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 October 2020
09.00 – 11.45

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	4
	1.4	Matters Arising and Action Log	Review	All	11
02 Staff Story					
09.05	2.1	Staff Story	Inform		Pres
03 Risk					
09.30	3.1	CEO's Report including: • Covid-19 • Recovery and Restoration Plan	Inform	Chief Executive	12
09.40	3.2	Significant Risk Register	Review	Director of Nursing	17
09.45	3.3	Board Assurance Framework 2020-21	Review/ Approve	Head of Corporate Affairs	22
04 Patients					
09.50	4.1	New Hospital	Discuss/ Approve	Director of Strategy	37
10.15	4.2	Mortality	Discuss	Acting Chief Medical Officer	62
10.25	4.3	Ophthalmology	Assure	Chief Executive/ Executives	70
10.35	4.4	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing & Midwifery	73
		BREAK			
05 Performance					
10.50	5.1	Integrated Performance Report (IPR)	Discuss	Executives	82
11.10	5.2	East of England Regional EPRR Annual Assurance Report 2021	Approve	Chief Operating Officer	124
06 Governance					
11.15	6.1	Reports from Committees: • AC.07.09.20 and Terms of Reference • NHC.22.09.20 • PAF.24.09.20 • QSC.25.09.20 • WFC.28.09.20 • SMT.8.09.20	Inform/ Approve	Chairs of Committees	136 144 145 146 Verbal 148
07 Questions from the Public					

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11.30	7.1	Opportunity for Members of the Public to have a pre-submitted question answered.			
08 Closing Administration					
11.40	8.1	Summary of Actions and Decisions	-	Chairman/All	
	8.2	New Risks and Issues Identified	Discuss	All	
	8.3	Any Other Business	Review	All	
	8.4	Reflection on Meeting	Discuss	All	

Public Board Meeting Dates 2020/21

02.04.20	01.10.20
04.06.20	03.12.20
06.08.20.	04.02.21

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 2020/21

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	Acting Chief Finance Officer	Simon Covill
Chair of Quality & Safety Committee (QSC)	Dr. Helen Glenister	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Pam Court	Acting Chief Medical Officer	Marcelle Michail

Chair of Workforce Committee (WFC)	Helen Howe	Director of Nursing & Midwifery	Sharon McNally
Chair of Charitable Funds Committee (CFC)	Dr. John Keddie	**Executive Members of the Board (non-voting)**	
Chair of Strategy Committee (SC)	Dr. John Hogan	Director of Strategy	Michael Meredith
		Director of People	Gech Emeadi
		Director of Quality Improvement	Jim McLeish
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Virtual Trust Board Meeting in Public
Thursday 6 August 2020 from 10:15 – 11:45

Present:	
Steve Clarke	**Trust Chairman (TC)**
Pam Court	Non-Executive Director (NED-PC)
Simon Covill	Acting Chief Financial Officer (ACFO)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Helen Howe	Non-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)
Marcelle Michail	Acting Chief Medical Officer (ACMO)
George Wood	Non-Executive Director (NED)
In attendance:	
Dr. Amik Aneja	General Practitioner (GP-AA), Board Advisor
Members of the Public	
Trevor Arnold	Siemens Healthcare
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 Simon Covill in his capacity as Acting Chief Financial Officer (ACFO) and Trevor Arnold, member of the public. The TC stated he was pleased to update that Non-Executive Director John Hogan (NED-JH) had had his term of appointment extended until 31.07.23.
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 04.06.20	
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.
02 RISK	
2.1 CEO's Report (including COVID-19 and Recovery and Restoration Plan)	
2.1	The CEO presented his report which was taken as read. In terms of COVID-19 (which had been discussed on a number of occasions over previous months) he reiterated his thanks both personally and on behalf of the Board for the hard work of colleagues in what had been an amazing response to the pandemic. At its peak there had been over 200 positive cases in the hospital but that had now significantly dropped off over recent weeks with numbers now down to between 0-3 at any one time with generally only one patient on ventilation. There had been a huge amount of change for staff over recent months, the tragic loss of two staff members and over 200 deaths within the hospital. There had been a huge amount of support put in place for staff particularly in relation to testing. Plans were now in place for the coming months in the build up to winter and the possibility of a second

	wave of COVID-19. Work was underway in terms of space requirements and learning from events in the first wave. There continued to be reduced diagnostic and elective activity although the majority of cancer activity had been maintained along with urgent surgery. This was now starting to impact on performance in terms of 52 breaches which now numbered more than 150 currently and the Chief Financial Officer (CFO) was leading on the recovery work.
2.2	The Chief Operating Officer (COO) updated that in terms of recovery she would like to extend her thanks to the clinical and operational teams who were working hard to recover performance standards across all areas. Diagnostics was one of the standards that (prior to COVID-19) was consistently achieved in the organisation. Detailed projections were now being worked up utilising all available capacity both internally and externally and it was hoped that performance would be back on track around Christmas time, albeit that would be challenging in terms of social distancing requirements.
2.3	The COO continued that in terms of elective performance patients on the waiting list had all been risk stratified and those waiting over 52 weeks were now being clinically reviewed. The vast majority of those were classified as 'priority 4' and were being reviewed by their GP in terms of alternative options and whether or not surgery was still required. Most were under the trauma and orthopaedic speciality. Any patient waiting outside the required standard would have a harm review undertaken and where appropriate, their case taken to a risk forum.
2.4	In relation to Cancer performance the focus was now on demand and capacity for the Endoscopy Service and the organisation was in the throes of developing a third Endoscopy room and to share resources locally. The Director of Quality Improvement (DoQI) was able to add there were also weekly regional discussions and a weekly task and finish group to address the current issues.
2.5	The COO informed colleagues that a Phase 3 Recovery letter had been received from Sir Simon Stevens, CEO of the NHS the previous week. The targets set out in the letter were challenging and teams were working hard to set their own internal trajectories. In terms of elective performance the expectation nationally was that activity would start to be restored around November/December which would be challenging for the organisation in terms of available capacity on site and social distancing requirements. The weekly Recovery Cell remained in place along with the weekly Access Board and thrice weekly Elective Activity Cell.
2.6	In response to the above NED-JH asked whether all revised trajectories were predicated on a second COVID wave not occurring. In response the COO confirmed a range of scenarios had been considered and a winter planning event was scheduled for September with Nursing and Infection Control colleagues to review capacity requirements.
2.7	At this point the Director of People (DoP) updated members that personal COVID risk assessments for staff were now at 84.4% (BAME staff at 78.7%) and those staff who were now returning to site after shielding were also being captured.
2.8	In response to a question from NED Helen Howe (NED-HH) in relation to the revised Cancer trajectory the COO was able to confirm there were detailed trajectories across all the tumour sites. The Cancer Board continued to be well attended and it was hoped that performance would return to the required standard around December, subject to Endoscopy capacity.
2.9	In relation to the letter from Sir Simon Stevens, the Acting Chief Financial Officer (ACFO) was able to add that it also referenced a change in financial arrangements. The retrospective top-up payment would continue for the next few months after which the block contract would continue with STP allocations for COVID. In summary some change would be seen from Month 6 albeit the numbers had not yet been confirmed. In the meantime the risk score in relation to the organisation's risk around finance would remain at 20 while the position continued to be uncertain.
2.10	At this point the CEO drew members' attention to page 12 of the pack which referenced the huge amount of estates change currently underway. The capital programme that year was huge (£45m) with most work vital to support the flow of patients and create a high quality

	environment for both staff and patients. Elements of that programme included a designated staff area, expansion of the multi-faith space and to provide a training and education facility at Parndon Hall by the end of the year. There had been much learning from the first wave of COVID and that would now be used to sustain facilities through to the move to a new hospital.
2.11	In terms of the new hospital work was progressing well and a clear steer/expectation had now been given in terms of pace for the HIP1 schemes. The options for the Outline Business Case (OBC) had been agreed which included the Trust's preferred way forward (new hospital on a greenfield site) and the organisation was still on track to deliver that OBC by the end of March 2021. The New Hospital Committee was working well (in terms of governance around the programme) and the engagement programme (including a new micro-site) had commenced, with a very positive response so far.
2.12	The Director of Strategy (DoS) was able to further update that clinical engagement in the programme to date had been significant with robust discussions particularly around Tteatres and clinical space. Key outputs that week would be the development of the clinical model and the demand and capacity analysis. Dialogue continued with both the ICS and West Herts. Hospital to ensure assumptions were aligned and to develop the Schedule of Accommodation (SoA) which was almost complete. Work would continue at pace to deliver the 2025 deadline and the team would remain close to regional colleagues and the other HIP1 organisations. Work around the digital strategy continued and good progress was being made.
2.13	In response to a question from NED Helen Glenister (NED-HG) the DoS was able to confirm that engagement to date had mainly been around the design brief for the new hospital, the outputs of which would be presented to September's Board. There would be a presentation in the private session that day on the emerging outputs of that but there were no gaps per se. A new Comms/Engagement Lead had just been appointed for the new hospital and a detailed plan would now be delivered and rolled out over the next couple of months. The Stakeholder Group would continue to meet monthly.
2.14	NED-HH asked a question in relation to the anticipated capital spend on the current site that year (£45m) and whether there were emerging plans around the use of the current site once the new hospital was in use. In response the DoS confirmed the team were working closely with Commissioners in terms of location of services as a whole (which ones to remain on the current site), and particularly the location of the Urgent Treatment Centre (UTC).
2.15	As a final point the CEO was able to update Board members on Executive appointments. Fay Gilder would join the Trust as Chief Medical Officer (CMO) in November and he extended huge thanks to the Acting CMO (Marcelle Michail) for her contribution during what had been an unprecedented time for the Trust. The Chief Financial Officer/Deputy CEO (Trevor Smith) had secured a role with EPUT and would leave the organisation at the end of August. His thanks were also extended to him for his work over the previous seven years. Interviews had taken place the previous day for a Chief Information Officer but no appointment had been made.
2.16	The TC thanked the CEO for a very informative update and added his thanks to staff for their valued contribution over previous months. The recovery work plan discussed above in terms of resuming services and delivering performance should not be underestimated. As a final point he endorsed the CEO's thanks to both Marcelle Michail and Trevor Smith.
2.2 Significant Risk Register	
2.17	This item was presented by the Director of Nursing & Midwifery (DoN&M). She highlighted there were no risks scoring 25 but there were 33 with a score of 20. Most related to the need for new equipment and mitigation was currently in place. Significant work was underway around how risks were reflected across the organisation and the Risk Management Strategy was under review. The format of the paper would change going forward.

	In summary the paper was a good news story for the organisation because whilst there were significant risks on the register, the majority would be addressed by the Capital Programme and would reduce risks by 50% by the end of the year.
2.18	As a final point she drew members' attention to an error in the table at point 2.2 (figures did not add up) which would be corrected for the next iteration.
2.19	In response to a concern raised by NED-JH about some of the clinical equipment risks and whether these were being addressed, the DoS confirmed the Capital Programme was being reviewed in terms of how capital was allocated against the risk ratings. The DoS acknowledged there was still more work to be done and it would require the HCGs to clearly identify their risks going forward.
2.20	NED-HH raised a concern around oversight of those risks currently at 15/16 which may be about to tip over to 20. In response the DoN&M confirmed oversight was robust. The Risk Management Group continued to meet monthlywith representatives from the HCGs and Corporate Services. Local risks were presented and reviewed, the outputs of which then informed the paper presented that day.
2.21	The TC thanked the DoN&M for her update.
2.3 Board Assurance Framework	
2.22	This item was presented by the Head of Corporate Affairs (HoCA) who informed members there were no proposed changes to the risk scores that month and all risks had been reviewed by the relevant Board Committees. One item to highlight was that a new risk had been added around potential delays to the delivery of the new hospital. The DoS would be the Executive Lead for that risk and it had been reviewed at New Hospital Committee (NHC) and had a current risk score of 16.
2.23	The DoS added that the risk had been added to the Risk Registers of all HIP1 organisations. Mitigation would be by means of sustaining pace and pressure and engagement with the construction market. In response to a question it was confirmed the Trust's scheme was the only one which was a new build on a greenfield site.
2.24	The CEO flagged there had been some media interest in the new hospital risk but in his view acknowledging the risk reflected good programme management.
03 PATIENTS	
3.1 Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	
3.1	This item was presented by the DoN&M who updated that in line with the shifting bed base and closures during COVID, the organisation had sustained a good fill rate which had enabled significant focus on staffing. The registered nurse demand for temporary staffing had been at circa 4000 shifts in January, but was now at circa 1000 in June. Recruitment continued but remained a risk. The vacancy rate was now at just over 8% and the ambition remained for Band 5 vacancies to be less than 2% by March 2021. That would require an additional 60 nurses and there were currently 84 in the pipeline. The domestic market was also being explored and it was expected some students would join the organisation in September which would also reduce the vacancy rate in Maternity with five new midwives. Work was also underway to fill some Band 6/7 vacancies.
3.2	The ACFO was able to confirm that in terms of temporary nurse spend, there had been a reduction of £0.4m between May and June.
3.3	In response to a question from the CEO in terms of how a vacancy rate of 8.5% compared with others, the DoN&M was able to confirm there was huge variability nationally but that rate sat well in comparison with regional organisations.
3.2 Mortality	
3.4	This item was presented by the ACMO who updated that the current position was that the SHMI continued to fall to 1.07 (with no significant diagnostic group) and was 'as expected'. However, HSMR remained 'higher than expected'.
3.5	Work continued with the Medical Examiners and structured judgement reviews (SJRs) and emerging themes were being discussed at QSC. The governance framework around the

	mortality reviews was being revised, starting with Mortality & Morbidity reviews. A prototype dashboard had been developed along with an options appraisal for a software solution which would enable the collection of real-time data to support the improvement work. A focus moving forward would need to be some work with the data analysts to understand why SHMI was reducing and HSMR was not.
3.6	As further assurance the DoQI was able to update that QSC the previous week had received a presentation on End of Life/Learning from Deaths. A medical assessment tool had been launched towards the end of COVID and in July 120 patient records had been audited with the outputs to be brought to a future QSC. The Deteriorating Patient work-stream had also been launched to provide oversight around AKI/Sepsis/vital signs. The Acting and Deputy CMO were meeting regularly to update and reassess the organisation's Mortality Improvement Plan which should be ready for presentation to QSC/ in September.
04 PERFORMANCE	
4.1 Integrated Performance Report (IPR)	
4.1	This item was introduced by the COO and key headlines under the organisation's 5Ps were as follows: <u>Patients</u> The DoN&M highlighted there was now an additional page within the document to track nosocomial infection rates for COVID. Some of the data gaps related to the suspension of national reporting in some areas but would resume over coming months. There was also now a section in the IPR for Mental Health, with an SLR in place with mental health partners to provide support and training in the organisation.
4.2	<u>Performance</u> Performance against the ED four hour standard had improved significantly over the previous month despite attendances now almost back in line with pre-COVID numbers. The new clinical standards for ED were due imminently and would be shared once formally released. In terms of winter planning, planning consent was awaited for the Medical Assessment Unit which would support the work around flow and Frailty. In addition there was work underway regionally in terms of the 111 Service which the COO herself was supporting and a number of areas were starting to pilot that work. She would keep colleagues updated. She was also supporting some work around the use of a capacity tool (SHREWD) to identify open capacity in the system.
4.3	In terms of ED performance the team had worked extremely hard and the organisation was now middle of the pack regionally, and in the top half for East of England trusts. Investment in expanded facilities by December would hopefully improve that performance further. As a final point it was confirmed the Trust was about to embark on its biggest 'flu vaccination programme ever.
4.4	<u>People</u> The DoP updated that although the organisation was currently compliant in terms of statutory/mandatory training, there was a significant portion of staff whose training would expire during September. The electronic training booklet had once again been issued in order to address that concern. In terms of recruitment data, time-to-hire was also a current focus and a new Head of Recruitment & Resourcing would be reviewing the data.
4.5	NED-HH asked whether, in terms of the cost of temporary medical staffing, it might be worth seeing the equivalent of the 'safer staffing report' for that cohort, in order to keep track of the spend. In response the ACMO stated that work had already started in conjunction with the Associate Medical Directors (AMDs) and also the Medical Director for NHSE/I in terms of a gateway programme, through which staff could be recruited. The CEO flagged that the temporary staffing action plan included medical staff.
4.6	<u>Places</u> The DoS requested that domestic staff be recognised for all their additional hard work during COVID, particularly with the significant number of staff (in that cohort) who were absent or shielding during the pandemic.

	He emphasised the significant backlog maintenance programme in place for the current year in order to make the hospital as safe as possible.
4.7	In response to the above the TC noted that every role mattered and expressed the Board's thanks to all staff for their contributions during the pandemic. The DoP requested that the volunteers also be included in that note of thanks.
4.8	Pounds The ACFO drew members' attention to page 77 of the pack which evidenced the organisation had been £100k off plan the previous month. The Trust was now heading for shortfalls on income and pressures on pay expenditure. Non-pay was currently underspent but would increase as elective activity recovered. There was work to do around capital spend, currently £3.7m ytd against an annual programme of £45m. A strong cash resource position was facilitating accelerated supplier payment and performance against seven-day payments. The revenue position remained uncertain. In response to a question in relation to the oversight of capital spend it was confirmed there were monthly milestones and a lead for each individual scheme.
05 GOVERNANCE	
5.1 Reports from Committees	
5.1	New Hospital Committee (NHC) – 27.07.20 As chair, the CEO confirmed the discussion had been around progress and pace so that key deliverables could be achieved. He updated there had been agreement (via the Options Appraisal Workshop) on the long list of options for OBC in line with Treasury Green Book process. There was a requirement nationally to undertake a BAU (business as usual) option which, for the Trust, was the current site. As mentioned earlier a new risk had been added to the BAF (delays to delivery of new hospital) and the Committee's terms of reference (ToR) had been slightly amended and approved. In line with the recommendation, Board members approved the Committee's revised ToR.
5.2	In response to a question from NED-GW in relation to any decision to go with single rooms for the new hospital, the CEO confirmed that would depend upon layout, visibility and technology. A shift to 100% single rooms would require changes to the way that staff worked and would have revenue implications. The architect had come up with some innovative ways to improve visibility. He flagged that the use of single rooms would help make any future hospital 'pandemic-proof'. In response to a concern raised by NED-HH the CEO confirmed that if any elements of the build became unaffordable from a capital/revenue point of view then assumptions would need to be reviewed/revised. NED-PC stated she had heard mixed reviews on the use of single rooms. In response the DoN&M provided assurance there was a raft of information which would inform the Trust's decisions and the organisation was currently working its way through that. . Infection control considerations would play a big part as would affordability.
5.3	Quality & Safety Committee (QSC) – 31.07.20 NED-HG highlighted the Committee had heard about the new NICE guidance in terms of elective pathways, and had been pleased to hear about the preparations for winter planning and any potential second COVID wave. It had welcomed the update that there had been a deep dive into SJRs prior to and during COVID with considerable learning on EoL care which would now support improvements for patients within the community. There had been an update on the progress against capacity issues in the Ophthalmology service and in terms of the number of Trust-wide complaints, the annual number had reduced from 206 in 2019/20 to 172 in the current year. QSC had also received an Annual Quality Governance report (for the first time) which had been helpful in identifying areas for future improvement. The Medicines Optimisation Strategy had been presented but delivery in some areas had fallen behind due to COVID so QSC had requested a further update on progress in six months.
5.4	Performance & Finance Committee (PAF) – 30.07.20 NED-PC updated there had been an in-depth discussion around the STP consolidation of Procurement services and PAF had supported the business case for investment in

	Domestic and House-Keeping services. PAF had been taken through the costs of the new hospital OBC.
5.5	Workforce Committee (WFC) – 27.07.20 NED-HH informed members that WFC had been updated on Staff COVID risk assessments and the OD Plan had been approved. The update on the Culture Improvement Programme and People section of the Recovery & Restoration Plan had been reviewed and supported (for discussion at a future Board Development session).
5.6	Senior Management Team (SMT) – 28.07.20 The CEO updated that all items discussed at SMT had either been escalated or discussed earlier in the meeting.
5.2 Report to Corporate Trustee/Trust Board from CFC.08.07.20	
5.7	Corporate Trustee (CT) – 08.07.20 Associate NED John Keddie (ANED-JK) updated that the key headline had been the approval of a Head of Fundraising post, to be funded from the general purpose fund (circa £67k) and to be a Band 8 post. The Committee had also approved the purchase of some chairs/trolleys for NICU.
5.8	In response to a point raised by NED-HH, it was agreed that opportunities for linking the Trust's volunteers to the charity would be reviewed.
5.9	The DoP flagged that NHS Charities monies had been used to support the health and wellbeing of staff during COVID in the provision of a 'First Class Lounge' service for staff.
5.10	In response to a point raised by NED-PC it was agreed to take the conversation around the banding of the Head of Fundraising post offline.
ACTION **TB1.06.08.20/05**	**Discuss the banding of the Head of Fundraising post offline.** **Lead: Associate NED John Keddie/NED Pam Court/DoP**
06 QUESTIONS FROM THE PUBLIC	
6.1	There were no questions from the member of public present.
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, other than the new hospital risk which had been added to the BAF (see minute 2.22 above).
7.3 Any Other Business (AOB)	
7.3	The COO informed members that the Staff Brief on a Tuesday mornings had now resumed and encouraged members to join where possible. The CEO added it had been agreed staff would be updated on any feedback following Board meetings. The messages that month would be: • The valued contribution of staff and volunteers over the previous four months. • The progress made on reducing nursing and midwifery vacancies. • Resumption of activity over coming months and associated challenges. • The importance of the 'flu vaccine for staff.
7.4 Reflection on Meeting	
7.4	Members agreed they were becoming more familiar with the technology required to support virtual meetings.

Signed as a correct record of the meeting:	
Date:	01.10.20
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 01.10.20

	A	B	C	D	E	F	G
1	**Action Ref**	**Theme**	**Action**	**Lead(s)**	**Due By**	**Commentary**	**Status**
26	TB1.04.06.20/02	Queen's Award	Send a letter of congratulations to the Patient Panel for their Queen's Award.	Chairman/ HoCA	TB1.06.08.20	Actioned.	Closed
27	TB1.06.08.20/05	Head of Fundraising Post	Discuss the banding of the Head of Fundraising post offline.	Chair CFC NED PC DoP	TB1.01.10.20	Actioned.	Closed

The Princess Alexandra Hospital NHS NHS Trust

3.1

Trust Board – 1 October 2020

Agenda Item:	3.1
Presented by:	Lance McCarthy – CEO
Prepared by:	Lance McCarthy – CEO
Date prepared:	25 September 2020
Subject / Title:	CEO Update

Purpose:	Approval		Decision		Information		Assurance	

Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting: - Performance highlights - COVID-19 response and recovery and winter planning - New hospital - Executive Director appointments - AGM and Events not in a Tent
Recommendation:	The Trust Board is asked to note the CEO report.

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

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

Chief Executive's Report
Trust Board: Part I – 1 October 2020

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

(1) Key performance headlines

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

Key Performance Indicator	Actual performance for latest month (August)	Comparison to last report
ED 4-hour performance	85.8%	↓ (worse); target = 95%
SHMI	105.9 (Mar 19 – Apr 20	↑ (better); as expected
C. Diff (hospital onset)	4	↑ (worse)
MRSA	0	→
Never Events	0	→
Incidents reported	1,017	↑ (worse)
No harm / minor harm incidents	96.9%	↑ (better)
Falls / 1,000 bed days	9.5	↓ (better)
6-week diagnostic standard	65.6%	↑ (better); target = 99%
Stat Man training	86.0%	↓ (worse)
Temporary staff % of pay bill	13.5%	↓ (better)
Staff turnover	9.96%	→

(2) COVID-19 response and recovery and winter planning

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 pandemic. There was an enormous amount of change in a very short space of time, with a large number of people working differently, in different teams, different locations and undertaking different roles, all to support our patients.

Response to the COVID-19 pandemic

In line with national guidance, to help manage the COVID-19 pandemic, we ceased elective operating (except for cancer cases and urgent cases) in March.

We, along with other Essex hospitals, experienced a very significant number of cases early in the pandemic and made a huge number of changes to how the hospital was run, co-ordinated and laid out to ensure we could maintain the safety of our patients and our colleagues. In addition to creating a separate 'red' Emergency Department for patients presenting with COVID-19 symptoms, we realigned our bed base and wards geographically in the hospital to create, as much as possible, a COVID-19 part of the hospital and a non-COVID-19 part of the hospital. We also significantly enhanced our critical care capacity and moved more than 90% of our outpatient consultations to virtual, many online.

At our peak, in April, our ventilated capacity for known COVID-19 patients was at almost 650% of our normal ventilated capacity, and at one point we had in excess of 150 positive COVID-19 patients being cared for in the organisation.

To date we have treated more than 500 patients with a positive COVID-19 test. Sadly 211 patients have died in our hospital as a result of COVID-19.

Over recent weeks we have started to see an increase in the number of patients presenting to the Trust with COVID-19 symptoms and an increase in the number of confirmed positive COVID-19 cases.

Impact of COVID-19 on services

We have some significant pressures currently in terms of patients waiting for diagnostics and for elective surgical interventions. For the first time in more than two years, we have patients who have been waiting for more than 52 weeks for their routine surgery, more than 200 in total, many of which are waiting for elective orthopaedic procedures.

We also have significant pressure and 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. We have expanded our endoscopy, CT and MRI capacity significantly to support the management of cancer patients.

In addition to our capacity, we are working closely and well with our independent sector colleagues at The Rivers and a number of other providers to maximise access to key services so that we can restore timely services to all of our patients.

All patients who have been waiting for longer than they would do normally are being reviewing by the relevant clinical team and reprioritised where relevant on a regular basis to ensure that we manage everyone's care and priority effectively and safely.

We have detailed and clear plans to get back up to more than 90% of our usual day surgery capacity by the end of September and inpatient elective capacity by November.

Referrals to PAHT for suspected cancer fell significantly during the height of the pandemic and I'm pleased that the rate of referral for suspected cancers has largely returned to pre-COVID-19 levels over the last 6 weeks.

Similarly, the demand for urgent care through our Emergency Department feel sharply through March and April, starting to pick up in May and is now up to 90% - 95% of pre-COVID-19 levels. Our performance against the 4-hour standard has been much improved over the last 4 months and consistently higher than 85% of patients seen, treated, admitted or discharged within 4 hours.

Routine GP referrals to the Trust however remain low, with recent weeks about 20% lower than normal pre-COVID-19 levels.

We will continue to communicate with the local population to try to provide assurance that our services and facilities are safe to use.

Restoration of services and winter planning

We are working well with health and care colleagues across West Essex to restore our services quickly and safely to pre-COVID levels, particularly focussed on the urgent cases and longest waiters.

As we move into the winter and the probability of a 2nd peak of COVID-19 cases, we are undertaking a significant amount of estate changes on the PAH site to support our patients and our colleagues. We are:

- about to start building work on a new facility to be co-located to Charnley Ward to enable us to co-locate all our urgent care assessment and provide a new model of care for patients. A new 2-storey building will be part open in December and fully open in January
- will also be reorganising the facilities on the ground floor next to our Emergency Department (ED) to provide enhanced frailty assessment space and support the speedier and better flow and care for our older people attending our ED

- have created the ability for us to have separate level 3 critical care facilities for known COVID-19 cases and confirmed non-COVID-19 patients
- created a Level 1 facility
- opening our on-site fracture clinic space in the autumn
- building a long awaiting high quality staff area (Alex Lounge)
- expanding our multi-faith space for colleagues and patients

All the above changes are planned to be in place and operational during 2020.

All system colleagues are working well together to plan for winter and a potential second COVID-19 peak. Other winter preparation includes the important ability to provide all our colleagues with access to the 'flu vaccination. Our vaccination programme has started and learning from last year's campaign as well as recent COVID-19 testing has been taken to ensure that we are able to quickly and effectively mobilise colleagues to provide the vaccination to all our people.

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

Staff support and testing

Whilst the number of patients attending the hospital fell significantly over recent months, the demands of treating COVID-19 patients have been significant and 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 and in particular I'd like to thank Essex Partnership University NHS Foundation Trust (EPUT) for the mental health and wellbeing support that they have provided for our colleagues.

To support the ongoing pandemic, 78.3% of our people have been tested for COVID-19 antibodies and vitamin D levels. 21% have antibodies detected, although this does not guarantee immunity, and 37% have either a deficient or insufficient level of vitamin D and have been advised to use supplements.

The results show some, but not significant, variations between professionals and departments. For example our scientists and administrative teams having slightly lower levels of antibody positive results than other colleagues.

As with the national picture, our staff from a BAME background have had a higher incidence rate of contracting COVID-19 than non-BAME colleagues with 28.6% of BAME colleagues tested returning positive antibody test results compared with 17.3% of our non-BAME colleagues.

All colleagues have been encouraged to complete a personal COVID-19 risk assessment to support decisions to maximise their health and wellbeing. At the time of writing this paper 92% of all colleagues had completed this with their line manager.

(3) New hospital

Work is progressing at pace on the development of the new hospital and hasn't slowed despite the management of the COVID-19 pandemic. We remain on track to complete an Outline Business Case by March 2021.

The clinical leadership and engagement to develop the new models of care has been fantastic and the output of this, together with the demand and capacity assumptions and the technology and partnering strategy are later on the agenda. Our demand and capacity assumptions are aligned with Hertfordshire and West Essex ICS' medium term financial plans and have been formally approved by West Essex CCG.

The schedule of accommodation has been developed as a result and is going through an iterative process of challenge to ensure that we can meet the expected future demands for services as cost effectively as possible. The 5-year transformation and modernisation plans to support the new models of care as part of our local ICP clinical strategy are also being developed.

Our engagement programme with colleagues and with the public started in August; the new hospital microsite is being visited on a regular basis and further focus groups are planned for the autumn and winter.

We remain in regular fortnightly formal discussions with regional NHSE/I colleagues and frequent formal discussions with national NHSE/I and DHSC colleagues and our timeline to completion remains challenging and ambitious with Full Business Case to be completed by June 2022, enabling us to have built relevant new facilities by the end of 2025.

(4) Executive Director appointments

By the time of the Trust Board we will have interviewed for our vacant Finance Director role and I will update on the appointment at the meeting.

We were unsuccessful in recruiting to our new Executive Director role, a Chief Information Officer in early August and are rethinking how we cover this key role to support our Chief Clinical Information Officer (CCIO) and all clinicians to ensure we invest in the right technology for our patients, including a new Electronic Patient Record.

With Trevor taking up the Chief Financial Officer role at Essex Partnership University NHS Foundation Trust, Sharon McNally, Director of Nursing, Midwifery and AHPs, has agreed to take on the Deputy Chief Executive responsibilities for the Trust in addition to her current role.

(5) AGM and Events not in a Tent

The first virtual AGM in the history of the Trust was held on 10 September and was attended by nearly 100 people, from both within and outside of the organisation. It was an opportunity to reflect on the challenges and the success of 2019/20 and to recognise the changes and service developments that have been implemented to benefit our patients. It was recorded in full and is available to view on our YouTube channel.

The COVID-19 pandemic has changed many things in all our lives and we are working very differently in most of what we do. Our annual 3-day Event in a Tent (EiaT) staff celebration and engagement event is no different. Over the last 3 years we have developed and expanded the range of events and this year, to ensure we can maintain social distancing we have gone virtual.

The 3-days of Events Not in a Tent run this year from 28 – 30 September and include a range of both live and pre-recorded events, covering staff health and wellbeing and mental health, updates on the new hospital development, quality improvement focussed discussions, culture sessions, long service awards, our amazing people staff awards, guest speakers about change and a session with Ruth May, Chief Nursing Officer for England. There will also be daily Executive team briefings and opportunities for colleagues to take part in quizzes, exercise classes and win a range of prizes. All events will be recorded and accessible via our YouTube channel for colleagues to engage with if they are unable to make the live events. It will be a fantastic 3 days and the biggest, best and most inclusive of our 4 EiaT so far!

Author: **Lance McCarthy, Chief Executive**
Date: **25 September 2020**

The Princess Alexandra Hospital NHS Trust

3.2

Trust Board (Public): 01.10.20

Agenda item:	3.2
Executive Lead:	Sharon McNally - Director of Nursing, Midwifery and Allied Health Professionals
Prepared by:	Lisa Flack - Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Governance & Quality Finola Devaney – Director of Clinical Quality Governance
Date prepared:	23 September 2020
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 number of significant risks has reduced from 117 in August to 96 significant risks with a score of greater than 15 in September. There are 0 risks with a score of 25. The three main themes for the 21 risks that score 20 are relating to Operational issues (4), backlog maintenance (6) and need for new equipment (3). See section 2.4 to 2.9 for actions and mitigations in place. In line with the new quality governance structure we are reviewing how risk is managed as an organisation, which includes a refreshed training programme.
Recommendation:	Trust board is asked to i) Note the content of the Significant Risk Register

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

Previously considered by:	Risk Management Group reviews risks monthly as per annual work plan New Ways of Working Group (SMT) - adjustment to risk rating and
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

The Princess Alexandra Hospital NHS Trust

3.2

1.0 INTRODUCTION

This paper details the Significant Risk Register (SRR) across the Trust; the registers were pulled from the web based Risk Assure system on 7 September 2020. 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 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 and includes all items scoring 15 and above. The risk score is arrived at using a 5 x 5 matrix of consequence x likelihood, with the highest risk scoring 25.

In line with the new quality governance structure we are reviewing how risk is managed as an organisation with additional training been provided to staff on how we to manage risks at a local level.

2.2 There are 96 significant risks on our risk register which is a decrease from (117) in the previous paper discussed in August Trust Board. The breakdown by service is detailed in the table below.

	Risk Score				
	15	16	20	25	Totals
COVID-19	3 (2)	0 (0)	2 (2)	0 (0)	**5 (4)**
Cancer, Cardiology & Clinical Support	10 (10)	1 (3)	3 (3)	0 (0)	**14 (16)**
Estates & Facilities	10 (11)	10 (11)	0 (1)	0 (0)	**20 (23)**
Finance	0 (0)	1 (0)	0 (0)	0 (0)	**1 (0)**
Information Data Quality and Business Intelligence	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
IM&T	0 (1)	2 (2)	0 (0)	0 (0)	**2 (3)**
Non-Clinical Health & Safety	2 (2)	1 (1)	0 (0)	0 (0)	**3 (3)**
Nursing	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Operational	1 (1)	0 (0)	4 (4)	0 (0)	**5 (5)**
Patient Safety & Quality	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Research, Development & Innovation	0 (0)	2 (1)	0 (0)	0 (0)	**2 (1)**
Resilience	1 (1)	0 (0)	0(0)	0 (0)	**1 (1)**
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Child Health	1 (1)	1(0)	2 (5)	0 (0)	**4 (6)**
Safeguarding Adults	0 (0)	0 (0)	1 (1)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	1 (1)	0(0)	0 (0)	**1(1)**
Women's Health	4 (5)	1 (0)	0 (0)	0 (0)	**5 (5)**
Medicine	2 (5)	7 (9)	3 (4)	0 (0)	**12 (18)**
Surgery	4 (10)	4 (4)	6 (13)	0 (0)	**14 (27)**
Totals	**40 (51)**	**35 (33)**	**21 (33)**	**0 (0)**	**96 (117)**

(The scores from paper presented at Trust Board in August 2020 are detailed in brackets)

2.3 There are 21 risks with a score of 20; this has decreased from 33 in the July 2020. A summary of these risks is below and all new risks identified since July are detailed:-

2.4 Our Patients

2.4.1 EPMA system

- To reduce risk of incorrect does of medication being given, the prescriber has to apply dose reductions in a specific way on the EPMA system (CMS/2019/360 on register since January 2019)
- To reduce risk of incorrect does of medication being given, the prescriber has to apply dose reduction of oral chemotherapy on each different administration day on the EPMA system (CMS/2019/383 on register since February 2019)
- Manual validation of every action performed by each new visions of EPMA is required as fixed issues on previous versions become live again (temporary RR1 raised in February 2020).
  Actions: Communications shared with prescribers and drug administrators for the steps/actions they need to take to mitigate these risks. Continuous mitigations need to be performed by pharmacists, nurses and doctors on the system. The suppliers and the trust are in continued dialogue for the next version planned in November 2020.

2.4.2 Surgery: Purchase a dermatome used for skin grafting in theatres
(The002/2020 raised February 2020)
Action: Order submitted in June, awaiting delivery, delivery date not yet received.

- Purchase additional Medisoft modules to have one for each of the ophthalmology specialities cared for in the Trust (OPH005/2019 initially raised May 2019, score adjusted May 2020)
  Action: Business case accepted in May 2020, order raised. Company will build the system to fully integrate with Cosmic and other Trust IT systems. Anticipate delivery in approx. 6 months and aiming for use by February 2021. The current software will continue to be used until the new system is available.

