The Princess Alexandra Hospital NHS Trust

AGENDA

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

Date and time: Thursday 4 February 2021
09.30 – 11.45

Venue: Microsoft Teams Meeting

	Item	Subject	Action	Lead	
01 Opening Administration					
09.30	1.1	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from previous meeting	Approve	Chairman	3
	1.4	Matters Arising and Action Log	Review	All	13
02 Risk					
09.40	2.1	CEO's Report including: • Covid-19 update	Inform	Chief Executive	14
10.00	2.2	Significant Risk Register	Review	Director of Nursing & Midwifery	20
10.10	2.3	Board Assurance Framework 2020-21	Review/ Approve	Head of Corporate Affairs	25
03 Patients					
10.20	3.1	New Hospital Programme Update	Discuss	Director of Strategy	40
10.35	3.2	Mortality	Discuss	Medical Director	47
10.45	3.3	Ockenden Report: • Trust Response • Serious incident report	Assure	Director of Nursing & Midwifery	53 58
10.55	3.4	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing & Midwifery	61
04 Performance and People					
11.05	4.1	Integrated Performance Report (IPR)	Discuss	Executives	71
05 Governance					
11.25	5.1	Reports from Committees: • QSC.22.01.21 • WFC.25.01.21 • NHC.26.01.21 • PAF.28.01.21	Inform/ Approve	Chairs of Committees	108 109 110 111
06 Questions from the Public					
11.40	6.1	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.			
07 Closing Administration					
	7.1	Summary of Actions and Decisions	-	Chairman/All	
	7.2	New Risks and Issues Identified	Discuss	All	
	7.3	Any Other Business	Review	All	
11.45	7.4	Reflection on Meeting	Discuss	All	

The Princess Alexandra Hospital NHS Trust

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	Director of Finance	Saba Sadiq
Chair of Quality & Safety Committee (QSC)	Dr. Helen Glenister	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Pam Court	Medical Director	Fay Gilder
Chair of Workforce Committee (WFC)	Helen Howe	Director of 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
NExT NED	Darshana Bawa	Director of People	Gech Emeadi
NExT NED	Darrel Arjoon	Director of Quality Improvement	Jim McLeish
		Chief Information Officer	Phil Holland
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Virtual Trust Board Meeting in Public
Thursday 3 December 2020 from 09:30 – 12:30

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:	
Laura Warren	Associate Director - Communications
Sarah Cowley (item 2.1)	Lead Nurse Safeguarding Adults
Jenny Abel (item 2.1)	Head of Transfer of Care
Members of the Public	
Clare Rose	Crown Commercial Service
Observers:	
Saba Sadiq	Chief Financial Officer (Designate)
Laura Warren	Associate Director - Communications
Apologies:	
Dr. Amik Aneja	General Practitioner (GP-AA), Board Advisor
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 and particularly the new Medical Director (MD), Fay Gilder. As colleagues for the Patient Story were present, that item was taken next.
02 PATIENT STORY	
2.1 Frank's Story	
2.1	The Director of Nursing & Midwifery (DoN&M) welcomed colleagues Sarah Cowley, Adult Safeguarding Lead (ASL) and Jenny Abel, Head of Transfer of Care (HoTC), who took members through the following story.
2.2	Frank was a 55 year old, who had been born in Iraq. Towards the end of his life he had been living near a local supermarket, in his car and prior to that in local council temporary accommodation as part of their cold weather provision. Cause of death had been multi-drug toxicity and liver cirrhosis. Frank had been homeless since September 2016 and remained so until his death. He had long-standing issues with alcohol which may have been his coping mechanism. He had PTSD from his experience in the Iraq war 1980 -1988 and an assault in 2009. His physical health was poor (hospital attendances for frostbite) and he had a history of diabetes, pancreatitis, cirrhosis and hypertension. Safeguarding referrals had been made in relation to self-neglect related to alcohol use. Between November 2016 and December 2017 he had had multiple hospital attendances for intoxication, medication requests and frostbite. Sadly Frank had died on 01.03.2018.

2.3	On review of the case, system recommendations had been: • A review of services for support for Mental Health patients. • Housing providers to consider a different option for support for such a complex needs case. • Better interagency working as no lead agency/professional took responsibility for coordinating the case. • To raise the safeguarding referral process agenda across agencies. • To improve awareness of professional curiosity of staff.
2.4	Recommendations specific to the Trust had been: • Review access to GP records to give overview of person's health needs. • Access to My Care Record from GP side. • Review training for staff in relation to mental health needs and PTSD. • Work in partnership with Mental Health Trust in relation to this. • Mental Health Quality Forum.
2.5	In response to a question from Non-Executive Director George Wood (NED-GW) about current arrangements for managing a similar case, it was confirmed that today, the local authority would take the lead on such a case, and they would progress that case in conjunction with the housing association. Patients similar to Frank were now tracked via an internal database which would provide the name of their key worker (who would be their housing officer). If there were any concerns as to who was leading those would be escalated to the Director of Social Care.
2.6	The Chief Operating Officer (COO) thanked the team for their story and particularly commended the work of the Discharge Team who went above and beyond for patients in terms of, for example, doing their shopping and supporting in their search for a home. In response to a second question it was confirmed that the DoN&M was the Executive Lead for Safeguarding and provided support to the team and any case concerns would be fed back to the local Safeguarding Adults Board. The team acknowledged the support they received from the Board in terms of raising the profile of safeguarding as a whole.
2.7	The Director of Strategy (DoS) thanked the team for their presentation and highlighted the impact of mental health issues on physical health services. He asked whether there was a specific issue in Harlow in terms of homelessness. In response it was confirmed Harlow did have a significant issue, in particular with patients displaced from other counties and therefore with no eligibility for access to funds in Essex. The DoS flagged that the One Health & Care Partnership (OHCP) work could make a real difference to homelessness.
2.8	As a final point the DoN&M updated that a system-wide SI review on cases such as Frank's had picked up a number of recommendations to be actioned across the system, particularly in terms of the pathway for patients. A mental health quality forum had now been established which brought together colleagues from NELFT, EPUT and Primary Care. The Trust's Vulnerable Patients Group now reported into its Quality & Safety Committee which would help move things forward. She thanked the team for their drive and 'professional curiosity' which was now making a difference for patients.
2.9	The TC also thanked the team for highlighting Frank's case and confirmed the profile of safeguarding would be raised with partners through the OHCP to ensure colleagues were aware of the situation in Harlow and the experience of patients like Frank.
ACTION **TB1.03.12.20/08**	**Board members to raise awareness of homelessness in Harlow through the OHCP.** **Lead: CEO/Trust Chairman**
1.1 Apologies	
2.10	No apologies were noted.
1.2 Declarations of Interest	
1.11	No declarations of interest were made. At this point in the meeting the TC updated that in line with previous Board discussions to improve the diversity of the PAHT Board, two appointments been made to the Board as part of the NHSI NExT NED scheme. Darrel Arjoon would start on 04.01.21 and Darshana Bawa on 14.01.21.
1.3 Minutes of Meeting held on 01.10.20	

1.12	These were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.13	There were no matters arising. The action log was noted and there were no comments.
03 RISK	
3.1 CEO's Report	
3.1	This item was presented by the CEO. He updated that MRSA had been removed from the metrics table as this had been consistently low for 18 months (and would continue to be reported in the IPR) but he had added two Maternity related indicators – number of stillbirths and Post-Partum Haemorrhage (PPH). He noted that Covid continued to have an impact on performance, particularly in terms of delivery against key access targets. This picture was mirrored nationally but the Trust had plans in place and teams were working hard to maintain services as effectively as possible.
3.2	In terms of COVID he thanked colleagues and teams for all their hard through waves one and two. There had been a significant increase over recent weeks in the number of patients presenting with symptoms. Currently there were 53 Covid positive inpatients with a handful of those on Optiflow or being ventilated. The hospital had seen 729 patients since the end of February and was continuing to see a steady increase in positive patients and also in those patients testing positive on day five. He was pleased to add that the hospital was now testing patients on admission, on day three and on day five.
3.3	He informed members that work to reconfigure the hospital continued. The Red ED moved back to the front of the hospital in September, having been working out of Harold Ward during the summer and red ITU pathways were now running from Henry Moore Ward, which was also providing Level 1 care and Optiflow for relevant patients. Three COVID wards were currently open. All the above had had an impact operationally and for the first time in more than two years there were patients who had been waiting more than 52 weeks for routine surgery. Demand on diagnostic services was also significant. Demand for urgent care also remained high including for non-COVID patients. On a positive note, he informed members that the new two storey adult assessment unit was on track to open its first floor in the week before Christmas and the ground floor by the end of January. This would provide much needed capacity and would support flow from the ED and performance against the ED four hour standard.
3.4	The CEO commended staff at all levels who had shown resilience under huge amounts of pressure. The People team were providing support for staff through various initiatives and mental health support was being provided by EPUT. Lateral flow testing for front line staff was also being rolled out with a 1% positive rate to date, slightly below the national average of 2.1%.
3.5	The DoN&M continued that in terms of nosocomial infections, data was reflected in the integrated performance report and the organisation continued to learn about the disease and its asymptomatic presentation. Intelligence was showing that 70% of positive patients swabbed positive on their first swab (30% therefore were asymptomatic at that point). She continued there had been eight clinical outbreaks in the organisation and five staff outbreaks. Some national learning and ten key recommendations had recently been published and the Quality & Safety Committee had requested progress against those for its December meeting and also for the Infection Control Board Assurance Framework to be refreshed. In terms of the ten key recommendations, six were already in train and had been for some time. In terms of the remaining four: • **To reduce the high numbers of patients in bedded bays** – the organisation was ensuring (where possible) that patients wore face masks and that curtains were pulled to the locker end. In one area a decision had been made to remove some beds to allow for 2m distancing but that was not feasible in all areas in terms of the bed capacity it would remove. Some transparent screens would be installed in those areas and the installation of air filtration systems was being discussed.

	• **To swab on day three** (as well as on admission and day five) – this was now in place as of the previous week. In addition all patients attending ED requiring admission to also be swabbed. • **No movement of patients around the organisation until two negative swabs received** – this was challenging for the organisation and being worked through with operational and nursing teams.
3.6	In response to the above the DoS asked for an update on staff morale. In response the COO confirmed that morale was mixed. Teams were working hard under huge amounts of pressure but staff sickness was also a factor. The People team were providing staff with support and senior management were taking time out to explain to staff in person the reasons for actions they were putting in place to support flow and help care for patients.
3.7	In response to a question from NED Helen Howe (NED-HH) the COO acknowledged that infection rates were rising in the Harlow area. There were a number of work-streams, both local and across the ICS, to review activity and capacity, particularly in terms of elective and how organisations could support each other. The organisation continued to work closely with the independent sector and some operating activity was taking place in the independent sector on a daily basis. Reviews were undertaken daily to anticipate COVID ward and also ITU capacity requirements.
3.8	The CEO continued that whilst the hospital was under pressure (as was the East of England), much lower patient numbers were currently being seen than during wave one – around 50% less currently. He acknowledged the incidence in Harlow was on the rise, (one of two areas), and the organisation was expecting to see an increase in COVID patients over the coming seven to ten days in line with that. He recognised the impact on elective services but confirmed the organisation was currently managing its inpatients safely.
3.9	In response to a question from NED John Hogan (NED-JH) in relation to the new Think 111 First service, the COO updated that the service had gone live on 01.12.20 across the ICS. Ten patients had already flowed through that service over the previous two days with excellent feedback from both patients and staff. In response to a second question the Director of Quality Improvement (DoQI) commended the hospital's laboratory where colleagues had worked tirelessly over recent days to roll out swabbing on day three. He also commended the work of the Staff Health & Wellbeing team in terms of symptomatic testing for staff allowing them to return to work as soon as possible if well.
3.10	The DoQI also updated that lateral flow testing had been rolled out to frontline staff to enable them to test themselves twice weekly. 600 staff were now doing this and the percentage of those testing positive was currently hovering around 1%, slightly lower than the national position. Take-up had been very positive with only seven declining so far. It was anticipated this would soon rollout to non-patient facing staff.
3.11	The DoQI continued that in terms of the COVID vaccine the Trust was part of a hub arrangement with the Lister hospital in Stevenage. Work was underway with regional and national colleagues around access to the vaccine for staff and with the ICP in terms of access more locally. Challenges would be around the stability of the vaccine and transportation.
3.12	As a final point the CEO updated on new Executive appointments. He welcomed Fay Gilder, the Trust's new Medical Director who had now been in post for one month, and he also confirmed that Saba Sadiq had been appointed to the role of Director of Finance and would join the organisation on 14.12.20. He thanked Simon Covill (who had acted into that position over the previous three months) for his dedication and commitment to the role. Finally he confirmed that Phil Holland had been appointed to the role of Chief Information Officer (on an 18 month secondment) and his start date was currently being agreed.
3.13	The TC thanked the CEO and colleagues for their update and also commended Simon Covill for his input over previous months.
3.2 Significant Risk Register (SRR)	
3.14	This paper was presented by the DoN&M who confirmed it had already been presented to both the Risk Management Group and Senior Management Team (SMT). She updated that a review of risk management across the organisation was being undertaken and a proposal

	would be submitted to SMT in January detailing a revised strategy and plans for a corporate risk register. The organisation continued to see a reduction in significant risks to 88 (with a score of 15 or over) with no risks currently scoring 25.
3.15	The COO was able to update that in terms of the Ophthalmology risk, work was underway and on track to deliver some new software and owing to the success of their diagnostic unit on Gibberd Ward, plans were now underway to identify a suitable location for that in the community. In relation to the risk around GI bleed rota and thanks to the work undertaken by the AMD in Medicine and his team, an internally sustainable rota had now been agreed along with investment and recruitment. Interim support would be retained from the Lister until the end of the year. As a final point she confirmed that in relation to the theatre roof repair, a programme had been agreed and would be underway from January 2021.
3.16	In response to a question from NED-JH in relation to Endoscopy, the COO updated that work on a third room was underway and in terms of the rota the team were looking to establish their own in-house. In the longer term that would be explored across the ICS. Discussions were underway with the Lister in terms of out-of-hospital provision.
3.17	The CEO commended the work undertaken in Ophthalmology in particular around the diagnostic hub which now had interest from Moorfields Eye Hospital. It was truly transformative and a good example of collaborative/community working.
3.3 Board Assurance Framework (BAF) 2020/21	
3.18	This item was presented by the Head of Corporate Affairs (HoCA) who updated there were no changes to the risk scores that month, but the wording of the finance risk had been revised.
3.19	The Acting Chief Financial Officer (ACFO) informed members that the risk score had been maintained at 20. Although contract arrangements with commissioners had been agreed, there remained some uncertainties around the income stream for M7-M12 and performance around delivery of efficiencies and levels of expenditure on COVID and the impact of COVID on the capital programme. The description of the risk had been amended to include the risk relating to delivery of the Capital Programme.
3.20	In line with the recommendation members approved the BAF and the revision of the wording around the finance risk.
04 PATIENTS	
4.1 New Hospital Programme Update	
4.1	This item was presented by the DoS. He updated that a significant amount of progress had been made over the previous few weeks and the drawings were now near completion. He thanked clinical colleagues (particularly during the pressures of COVID) for their input.
4.2	In line with the discussion above work was underway with the ICS in terms of the location of the Ophthalmology diagnostic hub and also how the facility at St Margaret's could be developed. There was now a detailed Communication Strategy (with thanks to the Director of People) which would be rolled out in the new year and a series of engagement events had been organised in conjunction with commissioners and the ICS to understand public/stakeholder requirements.
4.3	As a final point he confirmed a new lead had been appointed to the HIP programme as a whole and the hospital team were working very closely with him. The focus now was on modern methods of construction, repeatable design and net zero carbon. The aim remained to be the first all-electric acute hospital in the UK.
4.2 Mortality	
4.4	This item was presented by the Medical Director (MD) and the paper was taken as read. In terms of the two main indicators (HSMR/SHMI) the Trust had shown significantly high HSMR since November 2016 but the most recent 12 month rolling data point was 118.9. While the previous months showed special cause improvement that should be taken with caution as the Trust remained a significant outlier. The most recent SHMI value was 1.05 and the hospital had not alerted since April 2019.

4.5	The Learning from Deaths programme continued to mature with seven Medical Examiners in place and a Medical Examiner Officer. The programme and HSMR performance had driven several programmes of work. A focus continued on early recognition of renal failure and sepsis. In addition a review of the notes coded as 'senility and organic mental disorders', as flagged in the latest Dr Foster report, was being undertaken. The findings and recommendations from that would be presented at the December meeting of the Strategic Learning from Deaths Group.
4.6	The outputs of the external work undertaken had shown a high proportion of patients who attended at the end of life (something already known to the organisation). A programme of work was now underway around end of life including how to help patients to identify their preferred place of death in conjunction with community colleagues. Work was also underway around coding and palliative care codes which was having an impact on HSMR. Discussions were underway around a database to reflect progress.
4.7	NED-GW flagged that sepsis cases were growing by 10%-12% with more patients presenting too late. He asked if there was something that could be done to address that by working with primary care colleagues to publicise the symptoms more. In response the MD agreed that was an avenue that could definitely be explored.
4.8	In response to the above and also in relation to the patient story, NED Helen Glenister flagged the element around 'professional curiosity' and asked if there was more the organisation could do on that. In response the MD agreed and that it was an approach not often used, which should be articulated more.
4.3 Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	
4.9	This paper was presented by the DoN&M. Headlines were that the position was being sustained in terms of overall nursing fill due to a significant reduction in both the vacancy rate and in turnover. Despite COVID, since September the organisation had seen a net increase of 28 new nurses with a further 30-40 in the recruitment pipeline. There had also been 64 new healthcare support workers over previous months. 27 new nurse starters from overseas were due the following week.
4.4 Nursing, Midwifery and Allied Health Professionals Strategy	
4.10	The DoN&M presented the strategy and confirmed it was the first the organisation had published. A significant amount of work had been undertaken with colleagues and included the vision for PAHT2030 to set the ambition and priorities for nursing and midwifery, to lead delivery of care to achieve person-centred outcomes against three courageous goals. To make the strategy workable a three year plan had been devised. The majority of 2020/21 elements had already been delivered and the strategy would be monitored via the Nursing & Midwifery and AHP Senior Leadership team and also by Workforce Committee (WFC).
4.11	As chair of WFC NED-HH confirmed the committee had approved the strategy at its previous meeting with the only caveat to look at links to some ICS work around nursing vacancies and to look at opportunities to skill mix to a lower skill level as some duties currently undertaken by nurses could be undertaken by someone less skilled.
4.12	NED-HG stated that she welcomed and supported the strategy which was well articulated with a clear direction of travel. In line with the recommendation from the Workforce Committee, the Board approved the Nursing, Midwifery and Allied Health Professional Strategy.
05 PERFORMANCE	
5.1 Integrated Performance Report (IPR)	
5.1	This item was presented by the COO and the key headlines under the organisation's 5Ps were as follows: <u>Patients</u> The position had improved in terms of cases of C-difficile, pressure ulcers and falls. Of note was that there had been one never event, the first reported by the Trust since 2016. There

	had also been an increase in unscheduled Caesarean sections. Quality markers for LD and dementia were now included in the report.
5.2	Performance In line with previous discussions at PAF, the elective recovery programme was challenged and 200 patient procedures had been cancelled in previous weeks but were now being re-booked. Teams were working to identify additional capacity to support the recovery but there were now a number of patients who had waited over 52 weeks for their procedure, the majority in trauma and orthopaedics. **Cancer:** the investment in transparent screens should support capacity in the William's Day Unit in terms of chemotherapy slots and was being closely monitored by the team. Cancer performance as a whole was being closely monitored across the Trust and the system. **Diagnostics:** recovery performance was on trajectory and had good oversight by the team. **Length of Stay (LoS) and ED performance:** LoS was now at its lowest in three years and the number of stranded patients was well below the national trajectory at just 20.
5.3	People Staff turnover was below target therefore the focus now was on sickness absence, a large proportion of which was related to stress/anxiety. The SHAW team were working with the mental health first aiders on access to an app' and also to have trauma and risk advisors trained and ready to support staff. 'Time to hire' had decreased and WFC had received a deep dive into resourcing in Estates & Facilities to provide assurance on the position of those teams.
5.4	Places Members noted some backlog maintenance schemes had now been completed (previously delayed due to COVID). The Domestic Modernisation Programme was now being implemented and procurement was complete. That aligned with the modernisation of the portering function and a new EBME facility was now up and running which would support the maintenance of hospital equipment. As a final point it was confirmed the Alex Study Lounge had now been completed which would offer a quiet space for the consultant body.
5.5	Pounds Members noted a small change to the planned deficit of £0.5m to £400k following a request for the ICS to improve the system position by £4m. Year-to-date the organisation was recording a small surplus on that position, mainly driven by COVID allocation. In terms of revenue none of the funding for the elective incentive recovery schemes had been included in the position and additional guidance was awaited. In relation to capital, spend to date was £13m (of a £45m programme) but it was anticipated further spend would be seen in coming weeks relating to the adult assessment unit build. As a final point it was confirmed the cash position remained sufficient and creditors were being paid on time.
5.2 Workforce Race Equality Standards (WRES)	
5.6	This item was presented by the DoP and colleagues were reminded that the data had been signed off at the previous meeting in order to meet the deadline for publication. It had been agreed that the Board would discuss the data at the current meeting. Members noted the paper had been discussed at WFC that week including the work being undertaken in conjunction with the ICS.
5.7	The DoP continued it was worth noting that although the WRES data related to the period up to 31.03.20 and the 2019 Staff Survey, it indicated that BAME staff still had a worse experience compared to their white counterparts and featured less often in senior leadership roles. Actions had been discussed and were being undertaken in collaboration with the PAHT BAME staff network.
5.8	In terms of the ICS, work undertaken to date had shown that if there was a focus on race, it improved the position for staff with other protected characteristics. In terms of the report members noted the BAME staff network was funded, the chair was given protected time in

	the month on BAME issues, the organisation had run a Black History Month and reverse mentoring had been launched in the organisation with all Executives and the Trust Chairman included.
5.9	She drew members' attention to the ICS benchmarking data in the report which had been discussed at WFC.
5.10	Next steps would include regular meetings with the Inclusion & Diversity champions, work to recruit BAME staff and interventions to support staff prior to going down a disciplinary route. In addition there would be work to support BAME staff in relation to the organisation's talent pipeline. She cautioned that any work would need to be meaningful so discussions were underway as an ICS in terms of agreeing metrics.
5.11	More locally there had been agreement to appoint to a senior inclusion & diversity role and that would go out to advert very soon. There would also be a focus on bullying and harassment and advisors would be appointed. It was also intended to appoint to the role of a Clinical Freedom to Speak Up Guardian.
5.12	The TC thanked the DoP for her update and welcomed the work around interventions. He stated there was evidence to suggest that interventions of a variety of types at an early stage could prevent unnecessary escalations.
5.13	NED-HH updated that she had joined one of the BAME webinars and felt the challenge now was getting wider engagement with a focus on problem solving. Whilst the conversation had been robust, the issues around race equality could not be dealt with solely by the People team. In response the DoP agreed and stated that as SRO for equality in the ICS, a conversation that had been had was around how to break down the barriers for those who found the conversations uncomfortable. She committed that WRES would be a regular discussion item at public Board moving forward. The TC agreed, and said that progress would be monitored.
5.14	In response to the discussion above NED-HG stated it would be useful to have a staff story from a BAME staff member at Board. In response the DoP stated that whilst she agreed in principle, the feedback she was receiving from them was for the Board to reach out to them rather than for them to come to the Board.
ACTION **TB1.03.12.20/09**	**Public Board to receive a BAME staff story.** **Lead: Director of People**
5.15	In line with the recommendation the Board approved the key findings of the Trust's Workforce Race Equality Standard (WRES) report and noted the additional work undertaken with the ICS to improve the experience of its people.
5.3 Healthcare Worker Flu Vaccination Best Practice Management Checklist	
5.16	This item was presented by the DoQI who informed members that the document had been produced to provide assurance that the organisation had taken forward the self-assessment and was compliant with it. It was a requirement that the self-assessment be published in Trust Board papers for public assurance.
5.17	In line with the recommendation the Board noted the self-assessment.
06 GOVERNANCE	
6.1 Reports from Committees	
6.1	<u>New Hospital Committee – 23.11.20</u> There were no items to add and no comments from members. <u>Performance & Finance Committee – 26.11.20</u> There were no items to add and no comments from members. <u>Quality & Safety Committee – 27.11.20</u> There were no items to add and no comments from members. <u>Workforce Committee – 30.11.20</u>

	NED-HH (as chair) confirmed WFC had received the Nursing & Midwifery Strategy and an update on medical staffing. It had noted and commended the work of the hospital's volunteers particularly during COVID and that she herself (as chair of WFC) had been appointed as the organisation's Health & Wellbeing Guardian the role of responsibilities of which were still being worked through. The Committee was seeking more assurance around bullying and harassment and the Board would be kept updated. Senior Management Team – 10.11.20 There were no items to add and no comments from members.
Corporate Trustee	
6.2	Charitable Funds Committee - 18.11.20 There were no items to add and no comments from members.
6.3	The Princess Alexandra Hospital NHS Trust Charitable Fund Annual Report & Accounts 2019-20 This item was presented by Non-Executive Director John Keddie (NED-JK) as Chair of the Charitable Funds Committee (CFC). Members were informed that CFC had reviewed The Princess Alexandra Hospital Charitable Fund's 2019/20 accounts and report, and those were presented that day to the Trust Board (as Corporate Trustee) for approval.
6.4	NED-JK updated that revenues had increased during COVID by £165k (to £686k). The robust position would now be used as a marketing tool to enhance the position further in conjunction with work which would now be undertaken by the organisation's new Head of Fundraising, in particular to develop the Charity's Strategy moving forward.
6.5	In line with the recommendation the Trust Board (as Corporate Trustee) for The Princess Alexandra Hospital NHS Trust Charitable Fund: • Approved the Annual Report and Accounts 2019/20. • Approved the Letter of Representation, authorising the Chair of the Charitable Funds Committee and Acting Chief Finance Officer to sign the Letter. • Authorised that the Chair of the Charitable Fund Committee and the Acting Chief Finance Officer sign the accounts certificates. • Approved minor membership changes to the Terms of Reference of the Charitable Funds Committee (previously agreed at CFC.18.11.20.
07 QUESTIONS FROM THE PUBLIC	
7.1	There were no questions from the public.
08 CLOSING ADMINISTRATION	
8.1 Summary of Actions and Decisions	
8.1	These are presented in the shaded boxes above.
8.2 New Issues/Risks	
8.2	No new risks or issues were identified.
8.3 Any Other Business (AOB)	
8.3	There were no items of AOB.
8.4 Reflection on Meeting	
8.4	The TC reflected that the Patient Story had been instructive, eye-opening and encouraging. He had been pleased to learn of the efforts of staff to support those who were homeless and the hospital should be proud to be associated with that work. He had been pleased to hear of the learning in relation to COVID and the organisation's response to that. He had very much welcomed the Nursing Strategy and the progress on the WRES action plan. As it was the last meeting before Christmas he reminded colleagues of the virtual events taking place for staff on 17.12.20 and wished everyone a safe, and merry Christmas.

Signed as a correct record of the meeting:	
Date:	04.02.21

The Princess Alexandra Hospital NHS
NHS Trust

Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 04.02.21

	A	B	C	D	E	F	G
1	**Action Ref**	**Theme**	**Action**	**Lead(s)**	**Due By**	**Commentary**	**Status**
28	TB1.01.10.20/06	Mortality Outputs	Present to the Board and QSC the final output of the work undertaken by Richard Wilson around mortality.	MD	QSC.22.01.21 TB1.04.02.21	To be addressed at item 3.2 at TB1.04.02.21.	Proposed for closure
30	TB1.03.12.20/08	Homelessness	Board members to raise awareness of homelessness in Harlow through the OHCP.	CEO/TC	TB1.04.02.20	CEO has discusssed with colleagues at both Harlow Council and Essex County Council.	Closed
31	TB1.03.12.20/09	Staff Story	Public Board to receive a BAME staff story.	DoP	tbc		Open

The Princess Alexandra Hospital NHS NHS Trust

2.1

Trust Board – 4 February 2021

Agenda Item:	2.1
Presented by:	Lance McCarthy – CEO
Prepared by:	Lance McCarthy – CEO
Date prepared:	28 January 2021
Subject / Title:	CEO Update

Purpose:	Approval		Decision		Information		Assurance	

Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting: - Performance highlights - COVID-19 response - Capital developments - New hospital - PAHT 2030 - Executive Director appointments
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

2.1

Chief Executive's Report
Trust Board: Part I – 4 February 2021

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

(1) Key performance headlines

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

Key Performance Indicator	Actual performance for latest month (December)	Comparison to last report
ED 4-hour performance	73.2%	↓ (worse); target = 95%
HSMR	117 (Sep 19 – Aug 20)	↓ (better)
C. Diff (hospital onset)	5	↑ (worse); 25 cases year to date
Never Events	0	↓ (better)
Incidents reported	929	↓
No harm / minor harm incidents	92.5%	↓ (worse)
Falls / 1,000 bed days	11.73	↑ (worse)
Number of stillbirths	1	No change – below national rate / 1,000
PPH >1,500ml	4.5%	↑ (worse)
6-week diagnostic standard	62.2%	↓ (worse); target = 99%
Stat Man training	84.0%	↑ (better)
Temporary staff % of pay bill	14.90%	↓ (better)
Staff turnover	10.06%	↑ (worse)

The table of key indicators above shows the pressure that the Trust is under at the moment and the impact that the COVID-19 pandemic is having on our ability to maintain our underlying services in the way that we would wish to.

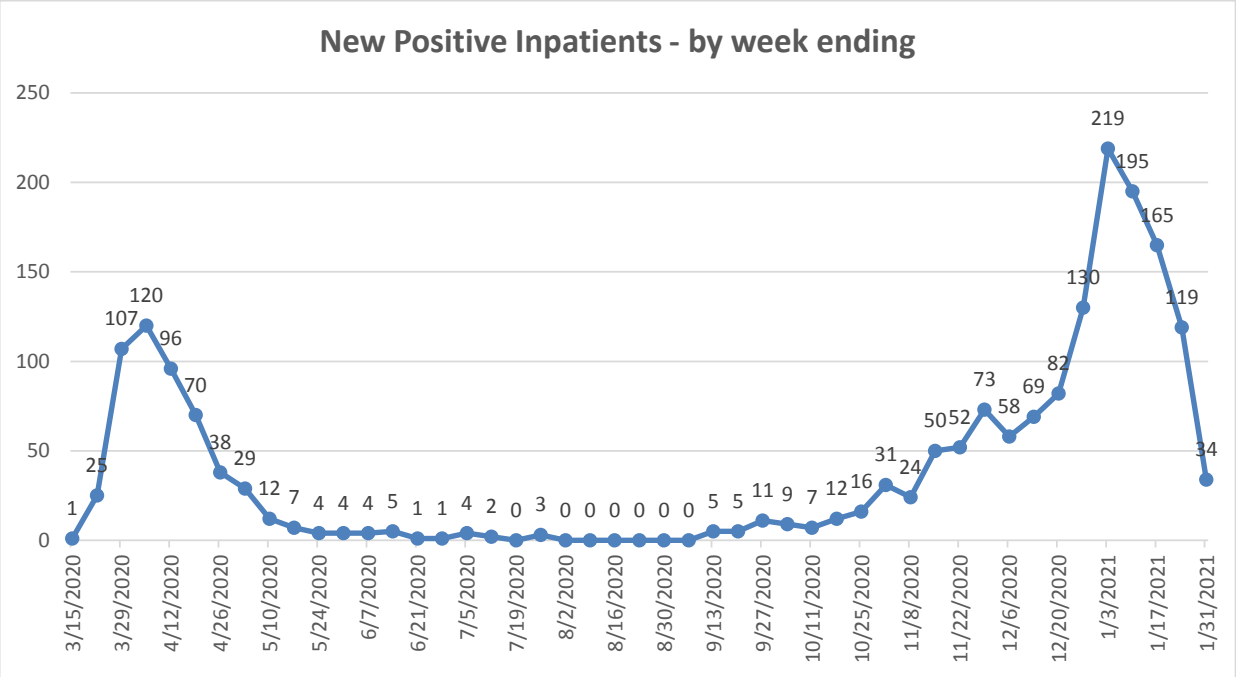
(2) COVID-19 response

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

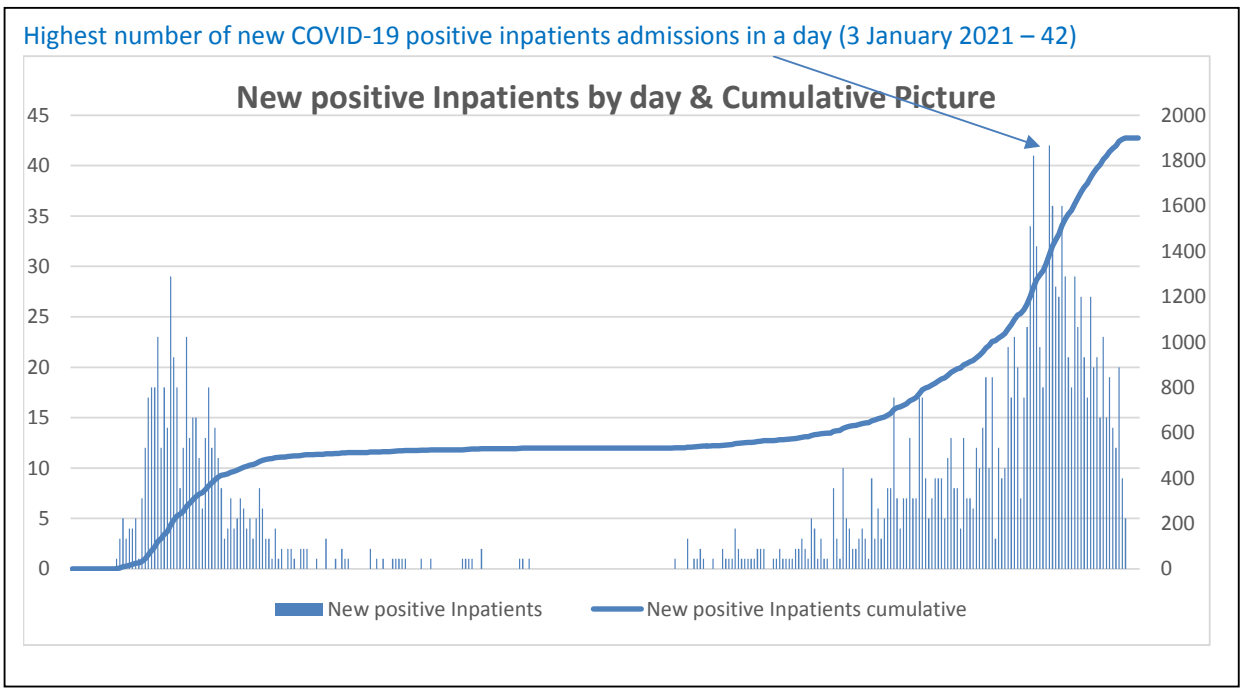
As a result of the high number of community infections and the significant pressure on all health and care services, the Essex Local Resilience Forum declared a major incident in January. We have been working with all public sector colleagues across Essex through the LRF.

