The Princess Alexandra Hospital NHS Trust

AGENDA

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

Date and time: Thursday 6 August 2020
10.15 – 11.45

Venue: Microsoft Teams Meeting

	Item	Subject	Action	Lead	
01 Opening Administration					
10.15	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	9
02 Risk					
10.20	2.1	CEO's report including: • Covid-19 • Recovery and Restoration Plan	Inform	Chief Executive	10
10.35	2.2	Significant Risk Register	Review	Director of Nursing	15
10.45	2.3	Board Assurance Framework 2020-21	Review/ Approve	Head of Corporate Affairs	21
03 Patients					
10.55	3.1	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing & Midwifery	36
11.05	3.2	Mortality	Discuss	Acting Chief Medical Officer	Verbal
04 Performance					
11.15	4.1	Integrated Performance Report (IPR)	Discuss	Executives	42
05 Governance					
11.30	5.1	Reports from Committees: • New Hospital Committee 27.07.20 and revised Terms of Reference • Quality and Safety Committee 31.07.20 • Performance and Finance Committee 30.07.20 • Workforce Committee 27.07.20 • Senior Management Team.27.07.20	Inform/ Approve	Chairs of Committees	83 85 88 90 91
11.40	5.2	Report to Corporate Trustee/Trust Board from CFC meeting 8.07.20	Inform	Chair of CFC	92
06 Questions from the Public					
	6.1	Opportunity for Members of the Public to have a pre-submitted question answered.			
07 Closing Administration					
11.45	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	
	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	Chief Finance Officer	Trevor Smith
Chair of Quality & Safety Committee (QSC)	Dr. Helen Glenister	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Pam Court	Chief Medical Officer	Dr. Andy Morris
Chair of Workforce Committee (WFC)	Helen Howe	Director of Nursing & Midwifery	Sharon McNally
Chair of Charitable Funds Committee (CFC)	Dr. John Keddie	**Executive Members of the Board (non-voting)**	
Chair of Strategy Committee (SC)	Dr. John Hogan	Director of Strategy	Michael Meredith
		Director of People	Gech Emeadi
		Director of Quality Improvement	Jim McLeish
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Virtual Trust Board Meeting in Public
Thursday 4 June 2020 from 09:30 – 11:15

Present:	
Steve Clarke	**Trust Chairman (TC)**
Pam Court	Non-Executive Director (NED-PC)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Helen Howe	Non-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)
Trevor Smith	Chief Financial Officer (CFO)
George Wood	Non-Executive Director (NED)
In attendance:	
Dr. Amik Aneja	General Practitioner (GP-AA)
Members of the Public	
There were no members of the public present	
Apologies:	
None	
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chairman (TC) welcomed all to the virtual Board meeting. In light of the current circumstances the agenda had been reduced and discussions would be concise.
1.1 Apologies	
1.2	No apologies were noted.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Meeting held on 02.04.20	
1.4	These were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising and the action log was noted.
02 RISK	
2.1 COVID-19	
2.1	This item was presented by the CEO. He updated that Andy Morris (Chief Medical Officer) who had been on secondment to the East of England Region, had now resigned from the Trust. His last working day had been the previous Friday, 29.05.20. Marcelle Michail would continue in the interim as Acting Chief Medical Officer (ACMO) and he requested that Andy's contribution to the Trust over the previous five years be recorded. He confirmed that the roles of Chief Medical Officer and Chief Information Officer were now out to advert with interview dates scheduled for July/August.
2.2	In terms of COVID he was able to update that ED attendances were now starting to increase to around 70% of normal figures. He reminded members that performance (against the ED four hour standard) had risen considerably over the previous six weeks although it had dipped below 90% over the previous week.

2.3	The CEO continued that members should note some recent media attention around the pressures the hospital had been under (ITU) during the COVID surge and around the recent Critical Care Network Peer Review. A couple of statements had been issued and the town's MP (Robert Halfon) would be interviewed by BBC Essex.
2.4	In terms of recovery, the Chief Financial Officer (CFO) was leading the Trust's Recovery Cell as the platform for planning for services restoration moving forward. In terms of New Ways of Working there would be a renewed focus on patient pathways and some probable changes to the management and governance structure of the Health Care Groups (HCGs). There would be a positive drive around the management of frail/elderly patients linking to the End of Life (EoL), Palliative Care and Community Service provision.
2.5	In response to a question from NED George Wood (NED-GW) it was confirmed that the acuity of patients attending ED had started to increase. It was noted that patients were concerned about presenting to Emergency departments and acorss the region work was underway to allay these fears.
2.6	NED Helen Howe (NED-HH) highlighted section 4.2 of the report around staff health and wellbeing and stated it would be useful to know going forward, which of the current initiatives would continue. In response the Director of People (DoP) stated that consideration was currently being given to that.
2.7	The CEO updated that the organisation was committed to providing a staff room for its people and an appropriate space had been identified. He also added that risk assessments were being undertaken for vulnerable staff, particularly BAME staff. The DoP added that the risk assessment for BAME staff had been revised and now included the provision of an independent assessor (if requested) and support lines and webinars were also running for that cohort of people.
2.8	In response to a question from NED-HH the CEO acknowledged that some elements of the COVID response had worked well and those would be taken forward. . In terms of the estate he recognised that whilst there would be a new hospital within five years, the current estate would also require significant investment in order to keep it safe and to support public confidence.
2.9	In relation to social distancing arrangements in the hospital, the Director of Quality Improvement (DoQI) added that over coming weeks there would be increased signage around the estate to support expectations around compliance with social distancing and newly appointed Safety Marshals would also raise that profile.
2.10	NED Pam Court (NED-PC) asked whether the organisation felt prepared for a second wave of COVID and were there any concerns about staff fatigue. In response the Director of Nursing & Midwifery (DoN&M) informed members that Covid had been an unprecedented event for all Trusts and work was underway to review and learn from the the Trust's response to Covid and determine which elements of that response would be replicated in a second wave. The Resilience Team would be revising the cell structure and the Infection Prevention & Control Cell was tracking all attendances in conjunction with intelligence from the Region and nationally. The site continued to be zoned and ITU was being redesigned to provide level 1 to 3 facilities and to develop an area where COVID patients could be cohorted.
2.11	The TC thanked the CEO for his update and commended the contributions made by the former Chief Medical Director, Andy Morris. He also acknowledged the scale of investment required in the current estate and was pleased to hear of the support put in place for staff and the risk assessment process for vulnerable staff.
2.12	In response to the above point around future investment in the current estate the CEO highlighted the implications of investing significant funds into facilities that would only be used for circa five years (until construction of the new hospital was complete) and the implications of that on the financial position moving forward.
2.13	In terms of the organisation's Recovery & Restoration Plan the CFO reported it was intended to not only keep staff informed but also help build public confidence in the re-opening of services. A key focus currently was demand and capacity modelling (in conjunction with system partners) and potential support from the independent sector.

	Outputs were starting to emerge which would facilitate ICS/STP discussions to ensure processes were in line with regional expectations and national guidance, particularly in relation to ensuring capacity for any future surge.
2.14	The TC thanked the CFO for his update and welcomed the progress and collaborative work.
2.2 Board Assurance Framework (BAF) 2020/21	
2.15	This item was presented by the Head of Corporate Affairs (HoCA) and taken as read. In line with the recommendation (and reviews at QSC and PAF respectively) it was agreed that the scores for BAF risk 1.0 (COVID-19) and for BAF Risk 4.2 (ED standard) both be reduced from 20 to 16. Members acknowledged that the reduced risk scores reflected the current risk position.
2.3 Major Incident Plan	
2.16	This item was presented by the Chief Operating Officer (COO). The plan was presented for annual review and a further attachment was being developed which related to the organisation's COVID response.
2.17	In response to a question from NED-PC it was confirmed that an incident would be declared a major incident if it was declared so nationally. COVID was a national level 4 incident and remained so currently.
2.18	The Board approved the Major Incident Plan.
03 PATIENTS	
3.1 Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	
3.1	This item was presented by the DoN&M and members noted the paper had already been discussed at both QSC and WFC. She apologised for an error in relation to ED care staff fill rate which should read 76% not 7.6%.
3.2	As in recent months the position remained positive and overseas interviews were continuing via Skype. The national data submission was expected to resume from that month.
3.3	In response to a question from the TC in terms of the domestic recruitment market, the DoN&M confirmed that would be a future source of Band 6/7 nurses and some external support was being procured to help to tap into that.
3.4	In response to the above the CFO confirmed that the main focus currently was on reducing temporary staffing costs and the Deputy Director of Nursing & MidwiferyHad attended PAF to explain the actions being taken to reduce nurse agency spend.
3.2 Mortality	
3.5	This item was presented by the ACMO. The paper described the organisation's approach to mortality review processes particularly during COVID and had been discussed in detail at QSC. She updated the Board on the good progress made to date and acknowledged that it was now time to take a fresh look at the data. In addition the Trust would reflect on which improvement workstreams had worked well and should continue. , A high level Mortality Strategy was i being developed. In addition a Mortality Team would now be established and for the time being one of the organisation's Associate Medical Directors (AMDs) would step into the gap left by the recent departure of the Deputy CMO.
3.6	NED-HH stated that going forward now it would be critical to embed any learning around process and doing something more 'tangible' in terms of the outcomes from the structured judgement reviews (SJRs). In response the ACMO agreed and stated that the learning from deaths strategy would provide a refocus on the whole governance process around mortality.
3.7	In response to the above and as further assurance the DoQI confirmed that the quality improvement workstreams continued and would be reported to QSC in July 2020.
3.8	In response to a question from NED-JH the ACMO confirmed her focus would be on the depth of coding and palliative care coding. A renewed focus on the data would support the work around the deteriorating patient and she would also be keen to undertake a risk stratification of patients, both those for palliative care but also those for active management.

	A deep dive would be undertaken in conjunction with primary care and community colleagues.
3.9	In response to the above NED Helen Glenister (NED-HG) added that recent discussions at QSC had concluded now was the time to move on from putting processes in place to learning and ensuring that was embedded. The CEO added he felt there was a big opportunity to be had in terms of EoL and frailty and also in reviewing the learning from the COVID response.
3.10	The TC thanked colleagues for their update.
04 PERFORMANCE	
4.1 Integrated Performance Report (IPR)	
4.1	This item was presented by the COO. Key headlines under the Trust's 5Ps were as follows: <u>Patients</u> It was flagged there had been some small changes to the IPR since presentation at the Board Committees. In terms of the stillbirth rate the table had been updated to include the PAHT rolling trend. In addition there had been a revision to the wording of SI relating to self-harm updates. Members also noted that the Quality Improvement Plan had been removed that month but would be reviewed and reinstated for the next iteration. <u>Performance</u> It was confirmed the IPR was being revised to reflect the position in terms of recovery and revised trajectories/targets. In addition the HCG performance review meetings would restart that month with the outputs reflected in the next iteration of the report. <u>People</u> Members noted that compliance with staff appraisal had been affected during the COVID response. <u>Places</u> It was noted there had been significant staff sickness amongst domestic staff and the pressures associated with the COVID response had resulted in increased use of temporary staff. He noted that a large amount of emergency work was being undertaken on the site. <u>Pounds</u> A further release of national information/guidance was expected in terms of adaptations to the finance regime for the remainder of the year. That would be used as part of the budget re-statement to be worked on. In terms of the current financial position, and as noted earlier in the meeting, the focus remained on the reduction of temporary staffing costs and a push on transformation (associated with the accelerated transformation during COVID). In terms of capital the programme of circa £43m for the year was being closely tracked to ensure in proceeded at pace, leads were being reminded to instigate investments to avoid any back-end loading.
4.2	The CEO acknowledged the recent concerns raised around temporary staffing costs and confirmed the executive team shared these concerns. Conversations had taken place at Executive level to agree and instigate actions to address the concerns. Deep dives into budgets (pay and non-pay) and a review of rotas to ensure they were aligned to budgets would commence. He acknowledged the associated KPIs were not yet in place and he would be looking to set those which would then inform discussions and tracking via the appropriate Board committees.
05 GOVERNANCE	
5.1 Data Protection Security Protection/Information Governance Update	
5.1	This item was presented by the CFO who reported that the organisation had published the toolkit on 19.05.20 (ahead of the deadline) meeting all 116 mandatory evidence requirements and 44 assertions, thereby achieving full compliance. His thanks went to the

	Information Governance (IG) team for their diligence and in particular, progress on achieving IG training compliance.
5.2	The Board noted the report and submission of a fully compliant Toolkit.
5.2 Reports from Committees	
5.3	New Hospital Committee – 11.05.20 – Chair: CEO Revised terms of reference (ToR) following the meeting were presented to the Board for approval. The CEO updated that the Committee's inaugural meeting had provided a detailed update for all members. The Board approved the Committee's ToR.
5.4	Quality & Safety Committee – 22.05.20 – Chair: NED-HG Members' attention was drawn to the recent increase in pressure ulcers, which the Committee noted had occurred during the COVID surge. The learning from that was now being embedded.
5.5	Performance & Finance Committee – 28.05.20 – Chair: NED-PC Members noted the Committee had been meeting on a weekly basis but would now look to review that going forward. Discussions at PAF had focussed on temporary staffing costs and the Month 1 financial position. PAF had agreed a reduction in the ED BAF risk score from 20 to 16 and noted the improved performance albeit attendances had recently reduced. It had been agreed further discussions would take place on the remit of PAF versus Workforce Committee (WFC).
5.6	Audit Committee 28.05.20 – Chair: NED-GW The unaudited accounts had been presented and it was noted that External Auditors were consulting on the final wording of Audit Opinion and Going Concern (due to the impact of COVID-19) with the final adoption of the accounts requiring these documents. The Committee had approved the content of the Accounts and recommended them to the Board for consideration that day. NED-GW commended the finance team for their hard work and efforts.
5.7	Workforce Committee – 01.06.20 – Chair: NED-HH Discussions had focussed on temporary staffing, the staff risk assessment and the actions being taken following the GMC Survey. In terms of the latter work had now started in relation to securing a college tutor, mentoring for junior doctors and support for non-training grades.
06 QUESTIONS FROM THE PUBLIC	
6.1	No members of the public were present.
07 CLOSING ADMINISTRATION	
7.1 Summary of Actions and Decisions	
7.1	These are presented in the shaded boxes above.
7.2 New Issues/Risks	
7.2	No new risks or issues were identified.
7.3 Any Other Business (AOB)	
7.3	There were on items of AOB.
7.4 Reflection on Meeting	
7.4	NED-GW suggested that the Board should congratulate the Patient Panel on receiving the *Queen's Award for Voluntary Service. T*he TC and members agreed that the TC would formally write to the Patient Panel on behalf of the Board.
ACTION **TB1.04.06.20/02**	**Send a letter of congratulations to the Patient Panel for their Queen's Award.** **Lead: Trust Chairman/HoCA**

Signed as a correct record of the meeting:	
Date:	06.08.20
Signature:	
Name:	Steve Clarke

The Princess Alexandra Hospital NHS
NHS Trust

Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 06.08.20

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.04.06.20/02	Queen's Award	Send a letter of congratulations to the Patient Panel for their Queen's Award.	Chairman/ HoCA	TB1.06.08.20	Actioned.	Closed

The Princess Alexandra Hospital NHS NHS Trust

2.1

Trust Board – 6 August 2020

Agenda Item:	2.1
Presented by:	Lance McCarthy – CEO
Prepared by:	Lance McCarthy – CEO
Date prepared:	28 July 2020
Subject / Title:	CEO Update

Purpose:	Approval		Decision		Information		Assurance	

Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting: - Performance highlights - COVID-19 response and recovery - New hospital - Development of Integrated Care Provider - 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 – 6 August 2020

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

(1) Key performance headlines

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

Key Performance Indicator	Actual performance for latest month (June)	Comparison to last report
ED 4-hour performance	90.7%	↑ (better); target = 95%
SHMI	109.6 (Jan 19 – Dec 19)	↑ (better); higher than expected
C. Diff (hospital onset)	0	→
MRSA	0	→
Never Events	0	→
Incidents reported	803	↓ (better)
No harm / minor harm incidents	95.4%	↓ (worse)
Falls / 1,000 bed days	10.0	↑ (worse)
6-week diagnostic standard	64.4%	↓ (worse); target = 99%
Stat Man training	93.0% (March data)	→
Temporary staff % of pay bill	13.5%	↓ (better)
Staff turnover	9.91%	New indicator

(2) COVID-19 response and recovery

As of previous Board reports over recent months, I want to reiterate my thanks to all my colleagues at PAHT for their hard work and amazing response to the COVID pandemic. There was an enormous amount of change in a very short space of time, with a large number of people working differently, in different teams, different locations and undertaking different roles, all to support our patients.

78% of our people have now been tested for antibodies and vitamin D levels. 21% have antibodies detected, although this does not guarantee immunity and 37% have either a deficient or insufficient level of vitamin D. The results show some variations between professionals, with our scientists and administrative teams having slightly lower levels of antibody positive results than other colleagues, and between departments, but there are no obvious or significant variations between department or profession. As with the national picture, staff from a BAME background have a higher incidence rate of contracting COVID-19 than non-BAME colleagues with 29% of BAME colleagues tested returning positive antibody test results compared with 17% of our non-BAME colleagues.

All colleagues are being encouraged to complete a personal COVID risk assessment to support decisions to maximise their health and wellbeing. At the time of writing this paper 79.5% of all colleagues had completed this with their line manager. I will continue to push the importance of this with all of our people.

At our peak, in April, our ventilated capacity for known COVID patients was at almost 650% of our normal ventilated capacity, and at one point we had in excess of 200 positive COVID patients being cared for in the organisation. Over recent weeks we have been treating between 0 and 3 known positive patients at any one time. This has enabled us to focus for the last few months on recovery and restoration of services that we reduced or stopped providing at the height of the pandemic.

We have some significant pressures currently in terms of patients waiting for diagnostics and for elective surgical interventions. For the first time in more than two years, we have patients who have been waiting for more than 52 weeks for their routine surgery, 162 in total, many of which are waiting for elective orthopaedic procedures.

We also have significant pressure and demand for our diagnostic services, endoscopy in particular, 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. In addition to our capacity, we are working closely and well with our independent sector colleagues at The Rivers and a number of other providers to maximise access to key services so that we can restore timely services to all of our patients.

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

Referrals to PAHT for suspected cancer fell significantly during the height of the pandemic and I'm pleased that the rate of referral for suspected cancers has largely returned to pre-COVID levels over recent weeks. Similarly, the demand for urgent care through our Emergency Department feel sharply through March and April, starting to pick up in May and is now up to >85% of pre-COVID levels. Routine GP referrals to the Trust however remain low, with recent weeks about 25% lower than normal pre-COVID levels. We will be communicating differently with the local population in the very near future to try to provide assurance that our services and facilities are safe to use.

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

- about to start building work on a new facility to be co-located to Charnley Ward (planning permission permitting) to enable us to co-locate all our urgent care assessment and provide a new model of care for patients
- will also be reorganising the facilities on the ground floor next to our ED to provide enhanced frailty assessment space and support the speedier and better flow and care for our older people attending our ED
- have created the ability for us to have separate level 3 critical care facilities for known COVID and confirmed non-COVID patients in the future
- created a Level 1 facility
- opening our on-site fracture clinic space in the autumn
- building a long awaiting high quality staff area (Alex Lounge)
- expanding our multi-faith space for colleagues and patients
- re-providing all of our staff training and education facilities

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

Other winter preparation includes the important ability to provide all our colleagues with access to the 'flu vaccination. Our vaccination programme will start in September and learning from last year's campaign as well as recent COVID testing has been taken to ensure that we are able to quickly and effectively mobilise colleagues to provide the vaccination to all our people.

(3) New hospital

Work is progressing at pace on the development of the new hospital and hasn't slowed despite the management of the COVID-19 pandemic.

Our preferred way forward, agreed by the Trust Board in March 2019, is to build a new hospital on a greenfield site next to the new junction 7a on the M11. We are working this up in detail, together with 3 other options (Business As Usual (current site with planned developments); Do minimum (part rebuild and part refurb of the current site); and new build on the current site) which will form an Outline Business Case. This will be complete by March 2021.

The new hospital programme is well resourced with support and expertise employed from programme managers, planners, land agents, architects, mechanical and engineering specialists, health planners and communications support. The clinical teams have been developing innovative new models of care for the future for integrated care across all specialties, and this work will support the schedule of accommodation, due to be complete by the end of August.

Our engagement programme has started with colleagues and with the public. We have had more than 300 responses over the last week to social media requests for members of the local population to join patient and visitor focus groups and the new hospital microsite website will be up and running in early August. Staff focus groups are running and will continue through the summer.

The new hospital programme is overseen by the New Hospital Committee, a formal committee of the Trust Board and supported by a New Hospital Executive group and a number of key workstreams. We are in regular fortnightly formal discussions with regional NHSE/I colleagues and frequent formal discussions with national NHSE/I and DHSC colleagues.

Our timeline to completion remains challenging and ambitious with Full Business Case to be completed by June 2022, enabling us to have built relevant new facilities by the end of 2025.

The new PAHT remains a vital part of our local clinical strategy, transformation and modernisation plans as well as a vital part of the local West Essex integrated care plans. It will support our ability to work much more at a 'place' level, with a wider focus on the health of the local population as a whole, and our transformation, service provision and success are fundamental to the opportunity, ambition and pride of the local population and achieving the transformation of Harlow as a place. Our plans and growth assumptions are aligned with the Hertfordshire and West Essex ICS' medium term financial plans.

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

We continue to work at pace and closely with our West Essex health and care colleagues to develop more system wide clinical pathways for the benefit of our patients. The response to the COVID-19 pandemic was fantastic across the whole system and this has paved the way for speedier integration of some services across the health and care sectors locally.

Our focus is on the transformation and modernisation of care pathways across all local health and care organisations to improve patient outcomes and experiences and the local population's health generally. The provision of different models of care, increased out of hospital care and radically transformed outpatient care are also all integral to the plans for a new hospital and the wider development and regeneration of the local area and aligned with the NHS Long Term Plan. Other areas of focus at the moment include community based ophthalmic services, development of more of an integrated urgent care service for our frailer population and heart failure services, as we continue to develop our 5-year Alliance contract with Essex Partnership University NHS Foundation Trust (EPUT) for the provision of integrated Musculoskeletal services for the local population.

We are continuing to develop further our plans for taking on the Lead Provider role for other services and pathways for the population of West Essex, but now with any potential formal novation of contracts or integration of non-clinical support services to happen from April 2021 at the earliest.

(5) Executive Director appointments

There are a number of changes afoot to our Executive Director colleagues.

With Dr Andy Morris' retirement in May, I'm pleased to inform the Board that after a recruitment and selection process last week, that I have appointed Dr Fay Gilder as our new Medical Director. Fay will

join us on 2 November from Cambridge University Hospitals NHS Foundation Trust, where she is currently a consultant anaesthetist and the clinical director for improvement and transformation. I want to take this opportunity to say a huge thank you to Dr Marcelle Michail who has been acting into the role since Andy's secondment to the Regional team during the COVID-19 pandemic. Marcelle has shown incredible strength of leadership and clarity of decision making over what has been some extraordinary months, has improved and increased medical engagement, led from the front and she has been a delight of a colleague to work with.

By the time of the Trust Board we will have interviewed for a new Executive Director role, a Chief Information Officer. The postholder will have responsibilities for the IT and digital agenda of the Trust and will work closely with our Chief Clinical Information Officer (CCIO) and all clinicians to ensure we invest in the right technology for our patients, including the need to upgrade / replace our patient administration system to ensure we have an effective Electronic Patient Record from which decisions can then be made about the need for other clinical systems that communicate effectively with those used by our primary care and community care colleagues. The post holder will also be instrumental in driving a much broader digital strategy for clinical and non-clinical departments, supporting the transformation and modernisation of the services aligned with their local strategies.

Finally, I want to wish Trevor Smith, Finance Director and Deputy CEO, congratulations and best wishes with his appointment to Chief Financial Officer at Essex Partnership University NHS Foundation Trust. Trevor will be leaving PAHT at the end of the month after 7 years here. The role has been advertised and will be interviewed for in September.

Author: **Lance McCarthy, Chief Executive**
Date: **28 July 2020**

The Princess Alexandra Hospital NHS Trust

2.2

TRUST BOARD - 6 August 2020

Agenda item:	2.2
Executive Lead:	Sharon McNally - Director of Nursing, Midwifery and Allied Health Professionals
Prepared by:	Lisa Flack - Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Governance & Quality Finola Devaney – Director of Clinical Quality Governance
Date prepared:	29 July 2020
Subject / title	Significant Risk Register

Purpose:	Approval		Decision		Information	√	Assurance	√

Key issues:	This paper presents the Significant Risk Register (SRR) for all our services. The Significant Risk Register (SRR) is a snapshot of risks across the Trust at a specific point and includes all items scoring 15 and above. In line with the Covid19 responsiveness, recovery and focus on risk - the number of significant risks has seen an increase and there are a total of 117 significant risks with a score of greater than 15. There are 0 risks with a score of 25. The three main themes for the 33 risks that score 20 are relating to the need for new equipment (10), backlog maintenance projects (7), and the EPMA system (3). See section 2.4 to 2.9 Developed during March, the Trust Covid19 risk register is featured in this paper. See section 2.9. In line with the new quality governance structure we are reviewing how risk is managed as an organisation, which includes a refreshed training programme.
Recommendation:	Trust board is asked to i) Note the content of the Significant Risk Register

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

Previously considered by:	Risk Management Group reviews risks monthly as per annual work plan, 15/7/20. Senior Managers Team – 28/7/20
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and the BAF
Legislation, regulatory, equality, diversity and dignity implications:	Management of risk is a legal and statutory obligation
Appendices:	Nil

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1.0 INTRODUCTION

This paper details the Significant Risk Register (SRR) across the Trust; the registers were pulled from the web based Risk Assure system on 8 July 2020. For the first time the Covid-19 Risk Register has been included. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

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

2.0 CONTEXT

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

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

2.2 There are 117 significant risks on our risk register which has increased from (74) in the previous paper discussed in April 2020. The breakdown by service is detailed in the table below.

	Risk Score				
	15	16	20	25	Totals
COVID-19	2 (1)	0 (2)	2 (3)	0 (0)	**4 (4)**
Cancer, Cardiology & Clinical Support	10 (10)	3 (3)	3 (4)	0 (0)	**16 (17)**
Estates & Facilities	11 (17)	11 (1)	1 (2)	0 (0)	**23 (24)**
Finance	0 (1)	0 (0)	0 (1)	0 (0)	**0 (0)**
Information Data Quality and Business Intelligence	1 (1)	0 (0)	0 0)	0 (0)	**1 (1)**
IM&T	1 (1)	2 (0)	0 (0)	0 (0)	**3 (1)**
Non-Clinical Health & Safety	2 (3)	1 (0)	0 (0)	0 (0)	**3 (3)**
Nursing	0 (1)	0 (0)	0 (0)	0 (0)	**0 (0)**
Operational	1 (1)	0 (0)	4 (4)	0 (0)	**5 (5)**
Patient Safety & Quality	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Research, Development & Innovation	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Resilience	1 (1)	0 (0)	0(0)	0 (0)	**1 (1)**
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Child Health	1 (1)	0 (0)	5 (4)	0 (0)	**6 (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)**
Family & Women's Health	5 (5)	0 (1)	0 (0)	0 (0)	**5 (5)**
Medicine	5 (5)	9 (10)	4 (6)	0 (0)	**18 (21)**
Surgery	10 (12)	4 (4)	13 (14)	0 (2)	**27 (32)**
Totals	**51 (33)**	**33 (23)**	**33 (18)**	**0 (0)**	**117 (74)**

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

2.3 There are 33 risks with a score of 20; this has increased from 18 in the April 2020 paper. A summary of these risks is below and all new risks identified since April is detailed are:-

2.4 Our Patients

2.4.1 EPMA system

- To reduce risk of incorrect does of medication being given, the prescriber has to apply dose reductions in a specific way on the EPMA system (CMS/2019/360 on register since January 2019)
- To reduce risk of incorrect does of medication being given, the prescriber has to apply dose reduction of oral chemotherapy on each different administration day on the EPMA system (CMS/2019/383 on register since February 2019)
- Manual validation of every action performed by each new visions of EPMA is required as fixed issues on previous versions become live again (temporary RR1 raised in February 2020).
  Actions: Communications shared with prescribers and drug administrators for the steps/actions they need to take to mitigate these risks. Continuous mitigations need to be performed by pharmacists (30), nurses (20) and doctors (10) on the system. The numbers represent the total number of mitigations that each staff group needs to complete. Supplier aiming for version 7 update by November 2020

2.4.2 Clinical Equipment

2.4.3 Purchase additional paediatrics equipment due to the current stock, with no parts available should a repair be needed or additional items are required to meet new models of care:

- Additional cardiac monitors are required (Dolphin02/2018 initially raised August 2018, and score increased February 2020, because the was an increase in the number of monitors that could not be repaired)
- Paediatric transport ventilator required (CH15/2020, initially raised November 2019, score increased March 2020). Historically, the paediatric department have always used the transport ventilators from critical care. However, as a result of Covid and an increasing numbers of critically ill adults and the potential for children, the paediatric team require their own transfer ventilator to use in the department until a child is retrieved if necessary, rather than being reliant on the single unit in critical care.
- **NEW:** Additional paediatric echocardiograph machine required (CH/06/2019 raised January 2019 and score increased May 20) as new national guidance released which increased our risk.
- **NEW:** CPAP machines required for respiratory support (CH16/2020 raised May 2020) as potential for use is increased due to Covid.
  Actions: Requests for all 4 pieces of equipment were approved by capital review group in July. Expect delivery by week commencing 7 September 2020.

