The Princess Alexandra Hospital NHS Trust

AGENDA

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

Date and time: Thursday 2 April 2020
11.30 – 13.00
Venue: Meeting Room 4, Kalmar House
Dial in details: (tbc)

	Item	Subject	Action	Lead	
01 Opening Administration					
11.30	1.1	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from previous meeting	Approve	Chairman	4
	1.4	Matters Arising and Action Log	Review	All	12
02 Risk					
11.35	2.1	COVID-19	Inform	Chief Executive/ Executives	Verbal
11.50	2.2	Board Assurance Framework 2019-20 including: • New risk: COVID-19 • Summary of changes during 2019/20	Review	Head of Corporate Affairs	13
03 Chief Executive's Report/Strategy					
11.55	3.1	CEO's Report	Discuss	Chief Executive	Verbal
12.10	3.2	PAHT 2030	Approve	Director of Strategy	28
04 Patients					
12.20	4.1	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing & Midwifery	52
05 People					
12.25	5.1	Staff Survey Results 2019	Discuss	Director of People	62
12.30	5.2	Fit and Proper Persons: Annual review	Inform	Director of People	67
12.35	5.3	Gender Pay Gap	Approve	Director of People	70
06 Performance and Places					
12.40	6.1	Integrated Performance Report (IPR)	Discuss	Executives	74
12.45	6.2	Interim Budget 2020/21	Discuss	Chief Finance Officer	110
07 Governance					
12.55	7.1	Reports from Committees: • WFC.23.03.20 • PAF.26.03.20 • Audit. 26.03.20 including Terms of Reference 2020/21 • QSC.27.03.20	Inform	WFC Chair PAF Chair Audit Chair QSC Chair	121 122 123 124 131

The Princess Alexandra Hospital NHS Trust

08 Questions from the Public					
	8.1	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.	No public in attendance as the meeting is being held remotely due to COVID-19.		
09 Closing Administration					
13.00	9.1	Summary of Actions and Decisions	-	Chairman/All	
	9.2	New Risks and Issues Identified	Discuss	All	
	9.3	Any Other Business	Review	All	
	9.4	Reflection on Meeting	Discuss	All	

Public Board Meeting Dates 2020/21

02.04.20	01.10.20
04.06.20	03.12.20
06.08.20.	04.02.21

The Princess Alexandra Hospital NHS Trust

Board Purpose:

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 Trust Board Meeting in Public
Thursday 6 February 2020 from 09:30 – 11:45 at
Harlow Leisure Zone, Second Avenue, Harlow CM20 3DT

Present:	
Steve Clarke	**Trust Chairman (TC)**
Lance McCarthy	Chief Executive Officer (CEO)
Pam Court	Non-Executive Director (NED-PC)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Helen Glenister	Non-Executive Director (NED-HG)
Andrew Holden	Non-Executive Director (NED-AH)
Helen Howe (non-voting)	Associate Non-Executive Director (ANED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
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)
Andy Morris	Chief Medical Officer (CMO)
Trevor Smith	Chief Financial Officer (CFO)
George Wood	Non-Executive Director (NED)
Staff Story:	
Laura Wood	Paediatric Nurse
Fiona Cook	Paediatric ED Manager
Valerie Brown-Beckford	PAHT – Leadership Development
Learning from Deaths:	
Jacqui Featherstone	Associate Director of Nursing & Midwifery
Andrea Philip	Associate Director of Operations – FAWS
Bobbie Phippin	Lead Midwife for Quality & Compliance
Lynne Staite	Deputy Head of Midwifery
Jyoti Rachna	Obs & Gynae Consultant
Observing:	
Dr. Amik Aneja	General Practitioner
Laura Warren	Associate Director of Communications
Shahid Sardar	Associate Director – Patient Engagement
Ann Nutt	Chair of Patient Panel
Members of the Public	
Elle Offer	NHS Professionals
Revd Dennis Nadin	Member of Public
Vicky Morgan	Liaison
Fiona Claridge	NHS Confederation
Casandra Daubney	Liaison
Apologies:	
John Hogan	Non-Executive Director (NED-JH)
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 meeting.
1.1 Apologies	
1.2	As above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Meeting held on 05.12.19	
1.4	These were agreed as a true and accurate record of that meeting with no amendments.

The Princess Alexandra Hospital NHS
NHS Trust

1.4 Matters Arising and Action Log	
1.5	There were no matters arising and no comments on any of the actions.
02 STAFF STORY	
2.1 Laura Wood – Paediatric ED Nurse *(19 minutes)*	
2.1	The Director of People (DoP) introduced Laura Wood, Paediatric ED Nurse (PED-N) and colleagues in support (as above). The PED-N told her story as follows: *Her early career had been as a holiday rep' but on returning home, and with the support of her family, she had decided to enrol at University and train to become a nurse. She had qualified in 2015 and undertaken her rotation at PAHT and decided that Paediatric Emergency Department (ED) was the place for her. Despite the challenges of working in a very busy department she was well supported and inspired by colleagues and encouraged to develop her skills further. She was currently undertaking a Children's ED post-graduate course. The best part of her job, she stated, was seeing a previously sick child leave the department well and on the road to recovery.*
2.2	Members thanked the PED-N for her story and remarked on her enthusiasm for her role and that she would be a great support to the organisation's nursing recruitment programme.
2.3	In response to a question from Non-Executive Director Pam Court (NED-PC), PED-N stated that she had chosen to work in Harlow, not only because she lived locally, but because she had found the Trust very friendly and supportive whilst she had been on rotation. In response to a further question in relation to challenging days she confirmed her team shared and talked about experiences and always tried to have a de-brief after any challenging incident.
2.4	In response to a question from the Chief Operating Officer (COO) the PED-N confirmed the one element which would improve her day would be for the department to be fully staffed (in terms of nurses). In addition, improved streaming out of ED to relevant departments would also help and more timely admission to ward areas. She stated she would also find it useful, for example on a night shift (if no doctor present), if medications could be started earlier i.e. at triage.
2.5	In response to a question from the Director of Nursing & Midwifery (DoN&M) the PED-N stated that her role was flexible in terms of working around her young family. In terms of career progression she felt much was dependent upon exam results rather than practical skills. In terms of moving from Band 5 to 6 the PED-N confirmed she had undertaken courses and made use of her study days but for her personally she would only feel comfortable progressing with a good few years' practical experience behind her. She acknowledged however that others may feel ready to move up earlier in their career.
2.6	The TC thanked the PED-N for her story and for highlighting that individuals progressed at different rates and that having had a previous (and very different) career had been very useful. The DoP thanked the PED-N's colleagues for their support which was pivotal in an individual's development.
03 RISK	
3.1 Significant Risk Register (SRR) *(1 minute)*	
3.1	This paper was presented by the Chief Medical Officer (CMO). He apologised for the error on the front sheet which should state 'Dermatology' not 'Rheumatology'. The paper was noted – members had no questions.
3.2 Board Assurance Framework (BAF) *(1 minute)*	
3.2	This item was presented by the Head of Corporate Affairs (HoCA) and was taken as read. There were no changes to risk scorings and all had been reviewed by the relevant Board Committees during the month. Members had no comments and the risk scores were confirmed.
04 CHIEF EXECUTIVE'S Report	
4.1 CEO's Report *(12 minutes)*	

4.1	The CEO presented his report. Key highlights were as follows: **Standardised Hospital Mortality Indicator** – had dropped slightly to 111.6 for the period September 18 to August 19. **Temporary staff as % of pay bill** (new indicator) – 16.3% **Front line staff 'flu vaccination** (new indicator) – 73.3% (target 80%) **Nursing Apprenticeship Scheme** – now launched with ten new starters for March 2020.
4.2	In terms of the new hospital work continued with regional and national colleagues on the business case approval process with the current expectation that approval to proceed to OBC (outline business case) would be within the next 12 months and then to FBC (full business case) 12-18 months after that. There would be a key meeting the following week with a representative from the Department of Health in addition to ongoing conversations with health and social care partners as to where the hospital sat as part of the 'place' agenda.
4.3	The CEO continued that in relation to the Integrated Care Partnership (ICP) work continued, with Commissioner colleagues in particular. An assurance process was currently being undertaken with NHSE to ensure risks were appropriately managed and benefits gleaned for patients.
4.4	The Board had recently approved the creation of a Chief Technology Officer (CTO) role that was about to go out to recruitment. The post holder would have responsibility for the IT and digital agenda of the Trust to ensure investment in the right technology for patients.
4.5	The Hertfordshire and West Essex STP-wide procurement of a third party to provide pathology services across the three acute Trusts and for primary care colleagues within the three CCGs remained on track. An Invitation to Participate in Dialogue (ITPD) had been issued to all bidders in December. Dialogue sessions were scheduled for March and April with a request for a Best and Final Offer (BAFO) expected to be issued in late May. A preferred supplier was expected to be chosen in the summer with a FBC coming to the Board in the autumn for final approval before the contract was issued.
4.6	At this point in the meeting the COO was able to update on an unannounced inspection by the CQC that week to the Trust's ED. The feedback had been largely positive and areas highlighted for improvement were known to the organisation and being worked on already. A written report would be provided within two weeks and would be published on the Trust's website. The team had fed back that continued improvements in the department were visible. It was agreed the report would be made available to members at the next Public meeting (02.04.20).
ACTION **TB1.06.02.20/23**	**Report from unannounced CQC inspection to ED on 03.02.20 to be made available for Trust Board on 02.04.20.** **Lead: Chief Executive Officer**
4.7	In response to two questions from NED-AH the following responses were received: 1) In relation to SHMI this was 'as expected'. Statistically it was irrelevant if it was rising or falling within the bracket. It was HSMR that was 'higher than expected'. 2) In terms of the new hospital the Government's desire was for the HIP Six organisations (Health Infrastructure Plan) to have their facilities in place by 2025. He acknowledged that timeframes for PAHT would be challenging but if it could hit OBC/FBC deadlines then it believed a date of December 2025 was achievable. Members acknowledged that would be challenging but believed the ambition and drive existed to secure that delivery.
05 PATIENTS	
5.2 Learning from Deaths Update *(10 minutes)*	
5.1	As the meeting was running ahead of schedule this item was taken next. The paper was presented by the Chief Medical Officer (CMO) and members noted the new reporting format. He was able to update that all adult deaths were now being reviewed by the Trust's Medical Examiners (and that had been the case for the past few months) and now that the software was working, Structured Judgement Reviews (SJRs) were also being undertaken. HSMR had remained 'higher than expected' for the 12 month reporting period to September 2019, however, the last five months HSMR had been 'as expected' with reduced outlier alerts – so some encouraging early signs in terms of the Trust's mortality rate. The focus

	going forward would be on learning and any emerging themes.
5.2	In response to a request for assurance from NED Andrew Holden (NED-AH) that the organisation was 'doing the right thing' in terms of its Mortality Programme, the CMO was able to confirm that the in-month HSMR had been slowly reducing for the past five months so, in his opinion, there was assurance that the programme was working The Director of Quality Improvement (DoQI) agreed, and stated that the intelligence gleaned from the SJRs confirmed that, and would also inform the mortality work programme for the coming year.
5.3	NED Helen Glenister (NED-HG) noted that the Quality & Safety Committee (QSC) had discussed that the focus would now be on sharing the learning. .
5.4	In response to a question raised by ANED-HH the DoQI was able to confirm that the Reporting & Recording work stream of the Mortality Programme was current reviewing medical and nursing documentation. Co-morbidities were included in the new medical assessment tool which was currently out to print which would change how patients were assessed and documented at the front of the pathway.
5.5	Members discussed that with the move towards more integrated working there would be a requirement to ensure that any electronic patient record system (EPR) linked both primary and secondary care to ensure patient histories/medications could be fully accessed by both. ANED-HH agreed that part of the solution would be investment in Pharmacy time at the front door and, as highlighted in the Staff Story above, enabling staff to undertake different roles (e.g. prescribing).
5.1 Learning from Deaths Presentation (FAWS) *(27 minutes)*	
5.6	This item was presented by the Associate Director of Nursing & Midwifery (ADoN&M) and her team (as noted above). She presented the details of the case as follows: *A 65 year old female, with an LD (learning disability) flag on Cosmic, had been admitted to PAHT in April 2018 for a gynaecological procedure. Post-operatively she had required a prolonged stay in Recovery and was transferred to a ward during the evening of 07.04.18. She spent five days on the ward being treated for hospital-acquired pneumonia and was discharged on 12.04.18. She had been found unresponsive at home by carers the following morning and was transferred back to A&E. Diagnostics revealed bilateral pulmonary emboli but no significant intracranial abnormality. A repeat CT scan two days later (due to drowsiness) revealed multifocal subacute ischaemic infarcts of which likely cause was a stroke. End of life pathway started that day and the following day the patient died.*
5.7	In terms of what had gone well in the patient journey members noted that the patient had remained in Recovery until stable and that there had been initial prompt escalation and comprehensive SHO review. There had been evidence of team work to discourage patient's self-discharge and regular Critical Care Outreach team physical reviews. She had also been prescribed prophylaxis enoxaparin post-surgery and on discharge.
5.8	Areas which had been highlighted for further review were: • No evidence of Consultant Obstetric review following surgery. • There had been referral to Medical team (review by telephone) but no physical review. • Completeness of documentation had also been of concern. • The red flag on Cosmic was unclear.
5.9	Following a multi-disciplinary review it was confirmed that the following lessons had been learned (and actions put in place): • There should be an allocated consultant every day to cover Gynae inpatients. All Gynae inpatients should be reviewed daily by clinician of at least Registrar grade. • Gynae patients should be discussed in FAWS morning handover and agreement reached as to which senior clinician would review. • Referrals to another speciality to be clearly documented and verbalised that a physical review was required. Any delays in review must be escalated to On-Call Consultant. • If a post-operative patient failed to recover as expected following surgery the operating surgeon should be informed and asked to review. • A review of the process in adding a generic Learning Disabilities flag to COSMIC to be

	carried out by the Learning Disabilities team. • To incorporate specific NHS guidance on gaining consent from people with LD into Trust consent policy. • All staff to accurately assess and document AVPU (Alert/Voice/Pain/Unresponsive) scores.
5.10	In response to the above the CMO stated it was worth pointing out that any Gynae patient was at risk of developing blood clots (which could lead to either cardiac arrest or death). He pointed out that even if a different treatment regime had been started (blood thinning) it was not known whether that would have made a difference to the outcome for this patient.
5.11	In response to a question from NED-GW it was confirmed that despite the fact the patient was discharged home with medication (to be administered by District Nurse (DN)), it was not clearly documented what the plan for that was. The first dose was missed as the DN did not attend until the following day.
5.12	In response to a question raised by NED-AH it was confirmed there was now no issue with allocating patients to consultants and they in turn taking responsibility for those patients. There was now an '*Obstetric Consultant of the Week'* and a '*Gynae Consultant of the Day*'.
5.13	NED-PC raised a question in relation to the LD flag on Cosmic and members were informed that the patient had been seen by the LD team at the pre-assessment stage and it had been deemed no specific additional actions were required in relation to that flag. It had transpired afterwards that the flag had been placed against the patient's record in 1957.
5.14	In response to a question from ANED-HH the CMO was able to confirm that the symptoms of pulmonary embolism and pneumonia were similar. It was noted that whilst the patient had not responded to treatment, she had responded sufficiently to be discharged.
5.15	The DoQI raised a question in relation to Medical review. In response it was confirmed that on re-admission the patient had received Medical review in person (previously it had been via telephone).
5.16	In response to a question from the TC the Obs & Gynae Consultant (OG-C) stated that a key action was to maintain continuity of care for the patient hence the decision to appoint a '*Gynae Consultant of the Day'* who handed over to the evening doctor at 17:30 and then picked up again at 08:30 the following morning.
5.17	NED-HG asked for some assurance around the fact that the patient's evening medication had been missed upon discharge. In response the team confirmed the process had now changed and the discharge team were no longer separate from the ward team facilitating closer working at the point of patient discharge. The CMO also pointed out that patients on anticoagulants were now flagged on the electronic system in addition to new commissioning arrangements with West Essex. This alleviated previous issues around stopping medications on admission and re-starting on discharge.
5.18	The TC thanked the team for presenting the story and highlighting the lessons learned, which were relevant not only to them but also to colleagues in other teams.
5.3 Nursing, Midwifery and Care Staff Levels including Nurse Recruitment *(6 minutes)*	
5.19	This update was presented by the Director of Nursing & Midwifery (DoN&M) and members noted the significant improvement in overall fill numbers. There were a number of Band 5 nurses still in the pipeline which would ensure delivery of the less than 10% vacancy target by 31.03.20. She was pleased to report there had been 27 new starters in January meaning the nurse vacancy rate was now closer to 12% currently. The team were confident of reducing the rate even further in 2020/21 with the focus going forward on Healthcare Support Worker and Band 6/7 vacancies.
5.20	In response to the above the CMO was able to confirm, from experience, that staff morale was improving with the increased staffing.
5.21	NED-GW raised a concern around the apparently low fill rate on Henry Moore Ward to which the DoN&M was able to provide assurance that as that ward had been deemed safe in terms of staffing, nurses had been moved from there to support other areas. It was agreed that going forward any red rated areas in the update would be supported by a brief narrative.
ACTION	**Any red rated areas in the Hard Truths Report to be accompanied by a short narrative**

TB1.06.02/20/24	**by way of explanation.** **Lead: Director of Nursing & Midwifery**
5.22	The DoN&M continued that the plan for 2020/21 would be to try and reduce nurse vacancies to less than 1% and in line with a request from the Performance & Finance Committee there had been agreement to consider revising the trajectory to the front end of the next year in order to glean the maximum possible benefits in-year.
5.23	The TC thanked the DoN&M for the update and applauded the team on the progress achieved to date in reducing nurse vacancies.
06 PERFORMANCE AND PLACES	
6.1 Integrated Performance Report (IPR) *(18 minutes)*	
6.1	This item was presented by the COO and it was noted relevant sections had been discussed at Board Committees in January. Key headlines under the organisation's five Ps were as follows: <u>Patients</u> This section was noted and there were no comments from members.
6.2	<u>Performance</u> The Trust was still experiencing some days with ED attendances over 300. Support from ECIST would come to an end in March and escalation calls with the Regulator were now moving from twice weekly to monthly. The Urgent Treatment Centre had gone live in December and there was good integrated working across Primary Care and the Emergency team. Despite continued high attendances there had been two recent days where performance against the ED 4 hour standard had been in the 90% bracket. For the fourth consecutive month the 62 Day Cancer Standard had been achieved. There had been some challenges in the RTT position in terms of capacity and the blip in Diagnostics performance was not expected to recur. In relation to Corona Virus the COO was able to provide assurance that processes had been established for the swabbing/isolation of any potential patients and there had been no issues to date.
6.3	In response to a question from ANED-HH in relation to the number of cancelled clinics in December it was confirmed there were a number of reasons including, capacity, insufficient patient numbers and operational pressures. Assurance was provided that the organisation was compliant with ASI (appointment slot issue) guidance and the position was monitored and tracked on a weekly basis. In addition the trajectory in place for all specialties was, by July 2020, to no longer have a review list and for all patients to leave clinic with a date for their next appointment (if required). As part of the Outpatient Transformation Plan it was intended to pilot (Feb/Mar) the texting of patients to remind them of their appointments.
6.4	In response to a question from NED-GW it was agreed that Outpatient capacity should be used to its maximum wherever possible and the move towards more integrated work with Primary Care would provide the platform for discussions around the future provision of diagnostics.
6.5	NED-HG raised a question in relation to the deterioration in ambulance handover times in December. In response the COO was able to provide assurance that of the five acute trusts in Essex, PAHT was the most improving trust in terms of performance.
6.6	<u>People</u> Members noted that 75% of frontline staff had received the flu vaccine, with a requirement to reach 80% by the end of February. That figure would rise to 90% for the coming year.
6.7	<u>Places</u> It was brought to members' attention that £4m of emergency capital funding had been received meaning there was a significant programme of work now in place very late in the financial year. Teams were working hard to deliver against that but with contingency plans also in place too.
6.8	<u>Pounds</u> In summary, despite better than planned performance in-month, the position was £4.9m off plan year-to-date. There would need to be a significant internal focus on careful financial management through the remaining seven weeks of the year to deliver the control total and secure a robust entry point into the new year. The delivery was of CT was dependent on

	receipt of planned non-recurrent income streams as well as cost reductions. The TC emphasised that that constant careful management would be critical.
07 GOVERNANCE	
7.1 Reports from Committees *(3 minutes)*	
7.1	Quality & Safety Committee – 24.01.20 – Chair NED Helen Glenister QSC had been assured around processes in place to deal with potential Corona Virus patients, turnaround times for cervical screening and safety in the ED. In terms of the 15 Steps visits these provided valuable learning and were appreciated by staff. Workforce Committee – 27.01.20 – Chair ANED Helen Howe WFC had noted the good news around significantly reducing nurse vacancies. Data from Staff Survey results was beginning to be collated. Performance & Finance Committee – 30.01.20 – Chair NED Andrew Holden The report was noted and there were no comments.
7.2 Report from Senior Management Team *(1 minute)*	
7.2	The CEO presented his report which included updates on Integrated Care, Heart Failure Service support and the Chemotherapy Management System.
08 QUESTIONS FROM THE PUBLIC *(9 minutes)*	
8.1	In response to two questions posed by Ann Nutt, Chair of the Patient Panel (CoPP) it was confirmed that the patient voice would be included in discussions around both the Integrated Care Partnership and the Outpatient Transformation Programme. In relation to the latter the COO agreed to pick that up with the CoPP outside the meeting.
8.2	Fiona Claridge from the NHS Confederation asked how the Trust had achieved the significant reduction in nursing vacancies. In response the DoN&M confirmed it was mainly through tenacity, joint working with colleagues (nursing, workforce, finance and estates) and being absolutely clear on trajectories.
8.3	Reverend Dennis Nadin (RDN) took the opportunity to inform the Board of his continuing concerns around the Trust's complaints process. RDN noted that following the Board meeting in December, he had been informed that his file would be reviewed by the Patient Panel but this had not happened and he had not been contacted by a representative of the Patient Panel. He asked Board members if the current complaints policy of apologising would now be replaced with learning from mistakes approach. In response the DoN&M reminded members that the Board had acknowledged at its December meeting that it had not got the (complaints) process right for RDN. She was able to assure RDN that the organisation had been undertaking a lot of work around processes and was committed to changing those and being more transparent in how it shared with the public what it had learned from its mistakes. She apologised once again for the delay in reaching a suitable conclusion with the complaint in question and it was agreed that RDN would make an appointment to meet with the CoPP (who was in attendance that day) to discuss further and resolve the issue.
09 CLOSING ADMINISTRATION	
9.1 Summary of Actions and Decisions	
9.1	These are presented in the shaded boxes above.
9.2 New Issues/Risks	
9.2	No new issues or risks were identified.
9.3 Any Other Business (AOB)	
9.3	There were no items of AOB.
9.4 Reflection on Meeting	
9.4	Members agreed that going forward the questions on the Learning from Deaths presentation should focus on the learning and gaining assurance that the same issue would not happen again. It was agreed that the detailed questioning around practices and

	processes would take place during the Serious Incident investigation.

Signed as a correct record of the meeting:	
Date:	02.04.20
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 02.04.20

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.02.20/23	CQC Unannounced Inspection	Report from unannounced CQC inspection to ED on 03.02.20 to be made available for Trust Board on 02.04.20.	CEO	TB1.02.04.20	Not presented in April as reduced agenda items. Report and response circulated to Board members by CEO on 20.03.20.	Proposed for closure
TB1.06.02.20/24	Hard Truths Report	Any red rated areas in the Hard Truths Report to be accompanied by a short narrative by way of explanation.	DoN&M	~~TB1.02.04.20~~	Item deferred - new date to be agreed.	Open

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board – 2 April 2020

Agenda item:	2.2								
Presented by:	Head of Corporate Affairs - Heather Schultz								
Prepared by:	Head of Corporate Affairs - Heather Schultz								
Date prepared:	26 March 2020								
Subject / title:	Board Assurance Framework 2019/20								
Purpose:	Approval	x	Decision		Information		Assurance		
Key issues:	The Board Assurance Framework 2019/20 is presented for review. A draft COVID-19 risk is attached for review. Changes to the risk scores in year and risks closed during 2019/20 are reflected in Appendix A. Risks, risk ratings and outcomes of Committee reviews in month are summarised (Appendix B) and detailed BAF risks as at April 2020 are attached (Appendix C). Following discussion at WFC in March it is recommended to Board that the risk score for BAF risk 2.1 Nurse Recruitment is reduced from 16 to 12.								
Recommendation:	The Board is asked to approve the Board Assurance Framework and reduction in risk score for BAF risk 2.1, note the changes made during 2019/20 as reflected in Appendix A and the April position reflected in Appendix B. Approve the new risk for COVID-19.								

