The Princess Alexandra Hospital NHS Trust

AGENDA

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

Date and time: Thursday 1 April 2021
09.00 – 12.30

Venue: Microsoft Teams Meeting

	Item	Subject	Action	Lead	
01 Opening Administration					
09.00	1.1	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from previous meeting	Approve	Chairman	5
	1.4	Matters Arising and Action Log	Review	All	15
09.05	Staff story: *Experience of Being an International Nurse at PAHT*				
02 Risk					
09.30	2.1	CEO's Report including: • Covid-19 update	Inform	Chief Executive	17
09.40	2.2	Significant Risk Register	Review	Director of Nursing & Midwifery	26
09.50	2.3	Board Assurance Framework 2020-21	Review/ Approve	Head of Corporate Affairs	31
03 Patients					
10.05	3.1	ED: CQC inspection	Discuss/ review	Chief Executive/ Executives	47
10.25	3.2	Learning from Deaths (Mortality)	Discuss	Medical Director	58
10.35	3.3	Maternity: • SI report • External review	Assure	Director of Nursing & Midwifery	64
10.50	3.4	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing & Midwifery	67
04 People					
11.00	4.1	Staff survey results and improvement plan	Discuss/ Approve	Director of People	74
11.15	4.2	Gender Pay Gap	Approve	Director of People	154
11.30		**BREAK**			
05 Performance					
11.40	5.1	Integrated Performance Report	Discuss	Executives	159
06 Places					
12.00	6.1	New Hospital Programme	Discuss	Chief Executive	200

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07 Governance					
12.10	7.1	Reports from Committees: • AC.08.03.21 • CFC.10.03.21 • NHC.22.03.21 • PAF.25.03.21 • QSC.26.03.21 • WFC.29.03.21 • SMT.09.03.21,16.03.21 and 23.03.21	Inform/ Approve	Chairs of Committees	205 206 207 208 209 Verbal 211
08 Questions from the Public					
	8.1	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.			
09 Closing Administration					
	9.1	Summary of Actions and Decisions	-	Chairman/All	
	9.2	New Risks and Issues Identified	Discuss	All	
	9.3	Any Other Business	Review	All	
12.30	9.4	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 Chairman	Steve Clarke	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
NExT NED	Darrel Arjoon	Director of Quality Improvement	Jim McLeish

Associate NED	Anne Wafula-Strike	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 4 February 2020 from 09:30 – 11:45

Present:	
Steve Clarke	**Trust Chairman (TC)**
Dr. Amik Aneja	General Practitioner (GP-AA), Board Advisor
Darrel Arjoon	NExT Non-Executive Director (NNED-DA)
Darshana Bawa	NExT Non-Executive Director (NNED-DB)
Pam Court	Non-Executive Director (NED-PC)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Phil Holland	Chief Information Officer (CIO)
Helen Howe	Non-Executive Director (NED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Lance McCarthy	Chief Executive Officer (CEO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Saba Sadiq	Director of Finance (DoF)
George Wood	Non-Executive Director (NED-GW)
In attendance:	
Laura Warren	Associate Director - Communications
Members of the Public	
Andrew Ripp	Styker
Clare Rose	Crown Commercial
Alan Leverett	Member of Public
Apologies:	
None	
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chairman (TC) welcomed all to the virtual Board meeting particularly Saba Sadiq attending her first public Board meeting as the new Director of Finance (DoF), Phil?the two new NExT NEDs (Darrel Arjoon and Darshana Bawa) and the three members of the public listed above. He also advised that the Board had successfully recruited a new Associate Non-Executive Director Anne Wafula-Strike, who would join the Board later that month.
1.1 Apologies	
1.2	No apologies were noted.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Meeting held on 03.12.20	
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	There were no matters arising and the action log was noted. In relation to action ref: TB1.03.12.20/09 (BAME Staff Story) it was agreed one would be presented to April's public meeting, in place of the scheduled one which had been deferred the previous year due to the pandemic.
02 RISK	
2.1 CEO's Report	

2.1	The CEO presented his report and in terms of performance indicators, highlighted that the impact of COVID had significantly affected the hospital's ability to maintain services in the normal way.
2.2	In terms of COVID he formally reiterated his thanks to all staff for their hard work, response to the pandemic and flexibility throughout. Numbers of new infections in the local community continued to decline as did new COVID admissions to the hospital and to critical care. He drew members' attention to the graphs in the paper and in particular the large number of positive cases during the week of New Year (219 inpatients) followed by a continued reduction in numbers aligned to the current period of national lockdown. The significant increase in demand had meant at one point that nine wards had been converted to COVID positive areas to ensure that pathways remained separate to non-COVID pathways. He reminded colleagues that Paediatric ED and 'red' ED had swapped locations to better manage patient flows and a 'red' ITU had also been established. Over the previous six weeks critical care had seen up to a maximum of 25 patients but the organisation had been supported well by the Regional Critical Care Network in terms of transfers out, and had itself also taken patients from other units, ensuring all patients had access to the right care, quickly.
2.3	The CEO continued that hospital had seen significant absence rates amongst its staff, which at one point had reached 14%. A formal staff redeployment programme was now operating and there had been huge support from staff agreeing to work in and support areas under more pressure than others.
2.4	He informed members that COVID had significantly impacted on the provision of services particularly on elective surgery. The focus therefore had been on the top two priority groups (P1 and P2) and obviously to maintain cancer surgery. However, elective surgery had had to stop due to the lack of critical care beds. In response to that significant additional diagnostic capacity had been introduced to manage cancer patients and to work with other units in the independent sector to maximise access for as many patients as possible. As further assurance he was able to confirm that patients who had been waiting longer than the agreed national standard were being reviewed and reprioritised on a regular basis by the clinical teams.
2.5	As a final point of which colleagues were aware, the hospital had opened a vaccination hub on 06.01.21 for the immunisation of its staff and other health and social care colleagues. Between then and 02.02.21 it had vaccinated 6829 individuals including just over 77% of its own staff. Work was now underway to ensure the remaining 23% of staff were provided with as much information as possible to support their choice. In response to recent media coverage regarding the take up of vaccinations by BAME staff he was able to confirm that 69.5% of BAME staff and 81.5% of non-BAME staff had received the vaccine.
2.6	The CEO updated that the hub was now closed as all colleagues had received their first dose, and would re-open in March to provide booster doses. Discussions were underway currently to see whether the hospital could support the primary care network (PCN) in terms of their mass vaccination programme in the Harlow Leisure Zone.
2.7	In terms of health and wellbeing support for staff during the pandemic that had continued during wave two and he reiterated his thanks to colleagues at EPUT who had supported a huge range of services for staff and also to the Trust's own People and SHAW teams who had done the same. Conversations were now underway to create a recovery plan for staff (and also for services) over coming weeks.
2.8	In response to the above NED George Wood (NED-GW) asked if the organisation had any indications of the percentage of patients previously discharged who would now be requiring ongoing support for respiratory (and/or other) conditions. In response it was noted that he exact percentage was not available at that time but rehab COVID clinics had been established in conjunction with primary and community care to support patients going forward. The Chief Operating Officer (COO) agreed to report back with a figure.
ACTION **TB1.04.02.21/10**	**Provide a figure for the percentage of COVID patients discharged from the hospital who were now requiring support for ongoing COVID-related conditions.** **Lead: Chief Operating Officer**

2.9	In response to the above the Medical Director (MD) updated that from a regional MDs call the previous day it had been suggested that provision to support ongoing COVID related conditions was currently insufficient and numbers of patients were unknown. That was therefore now being discussed at national level particularly in terms of resourcing and funding.
2.10	NED Helen Howe (NED-HH) asked if the reasons were clear for those staff who had not been vaccinated. In response it was confirmed by the Director of Quality Improvement (DoQI) that the analysis was still underway but he was able update there were concerns for some around the impact on fertility and others were holding out for the Oxford/AstraZeneca vaccine which they were now able to access at the mass vaccination centre. Further information had been provided to those who were uncertain about having the vaccine and there had been in an uplift in numbers since then.
2.11	In response to the discussion around rehab clinics the General Practitioner/Board Advisor (GP/BA) was able to update there had currently been circa 200 referrals to those in the area with a further 60 patients on the waiting list. He also acknowledged the impact on mental health services and the concerns around patients who had avoided accessing secondary care due to fears associated with the pandemic. His view was that what lay ahead for healthcare colleagues would be a huge mountain to climb which would require careful thinking in terms of the workforce which might be required to manage the demand going forward.
2.12	The CEO thanked the GP/BA for his update and stated that the hospital had seen a small drop in cancer referrals, a reason it had increased its diagnostic capacity. ED presentations had fallen during the pandemic and for non-COVID patients, those attending were more acutely unwell. The One Health & Care Partnership (OHCP) provided an opportunity to make a difference and to work as a system to provide the right resources to manage those later presentations. At this point the GP/BA advised that as of April he would be the Clinical Director for the Harlow North PCN which he was sure would only strengthen relationships between primary and secondary care to the benefit of patients. Board members congratulated the GP/BA on his appointment and stated they very much looked forward to working with him.
2.13	Moving to capital, the CEO continued that the organisation had continued to drive progress in terms of capital developments on site with the key one being the opening (first floor) of the new Adult Assessment Unit (AAU) in January. That would provide much needed additional capacity and enable improved flow of patients out of the ED.
2.14	In terms of PAHT2030 (ten year strategy) he updated this was now very close to being launched (Spring) and very much aligned with the NHS long-term plan and potential changes to integrated care systems. It would focus on five key areas (eHealth, new hospital, culture and organisational development, integrated care and corporate services modernisation).
2.15	As a final point he welcomed the new DoF and new Chief Information Officer (CIO) formally to the PAH Board.
2.16	The TC thanked the CEO for his update and stated he very much welcomed the new developments on the hospital site.
2.2 Significant Risk Register	
2.17	This paper was presented by the Director of Nursing & Midwifery (DoN&M) and taken as read. She reminded colleagues the risk register was a snapshot of risks at a given time and was a moving picture. A paper would be presented to that month's Senior Management Team (SMT) focussing on improvements to the Risk Management Strategy and establishing a Corporate Risk Register.
2.18	Members noted there were no risks currently scoring 25, but there were a number scoring 20. In terms of the Patient section, work had gone ahead on Dolphin Ward which had been repatriated over the previous weekend – that risk would therefore reduce. In relation to Places, work had begun on the theatre roof to address water ingress which it was hoped would be completed in the next two weeks. In addition the Safeguarding Team had now relocated to the improved working environment of Kao Park.

2.3 Board Assurance Framework 2020-21	
2.19	This item was presented by the Head of Corporate Affairs (HoCA). She informed members that the risks, risk ratings and outcomes of Committee reviews in month were summarised in the paper and two changes to the risk scores were recommended that month: • BAF risk 1.0 COVID: it was recommended the score be increased from 16 to 20. QSC had supported that recommendation. • BAF risk 5.1: The risk had been refreshed by the DoF and it was recommended the score be reduced from 20 to 16. PAF had supported that recommendation.
2.20	In relation to BAF risk 5.1 the DoF updated that it was made up of two elements, revenue and capital. The Trust was on track to deliver its financial plan and revenue risks were being mitigated.
2.21	In response to a comment from NED-HG in relation to risk 1.0 (COVID) it was noted that staff absence accentuated that risk. The CEO highlighted that in terms of that risk it would be important to ensure the specifics were identified. In the previous month those had related to the management of COVID positive patients and the hospital's ability to provide care. He would hope to see some change in the coming weeks where the risk shifted to a combination of medium-term management of patients who had had COVID and also the ability to reinstate other services. Underpinning both would be the impact on the workforce. The next phase would be about supporting colleagues through to the end of the pandemic. He agreed therefore to review the narrative around that risk to be more specific on its elements.
ACTION **TB1.04.02.21/11**	**Review the narrative around BAF risk 1.0 (COVID) to ensure all elements are captured.** **Lead: Director of Nursing & Midwifery/Head of Corporate Affairs**
2.22	In line with the recommendation the Board approved the Board Assurance Framework and the two changes to the risk scores.
03 PATIENTS	
3.1 New Hospital Programme Update	
3.1	The Director of Strategy (DoS) presented an update for members on the new hospital. He reminded colleagues that the timeline for the outline business case (OBC) had been rescheduled to October 2021 which would afford time for more focus on design and the use of modern methods of construction (MMC).
3.2	New hospital engagement events were underway with the first public event held in January. This had been extremely well attended and the question and answer session had been very positive. The second public event would be held that evening and he encouraged colleagues to join. Future events would be more targeted to the clinical model and access. In addition specific, hard to reach groups would be targeted.
3.3	Background work was continuing on the schedule of accommodation (SoA) to reduce its size. Clinical teams had challenged the 100% single room accommodation requirement which was now moving towards 70% with the addition of 30% four-bedded bays. Capital costs were also being scrutinised and MMC would be a key part of that in addition to driving down costs, improving quality and reducing timelines to delivery. The 'repeatable room' element was also being reviewed across the HIP programme and the Trust had signed a collaborative agreement with national colleagues to work together across the national programme and share information with others.
3.4	In response to a question from NED-HH it was confirmed that if the Ambulance Trust moved onto the site they themselves would be liable for that part of the land cost. Discussions were underway with EPUT in terms of mental health services also moving to the new site and the same considerations would apply to them.
3.5	In response to the above Associate NED John Keddie (ANED-JK) stated that the feedback received around the engagement events was that participants were finding the information useful, but felt they were not being consulted. . In response the DoS acknowledged that point and emphasised the events were 'listening' events and he would feed comments back to colleagues.

3.6	In addition ANED-JK agreed it would also be key to reach out to minority groups. The DoS agreed and confirmed a workshop had already been run, attended by a wide range of representatives from protected characteristic groups, and additional groups would continue to be targeted. The CEO added the team had also been working closely with local council colleagues to access their lists of minority groups and ways of communicating with them.
3.2 Mortality	
3.7	This item was presented by the MD and the paper was taken as read. She apologised for the error on the cover page which referred to aspiration pneumonia instead of senility. In terms of the work around 'senility and organic mental disorders' she confirmed work was underway around the coding of that. A summary of audit findings had shown themes of incorrect coding, incorrect and inconsistent documentation and inappropriate admissions due to lack of community support services. She stated she was drawing attention to that area because it linked to the Trust's elevated HSMR and inconsistencies in care because the organisation was not good at documenting its care well or coding. Both documentation and coding would need to be addressed moving forward and both linked to BAF risk 1.2, EPR (which she hoped would be addressed in the coming two years).
3.8	The MD also highlighted the work around patients who had died with a nosocomial COVID infection which was likely to have been caught whilst in hospital but where the cause of death needed further investigation. Each case had been identified as a Serious Incident (SI) and a structured judgement review (SRJ) would take place with a summary of learning to Quality & Safety Committee (QSC) in February.
3.9	The MD continued that the work undertaken by external consultant Richard Wilson had helped the organisation understand its mortality data better. SJRs had now been undertaken on every patient who had died with the primary diagnosis corresponding to an HSMR outlier, the outputs of which again, aligned with the challenges around coding and variations in care.
3.10	In terms of the broader programme of mortality work it had now been agreed to implement the Smart software package which would enable real-time data interrogation to enable more contemporaneous learning from each death. It would also enable learning from the work of the medical examiners (ME) to be more accessible. She expected the software to be up and running by April and hoped to appoint to the role of Lead ME by the end of the month. She was also working with the healthcare groups (HCGs) to produce a job description for a medical Patient Safety Quality Lead for each HCG, something the Trust had not previously had in place in a consistent way.
3.11	As a final point she updated that the Dr. Foster mortality outlier alerts had been reviewed over the last year and the SJRs had not identified any care or service delivery issues, but instead highlighted coding issues. Those cases therefore would no longer be referred for SJR. Instead, deep dives would be undertaken to ensure that any issues and learning could be taken forward.
3.12	In response to the above NED-GW flagged that the demographics of the hospital's patient population were such that it had a high number of very old and sick patients. In response the MD agreed and from conversations with partners it was also clear a large number of those were not dying in their preferred place of death. She had discussed with colleagues in the east of the region their approach to patients on an end of life pathway using the PEACE document. The PAH team would now be looking at how to introduce that which it was hoped would avoid hospital admissions at the end of the pathway.
3.13	In response to a query from ANED-JK in relation to the dots reflecting that HSMR was 'as expected' (grey) on graph 3.2, the MD acknowledged that could be an error and suggested that the data for June could in fact be red as the HSMR data was high. She acknowledged the lag in data and confirmed that October data was currently incomplete and could not be included in the report. A new EPR solution would be critical to address some of the data issues.
3.14	In response to a further question from ANED-JK the CEO confirmed that 'as expected', 'higher than expected' and 'lower than expected' were categories applied by Dr. Foster based on the analysis of data in the system. To determine that they would review actual deaths

	versus expected deaths which was based on the coding. That was why coding was so important. The figure of 100 indicated the same number of actual deaths as expected numbers of deaths.
3.15	At this point the DoQI was able to confirm that whilst the paper did not specifically update on aspiration pneumonia, a work-stream was in place in conjunction with the Expert Oversight Group to review that alert and the pathway changes to be made which would link with the new AAU. NED-HG updated that QSC had welcomed the change in focus as discussed above.
3.3 Ockenden Report	
3.16	Response to Ockenden ReportThis item was presented by the DoN&M and outlined the current position against the Immediate and Essential Actions in the Ockenden report (Dec 2020) and the Assurance Assessment Tool. Where the assessment tool had identified any gaps in the service, those had been highlighted to provide evidence of the actions in place to achieve full implementation. The report provided assurance to the Trust Board that Family and Women's Services (FAWS) were acting on recommendations following the report. QSC had received a verbal update in December 2020 and the HCG had also presented their report to QSC in January. The completed assurance assessment tool would be reported through the LMS and to regional teams by the 15th February 2021
3.17	Areas where further work was required were detailed as follows: Action 3 – Staff Training and Working Together She reminded members the Maternity Incentive Scheme had also focussed on MDT training over the last couple of years, an area where the Trust had reported compliance in 2019/20. However it was now being cautious in its assessment as meeting this training requirement during the pandemic had been challenging; currently compliance was recorded as 84%. Work was underway to improve compliance further and staff availability for training was starting to increase now that the second wave was starting to ease.
3.18	In terms of the requirement around out of hours consultant cover on Labour Ward that had been addressed and there were now twice daily/seven days per week ward rounds. A business case would be presented to the HCG Board in February outlining the workforce model to ensure the required level of hours could be sustained. Locums were also providing additional cover for the service.
3.19	Another requirement from the report had been for external funding for training to be ring-fenced and used to support the training agenda for staff to improve safety; and that the Board should support any refund from the maternity incentive scheme should be used to invest in service improvement.
3.20	Maternity Serious Incidents (SIs) Report The DoN&M continued that another requirement following Ockenden was that Trust Boards are sighted on any thematic analysis from SIs in maternity services. A detailed report had been discussed at QSC and the tabled report for the first time that day to the Board. She drew members' attention to the incident management structure which included daily HCG 'oversight of incidents' meetings, twice weekly meetings of the Incident Management Group with input into the review of all SIs by herself and the MD. In addition there was currently Executive oversight of maternity SIs on a twice monthly basis.
3.21	The DoN&M reminded members that in line with the CQC's rating of 'requires improvement' for maternity services, the service was part of the Maternity Safety Programme which allocated an Improvement Partner (MIP) to work with the team; SIs were also shared with our MIP to ensure openness and challenge. The Board was informed that since April 2020 there had been seven SIs in the service, five of which remained open. Section five of the report evidenced the ongoing work around those, actions taken and processes being strengthened. As further assurance she was able to update that over the last year Fetal Surveillance midwife had now been appointed along with a Lead Consultant. A review had also been undertaken of the Major Haemorrhage policy in line with PPH which members were aware was also an area of focus. Members also noted that maternity SIs were now being tracked in the IPR via the maternity dashboard to provide further assurance.

3.22	NED-JH asked a question in relation to action number 5 (Risk Assessment in Pregnancy) and requested reassurance that it was not just a case of carrying out the risk assessment but that there would be associated trigger points within that to ensure further action/s. In response the DoN&M confirmed that the risk assessment drove the pathway in terms of oversight, timeframe for scanning and place of birth.
3.23	The TC thanked the DoN&M for her updates which provided assurance on the work being done and the learning from incidents.
3.4 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
3.24	This report was also presented by the DoN&M. She updated that the paper had been discussed at Workforce Committee and would now, in line with a request from QSC, also be re-presented to that meeting for oversight of the quality and safety aspects. She informed colleagues that the report had been reworked to reflect the Trust's response to COVID. It provided information on management and oversight in terms of increased staff absence and changes in activity, across the organisation and NHS as a whole. She flagged that there were pandemic guidelines related to intensive care for the period, which the Trust had adhered to. There were no national guidelines on the management of staffing acute wards outside intensive care but the Trust was in line with the baseline of no more than a nurse to bed ratio of 1:8. She updated however that during the pandemic the organisation had had to move to a minimum staffing template which had been based on professional judgement and oversight from the senior nursing team. On occasions it had been close to a 1 to 10 ratio in some areas based on a review of activity and nursing numbers. Where the minimum template had not been sustained, a process had now been established for that to be reported as an incident.
3.25	In terms of the previous month the overall fill rate against the minimum template looked healthy but had dropped from the baseline template. The aggregated position for December which had dropped off towards the end of the month was in line with increased absences due to the new COVID variant.
3.26	In terms of the vacancy rate, the nursing team had worked hard to ensure the best position overall. She was pleased to report an overall vacancy rate of c. 7% and an improvement on the previous year. 31 new nurses had started since the beginning of November with a number still in the pipeline. Inroads had also been made in terms of the recruitment of healthcare support assistants with 62 appointed over the previous six months which had reduced the vacancy rate to 9%. The turnover rate remained stable at less than 10%.
3.27	NED-HH asked for some detail on the staffing of the new AAU. In response the DoN&M stated that. Whilst it was intended that AAU should be an assessment ward, the organisation was currently trying to minimise patient moves across the hospital so for now it had been opened as an amber ward for those not presenting with COVID and swabbing negative on admission. To facilitate that it had 'lifted and shifted' a ward including staffing from the older estate. She thanked colleagues who had supported that move.
3.28	NED-HH then asked for an update on progress with developing a medical staffing model. In response the COO confirmed that that the Associate Medical Director for Medicine had presented to WFC a summary of progress made to date and this work continued; colleagues were reviewing the medical establishment and templates following the model used for nursing staff. They would also be reviewing the allocation of junior doctors to manage patient flows and outputs would continue to be reported into the Workforce Committee (WFC) and Performance & Finance Committee (PAF).
3.29	NED Pam Court (NED-PC) thanked colleagues for the huge amount of work which had gone into maintaining staffing levels during the pandemic. She asked if the main reasons for absence remained those associated with COVID. In response the DoQI confirmed reasons were mixed and probably split 50/50 COVID/non-COVID.
04 PERFORMANCE & PEOPLE	
4.1 Integrated Performance Report (IPR)	

4.1	This item was presented by the COO and updates were provided under the organisation's 5Ps as follows: Patients There had been an increase in SIs that month which had taken into account the recording of nosocomial infections. There had also been an increase in cases of C-difficile with 24 cases now in the current financial year and linked to the pandemic. It was too early to understand the cause but that was being picked up by infection control colleagues and the Antibiotic Stewardship Committee. Members also noted an increase in falls per 1000 bed days and discussions had taken place at QSC around that to identify trends and learning. QSC had also had sight of the refreshed Harm Free Care Strategy and she highlighted there had been no increase in harms as a result of a fall. As indicated above, maternity SIs were now included in the report and there was a new Dementia/LD/Vulnerable Patients section. The DoN&M apologised that the data around LD incident rates was incorrect and would be reviewed.
4.2	Performance NED-JH asked whether the organisation had access to the outcomes for patients who had not been seen within four hours in the ED. In response the COO confirmed that all patients would still be seen and treated in the ED and a breach analysis was compiled for those who had fallen outside the 4 hour standard. Any cases of concern would be presented for clinical harm review. The DoQI added that the Urgent Care Board was currently reviewing outcomes for patients who were delayed in the ED in December 2020 and he would be happy to bring the results back to Board.
ACTION **TB1.04.02.21/12**	**Provide the detail on the outcomes for patients who had not been seen within four hours in the ED in December 2020.** **Lead: Director of Quality Improvement/COO**
4.3	In terms of performance the COO continued that in line with the reduction in COVID presentations being seen, the team were now moving forward with the work around the restoration of services for both admitted and non-admitted patients. The Trust was using the national framework for elective operations and working with the independent sector to offer some activity. As mentioned previously, all those on waiting lists were being regularly reviewed and prioritised. Ambulance colleagues were still working hard to support flow and work continued across the system and primary care on discharge pathways for patients.
4.4	In response to a question from NED-HG it was confirmed that some virtual outpatient activity was still happening, albeit some cases required a face-to-face appointment.
4.5	People The Director of People (DoP) drew members' attention to sickness absence particularly non-COVID related which was mainly down to stress and anxiety. There had been a huge focus on the health and wellbeing of staff with support from EPUT and the People/SHAW teams. An employee assistance programme was now running ICS-wide and the Trust had colleagues trained in mental health and trauma. A programme, 'Stop for a Moment' had been launched in critical care and offered psychological support. She cautioned that post-traumatic stress disorder (PTSD) could manifest itself up to 12 months after events and suggested that the Board receive an update on Staff Health and Wellbeing in April 2021.
ACTION **TB1.04.02.21/13**	**Provide an update to the Board in April on actions in place to support staff health and wellbeing. Director of People**
4.6	The DoP continued that compliance with statutory/mandatory training and appraisal had fallen off during COVID but would now be a focus moving forward and would be added to the workforce risk register. As a final point the DoP flagged an error in terms of the WRES reporting which would be updated for the next meeting.
4.7	Place The DoS reminded colleagues there had been significant investment in terms of the capital programme on site despite significant pressures. The domestic services team were currently seeing high levels of sickness and colleagues were working hard to maintain standards and

	undertake deep cleans. As mentioned previously repairs to the theatre roof were expected to be completed in the coming two weeks.
4.8	In response to a request from NED-JH it was agreed some pictures of the new AAU would be circulated to NED colleagues.
ACTION TB1.04.02.21/14	**Pictures of the new AAU to be circulated to NED colleagues. Lead: Director of Strategy**
4.9	Finance The DoF updated that the organisation was on track to deliver its financial target for the year, a deficit of £400k and its capital programme had been accelerated to ensure spend of £46m by year-end. Cash balances remained rich and in terms of planning for the coming year Q1 would be a rollover of numbers and further guidance would be issued by NHSE/I in terms of Q2-Q4.
05 GOVERNANCE	
5.1 Reports from Committees	
5.1	Committee Chairs were asked for key highlights and the following were noted: Quality & Safety Committee (QSC) – 22.01.21 The Chair, NED-HG had nothing additional to add. Workforce Committee (WFC) – 25.01.21 The Chair, NED-HH, drew members' attention to a useful committee paper (Dignity at Work) which she would encourage colleagues to read. New Hospital Committee – 26.01.21 The Chair, the CEO, confirmed key items had been raised earlier in the meeting. Performance & Finance Committee (PAF) – 28.01.21. The Chair, NED-PC, agreed that all key items had been covered.
06 QUESTIONS FROM THE PUBLIC	
6.1	At this point in the meeting the TC informed members that Alan Leverett (AL) (member of the public) had submitted three questions in advance which he would read out to understand whether they had been addressed during the course of the meeting.
6.2	The TC informed members that AL's first question had been in relation to the new hospital and communications with public and the fact that (only) 200 people had responded to an online survey. In response AL agreed that earlier discussions around public engagement and events had addressed his concerns and he had been pleased to hear of the work underway around that and plans to link with minority/hard to reach groups.
6.3	The TC updated that AL's next question had been in relation to the Trust's vaccination programme and encouraging those staff who were reluctant to be immunised. In response AL confirmed his question had been addressed but he asked why only the Pfizer vaccine had been used. In response the CEO stated that that was the vaccine that had been made available to the Trust by the national system.
6.4	AL's third question had related to the new hospital again and concerns that any additional requirements to increase its capacity could only be addressed by adding additional storeys. In response the DoS confirmed an increase in population had been taken into account and plans for expansion included (up to 20% over 20 years).
07 CLOSING ADMINISTRATION	
7.1 Summary of Actions and Decisions	
7.1	These are presented in the shaded boxes above.
7.2 New Issues/Risks	
7.2	No new risks or issues were identified.
7.3 Any Other Business (AOB)	

7.3	There were no items of AOB. The TC thanked members of the public for their attendance.
7.4 Reflection on Meeting	
7.4	Not undertaken.

Signed as a correct record of the meeting:	
Date:	01.04.21
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 04.03.21

	A	B	C	D	E	F	G
1	**Action Ref**	**Theme**	**Action**	**Lead(s)**	**Due By**	**Commentary**	**Status**
31	TB1.03.12.20/09	Staff Story	Public Board to receive a BAME staff story.	DoP	TB1.01.04.21	Addressed at item 1.0 at TB1.01.04.21.	Proposed for closure
32	TB1.04.02.21/10	Covid	Provide a figure for the percentage of COVID patients discharged from the hospital who were now requiring support for ongoing COVID-related conditions.	COO	TB1.04.03.21	See attached appendix.	Proposed for closure
33	TB1.04.02.21/11	BAF Risk 1.0	Review the narrative around BAF risk 1.0 (COVID) to ensure all elements are captured.	DoN&M/HoCA	TB1.04.03.21	Reflected in the paper at item 2.3.	Proposed for closure
34	TB1.04.02.21/12	ED Patient Treatment Times	Provide the detail on the outcomes for patients who had not been seen within four hours in the ED in December 2020.	DoQ&I/COO	TB1.04.03.21	Outcomes data for patients with long transit times were recently presented at Urgent Care Board (UCB). The analysis did not demonstrate poorer outcomes however it did show a high volume of patients attending ED at EoL .UCB have asked for another review of this patient cohort with our system partners and our ED consultants to gain further understanding and for the findings from that review to be reported back to UCB.	Proposed for closure
35	TB1.04.02.21/13	Staff Health and Wellbeing	Provide an update to the Board in April on actions in place to support staff health and wellbeing	DoP	TB1.01.04.21	Verbal update to be provided at TB1.01.04.21.	Open
36	TB1.04.02.21/14	AAU Images	Pictures of the new AAU to be circulated to NED colleagues.	DoS	TB1.04.03.21	Actioned	Closed

Item 1.4

Appendix to TB1 Action Log

Action ref: TB1.04.02.21/10 - provide a figure for the percentage of COVID patients discharged from the hospital who are now requiring support for ongoing COVID-related conditions.

Numbers are:

	Jan	**Feb**
No of accepted referrals	32	68
Referrals from primary care	30	67
Other	2	1
Caseload at end of month	99	136
Discharges	19	29

These are the numbers from Primary Care and CCG.

There is no data from PAH to show any direct referrals. This is a high level indication of patients accessing Long-COVID support.

25.03.21
Steph Lawton – Chief Operating Officer

The Princess Alexandra Hospital NHS NHS Trust

2.1

Trust Board – 1 April 2021

Agenda Item:	2.1
Presented by:	Lance McCarthy – CEO
Prepared by:	Lance McCarthy – CEO
Date prepared:	24 March 2021
Subject / Title:	CEO Update

Purpose:	Approval		Decision		Information		Assurance	

Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting: - Performance highlights - COVID-19 response - CQC section 29a warning notice - Capital developments - Staff survey results - New hospital - PAHT 2030 - Horizon scanning
Recommendation:	The Trust Board is asked to note the CEO report; note the progress made on key items and discuss the potential implications of the horizon scanning on our risks and strategy.

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

Previously considered by:	n/a
Risk / links with the BAF:	CEO report links with all the BAF risks
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	Summary of the recent white paper – Integration and Innovation: working together to improve health and social care for all – published on 11 February

2.1

Chief Executive's Report
Trust Board: Part I – 1 April 2021

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

(1) Key performance headlines

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

Key Performance Indicator	Actual performance for latest month (February)	Comparison to last report
ED 4-hour performance	70.8%	↓ (worse); target = 95%
HSMR	116 (Nov 19 – Oct 20)	↓ (better)
C. Diff (hospital onset)	3	↓ (better); 35 cases year to date
Never Events	0	No change
Incidents reported	689	↓
No harm / minor harm incidents	96.0%	↑ (better)
Falls / 1,000 bed days	9	↓ (better)
Number of stillbirths	0	↓ (better)
PPH >1,500ml	2.6%	↓ (better)
6-week diagnostic standard	54.2%	↓ (worse); target = 99%
Stat Man training	86.0%	↑ (better); target = 90%
Temporary staff % of pay bill	16.8% (January figures)	↑ (worse)
Staff turnover	9.89%	↓ (better)

The table of key indicators above shows improvements in most of the indicators compared with the previous Board meeting. The actual performance in a number of areas (ED and diagnostics) shows the pressure that the Trust is under at the moment and the impact that the COVID-19 pandemic is having on our ability to maintain our underlying services in the way that we would wish to.

(2) COVID-19 response

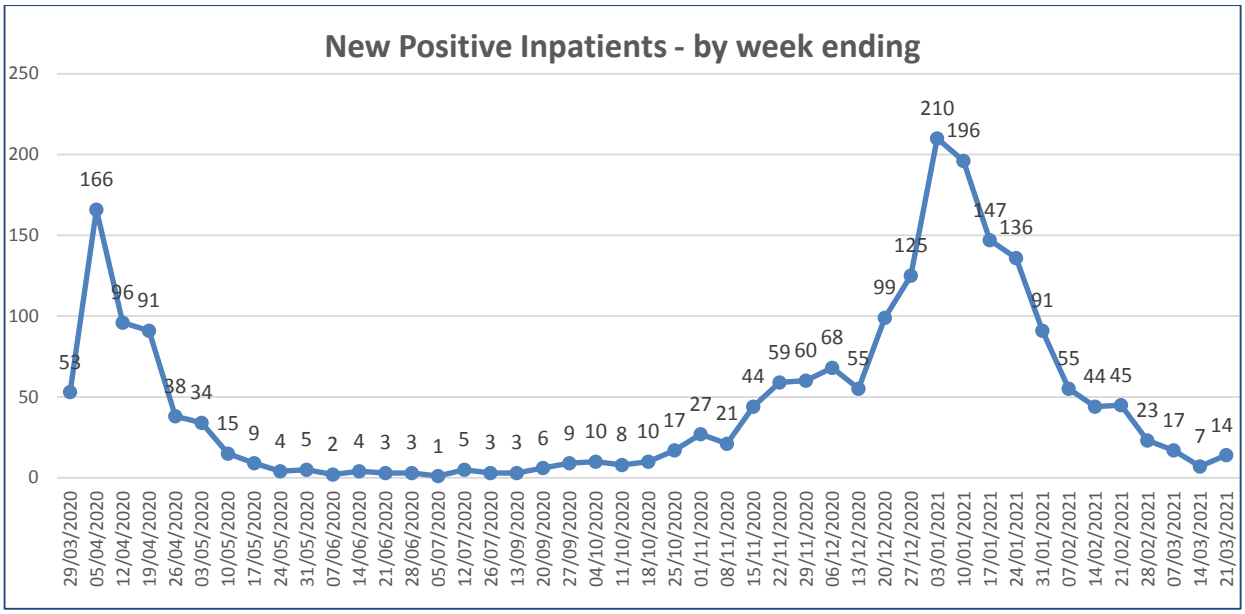
As of previous Board reports over recent months, I want to reiterate my thanks to all my colleagues at PAHT for their hard work and amazing response to the COVID-19 pandemic.

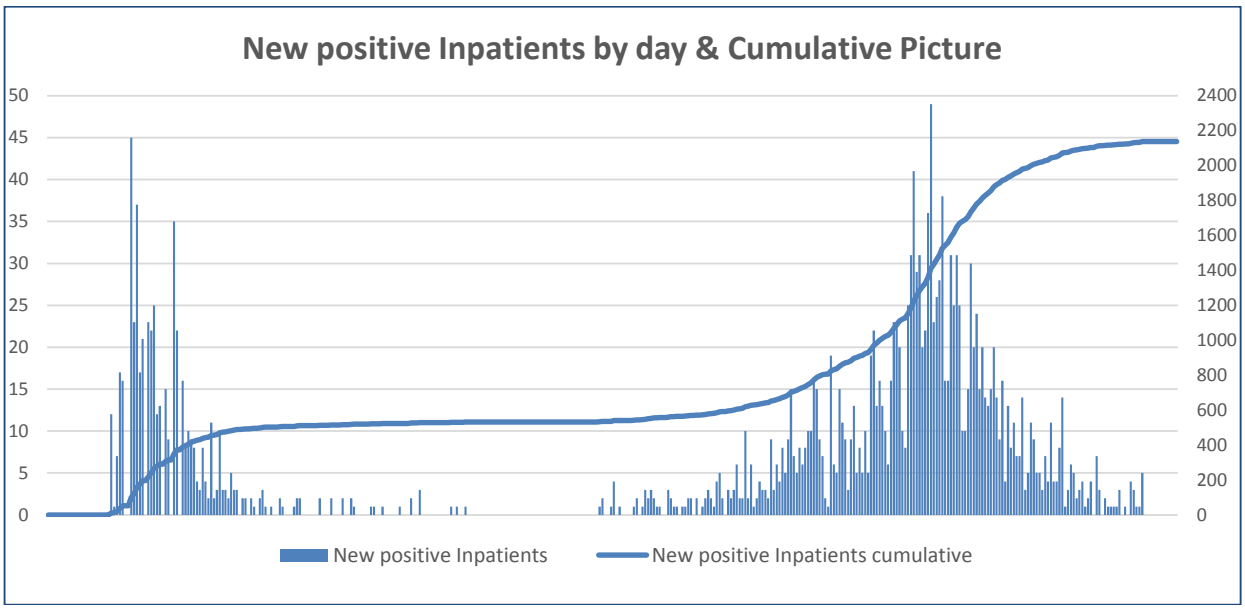
As you can see in the graphs below, we have seen a sustained reduction in the number of new COVID-19 positive inpatient admissions on a daily and weekly basis since our peak of 219 new positive inpatient admissions in w/e 3 January 2021, which was almost twice as high as the peak week of the first wave (w/e 5 April 2020).

Since this point we have seen a slow but steady decline in the number of new positive inpatient admissions, mirroring the reduction in the number of new COVID infections in our local communities. At the time of writing this paper, we have 11 COVID-19 positive inpatients in the Trust, of which 2 are on critical care, and our local and regional forecasts suggest that we will be admitting between 0 and 19 new positive inpatients admissions per week by the Easter weekend.

As many of our colleagues live in the local communities that we serve, the reduction in the number of new transmissions in the community has also seen our absence rates amongst colleagues reduce significantly, with sickness absence in February down to 4.2% (from more than 14% in some weeks in January).

To date we have cared for 2,138 COVID-19 positive inpatients. More than 1,620 have been discharged or transferred but sadly 505 have died in our hospital within 28 days of being COVID-19 positive.





This reduction in demand has enabled us to move back to caring for our COVID-19 positive patients from 9 ‘COVID wards’ down to a single ‘COVID ward’ and has enabled us to return our paediatric and adult emergency departments back to their usual places within the hospital.

Impact of COVID-19 on our services

The impact of the COVID-19 pandemic on all of our normal services has been significant.

We have reduced the amount of elective surgery that we can provide and have focussed on maintaining the top two priorities of patients, including cancer surgery. We now have a large number of patients who have been waiting for more than 52 weeks for their routine surgery and have had significant pressure on the demand for our diagnostic services so that we can ensure that we diagnose and treat suspected cancers in the timely manner that we have done for a number of years. As discussed last

month, we have expanded our endoscopy, CT and MRI capacity to support the management of cancer patients and have continued to work closely with our independent sector colleagues at The Rivers Hospital to maximise access to key services so that we can maintain timely services for some of our patients. Discussions are ongoing with colleagues from The Rivers Hospital regarding potential further support from 1 April.

All patients who have been waiting for longer than they would do normally continue to be reviewed by the relevant clinical team and reprioritised where relevant.

The demand for urgent care has increased in recent weeks and is almost back to pre-COVID-19 levels. Our performance against the 4-hour standard remains challenged and lower than pre COVID-19 levels due to the reduction in available beds in the hospital to manage the flow of urgent care patients in to from the ED.

Despite a huge amount of hard work from everyone across the local health and care system, the impact of COVID-19 on our services has been significant and it will be some time before we can recover our services fully and meet the access targets and waiting times that we achieved pre pandemic.

COVID-19 vaccination

We re-opened our hospital vaccination hub for the booster doses of health and social care workers at PAHT and the local health and care services. The other priority groups continue to be vaccinated through the Primary Care Network managed vaccination centres.

We vaccinated 6,829 health and care colleagues with the Pfizer vaccine through our hub and more than 80% of PAHT colleagues have now taken up the vaccine. There has been a lower uptake of the vaccine amongst our BAME colleagues and we have run a number of webinars and been supported by our local faith leaders and BAME Network colleagues to address this. Our Staff Health and Wellbeing (SHaW) team have also been having individual conversations with colleagues who have not yet taken the opportunity to have the vaccine to ensure they are all aware and up to date with the relevant guidance, to alleviate any concerns and to dispel any of the myths related to the vaccine. As a result a small number of colleagues have opted to have the vaccine in one of the local community hubs.

We reopened our vaccination hub on 17 March to provide the booster dose for all colleagues who had their primary dose through our hub. At the time of writing the paper we have provided more than 2,500 booster doses and have clear plans and appointments to be able to provide booster doses for all 6,829 colleagues by 14 April, all within the 12 week guideline of primary dose.

The vaccination roll out for the other priority groups identified by the Joint Committee on Vaccination and Immunisation in the community is going very well locally, regionally and nationally and we are in regular communication with primary care colleagues about our ability to support the mass vaccination centre that has recently opened at the Harlow LeisureZone should they need any additional support.

Staff support and testing

The demands of treating COVID-19 patients over the last year, and particularly through the 2nd wave has put a huge amount of physical and mental stress on many of our colleagues.

We have provided a range of health and wellbeing support for colleagues through this period, which is all accessible through our intranet. In particular I'd like to reiterate my thanks to Essex Partnership University NHS Foundation Trust (EPUT) for the ongoing mental health and wellbeing support that they have provided for our colleagues.

All colleagues have undertaken a personal COVID-19 risk assessment to support decisions to maximise their health and wellbeing and appropriate adjustments have been made to support relevant colleagues. Colleagues who have been shielding are being supported to come back into the organisation from 1

April in line with the changes to the national shielding recommendations. Returns will be individual specific and following conservations with relevant line managers and our SHaW team as well as the completion of an updated COVID-19 personal risk assessment.

To further support colleagues and to support the organisation in getting some closure about COVID-19 and learning from things that have gone well we are running a 12 week 'Back to Better' programme. This started on 8 March and includes a range of different types of event, webinars and information for colleagues and is coordinated across 4 themes of:

- Health and wellbeing
- Compassionate leadership
- Civility, values and behaviours
- Operational changes and pressures

(3) CQC Section 29a warning notice

Following an CQC unannounced assurance visit to our ED on Sunday 14 February, we were issued with a Section 29a warning notice on 2 March due to concerns from inspectors related to:

- Risk assessments not being completed for all patients within the emergency department.
- Timely risk assessment for patients presenting with acute mental health illness
- Concerns regarding full adherence to infection, prevention and control procedures.
- Lack of embedding of the process for the provision of the out of hours endoscopy service for patients presenting with acute upper gastrointestinal bleeding

We have until the end of March to show CQC colleagues significant progress made against the IPC and GI bleed concerns and until 1 June for the risk assessment concerns.

A comprehensive action plan and oversight process is in place to support ED colleagues in making the necessary changes to address the concerns raised by CQC colleagues and to ensure that all of our patients receive the best and safest care. This will be discussed at the Quality and Safety Committee before the Trust Board meeting.

There is a separate item later on the agenda related to this.

(4) Capital developments

We continue to invest our capital funds in the development of key facilities to support our patients colleagues across the site this year, recognising that this will be the last year of any large capital investments in physical facilities, with the expectation that the new Princess Alexandra Hospital will open in 2026.

Both floors of our new 2-storey Adult Assessment Unit have now opened and are operational, creating a dedicated assessment facility and a dedicated space for same-day emergency care provision. Both of these are key developments to support the management of and flow of our urgent care patients and are key building blocks in our ongoing improvement to urgent and emergency care services.

Very shortly, work to reorganise our facilities on the ground floor next to our ED will start to provide enhanced frailty assessment space, another key development to support urgent and emergency care delivery.

We have also just started a short ward refurbishment programme to address some of the long standing poor environments we have in a number of our ward areas, which we reduce our inpatient capacity for a number of months.

Subject to the approval of the business cases later today, we are also ready to start capital works to support some other key schemes for our colleagues including:

- Refurbishment and improvement of mortuary facilities
- Creation of a new large multi-professional, high quality staff rest facility
- New training and education facility

(5) Staff survey results

The latest national staff survey results and benchmarks against other organisations were published on 11 March.

The results were unfavourable and were a change from the previous 3 years of continued improvements. We scored significantly better than the previous year in just 1 question and worse in 24 questions.

We saw improvements in areas that we focussed on strongly from the last survey including staffing levels, having sufficient equipment, not experiencing physical violence and colleagues knowing what their responsibilities were. Disappointingly, given the focus we have had on colleagues' health and wellbeing over the last year this was not reflected in the survey results with this section of the survey scoring significantly lower than last year.

A clear plan to respond to the survey results has been developed and initiated and will be discussed in detail at the Workforce Committee before the Trust Board meeting.

There is a separate item later on the agenda related to this.

(6) New hospital

Work continues to progress at pace on the development of the new hospital and we continue to remain in regular contact with the national New Hospital Programme team, the national NHSEI team and the Regional NHSEI team to progress the whole new hospital programme and get to OBC submission in the autumn. We are still on track to bring the OBC to Board for approval in October.

Our engagement programme is strong and we continue to have regular conversations with all local MPs, councillors from all the local district councils, Essex CC colleagues and our internal colleagues. Detail on the success of our first two virtual town hall engagement events with the local population is outlined in the new hospital agenda item later, with the next events planned to take place at the end of May and start of June.

We remain on track to deliver against our challenging and ambitious timeline to have received formal approval of our business cases in time to enable us to have built the majority of the new Princess Alexandra Hospital by the end of 2025.

(7) PAHT 2030

Our 10-year strategy, PAHT 2030, will come to Board members next month for sign off before we launch it across the organisation and with local stakeholders. PAHT 2030 is our 10-year plan to enable us to achieve our vision and ambition.

It is aligned with the NHS Long Term Plan and the expected changes in healthcare provision and structure from the most recent white paper, including the development of integrated care systems.

Whilst not yet launched, given the size and scale of our ambitions, we continue to make significant progress in all of the 5 areas of focus within PAHT 2030:

- eHealth
- New Hospital

- Culture and Organisational Development
- Integrated care
- Corporate service modernisation

A similar 10-year strategy for our local Integrated Care Partnership, One Health and Care Partnership, is close to completion aligning patient pathway changes and developments across all local health and care services and the refresh of the Trust's values with associated behaviours and standards is nearly complete as one of the first significant actions in the Culture and OD theme.

As discussed here previously, PAHT 2030 puts digitisation, data sharing and the use of technology at the heart of all that we do and the first building block to this is the implementation of a high-quality Electronic Health Record. Our Outline Business Case for an EPR will be with Board members for approval next month before regional and national sign off to enable us to go out to procurement.

Once PAHT 2030 is launched we will track progress through a regular monthly report and a report to every Board meeting.

(8) Horizon scanning

The need for better horizon scanning for potential changes in legislation, national funding or international, national and regional clinical service developments is something that we have previously discussed as needing to improve.

I will bring a separate report on this to future meetings with a view to us discussing the potential implications of any known or expected changes on our key risks in the organisation, the risks to the non-delivery of our strategic objectives and our strategy in general.

The three key areas at present that have potential impacts on our current thinking and our strategy that need further consideration by the Board are:

- The recent white paper – Integration and Innovation: working together to improve health and social care for all – published on 11 February
- Potential changes to ICS boundaries included within the white paper, aligning them with local authority boundaries
- National Planning Guidance for 2021/22; not published at the time of writing this paper but expected to be published before we meet

I have attached my summary of the white paper from last month, with some annotations that are specific to us and our strategy. The key areas for discussion are alignment with PAHT 2030 and the implications of a possible ICS boundary change.

The national planning guidance is not yet out, so difficult to know exactly what the impact may be on PAHT, but I'm expecting it to focus on:

- Health and wellbeing of colleagues
- Ongoing management of COVID-19
- Restoration on non-COVID services
- Expected changes to the emergency are metrics and associated pathway developments
- An underpinning of the 'system by default' approach and the content of the white paper

Author: **Lance McCarthy, Chief Executive**
Date: **24 March 2021**

Appendix 1 – Summary of the white paper – Integration and Innovation: working together to improve health and social care for all – published on 11 February

I have summarised the White Paper below focussing on the key elements that are more relevant for secondary care and PAHT specifically. This is obviously from my personal perspective.

It focusses on Integrated Care Systems, collaboration, use of technology, population health and changes in accountability. Our thoughts and plans for our 10-year strategy (PAHT 2030) which we are about to launch are well aligned with all of these, but the White Paper does signal a lot of change and transformation in all that we do and how we think and how we build different relationships with organisations outside of PAHT. The White Paper also makes some significant changes to the MH Act.

Integrated care Systems (ICSs)

- To become statutory organisations
- To be aligned with local authority boundaries – for us that means a probable move out of the current Hertfordshire and West Essex ICS to an Essex wide ICS.
- To be responsible for:
  - developing a plan to meet the health needs of the population within their defined geography;
  - developing a capital plan for the NHS providers within their health geography;
  - securing the provision of health services to meet the needs of the system population

ICSs will have the ability to delegate functions to provider collaboratives and places (facilitated by proposals for joint committees).

Financial allocations and financial objectives for acute Trusts will continue to be set by NHS England but the ICS will be responsible for the performance management of Trusts across their system and for individuals organisations to support the system control total.

There will be the introduction of a new duty on us to work collaboratively with health and care colleagues in our system and to focus on the wellbeing of the whole population. [This aligns with our recent work to focus much more on supporting out of hospital activities and care; on supporting prevention and on supporting the reduction of health inequalities locally].

Ability to create joint committees at ICS and at a more local ICP (West Essex for us) that are joint decision making. [Aligning with our drive locally to ensure joint decision making across a wider footprint and across the different parts of the NHS (primary, secondary, community, MH etc)].

Improved data sharing across all organisations (patient information as well as patient outcome, activity and performance information).

All the above will change quite a lot of what we do currently, although aligned with recent changes; requiring us to continue to work in a much more joined up and collaborative way with other health and care providers in the local system; requiring us to continue to build strong relationships with ICS and other colleagues; requiring us to continue to work in greater collaboration with our provider colleagues (secondary care as well as other providers) – probably all on an Essex footprint.

Competition removal

- General direction of travel to remove competition in the NHS.
- A new provider selection regime (to be consulted on separately) to reduce competitive tenders for services – this has been less relevant for acute services than for community services for example, although some acute services have been tendered out local recently.

- Ability to create new NHS Trusts with ICSs recommending these for approval to the SoS. [This aligns with our desires to create a local Integrated Care Trust with local primary care and community care services in the same single organisation as the secondary care services provided by us at PAHT. It would help with new clinical models of care and the provision of care in a different setting, which is required for us to be able to make the new hospital a success. It would also support the fast forwarding of innovative technology, caring for acute patients in a non-acute setting and the transfer of patient information and data between different parts of the NHS system more effectively through a joined up EPR].
- Removal of statutory requirement for Local Education and Training Boards; enabling HEE to take a more prominent role

Increasing accountability

- Merger of NHS England and NHS Improvement to create a new NHS England
- Increased power for ministers to determine service reconfigurations and to intervene at all stages of the process rather than when referred to
- SoS to be able to transfer functions between Arm's Length Bodies and to be able to abolish them
- SoS to publish a document every 5 years on the workforce planning needed at national, regional and local level

Social Care and Public Health

- Promise to reform social care and redesign public health
- Reduce advertising on high fat, salt and sugar foods

Safety and Quality

- Creation of a new Independent Body (the Health Service Safety Investigations Body (HSSIB)) to investigate incidents related to the safety of patients and to encourage the spread of a learning culture. [This aligns with our desire to becoming much more of a learning organisation, to be more open with errors and mistakes and concerns and to spread the learning from incidents more widely within PAHT and across the local system and with our other acute providers – more openness and transparency].
- SoS ability to remove a profession from regulation but also to extend the professions to be regulated – eg: senior leaders and managers
- Establishment of a statutory medical examiners system to scrutinise all deaths. [We have made good progress with this but would need to enhance our Medical Examiners system and ensure that all deaths are reviewed and all Structured Judgement Reviews are undertaken in a timely manner and used to facilitate learning from every death in the hospital].
- MHRA to develop and maintain medicine registers
- NHS food and drink standards for patients, visitors and staff to be put on a statutory footing. [We will have some work to do on this but it aligns with our strong desire to see food as medicine, to continue to improve the food and drink offering for patients and colleagues and aligns with our vision of having a sky farm on the roof of the new hospital to support local food production and cooking from fresh with known provenance]

Lance McCarthy
12 February 2021

The Princess Alexandra Hospital NHS Trust

2.2

TRUST BOARD
1 APRIL 2021

Agenda item:	2.2
Executive Lead:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Lisa Flack – Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Quality Governance
Date prepared:	24 March 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 is 108 (section 2.1). The main themes for risks scoring 20 on the SRR are: 6 relating to equipment (5 are for Women's Health), 4 relating to our places: including backlog maintenance, and 6 relating to our performance (with 4 regarding emergency care). Actions and mitigations detailed in sections 2.4 to 3.3 The Trust's internal auditors' report was received and the overall assurance level has decreased from substantial to reasonable. An action plan to address the gaps is completed, work will be undertaken across all registers and not just those reviewed by the auditors. Work continues to refresh our risk management strategy which will further support the action plan.
Recommendation:	Trust board is asked to note 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 rotational basis so each service is monitored quarterly as per annual work plan Senior Management Team – March 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 pulled from the web based Risk Assure system on 01 March 2021. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

There is an annual work plan to ensure each areas register can be reviewed in detail on a rotation. However during the Covid-19 risk period the focus of the group has been on significant risks and 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/date 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.

There are 108 significant risks on our risk register which is an increase from 95 in the previous paper discussed in February at Trust Board. The breakdown by service is detailed in the table below.

	Risk Score				
	15	16	20	25	Totals
Covid-19	1 (2)	4 (2)	1(0)	0 (0)	**6 (4)**
Cancer, Cardiology & Clinical Support	6 (4)	10 (10)	(0)	0 (0)	**16 (14)**
Communications	0	1	0	0	**1**
Estates & Facilities	7 (7)	8 (7)	1 (1)	0 (0)	**16 (15)**
Finance	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Information Data Quality and Business Intelligence	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
IM&T	1 (0)	2 (2)	0 (0)	0 (0)	**3 (2)**
Integrated Hospital Discharge Team	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Learning from deaths	0 (0)	2 (3)	0 (0)	0 (0)	**2 (3)**
Non-Clinical Health & Safety	2 (2)	1 (1)	0 (0)	0 (0)	**3 (3)**
Operational	2 (2)	0 (0)	4 (4)	0 (0)	**6 (6)**
Research, Development & Innovation	0 (0)	2 (2)	1 (0)	0 (0)	**3 (2)**
Resilience	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
FAWs Child Health	0 (0)	2 (1)	0 (3)	0 (0)	**2 (4)**
FAWs Women's Health	6 (5)	5 (3)	6 (0)	0 (0)	**17 (8)**
Safeguarding Adults	0 (0)	0 (0)	1 (1)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Medicine	5 (4)	4 (4)	2 (2)	0 (0)	**11 (10)**
Surgery	7 (7)	5 (5)	3 (5)	(0)	**15 (17)**
Totals	**40 (36)**	**49 (43)**	**19 (16)**	**0 (0)**	**108 (95)**

(The scores from paper presented at Trust Board in February 2021 are detailed in brackets)

2.3 There are 19 risks with a score of 20; an increase from the update provided in February 202. A summary of these risks is below and all new risks are detailed:-

2.4 Our Patients

2.4.1 Equipment for FAWs

- **NEW**: Purchase an ultrasound scanner to be able to increase the number of women seen in EPU and GMBU, (2021/01/02 raised January 2021)
  Action: Capital orders raised and delivery expected by 31st March.

- **NEW:** Purchase two resuscitaires for the labour ward, current products used do not have products available to allow for repairs (2021/01/0 3 raised in January 2021)
  Action: Equipment has been ordered

- **NEW:** Portable ultrasound scanner for the Labour ward currently does not have products available so is not suitable for repair (2021/01/03 raised January 2021)
- **Action:** Scanner shared with paediatric department. Equipment has been delivered and installed.

- **NEW:** Require an ultrasound scanner to be permanently situated in the maternal and fetal assessment unit (2021/01/04 raised January 2021)
  Action: Share a scanner machine with labour ward currently. Equipment ordered and delivered.

- **NEW:** 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 available in paper copy. CTG delivered and awaiting installation.

  The risk rating for the above risks will be reviewed and score adjusted in line with the allocation of capital funding.

2.5 Our People

2.5.1 Consultant cover on rota in Maternity

- Consultant cover achieves 77 hours per week, with national requirement for availability at 98 hours a week. There is a high potential for consultants needing to be called into the trust (2020/10/01 assessed in August 2020 with a score of 20, but not visible on the system until the risk was amended /corrected in December).
  Action: All consultant job plans are on track for review by date set. Additional posts ae out to advert.

2.5.2 Medical Staffing cover for GI bleed

- 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). Despite support from NHS England the Trust was not successful in obtaining a formal partner engagement for an out of hours SLA.
  Action: Completed the upper GI bleed proforma, care bundle and SOP. The Trust has agreed to fund an out of hour's endoscopy service. A consultation is in progress to have staffing cover for an out of hours GI bleed rota by end of Q1 2021/2. Continuing to work with North and East Herts to develop a SLA.

2.6 Our Performance

2.6.1 ED performance

Four 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)
- Ensuring patients wait less than 12 hours from time of decision to admit (003/2016 on register since July 16) for operational team register.
- To achieve the ED four hours standard (MED57 on Medicine register since July 2016)
  Actions: Rapid assessment and treatment process monitoring flow through department. Daily patient tracking of discharges to facilitate admissions, actions taken on safety rounds, timely escalation with clear triggers. CDU and ENP pathways being rewritten. ED remedial action plan monitored through Urgent Care Programme Board. Winter surge actions are in place

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: Daily patient tracking of cancer list at meetings attended by Head of Performance & Planning. Cancer Board monitors recovery action plan and trajectory.

2.6.3 Covid impacting Trust performance

- **NEW:** TIART the Trust will have insufficient adult beds to admit emergency patients into during the second wave of Covid-19 in early 2021 due to the increasing Covid19 demand in addition to winter emergency demand, (C19-058 raised 29 January 2021).
  Action: Daily bed planning meetings review capacity across the trust. Minimised patient safety impacts. ICS and regional meetings in place for support system and to facilitate community support and to share elective and emergency surgery activity. Executive oversight allows senior escalation.

2.7 Our Places

2.7.1 Environment

- **Theatres for Surgery:**
  Water ingress due to structure of the roof, results in leaks, impacting the use of theatres for surgery and the sterile supply storage area.
- Roof leak into Theatre 1 (THE 006/2019, initially raised on 31/10/19).
- Roof leak into Theatre 7 (THE 008/2019, initially raised on 31/10/19).
  Action: A feasibility study to be completed prior to a date being set for repair of both theatre roofs as part of the capital work programme. The surgery team will need to review and adjust the planned activity to keep the theatres free to allow the completion of repairs. **26.03.21 Update: roof leaks have been repaired and risk scores reduced.**

- **Penn ward**: requires refurbishment. (Penn001/2020 raised January 2020)
  Action: Refurbishment work has commenced, expected to take 8 weeks

- **Safeguarding team:** Refurbishment required to the porta cabin office location (ASG/04/2019 on Safeguarding register initially raised July 2019 and score amended July 2020).
  Action: Space utilisation group identifying staff groups that can relocate to Kao Park, in turn this will free up space to relocate the safeguarding team to different location at PAH. Looking to refurbish the Maternity teaching room as office space to provide a location for this group of staff

2.7.2 Research team require a clinical space

NEW: Research and development require a location to conduct clinical trials as the Trust intends to grow the research conducted in the Trust (R&D 16/12/2017 with an amended score from 30 January 2021 as required to move location twice in 2021)

Action: Space allocation group asked to provide a location for use, currently working out of the new fracture clinic. Working with the new hospital team to ensure a location is available in the new site.

2.7.3 Waste Management

- As a result in shortages of the capacity to manage clinical waste in the south east of England (due to the pandemic) the Trust is unable to secure all clinical waste in empty bins, resulting in non-compliance with waste management legislation, (EFMwaste-01 raised December 2020).
  Action: Porters continue to collect waste and store it in cages within a locked compound. Trust discusses daily the position with current contractor and resolve issues locally where possible. Looking to source a third party provider to assist clearing the site.

2.8 Our Pounds: The Trust identified a risk associated with delivery of the capital programme. The Capital Working Group has mitigated risks and only two capital orders remain outstanding totalling £0.3m. Assurances that goods and services, including the required value of capital works to meet the capital target have been obtained from senior responsible officers (current score 4 x 4 = 16).

3.0 NEW Risks on the Significant Risk Register Scoring 15 and 16

3.1 Our Patients

- Require permanently available ECG monitoring on the labour ward (2021/01/01 raised 28 January 2021)
  Action: Borrowed ECG machine. Equipment ordered.

3.2 our People

- **Hospital bleep system**
  8X8 telephone system installed in AAU does not allow staff to access the bleep system (AAU280121 raised 28 January 2021)
  Action: Hospital at night available on iPad, medical team present in ward during office hours, radio issue of DECT phones. Trust to purchase a replacement system called common time, being progressed.

3.3 Our Places

- Water ingress in the UPS room where high risk IT equipment is located (EFM01.02.21 – Comp.room B raised February 2021).
  Action: Equipment has been raised and moved to a temporary location. Water control using a barrier method, daily inspection. To carry out repairs, move compressors by end of March.

4.0 Internal Auditor Review of Risk Management

- The Trust's internal auditors undertook their annual review of Risk Management across the Trust. The audit rating assigned is one of reasonable assurance (previous audit was substantial assurance, 2019).
- An action plan has been developed to address the recommendations and this was discussed at Risk Management Group. Actions will be undertaken across all risk registers and not just those reviewed by the auditors.
- Of note is the work captured under section 2.1 in relation to refreshing the Trust's risk management strategy and training plans.

5.0 RECOMMENDATION

Trust board is asked to note the content of the significant risk register.

The Princess Alexandra Hospital NHS Trust

Trust Board – 1 April 2021

Agenda item:	2.3
Presented by:	Heather Schultz- Head of Corporate Affairs
Prepared by:	Heather Schultz – Head of Corporate Affairs
Date prepared:	25.03.21
Subject / title:	Board Assurance Framework 2020/21

Purpose:	Approval	x	Decision		Information		Assurance	

Key issues:	The BAF 2020/21 is presented for review. It is proposed to reduce 3 risk scores this month and a summary of the changes made during the 2020/21 year is included as appendix 1: BAF risk 1.0 Covid – the risk score is to reduce from 20 to 16 BAF risk 3.3 Strategic change and organisational structure – the risk score is to reduce from 12 to 8, achieving the target risk score and consequently it is proposed to close the risk. BAF risk 3.4 Sustainability of local services – the risk score is to reduce from 16 to 12, achieving the target risk score and consequently it is proposed to close the risk.
Recommendation:	The Board is asked to approve the changes to the risk scores and note the 2020/21 summary of the risks.

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:	PAF, QSC and WFC in March 2021. EMT on 18 March 2021.
Risk / links with the BAF:	All BAF risks as attached.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with Healthcare legislation.
Appendices:	Appendix 1 – 2020/21 summary Appendix 2 – BAF 2020/21

Your future • Our hospital

respectful • caring • responsible • committed

Trust Board 1 April 2021 - Board Assurance Framework 2021

1.0 Purpose/Issue

The Board Assurance Framework (BAF) for 2020/21 is presented for review with proposed changes, as discussed at Committees during March 2020, summarised below. Appendix 1 provides a summary of the risks and changes in risk scores during 2020/21.

2.0 Board Assurance Framework Summary

April 2021 update:

The risks have been reviewed with executive leads and discussed at the relevant committees in March 2021 and it is proposed to make the following changes to the risk scores this month:

- **BAF risk 1.0 Covid** – the risk score is to reduce from 20 to 16 reflecting the current position in relation to the management of Covid patients in the hospital and reducing local prevalence. The description of the risk has been revised to reflect the specific elements of the risk that are now an area of focus for the Trust. The amended wording is reflected below (in red font):

  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~~ staffing levels, staff health and wellbeing, operational performance and patient outcomes.

- **BAF risk 3.3 Strategic change and organisational structure** – the risk score is to reduce from 12 to 8, achieving the target risk score and consequently it is proposed to close the risk. The risk relates to "the capacity and capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust". Significant progress has been made in relation to partnership working with the development of the One Health and Care Partnership and work continues to progress under the leadership of the CEO, Director of Strategy and Director of Quality Improvement.

- **BAF risk 3.4 Sustainability of local services** – the risk score is to reduce from 16 to 12, achieving the target risk score and consequently it is proposed to close the risk. The risk relates to "failure to ensure sustainable local services continue whilst the new hospital plans are in development". This risk was added to the BAF when the new hospital plans were in the early stages of development and since then, a risk relating to the New Hospital (Risk 3.5, scoring 16) has been added which covers elements of this risk whilst the sustainability of services on site is covered in BAF risk 3.1 Estate and infrastructure, scoring 20.

Summary of BAF for 2020/21:

Appendix 1 provides a summary of the BAF risks for 2020/21. The following changes were made to the BAF during the year:

- Two new risks were added; 1.0 Covid and 3.5 New Hospital.
- One risk was closed; 2.1 Nurse Recruitment, in April 2020. It is proposed to close two further risks as mentioned above.

- Three of the risk scores were reduced (2.1 Nurse Recruitment, which was closed following the reduction in score, 4.2 ED and 5.1 Finance) and the risk score for 1.0 Covid, increased and then reduced in year.
- There is currently one risk scoring 20 (Estate and Infrastructure) and seven with a risk score of 16 which places them in the category of extreme risks (red).

Recommendation:

The Board is asked to:

- Review and approve the changes to the risk scores detailed above
- Review and note the summary of changes to the BAF in 2020/21.