2.4.4 Surgery: Purchase additional equipment as the current stock can no longer be repaired:

- Replace the cardiopulmonary exercise testing machine (Anae 001/2020 raised February 2020)
  Action: Gathering quotes for competitive pricing, will complete an ATI by 30/9/20
- Purchase a dermatome used for skin grafting in theatres (The002/2020 raised February 2020)
  Action: Order submitted May 2020, expect delivery by end July 2020

2.4.5 Ophthalmology: Purchase additional equipment due to the current stock can no longer be repaired or that additional items are needed to meet new models of care:

- Purchase ORA system for ophthalmology (OPH002/2 020 raised February 2020)
  Action: Order submitted to the supplier In April, as it will be custom made, anticipate delivery by end of July 2020.
- Replace the Nidek Tonoref III machine for ophthalmology (OPH003/2020 raised February 2020)
  Action: Order raised April, and product delivered 18/6/2020. Surgery to commence use after staff have received training in July.

- Purchase ocular visualisation machine for glaucoma patients in ophthalmology (OPH004/2020 raised February 2020)
  Action: This equipment has been purchased, however use is delayed as it will generates aerosols. The ophthalmology team are awaiting the national guidance to assist in decision making regarding next steps.
- **NEW:** Purchase additional Medisoft modules to have one for each of the ophthalmology specialities cared for in the Trust (OPH005/2019 initially raised May 2019, score adjusted May 2020)
  Action: Business case accepted in May 2020, order raised. Company will build the system to fully integrate with Cosmic and other Trust IT systems. Anticipate delivery in approx. 6 months and aiming for use by February 2021. The current software will continue to be used until the new system is available.

2.4.6 Endoscopy

- The air handling unit does not comply with H&S recommendations (Endo 080719, on register since July 2019)
  Action: Installation of the air handling unit is in progress. This was delayed due to Covid19 restrictions, the anticipated handover to the Trust is by 31/7/2020
- To comply with national guidance Trust needs to purchase 3 drying storage cabinets for endoscopy/colonoscopies (Endos15 raised February 2020)
  Action: ATI written and signed off by all local stakeholders. For discussion at Capital group in July 2020.

2.4.7 Theatres

Water ingress due to structure of the roof, results in leaks, impacting the use of theatres for surgery and the sterile supply storage area.

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

2.5 People

2.5.1 Medical staffing

- **NEW:** 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.
- **NEW:** To deliver sufficient clinic capacity to meet the growth in the numbers of patients with glaucoma, additional doctors are required. (OpH004/2019 on register since June 2019, score amended in April 2020)
  Action: New consultant post holder started Sept 2019, fail safe officer appointed, establishing virtual and outsourced clinics to deliver additional capacity. Locums deployed to support the service. Of note, the ophthalmology action plan has executive oversight and a CEO assurance panel was held in July 20.

2.6 Performance

2.6.1 ED performance

Five 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 (3/2016 on register since July 16) for operational team register.
- Two risks for Medicine about achievement of the ED four hours standard (MED57 on Medicine register since July 2016) and (ED012 on Medicine register since July 2016)
  Actions: Rapid assessment and treatment process monitoring flow through department. Actions taken on safety rounds, timely escalation with clear triggers. CDU and ENP pathways being rewritten. ED remedial action plan monitored through Urgent Care Programme Board.

2.6.2 Cancer access standard

- Not achieving 85% of all patients referred by GP to receive treatment within the cancer 62 day standard (005/2016 on register since July 2016)
  Actions: Weekly patient tracking and escalations to Head of Performance. Cancer Board monitor pathways, improvement plans if required and weekly monitoring of performance.

2.6.3 Clinic Capacity

Ophthalmology

- **NEW:** Unable to undertake planned follow up within the required timeframe (OPH001/2018 initially raised November 2018, score amended April 2020)
  Action: Reviewing patients to determine those requiring diagnostics, virtual or face to face clinic appointments. Additional weekend clinics commenced. Of note, the ophthalmology action plan has executive oversight and a CEO assurance panel was held in July 20.

2.7 Places

2.7.1 Environment

Structure of the portacabin office location for the safeguarding teams.

- **NEW:** The building requires substantial refurbishment (EFM019 initially raised July 2019, score amended May 2020 on estates register)
- NEW: Refurbishment required to the portacabin office location (ASG/04/2019 on Safeguarding register initially raised July 2019 and score amended July 2020).
  Action: Space utilisation group identifying staff groups that can relocate to Kao Park, in turn this will free up space to relocate the safeguarding team into on site at PAH.
- Penn ward requires refurbishment. (Penn001/2020 raised January 2020)
  Action: Capital funding requested for completion of work during 20/21. Awaiting confirmation if this has been approved.

2.8 Pounds

2.8.1 No finance risks detailed

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

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

- **NEW:** Use of anaesthetic theatre machines (off label as long-term ventilator for ICU patients has received regulatory clearance). It is the sole responsibility of the device owner (the Trust) and is a risk. (C19-34 raised April 2020)
  Action: All controls are in place and are effective. Trust has requested 40 additional ventilators from NHSE

3.0 New Risks on the Significant Risk Register

3.1 Six significant risks scoring 15 or 16 have been raised since April 2020

3.2 New Risks - Score of 16

- **NEW:** Staff need to work at height to upgrade critical plant (EFM061 raised April 2020)
  Action: Contractors produce specifications showing how they will work safety and ensure risks are assessed.
- **NEW:** Patients are not visible on the patient tracking lists (PTL) on Cosmic, and continued care planning lists (CCP) on Cosmic (S&CC002/2929 raised May 2020)
  Action: Review being undertaken through operational group of patients on waiting list.

3.3 New Risks - Score of 15

- **NEW:** Not knowing Covid status of all patients could lead to infected patients being warded resulting in transmission to staff and patients (C19-019 raised April 2020)
  Action: In-house testing introduced in June and Trust complies with national guidance for testing of patients at day 1 and day 5
- **NEW:** Risk that during a Covid surge, insufficient staff trained in critical care will be available to transfer patients to other Trusts (C19-038 raised April 2020).
  Action: Transfers to be planned for daylight hours only, lower risk patients identified for transfers, a transfer team to be identified on the rota
- Transmission of Covid from or by pre/asymptomatic patients /staff could lead to increasing the numbers of patients and staff affected. (C19-050 raised June 2020)
  Action: Admission screening for patient's day 1, 5 with wards divided into red /green areas. Staff adhering to PPE guidance and all people to socially distance.
- Trust does not have anti-ligature bathrooms, these are required for high risk patients (EFM076 on register since June 2020)
  Action: reviewing the clinical assessment of high risk patients with our mental health partners and requested funding through the Capital plan for 20/21

4.0 RECOMMENDATION

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

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2.3

Trust Board - 6 August 2020

Agenda Item:	2.3
Presented by:	Head of Corporate Affairs - Heather Schultz
Prepared by:	Head of Corporate Affairs - Heather Schultz
Date prepared:	31 July 2020
Subject / Title:	Board Assurance Framework 2020/21

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Board Assurance Framework 2020/21 is presented for review. Risks, risk ratings and outcomes of Committee reviews in month are summarised in the attached appendix and detailed BAF risks as at the end of July 2020 are also attached. There are no changes to the risk scores this month. A new risk has been added to reflect the risk of delays to the delivery of the new hospital, Risk 3.5 and is scoring 16. The risk is monitored at the New Hospital Committee and the Director of Strategy is the executive lead for the risk.
Recommendation:	The Board is asked to approve the Board Assurance Framework and note the new risk.

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 July 2020.
Risk / links with the BAF:	As reflected in the attached BAF.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with national legislation and regulations and the Code of Governance.
Appendices:	Appendix A summary, and Appendix B - Board Assurance Framework 2020/21

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5P	Executive Lead	Committee	BAF Risks July 2020	Current risk score	Trend
	Chief Executive	QSC	1.0 Covid-19: Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered.	16	
	Chief Nurse/Chief Medical Officer	QSC	1.1 Outcomes:Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	16	
	Chief Finance Officer/DoI&IT	PAF	1.2 EPR Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes	16	
	DoP	WFC	2.3 Workforce: Inability to recruit, retain and engage our people	12	
	DoS	PAF	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	
	DoS	Trust Board/ Strategy Committee	3.2 Financial and Clinical Sustainability across health and social care system Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system.	16	
	DoS	Trust Board/ Strategy Committee	3.3 Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	12	
	DoS	Trust Board/ Strategy Committee	3.4 Sustainability of local services Failure to ensure sustainable local services continue whilst the new hospital plans are in development and funding is being secured.	16	
	DoS	Trust Board/ New Hospital Committee	3.5 New Hospital: There is a risk that the delivery of the new hospital will be delayed because of failure to engage with a suitable contractor or that the additional funding is not forth coming from the JIC even if the 3 conditions are met	16	NEW RISK
	COO	PAF	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	16	

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

The Princess Alexandra Hospital 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 Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objectives 1-5													
BAF 1.0		**COVID-19:** Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered.	Causes: i) Highly infectious disease ii) Failure of public to adhere to Public Health messages and increasing Covid demand iii) National issues regarding supply chains iv) Configuration of PAHT estate v) Current vacancy rates vi) Public perceptions around accessing services as normal	**5 X 5= 25**	Chief Executive supported by Executive team QSC	i) Level 4 national incident declared by NHS England ii) PAHT incident co-ordination centre and incident management team established iii) COVID-19 incident management governance structure in place iv) Compliance with national directives v) Ongoing engagement with STP and Local Resilience Forum, Local Delivery Board re-instated vi) COVID-19 patient pathways instigated vii) Staff being redeployed to provide additional support viii) Non COVID Priority Business Cell established for business as usual matters ix) Daily executive oversight of incident management x) Recovery and restoration planning (PAHT/ICP and ICS) xi) Separation of hospital into Covid and Covid free areas xii) Use of independant sector for elective surgery	i) Incident Management Team Meeting ii) Strategic Incident Management Cell iii) IPC Cell iv) Site Management Cell v) Communications Cell vi) People Cell vii) Recovery Cell viii) Clinical Cell	i) Incident management action and decision logs (daily) ii) QSC updates (March, to July 2020 iii) Trust Board updates (March, to August)	**4x4=16**	i) Loss of staff with key skills and training due to virus; shielding/isolating or sickness ii) Reliance on supplies nationally iii Modelling information for next peak (local, regional and national) dependant on lock down and public behaviour v) Plans for use of the Rivers	Compliance with risk assessments.	24.07.20	No change to risk score.	**5x2=10 (April 2021)**
			Effects: i) Increased numbers of patients and acuity levels ii) Shortages of staff, staff shielding and increased sickness iii) Shortages of equipment, medicines and other supplies iv) Lack of system capacity v) Staff concerns regarding safety and well-being vi) Changing national messaging vii) Potential for patient harm due to cancellation of elective surgery											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients, integrating care with our partners and improving our CQC rating													
BAF 1.1		Variation in outcomes in clinical quality, safety, patient experience and higher than expected mortality.	Causes: i) Unwarranted variation in care ii) System wide flow iii) Workforce gaps	4 X 5= 20	Director of Nursing/ Chief Medical Officer **Quality and Safety Committee**	i) Robust quality and safety governance structures in place including infection control ii) Robust Appraisal/ medical and nursing iii) End of Life and deteriorating patient simulation programme for all staff, across ICP and ICS iv) Education & training in communication skills such as breaking bad new s training. v) Sharing the Learning Programme vi) Commissioner review s 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) NHS/HSE Oversight xii) Red2 Green Board rounds supported by ECIST xiii) Patient Experience Strategy xiv) NED lead appointed for Mortality xv) Mortality Strategy including dashboard, tracker, updates on w orkstreams and learning from deaths. xvi) '15 steps' w alkabouts xvii) Nursing Establishment review (bi-annually) and succesful nursing recruitment campaign xviii) Safer Staffing policy xix) Real time patient feeback implemented across all w ards xx) Robust management of variations in neonatal outcomes xxi) Engagement in external review s 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 w orkshops held xxiv) Joint GIRFT and Modal Hospital quality improvement programme xxv) Patient flow module live xxvi) Electronic fluid prescribing pilot live xxvii) Appointment of medical PSIQ leads xxviii) Complaints process being revised and grading system introduced xxix) Fab Change accreditation xxx) Quality peer review process in place xxxi) Covid-19 governance structure/meetings in place	i) National Survey ii) Cancer Survey iii) CEO Assurance Panels iv) SIG meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings, PRMs and Patient Experience meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings/ Vulnerable Patient Group x) PLACE Inspections xi) Medicines Management Committee xii) End of Life and Mortality Surveillance Group xiii) AKI & Sepsis Group xiv) Urgent Care Improvement Board xv) Deteriorating Patient Group xvi) Cardiac arrest review panels xvii) Weekly Long Length of Stay meetings xviii) Quality Compliance Improvement Group	i) CEO Assurance Panels (as required) ii) Reports to QSC on Patient Experience March 2020, monthly Serious Incidents, monthly Safer Staffing, Patient Panel (bi-monthly) , Safeguarding, monthly Infection Control and Covid-19 updates iii) Monthly Mortality Improvement report to QSC including updates on ME reviews and monthly IPR report iv) Dr Foster reports, CQC inspection reports (March 18 and draft June 19) and GIRFT reports v) Real time Dr Foster reports and engagement vi) GMC Survey results (July 2019) and WFC report June 2020 vii) Clinical Audit internal audit report 18/19 - tiaa (limited assurance) viii) CMO/CFO Coding Meetings and quarterly Coding reports to PAF ix) Positive staff survey outcomes (2019) measuring safety culture and engagement x) Freedom to Speak Up Guardians quarterly reports to WFC (March 20) and Guardian of Safe Working reports to Trust Board (Dec18). xi) Patient stories and learning from deaths presentations to Public Board meetings (bi-monthly) xii) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) xiii) International Nurse Recruitment business case to SMT/PAF and Board (June/July 19) ~~xiv) Presentation to Board on role of Medical Examiner (Jan 2020)~~ xv) Presentation to QSC on documentation and strategic direction to having one electronic system (QSC February 20) xvi) Critical care network review peer review April 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 dine to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site footprint and bed constraints iv) Access to Qlikview v) NICE oversight and management of compliance with guidance vi) Frequency and consistency of approach to mortality reviews vii) **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey action plan in place iii) Ongoing work with Dr Foster in relation to mortality iv) Review of quality/safety and risk leadership structure v) NHS Patient Safety Strategy 2019 published. Trust to review and align to best practice vi) Structured Judgement Review champions being appointed	i) Clinical evidence of improvements made following compliance with national audits, NICE,NCEPOD. ii) Demonstrating an embedded learning programme from Board to ward.	18/07/2020	Risk rating not changed	4x3=12 September 2020
			Effects: i) Increase in complaints/ claims or litigation ii) Persistent poor results in National Surveys iii) Poor reputation iv) Recurrent themes in complaints involving communication failure v) Loss of confidence by external stakeholders vi) Higher than expected Mortality rates											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients, integrating care with our partners and improving our CQC rating **Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2020/21 and our local system control total**													
BAF 1.2		**EPR** Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes.	Causes: i) Poor engagement with the system, usability, time/skills ii) Timely system fixes/enhancements	5 X 4= 20	Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iv) Performance Mgt Framework in place. v) Training programme. vi) Super users in place to deliver focused support. vii) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability viii) Access Policy ix) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) x) Development of capacity planning tools/information x) PWC review and actions identified xii) ICT Newsletter issued xiii) Daily ICT/COSMIC meetings ongoing xiv) Real time data now available xv) CDS 011 now live xvi) Maternity MDS configuration completed. xvii) Monthly Contract Performance monitoring meeting with supplier established.	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews vii) Monthly EPR Board to Board meetings viii) Exec to Exec meeting on 25.11.19	i) Weekly Data Quality reports to Access Board and EDB ~~ii) External Audit reports to Audit Committee on Quality Account Indicators (July 19 - adverse conclusion)~~ iii) Monthly DQ reports to PAF and quarterly ICT updates iv) EPR outline business case developed and presented to SMT and PAF September 19.	4 X 4= 16	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Compliance with refresher training vii) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed. Responsiveness and quality of delivery of PFM - testing processes and actions identified by tiaa internal audit (limited assurance).	Jul-20	Risk rating unchanged	**4x3=12 end of ~~March~~ November 2020 (subject to monthly review of progress)**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** i) Ongoing training and support ii) Re-establishing relationship/engagement with Cambio iii) Refresher training underway iv) Revised roadmap to incorporate new statutory/legal requirements e.g GDPR				

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

The Princess Alexandra Hospital Board
Assurance Framework 2020-21

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered.		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
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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	**Effects:** i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels	**4 X 4 =16**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) Event in a Tent held annually viii) Staff recognition awards held locally and trust wide annually ix) Enhanced controls around temporary staffing x) Line Manager development programme underway xi) Behaviour workshops held xii) New consultant development programme launched xiii) Staff engagement groups and Staff Council xiv) International recruitment programme for nurses and ED doctors xv) Medical staffing review underway xvi) Additional recruitment ('Bring back staff') during Covid xvii) Provision of Health and Well-being support during Covid-19 including psychological support.	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 IPR (monthly) ii) People strategy deliverables iii) Staff survey results 2019 (WFC March 2020) iv) Staff friends and family results (WFC March 2020) v) Medical engagement surveys, action plans and GMC surveys (WFC November 2019 and June 2020) vi) WRES and WDES reports 2020	**4 x3 = 12**	Pulse surveys targeted for all staff Communications strategy Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Roll out of e-rostering to all areas ~~Management of staff health and well being during and post Covid~~ Actions i) Implementation of communication strategy - Q3 2020/21 ii) Recruitment plans for medical staff iii) Extranet for staff - Q1 20/21 iv) Staff survey action plan/health and well being, manager development and learning culture (Q2 20/21) ~~v) Ongoing psychological support for staff to be put in place - Covid-19~~ v) Completion of risk assessments (target of 100%) - Q2 vi) OD plan to support PAHT 2030 - Q3 vii) Refresh of culture plan - Q3	None identified.	20/07/2020	**Risk score not changed.**	**4 x2 = 8 (at end of 5 year People Strategy but to be reviewed in September 2020)**
			Effects: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation											

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

Risk Key														
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High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
Medium Risk		4-6												
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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
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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 Strategy Committee	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) STP Estates Strategy being developed. viii) STP Clinical Strategy in place ix) STP wide Strategy Group implemented x) Independant STP Chair and independant STP Director of Strategy appointed. STP meetings focussing on management of Covid-19	STP CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) STP Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and STP updates iii) STP report to Strategy Committee (Oct 2019) iv) STP lead's presentation to Trust Board (Aug '19).	**4 X 4= 16**	Lack of STP demand and capacity modelling. **ACTIONS:** System agreement on governance and programme management System leadership capacity to lead STP-wide transformation Trust to nominate representatives on proposed STP/ACP workstreams		01/07/2020	**No changes to risk rating.**	**4x3=12 September 2020**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

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		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
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	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 Jan 2020	**4x3=12**	i) Data quality impacting on business intelligence (SLR) **ACTIONS:** PAH long term strategy being developed	~~Reporting from EOCs/workstreams to be established.~~ Development of governance structures for integration and legislation CCG Accountable Officer process completed and new management structures.	01/07/2020	**Risk rating not changed.**	4 x 2= 8 **September 2020**
			Effects: i) Poor reputation ii) Increased stakeholder and regulator scrutiny iii) Low staff morale iv) Threatened stability and sustainability v) Restructuring fails to achieve goals and outcomes vi) Impact on service delivery and quality of care vii) Poor staff survey viii) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure ix) Undermines regulatory confidence to invest in hospital/system solutions											

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		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
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	Strategic Objective 3 : Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.4		**Sustainability of local services** Failure to ensure sustainable local services continue whilst the new hospital plans are in development. ~~and funding is being secured.~~	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in backlog maintenance iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) Complexity of STP vii) Insufficient quantity and expertise in workforce capability	**4 X 4= 16**	Director of Strategy New Hospital Committee	i) Potential new build/location of new hospital ii) STP Footprint and Estate Strategy developed. iii) Herts & West Essex STP Estates workstream iv) Pathology workstream led by CEO v) Estates and Facilities Infrastructure subgroup for West Essex vi) SOC affordability model vii) SOC approved and submitted to NHSI viii) Detailed analysis of current site option commissioned ix) Master planning work being aligned to Six Facet Survey and Health Planning, phasing of development on PAH site or off site. x) Alignment of strategic capital and tactical capital plans xi) MSK service developments underway xii) Funding confirmed xiii) PAH part of HIP 1 funding programme for capital investment xiv) PCBC completed, submitted and reviewed by NHSI xv) New members of strategy team appointed xvi) OBC in development (completion date is March 2021)	i) PAF, Strategy Committee and Board meetings ii) SMT Meetings iii) Capital Planning Group iv) Weekly Estates and Facilities meetings v) Stakeholder group vi) New Hospital Committee established	i) STP reports to Strategy Committee (bi-monthly) ii) Reports to SMT iii) STP work plans iv) Our New Hospital reports to Strategy Committee (Oct 2019 and updates to Board (May 2020). v) PAHT 2030 report to Trust Board (April 2020) vi) PCBC approved at Trust Board (September 2019) ~~vii) MAU business case approved at Trust Board September 2019~~ vii) New hospital update to Trust Board (May 2020)	**4 x 4 = 16**	i) Balancing short term investment in the PAH site vs the required long term investment ~~Gaps in Strategy team~~ Availability of clinical and non-clinical staff to provide input on plans during Covid. **ACTIONS:** Clinical strategy being developed and underpinned by 5P plans ~~Phase II work underway~~	i) Clinical strategy in development	01/07/2020	**No change to residual risk rating.**	**4 x 3 =12** **March 2021 (on completion of OBC)**
			Effects: i) Failure to deliver strategy and transformation project and service changes required for service and performance enhancement ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant vii) Poor patient experience, viii)Backlog maintenance ix) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health. x) Lack of integrated approach xi) Increased risk of service failure xii) Impact on throughput of patients												

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		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
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BAF 3.5		**New Hospital:** There is a risk that the delivery of the new hospital will be delayed because of failure to engage with a suitable contractor or that the additional funding is not forthcoming from the JIC even if the 3 conditions are met.	Causes: i) Challenged contractor market/insufficient skills and capability ii) Competition in the market due to large number of HIP schemes iii) High profile failures in hospital construction	**5 X 4= 20**	Director of Strategy New Hospital Committee	i) Soft market testing underway (contractors) ii) Detailed programme of work iii) Monthly meetings with national cash and capital team iv) Weekly meetings with regional team v) Weekly meetings with landowners vi) HOSC meetings held and agreement reached that consultation is not required	i) New Hospital Committee ii) Trust Board iii) External advisory meetings as required.	i) Monthly reports to Trust Board and New Hospital Committee. Ii) Letters of support received from HOSCs. Iii) Verbal confirmation received that programme management structure is appropriate. Iv) Expert advice received on procurement strategy.	**4x4=16**	Negotiations with landowners in the early stages.	None.	Jul-20	**New risk**	**3x3=9 (Nov 2020)**
			Effects: i) Significant delay/failure to deliver hospital by 2025 deadline ii) Increase in Capital costs through inflation iii) Delivery of a suboptimal hospital											

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		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
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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) Gaps in medical and nursing workforce iv) Lack of public awareness of emergency and urgent care provision in the community. v) Attendances continue to rise annually (5.1% over the last 2 years). vi) Changes to working practice and modernisation of systems and processes vii) Delays in decision making, patient discharges and delays in social care and community impacting on flow viii) Increases in minor attendances	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Escalation calls with NHSI vi) Work in progress to develop new models of care vii) Local Delivery Board in place viii) System reviewing provision of urgent care ix) Exec attendance at safety huddles x) ED action plan reported to PAF/Board xi) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries xii) Protection of assessment capacity work underway xiii) Weekly Urgent Care operational meetings and Urgent Care Board in place xiv) On site support from ECIST and NHSI medical lead xv) Focus on length of stay in ED for all patients xvi) Focus on improving assessment capacity xvii) GP attending weekly length of stay review meetings xviii) Covid controls in place including separation of ED, new pathways in place, reduced ED attendances xix) Improved ambulance handover process and improved staffing levels	i) Access Board meetings ii) Board, PAF and SMT meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) Escalation meetings with NHSI~~/NHSE~~ vii) Weekly HCG reviews viii) System Operational Group ix) Weekly Length of Stay meetings	i) Daily ED reports to NHSI ii) Monthly escalation reports to NHSE iii) Monthly PRM reports from HCGS iv) Monthly IPR reported to PAF/QSC and Board reflecting ED performance - delivery of standard has improved in the 4 weeks prior to review of risk.	**4x4=16**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings and weekly Urgent Care Board review	None noted.	01/07/2020	**Risk score not changed.**	**4x3 =12 September 2020 (on consistent delivery of standard - 95%)**
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2020/21 and our local system													
BAF 5.1		**Finance** Concerns around failure to meet financial plan including cash shortfall.	Causes: i) Operational performance impacting on financial performance including recovery of PSF/FRP ii) CCG affordability, QIPP's, contractual disputes and challenges, iii) ability to deliver recurrent CIP's, iv) workforce shortages and associated temporary staffing usage/costs v) high levels of unplanned expenditure including maintenance of aging estate, vi) Capture and billing of activity. vii) Potential impact of pension changes	**5 X 4= 20**	**Exec leads :** CFO **Committee** : Performance and Finance Committee	i) Access to Interim Revenue Support loans ii) Cost Improvement Programme iii) Formal reconciliation process with CCG iv) Internal and external Agency controls and reporting v) SMT, PAF and Audit Committee vi) Health Care Group PRM meetings vii) Enhanced Performance Reviews viii) Regular Balance sheet reviews ix) Approved Governance Manual x) Budget sign off process xi) Enhanced financial reporting and controls xii) Regulatory returns required e.g. agency spend xiii) Increased frequency of reporting for selected HCGs xiv) Medical agency protocol xv) Financial Recovery Plan - due Sept 2019 xvi) Demand and Capacity planning and HCGs year end forecasts xviii) Use of resources assessment 26.03.19 xxvix) The Trust and CCG are jointly developing revised system financial principles e.g. allocative/block payment or minimum guarantee payment xxx) CCG/STP/Central allocations and support at ICP and STP level	i) Internal Audit & External Audit opinion. ii) External reviews iii) NHSI/E reporting iv) Internal Trust reporting v) Cash Management group vi) Joint meetings with CCG vii) Delivery Group - weekly viii) Staffing Task Group and CQUIN Group	i) Monthly reports including bank balances and cash flow forecasts to PAF and Board ii) CIP reports iii) Internal Audit reports: Financial Reporting and Budget Monitoring (substantial assurance) Key Financial Systems (substantial assurance) Non-SLA Income (limited assurance) iv) Financial Recovery Plan v) FAM reports monthly vi) PRM packs monthly vii) Recovery plans and trajectories reported to Delivery Group (weekly) viii) Temporary staffing action plan (Board July 2020)	**5 x 4 = 20**	i) Organisational and Governance compliance e.g. waivers ii) Activity and capacity planning iii) CIP delivery iv) CQUIN - risk of recovering full income v) Management of temporary staffing costs	Demand and Capacity Workforce planning	01/07/2020		4 x 3 =12 (end Sept 2020)
			Effects: i) Ability to meet financial control target and loss of £21 PSF/FRF ii) Delay to payment to creditor/ suppliers ii) Increased performance management iv) Going Concern status v) Risk to securing central funds vi) Impact on capital availability vi) Unfavourable audit opinion (VfM,Section 30 Letter) vii) Restrictions on service development viii) Recruitment & retention ix) Increased likelihood of dispute/arbitration processes x)Reputational risks							**ACTIONS:** Future Modernisation Demand and Capacity Planning and Modelling to be regularised Clinical and operational forums in place to review QIPP schemes. ~~Review of Capital reporting and planning for 19/20 underway.~~ Intensive support for job planning, rota and roster management. Focus on Medicine and Surgery HCGs. Review of CIP processes Collective Executive targetting of temporary staffing				

Trust Board (Public) – 6 August 2020

3.1

Agenda item:	3.1
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery
Date prepared:	13 July 2020
Subject / title:	Abridged Report on Nursing and Midwifery and Care Staff Levels (Hard Truths) and an Update to Nursing and Midwifery Workforce Position

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	Staffing risk rating in month: Green This paper sets out an abridged version of the regular nursing and midwifery retrospective staffing report for the month of June 2020 and provides an update to the workforce position (part B). The fill rate for overall RN/RM in month was 105.7% and overall fill rate 100.3% Fill rates have been affected by the continued reconfiguration of the Trusts bed base in relation to Covid. Temporary staff usage has decreased in line with the reduced bed base and agency fill has been limited to hard to fill areas where there is a requirement for a specialist skill such as midwifery or RMN special. The overall nursing vacancy position remained stable in June at 8.4% and the Band 5 rate to 6.9% as due to Covid 19 any significant recruitment activity is on hold and staff are choosing not to leave or transfer employment at this time. Revised recruitment and retention trajectory is being developed based on the changed landscape of international travel.
Recommendation:	The Board is asked to note the information within this report

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

Previously considered by:	WFC.27.07.20 and QSC.31.07.20
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	Appendix 1: Ward level fill rates Appendix 2: Registered fill rates by month. RAG rated.