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:	WFC, PAF, QSC in March 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, Appendix B and Appendix C - Board Assurance Framework 2019/20

Your future | Our hospital

respectful | caring | responsible | committed

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: The emerging COVID-19 pandemic will overwhelm the Trust and wider health economy impacting on the health and safety of our patients and people, operational delivery, staffing, finances and procurement as well as the Trust's reputation.**	Causes: i) Highly infectious disease ii) Failure of public to adhere to Public Health messages iii) National issues regarding supply chains iv) Configuration of PAHT estate v) Current vacancy rates	**5 X 5= 25**	Chief Executive supported by Executive team	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 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	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 and April) iii) Trust Board updates (March and April) iv) Trust Incident Coordination Centre open 08:00 - 20:00 7 days a week	**5 X 4= 20**	i) Lack of staff capacity to deliver oxygen to required areas ii) Loss of staff with key skills and training due to virus iii) Reliance on supplies nationally	Under review	26.03.20		**5x2=10 (April 2021)**
			Effects: i) Increased numbers of patients and acuity levels ii) Shortages of staff 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											

BAF risks added, revised or closed during 2019/20

Appendix A

5P	Executive Lead	Committee	BAF Risks	Risk score	Comment
	DoP	WFC	2.2 Internal Engagement: Failure to communicate key messages and organisational changes to front line staff.	6	**Closed in August 2019 (target risk score achieved)**
	DoP	WFC	2.3 Inability to recruit, retain and engage our people	12	**Open: New risk added in August 2019.**
	DCFO/DQI	PAF	4.1 Supporting Functions (including Finance, IT, and Estates and Facilities) Concerns around the need to modernise the systems, processes, structures, capacity & capability of the business support functions.	12	**Closed in August 2019 (target risk score achieved)**
	CFO	PAF	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	20	**Open: Risk score increased from 15 to 20 in December 2019.**

5P	Executive Lead	Committee	BAF Risks April 2020	Current risk score	Trend
	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/DoN	WFC	2.1 Nurse Recruitment Inability to recruit to critical nursing roles.	12	↓
	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	⟷
	COO	PAF	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	20	⟷
	CFO	PAF	5.1 Finance Concerns around failure to meet financial plan including cash shortfall.	20	⟷

The Princess Alexandra Hospital Board Assurance Framework

2019-20

Our Patients – we will continue to improve the quality of care and experiences that we provide **our patients** and families, integrating care
Our People – we will support and develop our people to deliver high quality care within a culture that improves engagement, recruitment
Our Places – we will maintain the safety of and improve the quality and look of **our places** and work with our partners to develop an OBC
Our Performance – we will meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators
Our Pounds – we will manage **our pounds** effectively and modernise our corporate services to achieve our agreed financial control total

The Princess Alexandra Hospital NHS Trust

Risk Key														
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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)**
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								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, 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	**4 X 5= 20**	Director of Nursing/ Chief Medical Officer **Quality and Safety Committee**	i) Robust quality and safety governance structures in place including infection control ii) Robust Appraisal/ medical and nursing iii) End of Life and deteriorating patient simulation programme for all staff, across ICP and ICS iv) Education & training in communication skills such as breaking bad news training. v) Sharing the Learning Programme vi) Commissioner reviews and engagement in quality and Safety processes vii) Risk Management Training Programme viii) Escalation prescribing processes ix) Electronic handovers, Hospital at Night and E-Obs and observation compliance reports x) Schwartz Rounds xi) NHSI/NHSE Oversight xii) Red2 Green Board rounds supported by ECIST xiii) Patient Experience Strategy xiv) NED lead appointed for Mortality xv) Mortality Strategy including dashboard, tracker, updates on workstreams and learning from deaths. xvi) '15 steps' walkabouts xvii) Nursing Establishment review (bi-annually) and succesful nursing recruitment campaign xviii) Safer Staffing policy xix) Real time patient feeback implemented across all wards xx) Robust management of variations in neonatal outcomes xxi) Engagement in external reviews MBRRACE,HSIB and LeDeR and Healthcare Safety Investigation Branch (maternity) xxii) Medical examiners (MEs) and Lead ME appointed and Mortality Surveillance Group established xxiii) Complaints workshops held xxiv) Joint GIRFT and Model Hospital quality improvement programme xxv) Patient flow module live xxvi) Electronic fluid prescribing pilot live xxvii) Appointment of medical PS&Q leads xxviii) Complaints process being revised and grading system introduced xxix) Fab Change accreditation xxx) Quality peer review process in place	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 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 Nov 2019 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 startegic direction to having one electronic system (QSC February 20)	**4x4=16**	Lack of modernisation in some reporting processes including: i) Clinical audit plan developed and to be implemented - improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site footprint and bed constraints iv) Access to Qlikview v) NICE oversight and management of compliance with guidance vi) Frequency and consistency of approach to mortality reviews **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.	08/03/2020	Risk rating not changed	**1**
			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											

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								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients and families, 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 2019/20 and our local system control total**													
BAF 1.2		**EPR** Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes.	Causes: i) Poor engagement with the system, usability, time/skills ii) Timely system fixes/enhancements	**5 X 4= 20**	Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iv) Performance Mgt Framework in place. v) Training programme. vi) Super users in place to deliver focused support. vii) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability viii) Access Policy ix) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) x) Development of capacity planning tools/information xi) PWC review and actions identified xii) ICT Newsletter issued xiii) Daily ICT/COSMIC meetings ongoing xiv) Real time data now available xv) CDS 011 now live xvi) Maternity MDS configuration completed. xvii) Monthly Contract Performance monitoring meeting with supplier established.	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews vii) Monthly EPR Board to Board meetings viii) Exec to Exec meeting on 25.11.19	i) Weekly Data Quality reports to Access Board and EDB ii) 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).	16.03.20	Risk rating unchanged	**4x3=12 end of March 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
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The Princess Alexandra Hospital Board
Assurance Framework 2019-20

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			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – we will support and develop our people to deliver high quality care within a 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**													
BAF 2.1		**Nurse Recruitment** Inability to recruit sufficient numbers of registered nurses.	**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	5 X 4 =20	Director of People and Director of Nursing **Workforce Committee**	i) Participation in local and regional job fairs ii) Targeted overseas recruitment activity and proactive recruitment campaigns iii) Apprenticeships and work experience opportunities iv) Use of new roles in line with national direction v) Use of recruitment and retention premia as necessary vi) Use of TRAC recruitment tool vii) Use of a system to recruit pre-qualification students viii) Working in collaboration with STP and LWAB ix) Lead Nurse for Recruitment and Retention appointed x) Retention plan in place	i) PAF, QSC, WFC, EMT, SMT, Workforce and Board meetings ii) PRMs and Health Group Boards iii) Recruitment and Retention Group iv) People Board	i) Safer Staffing Reports (monthly to QSC, WFC and bi-monthly to Board) ii) Workforce report (progress on recruitment, retention, bank and agency) to WFC 23.03.20 iii) Incident reporting and monthly SI reports to QSC iv) Internal Audit report 18/19 on Recruitment (substantial assurance) v) International Nurse recruitment business case to SMT, PAF (June 2019) and Board (July 2019) vi) Monthly IPR report	~~4 x 4 = 16~~ 4 x 3 = 12	i) Limited ability to influence some of the pre-employment timeframes due to external requirements e.g. NMC registration Actions: Registered nurse vacancy rate to be included in IPR Ongoing monitoring of pre-employment phase of recruitment process to minimise delays	None noted.	11/03/2020	Risk rating reduced to 12.	4 x 3 = 12 March 2020 (on achieving end year position of less than 10%)
			Effects: i) Pressure on existing staff to cope with demand leading to overworked staff and increased sickness ii) Low staff morale and impact on engagement iii) Shortcuts and failure to follow processes and procedures due to workload and fatigue leading to higher chances of patient safety errors occurring iv) Lower staff retention rates v) Reduced attendance at training courses vi) Impact on patient experience										

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The Princess Alexandra Hospital Board
Assurance Framework 2019-20

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
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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	i) WFC, QSC, SC, PAF, WFC, SMT, EMT. ii) People board iii) JSCC, JLNC iv) PRMs and health care group boards	i) Workforce KPIs reported to WFC bi-monthly and IPR (monthly) ii) People strategy deliverables iii) Staff survey results 2019 (WFC Jan 2020) iv) Staff friends and family results (WFC Nov 19) v) Medical engagement surveys, action plans and GMC surveys (WFC November 2019)	**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 Actions i) Implementation of communication strategy - Q4 ii) Recruitment plans for medical staff ~~iii) New consultant development programme - Q3~~ iv) Extranet for staff - Q1 20/21 v) Staff survey action plan:health and well being, manager development and learning culture (Q2 20/21)	None identified.	10/03/2020	**Risk score not changed.**	**4 x2 = 8 (at end of 5 year People Strategy but to be reviewed in March 2020)**
			Effects: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation											

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	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
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 as part of Project Genesis (Our New Hospital) 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	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 (Oct 19). v) Ventilation audit report vi) Water Safety Report (PAH site) vii) Annual and quarterly report to PAF: Estates and Facilities (Feb 20) viii) IPR monthly ix) Sustainability report to PAF (Jan 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 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. viii) Sustainability Management Group to be established **ACTIONS:** i) Backlog maintenance review underway and alignment of capital to identified risks with business cases to support investments. ii) EBME review underway iii) Review of estates function underway iv) 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.	16/03/2020	**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.											

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								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 work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
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 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		07/01/2020	**No changes to risk rating.**	**4x3=12 March 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											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
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 falling to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we falling 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 work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
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 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:** ~~Trust's vision and mission statement being refreshed and 5P plans underway.~~ Strategy team being developed PAH long term strategy being developed	Reporting from EOGs/workstreams to be established Development of governance structures for integration and legislation CCG Accountable Officer process delayed and underway	07/01/2020	**Risk rating not changed.**	4 x 2= 8 **March 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												

Risk Key														
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High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
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	Strategic Objective 3 : Our Places – we will maintain the safety of and improve the quality and look of our places and work with our partners to develop an OBC for a new build, aligned with the further development of our local Integrated Care Alliance.													
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 **Trust Board**	i) Potential new build/location of new hospital ii) STP Footprint and Estate Strategy developed. iii) Herts & West Essex STP Estates workstream iv) Pathology workstream led by CEO v) Estates and Facilities Infrastructure subgroup for West Essex vi) SOC affordability model vii) SOC approved and submitted to NHSI viii) Detailed analysis of current site option commissioned ix) Master planning work being aligned to Six Facet Survey and Health Planning, phasing of development on PAH site or off site. x) Alignment of strategic capital and tactical capital plans xi) MSK service developments underway xii) Capital funding of £9.5m received xiii) PAH part of HIP 1 funding programme for capital investment xiv) PCBC completed, submitted and reviewed by NHSI	i) PAF, Strategy Committee and Board meetings ii) SMT Meetings iii) Capital Planning Group iv) Weekly Estates and Facilities meetings v) Project genesis steering group	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 (jan 2020). v) PAHT 2030 report to Strategy Committee (Oct 2019) vi) PCBC approved at Trust Board (September 2019) vii) MAU business case approved at Trust Board September 2019	**4 x 4 = 16**	i) Balancing short term investment in the PAH site vs the required long term investment Gaps in Strategy team **ACTIONS:** Strategy being developed and underpinned by 5P plans Phase II work underway	i) Strategy in development	07/01/2020	**No change to residual risk rating.**	**4 x 3 =12** **March 2020**
			Effects: i) Failure to deliver strategy and transformation project and service changes required for service and performance enhancement ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant vii) Poor patient experience, viii)Backlog maintenance ix) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health. x) Lack of integrated approach xi) Increased risk of service failure xii) Impact on throughput of patients												

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2019-20**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.2		**4 hour Emergency Department Constitutional Standard** Failure to achieve ED standard	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Gaps in medical and nursing workforce iv) Lack of public awareness of emergency and urgent care provision in the community. v) Attendances continue to rise annually (5.1% over the last 2 years). vi) Changes to working practice and modernisation of systems and processes vii) Delays in decision making, patient discharges and delays in social care and community impacting on flow viii) Increases in minor attendances	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Escalation calls with NHSI vi) Work in progress to develop new models of care vii) Local Delivery Board in place viii) System reviewing provision of urgent care ix) Exec attendance at safety huddles x) ED action plan reported to PAF/Board xi) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries xii) Protection of assessment capacity work underway xiii) Weekly Urgent Care operational meetings and Urgent Care Board in place xiv) On site support from ECIST and NHSI medical lead xv) Focus on length of stay in ED for all patients xvi) Focus on improving assessment capacity xvii) GP attending weekly length of stay review meetings	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) ~~Fortnightly~~ 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. v) Presentation on ED performance and 'next steps' to PAF and Board (May/June 19)	**4 x 5 = 20**	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.	11/03/2020		**4x3 =12 March 2020 (on 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											

The Princess Alexandra Hospital NHS Trust

Trust Board – 2 April 2020

3.2

Agenda Item:	3.2								
Presented by:	Lance McCarthy - Chief Executive Officer								
Prepared by:	Chloe Atkinson – Strategy & Development Manager								
Date prepared:	26.3.20								
Subject / Title:	PAHT 2030 update								
Purpose:	Approval	X	Decision		Information		Assurance		
Key Issues:	This presentation aims to inform and provide assurance of: • PAHT 2030 framework and content • PAHT2030 Strategic Priorities • Alignment of NHS Long Term Plan, One Health & Care Partnership & PAHT priorities • Development of PAHT Clinical Strategy • Next Steps for the programme								
Recommendation:	The Board is asked to approve: • PAHT 2030 Framework and Content • The 5 PAHT 2030 Strategic Priorities • The proposed next steps								
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:	EMT, Strategy Committee on 24 February 2020 Health Care Groups
Risk / links with the BAF:	Relevant to all BAF risks
Legislation, regulatory, equality, diversity and dignity implications:	Existing and future legislation and regulation at speciality level will be included within each Clinical Strategy. EIA's will be undertaken through the operational delivery process.
Appendices:	Presentation attached.

PAHT2030

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Progress & Proposals

Trust Board

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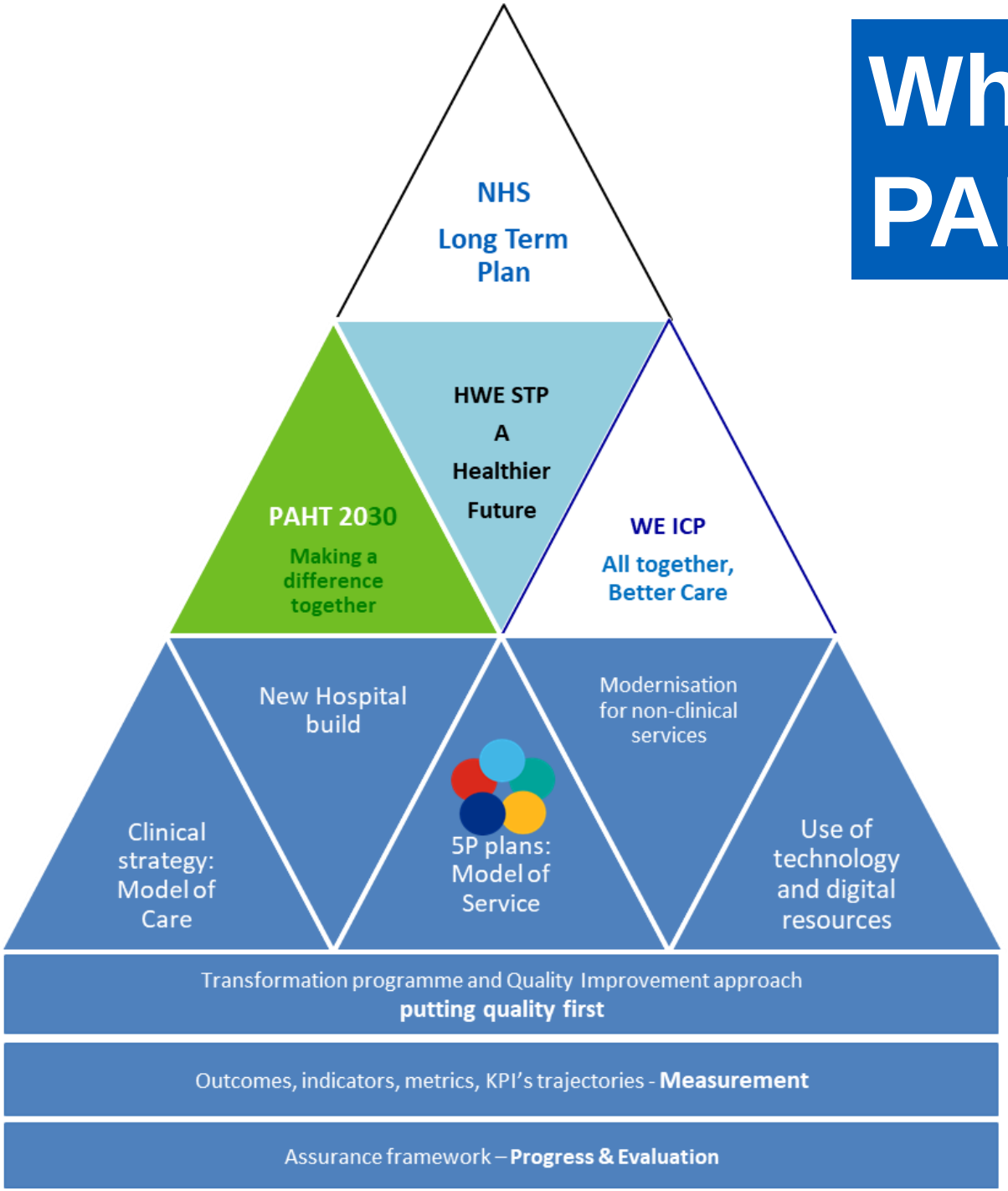
What is PAHT2030?



PAHT2030 Overview

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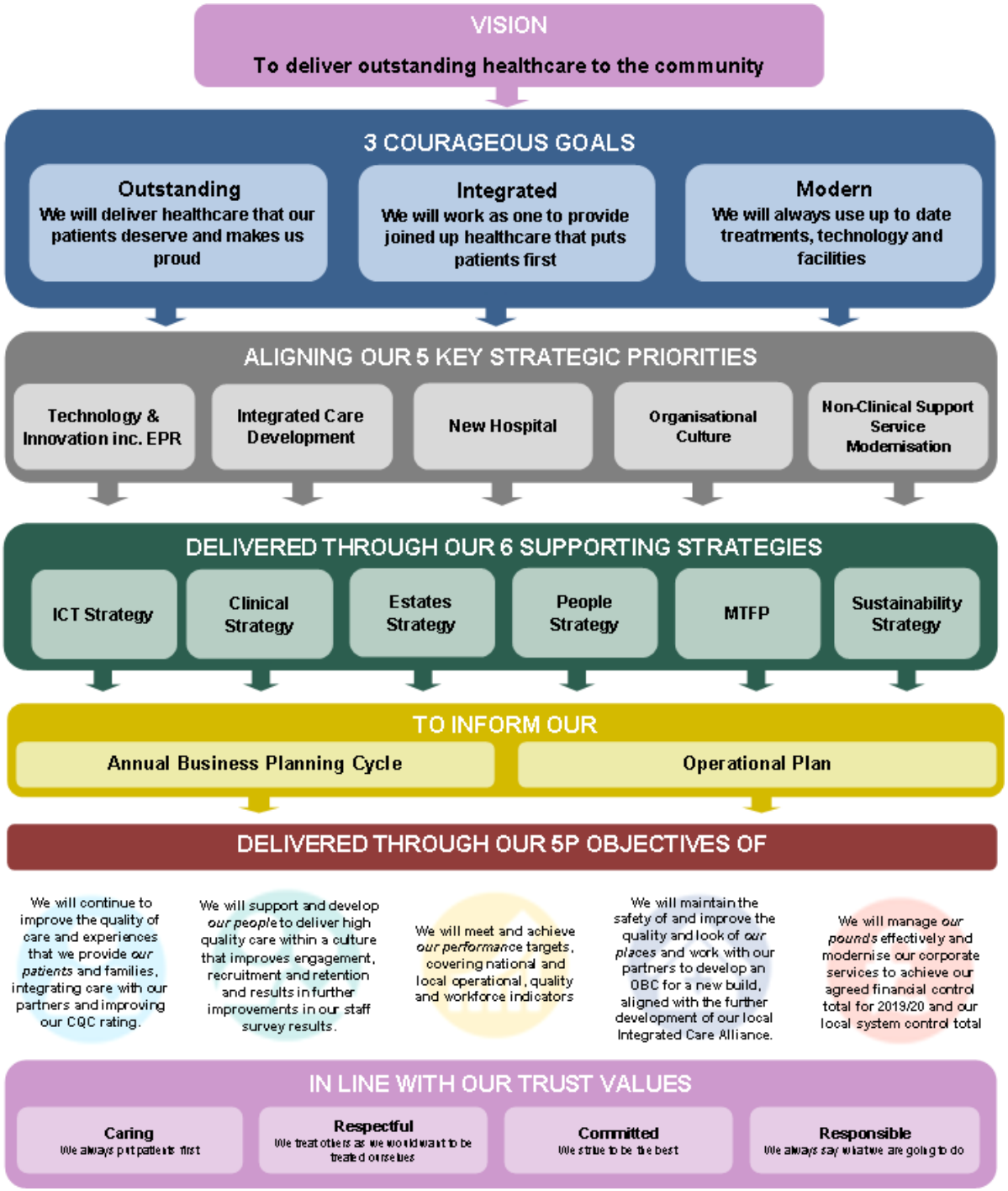
- PAHT's position within the local and national NHS landscape
- PAHT's responsibilities to our population and partners
- PAHT's strategic ambitions
- How PAHT will achieve our courageous goals through our 5 strategic priorities and 6 enabling strategies

Content - Landscape

- **Local System** – STP, ICP, County Councils, Innovation Corridor
- **Population** – JSNA, population growth, demographics,
- **Local case for change**
  - Improve the health and wellbeing of the population
  - Improve the patient and user experience of care (including quality and safety); and
  - To reduce the per capita cost per of healthcare
- **Current Service Delivery** – No. of beds, OPA's, A&E attendances, staff numbers etc.
- **Local challenges** – increases in A&E demand, failing infrastructure, recruitment difficulties, smaller bed base, unwarranted variation in care

PAHT2030 Framework



Content - Delivering the Priorities of the NHS LTP, STP and ICP locally

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NHS LTP	Out of hospital strategy: delivering a new service model for 21 Century	More action on Prevention & Health Inequalities	Delivering further progress on care quality & outcomes	People: NHS Staff will get the backing they need	Digitally Enabled Health Care will go mainstream across the NHS	Taxpayers' investment will be used to maximum effect
HWE STP	Develop integrated, person- centred models of care, designed to meet the needs of our population, delivered in local neighbourhoods wherever possible.	Living well and preventing ill health	Shift care from reactive to proactive when possible, and standardise our approach to treatments.	Put in place the staff, culture and systems we need to support the transformation we need.	STP Local Digital Roadmap	Providing better health & care that is good value for money
OHCP	Transforming our local services *PCN's, out of hospital models, strong hospital & specialist services*	Healthy & independent local people *Population health management, new models of care, prevention, tackling inequalities, good mental well-being*	Right team, right tech, right place *Estates, co-location, workforce & technology*			Achieving Financial Controls *Affordable health & social care system*
PAHT	Integrated Care Trust Development New Hospital	Organisational Culture Clinical Support Services Modernisation	Technology & Innovation inc. EPR System			Achieving Financial Controls *Affordable health & social care system*

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Content – Supporting Strategies

Clinical Strategy

Themes	Enablers	Aligned PAHT Priorities
• **Manage the rise in demand across elective care** • **Manage the rise in demand across non-elective care** • **Address unwarranted variation** • **Develop an integrated workforce model** • **Evidenced based pathways of care**	• Virtual Clinics • Aligned clinical governance model across organisations centred around the patient • Common outcomes frameworks which all AHP's across speciality / pathway work towards • Integrated clinical teams to include Consultants, Nurses, GPSI's, Therapists, Community Pharmacists etc. • Innovative Workforce Development – rotational posts, unique training opportunities, bespoke leadership programmes • Development of clear integrated pathways of care with adherence from all AHP's based upon up to date clinical research and robust evidence.	• New Hospital • Integrated Care Development • Organisational Culture • Technology & Innovation

Content – Supporting Strategies

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ICT Strategy

Themes	Enablers	Aligned PAHT Priorities
• **New EPR System** • **Sharing of documents across ICP partners** • **Virtual applications** • **Support for Flexible Working** • **Ease of Access**	• Employees will be able to access the global email directory for NHSMail and securely send emails to other partners. • Speed will greatly increase for access to applications delivered over HSCN (N3). • The ability to hold virtual conferences and join virtual conferences from any device will save travel time and cost • Partners with GovRoam membership will be able to securely log into PAHT networks to access their own systems. • PAHT employees will be able to join external partners (subscribed to GovRoam or EduRoam) securely and access our systems easily. • Sharing of documents internally and with partners is easier and improved. • Increased tracking and improved search facilities will reduce data storage and duplication of documents as well as reduce bandwidth and quotas for NHSMail • Telecoms systems will be aligned and allow for more flexible and mobile working, reducing revenue costs and aiding employee moves. • Teleconferencing will be integrated with instant messaging systems and Outlook for greater efficiency and productivity, allowing employees to utilise one system instead of multiple. • Applications will be able to talk to each other and allow for data to be available across multiple systems reducing the need to open and check lots of applications.	• New Hospital • Integrated Care Development • Non-Clinical Support Service Modernisation • Technology & Innovation

Content – Supporting Strategies

People Strategy

Themes	Enablers	Aligned PAHT Priorities
• **Staff Wellbeing** • **Recruitment** • **Integrated Workforce models** • **Organisational Development** • **Creation of new roles** • **Supporting our people through large scale change**	• Align and embed a health and wellbeing culture which is consistent with our vision, values and corporate goals • Develop and implement a workforce and resourcing plan which celebrates our employer brand and diversity • Invest appropriately in leadership and team development to attract and retain talent • Co-design and implement new service and workforce models across the STP and ACS • Maximise the use of technology to support professionals, productivity and efficiency	• Integrated Care Development • Non-Clinical Support Service Modernisation • Organisational Culture • Technology & Innovation • New Hospital

Content – Supporting Strategies

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Estates Strategy

Themes	Enablers	Aligned PAHT Priorities
• **Sustainable long term solution for local acute services** • **Guarantee the safety of PAHT services** • **Maintain quality of clinical services** • **Provide fit for purpose facilities** • **Transformation to integrated care.**	• Wider collaboration and integration • Attracts high quality workforce • Delivery of high quality patient experience • Improvement in access to care • Supports population health management and integrated care • Meets demand requirements • Staff recruitment and retention • Patient satisfaction • Improvement in hospital flow	• New Hospital • Integrated Care Development • Non-Clinical Support Service Modernisation • Technology & Innovation • Organisational Culture

Content – Supporting Strategies

MTFP

Themes	Enablers	Aligned PAHT Priorities
• **Efficiency and Financial Sustainability** • **Capital investment plans** • **Indicative capital assumptions** • **Prioritised list of further capital investments** • **Workforce needed to deliver STP/ICS service plans** • **Align activity volumes between providers and commissioners** • **ICS/ICA development – Model payment options** • **Population health management approach**	• Understanding of the drivers of the underlying position (including 'Do Nothing' position) and a clear and robust trajectory to achieve underlying recurrent balance ('Do Something' position), including an understanding of the working capital and cash requirements in the interim period. • Financial and activity projections underpinned by Integrated health and care strategy, transformational changes and benchmarked evidence. • STP wide collective principles developed including ways of working, approach to single control total, contracting/payment arrangements etc. • Draft Finance, activity and workforce plan (with clear timeline and process to finalise and to then be effectively used to measure system wide delivery (using KPIs) with risks and opportunities also fully articulated/understood). • Clear alignment across the STP (one 'integrated' plan), that all organisations have reviewed and agreed, and that is consistent with all internal plans, and all submissions to NHSE/I. • Confirmation of timeline for further internal assurance that both the medium term and draft 19/20 plans are deliverable, including robust implementation plans. • Risk assessment (including understanding of the downsides) and mitigation plans regarding these. • Model Hospital & GIRFT reports and analysis	• New Hospital • Integrated Care Development • Non-Clinical Support Service Modernisation • Technology & Innovation • Organisational Culture

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Patient & Public Engagement

- PAHT2030 Engagement Plan in development

  – Internally through Patient Panel, Volunteers, ICP Patient forums

  – Externally through National 3rd Sector organisations eg. Healthwatch, Diabetes UK etc

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Clinical Strategy Update, Models of Care & Transformational Change

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Clinical Strategies

- **Speciality based strategies**
  - Gastroenterology, Urology, Rheumatology etc
- **Condition based strategies**
  - Cancer, COPD, Diabetes etc
- **Population based strategies**
  - prevention & wellness, at risk & rising risk population, chronic care management, frail population

Alignment with One Health & Care Partnership Transformation Plan

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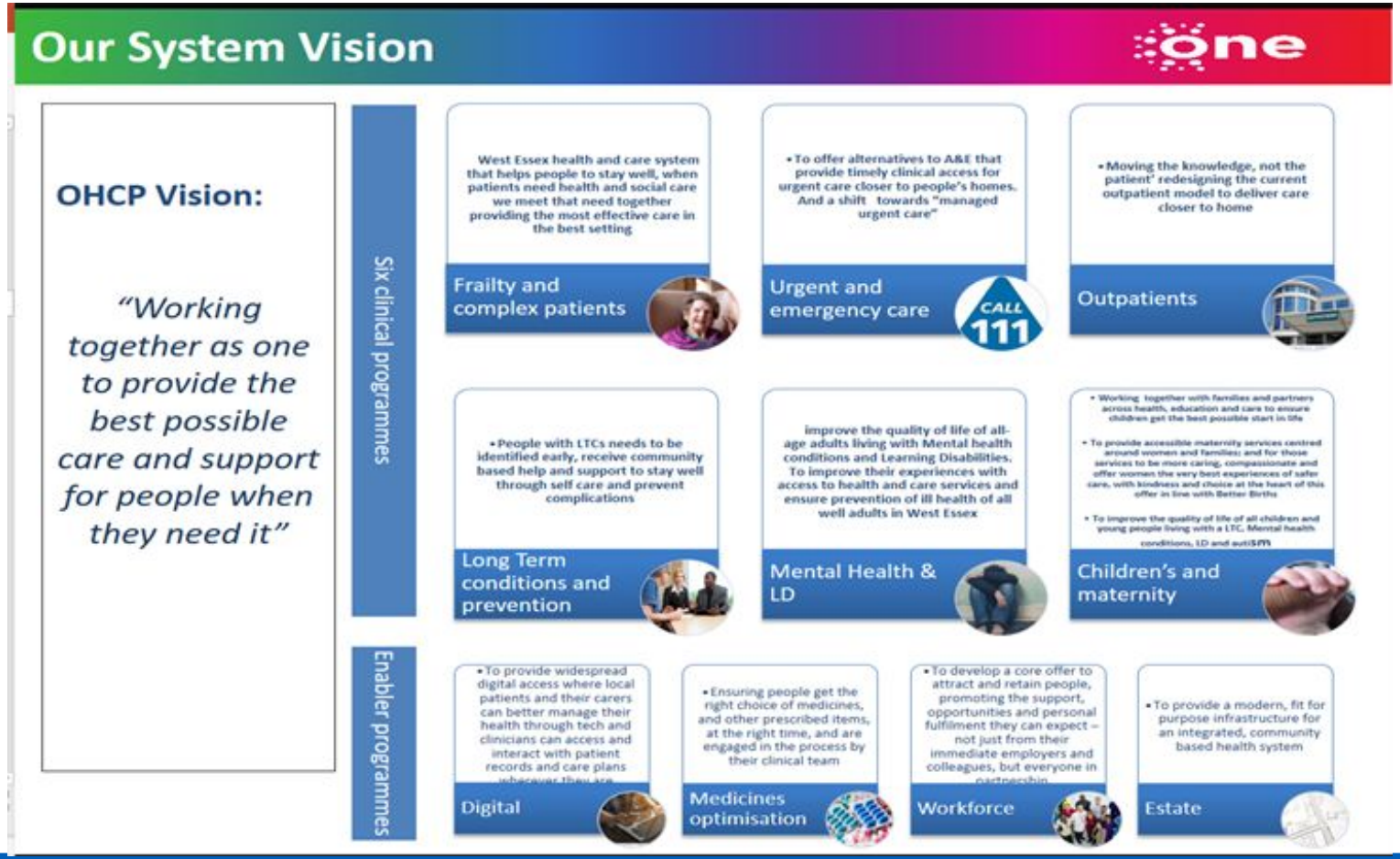

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Example of PAHT Speciality Based Clinical Strategy - Gastroenterology

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Drivers for Change

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Driver for change within our gastroenterology services

There is an increased risk of liver disease in people living with obesity and type 2 diabetes.