Heather Schultz, Head of Corporate Affairs

Board Assurance Framework Summary 2020.21

Ref.	Risk description	April 20	June 20	August 20	Oct 20	Dec 20	Feb 21	Year-end score (Apr 21)	Trend (Apr 20 – Mar 21	Executive lead
Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients, integrating care with our partners and improving our CQC rating										
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.	20 New risk	16	16	16	16	20	16	↓	CEO/ DoN&M
1.1	Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	16	16	16	16	16	16	16	↔	DoN&M/ MD
1.2	EPR: Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes.	16	16	16	16	16	16	16	↔	DoIMT/ CIO
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										
2.1	Nurse recruitment: Inability to recruit to critical nursing roles	12 Risk closed							↓	DoN&M
2.3	Workforce: Inability to recruit, retain and engage our people	12	12	12	12	12	12	12	↔	DoP
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.										
3.1	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20	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	16	16	16	↔	DoS
3.3	Capacity and capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	12	12	12	12	12	12	8 Risk closed	↓	DoS
3.4	Sustainability of local services: Failure to ensure sustainable local services continue whilst the new hospital plans are in development	16	16	16	16	16	16	12 Risk closed	↓	DoS
3.5	There is a risk that the new hospital will not be delivered to time and within the available capital funding.			16 New risk	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 the ED standard.	20	16	16	16	16	16	16	↓	COO
Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2020/21 and our local system control total										
5.1	There is a risk that the Trust will fail to operate within available resources leading to a financially unsustainable run rate at the end of 2020/21. In addition, the capital programme may be negatively impacted upon by the COVID-19 pandemic causing slippage in delivery of the programme.	20	20	20	20	20	16	16	↓	DoF

The Princess Alexandra Hospital Board Assurance Framework

2020-21

Risk Key															
Extreme Risk		15-25													
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**												
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 ~~the standard of care delivered.~~ staffing levels, staff health and wellbeing, operational performance and patient outcomes.	Causes: i) Highly infectious disease with new variant ii) Failure of public to adhere to Public Health messages and increasing Covid demand iii) National issues regarding supply chains iv) Configuration of PAHT estate v) Current vacancy 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 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 ~~viii) Non COVID Priority Business Cell established for business as usual matters~~ 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	i) Incident management action and decision logs ii) QSC updates monthly from (March 2020 to March 2021) iii) Trust Board updates (March, to April 2021) iv) Recovery Plans and submissions v) Covid risk register	**4x4=16** **~~4 x 5 = 20~~**	i) Loss of staff with key skills and training due to virus; shielding/isolating or sickness ~~ii) Reliance on national supply chain~~ ~~iii Modelling information for next peak (local, regional and national) dependant on lock down and public behaviour~~ v) Plans for use of the private sector ~~vi) Limitation with PAHT estate configuration and supply of oxygen~~		Mar-21	**Proposed to reduce score from 20 to 16.**	**4 x 3 = 12 (June 2021)**
			Effects: i) Increased numbers of patients and acuity levels ii) Shortages of staff, staff shielding and increased sickness 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											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
Medium Risk		4-6												
Low Risk														
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 and experiences that we provide our patients, integrating care with our partners and improving our CQC rating													
BAF 1.1		Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Unwarranted variation in care ii) System wide flow iii) Workforce gaps	**4 X 5= 20**	Director of Nursing/ Chief Medical Officer **Quality and Safety Committee**	i) Robust quality and safety governance structures in place including infection control ii) Robust Appraisal/ medical and nursing iii) End of Life and deteriorating patient simulation programme for all staff, across ICP and ICS 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 Q4 / Q1 2021/22 viii) Escalation prescribing processes ix) Electronic handovers, Hospital at Night and E-Obs and observation compliance reports x) Schwartz Rounds xi) NHSI/NHSE Oversight xii) Patient Experience Strategy xiii) NED lead appointed for Mortality xiv) Mortality Strategy including dashboard in development , tracker, updates on workstreams and learning from deaths. SMART tool/live database being implemented in May 21 xv) '15 steps' w alkabouts (on hold over covid) xvi) Nursing Establishment review (bi-annually) and successful nursing recruitment campaign xvii) Safer Staffing policy xviii) Real time patient feeback implemented across all wards xix) Robust management of variations in neonatal outcomes xx) Engagement in external reviews MBRRACE/HSIB and LaDeR and Healthcare Safety Investigation Branch (maternity) xxi) Medical examiners (MEs) and Lead ME appointed and Mortality Surveillance Group established xxii) Complaints w orkshops held xxiii) Joint GIRFT and Model Hospital quality improvement programme xxiv) Patient flow module ~~live~~ xxv) Electronic fluid prescribing xxvi) Appointment of medical PS&Q leads undertaken ay (May/June 21) xxvii) Complaints process being revised and grading system introduced xxviii) Fab Change accreditation xxix) Quality peer review process in place xxx Covid-19 governance structures/meetings in place xxxi) OD Plan agreed at WFC (June 2020) xxxii) HCG reconstructe consultation over Q1 2021/22 to strengthen the accountability and governance frameworks xxxiv) Appointment of DMD Q1 2021/22 w ill support quality, safety and outcome agenda.	i) National Survey ii) Cancer Survey iii) CEO Assurance Panels iv) Incident Management Group meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings, PRMs and Patient Experience meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings/ Vulnerable Patient Group x) PLACE Inspections xi) Medicines Management Committee xii) End of Life and Mortality Surveillance Group xiii) AKI & Sepsis Group xiv) Urgent Care Improvement Board xv) Deteriorating Patient Group xvi) Cardiac arrest review panels xvii) Twice weekly Long Length of Stay meetings xviii) Quality Compliance Improvement 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 Workforce and Quality 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 (March 18, and June 19) and GIRFT reports v) Real time Dr Foster reports and engagement vi) GMC Survey results and WFC report March 2021 ~~vii) Clinical Audit internal audit report 18/19 - tiaa (limited assurance)~~ viii) Quarterly Coding reports to PAF ~~ix) Positive staff survey outcomes (2019) measuring safety culture and engagement.~~ x) Freedom to Speak Up Guardians quarterly reports to WFC xi) Patient stories and learning from deaths reports to Public Board meetings (bi-monthly) xii) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) xiii) Critical care network review peer review April 2020 xiv) TARN review (QSC September and October 2020 and end March 21)	**4x4=16**	Lack of modernisation in some reporting processes including: i) Clinical audit plan developed and to be implemented - improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site footprint and bed constraints iv) Access to Qliksense v) NICE oversight and management of compliance with guidance vi) Frequency and consistency of approach to mortality reviews ~~vii) Recruiting Lead ME~~ **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey 2020/21 action plan in place iii) Ongoing work with Dr Foster in relation to mortality ~~i) NHS Patient Safety Strategy 2019 published. Trust to review and align to best practice~~ iii) EPR development and business case to PAF/Board March 2021 iv) Developing PAHT Quality Strategy	i) Clinical evidence of improvements made following compliance with national audits, NICE,NCEPOD. ii) Demonstrating an embedded learning programme from Board to ward.	01/03/2021	Risk rating not changed	**4x3=12 July 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 v) Recurrent themes in complaints involving communication failure vi) Loss of confidence by external stakeholders											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
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 and experiences that we provide our patients, integrating care with our partners and improving our CQC rating **Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2020/21 and our local system control total**													
BAF 1.2		**EPR** Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes.	Causes: i) Poor engagement with the system, usability, time/skills ii) Timely system fixes/enhancements	**5 X 4= 20**	Chief Information Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iv) Performance Mgt Framework in place. v) Training programme. vi) Super users in place to deliver focused support. vii) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability viii) Access Policy ix) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) x) Development of capacity planning tools/information xi) PWC review and actions identified xii) ICT Newsletter issued xiii) Daily ICT/COSMIC meetings ongoing xiv) Real time data now available xv) CDS 011 now live xvi) Maternity MDS configuration completed. xvii) Monthly Contract Performance monitoring meeting with supplier established. xviii) New EPR Board established – chaired by CEO xix) EPR replacement programme established and EPR requirements being gathered, 5 Business Change Managers in post and other EPR Trust resources being recruited xx) EPR Options appraisal development to complete mid December 2020 xxi) EPR FBC being developed and benefits realisation with link to HIMMS commissioned	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews	i) Weekly Data Quality reports to Access Board and EDB ii) Monthly DQ reports to PAF and quarterly ICT updates to PAF (September 2020) iii) Reports to EPR Programme Board iv) EPR outline business case to SMT, PAF and Board (March to April 21)	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Compliance with refresher training vii) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed. Responsiveness and quality of delivery of PFM - testing processes and actions identified by tiaa internal audit (limited assurance). 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 as uncapped liability – assurance PAH have declined supplier request on advice from NHSD	Mar-21	Risk rating unchanged	**4x3=12 end of ~~March~~ July 2021 (subject to monthly review of progress)**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** i) Ongoing training and support ii) Re-establishing relationship/engagement with Cambio iii) Refresher training underway iv) Revised roadmap to incorporate new statutory/legal requirements e.g GDPR v) CIO in place				

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 2020-21

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	**4 X 4 =16**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) Event in a Tent held annually viii) Staff recognition awards held locally and trust wide annually ix) Enhanced controls around temporary staffing x) Line Manager development programme underway xi) Behaviour workshops held xii) New consultant 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 ~~2019~~ 2020 (results to be reported March 2021) iv) GMC survey (WFC March 21) v) WRES and WDES reports 2020 (WFC and Board) vi) OD Framework approved (WFC June 2020) vii) Medical Safer Staffing Plan update to WFC November 2020 viii) Dignity at Work report January 2021 ix) Culture and values refresh (SMT March 21) x) Compassionate and inclusive leadership session (Board development session March 21)	**4 x3 = 12**	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 Actions i)-Recruitment plans for medical staff led by AMD (medicine) ii) Extranet for staff - Q1 21/22 iii) Staff survey action plan v) Review of raising concerns (FTSUG's, champions for bullying and harassment, senior inclusion lead) vi) CV19 staff vaccination implementation plan	None identified.	01/03/2021	**Risk score not changed.**	**4 x2 = 8** **March 2022**
			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											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
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) Under-investment in training of estate management & site development viii) Inability to undertake planned preventative maintenance ix) Lack of decant facility to allow for adequate repair/maintenance particularly in ward areas. x) Key workforce gaps in compliance, energy and engineering.	**5 X 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	i) Reports to SMT (as required) ii) Signed Fire Certificate iii) Annual H&S reports to Trust Board and 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 (February 2021) x) Internal Audit report (tiaa) - review of PPM (limited assurance report) - Audit Committee Dec 2019, action plan in place xi) Capital projects report (PAF March 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 - recent power failure March 21) iv) Maintaining oversight of the volume of action plans associated with compliance. **ACTIONS:** i) EBME review underway ~~ii) Review of estates function complete.~~	i) Estates Strategy /Place Strategy developing within ICS ii) Compliance with data collection and reporting iii) PPM data not as robust as required	01/03/2021	**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.											

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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 Evidence should link to a report from a Committee or Board.		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			
	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 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		01/03/2021	**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											

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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/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. Evidence should link to a report from a Committee or Board.		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			
	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 3.3		**Strategic Change and Organisational Structure** Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	**Causes:** i) Staff and stakeholders lack of awareness and/or understanding of drivers and issues cross the system ii) Scale, pace and complexity of change required. iii) Infrastructure (IT, buildings) not supportive of change iv) Financial resources lacking to support change v) Focus on immediate operational and financial priorities versus the longer term strategic planning vi) Lack of clarity regarding contracting and organisational models in support of ICP vii) Management resource and team with relevant capability and skills to drive change and strategy development to be developed. viii) Uncertainty around future CCG structure and relationships	**4 X 4= 16**	DoS Strategy Committee	i) Good relationships with key partner organisations ii) CEO chairing ICP Board iii) CEO and Chair attending STP meetings iv) Clinical Strategy being developed. v) Strategy Committee established and Strategy team in place vi) Development of MSK service and engagement of senior clinicians. vii) One Health and Care Partnership established viii) Financial principles for integrated working developed, allocative contract and due diligence underway ix) NHSE/I assurance process underway x) Legal advice sought on governance and staff transfers xi) Transformation plan in development	i) ICP Board and STP meetings ii) Expert Oversight Groups and workstreams (finance,people, IT) iii) ICP senior leaders meetings iv) Executive to executive meetings and Board to Board meetings (as required)	i) ICP Reports to Strategy Committee ii) CEO report to Board (bi-monthly) iii) ICP update Board development session August 2020.	**~~4x3=12~~ 4x2=8**	i) Data quality impacting on business intelligence (SLR) **ACTIONS:** PAH long term strategy being developed and PAHT 2030 to be presented to Board for approval in January 2021	Development of governance structures for integration and legislation CCG Accountable Officer process completed and new management structures.	01/03/2021	**Risk rating reduced to 8 and risk to be closed.**	4 x 2= 8 **March 2021**
			Effects: i) Poor reputation ii) Increased stakeholder and regulator scrutiny iii) Low staff morale iv) Threatened stability and sustainability v) Restructuring fails to achieve goals and outcomes vi) Impact on service delivery and quality of care vii) Poor staff survey viii) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure ix) Undermines regulatory confidence to invest in hospital/system solutions											

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edium 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/negative aAssurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance,			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3 : Our Places – 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 3.4		**Sustainability of local services** Failure to ensure sustainable local services continue whilst the new hospital plans are in development.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in backlog maintenance iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) Complexity of STP vii) Insufficient quantity and expertise in workforce capability	**4 X 4= 16**	Director of Strategy Trust Board	i) Potential new build/location of new hospital ii) STP Footprint and Estate Strategy developed. iii) Herts & West Essex STP Estates workstream iv) Pathology workstream led by CEO v) Estates and Facilities Infrastructure subgroup for West Essex vi) SOC affordability model vii) SOC approved and submitted to NHSI viii) Detailed analysis of current site option commissioned ix) Master planning work being aligned to Six Facet Survey and Health Planning, phasing of development on PAH site or off site. x) Alignment of strategic capital and tactical capital plans xi) MSK service developments underway xii) Funding confirmed xiii) PAH part of HIP 1 funding programme for capital investment xiv) PCBC completed, submitted and reviewed by NHSI xv) New members of strategy team appointed xvi) OBC in development (completion date is March 2021) xvii) £40m investment in the estate	i) PAF, Strategy Committee and Board meetings ii) SMT Meetings iii) Capital Planning Group iv) Weekly Estates and Facilities meetings v) Stakeholder group vi) New Hospital Committee	i) Reports to SMT ii) STP work plans iii) PAHT 2030 report to Trust Board (April 2021) iv) PCBC approved at Trust Board (September 2019) v) New hospital updates to NHC and Board monthly	~~4 x 4 = 16~~ **4x3=12**	i) Balancing short term investment in the PAH site vs the required long term investment **ACTIONS:** Clinical strategy being developed and underpinned by 5P plans PAHT 2030 to be presented to Board for approval in January 2020	i) Clinical strategy in development	01/03/2021	**Risk score to be reduced to 12 and risk to be closed.**	4 x 3 =12 March 2021
			Effects: i) Failure to deliver strategy and transformation project and service changes required for service and performance enhancement ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant vii) Poor patient experience, viii)Backlog maintenance ix) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health. x) Lack of integrated approach xi) Increased risk of service failure xii) Impact on throughput of patients												

Risk Key															
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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 delivery of the new hospital will be delayed because of failure to engage with a suitable contractor or that the additional funding is not forthcoming from the JIC even if the 3 conditions are met.~~ the new hospital will not be delivered to time and within the available Capital funding.	Causes: i) ~~Challenged contractor market/insufficient skills and capability.~~ ~~ii) Competition in the market due to large number of HIP schemes~~ ~~iii) High profile failures in hospital construction~~ i) 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	**5 X 4= 20**	Director of Strategy New Hospital Committee	~~i) Soft market testing postponed (contractors)~~ ii) Detailed programme of work iii) Monthly meetings with national cash and capital team iv) Weekly meetings with regional team v) Weekly meetings with landowners ~~vi) HOSC meetings held and agreement reached that consultation is not required~~ vii) New national team appointed to provide transaction support viii) detailed review of proposed solution to ensure it is deliverable within the available funding envelope ~~ix) Engagement events underway~~	i) New Hospital Committee ii) Trust Board iii) External advisory meetings as required. Iv) New Hospital SMT meetings	i) Monthly reports to Trust Board and New Hospital Committee. (November 2020) Ii) Letters of support received from ~~HOSCs~~ JIC. Iii) ~~Verbal~~ confirmation received that programme management structure is appropriate. Iv) Expert advice received on procurement strategy.	**4x4=16**	Negotiations with landowners ~~Actions:~~ ~~Soft market testing postponed, progressing and a bidders day planned.~~	None.	Mar-21	**Risk score not changed.**	**3x3=9** **September 2021**

Risk Key														
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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	**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) Covid-19 and associated pressures on the department~~ v) Lack of assesment and short stay capacity, lack of CDU space	**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 ~~viii) System reviewing provision of urgent care~~ 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 ~~Assessment unit - opened 16.01.21~~ xii) Think 111 First - went live December 2020 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	**4x4=16**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings and weekly Urgent Care Board review	None noted.	01/03/2021	**Risk score not changed.**	**4x3 =12** **~~March~~ July 2021 (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														
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Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2020/21 and our local system control total													
BAF 5.1		**Finance** There is a risk that the Trust will fail to operate within available resources leading to a financially unsustainable run rate at the end of 2020/21. In addition, the capital programme may be negatively impacted upon by the COVID-19 pandemic causing slippage in delivery of the programme.	**Causes:** i) The Trust has now agreed its operating plan for M7-M12. This is a requirement to deliver a deficit of £391k. Although the plan provides greater certainty on the level of income to be received from block contract arrangements some variables in delivery of the financial position remain. The main risks include the delivery of efficiencies (including reductions in temporary staffing) and containing Covid costs within funding envelopes against the backdrop of increase covid activity. ii) The Trust's capital programme is significant at c£45m and contains a significant number of Estates, equipment and ICT initiatives. A number of programmes are scheduled for delivery in Q3 and Q4. Ability to deliver schemes coud be impacted upon by the COVID-19 pandemic.	**5 X 4= 20**	**Exec leads:** DoF **Committee** : Performance and Finance Committee	(i) NHSE/I commitment to ensure NHS organisations break even in the first 6 months. For months 7 to 12 the Trust has an agreed financial plan in place (ii) Health Care Group performance review meetings are in place where performance is being monitored (iii) Cash management group reviews the Trust's cash position. In addition, fortnightly cashflow reporting in place to NHSE/I. (iv) Oversight by the EMT, SMT, PAF, Workforce and Audit Committee (v) Monthly monitoring of financial performance by NHSE/I through the submission of financial returns (revenue, capital and ad hoc) (vi) ICS capital programme in place in line with system Capital Resource Limit (CRL) which is being regularly monitored at system level (vii) Capital Review Group meets monthly to review the capital position including developing migitations for identified slippage (viii) COVID cost capturing process in place (ix) Internal audit reviewing COVID controls and associated governance (x) External audit programme in place	i) Internal audit reports ii) External audit opinion ii) External review iii) NHSI/E reporting iv) Internal Trust reporting v) Cash forecasts vi) CIP Tracker vii) Estates project plans	i) Monthly reports including bank balances and cash flow forecasts to PAF and Board ii) CIP reports iii) Internal Audit reports: Financial Reporting and Budget Monitoring (substantial assurance) Key Financial Systems (substantial assurance) iv) FAM reports monthly v) PRM packs monthly	**4x4=16**	i) instances of non-compliance across the organisation in relaiton to SFIs i.e. waivers not being obtained in a timely manner ii) Activity and capacity planning iii) CIP delivery and PMO function iv) Embedding management of temporary staffing costs	Demand and Capacity Workforce planning	01/03/2021	**Risk score not changed.**	4 x 3 =12 (Q4 2020)
			Effects: i) Ability to meet future financial control target if financial plan cannot be achieved as it will impact on future year's run rate ii) Impact on going concern status iii) Impact on future capital availability iv) Unfavourable audit opinion (VfM)							**ACTIONS:** Implementation of finance modernisation programme of work Work continues through PRMs to maintain and strengthen recurrent delivery of all elements of the financial plan (revenue, capital, CIP etc) Demand and capacity planning and modelling to be regularised				

The Princess Alexandra Hospital NHS Trust

Trust Board – 1 April 2021

3.1

Agenda item:	3.1
Executive Lead:	Finola Devaney Director of Clinical Quality Governance
Prepared by:	Sheila O'Sullivan – Associate Director of Governance and Quality
Date prepared:	15 March 2021
Subject / title	CQC assurance visit 14 February 2021

Purpose:	Approval		Decision		Information	√	Assurance	√

Key issues:

- On 14th February 2021, the CQC undertook unannounced inspection of our emergency department (ED).
- This was a follow up to the winter assurance inspection undertaken in February 2020.
- The organisation has a section 29a warning notice in place following an unannounced winter assurance CQC in 2020. This is in relation endoscopy provision out of hours (for severe gastrointestinal bleed), and documentation.
- On 2nd March 2021, a Section 29a Warning notice was issued in relation to 4 areas of concern: embedding of the GI service; lack of adherence to infection, prevention and control procedures; timely risk assessments for patients in the ED including; mental health risk assessments (appendix.1).
- Actions, oversight and monitoring is being achieved through twice weekly HCG meetings, weekly quality performance review meetings (PRMs) with the executive team and monthly reporting to QSC.

Recommendation:	The Board are asked to note the content of this report.

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

Previously considered by:	QSC 26/3/21
Risk / links with the BAF:	Risk reference no. Endo 08 current score 5 x 4 = 20
Legislation, regulatory, equality, diversity and dignity implications:	CQC have regulatory powers to issue warning notices Monitoring of safety, quality and effectiveness within governance is a mandatory requirement reviewed by the independent regulator (CQC)
Appendices:	I.CQC warning notice letter

The Princess Alexandra Hospital NHS Trust

1.0 Introduction

1.1 In February 2020 CQC undertook an unannounced Winter Assurance visit to our urgent and emergency care department (ED), which result in the Trust been issued with a section 29a warning notice for:

- The trust has not taken actions to mitigate the risks associated with the lack of endoscopy services out of hours.
- The trust has still not taken enough action to ensure that records of care and treatment are clear, up to date and easily accessible.

1.2 Following this inspection a quality improvement action plan was developed, which was shared with CQC and NHS England and NHS Improvement (NHSEI) with monitoring and oversight via the Quality Compliance Improvement Group, both areas have remained amber in delivery due to level of risk with mitigations in place to maintain patient safety. These risks have been shared throughout the year with NHSI, the CQC and our commissioners.

1.3 On 14th February 2021 CQC undertook a follow up unannounced visit to ED, as part of their regular review of services and to follow up and monitor progress following the issue of a Section 29A Warning Notice from February 2020.

1.4 On 2nd March, we received a section 29a warning notice in relation to 4 areas of concerns (listed under 2, 1)

1.5 The draft CQC report from the 14th February inspection has not yet been received and is anticipated imminently.

2.0 CQC section 29a Warning Notice (appendix.1).

Areas within the section 29a warning notice:

1. There was a lack of adherence to infection, prevention and control procedures.
2. The process for the provision of the out of hour's endoscopy service for patients presenting with acute upper gastrointestinal bleeding was not embedded.
3. Risk assessments were not being completed for all patients within the emergency department. This means that staff may not have completed appropriate mitigation and actions to keep patient safe.
4. We were not assured that patients presenting with acute mental health illness were receiving timely assessments.

3.0 Immediate Actions taken

3.1 <u>There was a lack of adherence to infection, prevention and control procedures response required by 30th March 2021.</u>

Immediate actions taken within ED:

- Our lead for infection prevention and control visited both the red and amber pathways with the Associate Director of Nursing for urgent care and the Director of Clinical Governance and the processes have been reconfirmed with colleagues in the department.
- all ED colleagues were reminded of national PPE guidance and the importance of appropriate and timely signage. Our last audit of ED staff awareness of PPE guidance undertaken in January 2021 showed a 93% compliance and understanding rate.
- AGP and PPE guidance reissued across the Trust through our daily COVID-19 update email.
- Agreement that our PPE champions will have a greater focus in the ED to support compliance.
- In line with the reduction in the number of new COVID-19 presentations, our red ED was relocated to its original site on 2nd March, the geography of simplifies pathways, reduces staff movements between areas and supports compliance.

Further actions undertaken and planned

- An external IPC peer review of RED and Amber pathways was undertaken on 4th March 2021 with colleagues from NHSEI and CCG at both ED and ward level. No immediate significant concerns were identified and an overall positive report was received. All minor areas of improvement identified have been actioned by the IPC and clinical teams.
- Weekly estates and facilities walk thought with clinical teams.
- New door signage relating to AGPs and PPE is in place.

Improvements across the Trust

- Reminders through the daily communications of the important of social distancing from colleagues when in offices
- New signage to be applied to office areas communicating the maximum number of colleagues to be in any room
- Continue to monitor both PPE and Hand hygiene compliance via PPE Champions
- Review the PPE stations at entrances to departments to ensure there cannot be cross contamination
- All leaders are asked to complete a review for their areas to ensure this learning is implemented and keep staff safe

3.2 <u>The process for the provision of the out of hour's endoscopy service for patients presenting with acute upper gastrointestinal bleeding was not embedded, response required by 30th March 2021.</u>

Immediate actions taken:

- Ensured that our senior ED nurses (nurse in charge) and doctor in charge are fully aware of the process.
- Ensure the policy and SOP are available on our intranet, with an ED-specific flowchart widely available within the department.
- The SOP has been updated further for the management of suspected upper GI bleeds and the policy has been disseminated to the whole ED team via email.
- Ensured that the flowchart is included in the bundle of urgent procedures throughout the department for everyone to be able to access quickly and this is being communicated to all colleagues through the daily huddles.
- OOH GI Bleed steering group established and lead by ADM for Medicine and reiterated the agreed process.
- Stress tests within the department

Further improvement actions taken and planned:

- Significant work and progress has been made throughout the preceding year with establishing an out of hour's GI service and cover. The risk has been noted in the significant risk register reported to Board (risk score 20, Jan 21)
- Work to establish establishing the internal OOH bleed rota through fruition of a consultation and a business case over the preceding year. We are actively recruiting to and are aiming to have in place by the summer.
- Until the GI rota is established, we have continued focus to formalise the agreement with a neighbouring Trust for patients to be transferred there on a case by case base and we have a process within PAHT to ensure we capture all potential patients at the start and end of each day, which we can evidence.

Improvements across the Trust

- Using our daily communications we have confirmed to staff Trust wide how this group of patients are managed out of hours

3.2.1 Actions implemented to address concerns regarding risk assessment, demonstrate improvements by 1st June 2021

Actions taken since Feb 2020

- Since 2020 we have a process in place for regular reviews of our documentation which has supported improvement and shown improvements in compliance with nursing risk assessment completion from less than 60% to more than 80% in the last 12 months.
- All nursing risk assessments with exception of Falls are within the electronic NEVECENTRE, which was developed since 2020 inspection.
- Quality improvement workstream refreshed and Medical Records Group TOR updated to reflect oversight documentation standards.

Immediate actions taken:

- Immediately instigated twice daily nursing documentation audits with real time feedback and training. These are undertaken by the nurse in charge with additional support and oversight from the matron, head of nursing and ED practice development nurse.
- Introduced formalised case-based reviews by the nurse in charge, where every shift they work with a colleague to review their documentation and discuss the risk and care needs.
- Highlighting findings from the audits and reviews in the safety huddles, safety rounds and board rounds.
- Ongoing spot checks by the local practice development nurse will continue to inform and enhance our underlying documentation improvement plan.
- A letter sent to all ED staff both nursing and medical, summarising the above actions and reiterating the importance of complying with professional standards for documentation is being drafted and will be sent to all over the next few days.

Further improvement actions taken and planned:

- Our Accreditation Matron commences in post in April 2021, in the medium term this role will oversee this regular review and data collection
- Undertake a review of all the ED documentation and risk assessment, using a back to basics approach to ensure there is clarity as to the priority of completion of risk assessments, the part of the pathway that each assessment should be completed within.
- Review of electronic platforms to maximise electronic documentation as appropriate

Improvements across the Trust

- Ward documentation was launched in 2020, this details the timing of risk assessments with all located in one booklet completed on admission
- The Trust will ensure the Ward Managers receive clarity on the requirement for regular documentation audits to take place across all wards and conversations to take place with staff to clarify expectations.

3.2.2 CQC were not assured that patients presenting with acute mental health illness were receiving timely assessments, demonstrate improvements by 1st June 2021.

Immediate actions taken:

- Review of the specific case identified by the inspectors to ensure any immediate actions and risk as timeliness of robust mental health risk assessment.
- Risk assessment actions as included under section 3.3.

Further improvement actions taken and planned:

- Mental Health Patient Pathway review to be undertaken with support of NHSEI and CCG – date to be confirmed.

4.0 Oversight and monitoring of immediate actions:

- Over the last year we have strengthened the leadership team within the urgent and emergency care service through creating a new post of Associate Director of Nursing and we are in the process of bringing forward our plans to have urgent and emergency care as a standalone division which will further support the local team and strengthen the management support and clinical leadership to the service.
- The ED HCG have established bi-weekly CQC quality improvement meetings to monitor compliance and evidence, with named CQC lead to support.
- Weekly Executive quality PRMs have been established to monitor overall progress, evidence of progress and support any immerging risks.
- The PRM is also focused on continuing to develop and enhance the culture in the urgent and emergency care service, which is well recognised as being a key driver and determinant of the provision of high quality and safe care.
- The Trust will undertake internal unannounced visits to the department both in house and out of hours.
- External peer review will be undertaken in May with the support of NHSEI, CCG and external Trust.

5.0 Next Steps

5.1 We are confident with the improvement measures outlined we will be able to demonstrate compliance against the Section 29a Warning Notice and will have mitigated the risks to ensure our patients are safe.

5.2 Monthly trust wide oversight of CQC and Trust Quality Improvement plan will continue under the quality compliance improvement group, the Clinical Effectiveness and Compliance Group and at QSC.

5.3 The Trust Quality Compliance action plan will be available in IPR.

6.0 Recommendations

The Board are asked to note the content of this report.

CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

For the attention of the Chief Executive
The Princess Alexandra Hospital NHS Trust
The Princess Alexandra Hospital
Hamstel Road
Harlow
Essex
CM20 1QX

1 March 2021

The Care Quality Commission
The Health and Social Care Act 2008
SECTION 29A WARNING NOTICE:
Provider: The Princess Alexandra Hospital NHS Trust

Regulated activities:
Treatment of disease, disorder and injury
Diagnostic and screening procedures
Surgical procedures

Our reference: RGP1-10471459720
Account number: RQW

Dear Lance McCarthy

This notice is served under Section 29A of the Health and Social Care Act 2008.

This warning notice serves to notify you that the Care Quality Commission has formed the view that the quality of health care provided by The Princess Alexandra Hospital NHS Trust for the regulated activities above requires significant improvement:

The Commission has formed its view on the basis of its findings in respect of the healthcare being delivered in accordance with the above Regulated Activities at the locations identified below.

The Princess Alexandra Hospital
Hamstel Road
Harlow
Essex
CM20 1QX

The reasons for the Commission's view that the quality of health care you provide requires significant improvement are as follows:

- **There was a lack of effective governance processes which meant that:**

    1. Risk assessments were not being completed for all patients within the emergency department.
    2. We were not assured that patients presenting with acute mental health illness were receiving timely assessments.
    3. There was a lack of adherence to infection, prevention and control procedures.
    4. The process for the provision of the out of hours endoscopy service for patients presenting with acute upper gastrointestinal bleeding was not embedded.

Why you need to make significant improvements in Urgent and Emergency services:

1. **Risk assessments were not being completed for all patients within the emergency department. This means that appropriate actions were not always identified to protect patients from avoidable harm.**

    You have been in repeated breach of Regulation 12: Safe care and treatment, of the Health and Social Care Act 2008 since December 2017. At our previous inspection, you were served a warning notice as care records did not always detail the complete care and treatment for patients.

    At our recent inspection on 14 February 2021, we reviewed 12 adult my patients journey through the urgent care system booklets, six did not have completed risk assessments for falls and pressure ulcers. In addition, we reviewed the electronic notes of patients A, B and C (DR01,02,03) who had been escalated to staff by the inspection team. We found that patient A had not had any risk assessments for pressure ulcers or venous thrombolytic embolism (VTE), patient B had not had any risk assessments completed and patient C's risk assessments were not completed in a timely manner (they had been in the department 4.5h).

    In your 'my patient journey though the urgent care system' guidance it suggests that all patient risk assessments should be completed within the first hour. This includes vital signs, falls, sepsis and mental health assessments. This action had not been completed in nine out of the 15 records we reviewed. The National Institute of Health and Care Excellence

guidance ‘Falls in older people: assessing risks and prevention’ (NICE, CG161) states that all elderly patients who present with a fall or have history of falls should be offered a falls risk assessment.

This meant staff were not aware of or able to mitigate risks to patients relating to pressure ulcers, falls or VTEs.

In your letter dated 25 February 2021, you acknowledged that trust audit data showed staff completed risk assessment in 60-80% of patients. We observed completion was 50%. While we acknowledge you have taken a number of actions to improve the completion of risk assessments, we are not assured there has been effective oversight of improvement in this area since previous concerns were raised in December 2019 or that the changes implemented are robust.

You are required to make the significant improvements identified above regarding the quality of healthcare by 1 June 2021.

2. **We were not assured that patients presenting with acute mental health illness were receiving timely assessments and appropriate care plans formulated.**

   During our inspection, we saw that a patient who was experiencing acute mental health illness had not received a risk assessment for 17 hours. This meant that there was no clear plan for how the patient would receive medical or personal care whilst in the department.

   Whilst no risk assessment was in place, it appears the patient was left unattended in a shower with potential environmental risks. We were concerned that the patient was left in the care of security guards without a risk assessment in place. We can see from your letter that security guards have training in safeguarding, but we were not assured this training covered mental health training. We were not assured that the security guards would have the skills to provide appropriate support for this patient without an appropriate risk management plan in place. This puts patients and staff at risk of harm.

   In your letter dated 25 February 2021, you acknowledged that a number of actions have now been taken to improve the completion of risk assessments for patients with mental health illness. However, while we feel immediate risks to patients have been mitigated, we are not assured that there are effective systems in place to ensure these actions are sustained.

You are required to make the significant improvements identified above regarding the quality of healthcare by 1 June 2021.

3. **There was a lack of adherence to infection, prevention and control procedures.**

   At our recent inspection, 14 February 2021, we saw a minimum of four nursing and medical staff not wearing appropriate personal protective equipment (PPE) in the amber resus area. This was not in line with the trust guidelines which were clearly displayed on the door to the area. We saw a staff member moving between Covid red and Covid green areas without changing their PPE. This meant that there was an increased risk of the spread of Covid to staff and patients. We were concerned that staff were not complying with the trust policy and guidelines.

   In your letter dated 25 February 2021, you acknowledged that a number of actions have now been taken to improve infection prevention and control within the department. However, while we feel immediate risks to patients have been mitigated, we are not assured that the changes implemented are yet embedded.

You are required to make the significant improvements identified above regarding the quality of healthcare by 30 March 2021.

4. **The process for the provision of the out of hours endoscopy service for patients presenting with acute upper gastrointestinal bleeding was not embedded.**

   At our recent inspection, 14 February 2021, we spoke with two members of staff who could not clearly describe the procedure to follow in the event of a gastro-intestinal (GI) bleed out of hours.

   In your letter dated 25 February 2021, you acknowledged that a number of actions have now been taken to improve the process around the out of hours GI service. We acknowledge that you have shared the policy with staff and feel this has mitigated the immediate risk of harm to patients. However, we are not assured there has been effective oversight of improvement in this area since previous concerns were raised in December 2019. We need assurances of how the trust is monitoring the implementation, effectiveness and awareness of the policy and process.

You are required to make the significant improvements identified above regarding the quality of healthcare by 30 March 2021.

Please note: If you fail to comply with the above requirement and thereby fail to make significant improvement to the quality of the health care you provide within the given timescale(s) we will decide what further action to take against you. Possible action includes the Commission informing NHS England and NHS Improvement, that the Commission is satisfied that there is a serious failure by the trust to provide services that are of sufficient quality to be provided under the NHS Act 2006 and seeking to discuss and agree with NHS England and NHS Improvement that a recommendation be made to the Secretary of State for the Secretary to appoint a trust special administrator in the interests of the health service because of that serious failure.

We will notify the public that you have been served this warning notice by including a reference to it in the inspection report. We may also publish a summary more widely unless there is a good reason not to.

You can make representations where you think the notice has been served wrongly. This could be because you think the notice contains an error, is based on inaccurate facts, that it should not have been served, or is an unreasonable response. You may also make representations if you consider the notice should not be published more widely.

Any representations should be made to us in writing within 10 working days of the date this notice was served on you. To do this, please complete the form on our website at: www.cqc.org.uk/warningnoticerepresentations and email it to: HSCA_Representations@cqc.org.uk

If you are unable to send us your representations by email, please send them in writing to the address below. Please make it clear that you are making representations and make sure that you include the reference number RGP1-10471459720.

If you have any questions about this notice, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Representations@cqc.org.uk

Write to: CQC Representations
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you contact us, please make sure you quote our reference number RGP1-10471459720 as it may cause delay if you are not able to give it to us.

Yours sincerely

Bernadette Hanney
Delegated Authority

cc.
NHS England
NHS Improvement

Trust Board – 1 April 2021

3.2

Agenda item:	3.2
Presented by:	Dr Fay Gilder – Medical Director
Prepared by:	Nicola Tikasingh – Matron for Quality and Mortality Lindsay Hanmore – ADON Quality improvement Robert Ayers – Deputy Director Quality Improvement Kevin Jennings – Programme Manager Bola Shoneye - Information Team Alex Schosland – Head of Information
Date prepared:	March 2021
Subject / title:	Learning From Deaths – February 2021 data and information

Purpose:	Approval		Decision		Information	X	Assurance	X
Executive Summary	This paper provides an update on our Learning From Death Process to the Quality and Safety Committee with assurance of PAHT compliance with National requirements.							
Recommendation:	To note: Issues with data submission for Dr Foster data (3.3) Nosocomial deaths update (4.5), Progress with SMART implementation (5.2)							

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:	This paper is also shared at the Strategic Learning From Death Group
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:	Appendix 1 – Mortality Dashboard

1.0 Purpose/issue

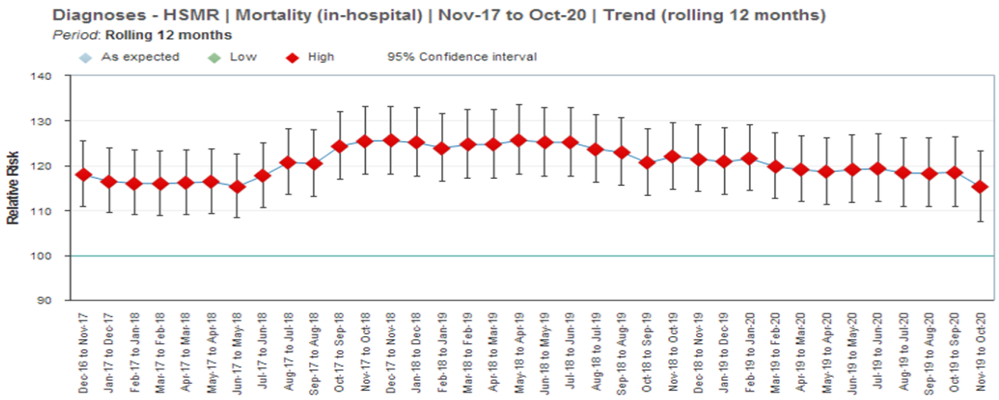
The purpose of this paper is to provide assurance on the implementation of the Learning from Death process, to highlight key pieces of learning and to provide progress updates on the current programme of work to improve clinical practice.

2.0 Background

PAHT now has a Learning from Death process that meets the National requirements.

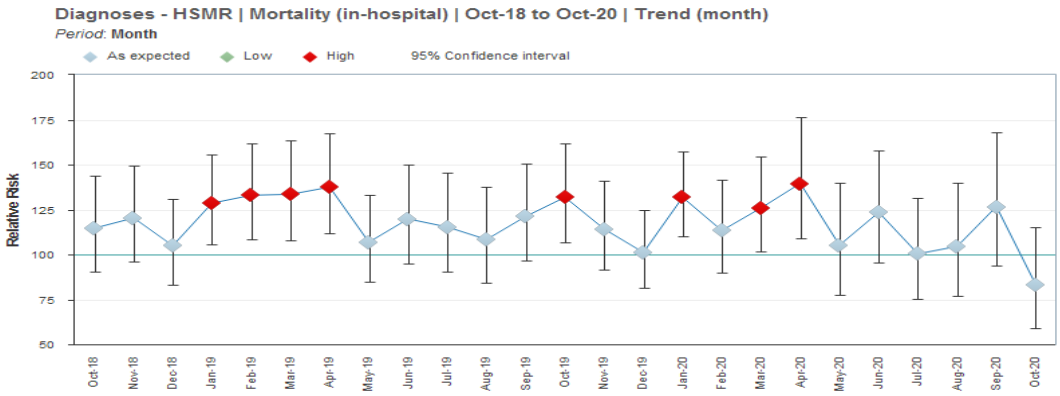
3.0 Current Dr Foster/ NHS D Data Headlines

3.1 Hospital Standard Mortality Rate (HSMR) - 12 month rolling



PAHT has shown significantly high HSMR since November 2016. The Relative Risk chart above shows the most recent 12 month rolling data point is 115.2. While the previous months show special cause improvement, this should be taken with caution as the Trust is still a significant outlier in our HSMR.

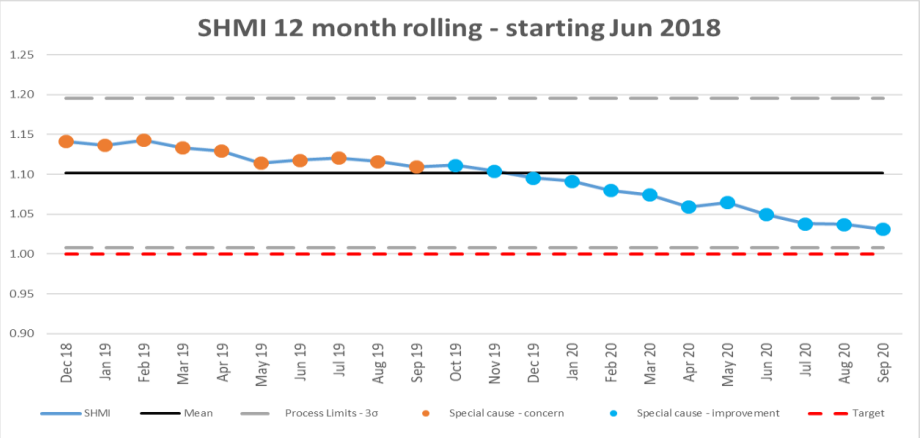
3.2 Hospital Standard Mortality Rate (HSMR) - in month



October 2020 was 83.4 (below national average but statistically “as expected”); our crude rate, 2.4%, was the lowest recorded.

3.3 Summary Hospital-level Mortality Indicator (SHMI)

The most recent SHMI value is 1.031 (September 2020). **We have not alerted since April 2019.**



There are 3 diagnostic groups that are significantly higher than expected (HSMR only) (appendix 1):

- Acute and unspecified renal failure
- COPD and Bronchiectasis
- Senility and organic mental disorders

Of the 10 diagnostic groups that have SHMI values calculated, all 10 are “As expected”.

3.3 Secondary Uses Service (SUS)

The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

Our SUS submission for September’s data was compromised due to a change within System C (our data needs to pass through this system in order to be uploaded to SUS). The change meant that our flex data (largely uncoded) could not be updated with freeze data. We are currently looking to refresh September’s data with a fully coded version. However, the process of running this dataset requires a change to our regular process and requires dedicated, thorough testing to ensure the new dataset is correct and that our current SUS process is not compromised. Our Business Intelligence Team is working on this as a top priority and we are hopeful to have a solution by the end of March 2021. It should be noted though, that HES data (which Dr Foster uses for HSMR and coded reports) will then be refreshed once the SUS data has been processed.

4.0 Summary of Learning from Death Data

4.1 In the reporting month of February 2021 there have been 83 deaths with 8 cases referred for a SJR. 2 of these cases were Nosocomial deaths, 4 deaths after surgery and 2 deaths that the medical examiner has picked up for learning.

4.2 There were 3 SJR's completed in February, 15 completed for January and 26 completed for December 2020. All these were for nosocomial deaths and the findings are the same as previously reported.

4.3 SJR's have also been referred for all patients who have died (of any cause) who have had their first vaccine to identify if there are any common themes. An audit of these cases (60 to date) is being undertaken to identify those themes and learning. Feedback from the audit is expected in April 2021.

4.4 There were 2 new cases referred to the second review panel for February 2021 deaths, which were both nosocomial COVID deaths. The second review panel reviewed 19 cases in total during February; these were all nosocomial cases. None of these cases were deemed to be avoidable deaths. Learning from these cases will be incorporated into the aggregated learning from deaths report, which will be shared with the CCG.

4.5 During the second wave (September 2020 to February 2021), there have been 313 COVID deaths with 60 of these listed as nosocomial deaths in total. (In February 2021 alone: 35 COVID deaths; 2 of which were nosocomial deaths).

4.6 The only incidents logged were the nosocomial cases – 2 logged on datix.

4.7 The CCG have advised that all nosocomial deaths that have been involved in part of a ward outbreak can be included in an aggregated report and action plan as the learning and themes will by very similar. All isolated cases (not part of a ward outbreak) will be investigated separately – there are 4 of these cases to date for the second wave.

5.0 Programme progress

51. Work is under way to finalise the Trust's Quality Strategy. Within this document the priority focus areas for mortality improvement will be included. This will help concentrate our focus as well as initiate the re-establishment of supporting programmes or work. There is a deputy medical director being appointed that will have a specific responsibility to leading and delivering the associated work programmes. The restructure of our Healthcare Groups will help to strengthen accountability and speciality level leadership.

5.2 SMART

The project team are working with the SMART team on a joint project plan for the implementation. Steps taken place so far:

- The procurement process has now been completed with both the revenue and capital purchase orders completed and sent to the supplier. The G-Cloud contract has also been completed and signed by the medical director
- As part of the agreed outcome from the IG review a SOP will be developed during the implementation of the SMART system
- A specification for the interface between Cosmic and SMART to populate the initial record in the system has been developed by the IT team and shared with the external developer
- An implementation working group has been set-up with weekly meetings to jointly work with the SMART team on the rollout of the system led by the Lead Medical Examiner
- The team is to schedule an initial meeting while the SMART implementation is taking place to develop the LFD and mortality dashboard incorporating all of the knowledge and work that has taken place so far including the external review.

Phase 1 (the implementation of SMART) will be completed by late April, beginning of May 2021.

6.0 Risks for Escalation

The Trust has a Corporate Mortality Risk Register and each individual project has its own risks and issues log. This is reviewed as part of the Strategic Learning From Deaths Group.

7/0 Recommendations

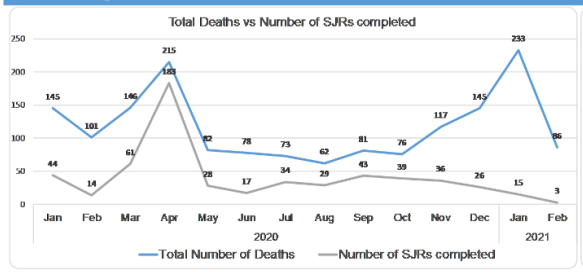
For the Group/Board to provide feedback on the contents of the paper to ensure a dynamic development of the information provided so that assurance can be provided.

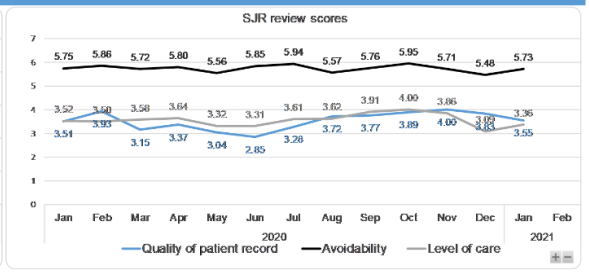
Appendix 1

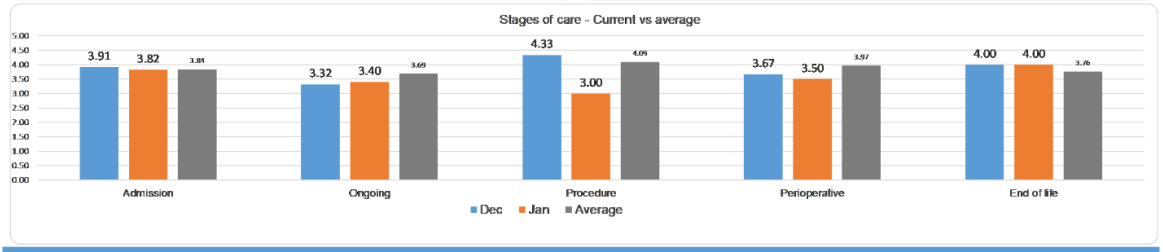
Mortality Dashboard

The Princess Alexandra Hospital NHS Trust

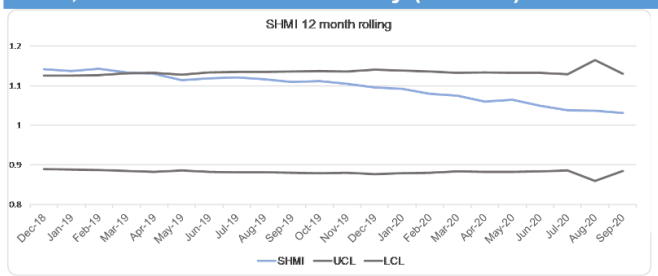
Learning from deaths

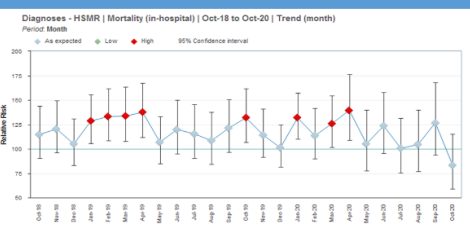


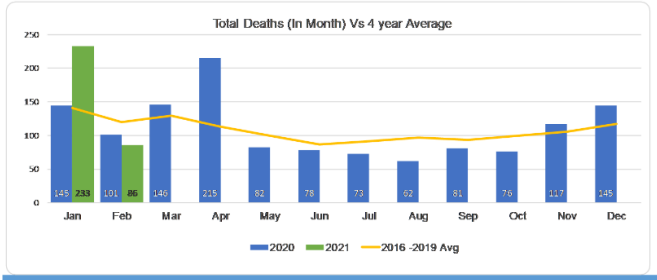


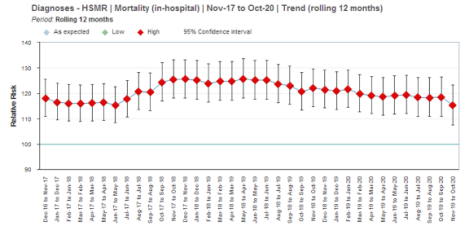


SHMI, HSMR and crude mortality (Cosmic)



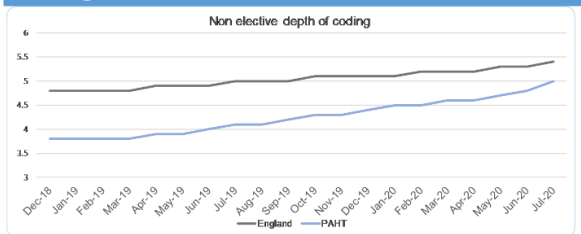


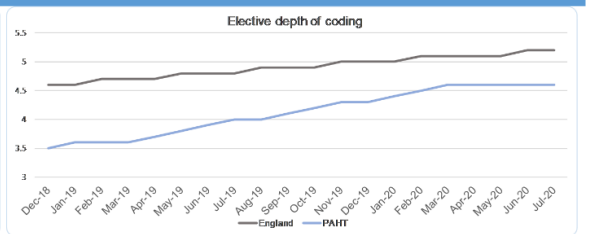


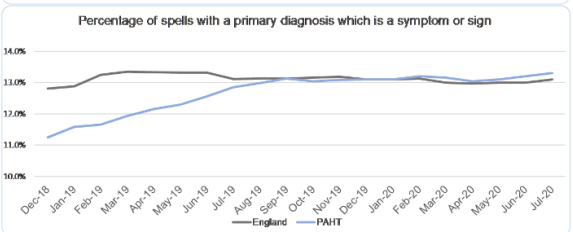


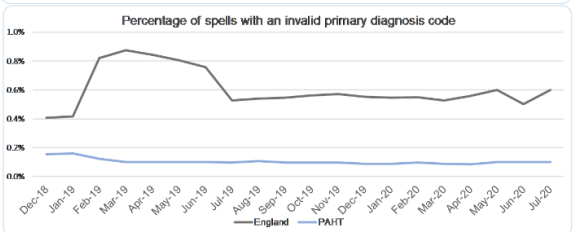
Diagnostic groups with alert status	Observed Deaths	Expected deaths	Excess deaths	HSMR
COPD and Bronchiectasis	30	20	10	152.1
Senility and organic mental disorders	17	9	8	184
Acute & Unspecified Renal Failure	44	31	13	141.5

Coding









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The Princess Alexandra Hospital NHS Trust

Trust Board – 1 April 2021

3.3

Agenda Item:	3.3
Presented by:	Jacqui Featherstone, Associate Director of Nursing & Midwifery; Erin Harrison: Lead Governance Midwife
Prepared by:	Erin Harrison: Lead Governance Midwife; Jacqui Featherstone: Associate Director of Nursing & Midwifery
Date prepared:	26/03/2021
Subject / Title:	Overview of Serious Incidents within maternity in Family And Women's Services

	Approval		Decision		Information	X	Assurance	X
Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	Following the Ockenden report published in December 2020, one of the essential actions 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 maternity and neonatal system (LMNS) for scrutiny oversight and transparency. Maternity currently have eight Open Serious Incidents (SI's). There have been 10 maternity cases reviewed by external investigators, the report has been completed, HCG have an associated action plan that has executive oversight.							
Recommendation:	To provide assurance to the Board that Family and Women's Services Health Group are continually monitoring compliance and learning from serious incidents.							

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

Previously	QSC 26/3/21
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity	To be compliant with the recent Ockenden report that was published in December 2020 with recommendations for maternity services.
Appendices:	N/A

The Princess Alexandra Hospital NHS
NHS Trust

3.3

1.0 PURPOSE

This paper outlines the open Serious (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, one of the essential actions from enhanced safety was that all Maternity SI's 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. It was suggested 3 monthly however this report will come monthly to QSC with abridged version via the Integrated performance report in the maternity dashboard to Board.

3.0 OVERSIGHT AND GOVERNANCE

All reported patient safety incidents are reviewed daily by healthcare group patient safety and quality group as per Trust Incident Management policy and bi weekly at the Trust wide Incident Management Group which agree actions and any escalations or external reporting in the form of serious incidents required.
All incidents are reported to the Patient Safety and Quality Group as well as the Quality and Safety Committee and reported serious incidents shared on the Trust Maternity dashboard.

All serious incidents reports and action plans are reviewed and agreed at the bi monthly serious incident assurance panel which is chaired by an Executive or Director. Additional maternity executive assurance and oversight in place fortnightly.

4.0 SERIOUS INCIDENTS

Since April 2020/21 the Trust have reported 10 serious incidents, of these,8 remain open and are within the agreed timeframe with root cause analysis investigations on going.
The themes within the open Sis are:

- Transfer of baby to a tertiary centre for additional care and treatment
- Additional care and treatment for the woman post delivery
- Reduced foetal movements/management of fetal growth resulting in Intrauterine death

5.0 MATERNITY EXTERNAL REVIEW

In addition, following a cluster in incidents over Autumn 2020, an external review was sought of 10 cases to identify if any overarching theme could be identified. The initial report has been received and is currently being checked for factual accuracy

No over-arching themes were found by the external reviewers that connected all the cases and for the majority they noted the care in a series of very disparate clinical situations was good.

Actions undertaken following report:

- Fortnightly meetings with Executive oversight
- Stakeholders event on 01.03.2021 (CCG, CQC, NHSI/E)
- Further stakeholder 19.04.2021 to review action plan
- Implemented weekly Maternity Risk Meeting as of 03.02.2021
- Interim Governance Lead Consultant and Lead Governance Midwife Appointed
- Audit undertaken on small for gestational age babies over timeframe of incidents occurring
- Work commenced to implement electronic e-obs – Currently using paper charts to mitigate this risk
- Serious incidents under investigation

Feedback from the next stakeholder event will be included in April's paper.

6.0 AREA OF IMPROVEMENT

Following any serious incident, immediate review of care and treatment is undertaken in the form of a rapid review and any immediate actions to reduce harm and reduce likelihood of similar incident reoccurring is actioned. Duty of candour is also undertaken and recorded.

Key area of improvement;

- Safety huddles in place to ensure teams are communicated with
- Post incident debrief with teams in place.
- Weekly sharing the learning updates to all staff in the form of newsletter
- Sharing incidents and best practice with LMNS (3 acute Trusts)
- All Cases have been presented at Mortality and Morbidity meeting for shared learning
- Review of existing guidelines/standard operating policy's undertaken and adapted if required
- Training and compliance in place for use of equipment such as CTG and external facilitators have supported
- Lead Risk Obstetrician now in place
- Strengthen the maternity risk and governance team
- Lead Governance Midwife now in place
- Fetal Surveillance Midwife in Post
- Lead Consultant for Fetal Surveillance in post
- Trust wide review of the major bleed protocol
- Implementation of Hot Week Consultant for consistency in plans and individualised care.
- New starter and locum induction programmes reviewed
- Learning shared with Community and Antenatal Team

7.0 RECOMMENDATION

It is requested that the Trust Board accept the report with the information provided and the ongoing work with the management and oversight of serious incidents.

Author: Erin Harrison: Lead Governance Midwife

Date: 26/03/2021

Trust Board – 1 April 2021

3.4

Agenda item:	3.4
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery
Date prepared:	March 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 This paper provides an oversight of the challenges faced by nursing and midwifery in trying to meet safe staffing levels across inpatient areas during February 2021. While every effort has been made to ensure the overall information is accurate due to factors above there remains a risk that some of the individual ward data remains inaccurate. Data where possible is provided against both the standard and minimum templates The overall nursing vacancy position remains Green and is currently 7%. 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:	
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers QSC.26.03.21 and WFC.29.03.21
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

1.0 PURPOSE

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

2.0 BACKGROUND

Over the month of February the Trust continued to see a reduction in the number of Covid positive patients and decreasing staff absence from Covid. The Trust response was to decrease the number of Covid positive wards and increase the number of non Covid wards Paediatrics and maternity services have been largely unaffected by the second wave. Critical care unit was required to have staffing to meet in super surge levels agreed with the critical care network but the number of Level 3 or equivalent patients was at or below surge level 2 – (12 x Level 3 or equivalent) .

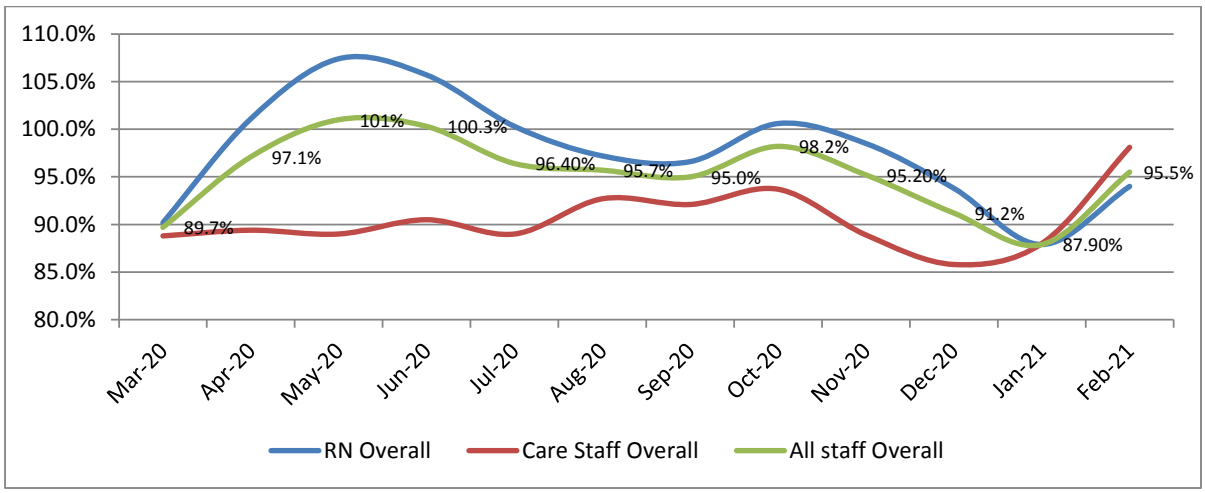
3.0 ANALYSIS

3.1 There were a high volume number of ward changes including opening and closing for part of the month, bed closures due to IPC issues and changing patient acuity. Due to the fluidity and rapidity of the changes, these will not all be reflected in the data. In addition, the data does not reflect the skill mix of staff which has been impacted by the amount of staff who have been redeployed from their normal area of practice.

3.2 The Trust Safer Staffing Fill rates for February 2021 against the standard templates for overall RN/RM in month has increased to 94.0%, which is an increase of 6.1% against January 2021.

3.3 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 February 21	91.3%	91.4%	97.5%	108%	94%	98.1%	95.5%
In Patient Ward average January 21	85.0%	82.4%	90.4%	96.2%	87.9%	88.0%	87.9%
Variance February 21 - January 21	↑6.3%	↑9.0%	↑7.1%	↑11.8%	↑6.1%	↑10.1%	↑7.6%



February data based on Standard Demand Templates

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 (%)
January 2021	72.6%	71.7%	91.6%	82.4%
February 2021	79.3%	88.2%	99.0%	85.1%

While there has been an increase in nurse staffing levels within ED, 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 Medicine and Urgent care teams supported by the Executive Team.

3.5 Critical care

Critical care staffing has been guided by 'Advice on acute sector workforce models during COVID' (NHSE) which recommends staffing ratios for critical care units based on patient acuity and staff competency. The advice defines 3 levels of staff competency and provides guidance on patient ratios for these different groups. Staff with current critical care knowledge and skills (defined as critical care nurses) should be supported by those who may have worked outside the area for some time critical care knowledge and skills (defined as RN 'A') or have a transferable skill set such as theatre recovery (defined as RN 'B'). The deployment of RN 'A' and 'B' nurses to support critical care nurses is recommended to ensure the overall ratio of nurse to patient is maintained at 1:1 for Level 3 patients or equivalent but enables the ratio of critical nurse to patient be reduced from the normal of 1:1 for a Level 3 patient to 1:2 or 1:3 during periods of surge and super surge activity.

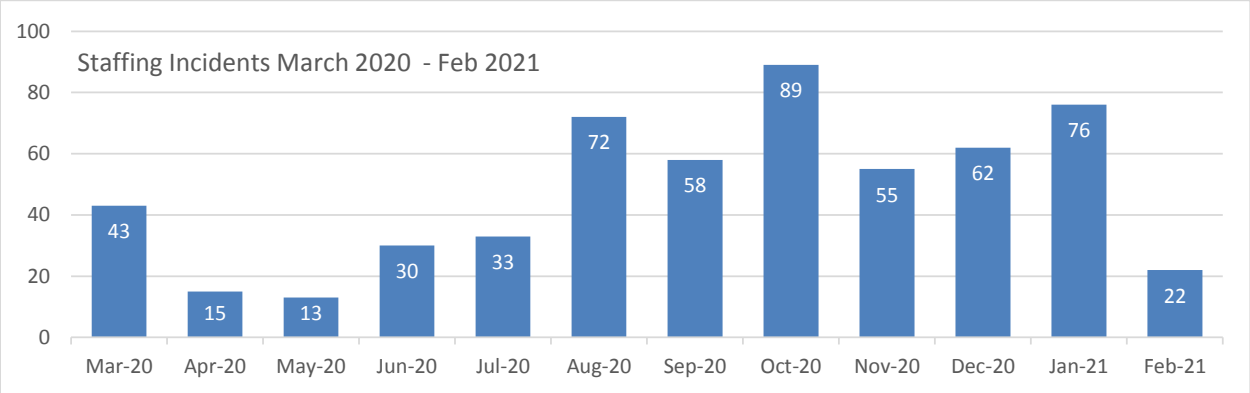
Across February the unit critical care activity reduced to below surge level 2 and critical care nurse to patient ratio was 1:1 across all shifts.

3.6 Fill rates by ward

Fill rates by ward have been produced against the standard planned templates (Appendix 1). Average fill rates below 75% for registered nurses against the standard planned template are reported in 1 area Kingsmoor ward. 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.

3.7 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 significantly decreased in month, though ED (6) and Tye Green (6) remain the main wards raising Datix reports in relation to staffing levels. 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 February 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 (↓1124 shifts) in February compared to January. February shows a decrease in agency usage (↓ 15 shifts). The overall fill rate increased from 59.4% to 67.5%

RN temporary staffing demand and fill rates*: (February 2021 data supplied by NHSP 5.3.2021)*

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
November 2020	3313	2401	61.1%	373	11.3%	72.9%	899	27.1%
December 2020	3621	1888	52.1%	440	12.2%	64.3%	1293	35.7%
January 2021	4210	2414	50.9%	360	8.6%	59.4%	1709	40.6%
February 2021	**3086**	**1739**	**56.4%**	**345**	**11.2%**	**67.5%**	**1002**	**32.5%**
February 2020	4247	2421	52.8%	942	22.2	74.9%	1064	25.1%

The HCSW demand shows also shows a reduction in unregistered demand (↓487 shifts), there was also an increase in fill rate from 56.9% in January to 73.0% in February. There was a significant increase in the number of agency HCA filled shifts (↑81 shifts).

HCA temporary staffing demand and fill rates: ***(February 2021 data supplied by NHSP 5.3.2021)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
October 2020	1444	1049	72.6%	0	0%	75.3%	613	24.7%
November 2020	1582	1041	65.8%	0	0%	65.8%	541	34.2%
December 2020	2031	1032	50.8%	40	2.0%	52.8%	959	47.2%
January 2021	2026	1082	53.4%	70	3.5%	56.9%	874	43.1%
February 2021	**1539**	**972**	**63.2%**	**151**	**9.8%**	**73.0%**	**416**	**27.0%**
January 2020	2647	1848	69.8%	0	0	69.8%	799	30.2%

B: Workforce:

Nursing Recruitment Pipeline

The overall nursing vacancy rate in February was 7.8%. The vacancy rate for Band 5 RN's was 9.2%. There are 110 nurses in the pipeline who hold offers, of which almost all are international nurses. There are 42 international nurse due to commence between now and the end of May 2022. There continues to be NHSE funding to cover costs of international recruitment and support to reduce nurse vacancies to < 1% in year.

The Trust has received an offer of further financial support from NHSE to escalate international recruitment for 2021/22 and will receive £7,000 per international nurse recruited from the end of October 2022.

Establishment V Staff in Post												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Funded Establishment WTE	942.61	942.61	942.61	942.61	942.61	966.25	966.25	966.25	966.25	966.25	966.25	966.25
Staff in Post WTE	871.00	868.00	866.00	858.00	862.00	856.00	884.00	884.00	900.00	899.00	891.00	897.00
Vacancy WTE	71.61	74.61	76.61	84.61	80.61	110.25	82.25	82.25	66.25	67.25	75.25	69.25
Actual RN Vacancy Rate	7.6%	7.9%	8.1%	9.0%	8.6%	11.4%	8.5%	8.5%	6.9%	7.0%	7.8%	7.2%
Forcast Vacancy Rate in Business Plan												

Band 5 Establisment V Staff in Post												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Funded Band 5 Establisment WTE	487.93	487.93	487.93	487.93	487.93	522.2	522.2	522.2	522.2	522.2	522.2	522.2
Band 5 Staff in Post WTE	447	446	446	450	446	471	471	474	470	467	474	490
Band 5 Starters	1	0	2	7	1	28	3	7	4	3	11	22
Vacancy Band 5 WTE	40.93	41.93	41.93	37.93	41.93	51.2	51.2	48.2	52.2	55.2	48.2	32.2
Actual Vacancy Rate	8.4%	8.6%	8.6%	7.8%	8.6%	9.8%	9.8%	9.2%	10.0%	10.6%	9.2%	6.2%
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
RNs (not Band 5)	2	0	0	0	0	4	6	2	0	3	1	3
Band 5 Newly Qualified + Local	1	0	1	7	1	7	3	5	0	3	0	2
Band 5 International Recruitment	0	0	0	0	0	21	0	18	13	0	11	20
Band 5 Starters	**1**	**0**	**1**	**7**	**1**	**28**	**3**	**23**	**13**	**3**	**11**	**22**
Total Starters	3	0	1	7	1	32	9	25	13	6	12	25

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
RNs (not Band 5) Leavers	3	1	7	0	2	1	6	5	6	8	2	2
Band 5 Leavers	3	1	2	3	5	3	3	4	8	6	4	6
Total Leavers	**6**	**2**	**9**	**3**	**7**	**4**	**9**	**9**	**14**	**14**	**6**	**8**
N&M Turnover %	10.53%	10.18%	10.12%	10.17%	10.17%	9.68%	10.12%	9.52%	9.97%	9.48%	8.71%	

Establishment V Staff in Post												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Funded Establishment WTE	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61
Actual RN Vacancy Rate	7.6%	7.9%	8.1%	9.0%	8.6%	9.2%	6.2%	6.2%	4.5%	4.6%	5.5%	4.3%
Band 5 Establisment V Staff in Post												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Funded Band 5 Establisment WTE	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93
Actual Vacancy Rate	8.4%	8.6%	8.6%	7.8%	8.6%	3.5%	3.5%	2.9%	3.7%	4.3%	2.2%	-1.0%

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: 17 March 2021

Appendix 1

Ward level data: fill rates February 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.

Analysis of areas with red fill rates has not been undertaken this month as there is still a number of DQ issues with the data and across the month we moved from standard planned to minimum templates.

	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
Harvey Ward	113.2%	62.9%	103.6%	90.4%	109.3%	76.1%	94.0%
Lister Ward	91.4%	96.7%	100.9%	98.8%	95.4%	97.6%	96.4%
Locke Ward	78.6%	106.8%	100.0%	115.6%	87.6%	110.2%	95.7%
Penn Ward	95.8%	109.5%	115.5%	116.0%	102.8%	112.0%	106.3%
Ray Ward	88.2%	65.5%	88.5%	124.5%	88.3%	84.0%	86.6%
Saunders Unit	95.7%	115.2%	95.5%	138.7%	96.1%	124.1%	106.2%
Tye Green Ward	104.3%	79.6%	106.2%	113.3%	105.1%	93.4%	100.0%
Winter Ward	108.7%	89.4%	133.3%	141.2%	118.7%	109.1%	114.7%
Charnley Ward	88.2%	105.6%	100.2%	160.5%	93.3%	126.4%	105.1%
AAU	115.1%	114.3%	117.0%	120.6%	116.0%	116.7%	116.3%
Kingsmoor	59.6%	67.7%	73.2%	79.8%	65.4%	72.6%	68.5%
Fleming Ward	80.5%	88.9%	104.5%	106.8%	90.7%	95.7%	92.5%
Harold Ward	88.4%	86.8%	98.8%	97.8%	92.8%	91.3%	92.1%
Neo-Natal Unit	93.5%	150.0%	97.2%	110.7%	95.4%	130.4%	101.2%
Dolphin Ward	91.5%	80.0%	91.1%	85.7%	91.3%	81.9%	88.9%
Maternity	83.1%	94.7%	81.6%	87.3%	82.4%	91.2%	84.8%
Total	91.3%	91.4%	97.5%	108.0%	94.0%	98.1%	95.5%

Appendix 2

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

	Report from the Associate Director of Nursing for the HCG		
Ward	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Kingsmoor	Overall fill rate RN 65.4% and HCSW 72.6% Overall Fill 68.5%	Safer Nursing Care data which captures occupancy and patient acuity shows that the number of hours of available staff met or exceeded those required for the majority of the shifts in month.	Nil

The Princess Alexandra Hospital NHS Trust

Trust Board – 1 April 2021

4.1

Agenda item:	4.1
Presented by:	Ogechi Emeadi, Director of people, OD and communications
Prepared by:	Martin Smith, Associate director for training, education and development
Date prepared:	19/03/2021
Subject / title:	Staff survey 2020 results and improvement plan

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:

This paper provides an overview of the 2020 PAHT NHS staff survey final results, and provides an initial comparison to results from previous years.

The final 2020 response rate was 38.2%, a 6.8% decrease to that of 2019. Medicine HCG was the only HCG to achieve a small increase in response.

Historical compassion: Only 1 question scored significantly better than last year, and 24 questions scored significantly worse.

Comparison with average: There were no questions that scored significantly better than last year, and 55 that scored significantly worse.

The national benchmarking report covers the 280 NHS organisations which took part in the 2020 survey, and shows how PAHT compares against 10 key 'themes'.

The paper also sets out the Trust's response plan, including the sharing of results, PAHT's 3 improvement priorities and development of corporate, HCG and divisional improvement/action plans.

Recommendation:

To review and discuss the results, and approve the response plans.