The increase in the number of COVID-19 positive cases that we have seen since we last met in December has been significant.

As you can see in the graphs below, we saw a sustained increase in the number of new COVID-19 positive inpatient admissions on a daily and weekly basis through December and the first few days in January, up to a peak of 219 new positive inpatient admissions in w/e 3 January 2021, almost twice as high as the peak week of the first wave (w/e 5 April 2020) where we had 120 new positive inpatient admissions. Our highest number of new positive inpatient admissions in a day was 42 on Sunday 3 January 2021.



Since this point we have seen a slow but steady decline in the number of new positive inpatient admissions, mirroring the reduction in the number of new COVID infections in our local communities. At the time of writing this paper, our local and regional forecasts suggest that we will be admitting approximately 70 new positive inpatients admissions this week.



This demand has necessitated us to significantly change a number of ways of working, not least of which has been the creation of up to 9 'COVID wards' to ensure that we can keep our COVID positive pathways separate from our non-COVID pathways. We have also reconfigured our emergency departments during January to ensure appropriate space and facilities to manage COVID and non-COVID pathways separately. Our critical care capacity has been running at above our normal levels since early December and we have been above our surge level for most of the last 6 weeks, with 25 patients on occasion receiving either level 2 or level 3 care. The regional critical care network has

worked very well to support us and other organisations in the region to transfer suitable patients to other organisations when under significant pressure.

At the time of writing this report we have 123 COVID-19 positive inpatients in the Trust, of which 13 are on critical care.

The impact of the new variant has seen transmission rates and new infections in our local communities rise dramatically over the last few months and given that many of our colleagues live in the local communities we have seen very high absence rates, with more than 14% absence at times in recent weeks. This has put significant strain on our ability to manage all parts of the Trust and many colleagues have worked in different teams, different locations and undertaken different roles to support their colleagues and our patients. In addition, we have introduced a formal redeployment process to support the hardest pressed professions and departments.

To date we have admitted 1,899 COVID-19 positive patients. More than 1,300 have been discharged or transferred but sadly 446 have died in our hospital as a result of COVID-19.

Impact of COVID-19 on our services

As shown in the table in section 1, the impact of the COVID-19 pandemic on all of our normal services has been significant.

We have reduced the amount of elective surgery that we can provide and have focussed on maintaining the top two priorities of patients, including cancer surgery. We now have patients who have been waiting for more than 52 weeks for their routine surgery and have had pressure on the demand for our diagnostic services so that we can ensure that we diagnose and treat suspected cancers in the timely manner that we have done for a number of years. We have expanded our endoscopy, CT and MRI capacity to support the management of cancer patients. In addition, we have continued to work closely with our independent sector colleagues at The Rivers to maximise access to key services so that we can maintain timely services for some 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.

The demand for urgent care remains lower than pre-COVID-19 levels and our performance against the 4-hour standard remains lower than pre COVID-19 levels due to the reduction in available beds in the hospital to manage the flow of urgent care patients in to from the ED.

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

COVID-19 vaccination

We opened our hospital vaccination hub for the vaccination of health and social care workers at PAHT and the local health and care services. The other priority groups are being vaccinated through the Primary Care Network managed vaccination centres.

At the time of writing 5,890 health and care colleagues have had their first dose of the Pfizer vaccine through our hub and more than 75% of PAHT colleagues have now taken up the vaccine. There has been a lower uptake of the vaccine amongst our BAME colleagues and we have run a number of webinars and been supported by our local faith leaders and BAME Network colleagues to address this.

By the time the Board meets, we will have closed the hub and will reopen it at the end of March to provide the booster dose for all relevant colleagues.

The vaccination roll out for the other priority groups identified by the Joint Committee on Vaccination and Immunisation in the community is going well and we are in discussions with primary care colleagues about supporting the mass vaccination centre that has recently opened at the Harlow Leisurezone.

Staff support and testing

The demands of treating COVID-19 patients since February has put a huge amount of physical and mental stress on many of our colleagues.

We have provided a range of health and wellbeing support for colleagues through this period and in particular I'd like to thank Essex Partnership University NHS Foundation Trust (EPUT) for the ongoing mental health and wellbeing support that they have provided for our colleagues.

All colleagues have undertaken a personal COVID-19 risk assessment to support decisions to maximise their health and wellbeing and appropriate adjustments have been made to support relevant colleagues.

(3) Capital developments

The last two months has seen a number of significant capital investments completed on site.

The first floor of our new 2-storey Adult Assessment Unit has opened to patients and the ground floor will open in the forthcoming weeks to create more space for the provision of same day emergency care. Both of these will enable and facilitate the better flow of urgent care patients in to and out of the hospital.

Our new fracture clinic facility was completed at the end of December and has been used to house the vaccination hub. Fracture clinic services will move into this space in the spring.

Our expanded multi-faith and sanctuary space has been completed providing colleagues and patients / visitors much needed calming space and much improved space for prayer.

Work is due to start shortly on a number of other key schemes, including:

- Refurbishment and improvement of mortuary facilities
- Creation of a new large multi-professional, high quality staff rest facility
- Reorganisation of facilities on the ground floor next to our ED to provide enhanced frailty assessment space
- New training and education facility

This will be the last year of any large capital investments in physical facilities, with the expectation that the new Princess Alexandra Hospital will open in 2026.

(4) New hospital

Work continues to progress at pace on the development of the new hospital.

The two sets of architects and the specialist advisors in Modern Methods of Construction (MMC) that we have employed continue to work closely together with each other and our clinical workstream leads to redesign the layout and configuration of the new hospital; maximising the quality of patient spaces whilst taking the benefits of MMC to ensure we minimise costs and maximise replication potential for future expansion and for the wider HIP programme.

We continue to remain in regular contact with the national HIP team, the national NHSEI team and the Regional NHSEI team to progress the whole new hospital programme and get to OBC submission in the autumn.

Our engagement programme is developing very well and since we last met, we have had strong engagement and conversations with all local MPs, councillors from all the local district councils, Essex CC colleagues, our internal colleagues and have started our virtual town hall engagement events with the local population. The first of the virtual town hall meetings was held on 21 January and had more than 120 attendees, who provided some really interesting feedback and ideas to help us design the entrance and front of house for the new hospital and asked many questions on a whole range of subjects. These questions and answers will be published on our new hospital page of our website and we will expand this library of Q&A after every event. The content of the questions and the feedback received from the event has been used to shape our next event this evening. Many more, theme-specific engagement events will be held on a regular basis over the next 5 years as we continue to develop plans for the new hospital and new models of care.

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

(5) PAHT 2030

Our 10-year strategy, PAHT 2030, is ready to launch across the organisation in the spring. PAHT 2030 is our 10-year plan to enable us to achieve our vision and ambition.

It is aligned with the NHS Long Term Plan and the recent national consultation on the development of integrated care systems; a white paper for which is due imminently. It has been designed in the context of the local health inequalities, immediate and medium-term impact of COVID-19 and the financial position of the NHS and the country as a whole.

It is the largest transformation programme that PAHT has ever seen; it is complex and it describes significant, interlinked developments, which require everyone to work in more integrated ways with colleagues inside and outside of the hospital, aligning with the ongoing development of One Health and Care Partnership with our local health and care colleagues.

PAHT 2030 is a plan that puts digitisation, data sharing and the use of technology at the heart of all that we do as well as culture and organisational development, as we are only going to be successful if we all exhibit the right behaviours and leadership and ways of working that are inclusive.

The 5 areas of focus in PAHT 2030 are:

- eHealth
- New Hospital
- Culture and Organisational Development
- Integrated care
- Corporate service modernisation

The first definitive actions underpinning and supporting PAHT 2030, which will be delivered during the spring are a refresh of our organisational values and behaviours including colleagues from across the whole Trust and the completion of a business case for a new Electronic Health Record.

(6) Executive Director appointments

I'd like to extend a warm welcome to Saba Sadiq, who started in the Trust as our Finance Director on 14 December 2020 and to Phil Holland, who started in the role of Chief Information Officer on 1 February 2021.

Author: **Lance McCarthy, Chief Executive**
Date: **28 January 2021**

The Princess Alexandra Hospital NHS Trust

2.2

TRUST BOARD
4 FEBRUARY 2021

Agenda item:	2.2							
Executive Lead:	Sharon McNally - Director of Nursing, Midwifery and Allied Health Professionals							
Prepared by:	Sheila O'Sullivan – Associate Director of Governance & Quality Finola Devaney – Director of Clinical Quality Governance							
Date prepared:	22 January 2021							
Subject / title	Significant Risk Register							
Purpose:	Approval		Decision		Information	√	Assurance	√
Key issues:	This paper presents the Significant Risk Register (SRR) for all our services. The Significant Risk Register (SRR) is a snapshot of risks across the Trust at a specific point and includes all items scoring 15 and above. The overall number of significant risks has increased to 95 currently on the register. The main themes for risks on the SRR are: Our places: including backlog maintenance 8, our people and staffing 6, our performance: operational issues 5 and equipment: 3 Actions and mitigations are in sections 2.4 to 3.3 In line with the new quality governance structure, we are undertaking a focused review of how risk is managed as an organisation, with a proposed way forward expected to report to SMT, with the date to be confirmed.							
Recommendation:	Trust board is asked to note the contents of the Significant Risk Register.							
Trust strategic objectives:	Patients	People	Performance	Places	Pounds			
	√	√	√	√	√			

Previously considered by:	Risk Management Group reviews risks on a rotation so each service is monitored quarterly as per annual work plan Executive Management team Triumvirate leads confirmed approval for all new items on SRR (in absence of SMT)
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and the BAF
Legislation, regulatory, equality, diversity and dignity implications:	Management of risk is a legal and statutory obligation
Appendices:	Nil

1.0 INTRODUCTION

1.1 This paper details the Significant Risk Register (SRR) across the Trust; the registers were pulled from the web based Risk Assure system on 30 December 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-19 risk period the focus of the group has been on significant risks and new and emerging risks

2.0 CONTEXT

2.1 The Significant Risk Register (SRR) is a snapshot of risks across the Trust at a specific point 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 95 significant risks on our risk register which is an increase from 88 in the previous paper discussed in December at Trust Board. The breakdown by service is detailed in the table below.

	Risk Score				
	15	**16**	**20**	**25**	**Totals**
Covid-19	2 (2)	2 (0)	0 (0)	0 (0)	**4 (2)**
Cancer, Cardiology & Clinical Support	4 (5)	10 (4)	0 (0)	0 (0)	**14 (9)**
Estates & Facilities	7 (10)	7 (10)	1 (0)	0 (0)	**15 (20)**
Finance	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Information Data Quality and Business Intelligence	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
IM&T	0 (0)	2 (2)	0 (0)	0 (0)	**2 (2)**
Integrated Hospital Discharge Team	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Learning from deaths	0 (0)	3 (3)	0 (0)	0 (0)	**3 (3)**
Non-Clinical Health & Safety	2 (2)	1 (1)	0 (0)	0 (0)	**3 (3)**
Operational	2 (1)	0 (0)	4 (4)	0 (0)	**6 (5)**
Patient Safety & Quality	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Research, Development & Innovation	0 (0)	2 (2)	0 (0)	0 (0)	**2 (2)**
Resilience	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
FAWs Child Health	0 (0)	1 (0)	3 (2)	0 (0)	**4 (2)**
FAWs Women's Health	5 (6)	3 (0)	0 (0)	0 (0)	**8 (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)**
Medicine	4 (4)	4 (6)	2 (3)	0 (0)	**10 (13)**
Surgery	7 (4)	5 (4)	5 (6)	0 (0)	**17 (14)**
Totals	**36 (37)**	**43 (35)**	**16 (16)**	**0 (0)**	**95 (88)**

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

2.3 There is 16 risks with a score of 20; the same as in December. A summary of these risks is below and all new risks identified since the October paper are detailed:-

2.4 Our Patients

2.4.1 FAWS: Paediatrics

- Additional demand on Dolphin ward requires high dependency area and an increase in numbers of cubicles to provide isolation, (Dolphin03/2020 on register June 2020). Score increased in September since moving to Nightingale ward for the refurbishment of Dolphin as there are fewer cubicles available down to 3 from 7.
  Action: Refurbishment in progress, anticipate completion by end of February 2021. If more than 3 children require a cubicle the team will either cohort a small group in a bay or complete non clinical transfer.

2.5 Our People

2.5.1 FAWS 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

- **AMENDED SCORE:** Consultant cover within maternity achieves 77 hours per week, with national requirement needing an availability of 98 hours a week. There is a high potential for consultants needing to be called into the trust (2020/10/01 assessed in August 2020 with a score of 20, but not visible on the system until the risk was amended /corrected in December).
  Action: All consultant job plans to be reviewed. Additional posts to go through recruitment process.

2.5.2 Medicine – Medical Staffing

- Trust does not have an out of hours GI bleed rota (Endo 08 initially raised October 2016, score amended after discussion within September Medicine Board meeting and increased to 20 in September 2020). Despite support from NHS England the Trust was not successful in obtaining a formal partner engagement for an out of hours SLA.
  Action: Completed the upper GI bleed proforma, care bundle and SOP. The Trust has agreed to fund an out of hour's endoscopy service. A consultation will be undertaken and the plan is to have an out of hours GI bleed rota by Q4 2021.

2.6 Our Performance

2.6.1 ED performance

Four risks regarding achieving the four hour Emergency Department access standard

- Compliance with the statutory standard for the Emergency department (ED) (001/2017 on operations team register since April 2014)
- Achieving the standard of patients being in ED for less than 12 hours (002/2016 raised July 2016 on operational team register)
- Ensuring patients wait less than 12 hours from time of decision to admit (003/2016 on register since July 16) for operational team register.
- 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. Daily patient tracking of discharges to facilitate admissions, actions taken on safety rounds, timely escalation with clear triggers. CDU and ENP pathways being rewritten. ED remedial action plan monitored through Urgent Care Programme Board. Winter surge actions are in place

2.6.2 Cancer access standard

- Not achieving 85% of all patients referred by GP to receive treatment within the cancer 62 day standard (005/2016 on register since July 2016)
  Actions: Daily patient tracking of cancer list at meetings attended by Head of Performance & Planning. Cancer Board monitors recovery action plan and trajectory.

2.7 Our 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).
- Roof leak into Theatre 7 (THE 008/2019, initially raised on 31/10/19).
  Action: A feasibility study to be completed prior to a date being set for repair of both theatre roofs. The surgery team will need to review and adjust the planned activity to keep the theatres free to allow the completion of repairs.

2.7.2 Other areas environment

- **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 to different location at PAH.

- **Penn ward**: requires refurbishment. (Penn001/2020 raised January 2020)
  Action: Capital funding requested for completion of work during 20/21. Will confirm date for refurbishment once winter pressure period has finished.

2.7.3 Waste Management

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

2.8 Our Pounds: No finance risks detailed

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

3.1 Our Patients

- **AMENDED SCORE:** Insufficient numbers of ultrasound scanning units for breast service (Rad/2019/06 raised in October 19 and score increased due to unit breakdown in December)
  Action: Equipment serviced regularly, attempting to source a unit for rental or loan

- **NEW:** Require additional phototherapy units to meet an increase in admissions (NICU07/2020)
  Action: EBME service current units, trust units are shared around and additional borrowed when needed, infants are transferred to other trusts for phototherapy. Business case to be developed.

- **NEW:** Second CT scanner is progressively requiring more engineering visits to ensure optimal working (Rad2020/02 raised December 20)
  Action: Gold level contract in place for same day engineering attendance. Air handling system to be installed and is part of the backlog maintenance on the capital plan.

- **AMENDED SCORE:** Delays to screening of bladder surveillance patients (URO010/2018,raised Sept 2018 and score adjusted due to an increase in numbers of patients due to Covid-19)
  Action: Liaising with external companies to provide additional flexile cystoscopy sessions at weekends

3.2 Our People

- **NEW:** Risk people will transmit Covid-19 potentially causing an outbreak through non-compliance with social distancing, hand washing and use of PPE (C19-056 raised December 20)
  Actions: training of staff, 6 PPE marshals, PPE competencies, measures to discourage large groups of staff in non-ward areas, wash stations.

- **AMENDED SCORE:** Covid-19 Maintenance of cleanliness standards in line with recommendations from Public Health England for Covid-19, with reduced porter services. (C19-011 raised August 20 and score increased in December due to reduction in staff available from NHSP)
  Action: working to gain staff using both agency and NHSP

- **NEW:** Pathology, As a result of staff leaving, maternity and long term sick leave the team have gaps in the leadership post holders (PATHBS20-12 raised Dec 2020)
  Action: Recruitment underway

- **AMENDED SCORE:** Speech and language therapist needed for critical care (raised initially July 20, with score increased to support 7 day working business case)
  Action: benchmarking our service with local acute trusts and to write a business case to request 1.0 WTE SALT for critical care

- **AMENDED SCORE**: Role of systemic chemotherapy lead nurse (SAC) is vacant (Canc/2019/06 raised June 2019, score increased December as staff member acting into the role is now on maternity leave)
  Action: Macmillan have agreed to fund the post for two years, the HCG to commence the recruitment process

3**.3 Our Pounds**

- **AMENDED SCORE**: Surgery healthcare group to achieve financial balance for current year (S&CC005.2020 raised in Sept 2020, increased as costs from workforce working in multiple sites (including Rivers), and increased staff costs due to vacancy, sickness, and self-isolation)
  Action: Budget restrictions on non-pay in place, weekly review to approve use of NHSP/agency, weekly performance monitoring

4.0 RECOMMENDATION

Trust Board are asked to note the contents of the SRR

Your future | Our hospital

NHS
The Princess Alexandra Hospital
NHS Trust

2.3

Trust Board - 4 February 2021

Agenda Item:	2.3
Presented by:	Head of Corporate Affairs - Heather Schultz
Prepared by:	Head of Corporate Affairs - Heather Schultz
Date prepared:	28 January 2021
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 January 2021 are also attached. There are two changes to the risk scores this month: - BAF risk 1.0 Covid: it is recommended the score is increased from 16 to 20. QSC supported this recommendation. - BAF risk 5.1: The risk has been refreshed by the DoF and it is recommended the score is reduced from 20 to 16. PAF supported this recommendation.
Recommendation:	The Board is asked to approve the Board Assurance Framework and the two changes to the risk scores.

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 January 2021.
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

respectful | caring | responsible | committed

5P	Executive Lead	Committee	BAF Risks 2020/21 (February 2021 update)	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.	**20 Recommended that risk score is increased from 16 to 20.**	
	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	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	3.3 Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	**12**	
	DoS	Trust Board	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	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**	
	DoF	PAF	5.1 Finance: There is a risk that the Trust will fail to operate within available resources leading to a financially unsustainable run rate at the end of 2020/21. In addition, the capital programme may be negatively impacted upon by the COVID-19 pandemic causing slippage in delivery of the programme.	**16 Recommended that risk score is reduced from 20 to 16.**	

The Princess Alexandra Hospital NHS
NHS Trust

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 with new variant ii) Failure of public to adhere to Public Health messages and increasing Covid demand iii) National issues regarding supply chains iv) Configuration of PAHT estate v) Current vacancy rates vi) Public perceptions around accessing services as normal	**5 X 5= 25**	Chief Executive 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 patients xiii) Staff vaccination programme xiv) Engagement with critical care network	i) Incident Management Team Meeting ii) Strategic Incident Management Cell iii) IPC Cell and Infection Control Committee iv) Site Management Cell v) Communications Cell vi) People Cell ~~vii) Recovery Cell~~ viii) Clinical Cell	i) Incident management action and decision logs ii) QSC updates (March, to January 2021) iii) Trust Board updates (March, to January 2021) iv) Recovery Plans and submissions v) Covid risk register	**~~4x4=16~~ 4 x 5 = 20**	i) Loss of staff with key skills and training due to virus; shielding/isolating or sickness ii) Reliance on national supply chain iii Modelling information for next peak (local, regional and national) dependant on lock down and public behaviour v) Plans for use of the private sector vi) Limitation with PAHT estate configuration and supply of oxygen		Jan-21	**Proposed to increase score from 16 to 20.**	**4 x 3 = 12 (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											

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	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 EEIST~~ 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 underway (April 21) 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 (bi-monthly), 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 (under development) iv) Dr Foster reports, CQC inspection reports (March 18 and June 19) and GIRFT reports v) Real time Dr Foster reports and engagement vi) GMC Survey results (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 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) Critical care network review peer review April 2020 xiv) TARN review (QSC September and October 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) Recruiting Lead ME **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 ii) NHS Patient Safety Strategy 2019 published. Trust to review and align to best practice iii) EPR development iv) Developing PAHT Quality Strategy	i) Clinical evidence of improvements made following compliance with national audits, NICE,NCEPOD. ii) Demonstrating an embedded learning programme from Board to ward.	13/01/2021	Risk rating not changed	**4x3=12 March 2021**
			Effects: i) Higher than expected Mortality rates ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Poor reputation v) Recurrent themes in complaints involving communication failure vi) Loss of confidence by external stakeholders											

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	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. xviii) New EPR Board established – chaired by CEO xix) EPR replacement programme established and EPR requirements being gathered, 5 Business Change Managers in post and other EPR Trust resources being recruited xx) EPR Options appraisal development to complete mid December 2020 xxi) EPR FBC being developed and benefits realisation with link to HIMMS commissioned	I) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews ~~vii) Monthly EPR Board to Board meetings~~	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.~~ iii) Reports to EPR Programme Board	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Compliance with refresher training vii) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed. Responsiveness and quality of delivery of PFM - testing processes and actions identified by tiaa internal audit (limited assurance). Supplier requests to remove contractual requirement to comply with national standards e.g. ISNs - 2 risks associated 1) exposes PAH to technical compliance issue as supplier not compelled to comply and 2) financial risk as uncapped liability – assurance PAH have declined supplier request on advice from NHSD	Nov-20	Risk rating unchanged	**4x3=12 end of March 2021 (subject to monthly review of progress)**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** i) Ongoing training and support ii) Re-establishing relationship/engagement with Cambio iii) Refresher training underway iv) Revised roadmap to incorporate new statutory/legal requirements e.g GDPR v) Recruitment of CIO				

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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)
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	Strategic Objective 2: Our People – we will support our people to deliver high quality care within a within a compassionate and inclusive culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
2.3		**Workforce:** Inability to recruit, retain and engage our people	**Causes:** i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels viii) Covid -19 **Effects**: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation. Covid-19 effects - delays in workforceplanning, recruitment programmes and additional health and wellbeing pressures on teams	**4 X 4 =16**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) Event in a Tent held annually viii) Staff recognition awards held locally and trust wide annually ix) Enhanced controls around temporary staffing x) Line Manager development programme underway xi) Behaviour workshops held xii) New consultant development programme launched xiii) Staff engagement groups and Staff Council xiv) International recruitment programme for nurses and ED doctors xv) Medical staffing review underway (Medical Safer Staffing) xvi) Additional recruitment ('Bring back staff') during Covid xvii) Provision of Health and Well-being support during Covid-19 including psychological support and absence line. xviii) Communications Strategy approved June 2020 xix) NHS People Plan and ICS People Plan xx) Webinars during Covid (BAME, Vaccination)	i) WFC, QSC, SC, PAF, SMT, EMT. ii) People board iii) JSCC, JLNC iv) PRMs and health care group boards v) People Cell established (Covid-19)	i) Workforce KPIs reported to WFC bi-monthly and inluded in IPR (monthly) ii) People strategy deliverables iii) Staff survey results ~~2019~~ 2020 (results to be reported March 2021) ~~iv) 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 (WFC and Board) vii) OD Framework approved (WFC June 2020) viii) Medical Safer Staffing Plan update to WFC November 2020 ix) Dignity at Work report January 2021	**4 x3 = 12**	Pulse surveys targeted for all staff Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Roll out of e-rostering to all areas Safer Medical Staffing plan in development Actions i) Recruitment plans for medical staff led by AMD (medicine) ii) Extranet for staff - Q1 21/22 iii) Staff survey action plan:~~health and well being, manager development and learning culture~~ (Q1 21/22) ~~iv) Completion of risk assessments (target of 100%) - Q2~~ v) Review of raising concerns (FTSUG's, champions for bullying and harassment, senior inclusion lead) vi) CV19 staff vaccination implementation plan and new targets requiring 90% of staff to be vaccinated	None identified.	10/01/2021	**Risk score not changed.**	**4 x2 = 8** ~~**(at end of 5 year People Strategy but to be reviewed in December 2020)**~~ **March 2022**

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	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	i) Reports to SMT (as required) ii) Signed Fire Certificate iii) Annual H&S reports to Trust Board and quarterly to PAF. iv) Ventilation assurance report v) Annual and quarterly report to PAF: Estates and Facilities September 20 - quarterly report) vi) IPR monthly ix) Annual Sustainability report to PAF (June 20 and update in October 2020) x) Internal Audit report (tiaa) - review of PPM (limited assurance report) - Audit Committee Dec 2019, action plan in place xi) Capital projects report (PAF June 20, October 2020 and weekly updates at EMT)	**5x4=20**	i) Planned Preventative Maintenance Programme (time delay) ~~ii) Ventilation systems~~ ii) Sewage leaks and drainage iii) Electrical Safety/Rewiring (gaps) iv) Maintaining oversight of the volume of action plans associated with compliance. **ACTIONS:** i) EBME review underway ii) Review of estates function complete.	i) Estates Strategy /Place Strategy developing within ICS ii) Compliance with data collection and reporting iii) PPM data not as robust as required	21/01/2021	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

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	Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iii) The resources required for delivery at a programme and workstream level have not been defined or secured iv) The current governance structure is under development given the shift in focus from planning to delivery. v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS Trust Board	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) STP Estates Strategy being developed. viii) STP Clinical Strategy in place ix) STP wide Strategy Group implemented x) Independant STP Chair and independant STP Director of Strategy appointed. xi) System agreement on governance and programme management ICS meetings focussing on management of Covid-19	STP CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) STP Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and STP updates (CEO report August and Development sessions in October/November 2020)	**4 X 4= 16**	Lack of ICS demand and capacity modelling. **ACTIONS:** ~~System agreement on governance and programme management~~ System leadership capacity to lead ICS -wide transformation		20/01/2021	**No changes to risk rating.**	**4x3=12** **~~December~~ March 2021**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 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			
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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 3.3		**Strategic Change and Organisational Structure** Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	**Causes:** i) Staff and stakeholders lack of awareness and/or understanding of drivers and issues cross the system ii) Scale, pace and complexity of change required. iii) Infrastructure (IT, buildings) not supportive of change iv) Financial resources lacking to support change v) Focus on immediate operational and financial priorities versus the longer term strategic planning vi) Lack of clarity regarding contracting and organisational models in support of ICP vii) Management resource and team with relevant capability and skills to drive change and strategy development to be developed. viii) Uncertainty around future CCG structure and relationships	**4 X 4= 16**	DoS Strategy Committee	i) Good relationships with key partner organisations ii) CEO chairing ICP Board iii) CEO and Chair attending STP meetings iv) Clinical Strategy being developed. v) Strategy Committee established and Strategy team in place vi) Development of MSK service and engagement of senior clinicians. vii) One Health and Care Partnership established viii) Financial principles for integrated working developed, allocative contract and due diligence underway ix) NHSE/I assurance process underway x) Legal advice sought on governance and staff transfers xi) Transformation plan in development	i) ICP Board and STP meetings ii) Expert Oversight Groups and workstreams (finance,people, IT) iii) ICP senior leaders meetings iv) Executive to executive meetings and Board to Board meetings (as required)	i) ICP Reports to Strategy Committee ii) CEO report to Board (bi-monthly) iii) ICP update Board development session August 2020.	**4x3=12**	i) Data quality impacting on business intelligence (SLR) **ACTIONS:** PAH long term strategy being developed and PAHT 2030 to be presented to Board for approval in January 2021	Development of governance structures for integration and legislation CCG Accountable Officer process completed and new management structures.	20/01/2021	**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											

Risk Key														
xtreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
edium Risk		4-6												
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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,			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3 : Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.4		**Sustainability of local services** Failure to ensure sustainable local services continue whilst the new hospital plans are in development.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in backlog maintenance iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) Complexity of STP vii) Insufficient quantity and expertise in workforce capability	**4 X 4= 16**	Director of Strategy Trust Board	i) Potential new build/location of new hospital ii) STP Footprint and Estate Strategy developed. iii) Herts & West Essex STP Estates workstream iv) Pathology workstream led by CEO v) Estates and Facilities Infrastructure subgroup for West Essex vi) SOC affordability model vii) SOC approved and submitted to NHSI viii) Detailed analysis of current site option commissioned ix) Master planning work being aligned to Six Facet Survey and Health Planning, phasing of development on PAH site or off site. x) Alignment of strategic capital and tactical capital plans xi) MSK service developments underway xii) Funding confirmed xiii) PAH part of HIP 1 funding programme for capital investment xiv) PCBC completed, submitted and reviewed by NHSI xv) New members of strategy team appointed xvi) OBC in development (completion date is March 2021)	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 **ACTIONS:** Clinical strategy being developed and underpinned by 5P plans PAHT 2030 to be presnetd to Board for approval in January 2030	i) Clinical strategy in development	20/01/2021	**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												

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												
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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, 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 postponed (contractors) ii) Detailed programme of work iii) Monthly meetings with national cash and capital team iv) Weekly meetings with regional team v) Weekly meetings with landowners vi) HOSC meetings held and agreement reached that consultation is not required vii) New national team appointed to provide transaction support viii) Meeting with national team on 3.11.20 ix) Engagement events underway	i) New Hospital Committee ii) Trust Board iii) External advisory meetings as required. Iv) New Hospital SMT meetings	i) Monthly reports to Trust Board and New Hospital Committee. (November 2020) Ii) Letters of support received from HOSCs. iii) Verbal confirmation received that programme management structure is appropriate. Iv) Expert advice received on procurement strategy.	**4x4=16**	Negotiations with landowners Actions: Soft market testing postponed ~~progressing and a bidders day planned~~	None.	Jan-21	**Risk score not changed.**	**3x3=9 ~~(Nov 2020)~~ March 2021**
			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												
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								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) Skill mix gaps in nursing and medical 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 impacting on flow viii) Covid-19 and associated pressures on the department	**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) Developing new models of care vii) Local Delivery Board in place viii) System reviewing provision of urgent care ix) ED action plan reported to PAF/Board x) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries xi) Weekly Urgent Care operational meetings and Urgent Care Board in place xii) Focus on length of stay in ED for all patients ~~xiii) Improved ambulance handover process and improved staffing levels~~ xiv) Assessment unit - opened 16.01.21 xv) Think 111 First - went live December 2020 xvi) Additional temporary ED capacity in place (moved Paeds ED)	i) Access Board meetings ii) Board, PAF and SMT meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) System Operational Group vii Weekly Length of Stay meetings viii) Urgent Care Board	i) Daily ED reports to NHSI ii) Monthly PRM reports from HCGS iii) Monthly IPR reported to PAF/QSC and Board reflecting ED performance	**4x4=16**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings and weekly Urgent Care Board review	None noted.	21/01/2021	**Risk score not changed. Target date for achieving target risk score revised to July 2021**	**4x3 =12** **~~March~~ July 2021 (on consistent delivery of standard - 95%)**
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
Medium Risk		4-6												
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	Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2020/21 and our local system control total													
BAF 5.1		**Finance** There is a risk that the Trust will fail to operate within available resources leading to a financially unsustainable run rate at the end of 2020/21. In addition, the capital programme may be negatively impacted upon by the COVID-19 pandemic causing slippage in delivery of the programme.	**Causes:** i) The Trust has now agreed its operating plan for M7-M12. This is a requirement to deliver a deficit of £391k. Although the plan provides greater certainty on the level of income to be received from block contract arrangements some variables in delivery of the financial position remain. The main risks include the delivery of efficiencies (including reductions in temporary staffing) and containing Covid costs within funding envelopes against the backdrop of increase covid activity. ii) The Trust's capital programme is significant at c£45m and contains a significant number of Estates, equipment and ICT initiatives. A number of programmes are scheduled for delivery in Q3 and Q4. Ability to deliver schemes coud be impacted upon by the COVID-19 pandemic.	**5 X 4= 20**	**Exec leads:** DoF **Committee** : Performance and Finance Committee	(i) NHSE/I commitment to ensure NHS organisations break even in the first 6 months. For months 7 to 12 the Trust has an agreed financial plan in place (ii) Health Care Group performance review meetings are in place where performance is being monitored (iii) Cash management group reviews the Trust's cash position. In addition, fortnightly cashflow reporting in place to NHSE/I. (iv) Oversight by the EMT, SMT, PAF, Workforce and Audit Committee (v) Monthly monitoring of financial performance by NHSE/I through the submission of financial returns (revenue, capital and ad hoc) (vi) ICS capital programme in place in line with system Capital Resource Limit (CRL) which is being regularly monitored at system level (vii) Capital Review Group meets monthly to review the capital position including developing migitations for identified slippage (viii) COVID cost capturing process in place (ix) Internal audit reviewing COVID controls and associated governance (x) External audit programme in place	i) Internal audit reports ii) External audit opinion ii) External review iii) NHSI/E reporting iv) Internal Trust reporting v) Cash forecasts vi) CIP Tracker vii) Estates project plans	i) Monthly reports including bank balances and cash flow forecasts to PAF and Board ii) CIP reports iii) Internal Audit reports: Financial Reporting and Budget Monitoring (substantial assurance) Key Financial Systems (substantial assurance) iv) FAM reports monthly v) PRM packs monthly	~~5x4=20~~ 4x4=16	i) instances of non-compliance across the organisation in relaiton to SFIs i.e. waivers not being obtained in a timely manner ii) Activity and capacity planning iii) CIP delivery and PMO function iv) Embedding management of temporary staffing costs	Demand and Capacity Workforce planning	14/01/2021	**Risk score reduced from 20 to 16.**	4 x 3 =12 (Q4 2020)
			Effects: i) Ability to meet future financial control target if financial plan cannot be achieved as it will impact on future year's run rate ii) Impact on going concern status iii) Impact on future capital availability iv) Unfavourable audit opinion (VfM)							**ACTIONS:** Implementation of finance modernisation programme of work Work continues through PRMs to maintain and strengthen recurrent delivery of all elements of the financial plan (revenue, capital, CIP etc) Demand and capacity planning and modelling to be regularised				

The Princess Alexandra Hospital NHS Trust

3.1

Agenda item:	3.1
Presented by:	Michael Meredith – Director of Strategy
Prepared by:	Richard Robinson
Date prepared:	27 January 2021
Subject / title:	New Hospital Update

Purpose:	Approval	x	Decision		Information	x	Assurance	

Key issues:	This paper updates members on: • Programme timeline • Engagement events that have been held and are planned • Development of the Schedule of Accommodation • Reducing capital cost
Recommendation:	To note the updates on the new hospital programme.