2.4.3 Endoscopy:

- To comply with national guidance Trust needs to purchase 3 drying storage cabinets for endoscopy/colonoscopies (Endos15 raised February 2020)
  Action: Drying cabinets fitted and now undergoing 30 days of testing to confirm compliance. Expected to be completed by end of September and following this can be used.

2.5 People

2.5.1 Medical staffing

- Paediatric registrar rota is not compliant with national standards as there is 1.5 WTE posts vacant. (CH02/2020 on register since March 2020, score adjusted April 2020)
  Action: Associate Nurse Practitioner and Locums are in place to ensure rota achieves compliance. Recruitment is ongoing

- **NEW:** Safety risk with not having in place an out of hours GI bleed rota (Endo 08 initially raised October 2016, score amended August 2020 after discussion within Medicine Board meeting
  Action: Completed the upper GI bleed proforma, care bundle and SOP. A consultation is planned to develop an in-house GI bleed rota, dates to be confirmed.

2.6 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.
- Two risks for Medicine about achievement of the ED four hours standard (MED57 on Medicine register since July 2016) and (ED012 on Medicine register since July 2016)
  Actions: Rapid assessment and treatment process monitoring flow through department. 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.

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.

2.7 Places - Environment

2.7.1 Theatres: 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 leaks into the consumable/drape store (THE005/2019 initially raised on 31/10/19)
- Roof leak into Theatre 1 (THE 006/2019, initially raised on 31/10/19).
- Roof leak into Theatre 6 roof leaks (THE 007/2019, initially raised on 31/10/19).
- Theatre 7 roof leaks (THE 008/2019, initially raised on 31/10/19).
  Action: Discussed at Capital Working Group 22/6/20, estates team require a feasibility study to be completed prior to a date being set for repair of both theatre roofs. The surgery team will need to review and adjust the planned activity to keep the theatres free to allow the completion of repairs.

- **Safeguarding:** Refurbishment required to the portacabin 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 into on site at PAH.

- **Penn ward**: requires refurbishment. (Penn001/2020 raised January 2020)
  Action: Capital funding requested for completion of work during 20/21. Awaiting confirmation if this has been approved.

2.8 Pounds

2.8.1 No finance risks detailed

2.9 Covid - The Covid risks are not listed on the Allocate Register

- A surge of patients requiring critical care, will result in the need to increase the numbers of staff working in the area, who will have limited knowledge of critical care (C19-33 raised April 2020)
  Action: Critical care bed capacity capped at 16. Additional patients will be transferred to partner trusts. Critical Care nurses will be available to oversee care for all patients and model of care will be in line with the four nation's pandemic ICU guidelines.

- Use of anaesthetic theatre machines (off label as long-term ventilator for ICU patients has received regulatory clearance). It is the sole responsibility of the device owner (the Trust) and is a risk. (C19-34 raised April 2020)

Action: All controls are in place and are effective. Trust has requested 40 additional ventilators from NHSE

3.0 New Risks on the Significant Risk Register

3.1 No new significant risks with a score of 15 or 16 have been raised since August 2020.

4.0 RECOMMENDATION

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

Your future | Our hospital

The Princess Alexandra Hospital NHS Trust

Trust Board - 1 October 2020

3.3

Agenda Item:	3.3							
Presented by:	Head of Corporate Affairs - Heather Schultz							
Prepared by:	Head of Corporate Affairs - Heather Schultz							
Date prepared:	23 September 2020							
Subject / Title:	Board Assurance Framework 2020/21							
Purpose:	Approval	x	Decision		Information		Assurance	
Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Board Assurance Framework 2020/21 is presented for review. Risks, risk ratings and outcomes of Committee reviews in month are summarised in the attached appendix and detailed BAF risks as at the end of September 2020 are also attached. There are no changes to the risk scores this month.							
Recommendation:	The Board is asked to approve the Board Assurance Framework.							

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

Previously considered by:	WFC, PAF, QSC, New Hospital Committee in September 2020.
Risk / links with the BAF:	As reflected in the attached BAF.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with national legislation and regulations and the Code of Governance.
Appendices:	Appendix A summary, and Appendix B - Board Assurance Framework 2020/21

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5P	Executive Lead	Committee	BAF Risks July 2020	Current risk score	Trend
	Chief Executive	QSC	1.0 Covid-19: Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered.	16	
	Chief Nurse/Chief Medical Officer	QSC	1.1 Outcomes:Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	16	
	Chief Finance Officer/DoI&IT	PAF	1.2 EPR Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes	16	
	DoP	WFC	2.3 Workforce: Inability to recruit, retain and engage our people	12	
	DoS	PAF	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	
	DoS	Trust Board/ Strategy Committee	3.2 Financial and Clinical Sustainability across health and social care system Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system.	16	
	DoS	Trust Board/ Strategy Committee	3.3 Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	12	
	DoS	Trust Board/ Strategy Committee	3.4 Sustainability of local services Failure to ensure sustainable local services continue whilst the new hospital plans are in development and funding is being secured.	16	
	DoS	Trust Board/ New Hospital Committee	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 forth coming from the JIC even if the 3 conditions are met	16	
	COO	PAF	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	16	

	CFO	PAF	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	20	

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.	Causes: i) Highly infectious disease 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 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 STP 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 surgery	i) Incident Management Team Meeting ii) Strategic Incident Management Cell iii) IPC Cell iv) Site Management Cell v) Communications Cell vi) People Cell vii) Recovery Cell viii) Clinical Cell	i) Incident management action and decision logs ~~(daily)~~ ii) QSC updates (March, to September 2020) iii) Trust Board updates (March, to August) iv) Recovery Plans and submissions	**4x4=16**	i) Loss of staff with key skills and training due to virus; shielding/isolating or sickness ii) Reliance on supplies nationally iii Modelling information for next peak (local, regional and national) dependant on lock down and public behaviour v) Plans for use of the Rivers	~~Compliance with risk assessments.~~	Sep-20	No change to risk score.	**5x2=10 (April 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		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 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 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) Red2 Green Board rounds supported by ECIST xiii) Patient Experience Strategy xiv) NED lead appointed for Mortality xv) Mortality Strategy including dashboard, tracker, updates on workstreams and learning from deaths. xvi) '15 steps' walkabouts xvii) Nursing Establishment review (bi-annually) and succesful nursing recruitment campaign xviii) Safer Staffing policy xix) Real time patient feeback implemented across all wards xx) Robust management of variations in neonatal outcomes xxi) Engagement in external reviews MBRRACE,HSIB and LeDeR and Healthcare Safety Investigation Branch (maternity) xxii) Medical examiners (MEs) and Lead ME appointed and Mortality Surveillance Group established xxiii) Complaints workshops held xxiv) Joint GIRFT and Model Hospital quality improvement programme xxv) Patient flow module live xxvi) Electronic fluid prescribing pilot live xxvii) Appointment of medical PS&Q leads xxviii) Complaints process being revised and grading system introduced xxix) Fab Change accreditation xxx) Quality peer review process in place xxxi) Covid-19 governance structure/meetings in place xxxii) OD Plan agreed at WFC (June 2020)	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 March 2020, monthly Serious Incidents, monthly Safer Staffing, Patient Panel (bi-monthly) , Safeguarding, monthly Infection Control and Covid-19 updates 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 draft June 19) and GIRFT reports v) Real time Dr Foster reports and engagement vi) GMC Survey results (July 2019) and WFC report June 2020 vii) Clinical Audit internal audit report 18/19 - tiaa (limited assurance) viii) CMO/CFO Coding Meetings and 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 (March 20) and Guardian of Safe Working reports to Trust Board (Dec18). xi) Patient stories and learning from deaths presentations to Public Board meetings (bi-monthly) xii) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) xiii) International Nurse Recruitment business case to SMT/PAF and Board (June/July 19) xiv) Presentation to QSC on documentation and strategic direction to having one electronic system (QSC February 20) xv) Critical care network review peer review April 2020 xvi) TARN review (QSC September 2020)	**4x4=16**	Lack of modernisation in some reporting processes including: i) Clinical audit plan developed and to be implemented - improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site footprint and bed constraints iv) Access to Qlikview v) NICE oversight and management of compliance with guidance vi) Frequency and consistency of approach to mortality reviews vii) **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey action plan in place iii) Ongoing work with Dr Foster in relation to mortality ~~iv) Review of quality/safety and risk leadership structure~~ v) NHS Patient Safety Strategy 2019 published. Trust to review and align to best practice vi) Structured Judgement Review champions appointed	i) Clinical evidence of improvements made following compliance with national audits, NICE,NCEPOD. ii) Demonstrating an embedded learning programme from Board to ward.	14/09/2020	Risk rating not changed	**4x3=12 ~~September~~ December 2020**
			Effects: i) Increase in complaints/ claims or litigation ii) Persistent poor results in National Surveys iii) Poor reputation iv) Recurrent themes in complaints involving communication failure v) Loss of confidence by external stakeholders vi) Higher than expected Mortality rates											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 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 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 Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iv) Performance Mgt Framework in place. v) Training programme. vi) Super users in place to deliver focused support. vii) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability viii) Access Policy ix) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) x) Development of capacity planning tools/information xi) PWC review and actions identified xii) ICT Newsletter issued xiii) Daily ICT/COSMIC meetings ongoing xiv) Real time data now available xv) CDS 011 now live xvi) Maternity MDS configuration completed. xvii) Monthly Contract Performance monitoring meeting with supplier established.	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews vii) Monthly EPR Board to Board meetings ~~viii) Exec to Exec meeting on 25.11.19.~~	i) Weekly Data Quality reports to Access Board and EDB ii) Monthly DQ reports to PAF and quarterly ICT updates to PAF (September 2020) iii) EPR outline business case developed and presented to SMT and PAF September 19.	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Compliance with refresher training vii) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed. Responsiveness and quality of delivery of PFM - testing processes and actions identified by tiaa internal audit (limited assurance).	Sep-20	Risk rating unchanged	**4x3=12 end of ~~March~~ November 2020 (subject to monthly review of progress)**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** i) Ongoing training and support ii) Re-establishing relationship/engagement with Cambio iii) Refresher training underway iv) Revised roadmap to incorporate new statutory/legal requirements e.g GDPR v) Recruitment of CIO			

Risk Key		
Extreme Risk		15-25
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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	**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 Effects: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation	**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 xvi) Additional recruitment ('Bring back staff') during Covid xvii) Provision of Health and Well-being support during Covid-19 including psychological support. xviii) Communications Strategy approved June 2020	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 (WFC March 2020) iv) Staff friends and family results (WFC March 2020) v) Medical engagement surveys, action plans and GMC surveys (WFC November 2019 and June 2020) vi) WRES and WDES reports 2020 vii) OD Framework approved (WFC June 2020) viii) Culture update (WFC June 2020)	**4 x3 = 12**	Pulse surveys targeted for all staff Communications strategy Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Roll out of e-rostering to all areas ~~Management of staff health and well-being during and post Covid~~ Actions ~~i) Implementation of communication strategy – Q3 2020/21~~ i) Recruitment plans for medical staff ii) Extranet for staff - Q1 20/21 iii) Staff survey action plan:health and well being, manager development and learning culture (Q2 20/21) ~~v) Ongoing psychological support for staff to be put in place - Covid-19~~ iv) Completion of risk assessments (target of 100%) - Q2 ~~vi) OD plan to support PAHT 2030 – Q3~~ ~~vii) Refresh of culture plan - Q3~~ v) Review of raising concerns (FTSUG's, champions for bullying and harassment, senior inclusion lead)	None identified.	15/09/2020	**Risk score not changed.**	**4 x2 = 8 (at end of 5 year People Strategy but to be reviewed in December 2020)**

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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		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 4= 20**	Director of Strategy **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report received (£105m) iii) Potential new build/location of new hospital iv) Capital programme - aligned to red rated risks. v) STP Estate Strategy developed and approved. vi) Modernisation Programme for Estates and Facilities underway vii) Robust water safety testing processes viii) Annual asbestos survey –completed and red risks resolved. ix) Trust's Estate strategy being developed x) Annual fire risk assessment completed and final report received, compliance action plan being developed. xi) New estates and facilities leadership team in place x) Sustainability Manager in post xi) Emergency Capital funding £4.3m xii) Compliance Manager appointed xiii) Significant capital programme for year c.£40m	i) PAF and Board meetings ii) SMT Meetings iii) Health and Safety Meetings iv) Capital Working Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings ~~viii) Project Genesis Steering Group~~	i) Reports to SMT (as required) ii) Signed Fire Certificate iii) Annual H&S reports to Trust Board and quarterly to PAF. ~~v) Ventilation audit report~~ ~~vi) Water Safety Report (PAH site)~~ vii) Annual and quarterly report to PAF: Estates and Facilities September 20 - quarterly report) viii) IPR monthly ix) Annual Sustainability report to PAF (June 20) x) Internal Audit report (tiaa) - review of PPM (limited assurance report) - Audit Committee Dec 2019, action plan in place xi) Capital projects report (PAF Feb and June 20)	**5x4=20**	i) Planned Preventative Maintenance Programme (time delay) ~~and amber backlog maintenance risks now emerging red risks~~ ii) Ventilation systems iii) Sewage leaks and drainage iv) Electrical Safety/Rewiring (gaps) v) Maintaining oversight of the volume of action plans associated with compliance. **ACTIONS:** i) EBME review underway ii) Review of estates function underway ~~iii) Compliance action plan (including PPM) in place~~	i) Estates Strategy /Place Strategy developing within STP ii) Compliance with data collection and reporting iii) PPM data not as robust as required ~~iv) PAM assurance not robustly updated.~~	01/09/2020	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

Risk Key														
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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		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iii) The resources required for delivery at a programme and workstream level have not been defined or secured iv) The current governance structure is under development given the shift in focus from planning to delivery. v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS Strategy Committee	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) STP Estates Strategy being developed. viii) STP Clinical Strategy in place ix) STP wide Strategy Group implemented x) Independant STP Chair and independant STP Director of Strategy appointed. STP 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 2020) iii) STP report to Strategy Committee (Oct 2019) ~~iv) STP lead's presentation to Trust Board (Aug '19).~~	**4 X 4= 16**	Lack of STP demand and capacity modelling. **ACTIONS:** System agreement on governance and programme management System leadership capacity to lead STP-wide transformation ~~Trust to nominate representatives on proposed STP/ACP workstreams~~		01/09/2020	**No changes to risk rating.**	**4x3=12 December 2020**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

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		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			
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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 Jan 2020 and August 2020	**4x3=12**	i) Data quality impacting on business intelligence (SLR) **ACTIONS:** PAH long term strategy being developed	Development of governance structures for integration and legislation CCG Accountable Officer process completed and new management structures.	01/09/2020	**Risk rating not changed.**	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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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
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		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,			
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	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 New Hospital Committee	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)	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 established	i) STP reports to Strategy Committee (bi-monthly) ii) Reports to SMT iii) STP work plans iv) Our New Hospital reports to Strategy Committee (Oct 2019 and updates to Board (August and September 20). v) PAHT 2030 report to Trust Board (April 2020) vi) PCBC approved at Trust Board (September 2019)	**4 x 4 = 16**	i) Balancing short term investment in the PAH site vs the required long term investment ~~Availability of clinical and non-clinical staff to provide input on plans during Covid.~~ **ACTIONS:** Clinical strategy being developed and underpinned by 5P plans	i) Clinical strategy in development	01/09/2020	**No change to residual risk rating.**	**4 x 3 =12** **March 2021 (on completion of OBC)**
			Effects: i) Failure to deliver strategy and transformation project and service changes required for service and performance enhancement ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant vii) Poor patient experience, viii)Backlog maintenance ix) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health. x) Lack of integrated approach xi) Increased risk of service failure xii) Impact on throughput of patients												

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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.	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	**5 X 4= 20**	Director of Strategy New Hospital Committee	i) Soft market testing underway (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	i) New Hospital Committee ii) Trust Board iii) External advisory meetings as required. Iv) New Hospital SMT meeting (September 2020)	i) Monthly reports to Trust Board and New Hospital Committee. (September 2020) Ii) Letters of support received from HOSCs. iii) Verbal confirmation received that programme management structure is appropriate. Iv) Expert advice received on procurement strategy.	**4x4=16**	Negotiations with landowners ~~in the early stages.~~ Actions: Soft market testing progressing and a bidders day planned	None.	Sep-20	**Risk score not changed.**	**3x3=9 (Nov 2020)**
			Effects: i) Significant delay/failure to deliver hospital by 2025 deadline ii) Increase in Capital costs through inflation iii) Delivery of a suboptimal hospital											

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**	**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) Gaps in ~~medical and nursing~~ workforce iv) Lack of public awareness of emergency and urgent care provision in the community. v) Attendances continue to rise annually (5.1% over the last 2 years). vi) Changes to working practice and modernisation of systems and processes vii) Delays in decision making, patient discharges and ~~delays in social care and community~~ impacting on flow viii) Increases in minor attendances	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management ~~v) Escalation calls with NHSI~~ vi) Work in progress to develop new models of care vii) Local Delivery Board in place viii) System reviewing provision of urgent care ~~ix) Exec attendance at safety huddles~~ x) ED action plan reported to PAF/Board xi) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries ~~xii) Protection of assessment capacity work underway~~ xiii) Weekly Urgent Care operational meetings and Urgent Care Board in place ~~xiv) On site support from ECIST and NHSI medical lead~~ xv) Focus on length of stay in ED for all patients ~~xvi) Focus on improving assessment capacity~~ ~~xvii) GP attending weekly length of stay review meetings~~ ~~xviii) Covid controls in place including separation of ED, new pathways in place, reduced ED attendances~~ xix) Improved ambulance handover process and improved staffing levels xx) Assessment unit build commenced 2020	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) Escalation meetings with NHSI/NHSE~~ ~~vii) Weekly HCG reviews~~ viii) System Operational Group ix) Weekly Length of Stay meetings x) Urgent Care Board	i) Daily ED reports to NHSI ~~ii) Monthly escalation reports to NHSE~~ iii) Monthly PRM reports from HCGS iv) Monthly IPR reported to PAF/QSC and Board reflecting ED performance ~~- delivery of standard has improved in the 4 weeks prior to review of risk.~~	**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.	01/09/2020	**Risk score not changed.**	**4x3 =12 December 2020 (on consistent delivery of standard - 95%)**
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 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 and 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)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2019/20 and our local system control total													
BAF 5.1		**Finance** Concerns around failure to meet financial plan including cash shortfall.	Causes:The adapted Financial Regime adopted Nationally during Covid involves fixed Block contract payments with 'Top Up' arrangements in place to ensure Trusts breakeven. These arrangement are expected to be in place until at least M5 of the financial year. These arrangements suspend Payment By Results and Control Totals ensure breakeven is met and sufficient cash resources are in place to meet operational activities. Productivity, efficiently, cost control and strong financial governance arrangements remain in place. There does remain uncertainty over National regime arrangements from m6 onwards. Uncertainty around the level of income recovery during months 7-12, including trading income reimbursement mechanisms.	**5 X 4= 20**	**Exec leads :** ACFO **Committee** : Performance and Finance Committee	i) Cash Management Group ii) Capital Working Group iii) Exec led Temporary staffing group iv) SMT, PAF and Audit Committee v) Health Care Group PRM meetings vi) Covid cost sign off process vii) Approved Governance Manual iix) Interim Budget approved ix) Two Weekly Cashflow Reporting to NHSI/E x) Monthly Regulatory returns xi) STP Capital oversight group xii) Recovery and Restoration cell	i) Internal Audit Reports ii) External Audit opinion. ii) External reviews iii) NHSI/E reporting iv) Internal Trust reporting v) Cash Forecasts vi) CIP Tracker	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 vii) Recovery plans and trajectories reported to Recovery cell viii) Temporary staffing action plan (Board July 20)	**5 x 4 = 20**	i) Organisational and Governance compliance e.g. waivers ii) Activity and capacity planning iii) CIP delivery and PMO function iv) Embedding management of temporary staffing costs	Demand and Capacity Workforce planning	18/09/2020		4 x 3 =12 (Q4 2020)
			Effects: i) Ability to meet future financial control target and recovery Financial Recovery Funds. ii) Impact to pay supplies within 7 days iii) Impact on Going Concern opinion iv) Impact on capital availability v) Unfavourable audit opinion (VfM,Section 30, UoR)							**ACTIONS:** Modernisation business case complete - approval sought. Recovery and restoration cell, Demand and Capacity Planning and Modelling to be regularised Clinical and operational forums in place to review QIPP schemes. Intensive support for job planning, rota and roster management. Review of CIP/PMO processes Collective Executive targetting of temporary staffing				

The Princess Alexandra Hospital NHS Trust

Meeting of Board of Directors – 1 October 2020

4.1

Agenda item:	4.1
Presented by:	Michael Meredith – Director of Strategy
Prepared by:	Richard Robinson - Ankura
Date prepared:	23 September 2020
Subject / title:	New Hospital

Purpose:	Approval	x	Decision		Information		Assurance	

Key issues:	The new Hospital Programme is delivering at pace and we are on target for OBC completion for March 2021. A number of key deliverables have been completed and are ready for Board approval. All documents have been approved by the New Hospital Committee, Senior Management Team (SMT) and the Executive Management Team (EMT). The Design Brief is a working document and will evolve overtime. Trust Board approval is sought on the following: • Demand & Capacity modelling • Models of Care • Technology & Partnering Strategy • Design Brief
Recommendation:	To approve the selected products and note the updates.

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:	New Hospital Committee Senior Management Team Executive Management team Clinical leads new hospital programme
Risk / links with the BAF:	BAF risk (3,5) “New Hospital”

Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	1. Demand & Capacity 2. Models of Care (for Board members this is available in Resources Area, and for members of public this will be available on the Trust's New Hospital microsite) 3. Technology & Partnering Strategy (for Board members this is available in Resources Area, and for members of public this will be available on the Trust's New Hospital microsite) 4. Design Brief (for Board members this is available in Resources Area, and for members of public this will be available on the Trust's New Hospital microsite) 5. High Level Programme 6. Schedule of Key Deliverables

1.0 Purpose/Issue

To seek Trust Board approval on specified New Hospital Programme key deliverables, and to update members on the New Hospital programme generally, including programme key risks and milestones.

2.0 Demand & Capacity Modelling

Approval is sought for the Demand and Capacity (D&C) modelling summarised at Appendix 1, comprising:

- Demographic & non-demographic growth, including age adjusted 2018 ONS demographic projections plus planned residential developments. The revised ONS growth projections for the local authority areas within PAH catchment are lower than the 2016 projections.
- Operational assumptions, such as utilisation, operating weeks, days & hours and LoS assumptions
- Activity changes such as changes in setting (e.g. inpatient to day case procedures) and reductions in elective, non-elective and outpatient activity aligned to STP & MTFP
- Other models of care changes and recent experience from our pandemic response (e.g. shift to virtual consultations)

D&C modelling was assured through review by the following internal and external stakeholders:

- Internal:
  - Information Team – 14th July
  - New Hospital Clinical, Operational & Nursing Leads – multiple meetings July
  - Healthcare Group Triumvirates – multiple meetings July
  - Executive Management Team – 7th August 2020
  - Senior Management Team – 14th August 2020
  - New Hospital Committee – 22 September 2020
- External:
  - Alignment with West Herts – 24th July 2020
  - E&NH & WE Joint CCG Modelling meeting – 13th August 2020
  - East & North Hertfordshire CCG Executive meeting – 17th Aug 2020 ust
  - East & North Hertfordshire CCG Governing Body – 27th August 2020
  - West Essex CCG Governing Body – 3rd September 2020

The next steps involve supporting clinical teams to review how the demand & capacity modelling translates into specific rooms and spaces in the Schedule of Accommodation (SoA) and overlaying the SoA with patients flow, clinical service delivery and workforce patterns to ensure the space supports improved patient/clinical care.

3.0 Models of Care

Approval is sought for the Models of Care (MoC) summarised at Appendix 2. The MoC were developed following a n extensive engagement programme across a wide range of clinical workstreams. Each workstream comprised of clinical and non-clinical staff from both PAH and across the system including community and primary care and a range of commissioners. The MoC focuses on the future role of the hospital:

- as a ‘nerve centre’ ensuring best and most appropriate use is made of specialist services whilst promoting self-care and integrated care

- moving activity away from the acute sector (where appropriate), but with secondary care co-ordination and support to the wider system

The MoC is underpinned by six key platforms which will drive innovation and continuous improvement:

- Remote consultation
- Remote surveillance and monitoring
- Machine learning and artificial intelligence
- Decisions aids
- Precision
- A Learning Health System

The Learning Health System approach will buffer PAHT against any imprecision in predicting future scientific, technical or digital developments by facilitating adaption to new and emerging technologies when they arise.

The main risk for the Trust (and wider System) is the scale of transformation required over the next 5 years and beyond as it moves toward building and opening the new hospital.

The MoC was assured through review by the following internal and external stakeholders:

- Internal:
  - New Hospital Clinical, Operational & Nursing Leads – multiple meetings July
  - Executive Management Team – 7th August
  - Senior Management Team – 14th August
  - New Hospital Committee – 22 September

- External:
  - East & North Hertfordshire CCG Executive meeting – 17th August
  - East & North Hertfordshire CCG Board – 27th August
  - West Essex CCG Board – 3rd September

Next steps include working with the ICP and ISC to develop a transformation plan to support the movement to the new models of care, the out-of-hospital strategy and deliver the System's demand management assumptions.

4.0 Technology & Partnering Strategy.

Approval is sought for the Technology & Partnering Strategy at Appendix 4. This document sets out:

- The vision – to become the leading digital hospital in the country when we open in 2026
- Key enablers – such as the need to become paperless
- Links to models of care – showing how technology will support our new ways of working
- Foundation technology – such as need to invest in cloud based computing and modern network and telephony solutions
- Technologies that need to be installed with the new building – such as AGVs, pneumatic tube systems, patient infotainment, airport style check in systems and digital twin
- Supporting technologies – including dispensing robots, closed loop mediation systems, hospital operation hub, AI, VR and AR solutions.

It is clear that the Trust will need a wide range of new skills and capabilities to fully deliver our ambition. Therefore, the strategy describes how we need to formulate our partnering strategy to identify those organisations and companies that can help deliver this vision:

- Instilling a digital culture and sharing the vision
- Investing in digital transformation as part of a wider organisation development programme
- Assessing our readiness for the journey and investing in change management methods and solutions
- Planning and building the digital foundation that our vision is based upon
- Undertaking further work on our partnering strategy as part of the OBC work.

The Technology & Partnering Strategy was assured through review by the following internal and external stakeholders:

- New Hospital Programme IMT & Digital Project Lead – 10 August 2020
- New Hospital Clinical, Operational & Nursing Leads – 11th August 2020
- ICT Senior Management Team Check and Challenge
- ICT Board Review & Sign Off – 20th August 2020
- Clinical Digital Design Senate Review & Sign Off – 27th August 2020
- EMT Review & Sign Off – 10th September 2020
- SMT Review & Sign Off – 15th September 2020
- New Hospital Committee – 22 September 2020

Interesting perspectives and challenges to our approach were received and need to be fully considered as we continue with the development of our amazing new hospital including: the need for a robust organisation development programme to be launched; whether quick wins could be deployed early; whether a best in breed EPR strategy should be followed; and where do we go to find reference sites to understand the art of the possible and inspire our people.

5.0 Design Brief

Approval is sought for the Design Brief at Appendix 5.

Inputs have been provided by patients, staff, stakeholders and technical advisors to provide the technical needs of the building and its plans as well as the tone and experience that our patients, visitors and community partners seek and have expressed so passionately.

The Design Brief was assured through review by the following:

- EMT – 10 Sep 2020
- SMT – 15 Sep 2020
- New Hospital Committee – 22 Sep 2020

Once approved this document will be shared with our design team who will take the content and translate it into plans and designs for the new hospital. It is important to note that this is a working document that will change over time as our ambition for the new hospital develops.

6.0 Programme Risk

Since the last meeting, the main changes to programme risk are:

- One newly identified and assessed risk was added to the risk register (K38, Revenue Affordability - 15)
- Three existing risks were upgraded:

- B3 Unforeseen Ground Conditions (new mitigated score Amber 9)
- K11 Land Acquisition (new mitigated score Red 15)
- K31 Lack of a Common Data Environment (new mitigated score Amber 9)

Red risks (post mitigation) have increased from 2 to 4:

- K10 Contactor Procurement (16)
- K11 Land Acquisition (15)
- K14 PWF not funded (15)
- K38 Revenue Affordability (15)

Amber 12 risks (post mitigation) have increased from 4 to 6:

- A6 Failure to build to brief
- K5 Judicial Review
- K8 Highways and transport implications
- K22 Incorrect demand & capacity modelling
- K23 Delay in appointing HR & Workforce lead
- K31 Lack of Common Data Environment

7.0 Progress against Milestones

Please see Appendix 6 for an updated high level programme view and Appendix 7 for a schedule of Key Deliverables.

NHSEI has asked for a more detailed programme plan for business case approval through CCG, system, Trust committees and Board. This will be worked up over the coming days.

Key Deliverable 9 (EIA Screening Report) will not now be achieved by 30 Sep 20 as we do not have an official site boundary agreed or scheme footprint fix. Action is in hand to agree a new target date with the LPA via a PPA.

4.1 APPENDIX 1

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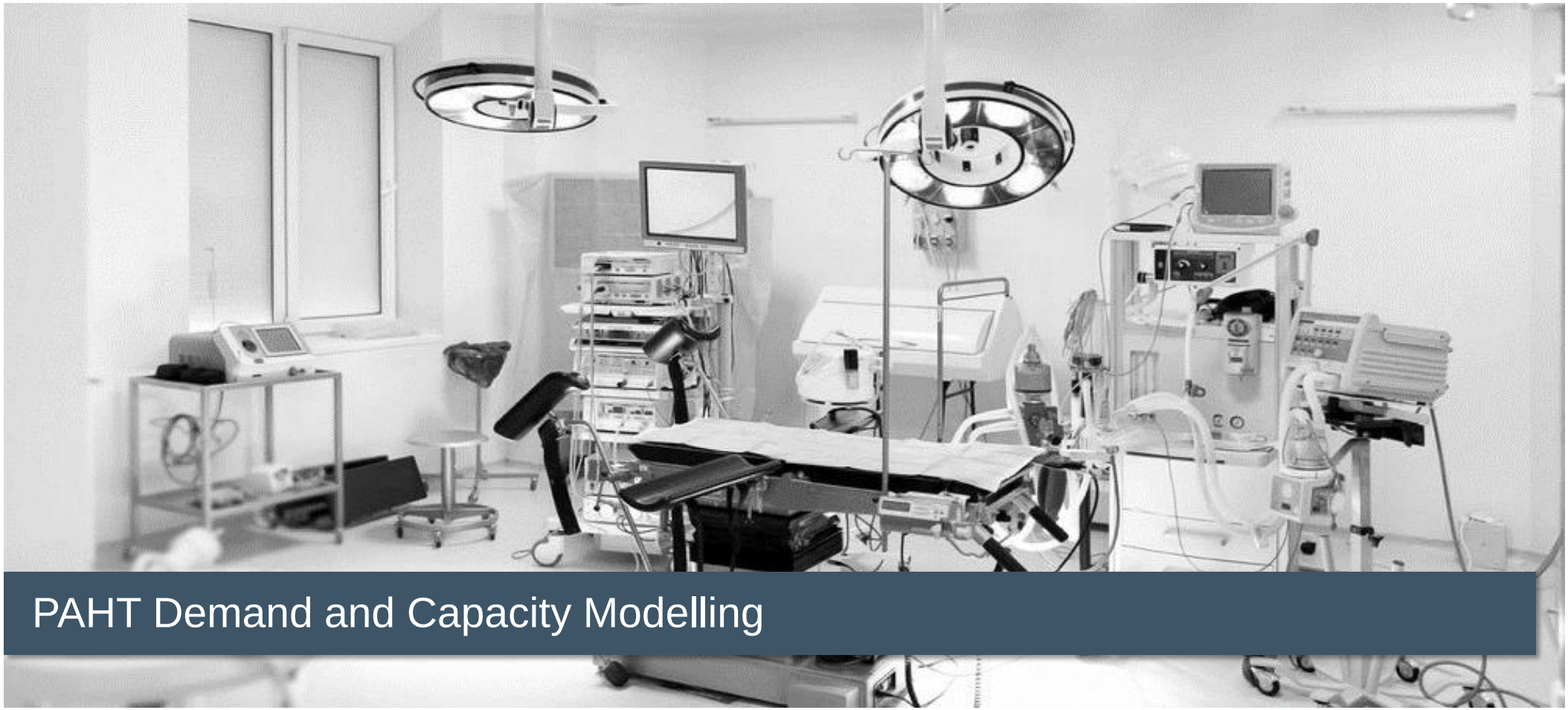
DRAFT



PAHT Demand and Capacity Modelling

Purpose of this Validation

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- To support the capacity estimation for the new hospital development OBC
- Agree the demographic and non-demographic growth assumptions
- Confirm activity change assumptions
- Review capacity projections

Demographic and Non-Demographic

Trust to confirm

- Age adjusted 2018 ONS demographic projection plus planned residential growth estimated to be **25.73%** over 20 years
- ONS birth rate projections to 20 years plus residential growth is c. **5.89%** applied to maternity and neonatal care
- Non-demographic growth of **1% pa** applied
- Increased demand in diagnostics of **c.38%** growth applied
- Should differential growth factors be applied for critical care?