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:	EMT and WFC.29.03.21
Risk / links with the BAF:	BAF 2.3 - Workforce: Inability to recruit, retain and engage our people
Legislation, regulatory, equality, diversity and dignity implications:	CQC – Well Led
Appendices:	1. 2020 NHS staff survey – Summary benchmark report

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4.1

1.0 Purpose

This paper outlines the headline results of the national NHS Staff Survey 2020 undertaken at PAHT, including comparisons to previous years' results, and the response plan agreed by EMT and SMT, for workforce committee approval.

2. Background

The annual NHS Staff Survey 2020 launched at PAHT on 28 September and closed on 27 November 2020. All substantive staff in post on 1 September 2020 were invited to complete the survey, excluding those on long-term sick for 90 days, on unpaid career breaks, bank or locum staff, student nurses and non-executive directors (as per national guidance). The survey was administered by our chosen provider, the Picker Institute (Picker).

This year PAHT reverted to issuing on-line surveys for all staff groups except those in Estates & Facilities, who were issued with paper surveys. A wide range of data reports have been received from Picker, and these are available on request from the DoP, including:

- Final management report
- RAG tables – including localities 1-3, staff group and demographic data
- Organisational level core questionnaire frequency tables
- Staff engagement reports
- Free text comments reports
- Locality reports
- Local questions report

The Picker reports compare our 2020 results from those recorded in previous years, and they also compare our results with 58 other similar acute trusts that use their surveying services.

The national benchmarking reports were made public by the NHS England's Survey Coordination Centre on 11th March. Any reporting outside of the Trust before this date was embargoed.

The national benchmarking report covers the 280 NHS organisations which took part in the 2020 survey, including all 220 NHS trusts (595,270 staff – 47% response rate).

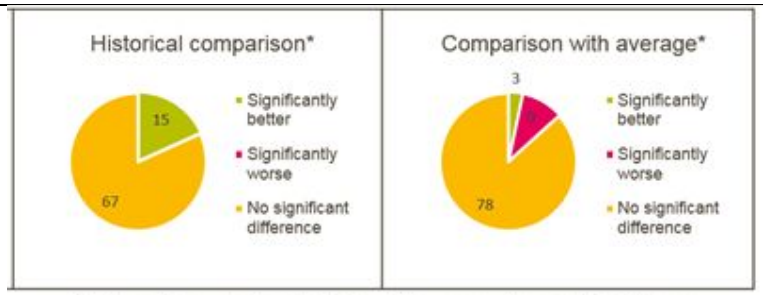
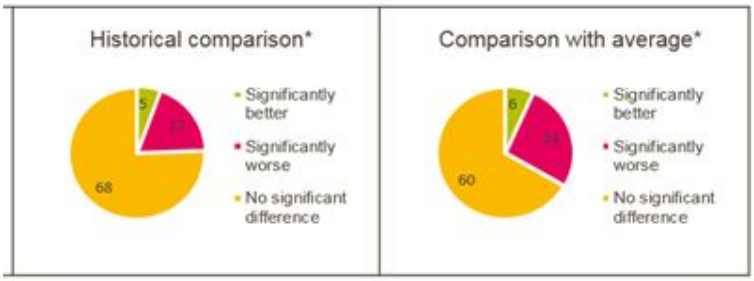
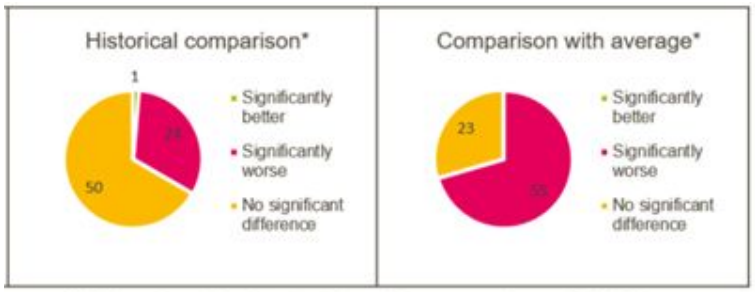
3. Response rates

The Trust achieved a 38.2% response rate (1368 respondents from an eligible sample of 3578 staff), a 6.8% decrease to that of 2019. We also remain below the average response rate for 58 similar Picker organisations (49.4%), with the worst performing acute Trust on 34.8% and the best performing acute Trust on 77.0%. For the PAHT national benchmarking report we are compared to 128 Acute and Acute & Community Trusts (402,201 staff – 45% response rate). Below is a comparison of the PAHT response rates from 2018, 2019 and 2020 by HCG, including the variance between 2019 and 2020.

HCG	Response rate 2018	Response rate 2019	Response rate 2020	Variance 2019-2020
CCCS	44%	51%	45.2%	- 6.8%
Corporate	79%	80%	63.3%	- 16.7%
Estates & Facilities	23%	66%	45.2%	- 20.8%
Family & Women's Services	35%	42%	36.2%	- 5.8%
Medicine	32%	24%	24.6%	+ 0.6%
Surgery	36%	35%	30.7%	- 4.3%
Totals	40%	45%	38.2%	- 6.8%

4. Overall historical comparison

The table below outlines how PAHT's 2020 results have changed from the previous two year's. The 'comparison with average' section refers to the average acute trust results using Picker as their provider. PAHT rank #57 of 59 acute Trusts (using Picker) for our overall positive score, and rank #56 for our historic positive score change.

2018 historical comparison	 *Chart shows the number of questions that are better, worse, or show no significant difference
2019 historical comparison	 *Chart shows the number of questions that are better, worse, or show no significant difference
2020 historical comparison	 *Chart shows the number of questions that are better, worse, or show no significant difference

The average scores have been calculated from all 59 acute Trusts that commissioned Picker to conduct their survey. The historical comparison tables contain positive scores, where higher scores indicate better performance.

Historical compassion: Only 1 question scored significantly better than last year, and 24 questions scored significantly worse.

Comparison with average: There were no questions that scored significantly better than last year, and 55 that scored significantly worse.

The historical and Picker average comparisons are shown below.

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Your Job (part 1 of 3)

		Historical					Picker Average	
		2016	2017	2018	2019	2020	Picker Average	Your Organisation
Q2a	Often/always look forward to going to work	56%	56%	61%	61%	56%	58%	56%
Q2b	Often/always enthusiastic about my job	74%	74%	76%	74%	72%	73%	72%
Q2c	Time often/always passes quickly when I am working	77%	76%	77%	76%	76%	76%	76%
Q3a	Always know what work responsibilities are	87%	87%	87%	89%	88%	86%	88%
Q3b	Feel trusted to do my job	91%	92%	91%	91%	90%	91%	90%
Q3c	Able to do my job to a standard I am pleased with	80%	76%	78%	82%	79%	80%	79%
Q4a	Opportunities to show initiative frequently in my role	73%	72%	74%	70%	68%	71%	68%
Q4b	Able to make suggestions to improve the work of my team/dept	74%	74%	76%	72%	70%	72%	70%
Q4c	Involved in deciding changes that affect work	51%	53%	54%	51%	47%	49%	47%
Q4d	Able to make improvements happen in my area of work	53%	57%	58%	54%	50%	54%	50%

Your Job (part 2 of 3)

		Historical					Picker Average	
		2016	2017	2018	2019	2020	Picker Average	Your Organisation
Q4e	Able to meet conflicting demands on my time at work	39%	42%	45%	48%	46%	49%	46%
Q4f	Have adequate materials, supplies and equipment to do my work	39%	40%	46%	46%	49%	58%	49%
Q4g	Enough staff at organisation to do my job properly	19%	23%	25%	27%	30%	37%	30%
Q4h	Team members have a set of shared objectives	69%	72%	74%	71%	69%	71%	69%
Q4i	Team members often meet to discuss the team's effectiveness	53%	60%	59%	57%	53%	56%	53%
Q4j	I receive the respect I deserve from my colleagues at work	-	-	71%	69%	66%	70%	66%
Q5a	Satisfied with recognition for good work	49%	49%	56%	54%	51%	56%	51%
Q5b	Satisfied with support from immediate manager	65%	69%	69%	68%	63%	68%	63%
Q5c	Satisfied with support from colleagues	79%	82%	82%	77%	76%	80%	76%
Q5d	Satisfied with amount of responsibility given	70%	73%	74%	71%	69%	74%	69%

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Your Job (part 3 of 3)

		Historical					Picker Average	
		2016	2017	2018	2019	2020	Picker Average	Your Organisation
Q5e	Satisfied with opportunities to use skills	67%	68%	71%	69%	66%	71%	66%
Q5f	Satisfied with extent organisation values my work	36%	39%	46%	46%	41%	48%	41%
Q5g	Satisfied with level of pay	30%	28%	34%	34%	31%	36%	31%
Q5h	Satisfied with opportunities for flexible working patterns	43%	48%	52%	50%	49%	55%	49%
Q6a	I have realistic time pressures	-	-	20%	22%	22%	24%	22%
Q6b	I have a choice in deciding how to do my work	-	-	52%	55%	51%	53%	51%
Q6c	Relationships at work are unstrained	-	-	43%	43%	39%	45%	39%
Q7a	Satisfied with quality of care I give to patients/service users	79%	78%	79%	82%	79%	82%	79%
Q7b	Feel my role makes a difference to patients/service users	88%	88%	90%	89%	89%	90%	89%
Q7c	Able to provide the care I aspire to	63%	63%	66%	69%	66%	70%	66%

Your Managers (part 1 of 2)

		Historical					Picker Average	
		2016	2017	2018	2019	2020	Picker Average	Your Organisation
Q8a	My immediate manager encourages me at work	-	-	70%	68%	64%	69%	64%
Q8b	Immediate manager can be counted on to help with difficult tasks	68%	73%	71%	70%	66%	70%	66%
Q8c	Immediate manager gives clear feedback on my work	57%	63%	62%	61%	56%	60%	56%
Q8d	Immediate manager asks for my opinion before making decisions that affect my work	51%	56%	56%	52%	49%	54%	49%
Q8e	Immediate manager supportive in personal crisis	70%	75%	75%	74%	70%	74%	70%
Q8f	Immediate manager takes a positive interest in my health & well-being	63%	70%	69%	66%	65%	68%	65%

Your Managers (part 2 of 2)

		Historical					Picker Average	
		2016	2017	2018	2019	2020	Picker Average	Your Organisation
Q8g	Immediate manager values my work	67%	74%	73%	71%	67%	71%	67%
Q9a	I know who senior managers are	79%	86%	86%	85%	81%	83%	81%
Q9b	Communication between senior management and staff is effective	36%	39%	45%	42%	37%	43%	37%
Q9c	Senior managers try to involve staff in important decisions	32%	36%	38%	35%	31%	34%	31%
Q9d	Senior managers act on staff feedback	29%	32%	36%	34%	30%	34%	30%

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Your Health, Well-Being and Safety at Work (part 1 of 3)

		Historical					Picker Average	
		2016	2017	2018	2019	2020	Picker Average	Your Organisation
Q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	67%	64%	63%	63%	64%	65%	64%
Q10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	37%	34%	38%	46%	40%	46%	40%
Q11a	Organisation definitely takes positive action on health and well-being	21%	24%	25%	28%	25%	31%	25%
Q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	72%	70%	70%	69%	67%	71%	67%
Q11c	In last 12 months, have not felt unwell due to work related stress	60%	60%	59%	59%	49%	56%	49%
Q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	38%	38%	38%	30%	46%	52%	46%
Q11e	Not felt pressure from manager to come to work when not feeling well enough	68%	72%	73%	69%	70%	73%	70%
Q11f	Not felt pressure from colleagues to come to work when not feeling well enough	77%	79%	78%	80%	76%	77%	76%
Q11g	Not put myself under pressure to come to work when not feeling well enough	7%	9%	8%	10%	6%	8%	6%
Q12a	Not experienced physical violence from patients/service users, their relatives or other members of the public	86%	86%	86%	89%	86%	85%	86%

Your Health, Well-Being and Safety at Work (part 2 of 3)

		Historical					Picker Average	
		2016	2017	2018	2019	2020	Picker Average	Your Organisation
Q12b	Not experienced physical violence from managers	99%	99%	99%	99%	99%	99%	99%
Q12c	Not experienced physical violence from other colleagues	98%	97%	98%	97%	98%	98%	98%
Q12d	Last experience of physical violence reported	59%	75%	67%	69%	70%	68%	70%
Q13a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	69%	71%	71%	73%	72%	74%	72%
Q13b	Not experienced harassment, bullying or abuse from managers	83%	83%	84%	85%	84%	87%	84%
Q13c	Not experienced harassment, bullying or abuse from other colleagues	79%	83%	80%	77%	77%	80%	77%
Q13d	Last experience of harassment/bullying/abuse reported	44%	47%	47%	54%	43%	46%	43%
Q14	Organisation acts fairly: career progression	80%	82%	83%	83%	79%	84%	79%
Q15a	Not experienced discrimination from patients/service users, their relatives or other members of the public	94%	94%	94%	94%	92%	93%	92%
Q15b	Not experienced discrimination from manager/team leader or other colleagues	92%	91%	92%	92%	90%	91%	90%

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Your Health, Well-Being and Safety at Work (part 3 of 3)

		Historical					Picker Average	
		2016	2017	2018	2019	2020	Picker Average	Your Organisation
Q16a	Organisation treats staff involved in errors/near misses/incidents fairly	45%	51%	56%	52%	50%	60%	50%
Q16b	Organisation encourages reporting of errors/near misses/incidents	85%	88%	88%	85%	84%	88%	84%
Q16c	Organisation takes action to ensure errors/near misses/incidents are not repeated	63%	68%	69%	65%	65%	73%	65%
Q16d	Staff given feedback about changes made in response to reported errors/near misses/incidents	51%	55%	61%	55%	56%	62%	56%
Q17a	Know how to report unsafe clinical practice	94%	97%	95%	94%	93%	95%	93%
Q17b	Would feel secure raising concerns about unsafe clinical practice	68%	71%	72%	68%	67%	72%	67%
Q17c	Would feel confident that organisation would address concerns about unsafe clinical practice	51%	58%	59%	55%	52%	60%	52%

Your Organisation

		Historical					Picker Average	
		2016	2017	2018	2019	2020	Picker Average	Your Organisation
Q18a	Care of patients/service users is organisation's top priority	70%	74%	80%	77%	75%	79%	75%
Q18b	Organisation acts on concerns raised by patients/service users	71%	73%	77%	71%	69%	74%	69%
Q18c	Would recommend organisation as place to work	48%	48%	57%	57%	53%	66%	53%
Q18d	If friend/relative needed treatment would be happy with standard of care provided by organisation	58%	58%	62%	61%	60%	73%	60%
Q18e	Feel safe in my work (New for 2020).	-	-	-	-	73%	79%	73%
Q18f	Feel safe to speak up about anything that concerns me in this organisation (New for 2020).	-	-	-	-	56%	65%	56%
Q19a	I don't often think about leaving this organisation	-	-	41%	42%	40%	48%	40%
Q19b	I am unlikely to look for a job at a new organisation in the next 12 months	-	-	49%	50%	49%	55%	49%
Q19c	I am not planning on leaving this organisation.	-	-	54%	56%	54%	61%	54%

Background Information

		Historical					Picker Average	
		2016	2017	2018	2019	2020	Picker Average	Your Organisation
Q26b	Disability: organisation made adequate adjustment(s) to enable me to carry out work (Modified for 2020)	-	-	-	-	66%	75%	66%

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5. Headline results

Outlined below are the headline Picker results across the Trust, identifying where we have made the most and least progress since last year, and how our scores compare to other acute Trusts.

	Most improved from last survey		Least improved from last survey
46%	Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	43%	Q13d. Last experience of harassment/bullying/abuse reported
30%	Q4g. Enough staff at organisation to do my job properly	49%	Q11c. In last 12 months, have not felt unwell due to work related stress
49%	Q4f. Have adequate materials, supplies and equipment to do my work	40%	Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours
70%	Q11e. Not felt pressure from manager to come to work when not feeling well enough	41%	Q5f. Satisfied with extent organisation values my work
70%	Q12d. Last experience of physical violence reported	6%	Q11g. Not put myself under pressure to come to work when not feeling well enough
	Top 5 scores (compared to average) (PAHT this year only achieved 3)		**Bottom 5 scores (compared to average)**
70%	Q12d. Last experience of physical violence reported	60%	Q18d. If friend/relative needed treatment would be happy with standard of care provided by organisation
88%	Q3a. Always know what work responsibilities are	53%	Q18c. Would recommend organisation as place to work
86%	Q12a. Not experienced physical violence from patients/service users, their relatives or other members of the public	50%	Q16a. Organisation treats staff involved in errors/near misses/incidents fairly
		49%	Q4f. Have adequate materials, supplies and equipment to do my work
		56%	Q18f. Feel safe to speak up about anything that concerns me in this organisation

A full range of Picker data reports (see 2.0 above) are available on request from the DoP.

6. Free text reports

There were over 1600 comments to the two free text questions, and the top themes are summarised below:

Q21a. Thinking about your experience of working through the Covid-19 pandemic, what lessons should be learned from this time?

1. Poor management support e.g. visibility, availability, communication, listening, mental health support, showing understanding
2. Poor/unclear communication e.g. ward moves, visiting guidelines, messages not reaching frontline staff, reliance on email, not involving staff
3. Poor experience of redeployment e.g. communication, support/orientation, training, impact on mental health, manager contact, ward moves, use of skills, morale, feeling unvalued
4. Poor experience of teams being separated
5. Insufficient PPE
6. Importance of teamwork

Q21b. What worked well during Covid-19 and should be continued?

1. Remote & flexible working options
2. IT equipment to support remote working
3. Team work / camaraderie / integrated working
4. Communication - regular email updates

7. National benchmarking report

Ten summary indicators are used in the national benchmarking reports. These are referred to as 'themes', and have been created from responses to certain survey questions. All 'themes' are scored on a scale that ranges from 0 (worst) to 10 (best). An overview of the 2020 NHS staff survey themed results is shown below, and a summary benchmark report is attached as appendix 1.

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	8.8	5.5	6.5	5.8	7.4	7.7	9.4	6.5	6.8	6.3
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	1,320	1,333	1,336	1,316	1,170	1,286	1,325	1,321	1,350	1,343

A full national benchmarking report, and a national benchmarking directorate report are also available on request from the DoP.

8. Response planning requirements

The Trust has a responsibility to ensure that the staff survey findings are effectively used to inform improvements to both the services we provide for patients, and the experience our people have working for our organisation (this is a CQC requirement).

The results overall reflect that 2020 was a really challenging year, and whilst all NHS organisations will have seen immense pressure brought on by the pandemic, our people report to have had a poorer experience compared to other acute trusts on average.

It is imperative that we pay close attention to what our people have told us in the 2020 survey, and show our people we are learning from what has worked well in some parts of the Trust, and within other organisations, and where feedback has been poor we are committed to seeking out how we can improve, and change things as part of our Back to Better campaign.

By analysing our results and conducting further staff engagement/listening events, we can draw up action plans which will be embedded and owned within HCG's and divisions, as well as identifying cross-cutting PAHT themes (our 3 top improvement priorities) that will need to be driven forward corporately. Managers at all levels will then be held accountable for a range of measurable ongoing improvements that can be reviewed at further listening events, and tested against our 2021 survey results.

9. Response plan approach

To enable a cohesive, collaborative and supportive review of our results and the development of corporate, HCG and divisional improvement action plans, a series of facilitated communication and listening workshop events will be held virtually. These events will communicate our results, listen to further feedback and improvement ideas from our people, formulate our improvement objectives and action plans, then identify and equip accountable and responsible managers to lead on each improvement objective/plan.

This work will feed into, and be supported and monitored by a new PAHT OD Steering group, led by our new AD for learning & OD, and supported by our OD and HRBP teams. Action plan progress will be monitored by the Executive team at PRM's, with bi-monthly assurance reporting to the Workforce Committee and updates to Trust Board.

EMT and SMT have identified and agreed 3 key corporate improvement priorities:

Priority 1: Improving the physical and mental health and wellbeing of our people

Priority 2: Improving our learning and safety culture, encouraging people to openly raise concerns and ensure they are acted upon (improving psychological safety)

Priority 3: Improving the effectiveness of line managers

The following key principles have also been agreed, taking into account these 3 priorities:

1. Identifying HCG/divisional additional improvement themes specific to their services' survey findings.
2. Involving staff across a range of roles and levels in forming improvement plans.
3. Identifying an accountable and responsible lead for each area's improvement objective/plan.
4. Ensure robust monitoring processes to support implementation of 'change at pace'.

These principles will be met through the following:

1. Analysis of 2020 survey results and key result trends over past three years.
2. Communication and sharing of our results and response planning to SMT, Trust Board, HCG's/Divisions, appropriate committees/groups/forums, EDI steering group, JSCC, Staff Council, all our people and external media.
3. Initial people engagement/listening improvement planning workshops at HCG/divisional levels.
4. Bringing together HCG/division stakeholders to identify key local priorities.
5. Finalise improvement action plans, identify and equip managers, who will then be held accountable for these plans.
6. Running workshops to inform and support the improvement plans.

7. Supporting leads to run further local listening workshops – assuring our people that their feedback is being listened to and acted upon.
8. Monitoring Trust/HCG/division level improvement plans via the OD Steering Group, and People Board. Progress concerns to be escalated via monthly HCG PRM's and HCG board meetings. Divisional level improvement plans to be monitored via HCG Board meetings (or equivalent senior meetings). Bi-monthly assurance updates to be presented at Workforce Committee and progress reported to Trust Board.

An improvement action planning template has been developed to capture the above, which will include:

- Trust level: top three strategic priorities and Trust-wide improvement actions
- HCG level: top three strategic priorities, plus local priorities and HCG-led improvement actions
- Divisional level: any additional identified priorities & division/team led improvement Actions

Staff survey HCG 'back to better' workshops have commenced, or have been scheduled as follows:

- 16/03/21 CCCS (completed with positive feedback)
- 19/03/21 Urgent and Emergency Care
- 23/03/21 Medicine
- 23/03/21 Corporate
- 26/03/21 FAWS
- 29/03/21 Estates & Facilities (pending confirmation)
- TBC Surgery

Workshops are being facilitated by OD staff in collaboration with HRBP colleagues, where availability allows. HCG senior leadership teams are being encouraged to invite leaders at all levels within all their departments to these workshops.

Workshop outputs will include, a summary of discussion points, ideas and any concerns. Senior leadership teams will use these outputs to agree an outline improvement plan to be shared at EMT on 08/04/21. 'Back to better' listening workshops will follow within HCGs, sharing the results and outline improvement plans, giving a wider range of staff opportunity to be involved in further shaping the improvement plans. Further workshops will be offered at divisional/team level, prioritising those with most challenging needs for OD support.

9.0 Communications plan

A communications plan to share information with staff and the public has been produced. Internally, the results and improvement plans will form part of our 'Back to better' campaign.

10.0 Recommendation

To review and discuss the results, and approve the response plans.

Martin Smith, AD for training, education and OD
19th March 2021

Survey Coordination Centre

NHS England

The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey

Summary Benchmark Report

Survey Coordination Centre

Organisation details

NHS England

The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey

Organisation details

Completed questionnaires	1,368
2020 response rate	38%

See response rate trend for the last 5 years

Survey details

Survey mode	Mixed
Sample type	Census

This organisation is benchmarked against:

Acute and Acute & Community Trusts

2020 benchmarking group details

Organisations in group: **128**

Median response rate: **45%**

No. of completed questionnaires: **402,201**

Survey Coordination Centre

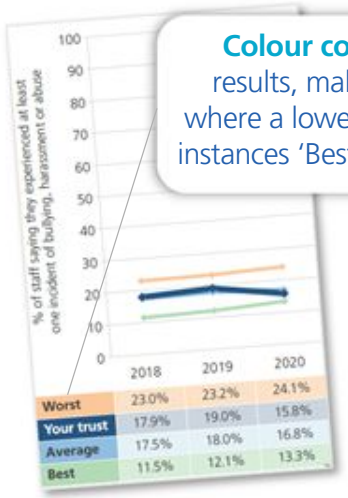
Using the report

NHS England

Key features

Question number and text (or the theme) specified at the top of each slide

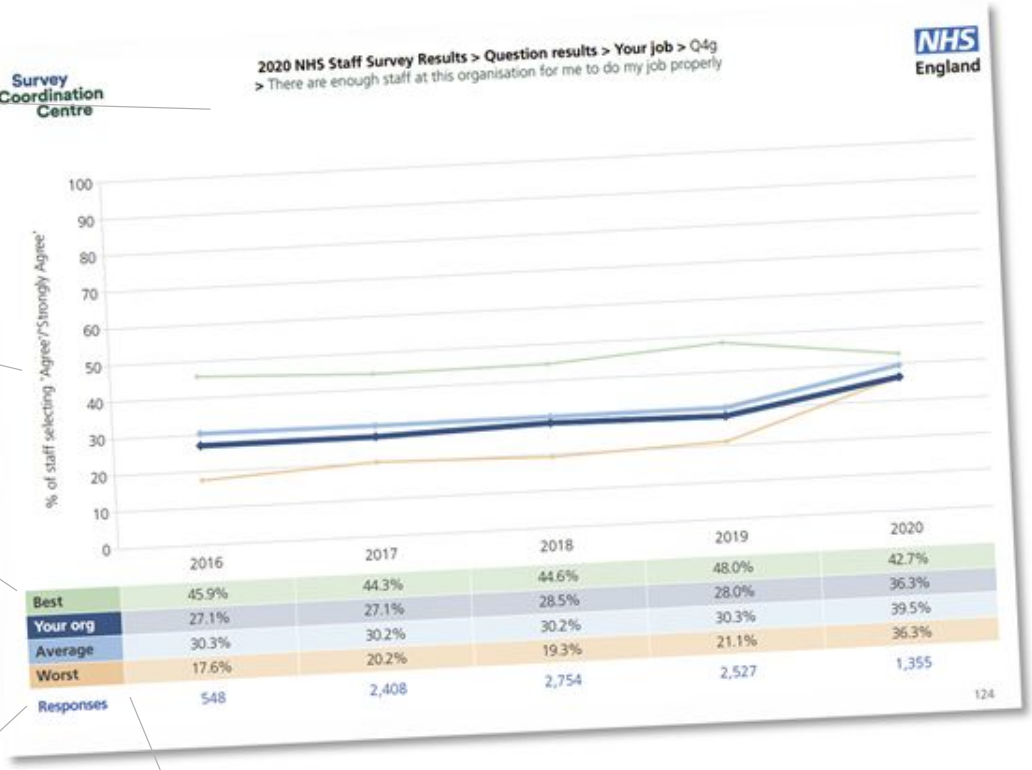
Question-level results are always reported as percentages; the **meaning of the value** is outlined along the axis. Themes are always on a 0-10pt scale where 10 is the best score attainable



Colour coding highlights best / worst results, making it easy to spot questions where a lower percentage is better – in such instances 'Best' is the bottom line in the table

Keep an eye out!

Number of responses for the organisation for the given question



'Best', 'Average', and 'Worst' refer to the **benchmarking group's** best, average and worst **results**

Full details on how the scores are calculated are provided in the **Technical Document**, under the Supporting Documents section of our results page

Survey Coordination Centre

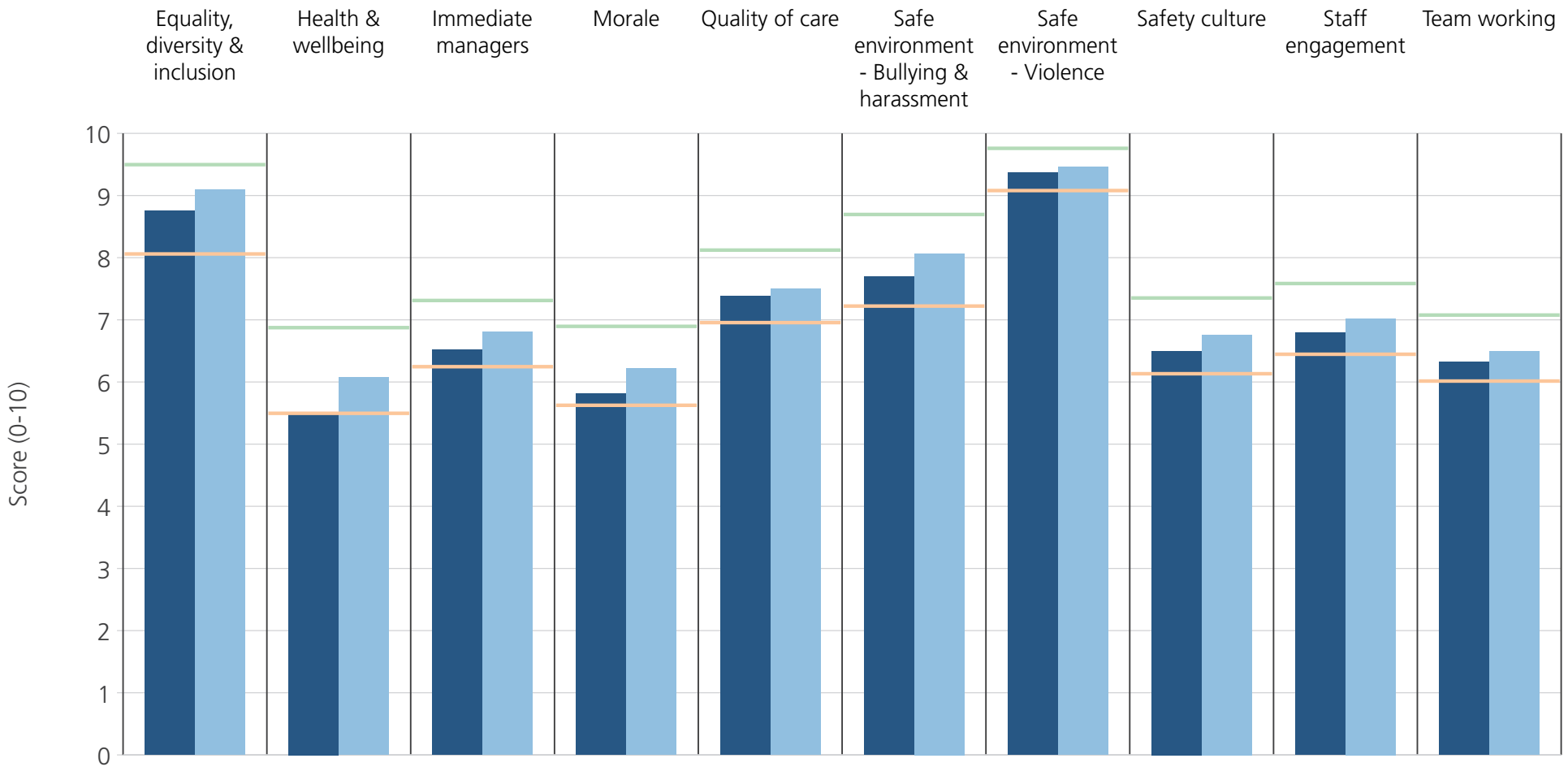
NHS England

Theme results

The calculation for the immediate managers theme has changed this year due to the omission of one of the questions which previously contributed to the theme. This change has been applied retrospectively so data for 2016-2020 shown in the charts are comparable for this theme, however these figures are not directly comparable to the results reported in previous years. For more details please see the technical document.

The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey Results



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	8.8	5.5	6.5	5.8	7.4	7.7	9.4	6.5	6.8	6.3
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	1,320	1,333	1,336	1,316	1,170	1,286	1,325	1,321	1,350	1,343

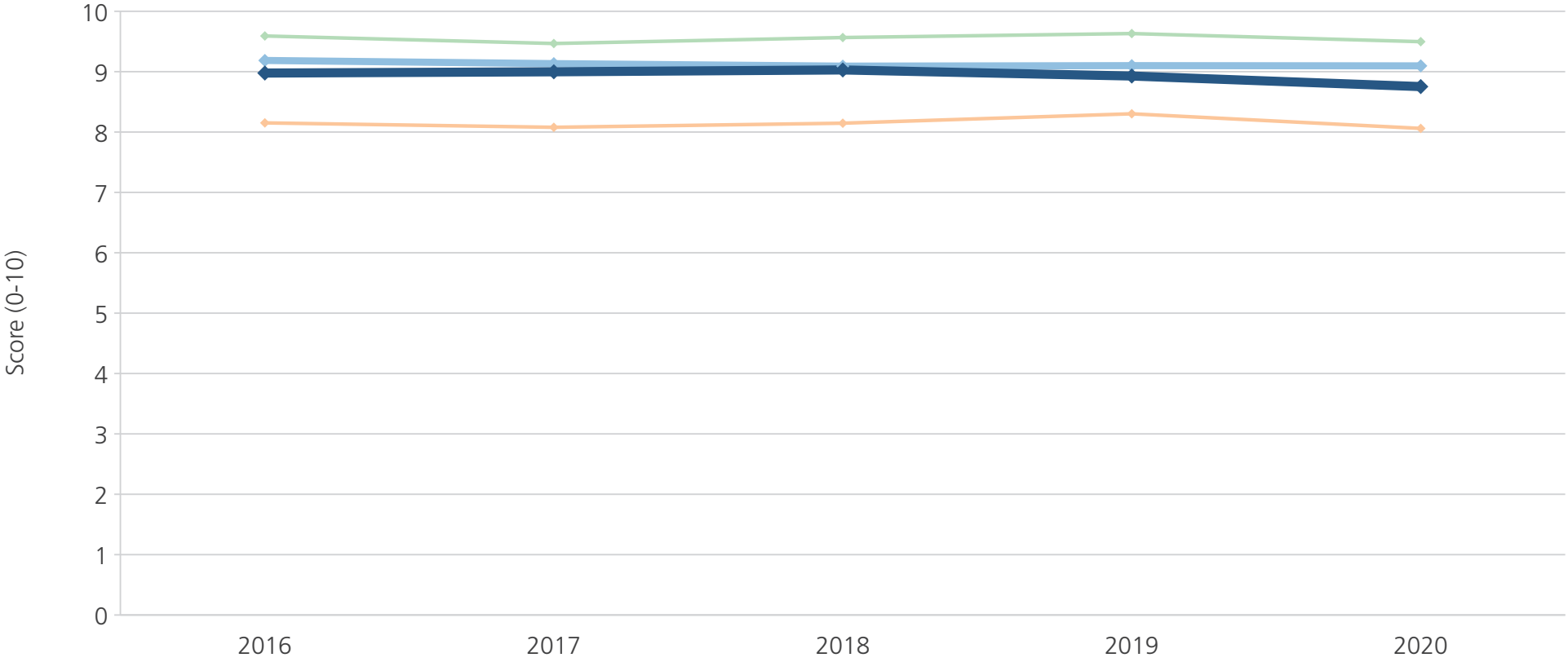
Survey Coordination Centre

NHS England

Theme results – Trends

The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey Results

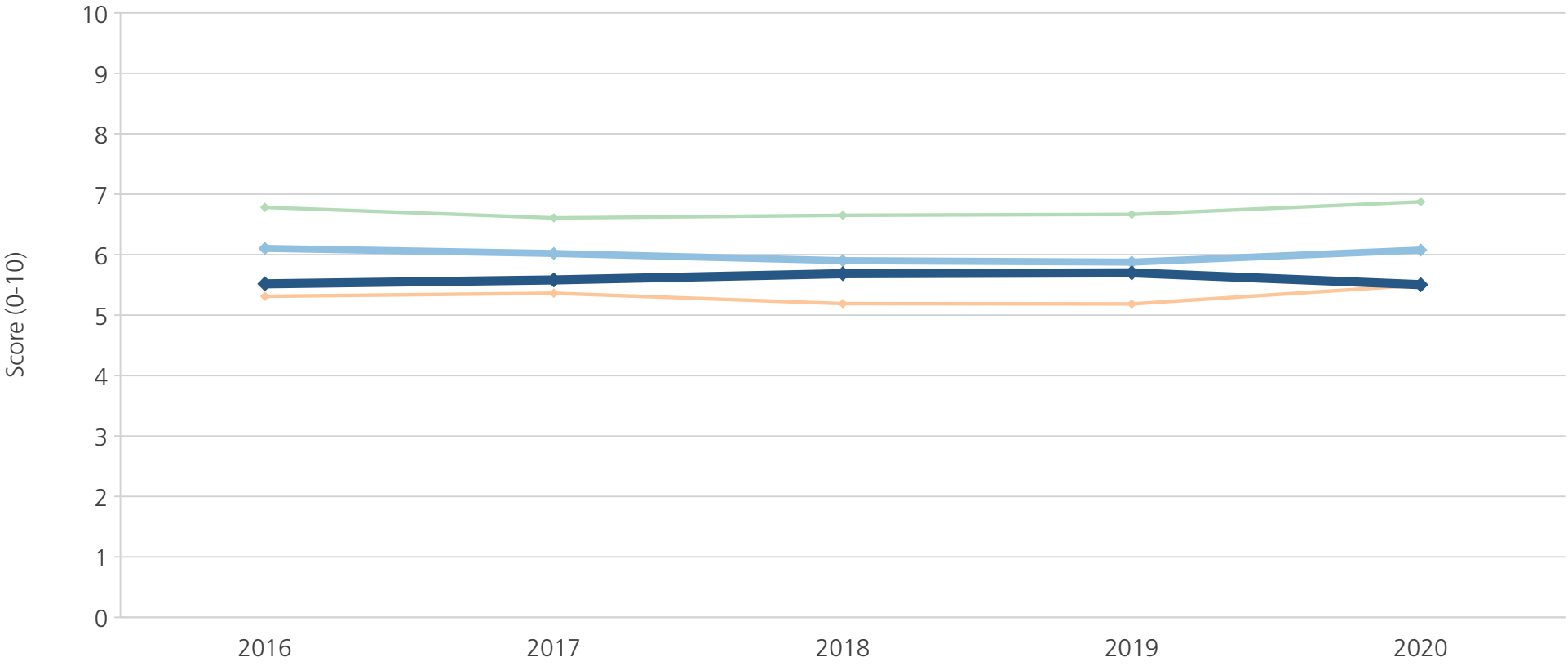


	2016	2017	2018	2019	2020
Best	9.6	9.5	9.6	9.6	9.5
Your org	9.0	9.0	9.0	8.9	8.8
Average	9.2	9.1	9.1	9.1	9.1
Worst	8.2	8.1	8.1	8.3	8.1
Responses	1,157	1,096	1,260	1,482	1,320

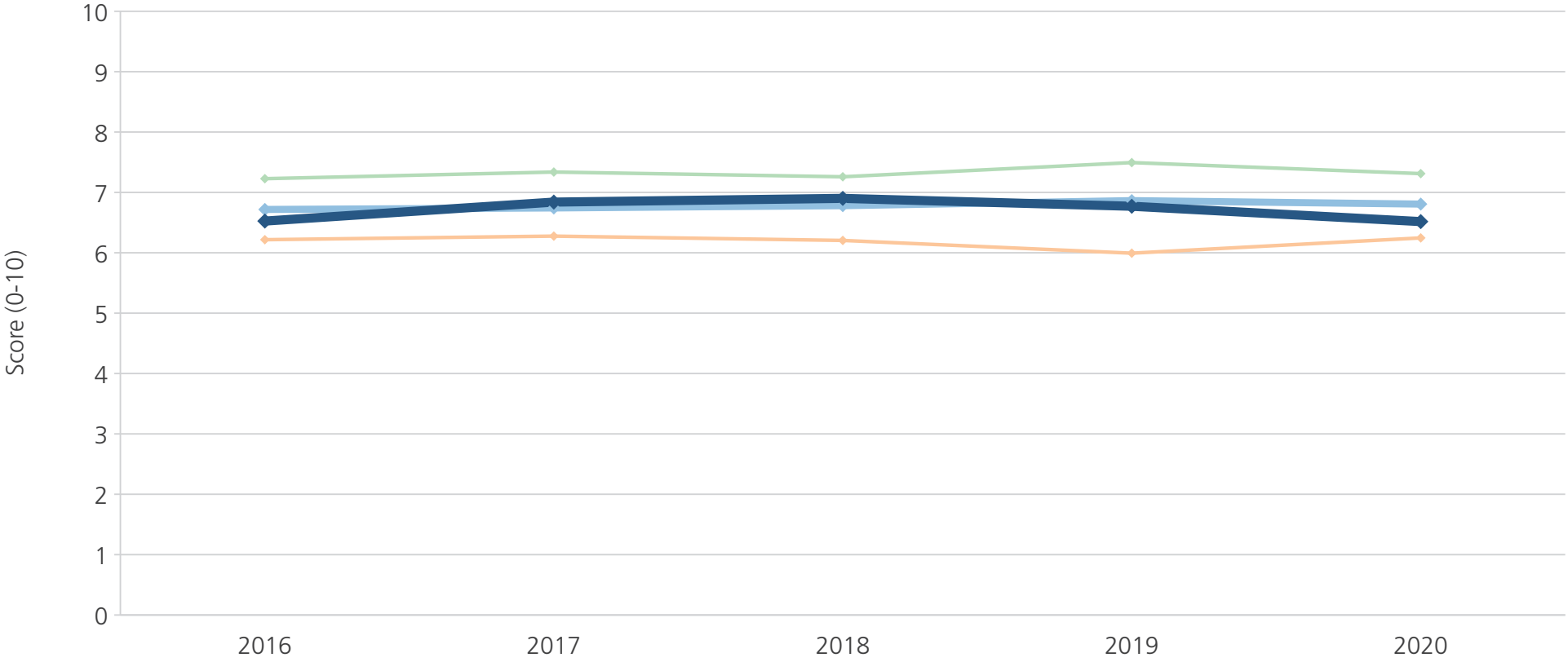
Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Trends > Health & wellbeing

NHS England



	2016	2017	2018	2019	2020
Best	6.8	6.6	6.7	6.7	6.9
Your org	5.5	5.6	5.7	5.7	5.5
Average	6.1	6.0	5.9	5.9	6.1
Worst	5.3	5.4	5.2	5.2	5.5
Responses	1,182	1,121	1,270	1,492	1,333

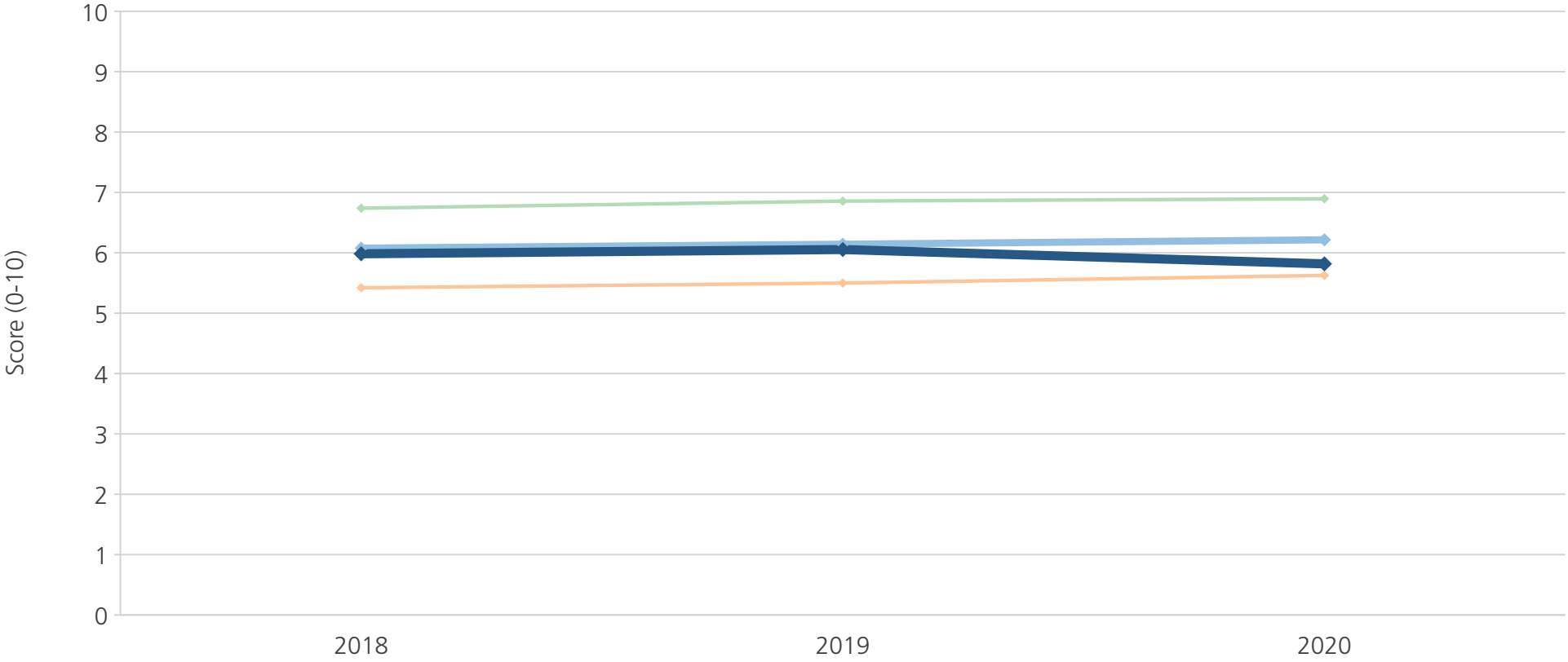


	2016	2017	2018	2019	2020
Best	7.2	7.3	7.3	7.5	7.3
Your org	6.5	6.8	6.9	6.8	6.5
Average	6.7	6.7	6.8	6.9	6.8
Worst	6.2	6.3	6.2	6.0	6.2
Responses	1,175	1,113	1,273	1,494	1,336

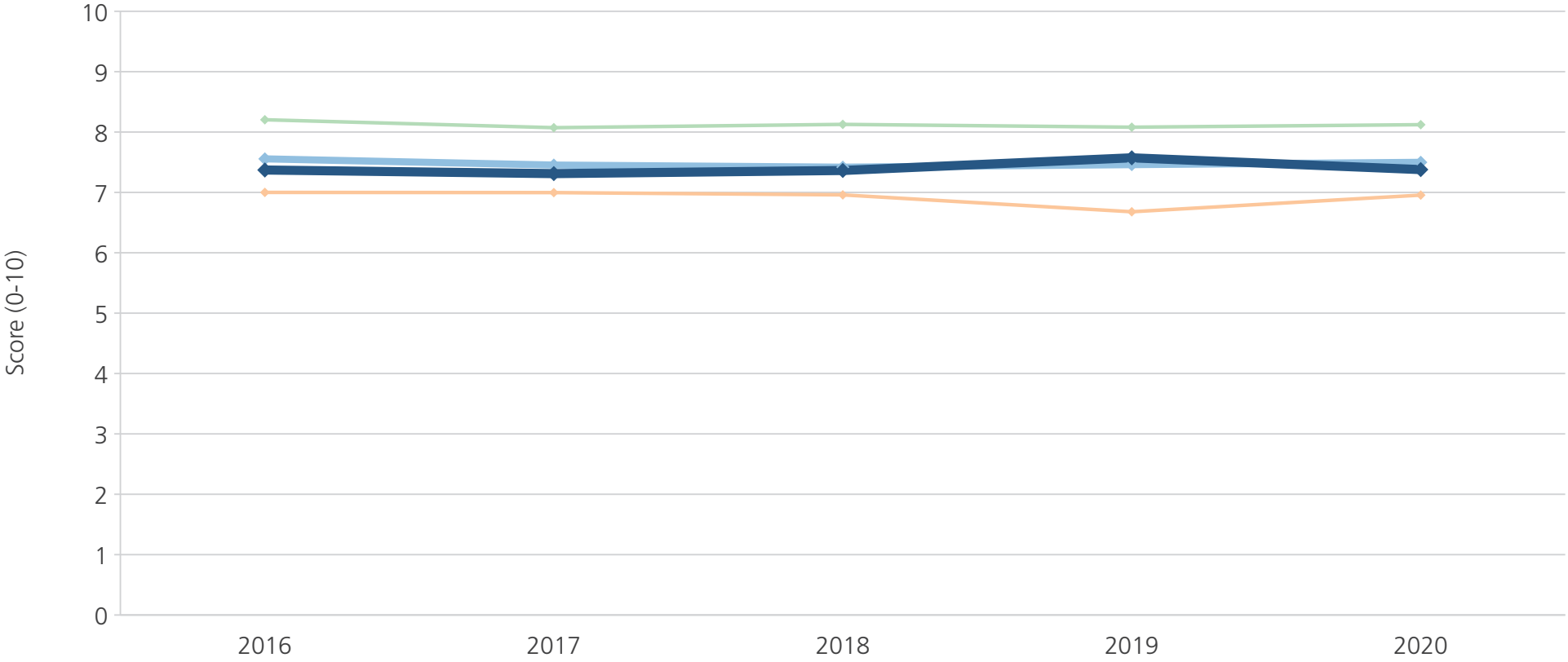
Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Trends > Morale

NHS England



	2018	2019	2020
Best	6.7	6.9	6.9
Your org	6.0	6.1	5.8
Average	6.1	6.1	6.2
Worst	5.4	5.5	5.6
Responses	1,245	1,470	1,316

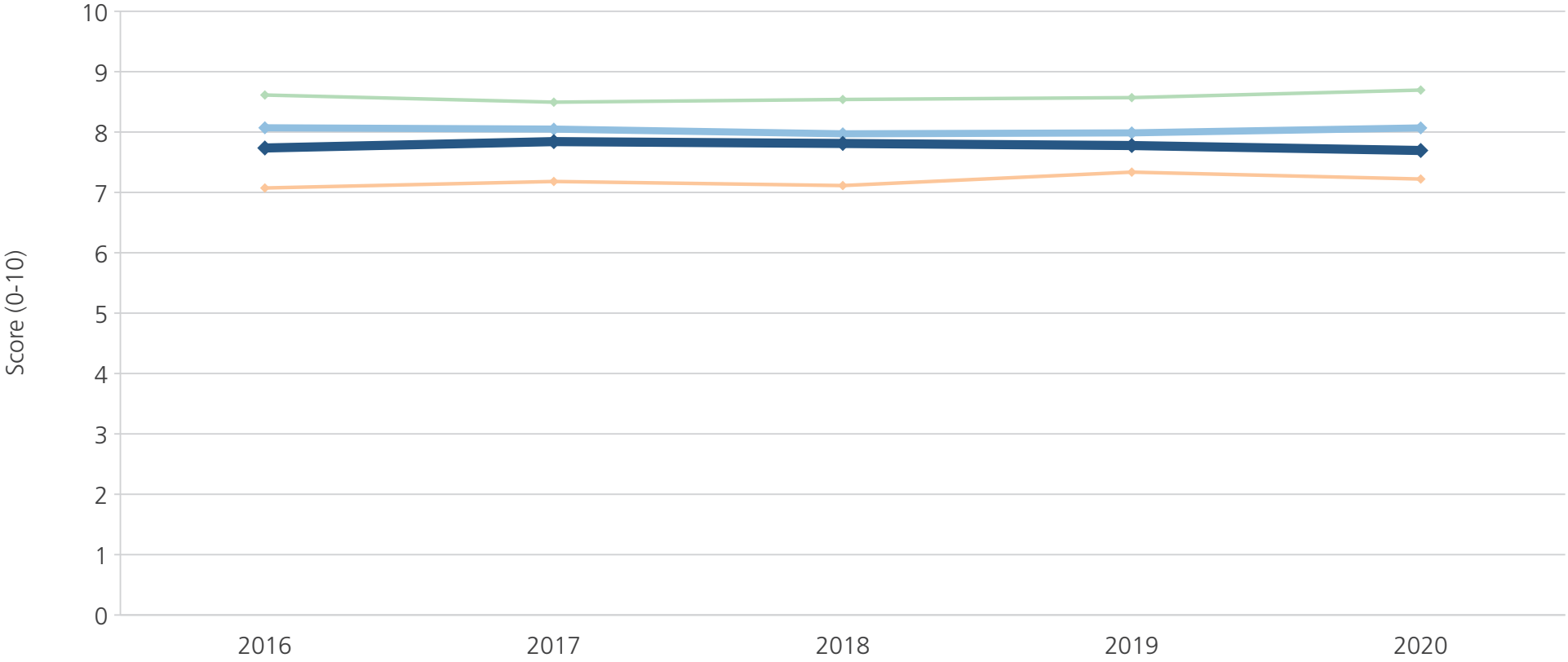


	2016	2017	2018	2019	2020
Best	8.2	8.1	8.1	8.1	8.1
Your org	7.4	7.3	7.4	7.6	7.4
Average	7.6	7.5	7.4	7.5	7.5
Worst	7.0	7.0	7.0	6.7	7.0
Responses	1,053	988	1,134	1,264	1,170

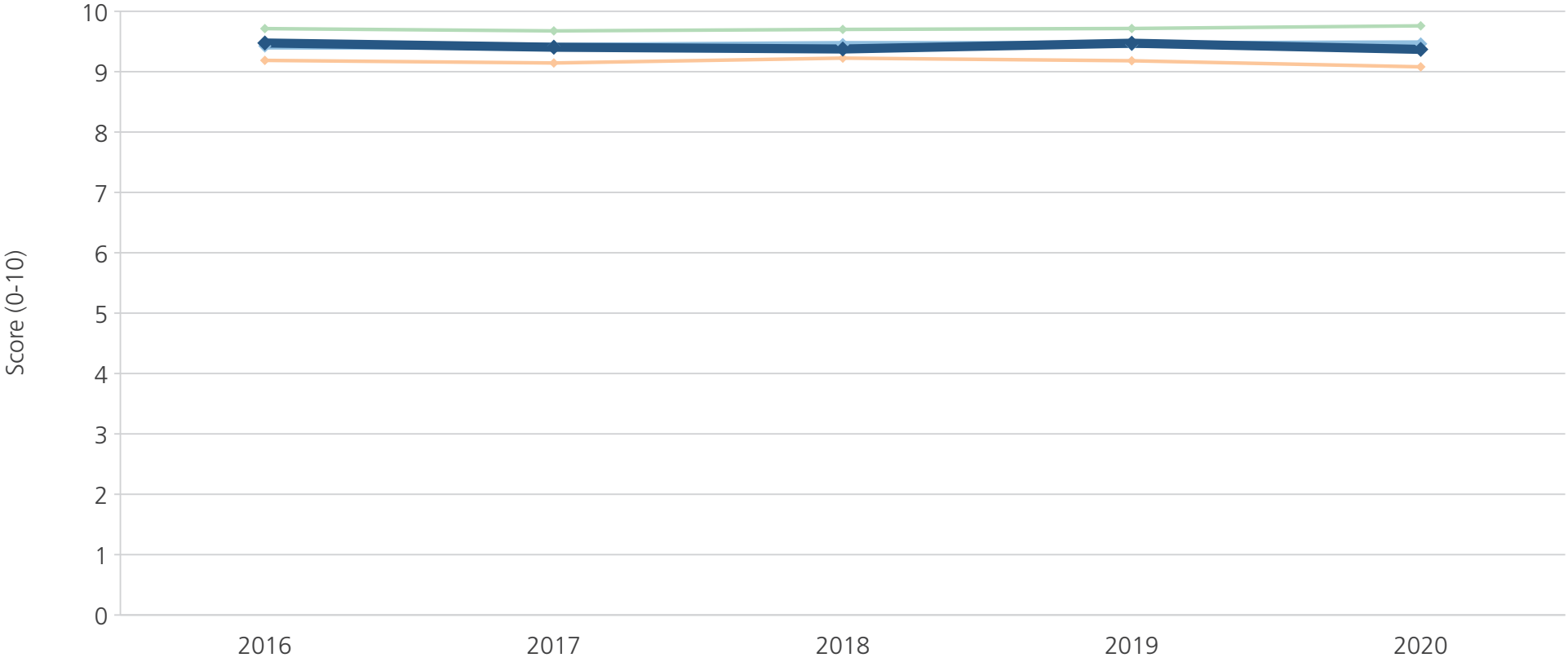
Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Trends > Safe environment - Bullying & harassment

NHS England



	2016	2017	2018	2019	2020
Best	8.6	8.5	8.5	8.6	8.7
Your org	7.7	7.8	7.8	7.8	7.7
Average	8.1	8.0	8.0	8.0	8.1
Worst	7.1	7.2	7.1	7.3	7.2
Responses	1,144	1,096	1,252	1,474	1,286

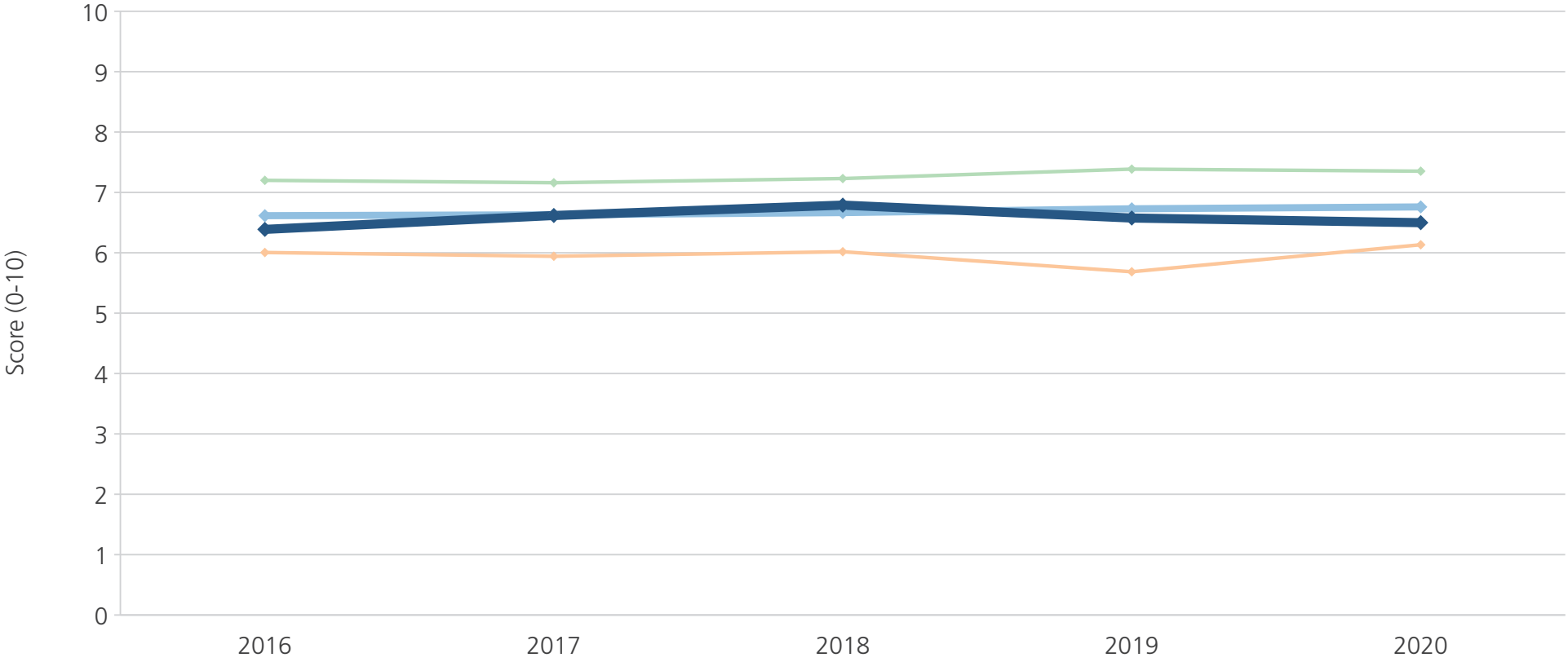


	2016	2017	2018	2019	2020
Best	9.7	9.7	9.7	9.7	9.8
Your org	9.5	9.4	9.4	9.5	9.4
Average	9.4	9.4	9.4	9.4	9.5
Worst	9.2	9.1	9.2	9.2	9.1
Responses	1,138	1,091	1,248	1,468	1,325

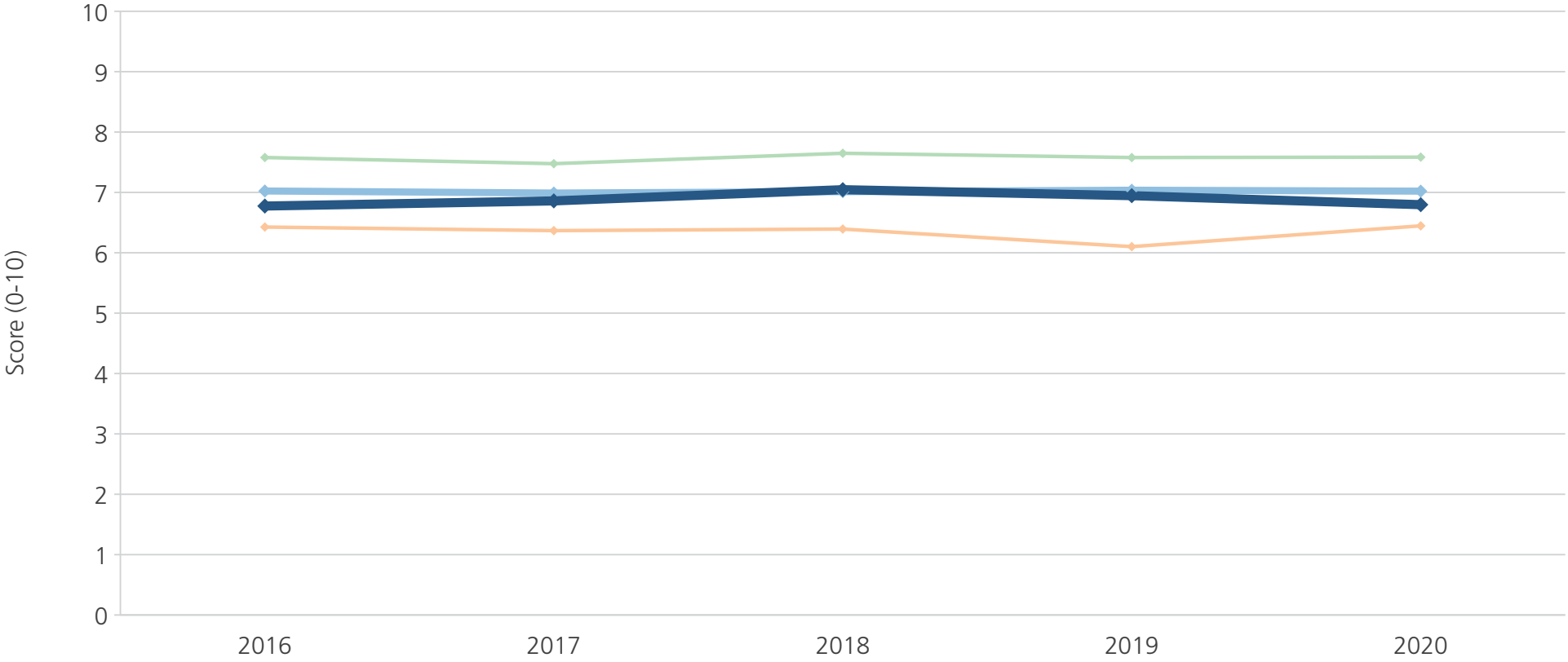
Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Trends > Safety culture

NHS England



	2016	2017	2018	2019	2020
Best	7.2	7.2	7.2	7.4	7.4
Your org	6.4	6.6	6.8	6.6	6.5
Average	6.6	6.6	6.7	6.7	6.8
Worst	6.0	5.9	6.0	5.7	6.1
Responses	1,171	1,109	1,257	1,490	1,321

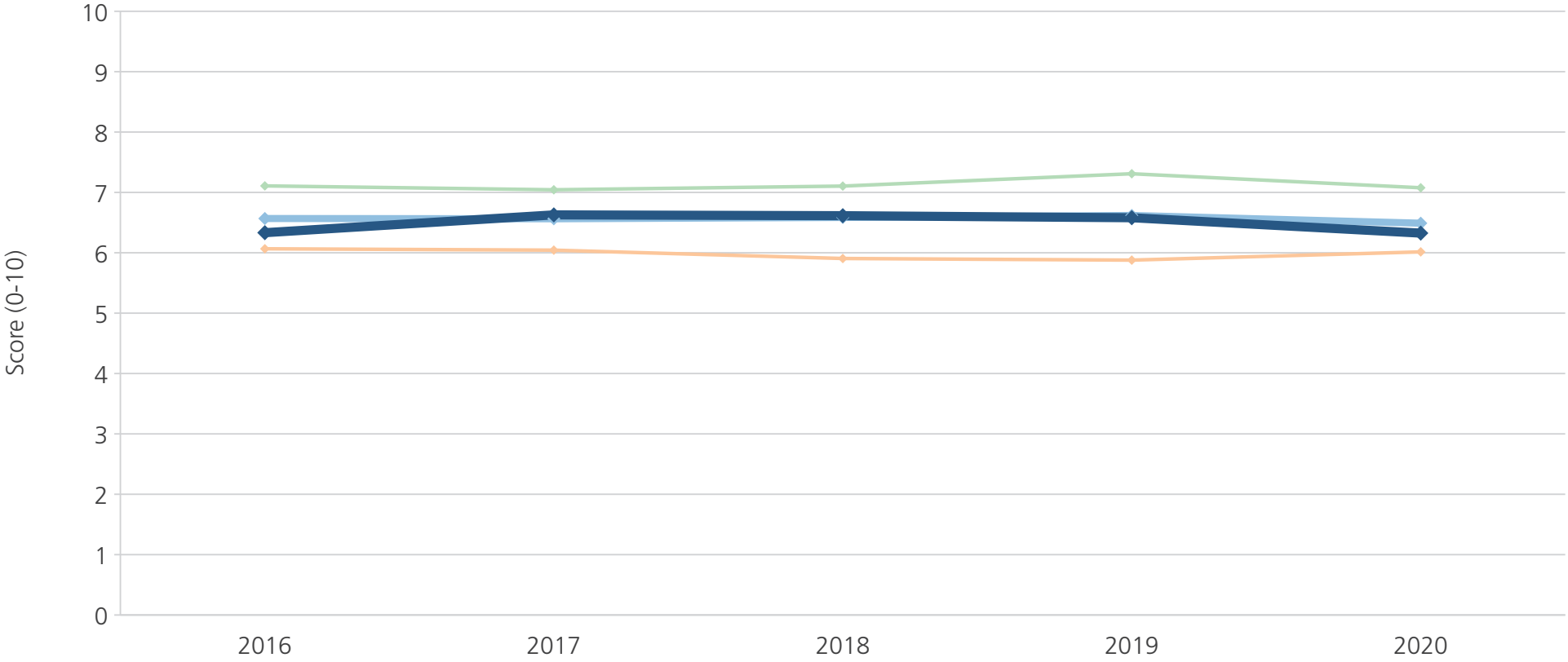


	2016	2017	2018	2019	2020
Best	7.6	7.5	7.6	7.6	7.6
Your org	6.8	6.9	7.0	6.9	6.8
Average	7.0	7.0	7.0	7.0	7.0
Worst	6.4	6.4	6.4	6.1	6.4
Responses	1,195	1,151	1,312	1,496	1,350

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Trends > Team working

NHS England



	2016	2017	2018	2019	2020
Best	7.1	7.0	7.1	7.3	7.1
Your org	6.3	6.6	6.6	6.6	6.3
Average	6.6	6.6	6.6	6.6	6.5
Worst	6.1	6.0	5.9	5.9	6.0
Responses	1,178	1,131	1,300	1,475	1,343

Survey Coordination Centre

NHS England

Theme results – Covid-19 classification breakdowns

The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey Results

Survey Coordination Centre

Covid-19 classification breakdowns

NHS England

Covid-19 questions

Staff were asked four classification questions relating to their experience during the Covid-19 pandemic:

a.	Have you worked on a Covid-19 specific ward or area at any time?	☐ Yes	☐ No
b.	Have you been redeployed due to the Covid-19 pandemic at any time?	☐ Yes	☐ No
c.	Have you been required to work remotely/from home due to the Covid-19 pandemic?	☐ Yes	☐ No
d.	Have you been shielding?	☐ Yes, for myself ☐ Yes, for a member of my household	☐ No

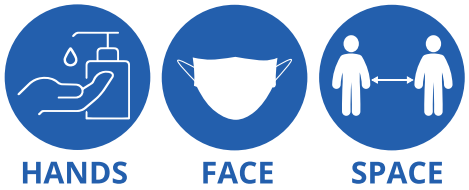
The charts on the following pages show the breakdown of theme scores for staff answering 'yes' to each of these questions, compared with the results for all staff at your organisation. Results are presented in the context of the highest, average and lowest scores for similar organisations.