Within the PAHT core catchment area there are 14,795 registered people living with obesity and approx. 10,321 registered with type 2 diabetes

It is estimated that up to 1 in every 3 people in the UK have early stages of non-alcoholic fatty liver disease (NAFLD). This equates to up to 150,000 within the PAHT care catchment area.

Threshold for bowel screening has reduced. Some predictions state a 25% increase in endoscopy over the next 5 years.

Lower than average day case activity

Increasing NEL activity year on year

Higher than national average LoS (10.5 days v 7.3 days)

Vision & Goals

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Our vision for gastroenterology services over the next 10 years:

We aim to be an innovative gastroenterology service delivering best practice and holistic care which meets the needs of our population.

Goals

To achieve this vision, the following three goals have been developed based upon the PAHT 2030 three overarching goals to be outstanding, integrated and modern:

Outstanding
to deliver a service which meets best practice guidelines and is designed and centred around the needs of our patients

Integrated
to work as a team with our patients and healthcare colleagues from across organisations to provide seamless care

Modern
to develop a service which is delivered by multi-professional clinicians in a modern environment with state of the art diagnostic and treatment technologies

Objectives

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Outstanding	Integrated	Modern
to deliver a service which meets best practice guidelines and is designed and centred around the needs of our patients	to work as a team with our patients and healthcare colleagues from across organisations to provide seamless care	to develop a service delivered by multi-professional clinicians in a modern environment with state of the art diagnostic and treatment technologies
Patients have timely access to diagnostics and treatment	Patients are supported by the most appropriate HCP at all times	Patients and HCP's can communicate through virtual means
Team of healthcare professionals all trained and practicing to the top of their licence	A full skill mix of HCP's can communicate across multiple organisations and teams	HCP's have the most up to date clinical skills
Develop mechanisms which align our internal metrics to national guidance	Shared quality measures for all HCP's across the health system	Develop new, innovative measures based on patient outcomes
Provide care from spaces which are convenient and accessible for patients	Face to face and virtual care provided from locations based on patient need	Provide diagnostics and treatment from fit for purpose premises
To provide best practice pathways for all our Gastroenterology services	Services respond to a population health based funding model	A system costing structure is developed to ensure funding is directed appropriately

Model of Care

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Current model	Year 1-2	Year 3-5	Year 5+	Future model
Patient attends OPA and diagnostic on different days	Patient has OPA and diagnostic on the same day			Patients receive diagnosis through a one stop service
Patient needs to visit hospital to access consultant	Patients can access specialist level support through their GP or community teams	Patients submit their health markers to consultant via mobile app	*% fewer Gastroenterology OPA attendances than in 2019	Patient accesses virtual care modelled around their needs
2x Endoscopy suites with capped capacity			Endoscopy capacity to meet growing demand and increase market share	More patients will have quick and easy access to endoscopy services provided by PAHT
Current waiting time of *** for a routine endoscopy		Maximum waiting time of *** for a routine endoscopy		Patients are diagnosed earlier
Effectiveness of care is predominantly measured on activity markers		Effectiveness of care based upon patient outcome markers		Care is measured solely based upon patient outcome
Single consultant Liver Service based within the hospital	Liver Nurse appointed and accessed within ED, over the phone and within the community	Integrated Management Plans across Primary and Secondary Care	Patients with liver disease will be diagnosed at an earlier stage	Patients receive proactive care and by a mixed team of HCPs
HCP's accountable too and work solely within one organisation	Joint posts are created to work across the ICT system			Patients receive diagnosis through a one stop service

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Prioritisation across Service Transformation Programme – size of the programme!

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PAHT high level clinical strategy route map

Specialty	2020-2021	2022-2024	2025-2030
Gastroenterology	Plans for updated endoscopy unit submitted based on demand and capacity review Phase 1 of integrated liver service implemented Single integrated team across WE system Outpatient modernisation Straight to test endoscopy implemented for routine patients	Clinical outcomes framework developed and aligned to practice across ICT Phase 2 of integrated liver service (outreach and prevention) 2 way app developed	Liver disease mortality has stabilised or reduced Workforce development programme is launched 20% of acute activity will be unplanned
Radiology	Radiology app or portal for patients to check and book appointments Regular meeting with other specialties for feedback and conversations One stop clinic Full 7-day service across all modalities Clear pathways and patient flows through radiology	Upskilling of staff and sharing of resources across the STP Reduction in outsourcing	Repatriation of some nuclear medicines work Appropriate facilities available for all patients IT and infrastructure to support STP networking AI to change the way the service operates and improve efficiency
Rheumatology	New integrated pathways of care implemented from MSK EOG Primary care network champions Skill mix review for appropriate staffing levels across the system New infusion space	Single governance structure across the system Community hub for rheumatology Access to virtual care for appropriate patients	Personalised patient medication through use of genomics Utilisation of AI to aid service delivery

Principles - Models of Care

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- **Aiming to display Model of Care for ICP which identifies PAHT's position**
  - Each speciality, service, pathway, team will develop Models of Care through Clinical Strategy Development
  - In – through – out model

- **Shared ICP and PAHT Golden Threads for Models of Care:**
  - Best in class practice
  - Evidenced based pathways of care to reduce unwarranted variation
  - Flexible access to services based on patient need
  - Care developed through population management approach
  - Integrated pathways of care
  - Boosting out of hospital care
  - Patients have more control over their own health and more personalised care

Next Steps for PAHT2020

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- **Set our strategic milestones for delivery of the PAHT Strategic Priorities**
- **Propose how we deliver large scale change across the Trust and OHCP System**
  - EPR, Integrated Care Trust, New Hospital, Clinical Service Transformation, Organisational Development
- **Prioritisation process for delivery & investment – clinical & investment prioritisation**
  - Trust wide prioritisation & One Health & Care Partnership prioritisation

The Princess Alexandra Hospital NHS Trust

4.1

Trust Board – 2 April 2020

Agenda item:	4.1
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Andy Dixon - Matron for Quality Improvement Sarah Webb – Deputy Director of Nursing and Midwifery
Date prepared:	March 2020
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels (Hard Truths) and an Update to Nursing and Midwifery Workforce Position

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	This paper sets out the regular nursing and midwifery retrospective staffing report for the month of February 2020 (part A), and provides an update to the workforce position (part B). Headlines: The summary position for the Trust Safer Staffing Fill rates for February 2020 is included in the table below with a comparison with January 2020 The fill rate for overall RN/RM in month has decreased to 94.9% which is a decrease of 0.3%. Fill rates have been affected by the continued opening of escalation beds to support winter pressures. For the 5th month in a row there has been no ward with a less than 75% fill rate (red) rating for qualified nursing. The overall nursing vacancy position reduced again in February to 10.0% and the Band 5 rate to 7.8%. While slightly behind original forecast vacancy rate this means we have achieved the objective of a less than 10% vacancy rate for qualified nurses by the end of 2019/20.
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:	QSC.27.03.20
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 Appendix 3: Ward staffing exception reports

The Princess Alexandra Hospital NHS Trust

4.1

1.0 PURPOSE

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

2.0 BACKGROUND

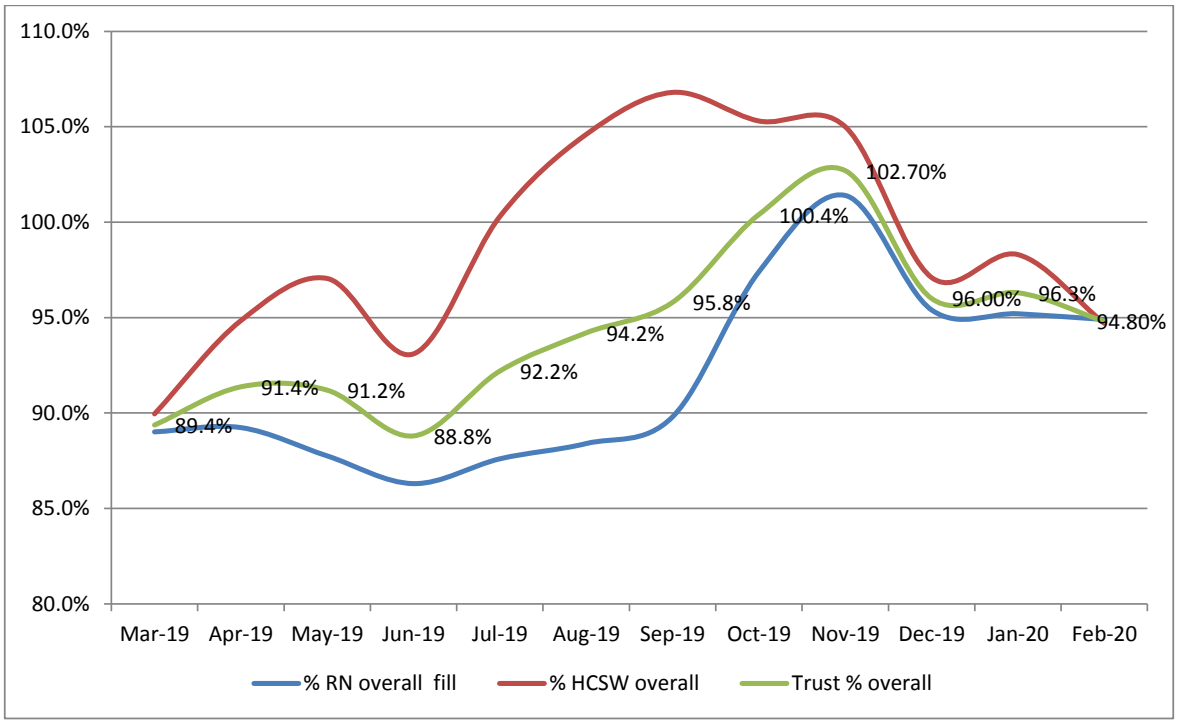
The report is collated in line with The National Quality Board recommendations (June, 2016).

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 February 2020.

3.2 The summary position for the Trust Safer Staffing Fill rates for February 2020 is included in the table below with a comparison with January 2020. The fill rate for overall RN/RM in month has decreased to 94.9% which is a decrease of 0.3%.

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
Trust average February 20	102%	89.2%	93.8%	102.5%	94.9%	94.7%	94.8%
Trust average January 20	102%	92.7%	93.0%	106.3%	95.2%	98.3%	96.3%
Change against January	-	↓3.5%	↑0.8%	↓3.8%	↓0.3%	↓3.6%	↓1.5%



3.4 Exception reporting: Appendix 4 shows the exception report for the wards where the fill rate is less than 75%The report includes analysis of the position, impact on quality, safety or experience and details actions in place to mitigate and improve the position where safe staffing is of concern**.** Following

benchmarking with other acute Trusts in the STP the threshold for the RAG rating has been adjusted this month with the following thresholds applied.

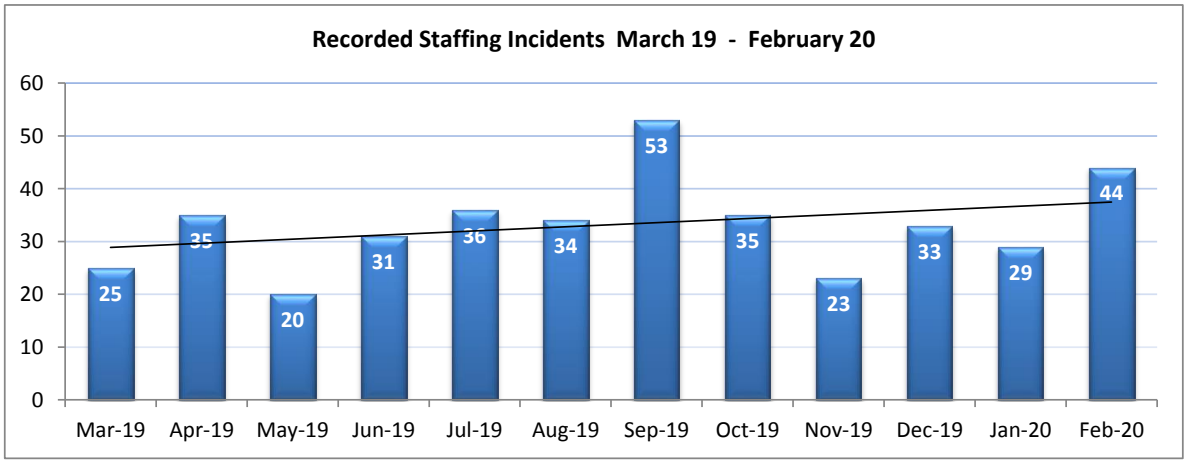
Red <75%	Amber 75 – 95%	Green >95%

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

	Day		Night	
January 2020	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
A&E Nursing	93.9%	91.9%	92.4%	95.9%
PAH Theatres	86.7%	50.6%	81.4%	15.9%
Endoscopy Nursing	79.2%	81.9%		

NB The demand template for endoscopy wasn't adjusted in time for this report and represents a data quality issue rather than clinical safety concern.

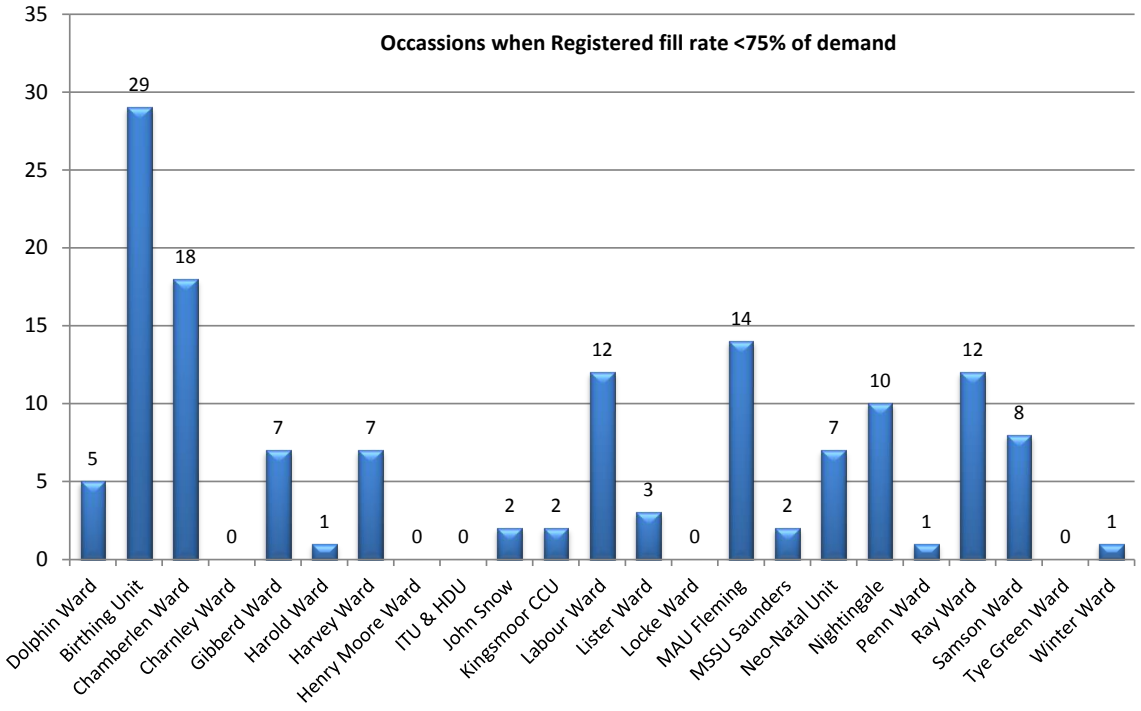
3.5 Datix reports: The trend in reports completed in relation to nursing and midwifery staffing is included below and shows an increase in February. All incidents continue to be reviewed by the safety and quality review process.



3.6 There were no beds closed as a direct result of safer staffing concerns during February 2020

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

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



3.8 Care Hours per Patient Day* (CHPPD) has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018). The table below shows the Trust data from the Model Hospital. Current model hospital data for national median is based on latest available data. This shows the Trust and National data from December 2019, this shows that while the Trust continues to exceed the National median for Registered CHPPD, it has also shows that it is below the national median for overall CHPPD and HCA CHPPD.

	Trust December 2019 data	National Median (Dec 2019)	Variance against national median
CHPPD Total	7.6	7.9	↓0.3
CHPPD RN	4.8	4.7	↑0.1
CHPPD HCA	2.7	3.2	↓0.5

Data checked on Model Hospital 2.3.2020

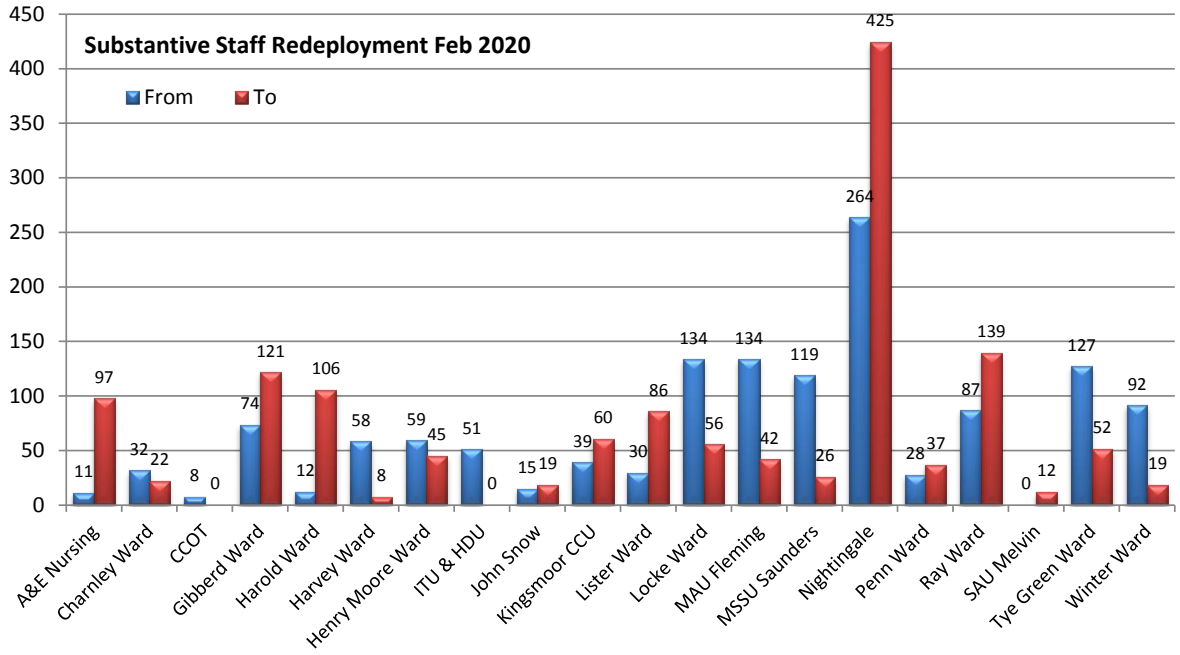
3.9 Mitigation:

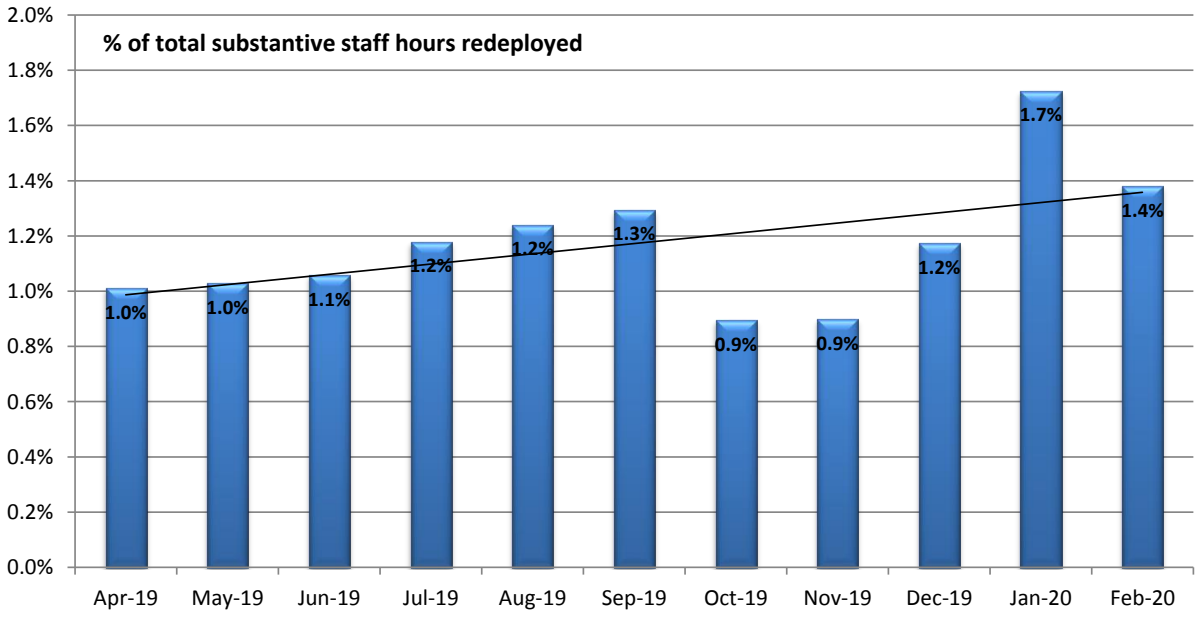
The day to day management of safer staffing across the organisation is managed through the daily staffing huddles and information from SafeCare to ensure support is directed on a shift: shift basis as required in line with actual patient acuity and activity demands. Ward managers support safe staffing by working in the numbers which continues to compromise their ability to work in a supervisory capacity.

3.10 Redeployment of staff:

The 2 graphs below show how the Trust is supporting safe staffing through redeployment of staff to meet acuity and dependency. The graph only shows the redeployment of substantive Trust staff and does not capture the moves of bank or agency staff. The maternity wards and Dolphin have been excluded from this report as they flex staff across the whole service dependant on patient and service needs.

The first graph shows the number of hours of staff redeployed from and to the adult inpatient ward to support safe staffing while the second graph shows the percentage of the total number of staff hours that are redeployed which has shown an increase against the previous month.





The accuracy of these reports continues to be dependent on the wards and site team redeploying staff, capturing and recording these moves in real-time in the e-Roster or SafeCare system.

While essential to ensure the safe staffing across the Trust moving substantive staff can impact on staff satisfaction and retention rates and therefore is monitored closely to minimise the impact on staff.

3.11 Bank and Agency fill rates:

The use of NHSP continues to support the clinical areas to maximise safer staffing. The Trust has worked with NHSP to increase the availability of resource, and are working in partnership to improve this further. The table below shows that there was a static registered demand (↑8 shifts) in February compared to January. There was an increase in NHSP fill, although there was a decrease in agency fill for RN, the overall fill rate for RNs increased by 7.2%.

The HCSW demand shows an increase (↑41 shifts) with the overall fill rate up by 1.0% against January.

RN temporary staffing demand and fill rates*: (February 2020 data supplied by NHSP 16.3. 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
November 19	4185	1888	45.1%	1043	24.9%	70.0%	1254	30.0%
December 19	3891	1703	42.3%	1020	27.9%	70.2%	1168	29.8%
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%
February 19	4069	1870	46.0%	1069	26.3%	72.2%	1,130	27.8%

HCA temporary staffing demand and fill rates: ***(February 2020 data supplied by NHSP 16.3. 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
November 19	2594	1872	72.2%	0	0%	72.2%	722	27.8%
December 19	2689	1805	68.5%	0	0%	68.5%	884	31.5%
January 20	2732	1855	67.9%	0	0%	67.9%	877	32.1%
February 20	2773	1910	68.9%	0	0.0%	68.9%	863	31.1%
February 19	2344	1734	74.0%	0	0.0%	74.0%	610	26.0%

B: Workforce:

Nursing Recruitment Pipeline

The nurse vacancy rate continues to fall steadily. The overall nursing vacancy rate in February fell to 10%. Although this is slightly behind the forecast rate of 9.7% the Trust remains on track to achieve the overall target of <10% by March 2020.

Band 5 posts continue to make up the bulk of the vacancy rate and in February the vacancy rate fell further 4.5% in month to 7.8 % slightly behind the forecast rate of 7.2%. The trajectory remains green as the number of starters planned for Q4 will keep us on track to meet forecast outturn position. The recruitment pipeline has over 100 nurses who are holding offers of employment and there is confidence that sufficient number of offer holders will convert into starters by the end of March to achieve the trajectory. The pipeline is supplemented with a better than expected domestic recruitment and in house assistant practitioners who have completed their top up programme to achieve registered nurse status.

The Recruitment and Retention Nurse is working with the DDoN to develop the pipeline for 2020/21 and target Band 6 and above vacancies which mow make up equivalent WTE vacancies as Band 5's The following table shows confirmed recruitment figures (in green) against the planned trajectory. turnover rate falling from 15.06% to 10.88% over the last 12 months.

The Princess Alexandra Hospital NHS Trust

Establishment V Staff in Post												
Funded Establishment WTE	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61	942.61
Staff in Post WTE	704	710.00	711.00	716.00	737.00	759.00	774.00	796.00	816.00	831.00	848.00	874.00
Vacancy WTE	238.61	232.61	231.61	226.61	205.61	183.61	168.61	146.61	126.61	111.61	94.61	68.61
Actual RN Vacancy Rate	25.3%	24.7%	24.6%	24.0%	21.8%	19.5%	17.9%	15.6%	13.4%	11.8%	10.0%	7.3%
Forcast Vacancy Rate in Business Plan	26.8%	26.9%	25.4%	24.0%	22.7%	19.3%	16.2%	13.1%	10.8%	9.7%	9.4%	9.3%

Band 5 Establisment V Staff in Post												
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Funded Band 5 Establisment WTE	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93	487.93
Band 5 Staff in Post WTE	289	294	296	302	322	347	364	387	411	428	450	478
Band 5 Starters	9	7	7	8	22	29	20	28	27	25	26	34
Vacancy Band 5 WTE	198.93	193.93	191.93	185.93	165.93	140.93	123.93	100.93	76.93	59.93	37.93	9.93
Actual Band 5 Vacancy Rate	40.8%	39.7%	39.3%	38.1%	34.0%	28.9%	25.4%	20.7%	15.8%	12.3%	7.8%	2.0%
Forcast Vacancy Rate in Business Plan	40.8%	41.0%	38.1%	35.4%	32.8%	26.2%	20.3%	14.3%	9.8%	7.8%	7.2%	7%

Projected Starters Pipeline												
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RNs (not Band 5)	1	1	2	2	4	1	2	3	1	5	1	1
Band 5 Newly Qualified + Local	3	2	0	1	1	3	7	3	4	5	12	14
Band 5 International Recruitment	6	5	7	7	21	26	13	25	23	20	14	20
Band 5 Starters	**9**	**7**	**7**	**8**	**22**	**29**	**20**	**28**	**27**	**25**	**26**	**34**
Total Starters	10	8	9	10	26	30	22	31	28	30	27	35

Projected Leavers WTE												
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
RNs (not Band 5) Leavers	2	3	3	3	3	4	4	4	5	7	6	3
Band 5 Leavers	3	2	5	2	2	4	3	5	3	8	4	6
Total Leavers	**5**	**5**	**8**	**5**	**5**	**8**	**7**	**9**	**8**	**15**	**10**	**9**
Nursing turnover %	15.06%	14.86%	14.79%	13.41%	12.13%	12.22%	11.83%	11.09%	10.13%	10.88%		

4.0 RECOMMENDATION

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

Author: Andy Dixon. Matron for Quality Improvement,
Sarah Webb, Deputy Director of Nursing and Midwifery

Date: 20th March 2020

The Princess Alexandra Hospital NHS Trust

Appendix 1.

Ward level data: fill rates February 2020.