Operational Assumptions (1/2)

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[1]Inpatient Assumptions	
Non Elective Utilisation	85.0%
Elective Utilisation	85.0%
Elective Operating Weeks	48
Gen Surgery and Gen Medicine Operating Weeks	52
Non Elective Operating Weeks	52
Operating Days	7.0
Operating Hours	24.0

[2]Day Case Operational Assumptions	
Operating Days	6.0
Operating Hours	12.0

[3]Endoscopy	
Operating Hours	8.0
Operating Days	6.0
Operating Weeks	48.0
Utilisation / Occupancy Rate	85.0%

[4]Imaging	
Operating Hours	12.0
Operating Days	7.0
Operating Weeks	50.0
Utilisation / Occupancy Rate	85.0%

Source

[1]Standard for patient safety and maximising efficiency

[2]Based on existing standard practice of 3x 4hr sessions

[3]As advised by the Endoscopy Service

[4]As advised by the Imaging Service

Operational Assumptions (2/2)

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[1]Operational - Maternity	
Elective Inpatient Occupancy	65.0%
Non Elective Inpatient Occupancy	65.0%
Theatre Utilisation	65.0%
Birthing Room Occupancy	85.0%

[1]Outpatients	F2F	Non F2F
Operating Hours	7.5	7.5
Operating Days	5.5	5.5
Operating Weeks	48.0	48.0
Utilisation Rate	85.0%	85.0%

[1]Critical Care	
Utilisation / Occupancy Rate	70.0%
Operating Weeks	52
Operating Days	7

[1]Operational - Emergency Department	
Occupancy Rate - Resus	45.0%
Occupancy Rate - Majors	70.0%
Occupancy Rate - Paediatrics	70.0%
Occupancy Rate - UTC	75.0%

[1]Operational - Theatres	
Utilisation	85.0%
Operating weeks per annum	48
Hours per session	4.0
Sessions per day	2
Operating days per week	6

[1]Assessment units	
Adult - Non Elective Utilisation	85.0%
Paediatric Utilisation	75.0%
Operating Weeks	52
Operating Days	7.0
Operating Hours	24.0

Activity Change

[5]Inpatient Activity Change	
General Medicine Shift to Day Case	22%
Non elective activity reduction (MTFP)	22%
Elective activity reduction (MTFP)	15%

[6]Theatres Activity Change	
Reduction in emergency cases	22%
Reduction in day cases	15%
Reduction in elective cases	15%

[7]Outpatients Activity change	F2F	Non F2F
Medical Shift to Non F2F	-70%	70%
Surgical Shift to Non F2F	-30%	30%
[8]Reduction in outpatient activity	-22%	-22%

Diagnostics	
Additional demand for Diagnostics services	38%

[5]Assumptions are aligned to STP / MTFP initiatives

[6]Assumptions are aligned to STP/ MTFP

[7]Changes agreed by PAHT outpatient clinical stakeholders workshop. Paediatric new to be all F2F, 70% of follow-up to be virtual

[8]22% reduction in Outpatient activity as per the One Health and Care Partnership

Methodology

1. Baseline activity
2. ONS demographic projections and planned residential developments
3. Non demographic growth
4. Impact of demand management
5. Operational assumptions
6. Indicative projected functional content

Illustrative Impact of Activity Change

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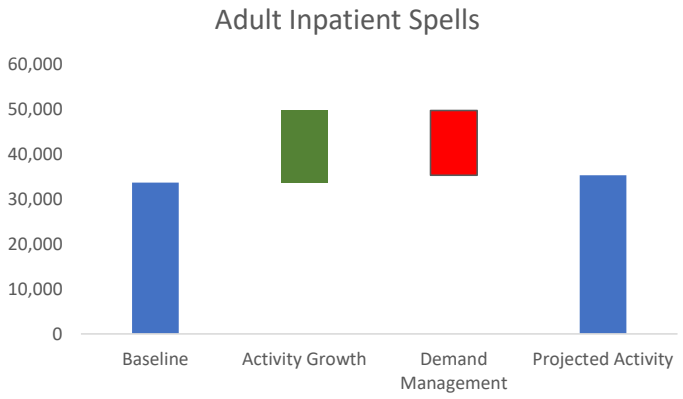

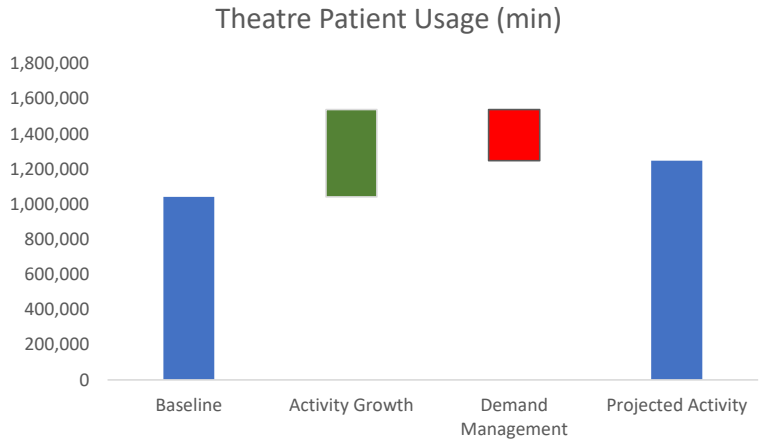

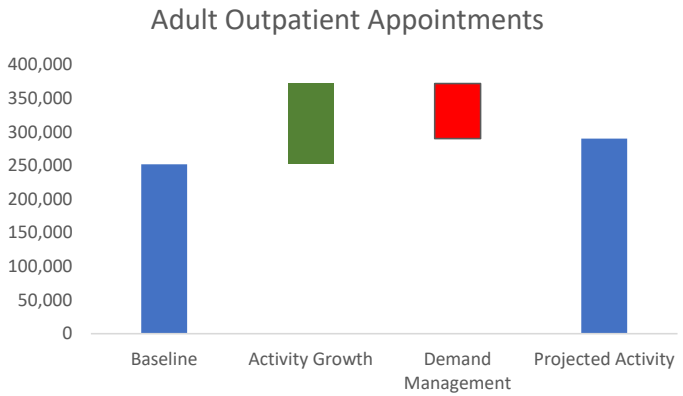

- Activity growth (green bar) represents the effect of demographic and non-demographic factors impacting on baseline activity
- The red bar represents the impact of demand management target to then result in the overall projected activity (last blue bar)

Capacity Projections

Outpatients

Outpatient Contact Type		Projected (2039)	Post Shift to Virtual	'Spaces' Required
[9]**Adult**	FA F2F	104,375	53,640	28
	FU F2F	177,596	75,307	
	Non F2F	8,037	161,061	24
Paediatric	FA F2F	24,217	24,217	10
	FU F2F	37,773	14,998	
	Non F2F	2,838	25,613	4

[9]Includes Gynaecology

Capacity Projection

Diagnostics

Diagnostic Type	Modality / Procedure	Baseline Activity	Projected Activity	Projected Capacity
Imaging	Plain Film	134,863	250,468	6
	MRI	16,995	31,563	3
	CT	30,245	56,171	6
	Ultrasound (non-obstetric)	61,595	114,394	11
	Nuclear Medicine	2,713	5,039	1
	[10]PET CT			1
	Mammography	6,716	12,473	2
	[11]Fluoroscopy / Hybrid Plain Film	3,560	6,612	1
	[12]Interventional Radiology and Cardiology Procedures	620	1,151	2
Physiological	Consult / Exam Rooms	36,906	68,543	11
Endoscopy	Procedure Rooms	12,899	23,911	6
Gynaecology	Procedure Rooms	2,309	4,288	2

[10]Requested by Trust stakeholders. PAHT activity is currently outsourced, increasing in use in future
[11]C.95% of activity undertaken in theatre, some remaining within a combined plain film room
[12]Interventional Radiology activity is in the IP dataset. Trust stakeholder request is to co-locate IR and Angiography Suite

Capacity Projections
Inpatients

Adult

Baseline Spells	Projected Spells	Beds
33,749	35,273	477

Paediatric

Baseline Spells	Projected Spells	Beds
5,942	8,092	30

Capacity Projections

Emergency and Urgent Care

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Point of Delivery	Baseline activity	Projected Activity	Spaces Estimated
[13]Resus	1,755	2,593	8
Majors (Majors + RAT)	47,168	69, 681	25
Further Assessment Area	9,771	14,435	4
Paediatrics	23,528	34,758	8
UTC (ENP + GP)	24,356	35,981	6
[14]Procedure Room			1
[14]Adult Mental Health Room			2
[14]CAMHS and Triage			2

[13]Includes two Paediatric ED high acuity / resus spaces. Six adult spaces based on overall attendances projected to be c. 150k per annum
[14]Activity data not available, but capacity considered necessary

Capacity Projections
Assessment

Assessment Unit	Current Activity	Projected Activity	Projected Spaces
[15]Adult Assessment	21,876	32,317	50
Paediatric Assessment Unit	1,002	1,480	6

[15]This includes ambulatory, CDU, frailty, gynaecology, medical and surgical assessment units. To be used flexibly as per the Trust's evolving model of care

Capacity Projections

Theatres

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Capacity	2 sessions/day, 6 days/Wk @85%	2 sessions/day, 5.5 days/Wk @85%	2 sessions/day, 5 days/Wk @80%	3 sessions/day, 6 days/Wk @85%	9 hr day, 6 days/Wk @85%
Main and day surgery theatres	**11**	**12**	**14**	**8**	**10**

Activity Type	Baseline Theatre Usage (Mins)	Projected Theatre Usage (Mins)
Non Elective	364,427	419,927
Elective	303,418	381,003
Day Case	373,618	441,557
Total	**1,041,463**	**1,242,487**

Excludes Obstetrics theatres and Cardiology/Radiology interventional theatres

Capacity Projections

Critical Care and Neonatal Care

Neonatal Care Type	Baseline	Projected	Cots Required
Intensive and High Dependency Care	300	318	6
[13]Special Care	709	751	10
Total	**1,009**	**1,068**	**16**

[13]This is a portion of the Transitional Care activity, most of which is a constituent of Postnatal IP

Critical care	Baseline Spells	Projected Spells	Beds
Adult High Dependency and Intensive Care	629	929	**20**

Capacity Projections

Maternity

Activity Type	Baseline Spells	Projected Spells
Births	4,256	4,507
Inpatient	9,084	9,619
Outpatient	37,692	39,912
Diagnostics / Procedures	20,484	21,691

Projected Clinical Spaces			
Birthing Rooms	Beds	Theatres	Consult/ Exam/ Treatment Rooms
14	53	2	14

Capacity Projections
Day Case

Category	Projected Recovery 'Spaces'
[17]Cardiology and Radiology	14
Chemotherapy treatment and recovery	24
Day Surgery	24
Endoscopy	12
Gynaecology	2
Main theatres	14

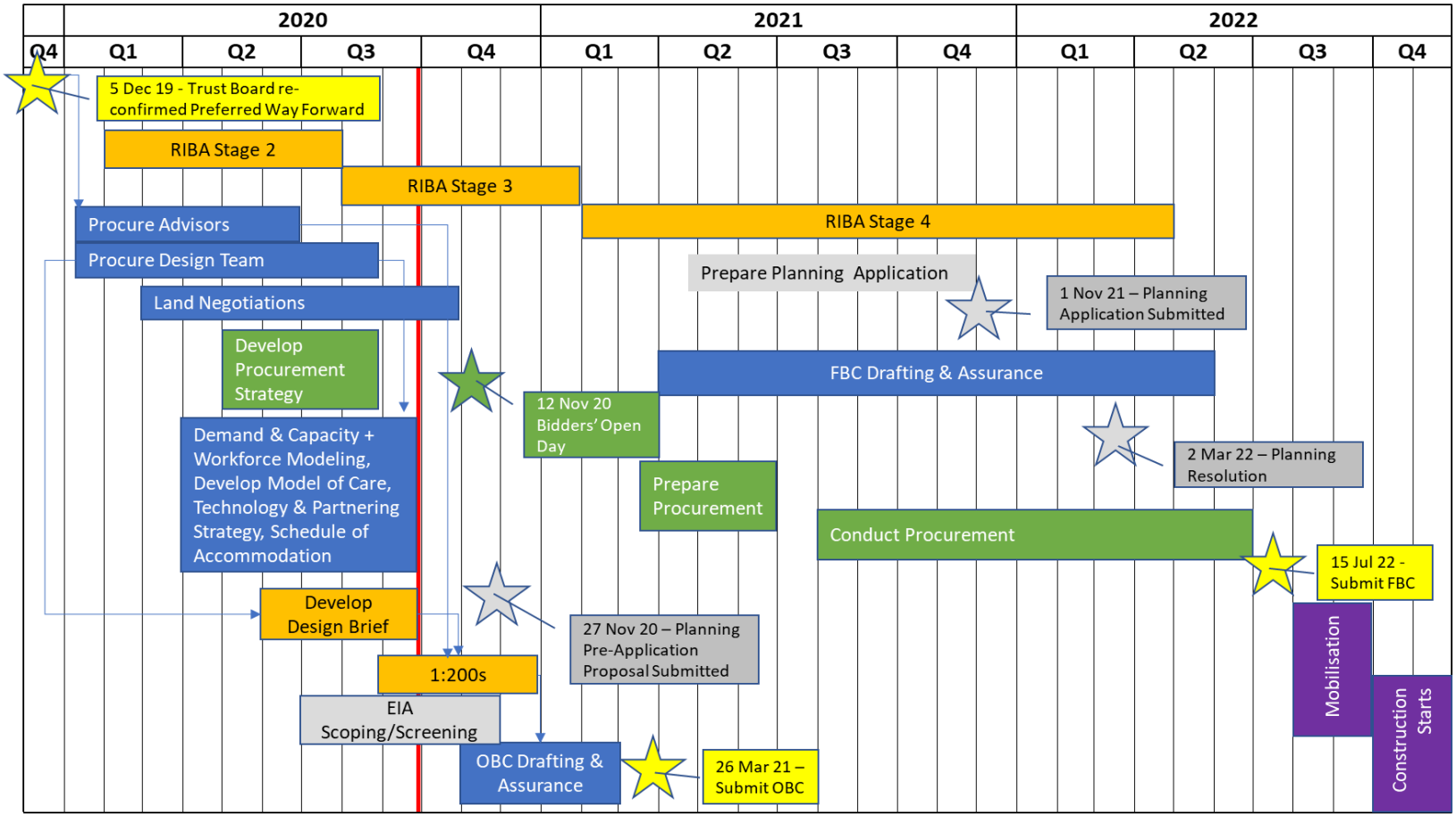
[17]Includes recovery recliners and day beds

- Day case spaces are a combination of beds and recliners linked to diagnostic and interventional procedure suites supporting specific patient pathways.
- The projected numbers are based on a combined assessment of activity, good practice and guidance.

4.1 APPENDIX 5

The Princess Alexandra Hospital NHS Trust

HIGH LEVEL PROGRAMME (AS AT 23 SEP 20)



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4.1 APPENDIX 6

The Princess Alexandra Hospital NHS Trust

NEW HOSPITAL PROGRAMME KEY DELIVERABLES – AS AT 23 SEP 20

Ser	Deliverable	Original Planned Date	Current Planned Date	Date Achieved
KD1	Written confirmation from CCGs that public consultation processes are not required	4 Jun 20		4 Jun 20 (WE) 9 Jun 20 (ENH)
KD2	Conditional contract on the Land signed	30 Jun 20		
KD3	Procurement Strategy drafted	18 Jun 20		18 Jun 20
KD4	RIBA Stage 2 Report issued by GDA	17 July 20		27 July 20
KD5	Design Brief issued to GDA	31 Jul 20		31 Jul 20
KD6	Model of Care TB Approval	6 Aug 20	1 Oct 20	
KD7	Technology and Partnering Strategies TB Approval	6 Aug 20	1 Oct 20	
KD8	Schedule of Accommodation TB Approval	6 Aug 20	1 Oct 20	
KD9	EIA Screening Report submitted to LPA	30 Sep 20	tbc	
KD10	EIA Scoping Report submitted to LPA	27 Nov 20	27 Nov 20	
KD11	Planning: Pre-App Proposal submitted to LPA	27 Nov 20	27 Nov 20	
KD12	RIBA Stage 3 Report issued by GDA	21 Jan 21	21 Jan 21	
KD13	First draft OBC completed	25 Jan 21	25 Jan 21	
KD14	OBC internal (Trust Board) Approval	4 Mar 21	4 Mar 21	
KD15	OBC submitted to NHSE/I for approval	26 Mar 21	26 Mar 21	
KD16	Procurement documentation complete	31 Oct 21	31 Oct 21	
KD17	Full planning application submitted to LPA	1 Nov 21	1 Nov 21	
KD18	RIBA Stage 4 Report issued by GDA	15 May 22	15 May 22	
KD19	FBC draft finalised	15 May 22	15 May 22	
KD20	Planning permission & Sec 106 Agreement issued	15 Jun 22	15 Jun 22	
KD21	FBC internal (Trust Board) Approval	15 Jun 22	15 Jun 22	
KD22	FBC submitted to NHSE/I for approval	15 Jul 22	15 Jul 22	
KD23	Construction complete (CPC)	Q4 2025	Q4 2025	
KD24	New Hospital operational	Q2 2026	Q2 2026	

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Trust Board (Public) – 01.10.20

4.2

Agenda item:	4.2
Presented by:	Marcelle Michail – Acting Chief Medical Officer
Prepared by:	Nicola Tikasingh – Matron for Quality and Mortality Lindsay Hanmore – ADON Quality Improvement Robert Ayers – Deputy Director Quality Improvement Kevin Jennings – Programme Manager End of Life Nick Kroll – Graduate Trainee – Informatics Information Team
Date prepared:	September 2020
Subject / title:	Learning From Deaths – August 2020 Information

Purpose:	Approval		Decision	X	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. It includes an updated dashboard outlining activity up to the end of August 2020. Since the Learning From Death process was implemented in 2020 there have been 901 deaths at the Trust and of these cases 383 (42%) have had a Structured Judgement Review undertaken, with an outcome of 4 avoidable deaths (level 1 or 2) recorded. The learning from these have been incorporated into the work stream. The paper provides details of the key learning identified from the reviews and this month provides a focus on the End of Life Quality Improvement programme							
Recommendation:	To note the progress being made on the learning from death process and the improvement work to address this.							

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 Appendix 2 – End of Life Quality Improvement Driver Diagram Appendix 3 – End of Life Dashboard

1.0 Purpose/issue

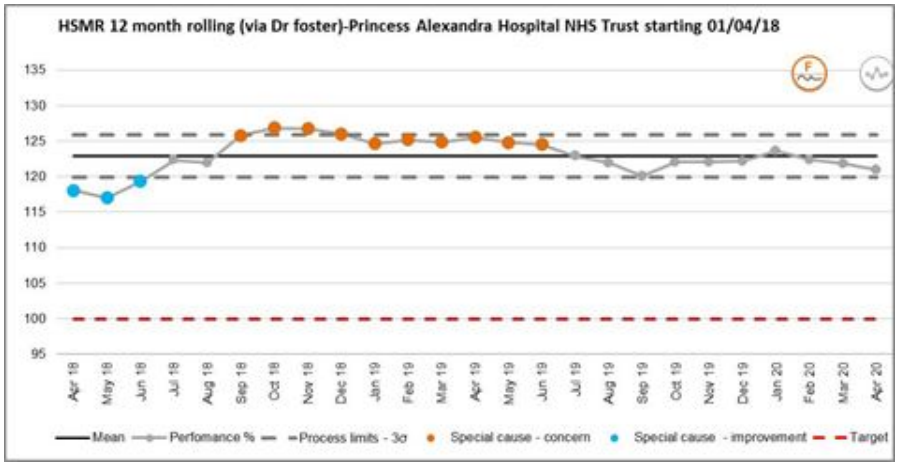
The purpose of this paper is to provide assurance on the implementation of the Learning from Death process, to highlight key pieces of learning and to provide progress updates on the current programme of work to improve clinical practice.

2.0 Background

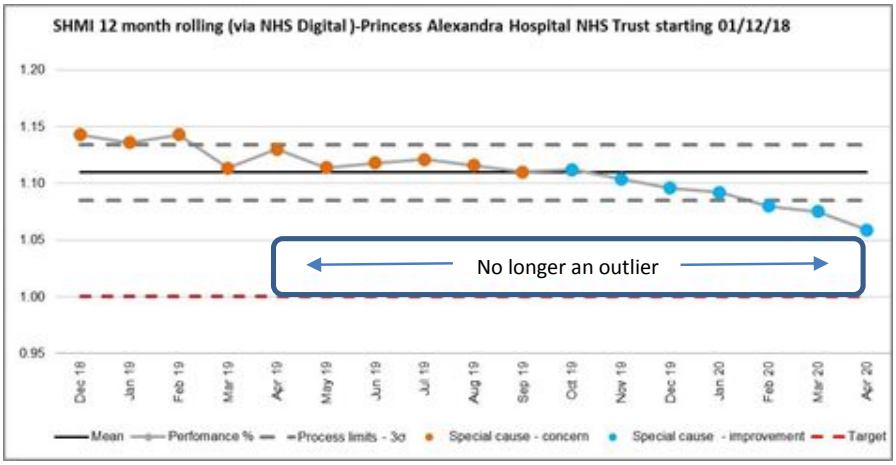
In March 2017, The National Quality Board published a framework for NHS trusts on identifying, reporting, investigating and learning from deaths in care. Over the past 6 months PAHT has further reviewed its processes and the associated policy to ensure they met the new requirements. The up to date Learning from Death policy was ratified at the Trust Policy Group on 4th August 2020.

Following successful implementation of the Medical Examiner (ME) role and introduction of the Structured Judgement Review (SJR) process there is a need to analyse and share the learning from these, to provide updates and assurance on the associated quality improvement works in progress and make recommendations for further improvement projects as new learning arises.

3.0 Current Dr Foster/ NHS D Data Headlines



PAHT has shown significantly high HSMR since November 2016. The SPC chart above shows the most recent 12 month rolling data point is 120.9.



The most recent SHMI value is 1.059. We have not alerted since April 2019.

There are 4 diagnostic groups that are significantly higher than expected (HSMR only):

- Pneumonia
- Septicaemia
- Aspiration Pneumonitis
- Acute and unspecified renal failure

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

4.0 PAHT Learning from death process

4.1 PAHT now has a Learning From Death process that meets the National requirements. Every death has a level one review by a Medical Examiner, at least 25% of all deaths are referred for a Structured Judgement Review (SJR) to be undertaken including all the mandatory reviews and those of our local outliers, and all other deaths are reviewed through the local Mortality and Morbidity process using a standardised level 2 review template. For any death that has an avoidability score of 1 or 2 (definitely avoidable or strong evidence of avoidability) these cases are referred to the Second Review Panel.

4.2 To continually embed the process Mortality and Morbidity workshops have been undertaken in September along with training on completion of SJRs. The objective is that all specialities will have introduced the new standardised format for M &Ms by October 2020 which is included in the project plan.

5.0 Summary of data

5.1 From this month’s SJRs the following have been identified as key pieces of learning:

- Aspiration pneumonia pathway to be reviewed – project group set up with clinical leadership provided by our Lead Respiratory Consultant.
- Missed opportunities to discuss preferred place of death – part of the End of Life Quality Improvement Programme which is also clinically led.

5.4 Positive aspects of care from SJRs include:

- Good care and treatment
- Early initiation of and delivery of good end of life care

5.4 1 x case in August was referred to the second review panel and an avoidability of death score was agreed to be 2 (strong evidence of avoidability). This will be raised as a serious incident. Learning will be shared at the Strategic Learning from Death Forum and the Deteriorating Patient Group.

5.5 A report detailing all deaths by specialty, ward/department and learning points from SJRs has been shared with the Healthcare Groups in preparation for their local M&M meetings and to ensure that learning is widely disseminated. Mortality reports per HCG have been collated and shared with the PSQ leads in preparation for HCG PSQ meetings.

6.0 Current Learning from Deaths Work programme

6.1 Quality Improvement Methodology

All quality improvement (QI) projects that are associated with improving patient outcomes (mortality rates) are either delivered:

a. Locally within healthcare groups and reported back through local PS&Q meetings and/or QSC when required (with advice, guidance and learning/development from the Quality First Team as/when required).
b. Or, when the Quality First Team are supporting the development/delivery of QI projects, via the Quality Improvement Board, Strategic Learning From Death Group and Q&SC.

In addition to this, the Deteriorating Patient Group will address any quality improvement associated with AKI, Sepsis, fluid balance chart compliance, vital sign compliance and escalation processes.

The Trust has also engaged an external consultant to analyse our HSMR and SHMI historical data to identify trends and root causes for our HSMR deterioration and make recommendations to address this.

6.2 The data, from the Learning from Death process has been amalgamated to inform our improvement programme going forward. The following are the programmes of work currently being taken forward by the Trust to address the key pieces of learning:

- End of Life Quality Improvement Programme
  More detailed focus below in section 7.0
- AKI/Sepsis
  Focus on early recognition and early intervention
  Business Case being prepared to purchase AKI/Sepsis Safety Track and Trigger tool on Nervecentre
  Review of healthcare records by Sepsis lead for every patient with a diagnosis of sepsis
  Improvements are being monitored via the Deteriorating Patient Group
- Speciality Assessment Tool
  Baseline audit undertaken and shared, targeted improvements identified to improve documentation and capture of co-morbidities
- Respiratory Pathway including aspiration pneumonia
  Developing solutions for better communication regarding patients feeding at risk.
  Project group set up and have completed Root Cause Analysis to inform focus for QI work for aspiration pneumonia
  Focus on compliance with Pneumonia admission care bundle with early identification and interventions
- Fractured neck of femur
  Focus on expediting patients safely and in a timely manner from ED to Orthogeriatric ward and ensuring escalation bed on ward always available.

The Learning from Death process is dynamic and will inform the need for further additions to this programme of work

6.3 On a monthly basis a more detailed focus will be on one aspect of the key learning from the review process. This report will provide a comprehensive update on the End of Life Quality Improvement programme

7.0 End of Life Quality Improvement Programme

7.1 The End of Life Quality Improvement Programme was shared at the July 2020 Quality and Safety Committee and this report will update on progress to date. The driver diagram for this programme can be reviewed in Appendix 2

7.2 The End of life dashboard can be reviewed in Appendix 3. It contains the baseline data to be used to measure improvement.

7.2 The End of Life Business Case which included a matron for End of Life Care and 0.5 wte clinical Psychologist for Cancer and SPCT was approved at the September Senior Management Team.

7.3 The following tests of change as part of the Improvement Programme are being progressed:

- AS IS hospice pathway referral process has been mapped, identifying opportunities for improvement and standardisation to improve timely transfer of patients to their preferred place of death.
- Read and write access to "System one" being trialled to reduce duplication in effort and to improve opportunities to expedite decision making
- E-learning developed and shared on how to complete end of life documentation in an aim to improve knowledge, understanding and compliance with best practice – to be formally launched early October.
- Sage and Thyme train the trainer sessions have been booked but may be delayed as currently only available as face to face sessions. Once implemented this will enable Trust staff to deliver training locally to support colleagues in the delivery of end of life care.
- Exploration of recording Preferred Place of Death (PPD) on Nervecentre to improve capture of information but also to provide evidence of meaningful conversations with patients and their carers.
- Baseline audit of individualised care plans undertaken and plan to repeat monthly to target and monitor improvements.
- Consents for next Bereavement Survey obtained with plans for next telephone survey to be undertaken in early November 2020.
- Development of single checking process of Controlled Drugs to enable patients to be transferred on and end of life pathway to Hospital at Home
- Collaboration with wider health economy to improve pathways, shared learning and improvements

8.0 Risks for Escalation

The Trust has now developed 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.

9.0 Recommendations

The Board is asked to note that the risk score in relation to the M&M process has been increased to reflect the inconsistent engagement at M&M meetings and variation in compliance with medically led SJR completion.

1. To note the progress with the Learning from Death process and the key actions being taken to embed the learning and to improve clinical practice.
2. 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

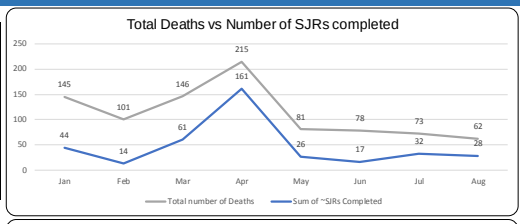
Mortality Dashboard

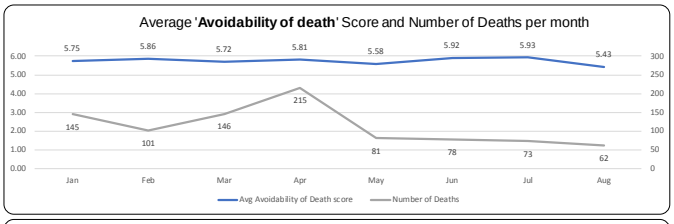
NHS The Princess Alexandra Hospital NHS Trust

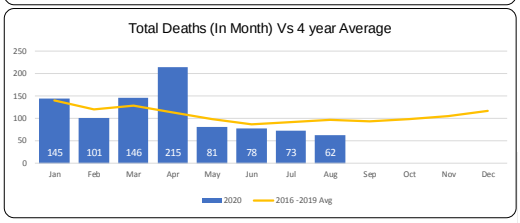
Mortality Review Figures for 2019/2020

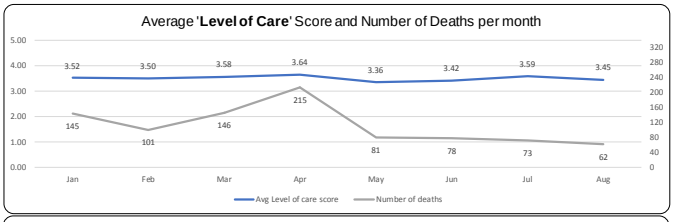
2019/2020	Total number of hospital deaths *	Number of adult deaths reviewed by a Medical Examiner	Percentage (%) of adult deaths reviewed by a Medical Examiner	Number of structured judgement	Percentage (%) of structured judgement reviews
Jan-20	145	144	99%	44	30%
Feb-20	101	100	100%	14	14%
Mar-20	146	146	100%	61	42%
Apr-20	215	214	100%	161	75%
May-20	81	79	100%	26	32%
Jun-20	78	77	100%	17	22%
Jul-20	73	72	100%	32	44%
Aug-20	62	61	100%	28	45%

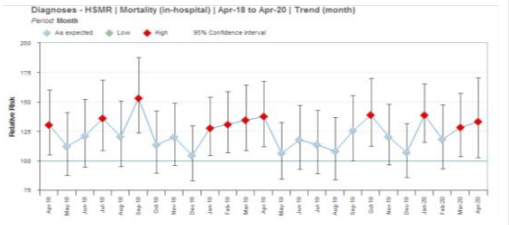
* Includes paediatric deaths

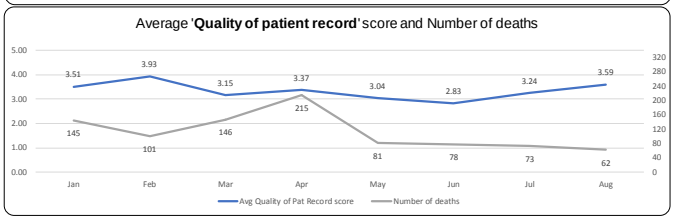








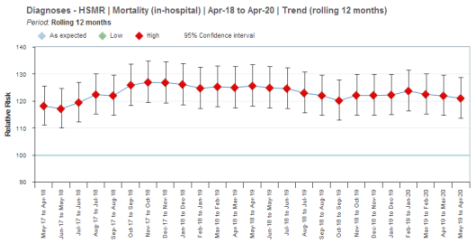


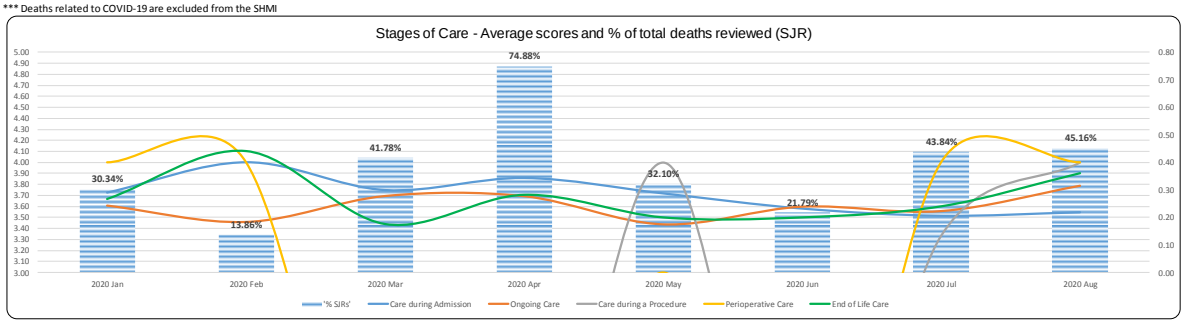


Relative Risk Alerts (Top 8)	CUSUM	Obs	Exp	RR	LCI	Trend
Viral infection	48	149	4.5	3286.3	2779.8	
Inflammation, infection of eye	1	2	0.2	1261.4	141.7	
Mycoses	0	2	0.2	1025.7	115.2	
Acute and unspecified renal failure	1	45	29.2	154.0	112.3	
Aspiration pneumonitis, food/vomitus	2	81	59.8	135.5	107.6	
Septicemia (except in labour)	0	141	112.5	125.3	105.5	
Lung disease due to external agents	1	7	2.7	258.1	103.4	

Reporting Period	Observed deaths	Expected deaths	SHMI Value	Banding Description
SHMI May 18 - Apr 19	1595	1410	1.130	As expected SHMI
SHMI Jun 18 - May 19	1590	1430	1.114	As expected SHMI
SHMI Jul 18 - Jun 19	1605	1435	1.118	As expected SHMI
SHMI Aug 18 - Jul 19	1610	1435	1.121	As expected SHMI
SHMI Sep 18 - Aug 19	1615	1445	1.116	As expected SHMI
SHMI Oct 18 - Sep 19	1610	1450	1.110	As expected SHMI
SHMI Nov 18 - Oct 19	1630	1465	1.112	As expected SHMI
SHMI Dec 18 - Nov 19	1630	1475	1.104	As expected SHMI
SHMI Jan 19 - Dec 19	1635	1490	1.096	As expected SHMI
SHMI Feb 19 - Jan 20	1645	1505	1.092	As expected SHMI
SHMI Mar 19 - Feb 20	1620	1500	1.080	As expected SHMI
SHMI Apr 19 - Mar 20	1630	1515	1.075	As expected SHMI
SHMI May 19- Apr 20	1560	1470	1.059	As expected SHMI

* Death counts are rounded to the nearest 5
** SHMI value rounded to 3 decimal places
*** Deaths related to COVID-19 are excluded from the SHMI





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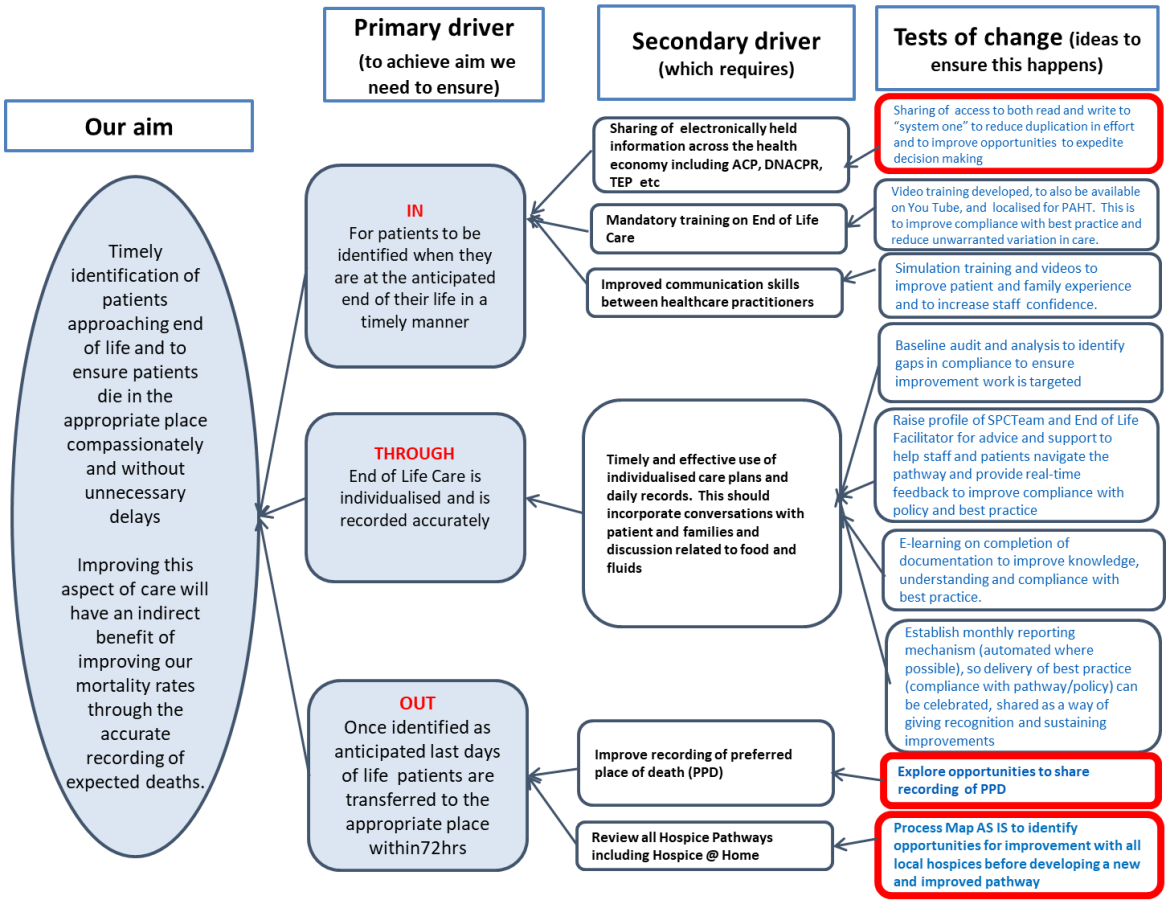
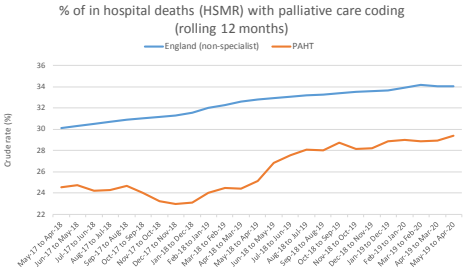
Appendix 2 – End of Life Quality Improvement Diagram



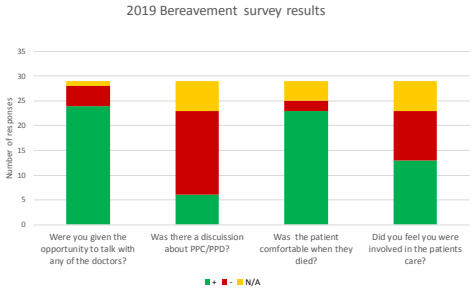
Appendix 3 – End of life dashboard

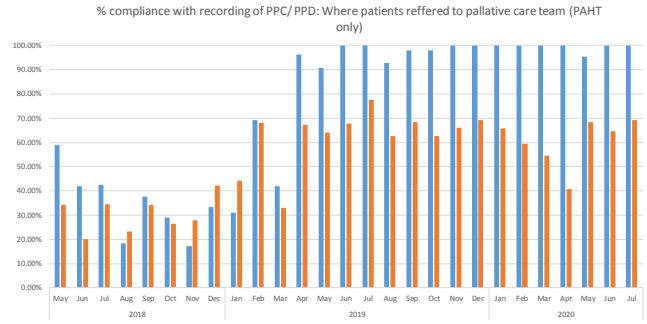
EOLC Dashboard

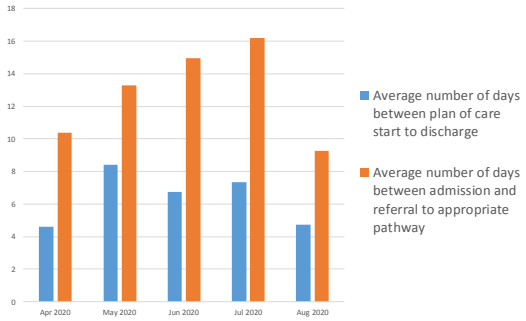
The Princess Alexandra Hospital NHS Trust

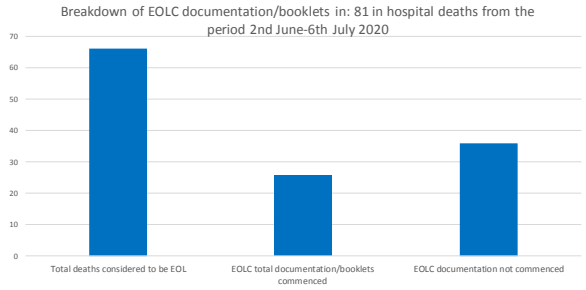


Reporting Period	Total deaths	Deaths in hospital	Deaths out of hospital (within 30 days)	Percentage of deaths which occurred in hospital	Englands average percentage of deaths which occurred in hospital
SHMI Apr 18 - Mar 19	1600	1195	400	75	70
SHMI May 18 - Apr 19	1595	1210	385	76	70
SHMI Jun 18 - May 19	1590	1215	375	76	70
SHMI Jul 18 - Jun 19	1605	1225	380	76	70
SHMI Aug 18 - Jul 19	1610	1215	395	75	70
SHMI Sep 18 - Aug 19	1615	1210	405	75	70
SHMI Oct 18 - Sep 19	1610	1200	410	75	70
SHMI Nov 18 - Oct 19	1630	1465	410	75	70
SHMI Dec 18 - Nov 19	1630	1220	410	75	69
SHMI Jan 19 - Dec 19	1635	1230	405	75	70
SHMI Feb 19 - Jan 20	1645	1235	410	75	69
SHMI Mar 19 - Feb 20	1620	1205	410	74	69
SHMI Apr 19 - Mar 20	1630	1200	430	74	68
SHMI May 19- Apr 20	1560	1120	435	72	68









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TRUST BOARD
1 October 2020

4.3

Agenda item:	4.3
Executive Lead:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Elizabeth Podd – Head of Performance & Planning Finola Devaney – Director of Clinical Quality Governance
Date prepared:	23rd September 2020
Subject / title	Ophthalmology Review Lists

Purpose:	Approval		Decision		Information	√	Assurance	√

Key issues:	Lists of patients requiring a follow-up appointment had increased without sufficient clinical capacity to review, see and treat patients. There were a number of long standing system issues within Cosmic Patient Administration System. Which required resolution. Demand for the service had increased with lack of capacity planning in place. Ophthalmology had a particularly high number of overdue appointments and patients not seen in the correct clinic first time which added to the overdue list of appointments. A lack of suitable and sufficient diagnostics and community pathways had delayed the service progressing. A targeted project to validate and book the overdue appointments has been undertaken. Trajectories were set and have been achieved. 12 patient safety incidents were raised, 8 have resulted in patient harm. All incidents are being managed through the Incident Management Process. An external CEO Assurance Panel was held in June 2020 and again in
Recommendation:	Trust board is asked to note the content of the paper and the progress made within the service.

