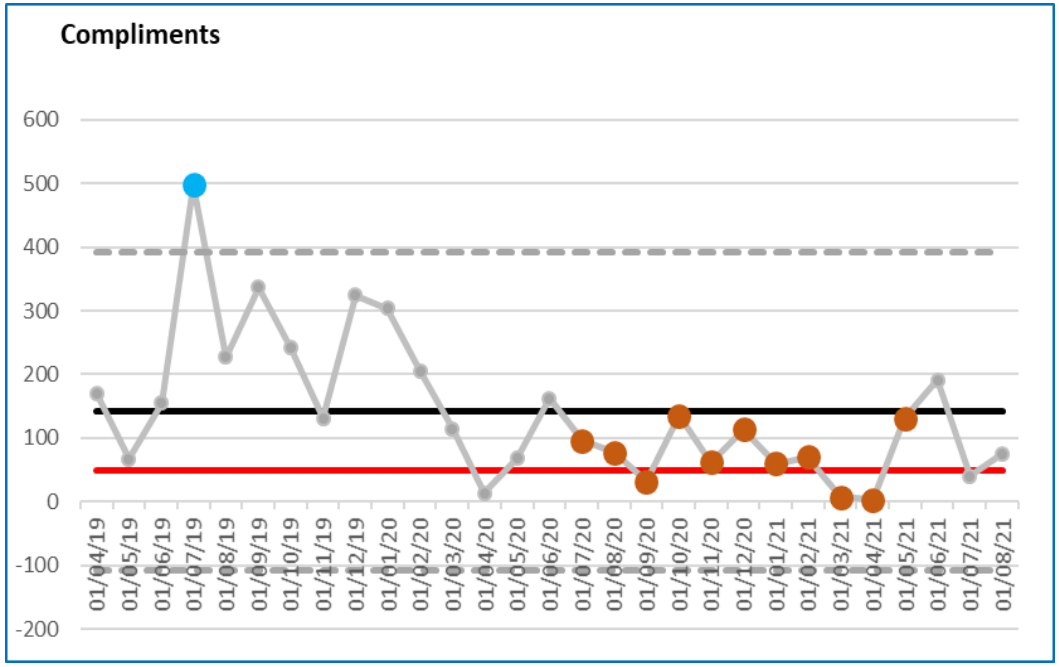
KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
Total Unscheduled C-Sections	Aug 21	19%	none			18%	12%	24%
PPH over 1500mls	Aug 21	4%	none			4%	1%	8%
Hospital Acquired Category 4 pressure ulcers	Aug 21	0	0			0	-1	1
Hospital Acquired Category 3 pressure ulcers	Aug 21	0	0			1	-3	5
Hospital Acquired Category 2 pressure ulcers	Aug 21	20	4			21	0	41
Hospital Acquired Category 1 pressure ulcers	Aug 21	0	8			6	-4	16
Hospital Acquired Deep tissue injury	Aug 21	20	none			24	2	46
Hospital Acquired Unstageable pressure ulcers	Aug 21	1	none			2	-4	7
CTG training compliance midwives	Aug 21	76%	85%			67%	46%	88%
CTG training compliance doctors	Aug 21	93%	85%			73%	49%	97%
Still births	Aug 21	1	none			1	-1	3
Patients detained under MHA	Aug 21	0	none			0	-1	2
Patients detained under section 136	Aug 21	0	none			1	-2	3
Mental health patient incidents	Aug 21	11	none			11	-1	23
Mental health patient complaints	Aug 21	0	none			0	-1	1
Mental health patient PALS	Aug 21	3	none			1	-1	3
Dementia patient falls	Aug 21	14	0			26	5	46
Dementia patient pressure sores	Aug 21	8	0			11	0	22
Patients with LD and Autism accessing inpatient services	Aug 21	36	none			18	-1	36
Patients who died in their preferred place of death	Aug 21	59%	none			57%	18%	95%
C-DIFF Hospital onset healthcare associated	Aug 21	4	none			2	-2	7
C-DIFF Community onset healthcare associated (Acute Admissio	Aug 21	3	none			1	-1	3
C-DIFF Community onset indeterminate association (Acute Adm	Aug 21	0	none			1	-1	3
C-DIFF Community onset community associated (No acute conta	Aug 21	3	none			1	-3	5
Covid-19 new positive inpatients	Aug 21	108	0			132	-171	434





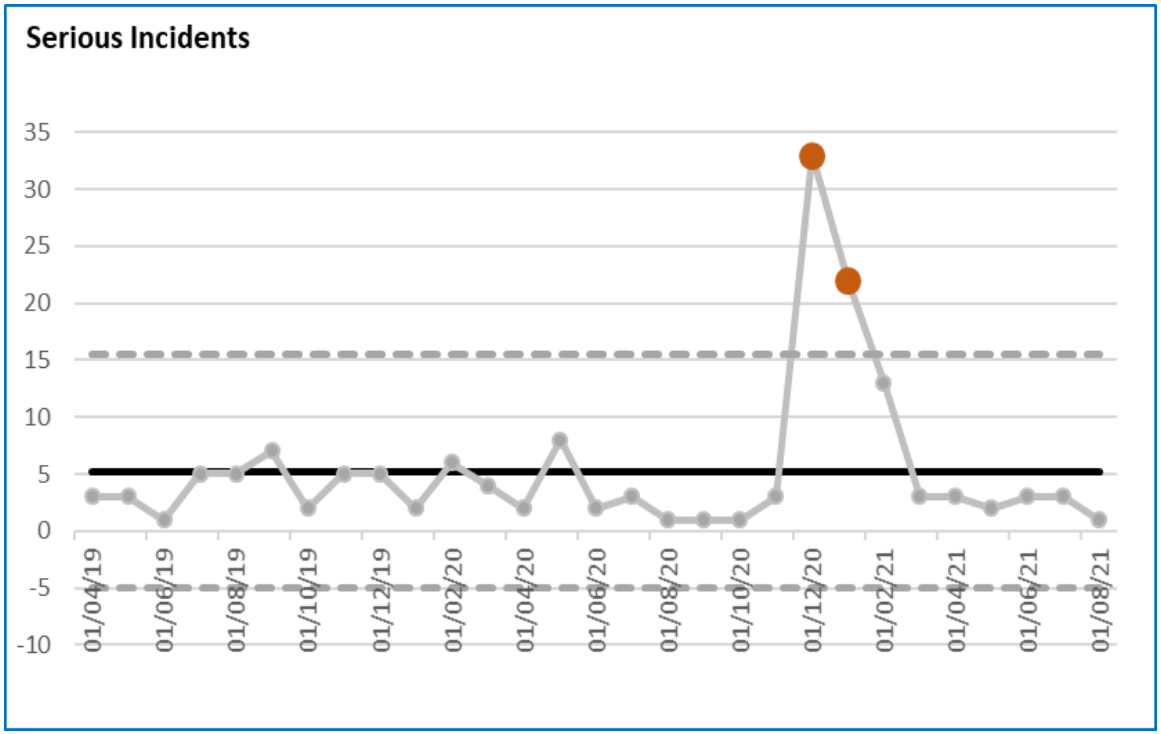
Aug-21
16
Variance Type
Common cause variation
Target
25
Target Achievement
Hit and miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Complaints	Common cause concerning variation while hitting & missing the target, on LCL.	Numbers remain at a consistent level since beginning of pandemic.	HCG have weekly catch ups with the patient experience team & 85% of all cases are investigated & closed within time, therefore reducing the number of open cases at one time. Action plans are also discussed & shared with staff for learning.	None needed at present.



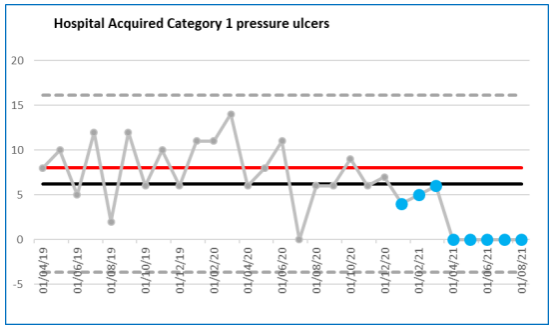
Aug-21
75
Variance Type
Common cause variation
Target
50
Target Achievement
Hit and miss target subject to random variation

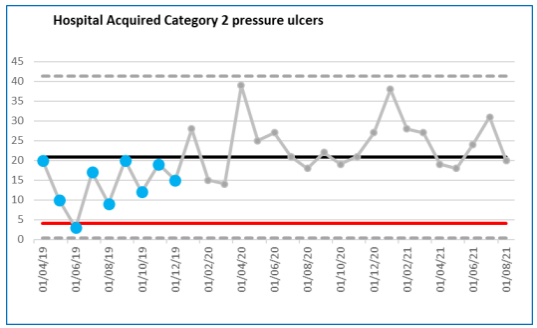
Background	What the chart tells us	Issues	Actions	Mitigation
Compliments	Common cause concerning variation while hit & missing the target	During the last 12 month compliments have seen a decline. This has improved since May. Return to BAU.	2110 - Intention to run compliments and PALS service promotion activities. 2108 Continue logging all compliments daily and encourage departments, wards, units and areas to regularly share their compliments via email or photocopy and share with the PE team.	None needed at present.

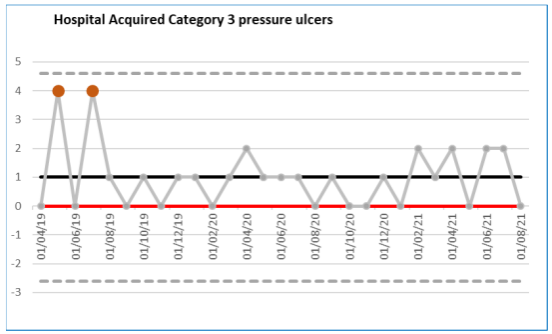


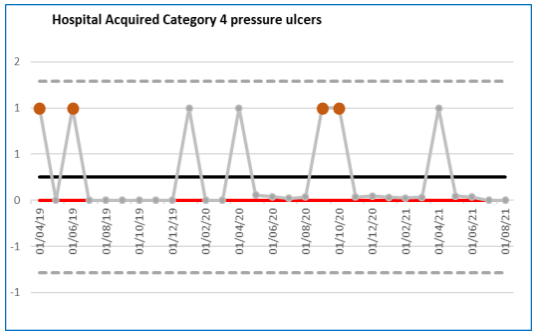
Aug-21
1
Variance Type
Common cause variation
Target
The trust does not have a target submission no. for SIs each month
Target Achievement
Our level of serious incidents reported per month is consistent & within our tolerance range

Background	What the chart tells us	Issues	Actions	Mitigation
Serious Incidents	Trust reporting numbers for serious incidents raised each month is consistent & within the internally set tolerance range	The significant spike seen during the winter months was associated with nosocomial Covid-19 hospital infections during wave 2 of the pandemic. We do not expect to see this replicated in future months.	Incident management group meets twice a week to review new incidents & those with completed investigations. Where an incident meets the national reporting criteria to be raised externally as a serious incident it will be raised. During August we raised one serious incident & closed one serious incident.	Daily local review of incidents by each healthcare group with appropriate second stage review at the incidents management group. IMG submits monthly report on both incident themes & serious incidents onto the Patient Safety Group.



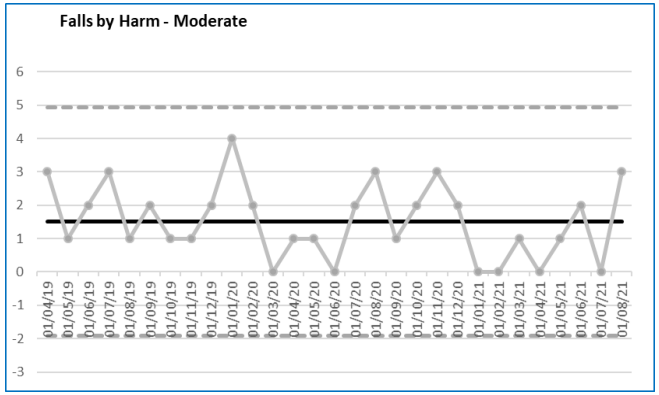


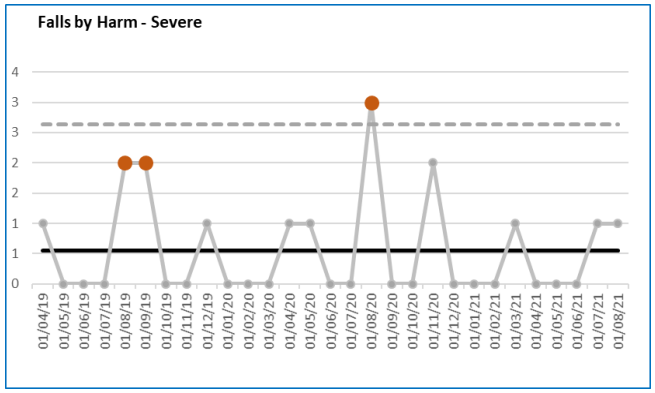




Aug-21
20
Variance Type
Common cause variation
Target
12
Target Achievement
Inconsistently hitting and missing target

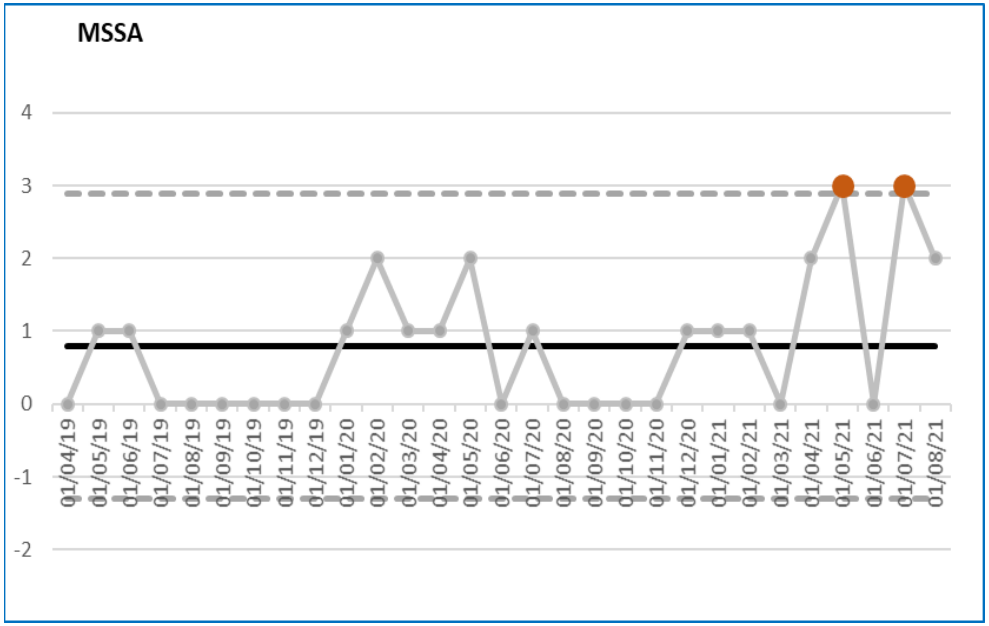
Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers grades 1 - 4	Common cause variation and inconsistently hitting and missing the target	There were a total of 42 pressure ulcers in August, 9 less than July. Of those 42 PUs, there were a total of 28 patients injured, meaning 6 patients sustained more than one PU during admission, there is a relation with PU acquisition and those patients proned due to covid. Only 1 moderate harm & all remaining were minor harms. Eight PUs were medical device related, attributable to proning face cushion (6 in total), ET tube (1) & stocking (1). The highest number of hospital acquired PUs were from COVID ITU (Henry Moore & High Dependency Unit) with 3 patients injured & a total of 12 PUs, due to prolonged hours of proning.	Tye Green & Fleming ward followed with 5 pressure ulcers in each area. Fundamentals of Care week on Tye green commenced on the 31st of August to enhance basic care & empower staff to deliver holistic care. TVNs are conducting quick rounds & providing refresher sessions during this time. TVNs will also conduct an SSKIN audit on Fleming & feedback will be provided to the ward manager & matron/ADDON.	As per updated pressure ulcer policy, the use of medical photography app (XERO) via Trust Ipads will aid validation of pressure ulcers & ensure moisture lesions/pressure ulcers are categorised appropriately. All ward managers/senior RNs to continue to cascade the pressure ulcer categorisation session to their staff.





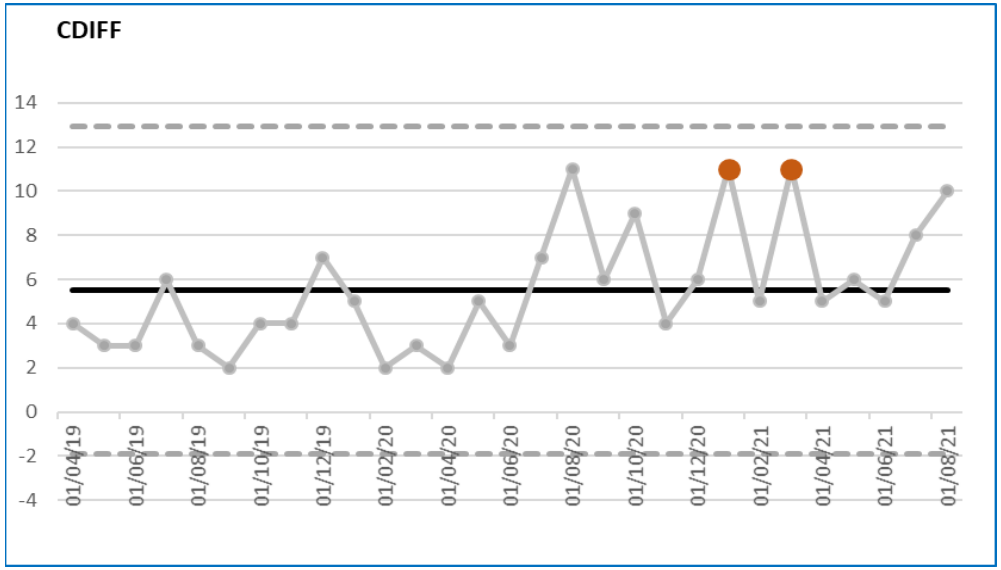
Aug-21
4
Variance Type
Common cause variation
Target
To reduce falls with harm by 50% by the end of March 2022.
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
Falls by harm	Common cause variation	The Trust's falls action plan aim is to reduce falls with harm by 50% by the end of March 2022	1. Strategic falls action plan is in place 2. The Enhanced Care programme is being embedded across the Trust 3. Falls awareness training is mandatory for all nursing and AHP staff 4. The STOPIT initiative is being rolled out across the Trust ((initiative to de-prescribe culprit medications)	No mitigating factors at this time



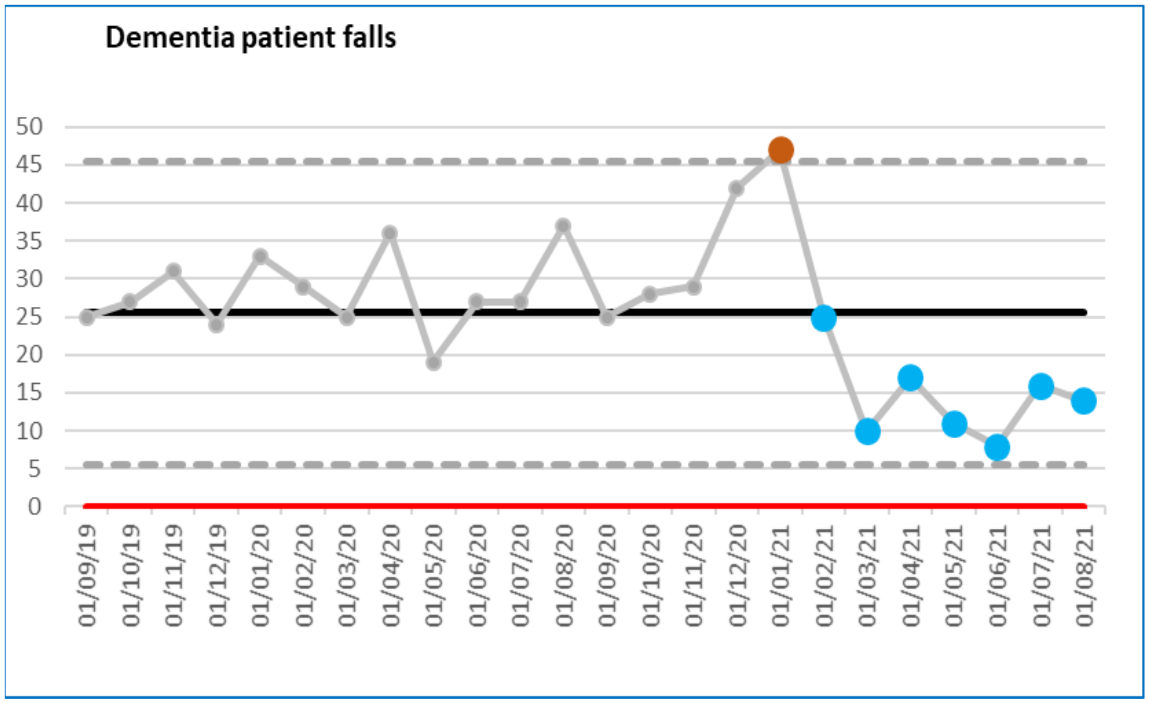
Aug-21
2
Variance Type
Common cause variation
Target
None
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
MSSA	Common cause variation	During 2021-2022 there has been a noticeable rise in hospital-onset, healthcare associated (HOHA) cases of MSSA bacteraemia. In 2020-2021, there were a total of seven cases for the year, compared with 10 cases that we have already seen between April & August this year.	RCA meetings have taken place to identify source (seven of the 10 cases appear likely to be hospital associated). Some of cases appear to be linked to IV devices - therefore actions are being taken to focus on line care practice. This will include enhance the existing training by working with the PDP team & Clinical Skills lead, additional refresher training for staff, prioritising ED initially, provision of pre-recorded IPC presentation including a focus on accurate documentation & VIP scores for invasive devices, support from company representative for re-training on Octenasin wash & sharing of learning through HCGs.	1. Use of Octenisan body wash to reduce risk of skin colonisation 2. Safety alert to all staff regarding appropriate siting of cannulas, e.g avoid ante-cubital fossa where possible 2. Body map documentation 3. Surveillance & review of all cases to identify sources & share learning