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:	Trust Board 3 December 2020 (Item 2) New Hospital Committee 26 January 2021 (Items 4 and 5)
Risk / links with the BAF:	BAF risk (3,5) “New Hospital”
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	1. High-level programme to construction start 2. Communication and Engagement Update

Meeting of Board of Directors – 4 February 2021

Your future • Our hospital

respectful • caring • responsible • committed

The Princess Alexandra Hospital NHS Trust

3.1

1.0 Purpose/issue

To update Board members on:

- changes to the timetable for OBC and
- the engagement events that have been held and are planned
- development of the schedule of accommodation

2.0 Change to the timetable for OBC

Agreement has been reached with all parties a revised timetable for development of the OBC, and PAH has since signed a Collaboration Agreement with DHSC and NHSEI. This change entails a delay in OBC completion, but enables additional benefits in clinical design, cost and programme to be realised, which will make the OBC more robust and more likely to pass easily through the approvals process.

The revised timetable sees design being completed and costed by the end of May 2021, and the OBC being developed and assured in time to achieve:

- 14 September 2021 – ICS Partnership Board approval.
- 21 September 2021 – NHC approval.
- 7 October 2021 – Trust Board approval and submission.

A revised high-level view of overall programme to construction start is at Appendix 1. Notwithstanding the above, we are investigating every opportunity to shorten the time required for development and assurance.

3.0 Engagement Events

In January a number of communications and engagement activities were conducted, marking the start of the rollout of our new hospital communications and engagement strategy. Over the past month two virtual events, briefings with MPs and local council members, an e-newsletter, a survey to inform design of the welcome experience and briefings for our people have all been undertaken.

The two virtual events aimed to give members of the public an opportunity to find out how the new hospital has progressed and provide an opportunity to shape the designs of the welcome areas and public-facing spaces. Using a variety of promotional materials and the support of local stakeholders a significant amount of publicity was achieved.

Feedback and questions received from these events are being used to inform the planning and content for future engagement activities.

Further detail is provided at Appendix 1 if required.

4.0 Schedule of accommodation

Detailed design of the clinical and non-clinical space continues at pace. Currently the scheme as drawn is not affordable. The design team is working closely with the clinical teams and the estates team to review the schedule of accommodation. Key areas being addressed are:

- Ward design: including the use of shared space e.g. shared staff change (or centralised staff change); shared office space; shared MDT rooms etc.
- A move away from 100% single rooms to 70:30 single-room:four-bed-bay design. This has been proposed by our clinical teams based on the local population demographic

and the target clinical model. Detailed review of options is under way with the clinical and nursing teams supported by our health planners and internal clinical work stream
- Review of circulation space
- Review of FM space
- Review of storage and support space
- Review of admin and all non-clinical space

It should be noted that any changes in service delivery and/or operational design (e.g. just in time delivery) are also being developed alongside these proposals with support of a range of technical advisors.

The team are confident that the optimal facility size can be reached.

6.0 Reducing capital cost

The recasting of the programme was designed to accommodate the maximum benefit of Modern Methods of Construction (MMC) in the development of the New Hospital. The Architects have been working with technical advisors to redesign the building to ensure that we maximise the benefits of MMC. This has led to an emerging new and exciting design that is currently in development. We have also been working closely with the local planners to ensure it meets the stringent design requirements of the Gilston Harlow development. We are confident that this design will not only reduce construction time but will reduce cost of delivery and support the national programme's drive for repeatability across the wider HIP programme.

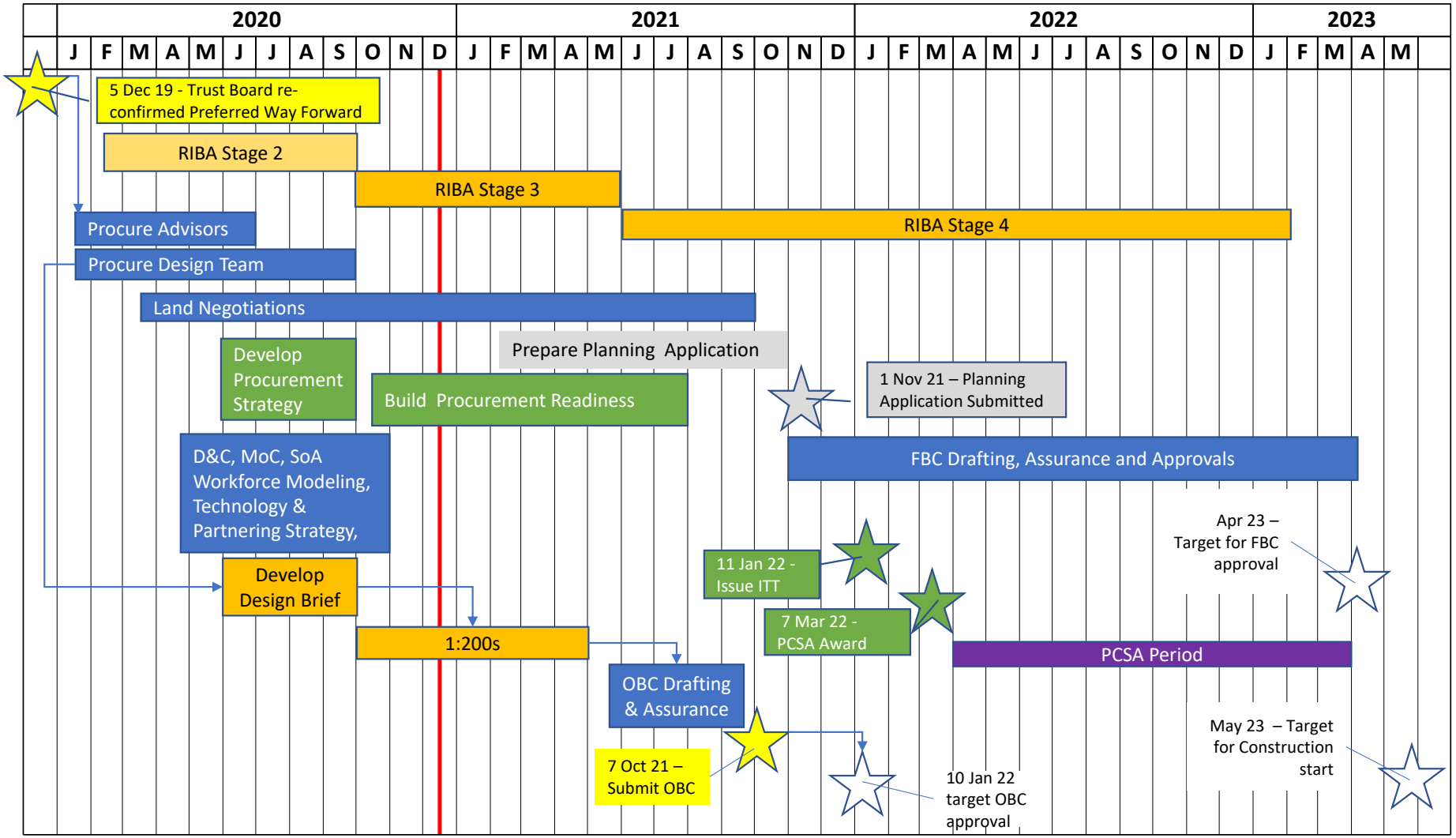
7.0 Recommendations

The Trust Board is requested to note the progress of the New Hospital Programme

Author: Richard Robinson
Date: 27 January 2021

APPENDIX 1

New Hospital High Level Programme – as at 27 January 2021



The Princess Alexandra Hospital NHS Trust

APPENDIX 2

Communication and engagement update

January 2021 has been a busy month with a number of communications and engagement activities launched, marking the start of the rollout of our new hospital communications and engagement strategy.

Following the change to the OBC timeline, we have kicked off our public events programme with two virtual events to bring the public up to speed on our progress, as well as engage their views on the welcome space design. We are keen that any events we run provide a genuine opportunity to influence our thinking.

Member briefings

We held private virtual briefings with local authority members across our catchment, prior to our first public engagement event on 21 January. These events signify the importance of partnership working and recognise the value members bring in their continued support of our plans.

In the first three weeks of January, Michael Meredith led briefings to members from Herts CC, Essex CC, Harlow DC, Epping Forest Council, Broxbourne BC and East Herts DC. Uttlesford DC declined a virtual event, instead we shared a written briefing for their members' newsletter.

The briefings were well received with good challenge. Access, transport and parking are common themes. We will arrange subsequent briefings after the May elections, (including avoiding any events during the pre-election period) as it is likely there will be new members to engage.

MP briefings

Lance McCarthy and Michael Meredith briefed Robert Halfon MP for Harlow, Dame Eleanor Laing MP for Epping Forest and Julie Marson MP for Bishops Stortford on progress and key issues.

Public Town Hall event

On 21 January, we hosted the first of two virtual public events on Teams with our project architects. The purpose of the event was to bring the public up to speed on progress as well as stimulate a discussion with the project architects on what the public would like to see in the hospital welcome area and public-facing spaces.

Robert Halfon MP joined us for the first event and delivered a short message of support.

Promotional materials were sent out to our communications contacts across the health system, local government, community and voluntary services, patient groups, carers groups, FE, BAME forums etc to help us reach further into our communities. We issued a news release to the local media and ran a publicity campaign on social media.

The event was widely promoted, attracting a significant amount of publicity. We joined by over 120 people on the night and there was a good degree of engagement with lots of challenging questions. Common questions included clarity on bed numbers and future capacity, transport and travel, access needs provision and desire to know precise location. All areas we were expecting to be challenged on.

Every attendee has since been sent an evaluation form and asked if they'd like to join future events including targeted focus groups. We're using the feedback, as well as our analysis of the most common areas of questioning to inform the planning and content of our next event.

Online survey

We launched an online survey to run alongside the public events for people to share their thoughts on the arrival and welcome experience at the new hospital in more detail. To date we have received nearly 200 complete responses.

Your questions, answered

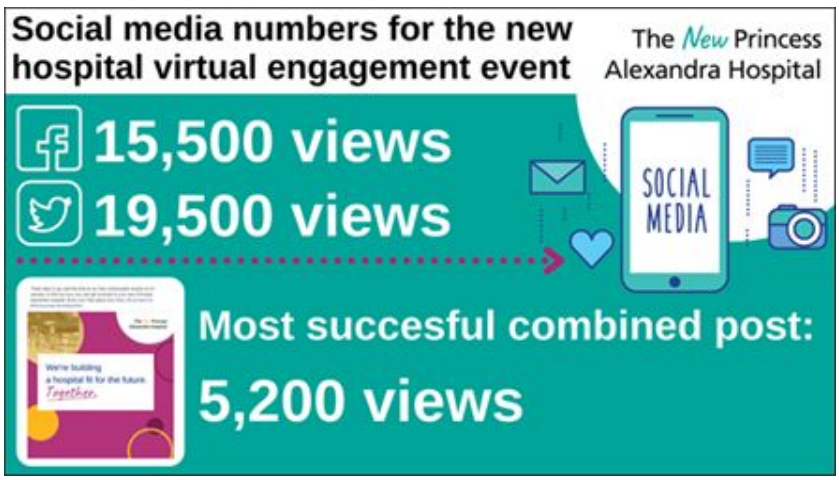
We've drafted and uploaded **Your questions, answered,** essentially a bank of FAQs, to our microsite. We're inviting the public to suggest any further questions for inclusion. Read the FAQs here.

New Hospital newsletter

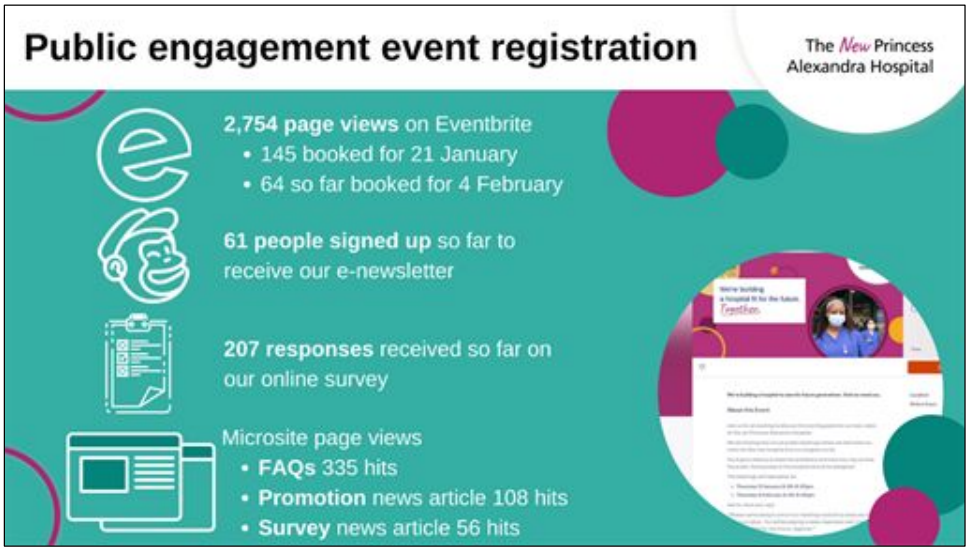
We have set up a new hospital e-newsletter and are running an ongoing campaign to encourage the public to sign up to receive our latest news and updates.

Social media

To help raise the profile of our various engagement activities, we've been running a social media campaign throughout January and early February.



Online analytics



Coming up

Further town hall public events are planned for the Spring when we will reveal the 1:200 drawings to the public for the first time. Around that we are looking to set up some satellite focus groups and stakeholder panels, particularly with hard-to-reach groups, so we can support them in their engagement with our plans.

We are working on large format environment graphics promoting the new hospital to be installed in the PAH site in the coming weeks. We also have plans to revamp the new hospital microsite to incorporate the new brand design and our desire to have more interactive content and functionality.

Jill Hogan
Communications and engagement lead – new hospital
28 January 2021

Trust Board – 4 February 2021

3.2

Agenda item:	3.2
Presented by:	Dr. Ahmed Soliman – Deputy CMO/Clinical Lead for Mortality
Prepared by:	Nicola Tikasingh – Matron for Quality and Mortality Lindsay Hanmore – ADON Quality improvement Robert Ayers – Deputy Director Quality Improvement Kevin Jennings – Programme Manager Bola Shoneye - Information Team
Date prepared:	January 2021
Subject / title:	Learning From Deaths – December 2020 data and information

Purpose:	Approval		Decision		Information	X	Assurance	X

Executive Summary	This paper provides an update on our Learning From Death Process to the Quality and Safety Committee with assurance of PAHT compliance with National requirements. The paper provides details of the key learning identified from the reviews and this month provides a focus on Aspiration Pneumonia
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 and QSC.22.01.21.
Risk / links with the BAF:	BAF 1.1 Variation in outcomes in clinical quality, safety, patient experience and "higher than expected mortality"
Legislation, regulatory, equality, diversity and dignity implications:	*'Learning from Deaths'* - National Quality Board, March 2017
Appendices:	Appendix 1 – Mortality Dashboard

1.0 Purpose/issue

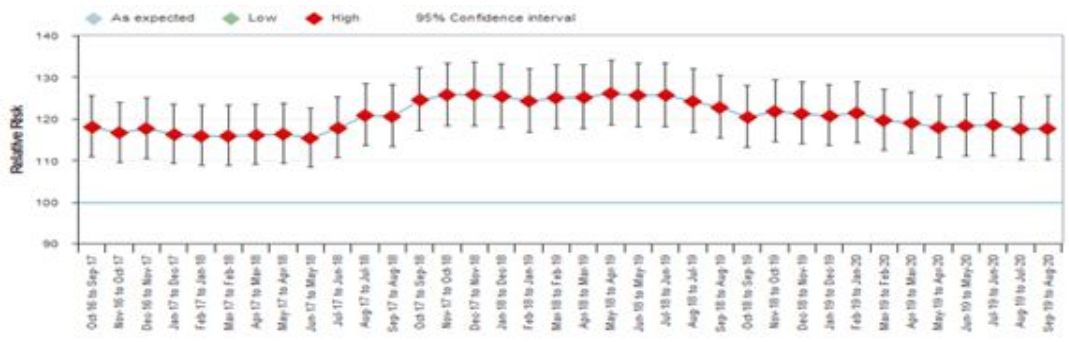
The purpose of this paper is to provide assurance on the implementation of the Learning from Death process, to highlight key pieces of learning and to provide progress updates on the current programme of work to improve clinical practice.

2.0 Background

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

3.0 Current Dr Foster/ NHS D Data Headlines

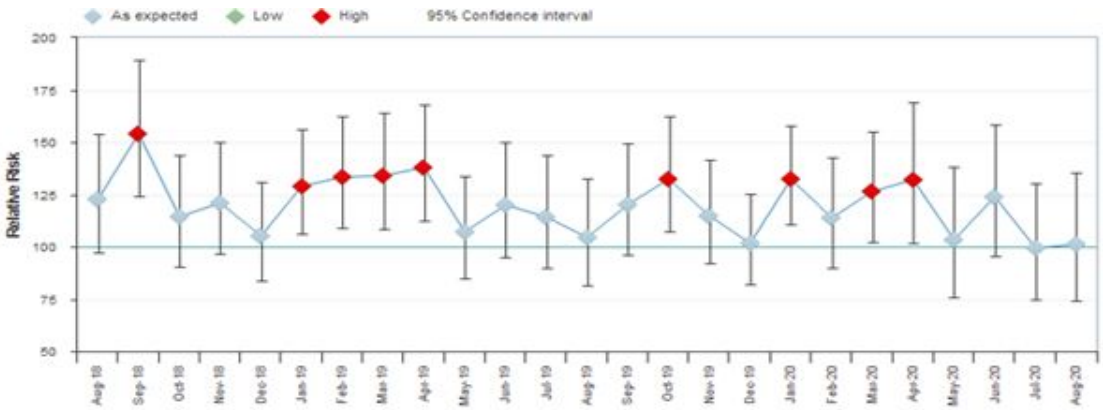
3.1 Hospital Standard Mortality Rate (HSMR) - 12 month rolling



PAHT has shown significantly high HSMR since November 2016. The Relative Risk chart above shows the most recent 12 month rolling data point is 117.6. While the previous months show special cause improvement, this should be taken with caution as the Trust is still a significant outlier in our HSMR.

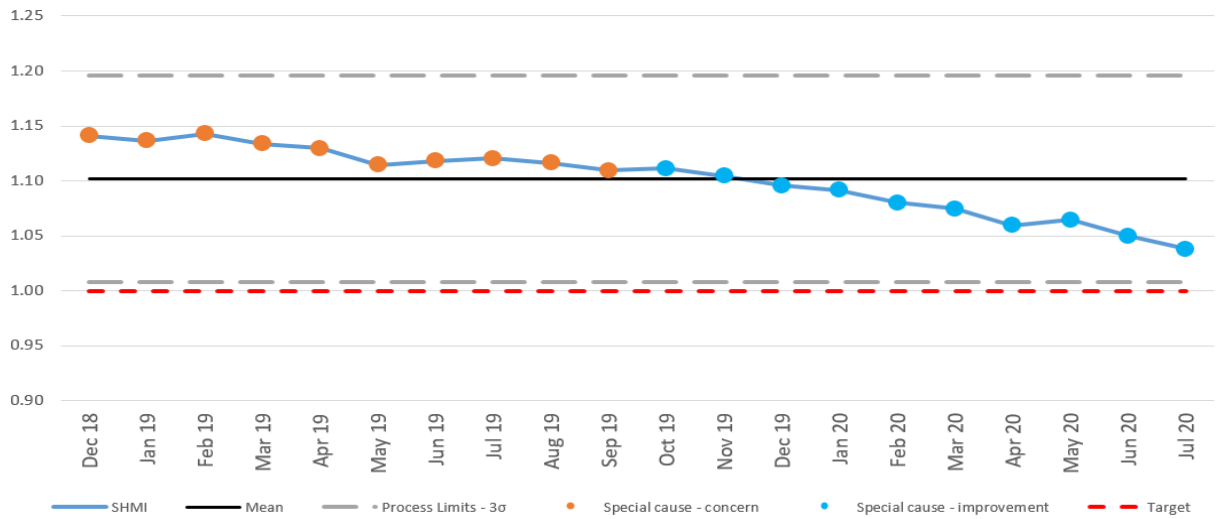
3.2 Hospital Standard Mortality Rate (HSMR) - in month

August 2020 was 101.1 (marginally above national average); however the last 2 months have been the lowest since October 2017.



Summary Hospital-level Mortality Indicator (SHMI)

The most recent SHMI value is 1.038 (July 2020). **We have not alerted since April 2019.**



There are 5 diagnostic groups that are significantly higher than expected (HSMR only) (appendix 1):

- COPD and Bronchiectasis
- Pneumonia
- Senility and organic mental disorders
- Septicaemia
- Fracture of neck of femur (hip)

Of the 10 diagnostic groups that have SHMI values calculated, 9 are “As expected” and 1 is “Lower than expected”.

4.0 Summary of Learning from Death Data

4.1 In the reporting month of December 2020 there have been 146 deaths, with 32 cases referred for a SJR. None of these SJR’s have been completed to date, due to the operational pressures that clinical staff are experiencing.

4.2 During the second COVID wave (September – November 2020), there have been 76 COVID in-patient deaths, with 11 classified as nosocomial deaths.

4.3 There were 72 COVID deaths in December 2020, with 19 of these being classified as nosocomial infections (the definition is below for your reference). All of these nosocomial infections have been reported as serious incidents and rapid reviews are being undertaken for each case. It is too soon to pull themes from these reviews; however an update will be provided in the February 2021 paper.

Hospital associated categories:

- Community onset, days 1-2 with day 1 being the day of admission.
- Days 3-7 Indeterminate.
- Day 8-14 Probable - for investigation
- Day 15 + Definite – for investigation

4.4 A specific template has been compiled to review the nosocomial infections to ensure that appropriate and accurate scrutiny is undertake to enable learning. Duty of candour has been performed for all of these cases, in line with national guidance.

4.5 The only incidents logged in relation to mortality reviews are the 29 nosocomial infections (18 for December 2020).

4.6 The Dr Foster mortality outlier alerts have been reviewed over the last year and the SJR's have not identified any care or service delivery issues. It has been identified that these highlight coding issues, therefore these cases will no longer be referred for SJR's, however deep dives will be undertaken to ensure that any issues and learning can be taken forward. Currently senior coding managers and a clinicians are reviewing these outliers to ensure that coding is accurate.

4.7 An audit on senility and mental health disorders was undertaken in November 2020 due to this being raised as a Dr Foster mortality outlier. Brief summary of findings:

Themes:

- Incorrect coding
- Incorrect documentation
- Inconsistent documentation
- Inappropriate admissions – lack of community support services
- Wording/Meaning of 2^0
- Cannot code words documented, such as:
  Likely, query, differential diagnosis, possibly or ?

Actions taken to date:

- Feedback has been given to the coders with some of the main finding from the audit.
- Coder have been asked to be careful and critical when it is documented in the medical records if they see "diagnosis secondary to diagnosis" to ensure that the main condition being treated is coded in the primary position.
- Only senior / ACC qualified coders will be undertaking the coding of deceased patients, which was implemented in October.
- Feedback to the Operational Learning from Deaths Group

Further recommendations:

1. Training for doctors on coding to be revised and include the following:
   - A clear, persistent and definitive primary diagnosis (main condition treated in episode of care) to be documented by clinicians.
   - Patient presenting conditions need to be listed in order of priority of treatment. This will ensure that coding captures the priority of treatment for patients who present with more than one initial diagnosis.
2. Feedback to be provided to the CCG to seek advice on how to improve admission avoidance. A meeting has been arranged for the end of January 2021. The CCG also attend the Strategic Learning from Deaths Group.
3. Spot check coding audit to commence next year during deep dives. Any issues/learning will be fed back to individual teams and to the Operational Learning from Deaths Group.
4. Feedback to the ED & Acute Medics M&M.

5.0 Programme progress

As a result of having to prioritise the Trust's response to the Covid-19 pandemic, there is not significant amount to update the Quality and Safety Committee across specific programmes. However; with regard to the mortality and learning from deaths software and dashboard there

was a meeting (23/12/2021) between the Chief Medical Officer, Medical Examiners, Mortality Matron, Quality First Team and a potential supplier to demonstrated a different system that meets all of the requirements outlined by key stakeholders. The agreed next steps for this project are as follows:

- Supplier to provide users access the demo system (COMPLETE).
- All of the ME's have agreed to access the system and 'test' that it meets their needs and feedback before 22nd January 2021.
- A decision about proceeding with the system will be taken on the 27th January 2021.

For 2021 and reminder of the financial year, the priority areas of focus for mortality improvement are recommended to be:

1. **Looking back (response)**
    a. Continue to strengthen learning from deaths and associated governance.
    b. Mortality outlier alert root causes to be understood, deep dives to be undertaken and targeted quality improvement projects established.
    c. Initial focus will continue work focused on: COPD and Bronchiectasis, Pneumonia, Septicaemia and Fracture of neck of femur (current mortality outliers).
2. **Looking forwards (prevention)**
    a. Reducing unwarranted variation in care, addressing inequalities in care and delivering new ways of work (supporting the realisation of new models of care enabled where possible using technology and partnership working).
    b. The HCG re-organisation provides an opportunity for establishing a trust wide programme to reduce variation, which the AMDs could lead with Quality First Team supporting. This programme would help strengthen the requirement for every speciality team to take ownership and responsibility to drive out unwarranted variation in care. The Quality First Team will help ensure a consistent quality improvement methodology and approach is adopted.
3. **Using data and evidence base to better target improvement**
    a. There is a decision to be made about keep existing learning from death software or replacing it with a system that meets requirements.
    b. There is a need to develop an automated dashboard that allows the user to see the big picture as well as deep dive into the detail (e.g. consultant, speciality and diagnosis) as close to real-time as possible. Increasing visibility and accessibility to this data and information will increase accountability if used as part of the accountability framework going forwards.
4. **Improved recording of care (documentation and coding)**
    a. Further work is needed to improve the accuracy of recording the diagnosis of the first episode of care.
    b. Clinician partnership working with coders is essential in our efforts as well as general education and communication (making the performance visible/accountable). It is proposed that the Quality First Team, and key stakeholders, work with AMDs to support clinician partnership working with coders.

7.0 Risks for Escalation

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

8.0 Recommendations

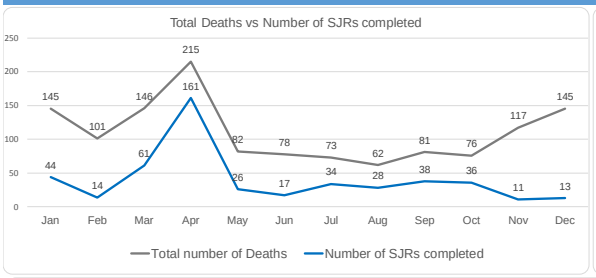
For the Group/Board to provide feedback on the contents of the paper to ensure a dynamic development of the information provided so that assurance can be provided.

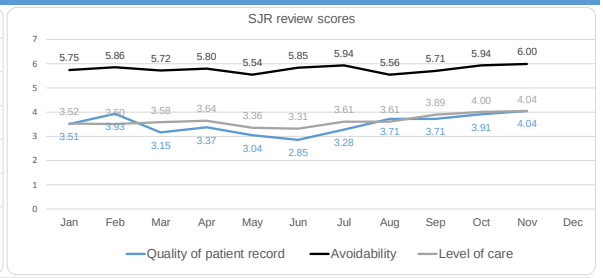
3.2

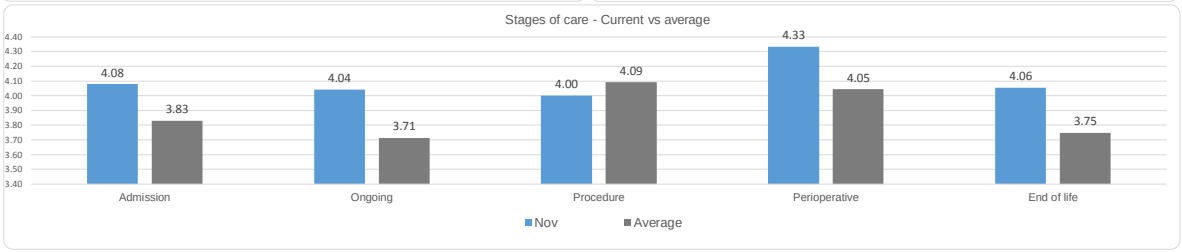
Appendix 1 — Mortality Dashboard

The Princess Alexandra Hospital NHS Trust

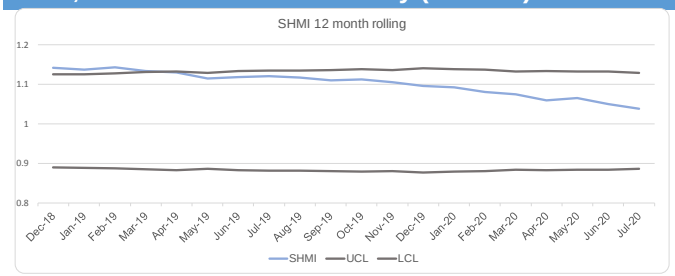
Learning from deaths

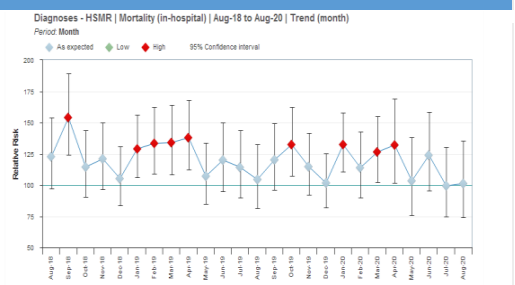


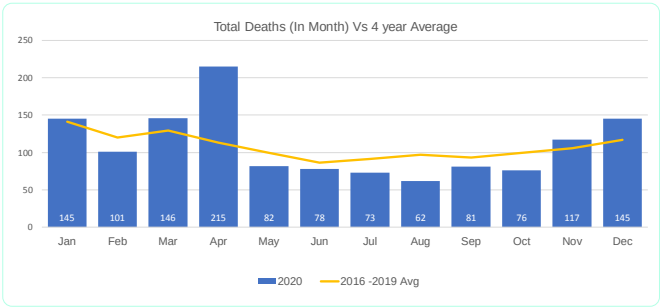


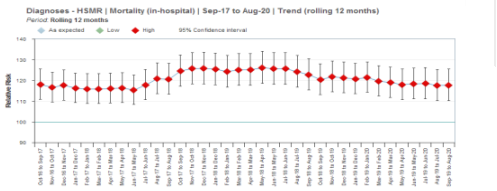


SHMI, HSMR and crude mortality (Cosmic)



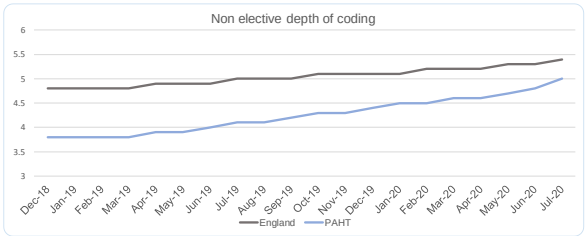


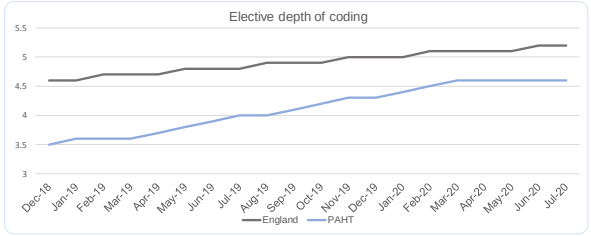


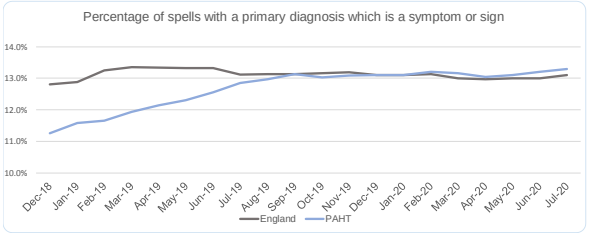


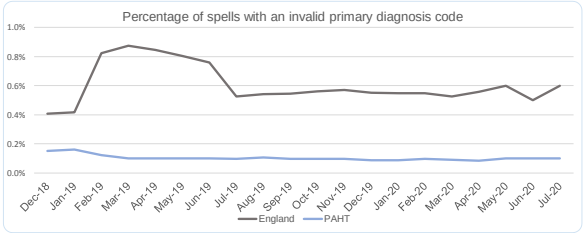
Diagnostic groups with alert status	Observed Deaths	Expected deaths	Excess deaths	HSMR
COPD and Bronchiectasis	33	22	11	148.5
Pneumonia	196	168	28	116.4
Senility and organic mental disorders	19	10	9	192.1
Septicaemia	132	108	24	121.8
Fracture of neck of femur (hip)	29	19	10	151.5

Coding









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The Princess Alexandra Hospital NHS Trust

3.3

Princess Alexandra Hospital NHS Trust
Board Meeting

Agenda Item:	3.4
Presented by:	Sharon McNally Director of Nursing, Midwifery and Allied Health Professionals
Prepared by:	Jacquelyn Featherstone, Associate Director of Nursing & Midwifery, Bobbie Phippin, Lead Midwife for Quality & Compliance
Date prepared:	25.01.2021
Subject / Title:	Family And Women's Services Ockenden Report update

Approval		Decision		Information	X	Assurance	X

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This paper outlines the current position using the Maternity services assessment and assurance tool against the 7 Immediate and Essential Actions in the Ockenden report (Dec 2020). The healthcare group have worked collaboratively with maternity staff and with the Local Maternity and Neonatal Systems (LMNS). Where the assessment tool has identified any gaps in the service, these have been highlighted to provide evidence of the actions in place to achieve full implementation.
Recommendation:	To provide assurance to the Trust Board that Family and Women's Services Health Group are acting on recommendations following the Ockenden 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

Previously considered by:	N/A
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the immediate and essential actions identified in the Ockenden report that was published in December 2020.
Appendices:	

1.0 PURPOSE

This paper outlines the current position using the Maternity Services assessment and assurance tool against the 7 Immediate and Essential Actions (IEAs) in the Ockenden report (Dec 20). The purpose is to provide assurance to the Trust board that the maternity services provided at this trust are safe and that national learning is incorporated into our maternity service.