	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
Dolphin Ward	110.4%	101.2%	86.7%	140.0%	99.9%	114.1%	103.5%
Kingsmoor CCU	86.3%	97.9%	98.3%	108.5%	91.4%	101.9%	95.1%
MAU Fleming	87.9%	119.7%	86.2%	93.3%	87.2%	107.1%	95.5%
Tye Green Ward	104.7%	80.2%	101.5%	99.7%	103.3%	88.1%	96.7%
Harvey Ward	91.8%	81.6%	102.3%	64.6%	96.1%	73.4%	85.7%
ITU & HDU	85.7%	143.5%	90.1%	137.8%	87.8%	140.5%	92.6%
John Snow	95.6%	89.3%	108.0%	108.6%	100.7%	96.6%	99.0%
Charnley Ward	98.3%	102.4%	120.1%	113.4%	106.0%	106.6%	106.2%
Lister Ward	98.5%	83.8%	89.2%	146.2%	94.2%	103.4%	98.2%
Locke Ward	108.3%	84.1%	98.3%	122.8%	104.1%	98.8%	102.2%
Neo-Natal Unit	81.9%	125.5%	81.0%	106.9%	81.4%	116.2%	87.2%
Nightingale	93.1%	61.2%	96.6%	62.0%	94.5%	61.6%	79.4%
Penn Ward	96.8%	116.6%	85.5%	136.8%	92.0%	124.3%	103.6%
Ray Ward	82.2%	70.6%	96.1%	129.9%	88.1%	89.2%	88.6%
MSSU Saunders	98.9%	77.4%	98.2%	97.5%	98.6%	85.6%	92.9%
Harold Ward	99.2%	85.6%	101.1%	86.7%	100.0%	86.1%	93.9%
Henry Moore Ward	91.0%	102.9%	104.1%	115.6%	96.3%	106.8%	99.9%
Gibberd Ward	94.3%	93.2%	102.3%	98.4%	97.6%	95.7%	96.6%
Winter Ward	99.4%	94.4%	114.6%	148.9%	104.8%	115.0%	108.7%
Chamberlen Ward	99.1%	63.5%	81.7%	65.5%	90.8%	64.5%	84.2%
Labour Ward	107.8%	84.4%	84.5%	86.2%	96.7%	85.3%	94.1%
Samson Ward	111.8%	68.6%	91.0%	91.0%	101.9%	77.1%	90.6%
Birthing Unit	81.2%	79.0%	74.7%	75.9%	78.1%	77.5%	77.9%
Trust total	102.0%	89.2%	93.8%	102.5%	94.9%	94.7%	94.8%

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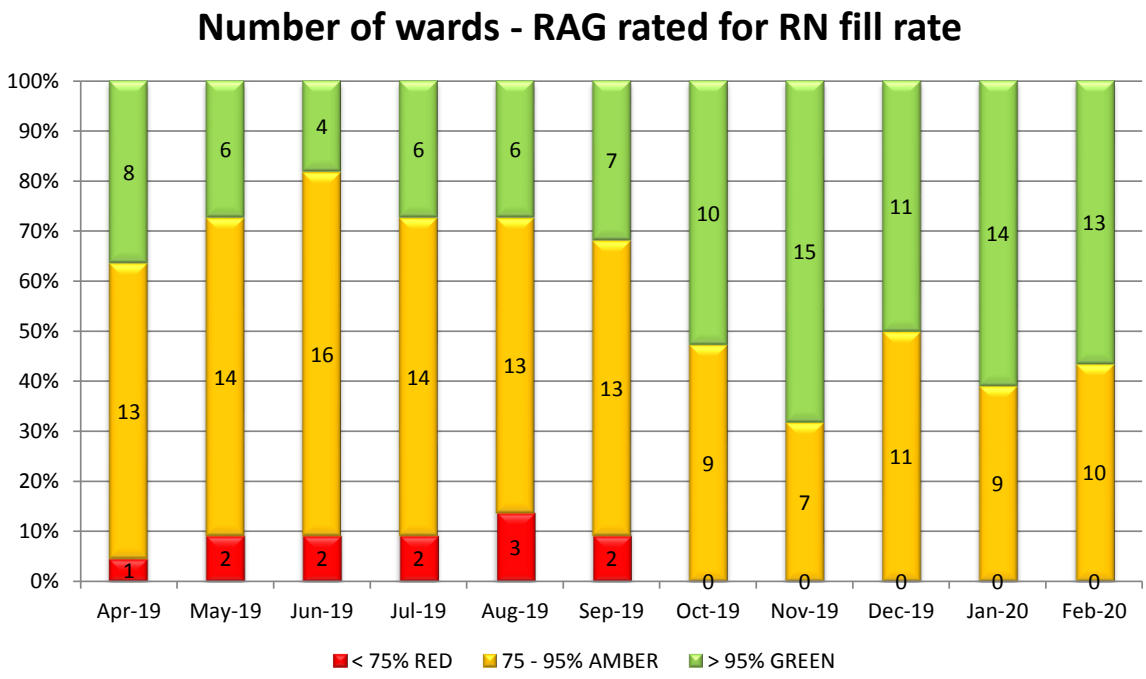
4.1

Appendix 2



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Appendix 3

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

	Report from the Associate Director of Nursing for the HCG		
Ward	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Harvey	Less than 75% fill rate of unqualified nurses	Nil	Nil required
Nightingale	Less than 75% fill rate of unqualified nurses	Nil	Nil required
Chamberlen	Less than 75% fill rate of unqualified nurses	Nil	Nil required

The Princess Alexandra Hospital NHS Trust

Trust Board – 2 April 2020

5.1

Agenda item:	5.1
Presented by:	Ogechi Emeadi, Director of people, OD and communications
Prepared by:	Martin Smith, AD for training, education and development Charlotte Jefferson, Head of organisational development
Date prepared:	26/03/20
Subject / title:	Staff Survey 2019 results: overview and response plan

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:	This paper provides an outline of the PAHT results from the NHS Staff Survey 2019 and the Trust's associated response plan. On 20 December 2019 we received initial results from our survey provider (Picker), including an overview of our progress since the 2018 survey, and how we compared to the 37 acute Trusts also using Picker to administer their surveys. On 18 February 2020 the NHS Staff Survey Coordination Centre released national benchmarking reports, providing comparisons against the 85 acute Trusts nationally, across ten key themes. As a Trust we have developed a response plan to the findings, which includes: • Identifying three top improvement priorities Trust-wide. • HCG improvement plans identifying actions against the top three priorities, in addition to two specific HCG priorities. • Staff survey workshops with all HCGs to develop improvement plans. • Action plan tracker template compiled to evidence ongoing progress, to be reviewed throughout the year at various Boards. • A communications plan to share the results and improvements made.
Recommendation:	To review and note the results and response plan, raising any concerns or comments.

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

Previously considered by:	Prior papers presented at People Board, SMT & Workforce Committee.
Risk / links with the BAF:	2.3 Workforce: Inability to recruit, retain and engage our people
Legislation, regulatory, equality, diversity and dignity implications:	Links to WRES / WDES reporting (separately reported to Equality & Diversity Steering Group)
Appendices:	Appendix 1. PAHT results comparison against the national key themes Appendix 2. PAHT staff survey response plan and progress to date

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5.1

1.0 Purpose/issue

This paper outlines the Trust's NHS Staff Survey 2019 results, and provides an overview of our staff survey response plan.

2.0 Background

The annual NHS Staff Survey 2019 launched on 2 October 2019 and closed on 29 November 2019. All substantive staff in post on 1 September 2019 were invited to complete the survey, with some exclusions as per national guidance.

The survey was administered by our chosen provider, the Picker Institute (Picker). Initial results were received from Picker on 20 December 2019 (including comparisons to the other acute 37 Trusts using Picker).

The national-level results were released by the NHS Survey Coordination Centre on 18 February 2020, and these provided comparisons for the 85 acute Trust's nationally.

3.0 2019 survey results providing comparison on our progress since 2018

The Trust achieved a 45% response rate (1520 respondents of 3392 eligible staff), which compares to a median national response of 47% (amongst similar Trusts in our benchmarking group). This represents a 5% response rate increase compared to 2018. A summary of response rates across our HCGs is provided below.

HCG	Response rate 2018	Response rate 2019	Variance
CCCS	44%	51%	7%
Corporate	79%	80%	1%
Estates & Facilities	23%	66%	43%
Family & Womens Services	35%	42%	7%
Medicine	32%	24%	-6%
Surgery	36%	35%	-1%

The results provided by Picker are focused at a local, organisational level, and provide further useful findings.

PAHT rank #26 of 37 acute Trusts (using Picker) overall for our results, dropping from our position of #21 of 43 acute Trusts in 2018.

Our headline results provided by Picker include the following (averages refer to the average scores of acute Trusts using Picker, not the national average).

	Most improved from last survey		Least improved from last survey
46%	Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	30%	Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties
54%	Q13d. Last experience of harassment/bullying/abuse reported	54%	Q22c. Feedback from patients/service users is used to make informed decisions within directorate/department
82%	Q3c. Able to do my job to a standard I am pleased with	57%	Q22b. Receive regular updates on patient/service user feedback in my directorate/department
82%	Q7a. Satisfied with quality of care I give to patients/service users	71%	Q21b. Organisation acts on concerns raised by patients/service users
69%	Q7c. Able to provide the care I aspire to	55%	Q17d. Staff given feedback about changes made in response to reported errors/near misses/incidents

	Top 5 scores (compared to average)		Bottom 5 scores (compared to average)
50%	Q19e. Appraisal/performance review: organisational values definitely discussed	30%	Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties
54%	Q13d. Last experience of harassment/bullying/abuse reported	61%	Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation
89%	Q12a. Not experienced physical violence from patients/service users, their relatives or other members of the public	46%	Q4f. Have adequate materials, supplies and equipment to do my work
85%	Q9a. I know who senior managers are	52%	Q17a. Organisation treats staff involved in errors/near misses/incidents fairly
82%	Q3c. Able to do my job to a standard I am pleased with	66%	Q28b. Disability: organisation made adequate adjustment(s) to enable me to carry out work

The national report shows PAHT's results against the national themes (appendix 1)

Copies of all the PAHT Picker data reports are available on request.

Copies of PAHTs, and all other NHS organisations national reports are available on the NHS Staff Survey Coordination website www.nhsstaffsurveys.com

4.0 PAHT staff survey response plan

Appendix 2 provides a summary of our response plan and progress to date. As per this plan, feedback from our Staff Council, People Board, SMT, and Workforce Committee in January 2020 guided the agreement at EMT of our top three improvements priorities.

- **Priority 1:** Improving the physical and mental health and wellbeing of our people
- **Priority 2:** Improving our learning and safety culture, encouraging people to openly raise concerns and ensure they are acted upon *(improving psychological safety)*
- **Priority 3:** Improving the quality and effectiveness of line management skills

These priorities are being communicated via HCG staff survey workshops; guiding the development of HCG improvement action plans. It should be noted that this work has experienced delays due to current incident planning priorities. The top three priorities will also form the basis of Trust-wide communication releases about improvements being made in relation to the findings, using the 'Making it Better. Together' campaign introduced in 2019.

5.0 Recommendation

The Board is asked to review and discuss the information provided, raising any concerns or comments.

The Princess Alexandra Hospital NHS Trust

Appendix 1. PAHT staff survey results comparison against the national key themes

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your org	8.9	5.7	6.8	6.1	5.8	7.6	7.8	9.5	6.6	6.9	6.6
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	1,482	1,492	1,494	1,470	1,238	1,264	1,474	1,468	1,490	1,496	1,475

Your

Appendix 2. PAHT staff survey response plan and progress to date

PAHT Staff Survey Response Plan	
January 2020	SMT, People Board, Workforce Committee & Staff Council review results and recommend top three improvement priorities. **Update:** complete
February 2020	EMT review above recommendations, and agree top three improvement priorities and associated Trust-wide improvement actions. **Update:** complete, pending agreement of specific aligned improvement actions
February - early March 2020	HCG staff survey workshops held to share the results and agree how HCGs will support achieving the top three priorities, in addition to identifying two further priorities addressing HCG-specific concerns. Managers across all departments invited. **Update:** all originally planned to take place by 13 March 2020. Estates & Facilities held on 27/2/20; Medicine held on 04/03/20; Corporate held on 05/03/20; Surgery held on 10/03/20; FAWS planned for 12/03/20 but cancelled (new date TBC); CCCS planned for 13/03/20 but cancelled (new date TBC).
March 2020	NHS Survey Coordination Centre release national staff survey findings report, including benchmarking data. This further informs the development of action plans. Findings to be presented at SMT, EMT and People Board (if received in time). **Update:** reports released earlier than expected on 18/02/20. National-level results shared at HCG workshops (so far), Equality & Diversity Steering Group (02/03/20) and Workforce Committee (23/03/20). Headline results shared with all staff via InTouch (email and magazine).
March – April 2020	Team-based staff survey workshops held to support team-level action plans *(optional as directed by HCG leads).* **Update:** planning ongoing to arrange these workshops.
31 March 2020	HCG-level action plans to be returned. **Update:** deadline requires extending due to cancellations of two of the HCG workshops (due to illness / COVID-19 incident planning).
April 2020	Action plans peer-reviewed at Staff Engagement Steering Group. **Update:** to be reviewed (Staff Engagement Steering Group arrangements under review).
May 2020	Action plans presented at People Board. **Update:** was on track to meet milestone.
Ongoing 2020	Assurance reporting on Trust-wide & HCG action plans via: • Staff Engagement Steering Group (June, August, October, December), escalating as required via monthly PRMs. • Updates to People Board (May, July, September, November) • Updates to Workforce Committee (May, September). • Updates to SMT and EMT (as requested). HCG Boards to monitor implementation of divisional/team level action plans locally. **Update:** was on track to meet reporting milestones.

The Princess Alexandra Hospital NHS Trust

Trust Board – 2/04/2020

5.2

Agenda Item:	5.2
Presented by:	Ogechi Emeadi – Director of People, OD and Communications
Prepared by:	Beverley Watkins – Deputy Director of People
Date prepared:	17 March 2020
Subject / Title:	Fit and Proper Persons Annual Review

Purpose:	Approval		Decision		Information		Assurance	

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	This paper presents an update of the annual Fit and Proper Person review undertaken by the Trust. (FPPT). The FPPT provides assurance to the Board that the Trust's eligible persons for the test are compliant with the regulations.
Recommendation:	The Board is requested to note the 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		

Previously considered by:	WFC on 23.03.20
Risk / links with the BAF:	Breach of Regulation 5 of the Health and Social Care Act 2008 entitles the CQC to take regulatory action against the Trust
Legislation, regulatory, equality, diversity and dignity implications:	Health and Social Care Act 2008
Appendices:	None

1.0 PURPOSE

This paper provides an update of the Trust's performance against the Fit and Proper Person Requirement policy which was revised following Care Quality Commission (CQC) findings and internal audit recommendations.

1.2 The FPPT process provides assurance to the Board that the Trust's eligible persons for the test are compliant.

2.0 CONTEXT

2.1 The fit and proper person requirements came into effect from 27 November 2014 for NHS Bodies.

2.2 The requirement seeks to ensure that we only employ individuals at deputy director level and above who are fit for their role, and we are required to assess the fitness of nominated individuals to ensure that they:

- of good character (schedule 4, part 2 of the regulations),
- have the appropriate qualifications (or equivalent experience), are competent and skilled (including that they show a caring and compassionate nature and appropriate aptitude),
- have the relevant experience and ability (including an appropriate level of physical and mental health, taking account of any reasonable adjustments);
- exhibit appropriate personal behaviour and business practices and;
- can supply certain information (including a Disclosure and Barring Service (DBS) check and a full employment history).

2.3 The intention of this regulation is to ensure that people who have director level responsibility for the quality and safety of care and for meeting the fundamental standards are fit and proper to carry out this important role.

2.4 The regulation applies to Director level roles but the Trust has identified a list of job roles ("the relevant workers") which are subject to the Fit and Proper Person test requirement. This list is attached as Appendix 10 to the Trust's Fit and Proper Persons Policy.

3.0 ANALYSIS

3.1 In monitoring the Trust's performance against the FPPT regulation, the following actions were undertaken;

i. Annual compliance checks, by way of the annual self-declaration (Appendix 5 to the FPPR policy) were undertaken in January 2020 and included self-declarations from all staff identified by the Trust as "relevant workers". 100% compliance (of 42 members of staff) was achieved for those staff currently in work; one member of staff is currently on long term sick leave.

ii. DBS checks with the appropriate level check applied depending on the nature of the role applied for (standard or enhanced check across all eligible posts)

iii. A revised monitoring spreadsheet which consists of all the checks as set out in the FPPR policy is in use for all eligible appointments. The spreadsheet is for internal use only but will enable evidence to be more readily produced for future compliance audits and inspections.

4.0 OTHER CONSIDERATIONS

4.1 Risks

4.1.1 Breach of Regulation 5 of the Health and Social Care Act 2008 entitles the CQC to take regulatory action against the Trust. The policy and its associated monitoring provides the governance framework to mitigate this risk.

4.2 Next Steps

4.2.1 The FPPR process will be monitored, through annual the self-declaration exercises & DBS update checks and further compliance reports presented on an annual basis and by exception.

5.0 RECOMMENDATION

5.1 The Board is asked to note the contents of this report.

Author: Beverley Watkins, Deputy director of people
Date: 17th March 2020

The Princess Alexandra Hospital NHS Trust

Trust Board – 2.04.20

5.3

Agenda Item:	5.3
Presented by:	Ogechi Emeadi - Director of People
Prepared by:	Nathaniel Williams, People Information & Systems Lead
Date prepared:	28.03.2020
Subject / Title:	Gender Pay Gap Reporting 2020

Purpose:	Approval	x	Decision	x	Information	x	Assurance	x

Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Princess Alexandra Hospital gender pay gap as at 31 March 2019 snapshot date report average mean hourly rate of 28% lower for women (29% in 2018) and average median hourly rate of 22% lower for women (a decrease from 2018). If we exclude Medical and Dental staff group, the mean pay gap is 0.61%. Bonuses (Consultants Clinical Excellence Awards) were paid to more men than women consultants. Mean average bonus payment is 16% lower for women (12% decrease from 2018) and Median average bonus payment is 34% lower for women (14% increase from 2018). The 4 pay quartiles show more women than men in each of the quartiles with a 3% increase in the upper quartile for women compared to the 2018 position.
Recommendation:	The report is presented to the Board for retrospective approval following approval at Workforce Committee on 23 March 2020.

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

Previously considered by:	WFC.23.03.20
Risk / links with the BAF:	BAF Risk 2.1 Workforce Capacity
Legislation, regulatory, equality, diversity and dignity implications:	The Trust is required by law to publish the gender pay gap report by 30 March 2020
Appendices:	N/A

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The Princess Alexandra Hospital NHS Trust

1. Introduction

The gender pay reporting legislation requires all organisations employing more than 250 people to measure and publish their gender pay information both on our website and the government's by 30 March 2020, based on earnings as at 31 March 2019 on our gender profile of 78% women and 22% men employees at PAH NHS Trust.

2. Background & context

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

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

2.3 The gender pay gap is not the same as equal pay. The NHS has a national pay structure, job evaluation system and contractual terms and conditions for medical and non-medical staff which have been developed in partnership with trade unions. This national framework provides a robust set of arrangements for pay determination.

2.4 The Gender Pay reporting requirements have been introduced to make the differences in pay between men and women more transparent across all industry sectors, enabling employers to consider the reasons for any differences and to take any corresponding action.

3. Requirements

The report is based on earnings as at 31 March 2019 and provides analysis on the following:

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

4. Gender Profile by Staff Group

This report is based on a gender staff profile of 78% Women and 22% men employees at the Princess Alexandra Hospital as at 31 March 2019 in the following staff groups:

Staff Group	Women	Men
Add Prof Scientific and Technic	81%	19%
Additional Clinical Services	89%	11%
Administrative and Clerical	81%	19%
Allied Health Professionals	75%	25%
Estates and Ancillary	67%	33%
Healthcare Scientists	64%	36%
Medical and Dental	40%	60%
Nursing and Midwifery Registered	92%	8%

The Princess Alexandra Hospital NHS Trust

5.3

5. **Mean and Median Ordinary pay gap**

Mean Avg Hourly Rate		
£22.56		£16.17
	28% Difference	
	0.9%↓from 2018	

Median Avg Hourly Rate		
£17.84		£13.99
	22% Difference	
	1.5%↓from 2018	

In aggregate the mean gender pay gap indicates that women earned 28% less than men a slight decrease from 2018 report whilst the median pay gap indicates for the reporting period that women earn 22% less than men a decrease of 1.5% from the 2018 report.

6. **Mean and Median Bonus pay gap**

At The Princess Alexandra Hospital NHS Trust, the only staff group in receipt of bonuses during the reporting period were consultants in accordance with the NHS national terms and conditions for medical staff. Bonus pay is exclusively made up of local and national Consultants Clinical Excellence Awards and discretionary points. In section 4 of this report, the gender breakdown for medical staff shows that this is the only staff group which employs more men (60%) than women (40%). The mean and median difference in bonus payments for medical staff during the reporting period is as follows:

Mean Avg Bonus Payment		
£13,196.72		£11,038.61
	16% Difference	
	↓ 11% from 2018	

Median Avg Bonus Payment		
£10,166.82		£6,660.33
	34% Difference	
	↑15% from 2018	

Analysis shows that women average mean bonus pay difference reduced significantly by 11% from 2018 but the median pay difference has increased by 15% from 2018. The Mean pay reduction is due to a widely publicised EBA (employee based award) rounds with workshops aimed at women colleagues to support them to apply. As a result these interventions, the below table shows the proportion of Women who were awarded CEA's in 2019 is higher compared to the 2018 position.

Total Relevant Consultants

Gender	Mar-18	Mar-19
Female	31.95%	29.82%
Male	68.05%	40.74%

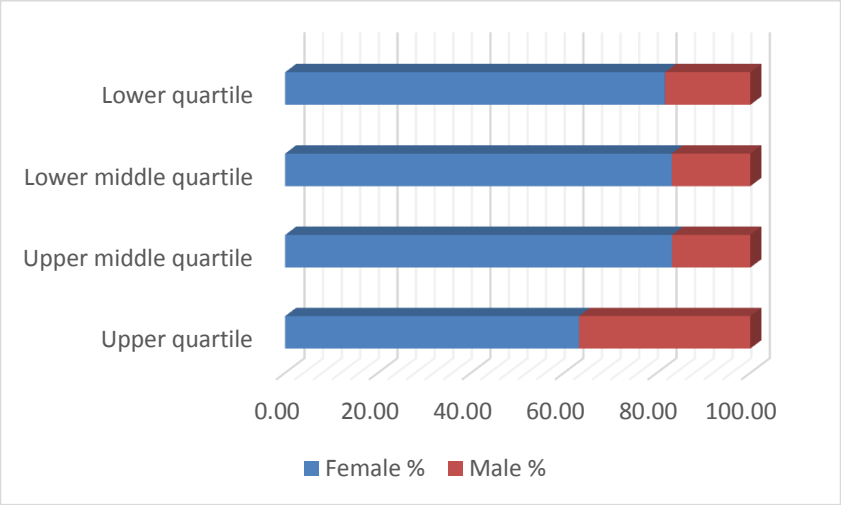
Total Relevant Employees

Gender	Mar-18	Mar-19
Female	0.62%	0.63%
Male	5.91%	5.80%

The increase in the median pay variance reflects the overall distribution of those awarded a CEA as it will take longer for the newly awarded consultants to progress up the CEA scale.

7. **Pay distribution by gender**

The table below shows the proportion of men and women employees in each quartile (the lower being lowest paid and upper being the highest paid staff). Quartiles are calculated by ranking the pay for each employee from lowest to highest.



8. **What are we doing about it?**

The Equality, Diversity and Inclusion Steering Group recommend the following:

- Review and encourage flexible working arrangements where practicable across all areas
- Raising awareness on shared parental leave
- Consider reviewing the impact of unconscious bias training
- Continue to deliver workshops on Consultants Clinical Excellence Awards
- Consider how to support consultant recruitment to encourage gender balance

The Equality, Diversity and Inclusion Steering Group will monitor delivery of these actions.

9. **Recommendation:**

The Board is asked to retrospectively approve the report for publication following approval by the Workforce Committee on 23 March 2020.

Author: Nathaniel Williams

Trust Board – 02.04.20

Agenda Item:	6.1
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Information Team, Executive Directors
Date prepared:	March 2020
Subject / Title:	Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	✓	Assurance	✓

Key Issues:	The report this month is reduced to metrics only due to operational pressures related to COVID-19.
Recommendation:	The Board is asked to note the current position.

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:	PAF.26.03.20 QSC.27.03.20
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	M11 IPR

6.1

NHS
The Princess Alexandra Hospital
NHS Trust

Integrated Performance Report
February 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.