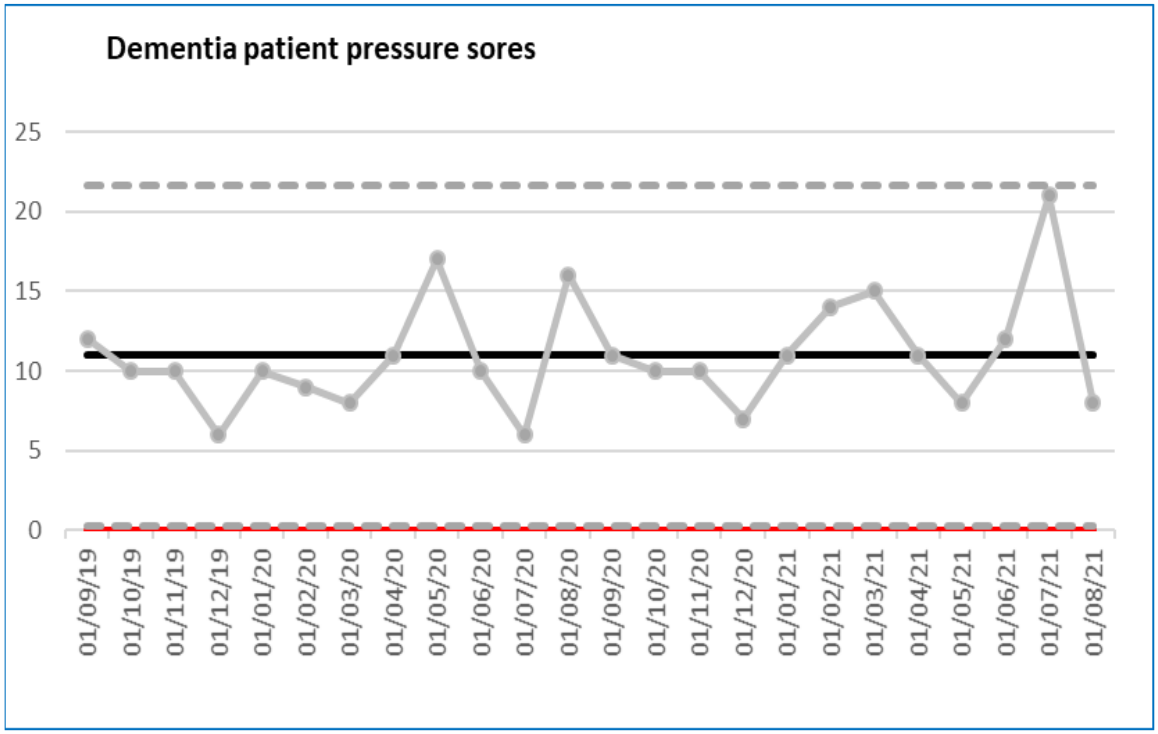
Aug-21
10
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
C.difficile	Common cause variation	1. The Trust has seen a significant rise in C.difficile cases over the last year (a total of 54 cases in 2020-2021; 145% increase from 2019-2020 when there were 23 cases). Community cases also rose. 2. The rise in cases is almost certainly associated with the pandemic & the increase in broad spectrum antibiotic prescribing (Cephalosporins); however there are likely to be a combination of factors involved including cleaning & hand hygiene / PPE. 3. Between April - July this year we have started to see a reduction in the Hospital Onset Health Care Associated cases; the Community Onset Health Care Associated cases remain at similar numbers. An increase was observed in August.	A review of the key control measures required to reduce the cases are being addressed through a C.difficile recovery action plan which focuses on ensuring compliance with: 1. Antimicrobial prescribing 2. Environment /increased cleaning 3.Prompt isolation 4. Hand hygiene 5. PPE 6.Prompt stool specimen collection 7. Commode & dirty utility audits 8.Increased teaching / cascading of key messages /attending ward manager meetings/ PPE Champions 7. Introduction of sporicidal wipes for commode cleaning in all clinical areas Ribo-typing of C.difficile specimens to support in detecting possible outbreaks or clusters of infection	1. Monitoring of cases (Infection Prevention & Control Committee & Trust Dashboard) 2. RCA reviews of all cases; this is undertaken by the IPC Team, DIPC/Microbiology Consultant, Antimicrobial pharmacist, senior medical & nursing colleagues caring for the patient - shared learning is achieved through the reviews 3. Antimicrobial Stewardship Committee meets monthly & is responsible for the monitoring of antibiotic prescribing 4. PPE Champion team in place who are supporting the IPC team in delivering the key messages 5. Appeals panel in place (led by CCG) to appeal against cases that have been considered to be 'unavoidable' 5. Although cases have increased, severity of infection has not; there have not been any deaths where C.difficile has been the cause of death



Aug-21
14
Variance Type
Special cause improving variation
Target
0
Target Achievement
Consistently failing target

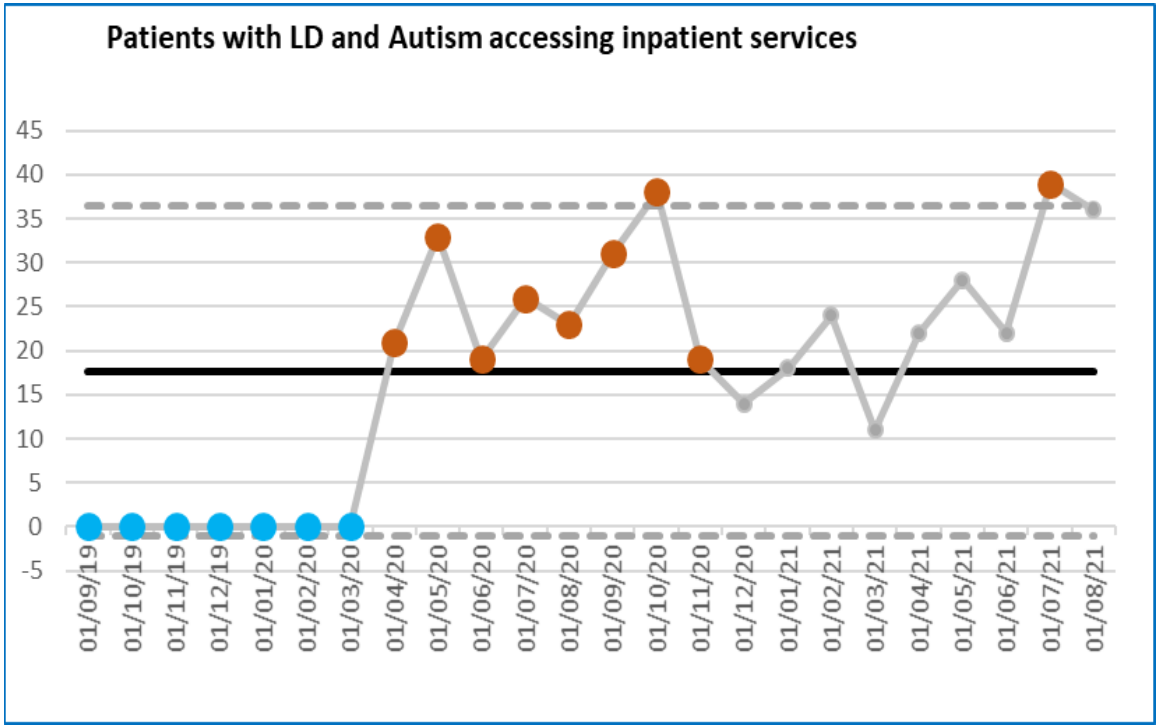
Background	What the chart tells us	Issues	Actions	Mitigation
Dementia patient falls	Special cause improving variation & consistently failing target	Decrease in falls within this patient group can be seen, this is positive improvement.	Actions in line with the Essential Care Strategy to reduce falls across all patient groups (see falls page)	N/A



Aug-21
8
Variance Type
Common cause variation
Target
0
Target Achievement
Consistently failing target

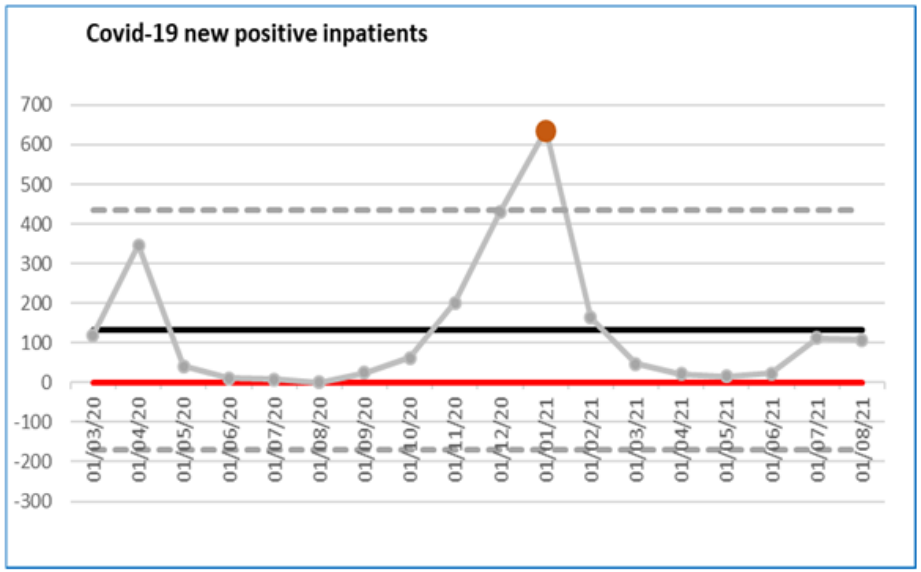
Background	What the chart tells us	Issues	Actions	Mitigation
Dementia patient pressure sores	Common cause variation & consistently failing target	Reduction in month of PUs in this patient group	Aligned to the Essential Care Strategy and detailed actions in place in relation to PU reductions (see PU page)	N/A

Patients



Aug-21
36
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

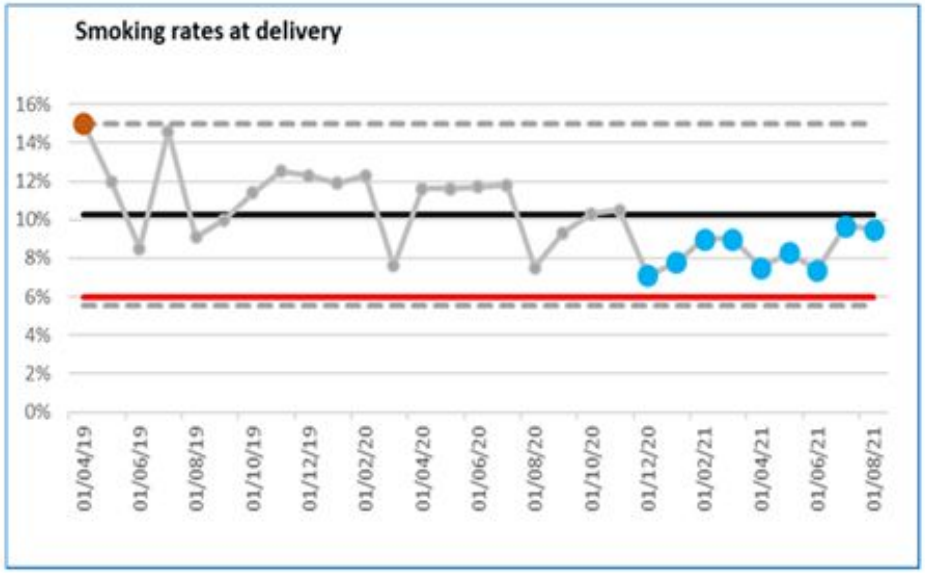
Background	What the chart tells us	Issues	Actions	Mitigation
Patients with learning disabilities & autism accessing inpatient services	Common cause variation	N/A	N/A	N/A



Aug-21
108
Variance Type
Common cause variation
Target
0
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Covid-19 new positive inpatients	Common cause variation & inconsistently hit & missing target	Nosocomial cases remained low in August (four cases, all indeterminate). Of the four cases, three had been doubly vaccinated, one was unvaccinated.	IPC Team collecting data on all cases related to vaccination status & review mortality data with Mortality lead nurse. Information relating to non-vaccinated cases shared with colleagues in the CCG / NHSE/I /PHE to review how this can be addressed in the community, & also shared information pertaining to changing data in August regarding deaths in vaccinated patients.	1. All measures in place relating to screening on admission & every 48 hours thereafter & monitoring for signs & symptoms of COVID-19 2. All other IPC measures in place, e.g screens between beds, wearing of masks, standard precautions, restricted visiting, cleaning protocols 3. Regional team advised the Trust is one of only two Trusts that are not seeing outbreaks - this is most likely due to our increased screening approach/surveillance & practices

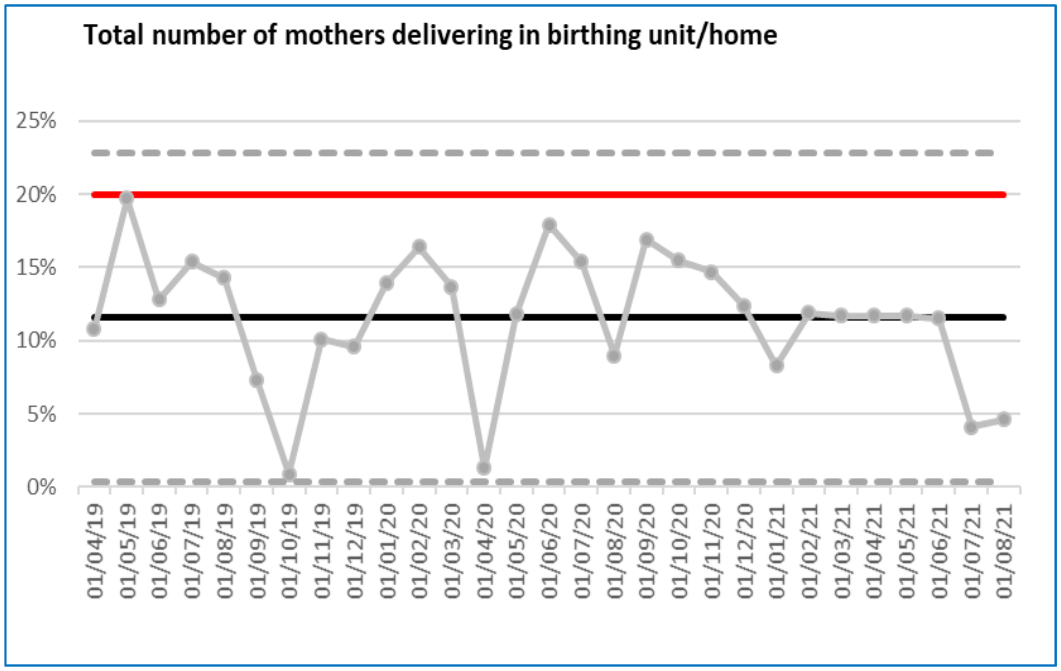
Patients



Aug-21
9.50%
Variance Type
Special cause variation
Target
6%
Target Achievement
Hit and miss target subject to random variation

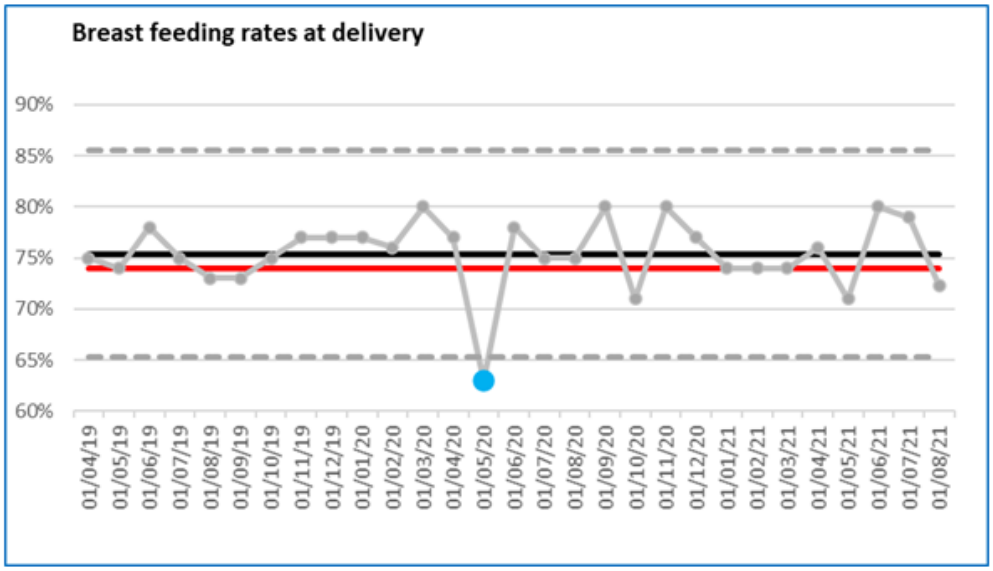
Background	What the chart tells us	Issues	Actions	Mitigation
Smoking rates at delivery	Special cause variation and inconsistently hit & missing target	Smoking at delivery	Nicotine Patches are being offered to all pregnant women who smoke & smoking is discussed at every contact All the Midwives have a smokerlyser device, which is used to assess the woman's CO level. Due to the risk of cross contamination due to COVID restrictions these are not able to be used at the current time. Some limited use of the smokerlysers has recommenced following a risk assessment. At the Booking appointment all women, regardless of smoking status, are encouraged to check their CO levels when smokerlysers are again permitted for use.	There has been a gradual reduction noted in the trend line, for the number of women smoking at delivery Women who smoke are offered additional routine scans to check their baby's growth Healthy Lifestyles midwife, with the remit of improving services & pathways for smoking in pregnancy, is due to commence in post this month (Sept 2021)

Patients



Aug-21
5%
Variance Type
Common cause variation
Target
20%
Target Achievement
Hit & miss target subject to random variation

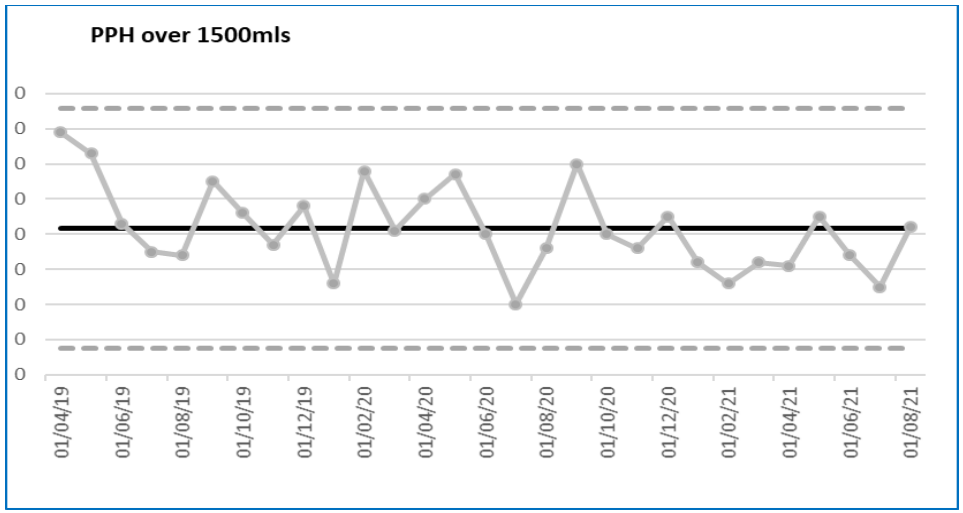
Background	What the chart tells us	Issues	Actions	Mitigation
Total no. of mothers delivering in birthing unit/home	Common cause variation & hit & missing target	Mothers delivering in birthing unit/home	The proportion of women delivering in the Midwife Led Birthing Unit in August 2021 was 4.1% & the proportion of home births was 1.0%. These rates are below the established targets & are being driven by the staffing acknowledged constraints within the maternity service.	The redeployment of some of the community continuity team Midwives has enabled the level of one to one care in labour to be maintained at a high level (99% of all women in labour had one to one care in August 2021).



Aug-21
72%
Variance Type
Common cause variation
Target
74%
Target Achievement
Hit & miss target subject to random variation

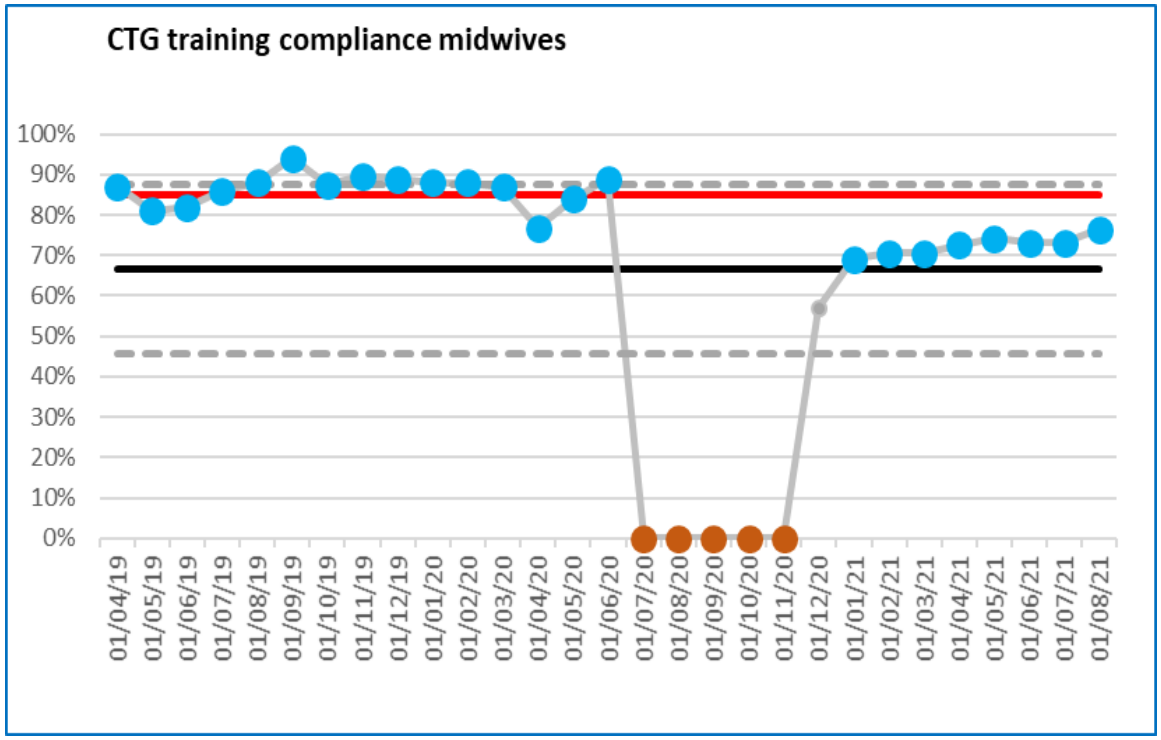
Background	What the chart tells us	Issues	Actions	Mitigation
Breast feeding rates at delivery	Common cause variation & inconsistently hit & missing target	Breast feeding rates at delivery	The Breast feeding at delivery rate for August was 72.3%, compared to 79% in July. The Baby Feeding Specialist Midwife is monitoring this trend & considering the potential effects of low risk women (who would usually deliver in the Birth Unit) delivering in the high risk Labour Ward.	Midwives who are currently shielding (due to Covid) are assisting the BFI midwife to conduct 'antenatal conversations', as recommended by the Baby Friendly organisation. This involves phone calls to pregnant women emphasising the importance of responding to your baby, skin to skin

Patients



Aug-21
4.20%
Variance Type
Common cause variation
Target
Not set
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
PPH over 1500mls	Common cause variation	PPH over 1500mls	All post-partum haemorrhages above 1000mls & massive obstetric haemorrhages above 1500mls are reviewed at PAHT & duty of candour is carried out for any women who receive blood transfusions. A thematic review is undertaken by reviewing the clinical notes & adding all information to a rolling excel log to help identify any trends or concerns. Additionally, the statistics are added to a run chart on a monthly basis. All concerns are reviewed with a Consultant Obstetrician & if appropriate, may be discussed at Incident Management Group (IMG) which may lead to a serious investigation depending on the incident.	PAHT currently uses Syntometrine which has been found to reduce PPH rates compared to Oxytocin 5iu. Rationale has been provided as this is not in line with NICE guidance. PROMPT/Emergency skills & drills training days cover PPH/MOH & new flowcharts/algorithms have been developed as a quick tool to use within labour rooms for emergencies. All PPH/MOH are reviewed by the patient safety team & escalated as required. Learning from incidents is shared with staff at safety huddles/multidisciplinary team meetings, monthly newsletters & training days.



Aug-21
76%
Variance Type
Special cause improving variation
Target
85%
Target Achievement
Hit & miss target subject to random variation

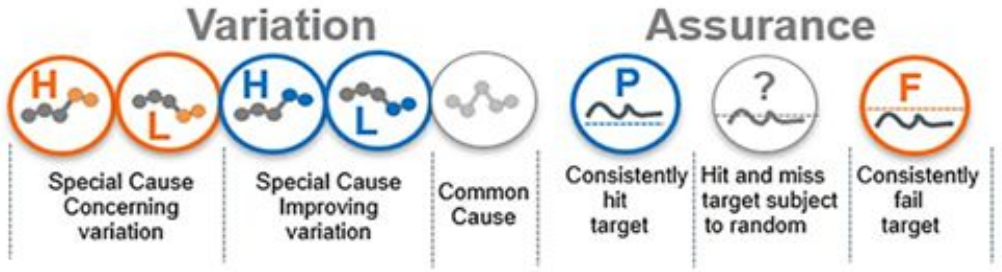
Background	What the chart tells us	Issues	Actions	Mitigation
CTG training compliance midwives	Special cause variation & inconsistently hit & missing target	Compliance with CTG training for midwives below trajectory	CTG Training for Midwives was 76.4% in August (red). Training has recently taken place & a number of Midwives are in the process of final assessment following attendance at this training.	165/182 midwives (90.7%) have now attended the training & all of these are expected to successfully pass their competency assessments. This figure is therefore on trajectory to improve for next month.