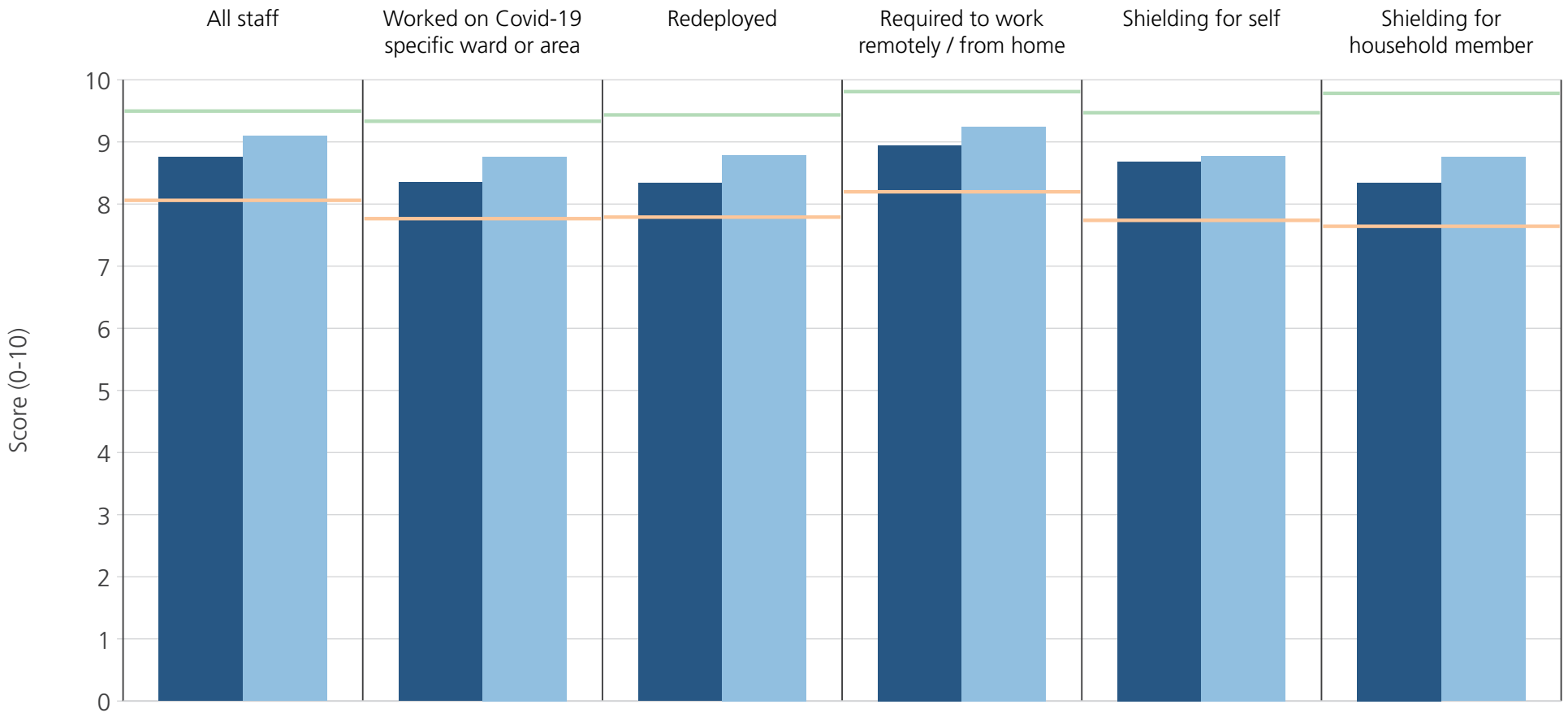
Comparing your data

To improve overall comparability, the data have been weighted to match the occupation group profile of staff at your organisation to that of the benchmarking group, as in previous charts. However, there may be differences in the occupation group profiles of the individual COVID-19 subgroups. For example, the mix of occupational groups across redeployed staff at your organisation may differ from similar organisations. This difference would not be accounted for by the weighting and therefore may affect the comparability of results. As such, a degree of caution is advised when interpreting your results.

Further information

Results for these groups of staff, including data for individual questions, are also available via the online dashboards. Please note that results presented in these dashboards have not been weighted where no benchmarking takes place and so may vary slightly from those shown in this report.



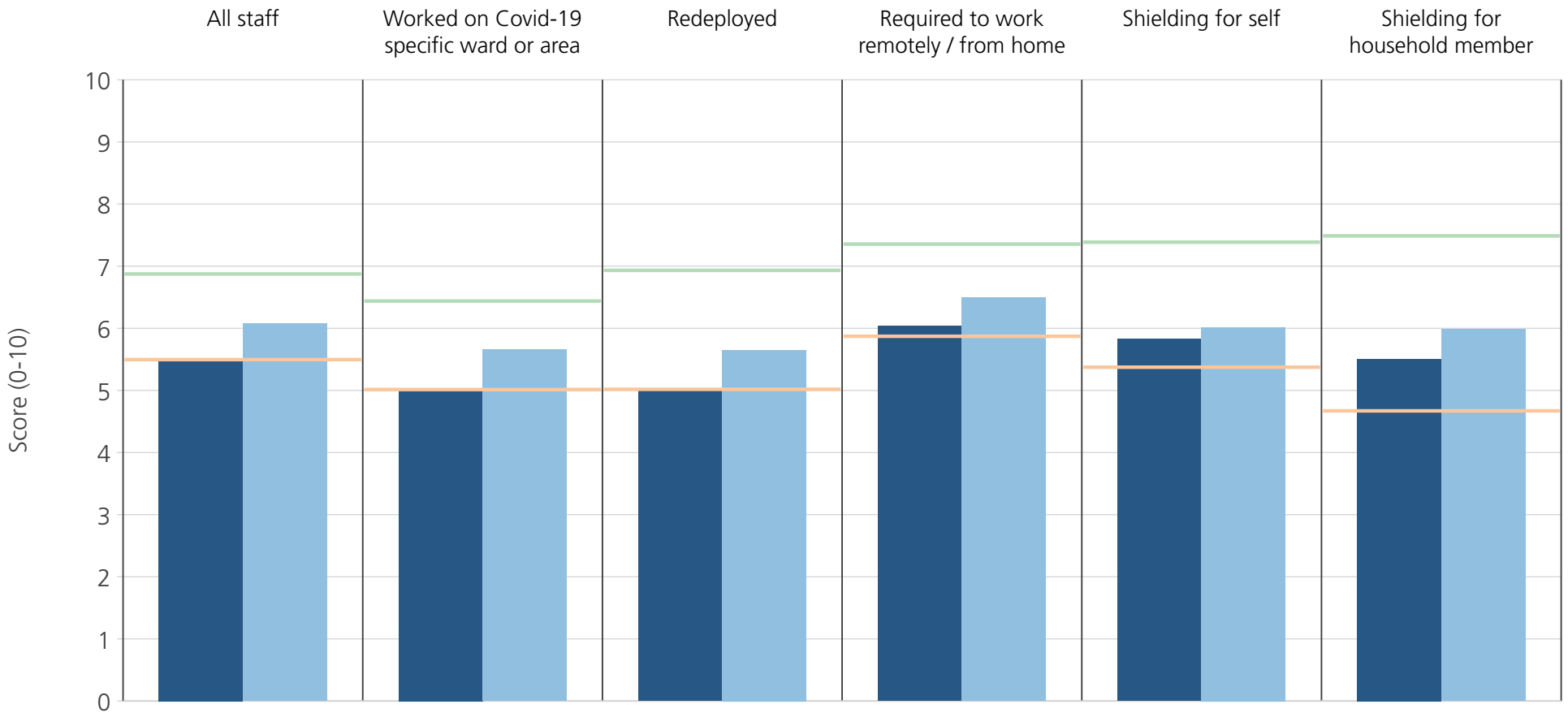


	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	9.5	9.3	9.4	9.8	9.5	9.8
Your org	8.8	8.4	8.3	8.9	8.7	8.3
Average	9.1	8.8	8.8	9.2	8.8	8.8
Lowest	8.1	7.8	7.8	8.2	7.7	7.6
Responses	1,320	523	302	334	113	29

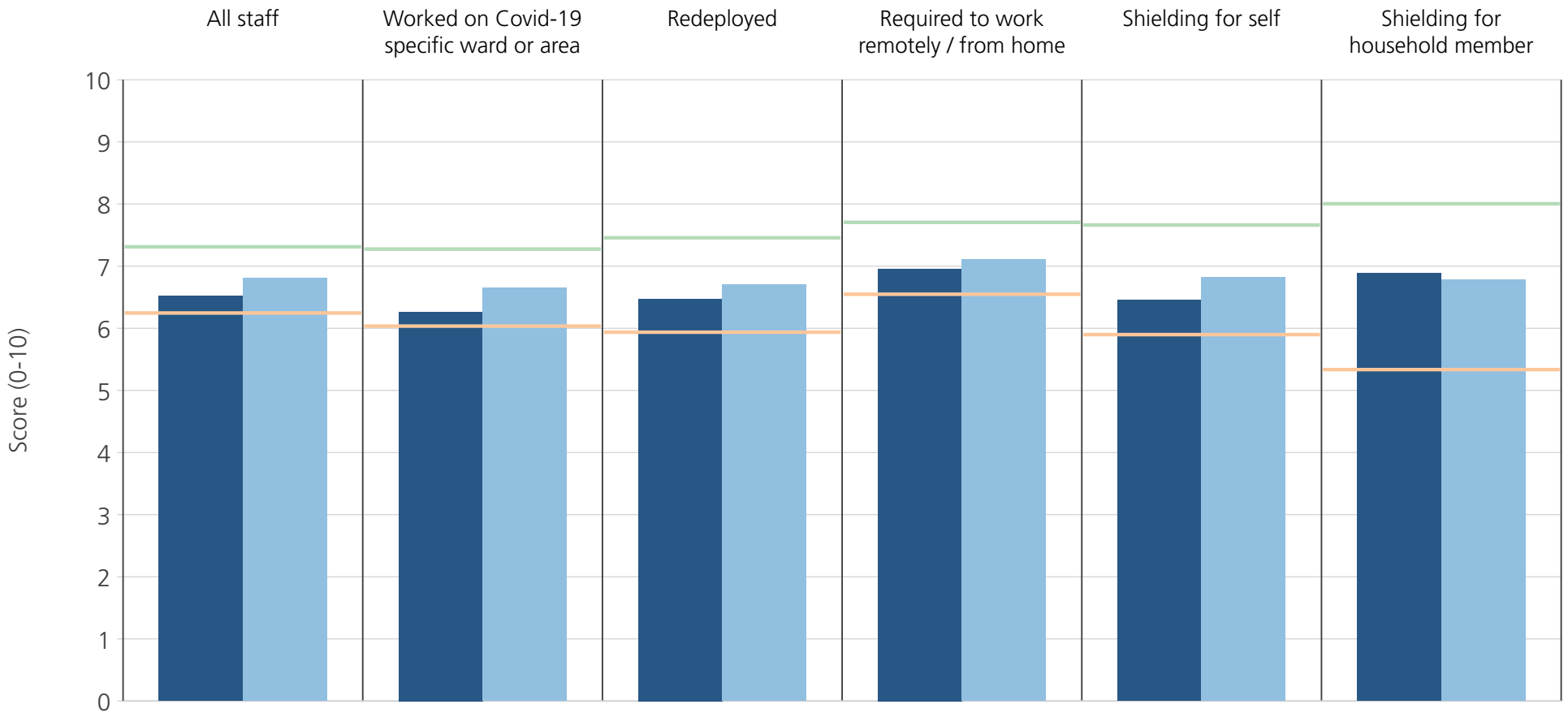
Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results – Covid-19 classification breakdowns > Health & wellbeing

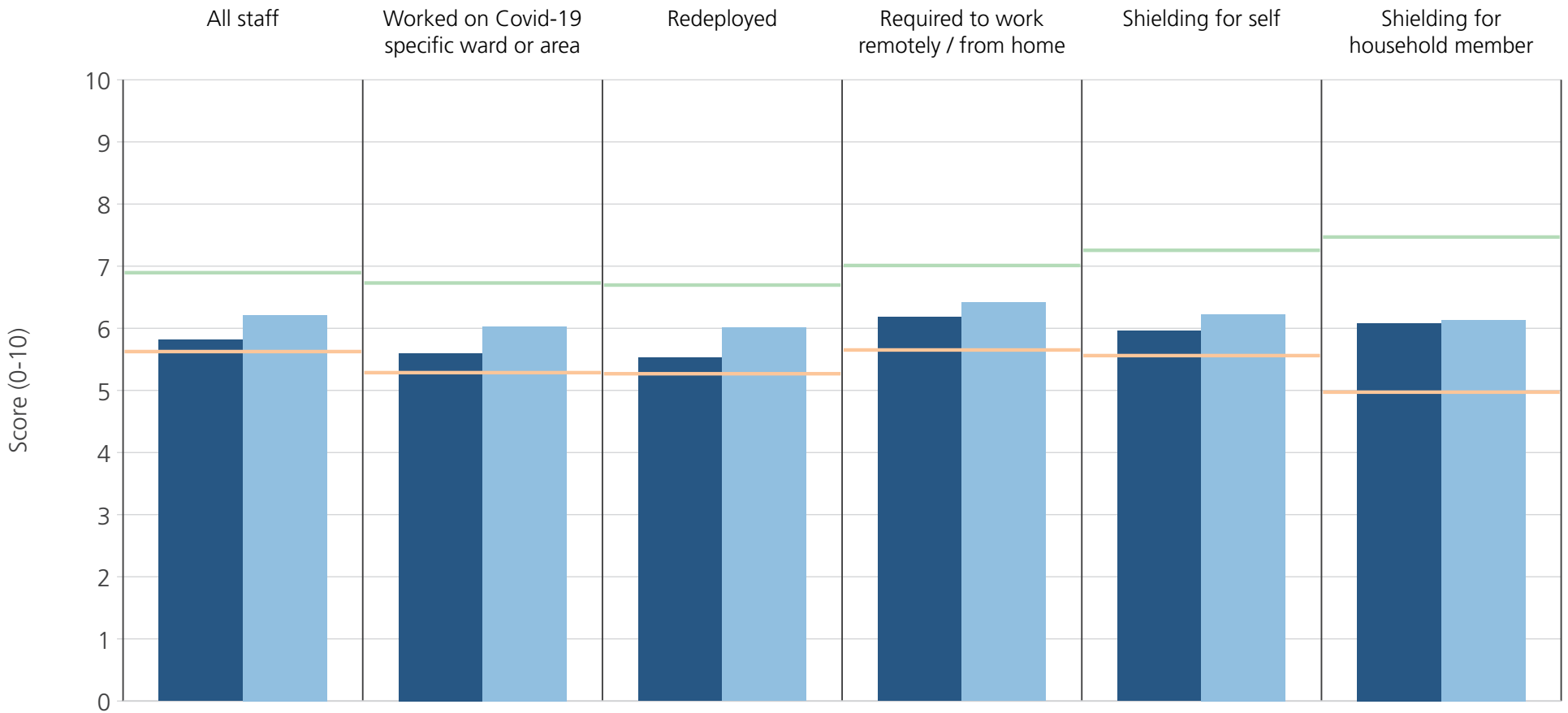
NHS England



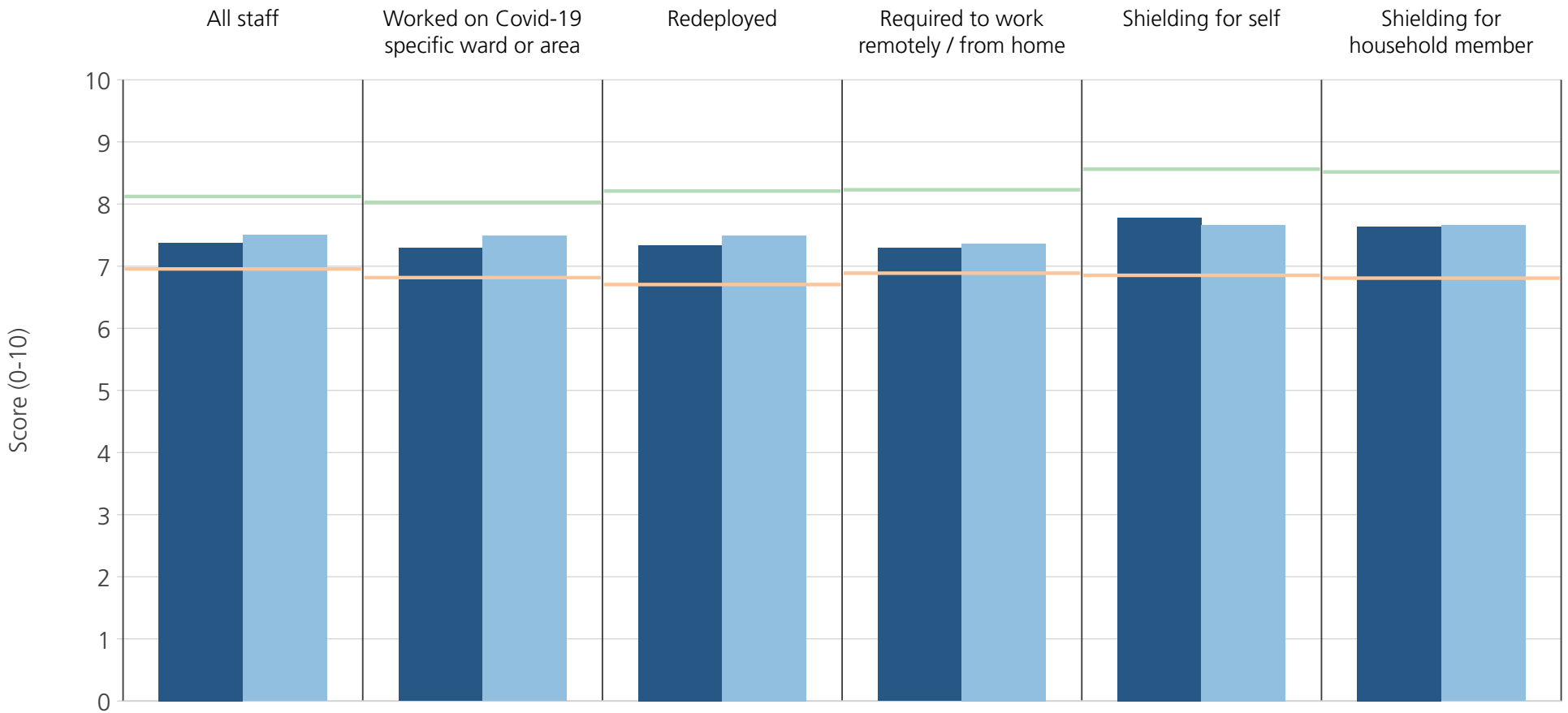
	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	6.9	6.4	6.9	7.4	7.4	7.5
Your org	5.5	5.0	5.0	6.0	5.8	5.5
Average	6.1	5.7	5.6	6.5	6.0	6.0
Lowest	5.5	5.0	5.0	5.9	5.4	4.7
Responses	1,333	527	303	335	113	30



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	7.3	7.3	7.5	7.7	7.7	8.0
Your org	6.5	6.3	6.5	7.0	6.5	6.9
Average	6.8	6.7	6.7	7.1	6.8	6.8
Lowest	6.2	6.0	5.9	6.5	5.9	5.3
Responses	1,336	523	301	334	112	30



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	6.9	6.7	6.7	7.0	7.3	7.5
Your org	5.8	5.6	5.5	6.2	6.0	6.1
Average	6.2	6.0	6.0	6.4	6.2	6.1
Lowest	5.6	5.3	5.3	5.7	5.6	5.0
Responses	1,316	519	301	333	112	30

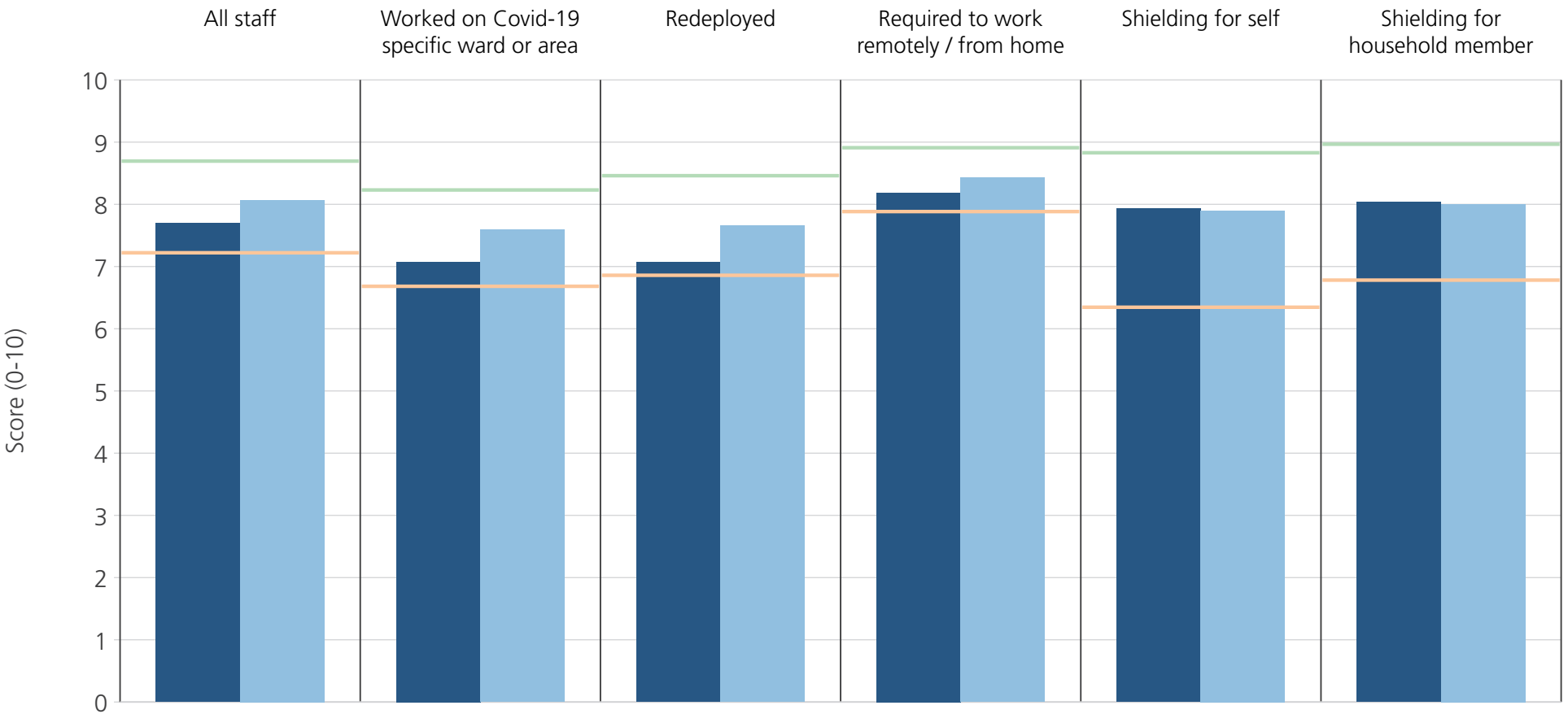


	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	8.1	8.0	8.2	8.2	8.6	8.5
Your org	7.4	7.3	7.3	7.3	7.8	7.6
Average	7.5	7.5	7.5	7.4	7.7	7.7
Lowest	7.0	6.8	6.7	6.9	6.9	6.8
Responses	1,170	506	289	238	97	23

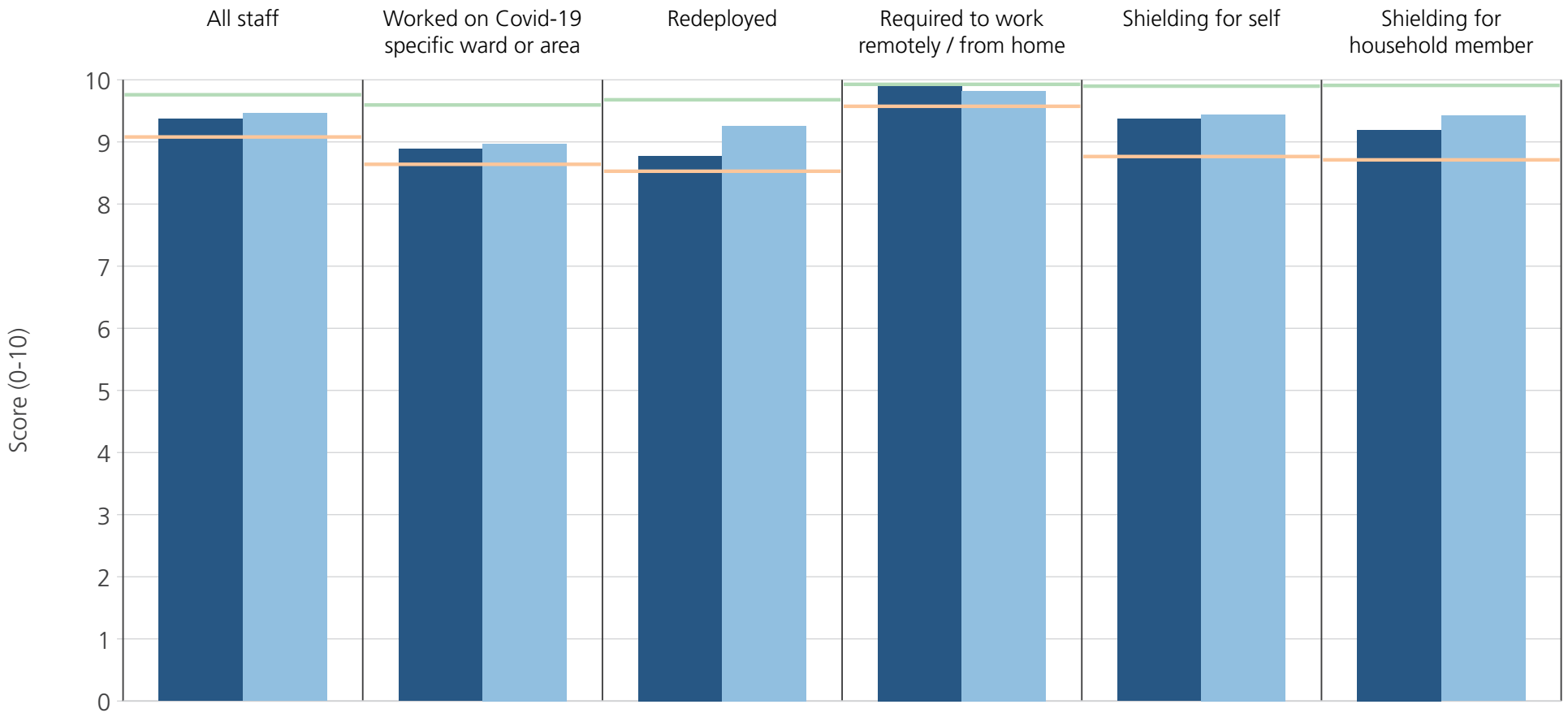
Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results – Covid-19 classification breakdowns > Safe environment - Bullying & harassment

NHS England



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	8.7	8.2	8.5	8.9	8.8	9.0
Your org	7.7	7.1	7.1	8.2	7.9	8.0
Average	8.1	7.6	7.7	8.4	7.9	8.0
Lowest	7.2	6.7	6.9	7.9	6.3	6.8
Responses	1,286	509	296	322	108	29

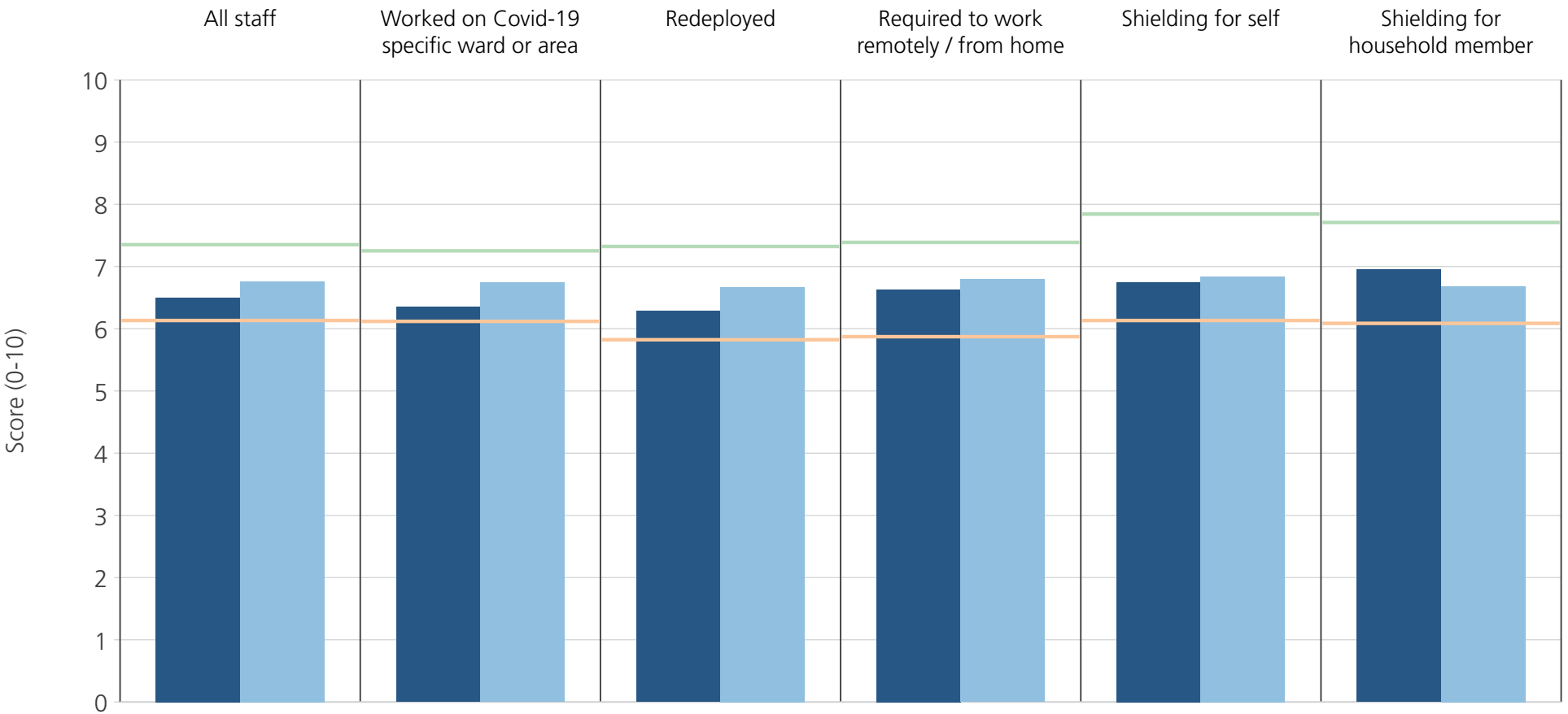


	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	9.8	9.6	9.7	9.9	9.9	9.9
Your org	9.4	8.9	8.8	9.9	9.4	9.2
Average	9.5	9.0	9.3	9.8	9.4	9.4
Lowest	9.1	8.6	8.5	9.6	8.8	8.7
Responses	1,325	523	303	334	112	30

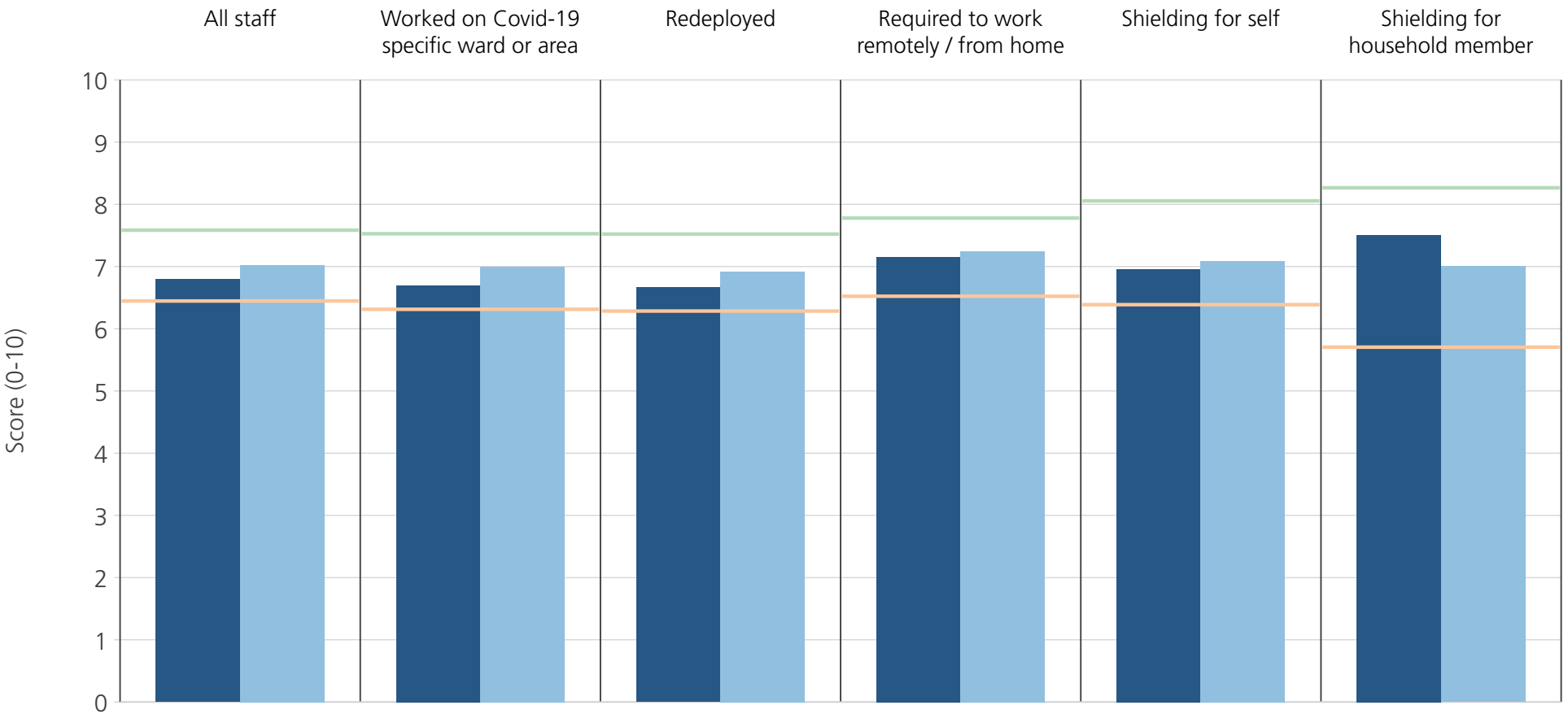
Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results – Covid-19 classification breakdowns > Safety culture

NHS England



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	7.4	7.3	7.3	7.4	7.8	7.7
Your org	6.5	6.4	6.3	6.6	6.7	6.9
Average	6.8	6.7	6.7	6.8	6.8	6.7
Lowest	6.1	6.1	5.8	5.9	6.1	6.1
Responses	1,321	522	302	333	113	30

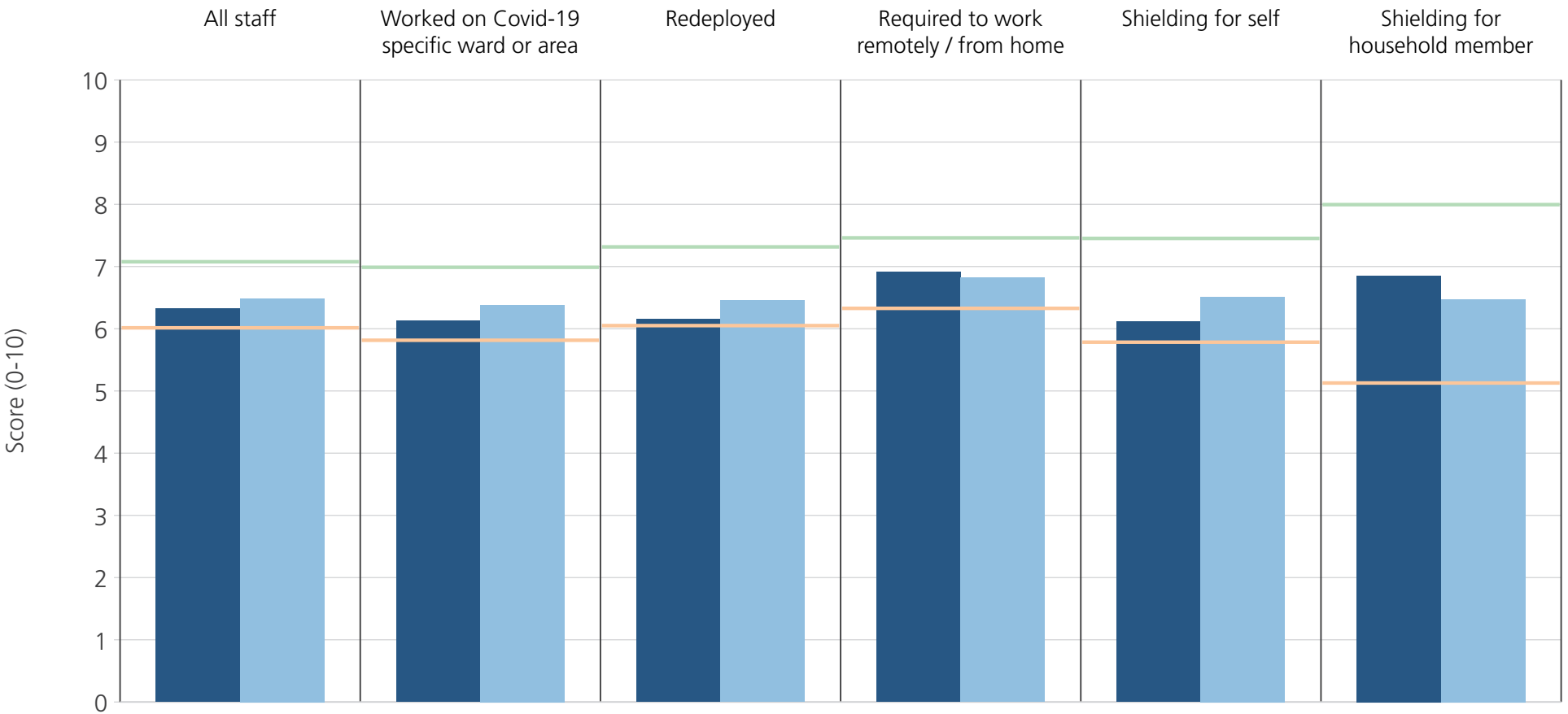


	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	7.6	7.5	7.5	7.8	8.1	8.3
Your org	6.8	6.7	6.7	7.2	7.0	7.5
Average	7.0	7.0	6.9	7.2	7.1	7.0
Lowest	6.4	6.3	6.3	6.5	6.4	5.7
Responses	1,350	523	301	333	112	30

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results – Covid-19 classification breakdowns > Team working

NHS England



	All staff	Worked on Covid-19 specific ward or area	Redeployed	Required to work remotely / from home	Shielding for self	Shielding for household member
Highest	7.1	7.0	7.3	7.5	7.5	8.0
Your org	6.3	6.1	6.2	6.9	6.1	6.9
Average	6.5	6.4	6.5	6.8	6.5	6.5
Lowest	6.0	5.8	6.1	6.3	5.8	5.1
Responses	1,343	519	298	332	111	30

Survey Coordination Centre

NHS England

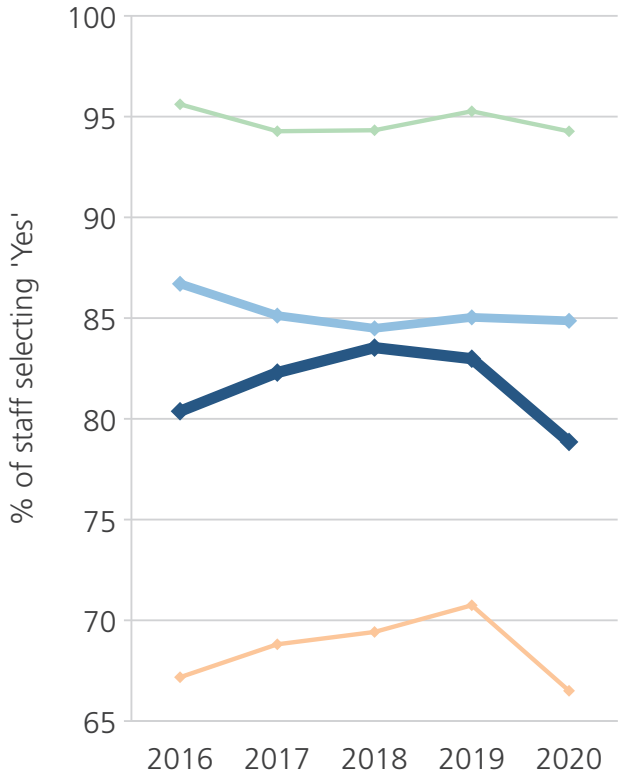
Theme results – Detailed information

The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey Results

Q14

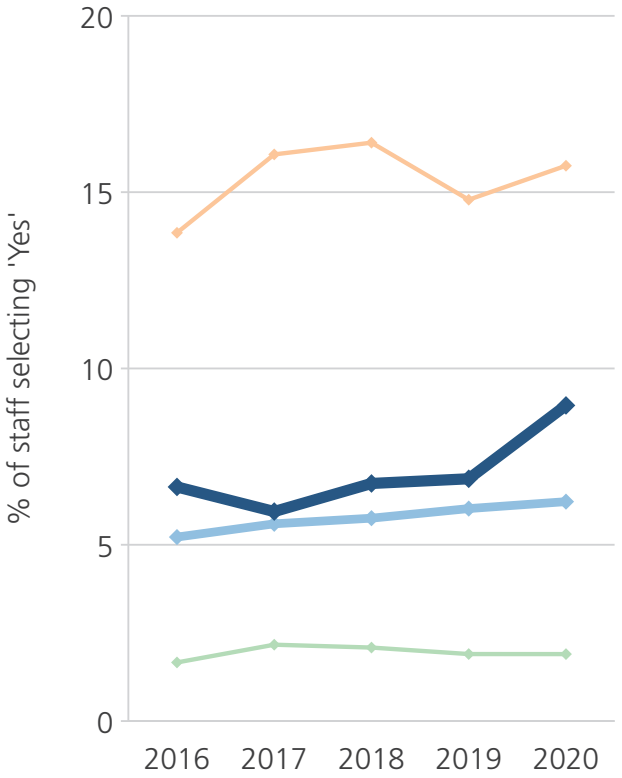
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



	2016	2017	2018	2019	2020
Best	95.6%	94.3%	94.3%	95.3%	94.3%
Your org	80.4%	82.3%	83.5%	83.0%	78.9%
Average	86.7%	85.1%	84.5%	85.0%	84.9%
Worst	67.2%	68.8%	69.4%	70.7%	66.5%

Q15a

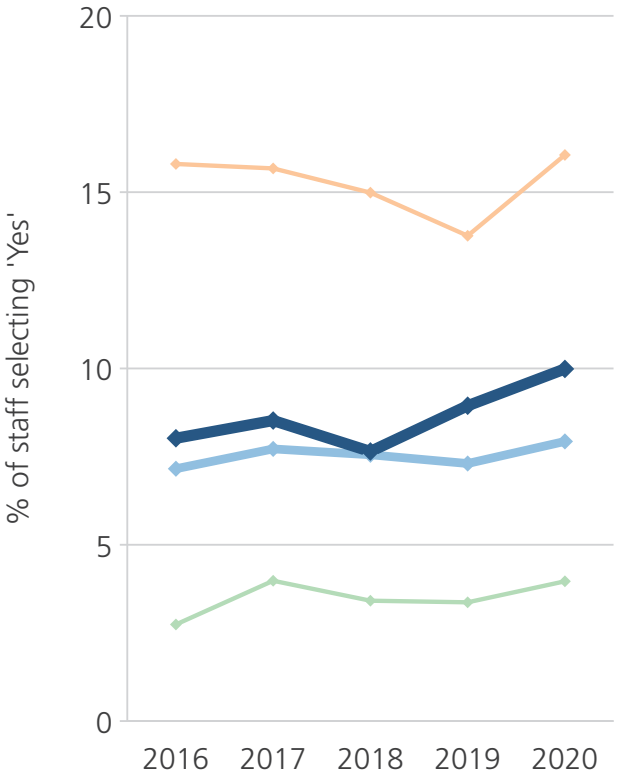
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



	2016	2017	2018	2019	2020
Worst	13.8%	16.1%	16.4%	14.8%	15.7%
Your org	6.6%	5.9%	6.7%	6.9%	9.0%
Average	5.2%	5.6%	5.8%	6.0%	6.2%
Best	1.7%	2.2%	2.1%	1.9%	1.9%

Q15b

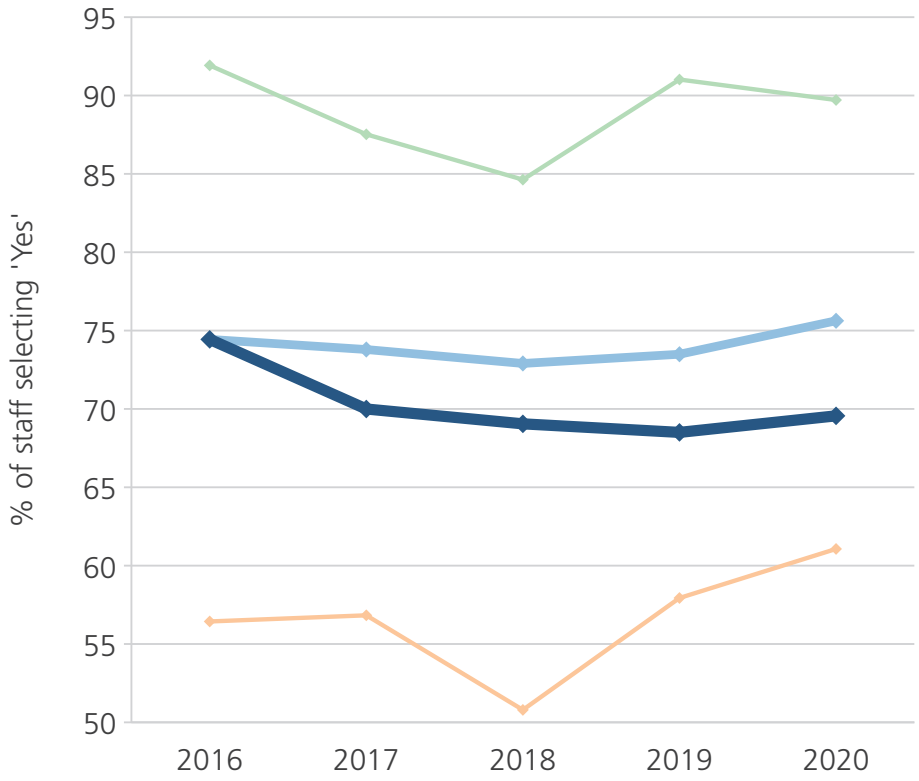
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2016	2017	2018	2019	2020
Worst	15.8%	15.7%	15.0%	13.8%	16.1%
Your org	8.0%	8.5%	7.6%	8.9%	10.0%
Average	7.2%	7.7%	7.6%	7.3%	7.9%
Best	2.7%	4.0%	3.4%	3.4%	4.0%

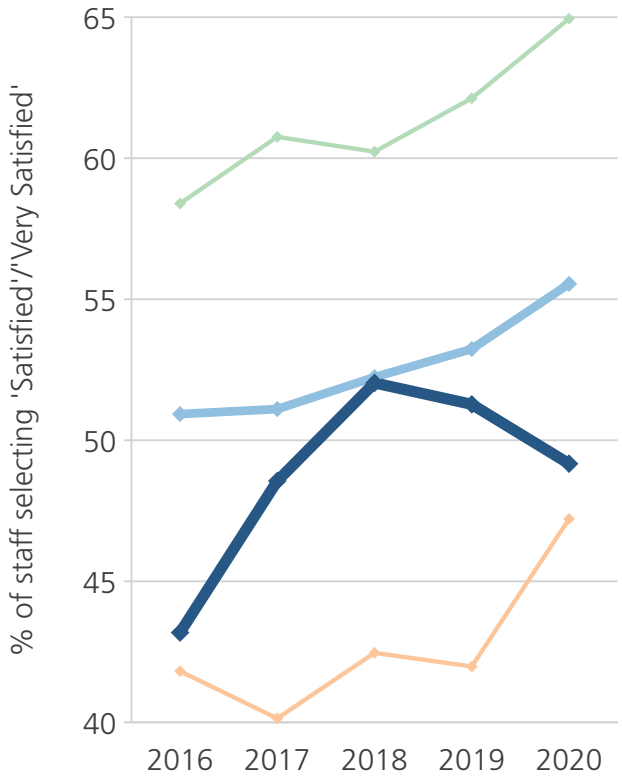
Q26b

Has your employer made adequate adjustment(s) to enable you to carry out your work?



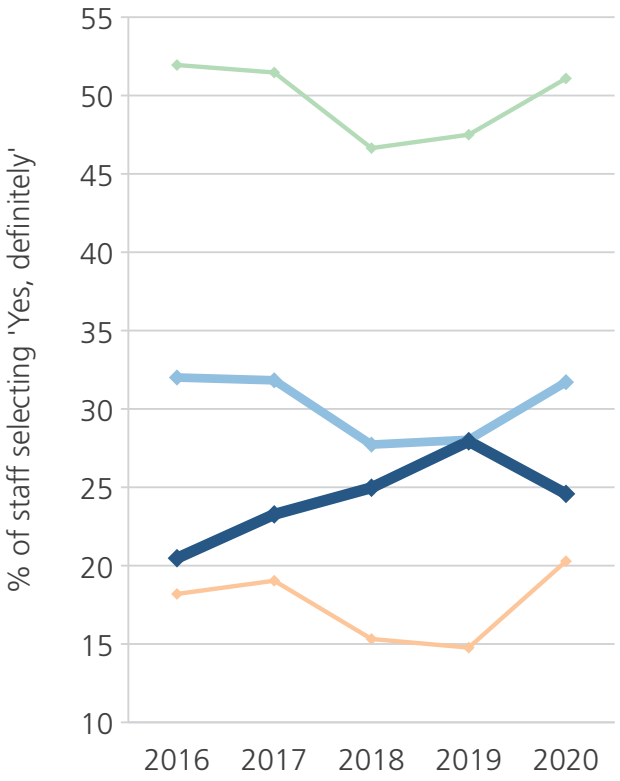
Best	91.9%	87.5%	84.6%	91.0%	89.7%
Your org	74.4%	70.0%	69.0%	68.5%	69.6%
Average	74.4%	73.8%	72.9%	73.5%	75.6%
Worst	56.4%	56.8%	50.8%	57.9%	61.1%

Q5h
The opportunities for flexible working patterns



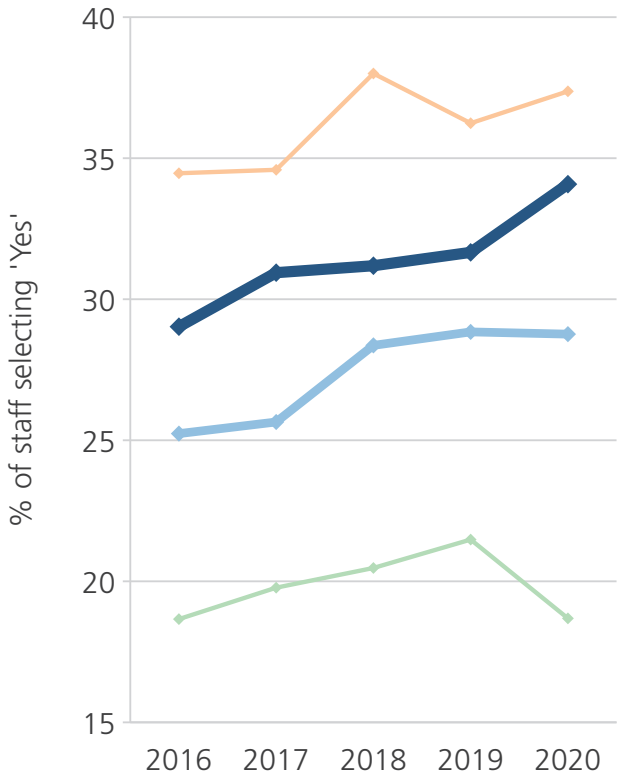
	2016	2017	2018	2019	2020
Best	58.4%	60.8%	60.2%	62.1%	64.9%
Your org	43.2%	48.6%	52.0%	51.3%	49.2%
Average	50.9%	51.1%	52.2%	53.2%	55.5%
Worst	41.8%	40.1%	42.5%	42.0%	47.2%

Q11a
Does your organisation take positive action on health and well-being?



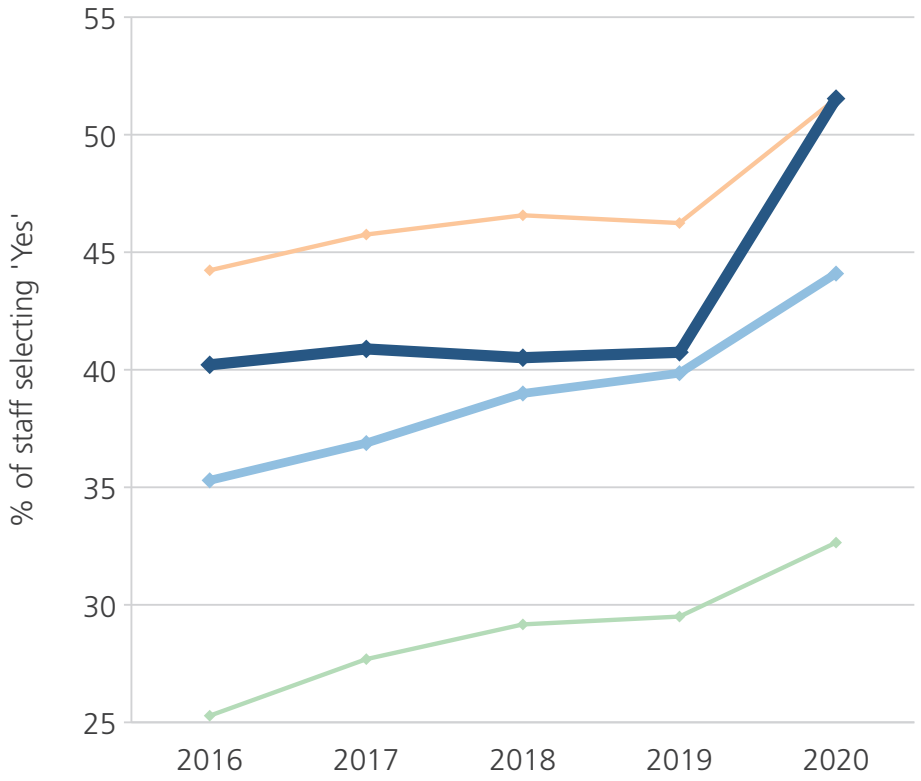
	2016	2017	2018	2019	2020
Best	51.9%	51.5%	46.6%	47.5%	51.1%
Your org	20.5%	23.3%	25.0%	27.9%	24.6%
Average	32.0%	31.8%	27.7%	28.0%	31.7%
Worst	18.2%	19.0%	15.3%	14.8%	20.3%

Q11b
In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?



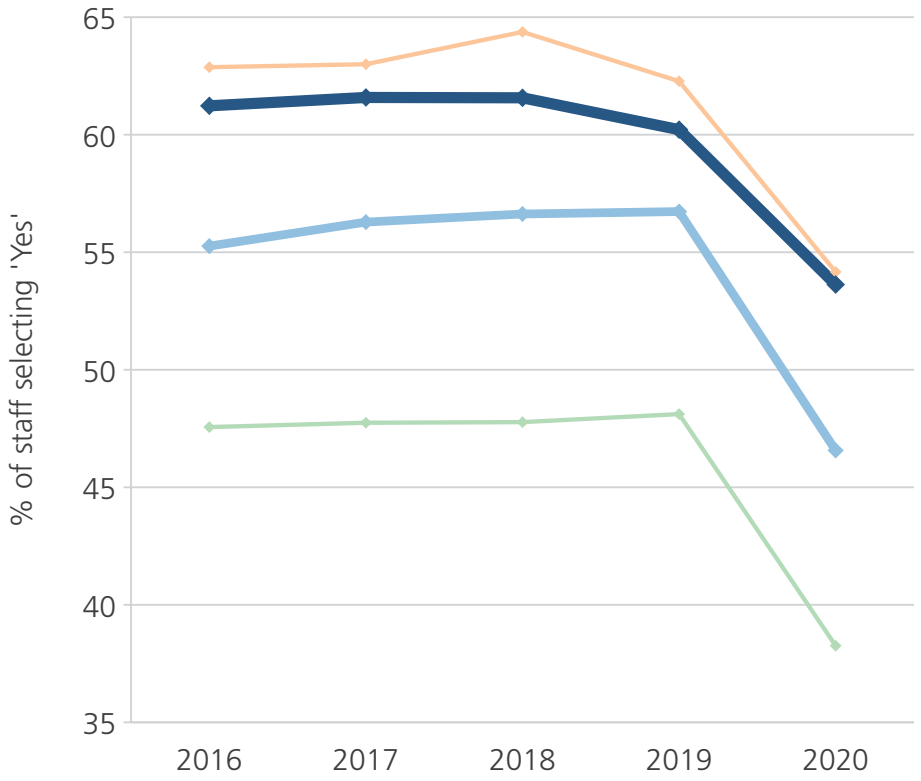
	2016	2017	2018	2019	2020
Worst	34.5%	34.6%	38.0%	36.2%	37.4%
Your org	29.0%	30.9%	31.2%	31.7%	34.1%
Average	25.2%	25.6%	28.4%	28.8%	28.8%
Best	18.7%	19.8%	20.5%	21.5%	18.7%

Q11c
During the last 12 months have you felt unwell as a result of work related stress?



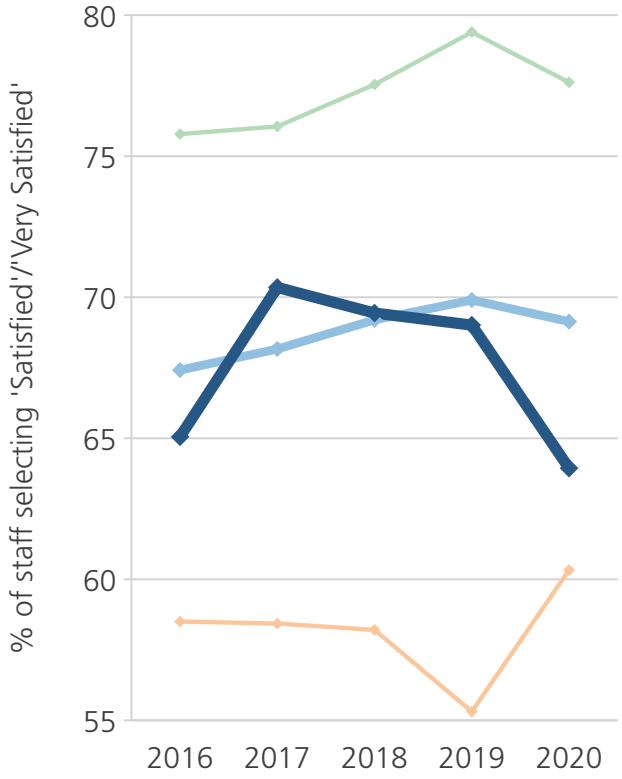
	2016	2017	2018	2019	2020
Worst	44.2%	45.8%	46.6%	46.2%	51.5%
Your org	40.2%	40.9%	40.5%	40.7%	51.5%
Average	35.3%	36.9%	39.0%	39.9%	44.1%
Best	25.3%	27.7%	29.2%	29.5%	32.6%

Q11d
In the last three months have you ever come to work despite not feeling well enough to perform your duties?



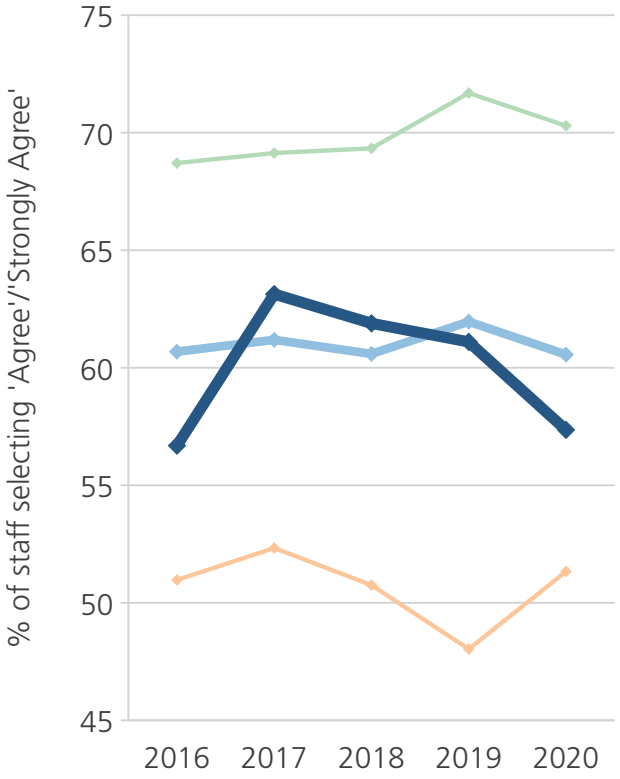
	2016	2017	2018	2019	2020
Worst	62.9%	63.0%	64.4%	62.3%	54.2%
Your org	61.2%	61.6%	61.6%	60.2%	53.6%
Average	55.3%	56.3%	56.6%	56.7%	46.6%
Best	47.6%	47.7%	47.8%	48.1%	38.3%

Q5b
The support I get from my immediate manager



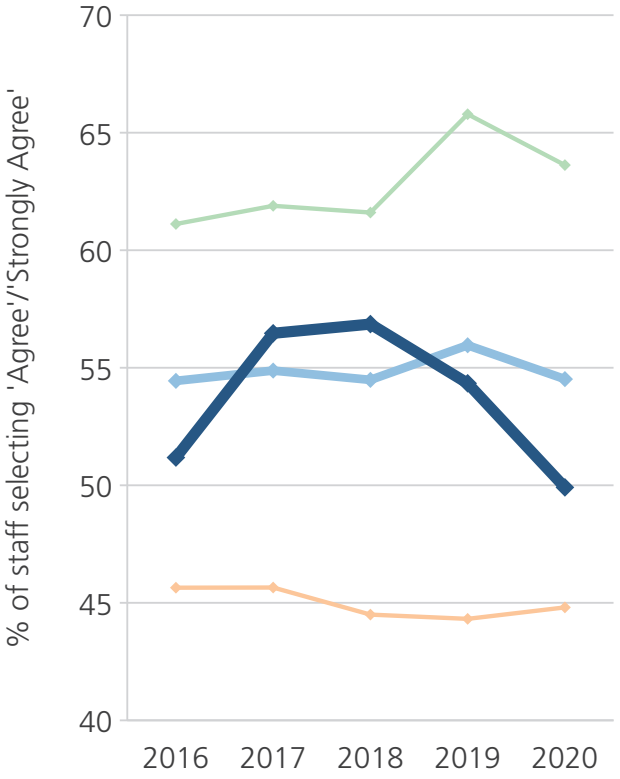
	2016	2017	2018	2019	2020
Best	75.8%	76.1%	77.5%	79.4%	77.6%
Your org	65.1%	70.3%	69.4%	69.0%	63.9%
Average	67.4%	68.2%	69.2%	69.9%	69.1%
Worst	58.5%	58.4%	58.2%	55.3%	60.3%

Q8c
My immediate manager gives me clear feedback on my work



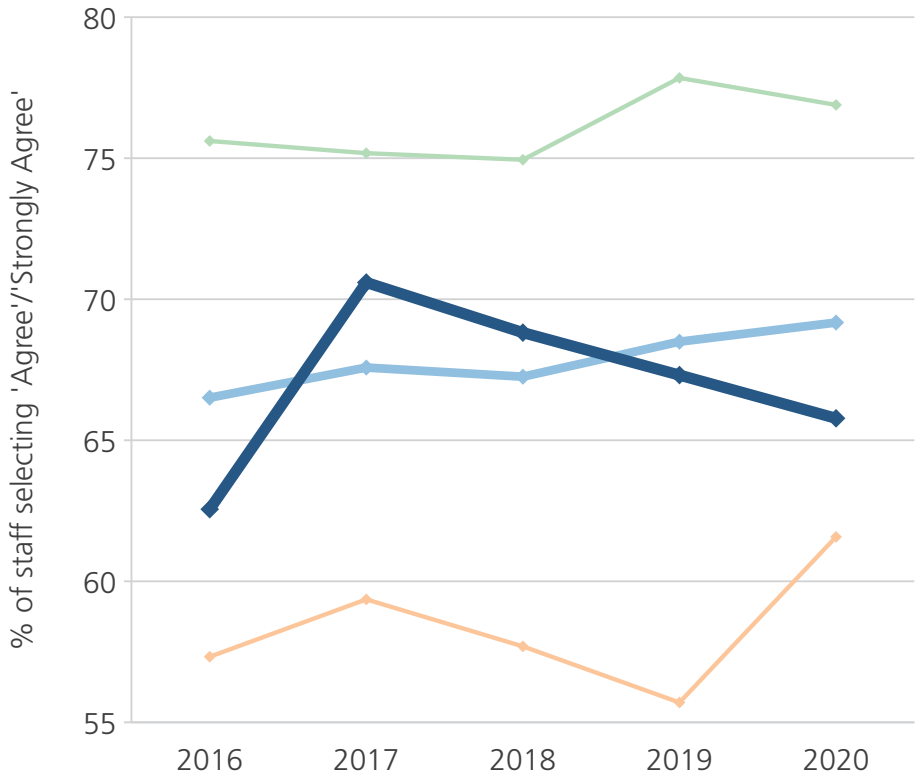
	2016	2017	2018	2019	2020
Best	68.7%	69.1%	69.3%	71.7%	70.3%
Your org	56.7%	63.1%	61.9%	61.1%	57.4%
Average	60.7%	61.2%	60.6%	62.0%	60.6%
Worst	51.0%	52.3%	50.8%	48.0%	51.3%

Q8d
My immediate manager asks for my opinion before making decisions that affect my work



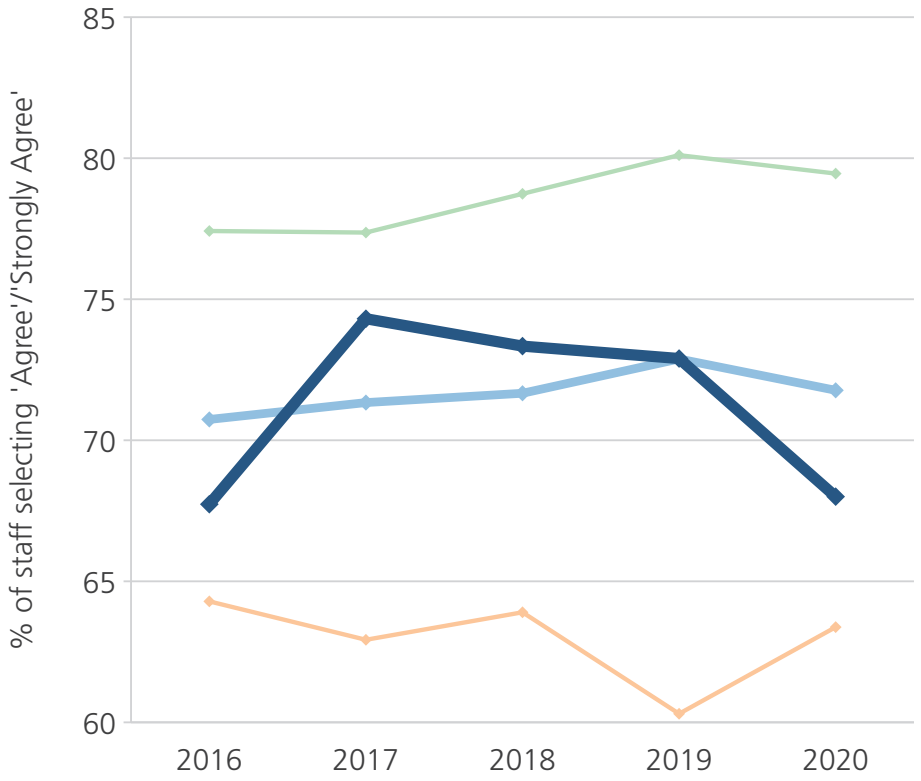
	2016	2017	2018	2019	2020
Best	61.1%	61.9%	61.6%	65.8%	63.6%
Your org	51.2%	56.5%	56.9%	54.3%	49.9%
Average	54.4%	54.9%	54.5%	56.0%	54.5%
Worst	45.6%	45.7%	44.5%	44.3%	44.8%

Q8f
My immediate manager takes a positive interest in my health and well-being



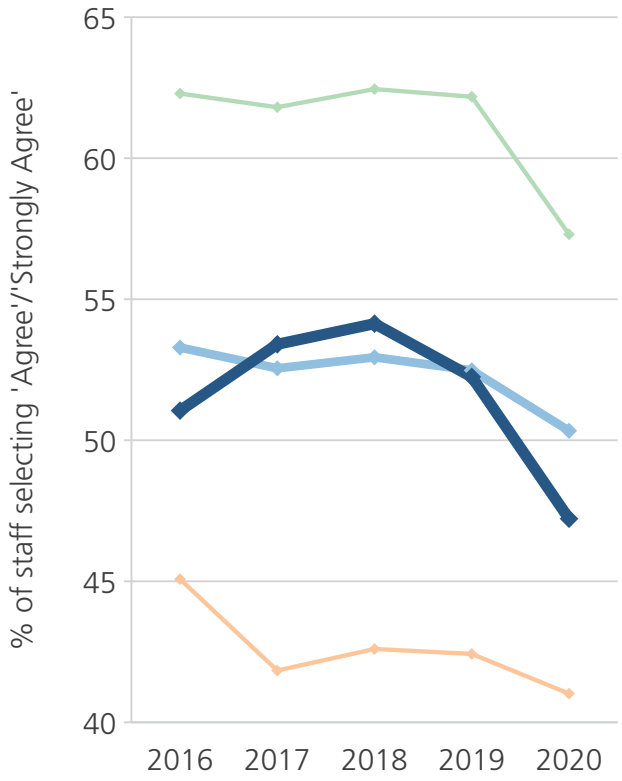
	2016	2017	2018	2019	2020
Best	75.6%	75.2%	74.9%	77.8%	76.9%
Your org	62.6%	70.6%	68.8%	67.3%	65.8%
Average	66.5%	67.6%	67.3%	68.5%	69.2%
Worst	57.3%	59.4%	57.7%	55.7%	61.6%