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Contact:

Lance McCarthy, Chief Executive Officer
Andy Morris, 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

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Trust Objectives

The Princess Alexandra Hospital NHS Trust

Our Patients

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

Our People

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

Our Places

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

Our Performance

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

Our Pounds

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

5Ps

In this month

The Princess Alexandra Hospital NHS Trust

Patients

Performance

People

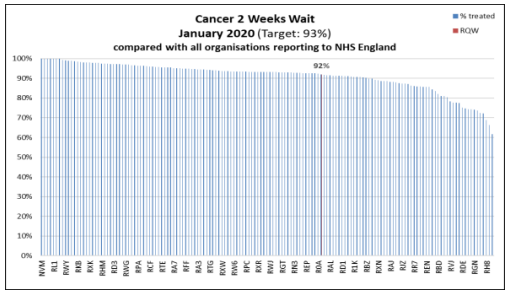
Pounds

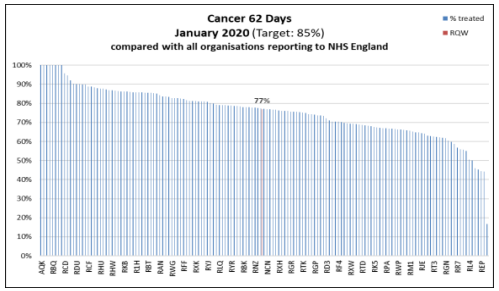
Places

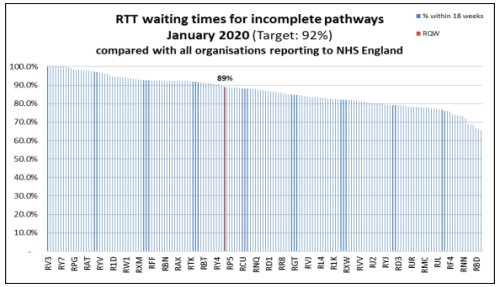
6.1

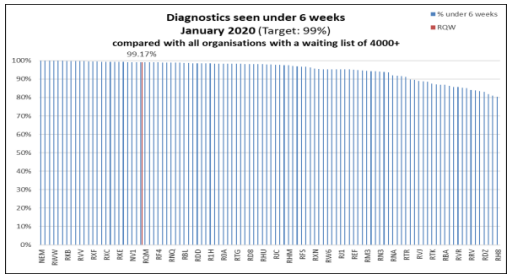
National Benchmarking
Compared with all organisations reporting to NHS England

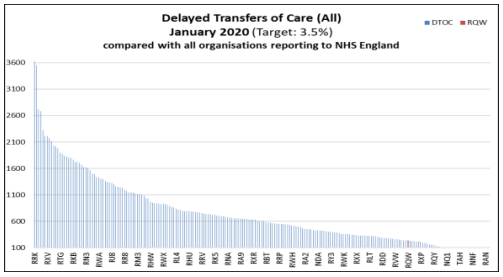
NHS
The Princess Alexandra Hospital
NHS Trust

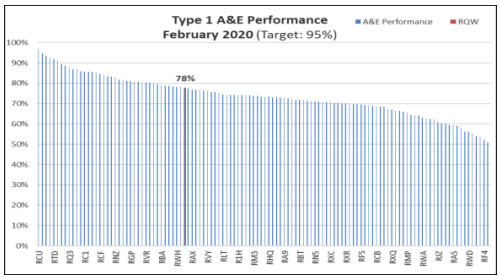


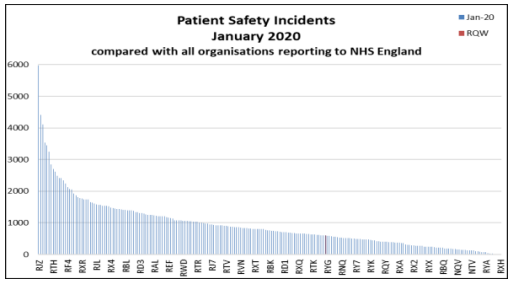


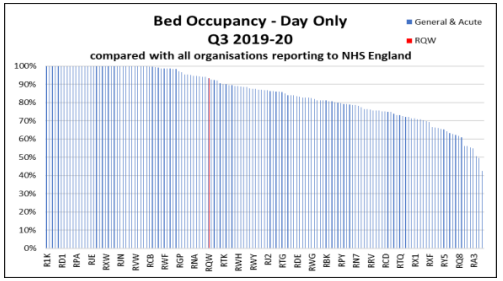


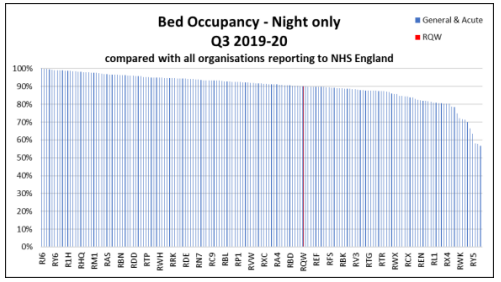












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Data Source: NHS England Statistics/Public Health England/Dr Foster

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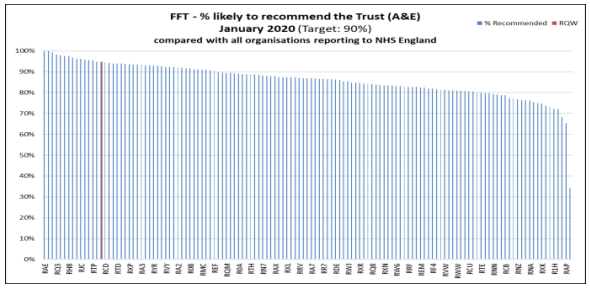
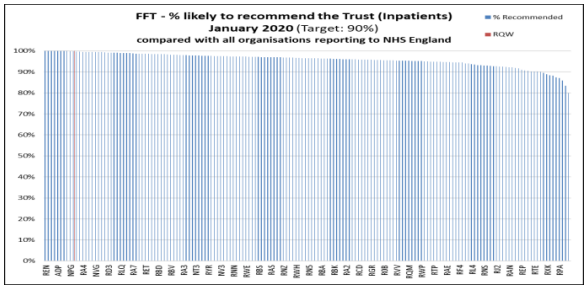
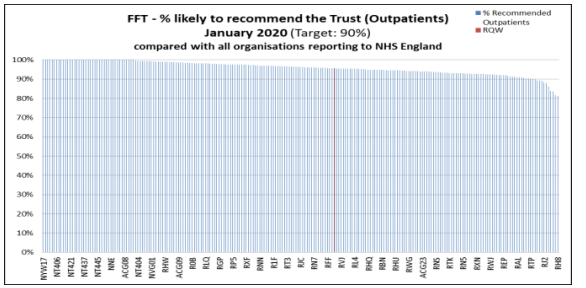
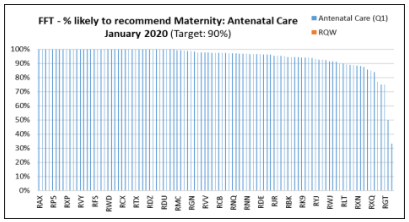
National Benchmarking
Compared with all organisations reporting to NHS England

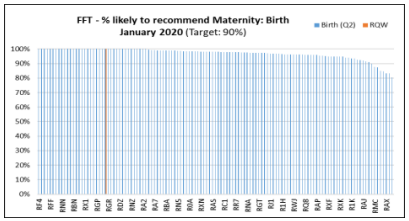
NHS
The Princess Alexandra Hospital
NHS Trust

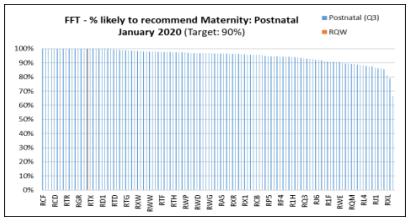


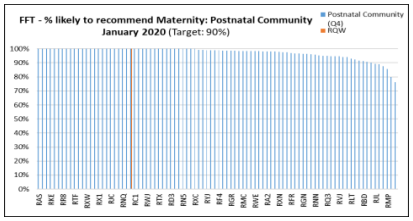


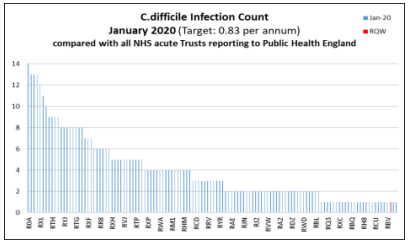


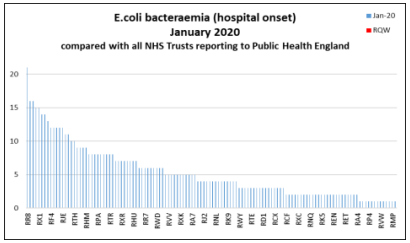


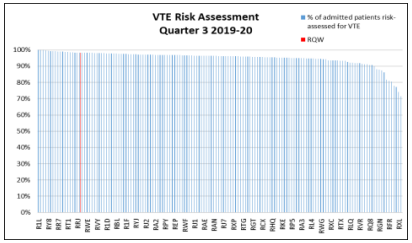


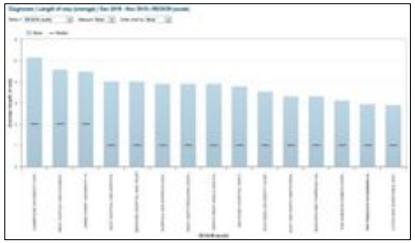












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Data Source: NHS England Statistics/Public Health England/Dr Foster

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Patient Experience

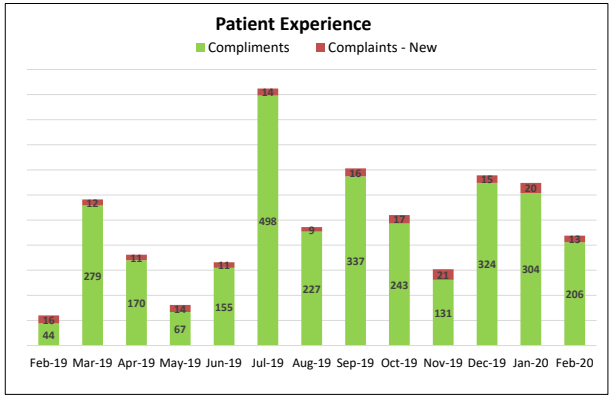
1 Our Patients Summary 1.1 Patient Experience

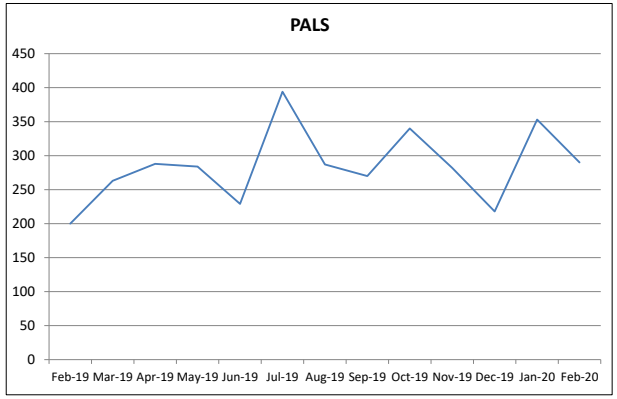
NHS The Princess Alexandra Hospital NHS Trust

18 contacts have been made regarding COVID-19 since the beginning of the outbreak, 6 PALS and 12 general enquiries. The six PALS cases relate to

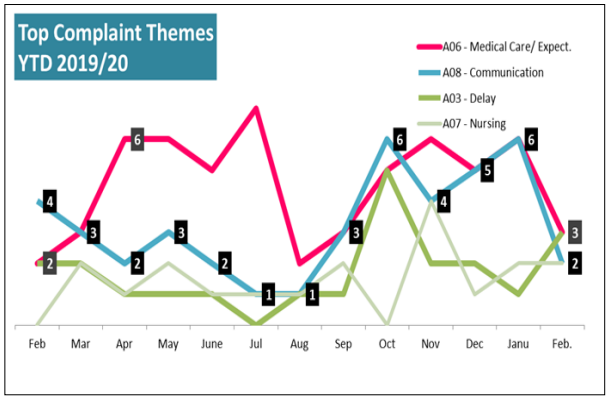
- Elective cancellation fears
- Delays from the results of testing
- Cleaning concerns and poor experience in the COVID pod
- Assurance regarding maternity services from a man whose partner will be giving birth here

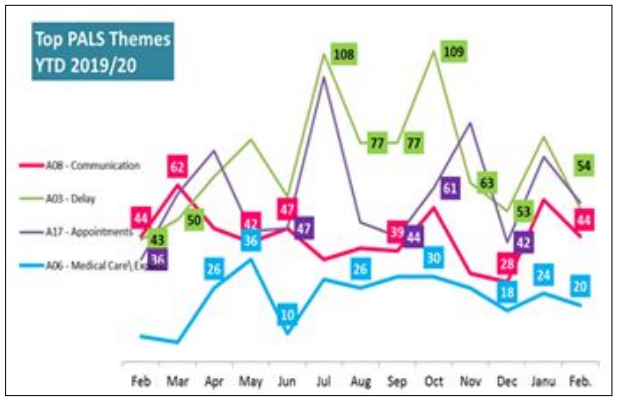
Business continuity measures are being considered to enable the resolution of 74 open cases and measures will be put in place to address these. We have observed a reduction in complaints overall but no change in PALS activity. Following a month (January 2020) where admission, discharge and transfer arrangements featured prominently in new complaints data (5) there have been none in February, however for PALS the notable item is a continuing high level of concern around parking issues, 15 of 24 premises issues raised in Feb relate to PCNs.

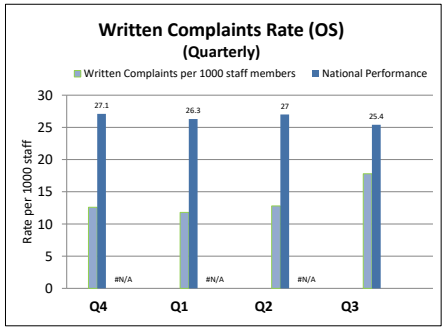




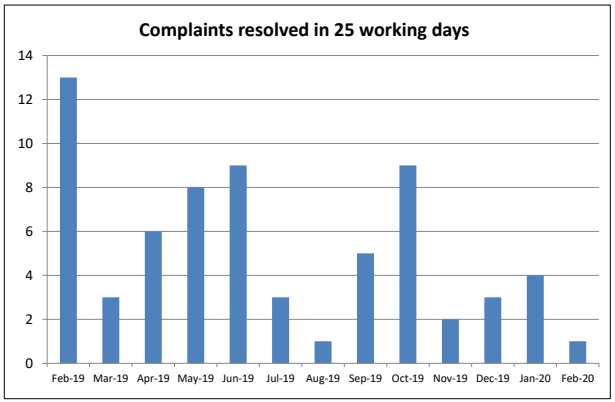
PALS converted to Complaints	
Feb-19	2
Mar-19	0
Apr-19	1
May-19	2
Jun-19	2
Jul-19	1
Aug-19	1
Sep-19	4
Oct-19	2
Nov-19	3
Dec-19	4
Jan-20	6
Feb-20	3

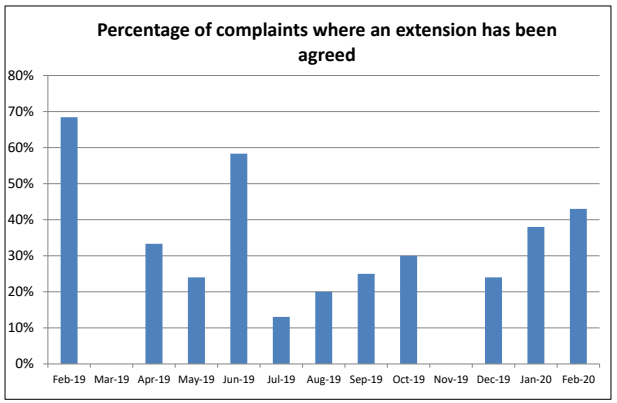


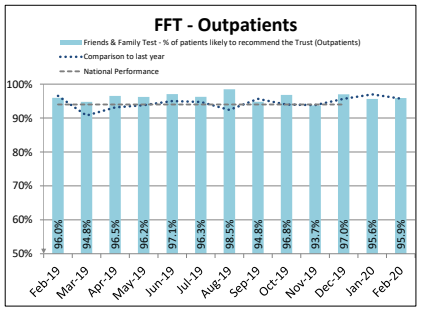


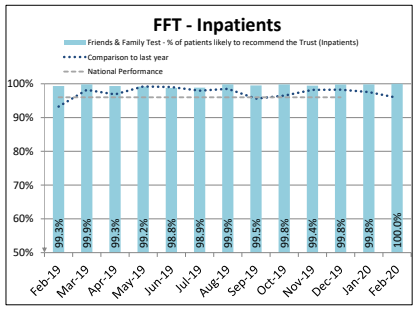


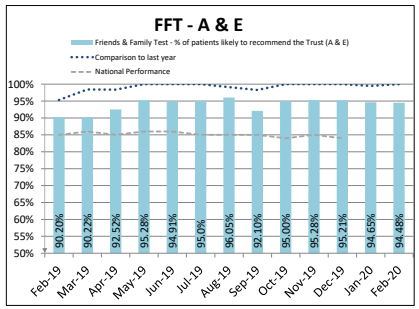
Patient Experience

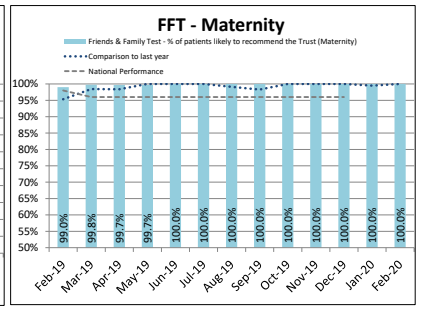












Patient Safety

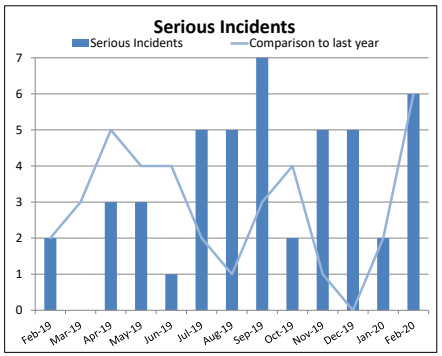
1 Our Patients Summary 1.3 Patient Safety

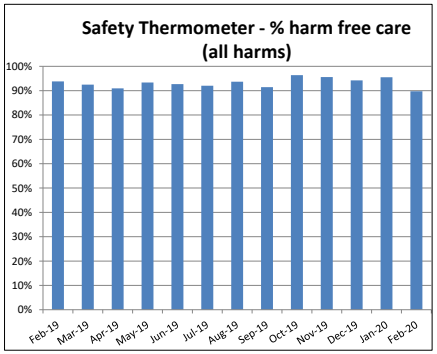
The Princess Alexandra Hospital NHS Trust

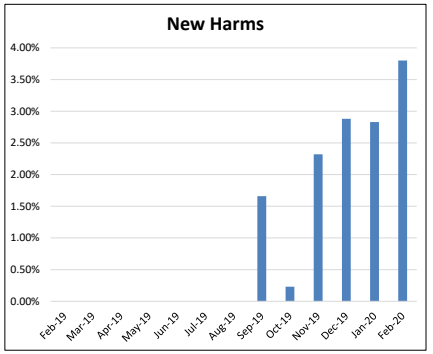
Incidents: There were 1105 (1131) incidents in total reported in February 2020 (January numbers detailed) of which 854 (874) incidents were for PAH.
There was 618 no harm and 215 minor harm which is 97.5% of the total. 19 incidents (14) moderate harm (2.3%), 2 (7) severe harm (0.23%) and no deaths. The percentage spread is consistent with previous months.

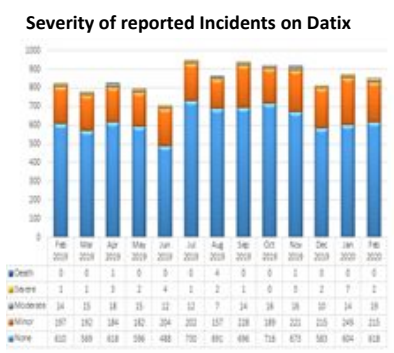
Breached national safety alerts: The trust continues to have open one safety alert beyond its deadline as a result of the manufacturer continuing to develop the electronic solution to resolve this issue regarding the haemofiltration/dialysis machines used within our critical care unit.

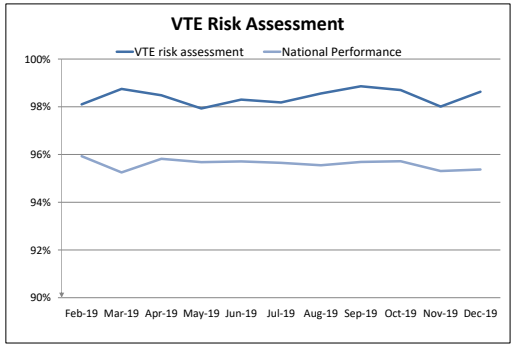
NRLS: Please note there may be small differences in the data detailed in the Incidents graph & NRLS graph. Incidents graphs is Trust incident data that logs an incident in the month it was reported. Trust data will also detail harms for staff. NRLS graph details incidents according to the date the incident occurred and is for patient safety incidents.

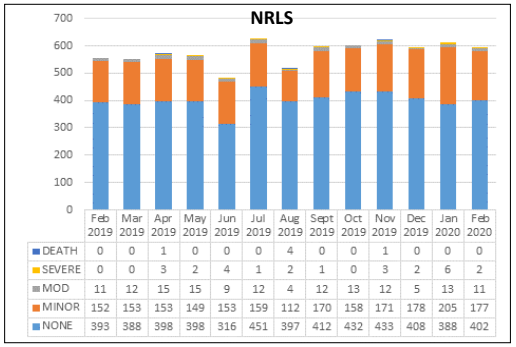




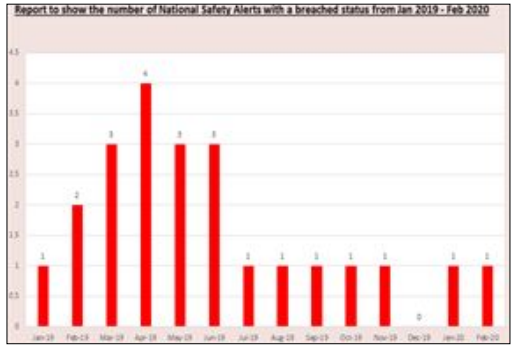




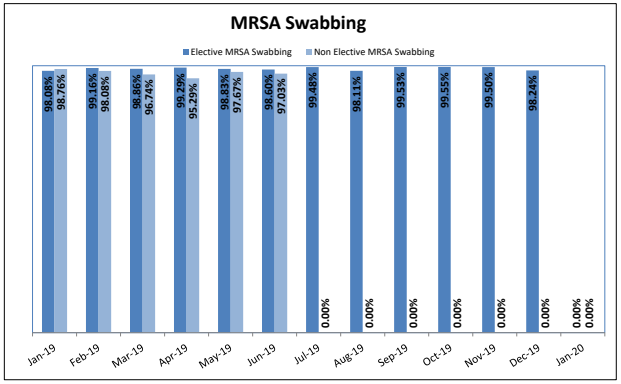




	Feb 2019	Mar 2019	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020
DEATH	0	0	1	0	0	0	4	0	0	1	0	0	0
SEVERE	0	0	3	2	4	1	2	1	0	3	2	6	2
MOD	11	12	15	15	9	12	4	12	13	12	5	13	11
MINOR	152	153	153	149	153	159	112	170	158	171	178	205	177
NONE	393	388	398	398	316	451	397	412	432	433	408	388	402



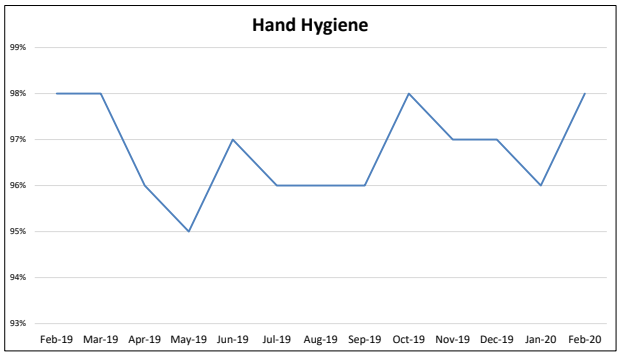
Infection Control



MSSA	
Feb-19	1
Mar-19	2
Apr-19	0
May-19	1
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

C-DIFF Total (to March 2019)	
Feb-19	0
Mar-19	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)	
Apr-19	2	1	1	0	4
May-19	1	1	1	0	3
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



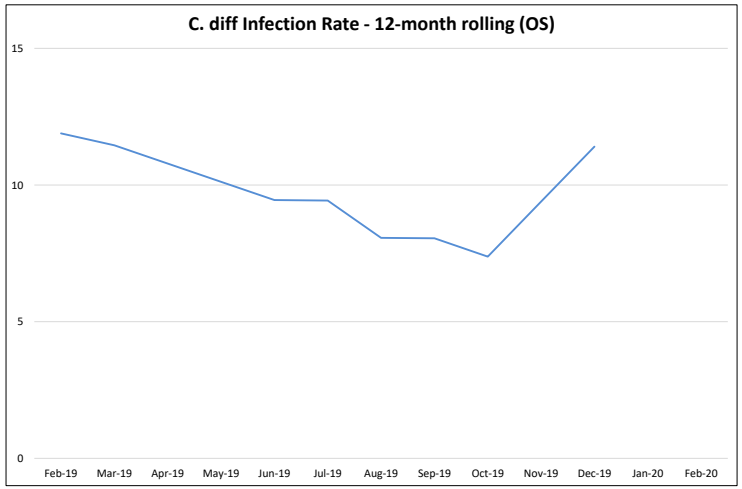
E Coli	
Feb-19	2
Mar-19	1
Apr-19	2
May-19	1
Jun-19	2
Jul-19	0
Aug-19	2
Sep-19	3
Oct-19	0
Nov-19	0
Dec-19	1
Jan-20	0
Feb-20	2

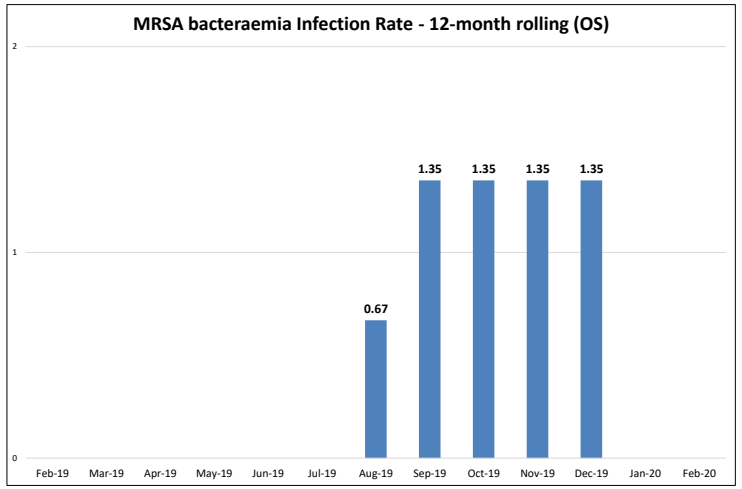
Klebsiella	
Feb-19	0
Mar-19	0
Apr-19	0
May-19	0
Jun-19	1
Jul-19	0
Aug-19	0
Sep-19	0
Oct-19	0
Nov-19	0
Dec-19	1
Jan-20	0
Feb-20	0

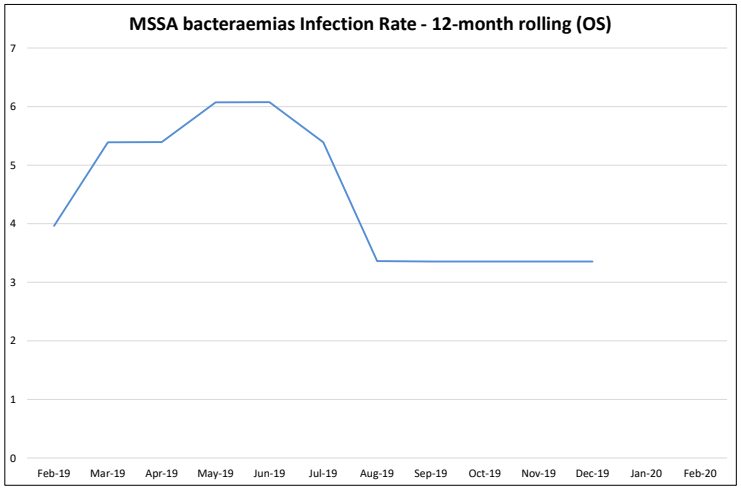
Pseudomonas	
Feb-19	0
Mar-19	0
Apr-19	0
May-19	0
Jun-19	0
Jul-19	0
Aug-19	0
Sep-19	1
Oct-19	2
Nov-19	0
Dec-19	0
Jan-20	0
Feb-20	0

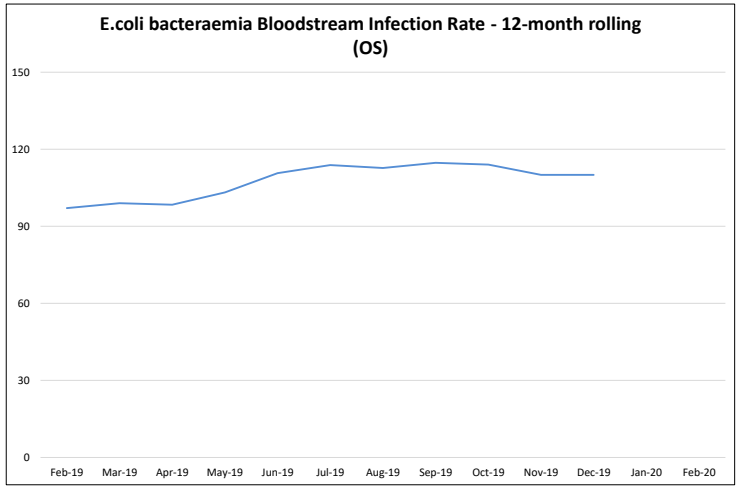
Infection Control

The following are the latest published data available.

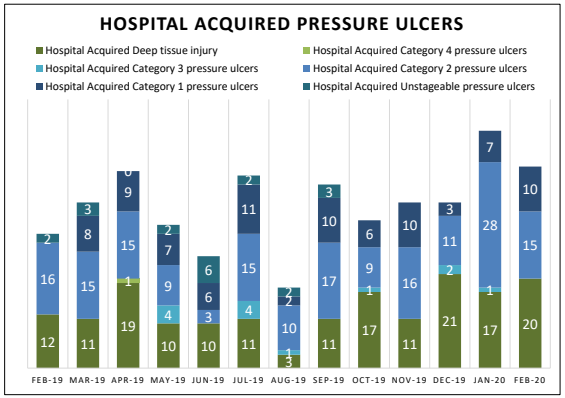


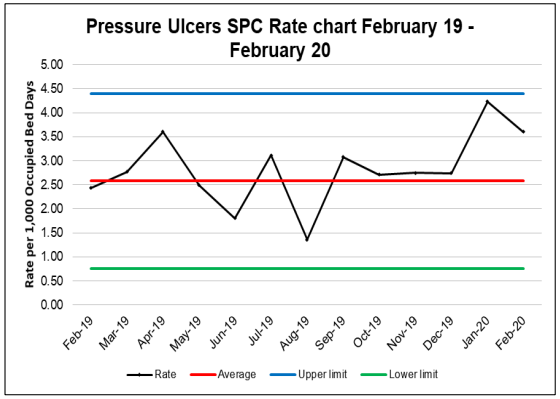


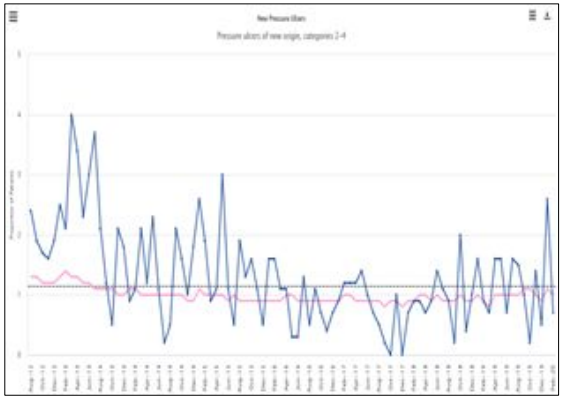


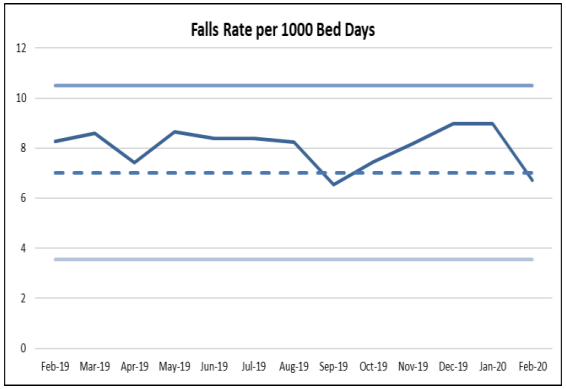


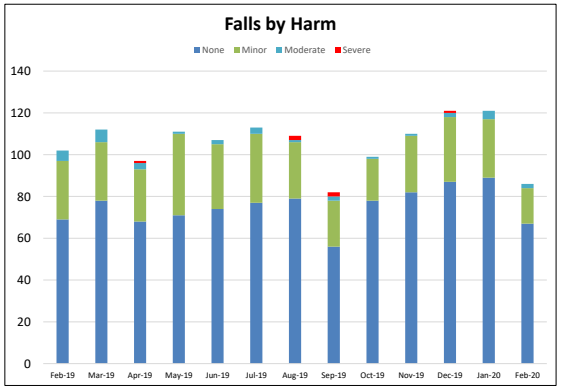
(Rolling 12-month count/rolling 12-month average occupied bed days per 100,000 beds.)