2.0 BACKGROUND

Following the independent review of over 250 cases and listening to many more families' experiences at the Shrewsbury and Telford Hospital NHS Trust, the first of several reports was published in December 2020, which identified the themes and recommendations that required immediate action and change across every maternity service in England.

3.0 ANALYSIS

The completion of the Maternity Services assessment and assurance tool has been devised to enable Trusts to assess the current position against the seven Immediate and Essential Actions (IEAs).

The healthcare group have worked collaboratively with maternity staff and with the LMNS to assess the 7 IEAs. Where gaps in the service have been identified, they have been highlighted to provide evidence of the actions required to achieve full implementation. Any risks identified have been escalated appropriately for further support and will be monitored through the accountability and governance frameworks.

Immediate and Essential Action 1: Enhanced Safety

The Enhanced Safety recommendation included the need to have regional clinical oversight in a timely way.

The assessment demonstrates there are many areas where this has been implemented through the local maternity and neonatal services (LMNS), and within our maternity service. The first of the LMNS Serious Incident oversight and scrutiny meeting was held on the 25.01.2021 and investigations and the system learning that came because of them is to be shared. There is a lead governance midwife for the LMNS who has oversight and works collaboratively with our trust.

A robust governance process is supported at executive level and is presented at both Trust board and the Quality Safety Committee.

Perinatal Mortality Reviews (PMRT) are undertaken at a local level and includes a multidisciplinary team across maternity, Neonatal and external representation. A report is presented quarterly to the Trust board.

Immediate and Essential Action 2: Listening to Women and Families

The Non-Executive Director's role within Family and Women's Services is embedded and there are frequent meetings with the team. Other examples of effective avenues for Women and Families to offer feedback include the perfect ward data, social media Maternity Voices Partnership (MVP) page, Baby Friendly Initiative (BFI) UNICEF baby friendly assessment and the PMRT perinatal tool. The health group work collaboratively with the patient experience team to ensure feedback is received on a monthly basis. Feedback is shared throughout the health group through clinical governance and the patient experience committee. National surveys also allow the health group to benchmark for improvements to our service.

We also work collaboratively with Healthcare Safety Investigation Branch (HSIB) and ensure that woman and families remain informed and supported throughout the investigation process and in line with duty of candour. We remain committed to enhancing our service though appointing an independent advocate and remain informed regarding the national discussions regarding funding and roll out.

Further improvements identified

- Currently the independent advocate role is not widely available nationally. The trust is committed to supporting this once the job specification and funding is available.

- Feedback mechanisms are in place and are available to women and their families however we remain committed to continuing to improve accessibility. The implementation of the new Quick Response (QR) code was rolled out in December 2020. Women are able to link into the QR code via app and provide immediate feedback. The health group are currently awaiting initial responses. It is the expectation that monthly feedback will be received to supplement our data and further inform our learning and improvement actions.

Immediate and Essential Action 3: Staff Training and Working Together

There are numerous examples of effective multidisciplinary team working across the health group that include prompt training, weekly Cardiotocograph (CTG) training sessions and training provided throughout the LMNS. The Covid-19 pandemic has had an adverse effect on being able to continue with all aspects of training but we have adapted and now use small face to face sessions alongside eLearning where applicable. Currently as a health group our training compliance is at 84% against the standard of 90% required by the Trust. This continues to be monitored closely and is reported at Maternity Board and Trust Quality Compliance Group.

All external funding for training is ring fenced and used to support the training agenda for staff.

Clinical Workforce planning is undertaken for both maternity and medical workforce. Birthrate plus was completed in May 2019 and identified a shortfall of 7.98 WTE midwives and 3.2 WTE maternity care assistants. An active recruitment process is in place and all funding has been confirmed to the health group budget to support recruitment.

From the 17th August 2020, the consultant labour ward hours increased from 60 hours to 77 hours. This was built into the new job plans taking on board the budgeted uplift in consultants and successful recruitment to these posts (3 new additional consultants).
From the 4th January 2021, the consultants have also introduced the second ward round at the weekends, thereby further increasing the consultant labour ward hours to 87 hours. However, this is not sustainable, as these hours do not form part of the consultant's current job plans.
To meet the National agenda of 98 hours consultant labour ward cover, while maintaining the remaining elective activity, a workforce model is being developed alongside Job planning review to understand the staffing requirements. This will inform a Business Case for additional consultants and will be presented at the health care group board in February 2021.

Risks Identified

- Due to the Covid-19 pandemic, there is a risk that the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme safety standard 8 may not be achieved. To mitigate this risk, small face-to-face groups are being undertaken weekly. In addition, live drills will commence from 5th February and will include all members of the multidisciplinary team. There is a commitment from all specialities to attend. This risk is included in the MIS updates to the Quality and Safety Committee and monitored though the PRM process.

Immediate and Essential Action 4: Managing Complex Pregnancy

All women that present at booking with complex pregnancies are currently screened to ensure they are allocated to the consultant that specialises in the most appropriate area to ensure their pathway is appropriate for their needs. There are guidelines available for individual medical conditions that highlight the requirement for a named lead consultant to be allocated. A spot audit has been undertaken and is available as evidence should this be required. To be able to monitor on-going compliance, an audit has been registered and the findings will be shared with the HealthCare Group Board.

Currently there are pathways in place for a referral to a tertiary centre. A standard operating procedure (SOP) has been developed to ensure the process is clear for all staff working in the health group. The development of maternal medicine specialist centres are being overseen by the LMNS with engagement from the health care group.

Compliance with the recommendations set out in Saving Babies Lives Care Bundle is monitored by undertaking spot audits and improvement actions are in place where further work is required. Any concerns are escalated through the regular Maternity Incentive scheme meetings.

Improvement Identified

- With effect from February and the commencement of a new Obstetric Consultant, all clinics will be allocated to a consultant.

Immediate and Essential Action 5: Risk Assessment throughout Pregnancy
Risk assessments are currently carried out at each contact with the woman. The information received is documented in the maternity notes and also completed on the electronic patient record. Senior members of the maternity team undertake a record keeping audit monthly and the data is collected to form part of an annual audit.

Currently the booking and Antenatal Clinic risk assessment guideline is under review to include the intended place of birth dependant on the ongoing clinical picture. The trajectory for the completion of the review is expected by the end of February 2021.

The revised maternity hand held records now have the intended place of birth question within the antenatal pages, which will encourage staff to review at each point of contact.

Immediate and Essential Action 6: Monitoring Fetal Wellbeing
There is a lead midwife and a lead obstetric consultant in post to provide expert advice with fetal monitoring and also to support the recommendations for saving babies lives. All adverse outcomes are reviewed and opinions sought for support and advice. To further enhance our process and oversight, a weekly governance meeting involving all members of the multidisciplinary team commences the first week of February 2021. At the weekly CTG training sessions, the health group identify case reviews, which contribute to further learning.

The health care group moved to physiological fetal monitoring in December 2020 and completed a comprehensive risk assessment, which is in line with the LMNS. All staff attended a masterclass session to provide comprehensive training prior to the roll out. A competency assessment is required to provide evidence of knowledge and is sent to all staff on completion of the masterclass. The decision to implement Physiological Fetal monitoring is documented and tabled at the HCG Board meetings as this is outside of the National Institute of Health (NICE) guidance.

Immediate and Essential Action 7: Informed Consent
The LMNS has developed a variety of applications to support women when making choices about their pregnancy journey. A mother and baby App is available to all women and the introduction of a padlet offers support and choice for women within the Black Asian and Minority Ethic (BAME) community.

The health care group have worked collaboratively with communications to update and improve the information that is available on the trusts' website. Information available to women includes choice of intended place of birth, mode of birth and the various environments available to all women dependant on their clinical picture.

Data and feedback that is received is used to improve our services and address thematic concerns. The Head of Midwifery also liaises with the MVP and the NHS England Clinical Commissioning Group (CCG) to understand what approach is best given the circumstance.

The Princess Alexandra Hospital NHS
NHS Trust

4.0 RECOMMENDATION

The Trust board note the outcome of the assessment and assurance tool, have assurance that Family and Women's Services Health Group have acknowledged the Ockenden Report and have appropriate actions in place to ensure the recommendations are met.

Author: Bobbie Phippin, Lead Midwife for Quality & Compliance Family and Women's Services.
Jacquelyn Featherstone Associate Director of Nursing and Midwifery

Date: 25/01/2021

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board
4 February 2021

3.3

Agenda Item:	3.3
Presented by:	Sharon McNally,Director of Nursing, Midwifery and AHPs
Prepared by:	Jacqui Featherstone, Associate Director of Nursing & Midwifery; Erin Harrison, Lead Midwife for Patient Safety & Quality; Finola Devaney, Director of Clinical Quality and Governance.
Date prepared:	28/01/2021
Subject / Title:	Overview of Serious Incidents within Maternity Services

Approval		Decision		Information	X	Assurance	X

Key Issues:	Following the Ockenden report published in December 2020, one of the essential actions from enhanced safety was that all Maternity serious incidents (SIs) with a summary of key issues must be sent to the Trust Board and at the same time to the local maternity and neonatal system (LMNS) for scrutiny oversight and transparency. Maternity currently have five Open Serious Incidents (SI's).
Recommendation:	To provide assurance to the Trust Board that Family and Women's Services Health Group are continually monitoring compliance

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

Previously considered by:	Quality & Safety Committee 22 January 2021
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the recent Ockenden report that was published in December 2020 with recommendations for maternity services.
Appendices:	N/A

1.0 PURPOSE

This paper outlines the open serious incidents (SI's) within Women's Health (Obstetrics and Gynaecology) with themes, areas for improvement and shared learning identified.

2.0 BACKGROUND

Following the Ockenden report published in December 2020, one of the essential actions from enhanced safety was that all Maternity SI's with a summary of key issues must be sent to the Trust Board and at the same time to the local LMNS for scrutiny, oversight and transparency. It was suggested 3 monthly however this report will come monthly to QSC with abridged version via the Integrated performance report in the maternity dashboard to Board.

3.0 OVERSIGHT AND GOVERNANCE

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

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

4.0 SERIOUS INCIDENTS

Since April 2020 the Trust have reported 7 serious incidents, of these, 5 remain open and are within the agree timeframe with root cause analysis investigations on going.
The themes within the open Sis are:

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

5.0 AREA OF IMPROVEMENT

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

Key area of improvement;

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

6.0 RECOMMENDATION

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

Author: Erin Harrison, Lead Midwife for Patient Safety and Quality
Finola Devaney, Director of Clinical Quality and Governance

Date: 28 /01/2021

Trust Board – 4 February 2021

3.4

Agenda item:	3.4
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery
Date prepared:	January 2021
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels and an update to Nursing and Midwifery Workforce Position

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	Staffing risk rating in month: RED This paper provides an oversight of the challenges faced by nursing and midwifery in trying to meet safe staffing levels across inpatient areas during December. The report details the changing picture that emerged over the month from good compliance with agreed standard templates at the start of the month to a position of working to provide the safest staffing with minimum staff at the end of the month as the Trust was hit by the second covid wave including high levels of staff absence. The paper outlines the actions taken in response to this changing picture. While every effort has been made to ensure the overall information is accurate due to factors above there remains a risk that some of the individual ward data remains inaccurate. Data where possible is provided against both the standard and minimum templates The data does not reflect the impact on care of a reduced skill mix as a result of redeployment of staff to support minimum templates from other areas. The overall nursing vacancy position continues to improve and now sits at 6.9%. The report details our pipeline of starters and summarises international recruitment activity which is supported by additional investment from NHSE.
Recommendation:	The committee is asked to note the information within this report

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

Previously considered by:	Workforce Committee 25th January 2021
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	Appendix 1: Safest staffing governance framework Appendix 2: Registered fill rates by month against standard planned template. RAG rated. Appendix 3: Registered fill rates by month against agreed minimum templates. RAG rated

1.0 PURPOSE

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

2.0 BACKGROUND

Over the month of December the Trust experienced rapidly increased number of covid positive patients and increasing staff absence from covid. The Trust response was to increase the number of Covid positive wards and reduce the number of non covid wards from 3 at the start of the month to 7 be the end and increasing the foot print of critical care to create increased surge capacity and reducing and ultimately stopping all but essential elective activity onsite. Paediatrics and maternity services have been largely unaffected by the second wave.

In response to these challenges a number of additional actions were instigated to ensure nurse staffing levels were as safe as possible. In line with guidance from the Chief Nurse's office the aim has been to ensure that care is the safest possible rather than safe care. Unlike critical care where guidance has been provided by the Critical Care Society and NHSE/I on patient care ratio's during surge and super surge, there is no guidance on minimum nurse to patient ratios for non-critical care patients. Utilising the guidance on safest staffing and the non mandated but recognised nurse to patient ratios of 1RN to 8 patients a minimum set of templates has been agreed to support ensuring safest care.

		Day		Night		Day	Night	
Ward Name	Bed Nb	Headcount RN	Headcount HCSW	Headcount RN	Headcount HCSW	RN:patient ratio	RN:patient ratio	Rationale
John Snow Ward	8 L1	3	3	3	2			
Melvin	7	1	1	1	1	7.0	7.0	RN single checking. Ratio above national 1:8
ADSU	10	2	0	2	0	5.0	5.0	Ratio above national 1:8 but poor layout
Kingsmoor Surgery	32	4	3	3	2	8.0	10.7	RN single checking. Ratio above national 1:8
A&E Nursing	28	19	10	16	9			Not dropped from BEST but regularly below.
New Assessment	28	3	3	3	2	9.3	9.3	Above national 1:8 G&A
Gibberd Ward	27	2	4	2	4	13.5	13.5	Low acuity and MFFD patients. Increased HCSW ratio
Harvey Ward	20	3	2	3	1	6.7	6.7	above national 1:8.
Lister Ward	28	3	3	3	2	9.3	9.3	
Locke Ward	28	3	3	3	2	9.3	9.3	
Penn Ward	28	3	3	3	2	9.3	9.3	
Ray Ward	28	3	3	3	2	9.3	9.3	
Saunders Unit	28	3	3	3	2	9.3	9.3	
Tye Green Ward	32	4	3	4	2	8.0	8.0	#NoF and increased enhanced care needs
Winter Ward	28	3	3	3	2	9.3	9.3	
Charnley Ward	27	3	3	3	2	9.0	9.0	
Fleming Ward	26	4	3	4	2	6.5	6.5	Cardiac CCU - higher acuity
Harold Ward	32	4	3	4	2	8.0	8.0	national 1:8

In addition to agreeing minimum templates the safe staffing governance processes has been strengthened with safe staffing huddles increased to three times a day with direct feedback into the daily bed planning meeting. The availability of staff, temporary staff, acuity of patients and numbers of beds closed due to infection control issues are taken into account with allocations. A Datix incident form is completed by the chair of the huddle if a ward area is left below minimum staffing describing the rationale and mitigation in place. A summary of the timetable of oversight and escalations is in Appendix 1.

All nurses and HCSW who have been working in non-essential areas or where services have been reduced have been redeployed to support ward teams. These include theatre staff to critical care, endoscopy and outpatient departments as well as paediatric and maternity staff. Additional incentive payments were agreed for bank shifts during to support fill rates in lien with ICS colleagues.

To support nursing staff a set of priorities of care have been developed to provide guidance and reassurance to staff when the staff allocation is at or below minimum staffing. The regulatory bodies have published support and guidance for staff who are working outside of their normal area of practice and these have been shared with staff alongside a letter to all staff from the senior nursing and midwifery team acknowledging the current staffing levels, levels of anxiety among staff and reminding staff how they can access emotional support offered both in house and from external sources.

3.0 ANALYSIS

3.1 The following information should be viewed in light of the rising pressure on staffing during the month which will not be reflected in the monthly average as fill rates were strong against the standard template at the start of the month but reflective of the minimum template by the end of the month. There was a high volume number of ward changes including opening and closing for part of the month, bed closures due to IPC issues and changing patient acuity and which will not all be reflected in the data. While overall fill rates against templates are represented where possible the information does not reflect the skill mix of staff which has been impacted by the amount of staff who have been redeployed from their normal area of practice.

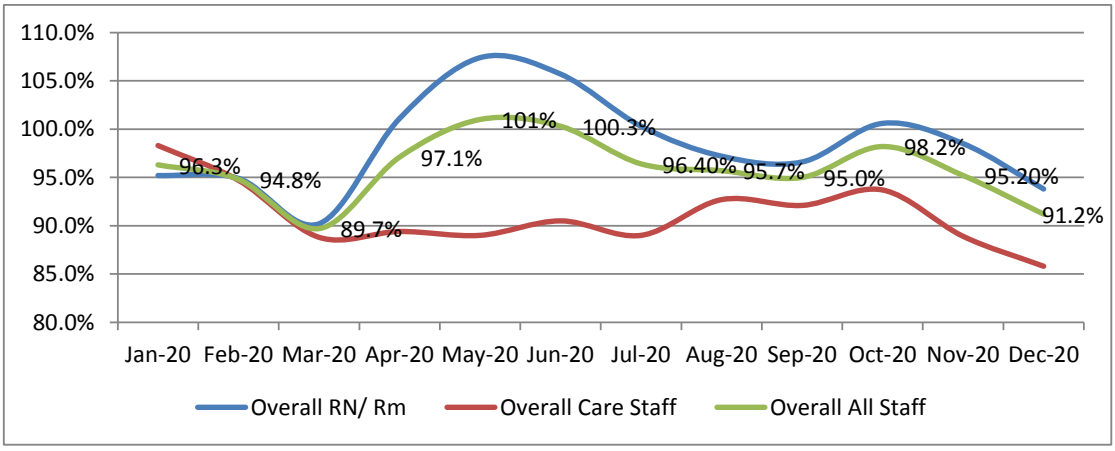
3.2 The Trust Safer Staffing Fill rates for December 2020 against the standard templates for overall RN/RM in month has decreased to 88.6%, which is a decrease of 7.3% against November 2020. Against the minimum surge templates the overall RN/RM for December is 95.9%

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

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
In Patient Ward average December 20	88.6%	79.6%	100.6%	94.7%	93.8%	85.8%	91.2%
In Patient Ward average November 20	95.9%	87.6%	101.8%	90.7%	98.5%	88.9%	95.2%
Variance November - December 2020	↓7.3%	↓8.0%	↓0.8%	↑4.0%	↓5.3%	↓3.1%	↓4.0%

The table below shows the actual staffing hours for December against the reviewed Standard Demand Template compared against the non-adjusted Minimum Demand Templates.

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 December 20 STANDARD TEMPLATE	88.6%	79.6%	100.6%	94.7%	93.8%	85.8%	91.2%
In Patient Ward average December 20 MINIMUM TEMPLATE	141.4%	100.1%	95.0%	84.8%	115.1%	92.5%	106.9%



December data based on Standard Demand Templates

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

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

Red <75%	Amber 75 – 95%	Green >95%

	Day		Night	
November 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	81%	73%	93%	70%

**Registered Nurse demand and fill.*

Nurse staffing levels within ED and in particular availability of skilled and experienced senior ED RN's remained a risk in December despite additional actions that have been taken to increase temporary staffing cover. Continues monitoring of risk and the potential impact on patient safety continues by the Medicine and Urgent care teams supported by the Executives.

3.4 Critical care

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

Across December as the unit moved from normal capacity to super surge status additional RN 'A' and RN 'B' nurses were redeployed to support the critical care nurses and maintain overall 1:1 patient to nurse ratios with the ratio of critical care nurse to patient reducing during shifts when the unit was under extreme pressure in line with this approach.

During December there were 9 shifts (out of 62) when critical care nurse to patient ratios were above 1:1 although this did not exceed 1:1.9

3.5 Fill rates by ward

Fill rates by ward have been produced against the standard planned templates (Appendix 2) and minimum templates (Appendix 3). Average fill rates below 75% for registered nurses against the standard planned template are reported in 2 areas Charnley and Henry Moore wards and Harvey however this does not reflect the fluctuating patient numbers on these wards over the month due to bed closures and changes in patient acuity against the norm for these areas following change of use. Appendix 3 shows that there were no areas with an average fill below 75% when measures against the minimum templates.

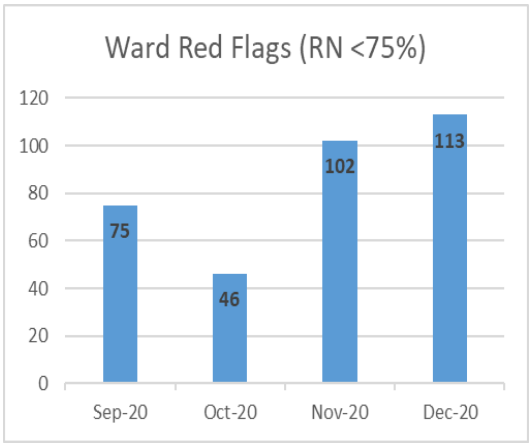
3.6 Datix reports: The trend in reports completed in relation to nursing and midwifery staffing is included below and shows that the number of incident recorded increased in month driven by 2 areas: ED (15) and Tye Green (25). Triangulation with patient safety incidents raised has not identified any patient safety issues as a direct result of the staffing concerns however close monitoring of trends in

patient safety issues is identifying an increase in month of incidents relating to essential care e.g. pressure ulcers, falls with harm etc.

3.7 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 against the standard ward template. This data has not been adjusted to reflect the minimum templates and this demonstrates the increasing pressure on staffing levels against the standard staffing templates in month.

	Adult in patient wa	NICU	Dolphin	Wards Total
Sep-20	70	0	5	75
Oct-20	43	0	3	46
Nov-20	72	2	28	102
Dec-20	101	1	11	113



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. The need for temporary staff is reviewed daily at the Safe Staffing daily meeting, staff redeployment along with a greater challenge continues and all shifts not required continue to be cancelled.

In December there has been an increase in registered requirements in response to opening additional ward areas, along with increased staff absence despite the overall reduction in vacancies. The main areas utilising agency staff continue to be A&E Nursing and Maternity where specialist skills are required. There was an increase in registered demand (↑ 308 shifts) in December compared to November. December shows a corresponding increase in agency usage (↑67 shifts). The overall fill rate fell from 72.9% to 64.3%.

RN temporary staffing demand and fill rates*: (December 2020 data supplied by NHSP 6.1.2021)*

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
October 2020	2815	1862	66.1%	288	10.2%	76.4%	665	23.6%
November 2020	3313	2401	61.1%	373	11.3%	72.9%	899	27.1%
December 2020	**3621**	**1888**	**52.1%**	**440**	**12.2%**	**64.3%**	**1293**	**35.7%**
December 2019	3631	1695	46.7%	931	25.6%	72.3%	1005	27.7%

The HCSW demand shows a significant increase in unregistered demand (↑449shifts), there was also a large reduction in fill rate from 65.8% in November to 52.8% in December. December saw the use of agency HCAs for the first time during 2020.

HCA temporary staffing demand and fill rates: *(December 2020 data supplied by NHSP 6.1.2021)*

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
October 2020	1444	1049	72.6%	0	0%	75.3%	613	24.7%
November 2020	1582	1041	65.8%	0	0%	65.8%	541	34.2%
December 2020	**2031**	**1032**	**50.8%**	**40**	**2.0%**	**52.8%**	**959**	**47.2%**
December 2019	2608	1754	67.3%	0	0%	67.3%	854	32.7%

B: Workforce:

Nursing Recruitment Pipeline

The overall nursing vacancy rate in December has fallen slightly to 6.9%. The vacancy rate for Band 5 RN's is 10%. There are 82 nurses in the pipeline who hold offers of which almost all are international nurses. 18 overseas nurse commencing in November and 13 from December have completed their OSCE at the beginning of January and will join the NMC register.

The targeted domestic recruitment campaign for HCSW has been successful and 62 HCSW have been appointed in the last six months. There are a further 20 in the recruitment pipeline.

The Trust has received financial support from NHSE to escalate international recruitment and will receive £7,000 per international nurse recruited from the end of October to the end of March 2021.

Turnover rates for registered nurses continue to fall and is 9.97%.

Establishment V Staff in Post												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Funded Establishment WTE	942.61	942.61	942.61	942.61	942.61	966.25	966.25	966.25	966.25	966.25	966.25	966.25
Staff in Post WTE	871.00	868.00	866.00	858.00	862.00	856.00	884.00	884.00	900.00	899.00	923.00	947.00
Vacancy WTE	71.61	74.61	76.61	84.61	80.61	110.25	82.25	82.25	66.25	67.25	43.25	19.25
Actual RN Vacancy Rate	7.6%	7.9%	8.1%	9.0%	8.6%	11.4%	8.5%	8.5%	6.9%	7.0%	4.5%	2.0%
Forcast Vacancy Rate in Business Plan												

Band 5 Establisment V Staff in Post												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Funded Band 5 Establisment WTE	487.93	487.93	487.93	487.93	487.93	522.2	522.2	522.2	522.2	522.2	522.2	522.2
Band 5 Staff in Post WTE	447	446	446	450	446	471	471	474	470	486	502	518
Band 5 Starters	1	0	2	7	1	28	3	7	4	22	22	22
Vacancy Band 5 WTE	40.93	41.93	41.93	37.93	41.93	51.2	51.2	48.2	52.2	36.2	20.2	4.2
Actual Vacancy Rate	8.4%	8.6%	8.6%	7.8%	8.6%	9.8%	9.8%	9.2%	10.0%	6.9%	3.9%	0.8%
Forcast Vacancy Rate in Business Plan												

Actual/Projected Starters Pipeline												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RNs (not Band 5)	2	0	0	0	0	4	6	2	0	10	10	10
Band 5 Newly Qualified + Local	1	0	1	7	1	7	3	5	0	2	2	2
Band 5 International Recruitment	0	0	0	0	0	21	0	18	13	20	20	20
Band 5 Starters	**1**	**0**	**1**	**7**	**1**	**28**	**3**	**23**	**13**	**22**	**22**	**22**
Total Starters	3	0	1	7	1	32	9	25	13	32	32	32

Projected Leavers WTE												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RNs (not Band 5) Leavers	3	1	7	0	2	1	6	5	6	2	2	2
Band 5 Leavers	3	1	2	3	5	3	3	4	8	6	6	6
Total Leavers	**6**	**2**	**9**	**3**	**7**	**4**	**9**	**9**	**14**	**8**	**8**	**8**
N&M Turnover %	10.53%	10.18%	10.12%	10.17%	10.17%	9.68%	10.12%	9.52%	9.97%			

4.0 RECOMMENDATION

The Board is asked to receive the information describing the position regarding nursing and midwifery recruitment, retention and vacancies.

Author: Sarah Webb, Deputy Director of Nursing and Midwifery

Date: **26 January 2021**

Appendix 1 Safest Staffing Timetable

Frequency	Time	Venue	Attendees	Purpose	Review	Complete
Daily	07:30am 08:00am	Site Office	Site Team Matrons	To review staffing for the start of the day shift and identify any risks that need to be addressed, devise and implement plan to mitigate Handover to Matrons	SafeCare Sunburst wheel, staffing plan from 11am and 16:00pm huddle, professional knowledge of site issues and last minute unavailability that may affect plan	Safest Staffing Record (Appendix 3)
Daily Monday – Friday	11:00am 15:00pm	Micros oft Teams	DDoN (Chair) ADoN (Deputy chair) Matron or HoN for each Zone, NHSP, Safe Staffing Lead, Site Team representative	Forward look at staffing for the second half of the Day shift along with the Night shift and identify any risks that need to be addressed and devise and implement plan to mitigate. The meeting will also review staffing for the next day and weekend on Friday	SafeCare Sunburst wheel, SafeCare compliance, Unavailability, Operational issues.	11:00am Safe Staffing Huddle Template (Appendix 2) 16:00pm Safest Staffing Record (Appendix 3) Pandemic only
Weekly Thursday	11:00am	Micros oft Teams	DDoN (Chair) ADoN (Deputy chair) Matron or HoN for each Zone, NHSP, Safe Staffing Lead, Site Team representative Ward Managers	As above This meeting will also focus on the previous week's census entry compliance and patient classification.	As above Retrospective SafeCare Census Entry Compliance reports Acuity Accuracy Audits results Prospective and retrospective Unavailability Report Prospective and retrospective Additional Duties Report	As above
Daily	20:00	Site Office	Site Team	Using professional knowledge of site issues and last minute unavailability review agreed night plan	SafeCare Wheel Agreed night staffing plan	Safest Staffing Record – Pandemic Only (Appendix 3)

Appendix 2

Ward level data: fill rates December 2020. *(Adjusted Standard Planned Ward Demand)*

Appendix 1 has captured the fill rate at ward level, the accuracy of this data is dependent on all ward / staff moves and redeployment being captured and recorded accurately in Health Roster.

Chamberlen Ward, Labour Ward, Samson Ward and Birthing Unit ward level data has been collated and reported as Maternity; this is gives a more accurate picture and reflects the way Maternity works.

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

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
Charnley Ward	72.6%	71.5%	88.0%	84.2%	79.1%	76.3%	78.1%
ITU & HDU	99.4%	82.6%	109.6%	82.6%	104.3%	82.6%	101.1%
John Snow Ward	83.0%	78.3%	115.1%	77.4%	96.1%	78.0%	88.5%
Henry Moore Ward	70.6%	N/A	103.2%	N/A	83.0%	N/A	91.9%
Gibberd Ward	99.7%	84.5%	107.1%	117.8%	103.3%	100.4%	102.3%
Harvey Ward	88.2%	62.8%	100.0%	65.9%	93.0%	64.3%	79.8%
Lister Ward	80.7%	73.7%	79.8%	89.1%	86.8%	80.0%	83.8%
Locke Ward	86.0%	96.0%	106.5%	88.7%	94.7%	93.2%	94.1%
Penn Ward	83.6%	76.7%	129.5%	104.4%	99.9%	87.2%	95.0%
Ray Ward	92.8%	72.0%	113.9%	126.8%	101.8%	89.2%	96.7%
Saunders Unit	85.8%	73.2%	97.2%	80.6%	90.6%	76.2%	84.3%
Tye Green Ward	95.3%	75.5%	105.3%	99.9%	99.5%	85.4%	93.4%
Winter Ward	90.9%	70.3%	88.8%	119.1%	90.0%	88.8%	89.6%
Fleming Ward	81.9%	74.8%	132.3%	101.5%	99.8%	84.9%	94.1%
Harold Ward	105.7%	95.4%	129.7%	118.4%	115.5%	104.1%	110.7%
Neo-Natal Unit	88.6%	89.2%	87.9%	103.5%	88.3%	96.4%	89.6%
Dolphin Ward	76.1%	85.7%	84.7%	87.1%	79.9%	86.2%	81.5%
Maternity	92.9%	93.0%	88.6%	92.4%	90.8%	92.7%	91.3%
Total	88.6%	79.6%	100.6%	94.7%	93.8%	85.8%	91.2%

Appendix 3

Ward level data: fill rates December 2020. (Non-adjusted Minimum Ward Demand)

Appendix 1 has captured the fill rate at ward level, the accuracy of this data is dependent on all ward / staff moves and redeployment being captured and recorded accurately in Health Roster.

Chamberlen Ward, Labour Ward, Samson Ward and Birthing Unit ward level data has been collated and reported as Maternity; this is gives a more accurate picture and reflects the way Maternity works.

Analysis of areas with red fill rates has not been undertaken this month as there is still a number of DQ issues with the data 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	121.0%	107%	117.4%	84.2%	119.2%	76.3%	99.6%
John Snow Ward	110.7%	78.3%	115.1%	77.4%	112.8%	78.0%	96.9%
Henry Moore Ward	105.9%	NA	103.2%	NA	104.6%	NA	115.8%
Gibberd Ward	100%	84%	107%	118%	103%	99.6%	102.2%
Harvey Ward	117.7%	188.3%	100.0%	197.8%	109.2%	192.8%	130.1%
Lister Ward	134.5%	98.2%	106.5%	133.7%	130.9%	111.7%	122.1%
Locke Ward	143.3%	96.0%	142.0%	88.7%	142.7%	93.2%	120.1%
Penn Ward	139.4%	76.7%	129.5%	104.4%	134.7%	87.2%	113.0%
Ray Ward	154.7%	96.0%	151.9%	126.8%	153.4%	107.7%	132.5%
Saunders Unit	143.0%	97.6%	129.6%	121.0%	136.6%	106.5%	122.8%
Tye Green Ward	119.2%	100.7%	105.3%	99.9%	112.5%	100.3%	107.3%
Fleming Ward	136.5%	74.8%	99.2%	101.5%	116.0%	84.9%	102.9%
Harold Ward	102.3%	92.3%	94.2%	76.4%	98.4%	84.7%	92.5%
Winter	151%	70%	118%	119%	135%	88%	110%
Neo-Natal Unit	88.6%	89.2%	87.9%	103.5%	88.3%	96.4%	89.6%
Dolphin Ward	76.1%	85.7%	84.7%	87.1%	79.9%	86.2%	81.5%
Maternity	92.9%	92.9%	88.6%	92.4%	90.8%	92.7%	91.3%
Total	141.4%	100.1%	95.0%	84.8%	115.1%	92.5%	106.9%

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 4 February 2021

4.1

Agenda item:	4.1
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Information Team/Executive Directors
Date prepared:	January 2021
Subject / title:	M9 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:	This month's IPR shows the detail of the performance for December 2020. There is no accompanying narrative this month due to the additional clinical & operational pressures. Page 1.4 Infection Control includes Covid-19 data on inpatient numbers, Covid mortality and infection rates during admission. Page 1.5 shows the Covid admissions and beds together with the forecast developed from regional modelling. The Performance section includes the recovery trajectories that were developed following the first wave of Covid. These will be further refined following this winter wave of Covid emergency admissions.
Recommendation:	The Board is asked to discuss the report and note the current position and further action being taken in areas below agreed standards.