Places

*We will maintain the safety of & improve the quality & look of **our places** & will work with our partners to develop an OBC for a new hospital, aligned with the development of our local Integrated Care Partnership.*

Places Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Estates Capital Programme update	AAU (ED support CT) – building works completed; Go-live date scheduled for 6th Sept Mortuary Refurbishment & Ext. Works Phase 2 – Body storage handed over 27th Aug Phase 3 – External areas, support offices mid-Oct-21 Clinical agile space – Additional user-led changes are recorded separately to retro-fit at year end following completion depending on slippage funding. Training & Education Facility – Revised phased completion is scheduled for end of Nov-21 Domestic Modernisation Medical records completed New laundry facility – progressing asbestos works with fit out to follow (end of Oct-21)	For information	
Estates backlog maintenance update	**Electrical infrastructure works** UKPN/G99 work in progress – application in progress Switchgears – Out to tender New substation – Tender evaluation in progress UPS/IPS – Out to market ADSU theatre ventilation duct work – Completed VIE Resilience – All equipments received & going through the QS certification process for the full amount	For information	
CQC preparedness	Fire safety doors - completed. Maternity CQC works commenced. Statutory asbestos remedial works - progressing on emerging business need basis. Parndon Hall - repair works to allow temporary use completed, preliminary works started for mothballing plans. Emergency dept CQC – Completed; awaiting access from HCG	For information	
Catering	Total food wastage is high at 4.57% which equates to total meals wasted (due to over-ordering) at 1549 for reporting period. Over-ordering is due to both ward-staff/house-keepers & patients changing their meal choice. The introduction of e-catering should see an improvement, as will provide 'real-time' ordering.	For information	
Cleaning / security	IPC agreement & support to retain extra hours for cleaning & security on all doors until September	For information	
War-on-waste / compliance	New partners Sust-n Ltd - 2 year contract focus - waste segregation & recycling programme. Key focus monthly audits, training / awareness across the hospital. Set to launch Trust Sustainability Steering Group - early October.	For increased visibility and awareness	

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Estates Responsiveness (Priority 2 - Urgent)	Aug 21	95%	95%			95%	92%	99%
Meals Served	Aug 21	33892	42120			37048	26742	47355
Catering Food Waste	Aug 21	5%	4%			5%	-1%	12%
Domestic Services (Cleaning) Very High Risk	Aug 21	98.0%	98.0%	H		97.6%	94.0%	101.1%
Domestic Services (Cleaning) High Risk	Aug 21	95.0%	95.0%			96.5%	93.0%	100.1%



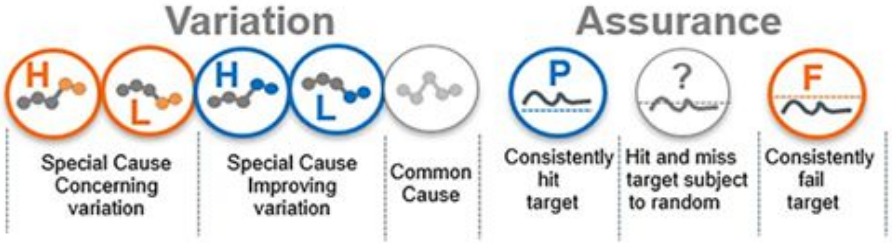
Performance

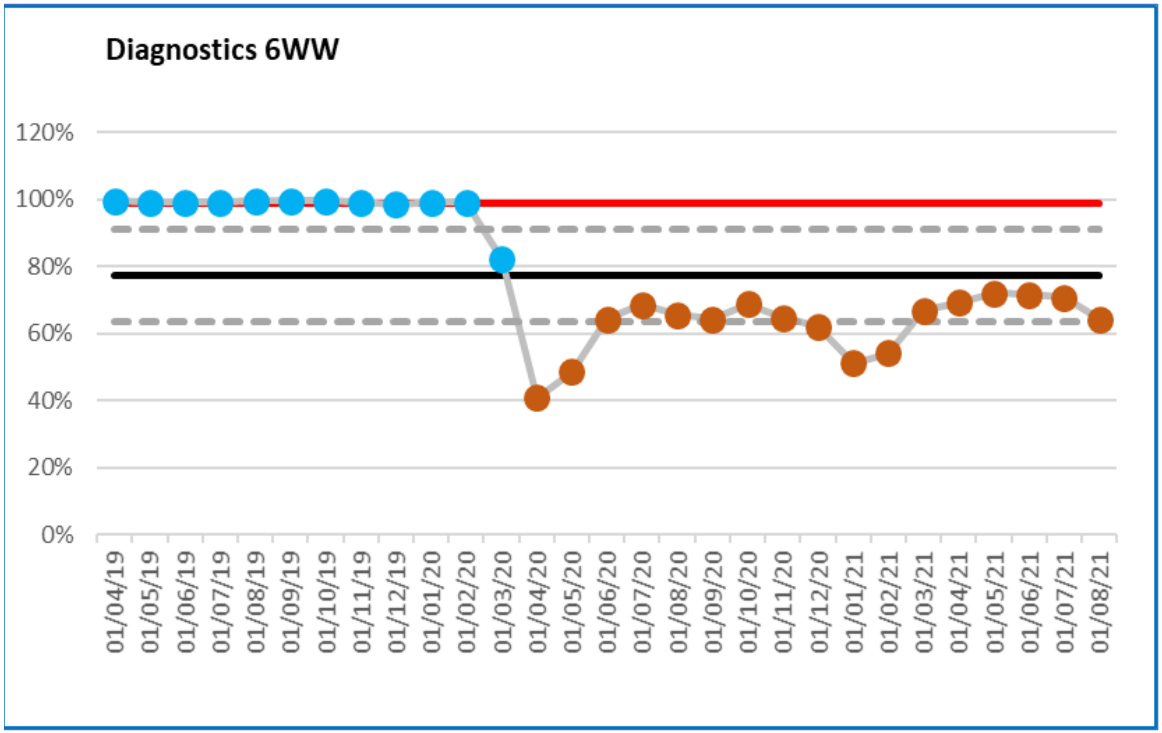
*We will meet & achieve **our performance** targets, covering national & local operational, quality & workforce indicators.*

Performance	Board Sub Committee: Performance & Finance Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Cancer 2ww	Staff annual leave combined with increased referrals have created a deterioration in performance. Clinic capacity has been reviewed & increased where possible.	For information	31/10/2021
O/P New to Follow-Up	Ratio has increased as a result of increased insourcing activity to support recovery.	For recognition	Ongoing
Four hour urgent care standard	Continued poor performance due to increased attendances & staffing limitations. However, regional comparison shows improvement in comparison to peers.	For recognition	Ongoing
62 day cancer	Continued low perfomance as backlog patients receive treatment. New improvement trajectories created.	For information	28/02/2022
52 week waits	Low clinical priority patients continue to wait over 52 weeks for treatment. Longwaiting patients re-prioritised, additional capacity in place & being sourced. Clinical harm review process being implemented.	For information	31/03/2022

KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
RTT incomplete	Aug 21	57%	92%			78%	73%	83%
RTT admitted	Aug 21	47%	90%			54%	25%	84%
RTT Non admitted	Aug 21	86%	95%			88%	86%	91%
RTT PTL vs RTT PTL & ASIs	Aug 21	89%	none			96%	93%	98%
Cancer 31 days First	Jul 21	93%	96%			95%	88%	101%
Cancer 31 days Subsequent Drugs	Jul 21	100%	98%			99%	94%	104%
Cancer 31 days subsequent surgery	Jul 21	90%	94%			93%	66%	120%
Cancer 2WW	Jul 21	72%	93%			86%	70%	101%
Cancer 62 day shared treatment	Jul 21	56%	85%			72%	52%	92%
Cancer 62 day screening	Jul 21	67%	90%			67%	11%	122%
Cancer 62 Day Consultant Upgrade	Jul 21	70%	90%			85%	66%	104%
Cancer 28 day faster diagnosis	Jul 21	74%	none			66%	51%	81%
4 Hour standard	Aug 21	69%	95%			77%	69%	85%
ED attendances	Aug 21	9892	none			8559	6595	10523
ED Admitted performance	Aug 21	36%	95%			53%	35%	71%
ED non admitted performance	Aug 21	78%	95%			85%	78%	93%
ED Arrival to Triage	Aug 21	63	15			41	24	58
ED Triage to examination	Aug 21	112	60			87	66	108
ED Examination to referral to specialty average wait	Aug 21	108	45			95	84	107
ED referral to be seen average wait	Aug 21	83	30			76	58	94
Seen by specialty to DTA	Aug 21	107	60			91	69	114
DTA to departure	Aug 21	219	30			164	59	269
Ambulance handovers less than 15 minutes	Aug 21	20%	100%			29%	16%	43%
Ambulance handovers between 15 and 30 mins	Aug 21	40%	0%			44%	36%	52%
Ambulance handovers between 30 and 60 mins	Aug 21	26%	0%			21%	10%	32%

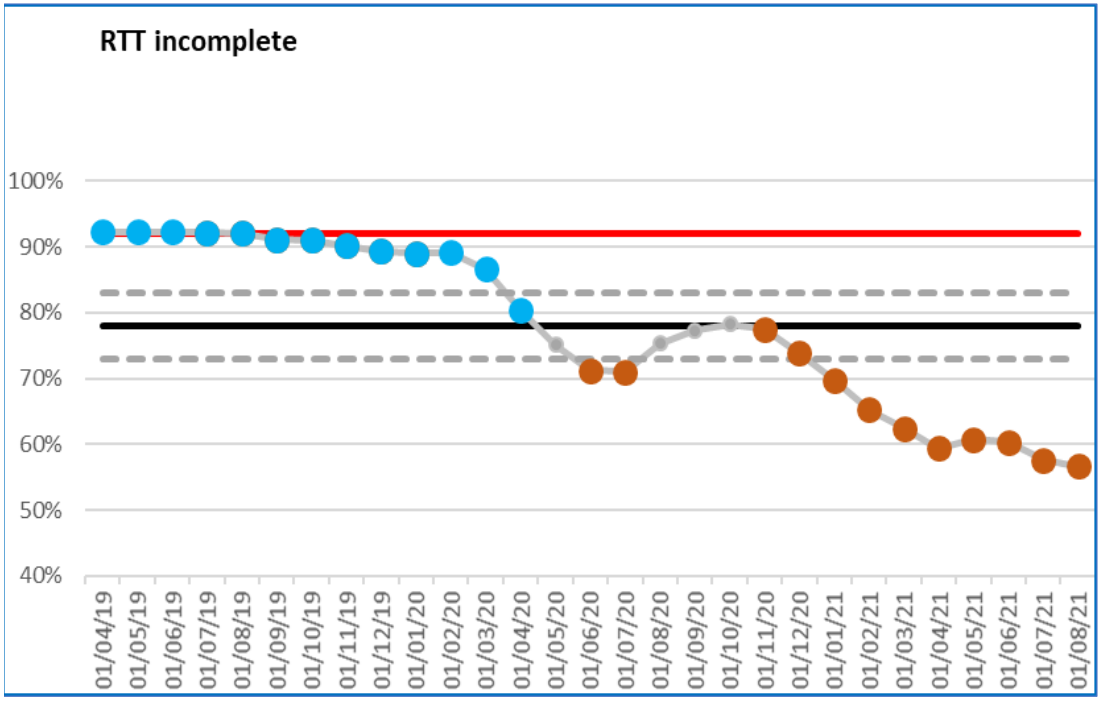
KPI	Latest month	Measure	National target	Performance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
Ambulance handovers > 60 mins	Aug 21	15%	0%			7%	-2%	15%
Diagnostics 6WW	Aug 21	64%	99%			77%	64%	91%
Occupied beds with stranded patients	Aug 21	158	80			143	87	200
Bed occupancy	Aug 21	91%	85%			88%	79%	96%
Discharges between 8am and 5pm	Aug 21	575	none			735	469	1002
Discharges between 5pm and 8am	Aug 21	696	none			696	424	969
LOS non elective	Aug 21	4.0	5.1			3.7	2.8	4.7
LOS elective	Aug 21	1.0	4.2			2.2	0.6	3.8
Short Notice clinical cancellations	Aug 21	50	0			45	-35	125
OP new to follow up ratio	Aug 21	2.1	2.3			2.1	1.8	2.5
OP DNA Rate	Aug 21	6%	8%			5%	3%	6%
52 Week waits	Aug 21	1394	0			427	261	593
Proportion of Majors Patient treated within 4 hours in ED Paeds	Aug 21	72%	95%			86%	73%	99%
Super stranded patients	Aug 21	50	25			40	13	67
12 Hour waits in ED from Arrival	Aug 21	620	0			351	77	625
12 Hour Trolley waits in ED from DTA	Aug 21	13	0			14	-18	47





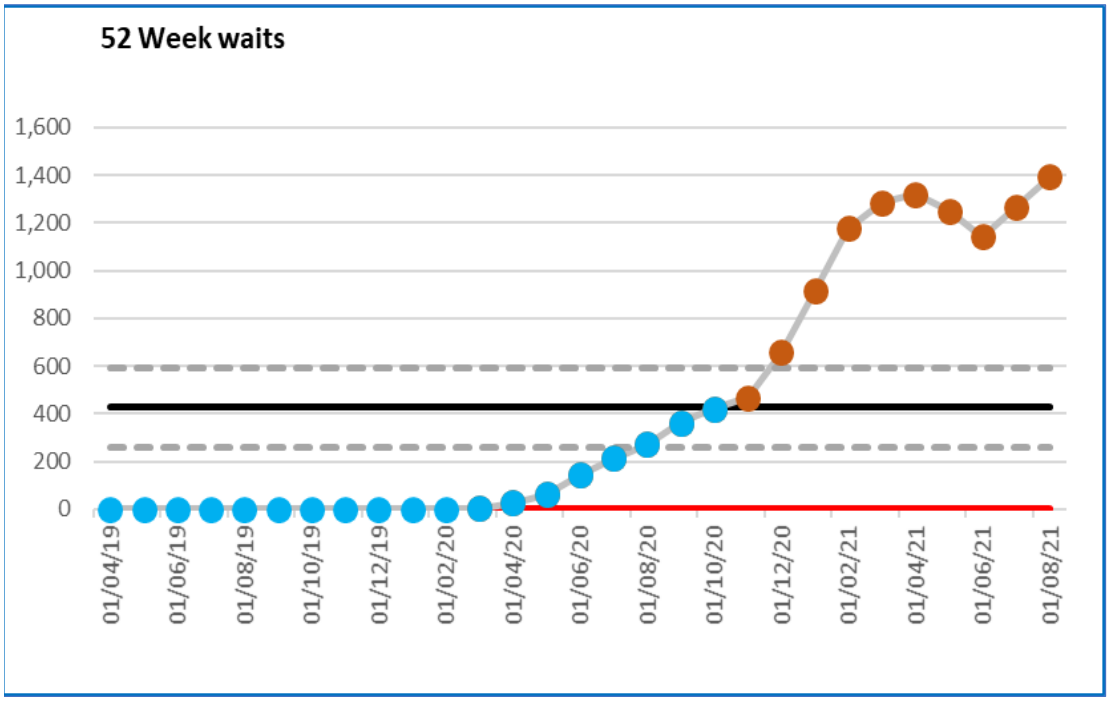
Aug-21
64.00%
Variance Type
Special cause variation
Target
99.00%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Diagnostics 6 week wait	Special cause concerning variation and consistently failing target	There is a significant backlog of diagnostic requests which have built up as a result of covid restrictions. The delay in the replacement of the MRI scanner is reducing capacity. Increased referral levels (+20%) continuing.	Additional capacity is being delivered as extra sessions & use of independent sector providers. "Smart" booking of longest waiting patients.	Clinical prioritisation (90%) of waiting list & review of long waiting patients on DM01 waiting list



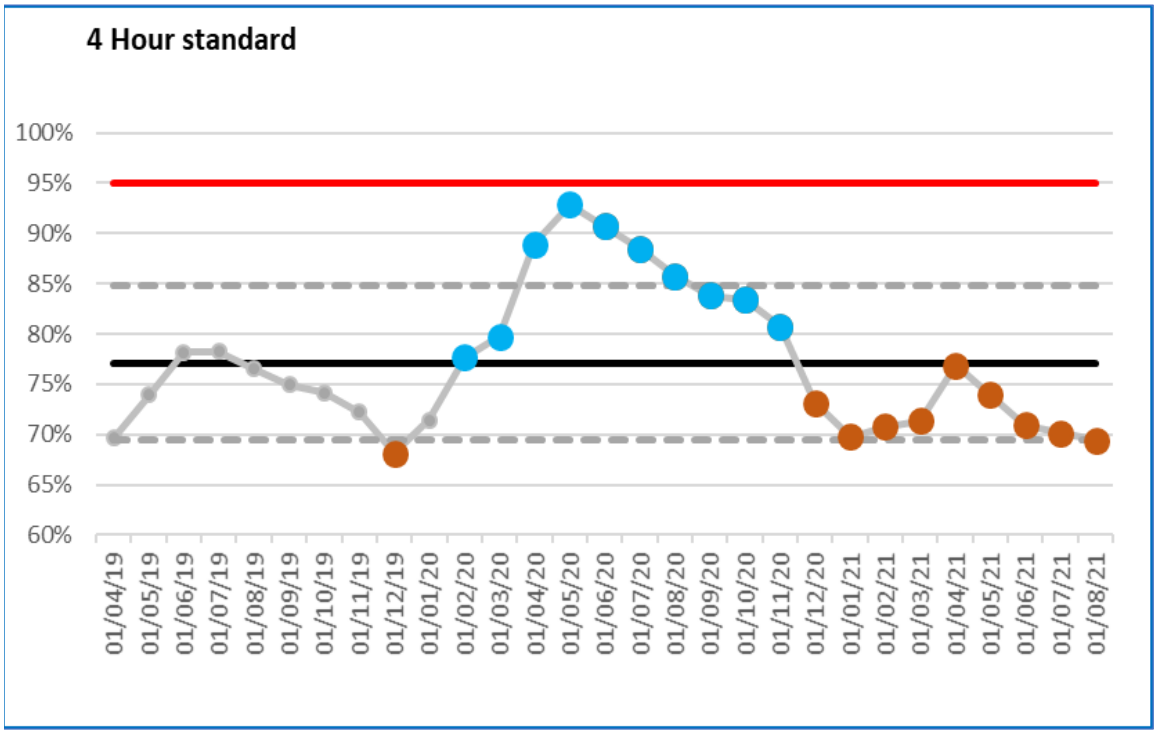
Aug-21
57%
Variance Type
Special cause variation
Target
92%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
RTT Incomplete	Special cause concerning variation and consistently failing target	The performance against the RTT standard has been below the target and statistical mean for 12 months as a result of covid activity pressure pausing elective activity. Elective work resumed (although paused for the 2nd half of July) and a higher number of patients are being treated that have breached 18 weeks.	Admitted backlog being booked & treated in clinical order not chronological. Virtual & face to face clinics and additional sessions being put on. Extensive outsourcing to Independent Sector & insourcing at PAH to increase capacity.	Admitted backlog clinically prioritised. Non admitted - clinical priority booking at sub specialty level. Clinical Reviews & harm reviews being undertaken. Diagnostic waiting list clinically prioritised.



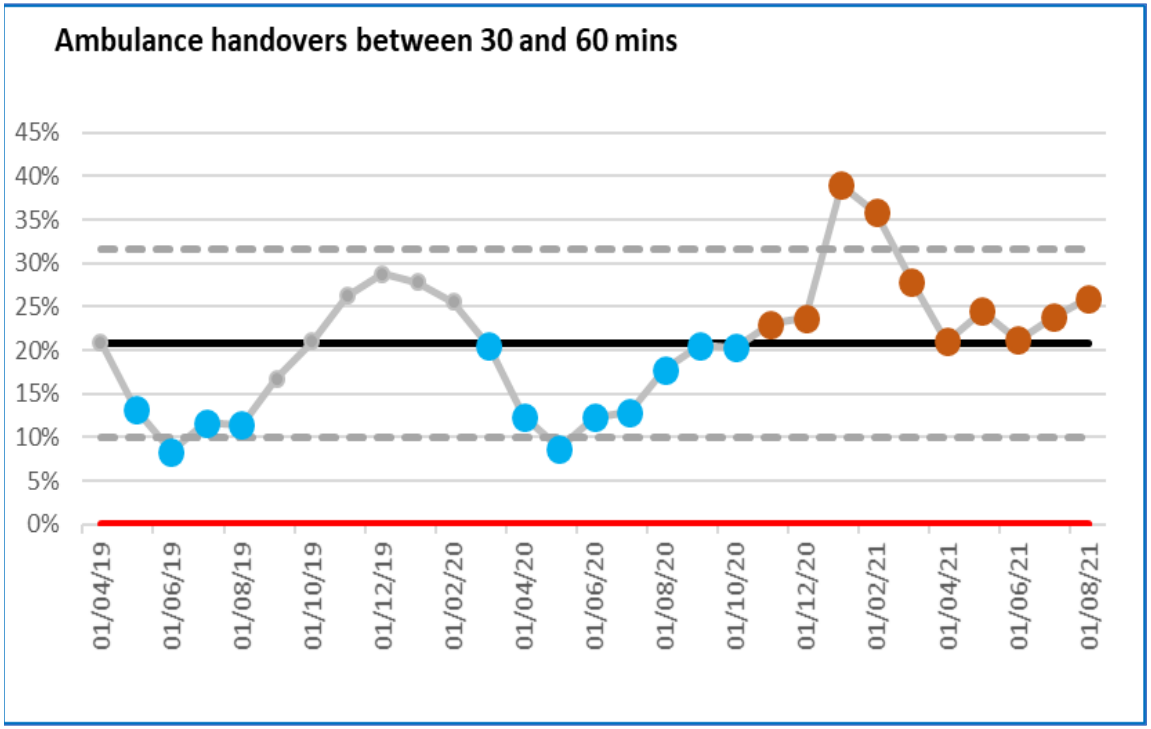
Aug-21
1394
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
52 week waits	Special cause concerning variation and consistently failing target	Booking in clinical priority order instead of chronological order has led to increasing numbers of long waiting lower priority patients.	All patients over 78 weeks increased in priority to P3. RTT Recovery trajectory developed to ensure that the Trust has no patient waiting over 104 weeks by 31/12/21. Ongoing outsourcing of lower priority patients to Independent sector Elective operating recommened on site for more complex patients.	Clinical review of long waiting patients being implemented with interim & treatment harm review process to monitor for potential harm.



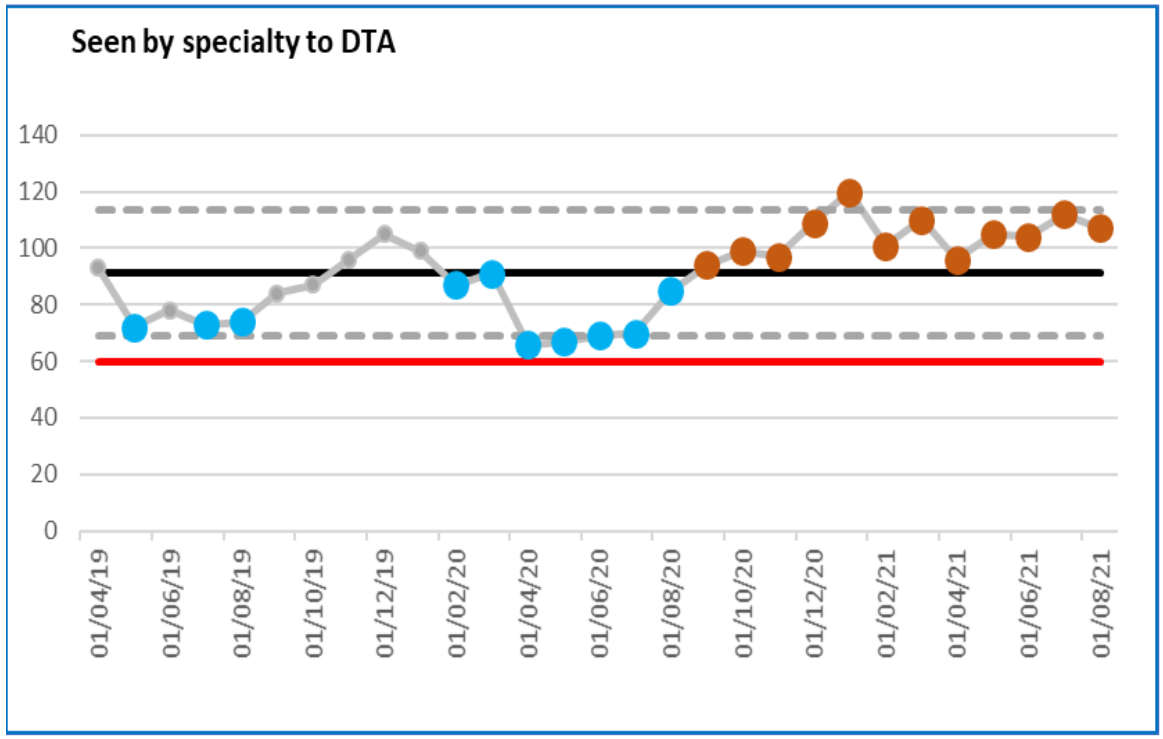
Aug-21
69%
Variance Type
Special cause variation
Target
95.00%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Four hour standard	Special cause concerning variation and consistently failing target	The performance against the four hour standard has been consistently below the statistical mean for four months and close to the lower control limit. Significant increases in attendances has exacerbated the pressure on the emergency pathways.	The Trust has implemented an improvement programme supported by external consultants Prism to improve the pathways and performance across all Urgent Care pathways.	Close review of daily processes by senior management team and executive directors. Regional comparisons have shown an improvement in performance compared to peers.