1.0 PURPOSE

To update and inform the Board on actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff in June 2020. To provide an update on plans to reduce the nursing vacancy rate over 2019/20.

2.0 BACKGROUND

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

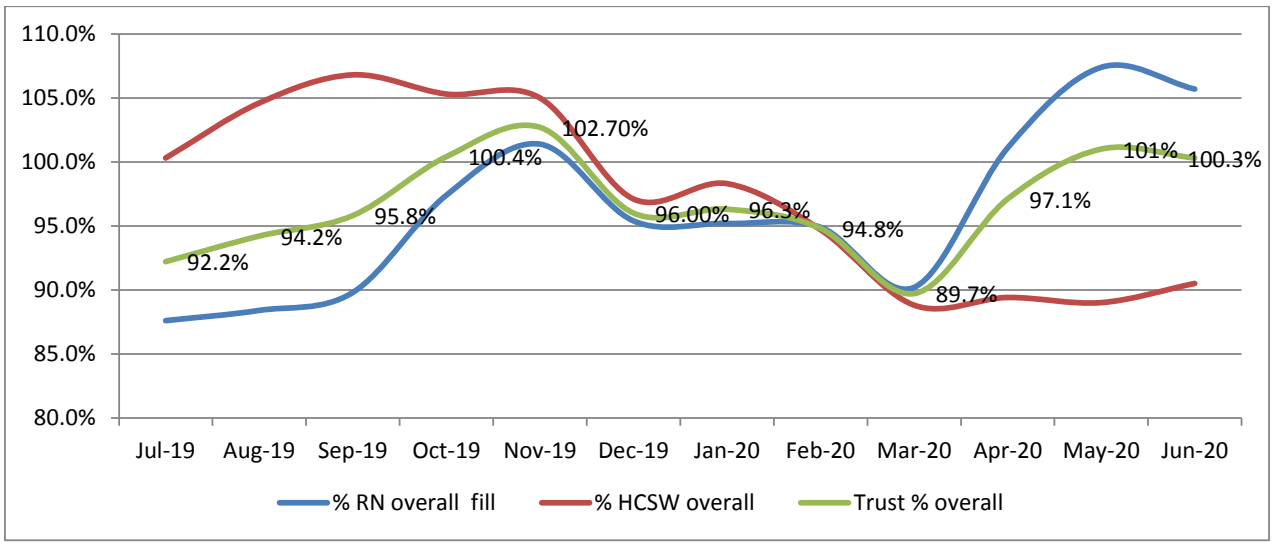
3.0 ANALYSIS

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

3.2 The summary position for the Trust Safer Staffing Fill rates for June 2020. The fill rate for overall RN/RM in month has decreased to 105.7%, which is a decrease of 1.7% against May 2020.

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

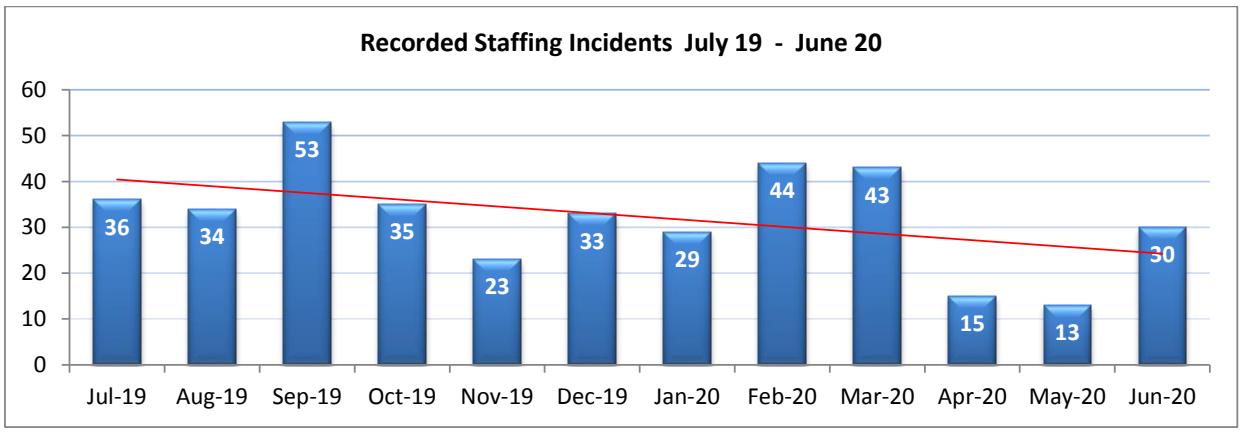
Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
In Patient Ward average June 20	110.1%	94%	100.4%	86.1%	105.7%	90.5%	100.3%
In Patient Ward average May 20	118.8%	94.8%	94.3%	81.9%	107.4%	89.0%	101%
Variance May – June 2020	↓8.7%	↓0.8%	↑6.1%	↑4.2%	↓1.7%	↑1.5%	↓0.7%



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

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
ED average June 20	91%	72%	97%	83%	93.8%	76.7%	87.5%
ED average May 20	89%	81%	106%	86%	96.9%	83.5%	91.9%
Variance May - June 2020	↑2%	↓9%	↓9%	↓3%	↓3%	↓6.8%	↓4.4%

3.5 Datix reports: The trend in reports completed in relation to nursing and midwifery staffing is included below and shows an increase in June. While the significantly improved fill rates continues across the wards, the reason for this increase in staffing Datix reports is due to staff concerns about ward moves and will be monitored going forward to understand if this is the start of an upward trend . All incidents continue to be reviewed by the safety and quality review process.



3.6 Bank and Agency fill rates:

The use of NHSP continues to support the clinical areas to maximise safer staffing, though with ward closures and staff redeployment along with a greater challenge on requirements, there has been a significant reduction in secondary staffing. The main areas utilising extra staff are A&E Nursing and Maternity. The need for secondary staff is reviewed daily at the Safe Staffing daily meeting and all shifts not required are cancelled. The table below shows that there was a large decrease in registered demand (↓875 shifts) in June compared to May. While the overall demand fell by 48% the overall fill rate also reduced by 9.8% to 83.8%. June also shows a dramatic reduction in agency usage.

The HCSW demand shows a corresponding reduction in demand (↓ 672 shifts) with a slight decrease in filtrate.

RN temporary staffing demand and fill rates*: (June 2020 data supplied by NHSP 2.7.2020)*

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
January 20	4324	1903	44.0%	993	23.0%	67.0%	1428	33.0%
February 20	4332	2276	52.5%	939	21.7%	74.2%	1,117	25.8%
March 20	5001	2461	49.32%	945	18.9%	68.1%	1,595	31.9%
April 20	3484	1684	48.3%	714	20.5%	68.8%	1086	31.2%
May 20	1857	1401	75.4%	337	18.1%	93.6%	119	6.4%
June 20	**982**	**748**	**76.2%**	**75**	**7.6%**	**83.8%**	**159**	**16.2%**
June 19	3597	1744	48.5%	1181	32.8%	81.3%	672	18.7%

HCA temporary staffing demand and fill rates: ***(June 2020 data supplied by NHSP 2.7.2020)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
January 20	2732	1855	67.9%	0	0%	67.9%	877	32.1%
February 20	2773	1910	68.9%	0	0%	68.9%	863	31.1%
March 20	3182	2037	64.0 %	0	0 %	64.0 %	1,145	36.0 %
April 20	2352	1391	59.1%	0	0%	59.1%	961	40.9%
May 20	1314	1095	83.3%	0	0%	83.3%	219	16.7%
June 20	**642**	**532**	**82.9%**	**0**	**0**	**82.9%**	**110**	**17.1%**
June 19	2308	1837	79.6%	0	0	79.6%	471	20.4%

B: Workforce:

Nursing Recruitment Pipeline

The overall nursing vacancy rate in June remained static at 8.4%. Bulk International nurse recruitment remains on hold due to Covid 19 travel restrictions but one overseas nurse managed to join the Trust in June. Overseas nurses who joined prior to Covid who had not sat their OSCE have now been invited to sit the test and will then join the NMC nursing register. We have 84 nurses in our international pipeline of which 13 have their visas secured and are waiting for travel restrictions to be lifted and a further 8 whose visas are in progress. The recruitment and retention nurse is working with the facilities team to explore options to support nurses who arrive and need to quarantine for 14 days on site.

there is a targeted domestic recruitment campaign for HCSW where there is a vacancy across inpatient wards of 70WTE as well as for experienced RN's for ED and RM's for Maternity as both areas have higher than average vacancy rates. There are currently 27 HCSW in the recruitment pipeline.

Turnover rates continue to remain low as follows:

Voluntary Turnover	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Nursing & Midwifery	12.37%	11.33%	11.31%	10.92%	10.43%	9.49%	10.16%	10.80%	10.76%	10.53%	10.18%	10.12%
Unregistered Nursing	16.08%	14.89%	13.95%	12.63%	12.75%	11.52%	12.63%	13.05%	12.33%	12.31%	12.41%	11.40%

A revised recruitment and retention programme is being developed for 2020/21 to take into account the impact of Covid 19 restrictions and the PDT team are working on developing a Band 5 to 6 rapid development programme. Due to Covid requiring the team to focus on upskilling staff as they are reallocated across the wards progress has been slower than hoped. It is the intention that a programme will be in place from March 2021.

4.0 RECOMMENDATION
5.0

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

Author: Sarah Webb, Deputy Director of Nursing and Midwifery
Date: **13th July 2020**

Appendix 1.

Ward level data: fill rates June 2020.

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

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

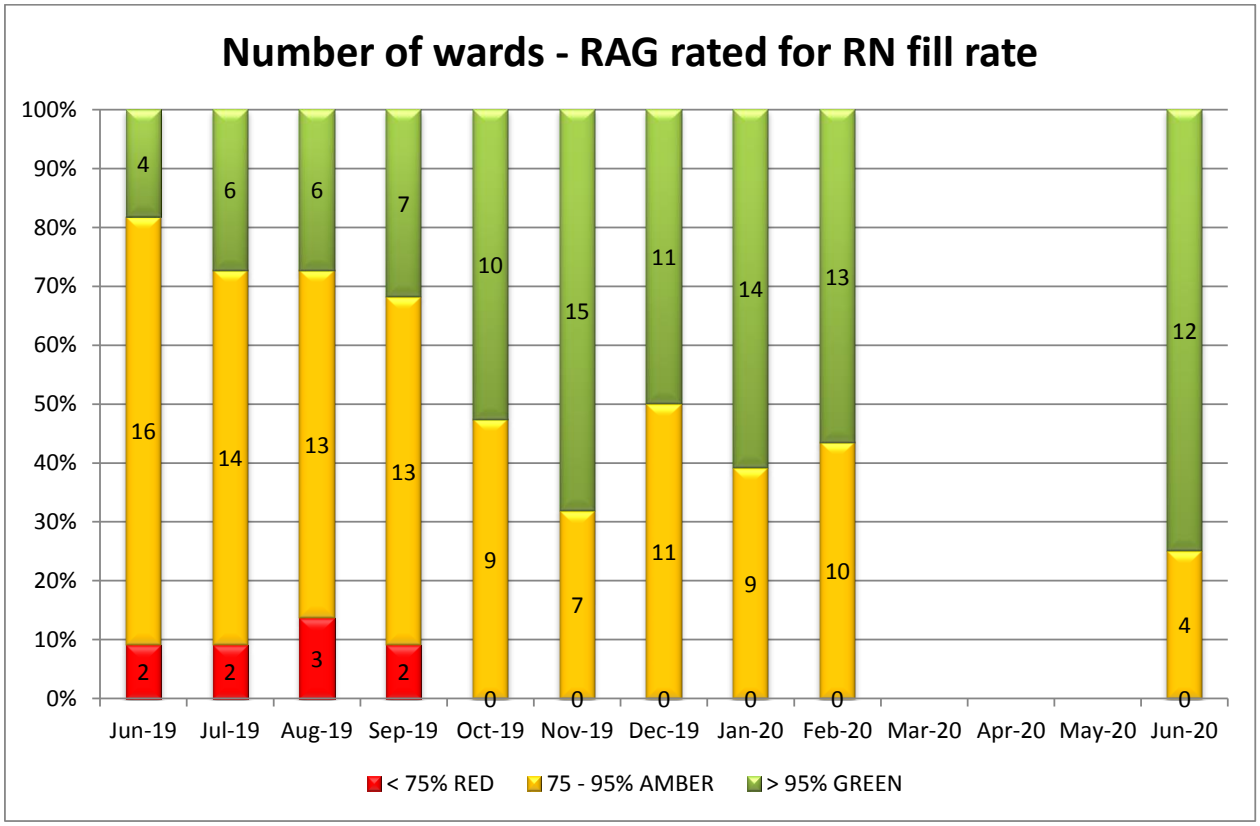
Analysis of areas with red fill rates has not been undertaken this month as there is still a number of DQ issues with the data due to the number of ward moves across the month.

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
ITU & HDU	99.5%	97.1%	88.5%	86.7%	94.0%	91.9%	93.8%
Winter Ward	142.1%	111.1%	112.1%	87.7%	129.4%	101.5%	117.2%
Nightingale Ward	199.8%	140.8%	163.2%	106.4%	182.3%	124.4%	157.5%
Lister Ward	128.6%	97.2%	104.2%	87.8%	118.2%	93.4%	107.4%
Fleming Ward	95.1%	96.0%	91.3%	73.6%	93.3%	86.9%	90.7%
Harvey Ward	96.5%	68.3%	116.7%	74.1%	115.2%	71.1%	94.9%
Saunders Unit	95.2%	74.3%	90.7%	74.4%	93.0%	74.4%	85.3%
Locke Ward	99.8%	79.0%	103.4%	76.7%	101.3%	78.0%	91.1%
Ray Ward	93.2%	83.7%	102.1%	97.2%	96.9%	89.2%	93.5%
Penn Ward	113.5%	112.1%	116.8%	133.3%	114.9%	120.1%	116.8%
Tye Green Ward	117.2%	108.4%	100.0%	102.3%	110.1%	105.9%	108.4%
Harold Ward	102.2%	59.1%	93.3%	71.2%	98.2%	64.0%	82.7%
Kingsmoor Ward	122.6%	124.7%	105.8%	87.8%	114.6%	107.1%	111.3%
Neo-Natal Unit	104.3%	126.7%	101.4%	136.7%	102.8%	131.7%	107.6%
Dolphin Ward	110.0%	119.4%	100.1%	114.6%	105.8%	117.0%	108.3%
Maternity	101.0%	85.6%	87.7%	65.3%	94.7%	75.8%	89.5%
Trust total	**110.1%**	**94.0%**	**100.4%**	**86.1%**	**105.7%**	**90.5%**	**100.3%**

Appendix 2

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

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



The Princess Alexandra Hospital NHS Trust

Trust Board – 6 August 2020

4.1

Agenda item:	4.1
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Information Team/Executive Directors
Date prepared:	July 2020
Subject / title:	M3 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:	**Patients:** A national directive to pause complaints during the pandemic from April to June saw significant decreases in feedback in both complaints and PALS, however, volume of activity has now begun to return to normal **Performance:** Recovery of all access standards are underway and monitored through the weekly recovery group. Inpatient capacity and utilisation of available space to support patient experience and patient flow is reviewed on a weekly basis. **People:** Restarting of mandatory training and appraisals has commenced. Covid risk assessments are currently around 80% completed. **Pounds**: The Trust is reporting break even position as required by the current financial regulations. It continues to reduce its reliance on temporary staffing and to proceed with its capital investments for the year (£45m) P**laces**: Work on the new hospital continues to develop in line with agreed trajectory.
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:	To be considered by PAF.30.07.20 and QSC.31.07.20
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report
June 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.

Contact:

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

respectful | caring | responsible | committed

Trust Objectives

The Princess Alexandra Hospital NHS Trust

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

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

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

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

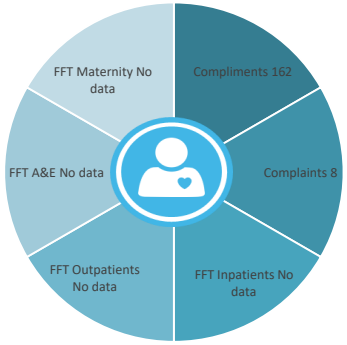
Our Pounds
Manage **our pounds** effectively to achieve our agreed financial control total for 2019/20.

5Ps

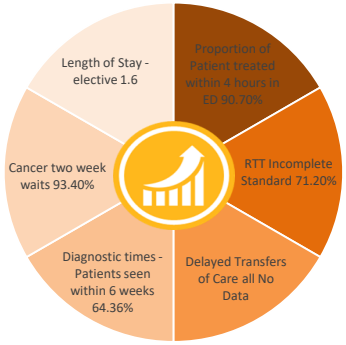
In this month

The Princess Alexandra Hospital NHS Trust

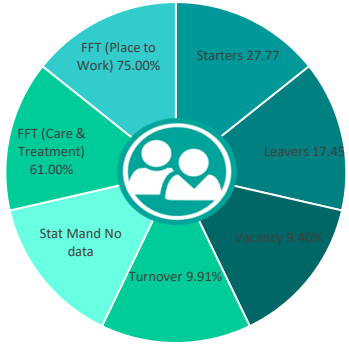
Patients



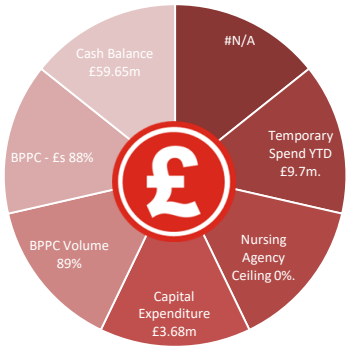
Performance



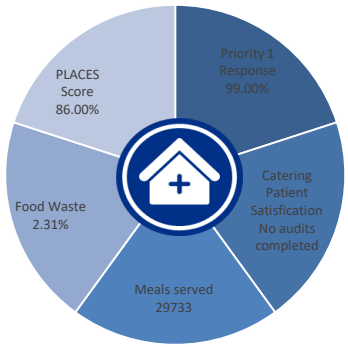
People



Pounds

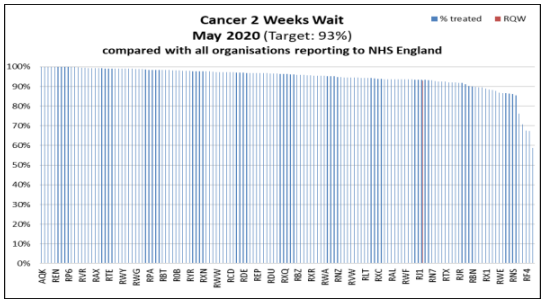


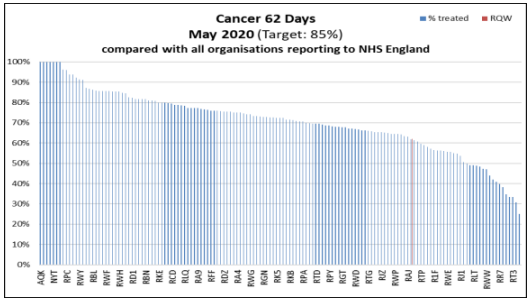
Places

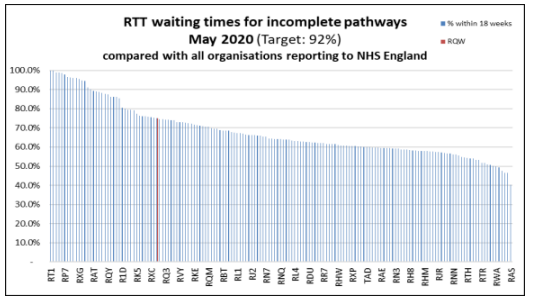


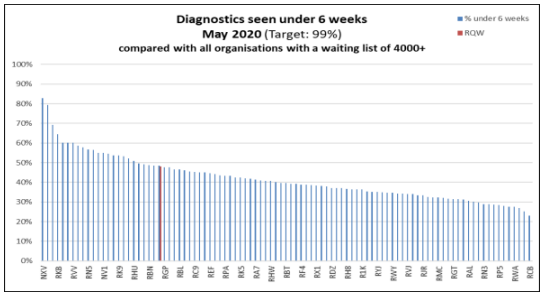
National Benchmarking
Compared with all organisations reporting to NHS England

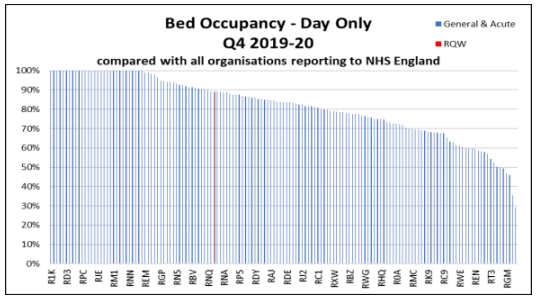
NHS
The Princess Alexandra Hospital
NHS Trust

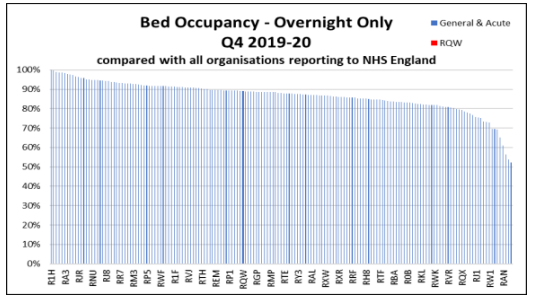


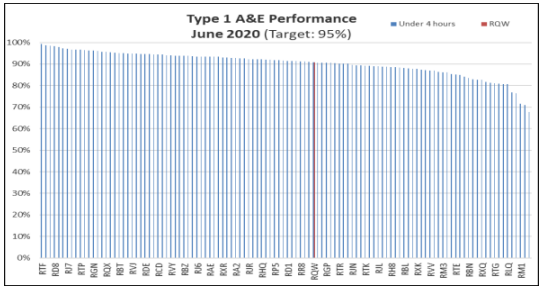


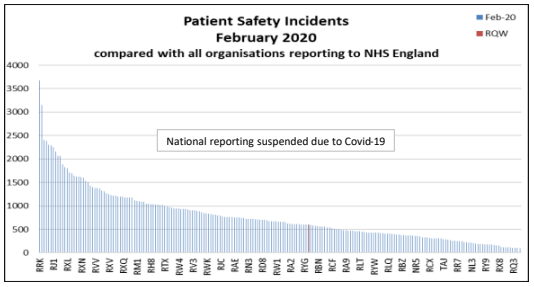


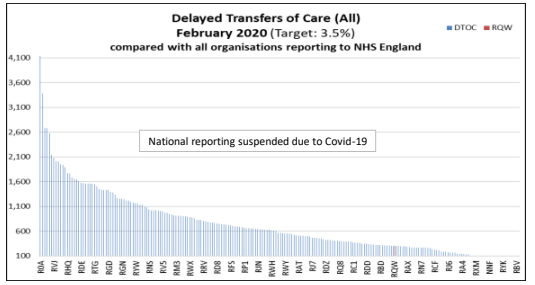










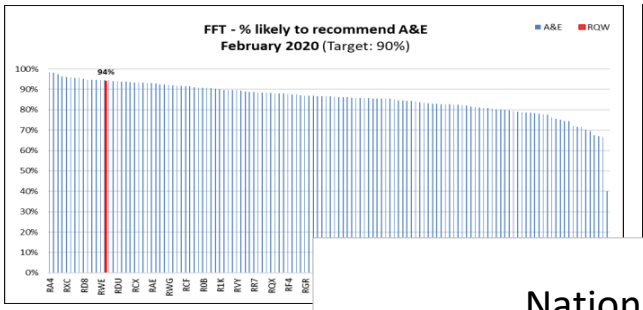


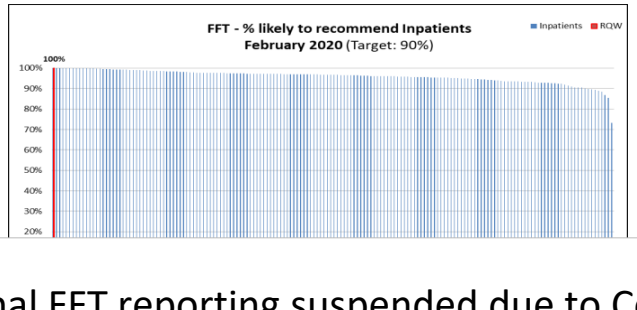
Your future | Our hospital

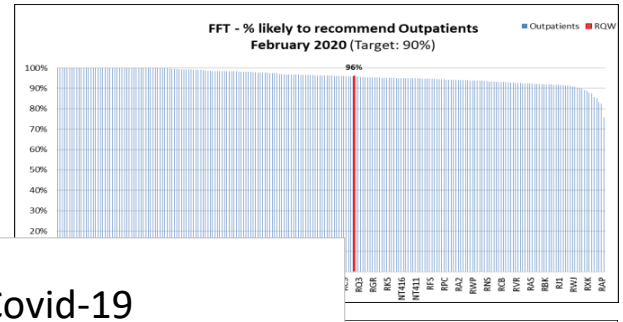
Data Source: NHS England Statistics/Public Health England/Dr Foster

National Benchmarking
Compared with all organisations reporting to NHS England

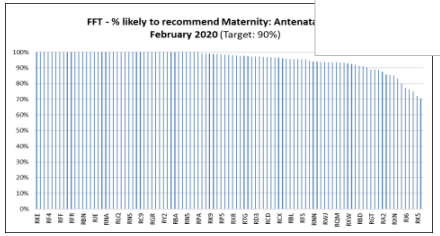
The Princess Alexandra Hospital NHS Trust

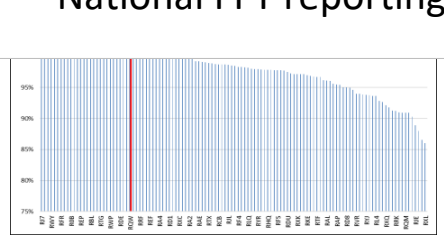


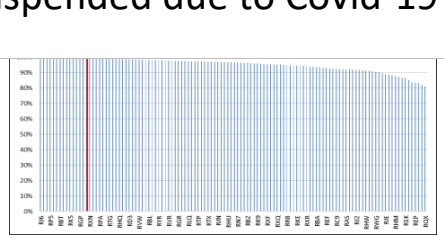


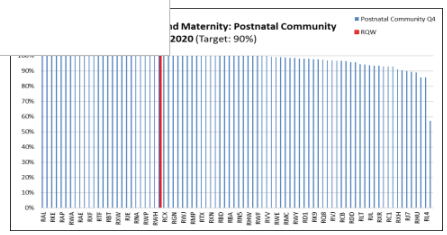


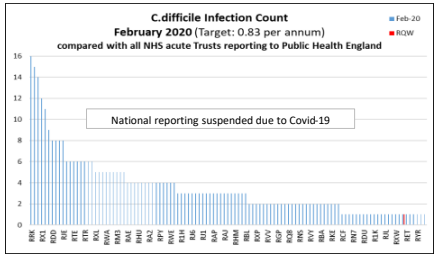
National FFT reporting suspended due to Covid-19

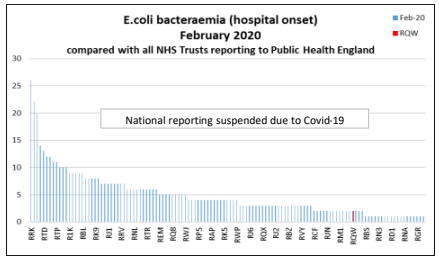


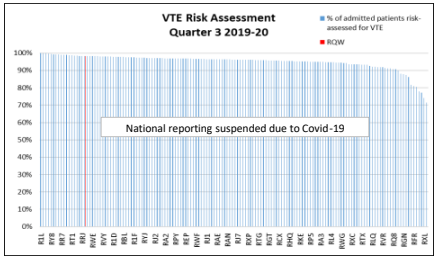


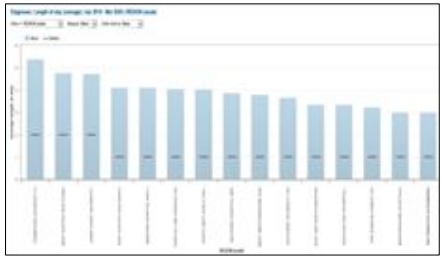












Your future | Our hospital

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

respectful | caring | responsible | committed

Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

The patient elements of the report reflects the reporting position of the organisation over the Covid period and the easing of a number of national reporting reqirements.