Q8g
My immediate manager values my work



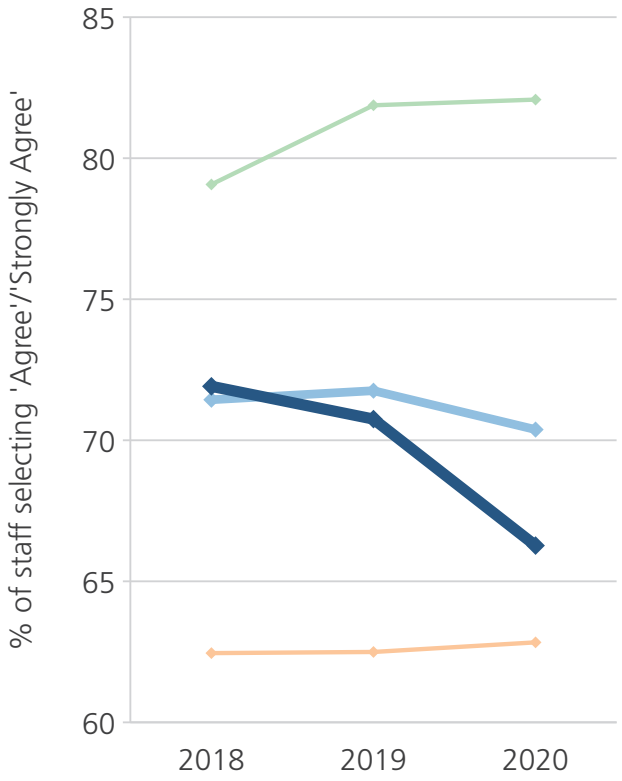
	2016	2017	2018	2019	2020
Best	77.4%	77.4%	78.7%	80.1%	79.5%
Your org	67.7%	74.3%	73.3%	72.9%	68.0%
Average	70.7%	71.3%	71.7%	72.9%	71.8%
Worst	64.3%	62.9%	63.9%	60.3%	63.4%

Q4c
I am involved in deciding on changes introduced that affect my work area / team / department



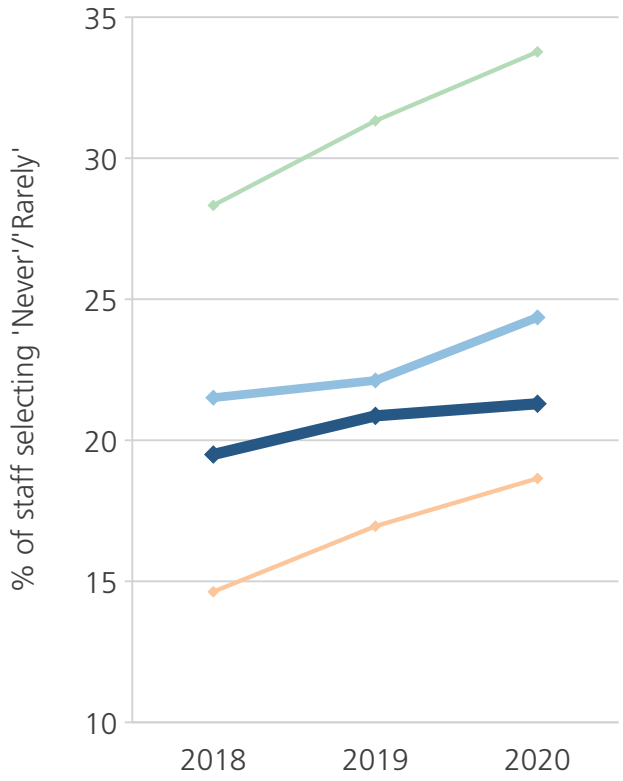
	2016	2017	2018	2019	2020
Best	62.3%	61.8%	62.5%	62.2%	57.3%
Your org	51.1%	53.4%	54.1%	52.2%	47.2%
Average	53.3%	52.6%	52.9%	52.5%	50.3%
Worst	45.1%	41.8%	42.6%	42.4%	41.0%

Q4j
I receive the respect I deserve from my colleagues at work



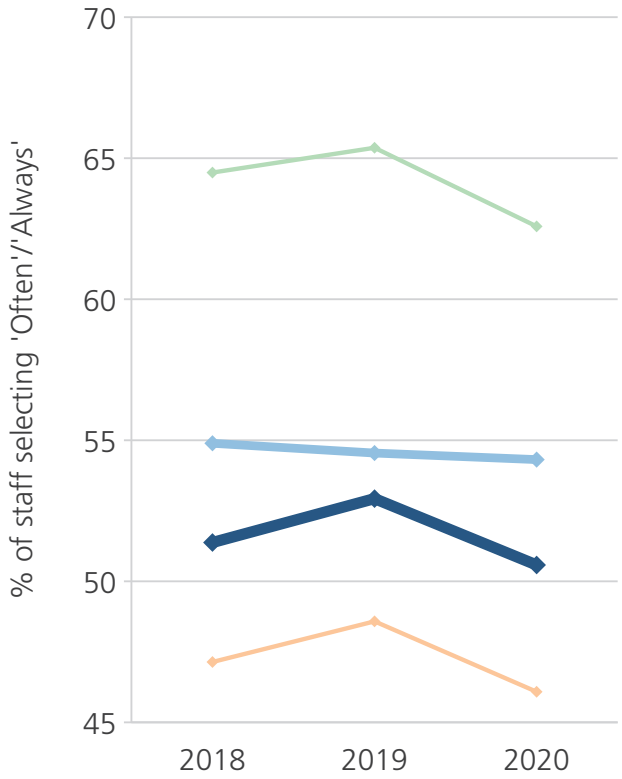
	2018	2019	2020
Best	79.1%	81.9%	82.1%
Your org	71.9%	70.8%	66.3%
Average	71.4%	71.8%	70.4%
Worst	62.5%	62.5%	62.8%

Q6a
I have unrealistic time pressures



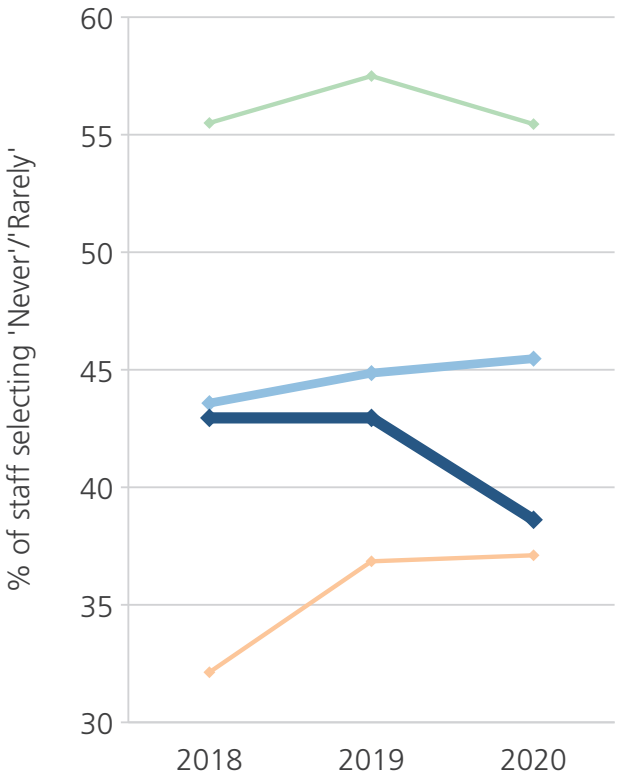
	2018	2019	2020
Best	28.3%	31.3%	33.8%
Your org	19.5%	20.9%	21.3%
Average	21.5%	22.1%	24.4%
Worst	14.6%	17.0%	18.6%

Q6b
I have a choice in deciding how to do my work



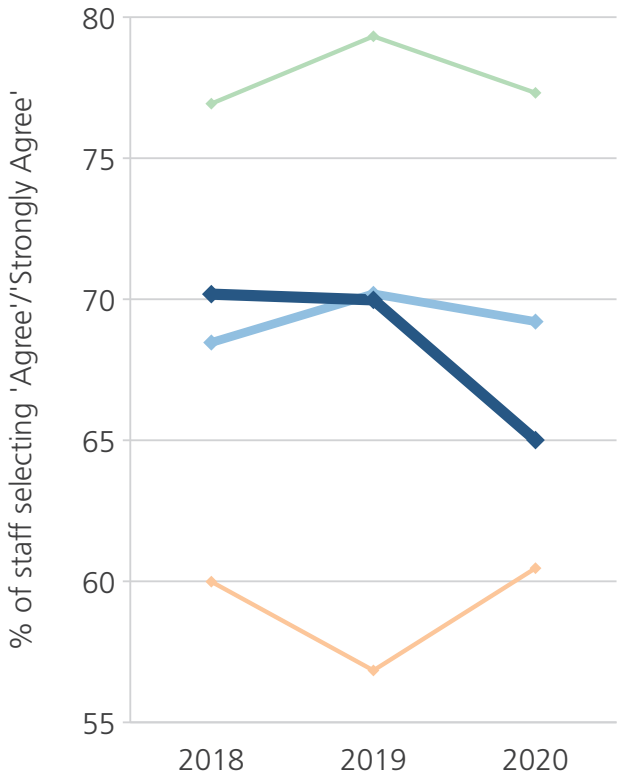
	2018	2019	2020
Best	64.5%	65.4%	62.6%
Your org	51.4%	52.9%	50.6%
Average	54.9%	54.5%	54.3%
Worst	47.1%	48.6%	46.1%

Q6c
Relationships at work are strained



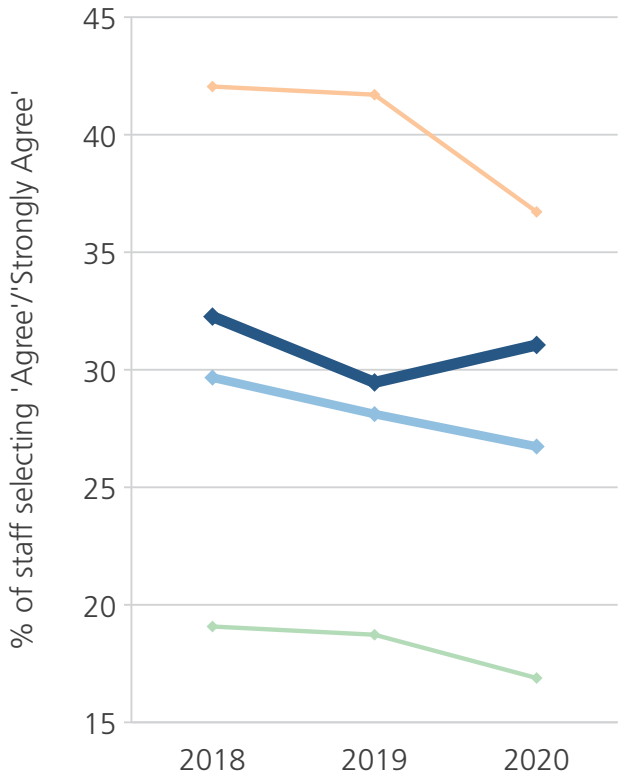
	2018	2019	2020
Best	55.5%	57.5%	55.5%
Your org	43.0%	43.0%	38.6%
Average	43.6%	44.9%	45.5%
Worst	32.1%	36.9%	37.1%

Q8a
My immediate manager encourages me at work



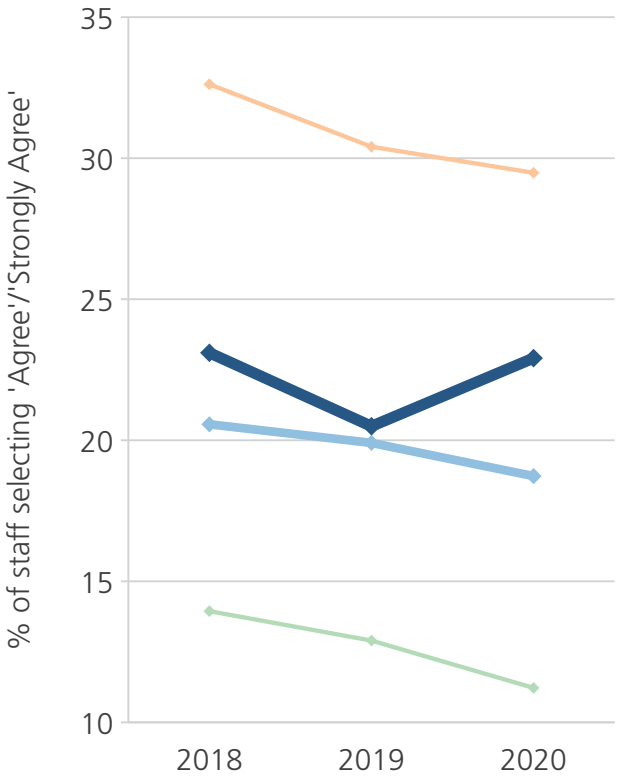
	2018	2019	2020
Best	76.9%	79.3%	77.3%
Your org	70.2%	70.0%	65.0%
Average	68.5%	70.2%	69.2%
Worst	60.0%	56.8%	60.5%

Q19a
I often think about leaving this organisation



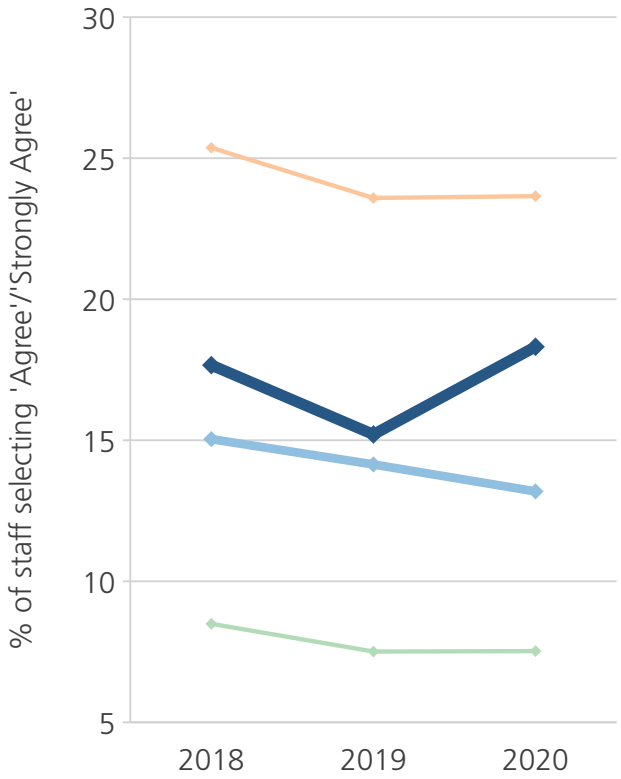
	2018	2019	2020
Worst	42.0%	41.7%	36.7%
Your org	32.3%	29.5%	31.1%
Average	29.7%	28.1%	26.7%
Best	19.1%	18.7%	16.9%

Q19b
I will probably look for a job at a new organisation in the next 12 months



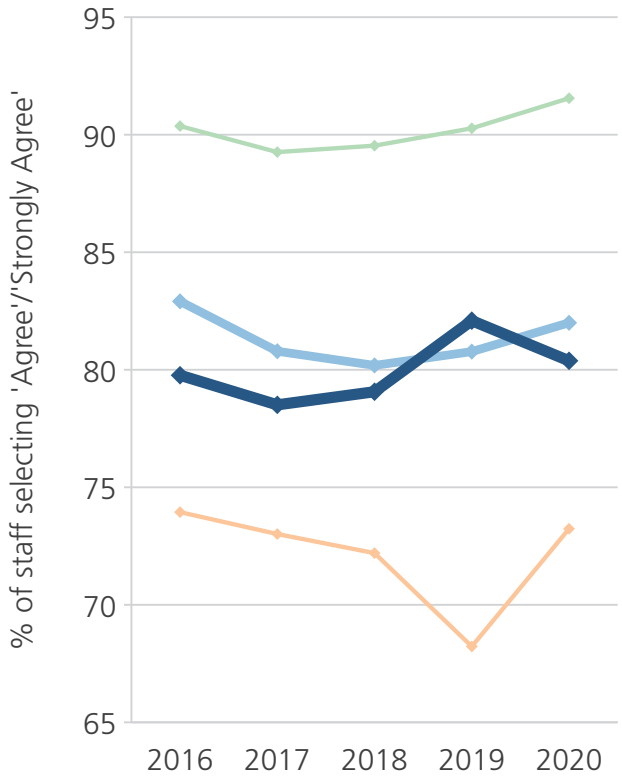
	2018	2019	2020
Worst	32.6%	30.4%	29.5%
Your org	23.1%	20.5%	22.9%
Average	20.6%	19.9%	18.7%
Best	13.9%	12.9%	11.2%

Q19c
As soon as I can find another job, I will leave this organisation



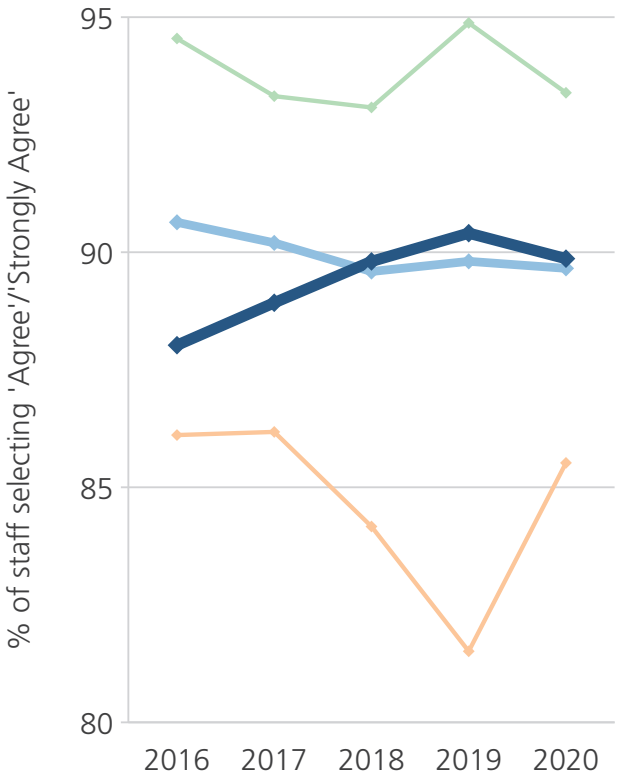
	2018	2019	2020
Worst	25.4%	23.6%	23.7%
Your org	17.7%	15.2%	18.3%
Average	15.0%	14.1%	13.2%
Best	8.5%	7.5%	7.5%

Q7a
I am satisfied with the quality of care I give to patients / service users



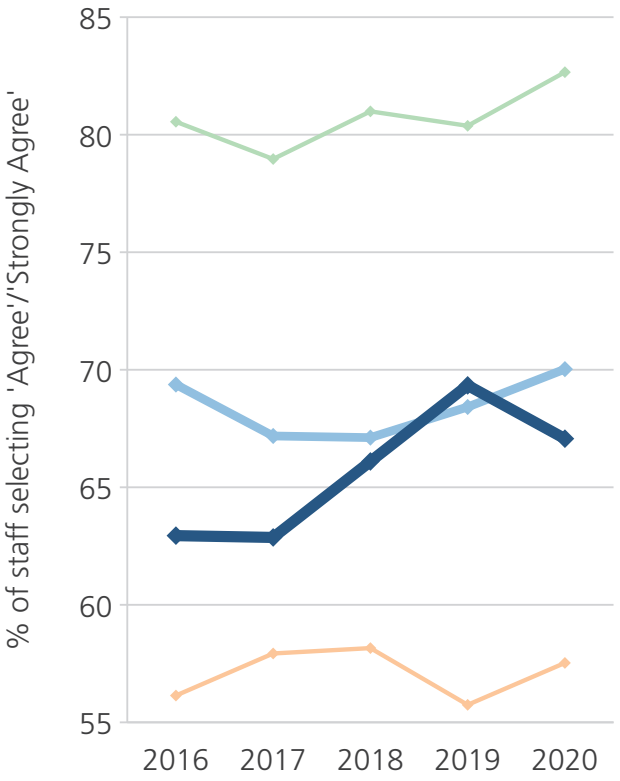
	2016	2017	2018	2019	2020
Best	90.4%	89.3%	89.5%	90.3%	91.6%
Your org	79.8%	78.5%	79.1%	82.1%	80.4%
Average	82.9%	80.8%	80.2%	80.8%	82.0%
Worst	73.9%	73.0%	72.2%	68.2%	73.2%

Q7b
I feel that my role makes a difference to patients / service users



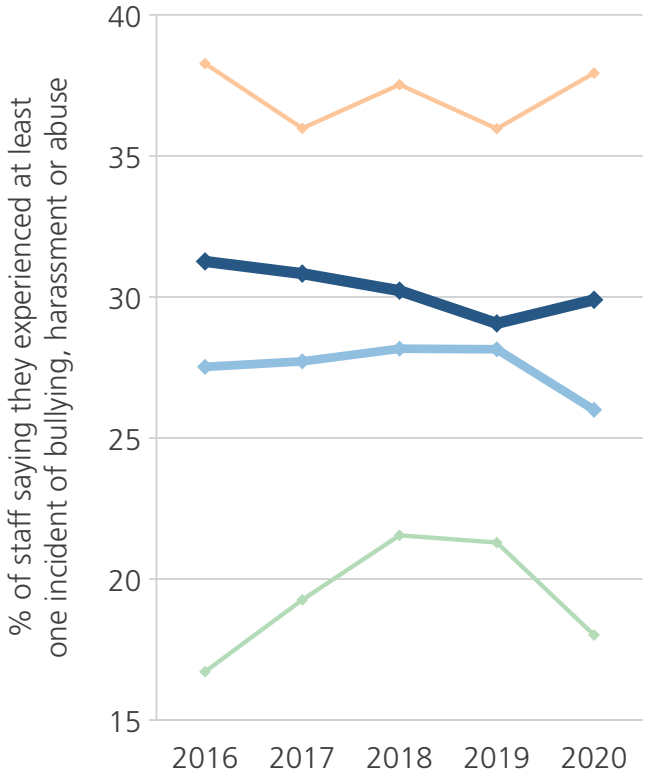
	2016	2017	2018	2019	2020
Best	94.5%	93.3%	93.1%	94.9%	93.4%
Your org	88.0%	88.9%	89.8%	90.4%	89.9%
Average	90.6%	90.2%	89.6%	89.8%	89.7%
Worst	86.1%	86.2%	84.2%	81.5%	85.5%

Q7c
I am able to deliver the care I aspire to



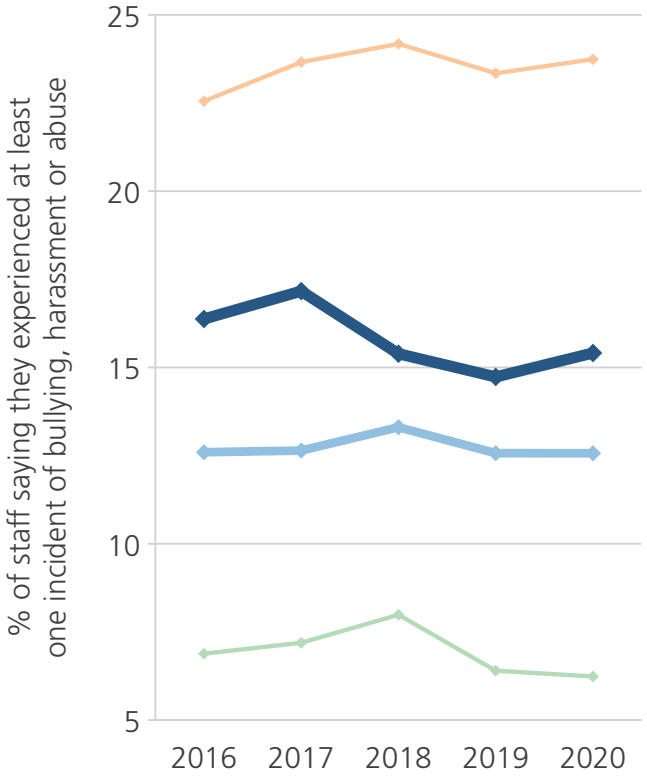
	2016	2017	2018	2019	2020
Best	80.6%	79.0%	81.0%	80.4%	82.7%
Your org	62.9%	62.9%	66.1%	69.3%	67.1%
Average	69.4%	67.2%	67.1%	68.4%	70.0%
Worst	56.1%	57.9%	58.2%	55.7%	57.5%

Q13a
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



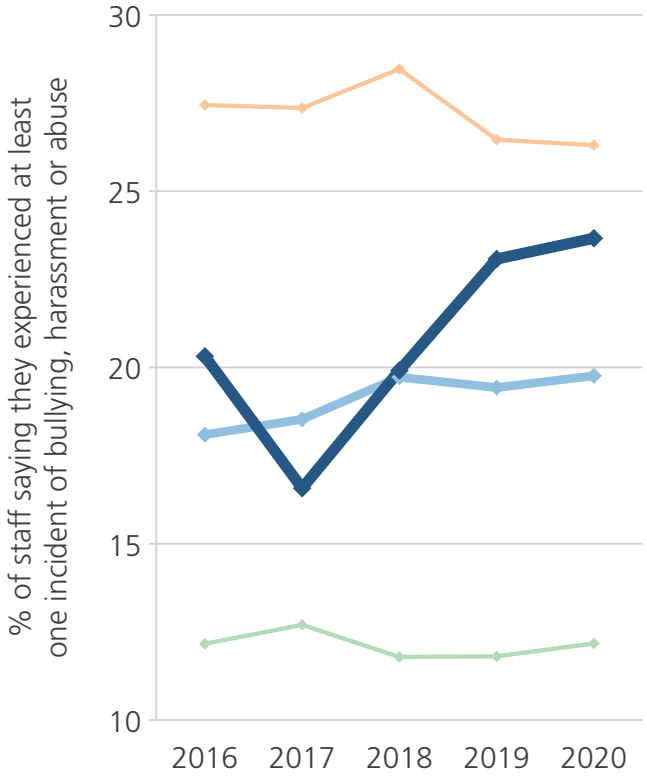
	2016	2017	2018	2019	2020
Worst	38.3%	36.0%	37.5%	36.0%	37.9%
Your org	31.3%	30.8%	30.2%	29.1%	29.9%
Average	27.5%	27.7%	28.2%	28.1%	26.0%
Best	16.7%	19.3%	21.5%	21.3%	18.0%

Q13b
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



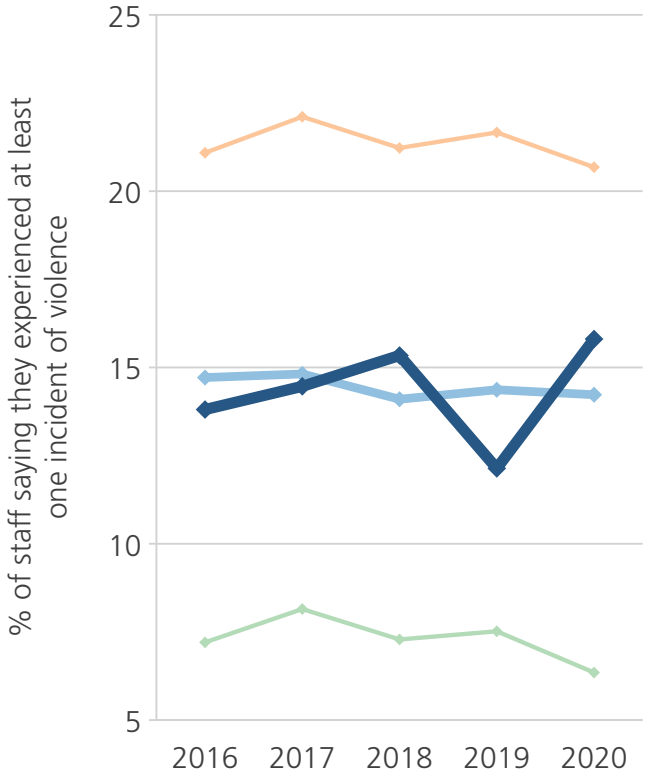
	2016	2017	2018	2019	2020
Worst	22.6%	23.7%	24.2%	23.3%	23.7%
Your org	16.4%	17.2%	15.4%	14.7%	15.4%
Average	12.6%	12.6%	13.3%	12.6%	12.6%
Best	6.9%	7.2%	8.0%	6.4%	6.2%

Q13c
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?



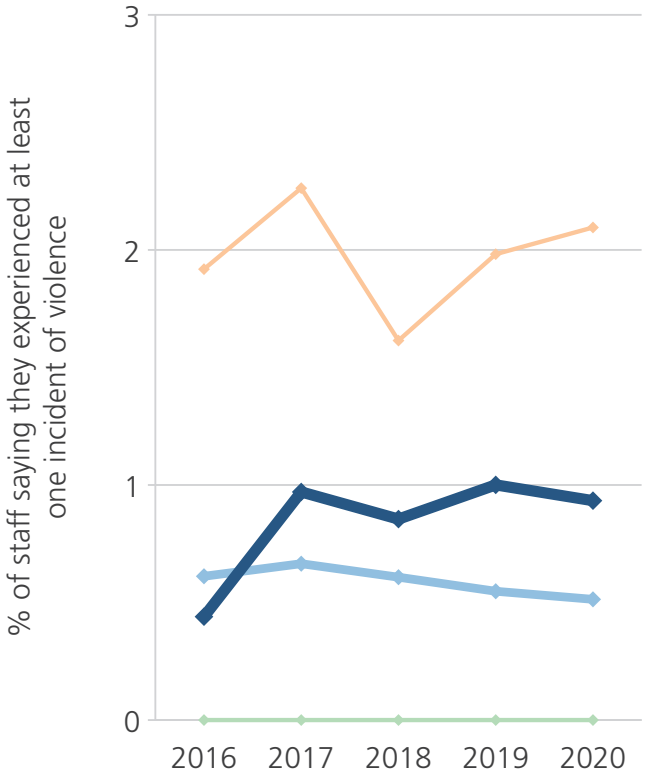
	2016	2017	2018	2019	2020
Worst	27.4%	27.4%	28.5%	26.5%	26.3%
Your org	20.3%	16.6%	19.9%	23.1%	23.7%
Average	18.1%	18.5%	19.7%	19.4%	19.8%
Best	12.2%	12.7%	11.8%	11.8%	12.2%

Q12a
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



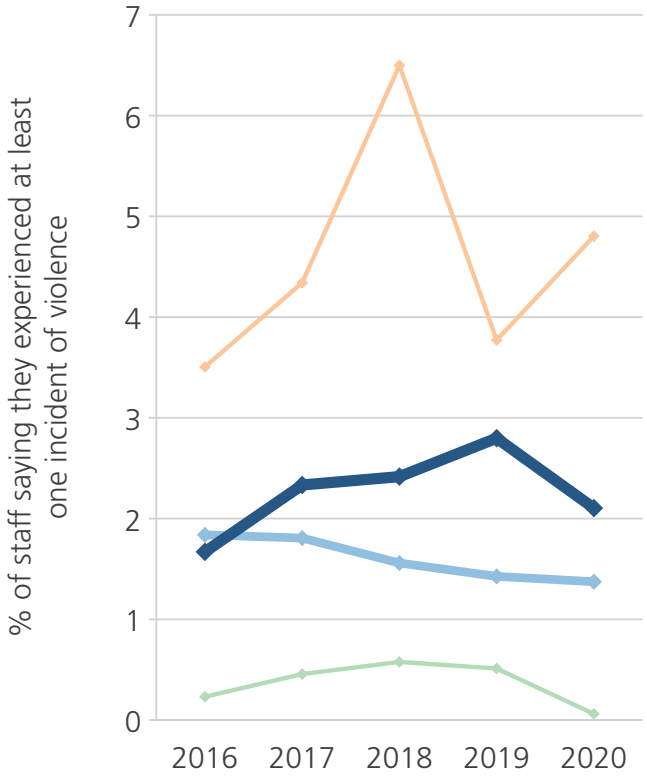
	2016	2017	2018	2019	2020
Worst	21.1%	22.1%	21.2%	21.7%	20.7%
Your org	13.8%	14.5%	15.3%	12.1%	15.8%
Average	14.7%	14.8%	14.1%	14.4%	14.2%
Best	7.2%	8.1%	7.3%	7.5%	6.3%

Q12b
In the last 12 months how many times have you personally experienced physical violence at work from managers?



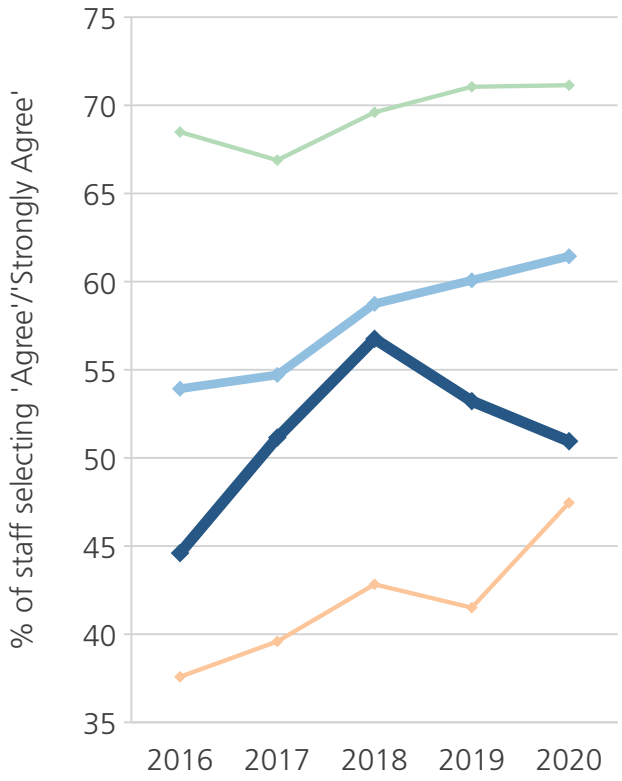
	2016	2017	2018	2019	2020
Worst	1.9%	2.3%	1.6%	2.0%	2.1%
Your org	0.4%	1.0%	0.9%	1.0%	0.9%
Average	0.6%	0.7%	0.6%	0.5%	0.5%
Best	0.0%	0.0%	0.0%	0.0%	0.0%

Q12c
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



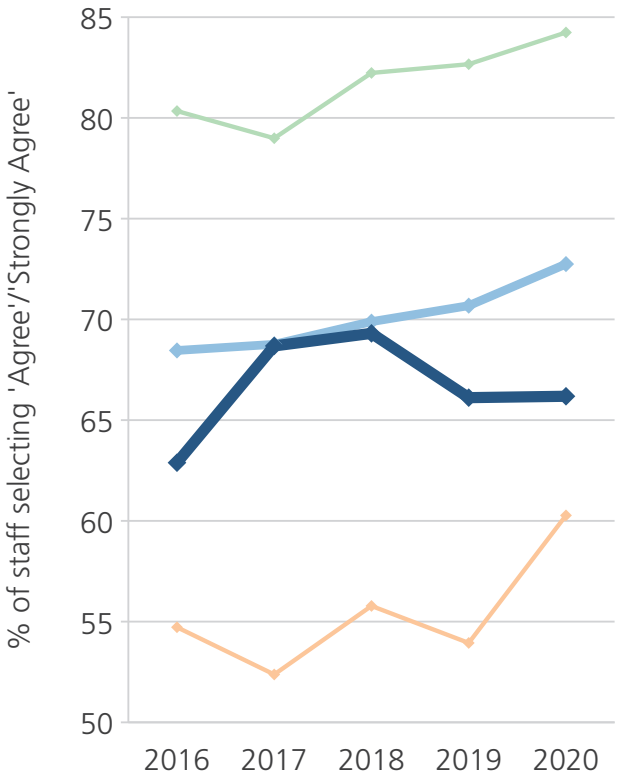
	2016	2017	2018	2019	2020
Worst	3.5%	4.3%	6.5%	3.8%	4.8%
Your org	1.7%	2.3%	2.4%	2.8%	2.1%
Average	1.8%	1.8%	1.6%	1.4%	1.4%
Best	0.2%	0.5%	0.6%	0.5%	0.1%

Q16a
My organisation treats staff who are involved in an error, near miss or incident fairly



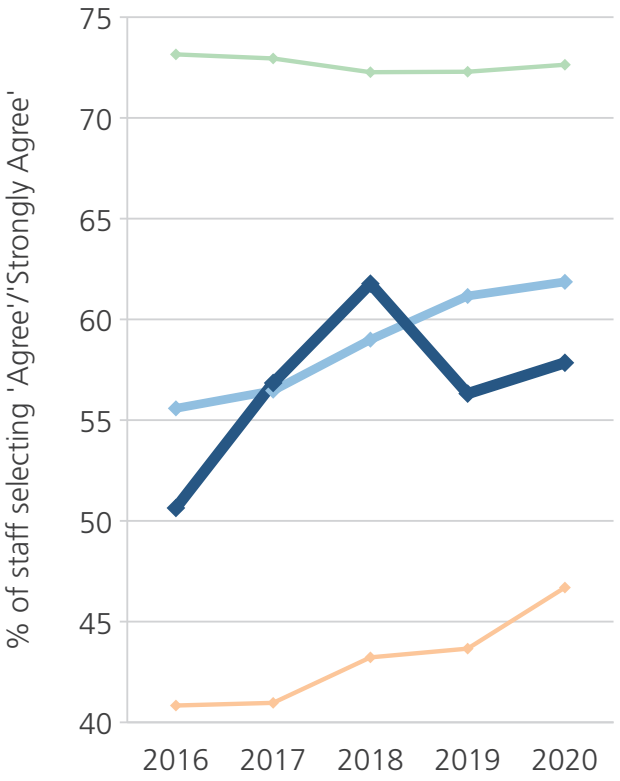
	2016	2017	2018	2019	2020
Best	68.5%	66.9%	69.6%	71.1%	71.1%
Your org	44.6%	51.2%	56.8%	53.2%	50.9%
Average	53.9%	54.7%	58.7%	60.1%	61.4%
Worst	37.6%	39.6%	42.8%	41.5%	47.5%

Q16c
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



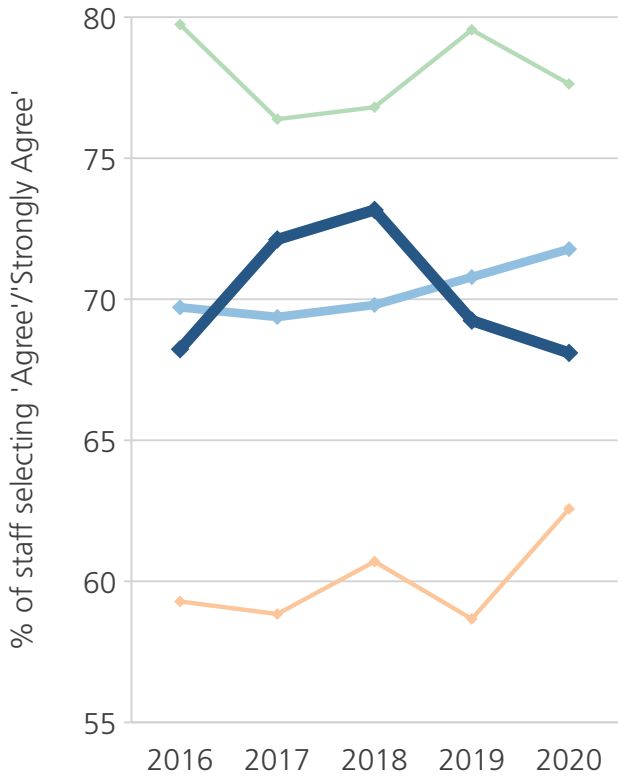
	2016	2017	2018	2019	2020
Best	80.3%	79.0%	82.2%	82.7%	84.2%
Your org	62.9%	68.7%	69.3%	66.1%	66.2%
Average	68.5%	68.8%	69.9%	70.7%	72.7%
Worst	54.7%	52.4%	55.8%	53.9%	60.3%

Q16d
We are given feedback about changes made in response to reported errors, near misses and incidents



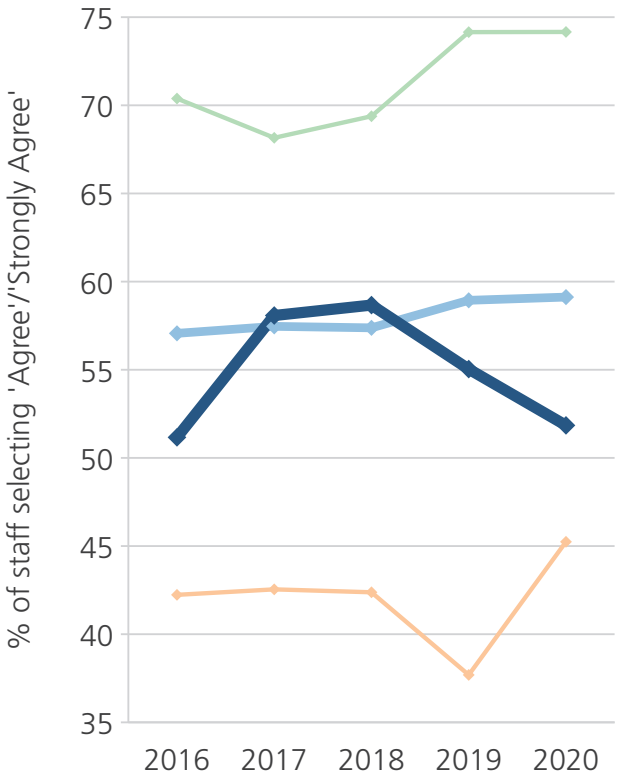
	2016	2017	2018	2019	2020
Best	73.2%	73.0%	72.3%	72.3%	72.6%
Your org	50.6%	56.8%	61.8%	56.3%	57.8%
Average	55.6%	56.5%	59.0%	61.2%	61.9%
Worst	40.8%	41.0%	43.2%	43.7%	46.7%

Q17b
I would feel secure raising concerns about unsafe clinical practice



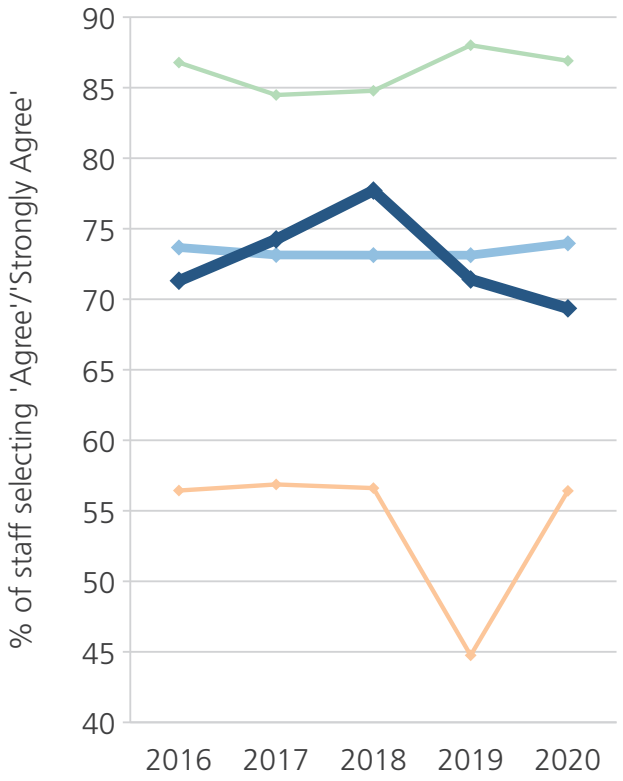
	2016	2017	2018	2019	2020
Best	79.7%	76.4%	76.8%	79.6%	77.6%
Your org	68.2%	72.1%	73.2%	69.2%	68.1%
Average	69.7%	69.4%	69.8%	70.8%	71.8%
Worst	59.3%	58.8%	60.7%	58.7%	62.6%

Q17c
I am confident that my organisation would address my concern



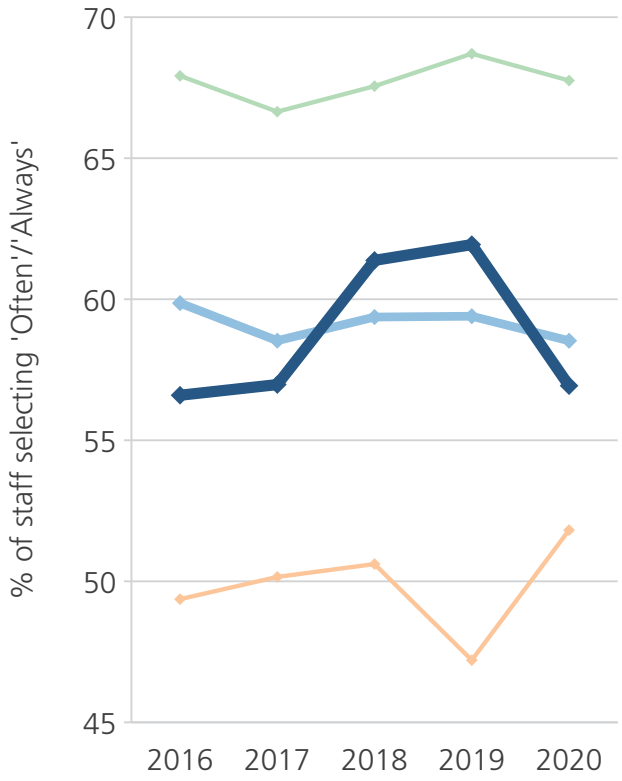
	2016	2017	2018	2019	2020
Best	70.4%	68.2%	69.4%	74.2%	74.2%
Your org	51.2%	58.1%	58.7%	55.0%	51.8%
Average	57.1%	57.5%	57.4%	58.9%	59.1%
Worst	42.2%	42.5%	42.4%	37.7%	45.2%

Q18b
My organisation acts on concerns raised by patients / service users



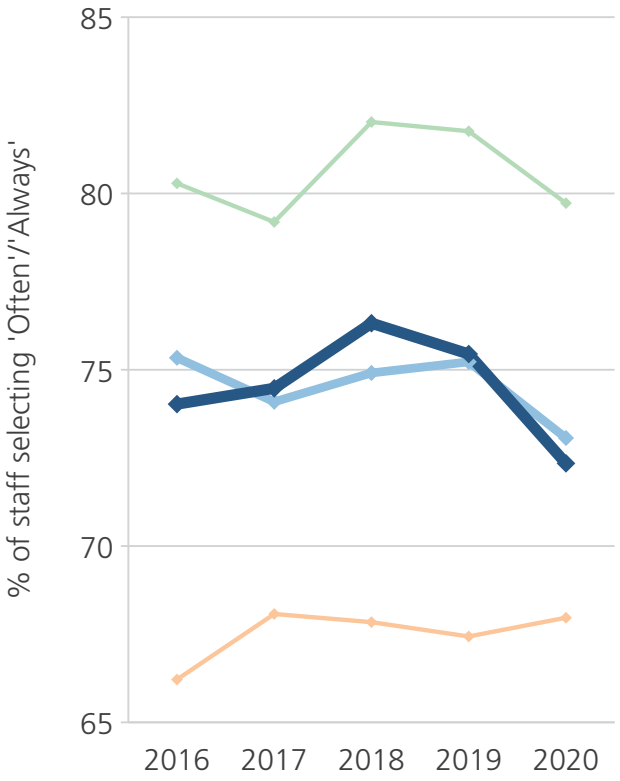
	2016	2017	2018	2019	2020
Best	86.8%	84.5%	84.8%	88.0%	86.9%
Your org	71.3%	74.2%	77.7%	71.4%	69.4%
Average	73.7%	73.1%	73.1%	73.1%	74.0%
Worst	56.4%	56.9%	56.6%	44.8%	56.4%

Q2a
I look forward to going to work



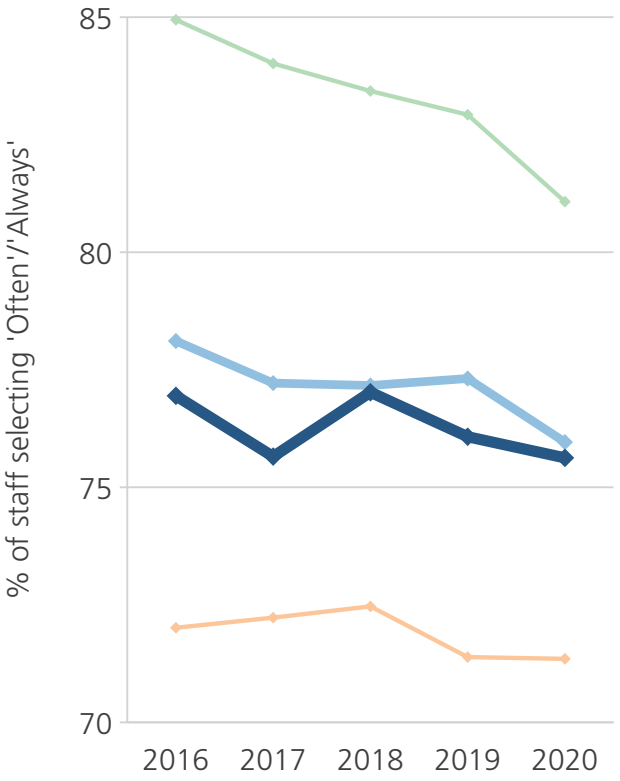
	2016	2017	2018	2019	2020
Best	67.9%	66.6%	67.6%	68.7%	67.8%
Your org	56.6%	57.0%	61.4%	61.9%	56.9%
Average	59.9%	58.5%	59.4%	59.4%	58.5%
Worst	49.4%	50.2%	50.6%	47.2%	51.8%

Q2b
I am enthusiastic about my job



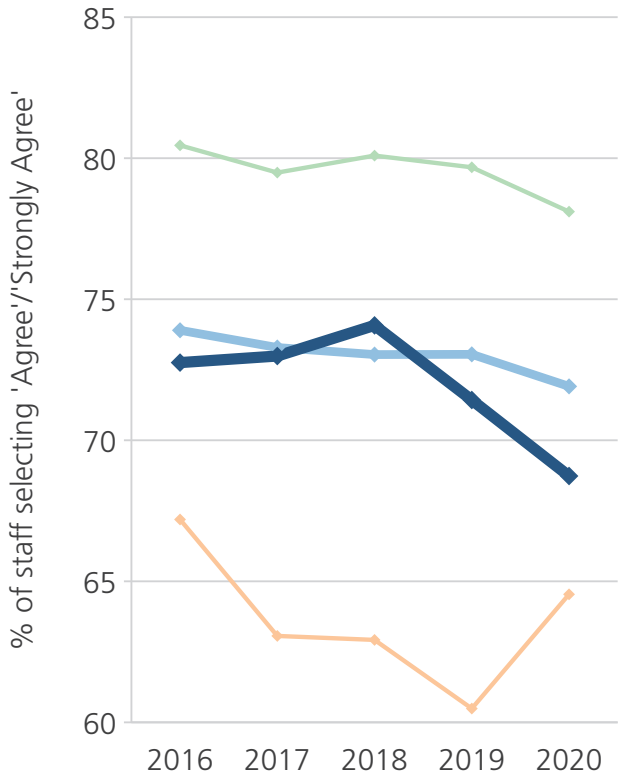
	2016	2017	2018	2019	2020
Best	80.3%	79.2%	82.0%	81.8%	79.7%
Your org	74.0%	74.5%	76.3%	75.4%	72.3%
Average	75.3%	74.1%	74.9%	75.2%	73.1%
Worst	66.2%	68.1%	67.8%	67.4%	68.0%

Q2c
Time passes quickly when I am working



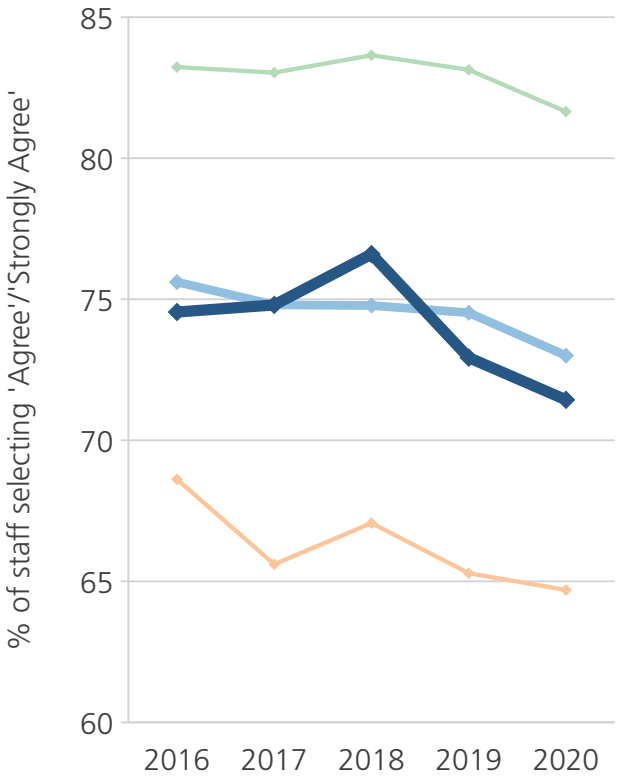
	2016	2017	2018	2019	2020
Best	84.9%	84.0%	83.4%	82.9%	81.1%
Your org	76.9%	75.7%	77.0%	76.1%	75.6%
Average	78.1%	77.2%	77.2%	77.3%	76.0%
Worst	72.0%	72.2%	72.5%	71.4%	71.4%

Q4a
There are frequent opportunities for me to show initiative in my role



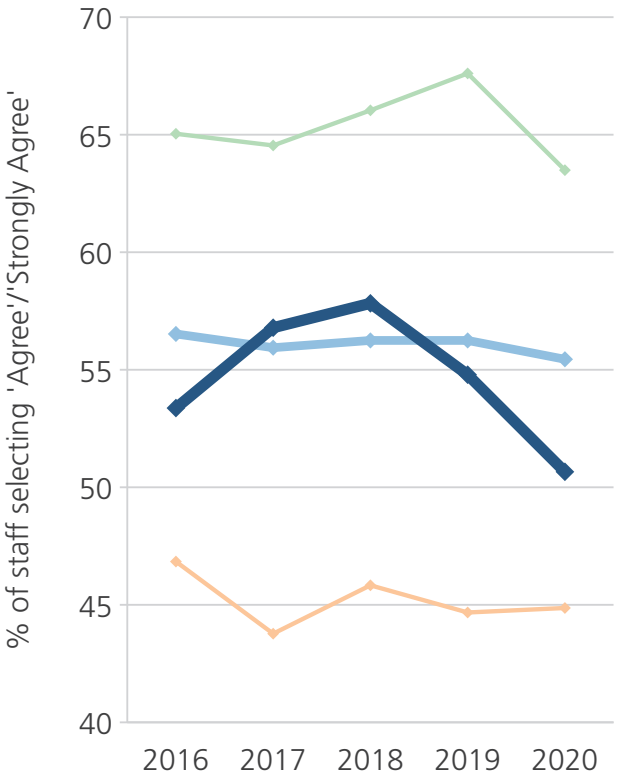
Best	80.5%	79.5%	80.1%	79.7%	78.1%
Your org	72.8%	73.0%	74.1%	71.4%	68.7%
Average	73.9%	73.3%	73.0%	73.0%	71.9%
Worst	67.2%	63.1%	62.9%	60.5%	64.5%

Q4b
I am able to make suggestions to improve the work of my team / department



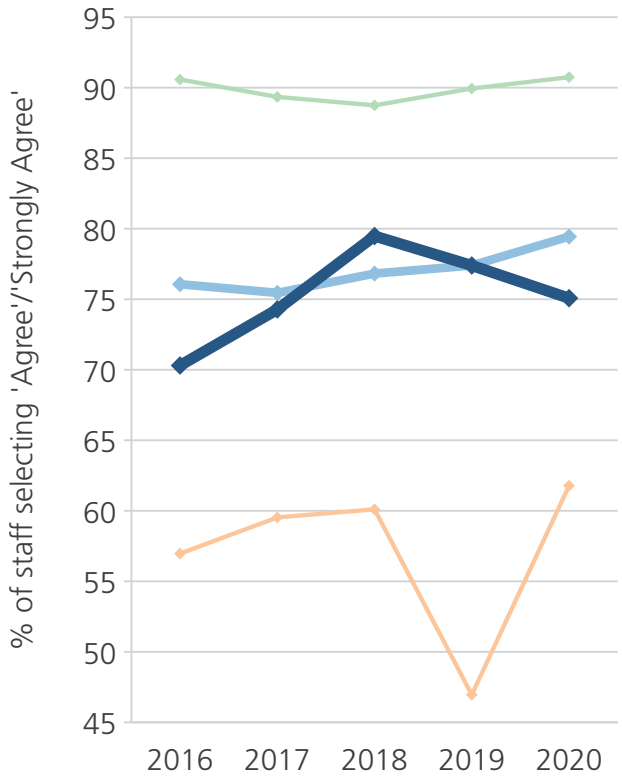
Best	83.2%	83.0%	83.6%	83.1%	81.7%
Your org	74.5%	74.8%	76.6%	72.9%	71.4%
Average	75.6%	74.8%	74.8%	74.5%	73.0%
Worst	68.6%	65.6%	67.1%	65.3%	64.7%

Q4d
I am able to make improvements happen in my area of work



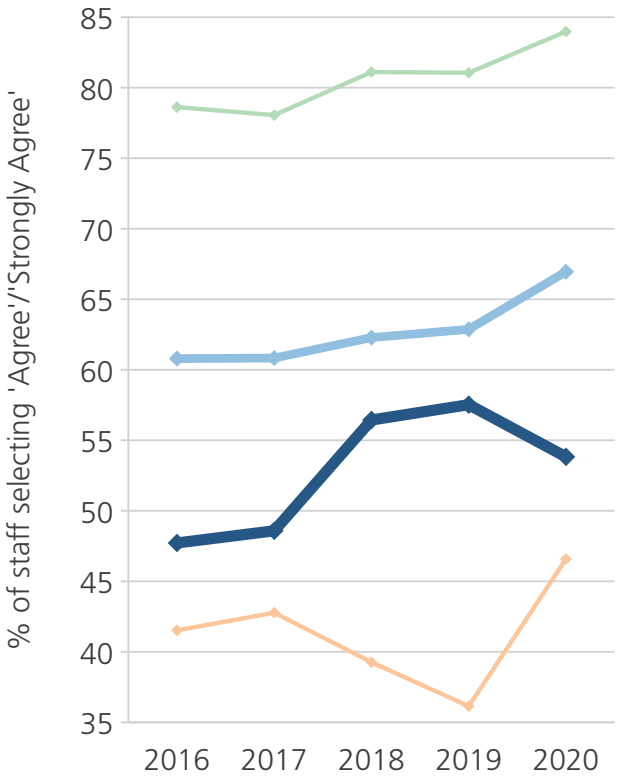
Best	65.0%	64.5%	66.0%	67.6%	63.5%
Your org	53.4%	56.8%	57.8%	54.8%	50.7%
Average	56.5%	55.9%	56.2%	56.2%	55.4%
Worst	46.8%	43.8%	45.8%	44.7%	44.9%

Q18a
Care of patients / service users is my organisation's top priority



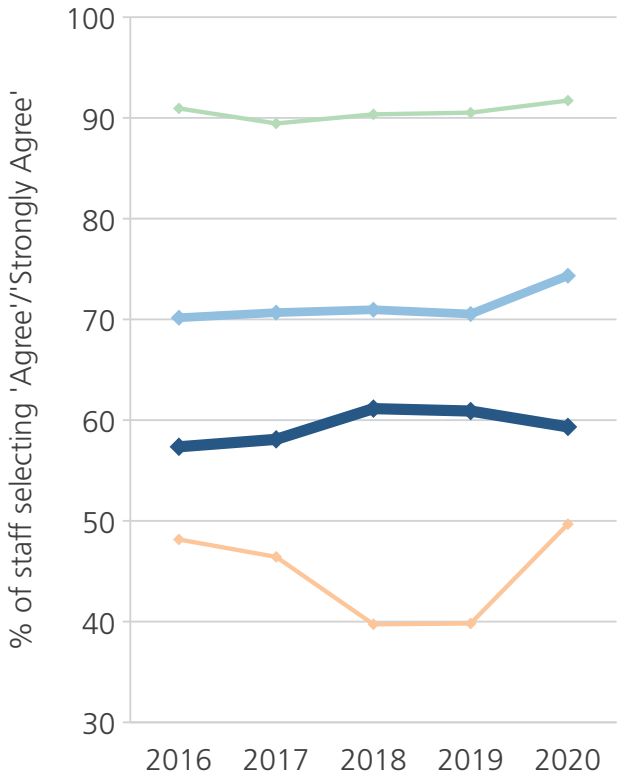
Best	90.6%	89.3%	88.7%	89.9%	90.7%
Your org	70.3%	74.3%	79.5%	77.4%	75.1%
Average	76.1%	75.5%	76.8%	77.4%	79.4%
Worst	57.0%	59.5%	60.1%	47.0%	61.8%

Q18c
I would recommend my organisation as a place to work



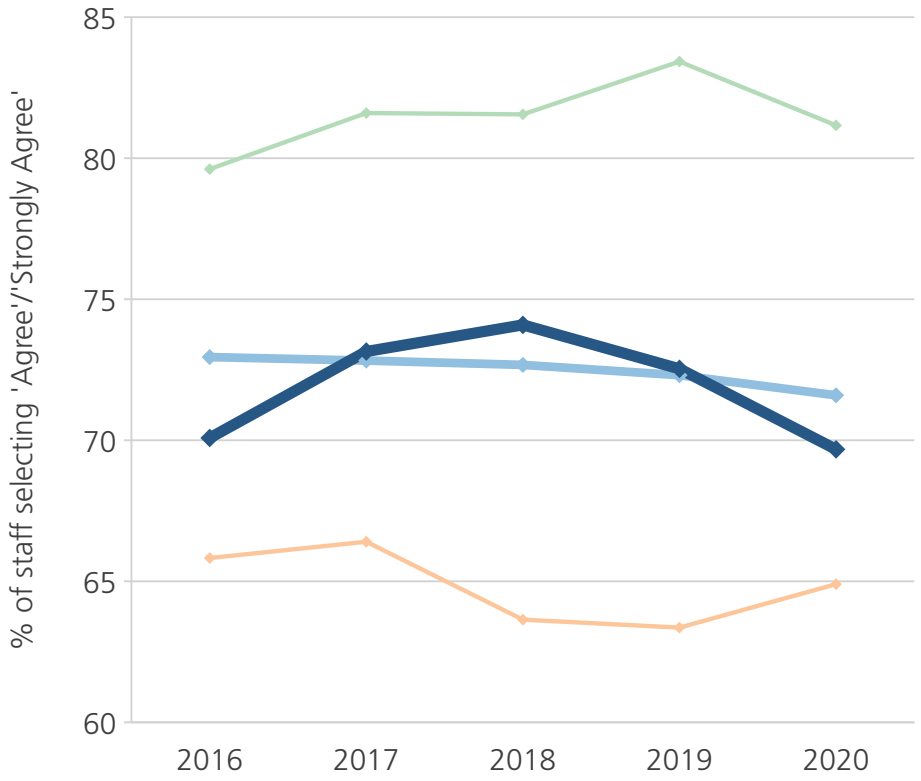
Best	78.6%	78.1%	81.1%	81.1%	84.0%
Your org	47.7%	48.6%	56.4%	57.5%	53.8%
Average	60.8%	60.8%	62.3%	62.9%	66.9%
Worst	41.5%	42.8%	39.3%	36.1%	46.6%

Q18d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



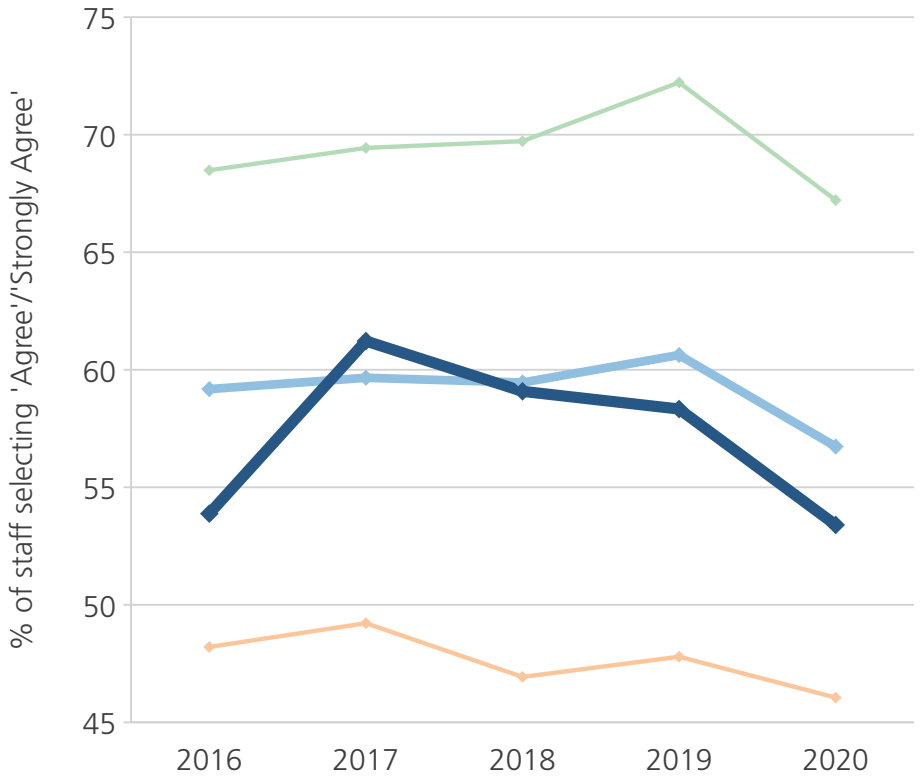
Best	90.9%	89.4%	90.4%	90.5%	91.7%
Your org	57.4%	58.1%	61.1%	60.9%	59.3%
Average	70.2%	70.7%	71.0%	70.5%	74.3%
Worst	48.2%	46.4%	39.7%	39.8%	49.7%

Q4h
The team I work in has a set of shared objectives



	2016	2017	2018	2019	2020
Best	79.6%	81.6%	81.6%	83.4%	81.2%
Your org	70.1%	73.1%	74.1%	72.5%	69.7%
Average	72.9%	72.8%	72.7%	72.3%	71.6%
Worst	65.8%	66.4%	63.6%	63.4%	64.9%

Q4i
The team I work in often meets to discuss the team's effectiveness



	2016	2017	2018	2019	2020
Best	68.5%	69.4%	69.7%	72.2%	67.2%
Your org	53.9%	61.2%	59.1%	58.3%	53.4%
Average	59.2%	59.7%	59.5%	60.6%	56.7%
Worst	48.2%	49.2%	46.9%	47.8%	46.1%

Survey Coordination Centre

NHS England

Workforce Equality Standards

The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey Results

Survey Coordination Centre

Workforce Equality Standards

NHS England

This section contains data required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Data presented in this section are unweighted.

Full details of how the data are calculated are included in the Technical Document, available to download from our results website.

Workforce Race Equality Standard (WRES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Race Equality Standard (WRES). It includes the 2017, 2018 and 2019 trust/CCG and benchmarking group median results for q13a, q13b&c combined, q14, and q15b split by ethnicity (by white / BME staff).

Workforce Disability Equality Standard (WDES)

- This contains data for each organisation required for the NHS Staff Survey indicators used in the Workforce Disability Equality Standard (WDES). It includes the 2018 and 2019 trust/CCG and benchmarking group median results for q5f, q11e, q13a-d, and q14 split by staff with a long lasting health condition or illness compared to staff without a long lasting health condition or illness. It also shows results for q26b (for staff with a long lasting health condition or illness only), and the staff engagement score for staff with a long lasting health condition or illness, compared to staff without a long lasting health condition or illness and the overall engagement score for the organisation.
- The WDES breakdowns are based on the responses to q26a ***Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?*** In 2020, the question text was shortened and the word 'disabilities' was removed but the question and WDES results still remain historically comparable.