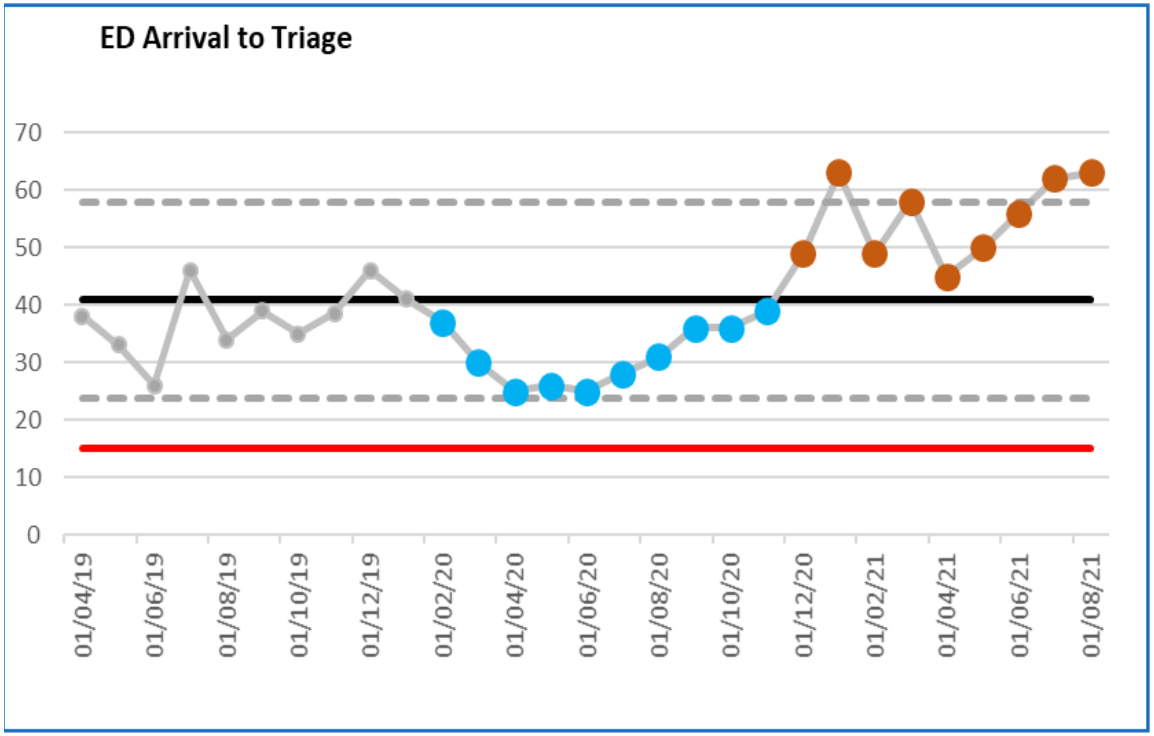
Aug-21
26%
Variance Type
Special cause variation
Target
0.00%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Ambulances handovers between 30 and 60 minutes	Special cause concerning variation and consistently failing target	The % of ambulance conveyances over 30 minutes has increased above the statistical average.	Workstream 1 and 2 of the Urgent Care Improvement programme supported by Prism is focussing on improving ambulance handovers . Increased attendances are impacting the ability of the department to reduce handover times.	Close review of daily processes by senior management team and executive directors.



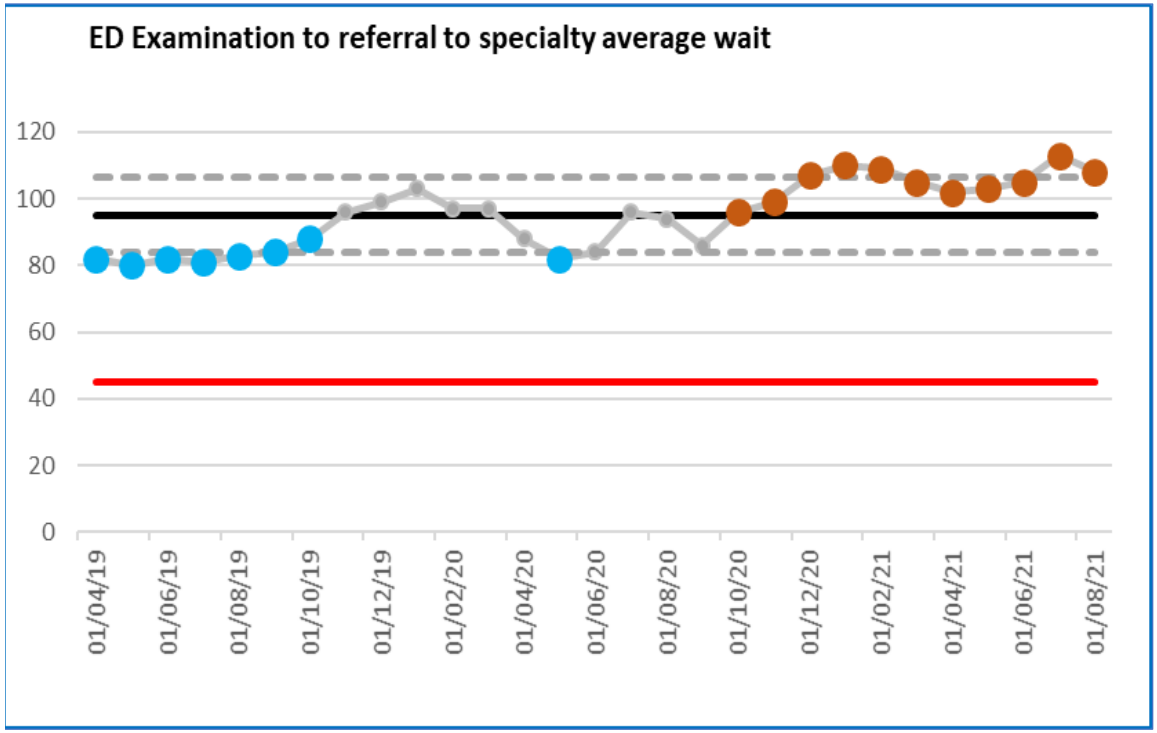
Aug-21
107 minutes
Variance Type
Special cause variation
Target
60 minutes
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Seen by specialty to DTA	Special cause concerning variation and consistently failing target	The average time from being seen by specialty to decision to admit has been consistently increased over the statistical average for 9 months	The Urgent Care improvement programme has refreshed Internal Professional Performance Standards which have been approved by SMT and are implemented. Training & communication of these standards and escalation processes are being delivered.	Close review through breach analysis & PRISM supported improvement work.



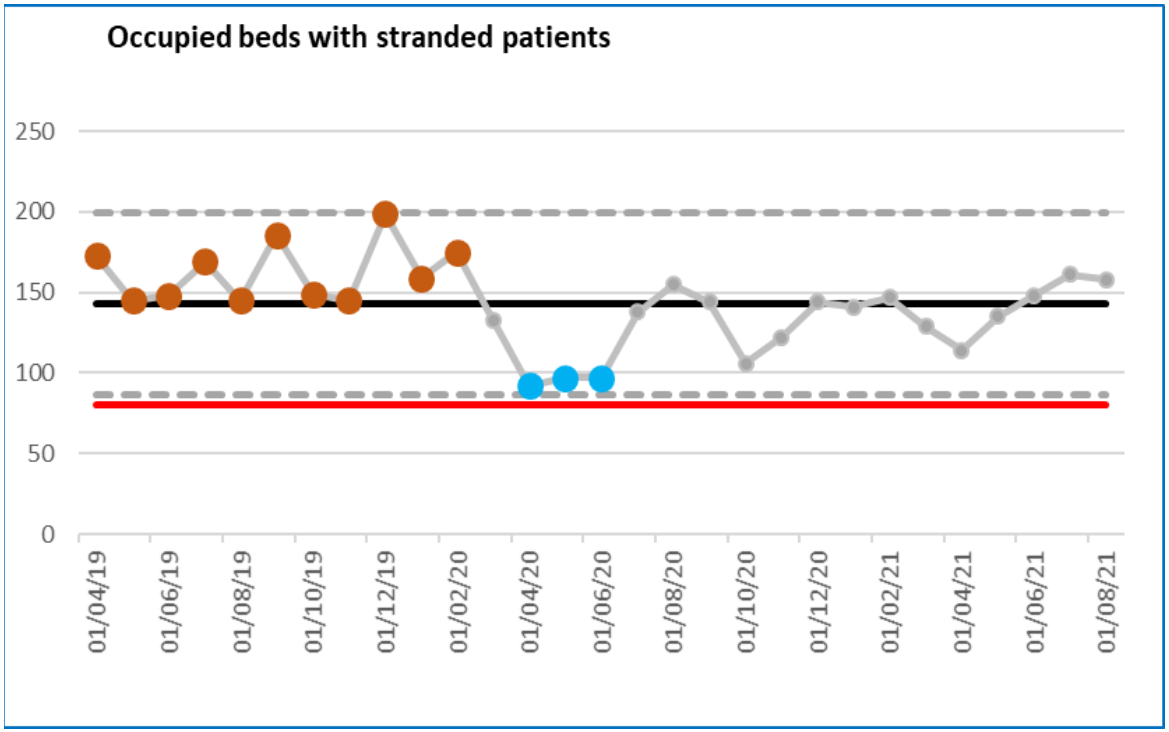
Aug-21
63 minutes
Variance Type
Special cause variation
Target
15 minutes
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Seen by specialty to DTA	Special cause concerning variation and consistently failing target	The average time from being seen by specialty to decision to admit has been consistently increased over the statistical average for 8 months	The Urgent Care improvement programme has refreshed Internal Professional Performance Standards which have been approved by SMT and are implemented. Training & communication of these standards and escalation processes are being delivered	Close review through breach analysis & PRISM supported improvement work.



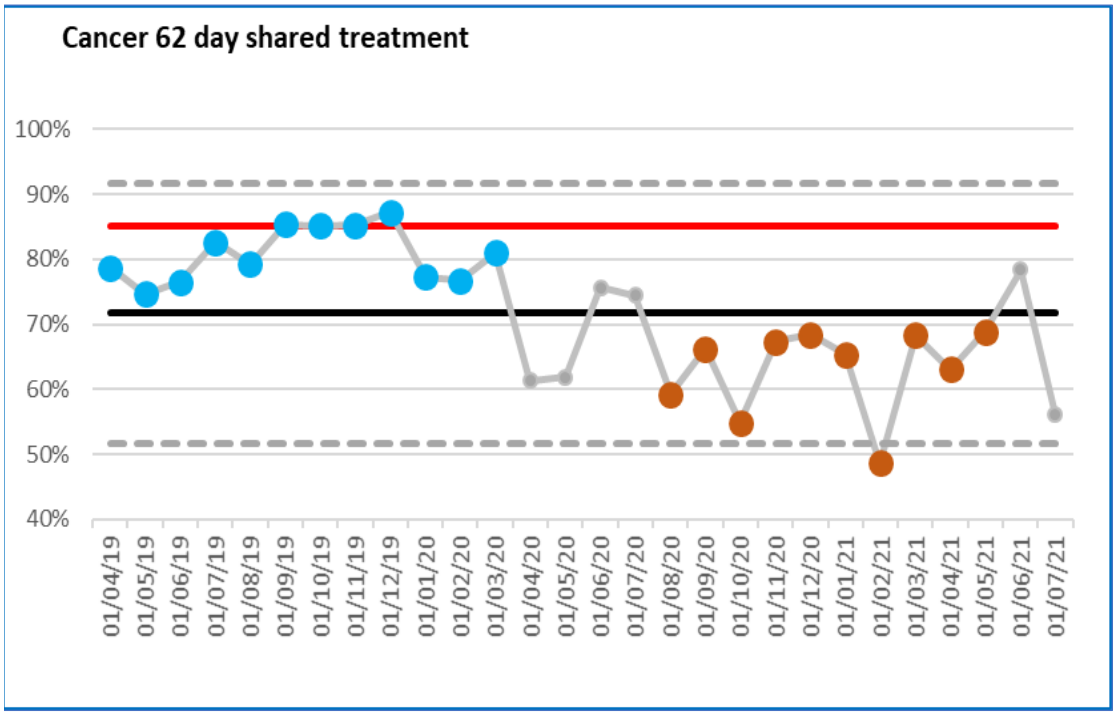
Aug-21
108 minutes
Variance Type
Special cause variation
Target
45 minutes
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
ED examination to referral to specialty average wait	Special cause concerning variation and consistently failing target	The average time from being seen by specialty to decision to admit has been consistently increased over the statistical average for 9 months	The Urgent Care improvement programme has refreshed Internal Professional Performance Standards which have been approved by SMT and are implemented. Training & communication of these standards and escalation processes are being delivered.	Close review through breach analysis & PRISM supported improvement work.



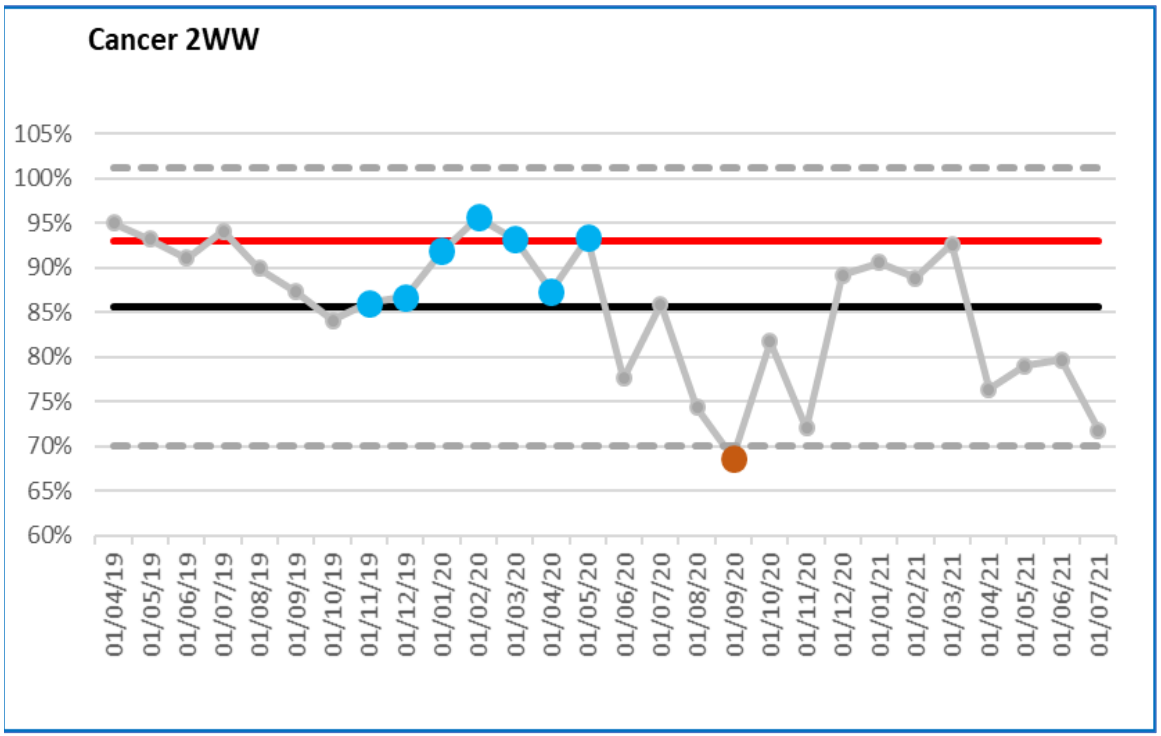
Aug-21
158
Variance Type
Common cause variation
Target
80
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Occupied beds with stranded patients	Common cause variation and consistently failing target	The performance against the target for stranded patients has failed consistently, however, we have shown common cause variation for the last 12 months	Length of stay reviews have recommenced and concentrate on top 10 LOS issues. ICP workstream has been implemented to improve discharge processes.	Review via daily bed meetings & weekly capacity planning meetings.



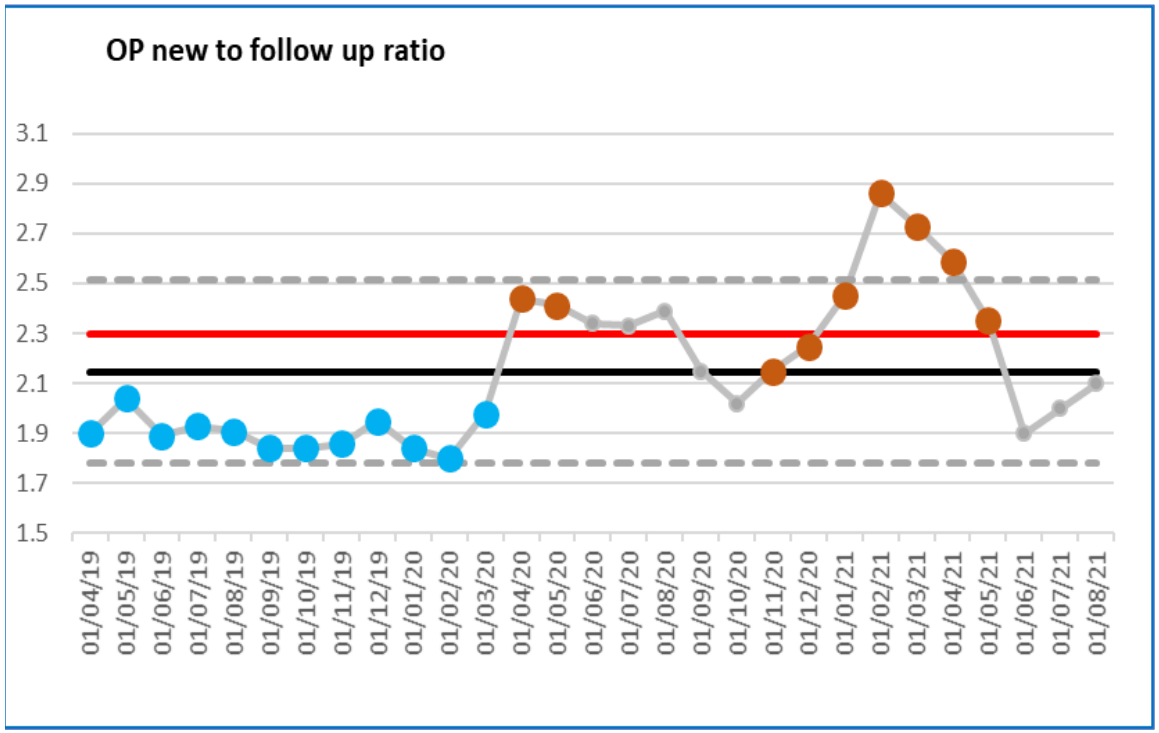
Jul-21
56%
Variance Type
Common cause variation
Target
85%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 62 day shared treatment	Common cause variation and hitting and missing target radomly	The performance against the target has failed for over 12 months.	The Trust has continued to focus on diagnosing & treating the backlog of patients that developed over the Covid period & the 62 day performance reflects the increased numbers of patients treated after 62 days in their pathway. Additional diagnostics & treatments are being delivered to clear the backlog & the Trust has refreshed the recovery trajectories to monitor performance against target.	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting.



Jul-21
72%
Variance Type
Common cause variation
Target
93%
Target Achievement
Inconsistently passing and falling short of target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 2 week wait	Common cause variation and inconsisrtently passing and falling short of the target	Increased referrals particularly in Breast & Skin Cancer. Increased staff absence annual leave.	All tumour sites have reviewed their clinics to create additional capacity. Further straight to test pathways and closer scrutiny of booking of patients.	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting.



Aug-21
2.1
Variance Type
Common cause variation
Target
2.3
Target Achievement
Inconsistently passing and falling short of target

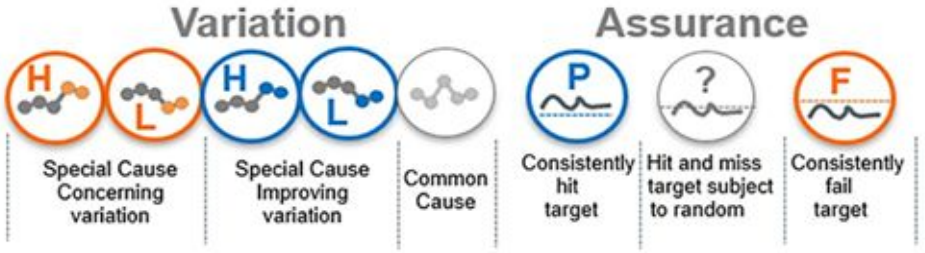
Background	What the chart tells us	Issues	Actions	Mitigation
OP new to follow up ratio	Common cause variation and inconsisrtently passing and falling short of the target	During Covid period the majority of activity delivered was overdue follow-up appointments (review lists) by virtual clinics. Additional insourcing to clear the overdue follow-up appointments is impacting the ratio.	Ongoing monitoring & increased volumes of activity to support recovery.	Not required - returning to normal values

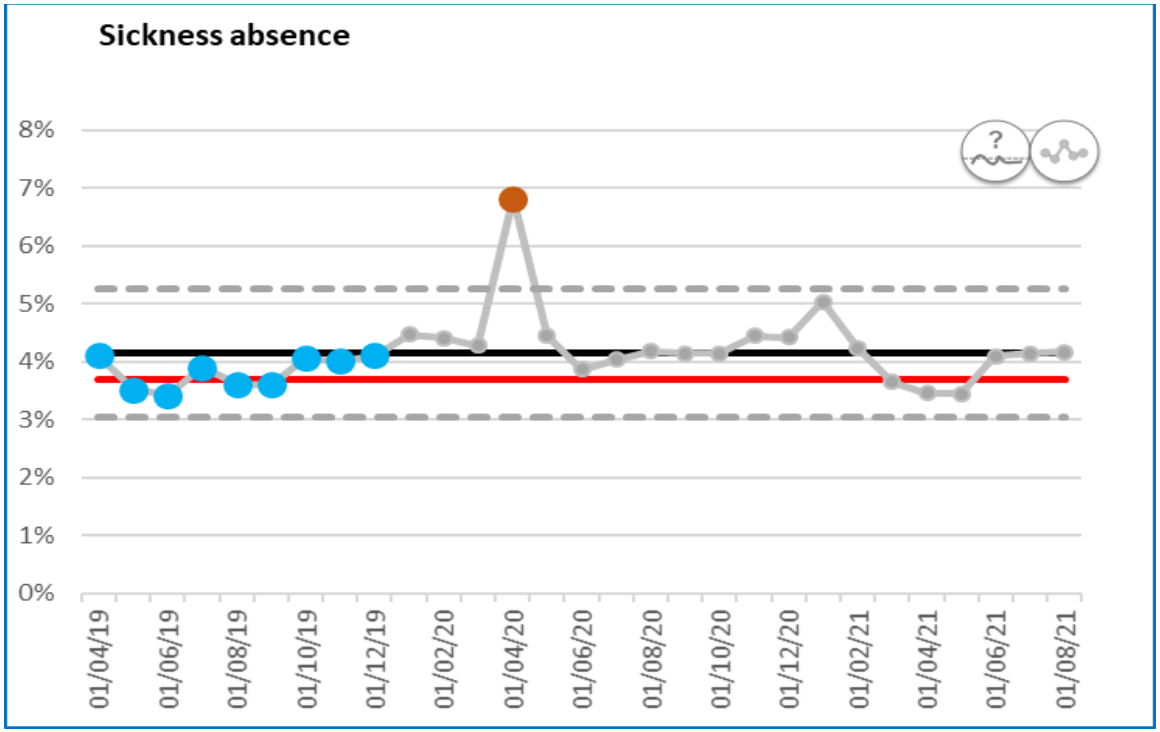
People

*We will support **our people** to deliver high quality care within a culture that continues to improve how we attract, recruit & retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.*

People Summary	Board Sub Committee: Worforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Appraisals	Appraisal were paused during the first COVID wave. Divisional feedback indicated that staff workplace moves over the last year have compounded appraisals being completed by the appropriate manager. Advice is being provided by the Learning & OD team & the HRBPs with regards to this & support with planning provided by HRBPs at divisional board meetings. Service level compliance reports provided to managers on a monthly basis.	For information	Q3
Sickness	Sickness absence is sitting just above the trust KPI for August. Absences relate to mental health & MSK. Action plans in place to support all long term absences & active signposting to psychological support & Physiomed, the trust's physiotherapy support service.	For information	Q3
Statutory and Mandatory training	There are low rates across the organisation following a pause on training over the last year. An analysis of non compliance highlighted a number of key themes including release from work place & some data integrity following staff workplace moves over the last year. LOD team supporting divisions with action plans to support the release of staff to undergo training. There will be training facilities on the main hospital site in the autumn.	For information	Q3
Vacancy	Overall the trust vacancy rate remains the same. International recruitment plans remain on track & medical staffing posts within Surgery are actively being recruited to.	For information	Q2/3