Patient experience: the Board will note that thematic learning from PALs and complaints over the period which relates to lost property and the working group which has been established in response.

The Friends and Family Test will recommence on 1st July.

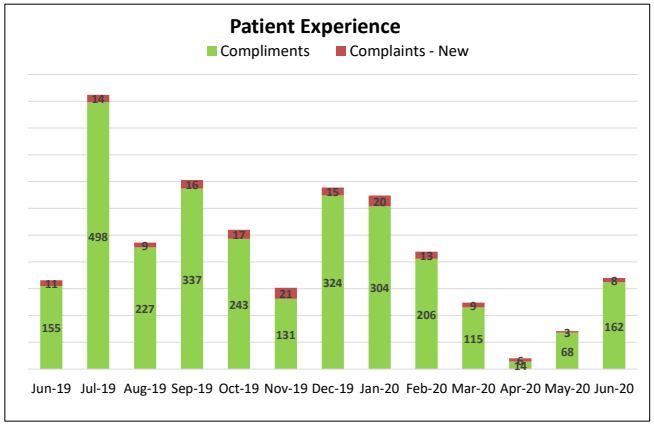
Infection control: to note the additional information included within the report relating to our Covid-19 position.

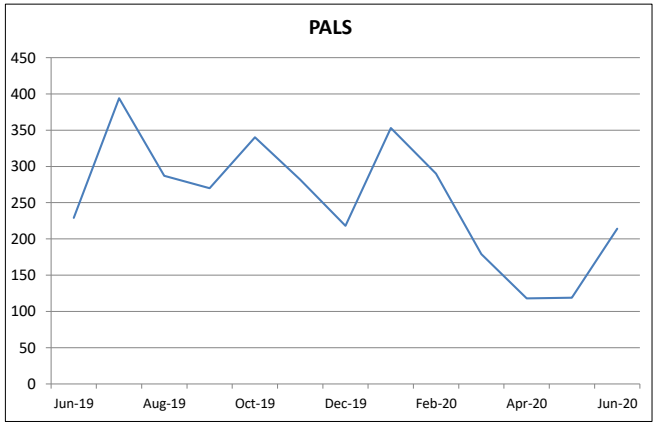
Patient Experience

1 Our Patients Summary 1.1 Patient Experience

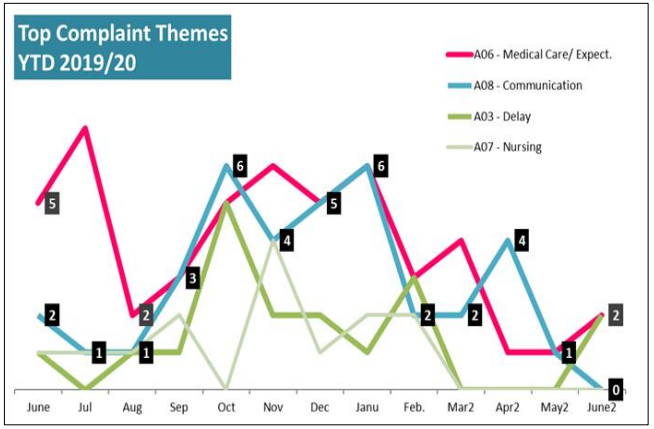
The Princess Alexandra Hospital NHS Trust

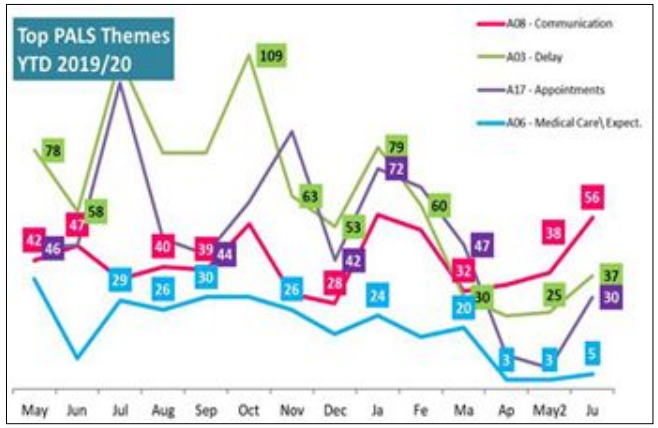
A national directive to pause complaints during the pandemic from April to June saw significant decreases in feedback in both complaints and PALS, however, volume of activity has now begun to return to normal after being down by 56% in April (PALS - 282 vs. 126 cases received) and then only very slightly down when comparing June (PALS 227 vs. 216). FFT data gathering was also paused to 1 July.
Actions on themes: Since lockdown began we have delivered over 353 video calls and 752 family messages at the time of writing. Lost property has been a particularly vexed issue as the exclusion of carers from the site has led to numerous cases of lost property, as a result the patient experience team have established a working group and in the first week made contact with over 200 families to support the return of property and this work is ongoing.

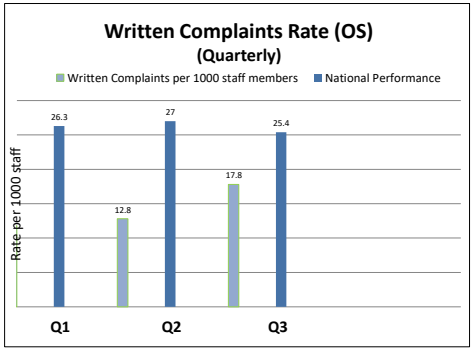




PALS converted to Complaints	
Jun-19	2
Jul-19	1
Aug-19	1
Sep-19	4
Oct-19	2
Nov-19	3
Dec-19	4
Jan-20	6
Feb-20	3
Mar-20	1
Apr-20	0
May-20	0
Jun-20	1

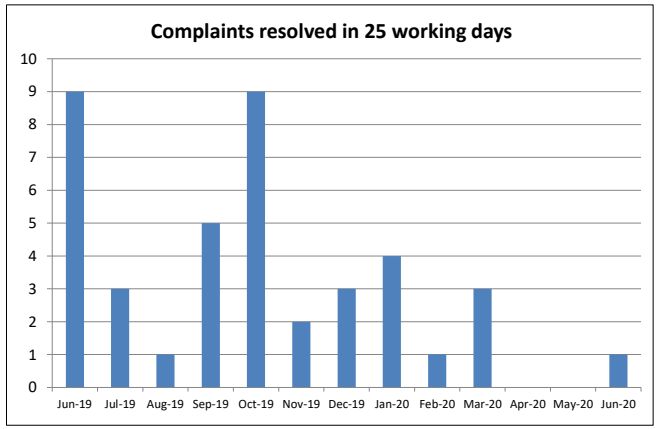


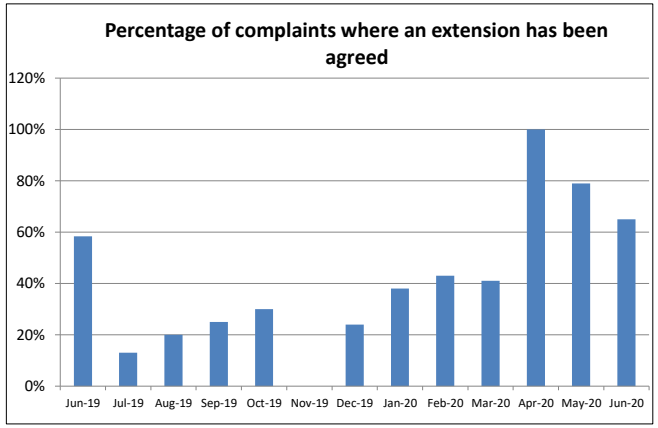


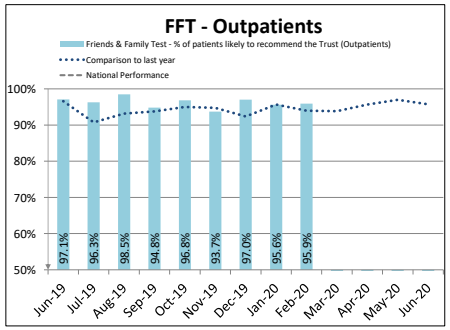


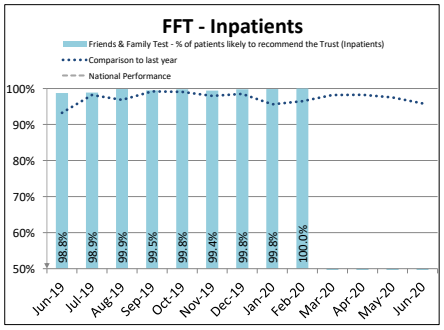
National collection suspended due to Covid-19

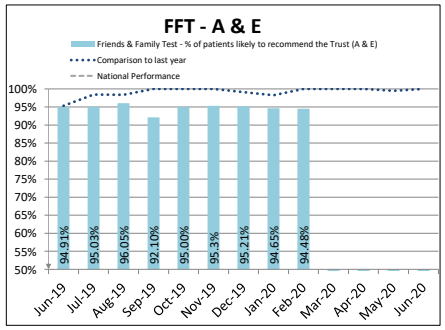
Patient Experience

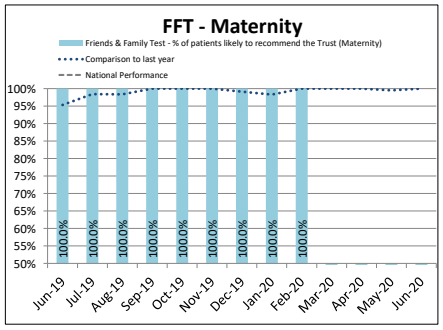












FFT national collection suspended due to Covid-19

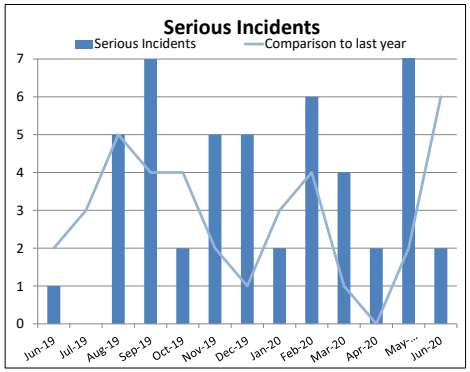
Patient Safety

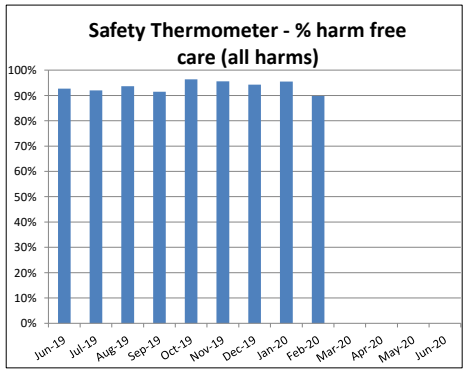
1 Our Patients Summary 1.3 Patient Safety

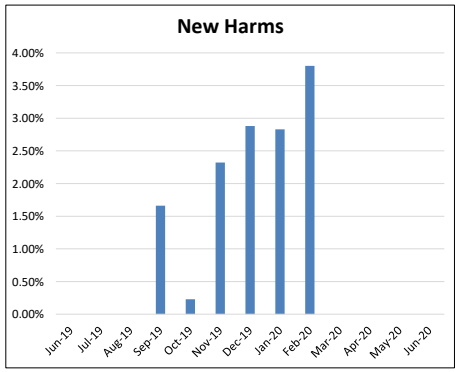
The Princess Alexandra Hospital NHS Trust

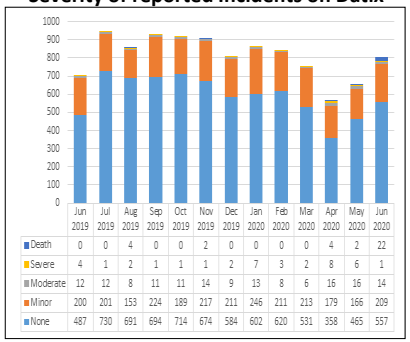
2 Serious incidents were reported externally in month:
• A patient attended the Emergency Department unexpectedly died shortly on arrival.
• A cluster of 21 incidents where nosocomial Covid infection was identified as a contributory factor in the patients death. This cluster relates to patients admitted in March and early April during the first few weeks of the pandemic. Learning from the investigations has been embedded in our covid patient management pathways.

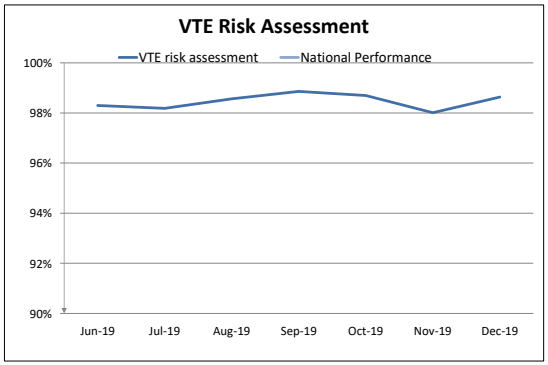
MDA.2019.037 – Prismaflex Haemofiltration Systems: The breach is agreed by the Trust as Baxter Technical are unable to provide the Trust with the required system update until August 2020. Look to close this alert in August once the software is updated.

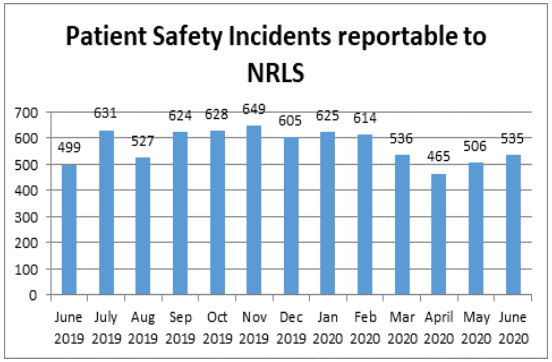


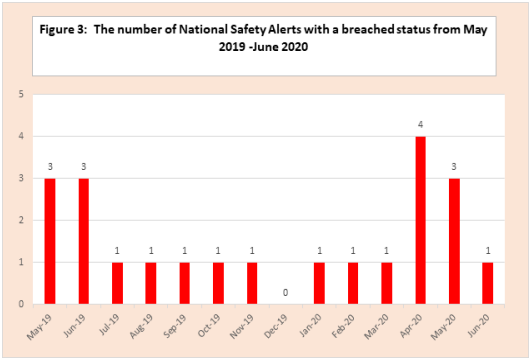










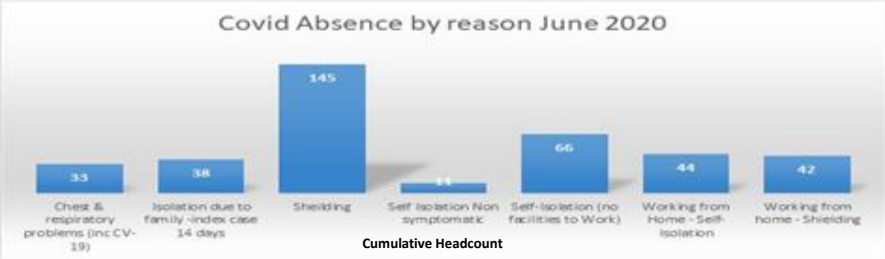


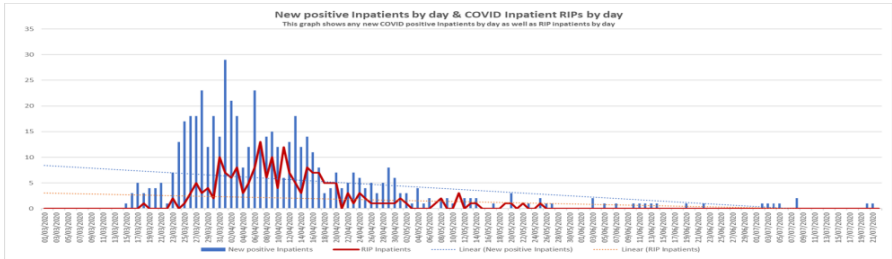
Infection Control

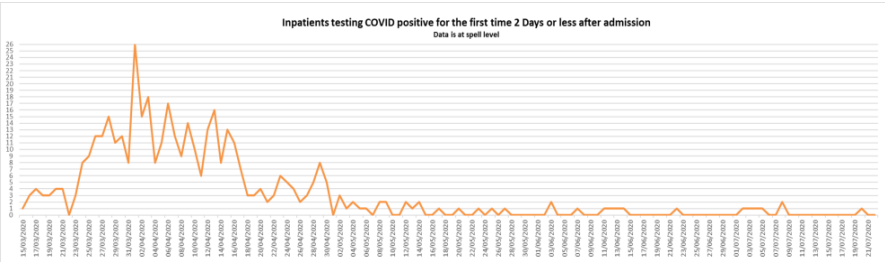
1 Our Patients Summary 1.4 Infection Control - Covid-19

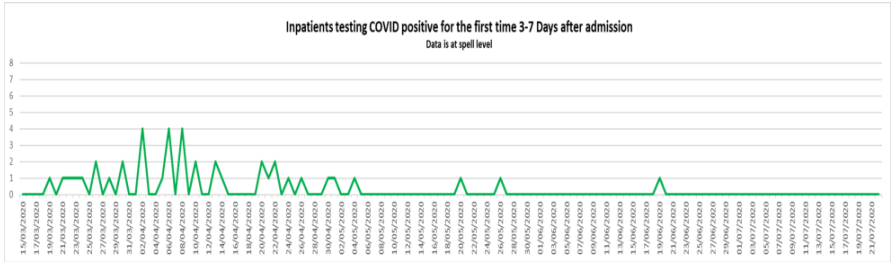
The Princess Alexandra Hospital NHS Trust

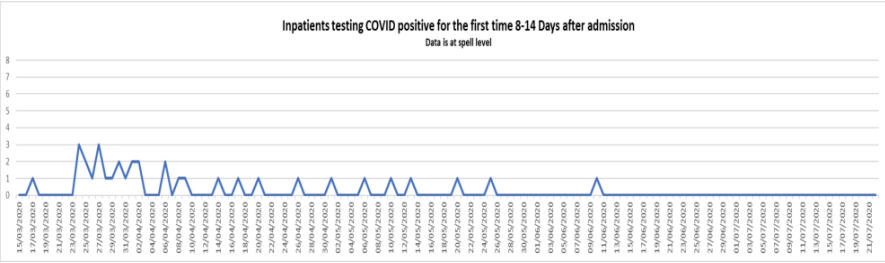
The data below shows the trend in the Covid-19 presentations and management across the organisation alongside the Covid absence (cumulative lost days). Of note is the reduced trend in Covid inpatients and the inpatient testing results.

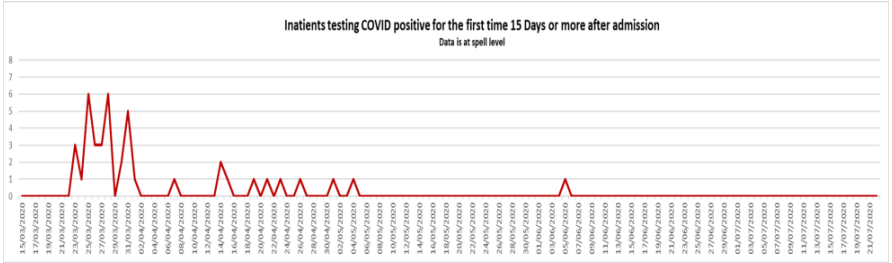












Infection Control

1 Our Patients Summary 1.5 Infection Control

NHS The Princess Alexandra Hospital NHS Trust

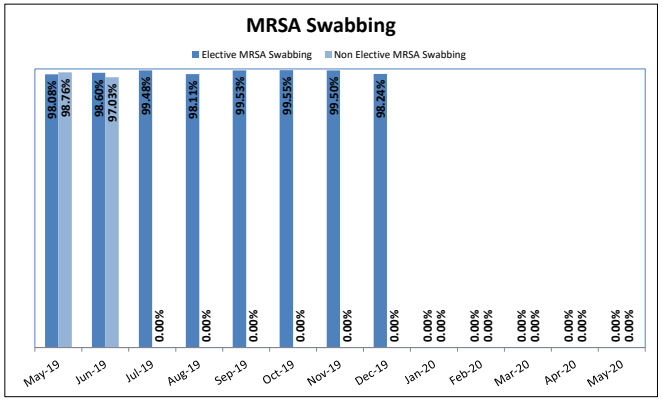
MRSA
There were no cases of Trust-attributable MRSA bacteraemia cases in June.
There are no Trust-attributable cases for the year.

MSSA
The Trust continues to have low numbers of MSSA bacteraemia & remains in the top quarter of best performing hospitals nationally. There were no Trust cases of MSSA in June. Trust cases are slightly higher when compared with June 2019 (three to date, compared with a total of six cases at the end of 2019-20).

C.difficile
No trajectory has been set for 2020 – 2021.
There has been one Hospital-onset healthcare-associated case (inpatient on Saunders ward).
RCAs are in the process of being undertaken for this.

Gram Negative Blood Stream Infections (GNBSIs)
There was one Trust-attributable case of E-coli bacteraemia (inpatient on Lister ward – primary focus of infection likely to be upper urinary tract infection).
There have been two Trust-attributable cases of Klebsiella sp. bacteraemia (inpatients on Nightingale & Kingsmoor ward). These cases are being reviewed by the IPC Team & an RCA will be completed if required.

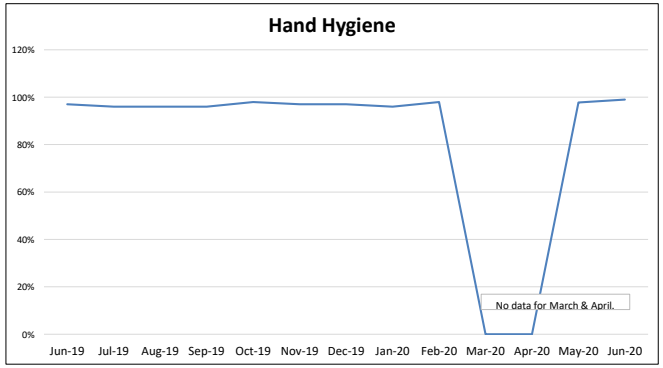
Hand Hygiene Audits – All wards/clinical department are expected to participate in monthly audits. The expectation is that 100% of clinical areas participate & the performance standard is 95% compliance. In June, there were three areas that scored less than 95% compliance & nine areas that did not submit the audit (some of the wards have been closed or moved to different areas, which includes outpatients areas which had only partially re-opened). Wards/departments are expected to discuss their results & agree appropriate actions within their health care group.
Cross-over (peer review) audits were stopped at the beginning of the COVID-19 pandemic due to the risk of transmission & the requirement to limit movements in clinical areas.