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

Previously considered by:	CEO Scrutiny Panel
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and the Significant Risk Register.
Legislation, regulatory, equality, diversity and dignity implications:	Management of risk is a legal and statutory obligation
Appendices:	Nil

The Princess Alexandra Hospital NHS Trust

4.3

1.0 INTRODUCTION

This paper gives further detail on the Ophthalmology Clinic Capacity risk referred to in the paper entitled Significant Risk Register.

2.0 CONTEXT

Following implementation of the Cosmic Patient Administration system in 2014, there have been a number of ongoing issues with how the system is operated for monitoring of access standards, predominately RTT pathways. There have been many attempts to implement solutions to ensure patients are placed on the correct pathway following outpatient intervention. The system configuration does not lend itself easily to change which has made oversight and monitoring more complex. However, with detailed process mapping, engagement from both operational, clinical and IT teams, the system changes have now been configured to ensure patients are placed on the correct pathways with appropriate follow up appointments visible for monitoring and tracking.

Patients requiring a follow-up appointment in the future have been placed on a waiting list to be booked closer to the time. Large volumes of patients waiting for an appointment built up, particularly in Ophthalmology. This was highlighted as a significant risk.

3.0 ACTION

The Trust carried out a detailed and extensive project in Ophthalmology to validate the list of patients and implemented a revised diagnostic & out-patient pathway that ensured that overdue appointments are cleared.

The project was overseen by the Executive Directors with regular reports and weekly oversight and escalation meetings. Additional meetings with CCG colleagues have also been in place during the recovery period.

An External CEO assurance panel was held in September 2020 with members from Care Quality Commission, West Essex CCG, East and North Herts CCG and NHS England present, the Trust provided the panel with assurance that the issues identified have been addressed and that the Trust will continue to ensure oversight at an executive level.

3.1 Our Patients

Between January and June 2020 following review of the patients awaiting treatment 13 patient safety incidents were identified, 9 of these patients did suffer some harm as a result, all the patients have been made aware and are currently having, or have received, treatment.

3.2 Performance

The lists of patients waiting a follow-up appointment are reviewed through the Access Board. A trajectory for clearance across all specialities has been set and progress is monitored weekly. The team are on trajectory to clear the backlog by the end of October. The Ophthalmology team will present their approach to the Access Board in October to share their learning to other specialties.

3.3 Places - Environment

A key part of the Ophthalmology new pathway was the creation of a diagnostic centre to deliver the multiple tests in a single patient visit that were then reviewed virtually by the clinicians and confirmation of results or invitation to a clinic appointment followed. This ensured that patients only attended the clinic setting when clinically required. The Trust is looking to establish a permanent location for the diagnostic centre in future and has commenced discussions with West Essex CCG regarding potential primary care locations. Patient feedback has been positive with excellent comments regarding access to the service.

The Princess Alexandra Hospital NHS Trust

4.0 RECOMMENDATION

Trust board are asked to note the content of the paper and to be assured that ongoing oversight will continue through Executive Director meetings, healthcare group performance reviews, external CCG oversight and formal committees.

Trust Board – 01.10.20

4.4

Agenda item:	4.4
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery
Date prepared:	September2020
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels (Hard Truths) and an Update to Nursing and Midwifery Workforce Position

Purpose:	Approval		Decision		Information	x	Assurance	x
Key issues:	*Staffing risk rating in month: Green* *This paper provides the regular nursing and midwifery retrospective staffing report for the month of August 2020 and provides an update to the workforce position (part B). While every effort has been made to ensure the overall information is accurate due to the number of moves of wards across the month there remains a risk that some of the individual ward data remains inaccurate.* *The fill rate for overall RN/RM in month has decreased to 97.2%, which is a decrease of 3.1% against July 2020 as a result of increase in number of wards and clinical areas that have reopened as part of the recovery plan. Rates remain above Jan and Feb 2020. Temporary staff usage has increased with the reopening of capacity across the Trust and the requirement for additional staffing across ITU and endoscopy to support covid pathway recovery.* *The overall nursing vacancy position has fallen slightly in month to 9.8% and Band 5 to 11.1% due to the uplift in posts from the 2019/20 establishment review. The international recruitment pipeline has 80 nurses ready to join us and the team are working on a detailed plan to cover quarantine on arrival, socially distanced OSCE training to bring as many as possible supported by the NHSE/I programme.*							
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:	PAF.24.09.20 and QSC.25.09.20
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	Appendix 1: Ward level fill rates Appendix 2: Registered fill rates by month. RAG rated.

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 August 2020. To provide an update on plans to reduce the nursing vacancy rate over 2019/20.

2.0 BACKGROUND

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

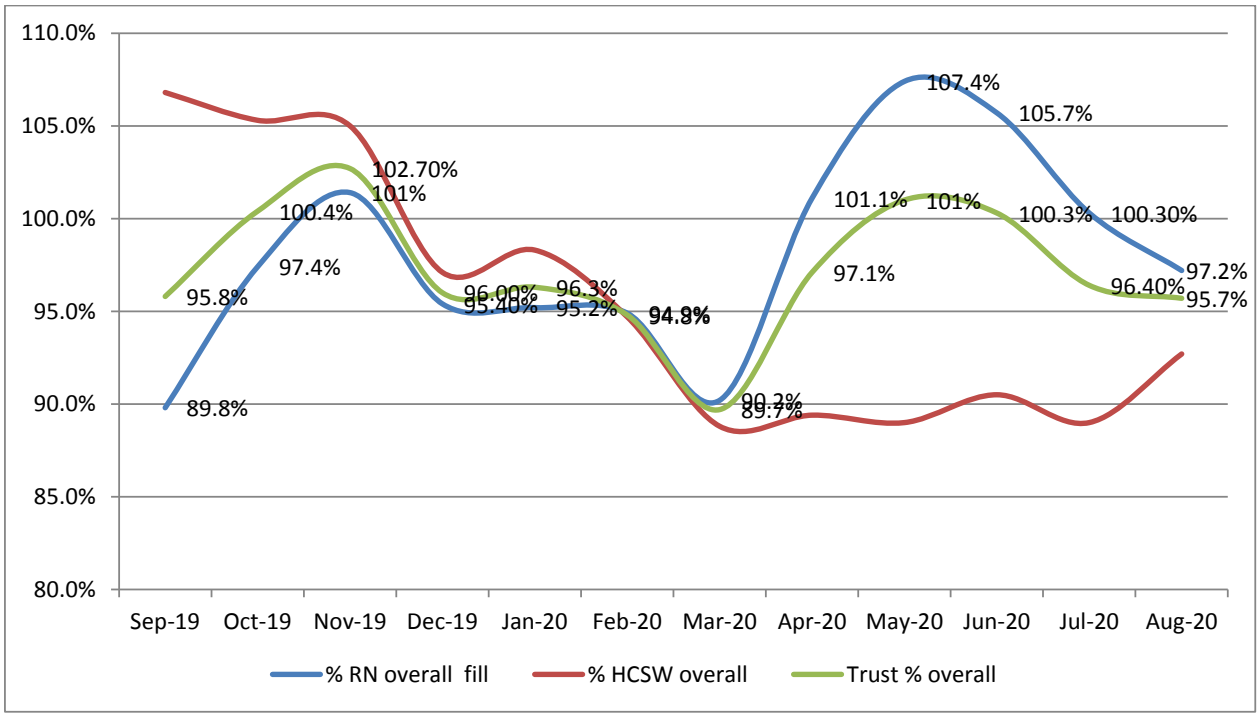
3.0 ANALYSIS

3.1 This report provides an analysis based on the actual coverage in hours against the agreed static demand templates for the calendar month of August 2020.

3.2 The summary position for the Trust Safer Staffing Fill rates for August 2020. The fill rate for overall RN/RM in month has decreased to 97.2%, which is a decrease of 3.1% against July 2020.

3.3 Fill rates continue to be supported in month by redeployment of nurses from closed inpatient wards and outpatients. Ward level breakdown of fill rate data is included in Appendix 1; the accuracy of this continues to be dependent on all staff moves being captured on Health Roster

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
In Patient Ward average August 20	96.5%	87.1%	98.1%	100.6%	97.2%	92.7%	95.7%
In Patient Ward average July 20	98.2%	89.3%	102.8%	88.6%	100.3%	89.0%	96.4%
Variance July - August 2020	↓1.7%	↓2.2%	↓4.7%	↑12%	↓3.1%	↑3.7%	↓0.7%



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

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

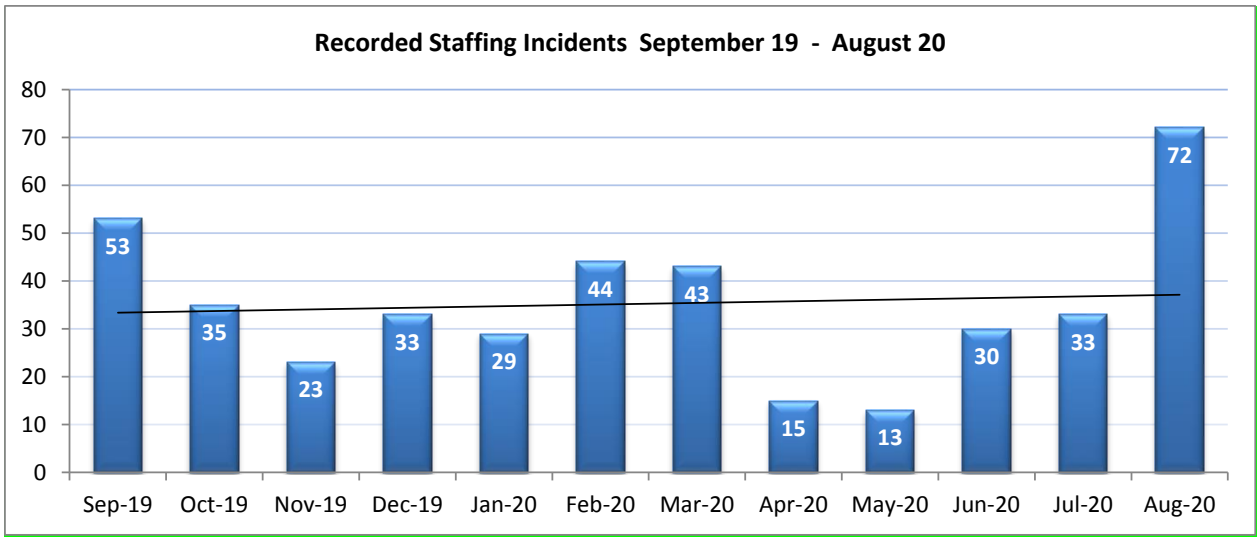
Red <75%	Amber 75 – 95%	Green >95%

	Day		Night	
September 2020	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
A&E Nursing	91%	78%	94%	85%
PAH Theatres *	90%	57%	138%	97%
Endoscopy Nursing	86%	81%		

**Registered Nurse demand and fill, ODP demand and fill excluded.*

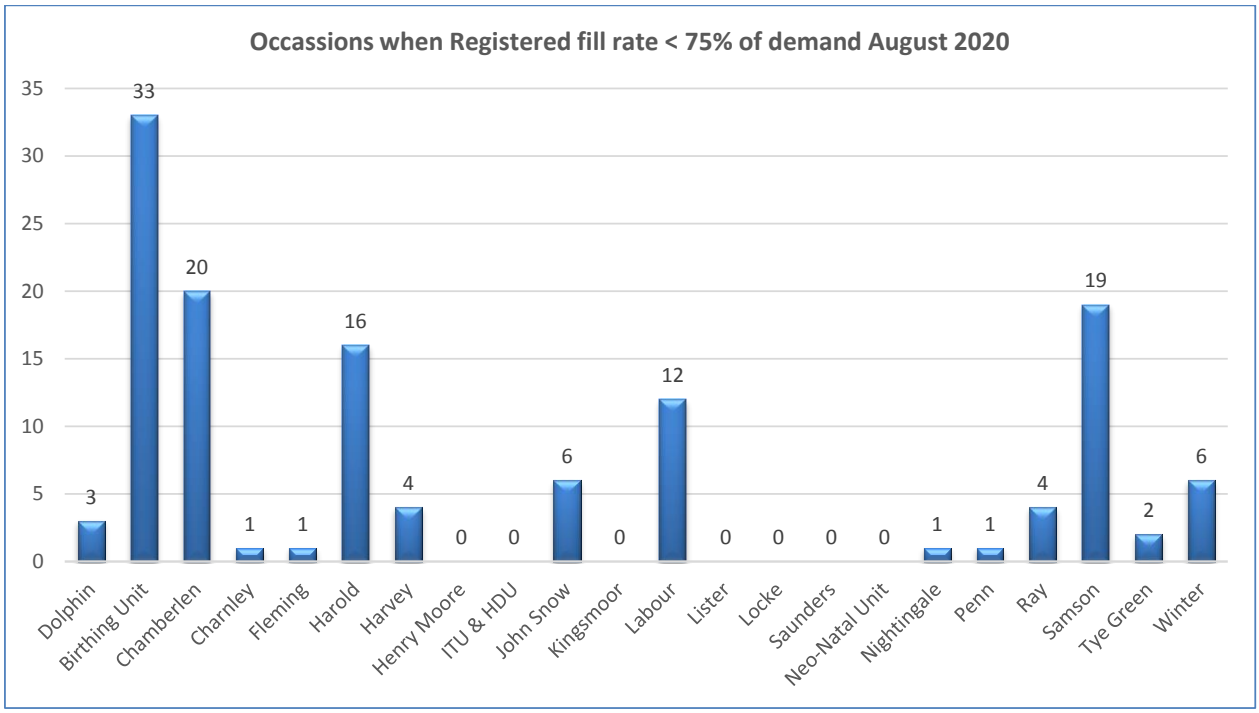
The demand template for theatres is under review and changes daily due to the number of areas open and responding to the requirement for a red and green pathway for elective surgery.

3.5 Datix reports: The trend in reports completed in relation to nursing and midwifery staffing is included below and shows a large increase of 39 in August, (with 12 of the 72 being raised by Tye Green). While the significantly improved fill rates continues across the wards, the increase in staffing Datix reports is driven by staff concerns of the number of staff moves and will be monitored going forward to understand if this is the start of an upward trend . All incidents continue to be reviewed by the safety and quality review process.



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

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



3.7 Care Hours per Patient Day* (CHPPD) has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018). The table below shows the Trust data from the Model Hospital. Current model hospital data for national median is based on latest available data. This shows the Trust and National data from February 2020, this shows that while the Trust continues to exceed the National median for Registered CHPPD, it has also shows that it is below the national median for overall CHPPD and HCA CHPPD.

	Trust Feb 2020 data	National Median (Feb2020)	Variance against national median
CHPPD Total	7.8	8.0	↓0.2
CHPPD RN	5.0	4.7	↑0.3
CHPPD HCA	2.8	3.2	↓0.4

Data checked on Model Hospital 3.9.2020

3.8 Bank and Agency fill rates:

The day-to-day management of safer staffing across the organisation is managed through the 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, though with clinical areas reopening there has been an increase in requirements. Staff redeployment along with a greater challenge continues. The need for temporary staff is reviewed daily at the Safe Staffing daily meeting and all shifts not required continue to be cancelled. The main areas utilising agency staff are A&E Nursing and Maternity. The table below shows that there was a further increase in registered demand (↑665 shifts) in August compared to July. August also shows an increase in agency usage (↑47 shifts). While some demand if due to vacancies within the nursing workforce there is an increased demand in theatres, ITU and endoscopy to enable the elective recovery activity to meet IPC guidance.

The HCSW demand shows a corresponding increase in demand (↑501 shifts).

RN temporary staffing demand and fill rates*: (August 2020 data supplied by NHSP 7.9 .2020)*

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
March 20	5001	2461	49.32%	945	18.9%	68.1%	1,595	31.9%
April 20	3484	1684	48.3%	714	20.5%	68.8%	1086	31.2%
May 20	1857	1401	75.4%	337	18.1%	93.6%	119	6.4%
June 20	982	748	76.2%	75	7.6%	83.8%	159	16.2%
July 20	1594	1139	71.5%	172	10.8%	82.2%	283	17.8%
August 20	**2259**	**1598**	**70.7%**	**219**	**9.7%**	**80.4%**	**442**	**19.6%**
August 2019	3855	1660	43.1%	1062	27.5%	70.6%	1133	29.4%

HCA temporary staffing demand and fill rates: ***(August 2020 data supplied by NHSP 7.9 .2020)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
March 20	3182	2037	64.0 %	0	0 %	64.0 %	1,145	36.0 %
April 20	2352	1391	59.1%	0	0%	59.1%	961	40.9%
May 20	1314	1095	83.3%	0	0%	83.3%	219	16.7%
June 20	642	532	82.9%	0	0	82.9%	110	17.1%
July 2020	856	650	75.9%	0	0%	75.9%	206	24.1%
August 20	**1357**	**1038**	**76.5%**	**0**	**0%**	**76.5%**	**319**	**23.5%**
August 19	2542	1963	77.2%	0	0%	77.2%	579	22.8%

B: Workforce:

Nursing Recruitment Pipeline

The overall nursing vacancy rate in August has fallen slightly to 9.8%. There are 80 nurses in the pipeline who hold offers of which 60 are international nurses. Four overseas nurses are commencing this month and there are plans for a further 8 next month. Overseas nurses who joined prior to Covid who will sit their OSCE in the next 2 months.

The targeted domestic recruitment campaign for HCSW has been successful and there are currently 70 HCSW in the recruitment pipeline. Maternity will commence 12 newly qualified midwives in September experienced RN's for ED and RM's for Maternity as both areas have higher than average vacancy rates.

Turnover rates continue to remain static at 10.17%.

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	953.11	953.11	953.11	953.11	953.11	953.11	953.11	953.11	953.11	953.11	953.11	953.11
Staff in Post WTE	871.00	868.00	869.00	863.00	860.00	854.00	859.00	868.00	877.00	888.00	897.00	906.00
Vacancy WTE	82.11	85.11	84.11	90.11	93.11	99.11	94.11	85.11	76.11	65.11	56.11	47.11
Actual RN Vacancy Rate	8.6%	8.9%	8.8%	9.5%	9.8%	10.4%	9.9%	8.9%	8.0%	6.8%	5.9%	4.9%
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	498.43	498.43	498.43	498.43	498.43	498.43	498.43	498.43	498.43	498.43	498.43	498.43
Band 5 Staff in Post WTE	447	449	450	447	443	447	455	463	473	481	489	497
Band 5 Starters	1	3	3	0	1	10	14	14	16	14	14	14
Vacancy Band 5 WTE	51.43	49.43	48.43	51.43	55.43	51.43	43.43	35.43	25.43	17.43	9.43	1.43
Actual Vacancy Rate	10.3%	9.9%	9.7%	10.3%	11.1%	10.3%	8.7%	7.1%	5.1%	3.5%	1.9%	0.3%
Forcast Vacancy Rate in Business Plan												

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	4	4	4	4	4	4
Band 5 Newly Qualified + Local	1	3	2	0	0	6	2	2	2	2	2	2
Band 5 International Recruitment	0	0	1	0	1	4	12	12	14	12	12	12
Band 5 Starters	**1**	**3**	**3**	**0**	**1**	**10**	**14**	**14**	**16**	**14**	**14**	**14**
Total Starters	3	3	3	0	1	14	18	18	20	18	18	18

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	3	3	3	3	3	3	3
Band 5 Leavers	3	1	2	3	5	6	6	6	6	6	6	6
Total Leavers	**6**	**2**	**9**	**3**	**7**	**9**	**9**	**9**	**9**	**9**	**9**	**9**
N&M Turnover %	10.53%	10.18%	10.12%	10.17%	10.17%							

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: **10th September 2020**

Appendix 1.

Ward level data: fill rates August 2020.

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.

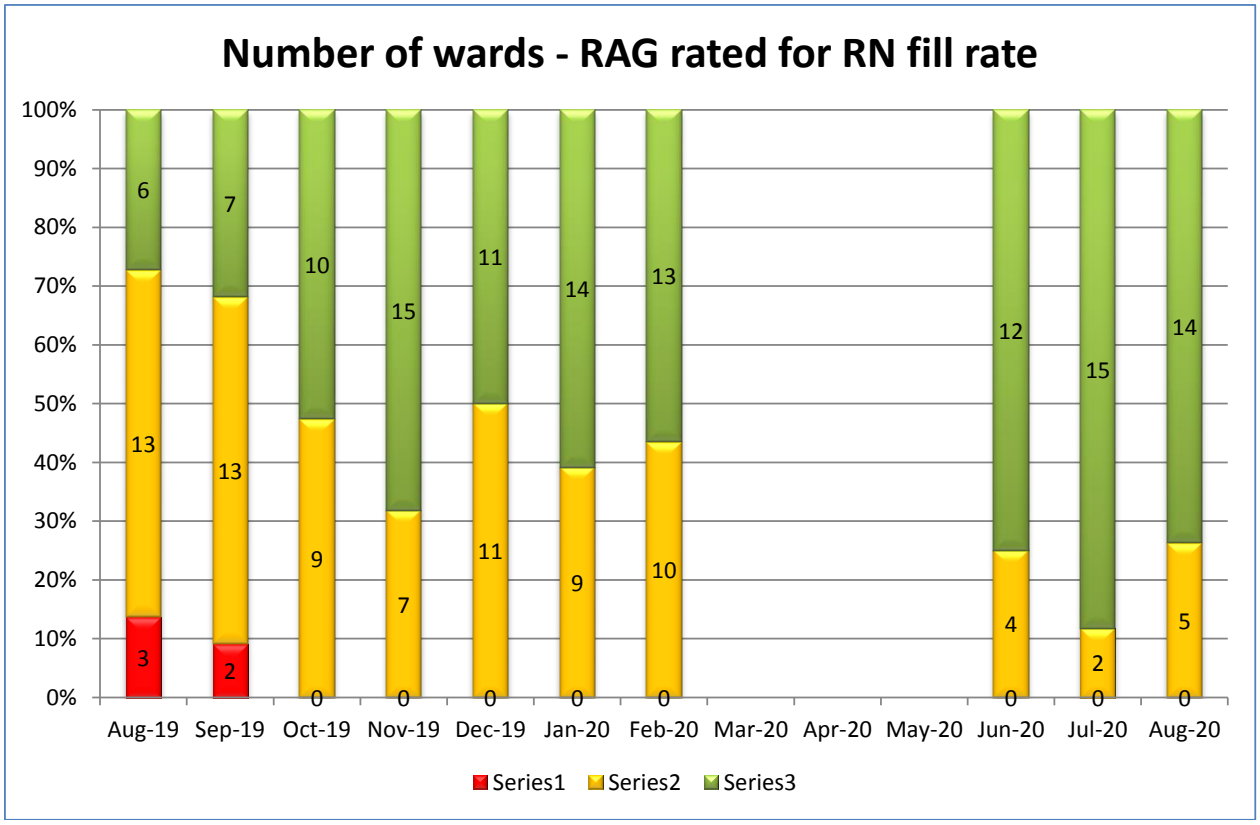
Analysis of areas with red fill rates has not been undertaken this month as there is still a number of DQ issues with the data due to the number of ward moves across the month.

	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
Charnley Ward	96.8%	108.4%	115.2%	111.5%	103.4%	109.8%	106.0%
ITU & HDU	103.6%	85.8%	103.9%	77.4%	103.8%	81.6%	101.6%
John Snow Ward	93.0%	80.3%	98.9%	100.0%	95.4%	87.8%	92.2%
Kingsmoor Ward	107.4%	115.7%	98.0%	101.1%	103.4%	108.7%	105.5%
Henry Moore Ward	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Harvey Ward	93.3%	73.3%	100.0%	85.8%	96.0%	79.3%	88.3%
Lister Ward	92.8%	78.2%	99.2%	92.4%	86.8%	84.0%	85.6%
Locke Ward	99.8%	61.3%	108.9%	98.7%	103.7%	75.5%	93.6%
Penn Ward	100.0%	100.4%	108.1%	109.9%	103.4%	104.3%	103.7%
Ray Ward	92.2%	78.4%	94.4%	126.7%	93.1%	93.6%	93.3%
Saunders Unit	95.3%	77.8%	102.6%	91.4%	98.4%	83.4%	91.8%
Tye Green Ward	94.8%	82.6%	97.6%	107.5%	96.0%	92.7%	94.6%
Winter Ward	91.4%	71.1%	108.6%	112.9%	97.5%	87.0%	93.4%
Nightingale Ward	98.4%	76.9%	112.0%	111.8%	103.9%	90.1%	98.2%
Fleming Ward	93.6%	109.5%	98.0%	121.0%	95.5%	113.9%	102.3%
Harold Ward	87.0%	99.0%	90.4%	148.4%	88.4%	115.5%	96.2%
Neo-Natal Unit	110.3%	102.9%	113.0%	90.3%	111.6%	96.6%	109.1%
Dolphin Ward	99.9%	75.8%	73.3%	108.4%	86.6%	86.7%	86.6%
Maternity	91.5%	96.3%	85.2%	80.4%	88.5%	88.7%	88.6%
Total	96.5%	87.1%	98.1%	100.6%	97.2%	92.7%	95.7%

Appendix 2

Ward level data was not collated for March, April and May 2020

Chamberlen Ward, Labour Ward, Samson Ward and Birthing Unit ward level data has been collated and reported as Maternity; this more accurately reflects the way Maternity currently works.



Appendix 3

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

	Report from the Associate Director of Nursing for the HCG		
Ward	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Harvey	HCSW Days	Nil – Additional supernumerary staff and staff returning from shielding on phased return available to support	Nil Required. HCSW recruitment to vacancies on track
Locke	HCSW Days	Nil – Additional supernumerary staff and staff returning from shielding on phased return available to support	Nil Required. HCSW recruitment to vacancies on track
Winter	HCSW Days	Nil – Additional supernumerary staff and staff returning from shielding on phased return available to support	Nil Required. HCSW recruitment to vacancies on track
Dolphin	RN Nights	Nil – Acuity and dependency and number of patients full template not required	Nil Required. HCSW recruitment to vacancies on track

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 01.10.20

5.1

Agenda item:	5.1
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Information Team/Executive Directors
Date prepared:	September 2020
Subject / title:	M5 Integrated Performance Report (IPR)
Purpose:	Approval [ ] Decision [ ] Information [x] Assurance [ ]
Key issues:	**Patients:** New policy for the management of complaint deadlines has been put in place. Sustained reduction in presentation & number of positive Covid-19 patients within the organisation. C.difficile: during July & August, there has been a rapid rise in cases but there does not appear to be any links between cases or association with the environment. Falls per 1000 bed days showed a small decrease from 9.88 to 9.42 compared to July. Pressure ulcer rates continue to steady with no reported Category 3 PUs in month. The rate of Post-Partum Haemorrhages (PPH) over 1.5L continues to be a focus for maternity and the department has moved to a new 'Physiological' interpretation of CTG monitoring during labour. The Mental Health Quality Forum is continuing the implementation of the Mental Health Act policy; the trust has commenced timely detaining of patients under the MHA which is one of the key actions of the forum. **Performance**: Recovery Phase 3 submission in place. Trajectories for access standards in place and monitored through weekly access board. Internal bed capacity remains under daily review. Pre covid levels of emergency attendances starting to be seen through the ED. Building work for additional assessment and frailty capacity underway ahead of winter. **People:** Recruitment continues to show positive improvements within nursing and medical staff. Temporary staffing expenditure remains under close review with clear actions in place. Trajectories in place for statutory and mandatory training and appraisals. **Pounds**: Against the Trust's interim plan there is an in-month variance of £0.4m and YTD variance of £1.4m. Under the current adapted financial regime the Trust is required to report a breakeven position by a retrospective 'Top up' funding adjustment. Covid costs now total £8.4m for the year to date. Temporary staffing costs continue to reduce. YTD Capital expenditure is £7.6m being £2.8m behind original plans. P**laces**: Work on the new hospital, schedule of accommodation and design brief remains key priority.
Recommendation:	The Board is asked to discuss the report and note the current position and further action being taken in areas below agreed standards.

The Princess Alexandra Hospital NHS Trust

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.24.09.20 and QSC.25.09.20
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	

5.1

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report

August 2020

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

Your future | Our hospital

Contact:

Lance McCarthy, Chief Executive Officer
Marcelle Michail, Acting Chief Medical 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

respectful | caring | responsible | committed

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

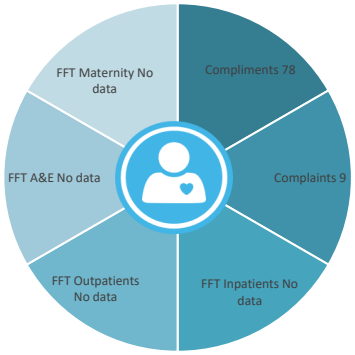
Manage **our pounds** effectively to achieve our agreed financial control total for 2019/20.