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Appraisals - non medical	Aug 21	83%	90%		F	82%	77%	88%
Agency staffing spend	Aug 21	4%	15%	L	P	5%	2%	8%
Bank staffing spend	Aug 21	12%	15%		P	12%	9%	14%
Vacancy Rate	Aug 21	8%	8%	L	F	10%	8%	11%
Staff turnover - voluntary	Aug 21	13%	12%	H	P	11%	10%	12%
Sickness absence	Aug 21	4%	4%		?	4%	3%	5%
Statutory and Mandatory training	Aug 21	88%	90%		?	89%	86%	92%

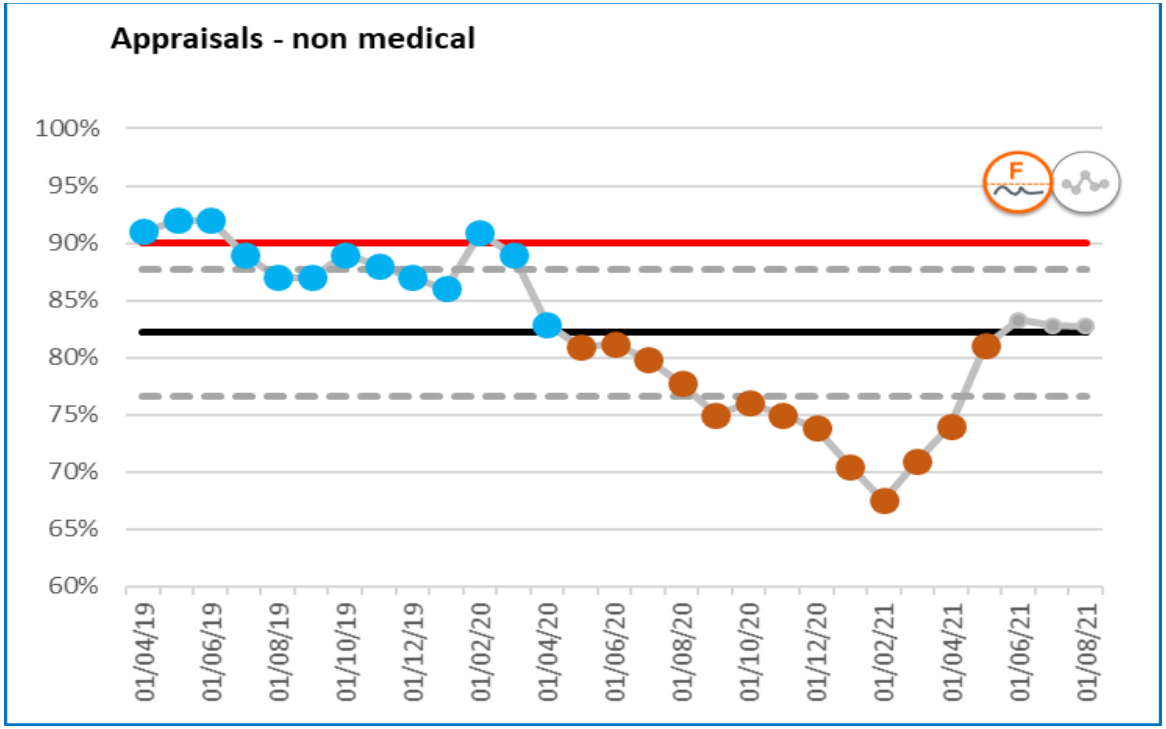




Aug-21
4%
Variance Type
Common cause variation
Target
4%
Target Achievement
Inconisistnently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Sickness absence	Variation indicates inconsistently passing & falling short of the target	Sickness absence remains just above the trust KPI for August. The top two absence reasons remain mental health & MSK	Action plans in place to support all long term sickness absence cases. Absence management coaching is taking place with managers across the divisions	Absence rates are discussed at monthly divisional board meetings & performance review meetings

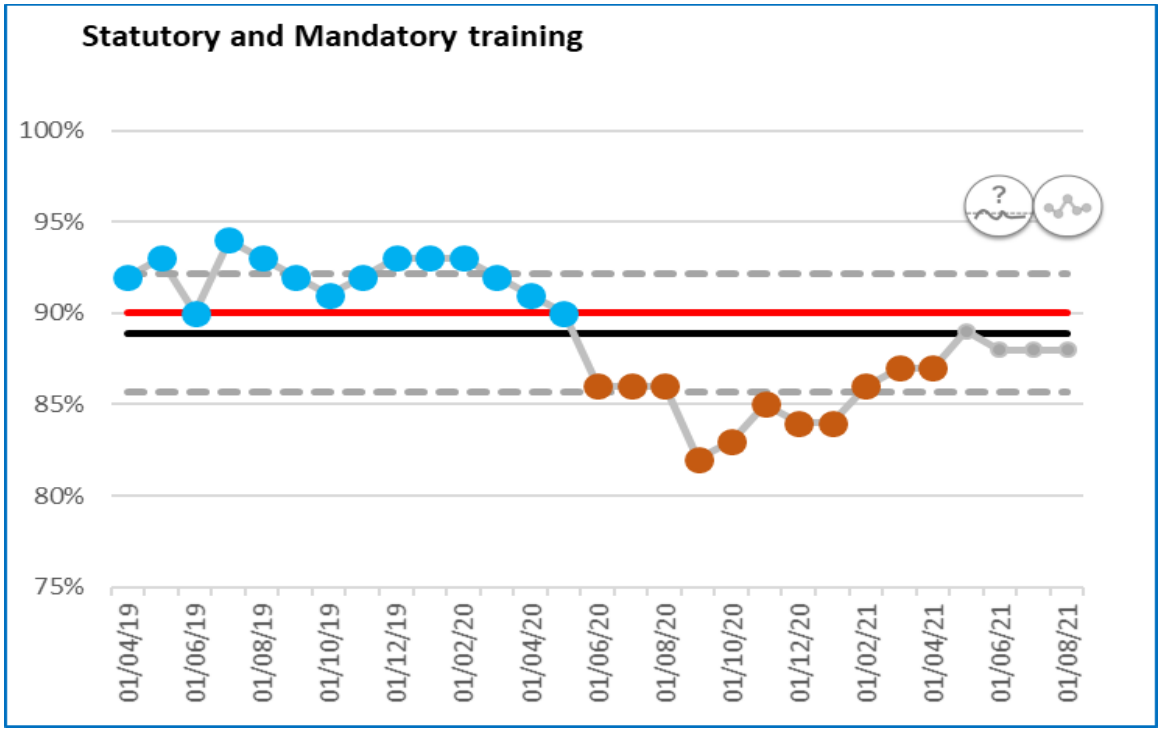
People



Aug-21
83%
Variance Type
Common cause variation
Target
90%
Target Achievement
Consistently failing target

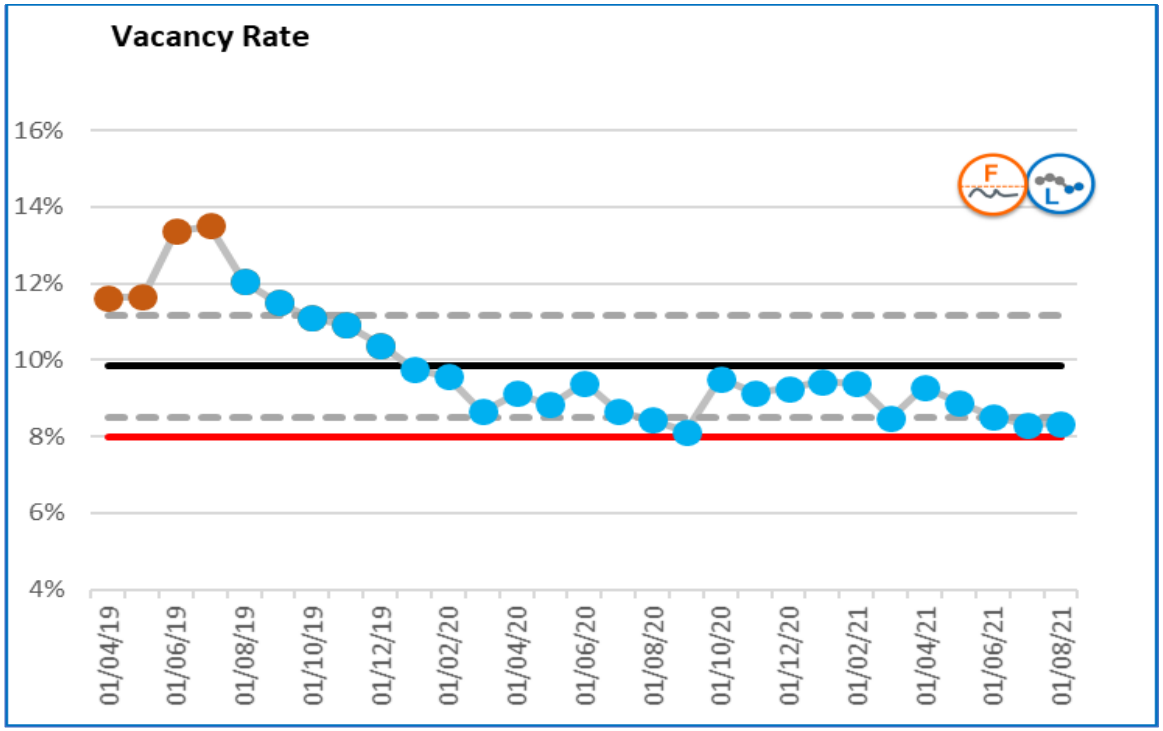
Background	What the chart tells us	Issues	Actions	Mitigation
Appraisal non medical	Common cause concerning variation & consistently falling short of target	Appraisals were paused during the first COVID wave. HCG feedback indicated that staff workplace moves over the last year have compounded appraisals being completed by the appropriate manager	Support with planning appraisals continues to be provided by HRBPs at divisional board meetings. Service level compliance reports provided to managers on a monthly basis. Support provided by the people information team on uploading appraisal data to ESR	Compliance rates discussed at monthly HCG board meetings & performance review meetings with actions agreed

People



Aug-21
88%
Variance Type
Common cause variation
Target
90%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Statutory and Mandatory Training	Common cause concerning variation & consistently failing target	There are low rates across the organisation following a pause on training over the last year. An analysis of non compliance highlighted a number of key themes including release from work place & some data integrity following staff workplace moves over the last year	LOD team supporting HCG with action plans to support the release of staff to undergo training. The new training centre based on the main hospital site is due to open in the autumn	Training data discussed at HCG board meetings on a monthly basis. New training venue based on site planned for autumn



Aug-21
8.00%
Variance Type
Special cause variation
Target
8.00%
Target Achievement
Consistently failing

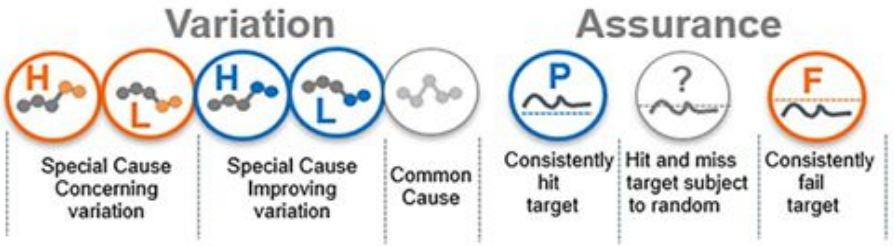
Background	What the chart tells us	Issues	Actions	Mitigation
Vacancy Rate	Special cause improving variation & consistently failing target	Vacancy rates remain the same. Recruitment focus in Q2 & Q3 remains with estates & facilities, allied health professionals & medical staffing within the surgery division	Ongoing international recruitment for nursing posts. Advertising estates & facilities domestic & housekeepers roles on a rolling basis. Medical stffing vacancies currently within the recruitment pipeline with candidates due to start in Q3 & Q4	Recruitment plans for divisions reviewed at divisional board meetings & at monthly performance review meetings.

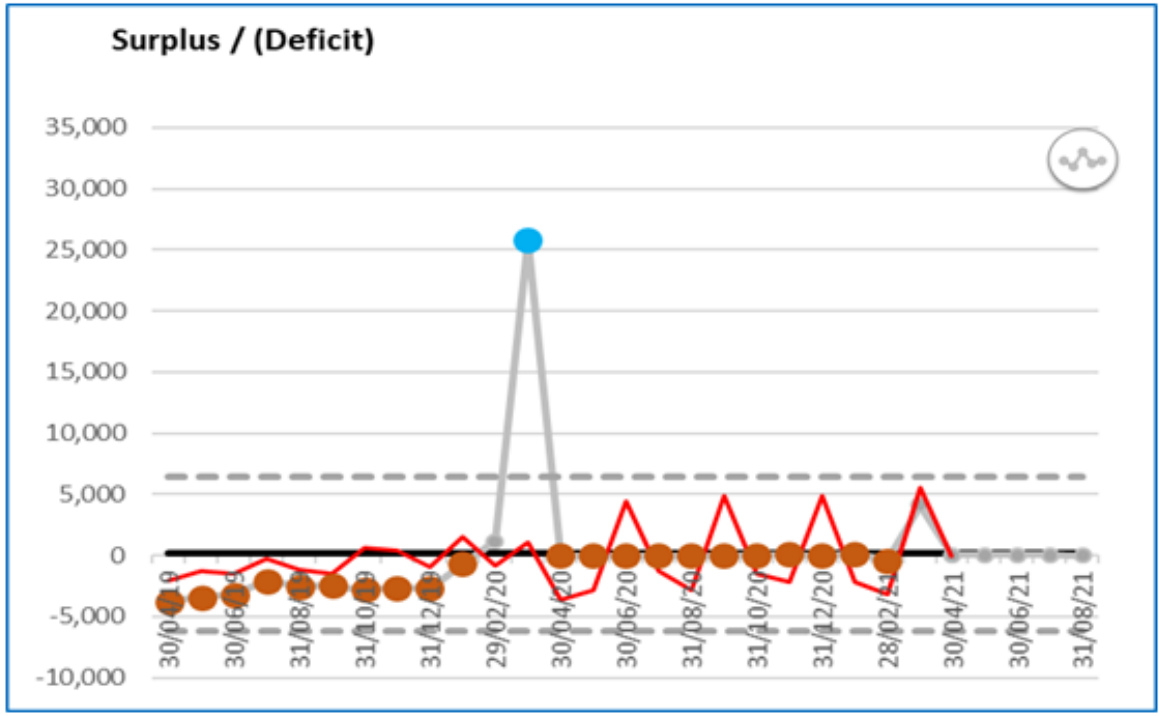
Pounds

*We will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way*

Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Surplus	The Trust has achieved, at August (month 5), a year-to-date surplus of £109k against a break-even plan.	For information	
CIP	There is a focus on ensuring that the Trust delivers it CIP target of £2.2m for H1 (April to September 2021) to ensure that the overall financial plan is delivered.	For information	
Capital Spend	The Trust has revised its capital profile following discussion with NHSE/I. Year-to-date capital spend is £7.8m against a capital plan of £7.9m.	For information	
	The Trust continues to have a healthy cash balance of £53.2m. There is a push to reduce aged payables & improve the Trust's performance against the Better Payment Practice Code.	For information	
	NHSE/I will be publishing planning guidance shortly which will form the basis of H2 & 2022/23 financial planning.	For information	

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Surplus / (Deficit)	Aug 21	12	0			158	-6157	6473
EBITDA	Aug 21	1474	0			1271	-5114	7657
CIP	Aug 21	777	0			583	-248	1414
Income	Aug 21	27002	0			25496	13606	37386
Operating Expenditure	Aug 21	25538	0			25138	19274	31003
Bank Spend	Aug 21	1993	0			1916	1286	2546
Agency Spend	Aug 21	613	0			836	439	1233
Capital Spend	Aug 21	7776	0			2780	-3998	9559

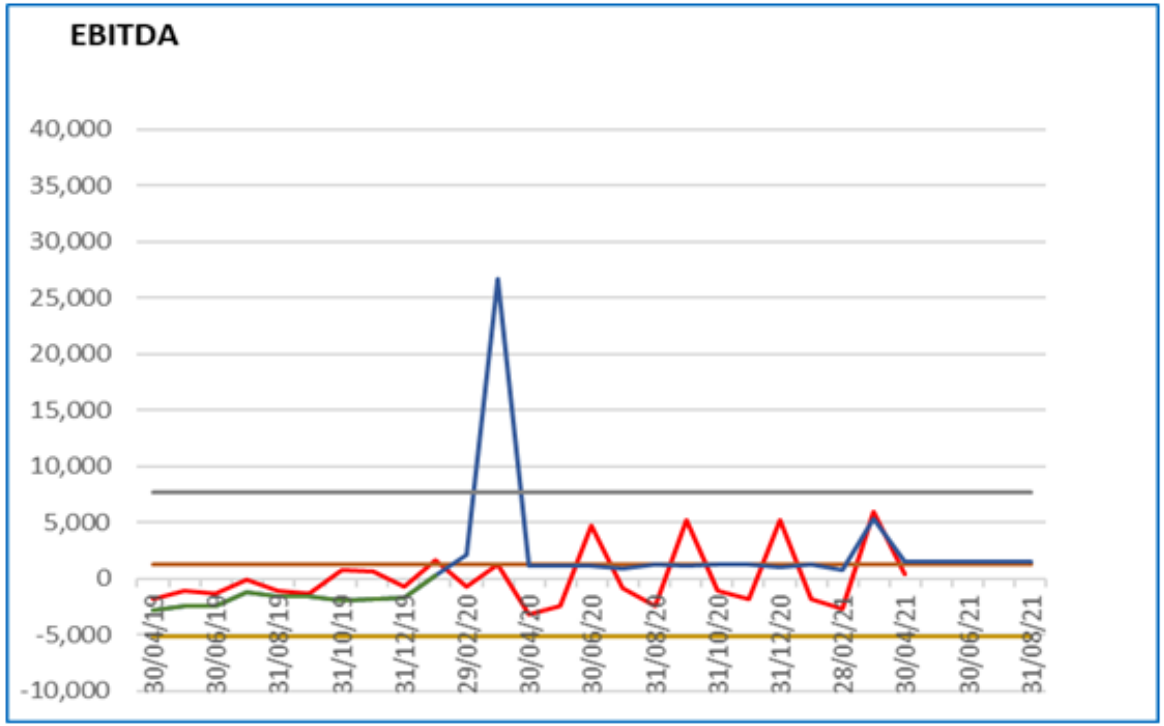




Aug-21
£12k
Variance Type
Common cause variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Surplus/Deficit	Common cause variation and inconsistently passing and falling short of the target	The Trust is forecasting a breakeven position.	There is a continued focus on CIP delivery and recovering elective activity.	N/A

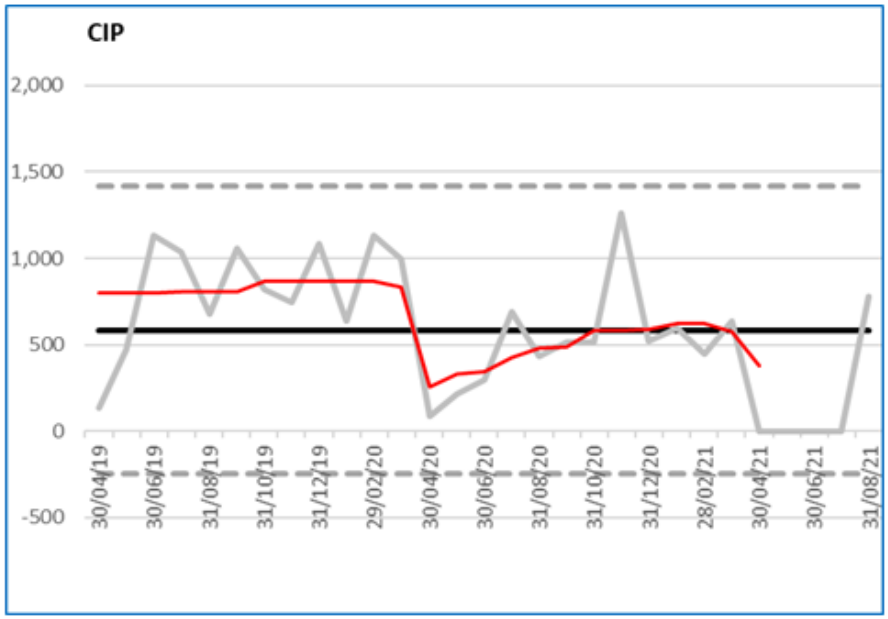
Pounds



Aug-21
1474
Variance Type
Common cause variation
Target
362
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
EBITDA	Common cause variation and inconsistently passing and falling short of the target	N/A	N/A	N/A

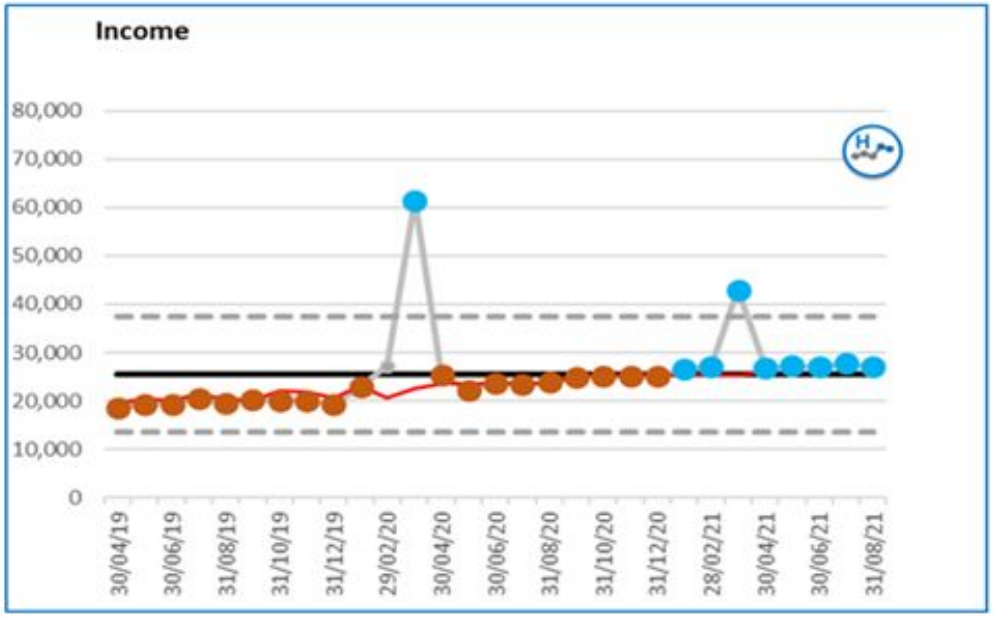
Pounds



Aug-21
£777k
Variance Type
Special cause variation
Target
£375k
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
CIP	Special cause variation and inconsistently passing and falling short of the target	£0.6m of potential CIPs have yet to go through the QIA process therefore cannot be recorded on top of the figures to date.	QIA reviews being undertaken in September 2021	N/A