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

Previously considered by:	QSC.22.01.21 and PAF.28.01.21
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	

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The Princess Alexandra Hospital NHS Trust

Integrated Performance Report December 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

Sharon McNally, Director of Nursing

Stephanie Lawton, Chief Operating Officer

Jim McLeish, Director of Quality Improvement

Ogechi Emeadi, Director of People

Michael Meredith, Director of Strategy

Saba Sadiq, Chief Finance Officer

Fay Gilder, Chief Medical Officer

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Trust Objectives

The Princess Alexandra Hospital NHS Trust

Our Patients

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

Our People

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

Our Places

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

Our Performance

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

Our Pounds

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

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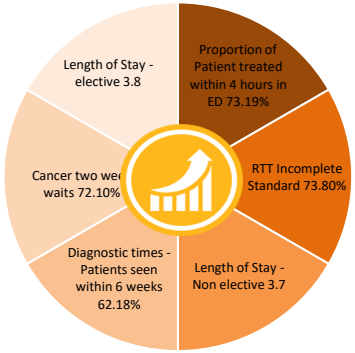
5Ps

In this month

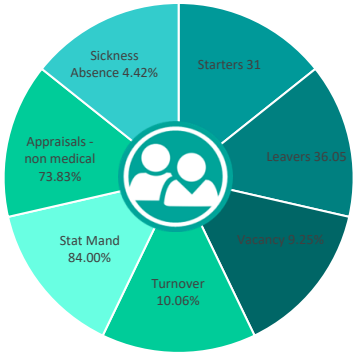
The Princess Alexandra Hospital NHS Trust

Patients

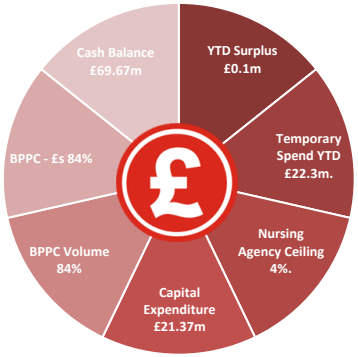
Performance



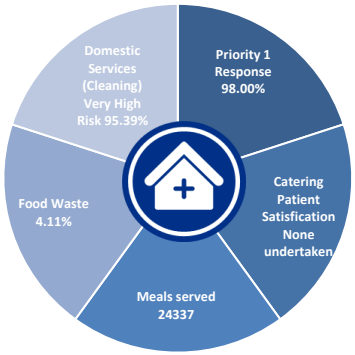
People



Pounds

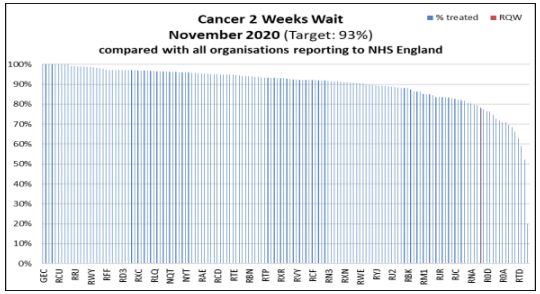


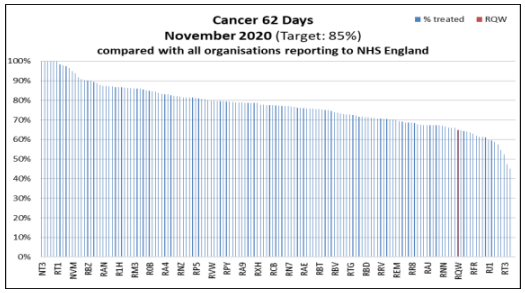
Places

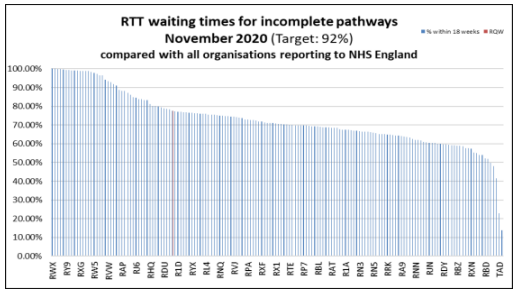


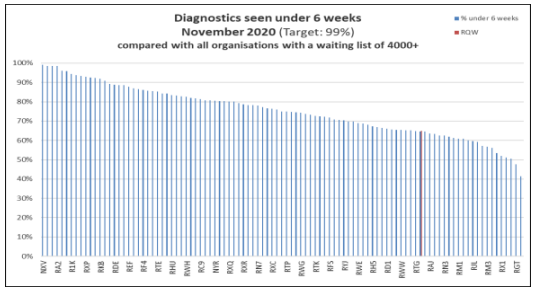
National Benchmarking
Compared with all organisations reporting to NHS England

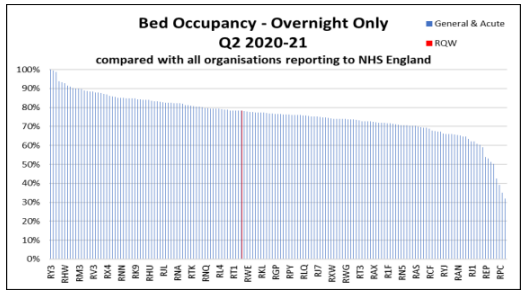
NHS
The Princess Alexandra Hospital
NHS Trust

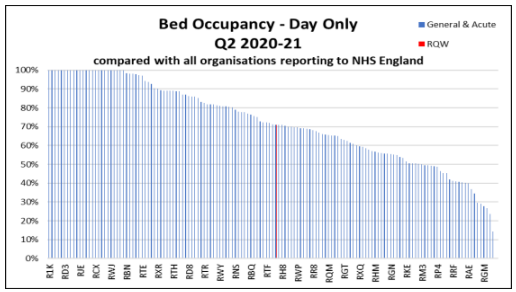


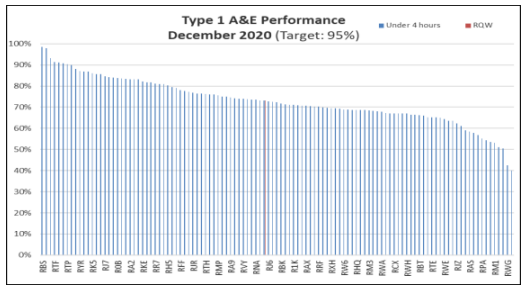












Your future | Our hospital

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

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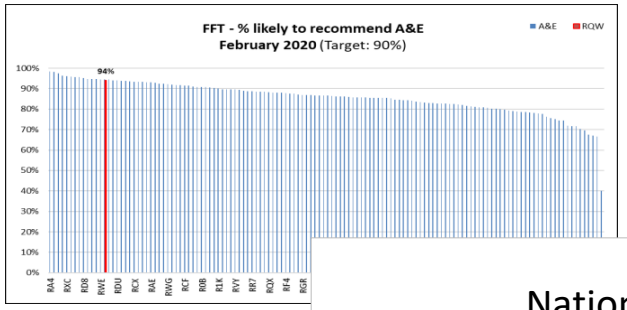
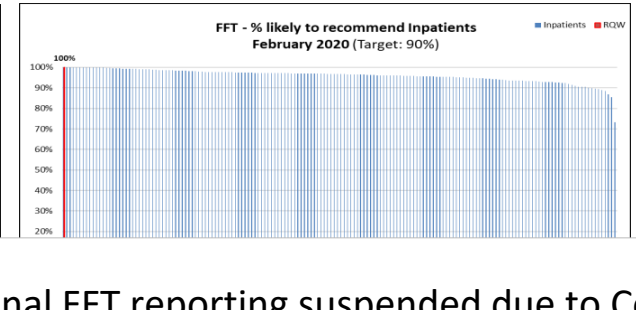
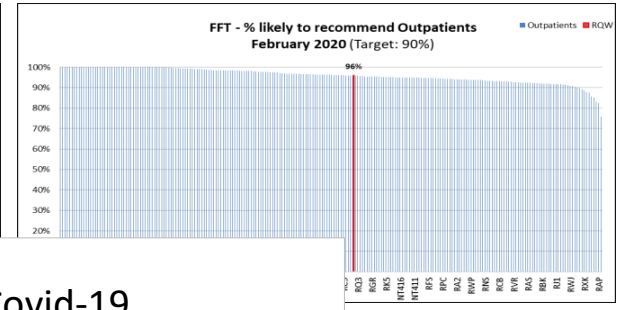
National Benchmarking
Compared with all organisations reporting to NHS England

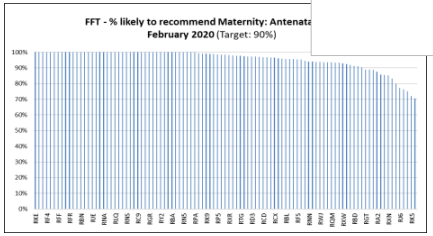
NHS
The Princess Alexandra Hospital
NHS Trust

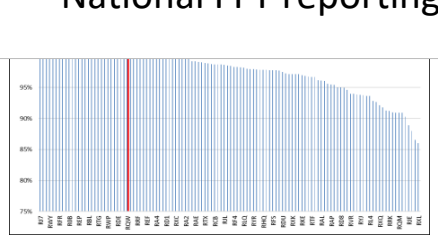


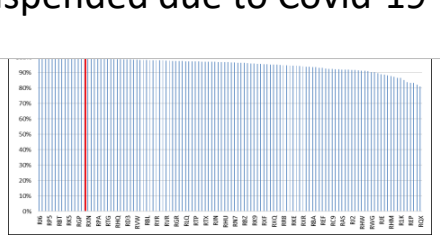


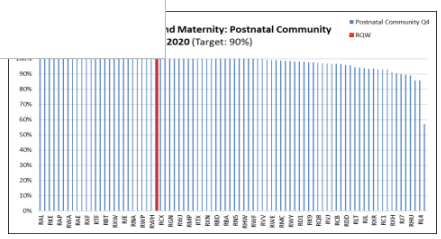


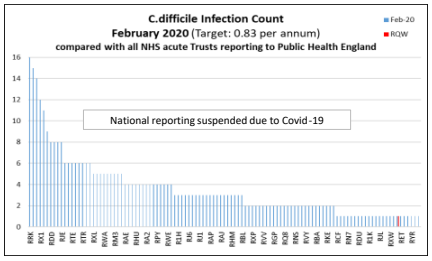
National FFT reporting suspended due to Covid-19

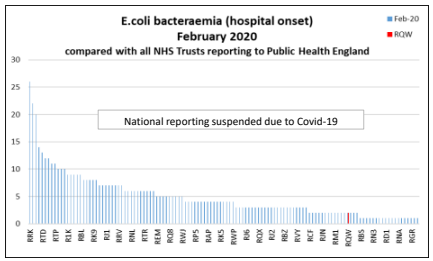


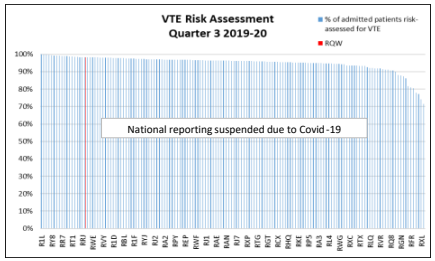


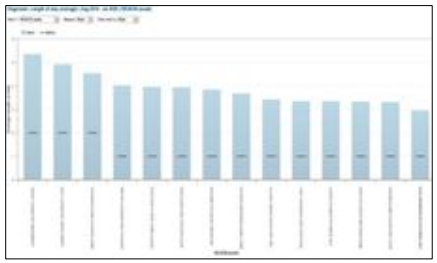












Your future : Our hospital

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

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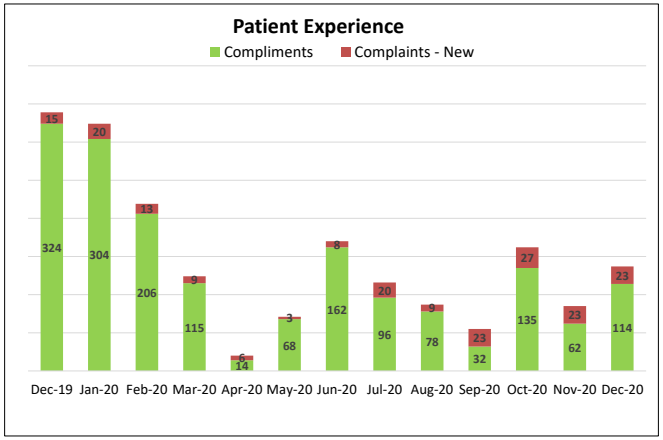
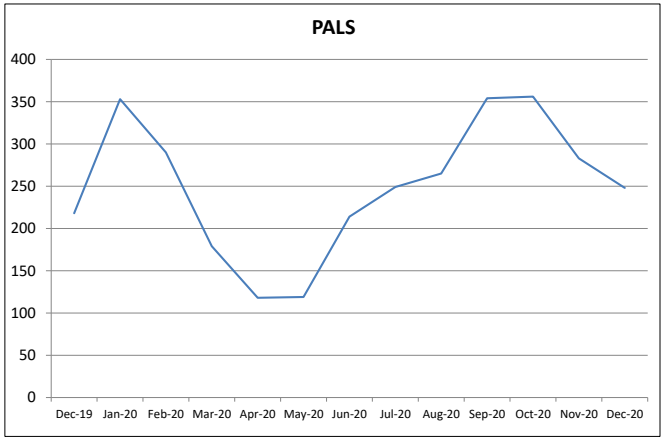
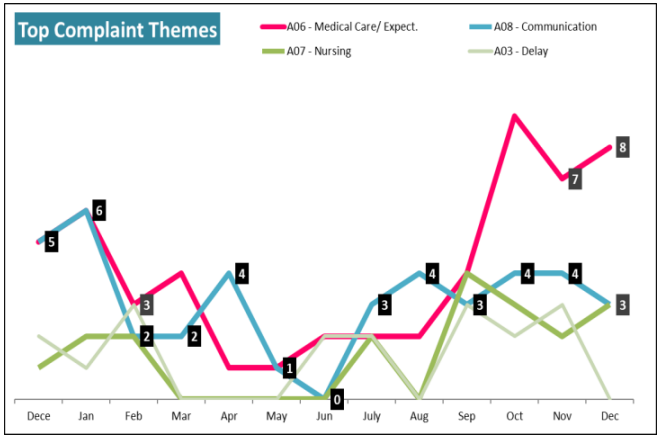
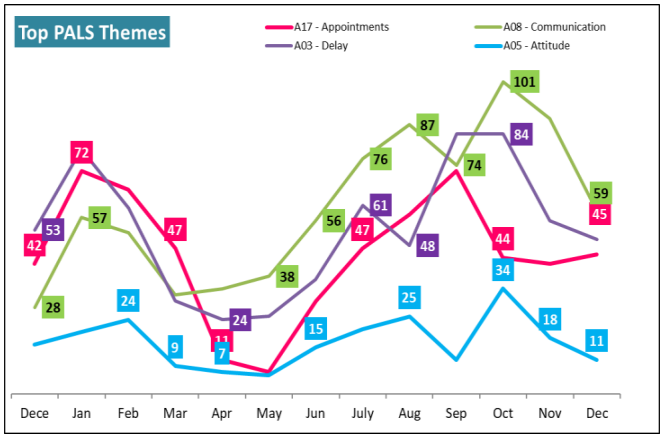
Patient Experience





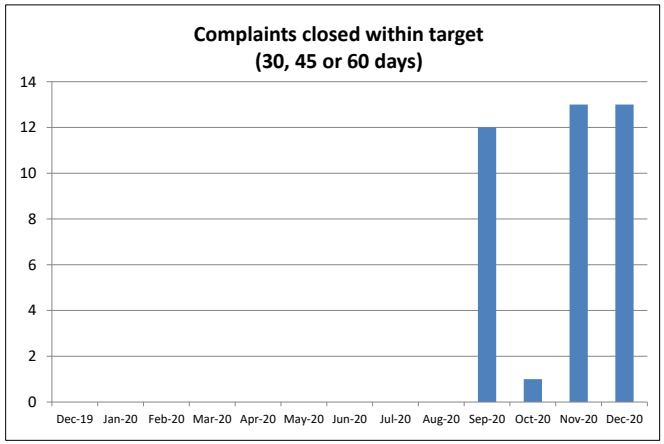
PALS converted to Complaints	
Dec-19	4
Jan-20	6
Feb-20	3
Mar-20	1
Apr-20	0
May-20	0
Jun-20	1
Jul-20	6
Aug-20	4
Sep-20	3
Oct-20	8
Nov-20	4
Dec-20	4

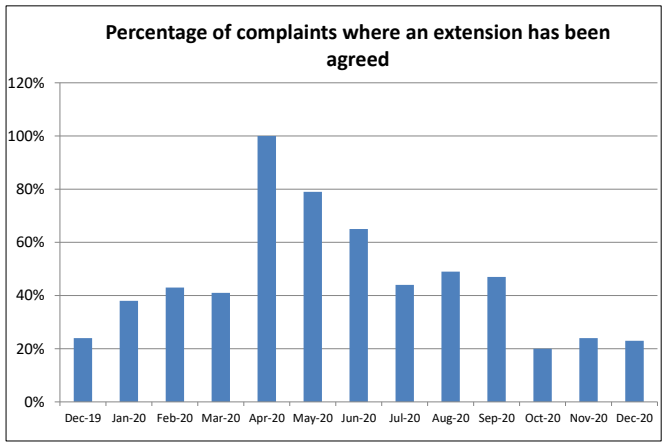


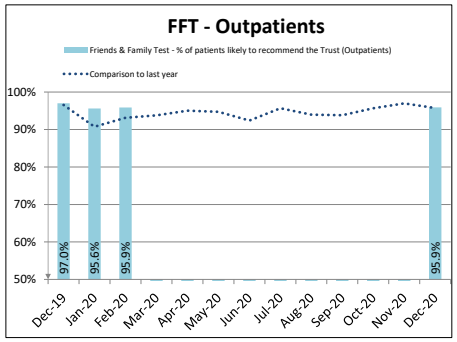


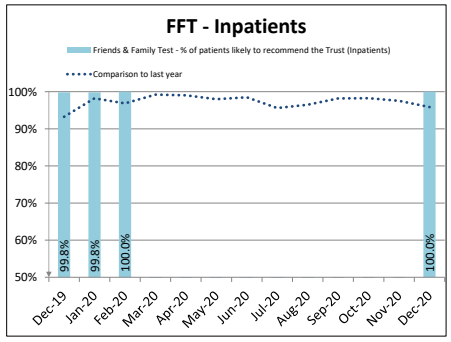
Patient Experience

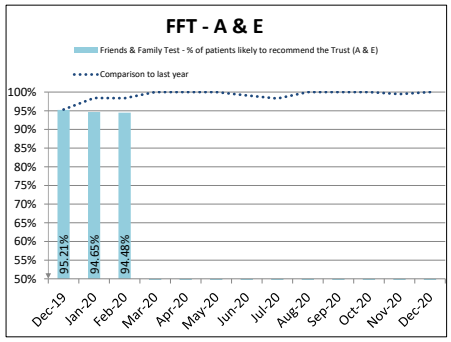
FFT has only been reintroduced this month which is reflective in the update. We are actively reviewing ways of capturing FFT going forward.

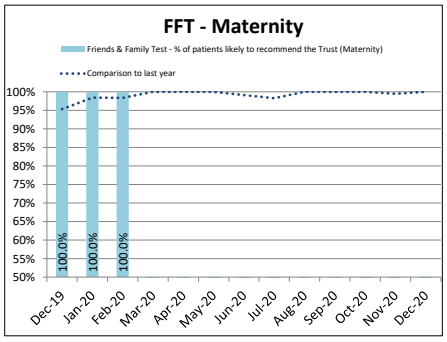












FFT submissions reinstated from January 2021 following suspension in March 2020 due to Covid-19

Patient Safety

1 Our Patients Summary 1.3 Patient Safety

NHS
The Princess Alexandra Hospital
NHS Trust

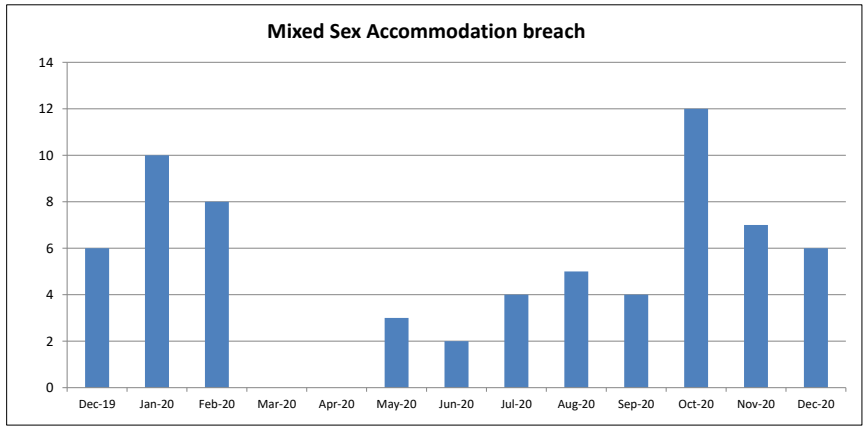
In month 929 incidents were reported, 642 no harm, 218 minor (combined 92.5%).
38 moderate (4.1%), 3 severe (0.4%) & 28 hospital onset COVID 19 deaths (3%) graded harms.

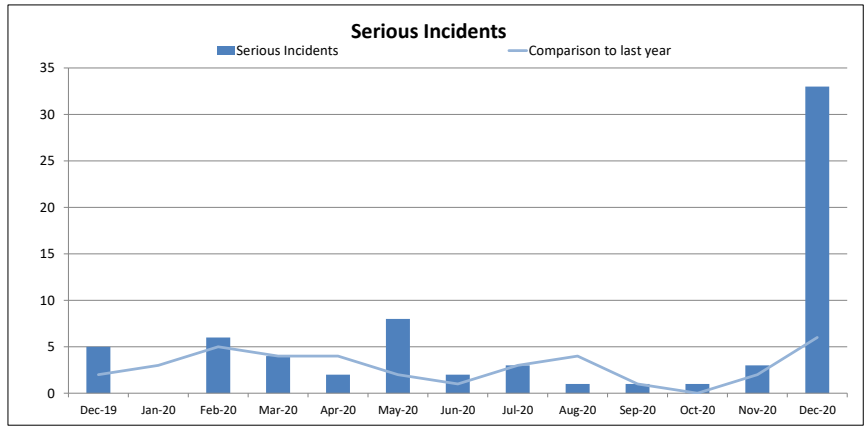
33 SIs were reported
•29 patients died with hospital acquired Covid-19 (since Sept 20). In line with national guidance, all patients that died with a hospital acquired Covid-19 infection are investigated under the SI framework
• 3 were maternity related
• 1 was surgical related

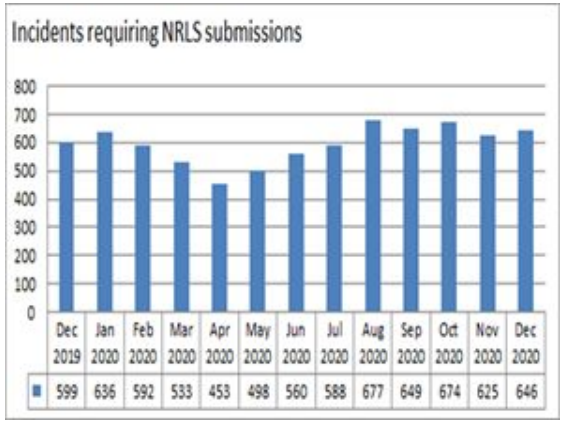
14 safety alerts were received in December; 13 have been actioned & closed, one requires ongoing action. The Trust currently has 6 open safety alerts.

The trust has previously reported that safety alert for door stops & door buffers (EFA 2019.005) had breached its deadline. MHRA has infored us that they have extended the national deadline to 30 April 2021.

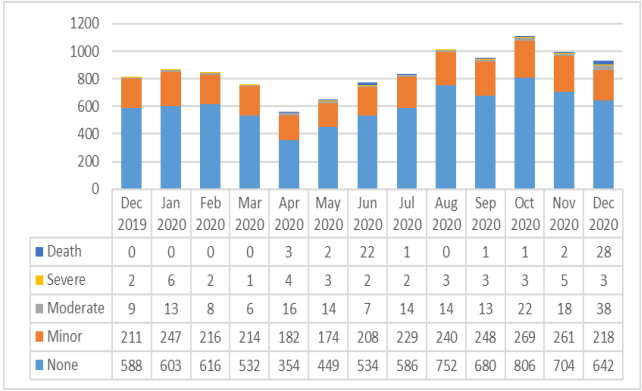
We have therefore retrospectively amended the data for October to December within this graph to show no breaches occurred at PAH.



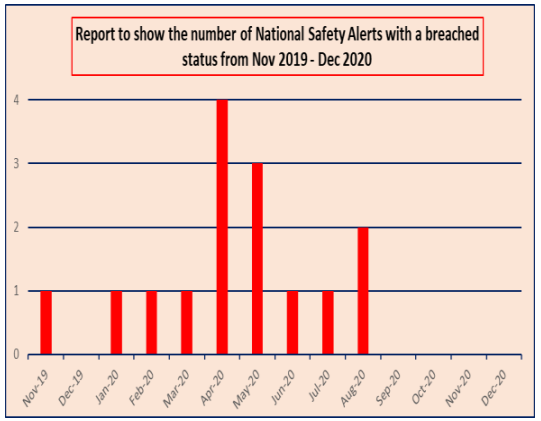




Severity of reported Incidents on Datix



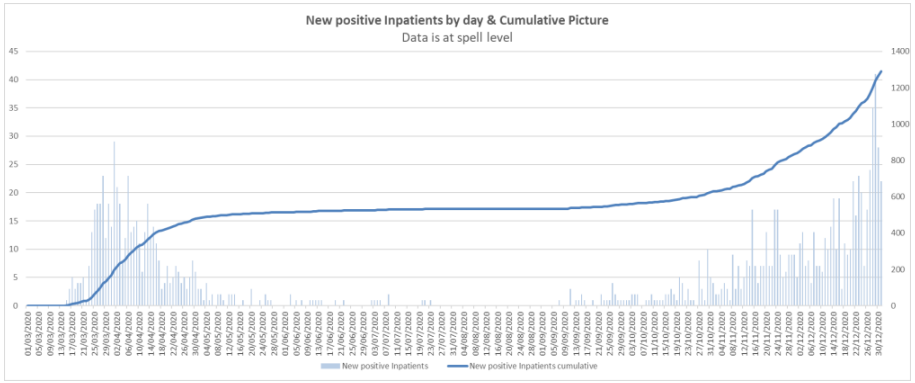
	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020
Death	0	0	0	0	3	2	22	1	0	1	1	2	28
Severe	2	6	2	1	4	3	2	2	3	3	3	5	3
Moderate	9	13	8	6	16	14	7	14	14	13	22	18	38
Minor	211	247	216	214	182	174	208	229	240	248	269	261	218
None	588	603	616	532	354	449	534	586	752	680	806	704	642

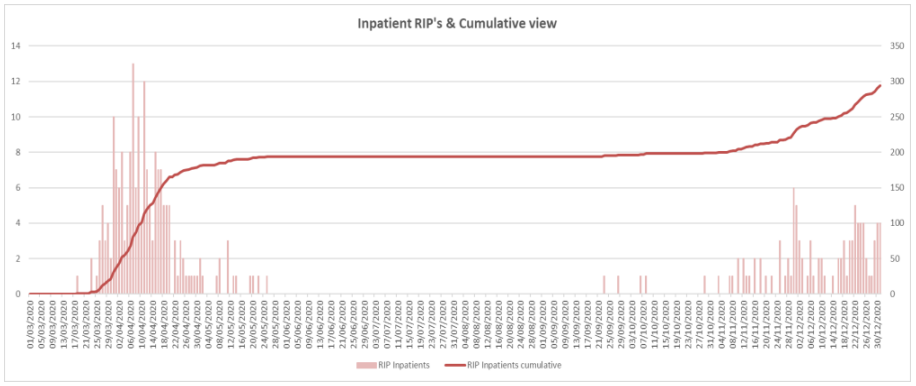


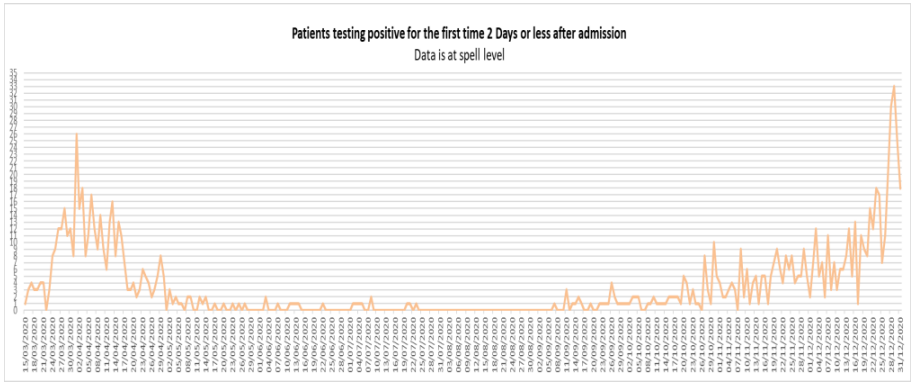
Infection Control

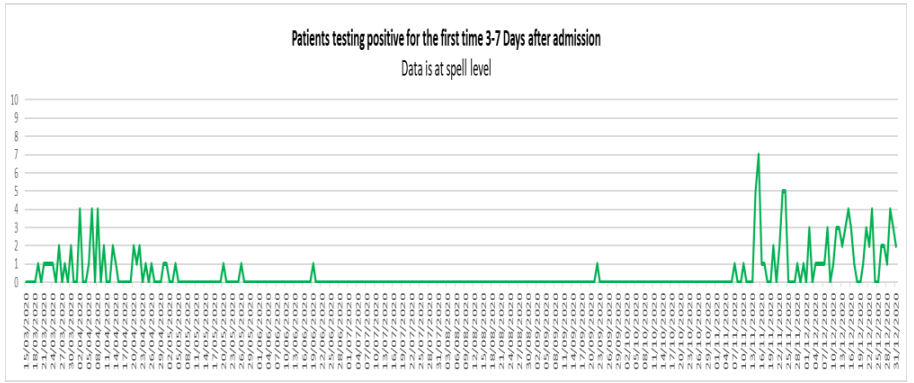
1 Our Patients Summary 1.4 Infection Control - Covid-19

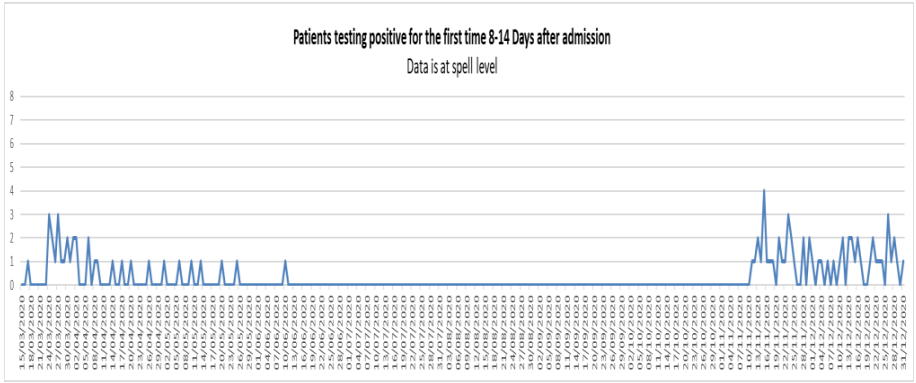
NHS
The Princess Alexandra Hospital
NHS Trust

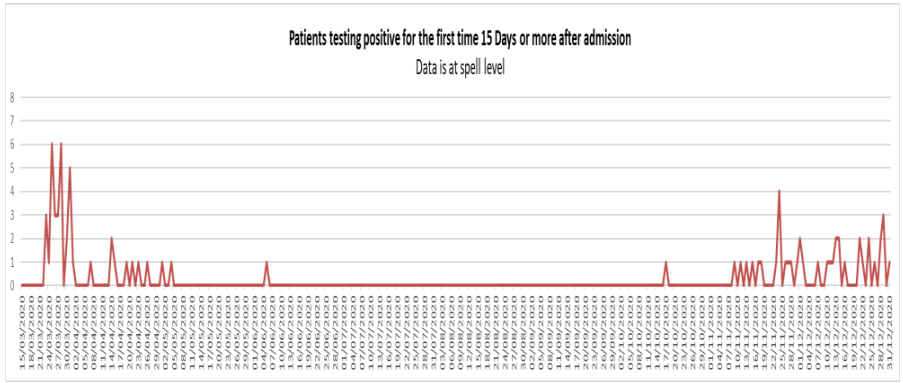




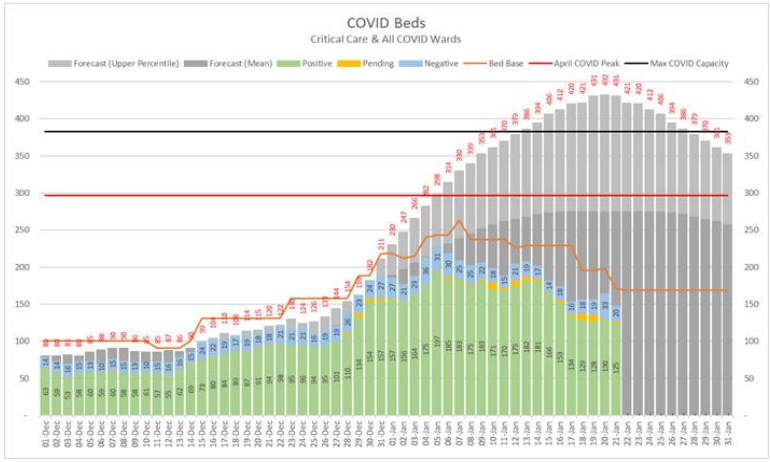


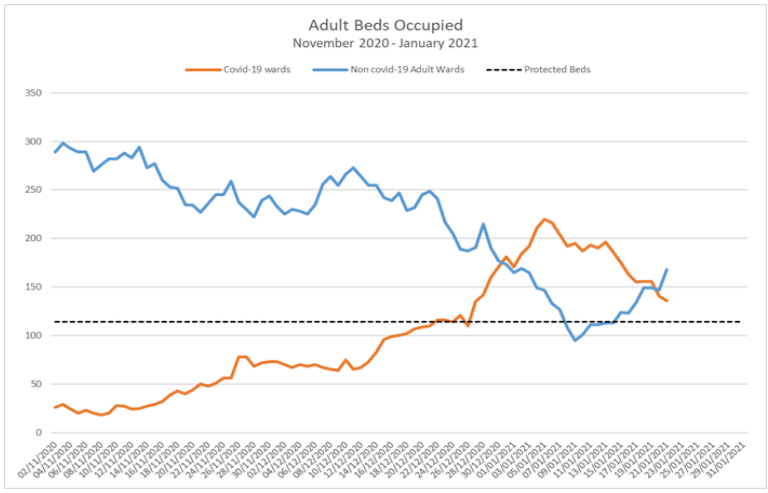






Covid-19


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


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

Infection Control

1 Our Patients Summary 1.6 Infection Control

The Princess Alexandra Hospital NHS Trust

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

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

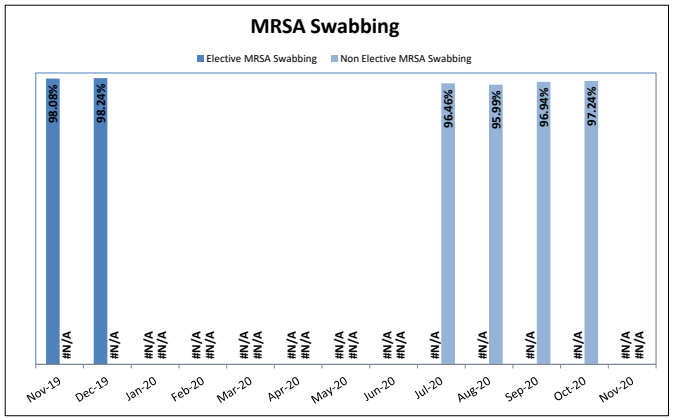
C.difficile During December, there were five cases. This is more than the previous two months, where numbers appeared to reduce again after a rise in July-September. There has been a focus on resuming microbiology ward rounds and monitoring antibiotic usage. Reviews of compliance with the Trust Antibiotic policy are undertaken for all cases. The December cases are in the process of being reviewed. There have been a total of 25 cases year to date (at the end of December).