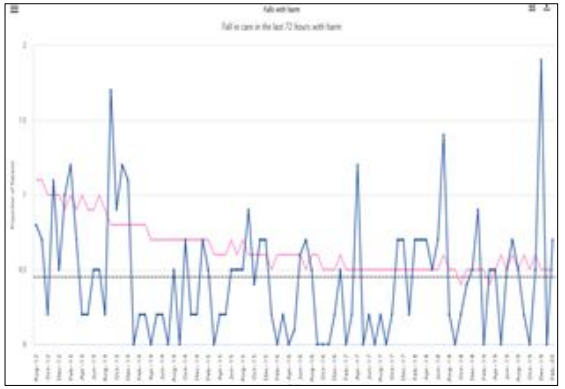

HOSPITAL ACQUIRED PRESSURE ULCERS
Hospital Acquired Deep tissue injury
Hospital Acquired Category 4 pressure ulcers
Hospital Acquired Category 3 pressure ulcers
Hospital Acquired Category 2 pressure ulcers
Hospital Acquired Category 1 pressure ulcers
Hospital Acquired Unstageable pressure ulcers
FEB-19 MAR-19 APR-19 MAY-19 JUN-19 JUL-19 AUG-19 SEP-19 OCT-19 NOV-19 DEC-19 JAN-20 FEB-20


Pressure Ulcers SPC Rate chart February 19 - February 20
Rate per 1,000 Occupied Bed Days
Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20
Rate
Average
Upper limit
Lower limit




Falls Rate per 1000 Bed Days
Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20


Falls by Harm
None
Minor
Moderate
Severe
Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20



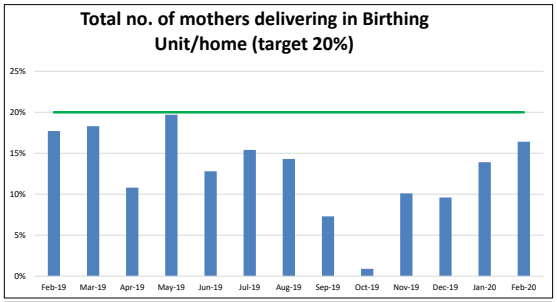
Family & Women's Service

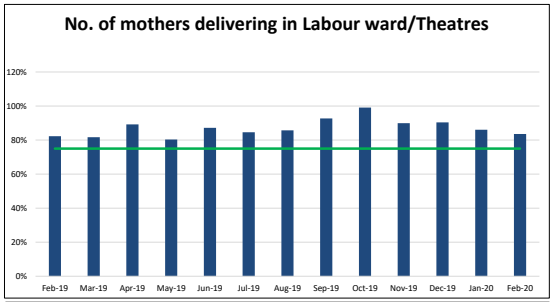
2 Our Patients Summary 1.7 Family & Women's Service

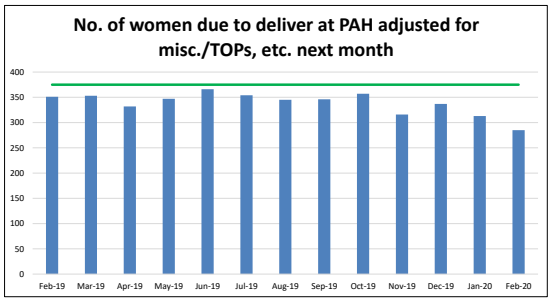
The Princess Alexandra Hospital NHS Trust

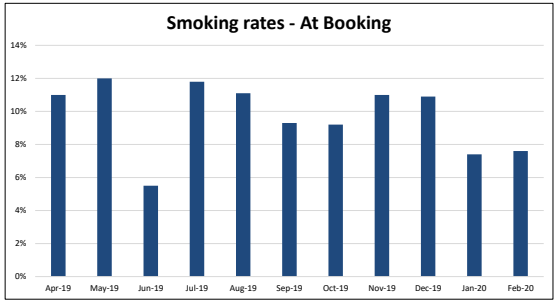
The elective C Section rate has reduced substantially in February 2020, which has contributed significantly to the lowest overall C Section Rate in the current financial year, at 25.4% of all deliveries. An audit of the indications for all PAH elective C Sections, between November and January, has been conducted and will be presented at the FAWS Board Meeting on 18th March 2020.

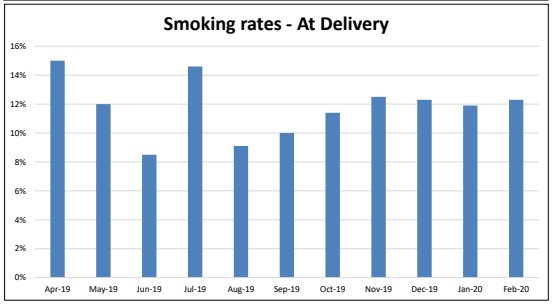
The rate of post-partum haemorrhage over 1500mls has increased in February to 5.8% of deliveries. Ongoing actions in regard to risk assessments at admission in labour are continuing. The effectiveness of the ongoing PPH Reduction Action Plan and the monthly rate of post-partum haemorrhage over 1500mls is being monitored closely.

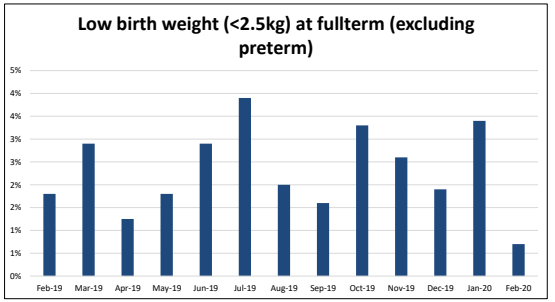


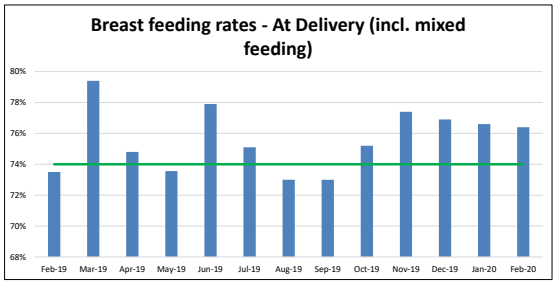


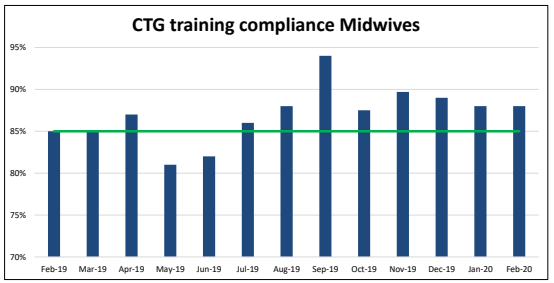


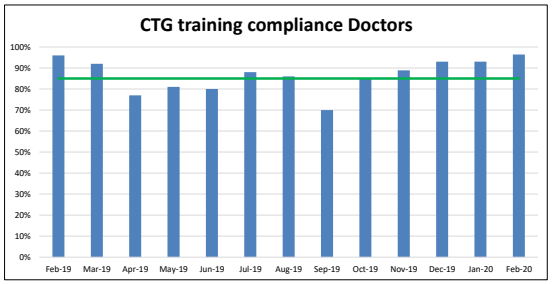




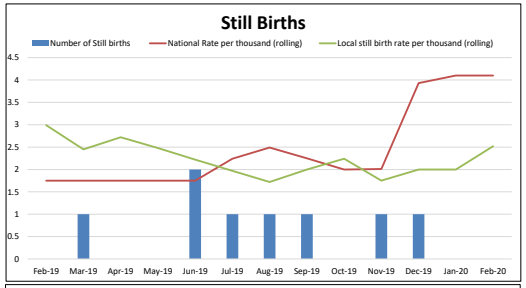


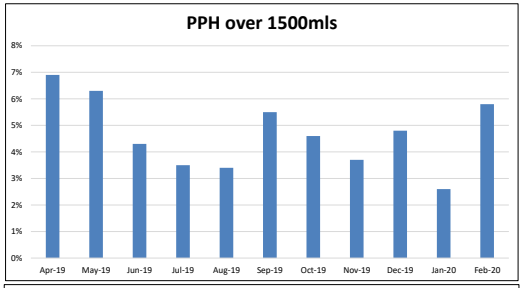


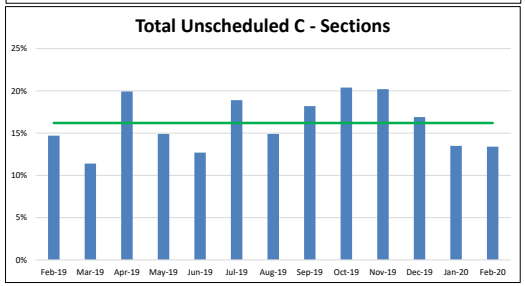


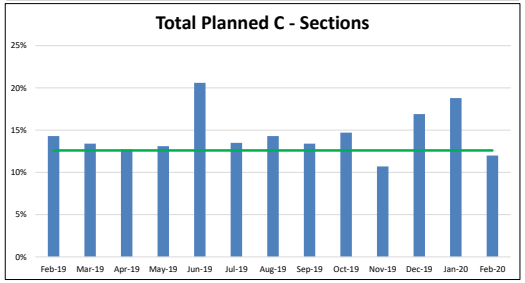


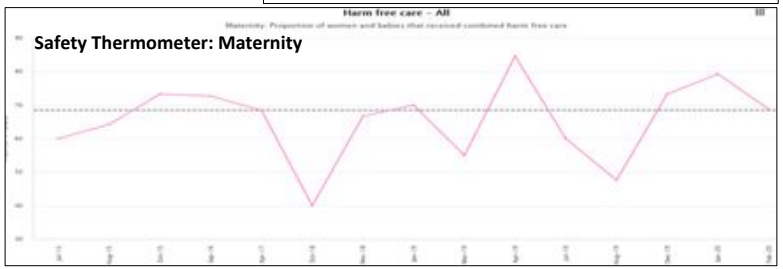
Family & Women's Service

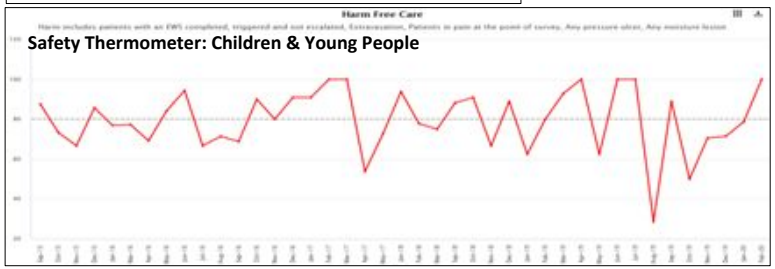




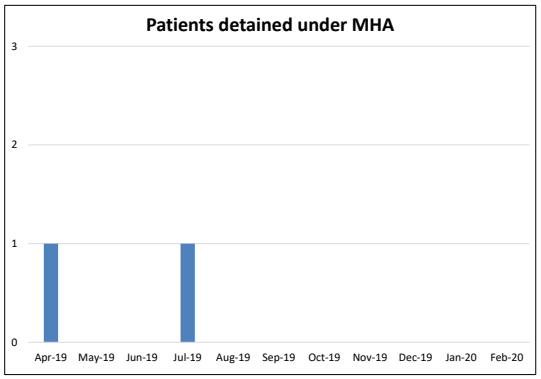


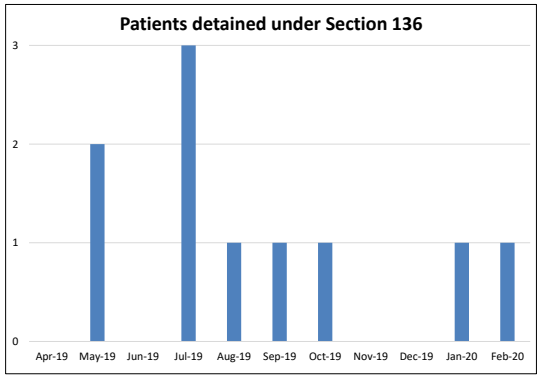


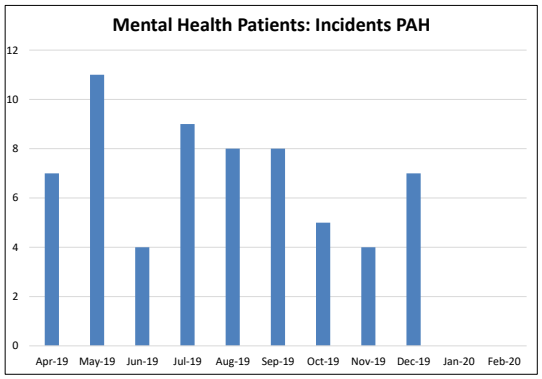


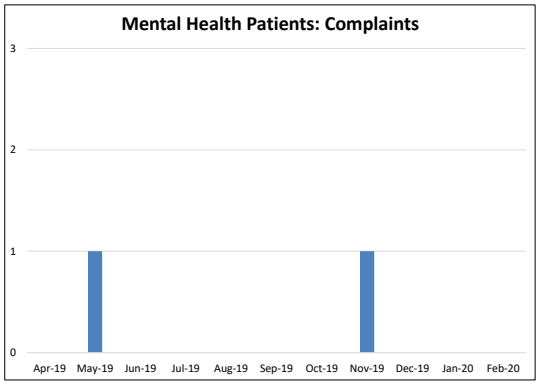


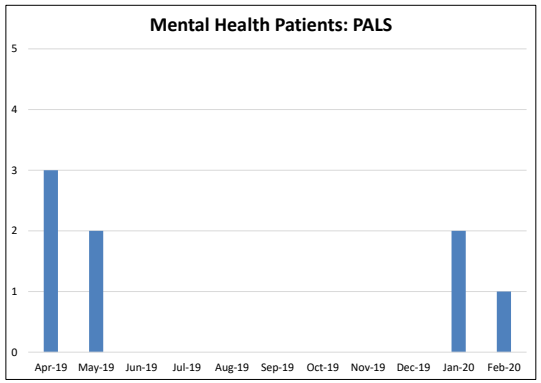
Mental Health

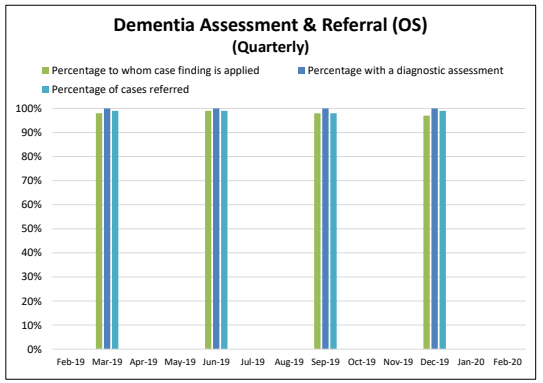




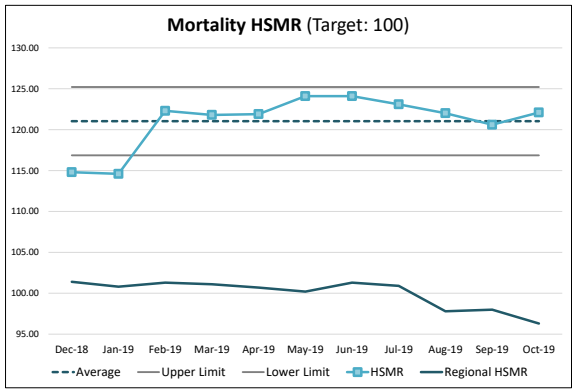


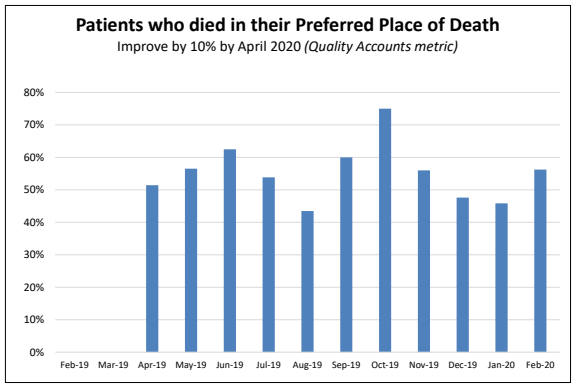






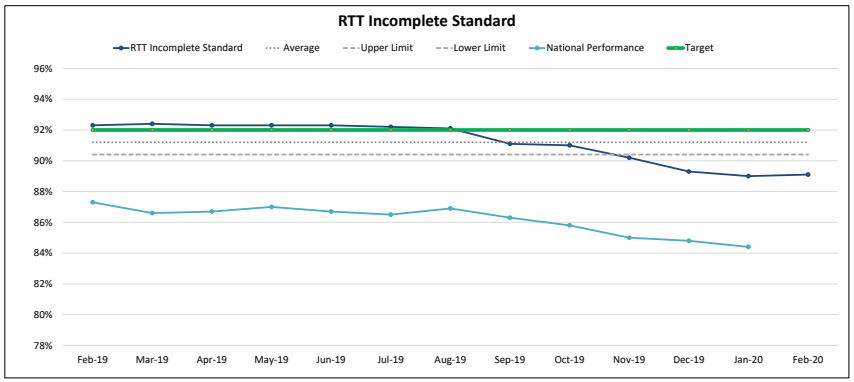
Mortality

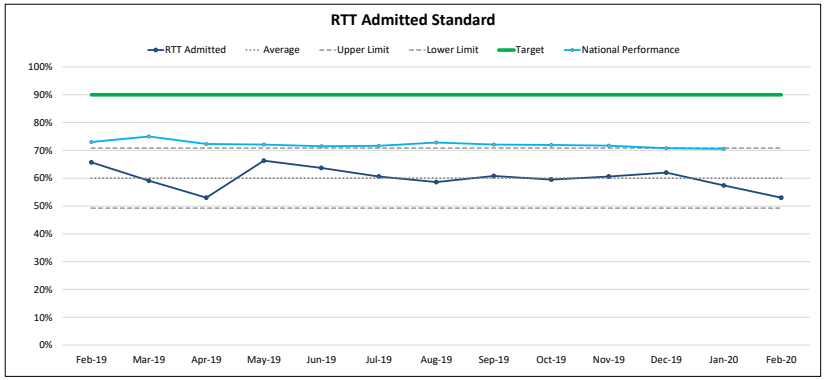


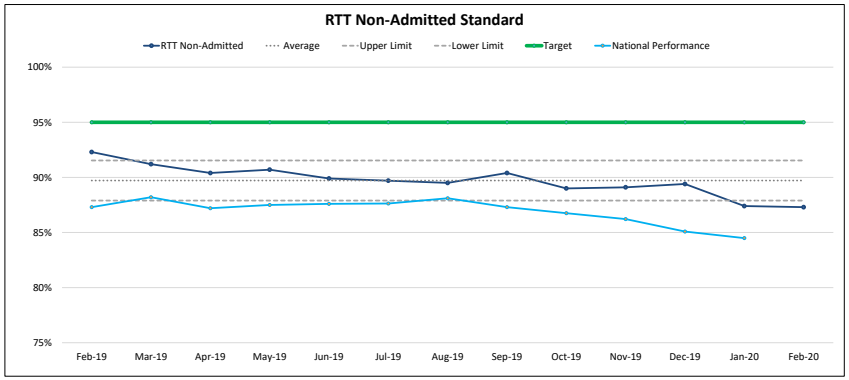


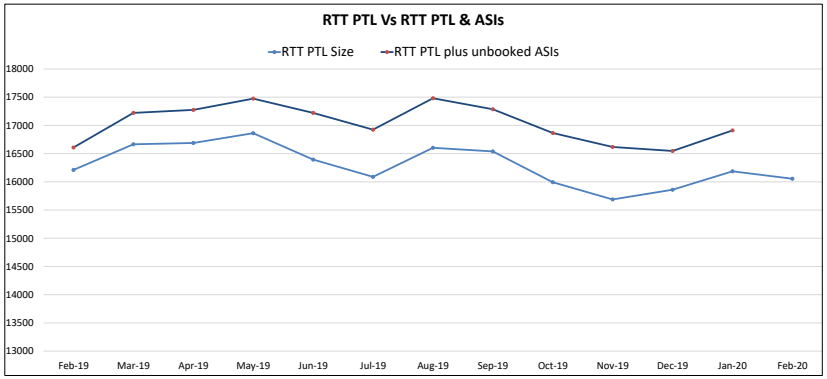
Mortality SHMI	
Feb-19	
Mar-19	
Apr-19	113.0
May-19	111.4
Jun-19	111.8
Jul-19	112.1
Aug-19	111.0
Sep-19	
Oct-19	
Nov-19	
Dec-19	
Jan-20	
Feb-20	

Mortality Outlier Alerts (QA)	
May 17 - Apr 18	4
Jun 17 - May 18	4
Jul 17 - Jun 18	4
Aug 17 - Jul 18	6
Sep 17-Aug 18	6
Oct 17 - Sep 18	9
Nov 17 - Oct 18	8
Jan 18 - Dec 18	7
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


RTT Incomplete Standard
RTT Incomplete Standard
Average
Upper Limit
Lower Limit
National Performance
Target
96%
94%
92%
90%
88%
86%
84%
82%
80%
78%
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20


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

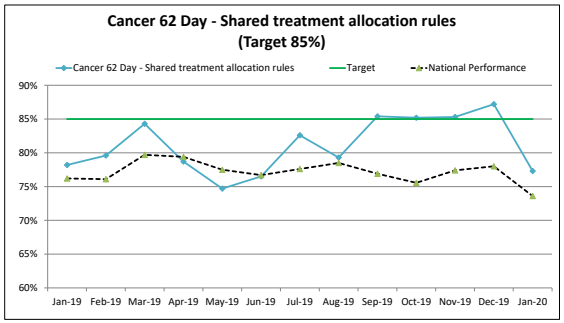

RTT Non-Admitted Standard
RTT Non-Admitted
Average
Upper Limit
Lower Limit
Target
National Performance
100%
95%
90%
85%
80%
75%
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20

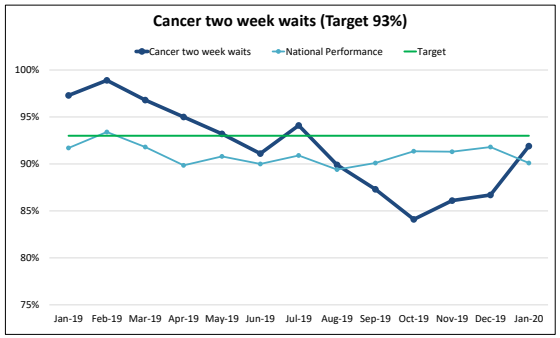

RTT PTL Vs RTT PTL & ASIs
RTT PTL Size
RTT PTL plus unbooked ASIs
18000
17500
17000
16500
16000
15500
15000
14500
14000
13500
13000
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20

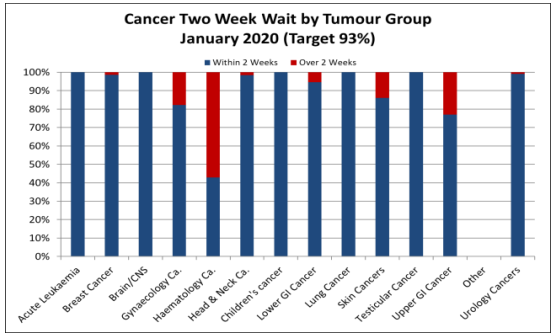
Cancer

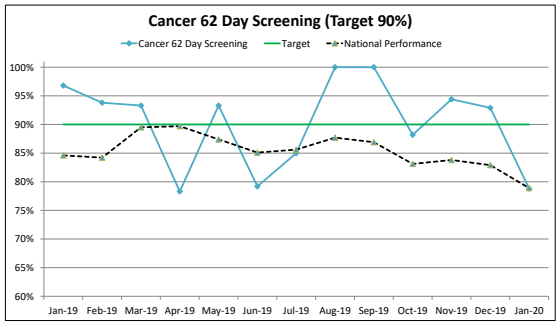
	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Jan-19	97.70%	97.40%	100.00%	100.00%
Feb-19	96.70%	97.30%	100.00%	100.00%
Mar-19	86.90%	96.90%	100.00%	100.00%
Apr-19	91.00%	100.00%	100.00%	100.00%
May-19	92.60%	97.80%	92.90%	75.00%
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%

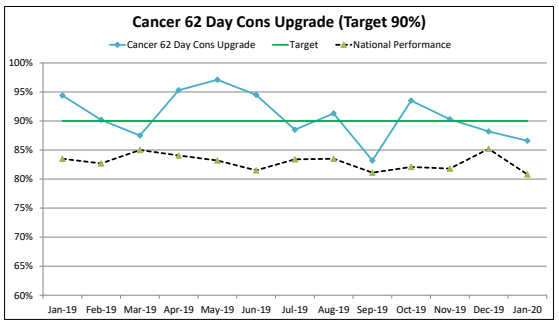
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