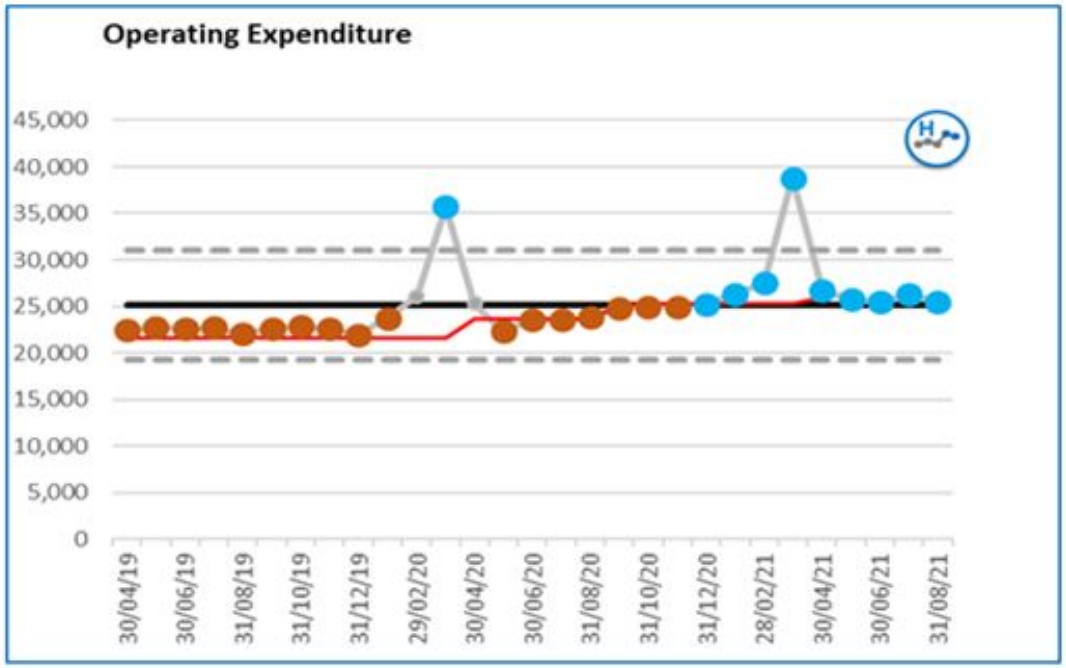
Pounds



Aug-21
£27,002k
Variance Type
Special cause improving variation
Target
£26,097k
Target Achievement

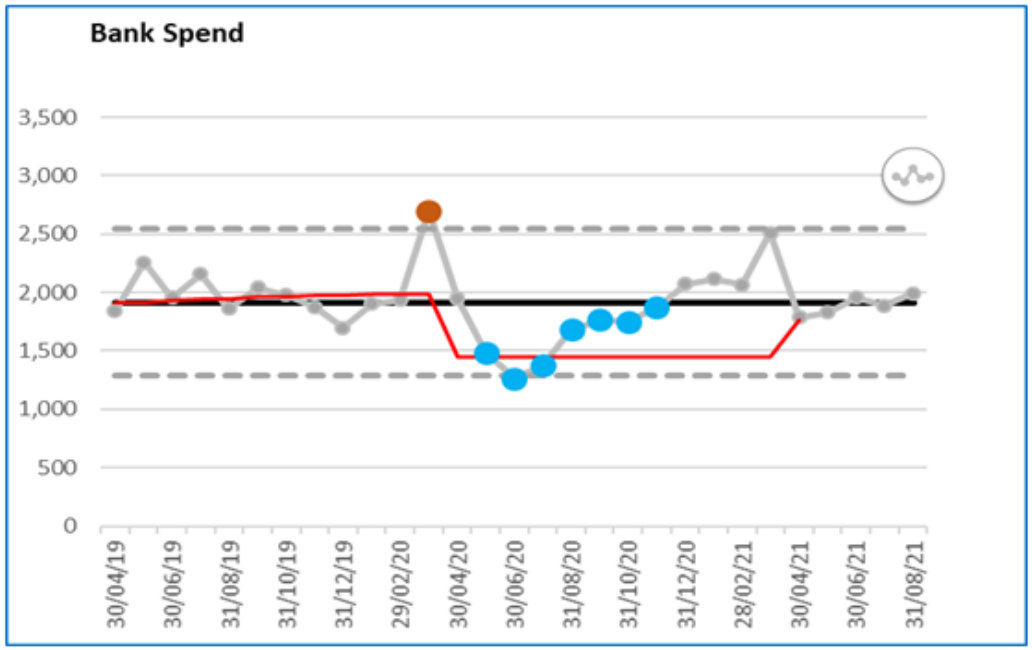
Background	What the chart tells us	Issues	Actions	Mitigation
Income	Special cause improving variation	More elective activity was performed therefore increasing the amount of ERF the Trust was entitled to hence the overperformance against the target.	N/A	N/A

Pounds



Aug-21
£25,538k
Variance Type
Special cause improving variation
Target
£26,710k
Target Achievement

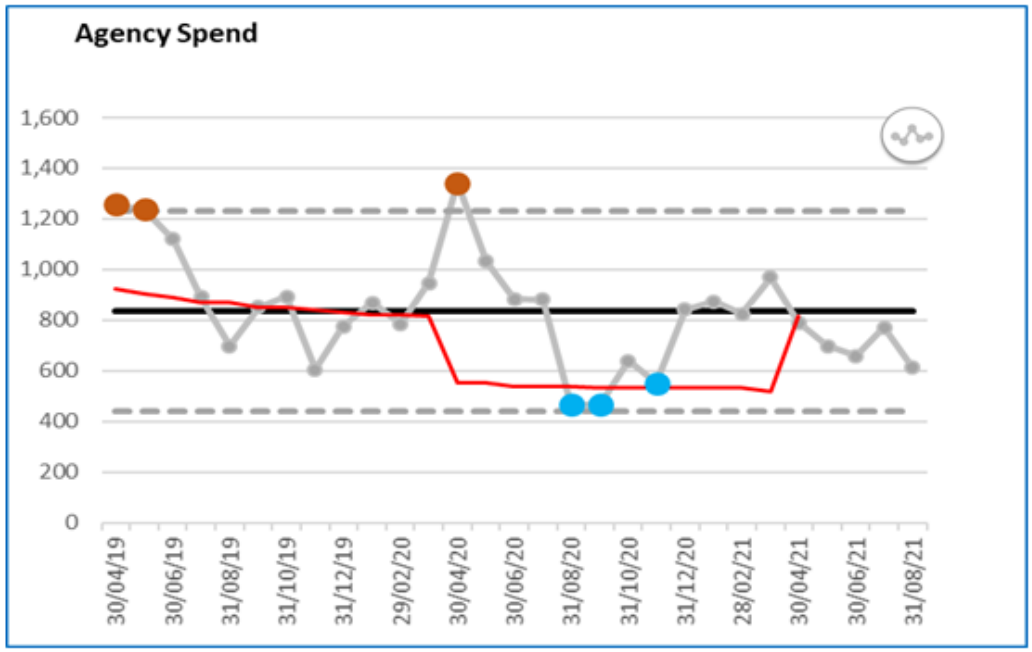
Background	What the chart tells us	Issues	Actions	Mitigation
Operating Expenditure	Special cause improving variation	Expenditure is, in the main, on plan.	Finance continue to work with budget holders to ensure that spend remains within budget and any potential overspends are brought back within budget.	N/A



Aug-21
£1,993k
Variance Type
Common cause variation
Target
1863
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Bank Spend	Common cause variation and inconsistently passing and falling short of the target	Bank spend is higher than this month's target due to trust vacancies	There is a Trustwide monthly meeting on bank and agency spend to ensure that there are plans in place to reduce this expenditure.	N/A

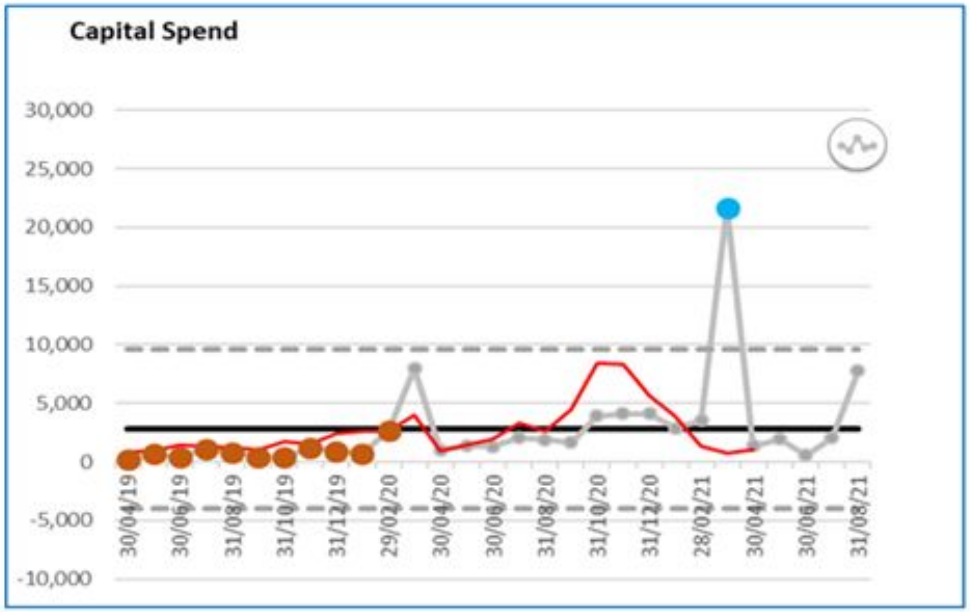
Pounds



Aug-21
£613k
Variance Type
Common cause variation
Target
886
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Agency Spend	Common cause variation and inconsistently passing and falling short of the target	Agency spend is below the target for this month, which has particularly	There is a Trustwide monthly meeting on bank and agency spend to ensure that there are plans in place to reduce this expenditure.	N/A

Pounds



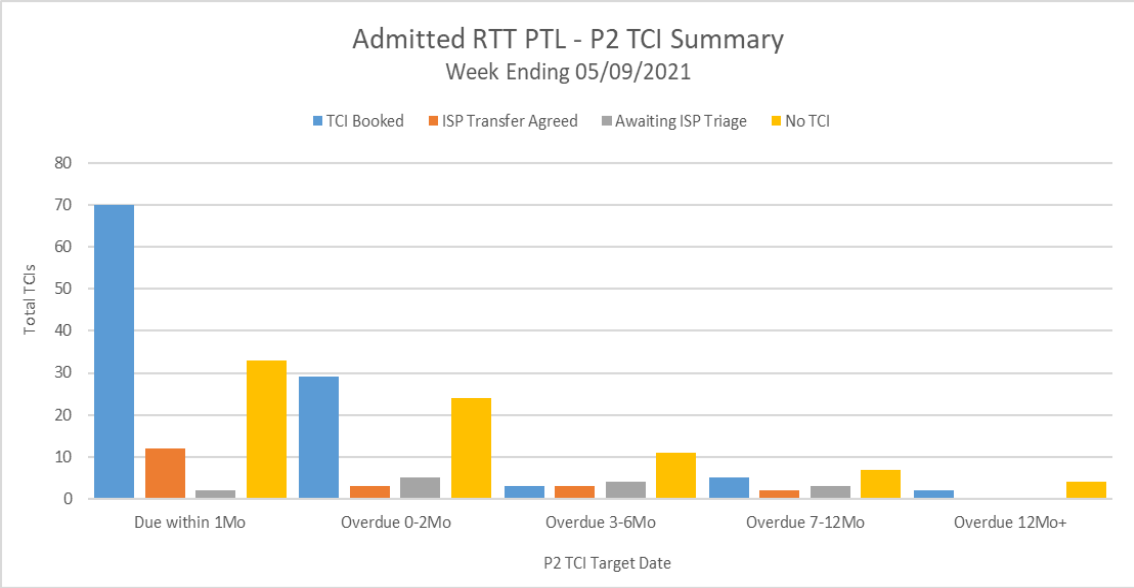
Aug-21
£7,776k
Variance Type
Common cause variation
Target
£7,873k
Target Achievement
Inconsistently passing and falling short of the target

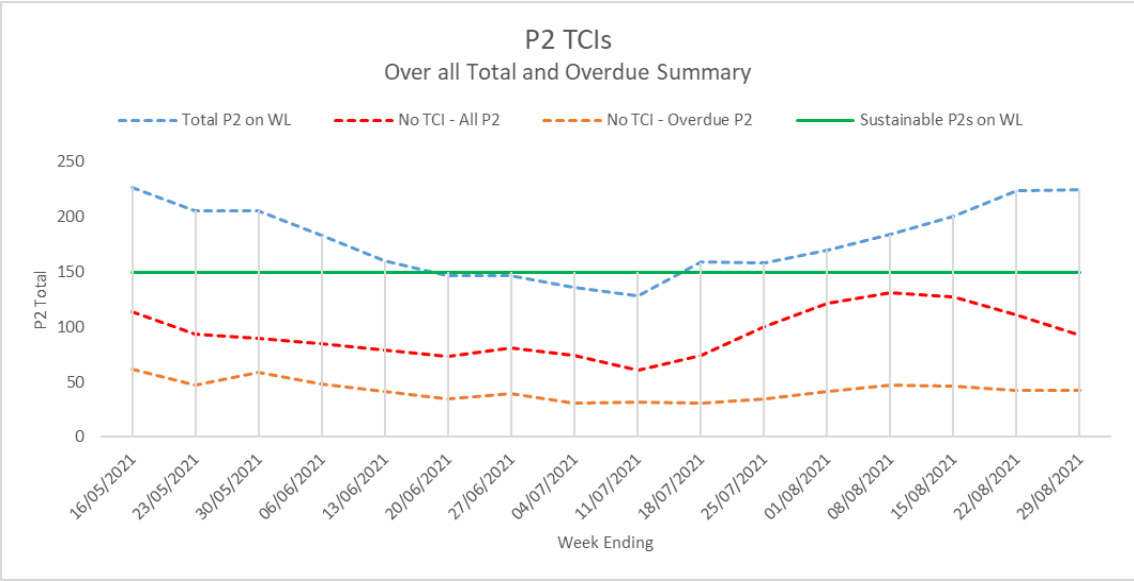
Background	What the chart tells us	Issues	Actions	Mitigation
Capital Spend	Common cause variation and inconsistently passing and falling short of the target	The capital plan has been reprofiled and spend is back on track against the revised capital plan.	The CWG is monitoring the capital spend on a monthly basis and will reprioritise the plan as and when needed	N/A

Pounds

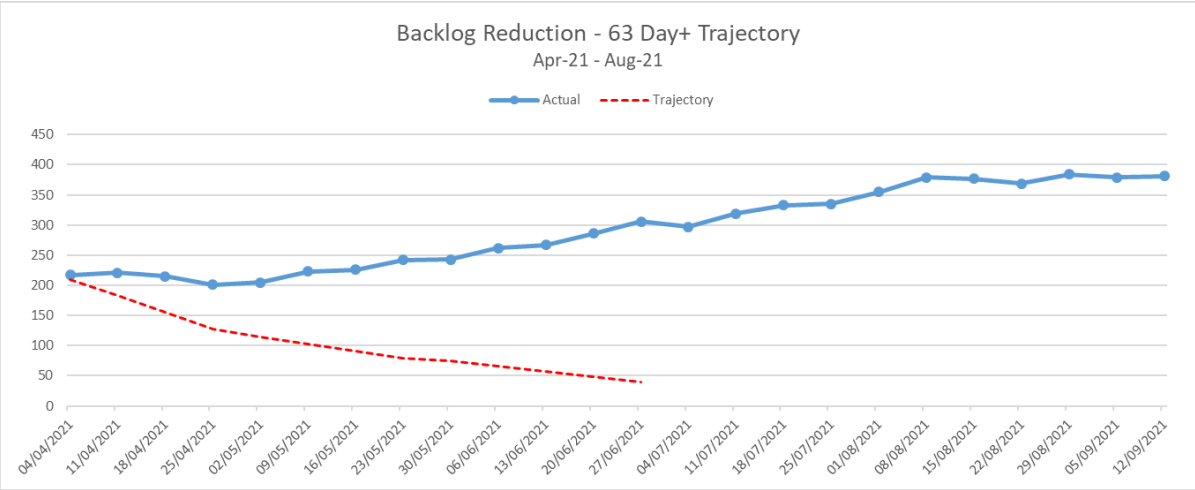
Appendix A – Recovery Dashboard

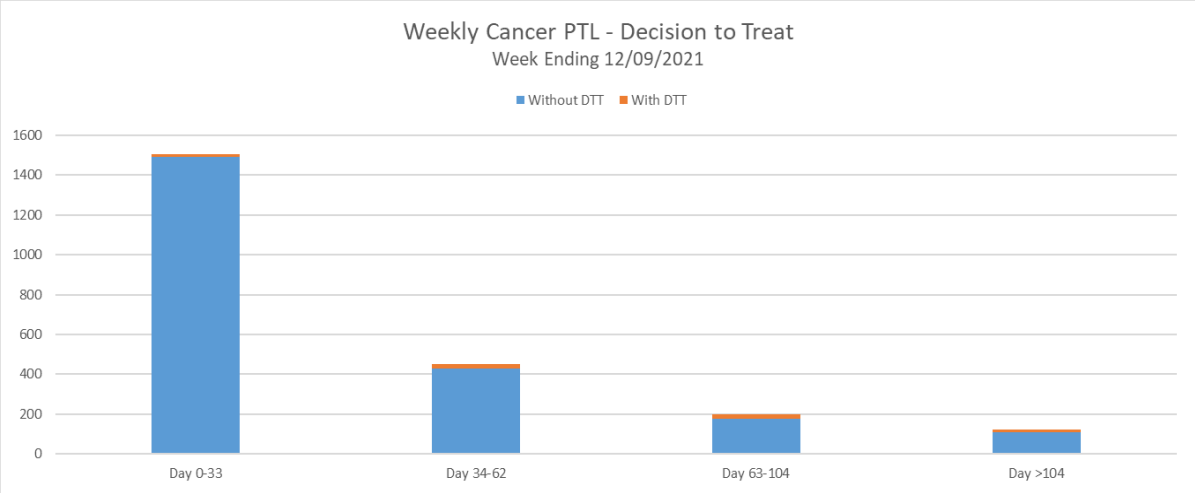
Clinical Prioritisation





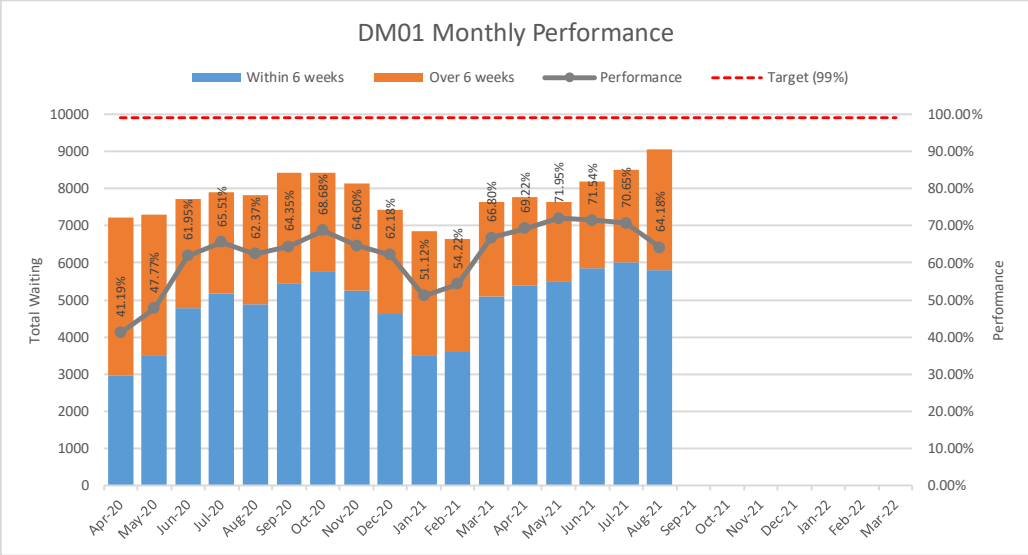
Cancer



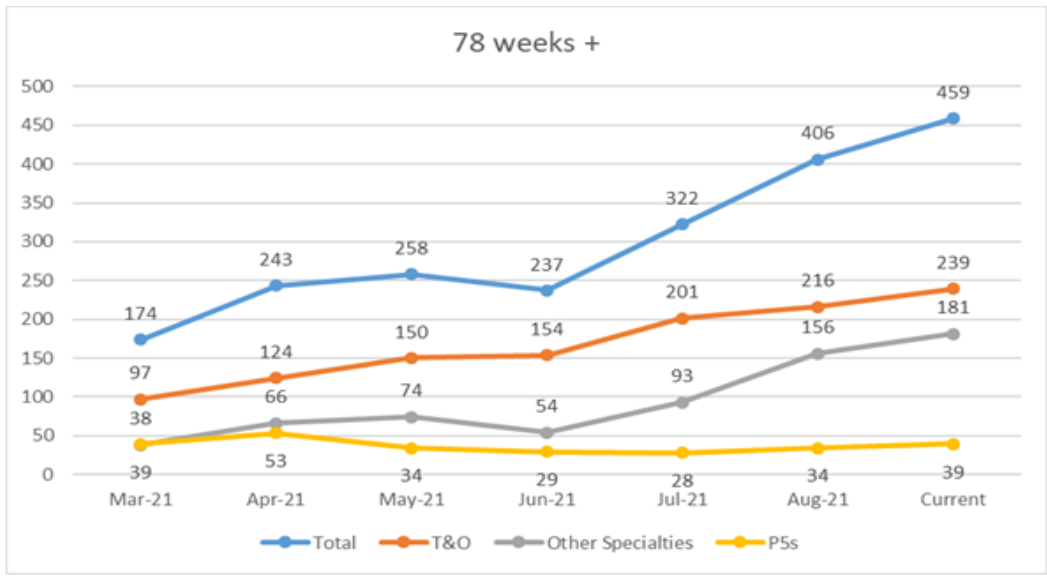


Month	Cancer Performance			
	2WW Performance	28 Faster Diagnosis Performance	31 Day Performance	62 Day Performance
Apr-19	91.0%	68.9%	100.0%	78.7%
May-19	92.6%	57.0%	97.8%	74.7%
Jun-19	91.1%	73.2%	98.1%	76.5%
Jul-19	94.1%	68.6%	99.0%	82.6%
Aug-19	89.9%	69.6%	98.9%	79.3%
Sep-19	87.3%	65.2%	99.1%	85.4%
Oct-19	84.1%	66.0%	100.0%	85.2%
Nov-19	86.1%	65.7%	100.0%	85.3%
Dec-19	86.7%	63.2%	97.9%	87.2%
Jan-20	91.9%	64.4%	94.4%	77.3%
Feb-20	95.7%	70.9%	96.9%	76.7%
Mar-20	93.2%	60.9%	97.1%	81.0%
Apr-20	87.4%	47.9%	95.1%	61.3%
May-20	93.4%	64.5%	90.7%	61.9%
Jun-20	77.6%	62.5%	86.9%	75.6%
Jul-20	85.9%	68.4%	91.1%	75.4%
Aug-20	74.4%	69.7%	87.1%	59.3%
Sep-20	68.7%	65.7%	90.2%	66.3%
Oct-20	81.7%	62.0%	87.4%	54.9%
Nov-20	72.1%	66.2%	92.6%	67.3%
Dec-20	89.2%	65.4%	93.7%	68.4%
Jan-21	90.6%	64.5%	89.3%	65.4%
Feb-21	88.9%	69.5%	87.5%	48.6%
Mar-21	97.5%	74.5%	93.3%	68.3%
Apr-21	76.4%	71.5%	93.5%	63.1%
May-21	79.0%	74.1%	100.0%	68.9%
Jun-21	79.7%	66.8%	96.2%	78.4%
Jul-21	71.9%	77.8%	92.6%	56.1%

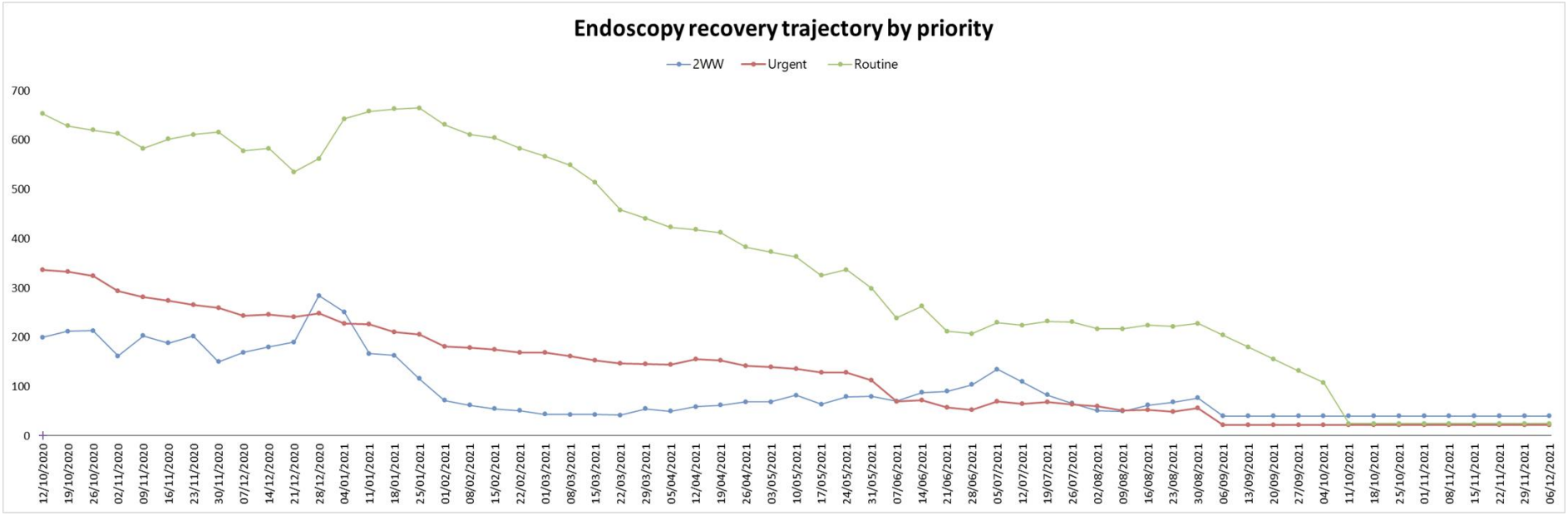
DM01


DM01 Monthly Performance
Within 6 weeks
Over 6 weeks
Performance
Target (99%)
Total Waiting
Perfomance
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
41.19%
47.77%
61.95%
65.51%
62.37%
64.35%
68.68%
64.60%
62.18%
51.12%
54.22%
66.80%
69.22%
71.95%
71.54%
70.65%
64.18%
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22