MSSA	
Jun-19	1
Jul-19	0
Aug-19	0
Sep-19	0
Oct-19	0
Nov-19	0
Dec-19	0
Jan-20	1
Feb-20	2
Mar-20	1
Apr-20	1
May-20	2
Jun-20	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)	
Jun-19	0	1	0	2	3
Jul-19	1	0	0	5	6
Aug-19	0	0	1	2	3
Sep-19	1	1	0	0	2
Oct-19	1	0	1	2	4
Nov-19	3	0	0	1	4
Dec-19	4	0	3	0	7
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



E Coli	
Jun-19	2
Jul-19	0
Aug-19	2
Sep-19	3
Oct-19	0
Nov-19	0
Dec-19	1
Jan-20	0
Feb-20	2
Mar-20	0
Apr-20	1
May-20	1
Jun-20	1

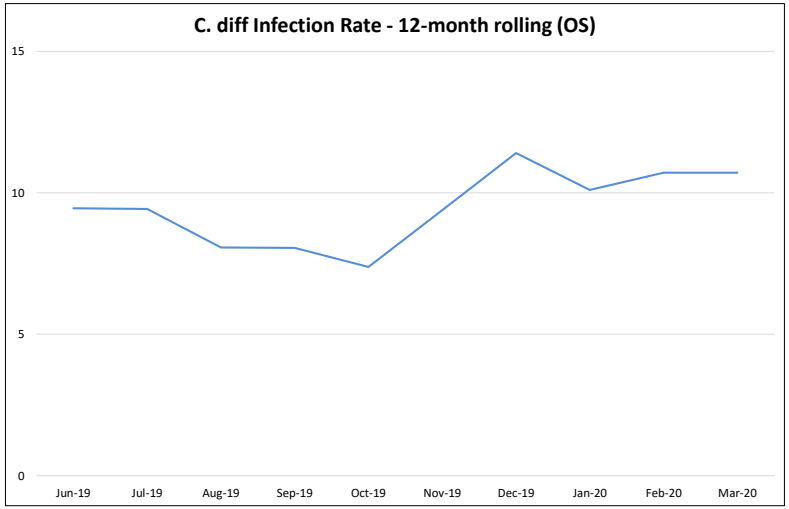
Klebsiella	
Jun-19	1
Jul-19	0
Aug-19	0
Sep-19	0
Oct-19	0
Nov-19	0
Dec-19	1
Jan-20	0
Feb-20	0
Mar-20	1
Apr-20	1
May-20	0
Jun-20	2

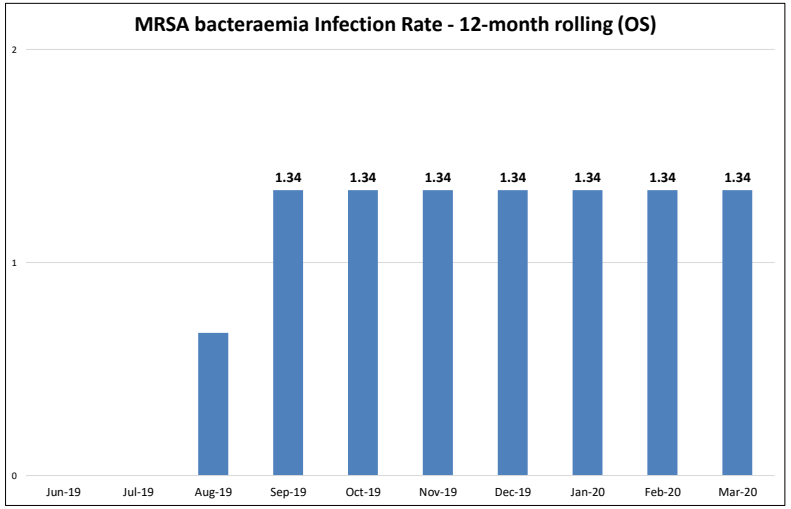
Pseudomonas	
Jun-19	0
Jul-19	0
Aug-19	0
Sep-19	1
Oct-19	2
Nov-19	0
Dec-19	0
Jan-20	0
Feb-20	0
Mar-20	0
Apr-20	0
May-20	1
Jun-20	0

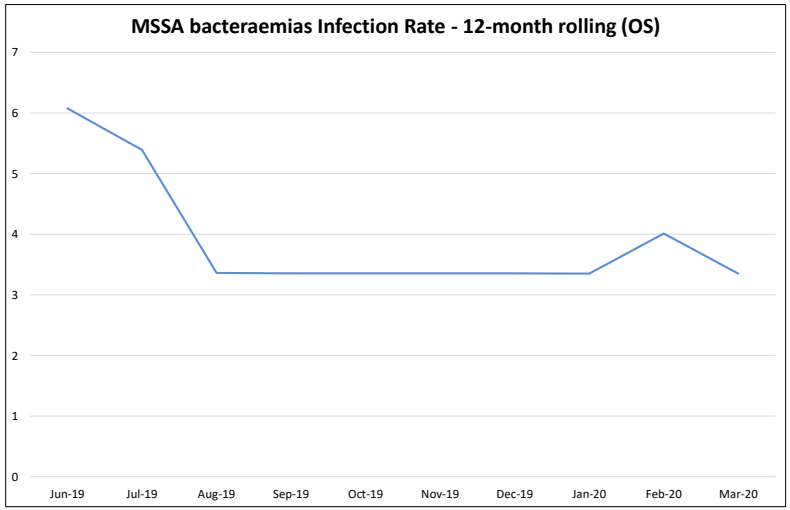
Infection Control

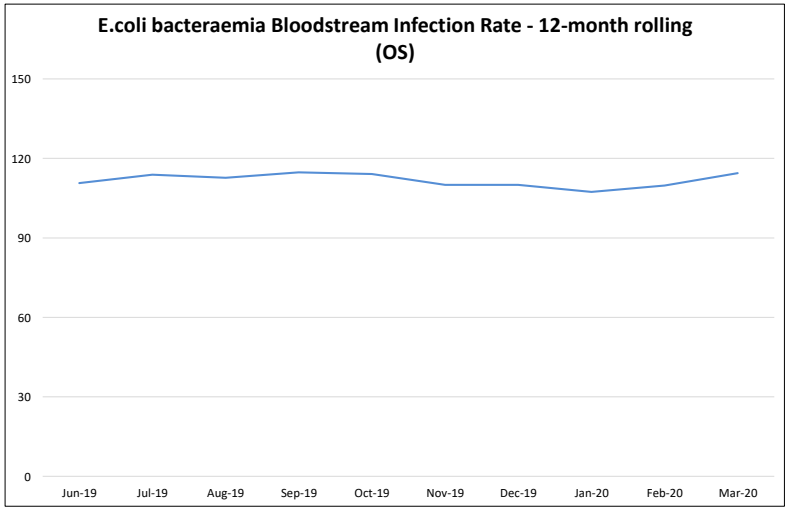
The following are the latest published data available.

No data published since April 20









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

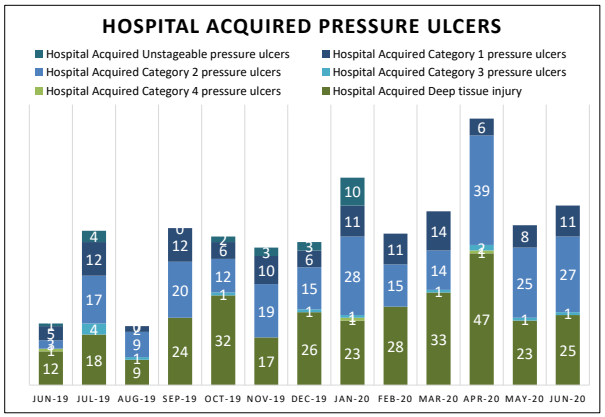
1 Our Patients Summary 1.7 Patient Safety

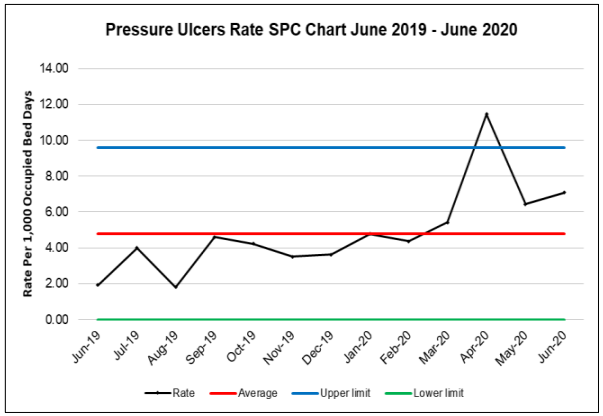
The Princess Alexandra Hospital NHS Trust

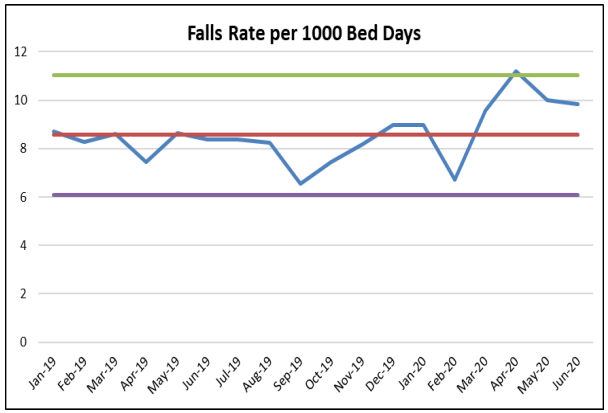
There were a total of 64 pressure ulcers in June, only 1 moderate harm (Category 3 PU) and remaining minor harms. No pressure ulcers deemed as Skin Changes at life's End (SCALE) were identified. 5 PUs were device related, from ETT, O2 mask, stocking and cervical collar.

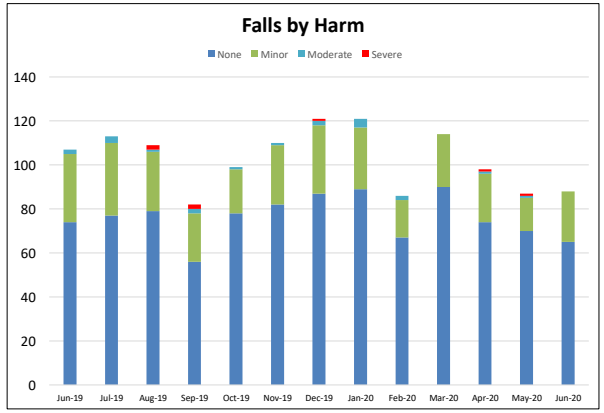
This month the highest number of hospital acquired pressure ulcers were from Locke Ward, with 13 PUs in total. TVNs are supporting the ward manager and matron with intensive support and re-training around pressure ulcer categorisation and preventative measures using the SSKIN bundle.

The number of falls remains unchanged in month. The Strategic falls action plan continues with work escalating with the commencement of the Lead Nurse for Falls Preventions commencing in post this month.









Family & Women's Service

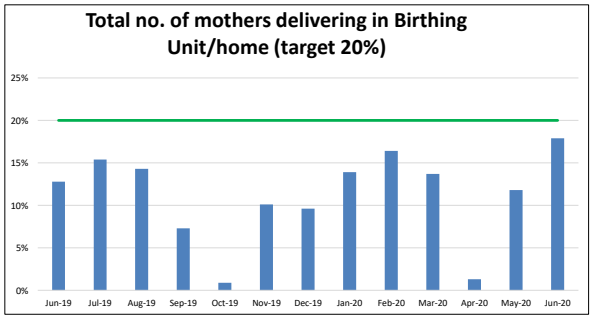
2 Our Patients Summary 1.8 Family & Women's Service

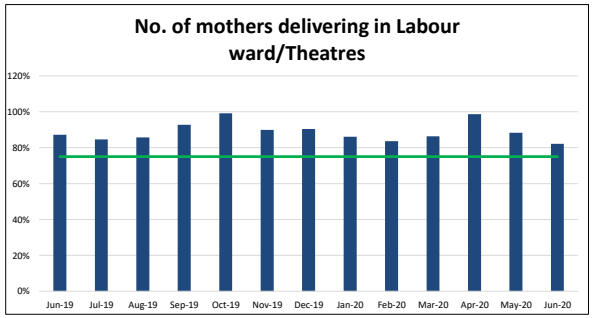
NHS
The Princess Alexandra Hospital
NHS Trust

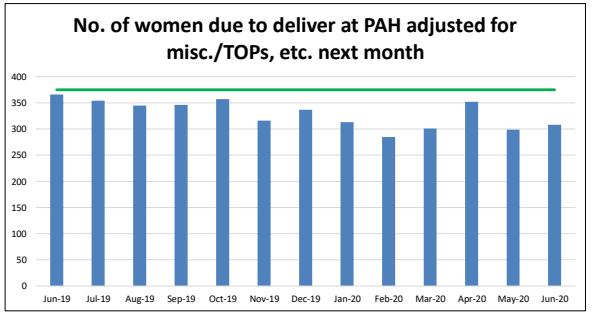
The number of babies born in the Birthing Unit in June 2020 has increased to 17.9% of all deliveries. This is the highest rate since May 2019 & it is planned to reach our target of 20% in the forthcoming months, as the benefits of our programme to increase the number of 'continuity of care' Midwifery Teams.

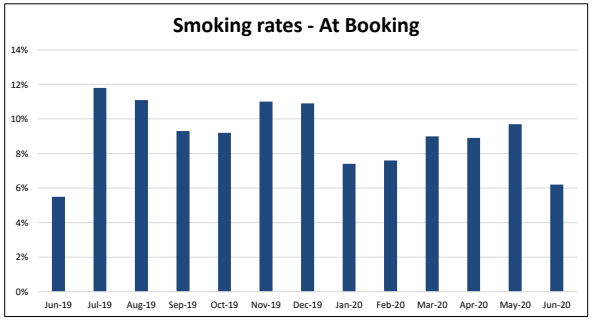
The rate of massive obstetric haemorrhage has reduced compared to previous months but at 4.0% continues to be above the expected rate. PAH is working with our LMNS partner Hospitals to compare processes & audits are ongoing to understand the root cause of this issue. Appropriate actions will be added to the ongoing action plan to reduce the incidence of massive obstetric haemorrhage.

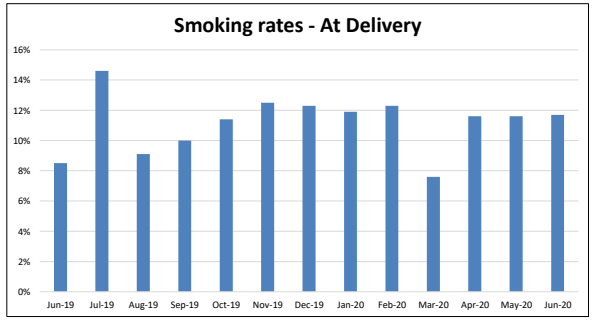
The overall C Section rate was 33.1% in June. Audits of C Sections & the clinical indications are being conducted & the June C Section Rate will be discussed at the FAWS Board Meeting.

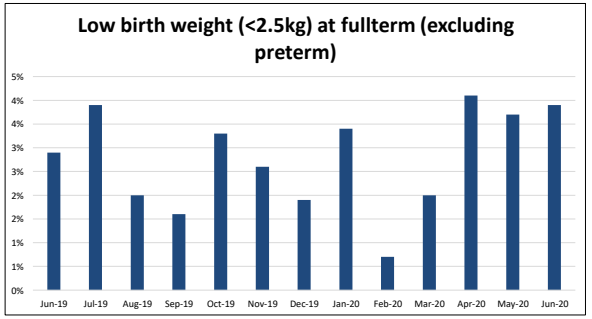


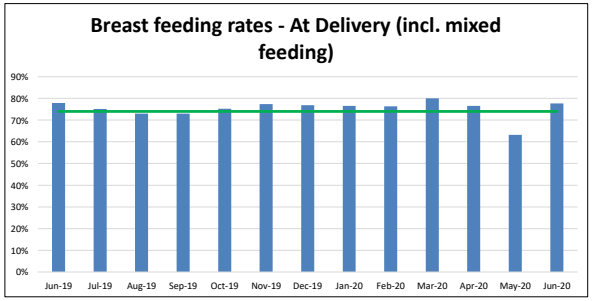


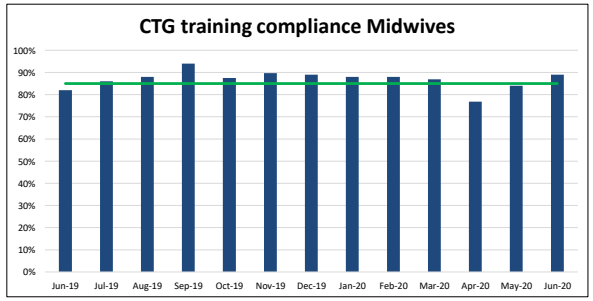


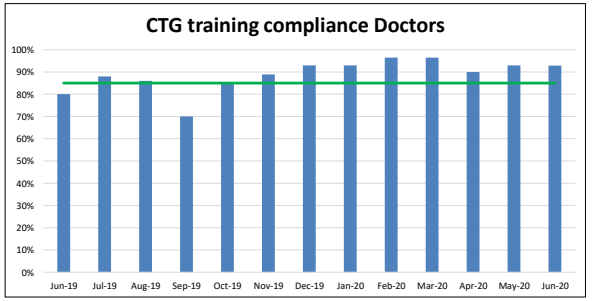




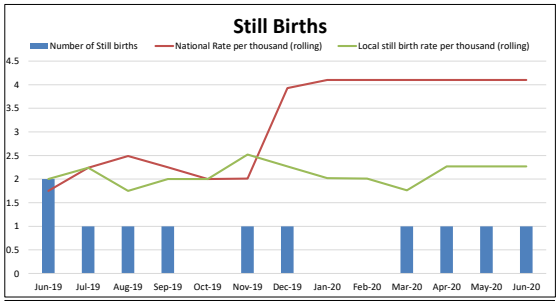


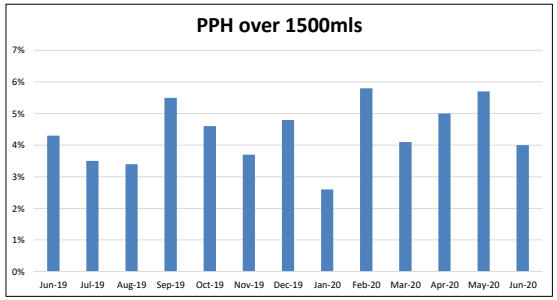


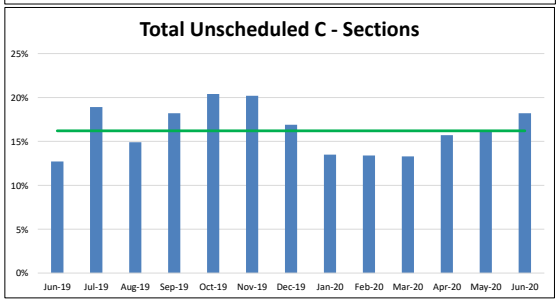


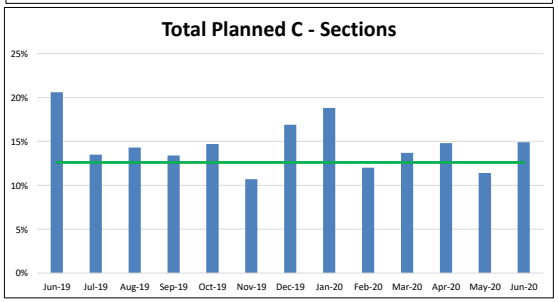


Family & Women's Service







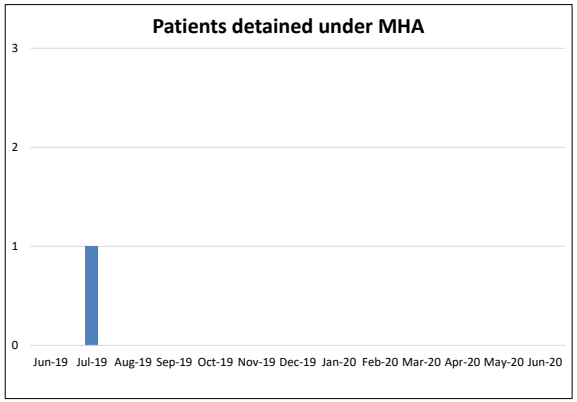


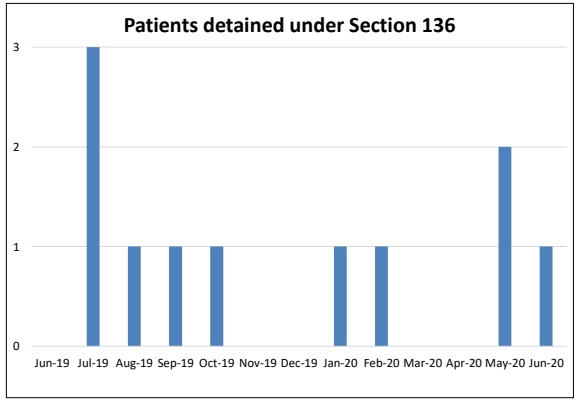
Mental Health

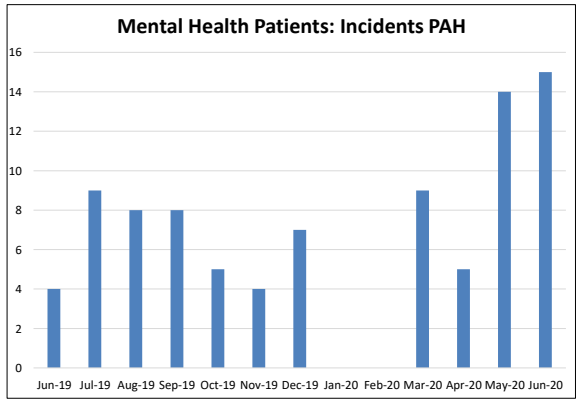
1 Our Patients Summary 1.10 Mental Health

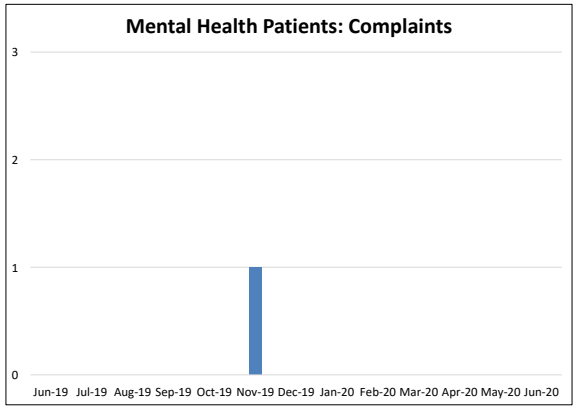
The Princess Alexandra Hospital NHS Trust

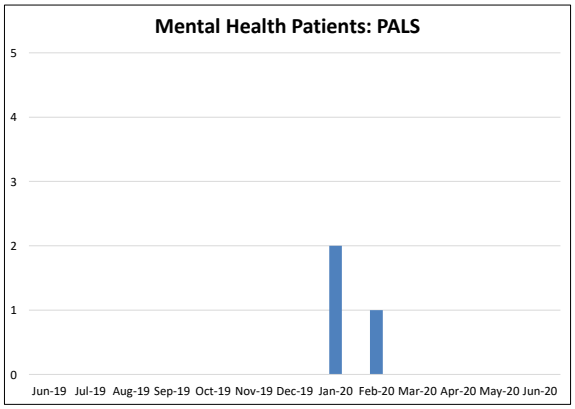
The Mental Health Quality Forum has recommenced following its suspension over the Covid19 period. The focus of the group is the implementation of the Mental Health Act policy, further embedding of the Core24 mental health liaison service and development of the organisations training and development programme in relation to mental health.

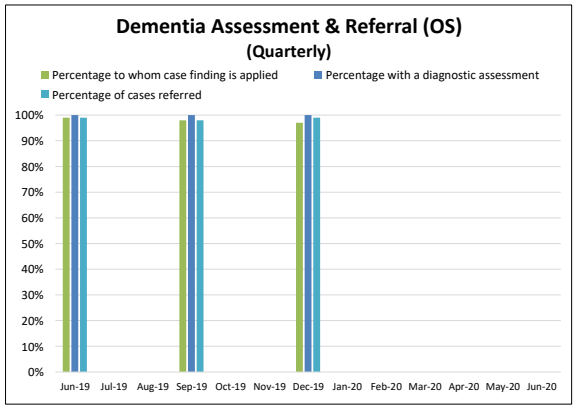






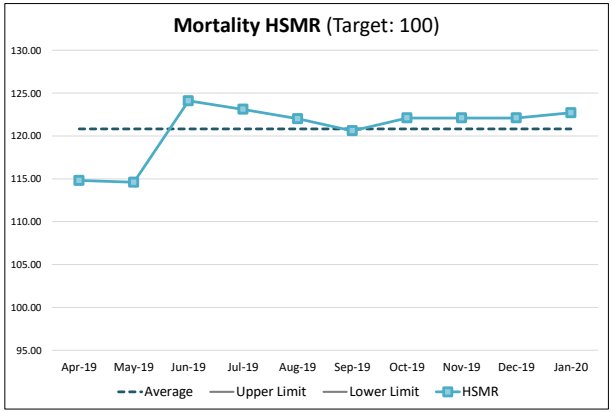


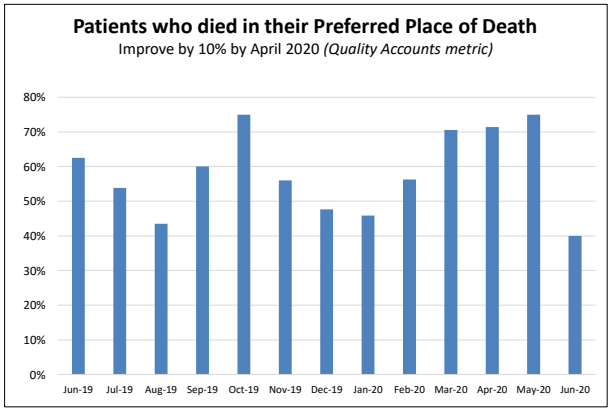




DAR national collection suspended due to Covid-19

Mortality





Mortality SHMI	
Jul-19	112.1
Aug-19	111.0
Sep-19	N/A
Oct-19	111.2
Nov-19	N/A
Dec-19	109.6
Jan-20	N/A
Feb-20	N/A
Mar-20	N/A
Apr-20	N/A
May-20	#N/A
Jun-20	#N/A

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

Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

The Trust's RTT 18 week performance has further decreased in June due to the continued reduction in elective operating & the reduced referrals from March onwards. Therefore the waiting list has different proportions of patients under & over 18 weeks from a normal distribution. The Trust has carried out the usual number of out-patient appointments, 80% virtually & elective operating has continued at The Rivers Hospital. PAH site operating commences in July through the Day Stay Unit & main theatres plans are in place for August. Patients are listed for surgery on a clinical priority basis & consequently the number of long waiting lowest priority patients are increasing. This is in line with national results & PAH are maintaining performance ahead of the national average. The Trust is developing an improvement trajectory at a specialty level that will inform overall Trust return to national targets. Recovery predictions will need to take into account the pattern of new referrals balanced against available capacity.

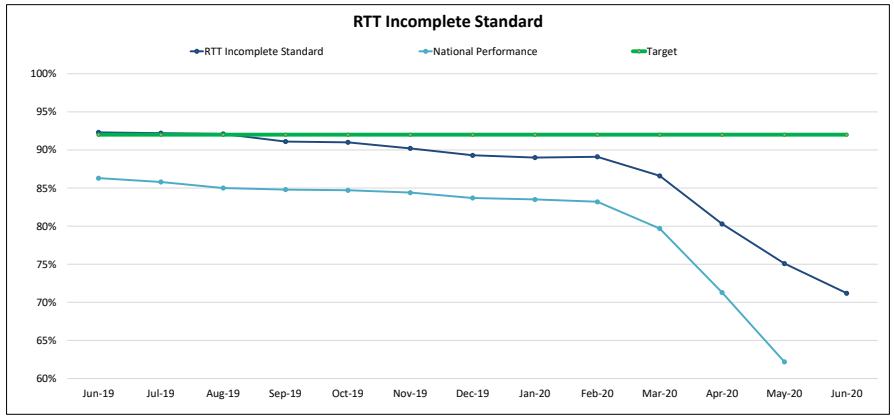
The number of Appointment Slot Issues (ASIs) continues to decrease positively, currently 4% of referrals due to reduced routine referrals & expansion of triaging. Urgent referrals have increased in the past two months, possibly reflecting "held back conditions or referrals" which we are monitoring closely. Cancer 2 week wait performance overall has returned to above national target in May with just three tumour sites under target. Children's cancer are very small numbers which creates fluctuations in performance, Lower GI & Urology have struggled to offer 2ww diagnostic appointments for endoscopy & flexi-sigmoidoscopy. Capacity is slowly improving but the backlog will take several months in Lower GI to clear. The team are working through detailed trajectories as part of the overall recovery plans. Monitoring will take place through recovery cell & performance review meetings.

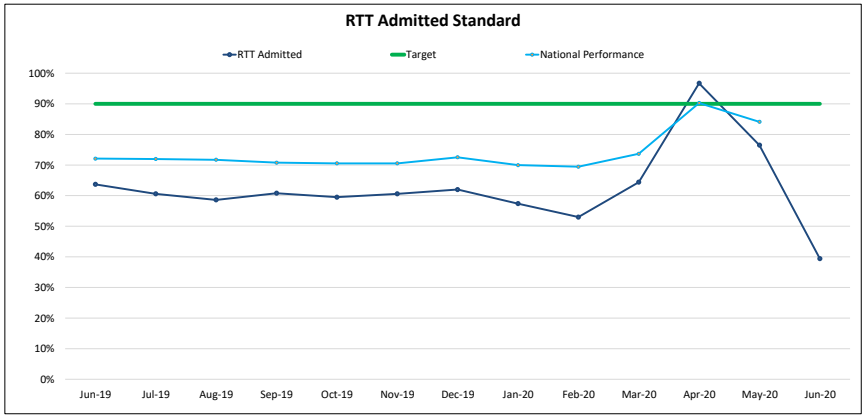
62 Day overall performance has slightly increased from April however it is significantly below both the target & average national performance. The impact of Covid on cancer pathways has been significant & despite maintaining as much operating at the Rivers Hospital as possible diagnostics & treatments have been delayed. Patients are prioritised & treated in clinical order which has impacted the waiting times of lower priority patients & contributes to the reduced performance. Recovery plans are in place & trajectories by tumour site are being developed.