Gram Negative Blood Stream Infections (GNBSIs) The Trust remains in a good position when compared nationally with other hospitals (within the top quarter). During December, there was one Trust-apportioned GNBSIs (Pseudomonas aeruginosa) bacteraemia.

To date, there have been 18 Trust apportioned cases of all GNBSIs.

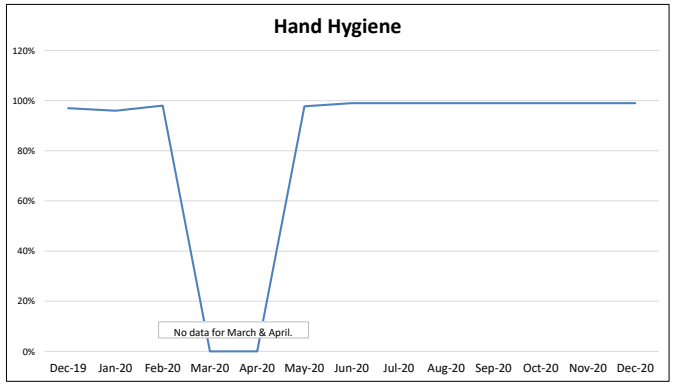
MRSA Screening MRSA screening data is not available for elective or non-elective from the Information Team for December:
- For Elective MRSA swabbing – the review of the exclusions / inclusions is still in progress and will be reviewed in detail in the New Year.
- For Non Elective MRSA swabbing – figures are available from July 2020 to October 2020 and there was an increase in performance of swabbing for October (97.24%)

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 and the performance standard is 95% compliance. During December, the overall Trust wide score was 99% compliance; however, there were seven areas that did not submit their audits (83% submission compliance). Wards/departments are expected to discuss their results and agree appropriate actions within their Health-Care Group. The PPE Champions are also undertaking monthly audits for hand hygiene and we will be reviewing how this will be reported going forward.



MSSA	
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	0
Sep-20	0
Oct-20	0
Nov-20	0
Dec-20	1

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



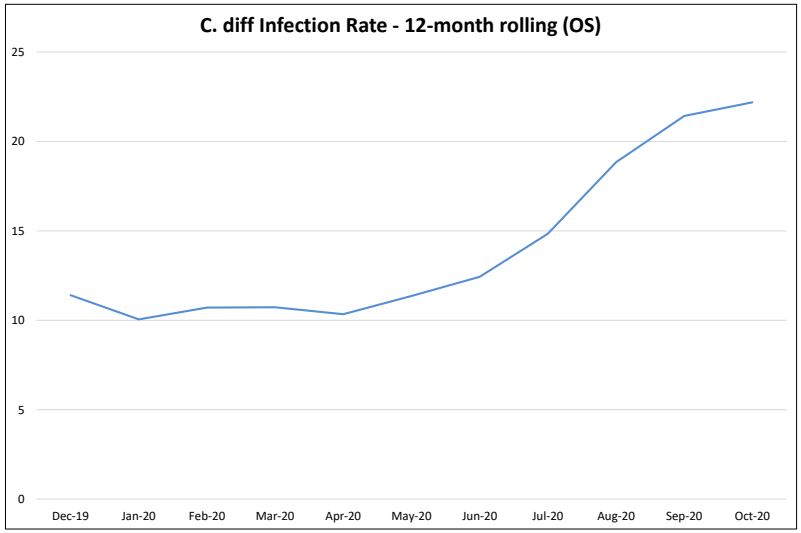
E Coli	
Dec-19	1
Jan-20	0
Feb-20	2
Mar-20	0
Apr-20	1
May-20	1
Jun-20	1
Jul-20	2
Aug-20	0
Sep-20	2
Oct-20	1
Nov-20	1
Dec-20	0

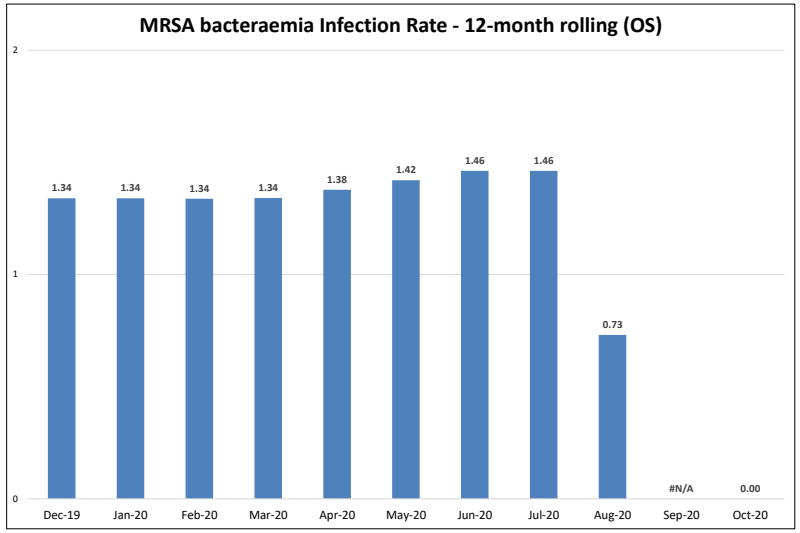
Klebsiella	
Dec-19	1
Jan-20	0
Feb-20	0
Mar-20	1
Apr-20	1
May-20	0
Jun-20	2
Jul-20	0
Aug-20	0
Sep-20	1
Oct-20	0
Nov-20	1
Dec-20	0

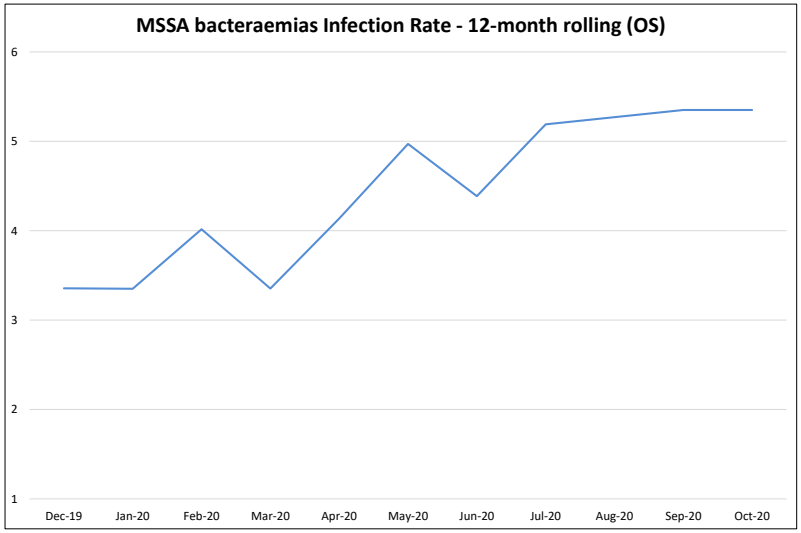
Pseudomonas	
Dec-19	0
Jan-20	0
Feb-20	0
Mar-20	0
Apr-20	0
May-20	1
Jun-20	0
Jul-20	0
Aug-20	0
Sep-20	1
Oct-20	0
Nov-20	0
Dec-20	1

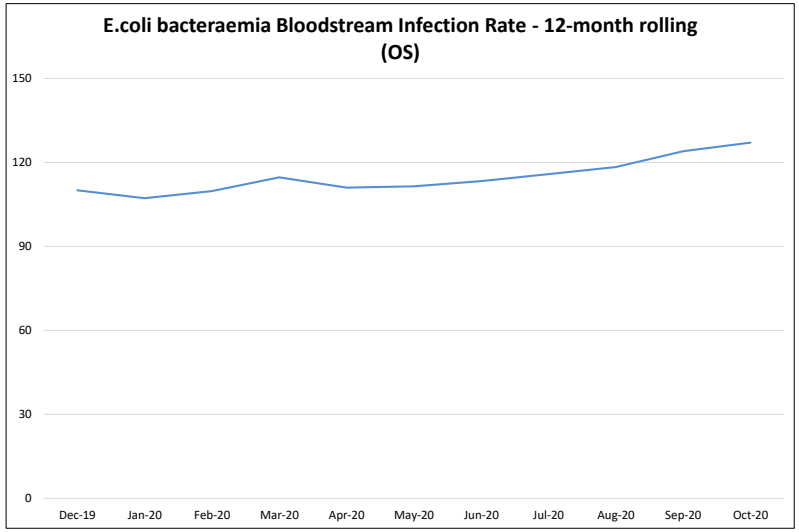
Infection Control

The following are the latest published data available.









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

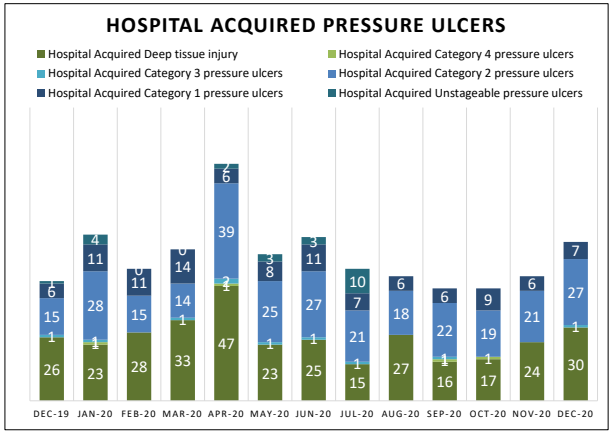
During December 2020 there were 141 reported falls which is a considerable increase from 109 in November. 111 falls were classified as no harm and 28 as minor harm. There were 2 reported moderate harm incidents but none reported as severe.

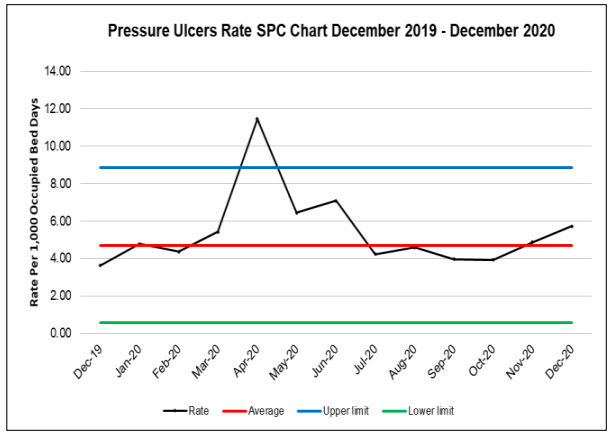
The 2 wards with the highest falls levels were Harvey (17 up from 12) and Ray (13 up from 5). Locke ward had 10 falls (up from 5), Fleming 7 falls (up from 3) and JSU 10 falls (up from 3).

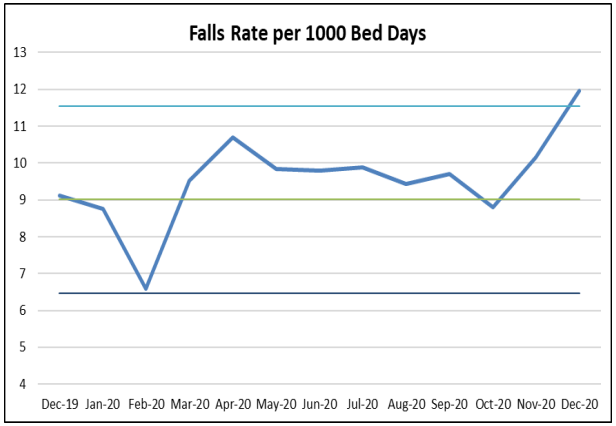
The falls rate per 100 patients showed a significant increase to 11.73 compared with 8.58 in November. However, the rate per 100 patients (falls with harm) stayed stable at 2.50 (2.52 in November).

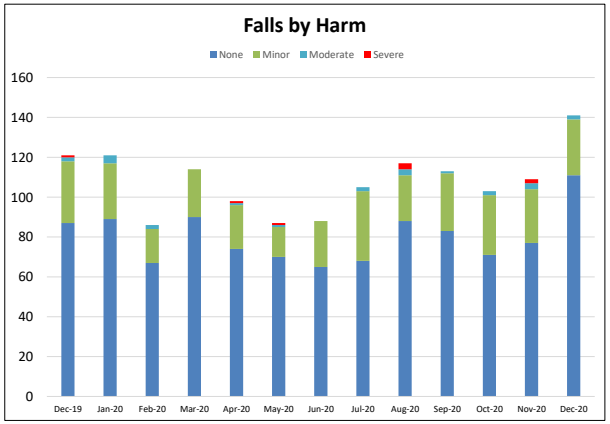
Falls per 1000 bed days also showed a significant increase from 10.15 in November to 11.97.

Occupied bed days rose from 10736 in November to 11779.









Family & Women's Service

2 Our Patients Summary 1.9 Family & Women's Service

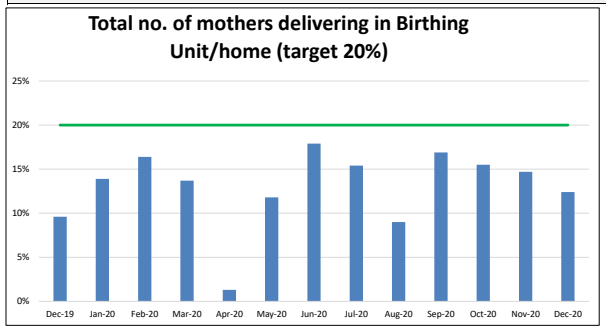
NHS
The Princess Alexandra Hospital
NHS Trust

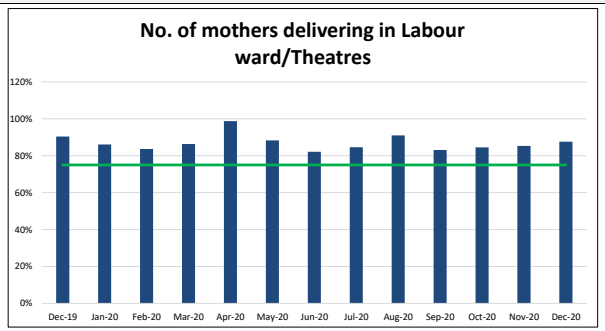
The Emergency C Section Rate at PAH had previously followed a continuously increasing monthly trend, from 13.3% in March 2020 to 25.7% in October 2020. In November 2020 the rate decreased to 23.9% & it has decreased again in December to 18.9%. An ongoing Emergency C Section Rate Action Plan is in place & Consultant Obstetrician Alex Field has been appointed as the Labour Ward Lead.

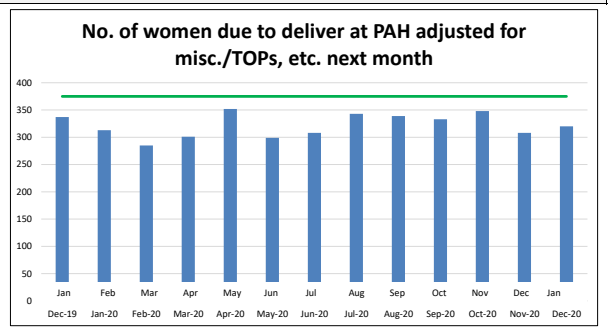
The rate of Post-partum Haemorrhage (PPH) over 1.5L was 4.5% of all PAH deliveries in December 2020. This rate continues to be of concern to the Multi-disciplinary Team & is the subject of investigations, analysis & ongoing actions. This includes working with our Maternity System Partner Hospitals to identify if there are any differences in Practices or any other lessons to be learned.

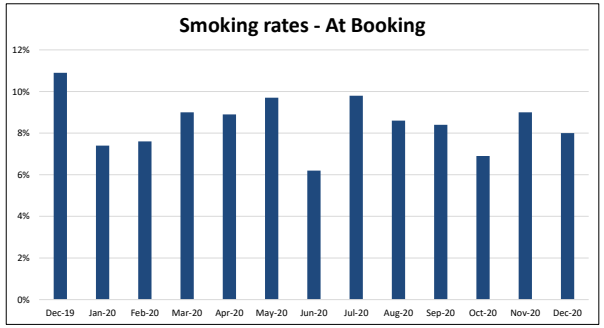
PAH has moved to a new 'Physiological' interpretation of CTG monitoring. The December Midwives Training compliance figure, of 57%, does not include Midwives who remain compliant by way of the previous training package.

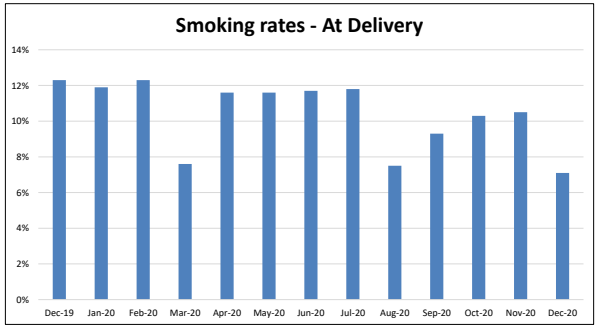
There were 4 Serious Incidents declared in December 2020, including 2 Serious Incidents reported to the Healthcare Safety Investigation Branch (HSIB).

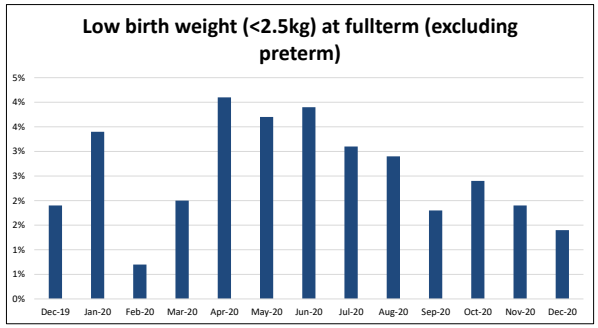


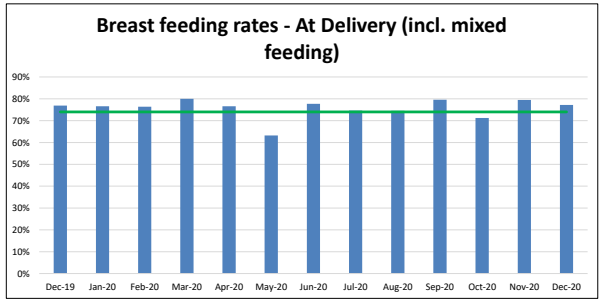


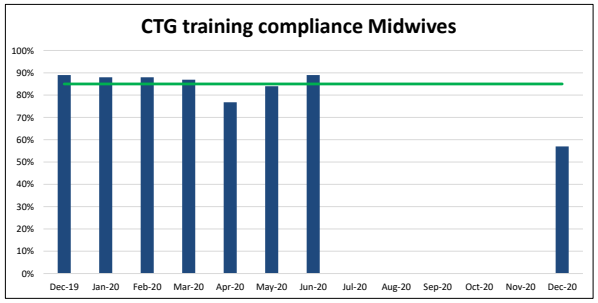


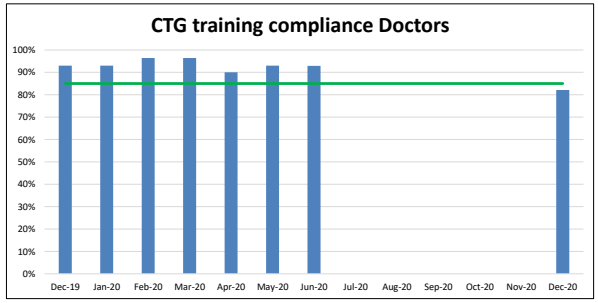








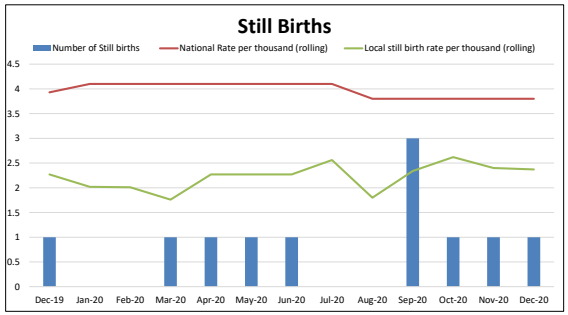


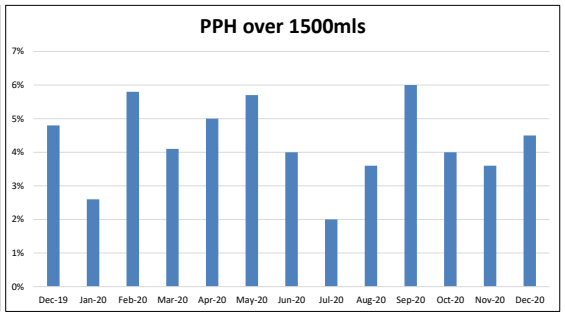


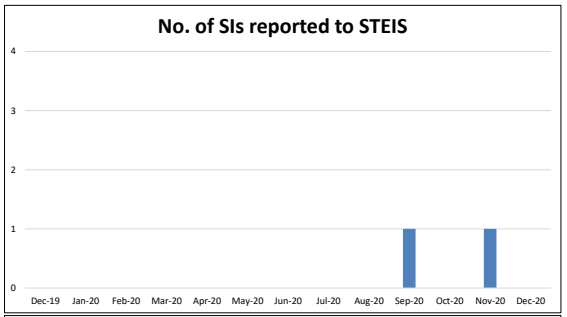
Family & Women's Service

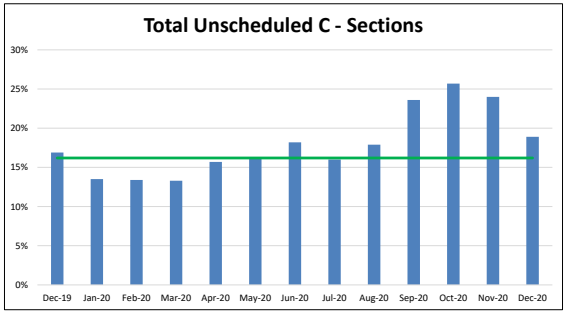
2 Our Patients Summary 1.10 Family & Women's Service

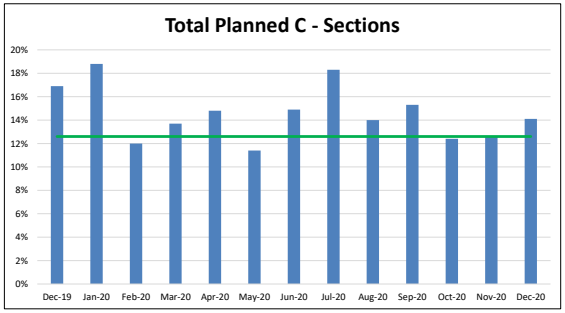
NHS
The Princess Alexandra Hospital
NHS Trust