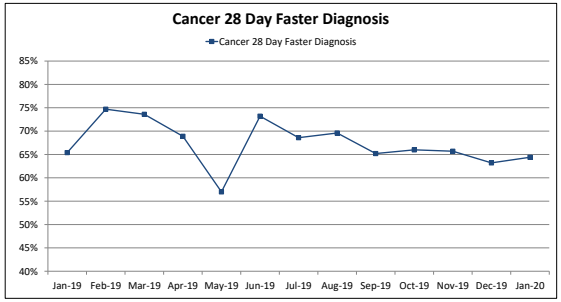




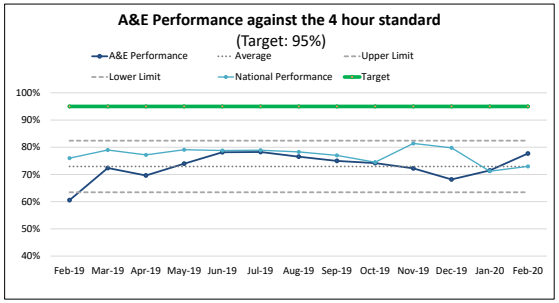


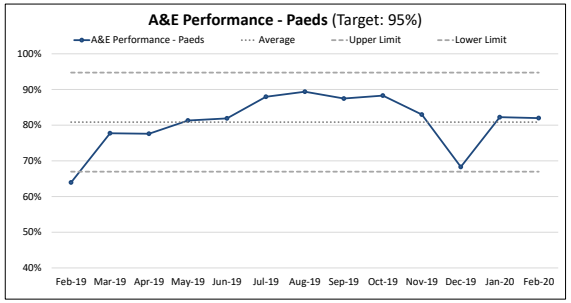


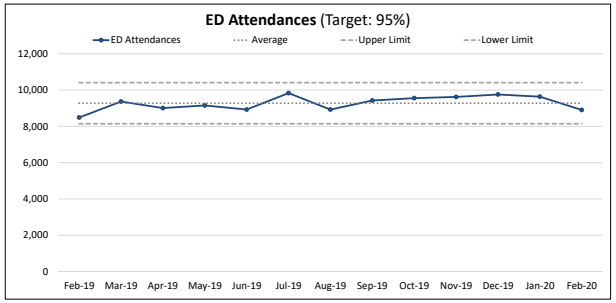


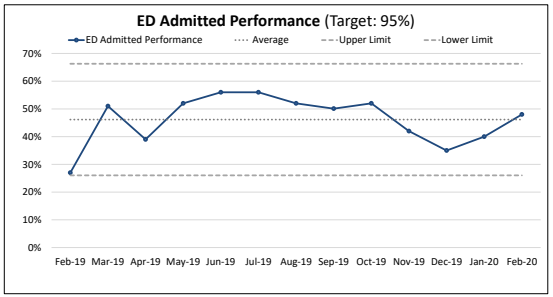


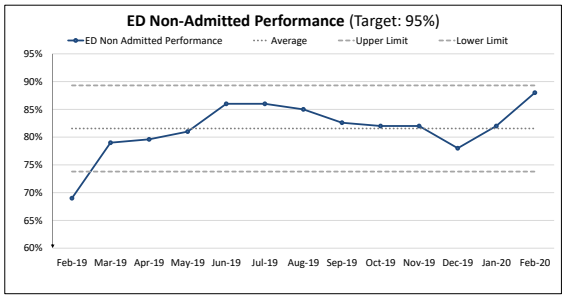
ED





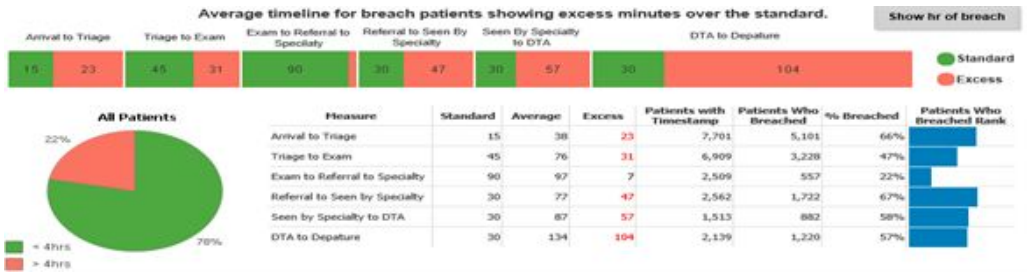




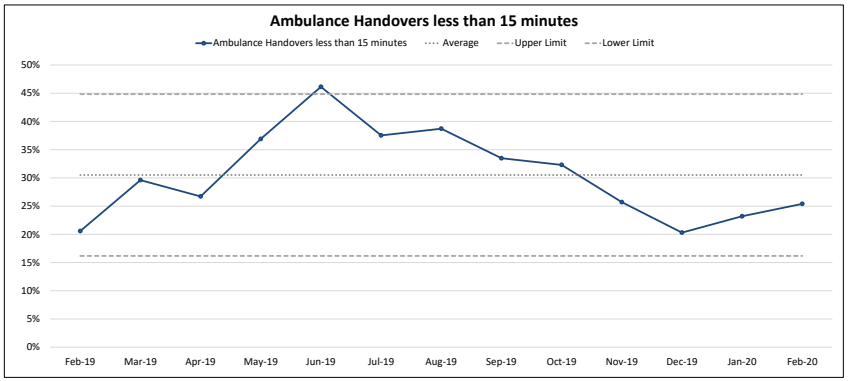


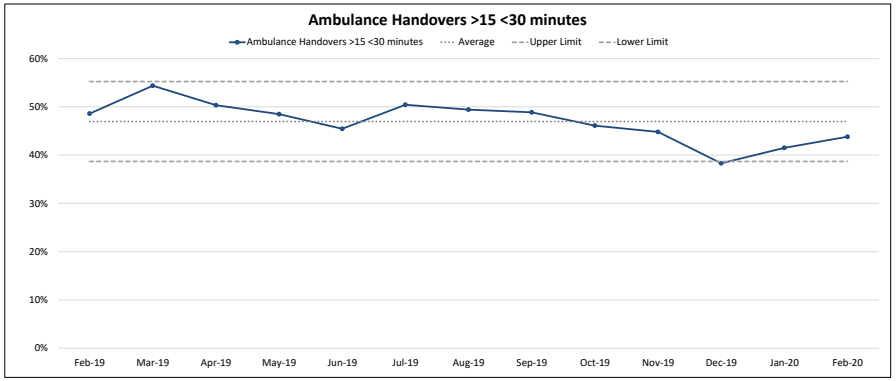
ED Internal Professional Standards

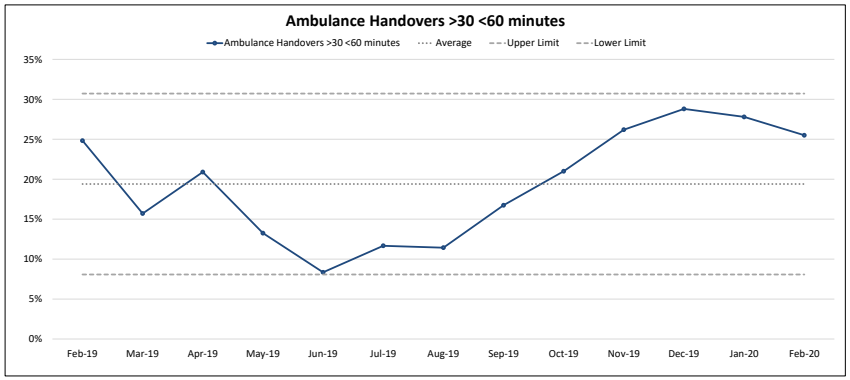
	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Arrival to Triage - Average Wait (Minutes)	43	35	38	33	26	46	34	39	35	38.628	46	43	38.086
Triage to Exam - Average Wait (Minutes)	118	106	99	99	91	90	93	102	108	102	104	91	76
Exam to Referral to Specialty - Average Wait (Minutes)	97	81	82	80	82	81	83	84	88	96	99	103	97
Referral to Seen by Specialty - Average Wait (Minutes)	85	73	75	69	67	65	79	70	78	98	90	87	77
Seen by Specialty to DTA - Average Wait (Minutes)	109	82	93	72	78	73	74	84	87	96	105	99	87
DTA to Departure - Average Wait (Minutes)	308	171	197	147	120	115	108	120	116	217	249	169	134

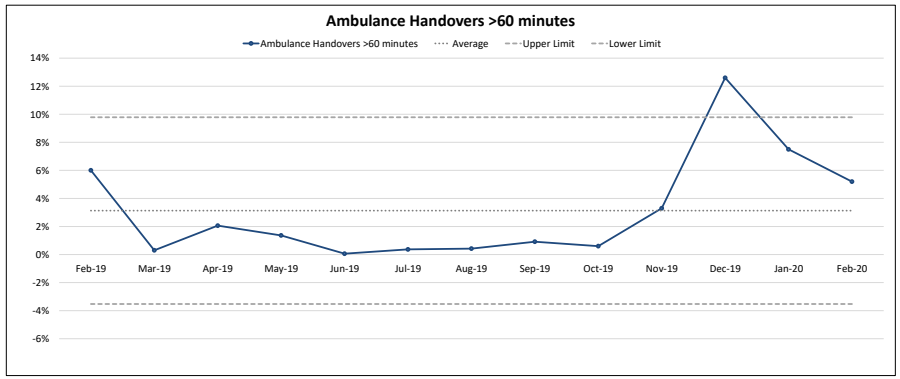


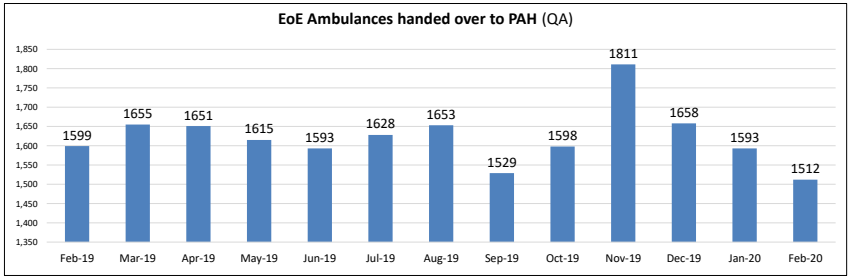
Ambulance


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

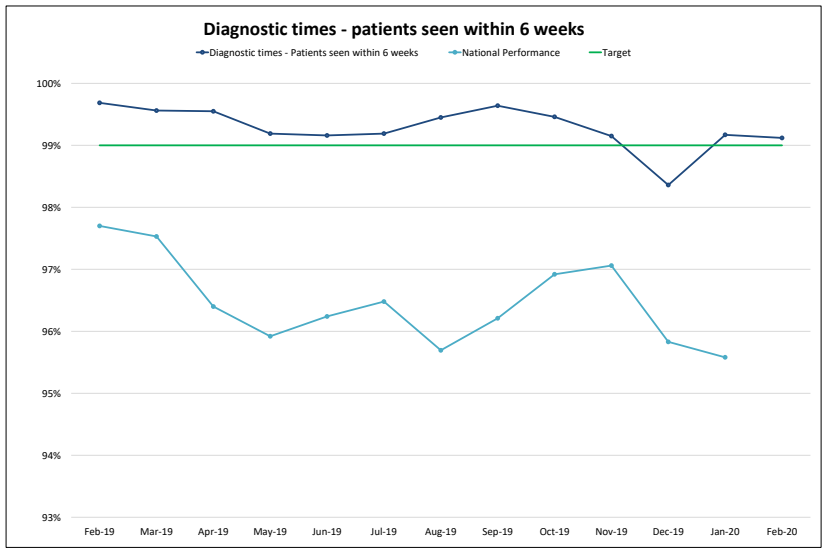

Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
60%
50%
40%
30%
20%
10%
0%
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20

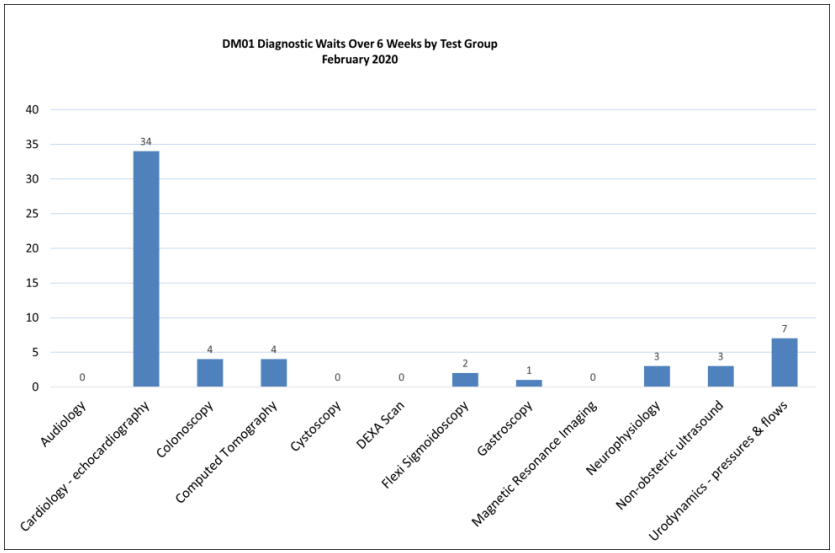

Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
35%
30%
25%
20%
15%
10%
5%
0%
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20


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


EoE Ambulances handed over to PAH (QA)
1,850
1,800
1,750
1,700
1,650
1,600
1,550
1,500
1,450
1,400
1,350
1599
1655
1651
1615
1593
1628
1653
1529
1598
1811
1658
1593
1512
Feb-19
Mar-19
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20

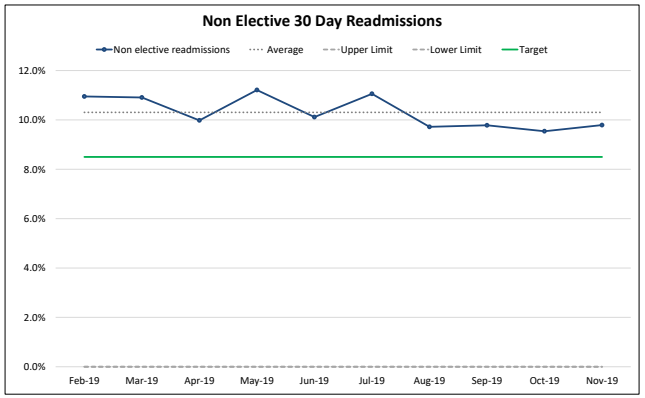
Diagnostics

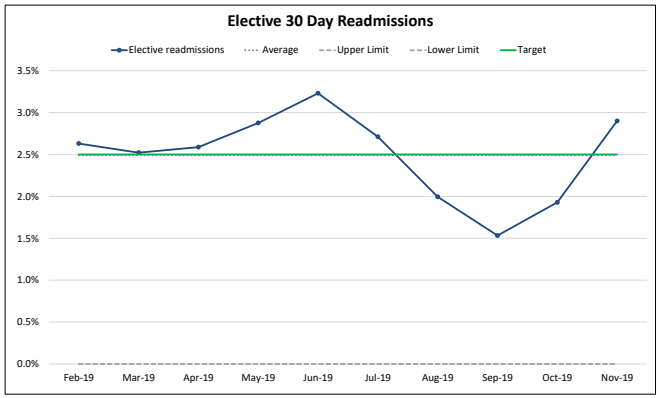


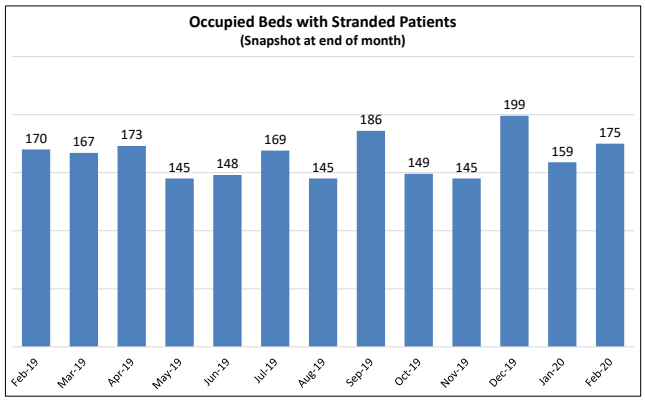


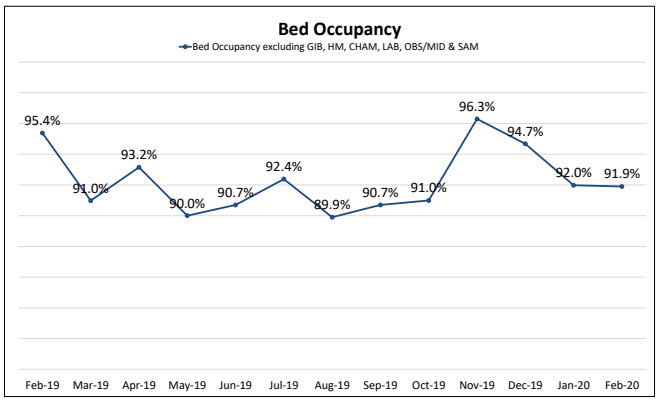
Test	% of Total Cohort - Feb 20	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Magnetic Resonance Imaging (MRI)	22.0%	100.00%	100%	100%	100%	100%	100%	100%	100.00%	99.86%	99.79%	99.84%	100.00%	100.00%
Computed Tomography (CT)	11.6%	99.70%	100%	99.73%	99.32%	100%	100%	99%	99.83%	100.00%	99.81%	100.00%	100.00%	99.48%
Non-Obstetric Ultrasound	41.5%	99.66%	100.00%	99.76%	99.92%	99.92%	100%	100%	99.96%	99.92%	99.92%	100.00%	100.00%	99.89%
DEXA	0.9%	100%	100.00%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Audiology - Audiology Asessments	2.9%	99.04%	98%	100%	99%	99%	100%	100%	100.00%	100.00%	100.00%	98.76%	98.40%	100.00%
Cardiology - Echocardiography	14.3%	100%	100.00%	99.75%	100.00%	100%	100%	100%	99.74%	98.34%	100.00%	100.00%	99.87%	96.38%
Neurophysiology	0.4%	100%	100%	100%	100%	83.33%	50%	67%	67%	86%	93%	97%	94%	89.29%
Urodynamics	0.5%	82%	90.00%	86.84%	89.66%	92.59%	90%	95%	94.74%	89.19%	92.00%	88.57%	81.82%	80.56%
Colonoscopy	2.9%	98.16%	95.24%	96.76%	90.71%	88.11%	85%	95%	99.24%	98.68%	89.14%	74.72%	88.52%	97.94%
Flexi Sigmoidoscopy	0.7%	100%	91%	97.67%	90.00%	93.10%	90%	93%	100.00%	94.29%	94.59%	69.05%	94.64%	95.56%
Cystoscopy	0.4%	100.00%	94.74%	100%	90.91%	92%	96%	94%	100.00%	96.30%	92.00%	86.21%	81.82%	100.00%
Gastroscopy	1.8%	100.00%	95.00%	95.35%	92.52%	88.46%	89%	97%	98.81%	99.07%	89.57%	83.16%	89.09%	99.15%

Readmissions & Stranded Patients

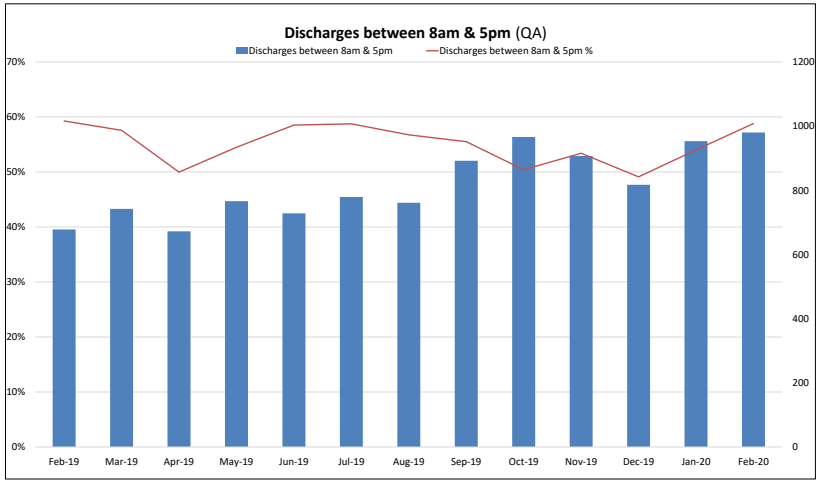


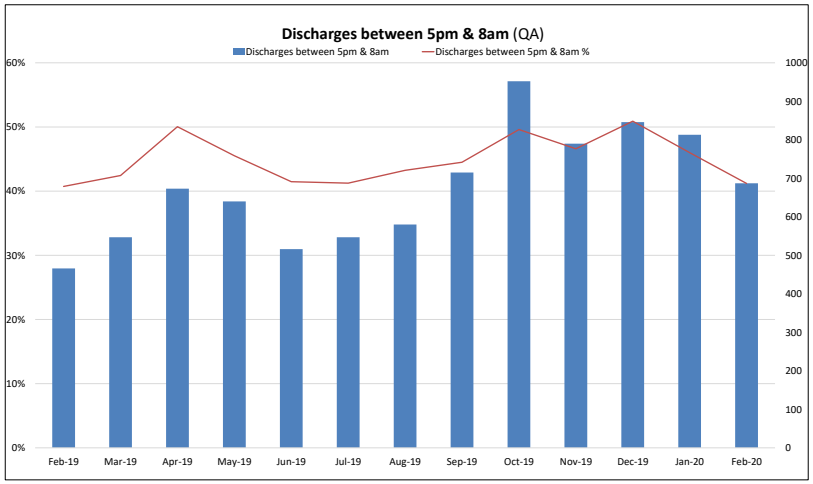


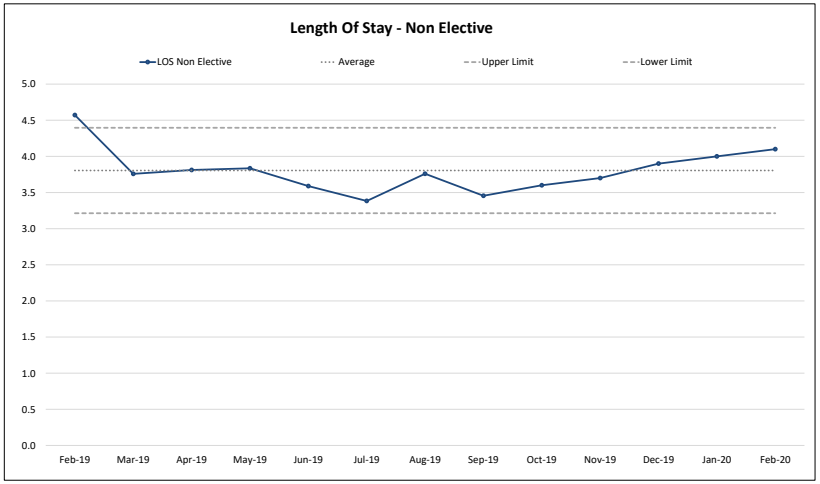


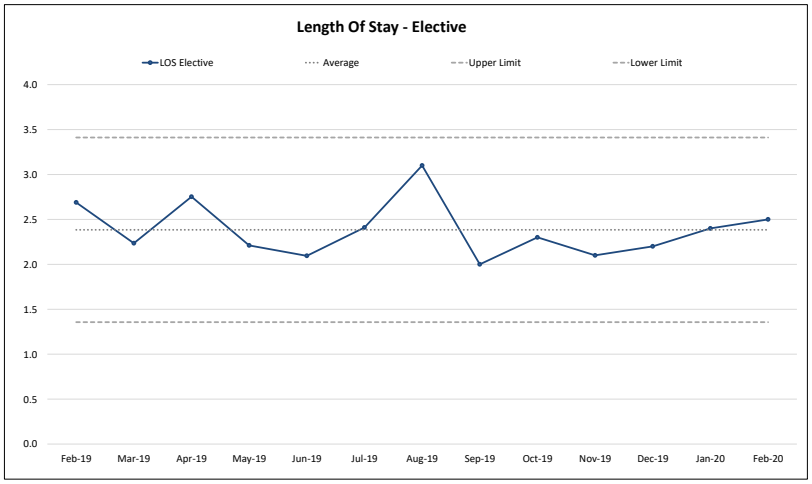


Discharges & LOS

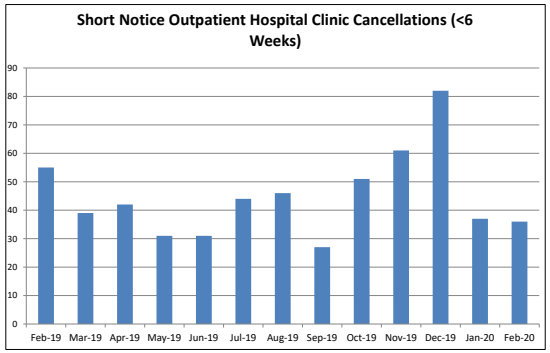


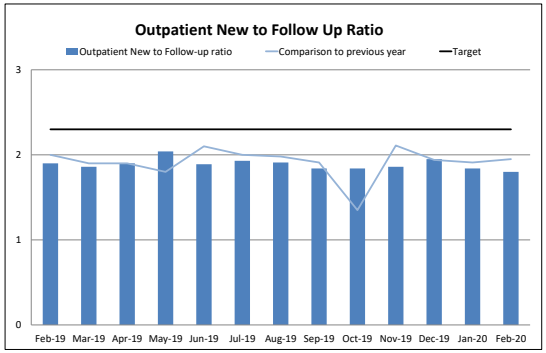


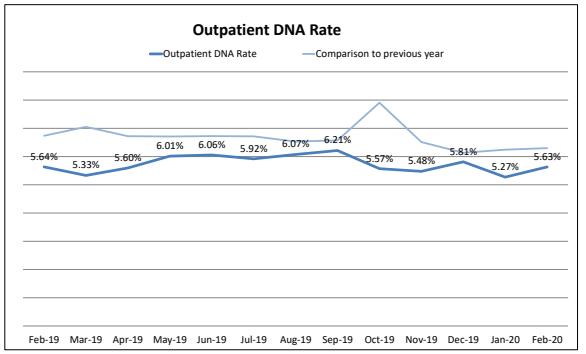


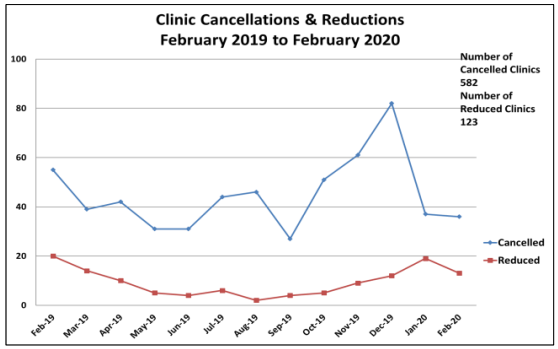


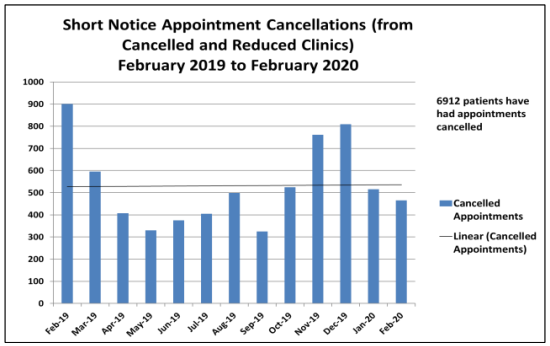
Outpatients & Cancelled Operations

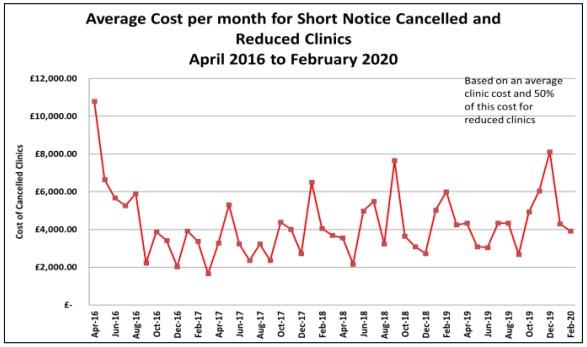












DNA Rate for Follow Up Appointments per Specialty for February

Specialty & Performing Unit	AHP Episode	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	Haematology	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%	6.1%	7.2%	5.3%	13.4%	7.7%	1.2%	6.3%	6.3%	8.0%	10.1%	6.7%	0.6%	5.7%	8.1%	0.3%	4.9%	3.2%	5.1%	0.7%	0.0%	0.0%	5.1%	4.3%	7.9%	13.5%	6.8%	10.2%	21.7%	5.2%	7.5%	5.2%	6.0%	5.3%	4.3%	10.6%	2.7%	5.4%

Workforce Indicators Summary

Agency Spend 5.08%
Bank Spend 12.54%

Staff In Post
3269
WTE

Training
93%

Sickness
4.4%

9.6%

Medical 100%
Non-Medical 90.9%

Turnover
11%

Scorecard

People Measures as at 29 February 2020	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3639.89	890.59	467.17	890.41	771.31	278.03	131.75	54.68	155.95
Vacancy Rate	8.0%	9.56%	6.50%	10.70%	14.54%	13.74%	10.28%	0.00%	4.40%	8.15%
Agency % of paybill	7.0%	5.1%	1.5%	2.7%	10.5%	5.4%	0.0%	0.0%	0.0%	0.7%
Bank Usage - wte	n/a	384.16	41.56	44.30	180.05	78.22	17.00	9.10	0.35	13.44
Agency Usage -wte	n/a	106.20	12.79	6.33	59.61	26.79	0.00	0.10	0.00	0.58
January 2020 Sickness Absence	3.7%	4.4%	4.2%	4.0%	4.4%	3.7%	9.2%	1.9%	0.8%	5.7%
Short Term Sickness	1.85%	2.4%	2.1%	2.4%	2.8%	2.2%	3.3%	1.2%	0.8%	3.0%
Long Term Sickness	1.85%	2.0%	2.1%	1.6%	1.6%	1.5%	6.0%	0.7%	0.0%	2.7%
Rolling Turnover (voluntary)	12%	11.0%	11.2%	8.6%	12.8%	10.7%	11.5%	9.9%	12.2%	8.7%
Statutory & Mandatory Training	90%	93%	97%	92%	90%	90%	98%	95%	97%	98%
Appraisal	90%	91%	95%	90%	86%	88%	95%	94%	93%	92%
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%
Flu Vaccination 19/20	100%	72%	66%	65%	65%	64%	49%	81%	56%	98%
Starters (wte)		41.92	9.28	2.00	8.64	4.00	0.00	15.00	2.00	1.00
Leavers (wte)		27.65	7.28	4.80	7.74	4.00	2.23	1.60	0.00	0.00
Time to hire (Advert to formal offer made)	31Days	47	50	57	41	49	0	21	56	30