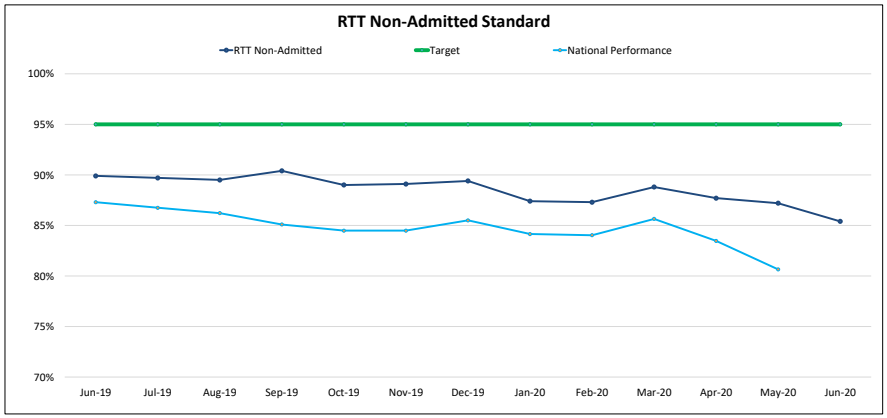
DM01 Diagnostic performance has also been impacted by Covid & available capacity was prioritised to cancer & urgent referrals. A detailed recovery plan & trajectory has been drawn up which is dependent on the continued support of Independent Sector providers to assist with all radiology modalities, bar plain film. Additional diagnostic CT capacity has been confirmed through another independent provider which will help improve the overall recovery trajectory. As mentioned in the cancer narrative the endoscopy service has a considerable backlog as only emergency scoping was allowed during Covid & the backlog clearance is underway, with a small Task & Finish Group led by two Executive Directors to develop additional capacity by creating a 3rd endoscopy suite with associated 7 day staffing.

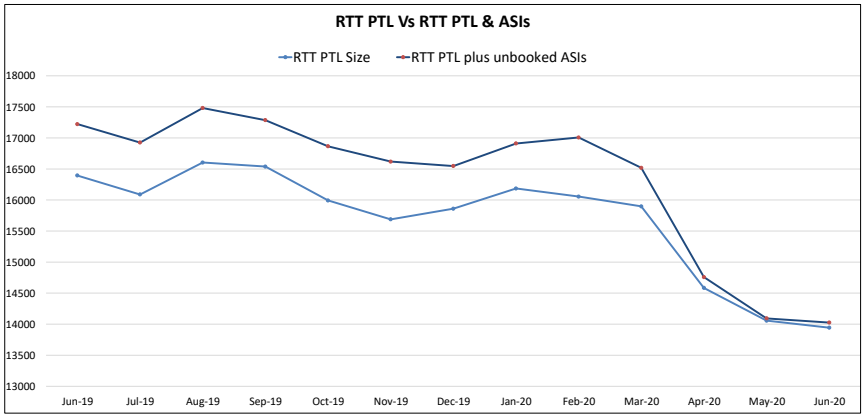
Emergency Care performance continues to be closely monitored with detailed plans in place to improve the internal professional standards. Separation of ED remains in place with some concerns identified in relation to waiting room capacity & maintaining social distancing ahead of winter. This continues to be reviewed daily. There are several workstreams in place both locally & across the STP/ICP. Strong support from NHSI to develop further capacity & support of the use of 111 services linked to emergency department plans are currently being worked through. Final planning consent for the additional assessment capacity is expected at the end of July which will enable works to commence to provide additional space ahead of winter. The Trust achieved 91.2% 4 hour performance in June. Detailed recovery trajectories are monitored through the Recovery Group on a weekly basis.

RTT


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


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

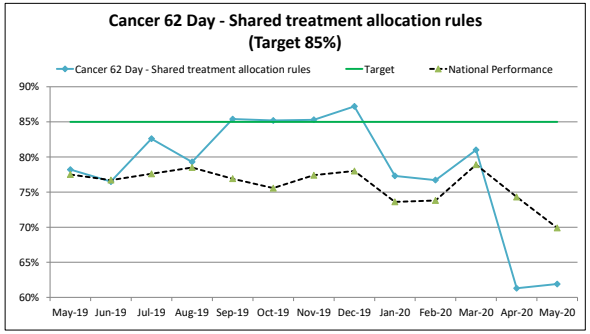

RTT Non-Admitted Standard
RTT Non-Admitted
Target
National Performance
100%
95%
90%
85%
80%
75%
70%
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20

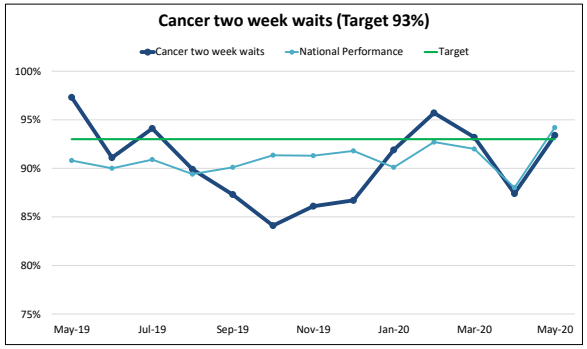

RTT PTL Vs RTT PTL & ASIs
RTT PTL Size
RTT PTL plus unbooked ASIs
18000
17500
17000
16500
16000
15500
15000
14500
14000
13500
13000
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20

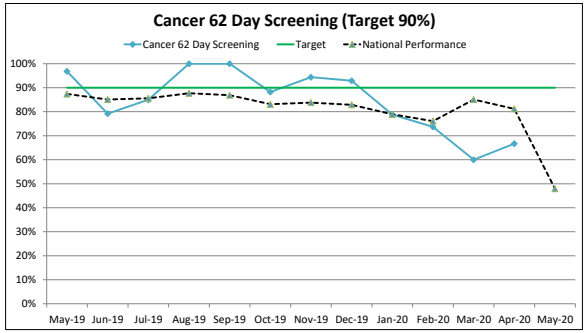
Cancer

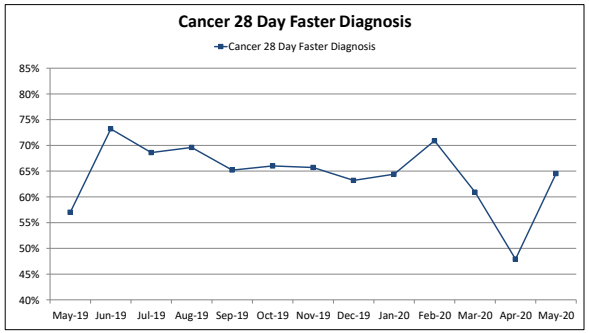
	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
May-19	97.70%	97.40%	100.00%	100.00%
Jun-19	76.10%	98.10%	100.00%	100.00%
Jul-19	95.70%	99.00%	100.00%	100.00%
Aug-19	97.50%	98.90%	100.00%	100.00%
Sep-19	99.10%	99.10%	100.00%	100.00%
Oct-19	99.10%	100.00%	100.00%	100.00%
Nov-19	97.60%	100.00%	100.00%	100.00%
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%

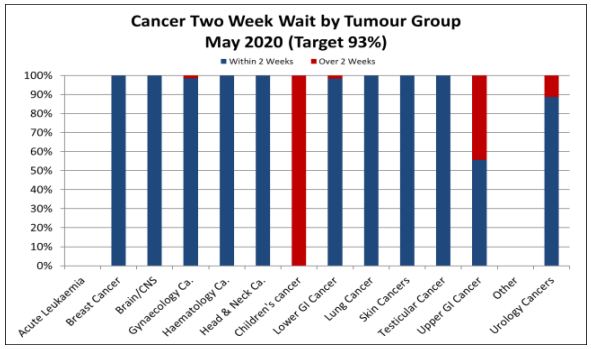
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

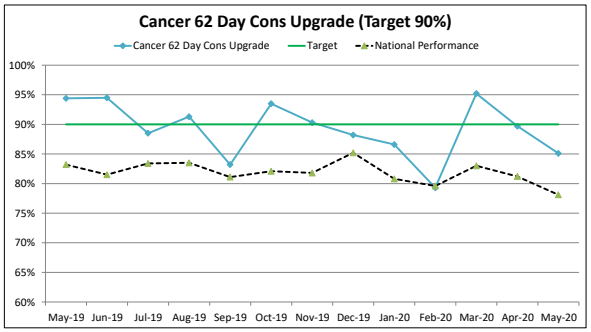




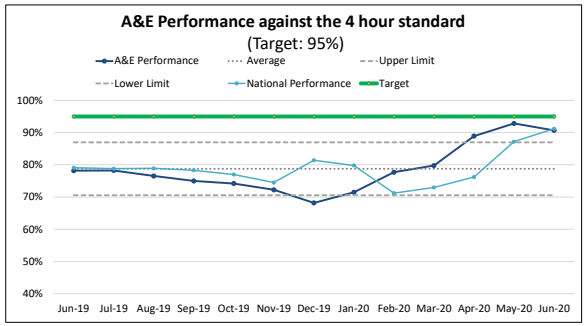


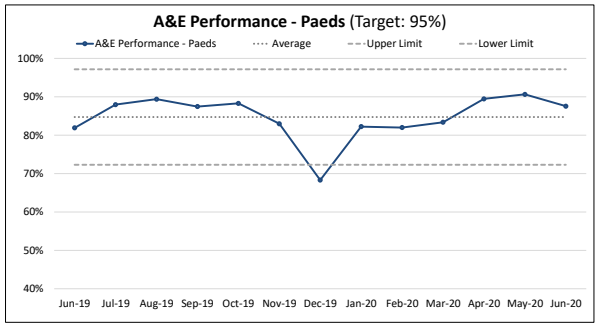


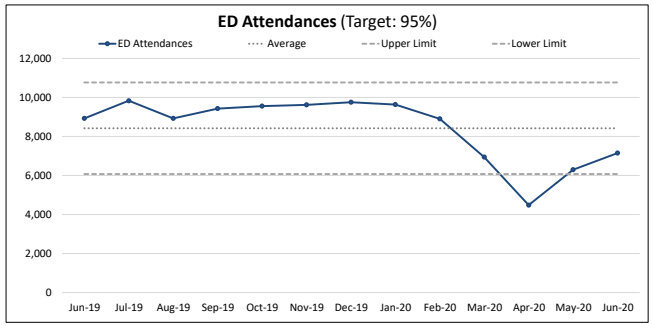


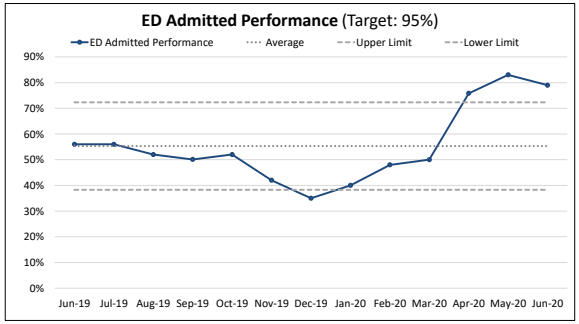


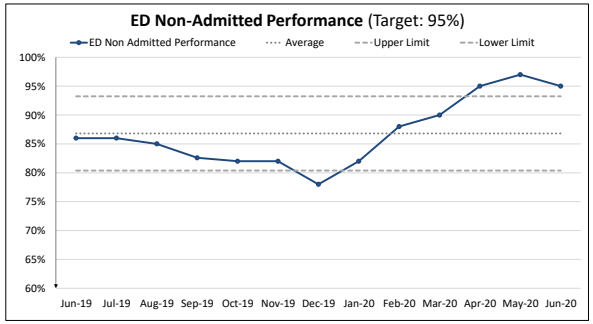
ED





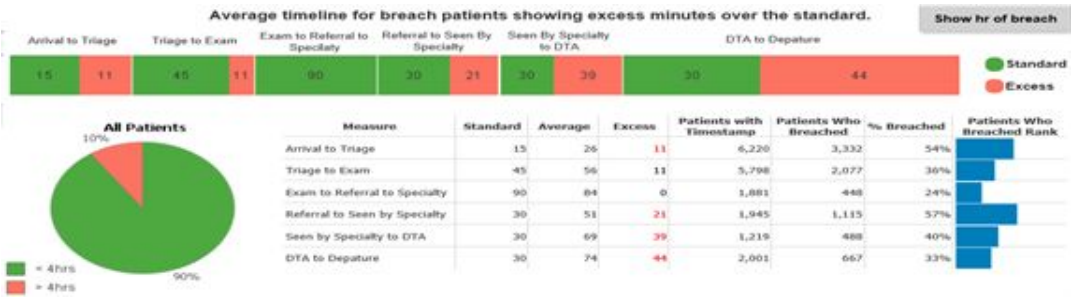


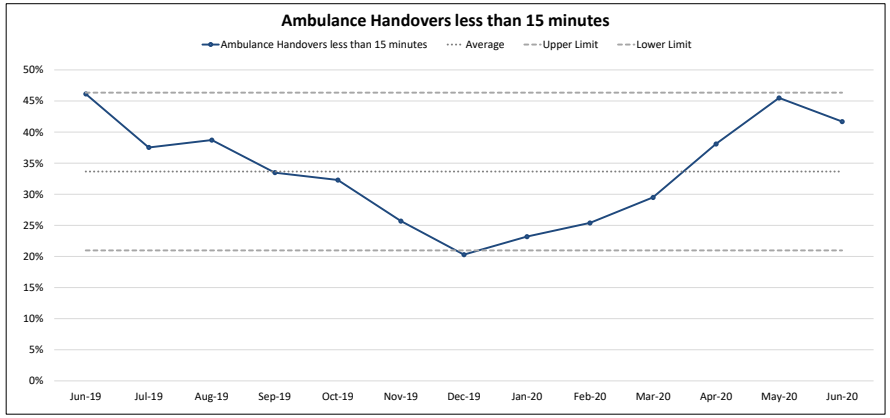


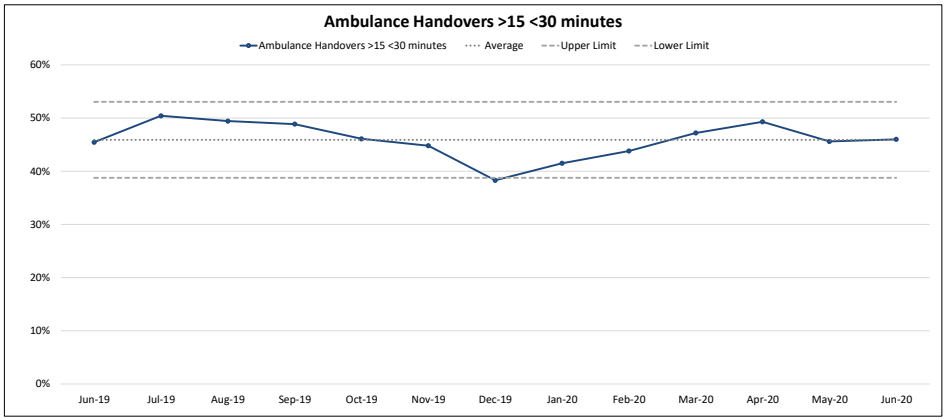


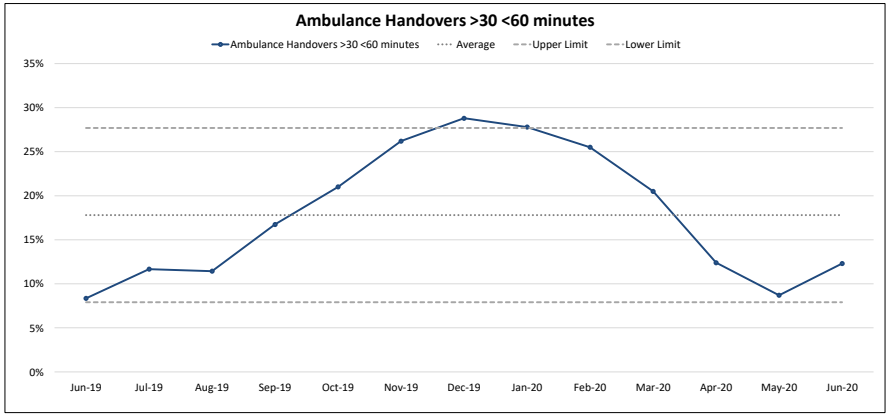
ED Internal Professional Standards

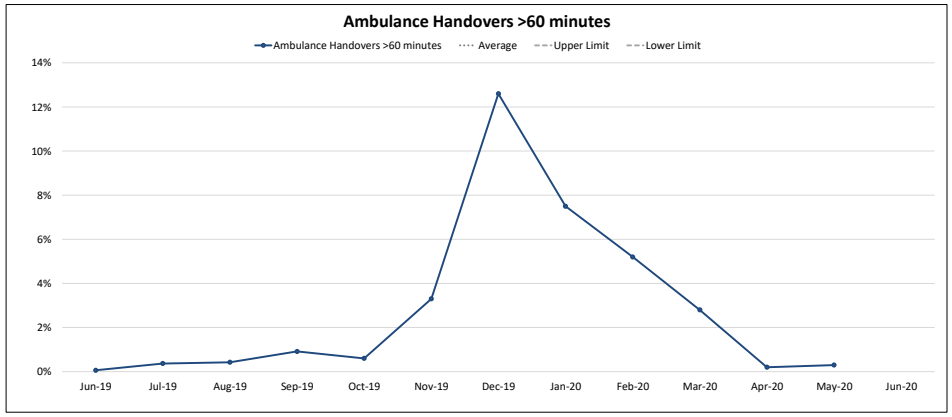
	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Arrival to Triage - Average Wait (Minutes)	26	46	34	39	35	38.63	46	41	37	30	25	26	25
Triage to Exam - Average Wait (Minutes)	91	90	93	102	108	102	104	91	76	60	41	44	56
Exam to Referral to Specialty - Average Wait (Minutes)	82	81	83	84	88	96	99	103	97	97	88	82	84
Referral to Seen by Specialty - Average Wait (Minutes)	67	65	79	70	78	98	90	87	77	74	54	48	51
Seen by Specialty to DTA - Average Wait (Minutes)	78	73	74	84	87	96	105	99	87	91	66	67	69
DTA to Departure - Average Wait (Minutes)	120	115	108	120	116	217	249	169	134	157	110	55	74

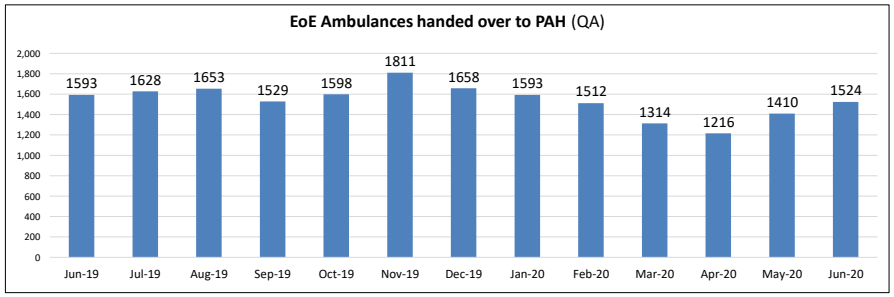



Ambulance Handovers less than 15 minutes
Ambulance Handovers less than 15 minutes
Average
Upper Limit
Lower Limit
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20

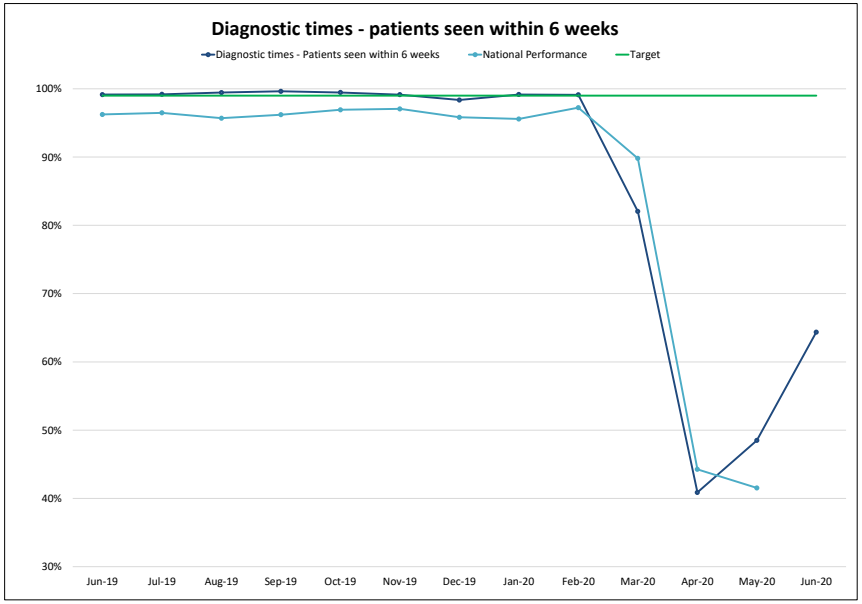

Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
60%
50%
40%
30%
20%
10%
0%
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20

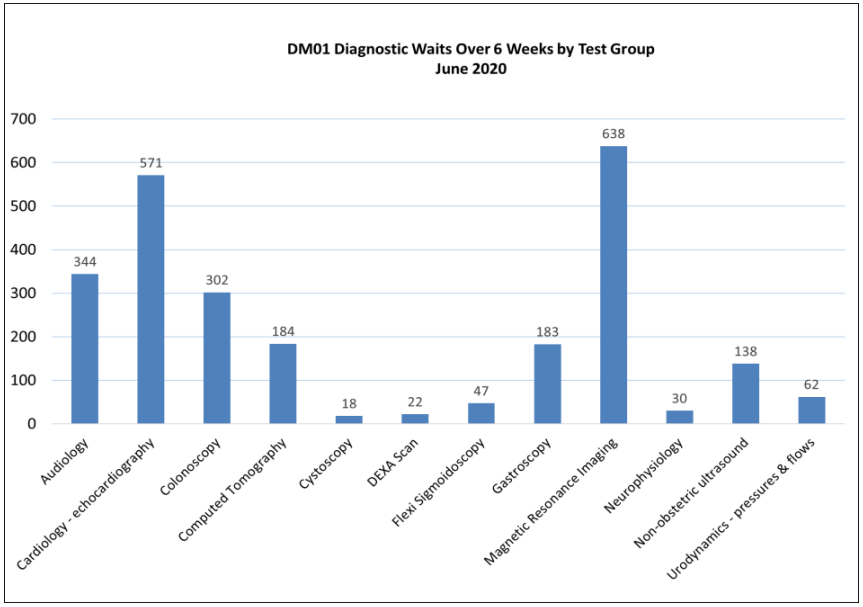

Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
35%
30%
25%
20%
15%
10%
5%
0%
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20


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


EoE Ambulances handed over to PAH (QA)
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1593
1628
1653
1529
1598
1811
1658
1593
1512
1314
1216
1410
1524
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20

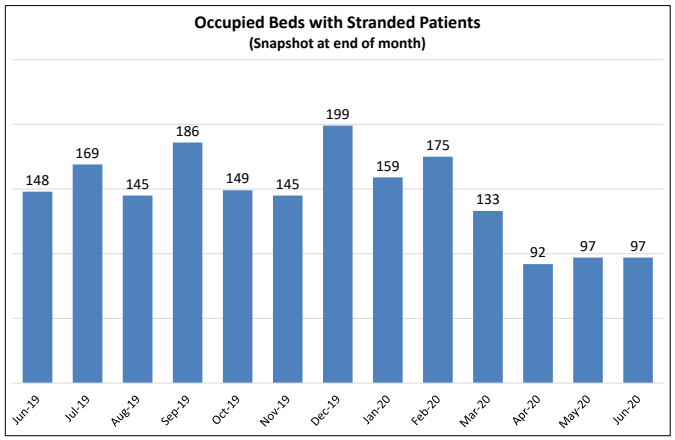
Diagnostics

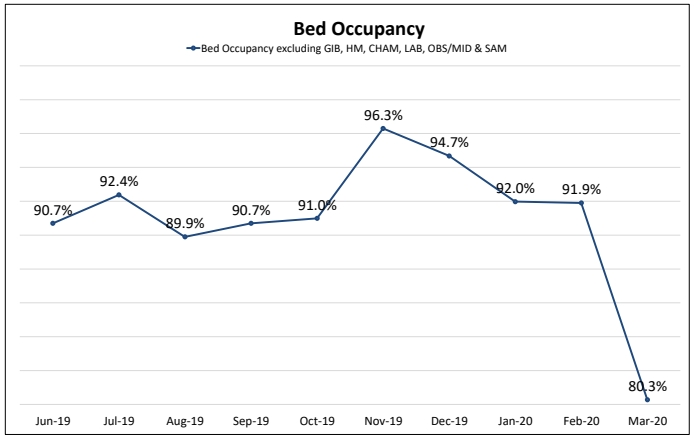




Test	% of Total Cohort - June 20	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Magnetic Resonance Imaging (MRI)	22%	100.00%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	78.41%	33.52%	38.24%	58.63%
Computed Tomography (CT)	11%	100.00%	100%	99.09%	99.83%	100%	100%	100%	100.00%	99.48%	85.30%	58.75%	60.69%	77.37%
Non-Obstetric Ultrasound	26%	99.92%	100.00%	99.86%	99.96%	99.92%	100%	100%	100.00%	99.89%	83.23%	39.20%	65.86%	92.61%
DEXA	1%	100%	100.00%	100%	100%	100%	100%	100%	100.00%	100.00%	-	-	100.00%	77.55%
Audiology - Audiology Asessments	5%	98.80%	100%	100%	100%	100%	100%	99%	98.40%	100.00%	68.82%	23.42%	11.02%	11.11%
Cardiology - Echocardiography	18%	100%	100.00%	99.86%	99.74%	98%	100%	100%	99.87%	96.38%	74.02%	37.55%	40.29%	55.46%
Neurophysiology	0%	83%	50%	67%	67%	85.71%	93%	97%	94%	89%	49%	42%	5%	36.17%
Urodynamics	1%	93%	90.00%	95.24%	94.74%	89.19%	92%	89%	81.82%	80.56%	91.11%	30.36%	30.30%	24.39%
Colonoscopy	7%	88.11%	84.62%	94.81%	99.24%	98.68%	89%	75%	88.52%	97.94%	93.58%	62.56%	38.41%	42.69%
Flexi Sigmoidoscopy	1%	93%	90%	92.86%	100.00%	94.29%	95%	69%	94.64%	95.56%	87.18%	48.98%	53.52%	55.66%
Cystoscopy	1%	92.31%	95.65%	94%	100.00%	96%	92%	86%	81.82%	100.00%	93.75%	64.52%	48.57%	55.00%
Gastroscopy	5%	88.46%	88.79%	96.83%	98.81%	99.07%	90%	83%	89.09%	99.15%	92.07%	58.37%	40.15%	44.88%