5Ps

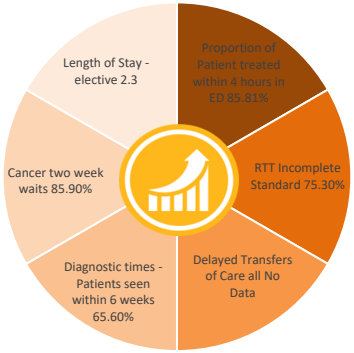
In this month

The Princess Alexandra Hospital NHS Trust

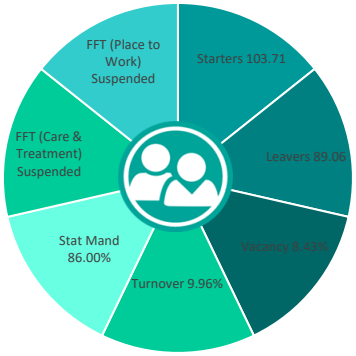
Patients



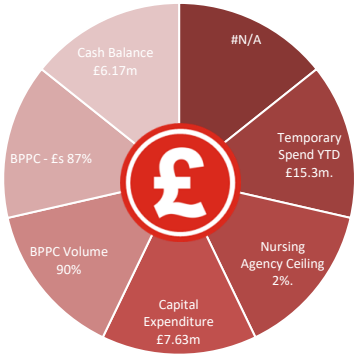
Performance



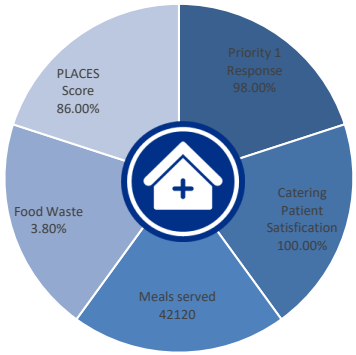
People



Pounds

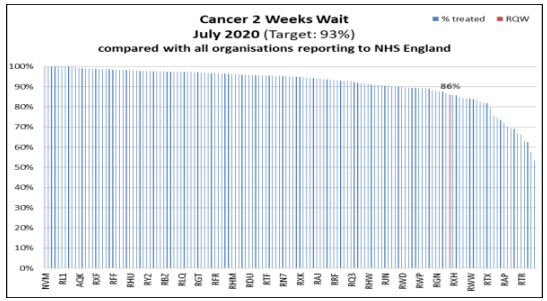


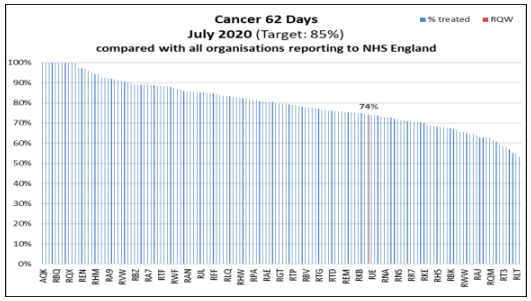
Places

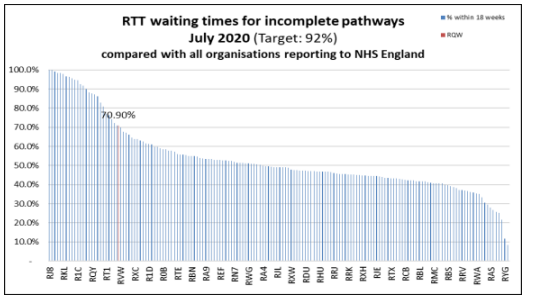


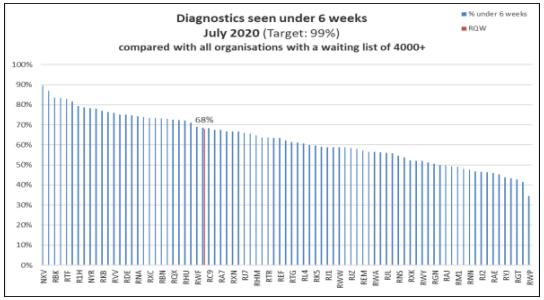
National Benchmarking
Compared with all organisations reporting to NHS England

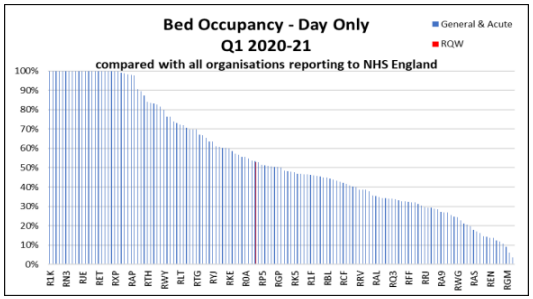
NHS
The Princess Alexandra Hospital
NHS Trust

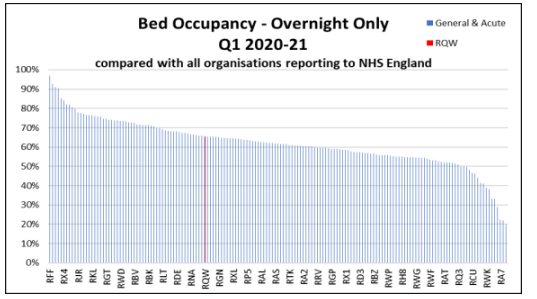


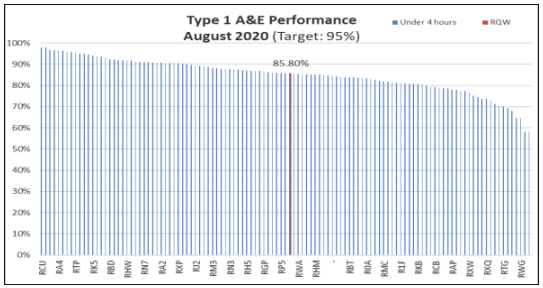


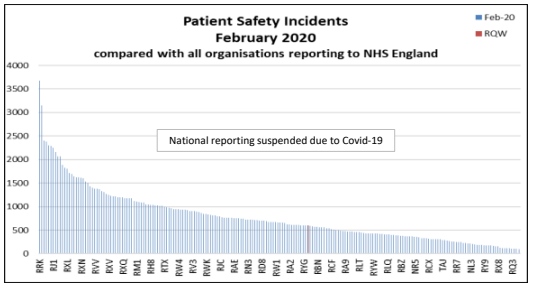


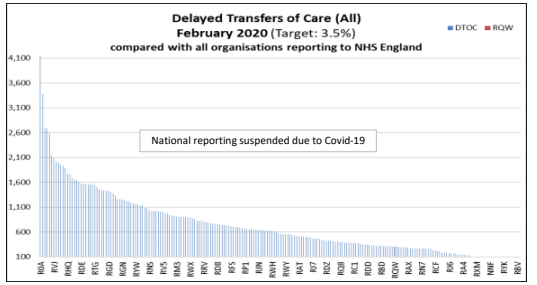












Your future | Our hospital

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

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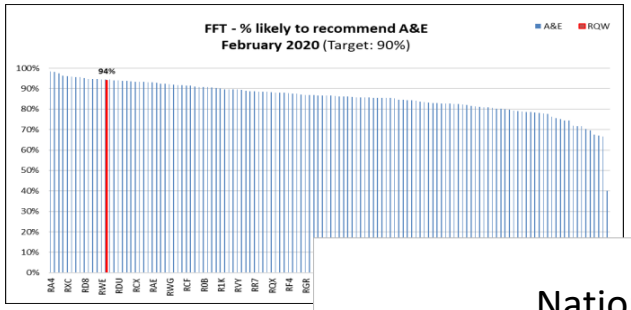
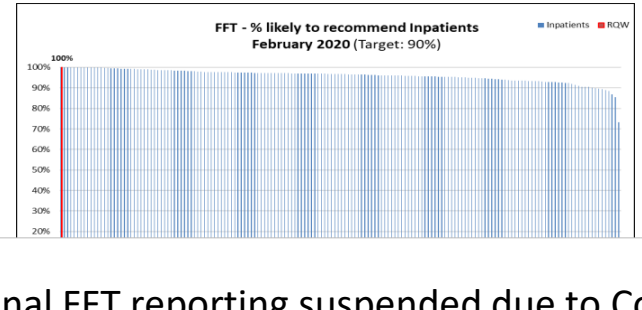
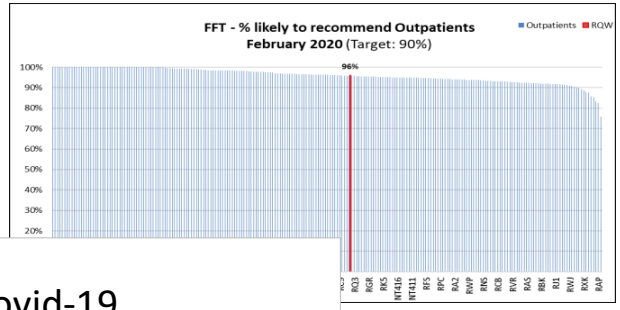
National Benchmarking
Compared with all organisations reporting to NHS England

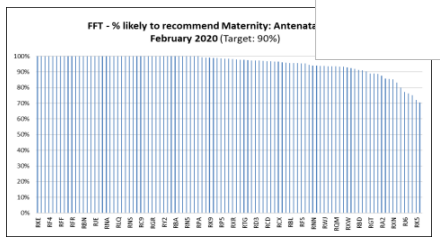
NHS
The Princess Alexandra Hospital
NHS Trust

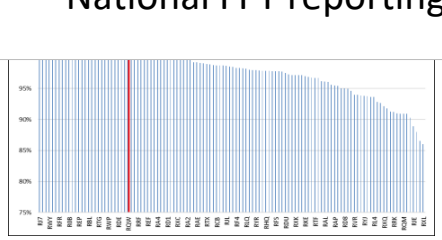


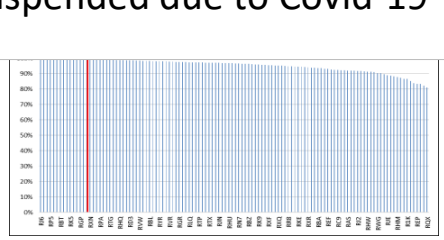


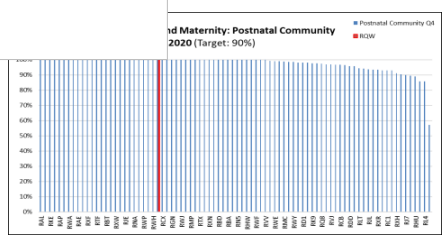


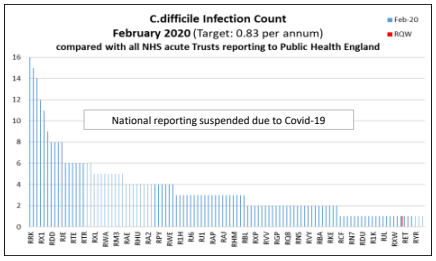
National FFT reporting suspended due to Covid-19

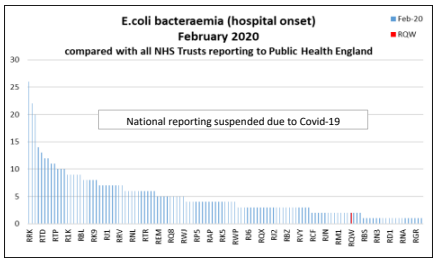


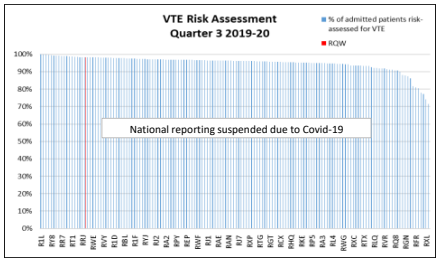


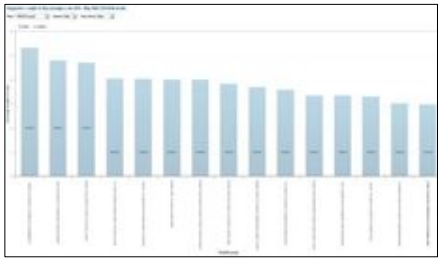












Your future : Our hospital

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

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Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

Patient experience: A new policy for the management of complaint deadlines has been put in place. 9 complaints & PALS 265 cases were opened in August.

Infection control: Information relating to Covid 19 has been included under the Infection Control page & shows the sustained reduction in presentation & number of positive patients within the organisation. C.difficile: during July & August, there has been a rapid rise in cases; three Community onset, health care associate cases, and six health-care associated cases were isolated in August (a total of 13 cases for the year). Following a review of the cases, there does not appear to be any links between cases or association with the environment; cases are distributed between Medicine and Surgery.

Harm free care: Falls per 1000 bed days showed a small decrease from 9.88 to 9.42 compared to July. Pressure ulcer rates continue to steady with no reported Category 3 PUs in month.

Maternity dashboard: The rate of Post-Partum Haemorrhages (PPH) over 1.5L continues to be a focus for the service. The PPH Task Force, which was formed in conjunction with our LMNS Partner Hospitals, continues to monitor & work on reducing the rate PPH over 1.5L
PAH has moved to a new 'Physiological' interpretation of CTG monitoring during labour. Doctors & Midwives are undergoing a new Training package & compliance figures will be available in the forthcoming months.

Mental Health: The Mental Health Quality Forum is continuing the implementation of the Mental Health Act policy; the trust has commenced timely detaining of patients under the MHA which is one of the key actions of the forum.

Patient Experience

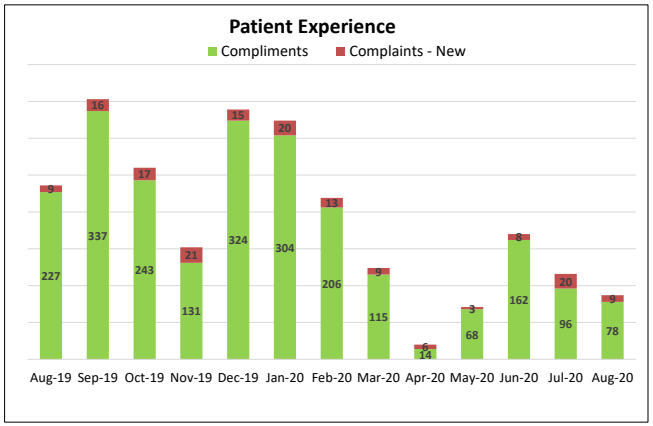
1 Our Patients Summary 1.1 Patient Experience

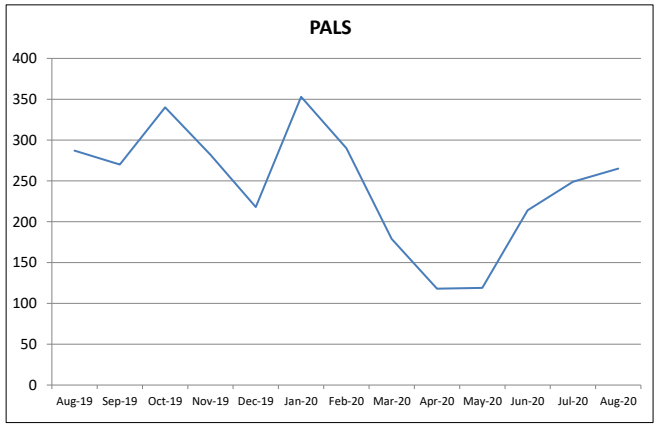
NHS The Princess Alexandra Hospital NHS Trust

After a significant reduction in feedback being received during the pandemic, feedback patterns are now changing. Since March, concerns about parking (evidenced by A13 – Equipment & premises) have all but disappeared as parking has been free & well supported by staff and security, this may change once charges are reintroduced. In the last five months only four complaints were received about delays compared to 14 in the preceding five. A rapid increase in PALS concerns about communication with over 50 PALS cases per month about communication (56, 76, 87) compared to cases in the 30s during preceding 3 months. A significant level of concern from the public about lost property emerged during the pandemic & we have been proactively managing our response to this with a new policy, renewed processes including serial numbered property bags, with all valuables placed in colour-coded self-sealing packs, a new centralised property safe & a renewed focus on information & communication to be launched regarding lost property.

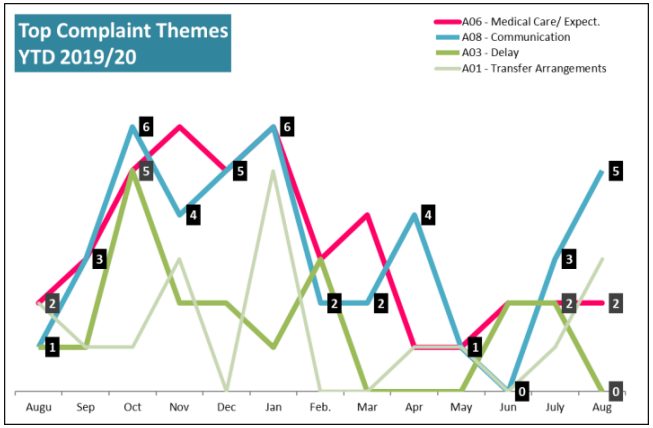
Admission, discharge & transfer appear to be emerging once again in complaints data as an area of concern for patients & carers and we will be closely monitoring this evidence to establish if there are systemic problems post pandemic.

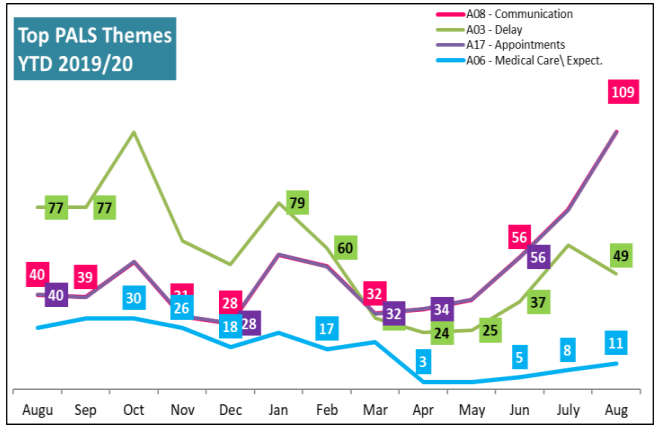
The oldest complaint case open relates to a Medicine issue opened on 10 April 2019 relating to Winter Ward, this was discussed at the Patient Experience Committee & Medicine HCG and have a planned meeting in place to close this down as this was further delayed due to the complaint pause. A new policy for the management of complaint deadlines has been put in place & so although not all cases are now inside a 30, 45, 60 timfeame, at the close of the reporting period all cases were within timeframe. PALS 265 cases opened in August, with 165 closed & total open 298.

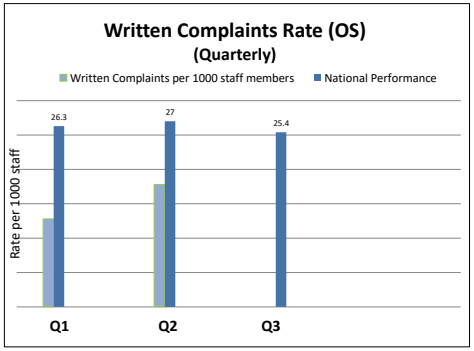




PALS converted to Complaints	
Aug-19	1
Sep-19	4
Oct-19	2
Nov-19	3
Dec-19	4
Jan-20	6
Feb-20	3
Mar-20	1
Apr-20	0
May-20	0
Jun-20	1
Jul-20	6
Aug-20	4

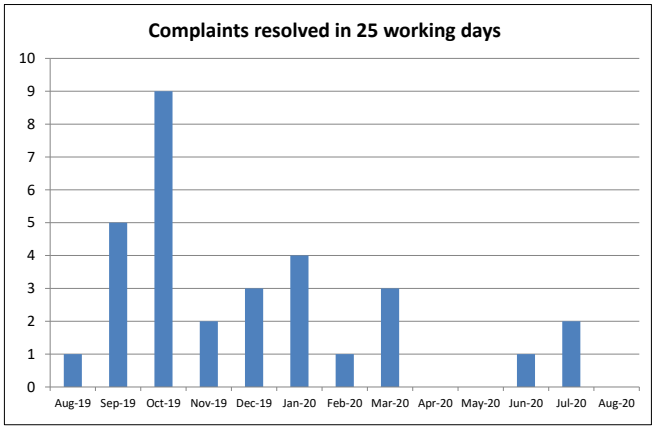


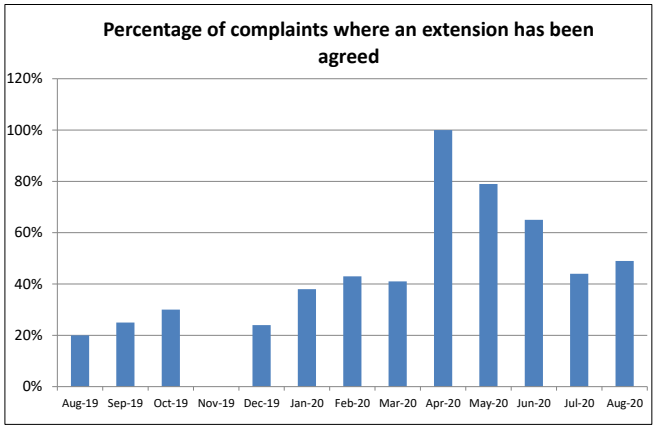


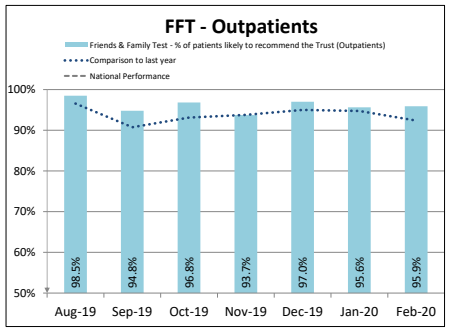


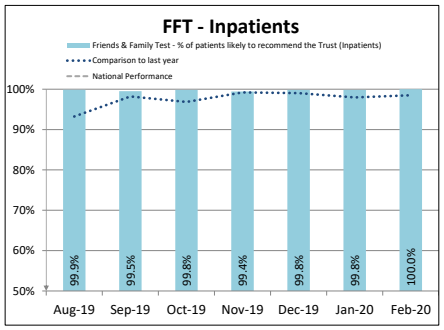
National collection suspended due to Covid-19

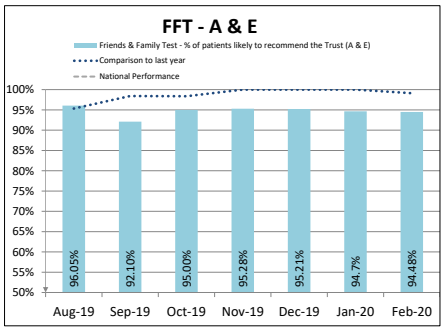
Patient Experience

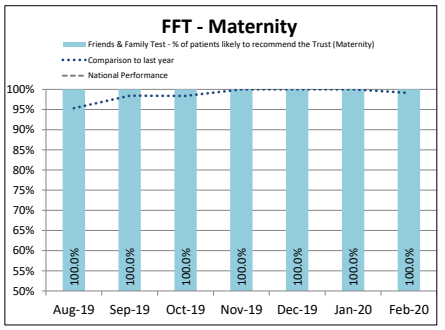












FFT national collection suspended due to Covid-19

Patient Safety

1 Our Patients Summary 1.3 Patient Safety

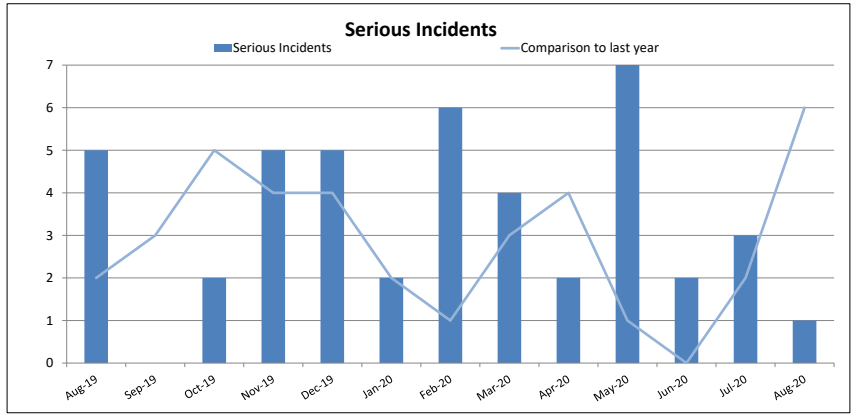
NHS The Princess Alexandra Hospital NHS Trust

1017 incidents were reported in August (761 no harm, 224 minor (97%), 25 moderate (2.4%), 5 severe (0.4%) and 2 death graded harms (0.2%).
The majority of incidents have been reported in Zone B (41%), non COVID-19 positive wards.

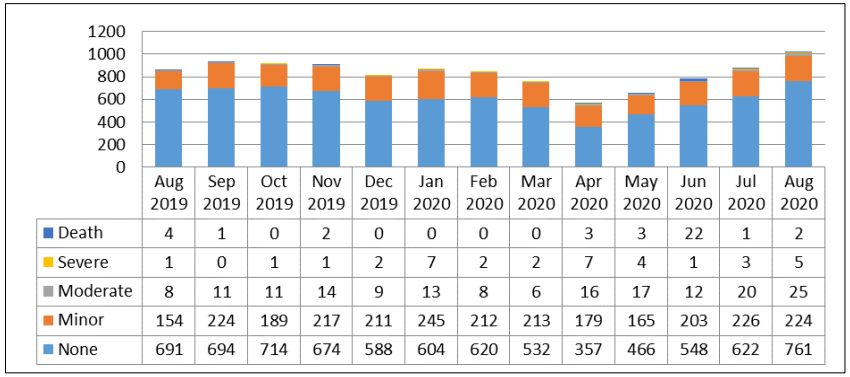
One Serious Incident was reported externally in month
- 1 unexpected death

Two Safety Alerts breached in August 2020.
- MDA.2019.037 – Prismaflex Haemofiltration Systems Agreed breach by the Trust since January 2020 as Baxter Technical were unable to action. The work was completed early August and we closed this alert
- MDA.2020.021 - Masks: From Cardinal Health

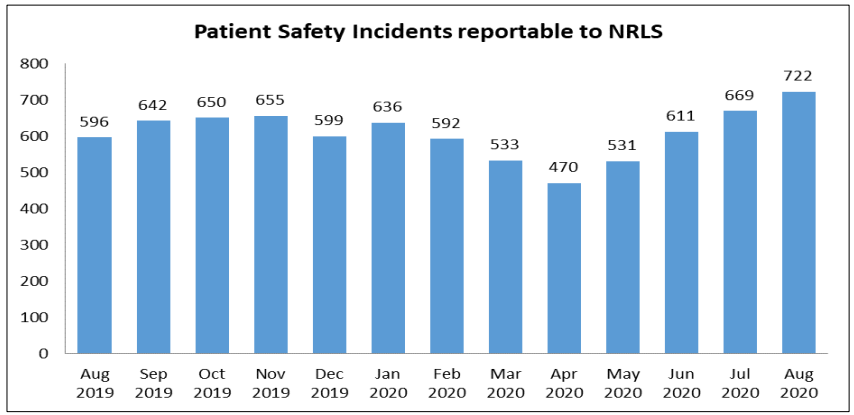
Actions were fully completed within the last day of the deadline. Due to unexpected staff leave the Trust was unable to update the CAS system until the next day, therefore this alert breached by 12 hours.

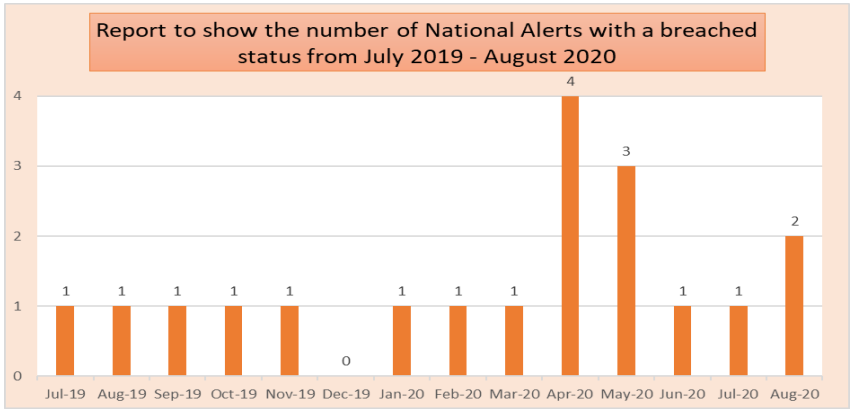


Severity of reported Incidents on Datix



	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020
Death	4	1	0	2	0	0	0	0	3	3	22	1	2
Severe	1	0	1	1	2	7	2	2	7	4	1	3	5
Moderate	8	11	11	14	9	13	8	6	16	17	12	20	25
Minor	154	224	189	217	211	245	212	213	179	165	203	226	224
None	691	694	714	674	588	604	620	532	357	466	548	622	761



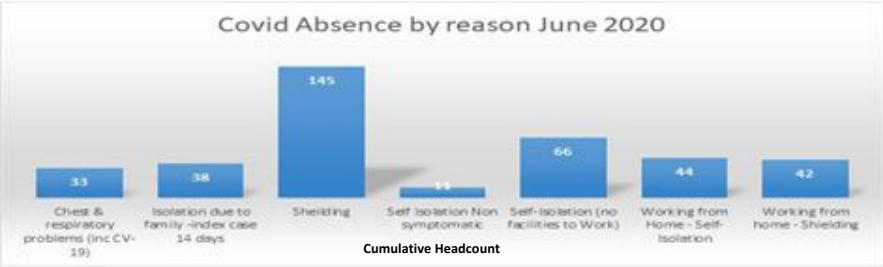


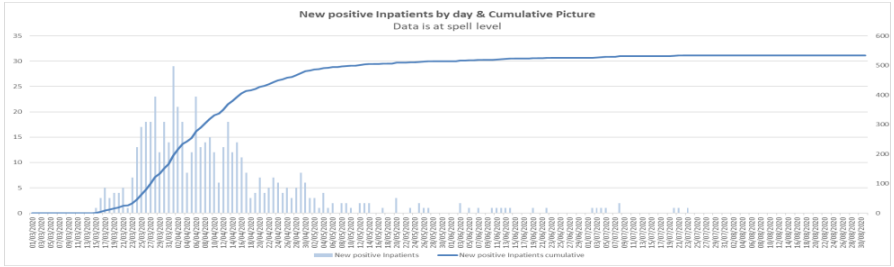
Infection Control

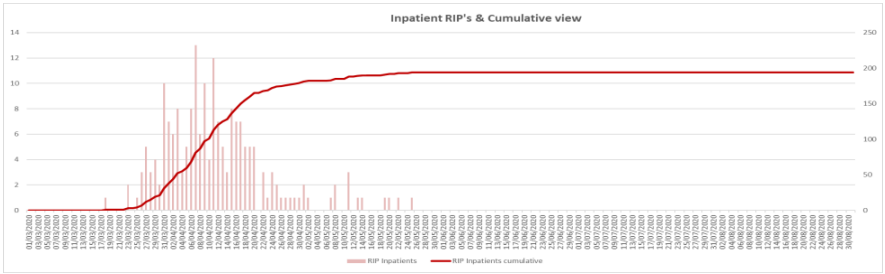
1 Our Patients Summary 1.4 Infection Control - Covid-19

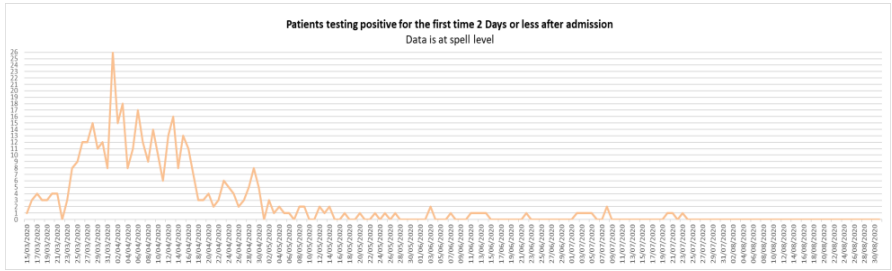
NHS
The Princess Alexandra Hospital
NHS Trust

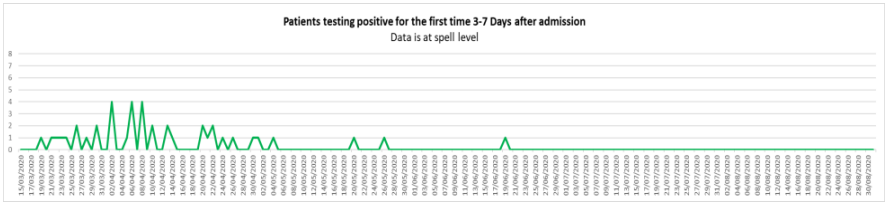
This page provides an update to the Covid19 position within the organisation.

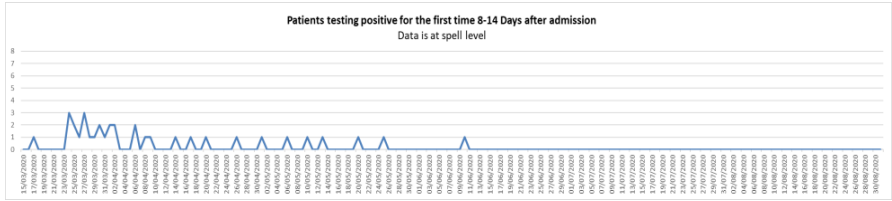


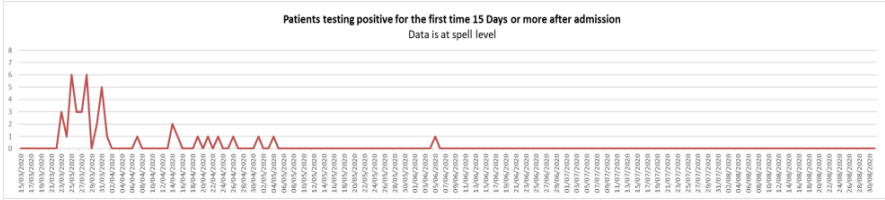












5.1

Infection Control

1 Our Patients Summary 1.5 Infection Control

NHS The Princess Alexandra Hospital NHS Trust

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

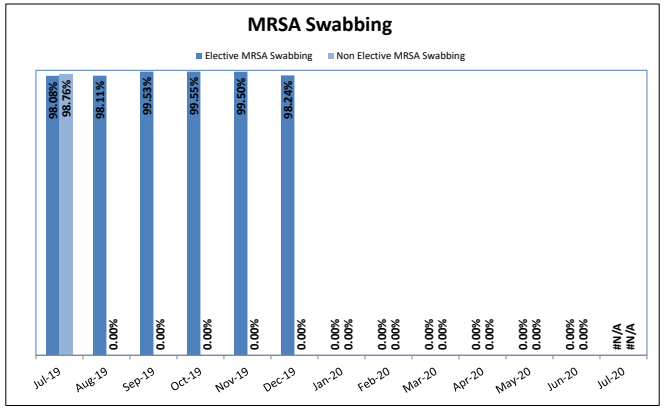
MSSA
There were no Trust apportioned cases of MSSA in August. In total, there have been four cases of Trust-apportioned MSSA bacteraemia year to date.

C.difficile
During July and August, there has been a rapid rise in cases; three Community onset, health care associate cases, & six health-care associated cases were isolated in August (a total of 13 cases for the year). Following a review of the cases, there does not appear to be any links between cases or association with the environment; cases are distributed between Medicine and Surgery. The review of cases suggests that there were lapses in antibiotic stewardship. A number of actions have been taken to address this including the microbiologists resuming ward rounds & monitoring antibiotic usage. Additionally, Consultants, AMDs & senior pharmacists have been informed of these findings & have been requested to ensure their teams are following the Trust antibiotic guidance.

Gram Negative Blood Stream Infections (GNBSIs)
The Trust remains in a good position when compared nationally with other hospitals (within the top quarter). During August, there were no Trust-apportioned GNBSIs.

MRSA screening
MRSA screening data is not available from the Information Team for August. A review of the exclusions criteria took place between the IPC team & the Informatics team, and communication has been cascaded to the Health care Groups to support with this.

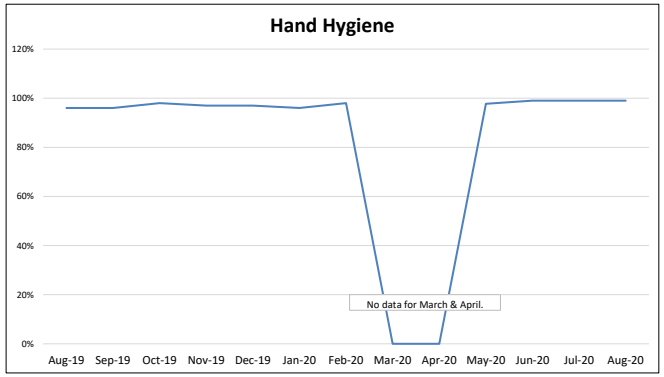
Hand Hygiene Audits – All wards/clinical department are expected to participate in monthly audits. Pre-COVID-19, these were undertaken as 'cross-over' audits, meaning staff did not audit themselves. However, this has now changed to wards undertaking their own hand hygiene audits to reduce unnecessary visits to clinical areas during the pandemic. The expectation is that 100% of clinical areas participate & the performance standard is 95% compliance. During August, the overall Trust wide score was 99% compliance (three areas scored under 95%), & eight (20%) areas did not submit the audit. Wards/departments are expected to discuss their results & agree appropriate actions within their Health Care Group.