RTT


78 weeks +
500
450
400
350
300
250
200
150
100
50
0
174
243
258
237
322
406
459
97
124
150
154
201
216
239
38
66
74
54
93
156
181
39
53
34
29
28
34
39
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Current
Total
T&O
Other Specialties
P5s

Endoscopy


Endoscopy recovery trajectory by priority
2WW
Urgent
Routine
700
600
500
400
300
200
100
0
12/10/2020
19/10/2020
26/10/2020
02/11/2020
09/11/2020
16/11/2020
23/11/2020
30/11/2020
07/12/2020
14/12/2020
21/12/2020
28/12/2020
04/01/2021
11/01/2021
18/01/2021
25/01/2021
01/02/2021
08/02/2021
15/02/2021
22/02/2021
01/03/2021
08/03/2021
15/03/2021
22/03/2021
29/03/2021
05/04/2021
12/04/2021
19/04/2021
26/04/2021
03/05/2021
10/05/2021
17/05/2021
24/05/2021
31/05/2021
07/06/2021
14/06/2021
21/06/2021
28/06/2021
05/07/2021
12/07/2021
19/07/2021
26/07/2021
02/08/2021
09/08/2021
16/08/2021
23/08/2021
30/08/2021
06/09/2021
13/09/2021
20/09/2021
27/09/2021
04/10/2021
11/10/2021
18/10/2021
25/10/2021
01/11/2021
08/11/2021
15/11/2021
22/11/2021
29/11/2021
06/12/2021

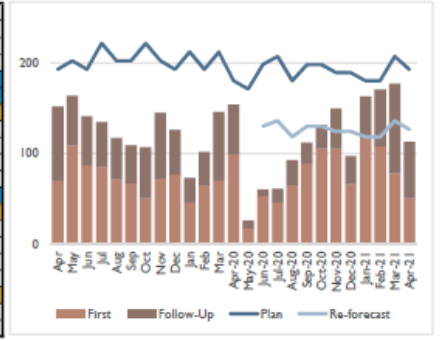
Appendix B – MSK Pathway

MSK Activity vs Plan (19/20, 20/21 & YTD 21/22)

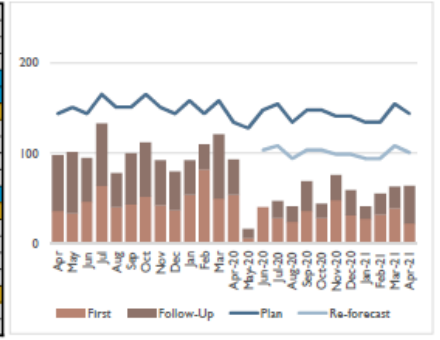
PRIMARY CARE - Stellar Healthcare Limited

PRIMARY CARE - SHL

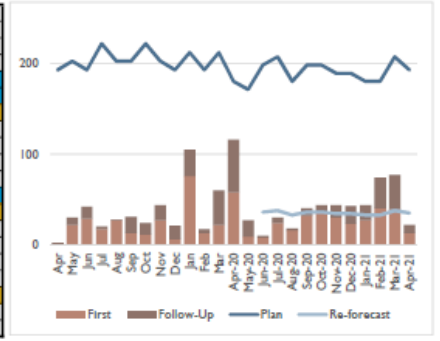
GPSI T&O		2019/20	Financial Month: Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
First	Actuals	868	70	109	87	85	71	67	50	72	77	46	64	70	99	17	53	46	65	89	105	105	66	117	108	78	50		
	Plan	1,534	121	127	121	139	127	127	139	127	121	133	121	133	113	107	124	130	113	124	124	119	119	113	113	130	121	115	133
	Rebased plan														73	70	73	76	70	73	73	70	76	70	67	76	73	70	73
	Re-forecast	60%															75	78	68	75	75	71	71	68	68	78	72	69	80
	Var	-666	-51	-18	-34	-54	-56	-60	-89	-55	-44	-87	-57	-63	-14	-90	-71	-84	-48	-35	-19	-14	-53	4	-5	-52	-71		
Follow-Up	Actuals	649	82	55	54	50	46	42	57	73	49	27	38	76	55	9	7	15	28	23	26	45	31	46	63	99	63		
	Plan	917	72	76	72	83	76	76	83	76	72	79	72	79	68	64	74	78	68	74	74	71	71	68	68	78	72	69	79
	Rebased plan															52	55	57	52	55	55	52	57	52	50	57	55	52	55
	Re-forecast	75%															56	58	51	56	56	53	53	51	51	58	54	51	60
	Var	-268	10	-21	-18	-33	-30	-34	-26	-3	-23	-52	-34	-3	-13	-55	-67	-63	-40	-51	-48	-26	-40	-22	-5	21	-9		
Total	Actuals	1,517	152	164	141	135	117	109	107	145	126	73	102	146	154	26	60	61	93	112	131	150	97	163	171	177	113		
	Plan	2,451	193	203	193	222	203	203	222	203	193	212	193	212	180	171	198	207	180	198	198	189	189	180	180	207	193	183	212
	Re-forecast																130	136	118	130	130	124	124	118	118	136	127	120	139
	Var	-934	-41	-39	-52	-87	-86	-94	-115	-58	-67	-139	-91	-66	-26	-145	-138	-146	-87	-86	-67	-39	-92	-17	-9	-30	-80		



GPSI Spine		2019/20	Financial Month: Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
First	Actuals	579	36	33	46	64	40	43	52	42	37	54	82	50	54	6	40	28	24	36	28	48	31	27	32	39	22		
	Plan	926	73	77	73	84	77	77	84	77	73	80	73	80	68	65	75	78	68	75	75	72	72	68	68	78	73	69	80
	Rebased plan														49	47	49	51	47	49	49	47	51	47	44	51	49	47	49
	Re-forecast	66%															50	52	45	50	50	47	47	45	45	52	48	46	53
	Var	-347	-37	-44	-27	-20	-37	-34	-32	-35	-36	-26	9	-30	-14	-59	-35	-50	-44	-39	-47	-24	-41	-41	-36	-39	-51		
Follow-Up	Actuals	633	62	68	49	69	38	57	60	50	43	38	28	71	39	10		19	17	33	16	28	28	14	23	24	42		
	Plan	902	71	75	71	82	75	75	82	75	71	78	71	78	66	63	73	76	66	73	73	70	70	66	66	76	71	67	78
	Rebased plan															51	53	56	51	53	53	51	56	51	49	56	53	51	53
	Re-forecast	74%															54	56	49	54	54	52	52	49	49	56	53	50	58
	Var	-269	-9	-7	-22	-13	-37	-18	-22	-25	-28	-40	-43	-7	-27	-53		-57	-49	-40	-57	-42	-42	-52	-43	-52	-29		
Total	Actuals	1,212	98	101	95	133	78	100	112	92	80	92	110	121	93	16	40	47	41	69	44	76	59	41	55	63	64		
	Plan	1,828	144	151	144	166	151	151	166	151	144	158	144	158	135	128	148	155	135	148	148	141	141	135	135	155	144	137	158
	Re-forecast																104	108	94	104	104	99	99	94	94	108	101	96	111
	Var	-616	-46	-50	-49	-33	-73	-51	-54	-59	-64	-66	-34	-37	-42	-112	-108	-108	-94	-79	-104	-65	-82	-94	-80	-92	-80		



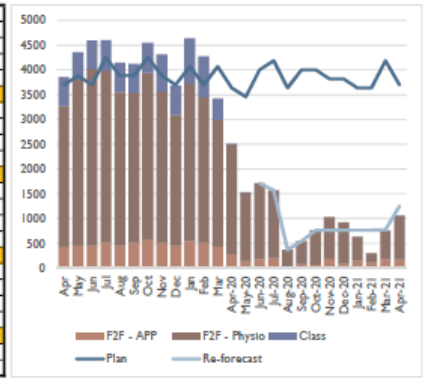
GPSI Rheumatology		2019/20	Financial Month: Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
First	Actuals	263		22	29	17	27	13	11	27	6	76	13	22	58	9	8	24	16	32	36	30	23	27	40	39	13		
	Plan	1,534	121	127	121	139	127	127	139	127	121	133	121	133	113	107	124	130	113	124	124	119	119	113	113	130	121	115	133
	Rebased plan														22	21	22	23	21	22	22	21	23	21	20	23	22	21	22
	Re-forecast	18%															22	23	20	22	22	21	21	20	20	23	22	21	24
	Var	-1271		-105	-92	-122	-100	-114	-128	-100	-115	-57	-108	-111	-55	-98	-116	-106	-97	-92	-88	-89	-96	-86	-73	-91	-108		
Follow-Up	Actuals	161	2	8	13	3	1	18	13	17	15	29	4	38	58	18	2	6	2	8	8	14	20	17	34	38	9		
	Plan	917	72	76	72	83	76	76	83	76	72	79	72	79	68	64	74	78	68	74	74	71	71	68	68	78	72	69	79
	Rebased plan														14	13	14	14	13	14	14	13	14	13	12	14	14	13	14
	Re-forecast	19%															14	14	12	14	14	13	13	12	12	14	13	13	15
	Var	-756	-70	-68	-59	-80	-75	-58	-70	-59	-57	-50	-68	-41	-10	-46	-72	-72	-66	-66	-66	-57	-51	-51	-34	-40	-63		
Total	Actuals	424	2	30	42	20	28	31	24	44	21	105	17	60	116	27	10	30	18	40	44	44	43	44	74	77	22		
	Plan	2,451	193	203	193	222	203	203	222	203	193	212	193	212	180	171	198	207	180	198	198	189	189	180	180	207	193	183	212
	Re-forecast																36	38	33	36	36	34	34	33	33	38	35	33	39
	Var	-2027	-191	-173	-151	-202	-175	-172	-198	-159	-172	-107	-176	-152	-64	-144	-188	-177	-162	-158	-154	-145	-146	-136	-106	-130	-171		



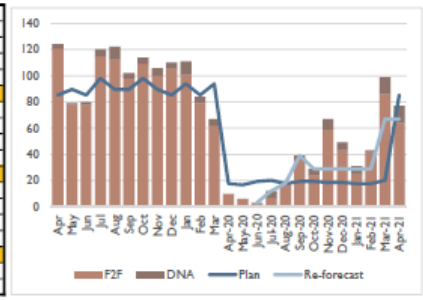
PRIMARY CARE - EPUT (Essex Partnership University NHS Trust)

COMMUNITY CARE - EPUT

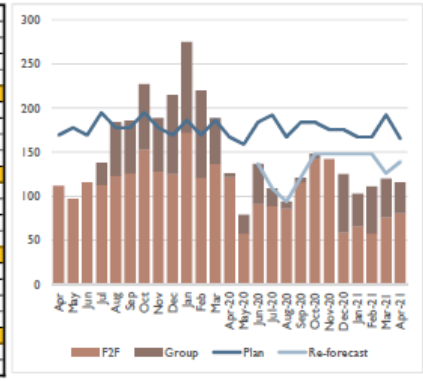
		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
			Financial Month																										
F2F - APP	Actuals	5,854	435	457	455	513	451	518	583	509	444	541	509	439	287	139	177	198	23	78	69	184	92	144	105	179	170		
	Plan	12,342	972	1020	972	1118	1020	1020	1118	1020	972	1069	972	1069	956	908	1051	1099	956	1051	1051	1003	1003	956	956	1099	972	923	1069
	Re-forecast																177	198	23	78	69	69	69	69	69	152	201	250	300
	Var	-6488	-537	-563	-517	-605	-569	-502	-535	-511	-528	-528	-463	-630	-669	-769	-874	-901	-933	-973	-982	-819	-911	-812	-851	-920	-802		
F2F - Physio	Actuals	37,083	2842	3343	3570	3472	3103	3014	3361	3053	2651	3181	2942	2551	2211	1385	1534	1371	348	467	695	847	826	489	201	578	876		
	Plan	28,925	2278	2391	2278	2619	2391	2391	2619	2391	2278	2505	2278	2505	2240	2128	2464	2576	2240	2464	2464	2352	2352	2240	2240	2576	2278	2164	2505
	Re-forecast																1534	1371	348	467	695	695	695	695	695	625	1050	1475	1900
	Var	8158	564	952	1292	853	712	623	742	662	373	676	664	46	-29	-743	-930	-1205	-1892	-1997	-1769	-1505	-1526	-1751	-2039	-1998	-1402		
Class	Actuals	7,640	584	559	568	617	594	589	605	754	584	923	828	435	17	3											17		
	Plan	5,732	451	474	451	519	474	474	519	474	451	496	451	496	444	422	488	510	444	488	488	466	466	444	444	510	451	429	496
	Re-forecast																												
	Var	1908	133	85	117	98	120	115	86	280	133	427	377	-61	-427	-419											-434		
Total	Actuals	50,577	3861	4359	4593	4602	4148	4121	4549	4316	3679	4645	4279	3425	2515	1527	1711	1569	371	545	764	1031	918	633	306	757	1063		
	Plan	49,628	3701	3886	3701	4256	3886	3886	4256	3886	3701	4071	3701	4071	3639	3457	4003	4185	3639	4003	4003	3821	3821	3639	3639	4185	3701	3516	4071
	Re-forecast																1711	1569	371	545	764	764	764	764	764	777	1251	1725	2200
	Var	949	160	473	892	346	262	235	293	430	-22	574	578	-646	-1124	-1930	-2292	-2616	-3268	-3458	-3239	-2790	-2903	-3006	-3333	-3428	-2638		



		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
			Financial Month																										
Pod Surg F2F	Actuals	1,158	121	78	78	115	112	98	109	100	105	101	79	62	10	6	2	7	18	36	24	59	43	25	42	86	64		
	Plan	1,083	85	90	85	98	90	90	98	90	85	94	85	94	18	17	19	20	18	19	19	18	18	18	18	20	85	81	94
	Re-forecast																2	7	18	36	24	24	24	24	24	59	59	59	59
	Var	75	36	-12	-7	17	22	8	11	10	20	7	-6	-32	-8	-11	-17	-13	0	17	5	41	25	7	24	66	-21		
DNA	Actuals	61	3	1	2	5	10	4	5	6	5	10	5	5			1	5		3	5	8	6	6	1	13	13		
	Plan	-																											
	Re-forecast																1	5		3	5	5	5	5	5	8	8	8	8
	Var	61	3	1	2	5	10	4	5	6	5	10	5	5			1	5		3	5	8	6	6	1	13	13		
Total	Actuals	1,158	121	78	78	115	112	98	109	100	105	101	79	62	10	6	2	7	18	36	24	59	43	25	42	86	64		
	Plan	1,083	85	90	85	98	90	90	98	90	85	94	85	94	18	17	19	20	18	19	19	18	18	18	18	20	85	81	94
	Re-forecast																3	12	18	39	29	29	29	29	29	67	67	67	67
	Var	75	36	-12	-7	17	22	8	11	10	20	7	-6	-32	-8	-11	-17	-13	0	17	5	41	25	7	24	66	-21		



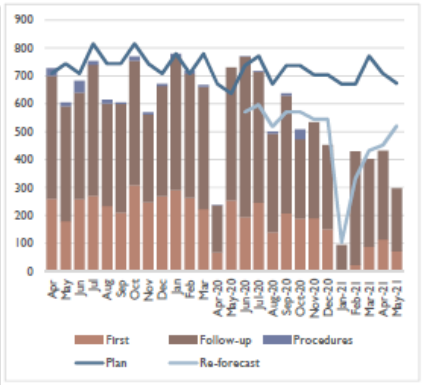
		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
			Financial Month																										
Pain service F2F	Actuals	1,323	112	97	116	113	123	126	153	128	125	172	121	137	122	58	91	89	86	116	142	142	59	66	58	76	81		
	Plan	1,029	81	85	81	93	85	85	93	85	81	89	81	89	80	76	88	92	80	88	88	84	84	80	80	92	79	75	87
	Re-forecast																91	89	86	116	142	142	142	142	142	70	80	90	100
	Var	494	31	12	35	20	38	41	60	43	44	83	40	48	42	-18	3	-3	6	28	34	58	-25	-14	-22	-16	2		
Group	Actuals	625				25	61	60	74	61	90	103	99	52	4	21	46	20	8	5	6		66	37	53	44	35		
	Plan	1,121	88	93	88	102	93	93	102	93	88	97	88	97	87	83	96	100	87	96	96	92	92	87	87	100	86	82	95
	Re-forecast																46	20	8	5	6	6	6	6	6	56	59	62	65
	Var	-496				-77	-32	-33	-28	-32	2	6	11	-45	-83	-62	-50	-80	-79	-91	-90		-26	-50	-34	-56	-51		
DNA	Actuals	761	15	27	32	44	66	80	88	93	78	86	80	72	46	22	29	35	16	33	160	109	62	66	55	55	44		
	Plan	58	5	5	5	5	5	5	5	5	5	5	5	5	5	4	5	5	5	5	5	5	5	5	5	5	5	4	5
	Re-forecast																29	35	16	33	160	160	160	160	160	57	59	61	63
	Var	703	10	22	27	39	61	75	83	88	73	81	75	67	41	18	24	30	11	28	155	104	57	61	50	50	39		
Total	Actuals	2,148	112	97	116	138	184	186	227	189	215	275	220	189	126	79	137	109	94	121	148	142	125	103	111	120	116		
	Plan	2,150	169	178	169	195	178	178	195	178	169	186	169	186	167	159	184	192	167	184	184	176	176	167	167	192	165	157	182
	Re-forecast																137	109	94	121	148	148	148	148	148	126	139	152	165
	Var	-2	-57	-81	-53	-57	6	8	32	11	46	89	51	3	-41	-80	-47	-83	-73	-63	-36	-34	-51	-64	-56	-72	-49		



SECONDARY CARE - The Princess Alexandra Hospital NHS Trust - OUTPATIENTS

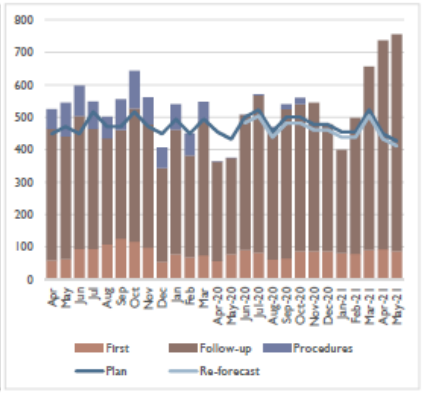
Orthopaedics

		2019/20	Financial Month: Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
First	Actuals	3,010	259	179	258	271	233	210	308	247	269	291	263	222	67	253	194	246	140	207	189	190	150	1	22	88	113	71	
	Plan	3,127	246	259	246	283	259	259	283	259	246	271	246	271	233	221	256	268	233	256	256	245	245	233	233	268	246	234	271
	Re-forecast	80%															205	214	186	205	205	196	196			50	100	187	217
	Var	-117	13	-80	12	-12	-26	-49	25	-12	23	20	17	-49	-166	32	-62	-22	-93	-49	-67	-55	-95	-232	-211	-180	-133	-163	
Follow-up	Actuals	4,978	441	412	381	469	368	390	447	315	394	478	444	439	169	477	575	470	353	423	285	344	302	94	408	314	319	226	
	Plan	5,534	436	458	436	501	458	458	501	458	436	479	436	479	412	392	453	474	412	453	453	433	433	412	412	474	436	414	479
	Re-forecast	80%															363	379	330	363	363	346	346	100	330	379	349	331	383
	Var	-556	5	-46	-55	-32	-90	-68	-54	-143	-42	-1	8	-40	-243	85	122	-4	-59	-30	-168	-89	-131	-318	-4	-160	-117	-188	
Procedures	Actuals	176	27	14	43	13	14	5	15	8	9	9	12	7	2		1	1	7	8	35	27	9				23		
	Plan	337	27	28	27	31	28	28	31	28	27	29	27	29	25	24	28	29	25	28	28	26	26	25	25	29	27	25	29
	Re-forecast	10%															3	3	3	3	3	3	3	3	3	3	3	3	3
	Var	-161	0	-14	16	-18	-14	-23	-16	-20	-18	-20	-15	-22	-23		-27	-28	-18	-20	7	1	-17				-4		
Total	Actuals	8,164	727	605	682	753	615	605	770	570	672	778	719	668	238	730	770	717	500	638	509	561	461	95	430	402	455	297	
	Plan	8,998	709	744	709	815	744	744	815	744	709	779	709	779	670	637	737	771	670	737	737	704	704	670	670	771	709	673	779
	Re-forecast																571	596	519	571	571	545	545	103	332	432	451	521	603
	Var	-834	18	-139	-27	-62	-129	-139	-45	-174	-37	-1	10	-111	-432	93	33	-54	-170	-99	-228	-143	-243	-575	-240	-369	-254	-376	



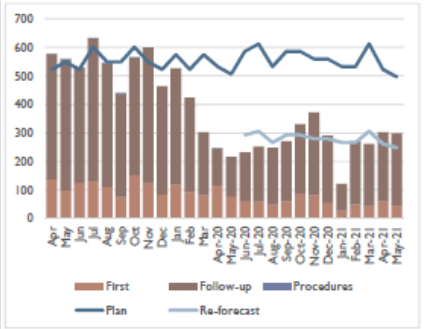
Rheumatology

		2019/20	Financial Month: Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
First	Actuals	1,027	59	62	94	94	107	125	116	97	54	77	68	74	56	77	91	82	61	65	86	87	86	81	79	90	92	87	
	Plan	825	65	68	65	75	68	68	75	68	65	71	65	71	66	63	72	76	66	72	72	69	69	66	66	76	65	62	71
	Re-forecast	100%															72	76	66	72	72	69	69	66	66	76	65	62	71
	Var	202	-6	-6	29	19	39	57	41	29	-11	6	3	3	-10	14	19	6	-5	-7	14	18	17	15	13	14	27	25	
Follow-up	Actuals	4,417	404	379	409	369	328	336	412	380	289	385	314	412	307	297	416	485	399	460	454	458	391	319	418	566	644	668	
	Plan	4,647	366	384	366	421	384	384	421	384	366	402	366	402	371	352	408	426	371	408	408	389	389	371	371	426	366	348	402
	Re-forecast	100%															408	426	371	408	408	389	389	371	371	426	366	348	402
	Var	-230	38	-5	43	-52	-56	-48	-9	-4	-77	-17	-52	10	-64	-55	8	59	28	52	46	69	2	-52	47	140	278	320	
Procedures	Actuals	976	62	104	95	86	66	94	115	84	63	78	68	61	1	1	1	3	9	15	20	26	15	15	9	12	5		
	Plan	226	18	19	18	20	19	19	20	19	18	20	18	20	18	17	20	21	18	20	20	19	19	18	18	21	18	17	20
	Re-forecast	10%															2	2	2	2	2	2	2	2	2	2	2	2	2
	Var	750	44	85	77	66	47	75	95	65	45	58	50	41	-17	-16	-19	-18	-9	-5	0	7	-4	-3	-9	-9	-13		
Total	Actuals	6,420	525	545	598	549	501	555	643	561	406	540	450	547	364	375	508	570	469	540	560	571	492	415	506	668	741	755	
	Plan	5,698	449	471	449	516	471	471	516	471	449	494	449	494	454	432	500	523	454	500	500	477	477	454	454	523	449	426	494
	Re-forecast																482	504	438	482	482	460	460	438	438	504	433	411	476
	Var	722	76	74	149	33	30	84	127	90	-43	46	1	53	-90	-57	8	47	15	40	60	94	15	-39	52	145	292	329	