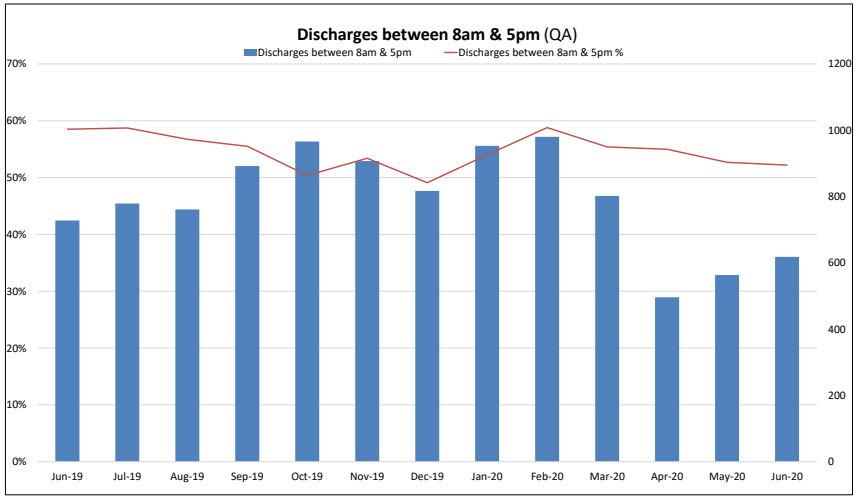
Stranded Patients

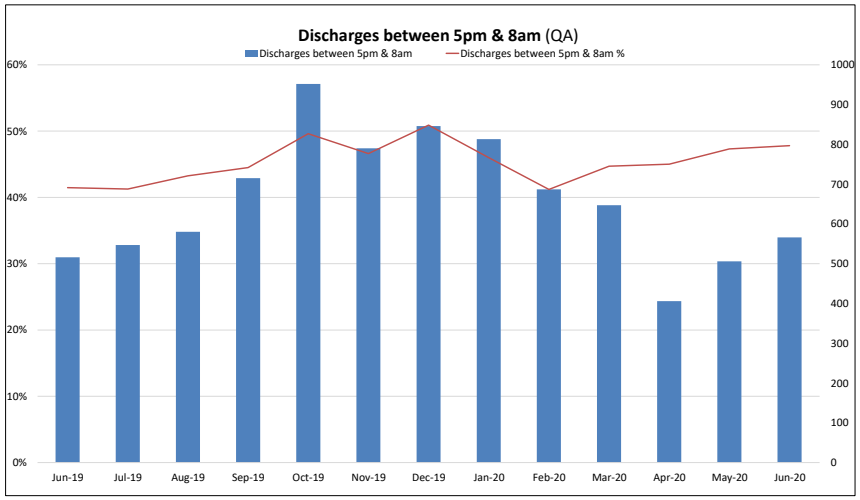


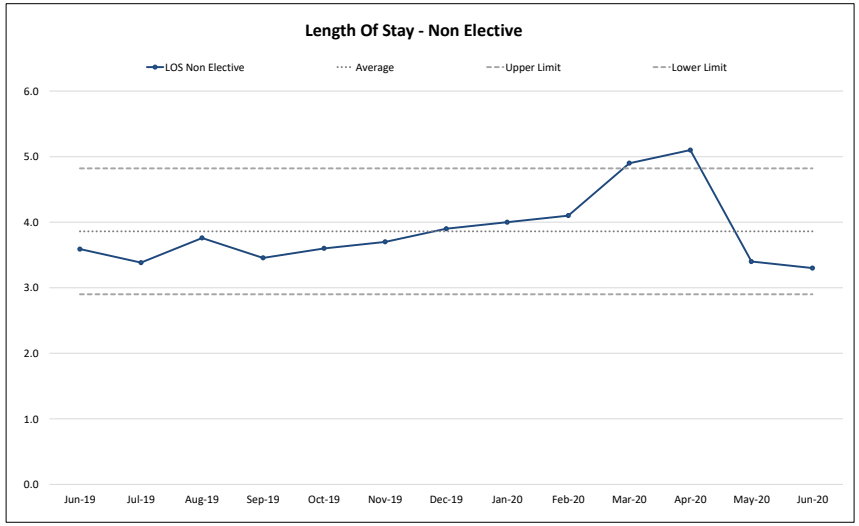


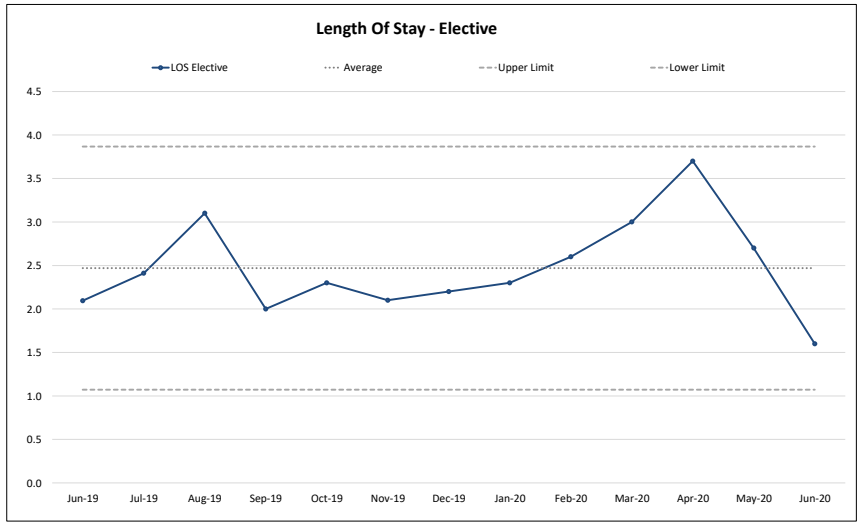
Collection suspended due to Covid-19

Discharges & LOS

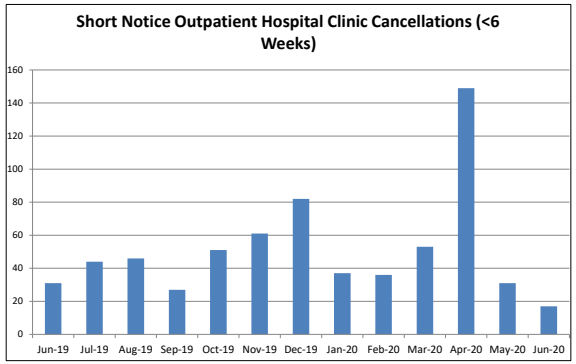


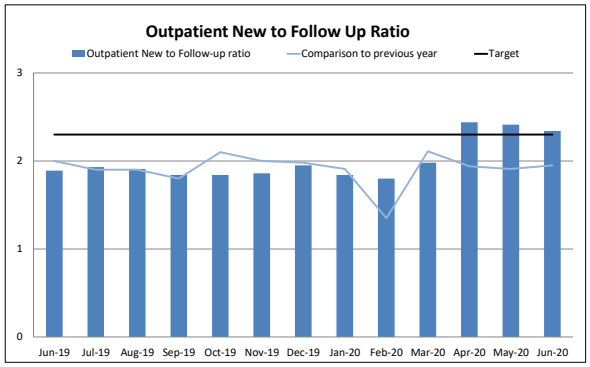


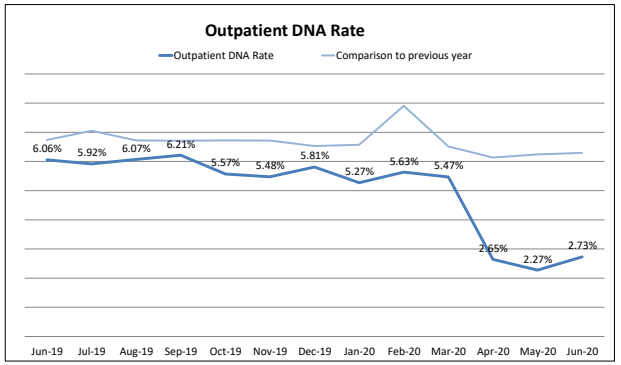


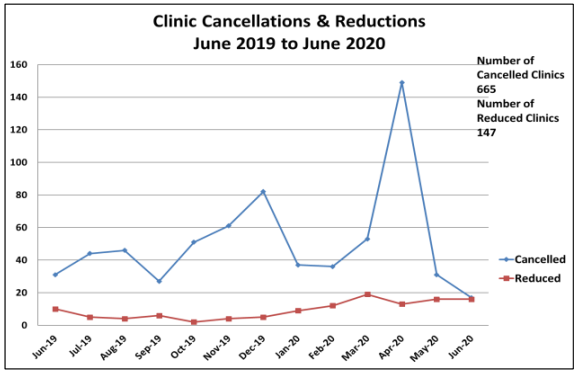


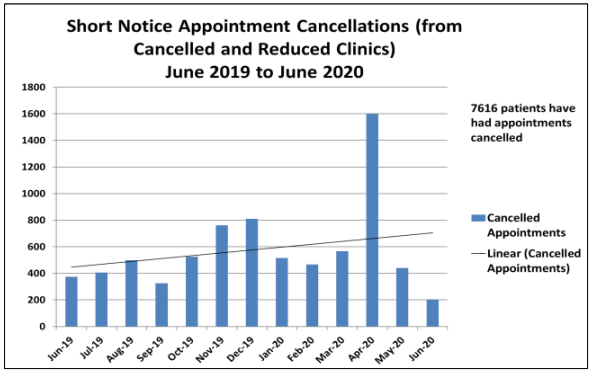
Outpatients & Cancelled Operations

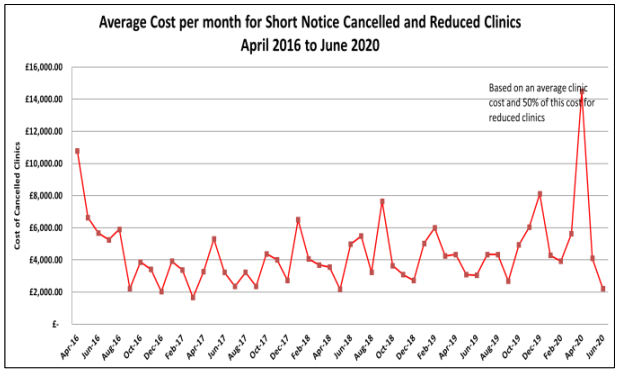












DNA Rate for Follow Up Appointments per Specialty for June

Specialty & Performing Unit	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	Gynaecology	Medical Oncology	Medicine for the Elderly	Neonatology	Neurology	Obstetrics	Ophthalmology	Optometry	Oral Surgery	Orthoptics	Paediatric Diabetic Medicine	Paediatrics	Physiotherapy	Respiratory Medicine	Rheumatology	Trauma & Orthopaedics	Urology	Vascular Surgery	Well Baby	Total
DNA Rate	0.0%	0.0%	5.4%	3.8%	5.2%	0.6%	0.8%	0.0%	5.4%	2.1%	2.2%	5.5%	0.3%	6.8%	6.3%	0.0%	0.2%	1.6%	0.1%	0.0%	0.0%	0.5%	2.3%	2.9%	0.0%	1.9%	18.7%	13.3%	6.3%	2.6%	2.5%	2.1%	0.8%	1.6%	1.7%	3.6%	2.7%

Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

People Measures

The overall trust vacancy rate is 9.4% just above the trust KPI but overall has continued to decrease month on month.

Vacancy rates continue to decrease across the three main staff groups. The nursing vacancy rate met the stretch target of 10% this year. Medical and Dental vacancies sit at just above 5%.

Temporary staffing has decreased across all staff groups over the last quarter with temporary staffing usage and recruitment pipeline are discussed as weekly establishment meeting.

During the COVID period, 97 staff were redeployed in to alternative roles and 67 supported with work adjustments to enable them to work in different ways.

Sickness absence has reduced over the last quarter, absence due to COVID related reasons has also reduced as expected.

Overall the trust met the KPI for statutory and mandatory training (90%) with support and guidance provided to those areas where compliance rates have reduced.

Health & Wellbeing

Antibody testing commenced in June, to date over 3113 staff have been tested. Vitamin D testing is also offered as part of this programme.

Trauma and risk (TRiM) training took place in June for PAHT staff with 15 staff across all staff groups trained.

In conjunction with EPUT, clinical reflection sessions were rolled out across the organisation and will continue over the coming months.

Workforce Indicators Summary

Agency Spend 5.55%
Bank Spend 7.94%

Staff In Post
3315
WTE

Training
No data

Sickness
3.9%

9.4%

Medical 100%
Non-Medical 81%

Turnover
10%

Scorecard

3 Our People Summary 3.2 Well Led

The Princess Alexandra Hospital NHS Trust

People Measures as at 30 June 2020	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3670.8	894.23	469.94	894.91	773.75	278.03	139.72	55.68	164.54
Vacancy Rate	8.0%	9.04%	6.03%	**11.56%**	**11.95%**	8.08%	**13.57%**	0.00%	4.63%	**14.17%**
Agency % of paybill	7.0%	5.5%	2.4%	2.3%	8.6%	6.5%	0.0%	0.0%	0.0%	6.6%
Bank Usage - wte	n/a	182.72	22.90	32.74	77.11	13.22	11.02	3.96	0.80	20.78
Agency Usage -wte	n/a	60.41	14.88	4.61	23.33	14.19	0.00	0.10	0.00	3.30
June 2020 Sickness Absence	3.7%	3.87%	3.68%	2.70%	**4.38%**	3.82%	**7.76%**	1.77%	2.43%	2.09%
Short Term Sickness	1.85%	2.07%	1.38%	1.40%	2.24%	1.97%	2.67%	1.66%	2.43%	0.64%
Long Term Sickness	1.85%	1.80%	2.30%	1.31%	2.13%	1.86%	5.09%	0.10%	0.00%	1.45%
Rolling Turnover (voluntary)	12%	9.91%	9.94%	9.30%	12.06%	7.89%	10.01%	9.06%	9.41%	10.85%
Statutory & Mandatory Training - May 2020	90%	90%	95%	88%	86%	84%	96%	95%	98%	93%
Appraisal	90%	81%	85%	80%	**78%**	**75%**	87%	82%	86%	85%
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)		27.77	8.53	2.00	6.44	6.00	0.00	3.00	1.00	0.80
Leavers (wte)		17.45	4.69	3.72	2.00	3.04	1.00	1.00	1.00	1.00
Time to hire (Advert to formal offer made)	31Days									

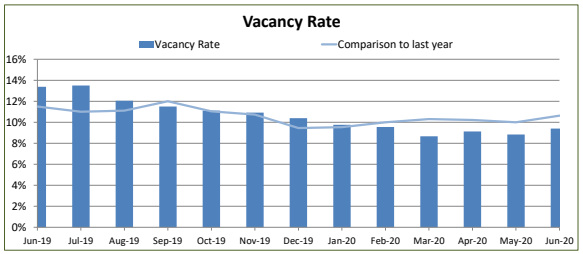
Above target	
Improvement from last month/above or below target	
Underachieving target	

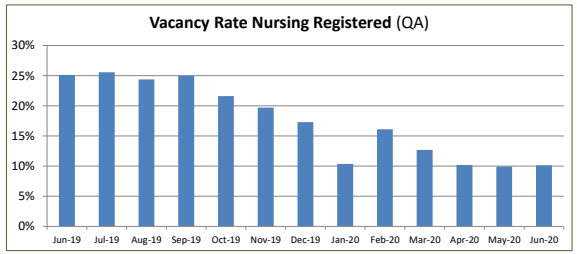
Workforce Indicators

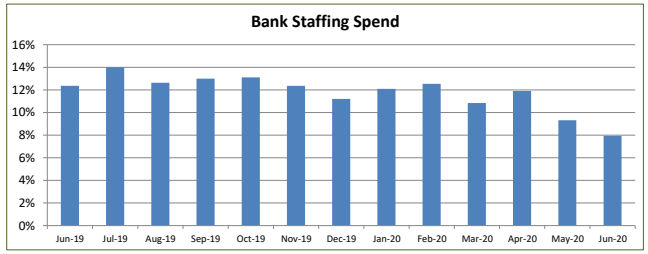
3 Our People Summary

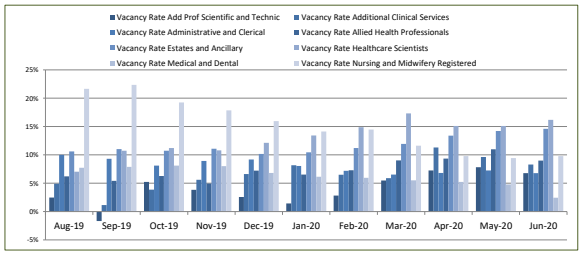
3.3 Well Led

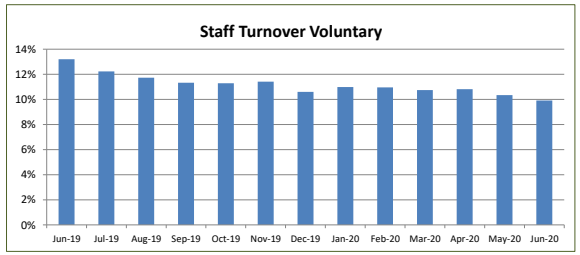
The Princess Alexandra Hospital NHS Trust

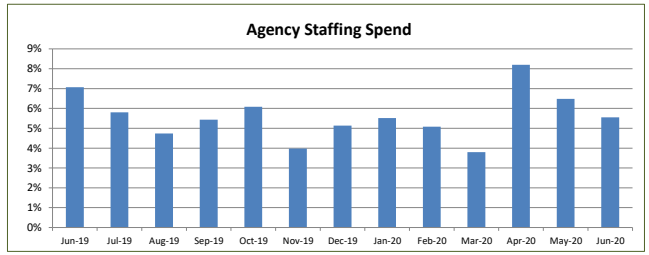


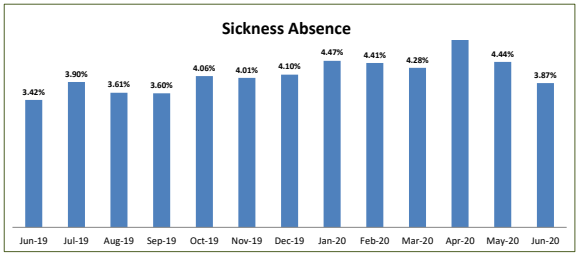


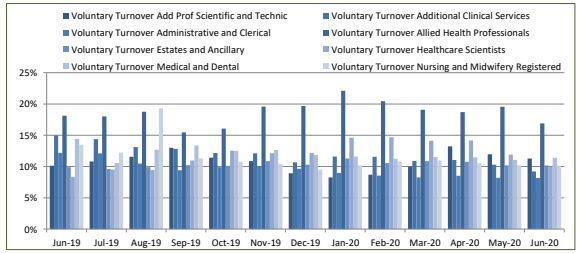


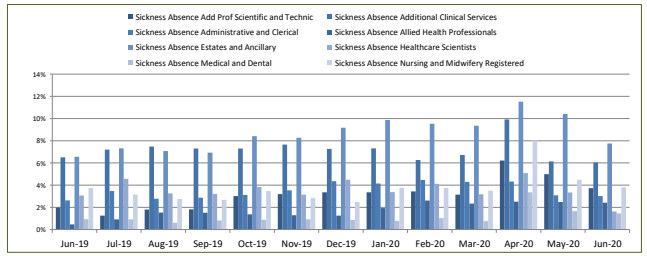




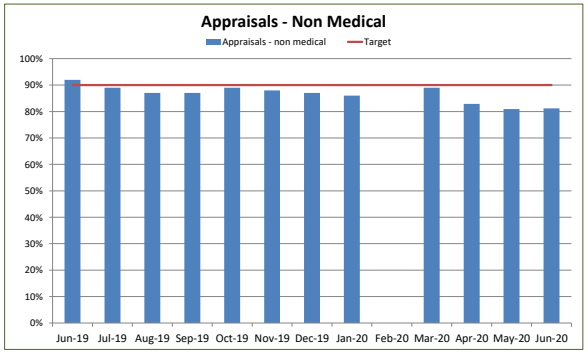


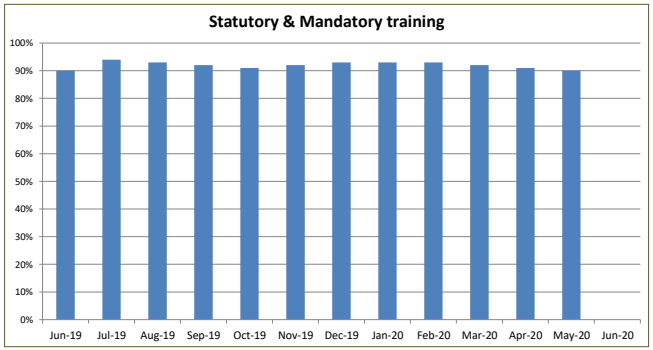


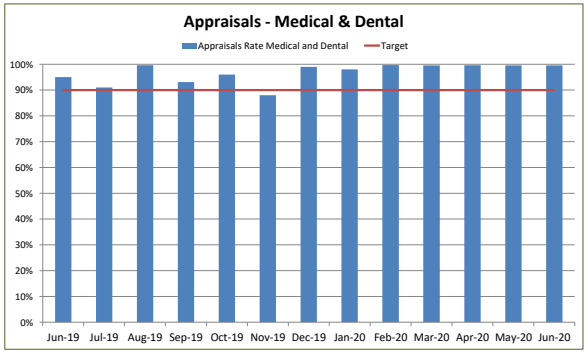


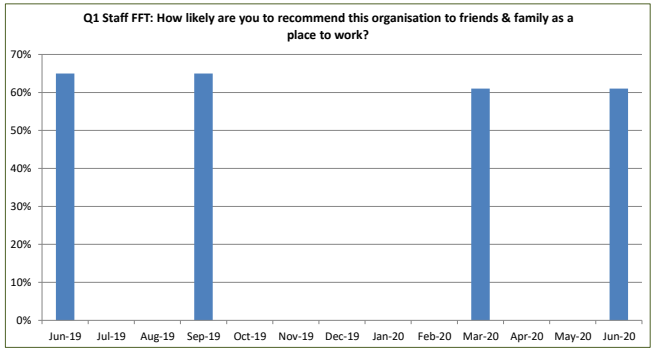


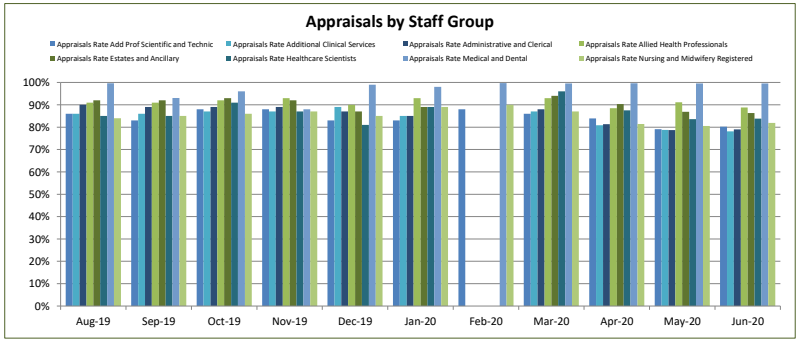
Workforce Indicators

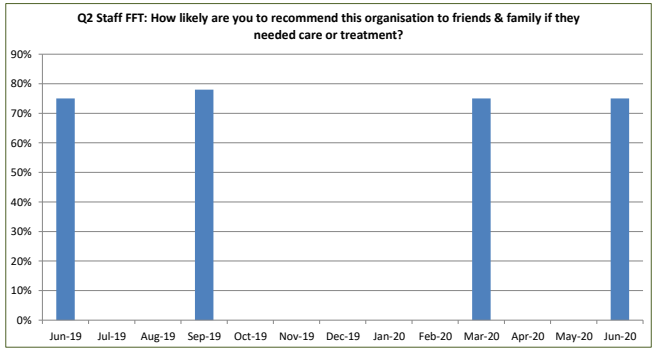












Workforce Indicators

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

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

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

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

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

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

Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

Domestics Due to the Shielding of the Facilities Compliance officer it was necessary to second a member of the Domestic team to carry out audits. This will remain in place until shielding has finished by August 2020. This change in role for one of the Domestic team has shown that members of the team are keen to progress into other roles within the department. The introduction of this new system will ensure more frequent audits on all areas & improve the real time information so that rectifications can be actioned, however, until government guidelines on social distancing are relaxed & other non-essential companies can return to work, training on the system is being delayed due to the supplier currently not able to attend site or for our staff to attend their premises for detailed training during June, as part of the domestic & housekeeping transformation project sees the arrival of the electronic system for National Specifications Cleaning.

Catering The number of meals produced for the wards by the kitchen has increased as more wards are opening than normal. The team have worked hard to produce excellent meals for staff in the restaurant to help in keeping up morale. They staff have also worked with & supported the Wingman Project.

Estates

Consultation: A programme is being drafted to share with the new HR business partner in preparedness for the development of a timeline to restart the implementation of the consultation.

Premises Assurance Model (PAM): Completion of all required documentation for the PAM submission is well underway. The increase in compliance over the last 12 months is evident from the data captured so far.

EBME relocation: The new EBME workshop is nearing completion. Relocation of the EBME function to an onsite facility, conducive to the activities being undertaken by the EBME team will mitigate risks relating to gaps in decontamination process, moving & handling, staff experience, task variation.

Planned Preventative Maintenance: PPM contracts are now in place for water management, ventilation systems, medical gas systems & the pressure system contract is to be awarded shortly. The emergency out of hours cover for critical functions has been reviewed & call off orders are in place with companies who have sufficient site knowledge & experience. This marks a significant increase in compliance with planned preventative maintenance for which the benefits can be evidenced in the comprehensive backlog maintenance capital plan for 2020/21.

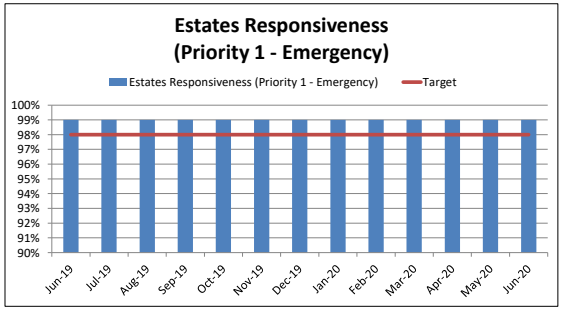
Water safety management: The scheduled quarterly water testing programme was carried out at the beginning of June. The results were good across the site & emphasised the importance of maintaining a suitable & sufficient maintenance regime through a pandemic period. All adverse results have now been rectified & those areas were resampled 10th July 2020 (awaiting results).

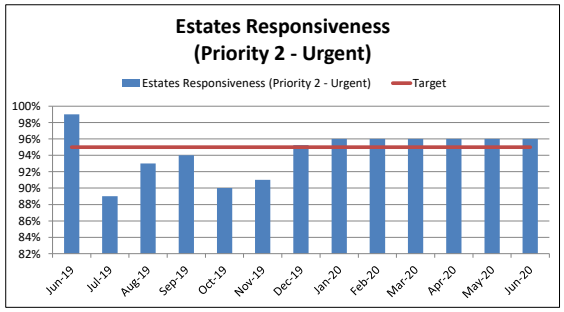
Drainage: We saw an increase in drainage blockages across the site through the month of June. We approached all operational leads to request assistance in reminding staff of the correct waste models. Engagement was very successful & we have seen a decline in the number & severity of blockages & leaks into July.

Ventilation systems: The RED area, HDU & Endoscopy have had new ventilation units installed to provide both air changes & comfort cooling. Since installation we have had not had any requests for cooling, heating or leaks (pipework related) in these areas.

Backlog maintenance: The Estates, Capital & Procurement team has been working in partnership over the last month to develop & finalise a governance driven BLM programme for 20/21. The programme has been developed using intelligence from maintenance, incidents & reactive remedial works. Following the initial programme development, risk assessments have been undertaken on all projects to ensure it reflects the 5 year plan. This has led to a higher percentage of refurbishment & component replacement rather than direct replacement of plant. This will ensure value for money in the time we remain on this site & limited operational downtime for service.