MSSA	
Aug-19	0
Sep-19	0
Oct-19	0
Nov-19	0
Dec-19	0
Jan-20	1
Feb-20	2
Mar-20	1
Apr-20	1
May-20	2
Jun-20	0
Jul-20	1
Aug-20	No data

C-DIFF (New categories including community from April 2019)

Month	Hospital Responsible		Community Responsible		Total
	Hospital onset healthcare associated	Community onset healthcare associated (Acute Admission within last 4 wks)	Community onset indeterminate association (Acute Admission within last 12 wks)	Community onset community associated (No acute contact within 12 wks)	
Jul-19	0	0	0	0	0
Aug-19	0	0	1	2	3
Sep-19	1	1	0	0	2
Oct-19	1	0	1	2	4
Nov-19	3	0	0	1	4
Dec-19	4	0	3	0	7
Jan-20	1	2	1	1	5
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



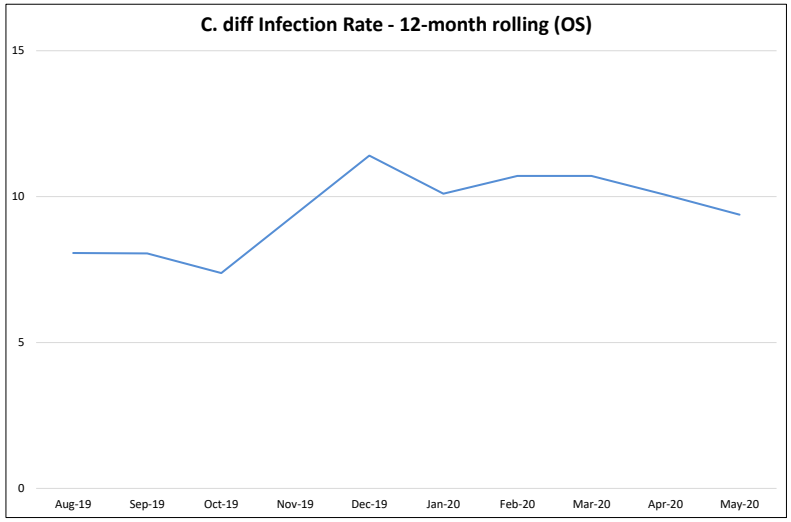
E Coli	
Aug-19	2
Sep-19	3
Oct-19	0
Nov-19	0
Dec-19	1
Jan-20	0
Feb-20	2
Mar-20	0
Apr-20	1
May-20	1
Jun-20	1
Jul-20	2
Aug-20	No data

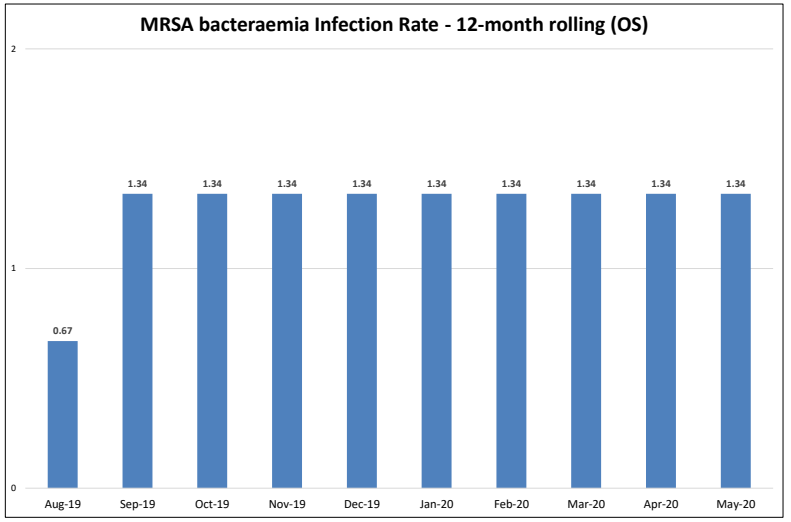
Klebsiella	
Aug-19	0
Sep-19	0
Oct-19	0
Nov-19	0
Dec-19	1
Jan-20	0
Feb-20	0
Mar-20	1
Apr-20	1
May-20	0
Jun-20	2
Jul-20	0
Aug-20	No data

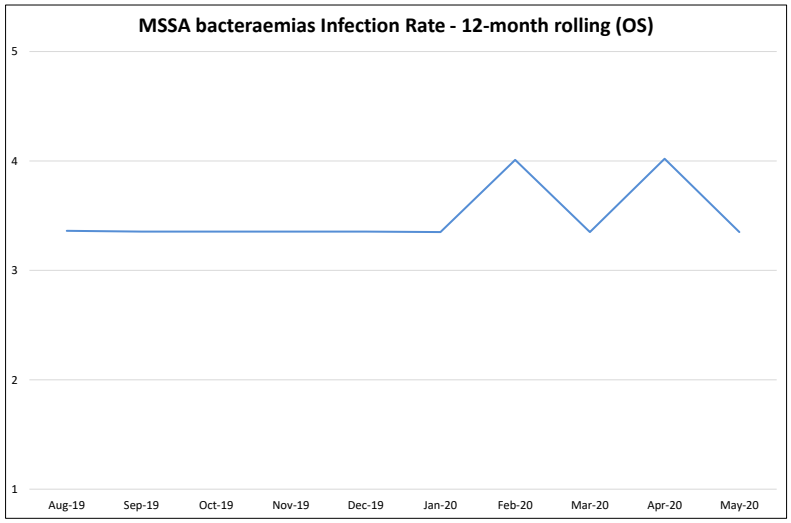
Pseudomonas	
Aug-19	0
Sep-19	1
Oct-19	2
Nov-19	0
Dec-19	0
Jan-20	0
Feb-20	0
Mar-20	0
Apr-20	0
May-20	1
Jun-20	0
Jul-20	0
Aug-20	No data

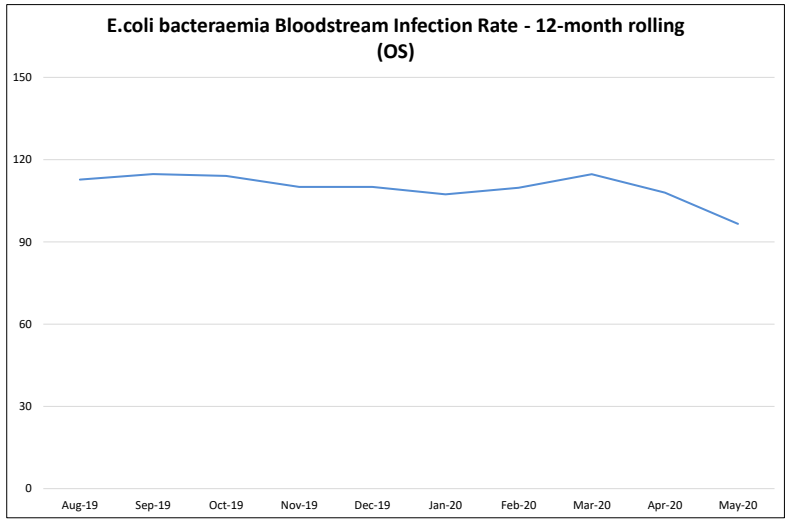
Infection Control

The following are the latest published data available.









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

1 Our Patients Summary 1.7 Patient Safety

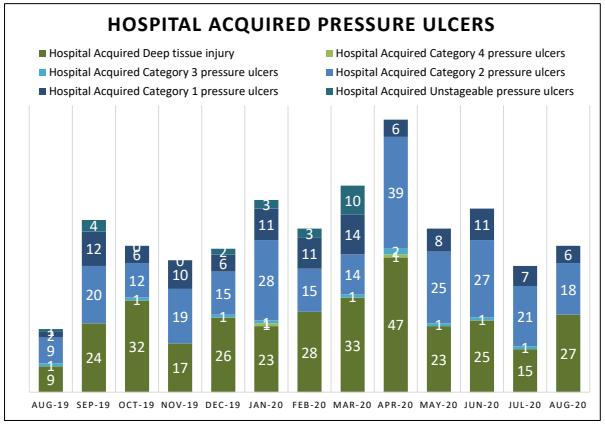
During August 2020, the falls rate per 100 patients showed a slight increase to 8.14 compared with 8.08 in July. However, there was a decrease in the rate per 100 patients (falls with harm) from 2.85 to 2.02.

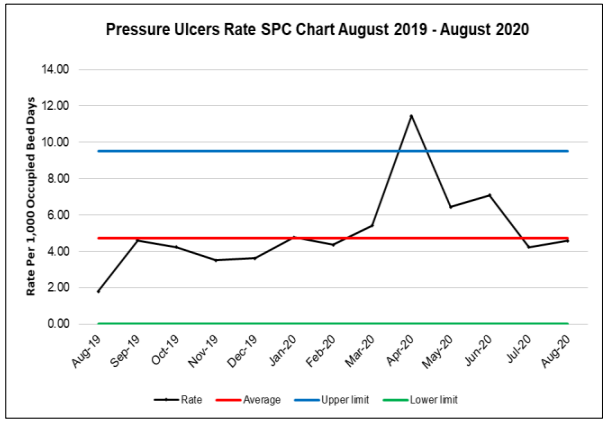
Falls per 1000 bed days showed a small decrease from 9.88 to 9.42 compared to July.

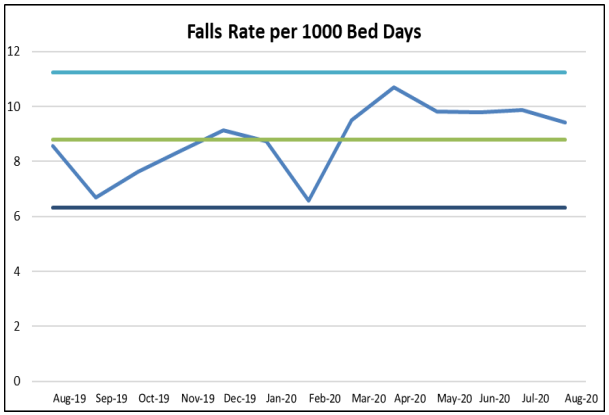
The total number of actual falls increased from 105 to 117, a figure which continues to be more comparable to the monthly rates prior to the COVID pandemic. However, there was an increase in the occupied bed days from 10632 to 12415 during August.

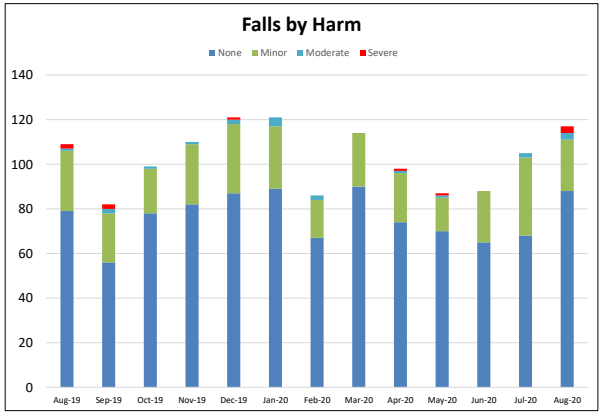
In month, the largest increase in falls were seen on Penn and Fleming wards. There were 3 moderate harm falls and 3 severe harm falls reported during August.

Pressure ulcer rates contune to steady with no reported Catagory 3 PUs in month.









Family & Women's Service

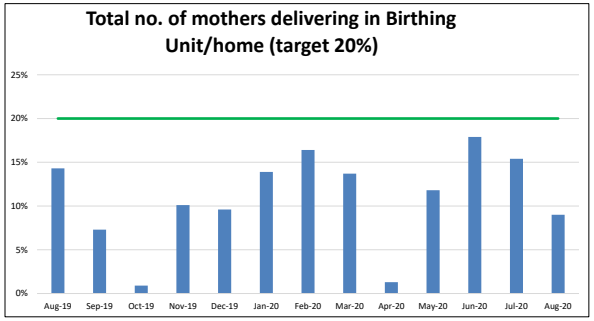
2 Our Patients Summary 1.8 Family & Women's Service

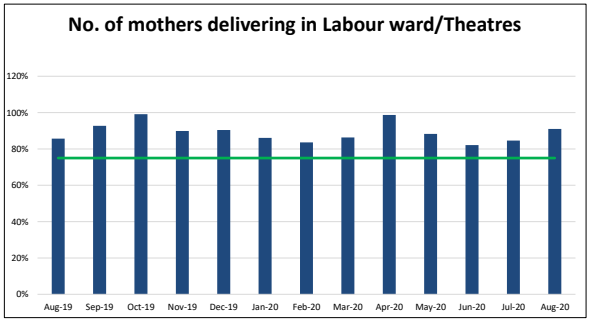
NHS
The Princess Alexandra Hospital
NHS Trust

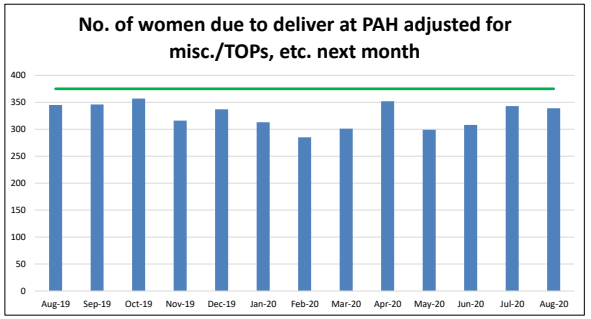
The rate of Post-Partum Haemorrhages (PPH) over 1.5L, has increased from 2% of all births in July 2020 to 3.6% in August 2020.
Although this represents a significant increase it is still an improvement when compared to previous months (April 2020 to June 2020 average rate of PPH over 1.5L was 5.0%). The PPH Task Force, which was formed in conjunction with our LMNS Partner Hospitals, continues to monitor & work on reducing the rate PPH over 1.5L.

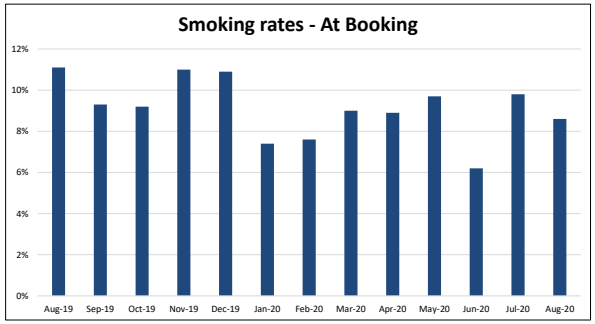
The C Section rate has remained higher than expected in August 2020 at 31.9% of deliveries. The indications for Elective C Sections in July & August are being audited by the Antenatal Clinic Team so that an analysis can be conducted & any appropriate actions will be identified. Once completed the audit will be presented at a FAWS multi-disciplinary Audit Meeting.

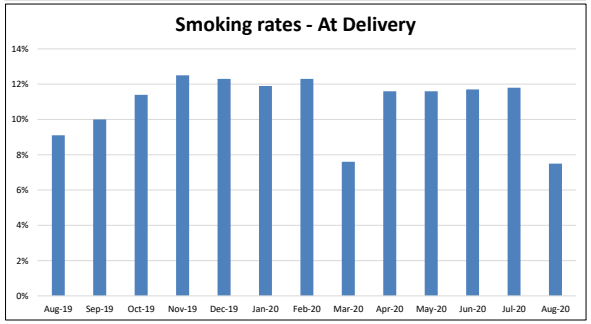
PAH has moved to a new 'Physiological' interpretation of CTG monitoring during labour. Doctors & Midwives are undergoing a new Training package & compliance figures will be available in the forthcoming months.

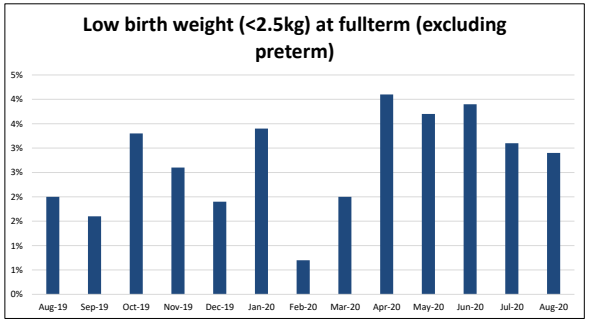


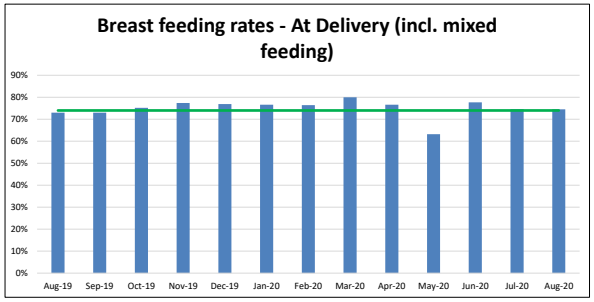


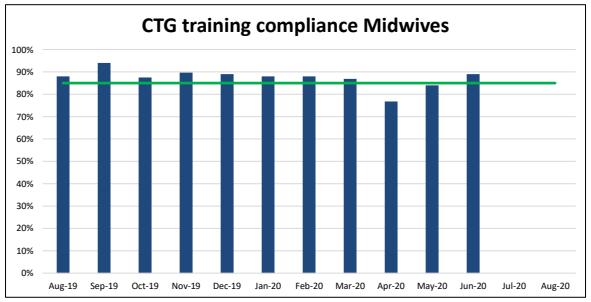


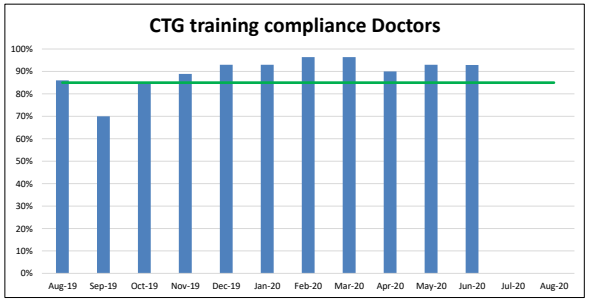




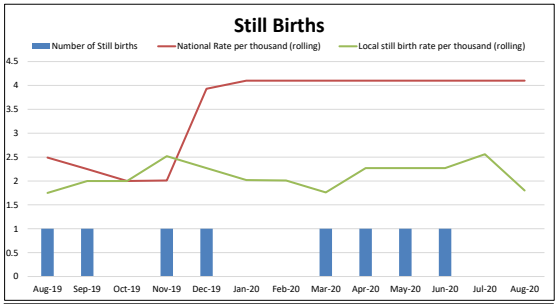


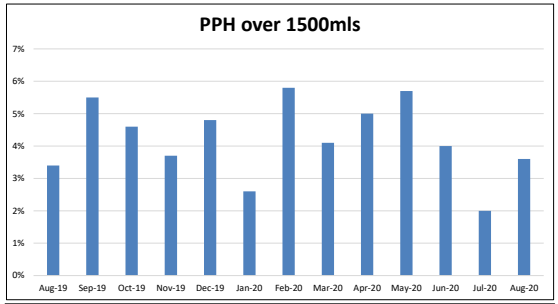


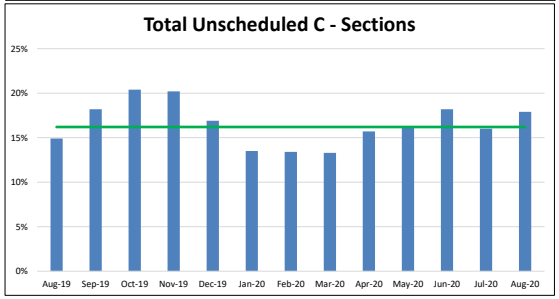


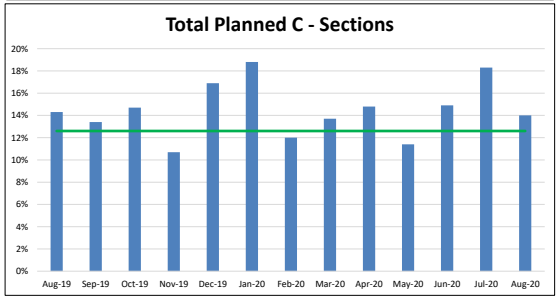


Family & Women's Service







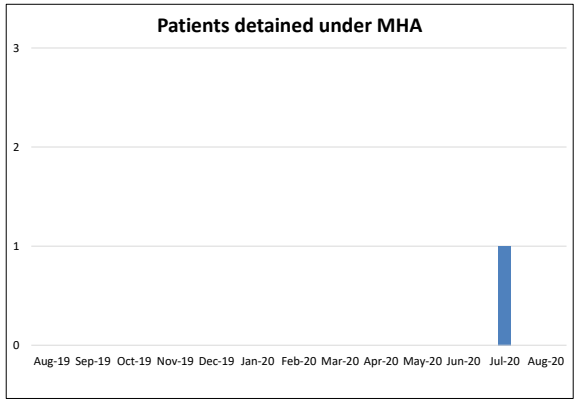


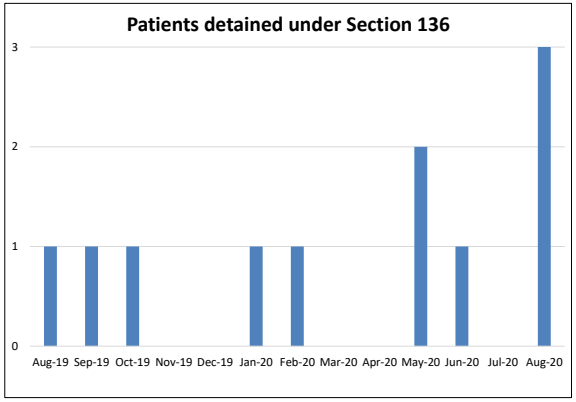
Mental Health

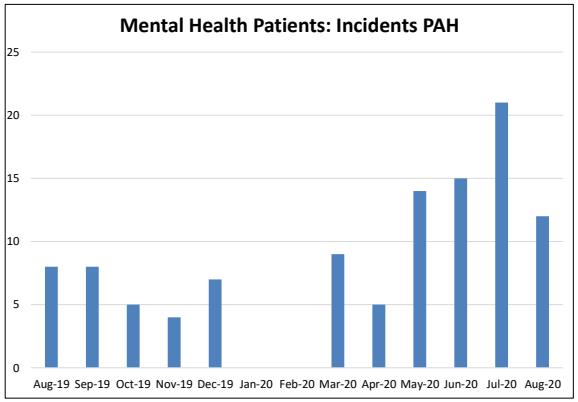
1 Our Patients Summary 1.10 Mental Health

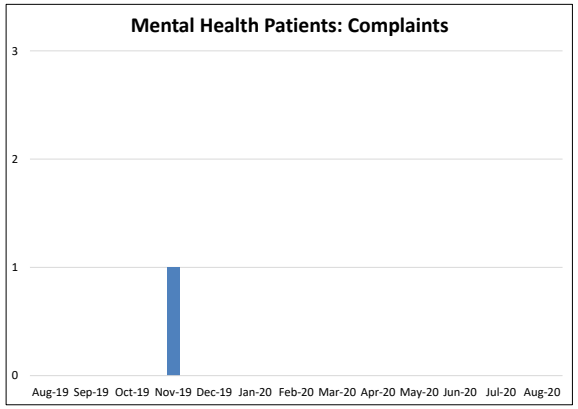
The Princess Alexandra Hospital NHS Trust

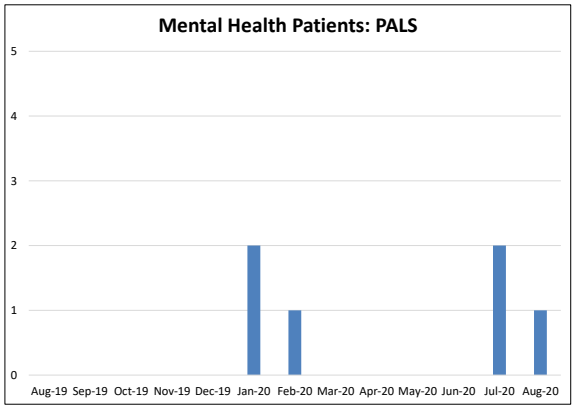
The Mental Health Quality Forum is continuing the implementation of the Mental Health Act policy, further embedding of the Core24 mental health liaison service and development of the organisations training and development programme in relation to mental health. The trust has commenced timely detaining of patients under the MHA which is one of the key actions of the forum.

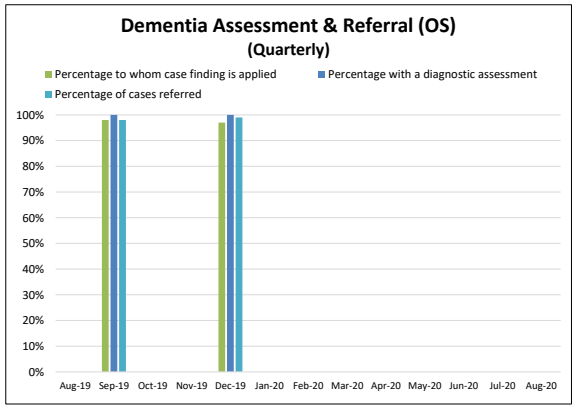












DAR national collection suspended due to Covid-19

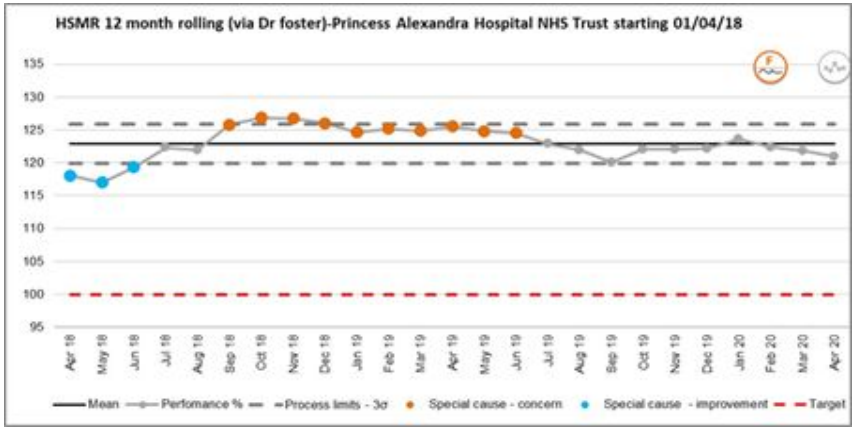
Mortality

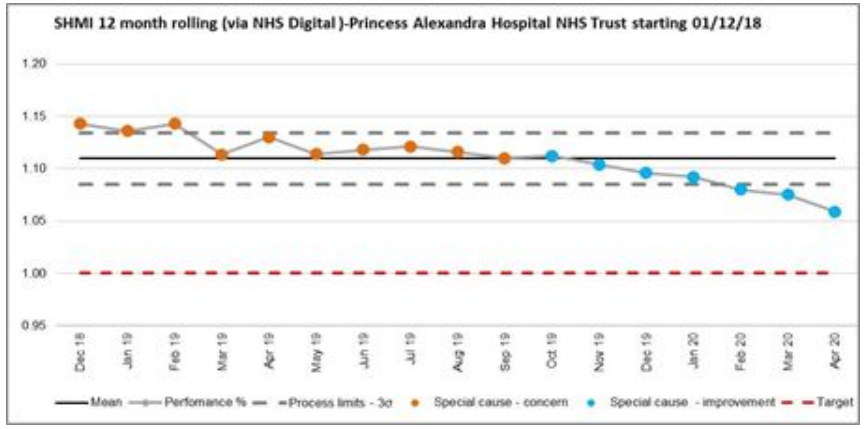
1 Our Patients Summary 1.11 Mortality

The Princess Alexandra Hospital NHS Trust

PAHT now has a Learning From Death process that meets the National requirements. Every death has a level one review by a Medical Examiner, at least 25% of all deaths are referred for a Structured Judgement Review (SJR) to be undertaken including all the mandatory reviews and those of our local outliers, and all other deaths are reviewed through the local Mortality and Morbidity process using a standardised level 2 review template. For any death that has an avoidability score of 1 or 2 (definitely avoidable or strong evidence of avoidability) these cases are referred to the Second Review Panel.

All quality improvement (QI) projects that are associated with improving patient outcomes (mortality rates) are either delivered:
a. Locally within healthcare groups and reported back through local PS&Q meetings and/or QSC when required (with advice, guidance and learning/development from the Quality First Team as/when required).
b. Or, when the Quality First Team are supporting the development/delivery of QI projects, via the Quality Improvement Board, Strategic Learning From Death Group and Q&SC.

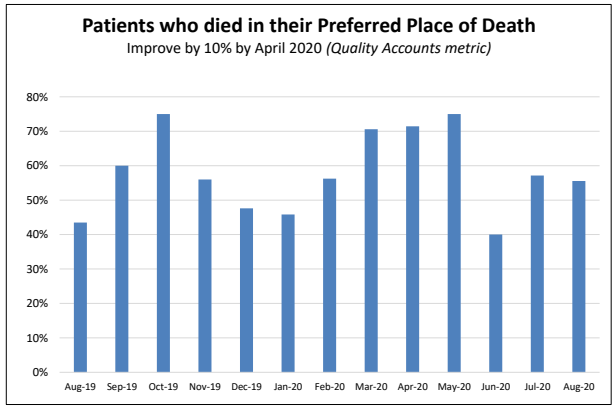




PAHT has shown significantly high HSMR since November 2016. The SPC chart above shows the most recent 12 month rolling data point is 120.9.

The most recent SHMI value is 1.059. We have not alerted since April 2019.

Mortality Outlier Alerts (QA)	
Feb 18 - Jan 19	**6**
Mar 18 - Feb 19	**7**
Jul 18 - Jun 19	**7**
Aug 18 - Jul 19	**6**
Sep 18 - Aug 19	**5**
Oct 18 - Sep 19	**5**
Nov 18 - Oct 19	**6**
Feb 19 - Jan 20	**6**
Apr 19 - Mar 20	**4**
Jun 19 - May 20	**8**



Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

Operational Performance Recovery and Delivery

Critical services have now been restored, though challenges remain due to IPC requirements and compliance with social distancing.

• Cancer backlog reduction plan in place to swiftly reduce >62 and >104 day patient numbers. Clinically prioritised PTL (Cancer & RTT) developed to ensure booking in clinical priority order, looking to create an STP prioritised PTL to use as surge and capacity support. Recovery trajectories to address all patients who have waited in excess of 62/104 days are in place with deadlines to clear by end of October. The exception to this will be services within lower GI and Endoscopy. Specific work to address these specialities is in place. Additional capacity for a 3rd endoscopy room is underway with clear oversight and management of all patients waiting by the AMD Medicine. Additional project support is being sought from within the system to assit with further review of pathways and processes.

• Numbers of patients > 6 weeks for diagnostics and >52 weeks for elective surgery have risen due to the pause on routine elective activity. This will remain challenging until additional capacity is brought online. Additional MRI and CT capacity are in place, with clear robust plans to return to national standard in December 2020.

• Independent Sector capacity is a vital part of recovery for cancer and elective activity, and is being expanded to patients including those on recovery pathways over 52 weeks.

Phase 3 Recovery Plan • A&E attendances & emergency admissions at plan level

•O/P appointments at 20/21 plan with 52% non face to face. RTT referrals still under 20/21 plan but cancer & urgent at & above plan (respectively)

•O/P procedures currently running through “amber” pathway (55% of 19/20), planned to increase to 100% green pathway by November.

•Day cases range from 52% in Sept (excluding IS) to 88%. A lot of daycases to go through IS as simpler and PTL casemix skewed to more complex work after Covid delays

•Elective in-patients range from 74% to 115% of 19/20 activity. Looking to run 7 regular elective theatres per day at PAH plus 2 additional per weekday and 4 day case additional theatres Sat & Sunday.

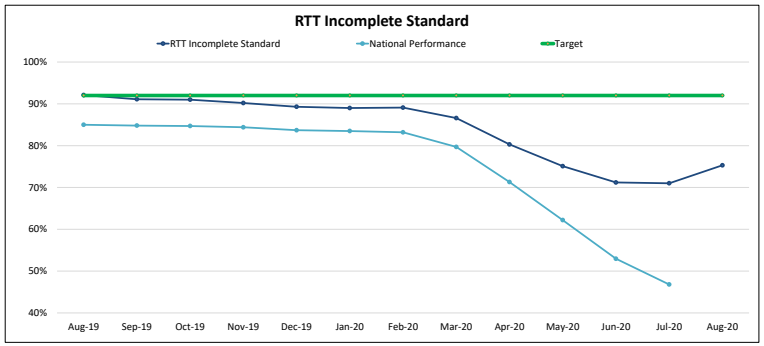
•Diagnostics all over 100% of 19/20 activity in order to catch up with backlog, surveillance patients and some modalities (MRI) increased referrals

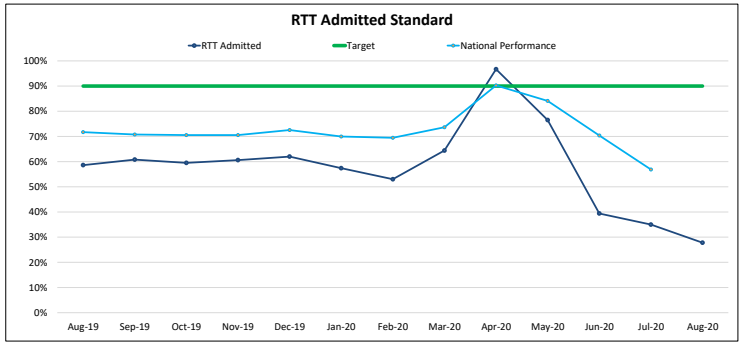
•Clinical & operational support is in place across the Trust for maintenance of elective recovery & to protect from Covid surge impacts as much as possible.

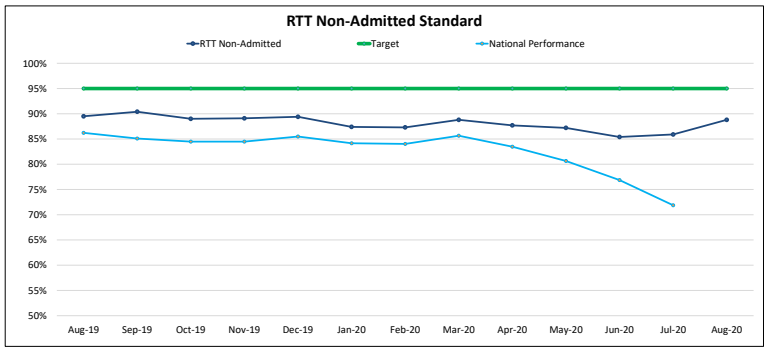
•Created a flag on Cosmic to identify patients at high risk from respiratory virus – to ensure we can identify those shielding and in need of particular care for current condition &/surgery

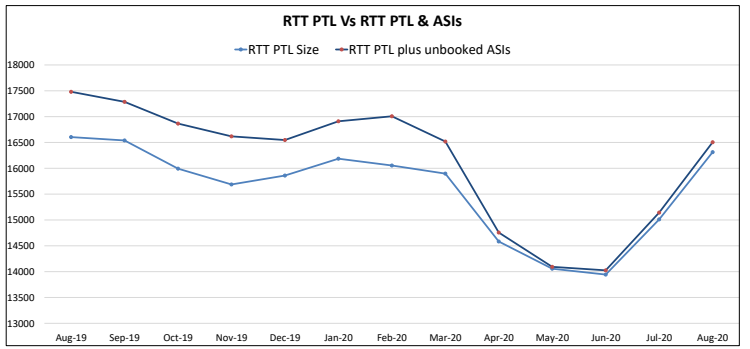
Ambulance conveyances and majors demand has risen to pre-Covid levels with an increase in acuity and compexity of patient presentations. Approvals to commence development and building of the Adult Assessment Unit are in place. A detailed project team and structure are in place with leadership from the AMD Emergency Care. Estimated completion date is December 2020. Work on the development and creation of the frailty assessment unit will be completed by the end of the year.