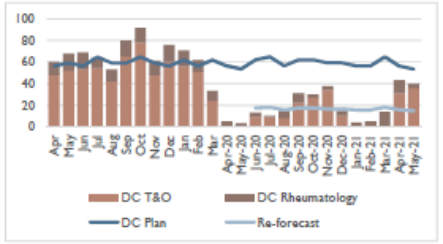
Physiotherapy

		2019/20	Financial Month: Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
First	Actuals	1,328	137	99	126	131	111	74	152	123	84	118	92	81	117	77	62	58	48	60	88	82	57	27	50	42	60	47	
	Plan	1,479	116	122	116	134	122	122	134	122	116	128	116	128	119	113	131	137	119	131	131	125	125	119	119	137	116	111	128
	Re-forecast	50%															65	68	59	65	65	62	62	59	59	68	58	55	64
	Var	-151	21	-23	10	-3	-11	-48	18	1	-32	-10	-24	-47	-2	-36	-69	-79	-71	-71	-43	-43	-68	-92	-69	-95	-56	-64	
Follow-up	Actuals	4,826	439	459	401	501	432	363	412	476	381	408	332	222	127	139	170	194	200	211	243	290	234	95	220	220	243	252	
	Plan	5,161	406	427	406	467	427	427	467	427	406	447	406	447	414	384	456	476	414	456	456	435	435	414	414	476	406	386	447
	Re-forecast	50%															228	238	207	228	228	217	217	207	207	238	203	193	224
	Var	-335	33	32	-5	34	5	-64	-55	49	-25	-39	-74	-225	-287	-255	-286	-282	-214	-245	-213	-145	-201	-319	-194	-256	-163	-134	
Procedures	Actuals	14	1	2	2	1	3	3	1	1					3							1					1		
Total	Actuals	6,168	577	560	529	633	546	440	565	600	465	526	424	303	247	216	232	252	248	271	331	373	291	122	270	262	304	299	
	Plan	6,640	523	549	523	601	549	549	601	549	523	575	523	575	533	506	586	613	533	586	586	560	560	533	533	613	523	497	575
	Re-forecast																293	306	266	293	293	280	280	266	266	306	261	248	288
	Var	-472	54	11	6	32	-3	-109	-36	51	-58	-49	-99	-272	-286	-290	-354	-361	-285	-315	-255	-187	-269	-411	-263	-351	-219	-198	



SECONDARY CARE - The Princess Alexandra Hospital NHS Trust - INPATIENTS

INPATIENTS			Financial Month																											
ELECTIVE		**2019/20**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
T&O	Actuals	640	51	59	56	50	50	50	64	52	54	54	69	31		1	19	16	40	50	68	25	3					22	21	
	Plan	714	*56*	*59*	*56*	*65*	*59*	*59*	*65*	*59*	*56*	*62*	*56*	*62*	*56*	*54*	*62*	*65*	*56*	*62*	*62*	*59*	*59*	*56*	*56*	*65*				
	Re-forecast	*80%*															*50*	*52*	*45*	*50*	*50*	*47*	*5*							
	Var	-74	-5	-0	-0	-15	-9	-9	-1	-7	-2	-8	13	-31		-53	-43	-49	-16	-12	6	-34	-56					22	21	
DC T&O	Actuals	631	48	52	53	54	42	65	78	48	60	56	51	24			9	9	8	22	27	34	10					31	36	
	Plan	581	*46*	*48*	*46*	*53*	*48*	*48*	*53*	*48*	*46*	*50*	*46*	*50*	*46*	*44*	*51*	*53*	*46*	*51*	*51*	*48*	*48*	*46*	*46*	*53*	*46*	*43*	*50*
	Re-forecast	*25%*															*13*	*13*	*11*	*13*	*13*	*12*	*12*	*11*	*11*	*13*	*11*	*11*	*13*
	Var	50	2	4	7	1	-6	17	25	-0	14	6	5	-26			-42	-44	-38	-29	-24	-14	-38					-15	-7	
DC Rheumatology	Actuals	158	12	16	16	10	11	15	14	13	16	15	11	9	5	3	4	1	7	9	3	4	5	4	5	14	12	4	
	Plan	133	*10*	*11*	*10*	*12*	*11*	*11*	*12*	*11*	*10*	*12*	*10*	*12*	*11*	*10*	*12*	*12*	*11*	*12*	*12*	*11*	*11*	*11*	*11*	*12*	*10*	*10*	*12*
	Re-forecast	*40%*															*5*	*5*	*4*	*5*	*5*	*4*	*4*	*4*	*4*	*5*	*4*	*4*	*5*
	Var	25	2	5	6	-2	0	4	2	2	6	3	1	-3	-6	-7	-8	-11	-4	-3	-9	-7	-6	-7	-6	2	2	-6	
Day Case Total	**Actuals**	**789**	**60**	**68**	**69**	**64**	**53**	**80**	**92**	**61**	**76**	**71**	**62**	**33**	**5**	**3**	**13**	**10**	**15**	**31**	**30**	**38**	**15**	**4**	**5**	**14**	**43**	**40**	
	DC Plan	**714**	*56*	*59*	*56*	*65*	*59*	*59*	*65*	*59*	*56*	*62*	*56*	*62*	*56*	*54*	*62*	*65*	*56*	*62*	*62*	*59*	*59*	*56*	*56*	*65*	*56*	*53*	*62*
	Re-forecast																*17*	*18*	*16*	*17*	*17*	*16*	*16*	*16*	*16*	*18*	*16*	*15*	*17*
	Var	**75**	**4**	**9**	**13**	**-1**	**-6**	**21**	**27**	**2**	**20**	**9**	**6**	**-29**	**-51**	**-51**	**-49**	**-55**	**-41**	**-31**	**-32**	**-21**	**-44**	**-52**	**-51**	**-51**	**-13**	**-13**	



The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 07/10/2021 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: George Wood – Chair of Audit Committee

DATE OF COMMITTEE MEETING: 06/09/2021

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
Annual Audit Committee Effectiveness Review 2020/21: Overall responses to the questions on the review checklist had been positive. The Committee's Terms of Reference (ToR) had been updated and were recommended to the Board for approval. **(Attached as Appendix 1)** **IA Progress report:** Two audits had been finalised since the last meeting, one of which provided a 'Substantial' level of assurance, and the other an advisory audit on EBME/Medical devices, therefore an assurance opinion was not applicable. **LCFS progress report:** The report was noted. **Waivers and losses:** During the period 1st April 2021 to 31st July 2021 were: • The value of losses and special payments totalled £ 172k (7 cases) • There were no debt write-offs for the period. The write off exercise will take place later in this financial year. • Waivers totalled £926k of which £95k were non-compliant. **External audit appointment**: A contract had been signed with KPMG as the new external auditors. It was noted at present Ernest and Young had not formally resigned.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee's progress against its Annual Work Plan is set out below:
The AC is making good progress against its annual work plan and will meet again on 6th December 2021.

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE

TERMS OF REFERENCE 2021/22

PURPOSE:

The Audit Committee (the Committee) shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance.

For the purposes of procuring the Trust's External Auditor, the Trust Board has nominated the Audit Committee to acts as its Auditor Panel in line with Schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

DUTIES:

The following comprise the Committee's main responsibilities:

Annual Work Plan and Committee Effectiveness

Agree an annual work plan with the Trust Board based on the Committee's purpose (above) and conduct an annual review of the Committee's effectiveness and achievement of the Committee work plan for consideration by the Trust Board.

Governance, Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee shall:

1. Review the risk and control related disclosure statements prior to endorsement by the Board; this shall include the Annual Governance Statement, Head of Internal Audit opinion, External Audit opinion and/or other appropriate independent assurances.
2. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
3. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's corporate objectives.
4. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks; this shall include Clinical Audit programme overseen by the Trust's Quality & Safety Committee.
5. Review the adequacy and effectiveness of policies and procedures:
    a. by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern
    b. to ensure compliance with relevant regulatory, legal and conduct requirements.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

1. Reviewing and approving the Internal Audit Strategy and annual Internal Audit Plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework).
2. Considering the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring co-ordination between the work of internal audit and external audit to optimise audit resources.
3. Conducting a regular review of the effectiveness of the internal audit function.
4. Periodically consider the provision, cost and independence of the internal audit service (not more than every five years unless circumstances require otherwise).

External Audit

The Committee shall review the findings of the external auditors and consider the implications and management's response to their work. In particular the Committee shall:

1. Discuss and agree with the external auditor, before the audit commences, the nature and scope of the external audit as set out in the annual plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.
2. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board;
3. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).
4. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.
5. Review the performance of the external audit service and report to the Public Sector Audit Appointments Ltd (PSAA) on any matters relating to the external audit service.

Annual Report and Accounts Review

The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board. The Committee shall review the annual report and financial statements before submission to the Board, particularly focusing on:

1. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
2. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
3. Changes in, and compliance with, accounting policies, practices and estimation techniques.
4. The meaning and significance of the figures, notes and significant changes.

5. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
6. Explanation of estimates or provisions having material effect.
7. The schedule of losses and payments.
8. Any unadjusted (mis)statements.
9. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
10. The letter of representation.

Annual Quality Account

The Committee shall seek assurance that:

1. The reporting in the Trust's Quality Account is in line with the Trust's quality priorities and performance and consistent with other sources of assurance on quality available to the Committee
2. The Quality Account presents a fair and balanced representation of the Trust's quality performance
3. The priorities for quality focus concur with those of the Trust's patients and its plans
4. External audit opinion confirms that the Quality Account meets statutory guidelines.

Governance Manual

1. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
2. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
3. Review the schemes of delegation and authority.

Management

The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

Counter Fraud/Bribery/Corruption Arrangements

The Committee shall ensure that the Trust has in place:

1. Adequate measures to comply with the ~~Directions to NHS Bodies on Counter Fraud Measures 2004~~Government Functional Standard GovS 013: Counter Fraud.
2. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
3. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with the Secretary of State's Directions on Fraud and Corruption.

The following comprise the Auditor Panel's main responsibilities:

Procurement of External Audit

In its capacity as Auditor Panel, the Committee shall:

1. Agree and oversee a robust process for selecting the external auditors in line with the Trust's procurement processes and rules.
2. Advise the Board on the selection and appointment of the External Auditor.
3. Ensure that any conflicts of interest are dealt with effectively.
4. Advise the Board on the maintenance of an independent relationship with the appointed External Auditor.
5. Advise the Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.
6. Approve the Trust's policy on the purchase of non-audit services from the appointed external auditor.
7. Advise the Board on any decision about the resignation or removal of the External Auditor.

ACCOUNTABLE TO: Trust Board.

REPORTING ARRANGEMENTS: A regular written report from the Committee shall be produced for the Board of Directors by the Committee Chairman and Lead Executive. It shall highlight areas of focus from the last meeting and demonstrate progress against the Committee annual work plan.

The Committee shall report to the Board of Directors at least annually:

- on its work in support of the Annual Governance Statement, (specifically commenting on the fitness for purpose of the Assurance Framework)
- the extent to which risk management processes are embedded within the organisation
- the integration of governance arrangements
- the appropriateness of evidence compiled to demonstrate fitness to register with the Care Quality Commission
- the robustness of the processes behind the Quality Account and the development of the Quality Report through a report from the Quality & Safety Committee.

The Chair of the Auditor Panel shall produce a report from the Panel outlining how it has discharged its duties.

CHAIRMAN Non-Executive Director.

COMPOSITION OF MEMBERSHIP: Members of the Committee shall be appointed from amongst the Non-Executive Directors and shall consist of not less than three members including the Committee Chairman, at least one of whom shall have recent and relevant financial experience. The Trust Chairman will not be a member of the Committee. Members of the Performance & Finance Committee and the Quality & Safety Committee shall be among the members of the Audit Committee.

The Auditor Panel shall comprise the entire membership of the Audit Committee. All members of the Auditor Panel will be independent Non-Executives Directors.

ATTENDANCE

Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee meetings within each reporting year. An attendance record will be held for each meeting and an annual register of attendance will be included in the Committee's annual report to the Board.

In addition to the members of the Committee, the following will be invited to attend each Committee meeting:

- Director of Finance ~~Chief Financial Officer~~ and Deputy Director ~~f~~of Finance ~~Chief Financial Officer~~
- Executive Lead for Risk Management
- Representatives from Internal Audit, External Audit and the Local Counter Fraud Service.

At least once a year, the Committee shall meet privately with the internal and external auditors.

The Chief Executive shall be invited to attend the Committee at least annually to discuss the process for assurance that supports the Annual Governance Statement. This shall be when the Committee formally considers the annual reports and accounts prior to Board approval.

To ensure appropriate accountability, other Executive Directors and, if required, members of the management team will be invited to attend when the Committee is discussing areas of risk or operation that are their responsibility.

The Chair of the Auditor Panel may invite Executive Directors and others to attend meetings of the Panel. However, these attendees will not be members of the Auditor Panel.

DEPUTISING ARRANGEMENTS

In the absence of the Committee Chairman, the Audit Committee shall be chaired by one of the Non-Executive Director members of the Committee.

Other deputies may attend but must be suitably briefed and designated and notified in advance, where possible.

QUORUM:

The quorum for any meeting of the Committee shall be the attendance of a minimum of two members. Each member shall have one vote and in the event of votes being equal, the Chairman of the Committee shall have the casting vote.

The quorum for any meeting of the Auditor Panel shall be the attendance of a minimum of two members.

DECLARATION OF INTERESTS

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

MEETING FREQUENCY:

There shall be four meetings of the Committee each year with additional meetings where necessary. This includes a meeting to focus on the pre-Board consideration of the Annual Reports and Accounts which will only consider usual business by exception.

The Auditor Panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the Committee.

MEETING ORGANISATION

Audit Committee

- Meetings of the Committee shall be set before the start of the financial year.
- The meeting shall be closed and not open to the public.
- The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees not less than five clear days* before the date of the meeting.

Auditor Panel

- The meeting shall be closed and not open to the public.
- The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees not less than five clear days* before the date of the meeting.
- The agenda items for discussion by the Auditor Panel shall be clearly distinguished from the items for discussion by the Committee.
- The minutes of the Auditor Panel shall be separate from the minutes of the Committee.

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

AUTHORITY

The Committee is constituted as a Committee of the Trust Board. Its constitution and terms of reference shall be as set out above, subject to amendment by the Board as necessary.

The Committee and the Auditor Panel are authorised by the Board of Directors to investigate any activity within these terms of reference. They are authorised to seek any information they require from any employee, and all employees are directed to co-operate with any request made by the Committee and Auditor Panel.

The Committee and the Auditor Panel are authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if they consider this necessary and to seek advice and support from the Head of Corporate Affairs and external experts as required.

TERMS OF REFERENCE

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

DATE APPROVED

By Committee: ~~7~~6 September 2021~~0~~
By Trust Board:

TO BE REVIEWED ANNUALLY

Next review due: September 202~~1~~2

The Princess Alexandra Hospital NHS Trust

6.1

AUDIT COMMITTEE MEMBERSHIP

Membership and Those in Attendance	
Members	
George Wood	**Non-Executive Director and Committee Chair**
Helen Howe	Non-Executive Director
Pam Court	Non-Executive Director
In Attendance (Board)	
Saba Sadiq	Director of Finance
Lance McCarthy	Chief Executive Officer
Fay Gilder	Chief Medical Officer
In Attendance (Internal & External Audit)	
Neil Abbott	tiaa
Dean Docherty~~Hannah Wenlock~~	tiaa (LCFS)
~~Debbie Hanson~~	~~Ernst & Young~~
~~Natalie Clarke~~	~~Ernst & Young~~
Dean Gibbs	KPMG
Amy Thompson	KPMG
Invited	
~~Simon Covill~~	Deputy ~~Chief Finance Officer~~ Finance Director
Secretariat	
Heather Schultz	Head of Corporate Affairs
Becky Warwick	Corporate Governance Officer

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS – 07.10.21 **Agenda Item: 6.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)
REPORT FROM: John Hogan – Acting QSC Chair
DATE OF COMMITTEE MEETING: 24.09.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **Infection Prevention & Control Update:** In terms of nosocomial infections the organisation was performing well and was one of only two organisations in the region with no outbreaks, part of which was due to the successes of its screening programme. In response to a request for COVID numbers by ethnic group, a discussion was undertaken on the difficulties in recording patient ethnicity at the time of admission, albeit the organisation was not an outlier in this regard.

- **ED Deep Dive:** Members of the Urgent & Emergency Care team provided an update on continuing current pressures in terms of attendances. The Committee was also updated on current considerations to treat lower acuity patients in more innovative ways in order to free up capacity and time in the ED for more seriously ill patients.

- **CQC 'must and shoulds':** The report was received for assurance in terms of the QPMO approach, oversight and new methodology in relation to rag rating progress. It also updated on the progress made to date against CQC findings (must & should), any new arising quality projects or issues, and risks to the programme and the projects. The introduction and implementation of the QPMO would drive forward the evidence base and progress against the organisation's Quality Improvement Plan. The Committee was pleased to note that of the 43 original 'must and should' actions, only 13 now remained red. (All actions had been rated as red at the start by the QPMO). QSC would continue to monitor progress on a monthly basis.

- **Annual Reports:** Annual Reports were presented and noted for Safeguarding Adults and Children and for Research & Development.

- **BAF Risks:** BAF Risk 1.0 (COVID): It was agreed the risk score would remain at 16. BAF Risk 1.1 (Variation in Clinical Outcomes): It was agreed the score would remain at 16 (despite the recent good news around HSMR there had once again been no data available that month on HSMR due to external issues).

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

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

- Medicine Healthcare Group Performance Update
- CQC Visit Update
- Report from Clinical Compliance Group
- Report from Clinical Effectiveness Group
- Report from Strategic Learning from Deaths Group (verbal)
- Learning from Deaths Update (verbal)
- Action Plan for PAH following Trauma Network Peer Review Visit (May 2021)
- Report from Patient Safety Group
- Report from Patient Experience Group
- Patient Safety, Quality & Effectiveness Update
- Update from Patient Panel
- Maternity SI Report
- M5 Integrated Performance Report
- Review List/ASI Update
- CQC Insight Report

• Horizon Scanning
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
• The Committee continues to make good progress against its work plan. .

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 07.10.21 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: New Hospital Committee (NHC)
REPORT FROM: Lance McCarthy (Committee Chair)
DATE OF COMMITTEE MEETING: 27.09. 21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

New Hospital Programme (NHP) Update:

- The National Design Convergence Review (DCR): A meeting between all pathfinder schemes and the national NHP had been called for 04.10.21 at which the national NHP would present the 'roadmap' for the pathfinder schemes.
- Planning Permission: Confirmation had been received from the planners at EFDC, HDC & ECC that they were content for the updated Planning Position Statement to be signed by all concerned which was very positive news.
- Commercial Strategy: The national NHP team was developing a Commercial Strategy for the delivery of the NHP programme, details of which had been shared with pathfinder organisations on 20.09.21.

Land Purchase:

- Negotiations for the purchase of the land continued.

New Hospital BAF Risk (3.5):

- In line with the recommendation it was agreed that the risk score should remain at 16.

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

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

- Standing agenda items including programme risks.
- Finance Update.

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

The Committee is making good progress against its AWP.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 07/10/21 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: Workforce Committee (WFC)
REPORT FROM: Helen Howe (Committee Chair)
DATE OF COMMITTEE MEETING: 27/09/21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

GMC Survey: The Committee received an update on the outlier areas in the annual GMC survey results. The 2021 GMC survey results were published in July 2021. The Royal College Tutors were asked to respond to the outlying areas with an improvement plan. It was noted HEE would be conducting their Engagement Visit to the departments of Emergency Medicine and Medicine on 12th October 2021. The committee noted that the survey had taken place during the pandemic and that the organisation had been amongst the hardest hit but expressed disappointment in the results and will receive an update on the action plan.

Quarterly Guardian of Safer Working (GoSW) Report: The GoSW gave an update on the exception reports made in the 3 month period April to June and highlighted the issues affecting safe working practices of junior doctors as well as the actions being taken to resolve them. The exception reports highlighted an urgent issue regarding the perceived lack of staff and senior support for junior doctors both in medicine and surgery. A work schedule review was initiated on Locke Ward and actions are being progressed. Progress will be monitored through the quarterly updates.

Annual Report on Medical Revalidation and Appraisals: The Committee received the report which related to the Appraisals & Revalidation 2020/21 for the permanent medical staff of The Princess Alexandra Hospital NHS Trust (PAHT). The Committee recommended the report to the Trust Board.

Annual Report on Equality, Diversity and Inclusion: The Committee received and approved the contents of the report, which provides assurance to the Board on the Trust's progress in Equality, Diversity & Inclusion in respect of the Equality Act 2010 and summarised key actions for 2021-22. The Workforce Race and Disability Equality Standards and the Gender Pay Gap report was included within the report.

Lessons Learnt – Employment Tribunal: The Committee received an update on a recent employment tribunal case. Following on from the case, a process had now been put in place to test rationale for withdrawal of offers prior to offers being withdrawn.

BAF risk 2.3 Inability to recruit, retain and engage our people: The Committee approved the change in the risk score from 12 to 16; in light of the staff survey results, Deloitte survey and Pulse survey. It was agreed the target score would remain at 8, with an extended target date of March 2023 from March 2022.

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

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

- Communications Update
- External Review of E-Rostering System
- Safer Nurse Staffing
- People Board update
- New Hospital – Workforce work stream update
- Staff Survey Response Plan

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

The Committee continues to make progress against its work plan and will meet again on 29th November 2021.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS – 07.10 .21 **Agenda Item: 6.1**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Pam Court - PAF Chairman
DATE OF COMMITTEE MEETING: 30.09.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **M5 Update** – **Income and Expenditure:** The H1 financial plan was a break-even plan. The YTD position for M5 was a surplus of £0.1m which had been delivered by a combination of income over-performance (income of £0.5m has been recognised to offset recovery activity expenditure) and pay and non-pay underspends. Temporary staffing costs had shown a small increase to £2.0m in month compared to July's £1.9m.

- **Capital:** The capital resource limit was £19.9m. YTD spend was £7.8m and was behind the re-profiled plan of £7.9m by £0.1m. The capital programme has an overplanning margin of £3.4m which the CWG is working mitigations to reduce prior to year-end.

- **Elective Recovery Fund (ERF):** YTD ERF had generated £3.6m income and there was expected to be expenditure of £3.1m in terms of recovery activity. Therefore, an income provision of £0.5m was included in the financial performance.

- **Cost Improvement Programme (CIP):** The CIP target for M5 was £1.9m with a current achievement against that of £0.8m so £1.1m behind plan. It was agreed there was more work to be done to identify additional projects, one of which would be theatre productivity.

- **Vascular Network Business Case (Combined Outline/Full business case):** This was presented and endorsed for Board sign-off.

- **Health & Safety Executive:** The HSE would undertake an inspection over three days in October. All pre-inspection paperwork had been submitted.

- **BAF Risks:** The risk scores for BAF Risk 5.1 (Revenue) and 5.2 (Capital) to remain at 12. BAF Risk 4.2 (ED 4 hour emergency standard) score to increase to 20. BAF Risk 1.2 (EPR) score to remain at 16 and BAF Risk 3.1 (Estate & Infrastructure) score to remain at 20. Actions in progress for each of the risks were noted in the supporting papers.

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

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

- M5 Integrated Performance Report
- Monthly Electronic Health Record Update
- ICS Procurement Update
- Annual Operating Plan Update
- Better Payment Practice Code Update
- Integrated Performance Report
- Contracts Register
- Service Line Reporting Update
- Bi-monthly New Hospital Update
- Sustainability & Development Plan Update
- Bi-monthly Health & Safety Update.
- Report from Health & Safety Committee
- Report from Capital Working Group

The Princess Alexandra Hospital NHS
NHS Trust

SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee continues to make progress against its work plan.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 7 October 2021 **Item No:**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy - Chairman
DATE OF MEETINGS: **14.09.21 and 21.09.21**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

- The following items were discussed at SMT meetings in September:

14 September 2021:

- CQC Update including Section 31 Notice
- Quality Briefing
- Significant Risk Register
- Ward Refurbishment Update
- RSV Surge Plan
- Guardian of Safer Working
- Update on Clinical Director/PS&Q Appointments
- Update on General Manager Appointments
- Pulse Survey
- Integrated Performance Report (IPR)
- M5 Financial Performance and H2 21/22 planning
- Capital Programme Update

21 September 2021:

- Deloitte Well Led Action Plan Update
- Whole Organisational Response - Urgent Care Pathway
- Patient Safety & Quality Strategy
- Patient Initiated Follow UP (PIFU)
- Board Risk Management & Appetite Discussion
- Capital Programme

6.1