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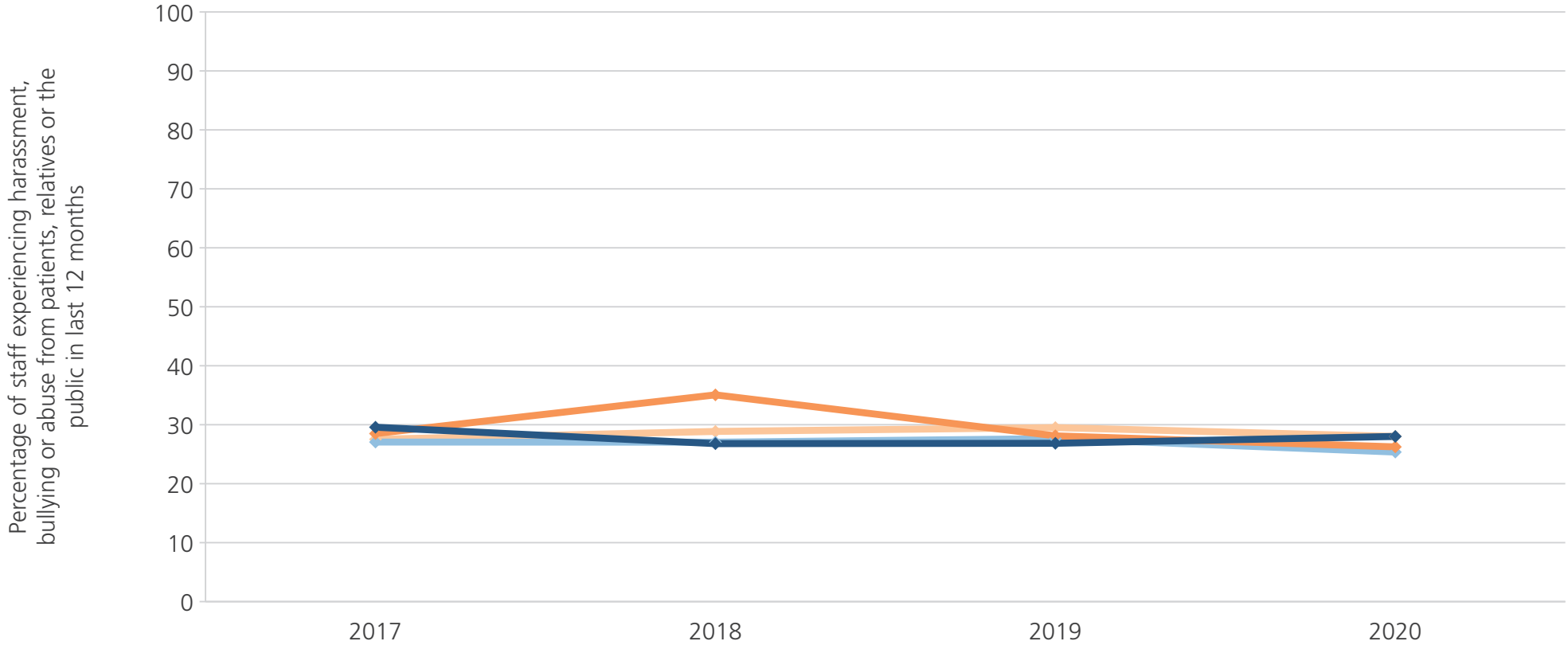
NHS England

Workforce Race Equality Standard (WRES)

The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey Results



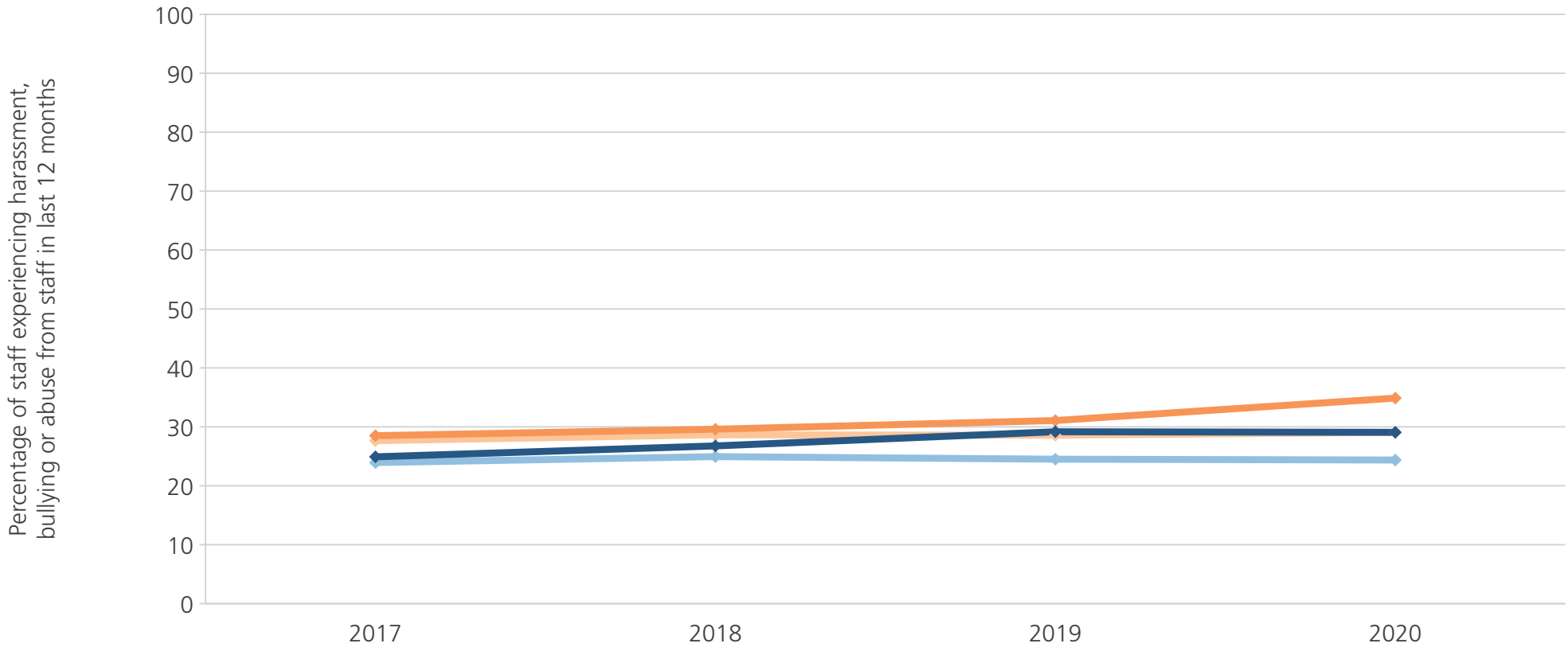
	2017	2018	2019	2020
White: Your org	29.6%	26.8%	26.8%	28.0%
BME: Your org	28.5%	35.1%	28.1%	26.2%
White: Average	27.1%	27.0%	27.6%	25.4%
BME: Average	27.5%	28.9%	29.5%	28.0%
White: Responses	869	978	1,151	946
BME: Responses	193	251	281	282

Average calculated as the median for the benchmark group

Survey Coordination Centre

2020 NHS Staff Survey Results > WRES > Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

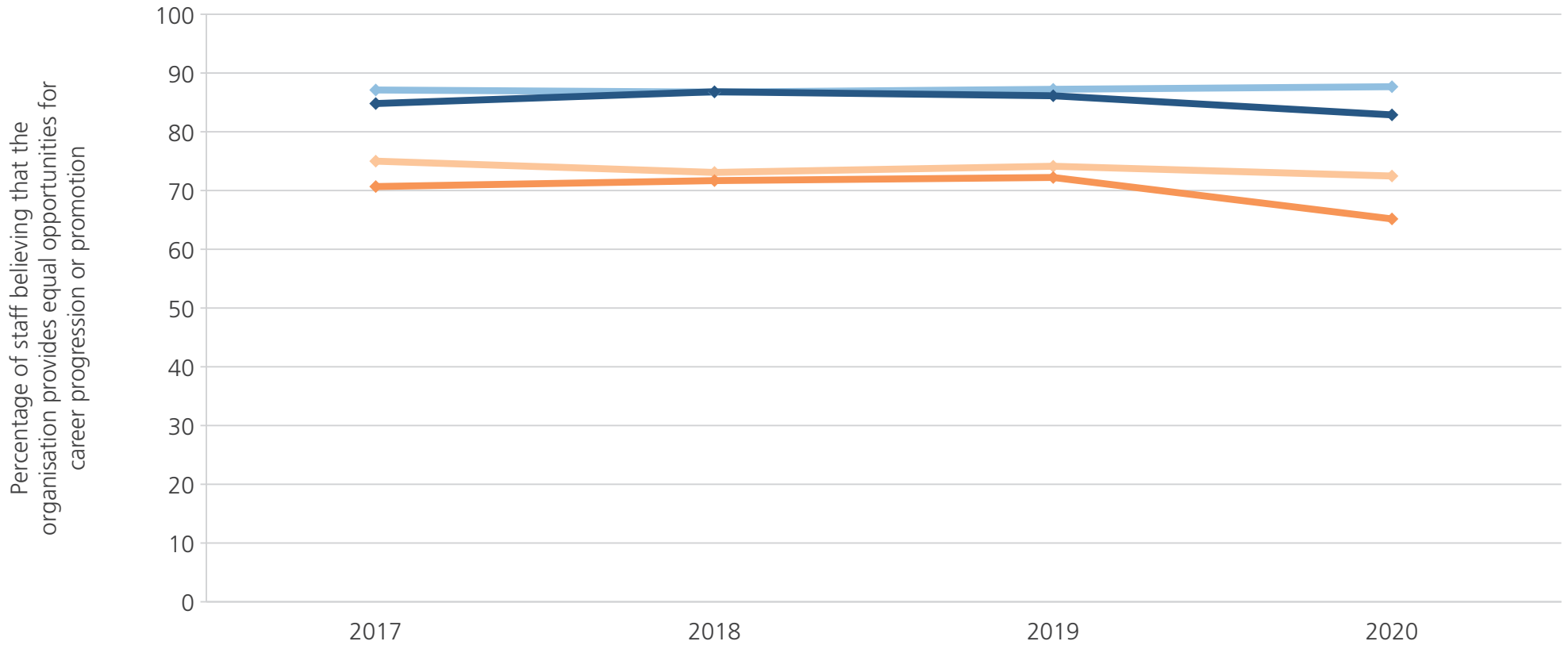
NHS England



	2017	2018	2019	2020
White: Your org	24.9%	26.8%	29.2%	29.1%
BME: Your org	28.5%	29.6%	31.1%	34.9%
White: Average	23.9%	24.9%	24.5%	24.4%
BME: Average	27.6%	28.7%	28.6%	29.1%
White: Responses	867	964	1,152	946
BME: Responses	193	250	280	281

Average calculated as the median for the benchmark group

2020 NHS Staff Survey Results > WRES > Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



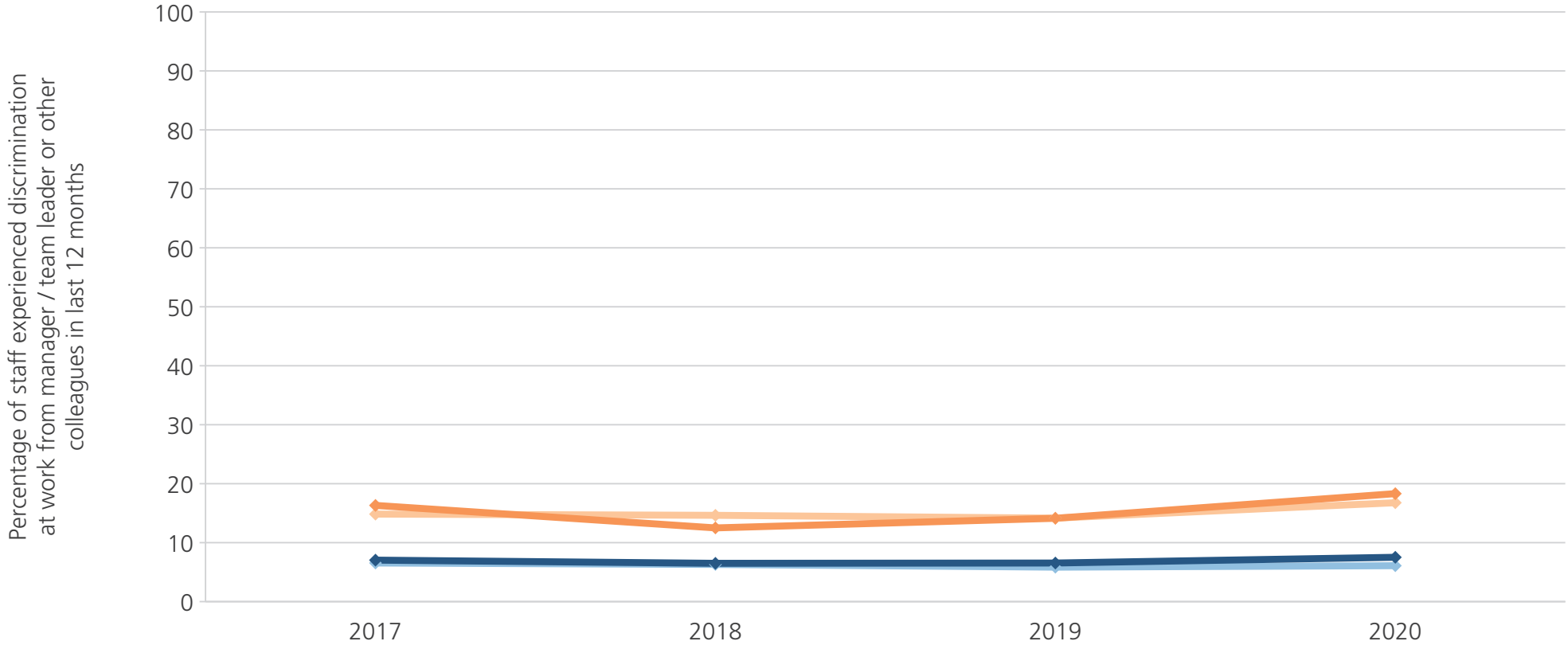
	2017	2018	2019	2020
White: Your org	84.8%	86.8%	86.1%	82.9%
BME: Your org	70.7%	71.7%	72.2%	65.2%
White: Average	87.1%	86.8%	87.2%	87.7%
BME: Average	75.0%	73.1%	74.1%	72.5%
White: Responses	612	652	757	619
BME: Responses	133	166	180	178

Average calculated as the median for the benchmark group

Survey Coordination Centre

2020 NHS Staff Survey Results > WRES > Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months

NHS England



	2017	2018	2019	2020
White: Your org	7.0%	6.5%	6.5%	7.5%
BME: Your org	16.3%	12.5%	14.1%	18.3%
White: Average	6.5%	6.3%	5.8%	6.1%
BME: Average	14.8%	14.6%	14.2%	16.8%
White: Responses	867	970	1,146	971
BME: Responses	190	248	276	284

Average calculated as the median for the benchmark group

Survey Coordination Centre

NHS England

Workforce Disability Equality Standard (WDES)

The approach to calculating the benchmark median scores and the way in which the data for Q13d are reported has changed this year. These changes have been applied retrospectively so historical data shown in the average calculations and all figures for Q13d are comparable. However, these figures are not directly comparable to the results reported in previous years. For more details please see the technical document.

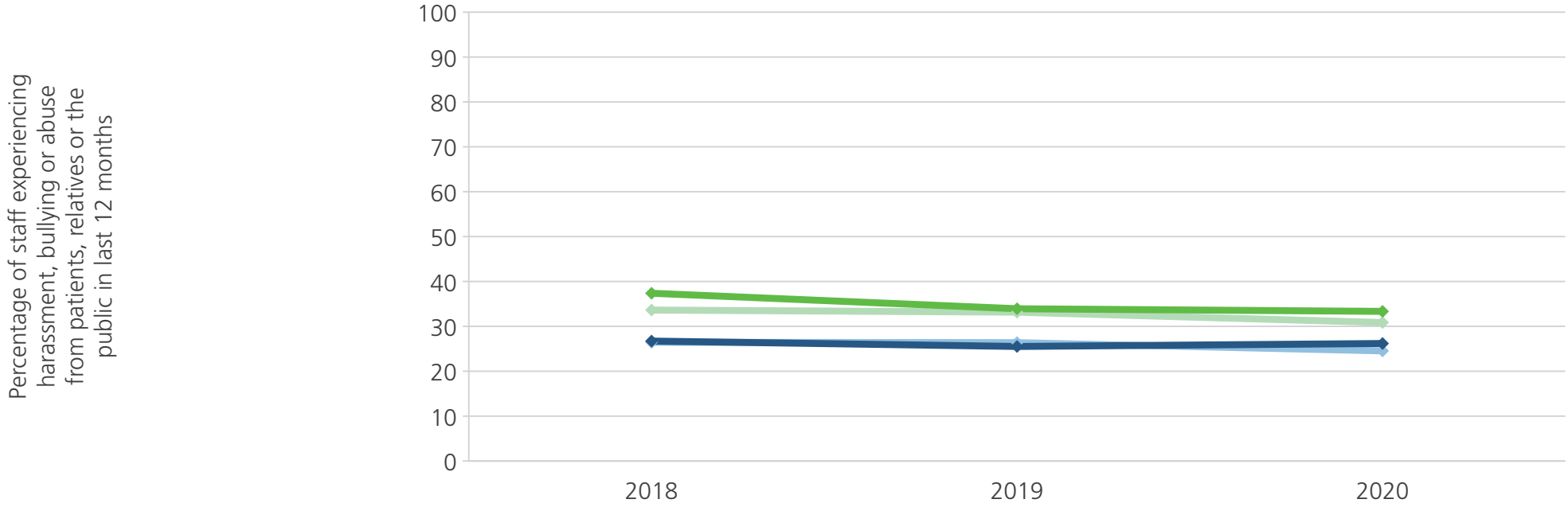
The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey Results

Survey Coordination Centre

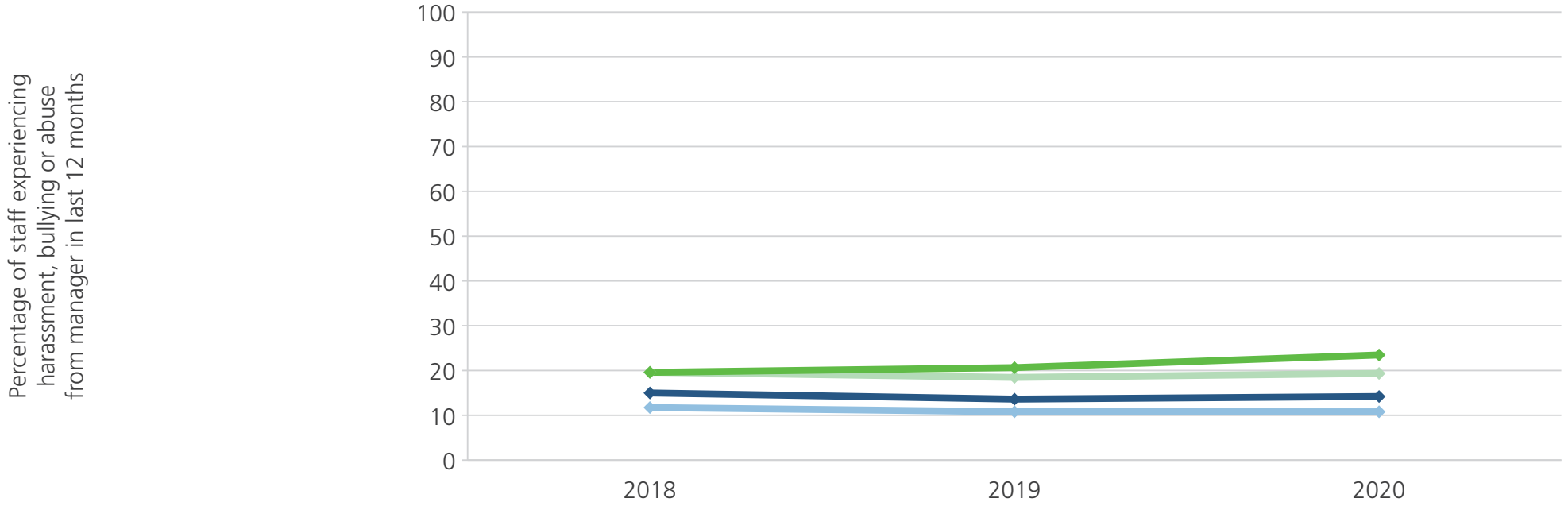
2020 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

NHS England



	2018	2019	2020
Staff with a LTC or illness: Your org	37.4%	33.9%	33.3%
Staff without a LTC or illness: Your org	26.7%	25.5%	26.2%
Staff with a LTC or illness: Average	33.6%	33.2%	30.9%
Staff without a LTC or illness: Average	26.5%	26.4%	24.5%
Staff with a LTC or illness: Responses	198	283	258
Staff without a LTC or illness: Responses	1,003	1,160	997

Average calculated as the median for the benchmark group



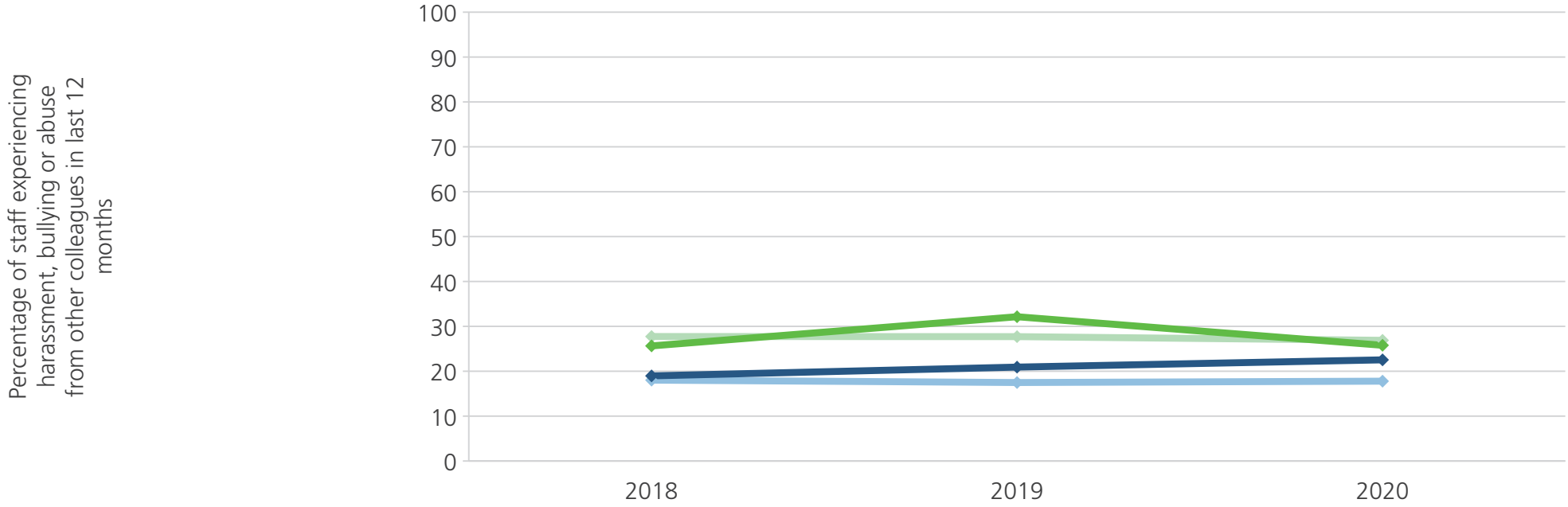
	2018	2019	2020
Staff with a LTC or illness: Your org	19.6%	20.6%	23.5%
Staff without a LTC or illness: Your org	15.0%	13.6%	14.2%
Staff with a LTC or illness: Average	19.6%	18.5%	19.3%
Staff without a LTC or illness: Average	11.7%	10.8%	10.8%
Staff with a LTC or illness: Responses	194	281	260
Staff without a LTC or illness: Responses	981	1,146	993

Average calculated as the median for the benchmark group

Survey Coordination Centre

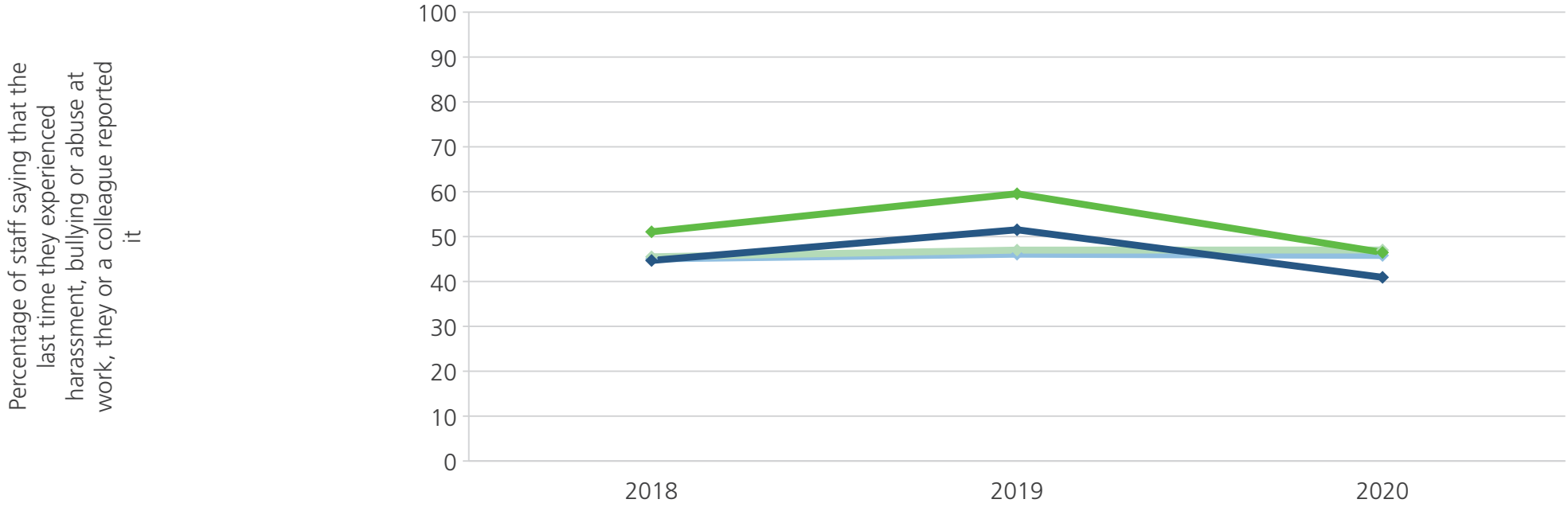
2020 NHS Staff Survey Results > WDES > Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months

NHS England



	2018	2019	2020
Staff with a LTC or illness: Your org	25.6%	32.1%	25.8%
Staff without a LTC or illness: Your org	19.0%	20.9%	22.5%
Staff with a LTC or illness: Average	27.7%	27.7%	26.9%
Staff without a LTC or illness: Average	18.0%	17.5%	17.8%
Staff with a LTC or illness: Responses	195	280	256
Staff without a LTC or illness: Responses	986	1,152	994

Average calculated as the median for the benchmark group



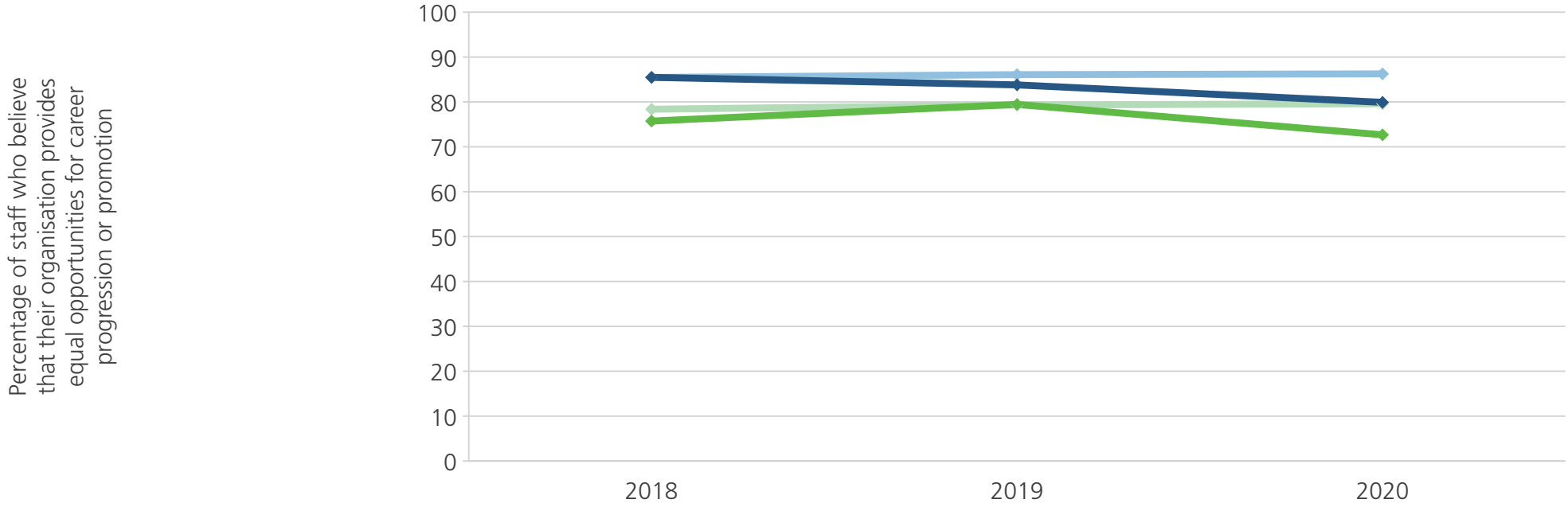
	2018	2019	2020
Staff with a LTC or illness: Your org	51.1%	59.5%	46.5%
Staff without a LTC or illness: Your org	44.7%	51.5%	40.9%
Staff with a LTC or illness: Average	45.5%	47.0%	47.0%
Staff without a LTC or illness: Average	45.0%	46.1%	45.8%
Staff with a LTC or illness: Responses	94	131	127
Staff without a LTC or illness: Responses	338	396	347

Average calculated as the median for the benchmark group

Survey Coordination Centre

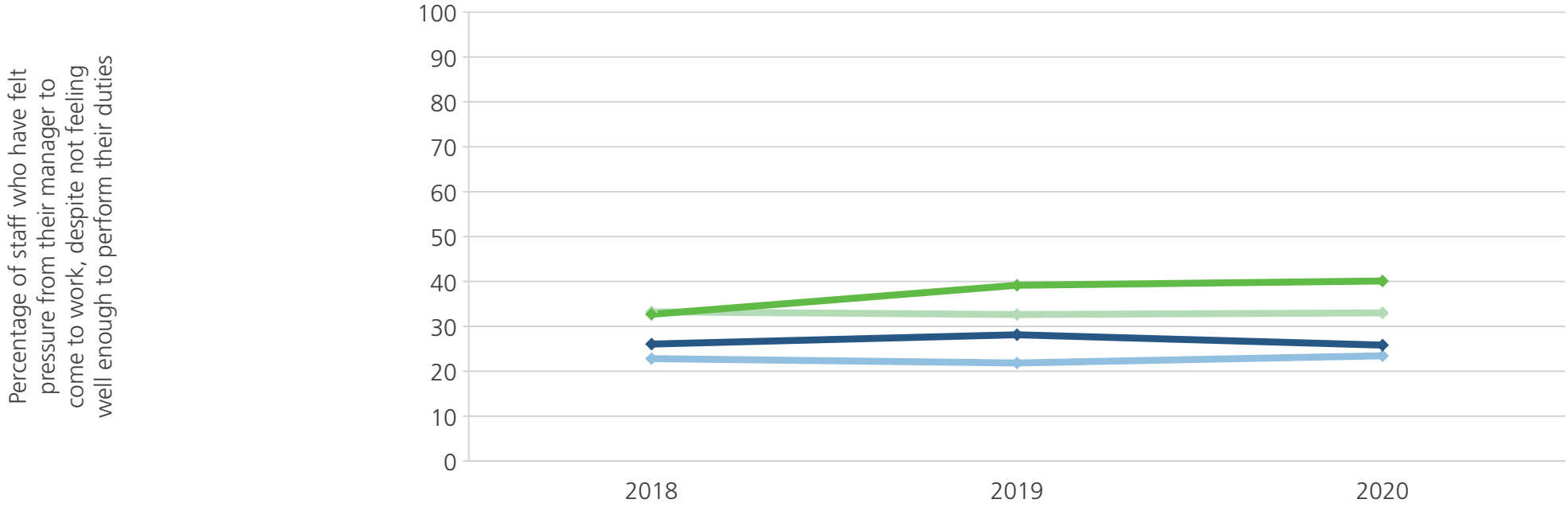
2020 NHS Staff Survey Results > WDES > Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion

NHS England



	2018	2019	2020
Staff with a LTC or illness: Your org	75.7%	79.4%	72.7%
Staff without a LTC or illness: Your org	85.5%	83.8%	79.9%
Staff with a LTC or illness: Average	78.4%	79.3%	79.6%
Staff without a LTC or illness: Average	85.5%	86.1%	86.3%
Staff with a LTC or illness: Responses	136	180	161
Staff without a LTC or illness: Responses	661	759	652

Average calculated as the median for the benchmark group



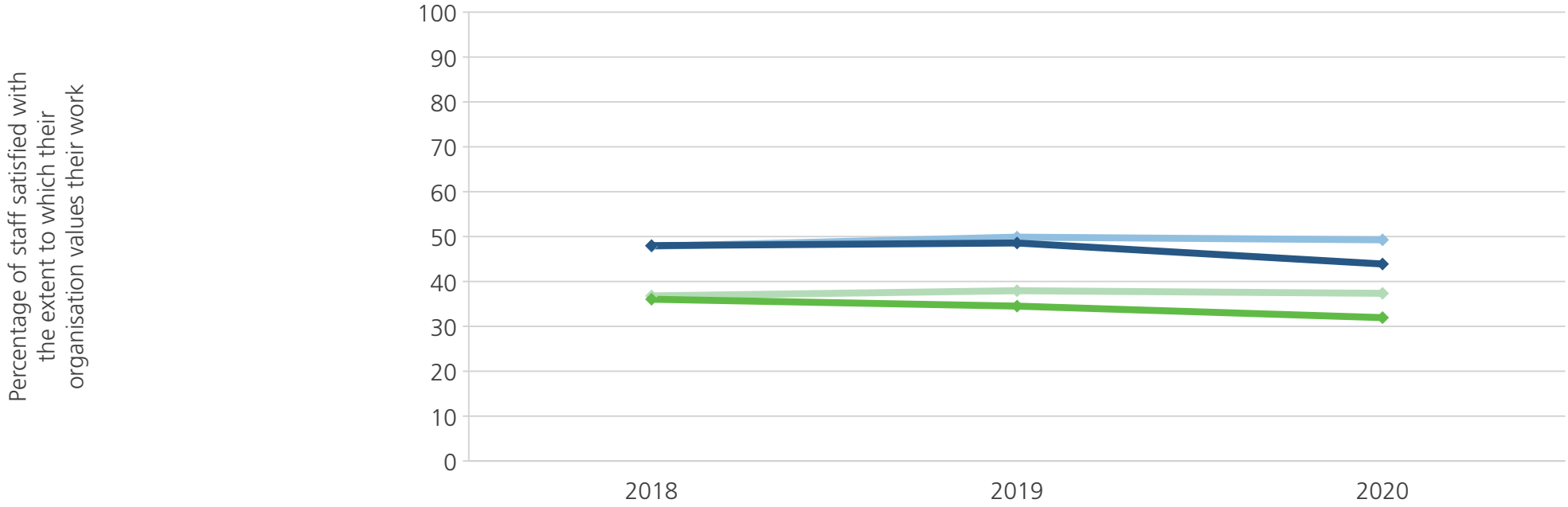
	2018	2019	2020
Staff with a LTC or illness: Your org	32.7%	39.2%	40.1%
Staff without a LTC or illness: Your org	26.0%	28.1%	25.8%
Staff with a LTC or illness: Average	33.2%	32.6%	33.0%
Staff without a LTC or illness: Average	22.8%	21.8%	23.4%
Staff with a LTC or illness: Responses	153	212	192
Staff without a LTC or illness: Responses	549	640	488

Average calculated as the median for the benchmark group

Survey Coordination Centre

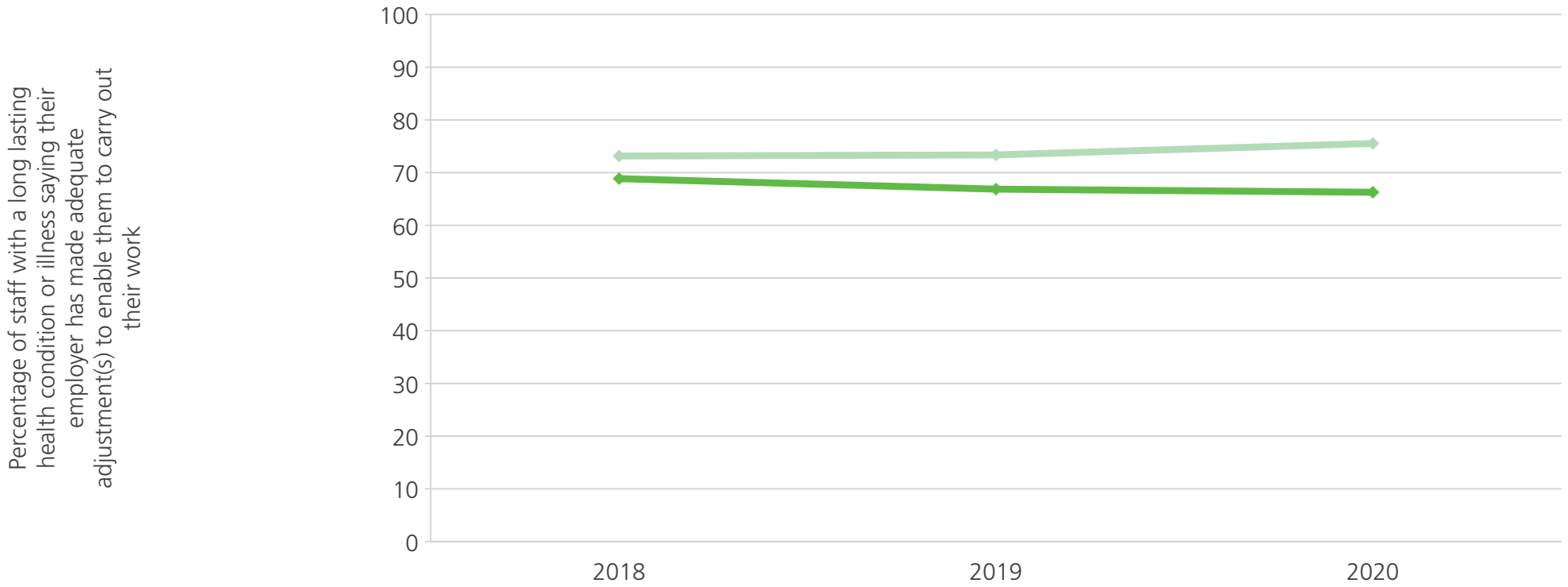
2020 NHS Staff Survey Results > WDES > Percentage of staff satisfied with the extent to which their organisation values their work

NHS England



	2018	2019	2020
Staff with a LTC or illness: Your org	36.0%	34.5%	31.9%
Staff without a LTC or illness: Your org	48.0%	48.6%	43.9%
Staff with a LTC or illness: Average	36.8%	37.9%	37.4%
Staff without a LTC or illness: Average	47.8%	49.9%	49.3%
Staff with a LTC or illness: Responses	197	284	263
Staff without a LTC or illness: Responses	994	1,155	1,023

Average calculated as the median for the benchmark group



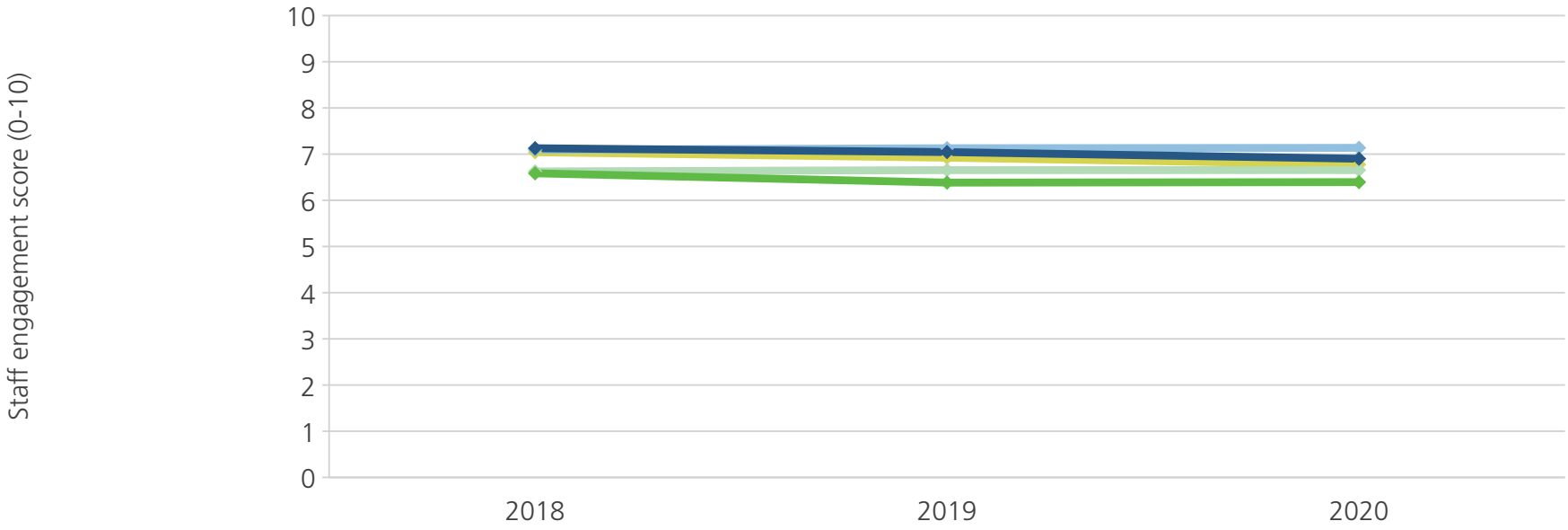
	2018	2019	2020
Staff with a LTC or illness: Your org	68.9%	66.9%	66.3%
Staff with a LTC or illness: Average	73.1%	73.4%	75.5%
Staff with a LTC or illness: Responses	122	172	169

Average calculated as the median for the benchmark group

Survey Coordination Centre

2020 NHS Staff Survey Results > WDES > Staff engagement score (0-10)

NHS England



	2018	2019	2020
Organisation average	7.0	6.9	6.8
Staff with a LTC or illness: Your org	6.6	6.4	6.4
Staff without a LTC or illness: Your org	7.1	7.0	6.9
Staff with a LTC or illness: Average	6.6	6.7	6.7
Staff without a LTC or illness: Average	7.1	7.1	7.1

Organisation Responses	1,312	1,496	1,350
Staff with a LTC or illness: Responses	198	285	265
Staff without a LTC or illness: Responses	1,005	1,169	1,027

Average calculated as the median for the benchmark group

Survey Coordination Centre

NHS England

Appendices

The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey Results

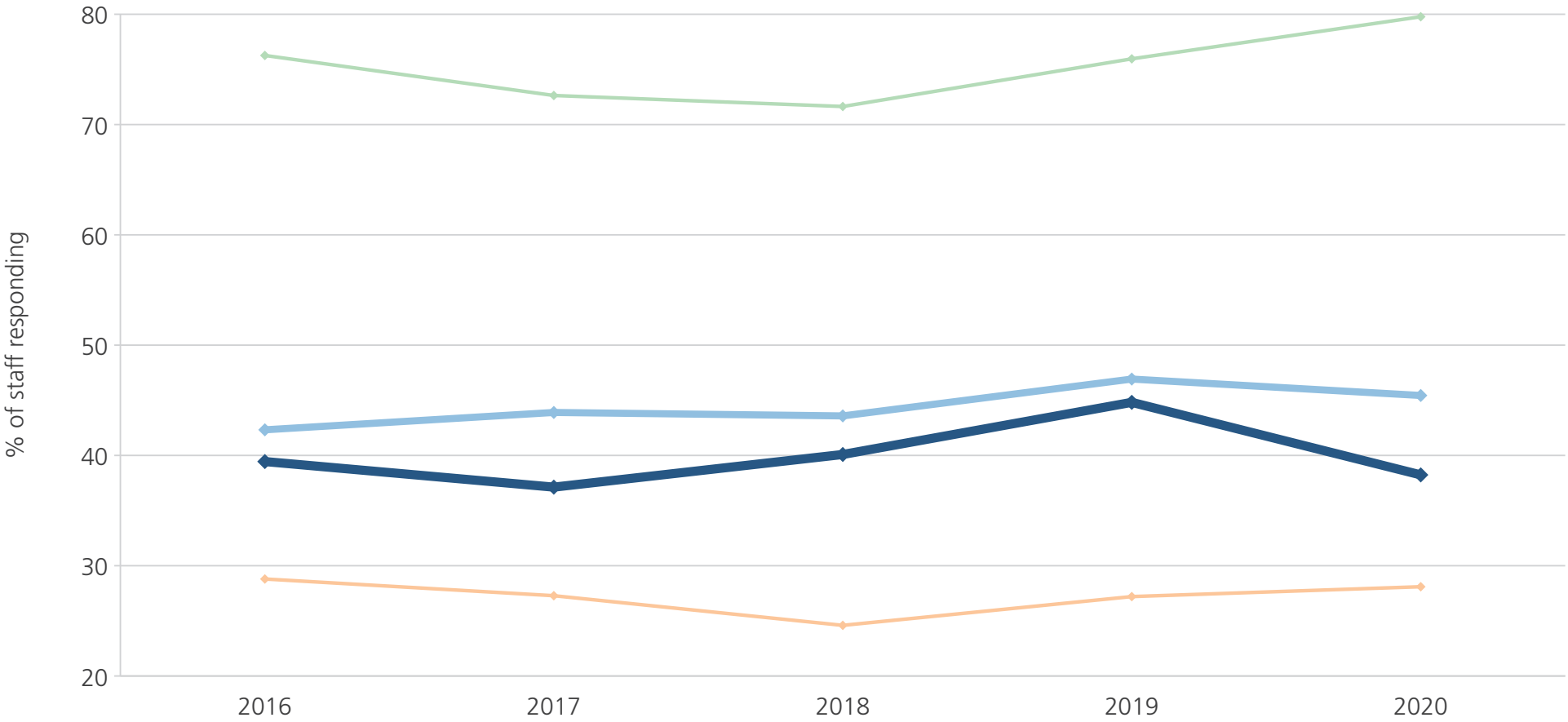
Survey Coordination Centre

NHS England

Appendix A: Response rate

The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey Results



	2016	2017	2018	2019	2020
Best	76.3%	72.6%	71.6%	76.0%	79.8%
Your org	39.4%	37.1%	40.1%	44.8%	38.2%
Median	42.3%	43.9%	43.6%	46.9%	45.4%
Worst	28.8%	27.3%	24.6%	27.2%	28.1%

Survey Coordination Centre

NHS England

Appendix B: Significance testing - 2019 v 2020 theme results

The Princess Alexandra Hospital NHS Trust

2020 NHS Staff Survey Results

The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the organisation's theme scores for both years and the number of responses each of these are based on.

The final column contains the outcome of the significance testing: ↑ indicates that the 2020 score is significantly higher than last year's, whereas ↓ indicates that the 2020 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	**8.9**	1482	**8.8**	1320	Not significant
Health & wellbeing	**5.7**	1492	**5.5**	1333	Not significant
Immediate managers †	**6.8**	1494	**6.5**	1336	↓
Morale	**6.1**	1470	**5.8**	1316	↓
Quality of care	**7.6**	1264	**7.4**	1170	↓
Safe environment - Bullying & harassment	**7.8**	1474	**7.7**	1286	Not significant
Safe environment - Violence	**9.5**	1468	**9.4**	1325	Not significant
Safety culture	**6.6**	1490	**6.5**	1321	Not significant
Staff engagement	**6.9**	1496	**6.8**	1350	↓
Team working	**6.6**	1475	**6.3**	1343	↓

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

† The calculation for the immediate managers theme has changed this year due to the omission of one of the questions which previously contributed to the theme. This change has been applied retrospectively so data for 2016-2020 shown in this table are comparable. However, these figures are not directly comparable to the results reported in previous years. For more details please see the technical document.

The Princess Alexandra Hospital NHS Trust

Trust Board – 1 April 2021

4.2

Agenda item:	4.2							
Presented by:	Ogechi Emeadi, Director of People, Communications and OD							
Prepared by:	Nathaniel Williams, People Information & Systems Lead							
Date prepared:	18 March 2021							
Subject / title:	Gender Pay Gap Reporting 2020							
Purpose:	Approval	x	Decision	x	Information	x	Assurance	x
Key issues:	• The gender pay gap as at 31 March 2020 reports :- • The average mean hourly rate as 27% lower for women (28% in 2019) • The average median hourly rate as 21% lower for women (22% in 2019) a continuous decrease year on year. • Agenda for change staff, (which excludes medical and dental, but includes very senior managers (VSMs), mean gap shows women earn 5% less than men and median gap is in favour for women earning more. • Medical and dental mean and median gap is 13% and 20% in favour for men.							
Recommendation:	For information and discussions							

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:	Workforce Committee 29.03.21
Risk / links with the BAF:	BAF Risk 2.1 Workforce Capacity
Legislation, regulatory, equality, diversity and dignity implications:	The Trust is required by law to publish their gender pay gap report
Appendices:	

The Princess Alexandra Hospital NHS Trust

1. Introduction

The gender pay reporting legislation requires all organisations employing more than 250 people to measure and publish their gender pay information based on earnings as at 31 March 2020, on our gender profile of 78% women and 22% men employees at PAH NHS Trust.

2. Background & context

2.1 The legislation framework can be referenced to the Equality Act 2010 -Specific Duties and Public Authorities - Regulations 2017

2.2 It is important to note that the gender pay gap reporting legislation is distinct from equal pay. Equal pay is concerned with men and women earning equal pay for the same or similar work. The gender pay gap is about the difference between men and women's average pay within an organisation

2.3 The NHS has a national pay structure, job evaluation system and contractual terms and conditions for medical and non-medical staff, which has been develop in partnership with trade unions. This national framework provides a robust set of arrangements for pay determination

2.4 The Gender Pay reporting requirements is introduce to highlight the differences in pay between men and women giving more transparent across all industry sectors. Enabling employers to consider the reasons for any differences and to take any corresponding action

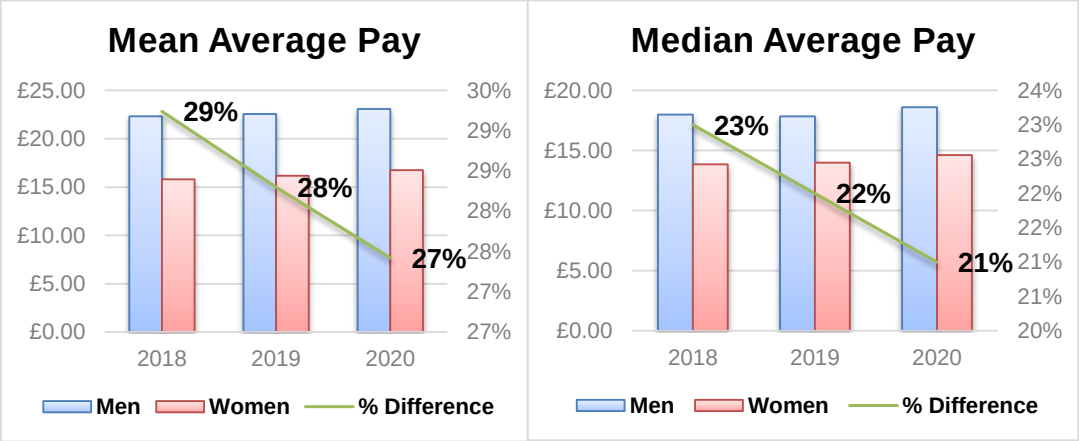
3. Requirements

The report is based on earnings as at 31 March 2020 on:

- Mean pay gap – the difference between the mean (average hourly earnings, excluding overtime) of men and women employees
- Median pay gap – the difference between the median (the difference between the midpoints of hourly rates of earnings, excluding overtime) of men and women employees
- Mean bonus gap – the difference between the mean bonus paid to men and women employees (bonus pay exclusively made up of local and national Consultant clinical excellence awards, discretionary points welcome bonus for our international Nurses)
- Pay distribution by gender – the proportion of men and women employees in the lower, lower middle, upper middle and upper quartile pay bands

The Princess Alexandra Hospital NHS Trust

4. Mean and median ordinary pay gap



The trust mean gender pay gap indicates that women earn 27% less than men for the reporting period, a continuous decrease from 2018 whilst the median pay gap indicates that women earn 21% less than men - an improvement from 2018 reporting period. The high pay difference is partly due to medical & dental staff being the highest paid staff group

The tables below give a clear separation of medical and dental staff group from Agenda for Change (AFC) pay bands including very senior managers for this reporting period only. This separation is based on a gender profile for 58% Men, 42% women for medical & dental staff and 17% Men, 83% women for AFC including very senior manager

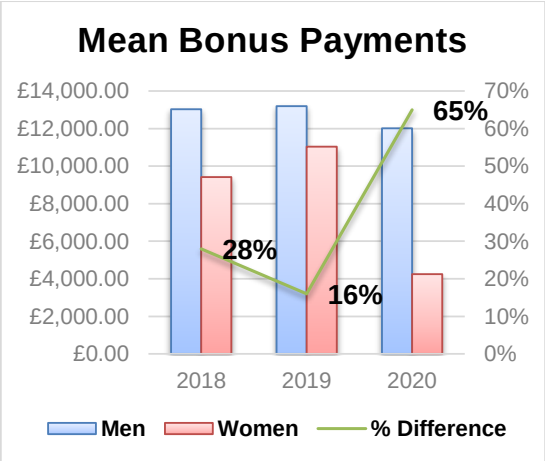
AFC &VSM	Mean Hourly Rate	Median Hourly Rate
Men	£16.57	£13.53
Women	£15.68	£14.08

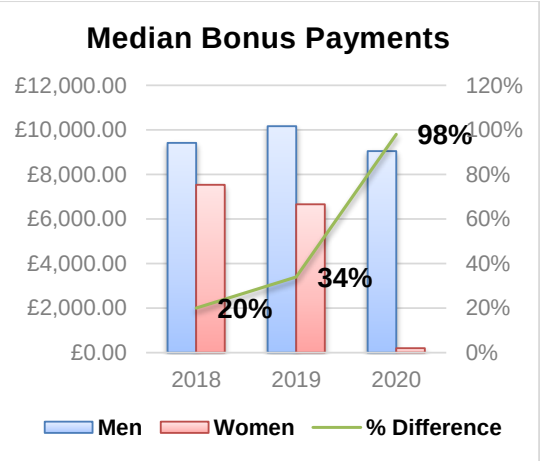
M&D only	Mean Hourly Rate	Median Hourly Rate
Men	£35.87	£34.65
Women	£31.25	£27.73

This separation clearly indicates the mean pay gap for Agenda for Change pay band including VSM, women earn 5% less than men and the median pay shows that women earns 4% more than men. For medical and dental staff, the mean and median pay gap indicate women earn 13% and 20% less than men respectively

5. Mean and median bonus pay gap

The only staff group prior to this reporting period in receipt of bonuses were consultants in accordance with the NHS national terms and conditions for medical staff. Within this reporting period, a relocation package for our international nurses include a welcome bonus. Therefore, bonus payments for this report are exclusively made up of local and national Consultants Clinical excellence Awards, Discretionary points and welcome bonus.





Analysis shows that the mean and median bonus payment difference for men and women in 2020 reporting period increased largely due to the £200 welcome bonus paid to our international nurses when compared to average payments of about £13k paid to a consultant receiving either clinical excellent awards or discretionary points.

The tables below gives a clear separation of the bonus paid to consultants and the welcome bonus paid to our international nurses for this reporting period

M&D only	Mean Bonus Payment	Median Bonus Payment
Men	£13,169.01	£12,063.96
Women	£10,639.34	£6,333.60

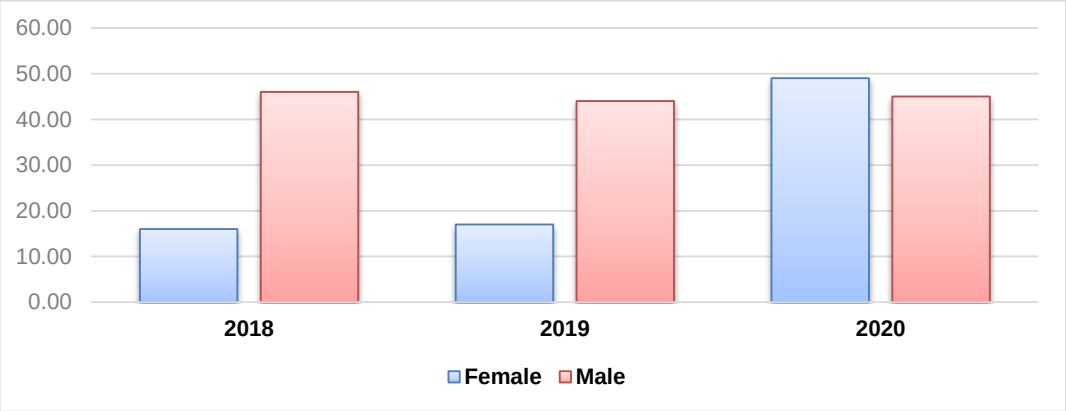
International Nurses	Mean Bonus Payment	Median Bonus Payment
Men	£200.00	£200.00
Women	£200.00	£200.00

This separation indicates that medical & dental consultants mean bonus payment in this reporting period is 19% in favour for men and median bonus payment is 48% in favour for men. There is no pay gap for the international nurses as they all each receive £200

The Princess Alexandra Hospital NHS Trust

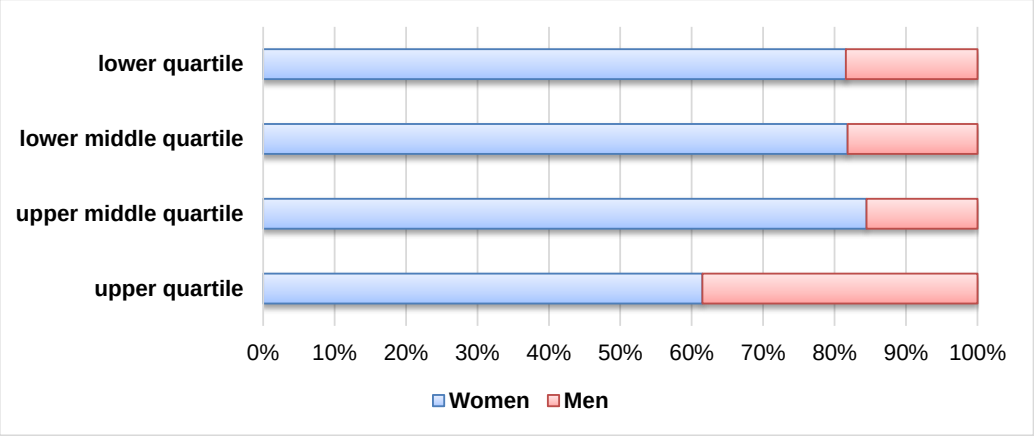
6. Total Employees paid bonus

The chart shows more women receive bonus payment this reporting period than men. The women increase is due to the thirty international nurses that receive the £200 welcome bonus compare to nineteen women consultants receiving clinical excellent award. Only four men receive the £200 welcome bonus.



7. Pay distribution by gender

The chart shows the proportion of men and women employees in each quartile. Employees are allocated into each quartile based on their hourly rate of pay. Lower quartile is our lowest pay quartile and upper quartile is our highest pay quartile.



Author: Nathaniel Williams, People Information & Systems Lead
Date: 23 March 2021

The Princess Alexandra Hospital NHS Trust

Trust Board – 1 April 2021

5.1

Agenda item:	5.1
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Elizabeth Podd
Date prepared:	February 2021
Subject / title:	M10 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:

This month's IPR shows the detail of the performance for February 2021.

Patients:
The number of complaints is steadily increasing this year and 100% were responded to within 3 working days. Over 96% of incidents have shown no or minor harm and we have declared 13 Serious Incidents, details are in the pack. We have decreased the number of falls and pressure ulcers in February and there were no still births or neonatal deaths.

People:
Trust vacancy has slightly increased although some vacancies are being held for re-organisation consultations. Staff turnover continues to be under the target of 12%. The majority of sickness reasons continue to be stress, anxiety and musculo-skeletal. Statutory training and appraisal rates are lower than target but are being focussed on in the departments for improvement. A number of Health & wellbeing services have been launched, "Here for You", "Time to talk" and "Back to Better".

Places:
The Trust encountered a loss of electrical supply on 1st March for a short period of time and no harm has been identified. This was unrelated to the power issues in January. Details of maintenance & capital works are in the report including positive feedback from NHSEI regarding Oxygen & ventilation management. New cleaning routine was introduced on 1st February, feedback from clinical staff and CQC visit is positive.

Performance:
RTT performance is still significantly impacted by lack of routine elective surgery & diagnostics on site, support from Independent Sector providers helps to maintain cancer provision. 2week wait performance is improving and 62 day performance is low due to treatment of more patients that have been waiting longer than 62 days. A&E performance is still challenged by reduced bed capacity and delayed discharge processes in addition to the restricted urgent care pathways such as the Assessment pathway, CDU & Frailty.

Pounds:
The financial position for Month 11 is a YTD deficit of £0.1m. YTD capital expenditure is £27.8m which is underspent against a YTD target of £41.8m. Cash resources remain sufficient with a Month 11 closing balance of £89.8m.

The Princess Alexandra Hospital NHS Trust

Recommendation:	The Committee 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:	PAF.25.03.21 and QSC.26.03.21
Risk / links with the BAF:	All BAF Risks
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	

5.1

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report
February 2021

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

Contact:

Lance McCarthy, Chief Executive Officer

Sharon McNally, Director of Nursing

Stephanie Lawton, Chief Operating Officer

Jim McLeish, Director of Quality Improvement

Ogechi Emeadi, Director of People

Michael Meredith, Director of Strategy

Saba Sadiq, Chief Finance Officer

Fay Gilder, Chief Medical Officer

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Trust Objectives

The Princess Alexandra Hospital NHS Trust

Our Patients

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

Our People

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

Our Places

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

Our Performance

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

Our Pounds

Manage **our pounds** effectively to achieve our agreed financial control total for 2020/21.

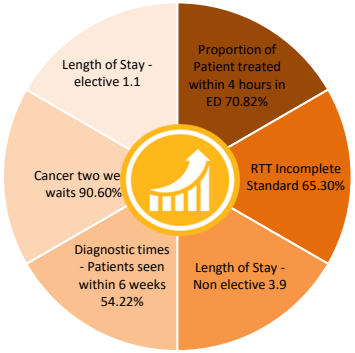
5Ps

In this month

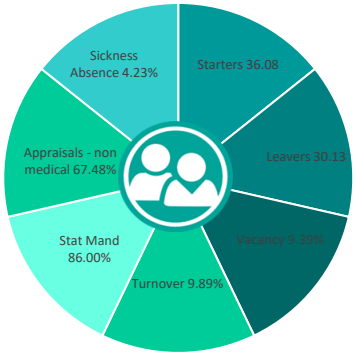
The Princess Alexandra Hospital NHS Trust

Patients

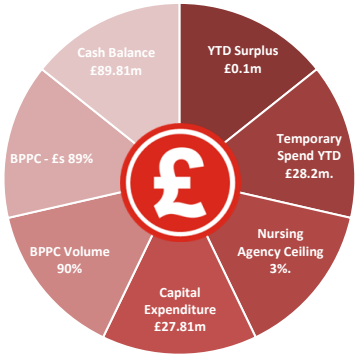
Performance



People



Pounds

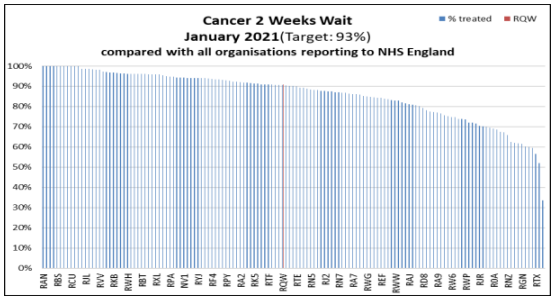


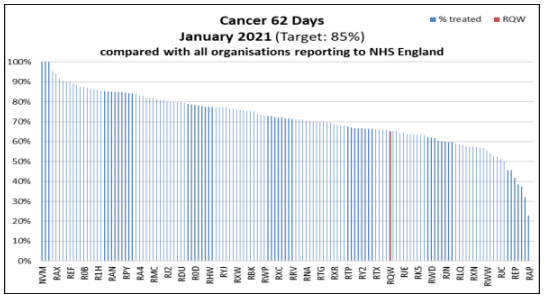
Places

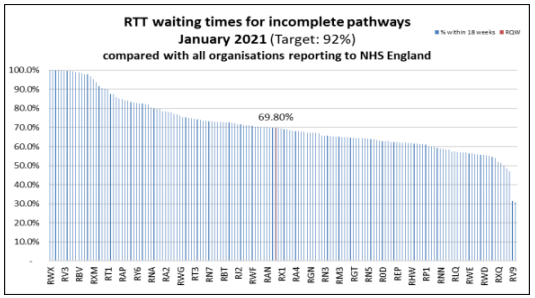
5.1

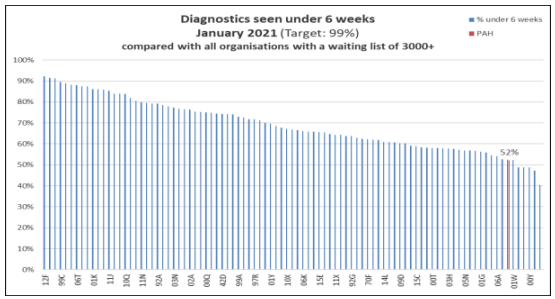
National Benchmarking
Compared with all organisations reporting to NHS England

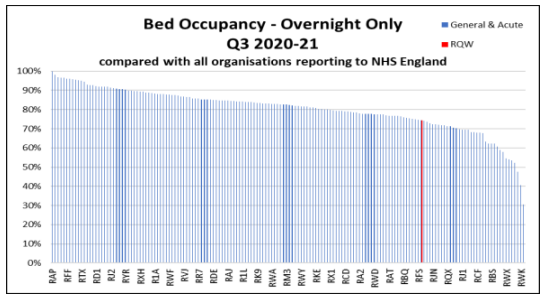
NHS
The Princess Alexandra Hospital
NHS Trust

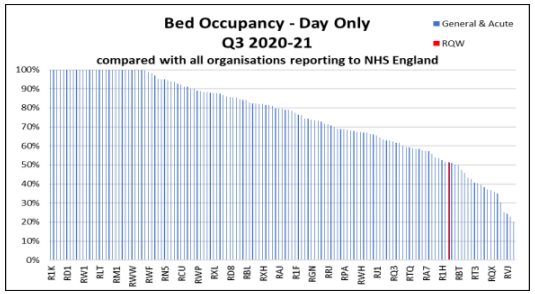


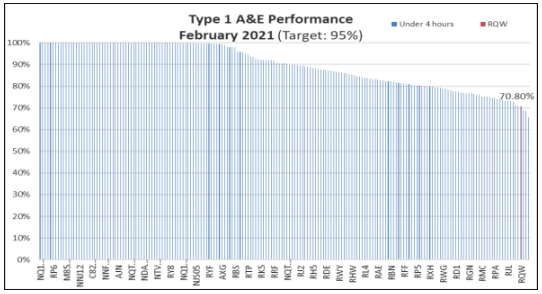












Your future | Our hospital

Data Source: NHS England Statistics

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Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

Patient Experience: the number of complaints received has been showing a steady increase and we are on trajectory to receive over 200 complaints this year up from 176 in 2019-20. 100% of cases received in month were acknowledged within 3 working days. The top themes from complaints has remained the same throughout the year, with an increasing prevalence of complaints relating to medical care and expectations. Section 1.1 provides further analysis and detail in relation to patient experience and the work on-going.

Patient safety: 689 incidents were raised in month, with >96% being no and minor harm. We declared 13 SIs. Details can be found under section 1.3.

Infection control: our activity & incidence of nosocomial infection are detailed under sections 1.4 - 1.5, with overall analysis of infection control under 1.6.

C. Difficile numbers have seen a decrease in February. However, it is too early to comment on whether this decrease is as a result of the measures in place (focus on resuming microbiology ward rounds and monitoring antibiotic usage). There have been a total of 35 cases year to date (at the end of February).

Harm Free Care: After an increase seen in January related to our covid 19 surge, February saw a decrease in our rate of Falls and PU injury (per 1,000 bed days). Further detail and analysis can be found under section 1.8.

Family and Women's: There were 3 Serious Incidents (SI) declared in February 2021, further detail can be found in the February Maternity SI report within the Board papers. There were no stillbirths or neonatal deaths in February. The rate of Post-partum Haemorrhage (PPH), over 1.5L, was 2.6% in February 2021, which is down from 3.2% in January. The latest National Rate is 2.8% (NMPA Clinical Report 2019).

Key performance metrics in relation to our most **vulnerable patients -** mental health, learning disability and dementia are included under sections 1.11 - 1.12.

Mortality is reported under section 1.13 and within the mortality paper to Board.

Patient Experience

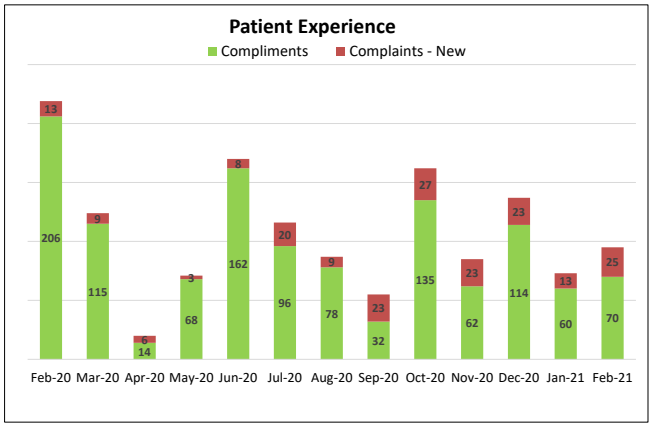
1 Our Patients Summary 1.1 Patient Experience

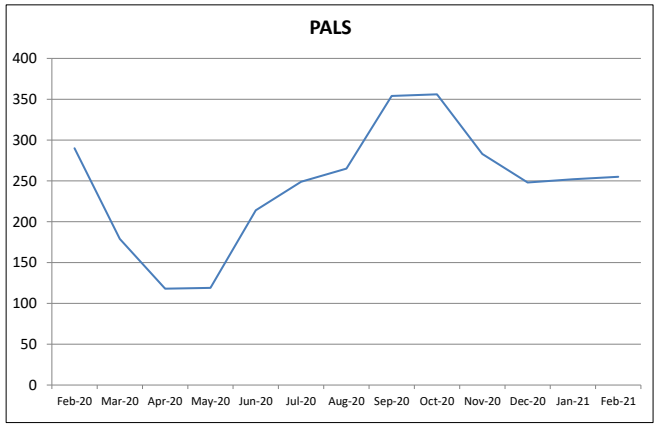
The Princess Alexandra Hospital NHS Trust

Performance: 25 complaints received in February and evidence of a continuing uptick in March 2021 with the Trust on trajectory to receive over 200 complaints this year up from 176 in 2019-20. 100% of cases were acknowledged within 3 working days and 100% of the 16 closed last month were closed within an agreed deadline, 4 with no change to the original deadline. 88 cases are currently open, up from 76. 255 PALS received in February, 8 referred to a complaint due to a significant push to close older cases, this is evidenced by 344 cases closed over the last month and now 128 open, down from 292.