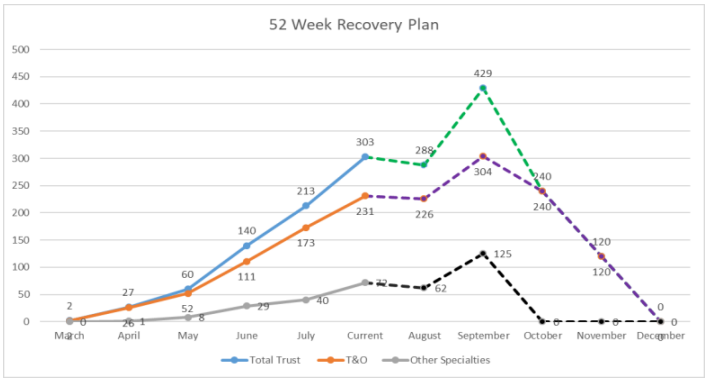
RTT


RTT Incomplete Standard
RTT Incomplete Standard
National Performance
Target
100%
90%
80%
70%
60%
50%
40%
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20


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


RTT Non-Admitted Standard
RTT Non-Admitted
Target
National Performance
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20

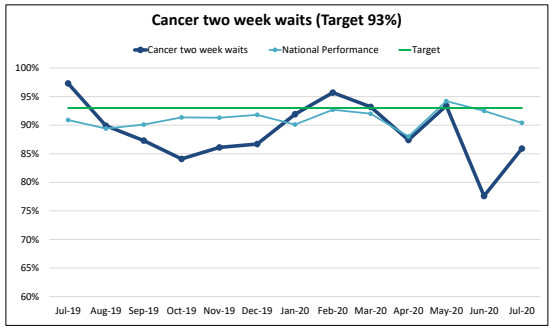

RTT PTL Vs RTT PTL & ASIs
RTT PTL Size
RTT PTL plus unbooked ASIs
18000
17500
17000
16500
16000
15500
15000
14500
14000
13500
13000
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20

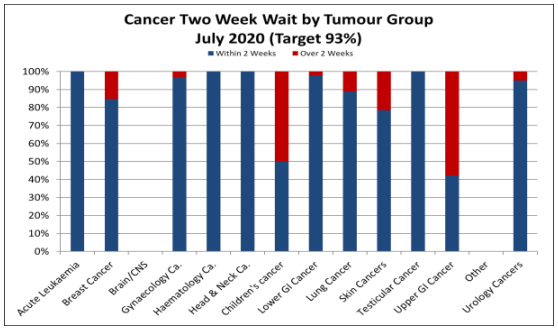

52 Week Recovery Plan
500
450
400
350
300
250
200
150
100
50
0
March
April
May
June
July
Current
August
September
October
November
December
Total Trust
T&O
Other Specialties

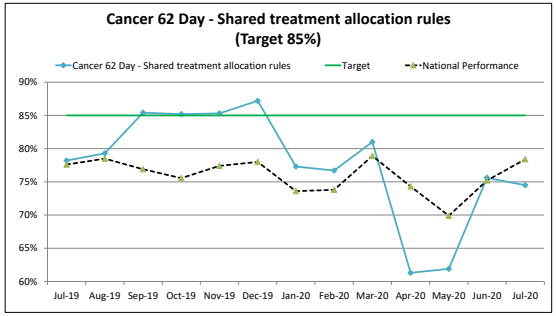
Cancer

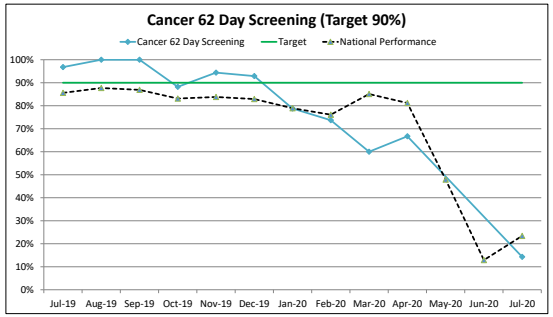
	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Jul-19	97.70%	97.40%	100.00%	100.00%
Aug-19	97.50%	98.90%	100.00%	100.00%
Sep-19	99.10%	99.10%	100.00%	100.00%
Oct-19	99.10%	100.00%	100.00%	100.00%
Nov-19	97.60%	100.00%	100.00%	100.00%
Dec-19	95.10%	97.90%	100.00%	100.00%
Jan-20	98.50%	94.40%	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%

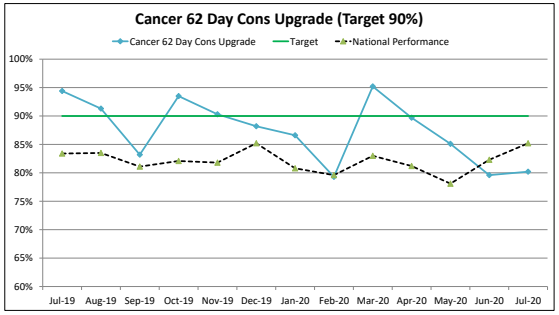
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

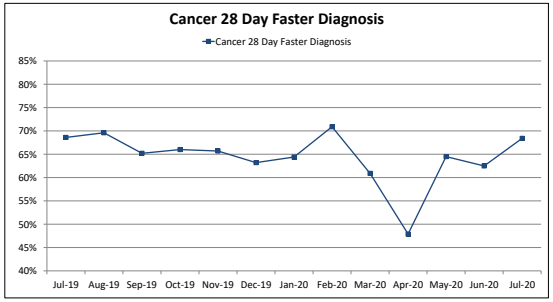


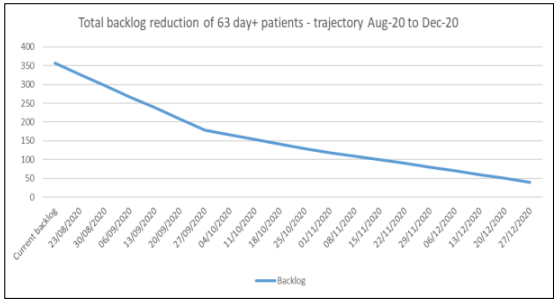




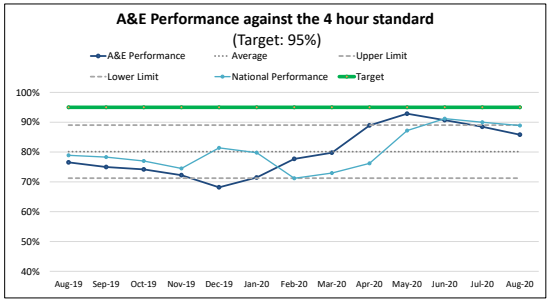


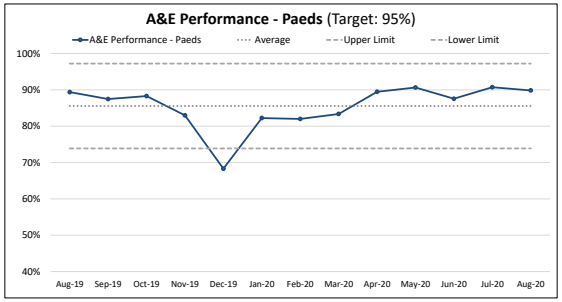


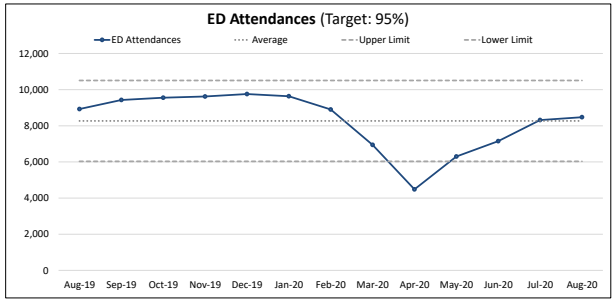


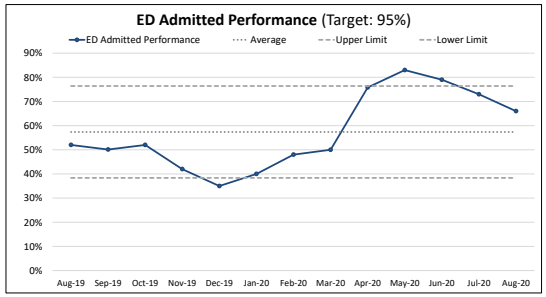


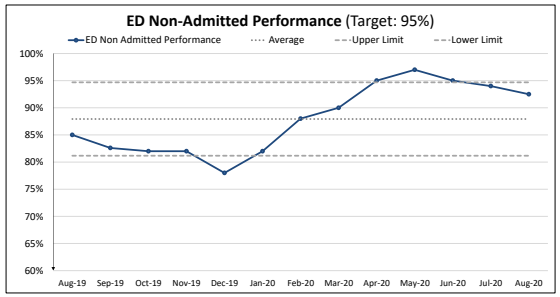
ED





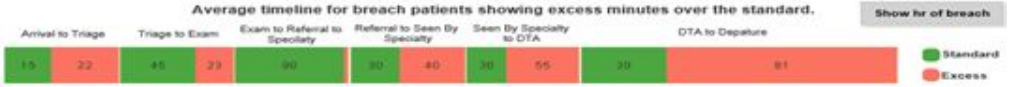






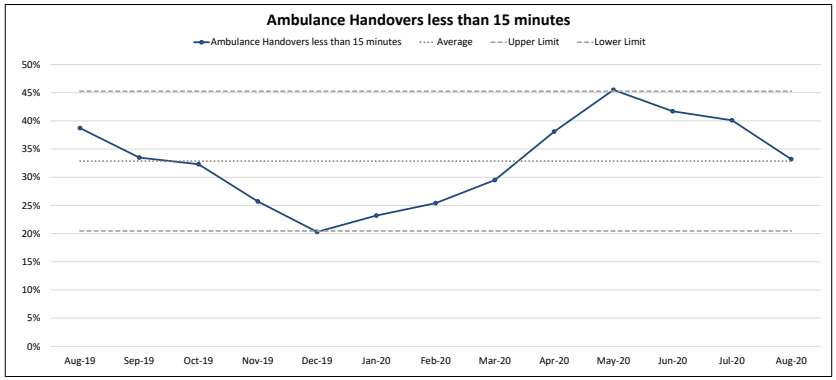
ED Internal Professional Standards

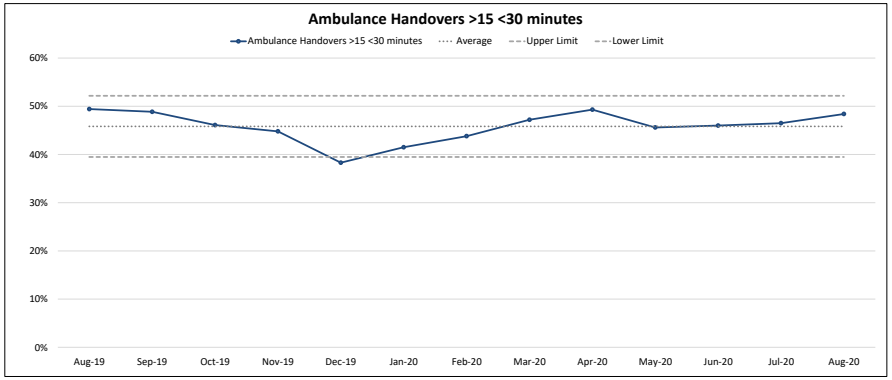
	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Arrival to Triage - Average Wait (Minutes)	34	39	35	38.63	46	41	37	30	25	26	25	29	37
Triage to Exam - Average Wait (Minutes)	93	102	108	102	104	91	76	60	41	44	56	78	68
Exam to Referral to Specialty - Average Wait (Minutes)	83	84	88	96	99	103	97	97	88	82	84	96	94
Referral to Seen by Specialty - Average Wait (Minutes)	79	70	78	98	90	87	77	74	54	48	51	64	70
Seen by Specialty to DTA - Average Wait (Minutes)	74	84	87	96	105	99	87	91	66	67	69	70	85
DTA to Departure - Average Wait (Minutes)	108	120	116	217	249	169	134	157	110	55	74	134	111

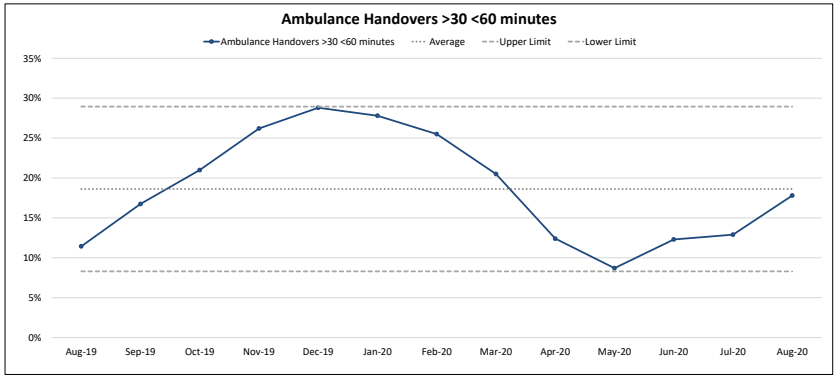


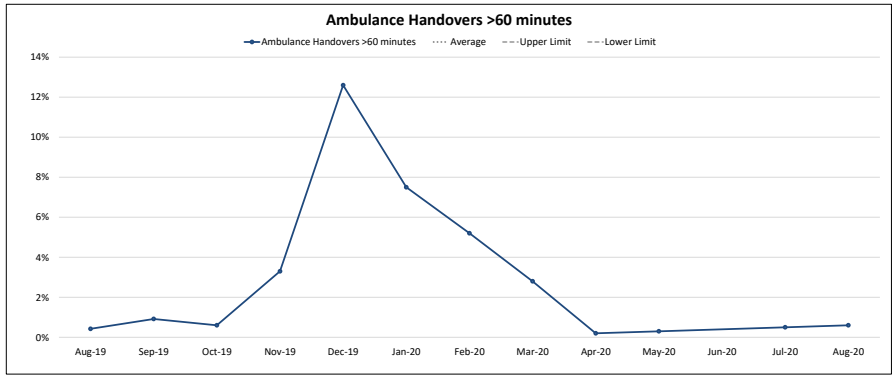
Measure	Standard	Average	Excess	Patients with Timestamp	Patients Who Breached	% Breached	Patients Who Breached Rank
Arrival to Triage	15	37	22	7,298	4,211	58%	
Triage to Exam	45	68	23	6,741	3,018	45%	
Exam to Referral to Specialty	90	94	4	2,133	559	26%	
Referral to Seen by Specialty	30	70	40	2,189	1,433	65%	
Seen by Specialty to DTA	30	85	55	1,364	583	43%	
DTA to Depature	30	111	81	2,169	842	39%	

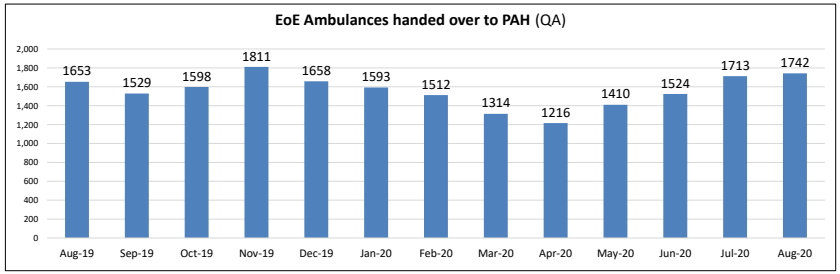
Ambulance


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%
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20

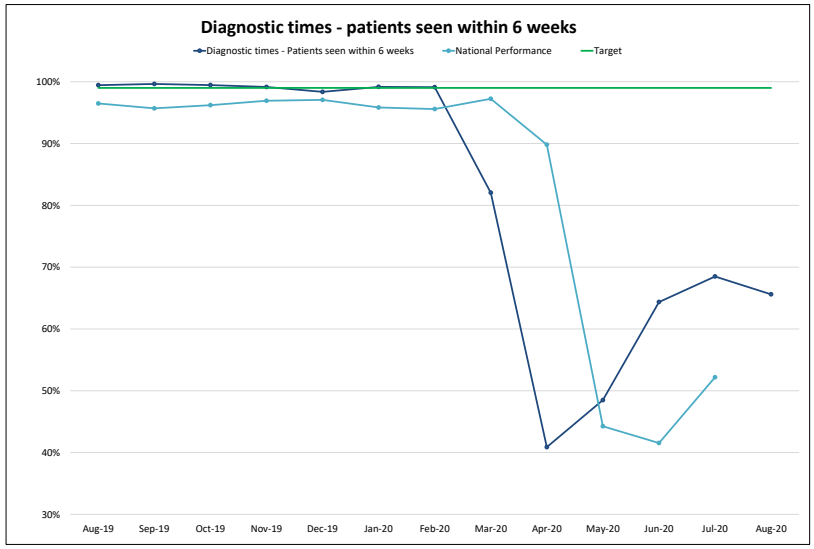

Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
60%
50%
40%
30%
20%
10%
0%
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20

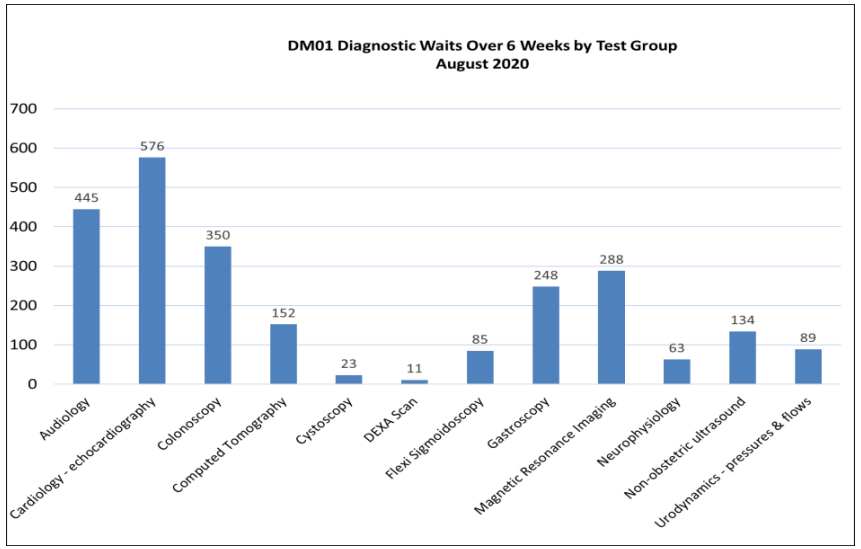

Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
35%
30%
25%
20%
15%
10%
5%
0%
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20


Ambulance Handovers >60 minutes
Ambulance Handovers >60 minutes
Average
Upper Limit
Lower Limit
14%
12%
10%
8%
6%
4%
2%
0%
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20


EoE Ambulances handed over to PAH (QA)
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1653
1529
1598
1811
1658
1593
1512
1314
1216
1410
1524
1713
1742
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20

Diagnostics

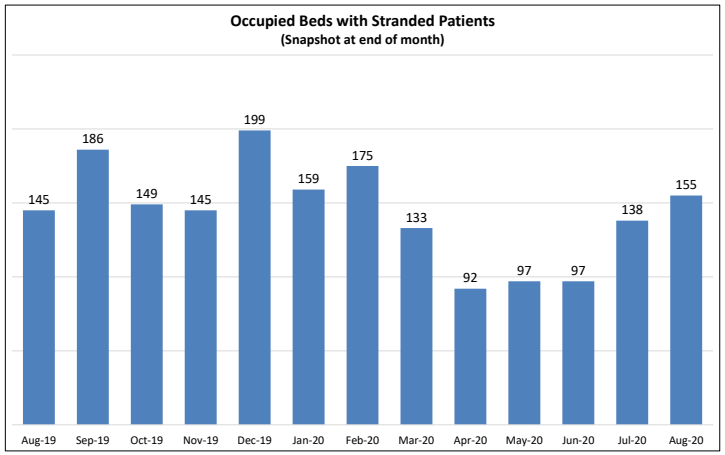


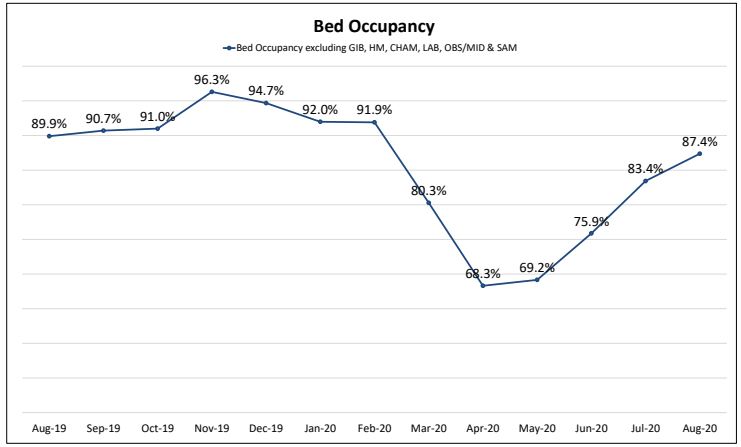


Test	% of Total Cohort - August 20	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
Magnetic Resonance Imaging (MRI)	19%	100.00%	100%	100%	100%	100%	100%	100%	78.41%	33.52%	38.24%	58.63%	78.79%	79.10%
Computed Tomography (CT)	10%	99.09%	100%	100.00%	99.81%	100%	100%	99%	85.30%	58.75%	60.69%	77.37%	80.00%	79.26%
Non-Obstetric Ultrasound	27%	99.86%	99.96%	99.92%	99.92%	100.00%	100%	100%	83.23%	39.20%	65.86%	92.61%	96.79%	93.18%
DEXA	1%	100%	100.00%	100%	100%	100%	100%	100%	-	-	100.00%	77.55%	88.24%	84.93%
Audiology - Audiology Asessments	8%	99.51%	100%	100%	100%	99%	98%	100%	68.82%	23.42%	11.02%	11.11%	25.35%	23.67%
Cardiology - Echocardiography	17%	100%	99.74%	98.34%	100.00%	100%	100%	96%	74.02%	37.55%	40.29%	55.46%	53.62%	51.76%
Neurophysiology	1%	67%	67%	86%	93%	97.22%	94%	89%	49%	42%	5%	36%	32%	28.41%
Urodynamics	1%	95%	94.74%	89.19%	92.00%	88.57%	82%	81%	91.11%	30.36%	30.30%	24.39%	16.30%	3.26%
Colonoscopy	7%	94.81%	99.24%	98.68%	89.14%	74.72%	89%	98%	93.58%	62.56%	38.41%	42.69%	40.42%	34.46%
Flexi Sigmoidoscopy	2%	93%	100%	94.29%	94.59%	69.05%	95%	96%	87.18%	48.98%	53.52%	55.66%	43.85%	31.45%
Cystoscopy	1%	93.55%	100.00%	96%	92.00%	86%	82%	100%	93.75%	64.52%	48.57%	55.00%	41.03%	54.00%
Gastroscopy	5%	96.83%	98.81%	99.07%	89.57%	83.16%	89%	99%	92.07%	58.37%	40.15%	44.88%	40.05%	28.94%

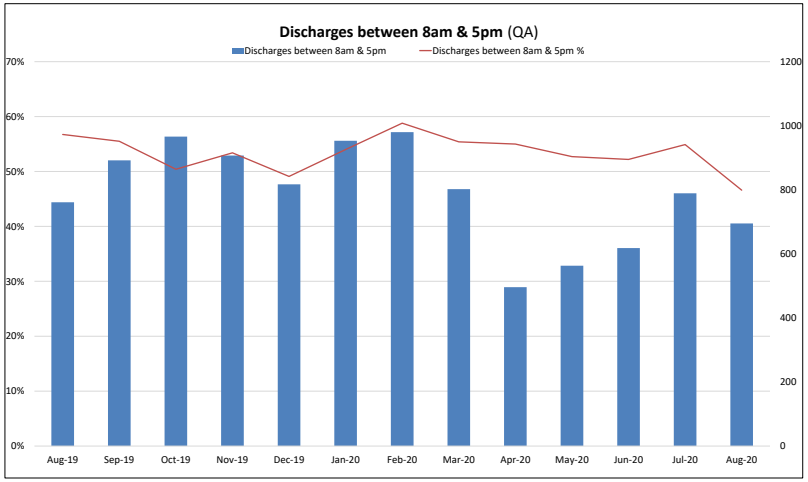
Stranded Patients

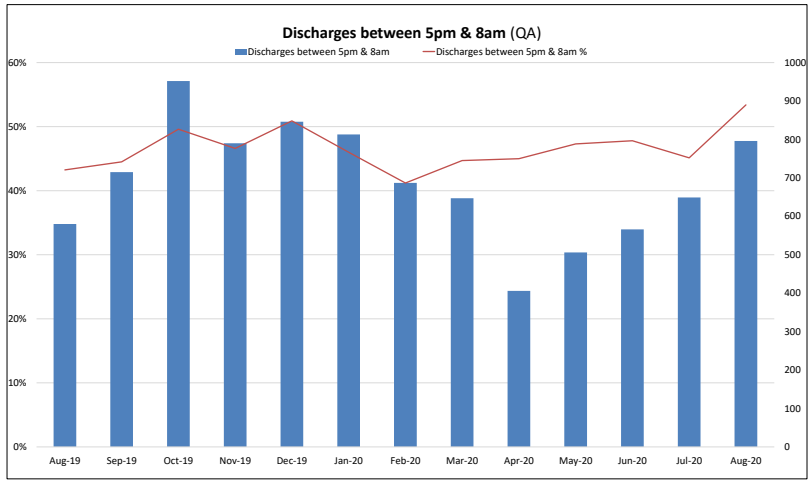
Trajectories for Diagnostic Recovery

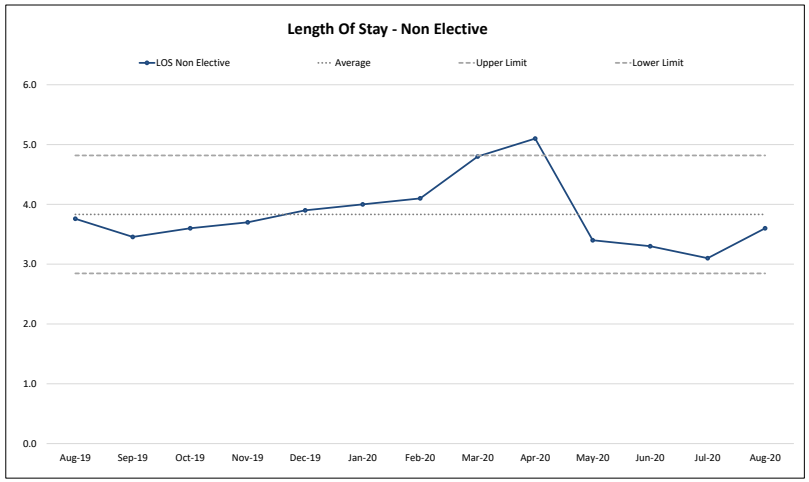


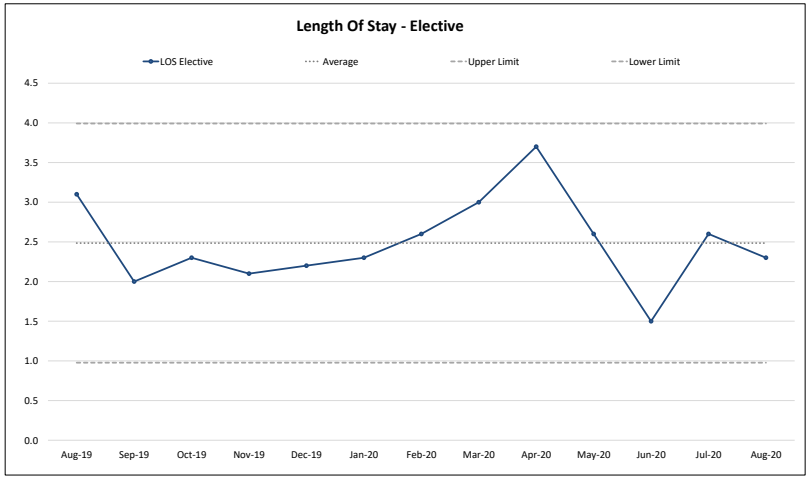


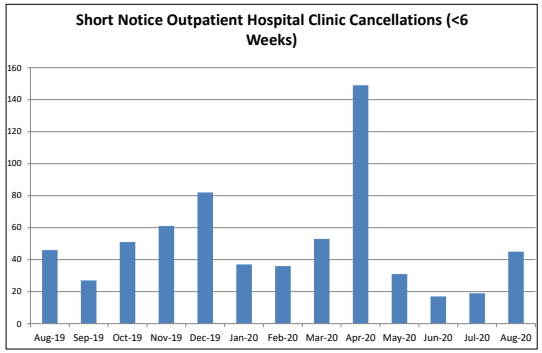
Discharges & LOS

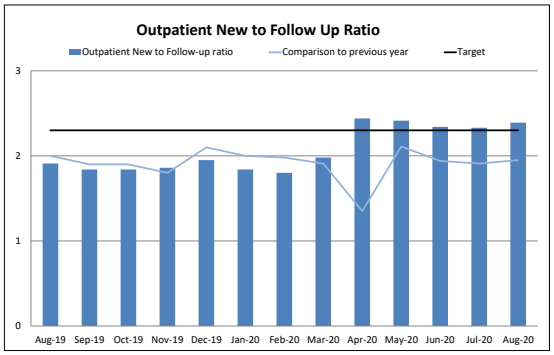


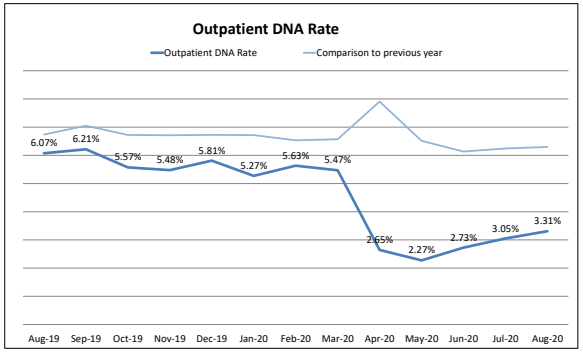


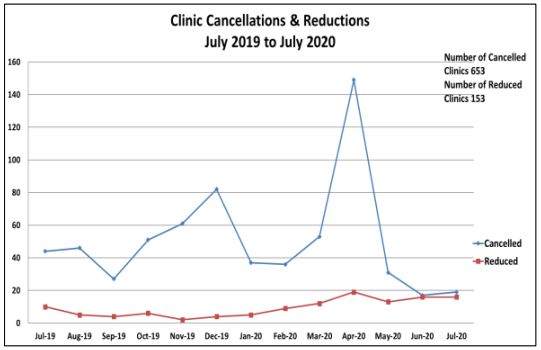


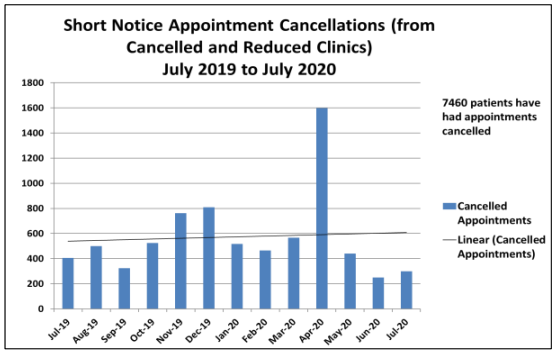


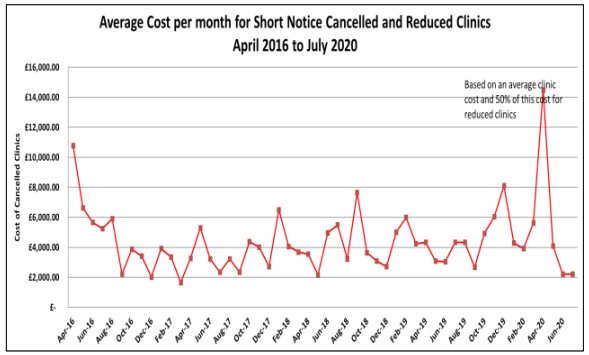






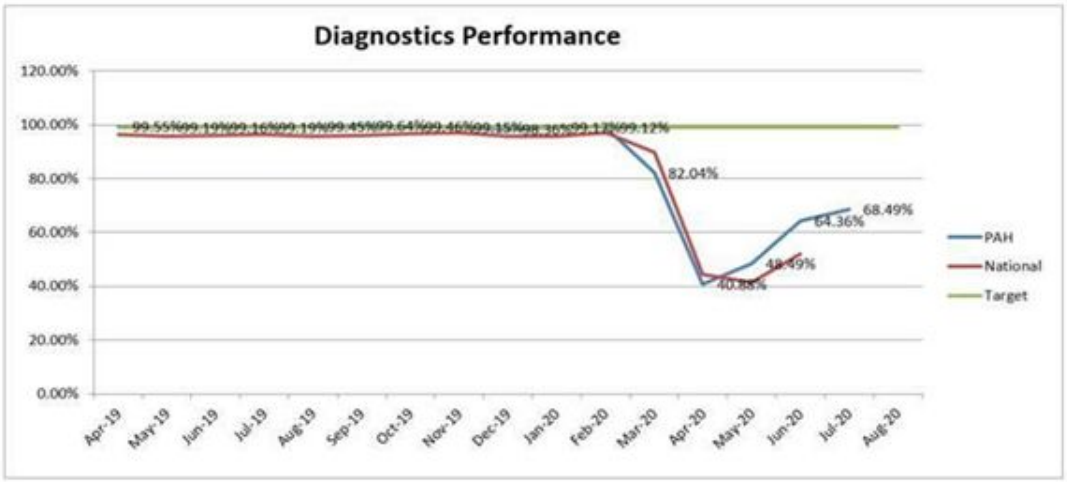


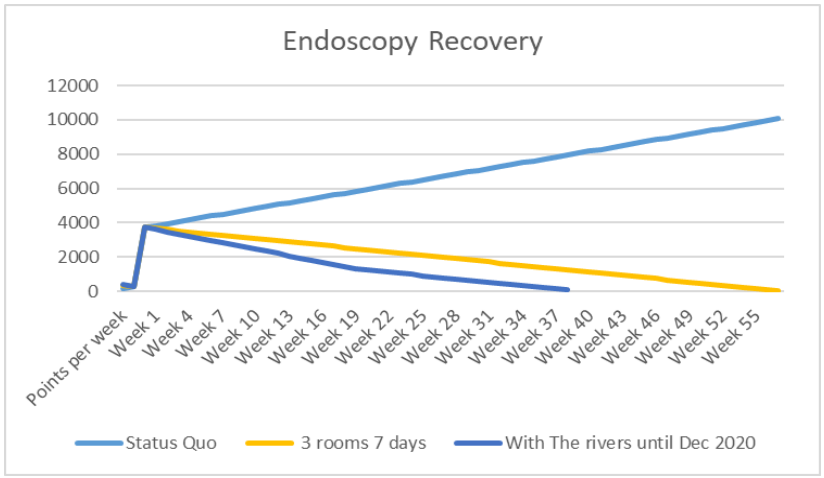




DNA Rate for Follow Up Appointments per Specialty for August

Specialty & Performing Unit	Accident & Emergency	Anaesthetics	Anticoagulant Service	Breast Surgery	Cardiology	Clinical Haematology	Clinical Oncology	Colorectal Surgery	Community Midwifery	Dermatology	Diabetic Medicine	Dietetics	Endocrinology	ENT	Gastroenterology	General Medicine	General Surgery	Gynaecology	Medical Oncology	Medicine for the Elderly	Neonatology	Neurology	Obstetrics	Ophthalmology	Optometry	Oral Surgery	Orthoptics	Paediatric Diabetic Medicine	Paediatrics	Physiotherapy	Respiratory Medicine	Rheumatology	Trauma & Orthopaedics	Urology	Vascular Surgery	Well Baby	Total
DNA Rate	0.0%	50.0%	3.6%	7.4%	7.2%	0.2%	0.0%	0.0%	4.3%	2.0%	5.6%	5.1%	0.0%	7.4%	3.1%	0.5%	0.0%	2.0%	0.4%	0.0%	3.4%	0.0%	2.4%	4.3%	14.8%	1.1%	9.2%	11.8%	8.2%	5.0%	2.9%	2.4%	3.8%	0.9%	0.0%	3.3%	3.3%


Diagnostics Performance
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
82.04%
64.36%
68.49%
PAH
National
Target
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20


Endoscopy Recovery
12000
10000
8000
6000
4000
2000
0
Points per week
Week 1
Week 4
Week 7
Week 10
Week 13
Week 16
Week 19
Week 22
Week 25
Week 28
Week 31
Week 34
Week 37
Week 40
Week 43
Week 46
Week 49
Week 52
Week 55
Status Quo
3 rooms 7 days
With The rivers until Dec 2020

Executive Summary Our People

NHS
The Princess Alexandra Hospital
NHS Trust

People measures

The overall trust vacancy rate is 8.4% just above the trust KPI of 8%.

Vacancy rates continue to decrease across the trust and we are recommencing our programme of international recruitment for both nursing and medical staffing.

Temporary staffing spend and recruitment continue to be discussed at weekly establishment meetings to ensure that projected pipelines are on track. High usage remains within IMT supporting the roll out of windows 10, 8x8 telephony system and other systems updates.

Sickness absence remains the same as the previous month; HR business partner meetings continue to take place with the HCGs to actively support absence management cases

Statutory and Mandatory training has fallen below the trust KPI and currently sits at 86%. The learning and development team have introduced a training booklet to support employees to complete their training.

Friends and family test continues to be on hold. A COVID 19 pulse check survey took place in June, the overall response rate was 31.91% and overall the responses were positive, however, there is some learning to take place which will form part of HCG action plans.

Average time to hire across the trust is 49 days. Overall this is decreasing due to delays relating to a number of factors including the candidates on hold due to shielding.

Health and Wellbeing

At the end of August there was over 90% return on risk assessments. Employees with outstanding risk assessments will be contacted directly by the Director of People to encourage completion.

The trust are in discussion with the ICS to roll out a Health and Wellbeing agenda covering self-care, compassionate leadership and trauma therapy.