Places


Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20


Estates Responsiveness (Priority 2 - Urgent)
Estates Responsiveness (Priority 2 - Urgent)
Target
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
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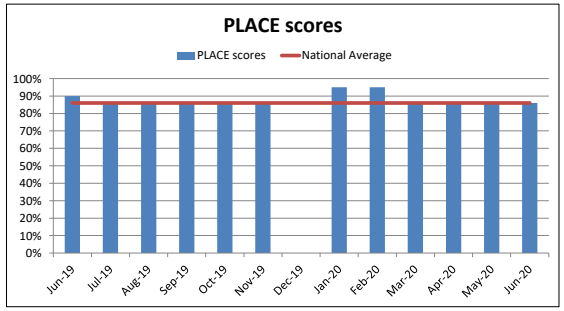
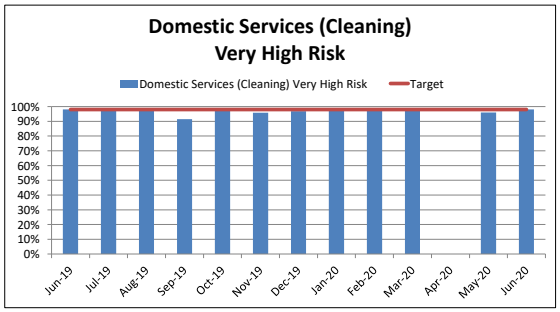
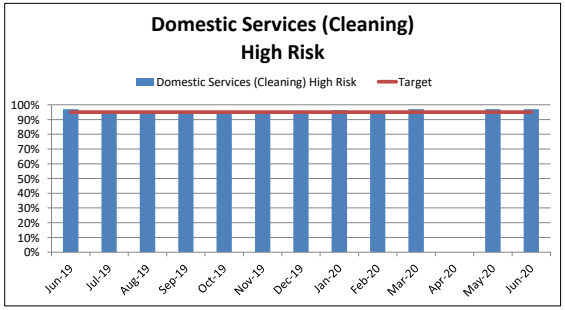
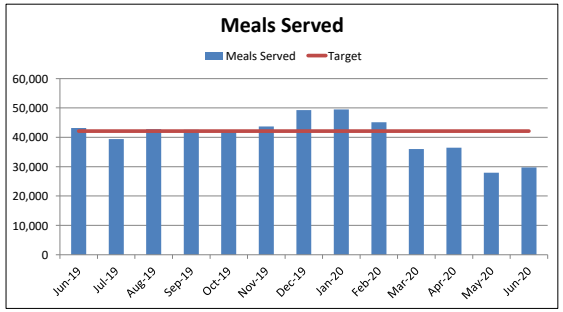
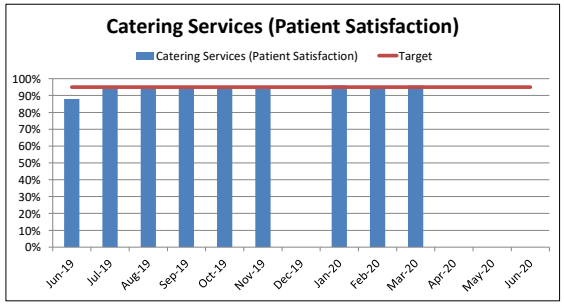
Feb-20
Mar-20
Apr-20
May-20
Jun-20

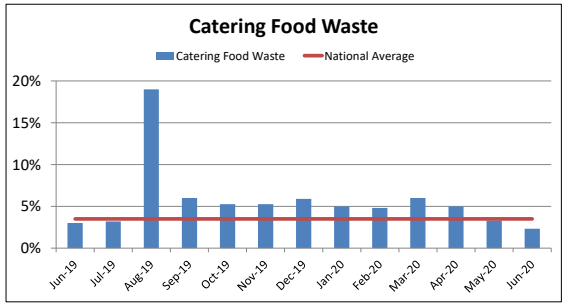

PLACE scores
PLACE scores
National Average
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20


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


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


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


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


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

Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

As required by the current financial regime the Trust is reporting a breakeven position. The underlying position against the NHSI/E plan is an in month deficit variance of £0.1m with a cumulative deficit variance of £0.8m. This deficit is returned to a breakeven position by the Trust claiming a retrospective "top-up" adjustment. Covid costs reduced to £1.5m from £2.0m in M2.

Overspends are arising on pay expenditure including temporary staffing expenditure in M3 which totalled £2.1m reduced from £2.5m in M2. In addition shortfalls in trading income are also being incurred as a direct impact of trading activities impacted by Covid. Non pay underspends are supporting pay and income shortfalls as spend on elective surgery consumables is lower than planned although non pay spend has increased between M2 and M3 as more activity is performed.

In-month capital expenditure was £1.3m, YTD spend is £3.7m including Covid related capital bids. This spend is lower than expectations that are required to deliver the plan. The Trust has an annual capital plan of c£40m. The Capital Working Group (22/6) is focusing on critical paths, milestone plans and profiled monthly trajectories from all project leads.

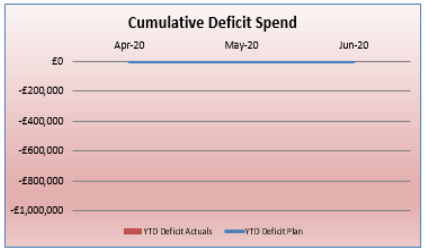
Cash resources remain sufficient with balances at £59.7m.

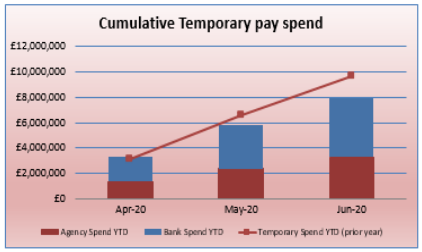
Pounds

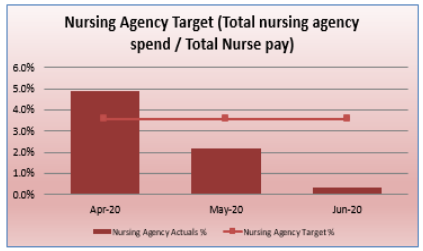
5 Our Pounds Summary — 5.1 Overall financial position

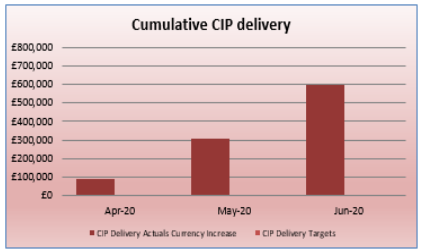
The Princess Alexandra Hospital NHS Trust

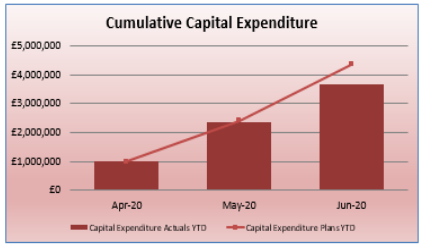
OUR POUNDS		
Metric	Annual Plan	Latest month
Deficit	£0	£0
Agency Spend £s	-£10,292,000	-£3,258,488
Bank Spend £s	TBC	-£4,696,785
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3.6%	0.3%
Capital Expenditure	-£42,618,000	-£3,679,000
BPPC Volume	95%	89%
BPPC - £s	95%	88%
Cash Balance	£1,000,000	£59,654,000

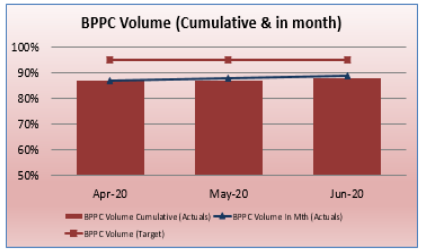


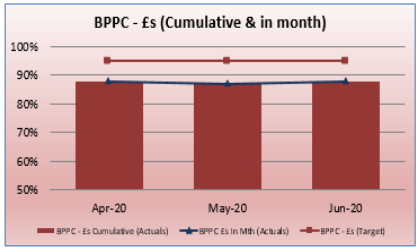


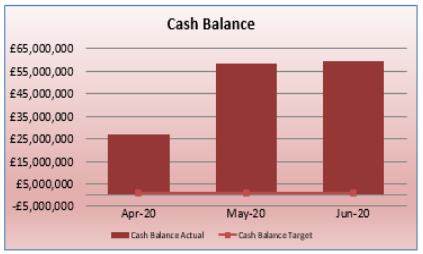












CQC Rating

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

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

respectful | caring | responsible | committed

Commissioning for Quality and Innovation

2019/20 CQUIN Forecast

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

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

Quality Improvement Plan Projects	Executive LEAD	Senior Responsible Officer	MUST / SHOULD	Performance Sep 19	Performance Oct 19	Performance Nov 19	Performance Dec 19	Performance Jan 20	Performance Feb 20	Performance Mar 20	Performance Apr 20	Performance May 20	Performance Jun 20	Completed progress and next steps
1. Governance Project	Director of Nursing	Associate Director of Governance	MUST: 5, 10, 13, 17, 20, 21 Should: 1, 4, 5, 14											**Overall Summary:** Project on track against work plan milestones. **Completed:** Benchmark PAH governance structures against 5 other trusts. Reviewed & mapped the current safety, quality & governance meeting structures across the four HCGs. Collated the current TOR for all QSC sub groups. **Actions to complete in January/February:** All QSC sub groups requested to review their TOR, agenda & action log to bring it into line within new trust documents. Reviewing & develop an amended governance meeting structure with a plan to take a fully consulted proposal to relevant committees in February 2020 for approval. Develop an outline of the future Trust governance people structure.
2. Documentation Project	Director of Nursing	Deputy Director of Nursing	MUST: 1, 5, 6, 12 Should: 6, 17											**Overall Summary:** Documentation working group is in place for nursing for six months. **Completed:** Nursing documentation work plan completed for admission assessment to be moved to nerve centre. Scoped improvements required within the work plan. Documentation policy including competencies & audit programme is complete. **Actions to complete in January:** Project plan to build all nursing admission assessments onto Nerve centre in progress along with training plan & roll out to be developed. Developing a single falls risk assessment for use from front door in line with community risk assessment & when complete will move to Nerve centre. Changes to the paper documentation of care for comfort rounding, repositioning, pain assessment, VIP, catheter care & fluid charts completed & awaiting proof from the printers. Non-essential risk assessment booklet at first draft stage.
3. Training Project	Director of People	Associate Director of Ops FAWs and Associate Medical Director for Surgery	MUST: 2, 8, 18, 22 Should: 3, 13, 15, 16											**Overall Summary:** Slow gradual improvement, Trust compliance: December 93%, November 92%, October 91% **Completed:** Data available for all staff groups & shared with senior leaders across the Trust. Detailed breakdown on medical & dental training data is with the HCGs & actions & trajectories are discussed at Performance Review Meetings. **Actions to complete in January:** Identified staff with the most out of date Stat/Mandatory training compliances & targeted support is provided. A letter is being sent out from CFO & CMO to staff who have very out of date IG compliance. As part of streamlining programme the trust will ensure that doctors can transfer stat/man training compliances from other trusts to here. Specific training sessions to be organised for consultants & middle grades to attend on one day. Discussions at MAC by HR director to discuss how the medical teams will achieve compliance.
4. Nurse Vacancy Project	Director of Nursing	Deputy Director of Nursing	MUST: 3, 4, 11											**Overall Summary:** Project on plan for recruitment of nursing staff. **Completed:** Retention plan approved at the nursing recruitment & retention group with a revised target to achieve is <10%. **Actions to complete in January:** Establishment review & nursing workforce retention plan to be discussed & approved by Trust Board. Working on the business case for overseas recruitment for 2020/21 with aim to reduce vacancy to <1%. Refresh domestic recruitment advertising campaign to increase domestic recruitment. Finalise the retention strategy.
5. Maternity Action Plan	Director of Nursing	Associate Director of Nursing & Midwifery	MUST: 14, 15, 16 Should: 10											**Overall Summary:** Good progress and delivering against milestones planned. Progress against this plan was monitored in December by both CCG (WE) and the executives at the monthly performance review meetings. **Completed:** PDSA cycle 1 for baseline has been completed. Stickers used for all CTGs documented in notes in line with national guidance. Compliance with life support training achieves Trust standard. **Actions to complete in January:** Commence audits to monitor progress against the must and should do actions
6. Infection prevention & control in Maternity Unit project	Director of Nursing	Associate Director of Nursing & Midwifery	Should: 6, 7, 8											**Overall Summary:** Project on track against milestones in the work plan. **Completed:** Cleaning process in maternity theatres changed and mirrors that of the main theatres. Started to use recovery and theatre environment checklist. IP&C team are included in all processes for maternity in respect to estates work. **Actions to complete in January:** Compliance audits of cleaning standards in Labour ward theatres to commence.
7. Workforce in Family & Women's Project	Director of Nursing	Associate Director of Nursing & Midwifery	Should: 11, 19											**Overall Summary:** Project on track against milestones in the work plan. **Completed:** Confirmed other local trusts have a generic physiotherapist in post Mon to Friday. Birth rate plus maternity workforce review completed. Job description completed for joint role with physiotherapist in NICU & Paediatrics also Occupational Therapy JD completed. **Actions to complete in January:** Develop a SOP to access physiotherapy services.
8. Maternity Strategy Project	Director of Nursing	Head of Midwifery	Should: 12											**Overall Summary:** Project on track against milestones in the work plan. **Completed:** 11 Transformation projects are underway with Trust senior maternity staff aware & updated on this work through their PRM Maternity voices partnership & the HCG PS&QG meeting of the strategic direction for the service. **Actions to complete in January:** Governance lead for LMS to be appointed to develop shared dashboards.
9. Health & Safety Project	Chief Operating Officer	Health, Safety and Governance Manager	MUST: 9, 19											**Overall Summary:** Most recent audits completed by Health & safety team from November 2019 show 62% for all COSHH cabinets being locked. 98% for correct substances stored in the hazardous substances cupboard. The expected COSHH compliance is 100% as a statutory requirement. **Completed:** Health & Safety team have completed Datix incidents for areas showing non-compliance as this is a statutory breach. This is escalated to local ward leaders to address the gaps. **Actions to complete in January:** Additional training has been given to wards & departments for non-compliant areas. Audit results shared with HCG clinical leaders. Working towards adding COSHH compliance being added to the perfect ward monthly audits. Matrons are undertaken additional spot checks for areas with poor compliance.
10. Estates Project	Director of Estates & Strategy	Strategic Head of Estates with the Environment & Sustainability Officer	MUST: 7 Should: 9											**Overall Summary:** Project delivering on current work plan for crockery management. **Completed:** Substantial progress regarding waste contract & monitoring across the trust. Developed waste management strategy. Trust has waste disposal certificates. **Actions to complete in January**: Commence training for 25% of the domestics to support compliance with disposal to make it easier to recycle waste. Developing checklist for broken crockery bin. Audits to monitor compliance have commenced. Roll out of electrical equipment safety testing at time of use to be included in the project plan.

Quality Improvement Plan Projects	Executive LEAD	Senior Responsible Officer	MUST / SHOULD	Performance Sep 19	Performance Oct 19	Performance Nov 19	Performance Dec 19	Performance Jan 20	Performance Feb 20	Performance Mar 20	Performance Apr 20	Performance May 20	Performance Jun 20	Completed progress and next steps
10. Children & Young Peoples Transition Project	Director of People	Neonatal Unit Manager	Should: 18											**Overall Summary: Should 18 (Children)** Leading on developing the sickle cell transition pathway as there is a small cohort of children that are coming up to the transition age so the pertinent to move forward with. **Completed:** Trust is part of cohort 2 National Transition Collaborative working towards project plan to be presented at March 2020 national meeting. Letter & questionnaire sent out to relevant children & their families in December asking for their feedback on the project plan. **Actions to complete in January:** Awaiting responses from patients/families to project questionnaire & will need to analyse responses received to amend the project plan developed.
11. Mortality	Chief Medical Officer		MUST: 12											The mortality project is being monitored through the Mortality Improvement Group & so is not tracked in this paper.
12. Urgent Care	Director of Nursing		Should: 2											The urgent care project is being monitored through the Urgent Care Programme Board so is not tracked in this paper.
13. End of Life	Director of Nursing		Should: 20											**Overall Summary for Should 20 (End of Life):** Money identified within CCCS budget to fund a band 7 to enable a 7 day service to commence. Recruitment process has commenced. **Actions to be completed in January:** Full business case being developed for educational post & psychologist to support the service to move towards an outstanding rating. This is being completed by CCCS in readiness for the new year cost pressure discussions.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06.08.20 **AGENDA ITEM NO: 5.1**

REPORT TO THE BOARD FROM: New Hospital Committee (NHC)
REPORT FROM: Lance McCarthy (Committee Chair)
DATE OF COMMITTEE MEETING: 27.07.20 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

5.1

- **Progress Update:** The Committee noted robust progress across all projects and work-streams, and in line with stipulated timelines.

- **Key Deliverables:** Key deliverables for the work programme were presented through to July 2022 and submission of the full business case.

- **Options Appraisal:** A first Options Appraisal workshop was held on 04.05.20 at which Investment Objectives, Critical Success Factors, and Constraints and Dependencies were agreed with regional and national colleagues. A second workshop was held on 29.06.20 to evaluate a long list of options in accordance with the HMT Green Book process. It was decided the short list should include:
    1. The "preferred way forward" (combination of choices most likely to deliver the SMART objectives) – New Build Greenfield site.
    2. The Business as Usual benchmark – Current site with planned developments only.
    3. A viable "do-minimum" option that meets minimum core requirements to achieve the objectives identified – Part refurbishment, part new build.
    4. At least one viable alternative option – New build on current site.

  The above would now undergo economic analysis to determine a "preferred option" (as opposed to "preferred way forward"). That option would then be fully developed to outline business case and then full business case.

- **Risks:** The following key risks were highlighted:

1. K34 - Developing FBC in advance of OBC approval (amber rating)
2. K23 - Delay in appointing HR & Workforce Lead (amber rating – increase to 6)
3. K26 - Delay in appointing Comms & Engagement Lead (amber rating – increase to 6)

It was noted that there are a significant number of programme risks, some of which will continue to be scored as high risks despite the mitigating actions being taken; the programme risk register is reviewed by the New Hospital Committee at each meeting.

- **Revised Terms of Reference** - It was noted that Committee members were now solely those employed by the Princess Alexandra Hospital Trust (PAHT) and that all other individuals would be noted as attendees. The revised ToR were agreed and recommended to Board for approval (attached).

- **Strategic Assumptions** - It was agreed that the detail within the paper on strategic assumptions would not be discussed as it was still to be presented to SMT but several significant principles were noted:

    - No plans for any significant service expansion, only to provide some bariatric surgery.
    - No plans for a helipad.
    - 100% single rooms, impact of this to be worked through.
    - Plans to be 100% digital.
    - Agreed principles on hard/soft facilities management (FM): to be automated wherever possible, complete separate public/business flow and minimal storage in clinical areas.

The Princess Alexandra Hospital NHS
NHS Trust

SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
In addition to the above, NHC received reports on the following agenda items: • Finance Report
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
A work plan is being developed.

The Princess Alexandra Hospital NHS Trust

5.1

PAH NEW HOSPITAL COMMITTEE

TERMS OF REFERENCE

INTRODUCTION:

The current facilities at Princess Alexandra Hospital are no longer fit for purpose, presenting clinical operational and financial risks to The Princess Alexandra Hospital NHS Trust (PAH). The condition of the estate adversely impacts on PAH's ability to attract appropriate staff and its ability to deliver the required CIPs to ensure financial sustainability. The estate has been identified by the CQC as "*one of the top risks for the Trust*".

Significant investment is required to:

- Maintain the performance of PAH's services or guarantee the safety of its services
- Support the implementation of the Hertfordshire and West Essex Integrated Care Strategy and PAH's aspiration to become an Integrated Care Trust
- Ensure PAH's financial sustainability.

This requirement was recognised with the inclusion of PAH in the government's Health Infrastructure Plan (HIP) as one of the first 6 new large hospitals to be allocated funding for delivery of new hospital facilities by 2025.

PAH's New Hospital Programme is critical in providing fit for purpose facilities to maintain the quality of clinical services for patients and support financially sustainable service transformation to integrated care. It is also essential in ensuring that the future needs of the local population, which is forecast to grow considerably, are met.

PURPOSE:

The PAH New Hospital Committee is established under delegated authority from the Trust Board to oversee the strategic direction and progress of the new build and provide a forum to monitor progress of the new hospital programme, including mitigation of risks and management of financial elements.

DUTIES:

- To maintain oversight of the governance arrangements for the programme, ensuring robust recommendations are made to the Trust Board on key commercial and strategic decisions;
- To ensure that the right structures, leadership and capability are in place to deliver the project successfully;
- To review the outline business case and full business case prior to making an appropriate recommendation to the Trust Board,
- To have ultimate oversight responsibility for the successful delivery of the programme within the parameters agreed by the Trust Board.
- To monitor the progress of the programme and achievement of its core aims and objectives within agreed timescales, ensuring any potential variances to plan are highlighted in a timely way.
- To ensure the project is delivered in a joined-up way across PAH departments and directorates;
- To take a strategic overview of communications activity;
- To maintain oversight of the Programme Budget and delivery of the project within the agreed Budget;

- To receive regular reports on the action being taken to remove or mitigate the principal risks, and to review and approve updates, monitor controls and examine assurance sources.

ACCOUNTABLE TO:	Trust Board.
REPORTING ARRANGEMENTS:	Following each meeting of the New Hospital Committee a report shall be produced for the Board of Directors by the Committee Chairman.
CHAIRMAN:	Chief Executive Officer
COMPOSITION OF MEMBERSHIP:	• Director of Strategy/New Hospital Project Director • Non-Executive Director x 2 • CFO, COO, CMO.
ATTENDANCE:	Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee meetings within each reporting year. An attendance record shall be taken at each meeting.
INVITED TO ATTEND:	The Committee may invite internal and external attendees to attend the Committee to provide advice, support and information. The Deputy Programme Director and Senior Estates Advisor will be required to attend every meeting.
DEPUTISING ARRANGEMENTS:	In the absence of the Chairman of the Committee, a non-executive member shall chair the meeting.
QUORUM:	The quorum for any meeting of the Committee shall be two members, one of which must be a Non-Executive member and the Director of Strategy or another Executive member.
DECLARATION OF INTERESTS:	All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.
LEAD EXECUTIVE:	Director of Strategy
MEETING FREQUENCY:	Meetings shall be held monthly, but extra-ordinary meetings may be called at key points within the programme
MEETING ORGANISATION:	• The meeting shall be closed and not open to the public. • The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee. • A draft agenda shall be developed by the Head of Corporate Affairs and lead executive and agreed by the Committee Chairman at least ten clear days* before the next meeting. • All final Committee reports must be submitted six clear days* before the meeting. • The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees five clear days* before the date of the meeting and not less than three clear days* before the date of the meeting. *'clear day' means any day which is not a Saturday or Sunday or a public or bank holiday.

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

The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from inside or outside the Trust with relevant experience and expertise if it considers this necessary

TERMS OF REFERENCE: The terms of reference of the Committee shall be reviewed annually and approved by the Trust Board.

DATE APPROVED: By Committee:
By Trust Board:

PAH New Hospital Committee Membership	
Members	
Chair and SRO	Lance McCarthy
Director of Strategy	Michael Meredith
Non-Executive Director	John Hogan
Non-Executive Director	John Keddie
CFO	Trevor Smith
CMO	Marcelle Michail
COO	Stephanie Lawton
Attendees	
NHSE/I Land and Planning Advisor – Kevin Hopkinson Deputy Programme Director – Helen Davis Senior Estates Advisor – Mark Cammies Hospital Construction Specialist - Andrew Panniker CCG Representative - TBC Representative from NHSE/I - Simon Wood/Nigel Littlewood	
Secretariat	
Corporate Affairs	

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06.08.20 **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: 30.07.20 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **Month 3 Position:** Against the Trust's interim plan there was an in-month variance of £0.1m and YTD variance of £0.8m. Under the current adapted financial regime the Trust was required to report a breakeven position by a funding adjustment. Going forward the focus needed to continue on temporary staffing, delivery of in-flight/re-instatement of CIP initiatives, stringent cost control and capital investment schemes. YTD capital expenditure was £3.7m with a continued focus on the critical paths and milestone plans driving delivery of the profiled plans (total c£45m).

- **Temporary Staffing:** Within the pay deficit for M3 was temporary staffing expenditure of £2.1m which was a reduction of £0.4m (all nursing) compared to M2. The cumulative temporary staffing expenditure was £8.0m which was a reduction of £1.7m compared to M3 YTD in 2019/20. It was noted that the additional staffing support in Estates & Facilities (due to Covid) was now expected to step-down in August. Progress against the key areas of the temporary staffing action plan was received by the Committee.

- **Financial Regime:** Guidance was still awaited around the new financial regime. Existing processes were likely to remain in place until August/September after which it was expected that for the second half of the year processes would be tighter and more challenging with Covid reimbursement expected to be prospective through system financial envelopes rather than the current retrospective recovery process. It was anticipated that 'financial envelopes' would be allocated to each ICS with the system then determining how that was spent. Planning therefore would be key going forward.

- **STP Consolidation of Procurement Services**: Following the last PAF meeting there was now a list of items to be worked through, with the support of ICS and NHSE/I colleagues. Concerns included the relatively low saving projections compared to the significant level of discretionary spend across the ICS. It was agreed an extra-ordinary PAF may be convened during August if required to consider the final FBC ahead of September PAF/October Board for approval.

- **Domestics Modernisation Business Case:** It was agreed to recommend the case for approval to Board in August subject to the option of lease rather than purchase being considered.

- **OBC Costs:** The Committee noted the current forecast of fees and costs in relation to the production of the OBC, enabling works and the prospective land purchase, together with project timelines and key next steps. The above was against a capital allocation of £9.238m for 2020/21. The financial planning timetable was presented and discussed together with some of the major accounting matters. It was agreed that a further update would be provided in September and then at least every other month going forwards.

- BAF risks 4.2 (ED standard), 5.1 (Finance), 1.2 (EPR) and 3.1 (Estate and Infrastructure) - all risk scores remain unchanged.

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

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

- Recovery and Restoration, including waiting list and 52 week breach numbers.

• IM&T Quarterly Update for which members commended the progress and asked for it to be formally acknowledged with IT colleagues.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee continues to make progress against its work plan although, as previously, certain agenda items were deferred by agreement with the Chair due to the current pressures relating to COVID-19.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06/08/20 **AGENDA ITEM NO: 5.1**

REPORT TO THE BOARD FROM: Workforce Committee

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 27/07/20

5.1

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
• The Workforce update was noted and the Trust's compliance rate for all staff risk assessments is 79.5% and for black, Asian, minority ethnic (BAME) staff is 72% • Freedom to Speak Up - the quarterly report from the guardians was discussed and it was noted that 2 additional clinical guardians are being recruited to support clinical staff groups. • Communications Strategy - the strategy was reviewed and approved. • The OD Plan was approved and the update on the Culture Improvement Programme and the People section of the Recovery and Restoration plan were reviewed and supported. The next Board Development session on 3 September will focus on the OD framework and Culture Improvement Programme. • The Committee effectiveness review has been undertaken and will be reported to the next WFC meeting and Trust Board however, in the interim it was noted that there are no changes to the terms of reference and minor adjustments to the work plan have been agreed.
SECTION 2 – ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
The following are highlighted for the Board's awareness and/or assurance:
• BAF risk 2.1 was reviewed and the recommendation that the score remain at 12 was supported. • An update on the NHSP contract was noted. • Nursing, Midwifery and Care Staff Levels and Recruitment update noted. • Voluntary Services quarterly update noted. • Training and education update noted including the update on the launch of the reverse mentoring programme.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee's progress against its Annual Work Plan is set out below:
The Committee is making good progress against the work plan and reporting has re-commenced in line with the work plan.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06.08.20 **AGENDA ITEM NO: 5.1**

REPORT TO THE BOARD FROM: Senior Management Team
REPORT FROM: Lance McCarthy - Chairman
DATE OF MEETINGS (Monthly going forward): 28.07.20

5.1

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
The following items were discussed at the first SMT meeting held since Covid; going forward meetings will be held monthly: • Domestics Modernisation Business Case – supported and recommended to Board for approval. • New Hospital update • ICP/ICS update • Ophthalmology update • Recovery and Restoration update/ Financial Results - Month 3 • Significant Risk Register • Internal meeting updates: - Capital Working Group - Trust Policy Group - Access Board - Cancer Board

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 06.08.20 **AGENDA ITEM NO: 5.2**

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

REPORT FROM: John Keddie – Chairman

DATE OF COMMITTEE MEETING: 08.07.20

5.2

SECTION 1 – MATTERS FOR THE CORPORATE TRUSTEE/TRUST BOARD'S ATTENTION
The following items are escalated for noting: • The committee approved the Head of Fundraising post for a one year fixed term and agreed the funding source. • A bid from NICU for funding to purchase recliner chairs and trolleys for the neonatal unit (£38.2k) was considered and unanimously supported by members. • The draft annual report and accounts were reviewed and the approach to the annual report was agreed. The following reports were received: • Charitable funds finance report • Fundraising update
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The CFC is making good progress against its annual work plan.

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