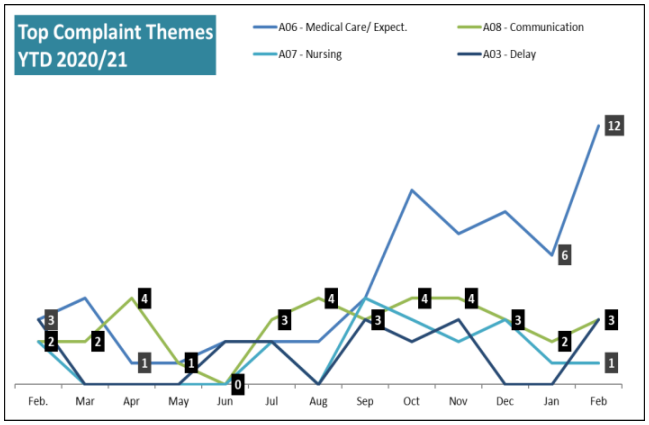
No significant changes in trending themes but we continue to introduce innovations in patient engagement and experience in response to these issues:

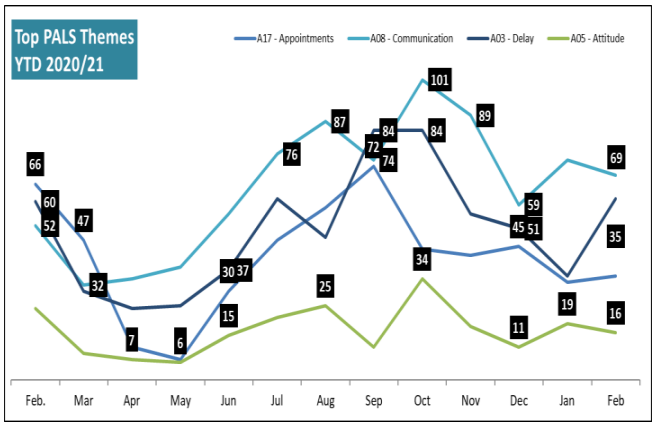
- We continue to operate virtual visiting and messaging services for families in February, but with a reduction in total visits per month, with discretionary visiting beginning to have a greater impact. 1440 video calls and 1482 messages. A recent journal publication on this work by members of the VV team can be found here: The Benefits and Risks of a Virtual Visiting Service for Patients and Their Relatives
- Charitable Funds Committee have approved the development of a fixed term role to support Carer Experience and this will go out to advert in April. An end of life volunteer coordinator has been appointed and will be starting in April.
- The ITU communication service covering transfers of care and ITU terminology has now supported 109 families through the course of the project.
- Cancer information films in five community languages in Italian, Polish, Romanian (the top three PAH interpreting languages) and Urud and Punjabi (the top two at Alliance level) have now been completed as a result of funding from the East of England Cancer Alliance and the playlist is available here: Italian. One step at a time. One patient's experience of cancer diagnosis, treatment, survival. - YouTube



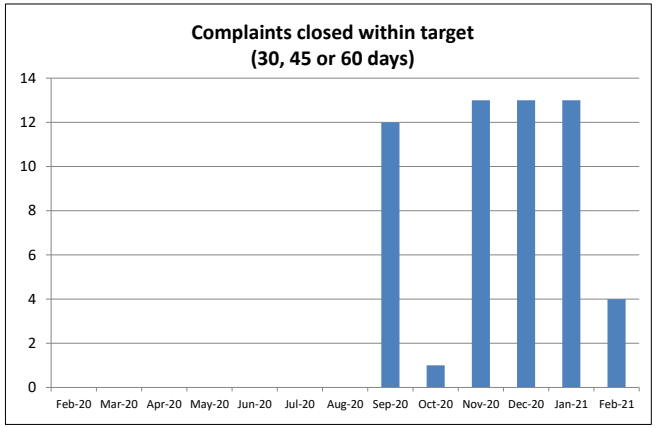


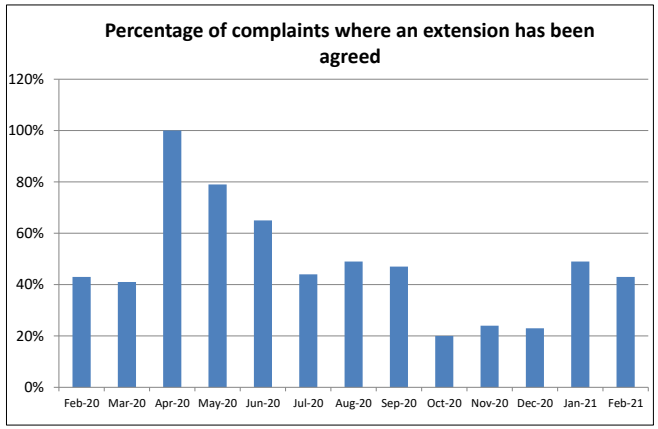
PALS converted to Complaints	
Feb-20	3
Mar-20	1
Apr-20	0
May-20	0
Jun-20	1
Jul-20	6
Aug-20	4
Sep-20	3
Oct-20	8
Nov-20	4
Dec-20	4
Jan-21	0
Feb-21	8

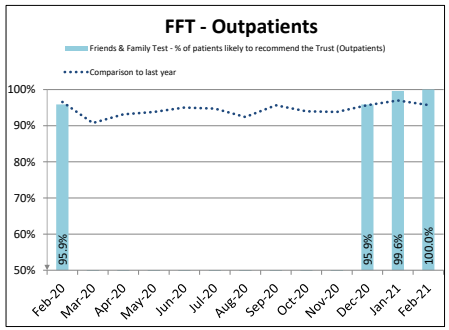


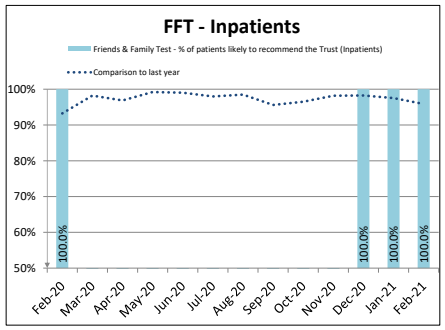


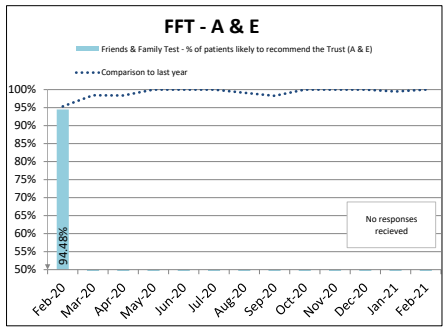
FFT Maternity have moved to QR codes and we are waiting to analyse this data. The ED data will be moving to text alerts from 1 April.

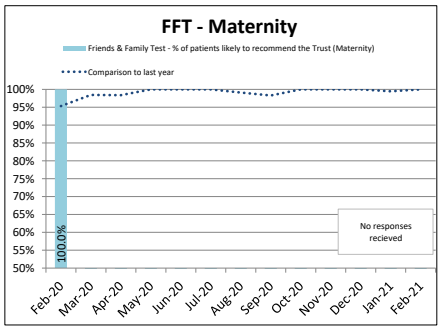












FFT submissions reinstated from January 2021 following suspension in March 2020 due to Covid-19

Patient Safety

1 Our Patients Summary 1.3 Patient Safety

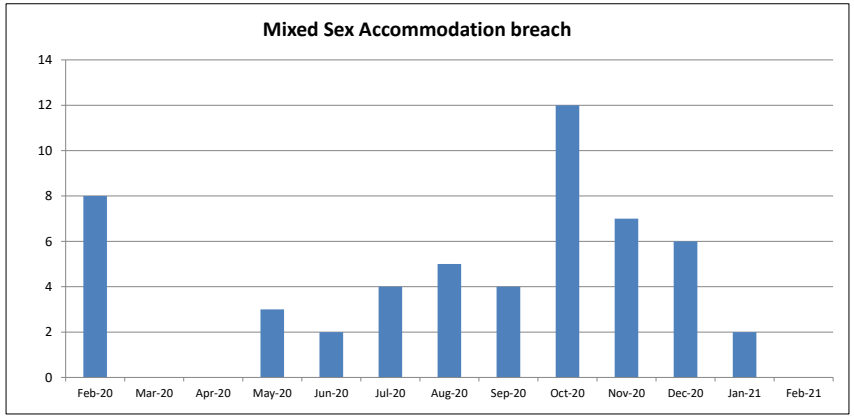
NHS
The Princess Alexandra Hospital
NHS Trust

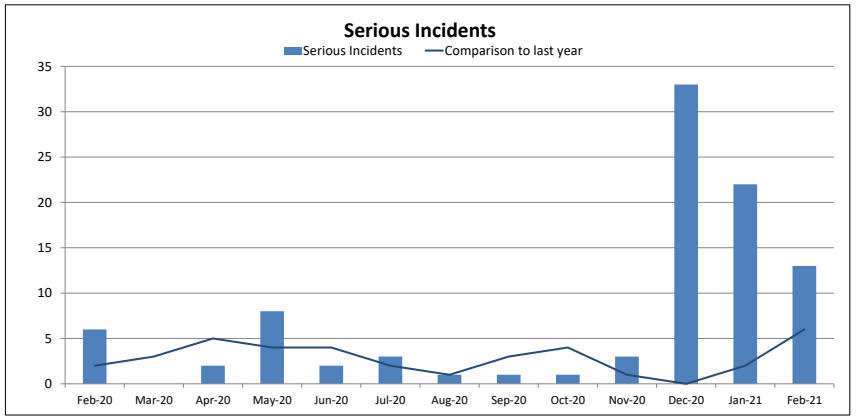
689 incidents were raised in month, with >96% being no and minor harm, 17 (2.4%) moderate harm and 2 (0.3%) severe, and 6 (0.9%) relating to patients that died with a covid 19 nosocomial infection.

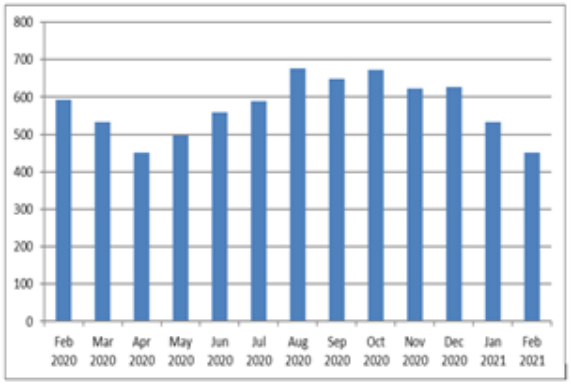
13 SIs were reported in month
- 9 were patients that developed a hospital onset COVID-19 infection.
- 3 maternity incidents
- 1 delay in diagnosis

14 safety alerts were received in month, 11 have been actioned and closed. 3 are pending closure.

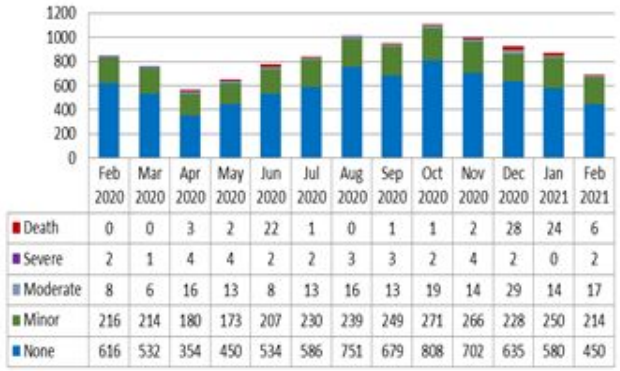
The Trust currently has 1 alert that has breached its deadline: EFA.2020.001: Food Safety in the NHS has a deadline of 12/02/2021, compliance actions are underway and will deliver by end June.



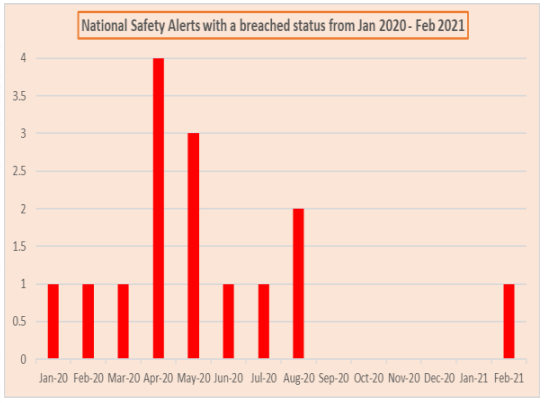




Severity of reported Incidents on Datix



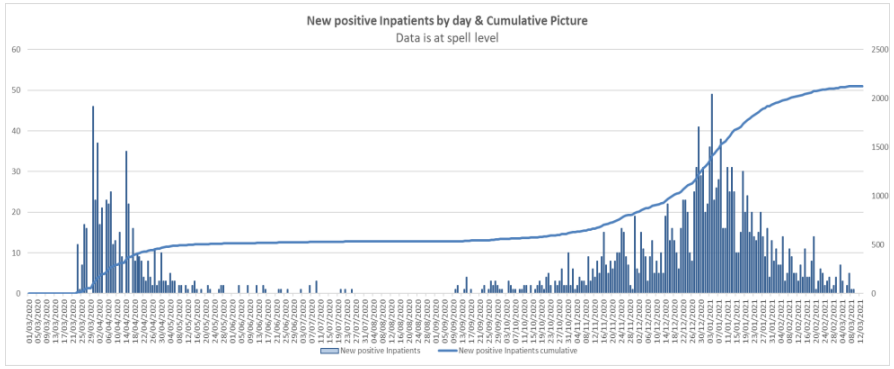
	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021
Death	0	0	3	2	22	1	0	1	1	2	28	24	6
Severe	2	1	4	4	2	2	3	3	2	4	2	0	2
Moderate	8	6	16	13	8	13	16	13	19	14	29	14	17
Minor	216	214	180	173	207	230	239	249	271	266	228	250	214
None	616	532	354	450	534	586	751	679	808	702	635	580	450

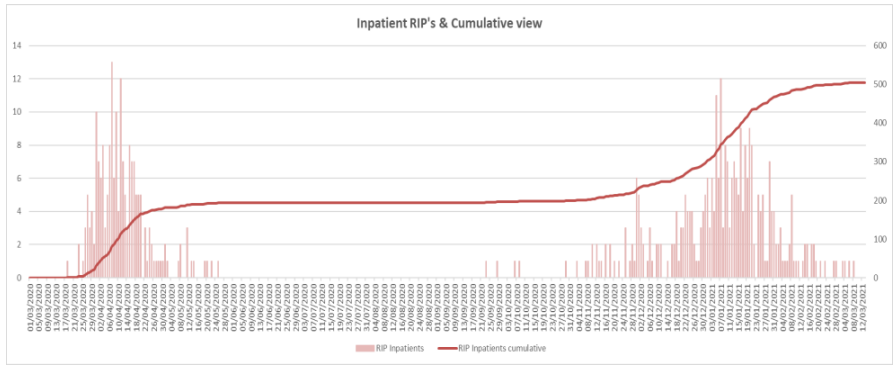


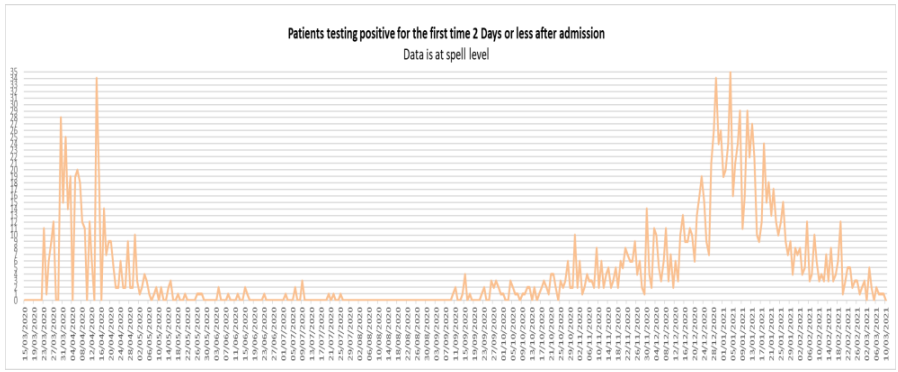
Infection Control

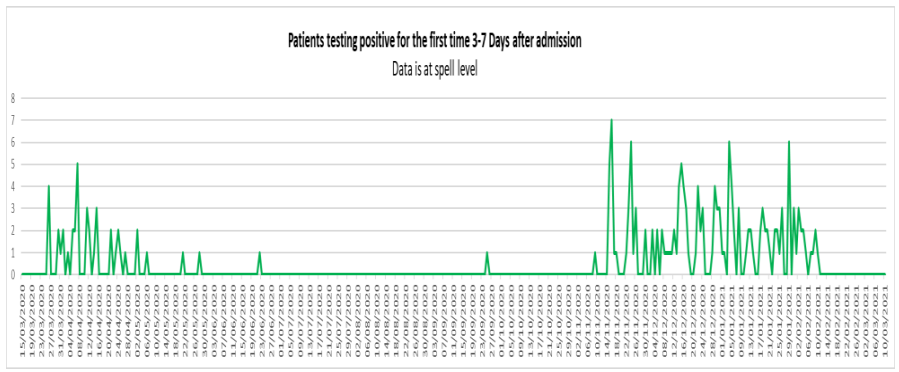
1 Our Patients Summary 1.4 Infection Control - Covid-19

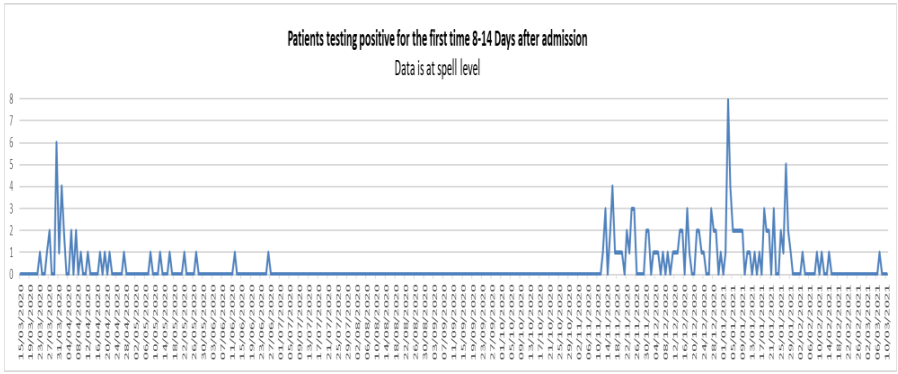
The Princess Alexandra Hospital NHS Trust

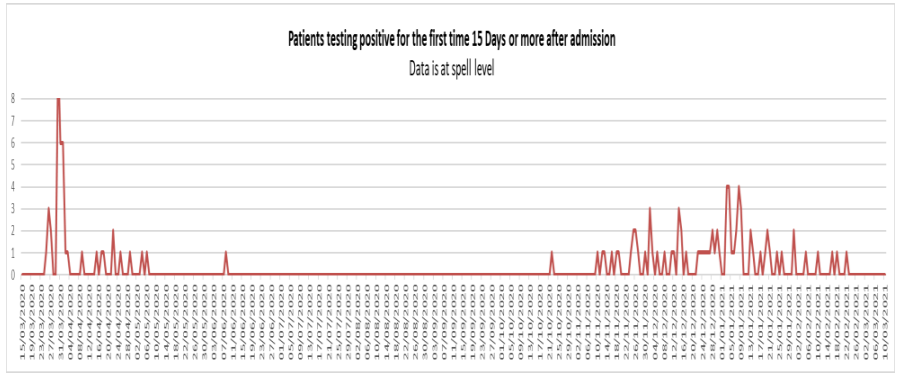




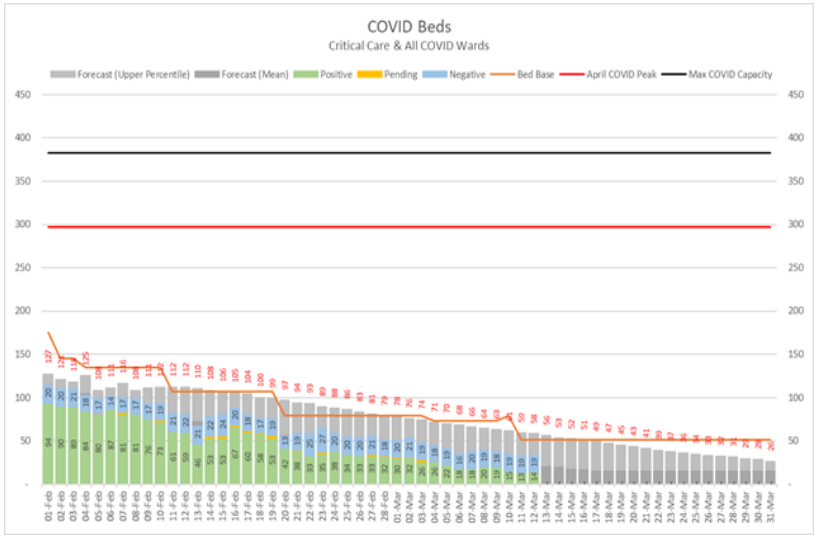


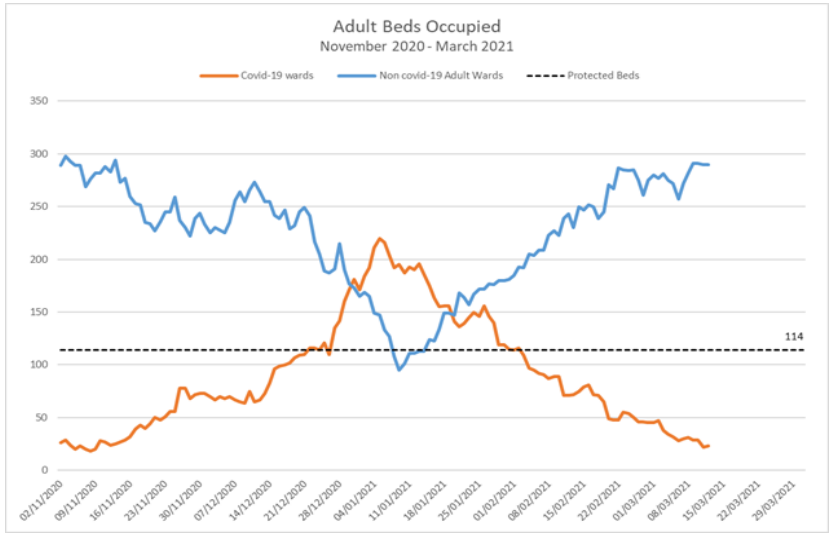






Covid-19


COVID Beds
Critical Care & All COVID Wards
Forecast (Upper Percentile)
Forecast (Mean)
Positive
Pending
Negative
Bed Base
April COVID Peak
Max COVID Capacity


Adult Beds Occupied
November 2020 - March 2021
Covid-19 wards
Non covid-19 Adult Wards
Protected Beds
114

Infection Control

1 Our Patients Summary 1.6 Infection Control

The Princess Alexandra Hospital NHS Trust

MRSA There were no cases of Trust-apportioned MRSA bacteraemia cases in February. There have been no Trust-apportioned cases for the year to date.

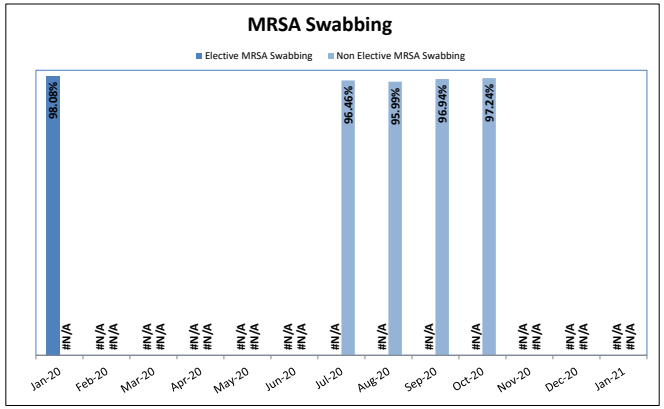
MSSA There was one hospital attributable case during February – this case is currently being reviewed to identify the source of infection. In total, there have been six cases of Trust-apportioned MSSA bacteraemia for the year (at the end of February). The Trust continues to be one of the top-performing hospitals in terms of our low numbers of cases.

C.difficile As previously reported, the Trust has seen an increase in C.difficile cases over the last few months. During February there were three cases (compared to seven in January). However, it is too early to comment on whether this decrease is as a result of the measures in place (focus on resuming microbiology ward rounds and monitoring antibiotic usage). Reviews of compliance with the Trust Antibiotic policy are undertaken for all cases. The February cases are in the process of being reviewed. There have been a total of 35 cases year to date (at the end of February).

Gram Negative Blood Stream Infections (GNBSIs) The Trust remains in a good position when compared nationally with other hospitals (within the top quarter). During February, there were two Trust-apportioned GNBSIs (One Escherichia coli and one Klebsiella pneumonia) bacteraemia. To date, there have been 21 Trust apportioned cases of all GNBSIs.

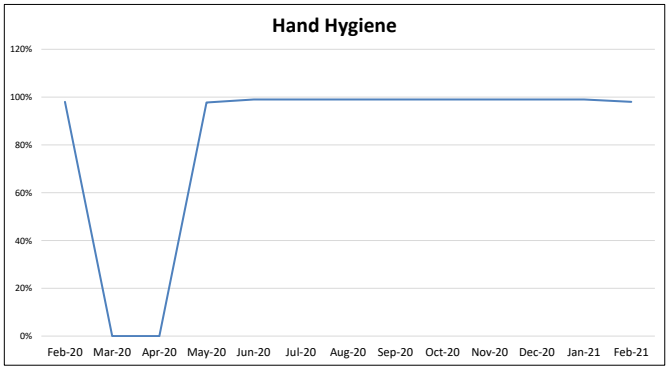
MRSA Screening MRSA screening data is not available for elective (due to ongoing re-write) or non-elective (due to lack of capacity to complete ED validation) from the Information Team for February

Hand Hygiene Audits All wards/clinical department are expected to participate in monthly audits. The expectation is that 100% of clinical areas participate and the performance standard is 95% compliance. During February, the overall Trust wide score was 98% compliance; however, there were three areas that did not submit their audits (93% submission compliance). Wards/departments are expected to discuss their results and agree appropriate actions within their Health-Care Group. The PPE Champions are also undertaking monthly audits for hand hygiene and we will be reviewing how this will be reported going forward.



MSSA	
Feb-20	2
Mar-20	1
Apr-20	1
May-20	2
Jun-20	0
Jul-20	1
Aug-20	0
Sep-20	0
Oct-20	0
Nov-20	0
Dec-20	1
Jan-21	1
Feb-21	1

C-DIFF (New categories including community from April 2019)					
	Hospital Responsible		Community Responsible		
Month	Hospital onset healthcare associated	Community onset healthcare associated (Acute Admission within last 4 wks)	Community onset indeterminate association (Acute Admission within last 12 wks)	Community onset community associated (No acute contact within 12 wks)	Total
Feb-20	1	1	0	0	2
Mar-20	1	0	0	2	3
Apr-20	0	1	1	0	2
May-20	1	0	0	4	5
Jun-20	1	0	1	1	3
Jul-20	4	1	2	0	7
Aug-20	6	2	2	1	11
Sep-20	4	0	2	0	6
Oct-20	2	1	5	1	9
Nov-20	1	1	1	1	4
Dec-20	5	0	1	0	6
Jan-21	7	2	1	1	11
Feb-21	3	2	0	0	5



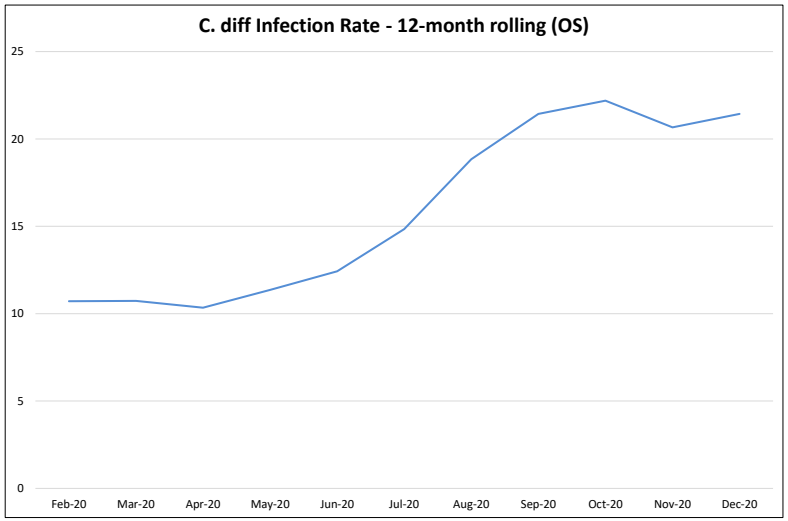
E Coli	
Feb-20	2
Mar-20	0
Apr-20	1
May-20	1
Jun-20	1
Jul-20	2
Aug-20	0
Sep-20	2
Oct-20	1
Nov-20	1
Dec-20	0
Jan-21	1
Feb-21	1

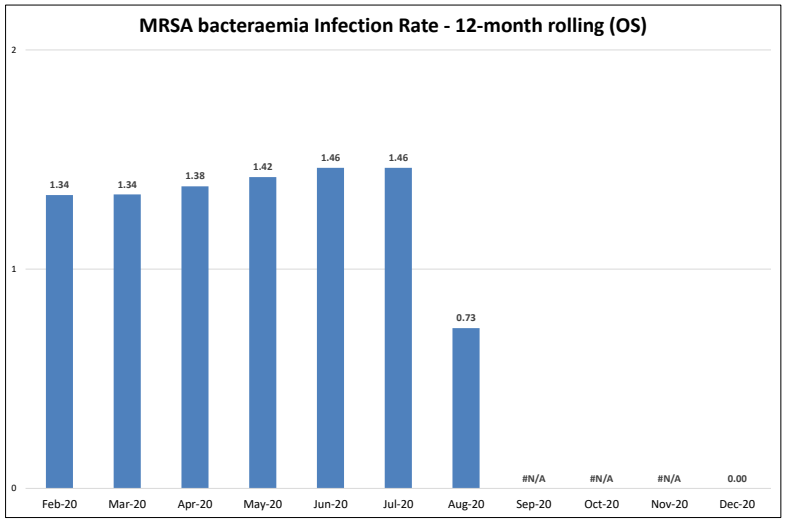
Klebsiella	
Feb-20	0
Mar-20	1
Apr-20	1
May-20	0
Jun-20	2
Jul-20	0
Aug-20	0
Sep-20	1
Oct-20	0
Nov-20	1
Dec-20	0
Jan-21	1
Feb-21	1

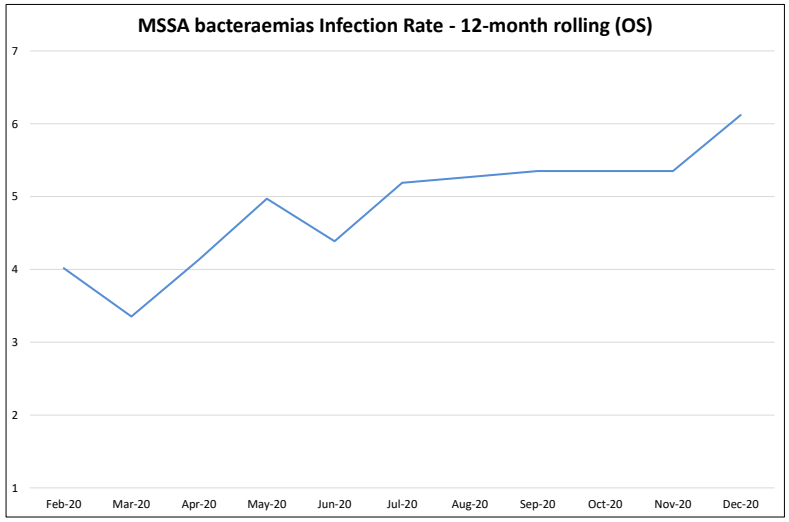
Pseudomonas	
Feb-20	0
Mar-20	0
Apr-20	0
May-20	1
Jun-20	0
Jul-20	0
Aug-20	0
Sep-20	1
Oct-20	0
Nov-20	0
Dec-20	1
Jan-21	0
Feb-21	0

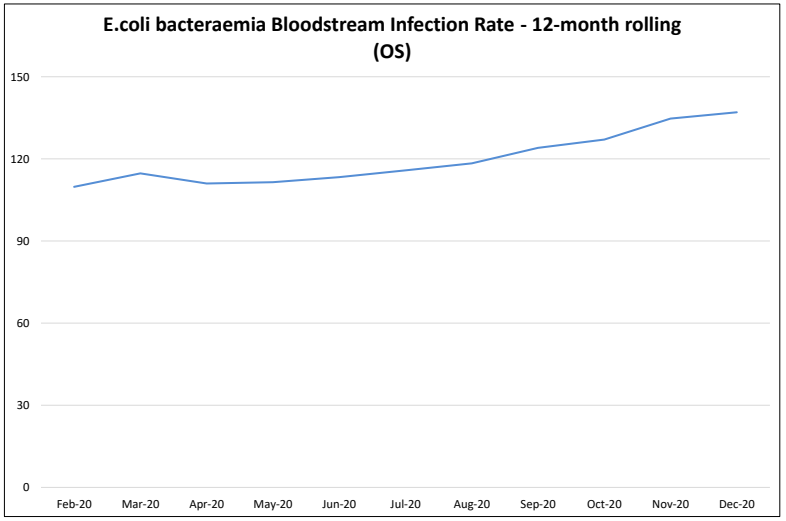
Infection Control

The following are the latest published data available - 2 month time lag









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

1 Our Patients Summary 1.8 Patient Safety

NHS
The Princess Alexandra Hospital
NHS Trust

Pressure Ulcers: There were a total of 60 pressure ulcers in February (as opposed to 53 incident reports), a reduction of 33 from January. Of those 60 PUs, there were a total of 43 patients who had a pressure ulcer, meaning some of the patients had more than one pressure ulcer during admission, the highest being one patient with 4 pressure ulcers in total from ITU COVID ward.

Four were moderate harms & the remaining were minor harms. Seven pressure ulcers were medical device related, attributable to oxygen devices, NG tube, ET Tube, cast & stockings.

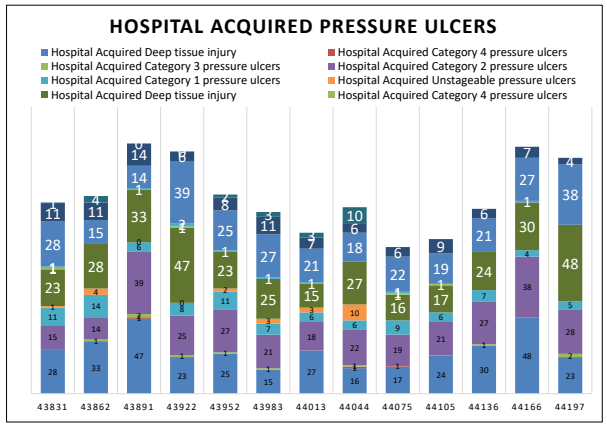
The highest number of hospital acquired pressure ulcers remain from Henry Moore COVID Critical Care with 11 PUs in total. Charnley ward followed with 8 hospital acquired pressure ulcers in total. Adult Assessment Unit and Kingsmoor (COVID ward) followed with 7 hospital acquired pressure ulcers each. We will be performing mini audits on those three wards to identify any gaps in care & work with respective teams for action plans.

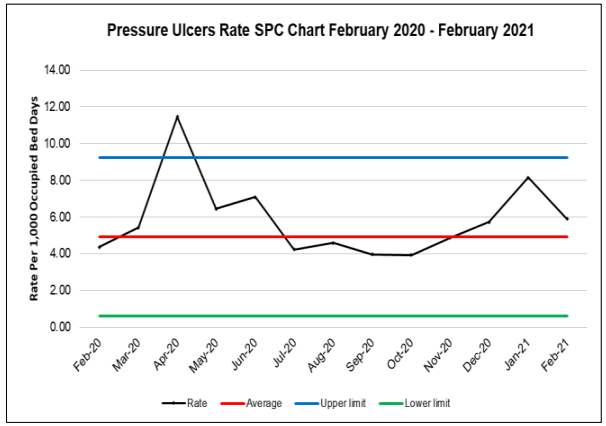
We have recently updated our pressure ulcer strategy for the coming financial year, which wil lbe launched after ratfication.

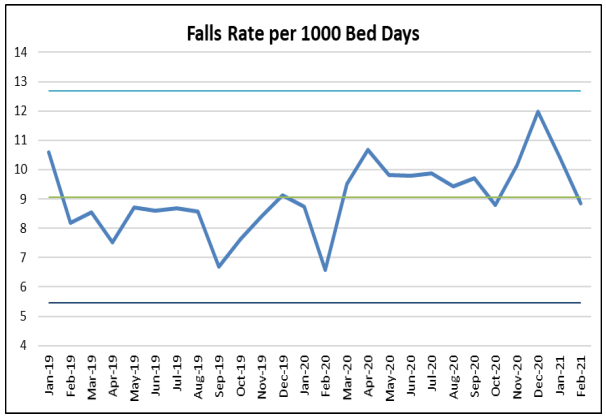
Falls: During February 2021 there were 93 reported falls which is a reduction from 121 in January 2021. 69 falls were classified as no harm and 24 as minor harm. There were no reported moderate harm or severe harm incidents. This is the 2nd month with no moderate or severe harm incidents.

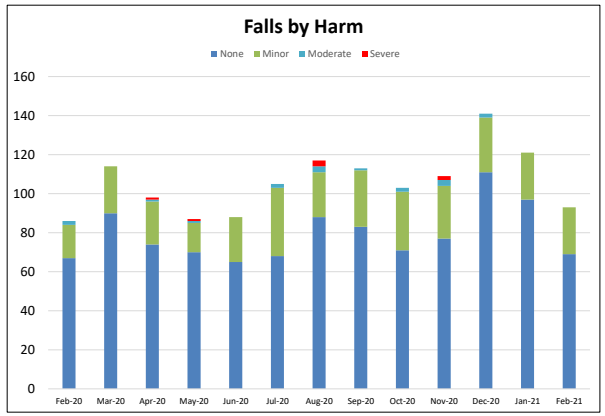
The rate per 100 patients (falls with harm) showed a slight increase to 2.55 (up from 2.14 in January 2021) although there was a reduction in admissions from 1124 to 940.

Falls per 1000 bed days also showed a decrease to 8.84 (down from 10.43). There was a reduction in occupied bed days from 11604 to 10525.









Family & Women's Service

2 Our Patients Summary 1.9 Family & Women's Service

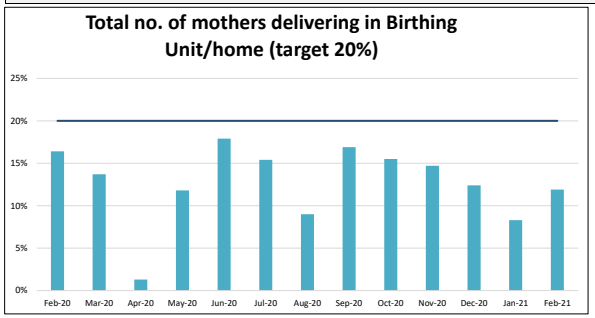
The Princess Alexandra Hospital NHS Trust

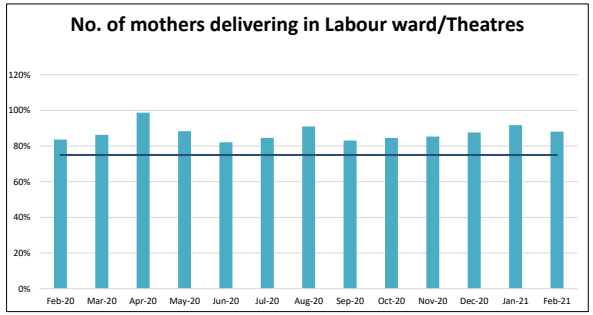
There were 3 Serious Incidents (SI) declared in February 2021. These incidents occurred in September 2020 and, following investigation and further review, they have been declared as SIs. There were no Serious incidents reported to the Healthcare Safety Investigation Branch (HSIB) and there were no stillbirths or neonatal deaths in February.

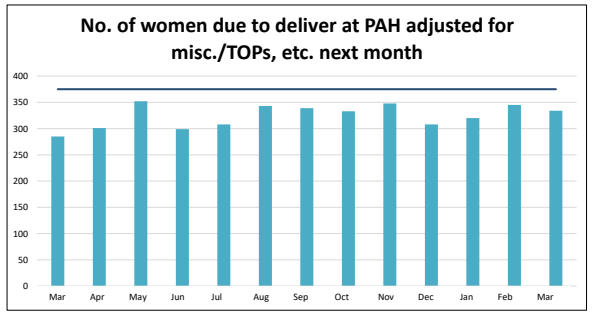
The number of women, delivering in the Midwife Led Birthing or having a Home Birth Unit, has recovered slightly from 8.3% in January 2021 to 11.9% . The Midwife Unit has had to close on occasions due to staff shortages but Home birth services have not been affected (3.3% in February).

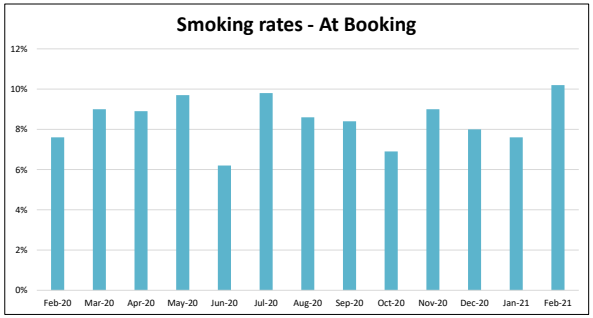
The Emergency C Section rate at PAH had consistently fallen each month from 23.9% in November 2020 to 18.9% in December 2020 and 17.9% in January 2021. In February the rate has fallen again, but only slightly, to 17.8% and continues to be closely monitored.

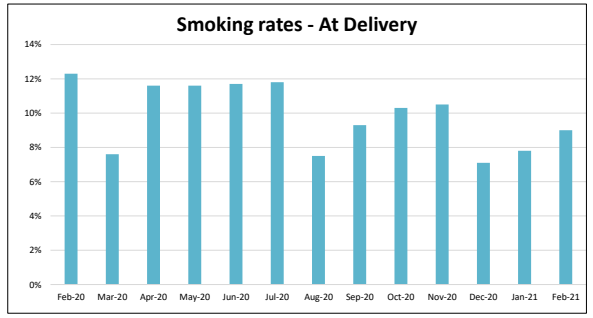
The rate of Post-partum Haemorrhage (PPH), over 1.5L, was 2.6% in February 2021, which is down from 3.2% in January. The latest National Rate is 2.8% (NMPA Clinical Report 2019).

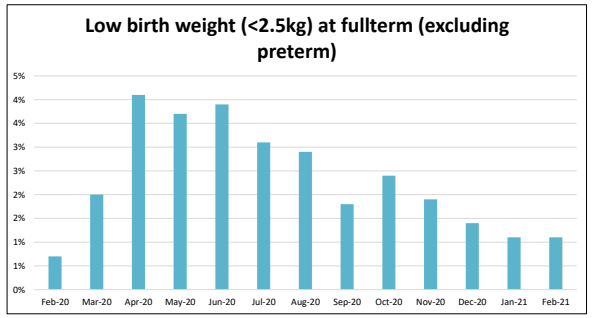


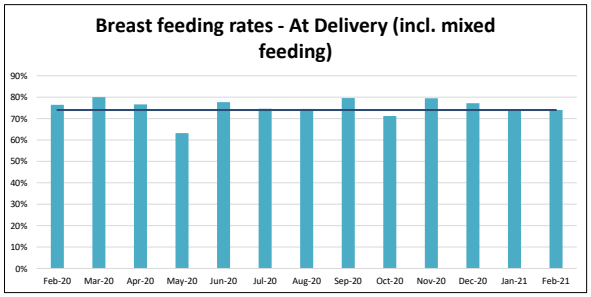


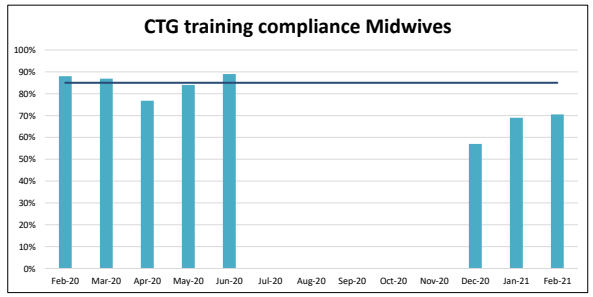


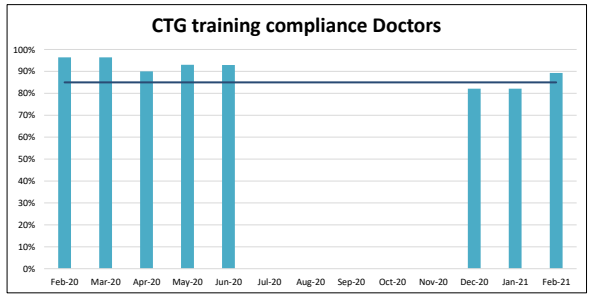












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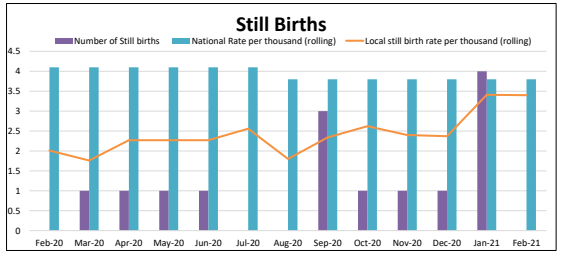
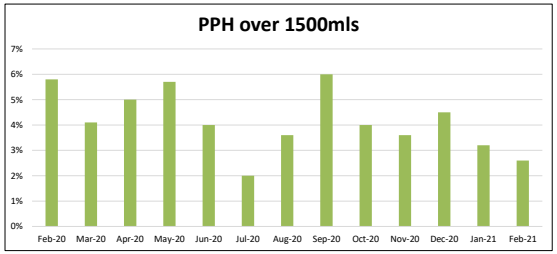
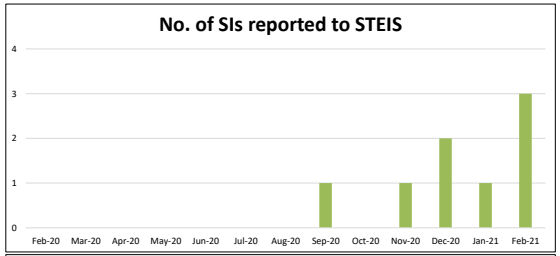
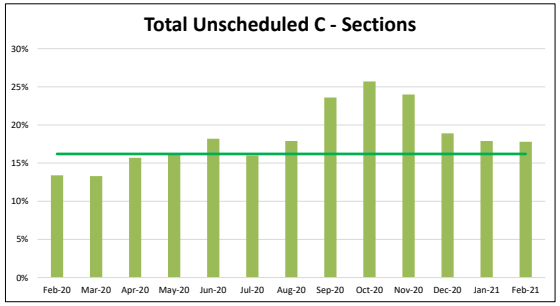
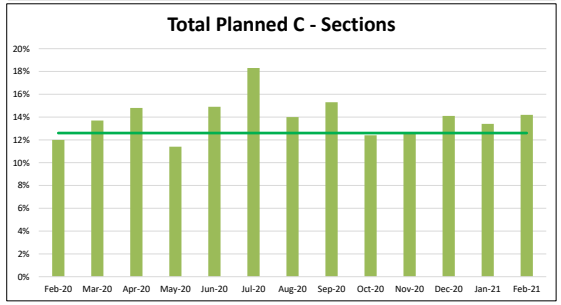
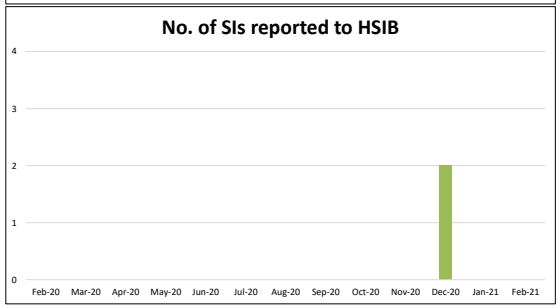










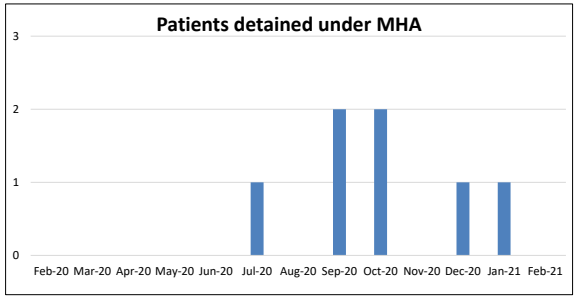


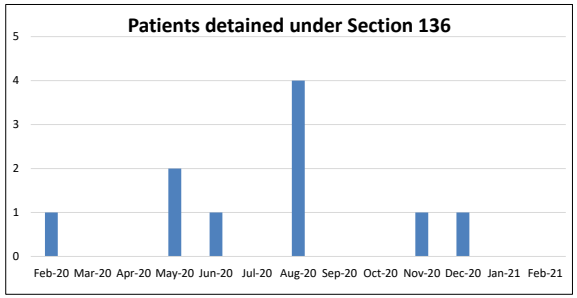
Mental Health

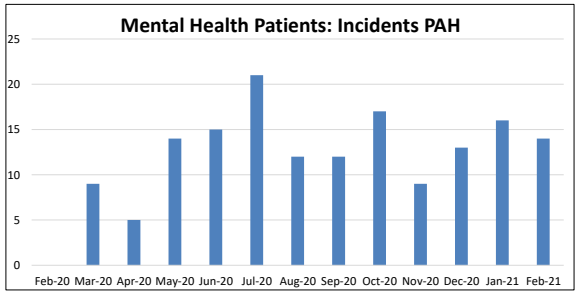
1 Our Patients Summary 1.11 Mental Health

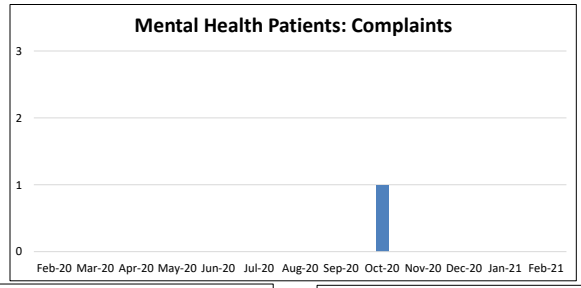
The Princess Alexandra Hospital NHS Trust

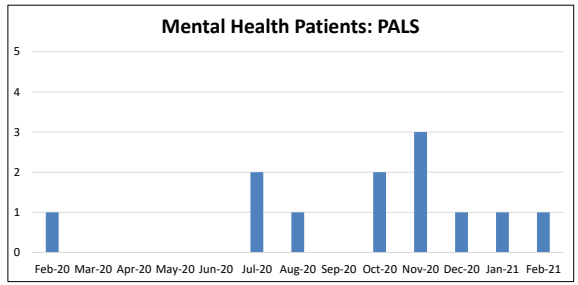
This section details the trends relating to Mental Health and our Vulnerable Patients. The work is overseen by a number of groups, all of which have oversight at the new quarterly Vulnerable Person Group chaired by Director of Nursing.

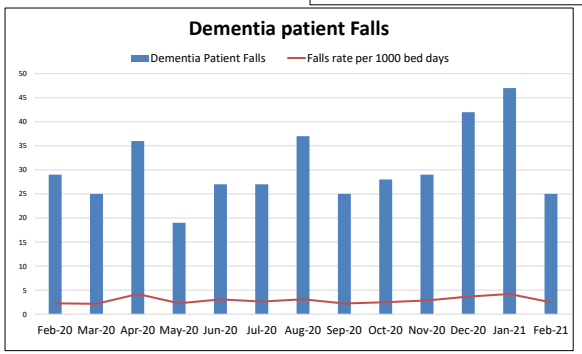


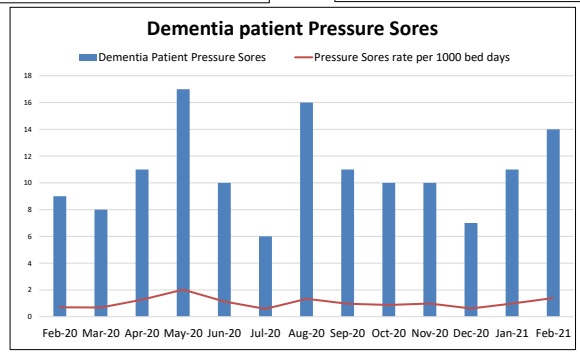


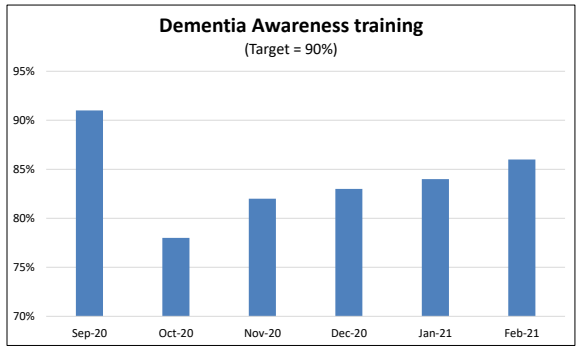




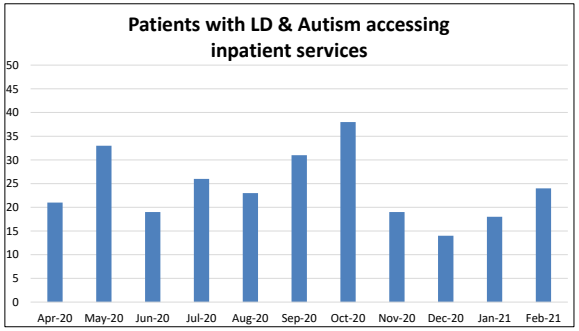


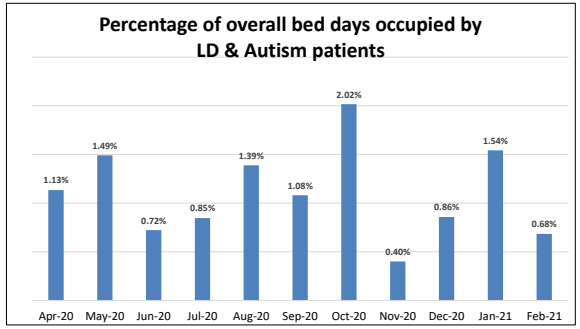


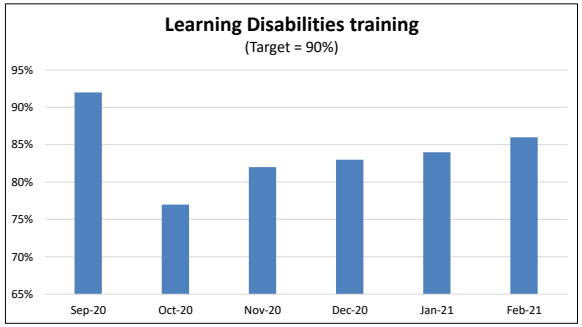


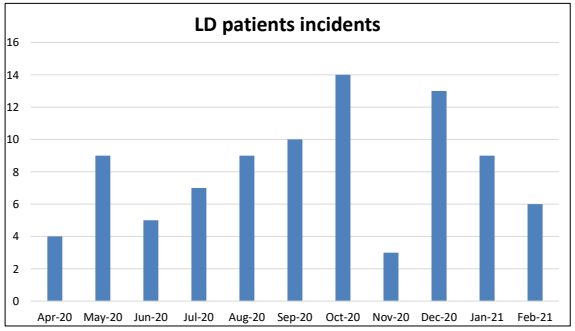


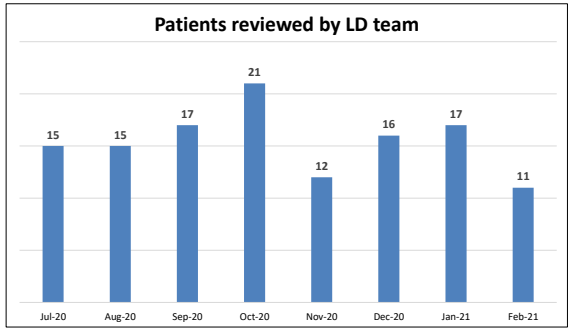
Learning Disabilities & Autism

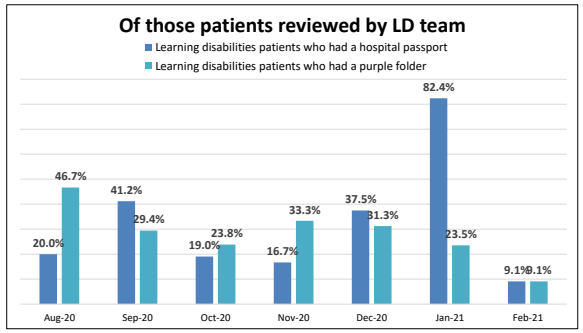








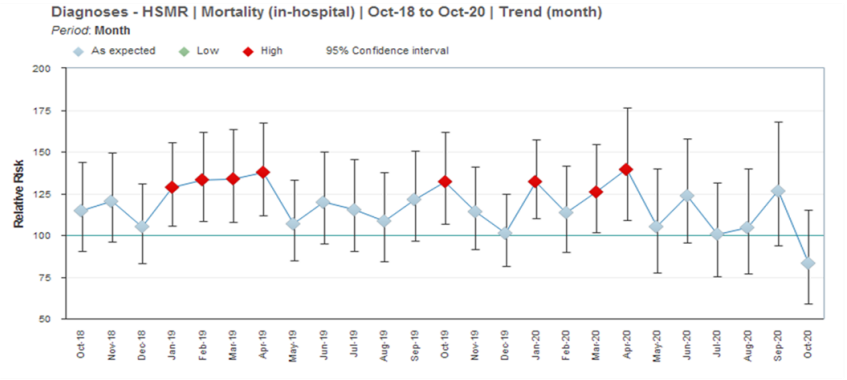


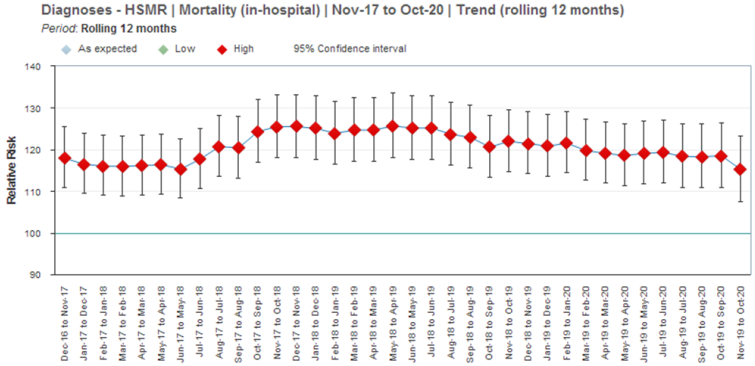


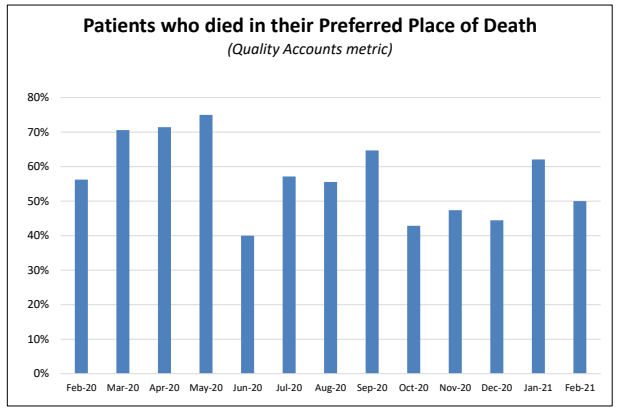
Mortality

1 Our Patients Summary 1.13 Mortality

The Princess Alexandra Hospital NHS Trust







Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

People measures

• The overall trust vacancy rate has increased slightly in February to 9.4%. Some support posts are on hold for potential redeployments following an admin wide consultation. Posts are recruited to where there is an immediate need and the work around redeployment is in its final stages

• The recruitment pipeline for HCSW and international nurses continues to be on track. Recruitment plans around hard to recruit medical posts are currently being agreed

• Staff turnover continues to sit under the trust KPI of 12%. Staff survey results and staff survey action plans will focus on topics that continue to support trust turnover to remain below the trust KPI

• The majority of sickness absence reasons continue to be related to stress and anxiety and musculoskeletal (MSK). The increase in stress and anxiety cases has been attributed to COVID related fatigue. Staff health and wellbeing and the business partnering team are advising managers with support to these cases. The trust is seeing an overall reduction in COVID related absences

• Overall KPI for statutory and mandatory training remains at 86%. Appraisal rates at 68% are also below the trust KPI. Appraisal and statutory and mandatory pay progression will recommence from the new financial year which should see an improvement in these figures. Each of these KPIs is discussed at HCG performance review meetings

• Time to hire days have also decreased over the last 2 quarters and links to establishment meetings where bottle necks can be identified and addressed

Health and Wellbeing

• The ICS health and wellbeing provision “Here for you” went live in February. This is a psychological support service available to all staff which is led by clinically trained staff who make an assessment and then refer on to the most appropriate service

• The trust commenced a programme of peer support sessions called “time to talk”. The initiative is staffed by mental health first aiders and TRiM trainers, trained by the trust and have provide drop in sessions 7 day per week across all shift patterns

• The trust are in the process of planning an people focused recovery plan called “back to better”. This will be a 12 week programme based on four topics focused on health and wellbeing, leadership and values and behaviours.

Workforce Indicators Summary

Agency Spend TBC
Bank Spend TBC

Target: 15%

Staff In Post
3373
WTE

Training
86%

Target: 90%

Sickness
4.23%

Target: 3.7%

9.39%

Target: 8%

Turnover
9.89%

Target: 12%

Medical Suspended
Non-Medical 67%

Target: 90%

The Princess Alexandra Hospital NHS Trust

Scorecard

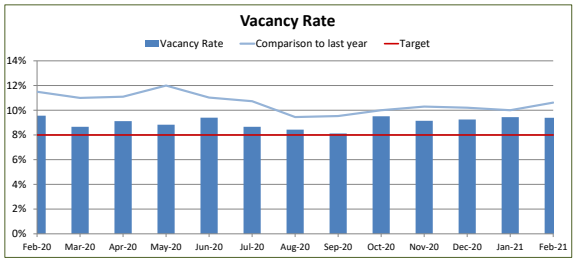
People Measures as at 28 February 2021	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3760.71	905.32	483.39	957.5	771.67	278.29	147.32	52.68	164.54
Vacancy Rate	8.0%	9.39%	8.66%	8.52%	11.52%	12.42%	14.79%	0.00%	0.00%	9.97%
Agency % of paybill	7.0%	4.7%	1.6%	1.3%	5.4%	6.7%	20.5%	3.6%	0.0%	6.4%
Bank Usage - wte	n/a	321.13	34.75	46.92	139.67	36.45	30.39	5.71	2.14	22.12
Agency Usage -wte	n/a	128.97	11.03	3.49	37.70	21.68	42.05	8.22	0.00	4.80
February 2021 Sickness Absence	3.7%	4.23%	3.15%	3.91%	4.65%	4.75%	9.38%	2.22%	0.20%	2.05%
Short Term Sickness	1.85%	1.87%	1.10%	1.46%	2.27%	2.48%	2.74%	1.84%	0.13%	1.56%
Long Term Sickness	1.85%	2.37%	2.05%	2.45%	2.38%	2.27%	6.64%	0.38%	0.07%	0.48%
Rolling Turnover (voluntary)	12%	9.89%	10.73%	9.46%	10.92%	8.21%	8.06%	9.21%	14.82%	10.76%
Statutory & Mandatory Training	90%	86%	93%	85%	81%	81%	83%	90%	91%	99%
Appraisal	90%	68%	77%	65%	66%	60%	58%	60%	75%	81%
FFT (care of treatment) Q2	67%	78%	76%	84%	83%	78%	61%	75%	68%	82%
FFT (place to work) Q2	61%	65%	56%	72%	69%	62%	45%	75%	60%	67%
Starters (wte)		36.08	4.60	2.80	8.38	7.30	0.00	11.00	2.00	0.00
Leavers (wte)		30.13	9.20	4.04	6.12	9.19	1.58	0.00	0.00	0.00
Time to hire (Advert to formal offer made)	31Days									

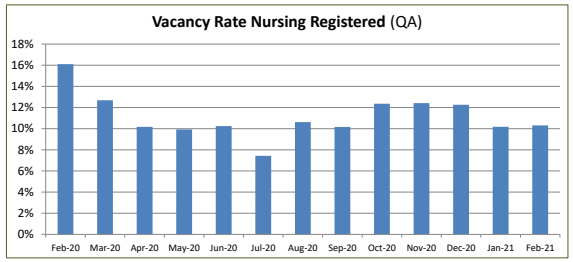
Workforce Indicators

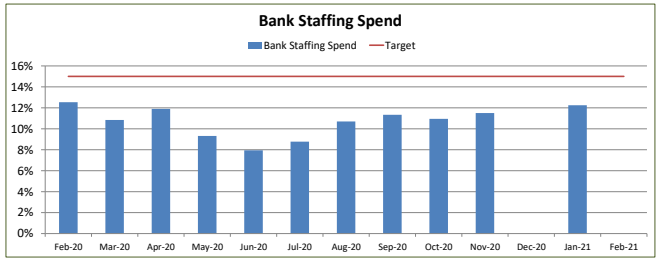
3 Our People Summary

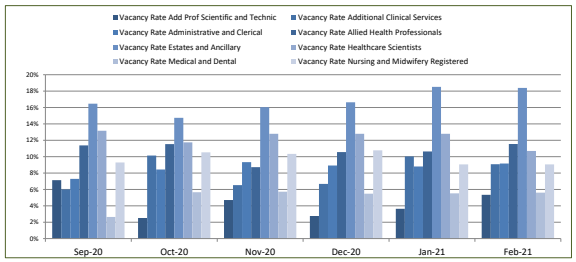
3.3 Well Led

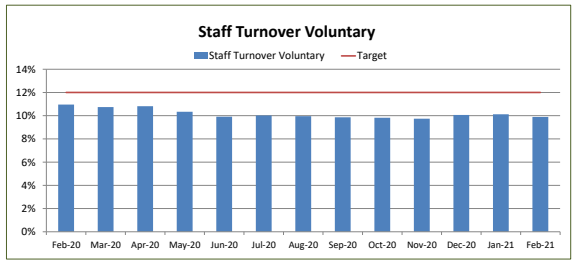
The Princess Alexandra Hospital NHS Trust

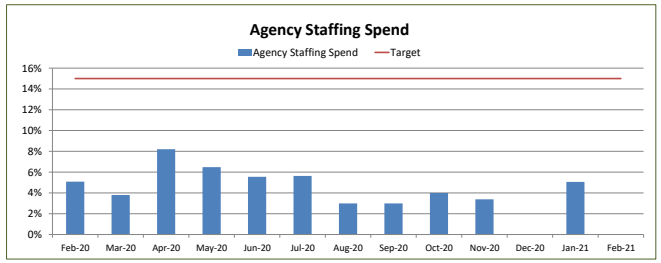


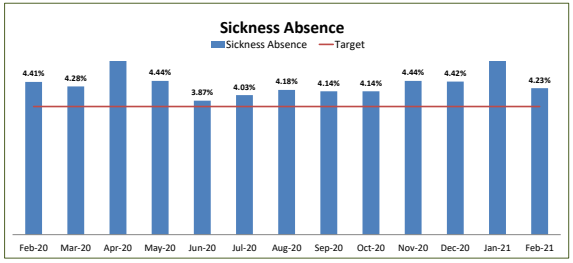


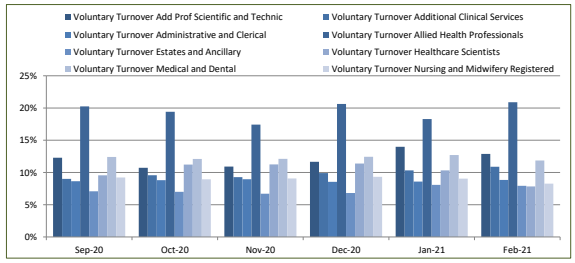


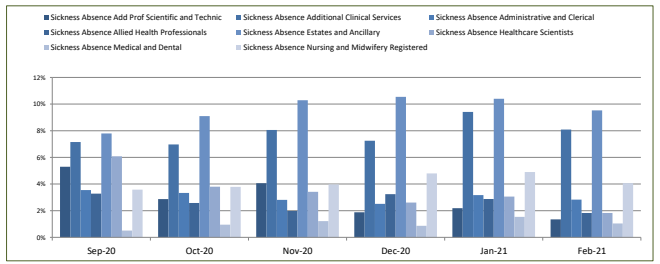


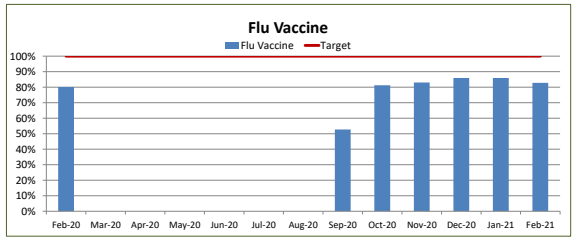




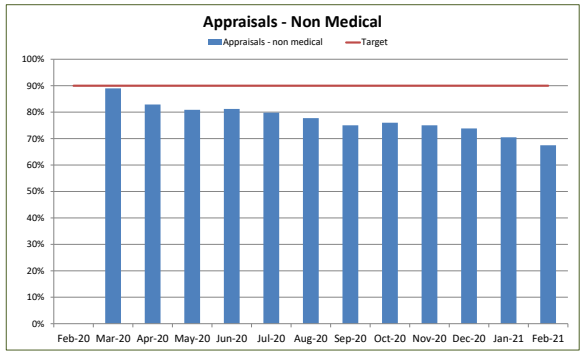


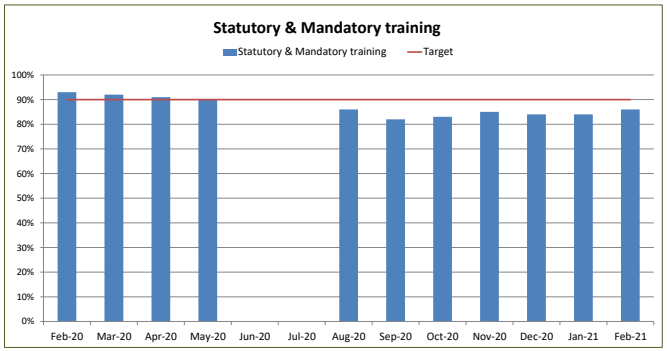


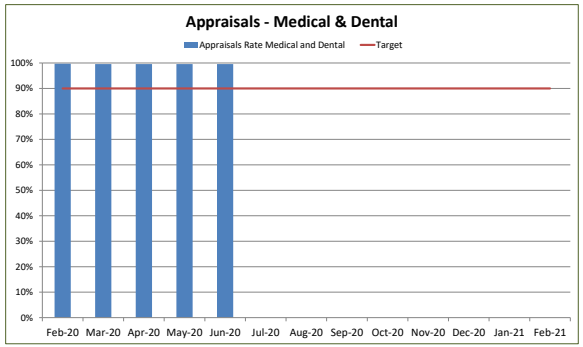


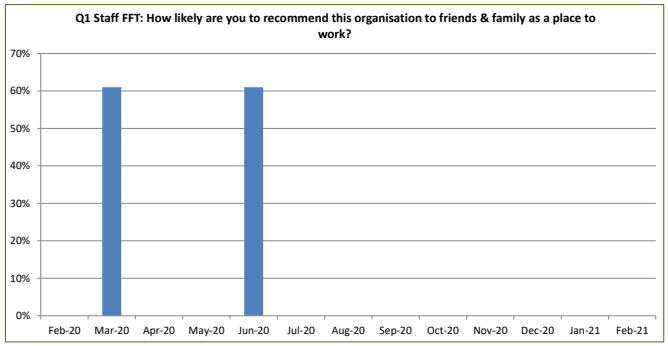


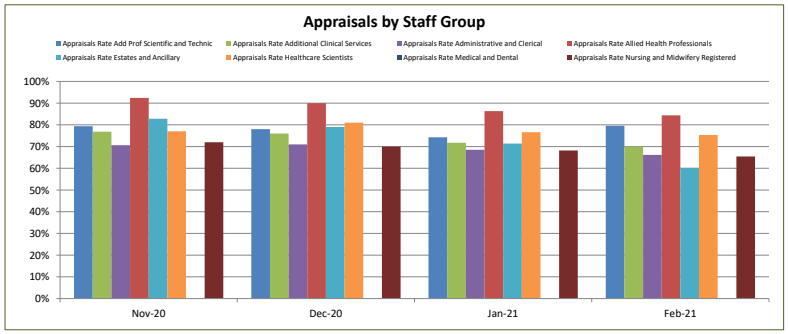
Workforce Indicators

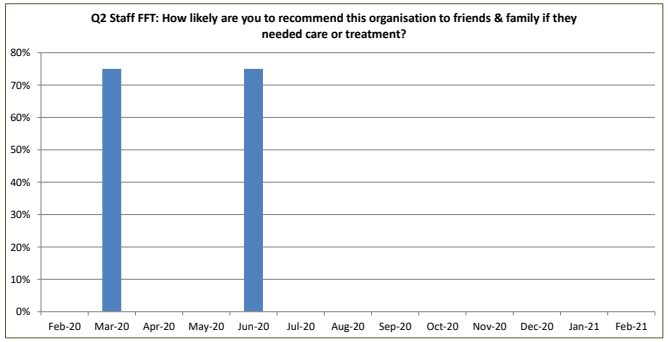












Annual Staff Survey 2019 & Workforce Race Equality Standard (WRES)

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

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

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

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

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

Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

Estates Loss of Electrical Supply to North Side: On Monday 1st March at approximately 1350hrs the Trust experienced a failure of the mains power supply and the back-up generator did not run. The power was lost for approximately 18 minutes and was associated with a fault on the LV system. Approximately 45% of the site was affected. This included ED, paediatric ED, theatres, five ward areas, radiology, mortuary and sterile services and a section of the retail and non-clinical areas. At this stage, no harm has been reported. Power was restored by the in-house electrical team and controlled tests were undertaken with an HV contractor to ensure the generator would function within normal parameters in the event of a mains power in the unlikely event of a problem with power from the national grid.
The fault has been isolated which was related to the configuration of aged electrical infrastructure and its integration to the installation of a new generator carried out in 2019. A full investigation is underway with relevant stakeholders and the Trust Authorising Engineer. Resilience and business continuity plans were implemented as designed and functioned as intended to mitigate risks as far as is reasonably practicable. Critical incident briefings were initiated at local and regional level. This incident is unrelated to the power issues experienced by the Trust in January which were related to a failure on the national grid. A final report to the Trust Executive Board to be presented in April following full investigation into this matter led by Estates with input from Authorising Engineer (Electrical) – external independent contractor.