Workforce Indicators Summary

Agency Spend 2.99%
Bank Spend 10.70%

Staff In Post
3341
WTE

Training
86%

Sickness
4.2%

8.4%

Turnover
10%

Medical Suspended
Non-Medical 78%

Scorecard

NHS The Princess Alexandra Hospital NHS Trust

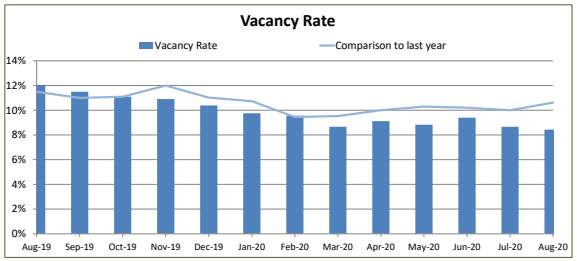
People Measures as at 31 August 2020	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3671.9	891.42	470.64	894.91	776.36	278.03	140.32	55.68	164.54
Vacancy Rate	8.0%	8.43%	5.90%	7.67%	9.30%	11.36%	**14.56%**	0.00%	3.20%	**12.02%**
Agency % of paybill	7.0%	3.0%	1.5%	3.1%	2.0%	5.4%	0.0%	1.4%	0.0%	6.2%
Bank Usage - wte	n/a	277.54	24.64	39.32	126.39	50.46	20.36	4.42	0.81	11.14
Agency Usage -wte	n/a	51.90	10.21	10.23	12.16	14.60	0.00	0.10	0.00	4.60
August 2020 Sickness Absence	3.7%	4.18%	3.88%	4.36%	4.50%	3.76%	**7.59%**	2.55%	1.33%	2.83%
Short Term Sickness	1.85%	1.80%	1.51%	1.86%	2.21%	1.45%	3.33%	1.37%	0.54%	1.09%
Long Term Sickness	1.85%	2.38%	2.37%	2.50%	2.29%	2.31%	4.25%	1.18%	0.79%	1.75%
Rolling Turnover (voluntary)	12%	9.96%	9.93%	9.78%	11.05%	8.72%	8.48%	11.83%	11.59%	10.68%
Statutory & Mandatory Training	90%	86%	92%	86%	82%	**79%**	93%	89%	81%	96%
Appraisal	90%	**78%**	81%	**76%**	**73%**	**71%**	89%	**75%**	81%	83%
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)		103.71	11.03	6.00	48.44	31.24	0.00	1.00	1.00	5.00
Leavers (wte)		89.06	15.14	10.73	28.23	31.27	0.00	2.30	0.00	1.40
Time to hire (Advert to formal offer made)	31Days									

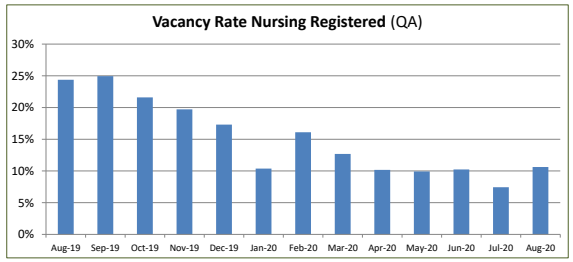
Workforce Indicators

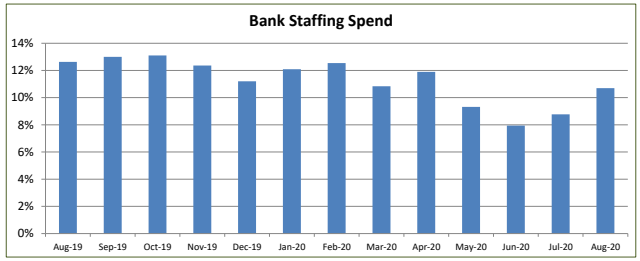
3 Our People Summary

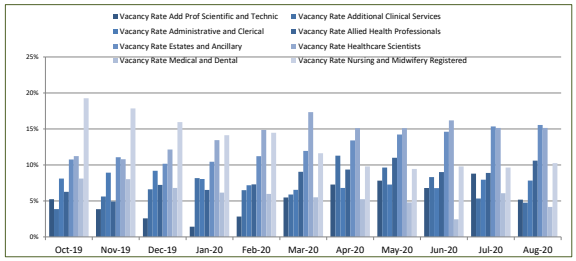
3.3 Well Led

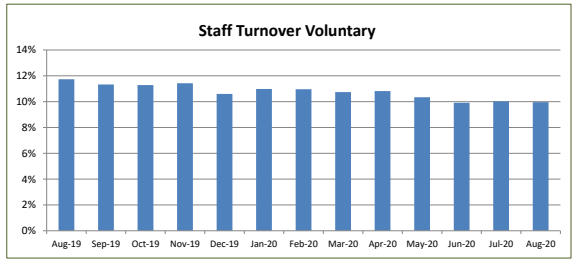
NHS The Princess Alexandra Hospital NHS Trust

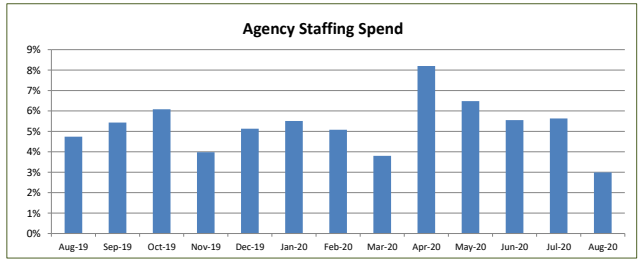


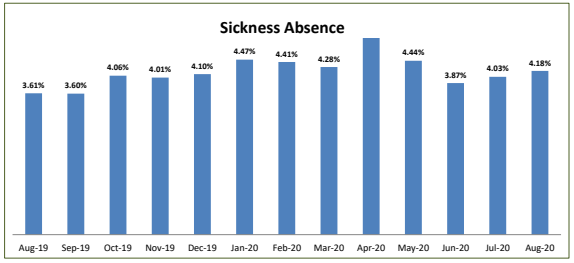


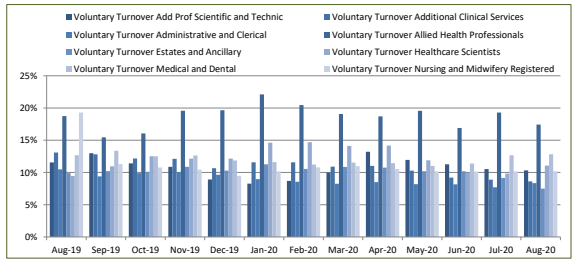


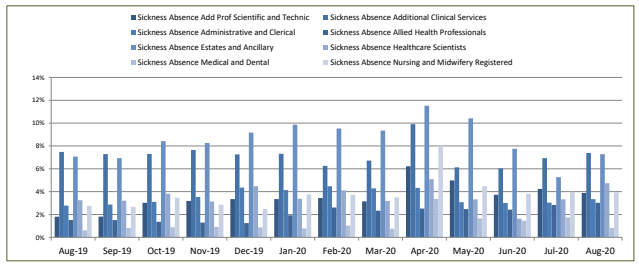




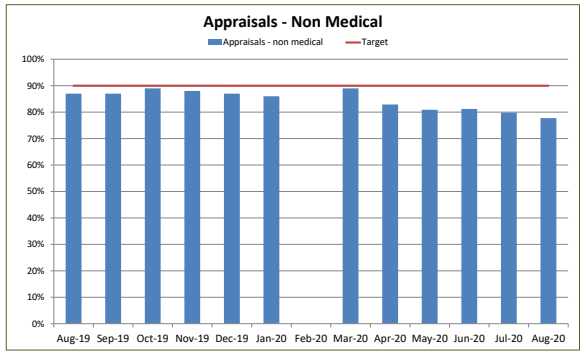


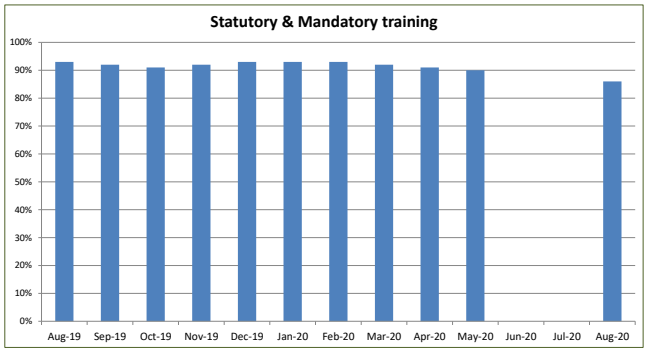


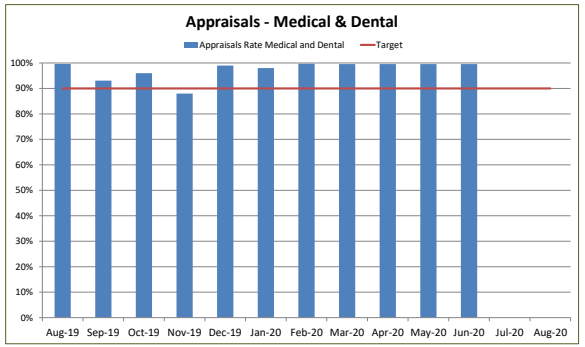


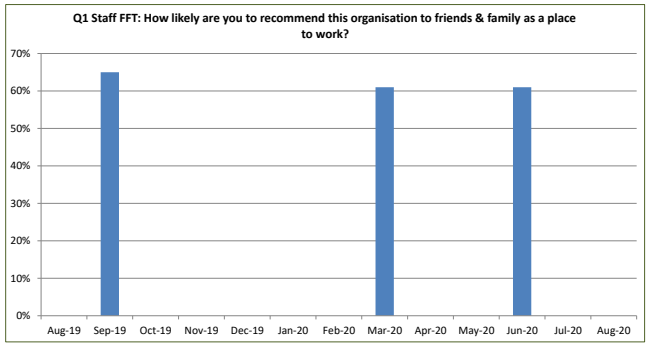


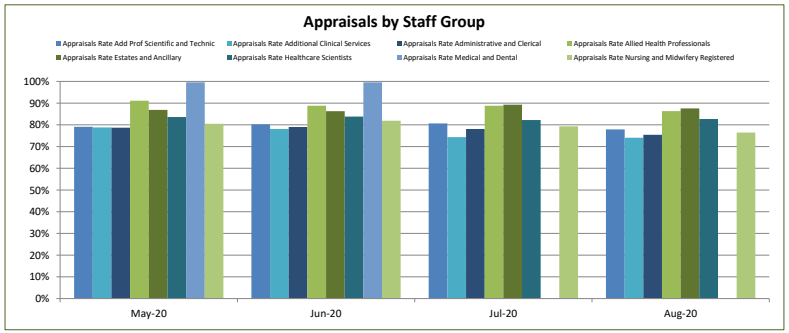
Workforce Indicators

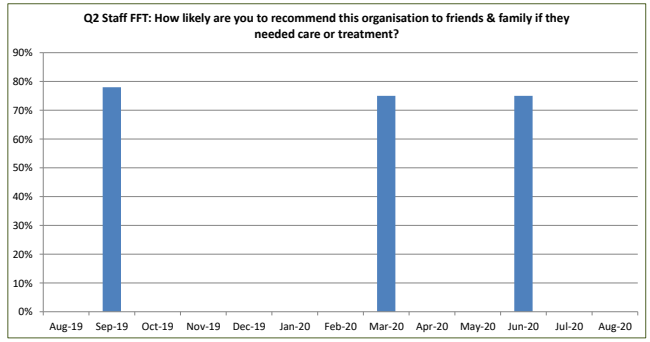












Annual Staff Survey 2019 & Workforce Race Equality Standard (WRES)

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: The Estate's Department have seen a complete return to 'business as usual', alongside successfully implementing significant service transformation. During August saw the Estates Consultation go-live and conclude successfully with positive outcomes including;
• Succession for 7 existing staff members
• 5 staff members were successful in roles in line with their first preference
• 2 staff members were transferred over to facilities department
• 1 staff were transferred over to EBME
• Remainder of staff were either slotted in or offered reasonable offer of employment resulting in zero redundancies following restructuring.

The Estates new operating model was successfully implemented on 31st August 2020 as planned. The key elements of change include;
• Estates services are now providing extended cover from 08:00 – 20:00, to improve services to both patients and staff.
• Restructured safety management model including robust out of hours service response and improved helpdesk services with increased cover to 20:00.
• All critical engineering services now have a planned and preventative maintenance contract in place.

Other areas of work which have progressed during the August reporting period include;
• Asbestos risk assessments completed and up to date records maintained.
• Water safety – risk assessments are complete covering entire site. Remedial works associated with the high & moderate risks are scheduled in this year's capital plan.
• Electrical safety – The 5yr rolling programme of fixed wire testing is on schedule. Fault reports are utilised to prioritised remedial works.
• PAT Testing – PAT testing rolling programme is on schedule in line with Trust's Electrical Safety Management Policy & both electronic & hard copy test records are up to date.
• Ventilation system – Annual re-inspection & verification reports are completed (new PPM contract in place).

Domestics: Getting back to 'business as usual' theme continues for the Domestics Department with August seeing a return of all 22 shielding members of staff. The reliance on agency staff support has been completely removed, with any additional requests now being made via NHSP staff resource. With Board approval now received for the transformation & modernisation of the domestics service, plans are well underway to implement this programme. Equipment is being ordered via Procurement & the launch of Domestic Consultation gearing up to go-live on the 10th September for 60 days.
The introduction of the computerised monitoring system has shown a significant improvement in the National Standard Cleanliness (NSC) scores.

Catering: The number of patient meals served is now increasing in-line with the hospital starting to get back to business as usual. Work is underway on the implementation of the catering electronic solution, which has a scheduled go-live date of mid-October. The benefits of utilising this new system will reduce food wastage & improve patient experience.

A complete revamp of the evening restaurant menu is underway and will include a "Hello Fresh" style offer for staff to purchase and cook at home.

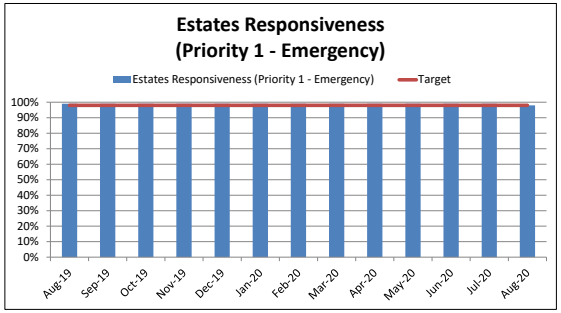
Estates Capital Programme 2020-21: Oversight of the programme continues with the programme management team making a very positive impact on achieving our objectives for the delivery of a comprehensive capital programme. Weekly programmes meetings have been established with all key Trust representatives, capital and management accountant teams, procurement, estates operations team and scheme project managers, the consultancy services are provided by Caston's reporting directly to the Associate Director of Estates and Facilities. A programme risk register has been established and is being monitored and reported upon on a weekly basis via the Programme Management Office and included within each of local programme board agenda.

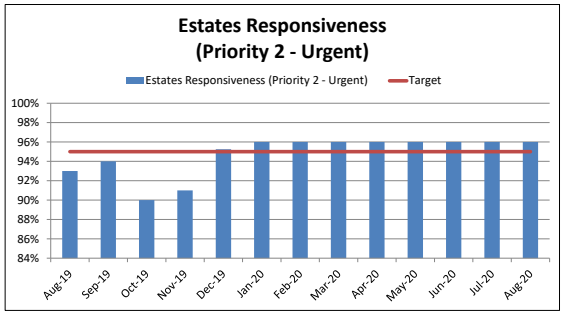
Emergency backlog maintenance schemes: Excellent progress has been made with the development of these schemes. Of the total 37 schemes within the programme, 17 authority to invest (ATI's) have now been approved at the Capital Working Group (CWG) meetings and the remainder are in full design and development, it has been agreed that these will not be presented formally to CWG until they have progressed through the design and procurement route to achieve firm costs.

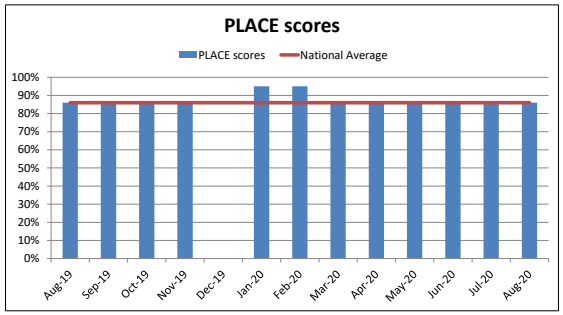
Development Projects: Steady and positive progress has been made with all development schemes. The majority have now progressed past feasibility stage and are moving into final design ahead of going out to tender. All projects are adhering to the programme timetable, if a delay is identified - immediate completion of a delay notification is required and submitted for escalation. Development projects include:

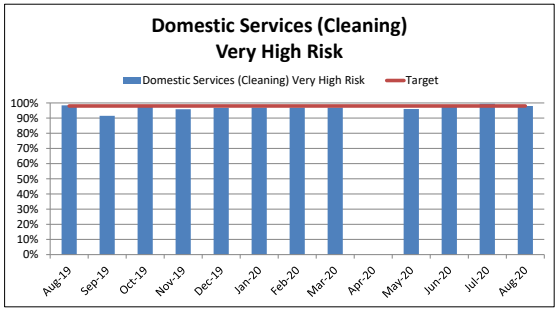
• Alex lounge (staff welfare facility)
• Alex training and education centre
• Williams day unit
• Multi-faith facility
• Pre-assessment unit
• Alex study
• Fracture clinic
• Adults assessment unit
• Endoscopy 3rd room

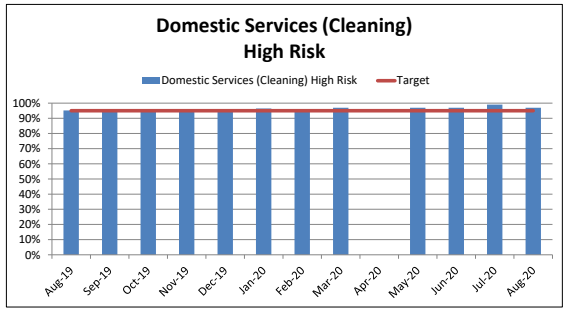
Places

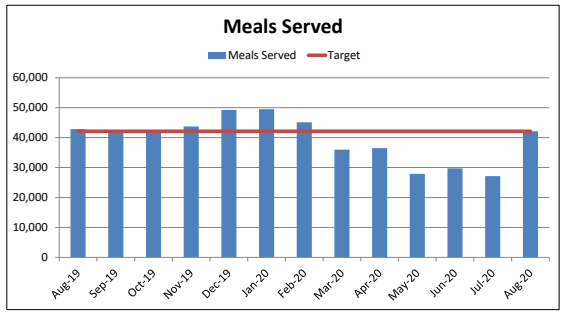

Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20

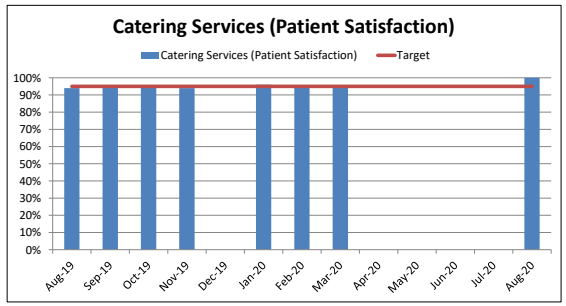

Estates Responsiveness (Priority 2 - Urgent)
Estates Responsiveness (Priority 2 - Urgent)
Target
100%
98%
96%
94%
92%
90%
88%
86%
84%
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20


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


Domestic Services (Cleaning) Very High Risk
Domestic Services (Cleaning) Very High Risk
Target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20


Domestic Services (Cleaning) High Risk
Domestic Services (Cleaning) High Risk
Target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20


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


Catering Services (Patient Satisfaction)
Catering Services (Patient Satisfaction)
Target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
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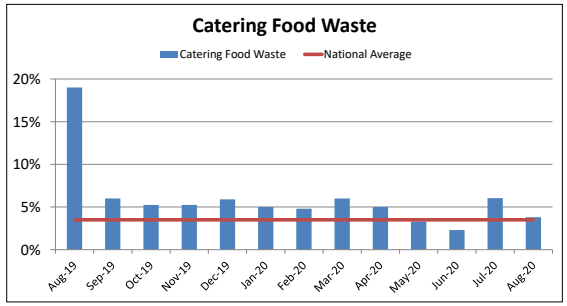
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20


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

Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

Against the Trust's interim plan there is an in-month variance of £0.4m and YTD variance of £1.4m. Under the current adapted financial regime the Trust is required to report a breakeven position by a retrospective 'Top up' funding adjustment.

Covid costs now total £8.4m for the year to date. Temporary staffing costs continue to reduce and now stands at £2.1m in the month being £2.9m lower than this point this time last financial year.

National guidance is that the current Adapted Financial Regime will be in operation until end of M6. This will then be replaced revised block contract and top up payments with a stronger focus on System control totals. Continued focus on productivity, efficiency and cost control must remain in place as services are restored and future financial arrangements developed.

YTD Capital expenditure is £7.6m being £2.8m behind original plans. Continued focus on delivery of the critical paths and milestone plans that drive the profiled plans.

Cash resources remain sufficient with balances at £61.7m.

Pounds

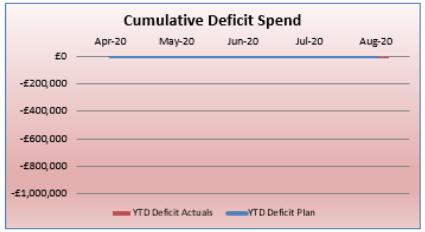
5 Our Pounds Summary

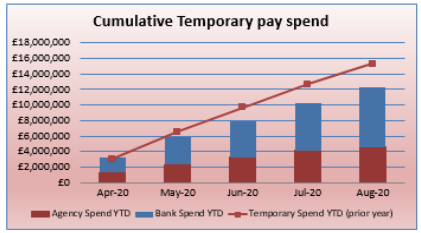
5.1 Overall financial position

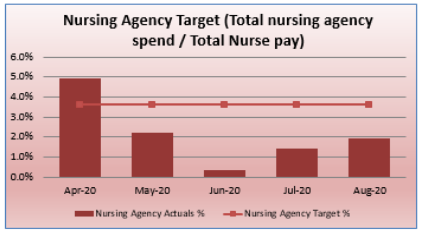
NHS The Princess Alexandra Hospital NHS Trust

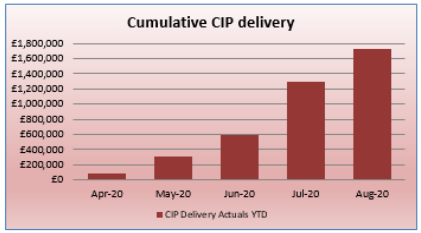
OUR POUNDS

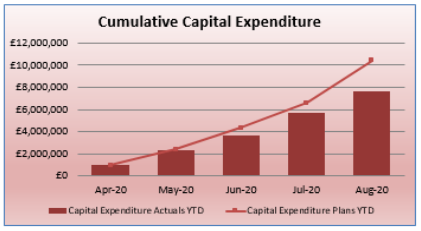
Metric	Annual Plan	Latest month
Deficit	£0	£0
Agency Spend £s	-£10,292,000	-£4,610,314
Bank Spend £s	TBC	-£7,751,169
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3.6%	1.9%
Capital Expenditure	-£42,618,000	-£7,633,000
BPPC Volume	95%	90%
BPPC - £s	95%	87%
Cash Balance	£1,000,000	£61,711,000

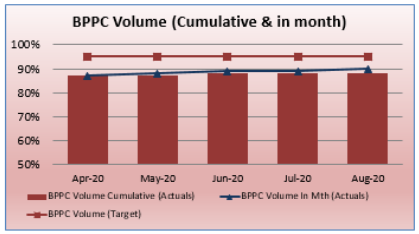


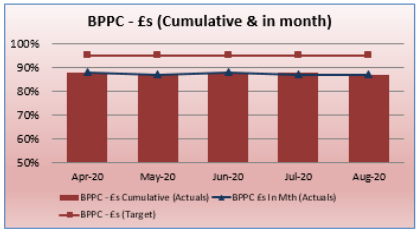


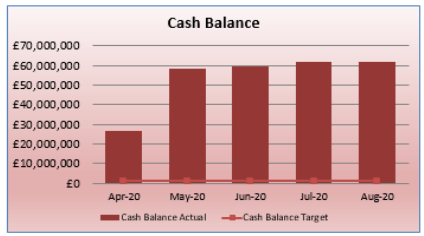












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CQC Rating

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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Commissioning for Quality and Innovation

2019/20 CQUIN Forecast

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

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

Quality Improvement Plan Projects	MUST / SHOULD	Performance in Sept 19	Performance in Oct 19	Performance Nov 19	Performance Dec 19	Performance Jan 2020	Performance Feb 20	Performance Mar 20	Performance Apr 20	Performance May 20	Performance Jun 20
1. Governance Project	MUST: 5, 10, 13, 17, 20, 21 Should: 1, 4, 5, 14										
2. Documentation Project	MUST: 1, 5, 6, 12 Should: 6, 17										
3. Training Project	MUST: 2, 8, 18, 22 Should: 3, 13, 15, 16							Statutory Mandatory training suspended due to Covid exception resuscitation	Statutory Mandatory training suspended due to Covid exception resuscitation		
4. Nurse Vacancy Project	MUST: 3, 4, 11										
5. Maternity Action Plan	MUST: 14, 15, 16 Should: 10										
6. Infection prevention & control in Maternity Unit project	Should: 6, 7, 8										
7. Workforce in Family & Women's Project	Should: 11, 19										
8. Maternity Strategy Project	Should: 12										
9. Health & Safety Project	MUST: 9, 19									Audits suspended due to Covid	
10. Estates Project	MUST: 7 Should: 9										
10. Children & Young Peoples Transition Project	Should: 18										
11. Mortality	MUST: 12										
12. Urgent Care	SHOULD 2										
13. End of Life	Should: 20										
14. Pain Management	Trust Action										

The Princess Alexandra Hospital NHS Trust

Trust Board – 01.10.20

5.2

Agenda item:	5.2
Presented by:	Stephanie Lawton, Chief Operating Officer
Prepared by:	Stephanie Lawton, Chief Operating Officer
Date prepared:	25 September 2020
Subject / title:	Core Standards – Emergency Planning and Resilience

Purpose:	Approval	x	Decision		Information		Assurance	x
Key issues:	It is a requirement for the Emergency Preparedness and Resilience Core standards that the Trust Board has oversight of each of the standards and compliance against these. The Trust assessment confirms we are fully compliant against each standard without any outstanding actions. In 2020/21, NHS providers are required to review the submissions and evidence and include all lessons learnt during Covid 19 and winter planning. The detailed discussion with CCG and NHSI is scheduled for 5 October 2020. There are no areas of concern identified.							
Recommendation:	The Trust Board are asked to note the content of the report and the level of compliance and evidence submitted and support its submission.							

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:	n/a
Risk / links with the BAF:	Emergency and Winter Planning
Legislation, regulatory, equality, diversity and dignity implications:	EPRR
Appendices:	

Your future | Our hospital

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Please select type of organisation: **Acute Providers**

Publishing Approval Reference: 000719

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	9	0	0
CBRN	14	14	0	0
Total	64	64	0	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	15	0	0
Long Term adaptation planning	5	5	0	0
Total	20	20	0	0

Overall assessment:	Fully compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan

5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	**Duty to maintain plans**	**Mass countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
23	**Duty to maintain plans**	**Excess death planning**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
24	**Command and control**	**On-call mechanism**	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.

25	**Command and control**	**Trained on-call staff**	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies

32	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	• Documented processes for accessing and utilising loggists • Training records
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising
35	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard co
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard co
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing

39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings
41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the comitmement to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement

48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG **Red (not compliant)** = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant)** = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant)** = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Severe Weather **Domain: Severe Weather Response**											
1	**Severe Weather response**	**Overheating**	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	Heatwave plan	Fully compliant				
2	**Severe Weather response**	**Overheating**	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	Heatwave plan	Fully compliant				
3	**Severe Weather response**	**Staffing**	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	Cold weather plan Business Continuity Plans	Fully compliant				
4	**Severe Weather response**	**Service provision**	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	Y	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care	Cold weather plan Business Continuity Plans	Fully compliant				
5	**Severe Weather response**	**Discharge**	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	Cold weather plan Business Continuity Plans	Fully compliant				
6	**Severe Weather response**	**Access**	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and clearance plans activated by predefined triggers	Y	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisations boundaries. When snow / ice occurs there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	E&F plans include third part gritting and snow clearence	Fully compliant				
7	**Severe Weather response**	**Assessment**	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result.	Cold weather plan Heatwave Plan	Fully compliant				
8	**Severe Weather response**	**Flood prevention**	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Y	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	PPM In place for estate	Fully compliant				
9	**Severe Weather response**	**Flood response**	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	Trust engages fully with ERF All on call staff have access to ResilienceDirect	Fully compliant				
10	**Severe Weather response**	**Warning and informin**	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	Cold Weather Plan Heatwave Plan Winter plans	Fully compliant				

11	Severe Weather response	Flood response	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Y	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	Risks are assessed as required and recorded on risk registers, risk registers reviewed at Risk Management Group (Board Committee)	Fully compliant				
12	Severe Weather response	Risk assess	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Y	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these.	Risks are assessed as required and recorded on risk registers, risk registers reviewed at Risk Management Group (Board Committee)	Fully compliant				
13	Severe Weather response	Supply chain	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	Y	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	Procurement department business continuity arrangements	Fully compliant				
14	Severe Weather response	Exercising	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Y	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	Yes, used live during heat wave 2019 with lessons identified	Fully compliant				
15	Severe Weather response	ICT BC	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Y	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	ICT BC exercise in 2019	Fully compliant				
Domain: long term adaptation planning											
16	Long term adaptation planning	Risk assess	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Y	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions	Sustanability strategy as part of STP including climate change, air pollution etc	Fully compliant				
17	Long term adaptation planning	Overheating risk	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	Y	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	Recorded on risk registers	Fully compliant				
18	Long term adaptation planning	Building adaptations	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Y	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	Sustanability included as part of all new builds and all builds comply with HTM. Sustanability strategy as part of STP including climate change, air pollution etc	Fully compliant				
19	Long term adaptation planning	Flooding	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Y	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	Sustanability included as part of all new builds and all builds comply with HTM. Sustanability strategy as part of STP including climate change, air pollution etc	Fully compliant				
20	Long term adaptation planning	New build	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Y	The organisation has relevant documentation that it is including adaptation plans for all new builds	Sustanability included as part of all new builds and all builds comply with HTM. Sustanability strategy as part of STP including climate change, air pollution etc	Fully compliant				

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01/10/2020 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: George Wood – Chair of Audit Committee

DATE OF COMMITTEE MEETING: 07/09/2020

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
Annual Audit Committee Effectiveness Review 2019/20: Overall responses to the questions on the review checklist had been positive. In relation to one of the 'points for discussion' in the paper (the need to regularise clinical input) the Committee noted that this should become more consistent when the newly appointed Chief Medical Officer (CMO) joined the Trust in November. The Committee's Terms of Reference (ToR) had been updated, with proposed amendments relating only to the membership/attendees and were recommended to the Board for approval. **(Attached as Appendix 1)** **IA Progress report:** Two audits had been finalised since the last meeting, the first of which was the GDPR follow-up and the second was the Long-Term Capital Programme. **LCFS progress report:** The report was noted. **External Audit annual letter (year ending 31 March 2020):** The committee noted the contents of the audit letter which is required to be issued to the Trust following completion of the audit procedures. Covid-19 had an impact on a number of aspects of the 2019/20 audit as previously reported. There had been the limitation of audit scope which resulted in the qualification of the opinion in relation to inventory due to the Trust not being able to undertake the required stock takes because of the impact of Covid-19 and associated restrictions on movement and external auditors not being able to attend the stock takes, as planned. The Trust planned to undertake stock takes by the end of September. **Waivers and losses:** During the period 01.04.20 to 31.07.20 (Covid-19 peak): • The value of losses for the period had totalled £28k (4 cases) • Waivers during the period had totalled £1,405,575 (40 cases) **External audit tender:** The timetable for the re-tender of External Audit services was discussed and agreed; the process would run from September through to end of December 2020. In line with the recommendation the Committee agreed that the Trust should run a competitive process within the SBS Procurement Framework for the appointment of External Auditors (including independent examination of the Trust's Charitable Funds accounts).
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.

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

PURPOSE:

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

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

DUTIES:

The following comprise the Committee's main responsibilities:

Annual Work Plan and Committee Effectiveness

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

Governance, Internal Control and Risk Management

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

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

Internal Audit

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

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

External Audit

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

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

Annual Report and Accounts Review

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

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

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

Annual Quality Account

The Committee shall seek assurance that:

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

Governance Manual

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

Management

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

Counter Fraud/Bribery/Corruption Arrangements

The Committee shall ensure that the Trust has in place:

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

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

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

The following comprise the Auditor Panel's main responsibilities:

Procurement of External Audit

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

ACCOUNTABLE TO: Trust Board.

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

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

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

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

CHAIRMAN Non-Executive Director.

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

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

ATTENDANCE Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee

meetings within each reporting year. An attendance record will be held for each meeting and an annual register of attendance will be included in the Committee's annual report to the Board.

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

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

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

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

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

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

DEPUTISING ARRANGEMENTS

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

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

QUORUM:

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

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

DECLARATION OF INTERESTS

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

MEETING FREQUENCY:

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

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

The Princess Alexandra Hospital NHS Trust

MEETING ORGANISATION

Audit Committee

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

Auditor Panel

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

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

AUTHORITY

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

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

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

TERMS OF REFERENCE

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

DATE APPROVED

By Committee: 7 September 2020
By Trust Board:

TO BE REVIEWED ANNUALLY

Next review due: September 2021

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE MEMBERSHIP

Membership and Those in Attendance	
Members	
George Wood	**Non-Executive Director and Committee Chair**
Helen Howe	Non-Executive Director
Pam Court	Non-Executive Director
In Attendance (Board)	
TBC	Chief Financial Officer (Lead Exec)
Lance McCarthy	Chief Executive Officer
Faye Gilder	Chief Medical Officer
In Attendance (Internal & External Audit)	
Thanzil Khan	tiaa
Neil Abbott	tiaa
Hannah Wenlock	tiaa (LCFS)
Debbie Hanson	Ernst & Young
Natalie Clarke	Ernst & Young
Invited	
Simon Covill	Deputy Chief Finance Officer
Secretariat	
Heather Schultz	Head of Corporate Affairs

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01.10.20 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: New Hospital Committee (NHC)
REPORT FROM: Lance McCarthy (Committee Chair)
DATE OF COMMITTEE MEETING: 22.09.20 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

General Project Update – the Committee noted the positive progress made to date against the timeline for completion of Outline Business Case by March 2021 and Full Business Case by July 2022. Options for land purchase were discussed and will be discussed in the private session of the Board meeting. The finance update was noted.

Demand and Capacity Model: NHC reviewed the modelling and recommended it to Board for consideration. (Public Board, New Hospital agenda item)

Model of Care: Discussed and recommended to Board (Public Board, New Hospital agenda item). The size and scale of the underpinning transformation programme was acknowledged.

Schedule of Accommodation (SoA): The SoA was discussed and the final version will be presented to Board for approval.

Technology & Partnering Strategy: NHC approved and recommended to Board the Trust's Technology & Partnering Strategy produced by the Model of Care teams, Trust's ICT Team and CCIO, Grant Thornton and Channel 3. (Public Board, New Hospital agenda item)

Design Brief: Reviewed and recommended to Board for approval. (Public Board, New Hospital agenda item)

New Hospital BAF Risk 3.5: The risk was discussed and members agreed the scoring should remain at 16.

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

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

N/A

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: 01.10.20 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Pam Court - PAF Chairman
DATE OF COMMITTEE MEETING: 24.09.20 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **New Financial Regime:** The Committee received a briefing note outlining the new Financial Regime to be operated from M7-M12 and how that differed from M1-M6. Members noted the associated risks, uncertainty and opportunities it would bring.

6.1

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

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

- M5 Revenue Update (including temporary staffing)
- Capital Update
- BAF risks 4.2 (ED Standard), 5.1 (Finance), 1.2 (EPR) and 3.1 (Estate and Infrastructure) - all risk scores remain unchanged
- Recovery & Restoration
- M5 Integrated Performance Report
- Quarterly Data Quality Update
- Quarterly Coding Update
- Procurement Update (including quarterly Contracts Management update)
- Feedback on Surgery Deep Dive
- Modernisation of Procurement & Finance Functions
- New Hospital Bi-Monthly Update
- Estates & Facilities Quarterly Update
- Health & Safety Bi-Monthly Update

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

The Committee continues to make progress against its work plan although, as previously, certain agenda items were deferred by agreement with the Chair due to the current pressures relating to COVID-19.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01.10.20 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)
REPORT FROM: Helen Glenister – QSC Chair
DATE OF COMMITTEE MEETING: 25.09.20 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- A small cluster of incidents identified in Maternity have been reviewed by the Incident Management Group. An executive round table meeting has been scheduled and outcomes will be formally reported back to QSC.

- The Infection Control team have identified and managed a colonisation of Serratia on NICU. No new colonisations have been identified since 1 September 2020.

- An increasing prevalence of C.difficile was noted with 13 cases year to date (included in IPR on the Board agenda). The RCAs for the cases have not identified gaps in practice in relation to isolation or obtaining a specimen, however an increasing focus on antibiotic stewardship has commenced.

- An update was received on the Trauma Service and actions taken since the peer review in April 2019. A further update will be provided following the next visit from the network on 2 October 2020.

- An update on the Ophthalmology service was received. (Board agenda item)

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 and Annual Report
- Report from Strategic Learning from Deaths Group
- Learning from Deaths Update
- ITU Rapid Response Peer Review Update
- Review List Update including Ophthalmology
- Recovery Update
- Report from Patient Safety Group
- Monthly Patient, Safety, Quality & Effectiveness Report
- Sharing the Learning Update
- Report from Patient Experience Group
- Patient Experience Report
- Update from Patient Panel
- Update on Trauma Service
- Surgery Healthcare Group Quarterly Performance Update
- Draft Quality Account
- CQC QIP Preparedness 2020/21
- CQC Oversight Report
- M5 Integrated Performance Report

• BAF Risks (1.0-COVID-19 and 1.1- Variations in Clinical Outcomes – scoring discussed and both scores to remain unchanged at 16).
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
• The Committee continues to make good progress against its work plan.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 01.10.20 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: Senior Management Team
REPORT FROM: Lance McCarthy - Chairman
DATE OF MEETINGS (Monthly going forward): 8 September 2020

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
The following items were discussed at the SMT meeting held on 8 September 2020: - Trauma Review - Well Led Framework: KLOE 5 (process for managing risks/issues & performance) – self assessment reviewed - Organisational Development Plan - Staff Survey results – COVID-19 - Financial Results - Month 4 & 5/ Recovery and Restoration update - Procurement and Finance Modernisation Update - Specialist Palliative Care and End of Life Business Case (approved) - Self Service Business Case (approved) - ATI 2 New Digital Mammography Units (approved) - Temporary Staffing – Medical Rotas - Accountability Framework (revised version) - Information Governance Update