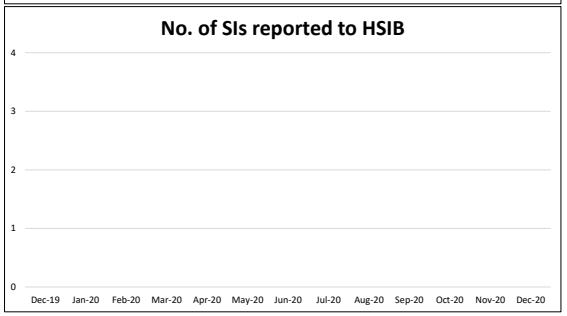




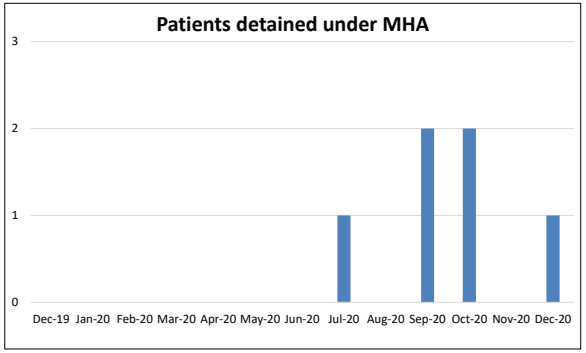


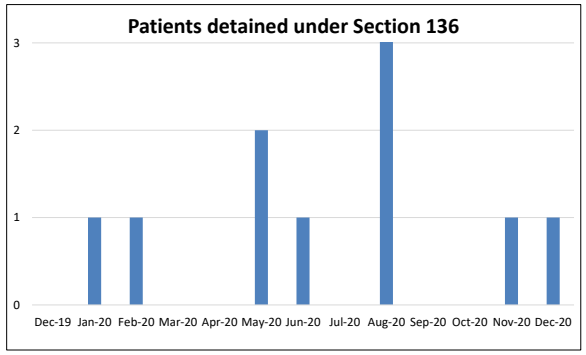


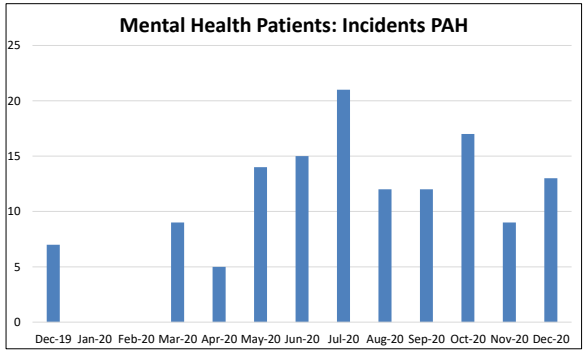


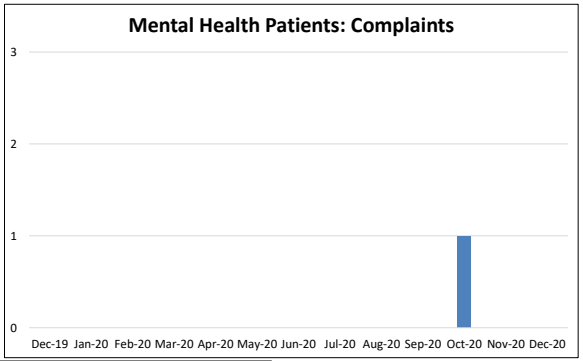


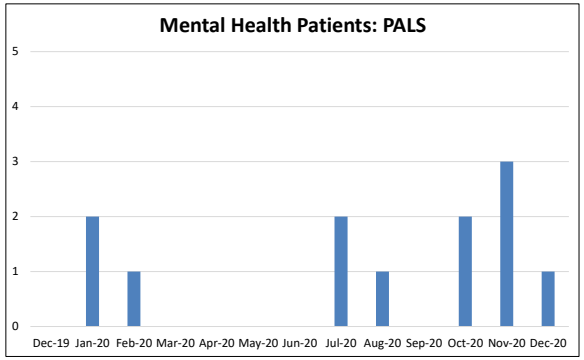
Mental Health

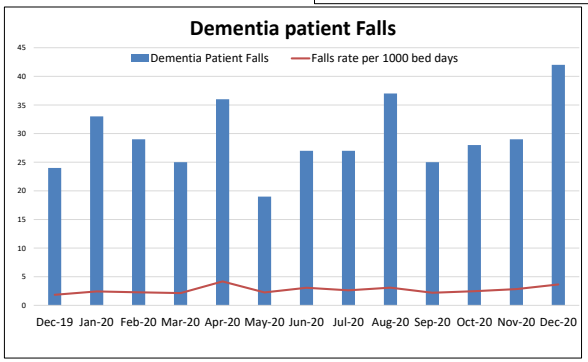


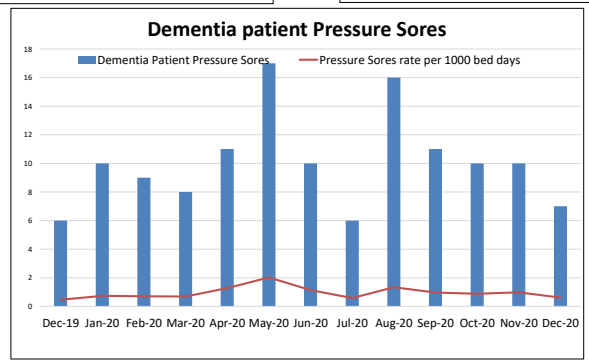


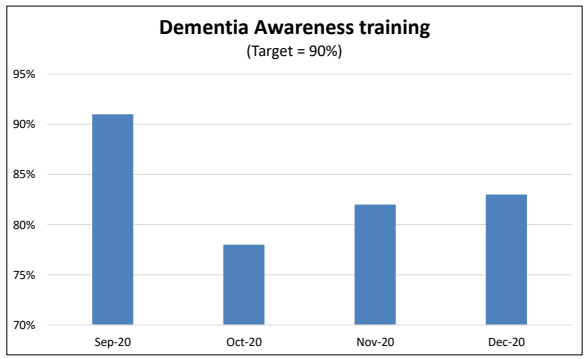




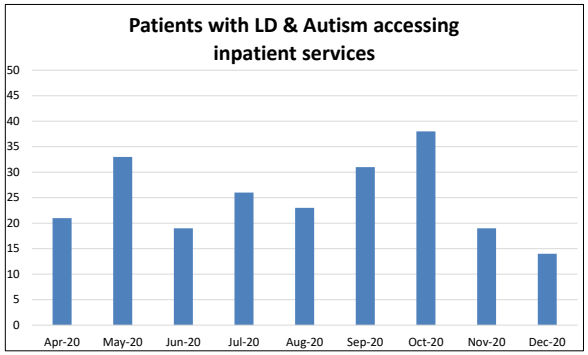


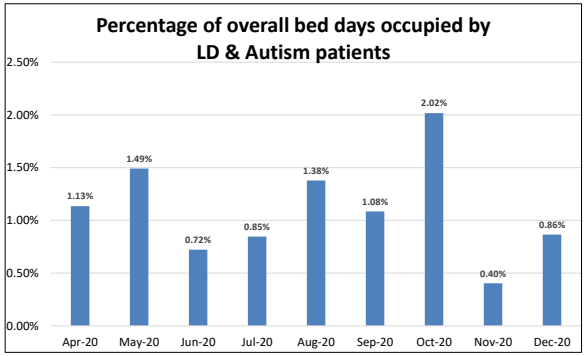


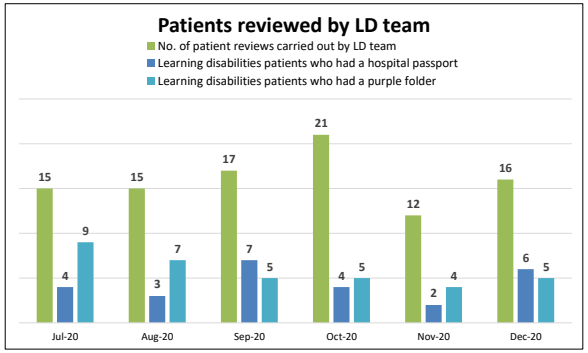


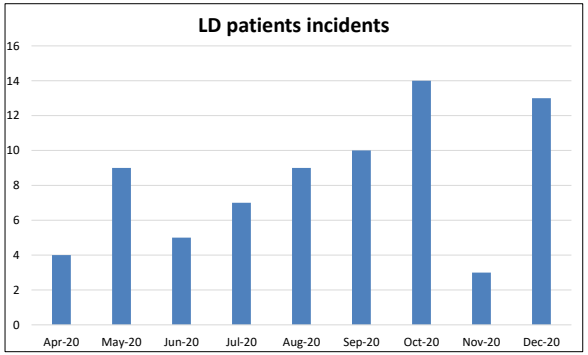


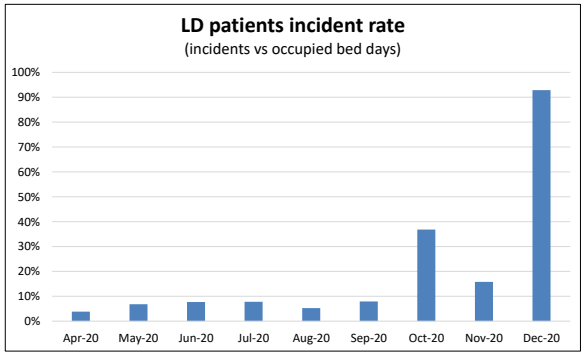
Learning Disabilities & Autism

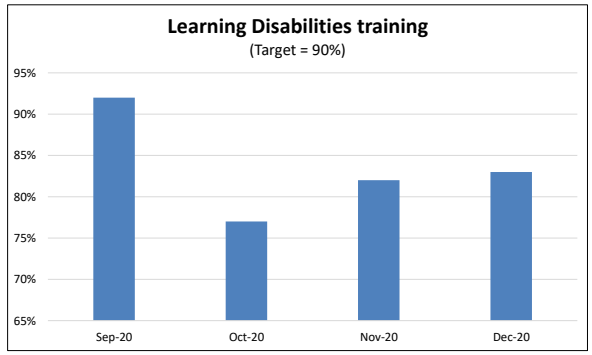








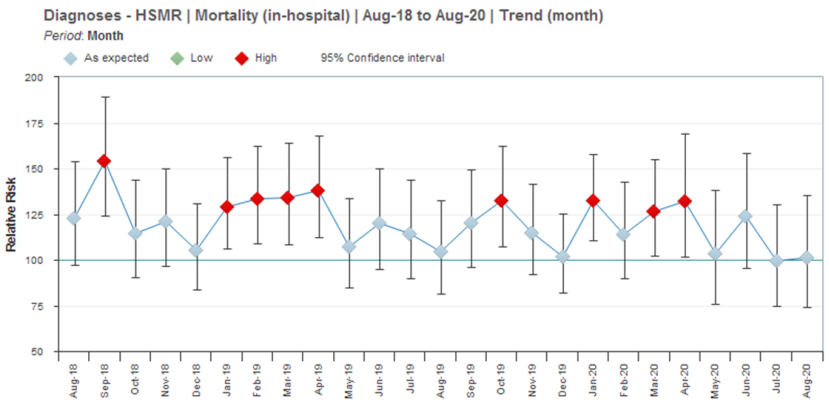


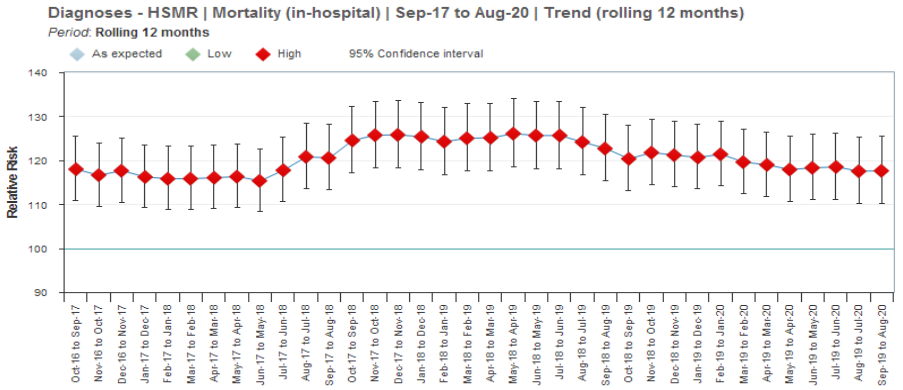


Mortality

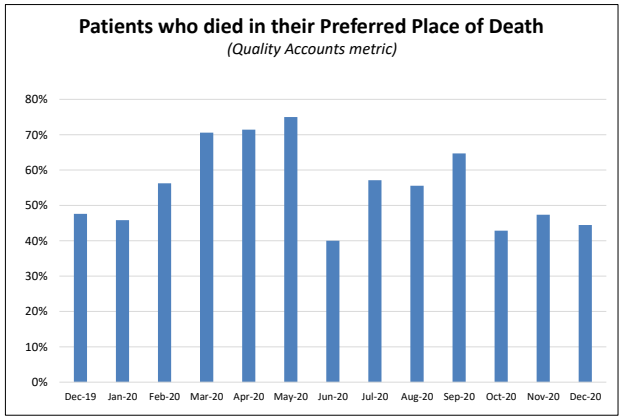
1 Our Patients Summary 1.13 Mortality

The Princess Alexandra Hospital NHS Trust

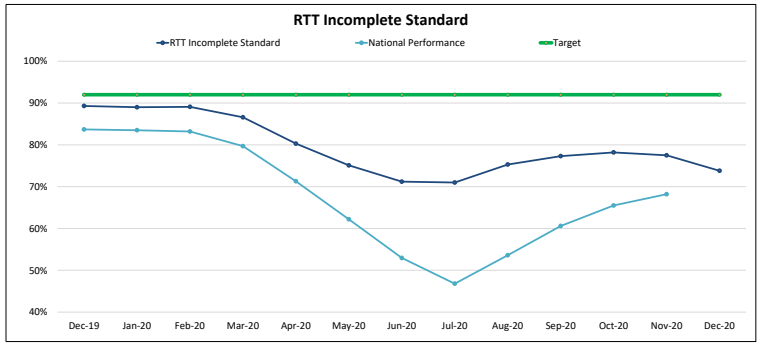


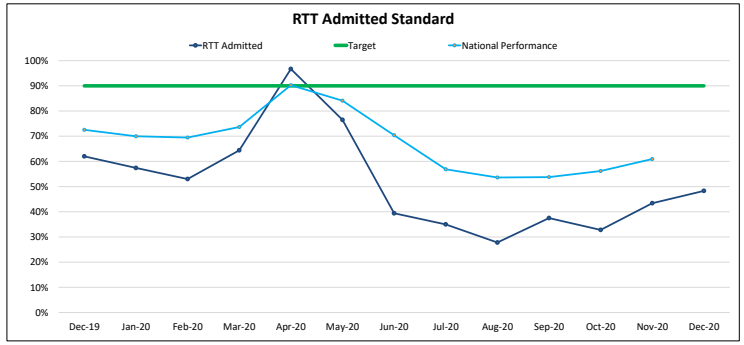


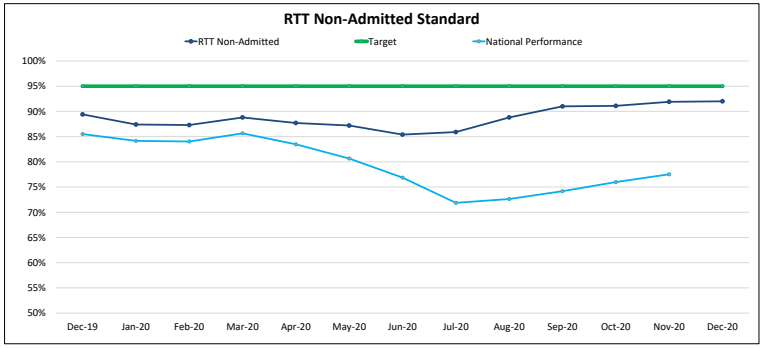
Mortality Outlier Alerts (QA)	
Jul 18 - Jun 19	7
Aug 18 - Jul 19	6
Sep 18 - Aug 19	5
Oct 18 - Sep 19	5
Nov 18 - Oct 19	6
Feb 19 - Jan 20	6
Apr 19 - Mar 20	4
Jun 19 - May 20	8
Jul 19 - Jun 20	6
Aug 19 - Jul 20	7
Sep 19 - Aug 20	6

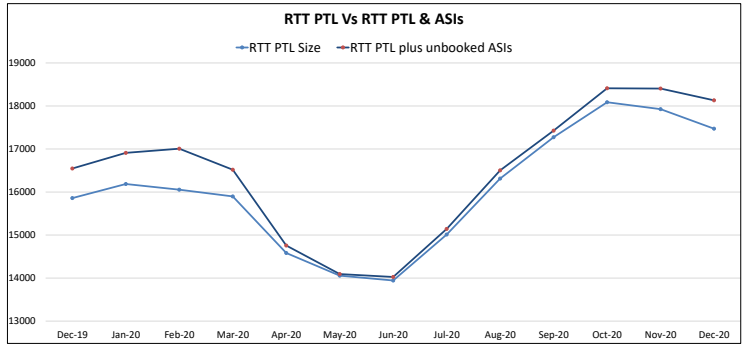


RTT


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


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

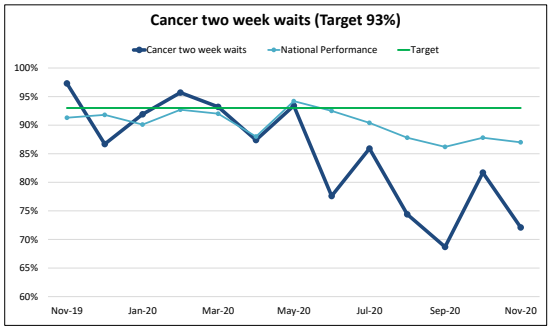

RTT Non-Admitted Standard
RTT Non-Admitted
Target
National Performance
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20

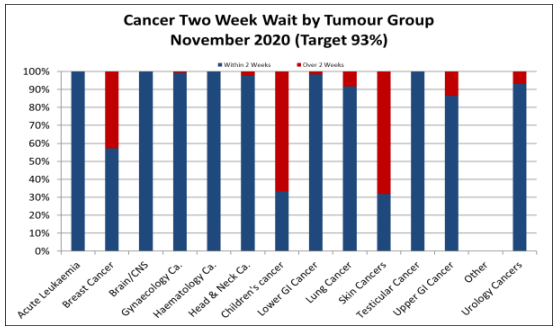

RTT PTL Vs RTT PTL & ASIs
RTT PTL Size
RTT PTL plus unbooked ASIs
19000
18000
17000
16000
15000
14000
13000
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20

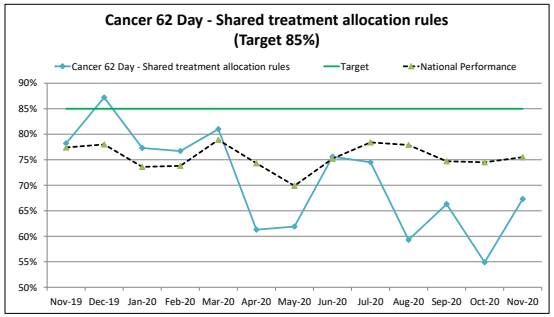
Cancer

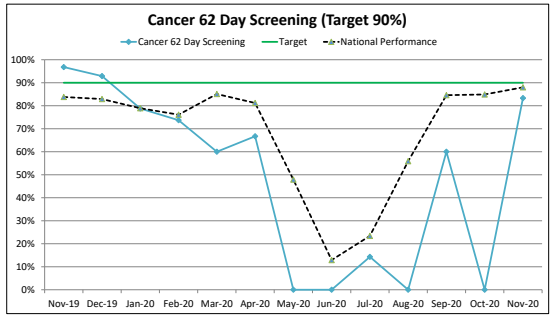
	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Nov-19	97.70%	97.40%	100.00%	100.00%
Dec-19	95.10%	97.90%	100.00%	100.00%
Jan-20	98.50%	94.40%	100.00%	100.00%
Feb-20	98.60%	96.90%	100.00%	100.00%
Mar-20	98.80%	97.10%	100.00%	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%
Aug-20	92.30%	87.10%	100.00%	66.70%
Sep-20	92.90%	90.20%	100.00%	100.00%
Oct-20	91.10%	87.40%	100.00%	100.00%
Nov-20	61.50%	92.60%	100.00%	80.00%

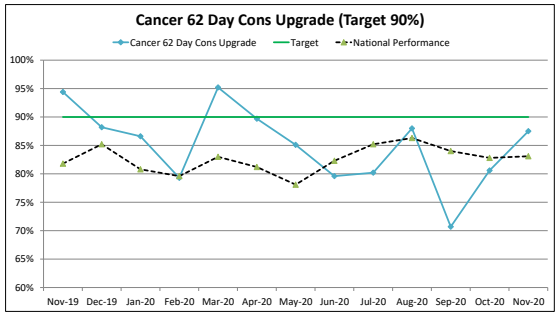
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

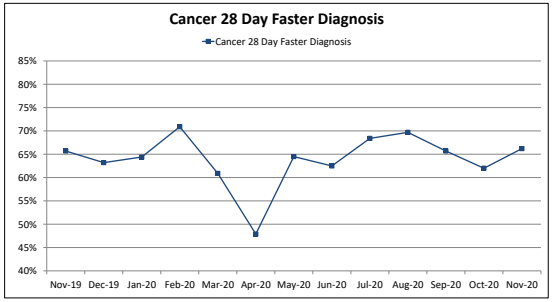




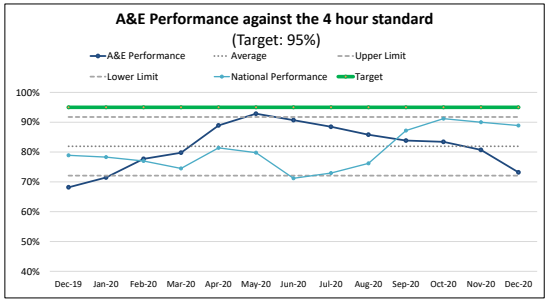


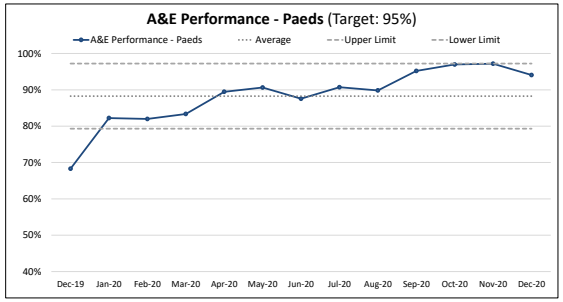


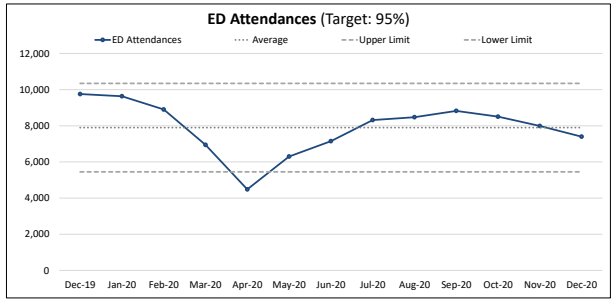


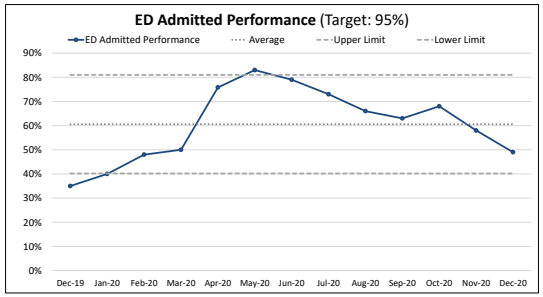


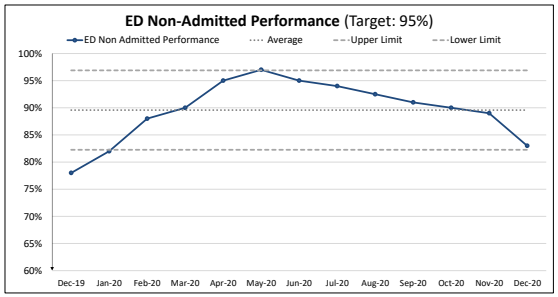
ED







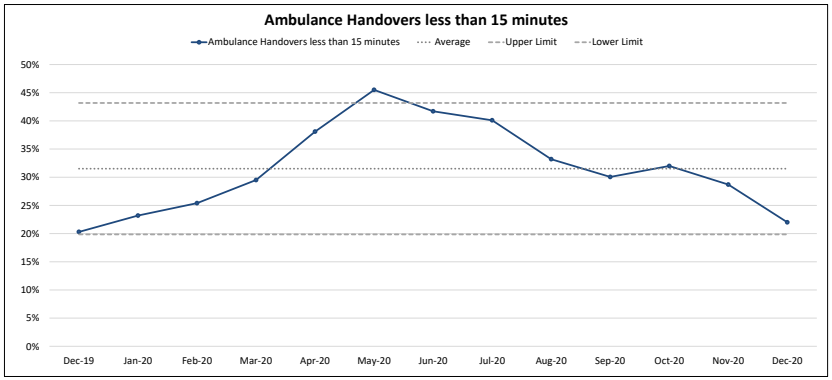


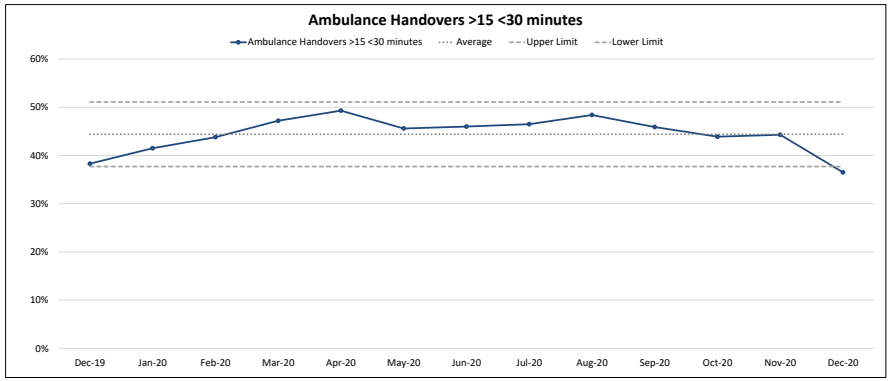


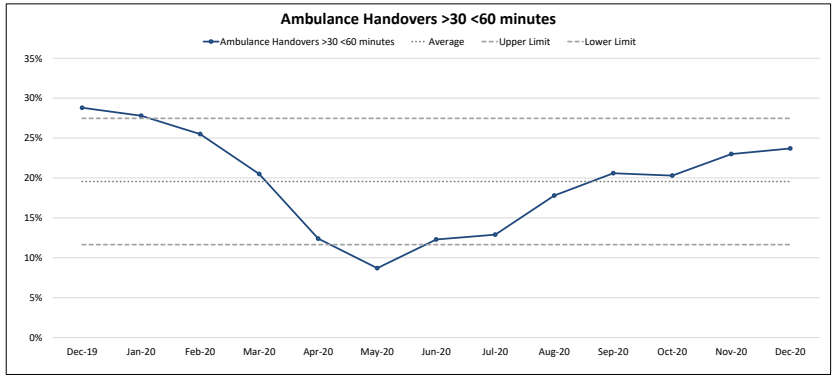
ED Internal Professional Standards

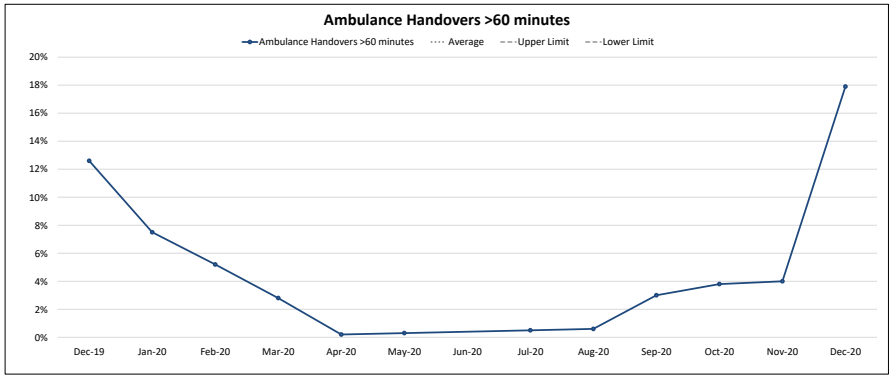
	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Target
Arrival to Triage - Average Wait (Minutes)	46	41	37	30	25	26	25	28	31	36	36	39	49	15
Triage to Exam - Average Wait (Minutes)	104	91	76	60	41	44	56	78	68	79	80	73	79	45
Exam to Referral to Specialty - Average Wait (Minutes)	99	103	97	97	88	82	84	96	94	86	96	99	107	90
Referral to Seen by Specialty - Average Wait (Minutes)	90	87	77	74	54	48	51	64	70	73	75	88	94	30
Seen by Specialty to DTA - Average Wait (Minutes)	105	99	87	91	66	67	69	70	85	94	99	97	109	30
DTA to Departure - Average Wait (Minutes)	249	169	134	157	110	55	74	134	111	132	100	178	254	30

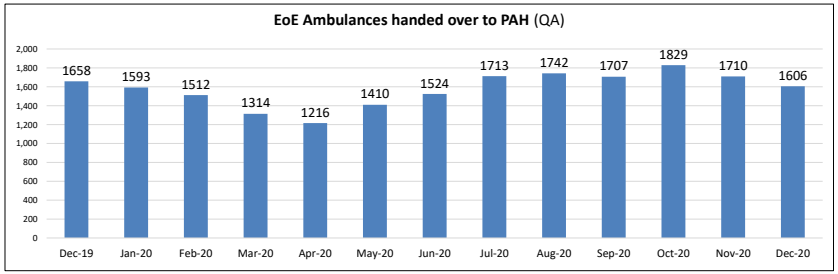
Ambulance


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

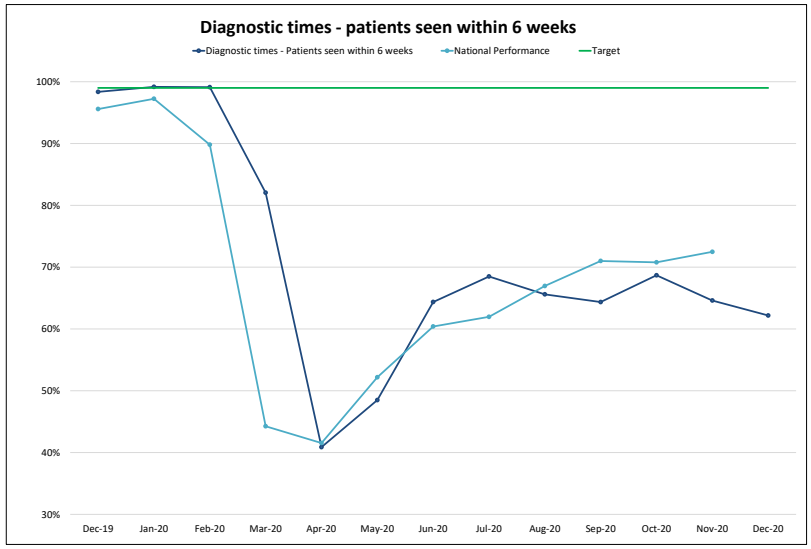

Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
60%
50%
40%
30%
20%
10%
0%
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20

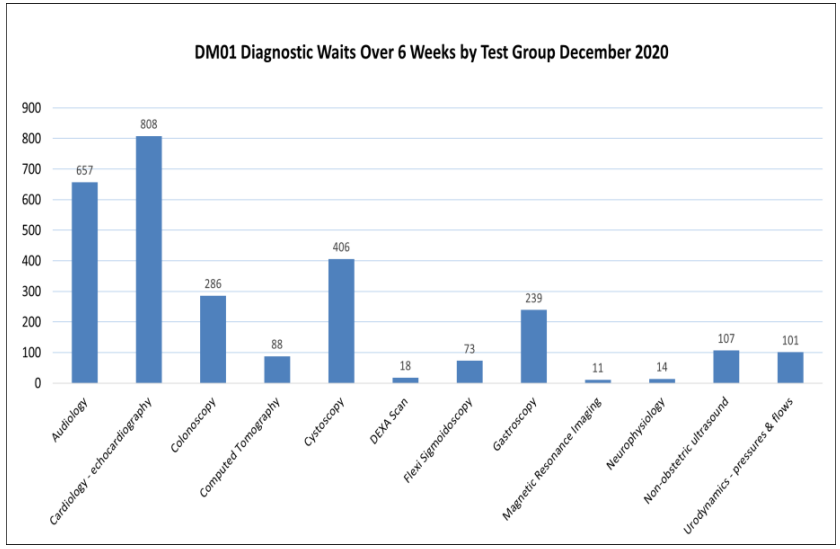

Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
35%
30%
25%
20%
15%
10%
5%
0%
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20


Ambulance Handovers >60 minutes
Ambulance Handovers >60 minutes
Average
Upper Limit
Lower Limit
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-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
1658
1593
1512
1314
1216
1410
1524
1713
1742
1707
1829
1710
1606
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20

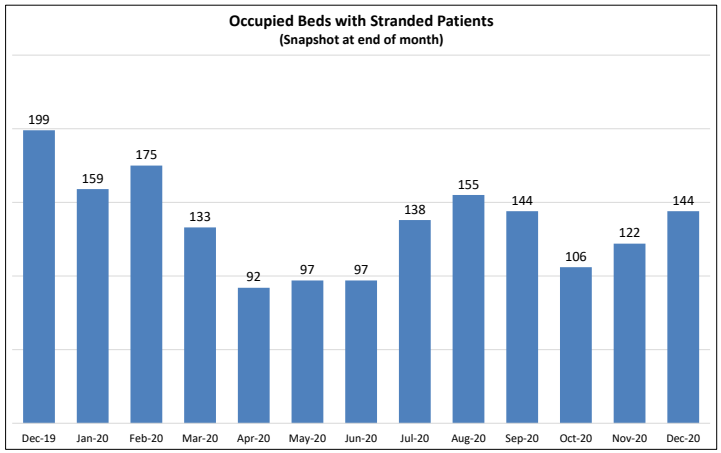
Diagnostics

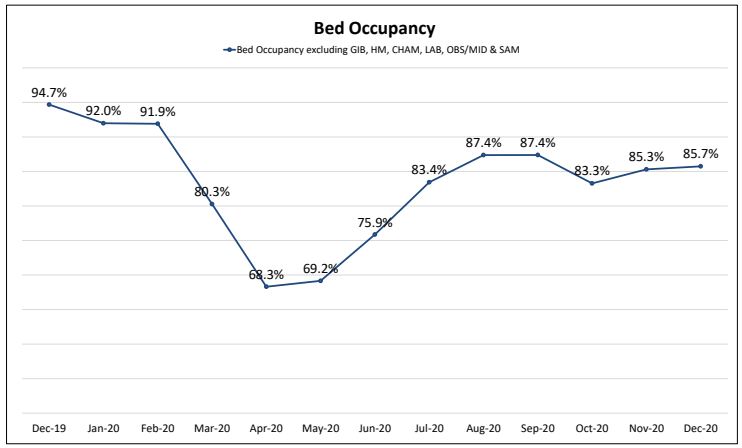




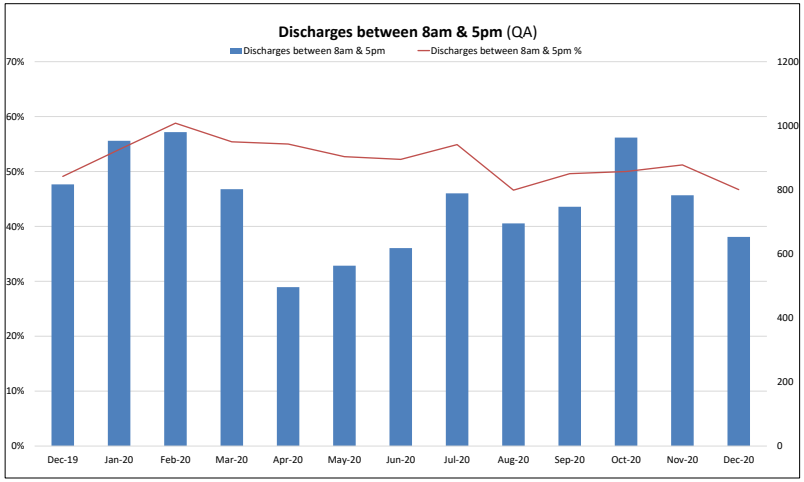
Test	% of Total Cohort - December 20	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Magnetic Resonance Imaging (MRI)	6%	99.84%	100%	100%	78%	34%	38%	59%	78.79%	79.10%	73.93%	89.31%	81.85%	97.51%
Computed Tomography (CT)	7%	100.00%	100%	99.48%	85.30%	59%	61%	77%	80.00%	79.26%	88.69%	90.24%	91.78%	83.91%
Non-Obstetric Ultrasound	30%	100.00%	100.00%	99.89%	83.23%	39.20%	66%	93%	96.79%	93.18%	95.77%	96.73%	92.40%	95.27%
DEXA	2%	100%	100.00%	100%	-	-	100%	78%	88.24%	84.93%	93.20%	92.86%	97.56%	86.26%
Audiology - Audiology Asessments	11%	98.76%	98%	100%	69%	23%	11%	11%	25.35%	23.67%	24.70%	29.85%	23.79%	16.84%
Cardiology - Echocardiography	21%	100%	99.87%	96.38%	74.02%	38%	40%	55%	53.62%	51.76%	52.13%	54.26%	50.23%	47.43%
Neurophysiology	1%	97%	94%	89%	49%	42.11%	5%	36%	32%	28%	30%	47%	65%	73.58%
Urodynamics	1%	89%	81.82%	80.56%	91.11%	30.36%	30%	24%	16.30%	3.26%	11.11%	5.71%	3.74%	6.48%
Colonoscopy	7%	74.72%	88.52%	97.94%	93.58%	62.56%	38%	43%	40.42%	34.46%	39.23%	46.34%	44.24%	45.42%
Flexi Sigmoidoscopy	2%	69%	95%	95.56%	87.18%	48.98%	54%	56%	43.85%	31.45%	38.89%	39.55%	44.35%	38.14%
Cystoscopy	8%	86.21%	81.82%	100%	93.75%	65%	49%	55%	41.03%	54.00%	25.55%	35.23%	32.02%	32.11%
Gastroscopy	4%	83.16%	89.09%	99.15%	92.07%	58.37%	40%	45%	40.05%	28.94%	29.92%	38.19%	25.65%	24.37%

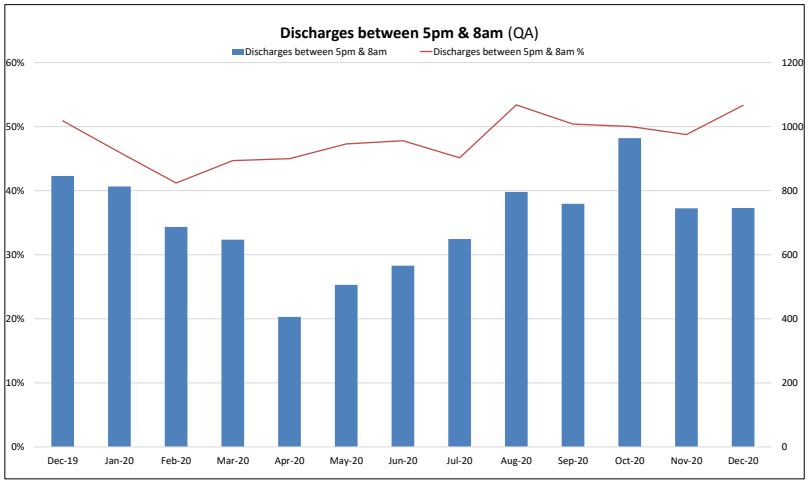
Stranded Patients

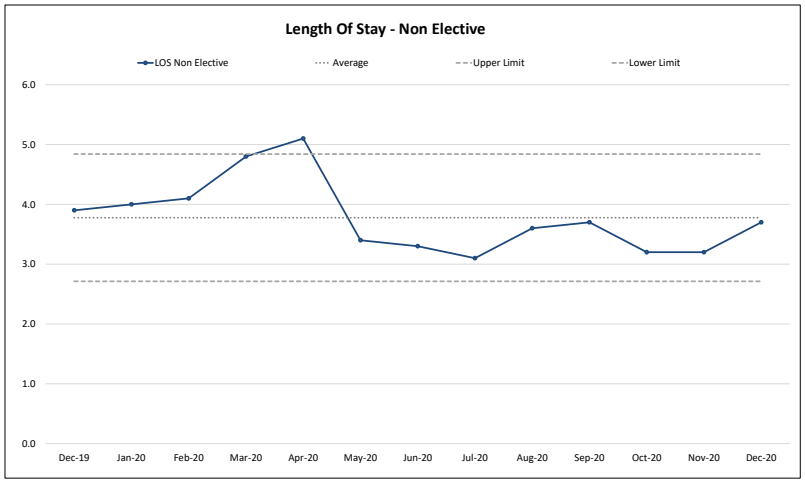


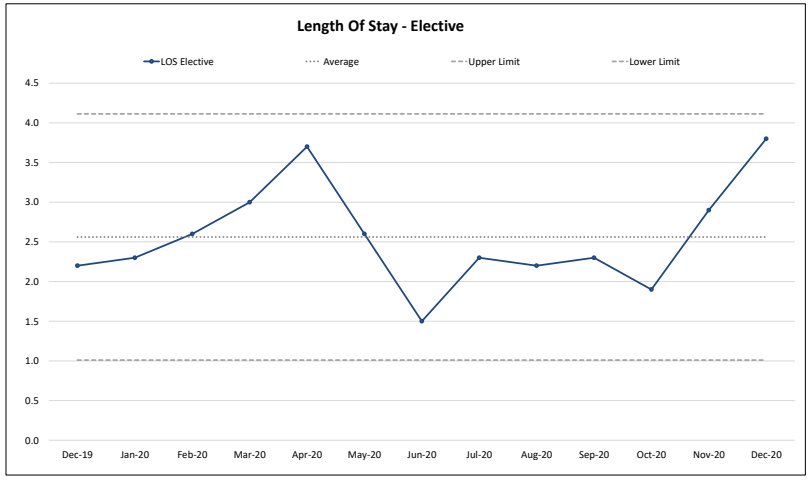


Discharges & LOS

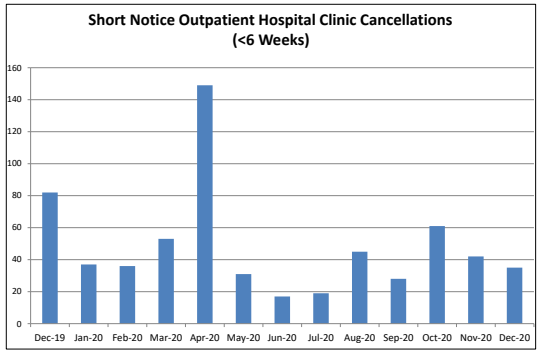


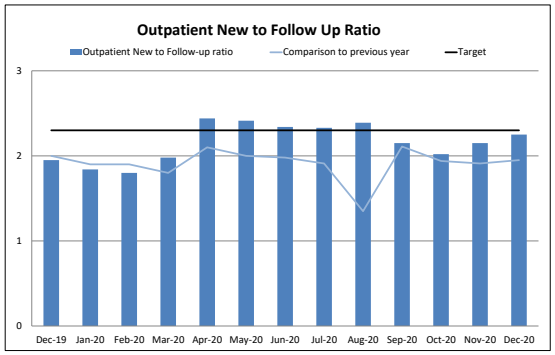


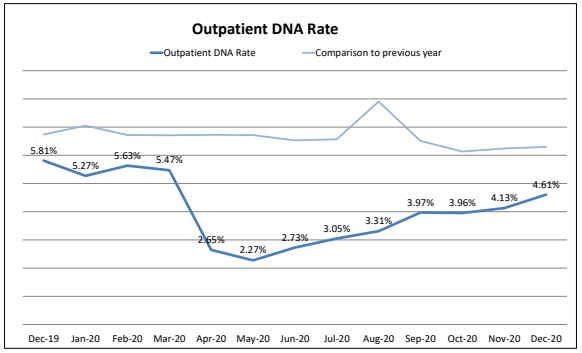


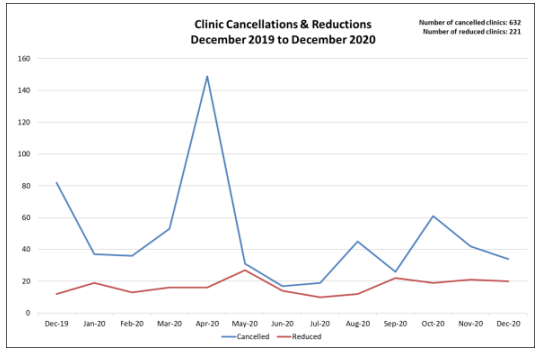


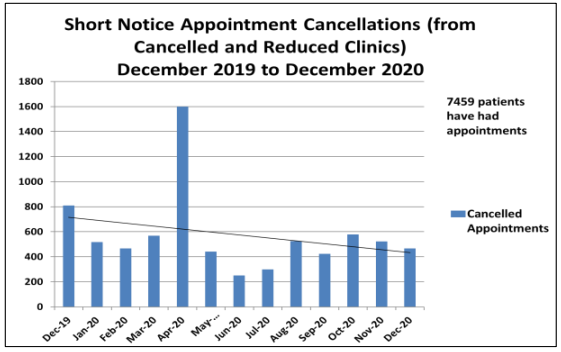
Outpatients & Cancelled Operations

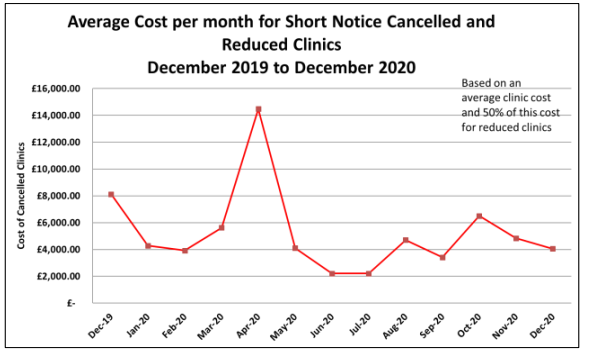








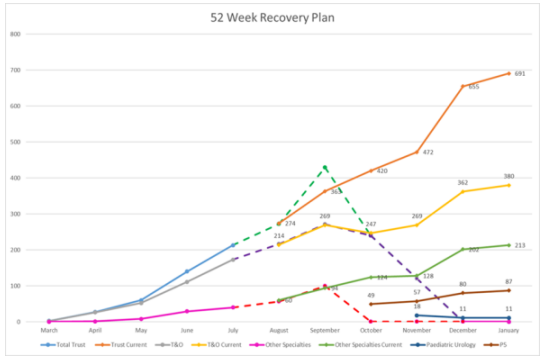


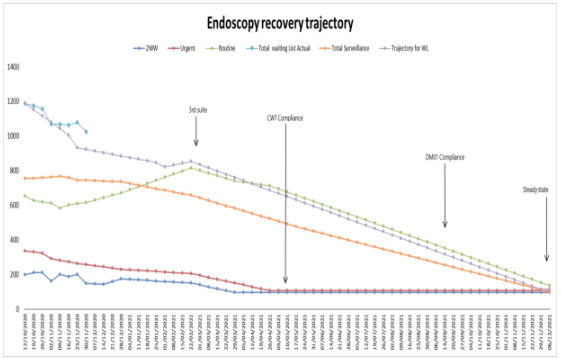


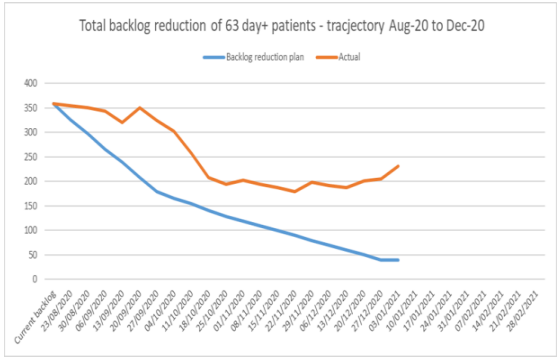
DNA Rate for Follow Up Appointments per Specialty for December