All pressure system equipment detailed in written scheme has undergone its thorough inspection.
Remedial works for all critical ventilation plant is now complete and quarterly HTM inspections are being carried out.
The new HV substation/transformed has entered design stage.
New pendant installation for ITU is underway.
IPS/UPS installation and refurbishment has entered design stage.
New fire safety maintenance contract has been awarded.
Positive feedback from NHSE/I regarding Oxygen and ventilation management following last week's inspection.
New Estates office refurbishment to assist with safe management of contractors to be complete 18th March 21.

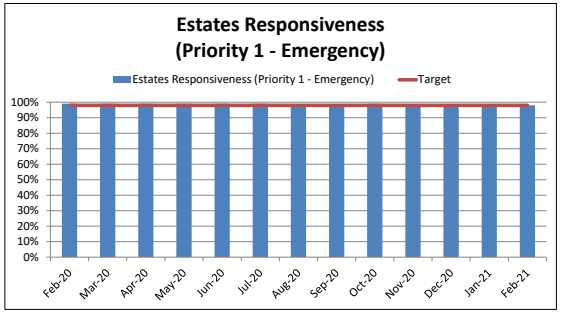
Capital
AAU/SDEC build completed and occupied
Frailty Assessment and Short Stay project started after decant
Mortuary/Alex Lounge development on site with enabling works
Williams Day Unit decanted and strip out commenced.
Completion of 80% of BLM projects with balance by year end
Colposcopy refurbishment & Endoscopy Room 3 contractors on site
Alex Education and Training Facility contractors on site
Chamberlen showers and Labour birthing rooms contractors on site
Dolphin Ward Phase 1 complete and additional works on site
Pre assessment to A31 nearing completion.
Key risks:
COVID-19 and capacity affecting access to clinical areas and Brexit affecting supplies
Delays for completion of Lift for AAU due end of March and CT scanner for ED due April as clashing with Frailty Assessment build

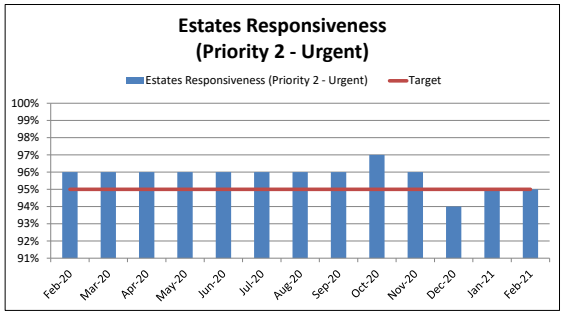
Facilities
The national standard of cleanliness audits are now carried out jointly with a clinical member of the team present. All scores remain above the national standards.
The new cleaning routine was introduced on 1st February 2021 initial feedback from clinical staff is the longer cleaning hours are proving helpful with the turnaround of beds and side rooms.
The CQC visit in February was positive due to the new working hours.
The training of the housekeeping staff is ongoing, in addition the staff have been given access to online Food Hygiene and Allergen training.

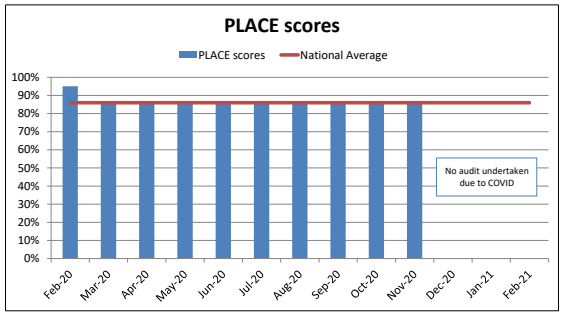
Places

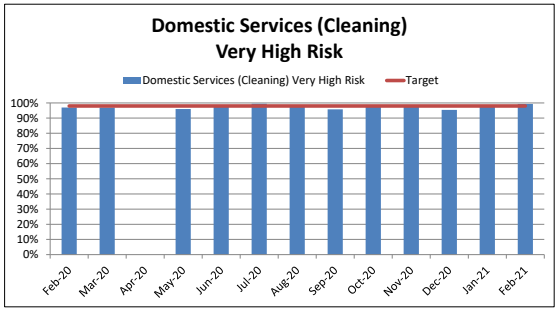
4.1 Cleanliness & Catering

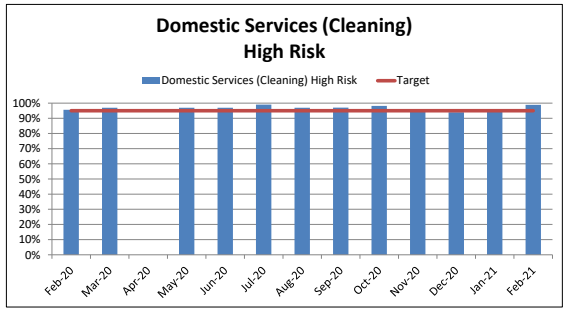
The Princess Alexandra Hospital NHS Trust

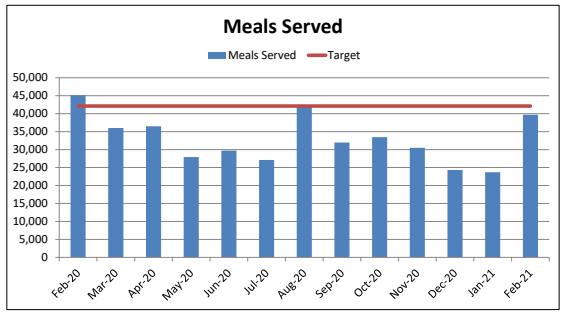


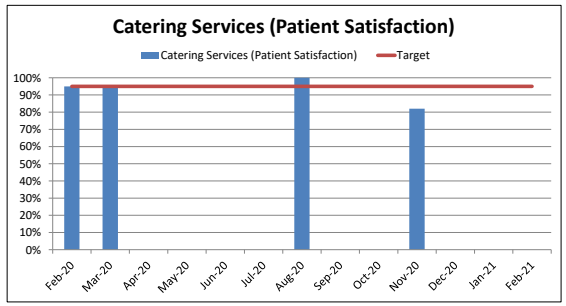


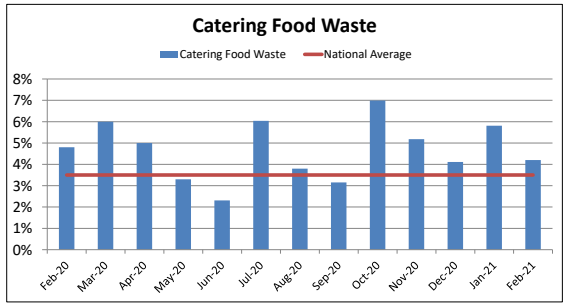












Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

RTT performance continues to be impacted by Covid pressures where non admitted routine activity can only be seen virtually and admitted treatments are only being made for the higher clinical priorities (P1 & P2). The Trust is utilising the independent sector hospitals to support with both cancer patients and the P3 & P4 routine patients. A bed model for the coming 3 months proposes for limited elective operating to open up at the end of March and a proposal to open up routine & face to face activity is being prepared. The gap of unbooked ASIs is growing due to the lack of face to face routine clinics currently.

2 week wait cancer performance has improved and further tumour site improvements are expected in February due to focus on the early stage of the pathway to ensure that we diagnose early in the pathway and prevent a growing backlog for treatments. 62 day performance is still impacted by treating a higher number of patients that have breached. The tumour sites have developed a recovery trajectory for both 2ww & 62 day performance which will be monitored at Cancer Board.

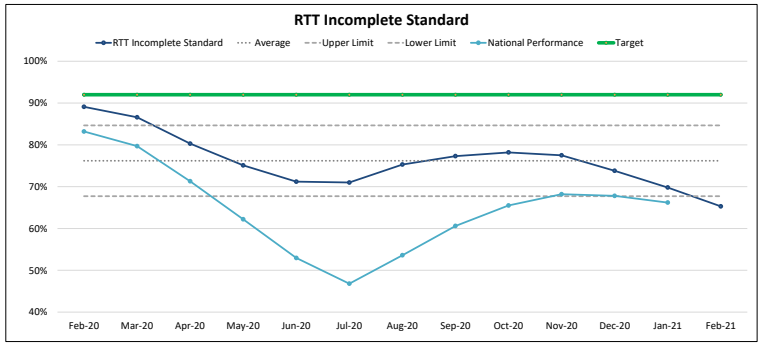
A&E performance continues to be challenged by the high bed occupancy, requirement to maintain separate Covid wards, community bed capacity and ongoing demand. Daily bed planning meetings have developed a capacity plan for the coming 3 months that should allow the Adult Assessment pathway to be re-commenced and allow the use of CDU, Frailty and Same Day Emergency Care in March. A recovery plan for Urgent Care is being developed encompassing the CQC Inspection actions along with performance improvement across all of the urgent care services.

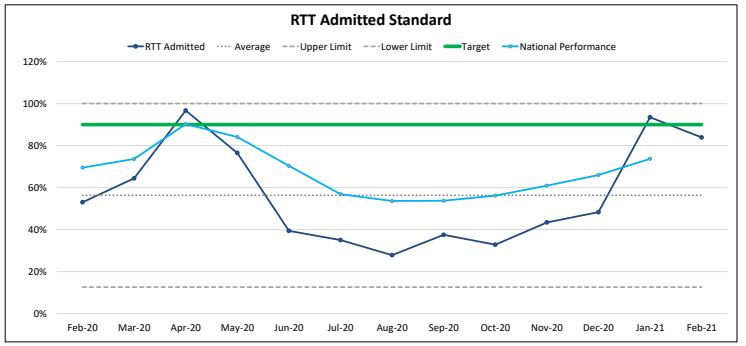
DM01 Diagnostic performance is directly impacted by the ongoing pause of routine services which were re-opening in early March. Maximum use of Independent Sector capacity will assist in the recovery and a trajectory back to national performance standards is being developed.

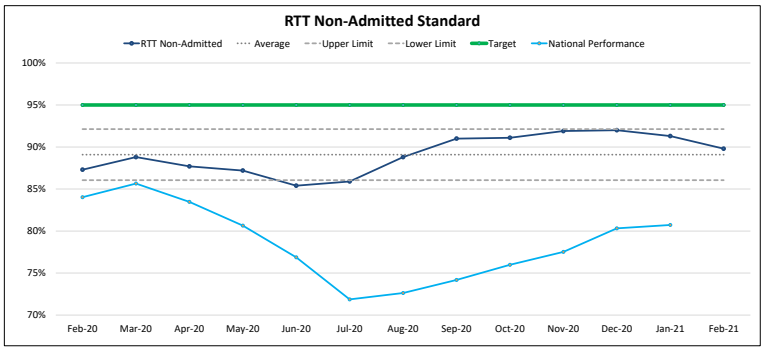
Short notice out-patient cancellations have improved in February and the new to follow-up ratio has increased, both as a result of the switch back to virtual clinics during the Covid period and pause on routine and face to face clinics, (first appointments are preferable face to face).

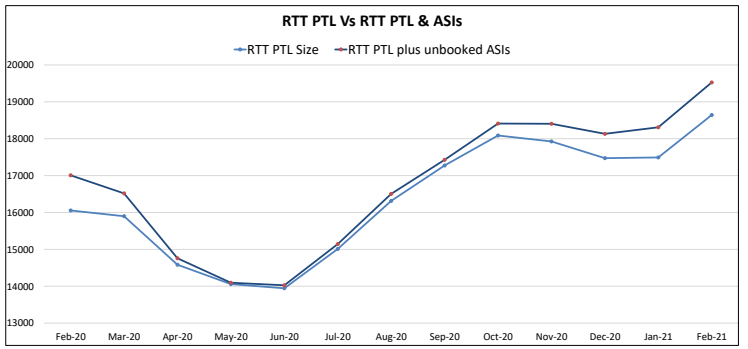
Recovery activity is low for elective day & in-patients as the Trust is only operating in 2 theatres at the Ramsay Rivers Hospital on cancers and urgent P2s. Some support from surrounding Trusts is being given for other high priority elective patients.

RTT


RTT Incomplete Standard
RTT Incomplete Standard
Average
Upper Limit
Lower Limit
National Performance
Target
100%
90%
80%
70%
60%
50%
40%
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21


RTT Admitted Standard
RTT Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
120%
100%
80%
60%
40%
20%
0%
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21

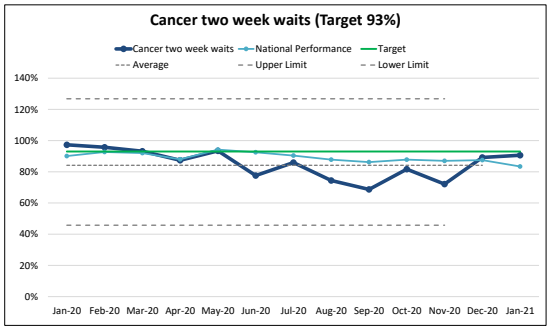

RTT Non-Admitted Standard
RTT Non-Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
95%
90%
85%
80%
75%
70%
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21

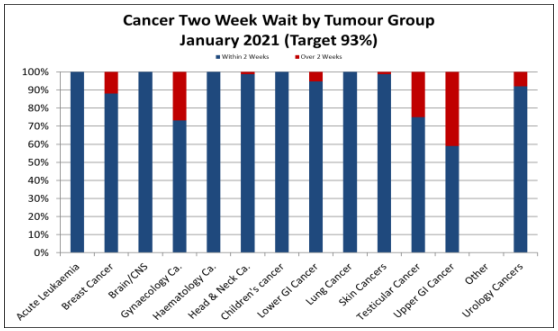

RTT PTL Vs RTT PTL & ASIs
RTT PTL Size
RTT PTL plus unbooked ASIs
20000
19000
18000
17000
16000
15000
14000
13000
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21

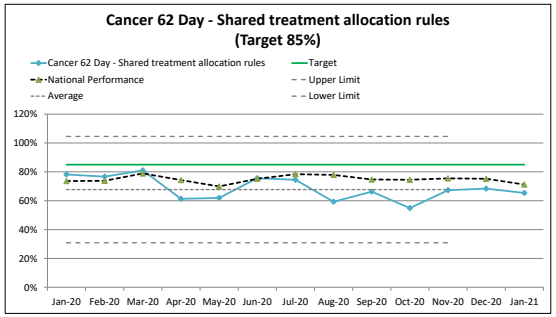
Cancer

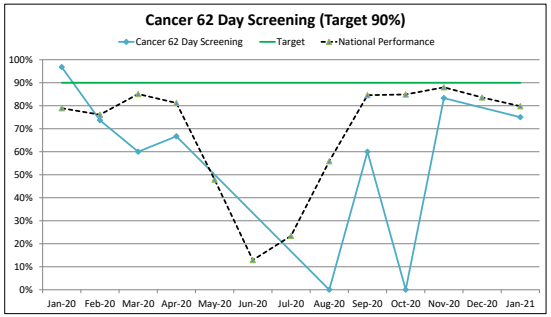
	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Jan-20	97.70%	97.40%	100.00%	100.00%
Feb-20	98.60%	96.90%	100.00%	100.00%
Mar-20	98.80%	97.10%	100.00%	100.00%
Apr-20	91.90%	95.10%	100.00%	90.00%
May-20	97.50%	90.70%	100.00%	100.00%
Jun-20	89.80%	86.90%	100.00%	66.70%
Jul-20	82.50%	91.10%	100.00%	85.70%
Aug-20	92.30%	87.10%	100.00%	66.70%
Sep-20	92.90%	90.20%	100.00%	100.00%
Oct-20	91.10%	87.40%	100.00%	100.00%
Nov-20	61.50%	92.60%	100.00%	80.00%
Dec-20	79.90%	93.70%	100.00%	83.30%
Jan-21	86.80%	89.30%	88.00%	100.00%

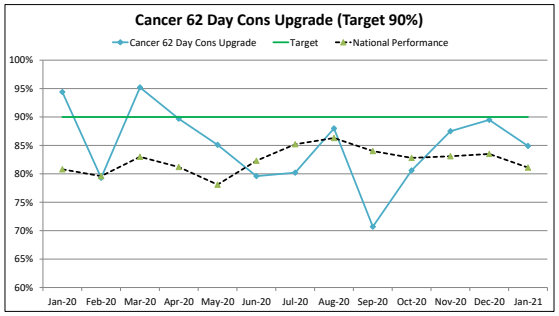
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

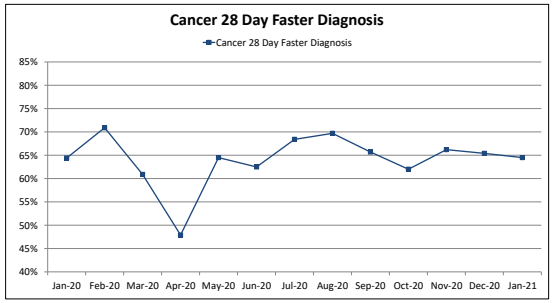








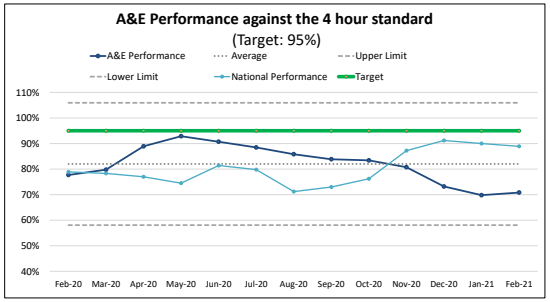


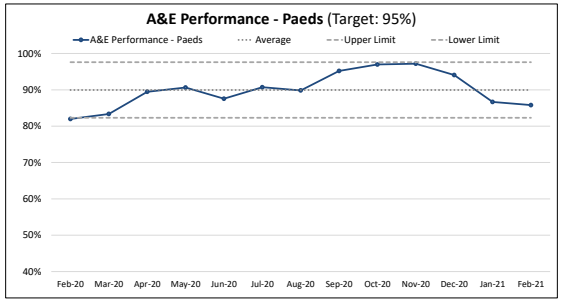


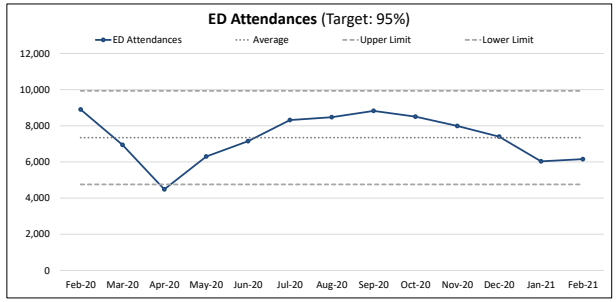
ED

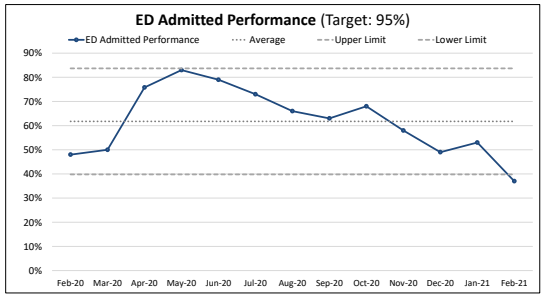
2 Our Performance Summary 2.3 Responsive

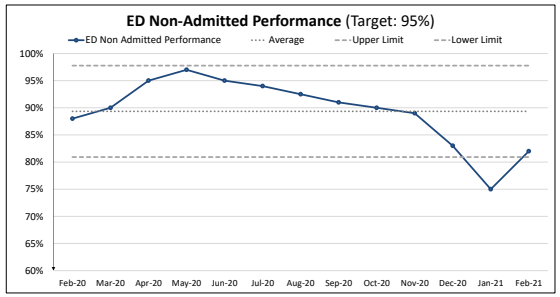
The Princess Alexandra Hospital NHS Trust







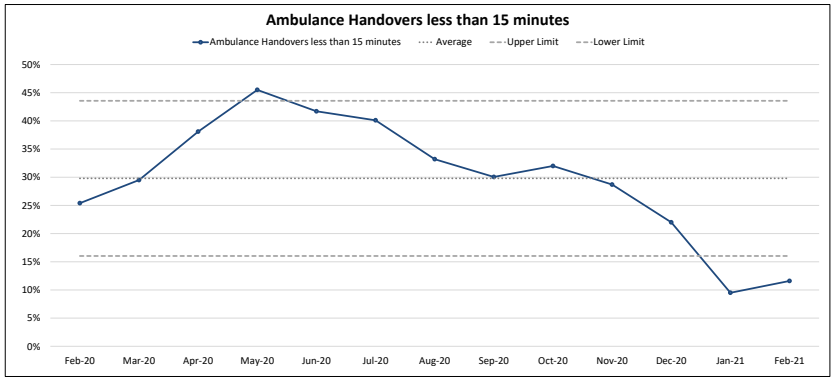


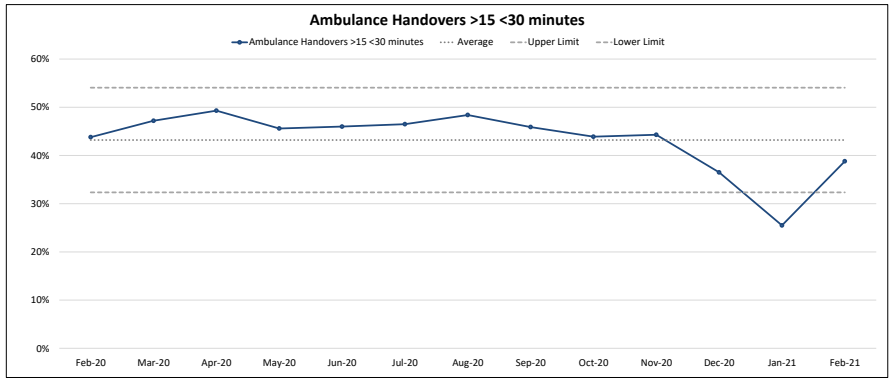


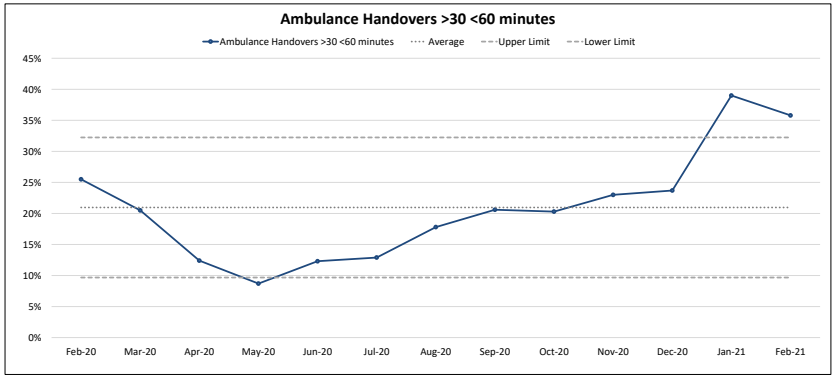
ED Internal Professional Standards

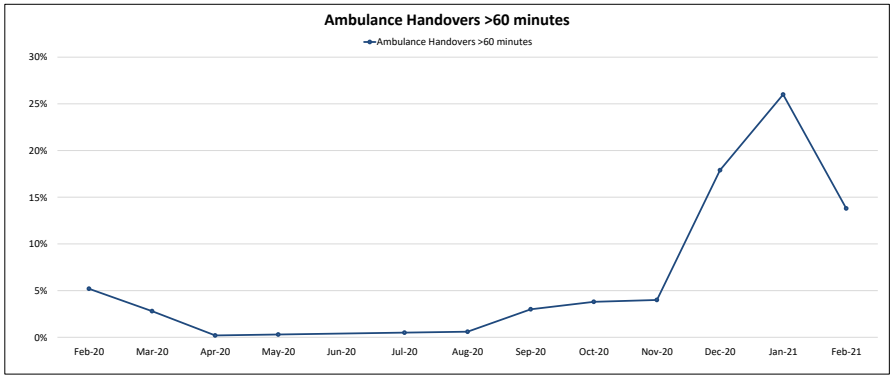
	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Target
Arrival to Triage - Average Wait (Minutes)	37	30	25	26	25	28	31	36	36	39	49	63	49	15
Triage to Exam - Average Wait (Minutes)	76	60	41	44	56	78	68	79	80	73	79	80	76	45
Exam to Referral to Specialty - Average Wait (Minutes)	97	97	88	82	84	96	94	86	96	99	107	110	109	90
Referral to Seen by Specialty - Average Wait (Minutes)	77	74	54	48	51	64	70	73	75	88	94	98	80	30
Seen by Specialty to DTA - Average Wait (Minutes)	87	91	66	67	69	70	85	94	99	97	109	120	101	30
DTA to Departure - Average Wait (Minutes)	134	157	110	55	74	134	111	132	100	178	254	319	273	30

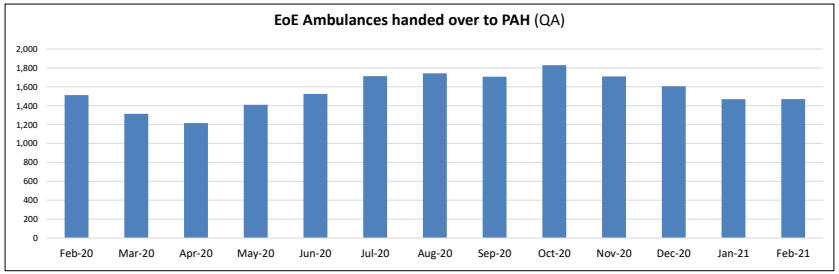
Ambulance

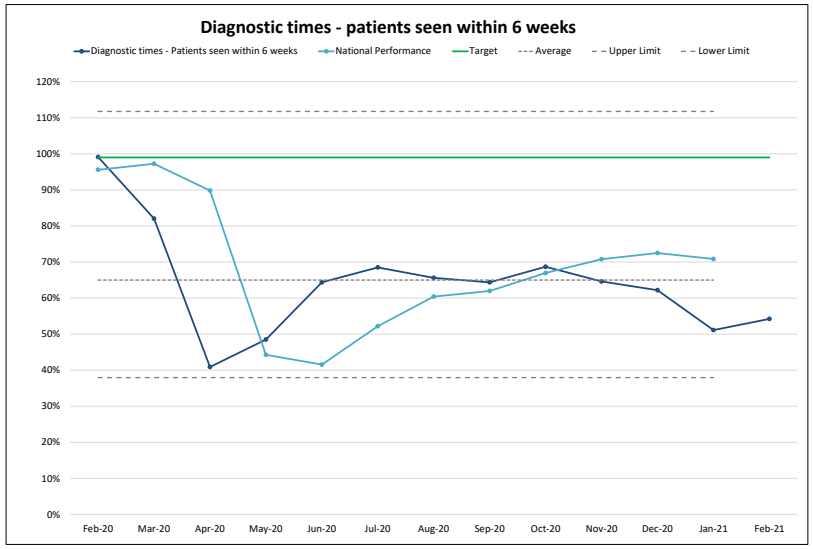

Ambulance Handovers less than 15 minutes
Ambulance Handovers less than 15 minutes
Average
Upper Limit
Lower Limit
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21

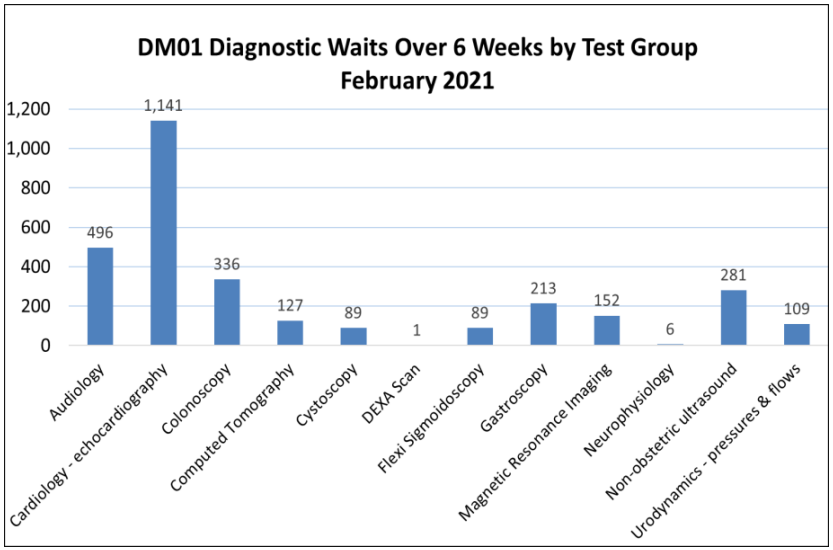

Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
60%
50%
40%
30%
20%
10%
0%
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21


Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21


Ambulance Handovers >60 minutes
Ambulance Handovers >60 minutes
30%
25%
20%
15%
10%
5%
0%
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21

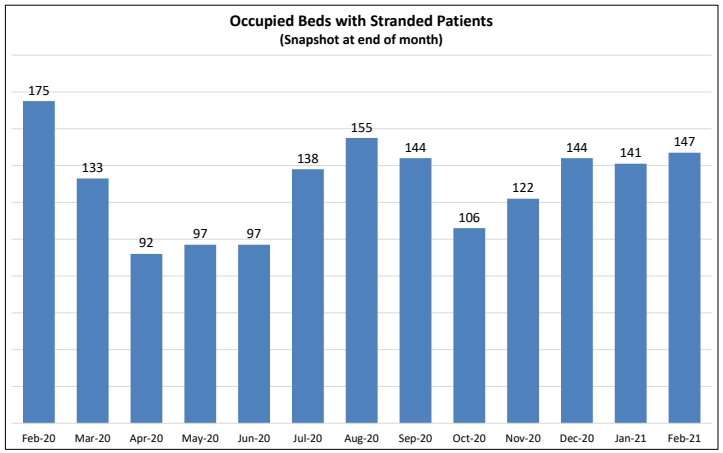

EoE Ambulances handed over to PAH (QA)
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21

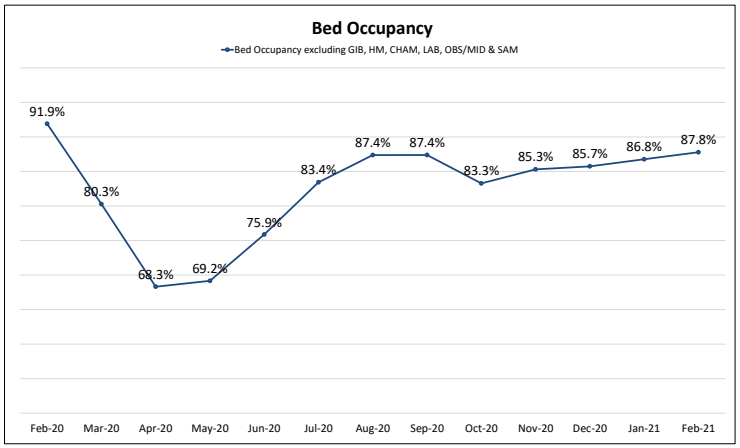




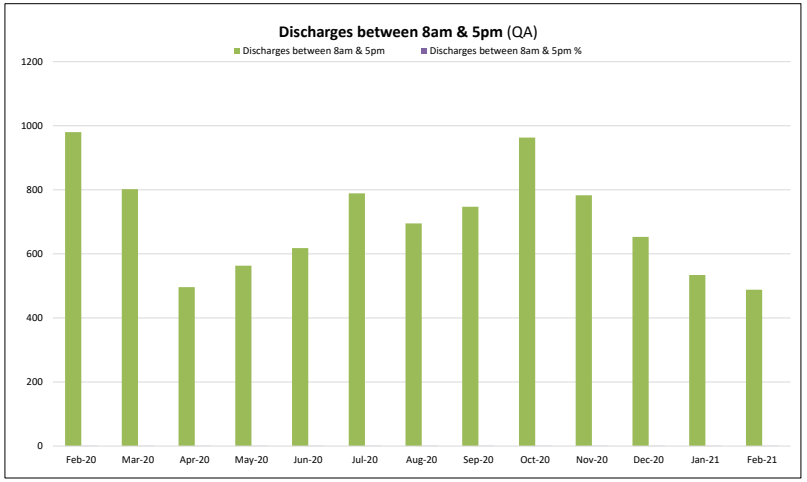
Test	% of Total Cohort - February 2021	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Magnetic Resonance Imaging (MRI)	10%	100.00%	78%	34%	38%	59%	79%	79%	73.93%	89.31%	81.85%	97.51%	82.68%	77.81%
Computed Tomography (CT)	9%	99.48%	85%	58.75%	60.69%	77%	80%	79%	88.69%	90.24%	91.78%	83.91%	79.03%	78.40%
Non-Obstetric Ultrasound	27%	99.89%	83.23%	39.20%	65.86%	92.61%	97%	93%	95.77%	96.73%	92.40%	95.27%	85.74%	84.37%
DEXA	0%	100%	-	-	100%	78%	88%	85%	93.20%	92.86%	97.56%	86.26%	51.83%	50.00%
Audiology - Audiology Asessments	9%	100.00%	69%	23%	11%	11%	25%	24%	24.70%	29.85%	23.79%	16.84%	12.57%	19.09%
Cardiology - Echocardiography	28%	96%	74.02%	37.55%	40.29%	55%	54%	52%	52.13%	54.26%	50.23%	47.43%	39.24%	39.21%
Neurophysiology	0%	89%	49%	42%	5%	36.17%	32%	28%	30%	47%	65%	74%	56%	80.65%
Urodynamics	2%	81%	91.11%	30.36%	30.30%	24.39%	16%	3%	11.11%	5.71%	3.74%	6.48%	7.96%	7.63%
Colonoscopy	6%	97.94%	93.58%	62.56%	38.41%	42.69%	40%	34%	39.23%	46.34%	44.24%	45.42%	25.48%	13.18%
Flexi Sigmoidoscopy	1%	96%	87%	48.98%	53.52%	55.66%	44%	31%	38.89%	39.55%	44.35%	38.14%	22.52%	9.18%
Cystoscopy	3%	100.00%	93.75%	65%	48.57%	55%	41%	54%	25.55%	35.23%	32.02%	32.11%	28.11%	57.00%
Gastroscopy	4%	99.15%	92.07%	58.37%	40.15%	44.88%	40%	29%	29.92%	38.19%	25.65%	24.37%	15.88%	10.13%

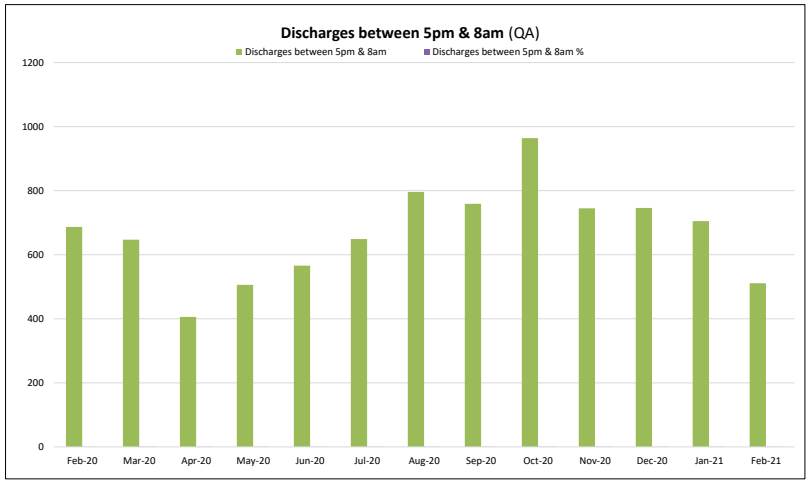
Stranded Patients

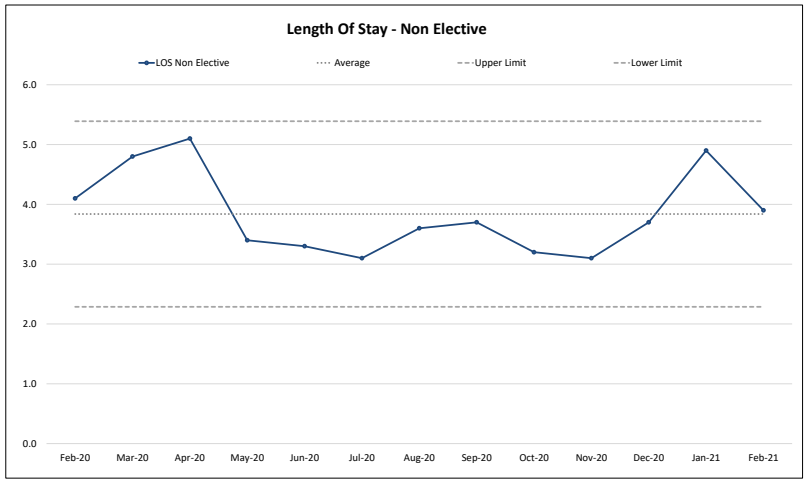


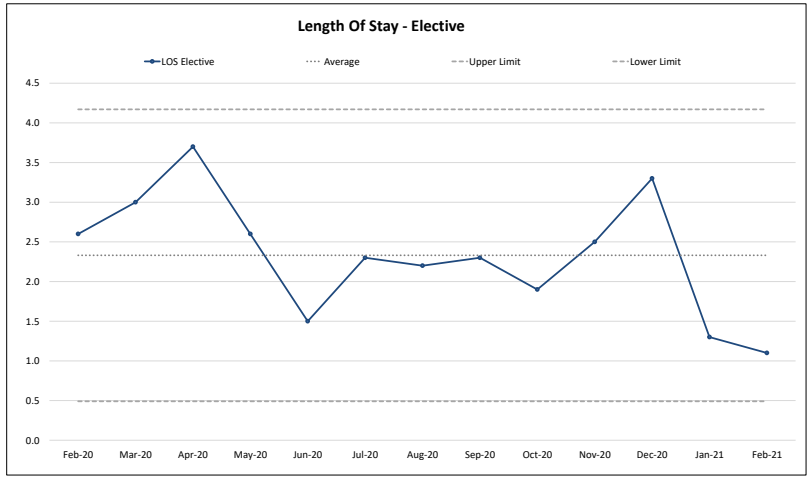


Discharges & LOS

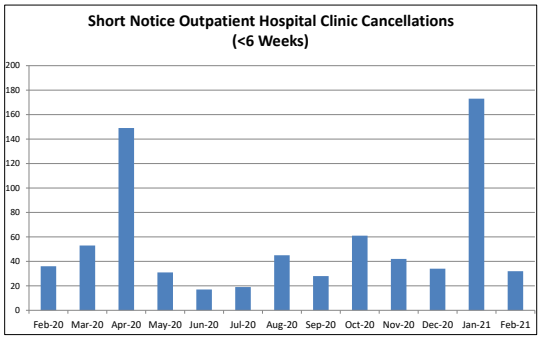


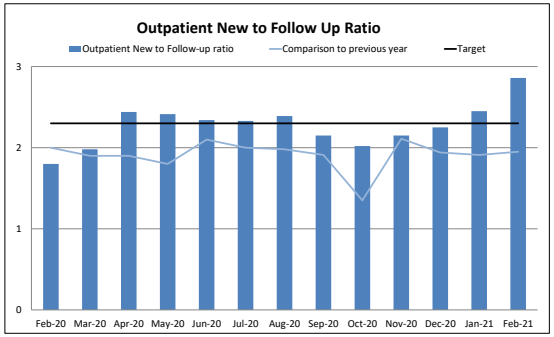


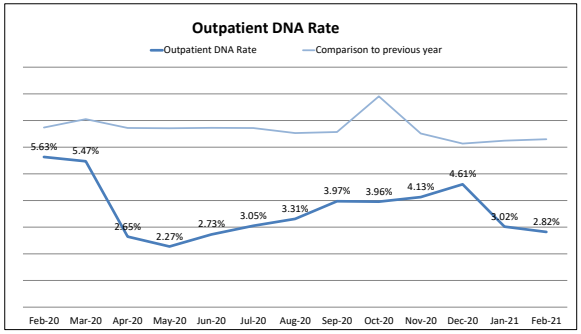


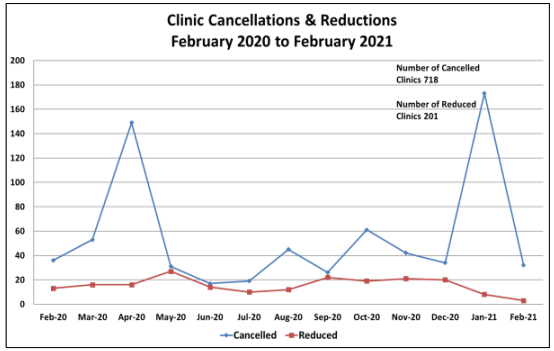


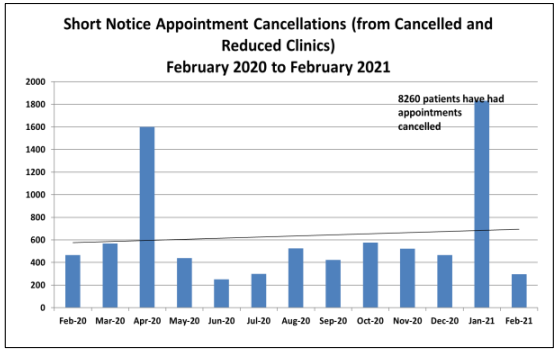
Outpatients & Cancelled Operations

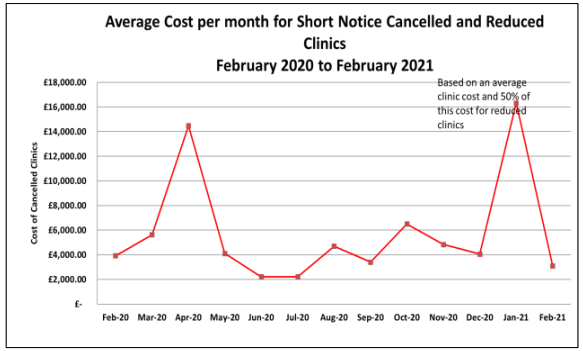








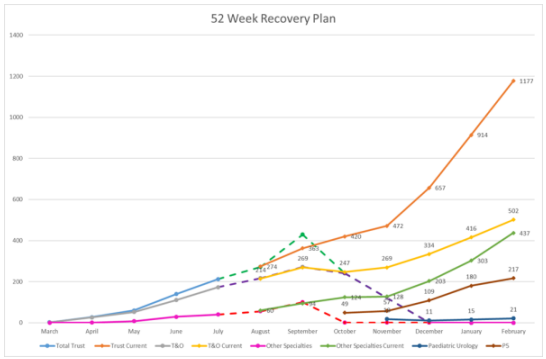


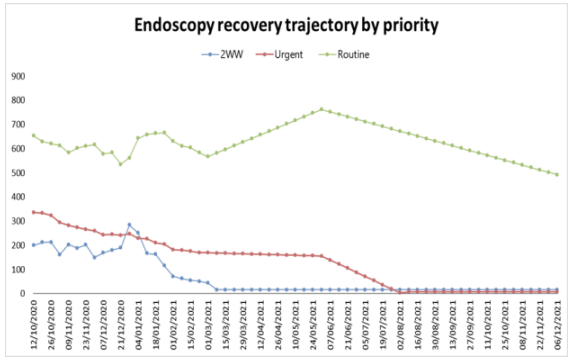


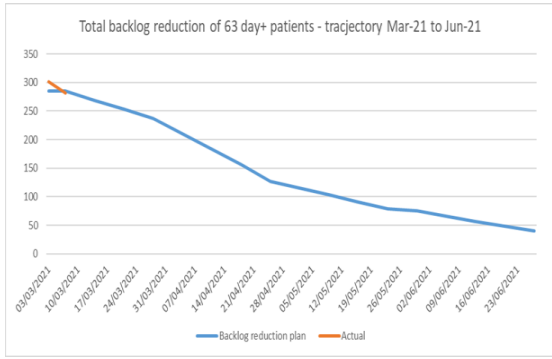
DNA Rate for Follow Up Appointments per Specialty for February

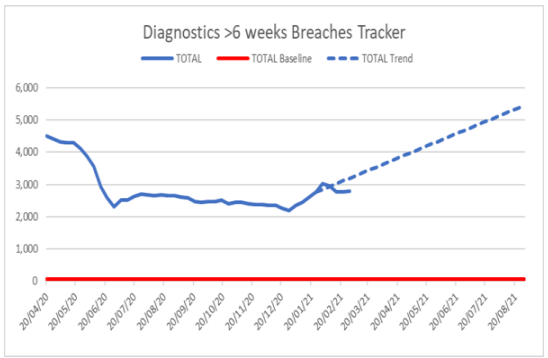
Specialty & Performing Unit	Accident & Emergency	Anticoagulant Service	Breast Surgery	Cardiology	Chemical Pathology	Clinical Haematology	Clinical Oncology	Colorectal Surgery	Community Midwifery	Dermatology	Diabetic Medicine	Dietetics	Endocrinology	ENT	Gastroenterology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology	Medical Oncology	Midwife Episode	Neonatology	Neurology	Obstetrics	Ophthalmology	Optometry	Oral Surgery	Orthoptics	Paediatric Diabetic Medicine	Paediatrics	Physiotherapy	Respiratory Medicine	Rheumatology	Trauma & Orthopaedics	Urology	Vascular Surgery	Well Babies	Total
DNA Rate	0.0%	0.0%	7.4%	4.4%	0.0%	1.1%	1.2%	0.0%	4.1%	1.8%	3.2%	5.6%	0.4%	5.7%	1.5%	0.0%	0.4%	0.0%	1.7%	0.4%	0.0%	6.5%	1.7%	2.3%	3.3%	2.0%	2.8%	12.9%	2.8%	7.5%	0.5%	0.7%	2.5%	4.1%	3.2%	1.1%	2.8%	2.8%

Recovery Trajectories









	Metric	Feb-20 Actuals	Feb-21 Actuals	Feb-20 vs Feb-21
Outpatients	First appointments	10,966	7,182	65.5%
	Follow up appointments	19,572	17,605	89.9%
	procedures	TBC	TBC	TBC
	Face to face	TBC	TBC	TBC
	Virtual	TBC	TBC	TBC
Inpatients	Day cases	2,029	1,009	49.7%
	Elective	292	42	14.4%
	Non-elective	3,184	2,386	74.9%
ED	A&E attendances	9,641	6,034	62.6%

Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

The financial position for Month 11, February, is a YTD deficit of £0.1m which is £0.2m favourable against plan. The Trust remains on target to achieve its annual financial plan of a £0.4m deficit. This position excludes the impact of any additional annual leave accruals above 19/20 levels with these expected to be compensated for.

Compared to original plans the favourable position includes surpluses generated from lower than expected activity against the elective programme and receipt of unplanned income, e.g. reimbursement for vaccination and testing programme.

YTD capital expenditure is £27.8m which is underspent against a YTD target of £41.8m. Significant work is underway to spend the remaining capital to ensure that the Trust delivers its Capital Resource Limit of £46.4m.

Cash resources remain sufficient with a Month 11 closing balance of £89.8m.

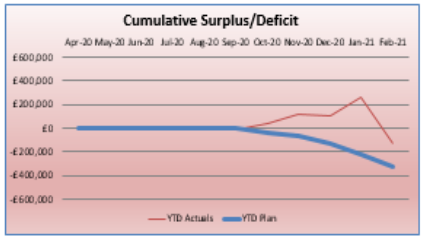
The Trust is finalising 2021/22 revenue and capital budgets which will be approved at the April Board. Revenue budgets will be based on a 'rollover basis' for Q1 of 2021/22 and will be refreshed when further National guidance is received.

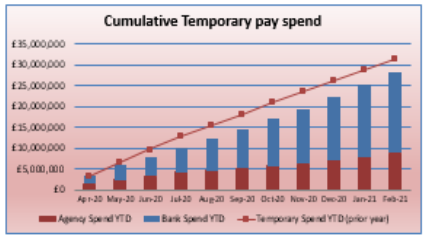
Pounds

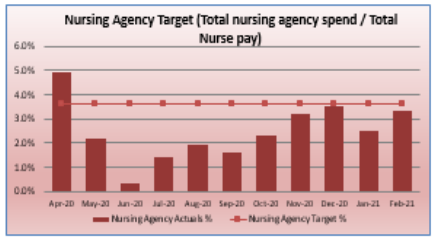
£ 5 Our Pounds Summary — 5.1 Overall financial position

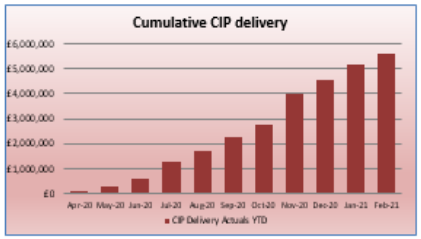
NHS
The Princess Alexandra Hospital
NHS Trust

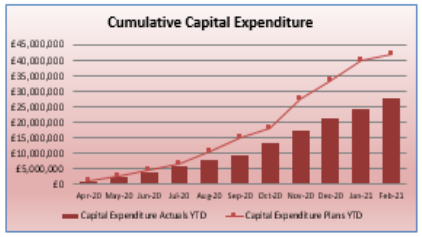
OUR POUNDS		
Metric	Annual Plan	YTD Actuals
Surplus/(Deficit)	-£391,000	-£128,972
Agency Spend £s	-£10,292,000	-£8,809,576
Bank Spend £s	TBC	-£19,401,545
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3.6%	3.3%
Capital Expenditure	-£43,089,000	-£27,814,000
BPPC Volume	95%	87%
BPPC - £s	95%	88%
Cash Balance	£1,000,000	£89,814,000

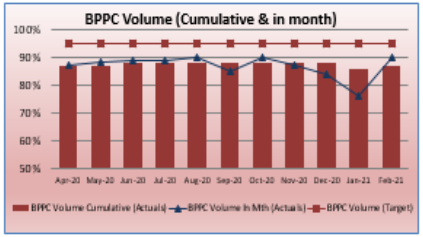


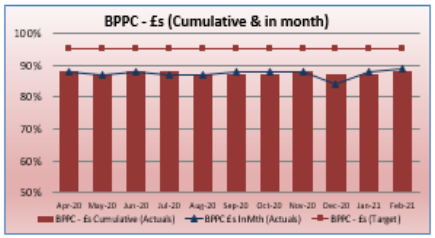


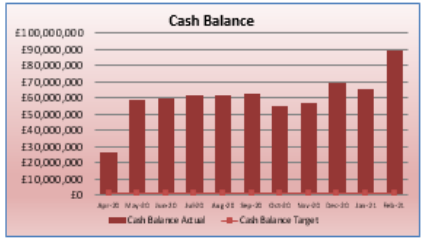












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CQC Rating

NHS
The Princess Alexandra Hospital
NHS Trust

CQC

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

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

CQC Inpatient Survey (OS)

20 June 2019

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

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

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5.1

The Princess Alexandra Hospital NHS Trust

Meeting of Board of Directors – 1 April 2021

Agenda item:	6.1
Presented by:	Michael Meredith – Director of Strategy
Prepared by:	Michael Meredith – Director of Strategy
Date prepared:	24 March 2021
Subject / title:	Trust Board Update

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:	Updates are provided regarding: • Ongoing work to finalise design and reduce size and cost • Alignment of enabling works with Essex County Council • Engagement with the National programme • Public engagement • Timelines
Recommendation:	To discuss and note the provided updates

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

Previously considered by:	New Hospital Committee 22 March 21
Risk / links with the BAF:	BAF risk (3,5) “New Hospital”
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	1. Public engagement programme

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The Princess Alexandra Hospital NHS Trust

1.0 Purpose

To update members regarding progress on the New Hospital project.

2.0 Design and Cost

Work continues to finalise the size and cost of the new hospital.

The fourth iteration of department layouts (1:200) will be presented to all user groups w/c 12 April, with the intention of having all departments signed off by the end of April. This will be followed by formal clinical sign off by the end of May.

A full elemental cost update is underway including the identification of target savings for Value Engineering (VE) and Modern Methods of Construction (MMC). All design disciplines and all design components have been challenged to identify betterment savings that do not compromise the design, model of care or operational effectiveness of the new hospital, and VE workshops have been scheduled.

Ability to achieve the savings will be tested further as the OBC is concluded and then throughout the FBC process.

Essex Partnership University NHS Trust (EPUT) confirmed they could not commit to moving to the new hospital site. This required several masterplan layout changes, most notably the training and development building being relocated to the west of the site.

3.0 Enabling Works

The new site requires the following infrastructure to unlock the new hospital:

- Highways access off Campion's roundabout to be achieved prior to construction start.
- Harlow Town Gas Main to be diverted by the early phases of main hospital construction.
- Electric supply to site prior to construction start, then connection of the new hospital substation to the power network.

3.1. Highways Access. PAH is working closely with Essex County Council (ECC) and their contractor to ensure works are delivered within the planning permission already granted for the M11 new Junction 7a. Where this cannot be achieved, an additional planning application will be made. ECC's contractor is currently collating revised instruction date(s). It is expected that future instructions will be sequenced as follows:

- Elements which can be undertaken within the M11 J7a planning consent – April 2021.
- Elements which require a new planning consent and PAH land acquisition – Q4 2021.

3.2 **Gas Main Relocation**. Cadent have provided an indicative programme from detailed design through to the gas main diversion becoming operational (the design and construction stages are summarised in the table below). PAH will need to commit funding ahead of each activity start date.

*Table 1. Cadent Gas timeline for gas main design and construction (*these dates pre-empt new hospital OBC approval).*

Activity	Start	End
Detailed design	April 2021*	November 2021
Procurement of materials	August 2021*	January 2023
Construction	February 2023	October 2023

3.3 **Electric Supply.** The current capital cost estimate includes an allowance for provision of electric power to the site. UK Power Network (UKPN) propose that PAH's capacity request will be met by connecting the new hospital site to Rye House via the West Harlow Grid. Hoare Lea (the Trust's advisers) have been tasked to provide formal quotations, expecting the Trust will need enter into commitments by mid-Summer 2021.

4.0 Engagement with the National Programme

A round table discussion was held on 25 Feb 21 for PAH with the leadership of the national programme (Craig McWilliam and Natalie Forrester). A good discussion took place, during which the Trust outlined its plans, and in return the national team confirmed some policy and priority items for Trust consideration. Informal feedback received since the event has been positive and the Trust is looking forward to receiving formal feedback.

5.0 Public Engagement

Please see Appendix 1 for a summary of public engagement events already held and planned up to mid-2021.

6.0 Timelines

- Target date for OBC submission: 7 Oct 21
- Target date for FBC submission: Oct 22 (assuming OBC approval)
- Target date for FBC approval: Apr 23 (assuming 6 months)
- Target date for construction to start: May 23.

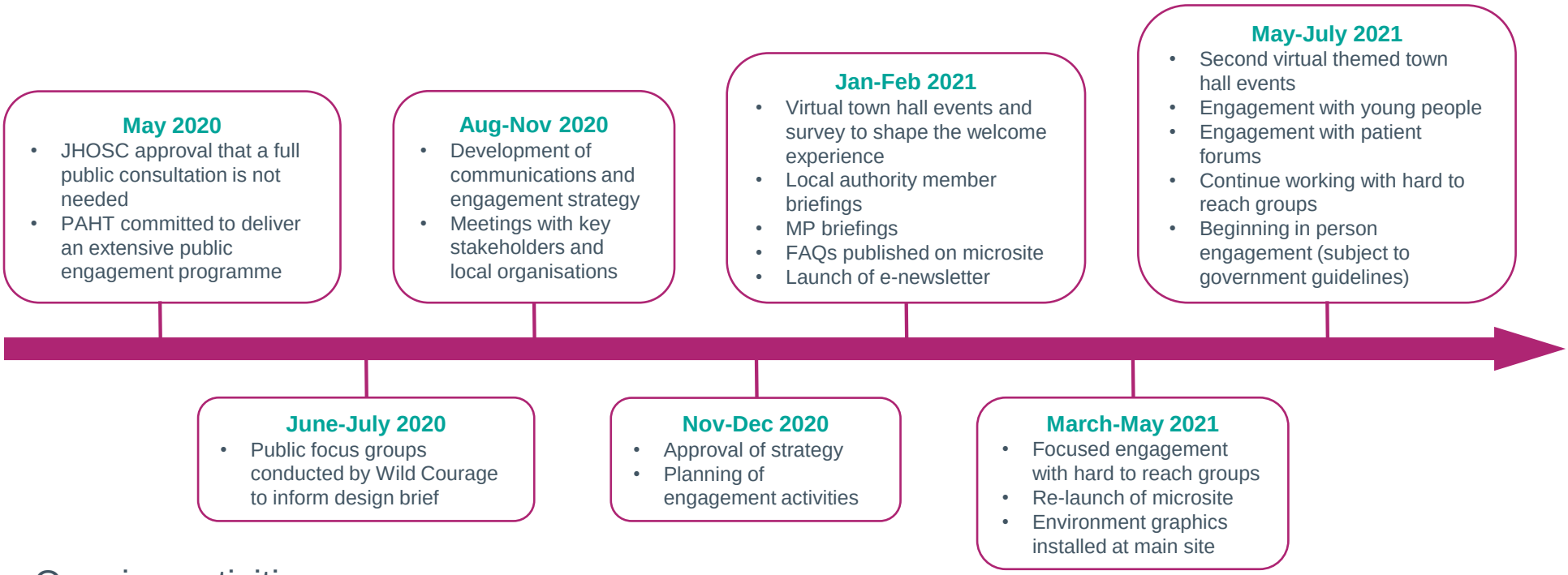
7.0 Recommendation

The Board is asked to note the updates provided.

Author: Michael Meredith
Date: 24 March 21

Public engagement programme

The New Princess Alexandra Hospital



Ongoing activities:

- developing **a network of contacts** to support delivery
- **social media** updates, **staff briefings** and **press releases**
- **e-newsletter** updating on latest news and engagement opportunities
- monthly **stakeholder group** and monthly **DHSC/HIP hospitals communications leads group**

January public engagement

The New Princess Alexandra Hospital

406 members of staff attended or viewed an internal briefing

95% of people rated PAH's second event excellent or very good

229 people attended one the virtual public events

715 hits on the frequently asked questions

80,000 views across PAH social media channels

Eventbrite

over **4,000 views** on the event page

230 responses to the online survey

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01/04/2021 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: George Wood – Chair of Audit Committee

DATE OF COMMITTEE MEETING: 08/03/2021

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
IA Progress report: Eight audits had been finalised since the last meeting. The Head of Internal Audit Opinion was unavailable due to delays in completion of the audit of the programme due to Covid, but an indication was given that the opinion would be one of reasonable assurance. **Internal Audit Plan for 2021/22:** The plan was approved. **LCFS progress report:** The report was noted and the Counter Fraud Plan for 2021/22 was approved. **External Audit Plan for 2021/22:** The plan was approved. **Registers of Interest and Gifts and Hospitality:** The Committee received the registers and approved them for publication subject to minor changes. **Waivers and losses:** During the period 01.11.20 to 31.01.21 • The value of losses for the period had totalled £36k (12 cases) • Waivers during the period had totalled £1,003,054 (44 cases) • Debt write-offs were £30k (1,133 cases).
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 Thursday 27 May 2021.

7.1

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01.04.21 **AGENDA ITEM NO: 7.1**

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

REPORT FROM: John Keddie – Associate Non-Executive Director

DATE OF COMMITTEE MEETING: 10.03.21

SECTION 1 – MATTERS FOR THE CORPORATE TRUSTEE/TRUST BOARD'S ATTENTION
The following items are escalated for noting: • The financial position was noted; total fund balances at M10 were £748k. During the period the charity received income totalling £361k and incurred expenditure of £255k. • Fundraising Business Plan was approved. • The Butterfly Hub update was received and it was noted the full costing of the project needed further discussion prior to it being approved. • A bid for funds for the Carer Support Role (18 month fixed term contract) that was previously discussed in November 2020, was updated following receipt of a second tranche of funding from NHS Charities and was approved subject to further discussions around future funding for the role at the end of the fixed term contract. The following reports were received: • Fundraising update – the committee commended the work done to date by the Trust's newly appointed Head of Fundraising. • Charity Risk Register
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The CFC is making good progress against its annual work plan and will meet again on Friday 9 July 2021.

7.1

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NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01.04.21 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM: New Hospital Committee (NHC)
REPORT FROM: Lance McCarthy (Committee Chair)
DATE OF COMMITTEE MEETING: 22.03.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **Land Sale:** Negotiations are ongoing with the land owners and their agents.
- **Capital/Area Update:** A full elemental cost update had been undertaken since the last reporting period and a revised capital cost estimate had been generated. Huge progress had been made to reduce the schedule of accommodation (and associated costs) and clear next steps and have been identified to continue over this process over the next month.
- **Enabling Works:** The Board has previously committed to £630k of enabling works of the total of £3.9m required. Timings for future commitments will be confirmed with national colleagues and relevant papers will then be provided for NHC, PAF and Board approval.
- **System Infrastructure Developments:** An update was provided on the aligned work across the wider system, including the St Margaret's site, West Essex Local Estates Forum, Mental Health facilities and the future provision of PAHT services on sites other than the main site.
- **Standing Items/Programme:** The national new hospital programme would be undertaking a 'key findings' workshop on 14.04.21 which would concentrate on three areas: 1) Size of building (looking at demand and capacity modelling and development of the SoA) 2) Design (how the SoA had been translated into design) and 3) Costings. All three elements should provide assurance for all that elements were on track and that any gaps/omissions would be identified.

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

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

- No additional items

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

A work plan is being developed.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01.04.21 **AGENDA ITEM NO: 7.1**
REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Pam Court - PAF Chairman
DATE OF COMMITTEE MEETING: 25.03.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **Business cases:** PAF reviewed and endorsed the following cases for approval by the Board:
  - ALEX Lounge/Mortuary
  - Training Facility
  - Williams' Day Unit
  - Dolphin Ward (Phase 1)

- **M11 Update** – revenue position reported a year to date deficit of £0.1m. This is £0.2m better than plan. Year to date capital spend is £27.8m which is £14m behind plan however there is a plan to spend the remaining capital (£18.6m) to achieve the capital resource limit by year-end. Cash balances are sufficient to meet 'trading' operations.

- **BAF Risks** – The following were agreed: BAF Risk 5.1 (Finance) risk score to remain at 16. BAF Risk 4.2 (ED 4 hour emergency standard) score to remain at 16 BAF Risk 1.2 (EPR) score to remain at 16 and BAF Risk 3.1 (Estate & Infrastructure) score to remain at 20 although improvements were noted. The Estates risk is the highest scoring risk on the BAF.

- **EPR outline business case:** PAF received a presentation on the outline business case for a new EPR (this will also be presented to Board members on 1.04.21).

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

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

- M11 Integrated Performance Report
- New Hospital update
- 2021/22 Interim Revenue Budget and Activity Plan
- Health and Safety update

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

BOARD OF DIRECTORS (Private)

MEETING DATE: 01.04.21 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)
REPORT FROM: Helen Glenister – QSC Chair
DATE OF COMMITTEE MEETING: 26.03.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

CQC Inspection of ED:

A very detailed discussion was held and the Committee was assured in terms of the comprehensive programme of work underway and detailed action plan (including associated implementation and monitoring plans). The draft report from CQC is awaited.

Members of the Urgent Care team presented the working draft of the action plan. The key element of leadership and accountability/responsibilities was also discussed. Ownership of the overall action plan and each of the actions was confirmed. The Committee requested evidence of improvements being made and of practices becoming embedded as the improvement work and audits move forward. For its next meeting the Committee requested a deep dive into the organisation's Quality Improvement Plan (CQC Must and Should actions).

BAF Risks:

The following were agreed: BAF Risk 1.0 (COVID) risk score to reduce from 20 to 16. The risk description had also been revised to reflect the impact of COVID on staffing levels, health and wellbeing, operational performance and patient outcomes. BAF Risk 1.1 (Clinical Outcomes) risk score to remain at 16.

System Discharge Deep Dive:

A very informative presentation was provided which illustrated how the organisation was working in conjunction with partners to do its very best for patients, and striving to improve further.

Mortality:

Risks in terms of the Mortality Improvement Programme were highlighted as 1) Learning 2) To Refresh the programme and embed the learning 3) Ensuring SJRs are undertaken and recruiting to substantive posts within the team. The detailed Mortality report is included on the public Board agenda.

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

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

- COVID-19 Update
  - Report from Infection Prevention & Control Committee
  - Infection Control: Monthly Update
- Report from Strategic Learning from Deaths Group
- Learning from Deaths Update
- Report from Patient Safety Group
- Monthly Patient, Safety, Quality & Effectiveness Report
- Maternity SI Report
- Maternity Incentive Scheme Update
- Report from Clinical Effectiveness Group
- M11 Integrated Performance Report
- Medicine HCG Performance Update

• Update on Nurse Staffing Levels (Hard Truths) • Patient Experience Update/Update from Patient Panel
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
• The Committee continues to make good progress against its work plan and reviewed the draft workplan for 2021/22.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01.04.21 **AGENDA ITEM NO: 7.1**
REPORT TO THE BOARD FROM: Senior Management Team
CHAIR: Lance McCarthy - Chairman
DATE OF MEETINGS: 09.03.21, 16.03.21 and 23.03.21

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at the SMT meetings held during March 2021:

9.03.21

- Quality, Safety and Effectiveness Report (as reported to QSC)
- Urgent & Emergency Care Pathway Refresh
- Staff Survey Results
- Back to Better campaign
- Trust values refresh
- Transformation update
- Clinical Digital Strategy
- HCG Restructure (for sign-off prior to consultation launch)
- Capacity Reset Plan – The Way Forward
- Significant Risk Register (pre-Board review)
- ICE/Pathweb switch-off
- Financial Update: M11 Update, M12 Highlights and Capital Update
- AI in Radiology Business Case

16.03.21 New Hospital SMT and business case review:

- New hospital: Land Update
- Workforce Assumptions
- Health Care Group re-structure
- Finance: Capital Programme and budget setting
- Business cases:
  - Training Facility
  - Oxygen
  - Williams Day Unit

23.03.21 Extraordinary SMT:

- EPR: Outline Business Case update

7.1