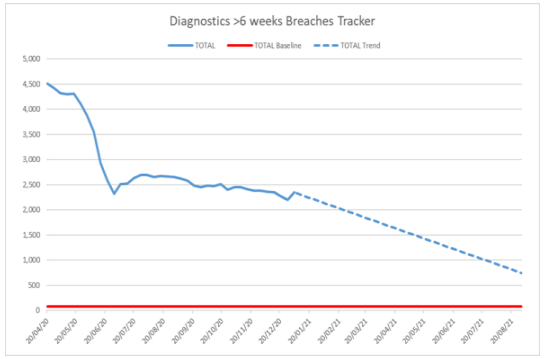
Specialty & Performing Unit	Accident & Emergency	Anaesthetics	Anticoagulant Service	Breast Surgery	Cardiology	Chemical Pathology	Clinical Haematology	Clinical Oncology	Colorectal Surgery	Community Midwifery	Dermatology	Diabetic Medicine	Dietetics	Endocrinology	ENT	Gastroenterology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology	Medical Oncology	Neonatology	Neurology	Obstetrics	Ophthalmology	Optometry	Oral Surgery	Orthoptics	Paediatric Diabetic Medicine	Paediatrics	Physiotherapy	Respiratory Medicine	Rheumatology	Trauma & Orthopaedics	Urology	Vascular Surgery	Well Babies	Total
DNA Rate	0.0%	33.3%	0.0%	18.7%	3.1%	3.3%	0.4%	1.2%	1.3%	3.5%	2.6%	2.6%	6.6%	2.2%	9.8%	5.2%	0.2%	1.6%	0.0%	1.7%	1.4%	5.0%	2.1%	2.9%	7.4%	17.3%	3.5%	17.2%	8.3%	8.0%	4.8%	1.9%	1.4%	11.8%	2.4%	0.0%	3.5%	4.4%

Recovery Trajectories









	Metric	Dec-19 Actuals	Dec-20 Actuals	Dec-19 vs Dec-20
Outpatients	First appointments	9,274	8,908	96.1%
	Follow up appointments	17,236	20,085	116.5%
	procedures	TBC	TBC	TBC
	Face to face	TBC	TBC	TBC
	Virtual	TBC	TBC	TBC
Inpatients	Day cases	1,766	1,420	80.4%
	Elective	284	128	45.1%
	Non-elective	2,943	2,852	96.9%
ED	A&E attendances	9,760	7,400	75.8%

Workforce Indicators Summary

Agency Spend #N/A
Bank Spend #N/A

Target: 15%

Staff In Post
3375
WTE

Training
84%

Target: 90%

Sickness
4.42%

Target: 3.7%

9.25%

Target: 8%

Turnover
10.06%

Target: 12%

Medical Suspended
Non-Medical 74%

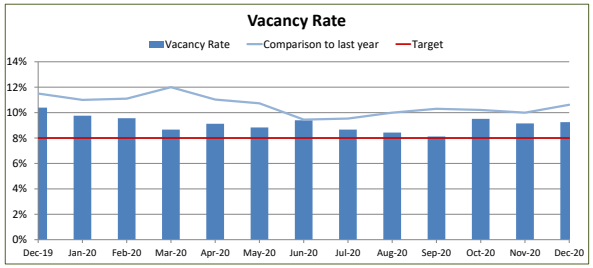
Target: 90%

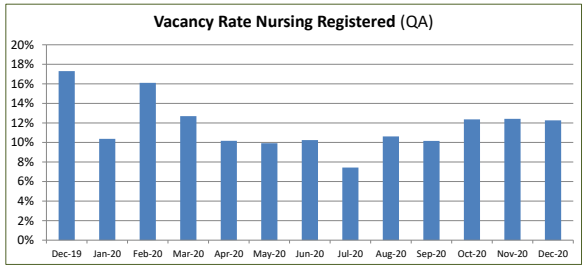
Scorecard

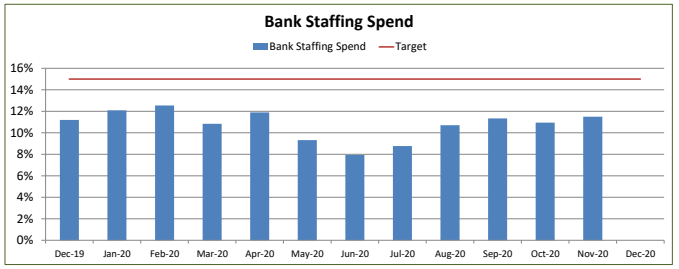
The Princess Alexandra Hospital NHS Trust

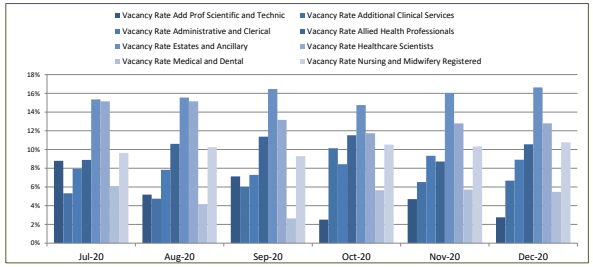
People Measures as at 31 December 2020	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3756.93	903.54	483.39	945.9	782.27	278.29	146.32	52.68	164.54
Vacancy Rate	8.0%	9.25%	7.87%	9.35%	13.29%	12.14%	14.46%	0.00%	0.00%	11.56%
Agency % of paybill	7.0%	5.1%	3.9%	1.0%	5.4%	7.9%	1.3%	0.0%	0.0%	0.0%
Bank Usage - wte	n/a	259.49	29.04	29.43	105.44	46.55	24.58	5.90	1.81	13.93
Agency Usage -wte	n/a	81.59	13.71	1.23	23.38	25.51	2.32	6.17	0.00	9.27
December 2020 Sickness Absence	3.7%	4.42%	3.72%	3.97%	4.85%	4.56%	**9.70%**	2.15%	2.11%	1.80%
Short Term Sickness	1.85%	2.12%	1.87%	1.44%	2.67%	2.26%	3.22%	2.15%	0.24%	0.77%
Long Term Sickness	1.85%	2.30%	1.85%	2.53%	2.18%	2.30%	6.48%	0.00%	1.87%	1.03%
Rolling Turnover (voluntary)	12%	10.06%	11.02%	9.66%	11.61%	8.27%	7.62%	8.65%	**14.70%**	10.09%
Statutory & Mandatory Training	90%	84%	92%	84%	79%	77%	82%	81%	82%	97%
Appraisal	90%	**74%**	82%	**71%**	**69%**	**68%**	**79%**	**55%**	**73%**	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)		31.00	5.00	2.00	3.00	2.00	0.00	14.00	2.00	3.00
Leavers (wte)		36.05	8.31	5.40	11.94	5.80	3.60	0.00	0.00	1.00
Time to hire (Advert to formal offer made)	31Days									

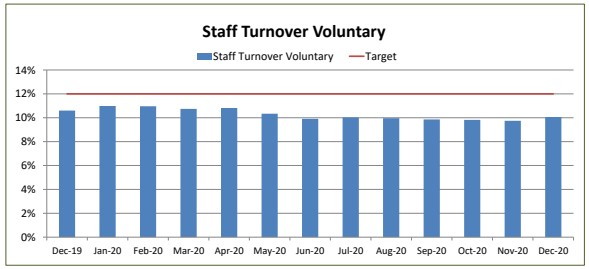
Workforce Indicators

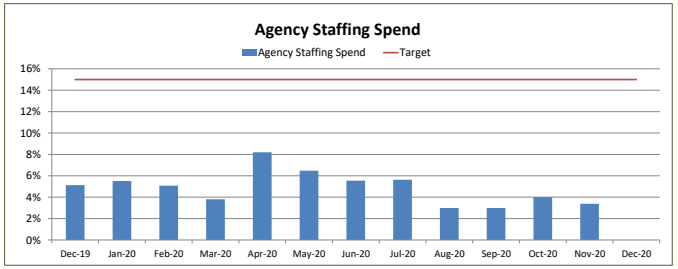


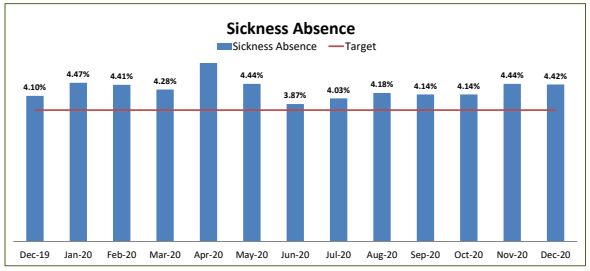


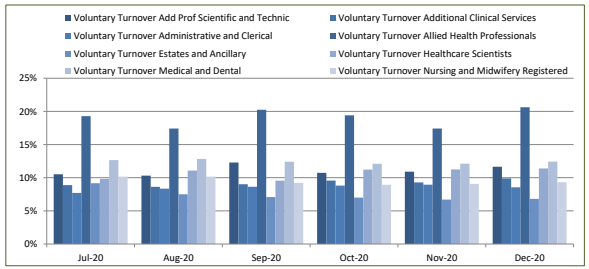


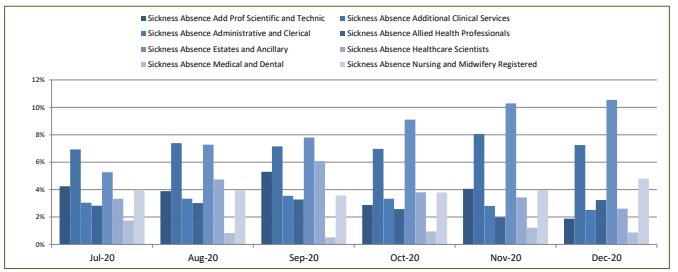


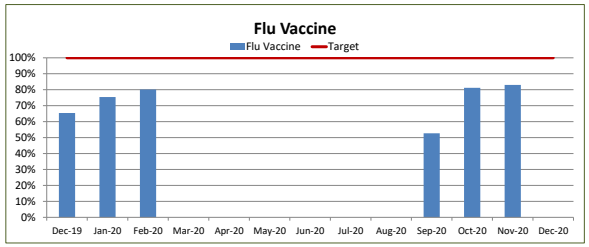




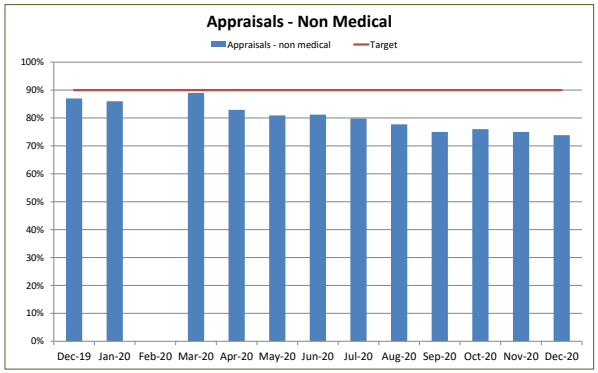


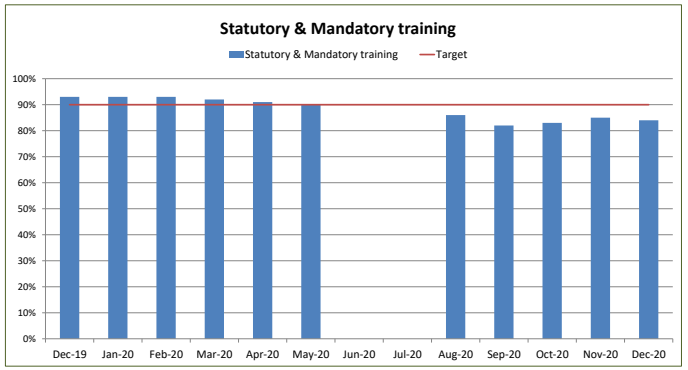


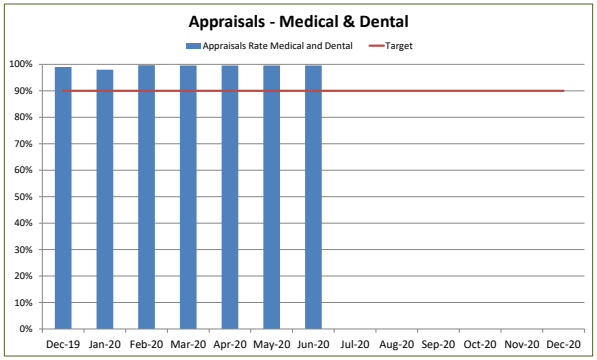


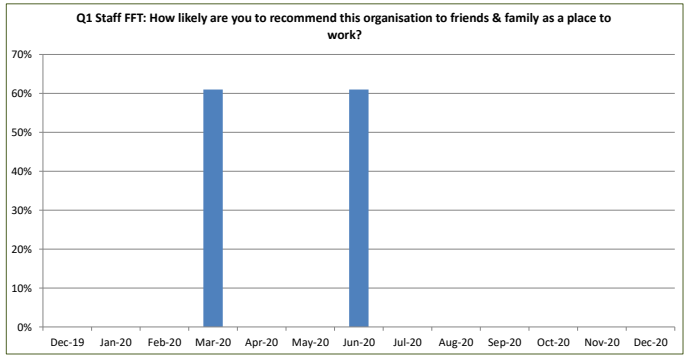


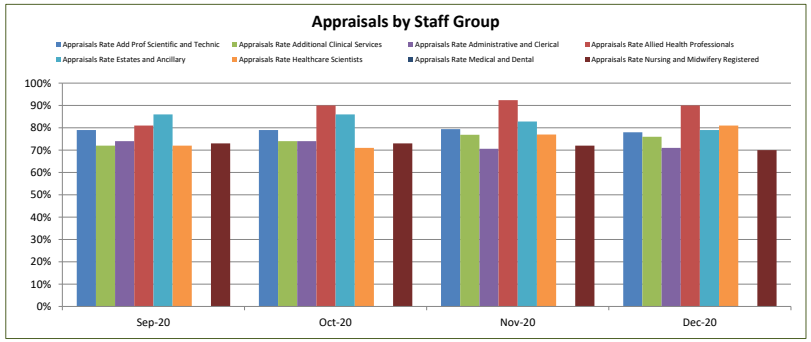
Workforce Indicators

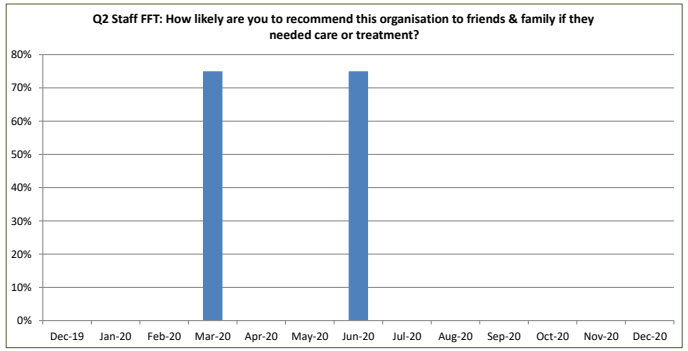












Workforce Indicators

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

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

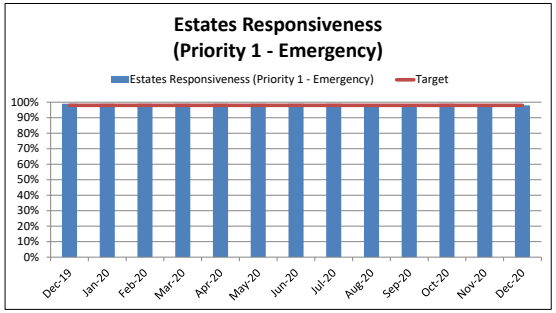
Measure	*Average rating of:*	*Percentage*
Support & Compassion	% experiencing harassment, bullying or abuse from staff in the last 12 months*	19.50%
	% not experiencing harassment, bullying or abuse at work from managers in the last 12 months	84.40%
Teamwork	% agreeing that their team has a set of shared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

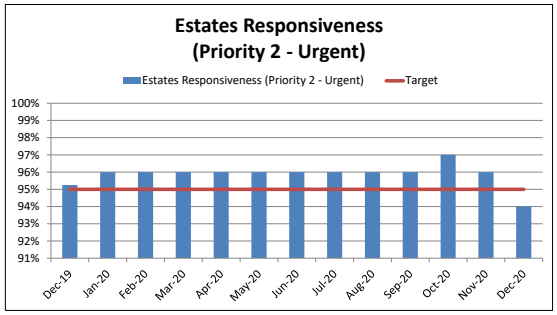
*Note that this is a 'negative' experience question & does not exist within the structure of the NHS Staff Survey (all answers are scored positively); the survey asks about experience of harassment, bullying or abuse from 'managers' and 'other colleagues', but not 'staff'. Provided is the data for the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

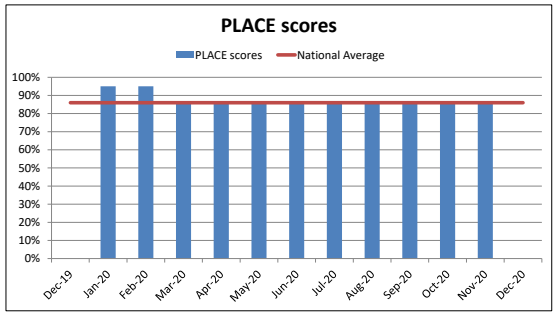
**Again, please note this is a 'negative' experience question & this specific data is not explicitly reported in the results – calculations are based on the raw data.

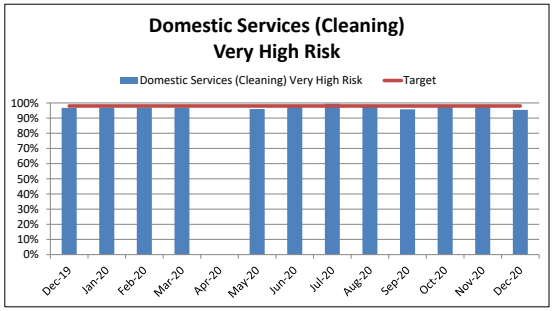
WRES Indicator No.	WRES Report March 2018	WRES Report March 2019	Direction
9. Percentage difference between PAH Board voting Membership and its overall workforce	White = 100% BME = 0%	White = 100% BME = 0%	⟺
Percentage difference between PAH Executive board membership and its overall workforce	White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

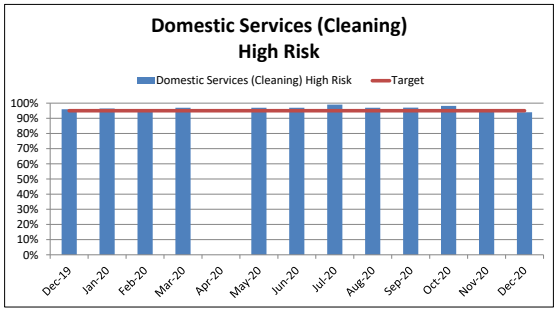
Places

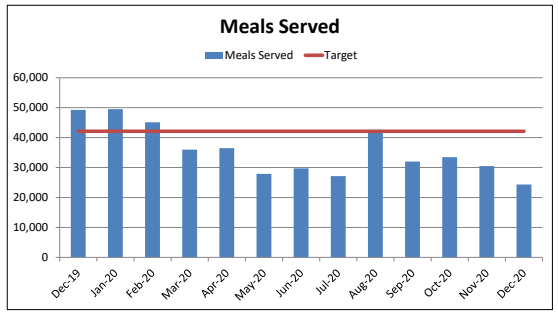

Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20

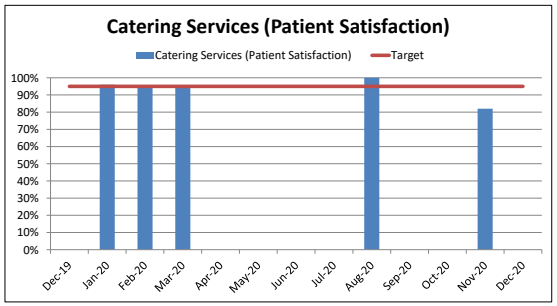

Estates Responsiveness (Priority 2 - Urgent)
Estates Responsiveness (Priority 2 - Urgent)
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20

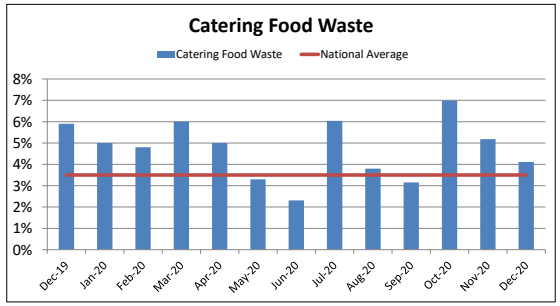

PLACE scores
PLACE scores
National Average
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20


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


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


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


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


Catering Food Waste
Catering Food Waste
National Average
8%
7%
6%
5%
4%
3%
2%
1%
0%
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20

Executive Summary Our Pounds

NHS
The Princess Alexandra Hospital
NHS Trust

At M9 the Trust is reporting a year-to-date (YTD) surplus of £0.1m against a planned deficit of £0.1m (£0.2m favourable to plan). The Trust's annual plan remains £0.4m deficit.

At M9 YTD capital expenditure totalled £21.4m against a plan of £33.4m, a £12m underspend. This leaves £24.2m to spend within the remaining 3 months of this financial year.

Cash balance is £69.7m with a plan to reduce this prior to year end.

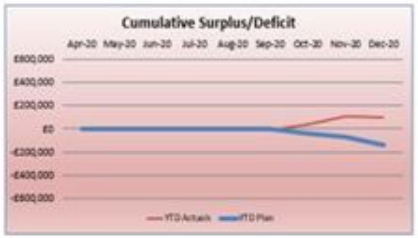
The Trust's 2021/22 financial plan will be developed, in line with national guidance. The current financial regime will be rolled forward for Q1 of 2021/22.

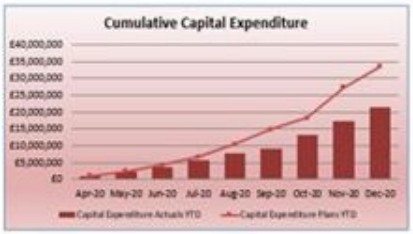
Pounds

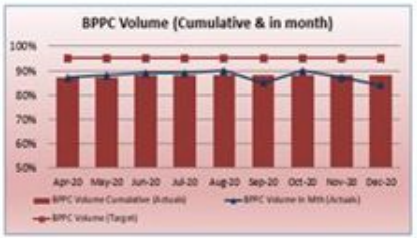
£ Our Pounds Summary — 5.1 Overall financial position

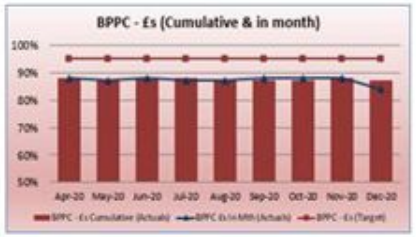
NHS The Princess Alexandra Hospital NHS Trust

OUR POUNDS		
Metric	Annual Plan	YTD
Surplus/(Deficit)	-£391,000	£98,398
Agency Spend £s	-£10,292,000	-£7,109,629
Bank Spend £s	TBC	-£15,217,475
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3.6%	3.5%
Capital Expenditure	-£43,089,000	-£21,365,000
BPPC Volume	95%	88%
BPPC - £s	95%	87%
Cash Balance	£1,000,000	£69,666,000









respectful | caring | responsible | committed

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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The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS (Private)

MEETING DATE: 04.02.21 **AGENDA ITEM NO: 5.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)
REPORT FROM: Helen Glenister – QSC Chair
DATE OF COMMITTEE MEETING: 22.01.21 (Virtual Meeting)

5.1

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **COVID-19:** The Committee was provided with a detailed update on the current position within the Trust and in particular on the following:
  - Decision taken the previous day that all patients to be swabbed either Mon/Wed/Fri or Tues/Thurs/Sat to ensure all patients being captured at regular swabbing points.
  - Cleaning to be increased to four times daily (from three) to ensure consistent standards.
  - To continue efforts to ensure isolation for those patients requiring it, particularly those who were immuno-suppressed and /or extremely clinically vulnerable (this was challenging due to limited numbers of side rooms).
  - To review the strategy around use of FFP3 across the Trust in light of the highly transmissible new variant.
  - BAF Risk 1.0 Covid was reviewed and members supported the recommendation to increase the risk score from 16 to 20.
- **Maternity SIs** - Following the Ockenden report published in December 2020, one of the essential actions related to enhancing safety was that all Maternity SIs (along with a summary of key issues) must be provided for the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. The report provided to QSC provided assurance in relation to ongoing investigations and future reports would focus more on the learning and changes made to the service as a result of the pending investigations. The report is included in the Board papers.
- **BAF Risk 1**.1 (variation in clinical outcomes) – It was agreed the risk score should remain at 16.
- **Pressure Ulcers/Falls** – The Committee noted the increased reporting around both which was in line with the pressures of COVID wave 2, but also noted no increase in harms or tissue damage in ITU, in line with the learning from COVID wave 1. QSC will continue to monitor the position.

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
  - Infection Control: Monthly Update
  - Infection Control BAF
- Learning from Deaths Update
- Monthly Patient, Safety, Quality & Effectiveness Report
- M9 Integrated Performance Report
- Report from Vulnerable Patients Group

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

- The Committee continues to make good progress against its work plan. In line with the decision made by the Board on 14 January 2021, the agenda/meeting duration were shortened due to the pressures associated with Covid-19.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 04.02.21 **AGENDA ITEM NO: 5.1**

REPORT TO THE BOARD FROM: Workforce Committee (WFC)
REPORT FROM: Helen Howe (Committee Chair)
DATE OF COMMITTEE MEETING: 25.01.201 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
Dignity at Work: The committee received an update on the Trust's approach to reducing and ultimately eradicating bullying and harassment, initiatives to raise awareness, targeted resolutions and the focus on the culture of the workplace. **Workforce report and Covid update:** The workforce metrics were reviewed and an update was received on sickness absence, shielding and redeployment, COVID vaccinations and Staff Health and Wellbeing during Covid. WFC acknowledged that staff are fatigued and need a break before the recovery phase is launched. **Safer staffing:** The report was discussed and is on the Board agenda for discussion. **BAF risk 2.3 Inability to recruit, retain and engage our people:** Recommended that risk score remain 12 and noted that target date for achieving target risk score has been revised to March 2022 to align with receipt of the next staff survey results.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
In addition to the above, WFC received reports on the following agenda items: • Communications Update • Training and Education Update • Health and Wellbeing Guardian
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee continues to make progress against its work plan although certain agenda items were deferred as agreed at Trust Board on 14 January 2021 due to the current pressures in the organisation relating to COVID-19.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 04.02.21 **AGENDA ITEM NO: 5.1**

REPORT TO THE BOARD FROM: New Hospital Committee (NHC)
REPORT FROM: Lance McCarthy (Committee Chair)
DATE OF COMMITTEE MEETING: 26.01.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

Enabling Works: PAH's Preferred Way Forward (PWF) for the New Hospital required new highways infrastructure to be delivered to provide access to the greenfield site, namely:

1) Amendments to Campion's Roundabout to provide vehicle access to the site from Day 1.
2) An Underpass to facilitate a future Sustainable Transport Corridor to be open in the 2030s.

The Committee approved proceeding with 1) above but to delay the works associated with 2) above in line with the considered opinion of the team that the risks associated with delivering the underpass as part of the M11 J7a were insurmountable. The Committee acknowledged that the alternative (to construct the underpass later as per the delivery methodology presented by the ECI Report (42-week delay)) presented considerable risks.

Move Away from 100% Single Room Accommodation: External support had been commissioned to complete a review of all current designs including ward configuration to support care of different patient cohorts and potential nursing models to support a move away from 100% single room accommodation. Whilst the Committee supported that move, it agreed the arguments should be further explored and agreed with clinical colleagues.

OBC Costs: The Committee received an update on spend to date against the initial allocation of £8.5m of Capital monies to fund the preparation of the OBC. Members agreed discussions (with NHSE/I) would need to take place around the possibility of carrying funding over into the coming financial year, and the likely amount of any potential additional funding for 2021/22, given the OBC timeframe for completion had now moved into October of that year.

Programme Risks: Members noted a deep dive would be undertaken into the programme's risk register in conjunction with Executive Leads and a second internal assurance review would be undertaken in advance of the Gateway programme (which had been deferred) to review each individual project and ensure key messaging was correct.

BAF Risk 3.5 New Hospital: The risk was discussed and it was agreed that the score should remain at 16. A review of the high scoring risks on the programme risk register will be undertaken to determine whether any other risks should be added to the BAF. This will be reported back to the next meeting.

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

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

- Land update (verbal)
- Update on programme affordability
- Standing Items:
- Decisions, Risks and Issues, (Changes), Programme

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: 04.02.21 **AGENDA ITEM NO: 5.1**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Pam Court - PAF Chairman
DATE OF COMMITTEE MEETING: 28.01.21 (Virtual Meeting)

5.1

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **M9 Update** – The M9 revenue position had reported a YTD surplus of £0.1m, £0.2m better than plan. The Trust's annual plan remained £0.4m deficit. YTD capital spend was £21.4m, £12m behind plan with the annual capital programme remaining at £45m – Capital Working Group meetings were being held on a fortnightly basis to monitor the position to year end. Cash balances remained sufficient. The YTD revenue variance included income shortfalls of £0.4m offset by pay and non-pay underspends totalling £0.6m. Temporary staffing costs had increased to £2.9m (M8 £2.4m) due to increased operational pressures.

- **BAF Risks** – The following were agreed: BAF Risk 5.1 (Finance) risk score to reduce from 20 to 16. BAF Risk 4.2 (ED 4 hour emergency standard) score to remain at 16 and target date for achieving target risk score was revised to the summer. BAF Risk 1.2 (EPR) score to remain at 16 and BAF Risk 3.1 (Estate & Infrastructure) score to remain at 20 although improvements were noted.

- **Planning 2021/22** - NHSE/I had provided initial guidance on business planning for 2021/22. Key elements were that for quarter 1 of 2021/22, system revenue envelopes would be based on 'rolled forward' values from 2020/2. PAF considered and supported a proposal that a hybrid budget is developed for 2021/22. It will consist of two elements, a budget for Q1 as there is clarity over this element of funding and a provisional budget for Q2 to Q4 until further guidance is published. The provisional budget will be revisited to ensure that it is in line with the guidance when published.

- **New Hospital** - The financial case was progressing well and modelling and assumptions were currently being reviewed. The affordability gap was being worked through and that too was progressing well. To support the economic case, various workshops were taking place and a comprehensive investment appraisal would be undertaken. In terms of programme costs the current spend was £4.3m with circa £8m remaining. Current forecasting was indicating a further spend of £7m. Mitigations were being developed to ensure that there was no underspend.

- **Operational Performance** - Members noted the continuing challenges to operational performance associated with the second wave of Covid but were assured of actions in place to mitigate all risks where possible.

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

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

- M9 Integrated Performance Report
- Procurement Update

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

The Committee continues to make progress against its work plan.