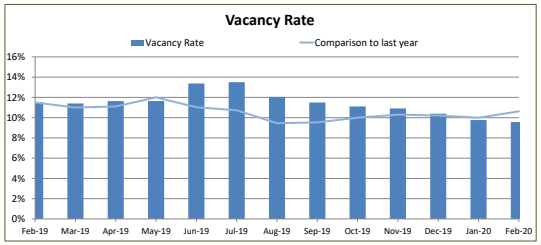
Above target	
Improvement from last month/above or below target	
Underachieving target	

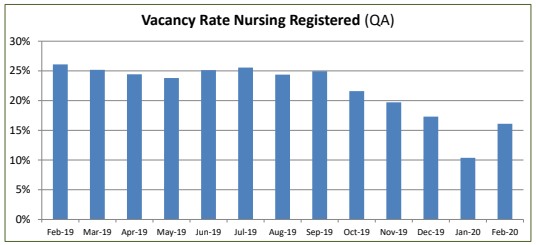
3 Our People Summary

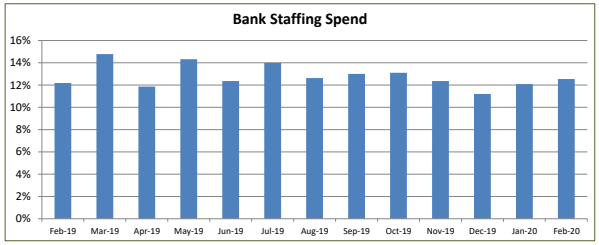
3.3 Well Led

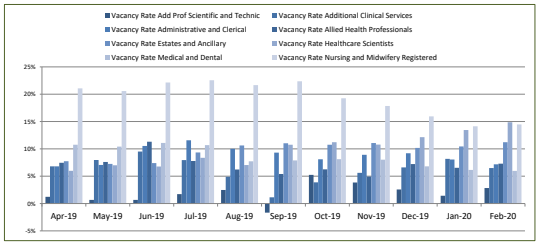
NHS
The Princess Alexandra Hospital
NHS Trust

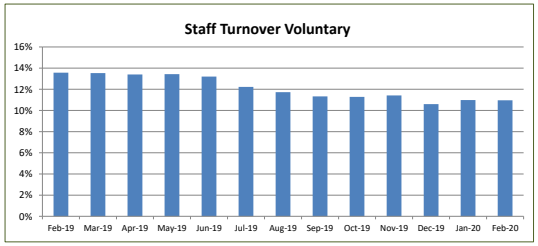
Workforce Indicators

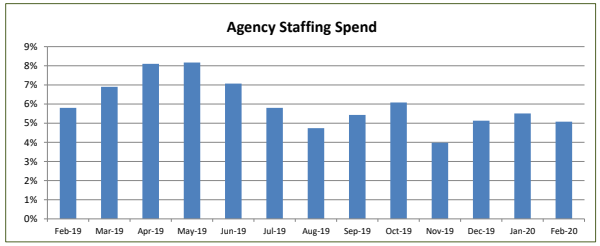


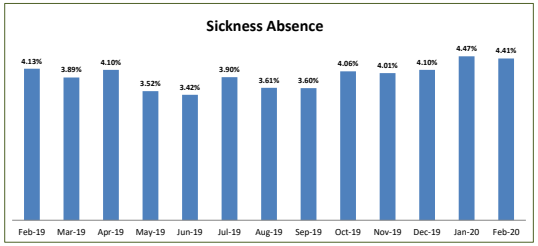


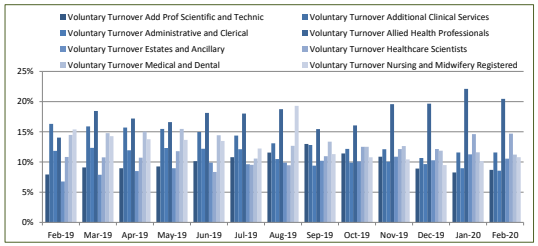


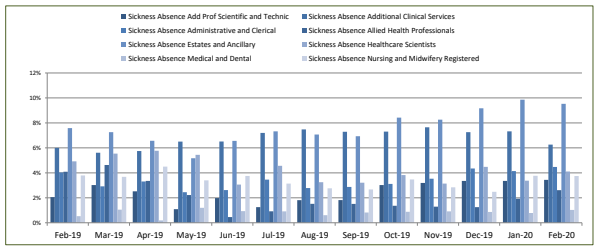


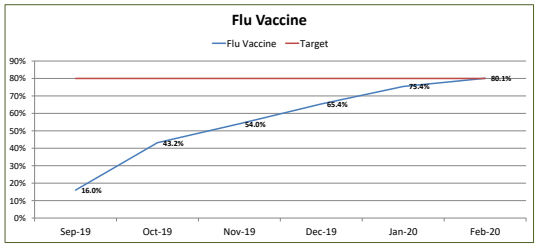




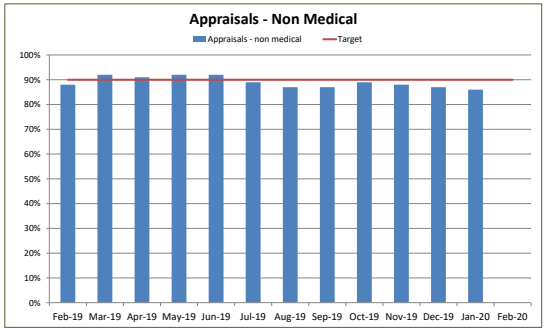


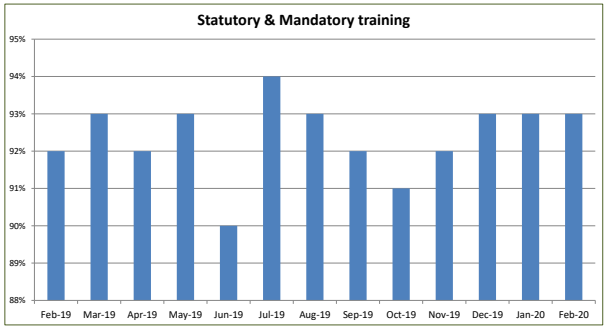


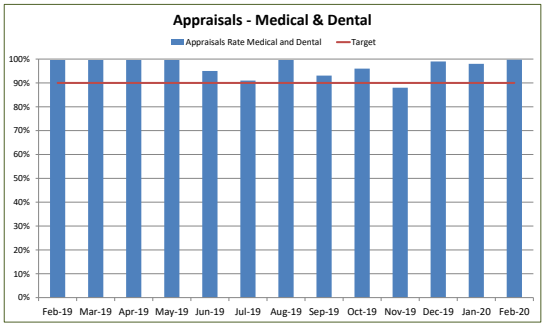


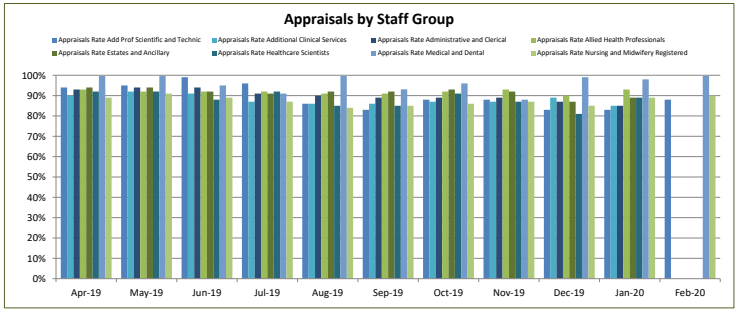


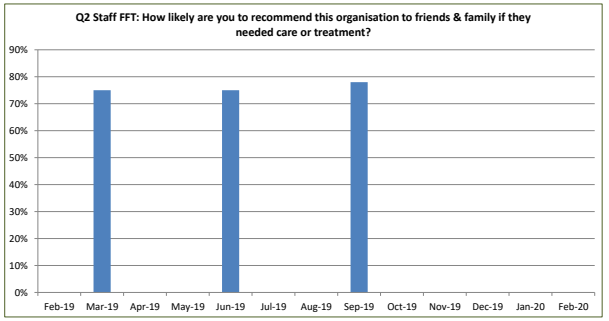
Workforce Indicators











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

Estates – The estates responses to the urgent jobs raised has increased slightly due to the increase in backlog maintenance being completed which prevents some of the issues arising. The consultation for the Estates team has been published and the 1:1 meetings with staff are taking place.

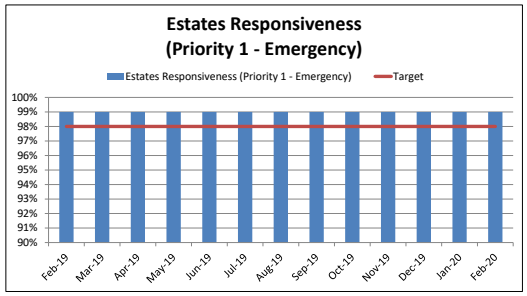
Domestic Services – There has been drop in the very high risk and high risk areas due to these areas having their allocated cleaning hours reduced due to sickness and annual leave commitments. The Domestics have also been responsible for the deep cleaning of the Covid-19 Pod. Each clean takes approx. 1 hour to clean; in February the POD was cleaned 21 times. The order has now been raised for the new computerised auditing tool for the domestics, portering and catering.

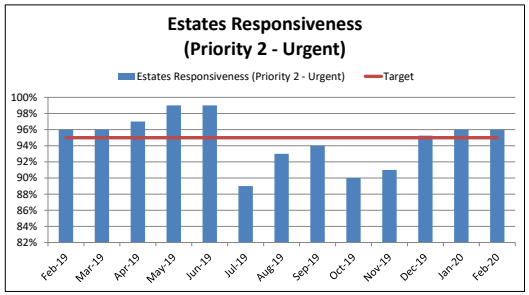
Catering Services – The number of meals prepared and served to patients decreased this month, food wastage is still above the standard. The catering team are working alongside the domestic team to reduce the waste further.

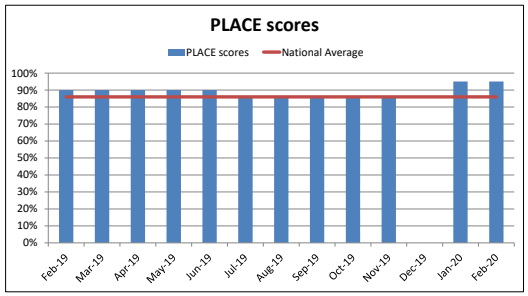
Capital Services - Currently there are 15 approved Capital funded projects within the financial year 2019/2020 and a further 21 via the NHSI Emergency Funded Backlog Maintenance bid process. Of the projects, 11 are practically complete and in there defects period, 22 are onsite/planned to start in Q3 through to March 2020 and 1 in the design/tendering stage. The team has produced a list of projects for the financial year 2020-2021 for due consideration along with other HCGs at the Capital Working group meetings to plan for an early 2020 start following Trust approval.

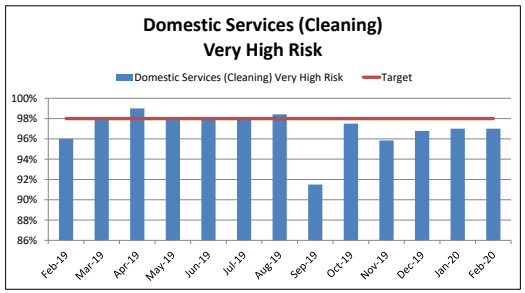
Mandatory Training and Appraisals – Appraisal compliance is 98% this month and Mandatory training is 98% above the trust's standards on both. Managers have worked hard to achieve these figures and are now working to ensure maintaining this level of compliance.

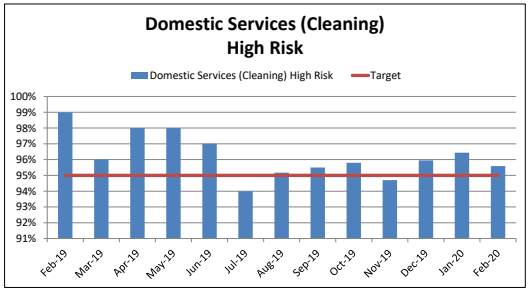
Places

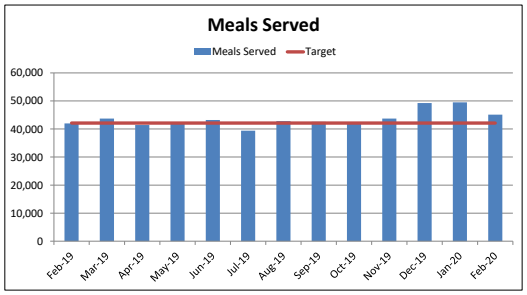

Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target

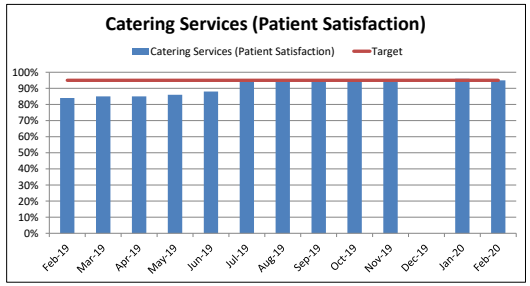

Estates Responsiveness (Priority 2 - Urgent)
Estates Responsiveness (Priority 2 - Urgent)
Target

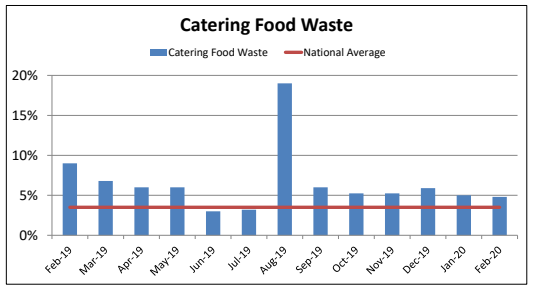

PLACE scores
PLACE scores
National Average


Domestic Services (Cleaning) Very High Risk
Domestic Services (Cleaning) Very High Risk
Target


Domestic Services (Cleaning) High Risk
Domestic Services (Cleaning) High Risk
Target


Meals Served
Meals Served
Target


Catering Services (Patient Satisfaction)
Catering Services (Patient Satisfaction)
Target


Catering Food Waste
Catering Food Waste
National Average

Pounds

CQC

CQC Rating

NHS
The Princess Alexandra Hospital
NHS Trust

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

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

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

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

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.

Your future | Our hospital

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

Trust Board – 2 April 2020

Agenda Item:	6.2
Presented by:	Trevor Smith - CFO
Prepared by:	Simon Covill, Deputy Chief Finance Officer – Operational Finance
Date prepared:	26 March 2020
Subject / Title:	Interim Budget Arrangements 20/21

Purpose:	Approval	✓	Decision		Information		Assurance	

Key Issues:	The operational planning process has been suspended due to the Covid-19 outbreak. A simplified basis of contracting for the duration of the crisis is being put in place i.e. block contracts. The Trust is assessing the impact of the new arrangements whilst it awaits further information to be released from the national team. The intention is to use this information to set an Interim budget for the April Board. If appropriate an extraordinary PAF call will be convened to discuss the detail as numbers emerge.
Recommendation	To note the current position.

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

Previously considered by:	PaF – 26 March 2020 (Revenue). EMT and SMT Capital
Risk / links with the BAF:	BAF 5.1 – Achievement of financial balance.
Legislation, regulatory, equality, diversity and dignity implications:	The Trust must ensure that budget arrangements are in place to manage financial resources.
Appendices:	Appendix 1 – Covid-19 Financial Governance implications

The Princess Alexandra Hospital NHS
NHS Trust

Interim Budget Arrangements 2020/21

1. Background

Revenue
The operational planning process has been suspended due to the Covid-19 outbreak and a number of significant adaptions to the financial regime have been put in place (appendix 1).

The Trust had previously submitted its 2020/21 initial operating plan which was to form the basis of the Trust 2020/21 financial plan. With the outbreak of the Covid-19 crisis a simplified basis of contracting for the duration of the crisis is being put in place to ensure organisations have sufficient funds to respond to the incident.

The simplified approach includes the establishment of block contracts arrangements (i.e. suspension of PbR) up until at least 31 July 2020.

The basis of block contract levels have been calculated from an extrapolated Agreement of Balances exercise undertaken in M9 19/20. The annualised results have been uplifted by 2.8%, representing tariff uplift 2.5% and CNST 0.3%. No efficiency factor (-1.1%) has been applied on the grounds during the crisis it is unlikely efficiency will be delivered. This approach will be supplemented by top up payments to cover the suspension of Provider to Provider invoicing, NCAs and to cover reasonable costs in dealing with the crisis.

The above approach is substantially different from the income basis applied in the initial budget setting exercise, most notably original income assumptions included growth and efficiency whereas block contracts exclude these. Locally the impact of the fye of MSK budget will need to be discussed as this has only partially been captured in the central block contract calculation.

As a result of the adoption of block contract arrangements, the reassessment of income levels, and a consequential recast of expenditure budgets and efficiency targets is now required. The Trust is therefore making a full assessment of the national guidance including further details of 'top up' payments. It is recommended that 19/20 budgets are initially established on the following basis:

1. Rolled over closing 2019/20 Establishments.

2. Roll-over of 2019/20 non pay budgets.

3. Delivery of original £12m CIP targets reduced where CIP schemes are assessed as no longer deliverable or reduced due to Covid-19.

4. Where achievable, and not impacted by Covid-19, reductions in temporary levels should continue recognising original targets will not be delivered to scales previously required.

It is intended to complete the interim budget, subject to national guidance for the April Board. If appropriate an extraordinary PAF meeting call will be convened to consider these numbers.

Capital
The 202/21 capital programme, as submitted to NHSI and previously discussed at PAF, is planned to deliver around £41m of investment. This includes approximately £31m of DHSC funding (new hospital, MAU, Emergency capex and IT monies). Initial capital allocations are anticipated and these will form the basis of the interim capital budget.

It is recommended that the Board:
Notes the on-going work to establish an Interim Budget for 2020/21.

Author: Simon Covill, Deputy Operational Finance
Date: 26 March 2020

ANNEX: CORONAVIRUS COST REIMBURSEMENT

This guidance sets out the amended financial arrangements for the NHS for the period between 1 April and 31 July. These changes will enable the NHS and partner organisations (including Local Authorities and the Independent Sector) to respond to COVID-19. We will continue to revise this guidance to reflect operational changes and feedback from the service as the response develops.

We will shortly be making a payment on account to all acute and ambulance providers to cover the costs of COVID-19-related work done so far this year, with final costs for the current financial year being confirmed as part of the year end processes. This initial payment will be based on information already submitted by providers. Future payments will be based on further cost submissions.

All NHS providers and commissioners must carefully record the costs incurred in responding to the outbreak and will be required to report actual costs incurred on a monthly basis. Accurate record keeping during this time is crucial - record keeping must meet the requirements of external audit, and public and Parliamentary scrutiny.

To support reimbursement and track expenditure we will in due course be asking all relevant organisations to provide best estimates of expected costs from now until the expected end of the peak outbreak. We will provide further guidance with relevant assumptions in order to support you in making these estimates.

REVENUE COSTS

Contractual payments and provider reimbursement

We are suspending the operational planning process for 2020/21.

We will provide all NHS providers a guaranteed minimum level of income reflecting the current cost base on the following basis:

a) Commissioners should agree block contracts with the NHS providers with whom they have a contract (NHS Trusts, Foundation Trusts, Mental Health, Community and Ambulance trusts) to cover the period 1 April to 31 July. This should provide a guaranteed monthly payment. For CCGs the value of this payment will be calculated nationally for each CCG/provider relationship. This figure will be based on the average monthly expenditure implied by the provider figures in the M9 Agreement of Balances return plus an uplift that allows for the impact of inflation (including pay uplifts and CNST) but excluding the tariff efficiency factor. It will not include activity growth. For mental health trusts the uplift will include an additional sum consistent with

delivering the Mental Health Investment Standard. The monthly payment should include CQUIN and assume 100% delivery.

b) Trusts should suspend invoicing for non-contracted activity for the period 1 April to 31 July. A sum equivalent to the historical monthly average will be added to the block contract of the provider's coordinating commissioner. Providers should continue to record all activity including NCAs in SUS in the normal way.

c) A national top-up payment will be provided to providers to reflect the difference between the actual costs and income guaranteed by steps 1 and 2 where the expected cost base (which will be calculated as the average monthly expenditure over the period November to January uplifted for inflation) is higher. The Financial Recovery Fund and associated rules will be suspended during this period. The top-up payment will take into account individual provider CNST contributions compared to that funded in the allowance for cost inflation.

We will provide these numbers to Commissioners and Providers on Monday 23 March.

Providers should claim for additional costs where the block payments do not equal actual costs to reflect genuine and reasonable additional marginal costs due to COVID-19. These reasonable costs should include:

a) Evidenced increases in staffing costs compared to the baseline period associated with dealing with increased total activity.

b) Increases in temporary staffing to cover increased levels of sickness absence or to deal with other caring responsibilities (e.g. to look after other family members).

c) Payments for bank or sub-contractor staff to ensure all sickness absence is covered consistent with Government's announced policy and public health advice which aren't otherwise covered under normal practice; and

d) Additional costs of dealing with COVID-19 activity. For example: the costs of running NHS111 assessment pods; increases in the volumes required or prices of equipment to deal with the response to the virus which aren't offset by reductions elsewhere; extra costs of decontamination and transport for the ambulance service; higher testing volumes in acute-based laboratories; and community-based swabbing services.

Claims should be made on a monthly basis, alongside regular monthly financial reports. This should provide sufficient funds for providers to deliver a break-even

position through the period and will provide the basis against which we will monitor financial performance.

We will monitor the impact of any changes in income levels from non-NHS services, in particular from local authorities. Providers should escalate to regional teams as appropriate.

The payments made by commissioners under block contract arrangements should not be revised to reflect any short falls in normal contractual performance during this period. The majority of NHS acute providers are already exempt from the majority of contract sanctions; for the duration of the outbreak until further notice any remaining contract sanctions for all NHS provider groups are to be suspended.

It is important that providers and commissioners pay promptly during this time, so that cash flow for NHS and non-NHS suppliers of goods and services does not become a barrier to service provision.

The arrangements described above should mean there is minimal requirement for interim working capital support during this period. Providers that believe they require supplementary working capital support should follow the normal procedure to access such support.

Funding for commissioners

Commissioner allocations for 2020/21 have already been notified as part of operational planning and will not be changed. However, in assessing individual commissioner financial positions and affordability we will take into account:

a) The impact of the block contracting approach set out above including both the cost of removing the tariff efficiency factor and the benefit of excluding activity growth from the calculation.

b) Expected reductions in investments for service developments
   - the temporary arrangements for non-contracted activity, transferring funding to make sure that lead commissioners have adequate funds to pay providers; and
   - the costs of additional service commitments as described below for example for out of hours provision, additional NHS111 investment, purchase of step-down beds and provision of rapid discharge/ additional social care capacity.

c) We will also be reviewing planned transformation initiatives, and where we consider that these will not be able to proceed during the coronavirus emergency we will reflect this in the distribution of transformation funding.

d) In addition, a number of NHS commissioners are dependent on additional central support to fully cover their expenditure. NHSE/I will calculate a central top up payment on broadly the same basis as FRF to cover the difference between allocations as set out above and expected costs.

Financial Governance

The maintenance of financial control and stewardship of public funds will remain critical during the NHS response to COVID-19. Chief Executives, Accountable Officers and Boards must continue to comply with their legal responsibilities and have regard to their duties as set out in Managing Public Money and other related guidance. Any financial mismanagement during this period will be dealt with in exactly the same way as at any other time.

We recommend that NHS organisations undertake an urgent review of financial governance to ensure decisions to commit resources in response to COVID-19 are robust. Naturally, all organisations should test the resilience of their finance functions and business continuity plans to make sure that the most important elements (running payroll, paying suppliers, core reporting) can continue even with significant staff absences. We are also asking you to consider the resilience of your fraud prevention arrangements.
As normal financial arrangements have been suspended, no new revenue business investments should be entered into unless related to Covid-19 or unless approved by NHSE/I as consistent with a previously agreed plan. Where costs have already been committed or contractual commitments entered into, providers should agree an approach with NHSE/I as above.

Normal consultancy approval and agency reporting requirements must be maintained during this period.

SPECIFIC ADDITIONAL FUNDING CONSIDERATIONS

Purchase of enhanced discharge support services

CCGs will be asked to work with their local authority partners to commission additional out-of-hospital care and support capacity, in particular to facilitate step down of patients from secondary care and so free up acute beds. These are expected to be a blend of care home beds, hospices, and home-care support.

Detailed operational guidance for the procurement and management of these beds will be issued separately including more detailed finance guidance. To make sure that funding decisions do not restrict the pace of discharges, additional resources will be provided to pay for the community bed or a package of care post-discharge for any

patient that needs it. New guidance will also ensure that eligibility assessments do not delay new care packages being put in place. We will continue to review this approach and will ask CCGs and local authorities to move to standard commissioning and funding routes once the impact of Covid-19 sufficiently diminishes – you should plan therefore on the basis of an average length of care package.

Additional funding will be provided based on monthly cost returns from CCGs.

Specialised services

As described above, Specialised Services contracts will follow the same principles as CCG commissioned activity, and block values will be based on the average 2019/20 expenditure up to month 9, with an uplift to recognise the impact of pay uplifts and other cost increases.
Arrangements for pass through Drugs and Devices costs will continue to operate as currently on a cost and volume basis, to ensure that providers do not face any financial consequences of any increases in activity or cost.

Specialised providers will be required to respond to the most serious cases of COVID-19 through the provision of High Consequence Infectious Disease units, Extracorporeal Membrane Oxygenation services and other specialised care functions. Any specific investments and costs incurred by these units are being coordinated through the National Highly Specialised team.

NHS 111

NHS 111 has been commissioned nationally to provide a dedicated Covid-19 response service. This service will continue to be contracted for and funded nationally. In addition, having reviewed the pressures on the wider NHS 111 service additional funding will be released from NHSE/I via lead commissioners, who will then make necessary arrangements for payment to NHS 111 providers.

General Practice

The key principle is that from 1 April we free up practices to prioritise workload according to what is necessary to prepare for and manage the outbreak, and therefore guarantee that income will be protected if other routine contracted work has to be substituted. This does not prevent us from continuing to measure activities (for example those undertaken with QOF) but it ceases to put 2020/21 income at risk for performance.

We will make sure that funding does not influence clinical decision making by ensuring that all GP practices in 2020/21 continue to be paid at rates that assume they would

have continued to perform at the same levels from the beginning of the outbreak as they had done previously, including for the purposes of QoF, DES and LES payments.

CCGs should plan to make payments on this basis. NHSE/I will reimburse any additional costs as part of our wider finance agreement on Covid-19.

Out of Hours Provision

CCGs have been asked to procure additional GP out of hours provision in order to provide home-based care for any patients that have tested positive for coronavirus in the community. CCGs will be reimbursed for the additional costs incurred in delivering this service through the allocations process. CCGs will be required to submit a monthly return of additional cost incurred which will provide the basis of additional payments. To keep the administrative burden to a minimum, where a CCG has contracted for this service on behalf of itself and others, reimbursement will be directed through the lead CCG.

Community Pharmacy

Where required, CCGs will be reimbursed for the following:

a) An NHS Urgent Medicines Supply Service for patients whose General Practice is closed.

b) A Medicines Delivery Service to support Covid-19 positive and vulnerable patients self-isolating at home.

c) Payments to contractors who are required to close due to Covid-19 related reasons.

Optometry and dental

For the time being we expect that funding for dentistry and optometry will continue in line with existing contractual arrangements using assumptions rolled over from 2019/20 where required. We will keep this under review and address any issues as they arise.

Third and Independent Sector Providers

Details of reimbursement for any additional services to be procured from the third sector or from independent sector organisations will be issued in due course.

CAPITAL COSTS

NHSE/I will shortly issue indicative capital allocations for 2020/21. Additional capital expenditure will be required to support our response to the virus in a number of areas, including purchase of pods, capital modifications to existing estate, purchasing of ventilators and other medical equipment, and IT assets to enable smarter working including remote consultations. In a number of cases NHSE/I may bulk-purchase assets to secure the necessary resource as quickly as possible. However, this will not always be practical or desirable, so below are the arrangements for providers and commissioners to access capital in relation to the COVID-19 response. The key criteria against which we will assess claims are:

a) The proposed expenditure must be clearly linked to delivery of our COVID-19 response;
NHS
b) In the case of asset purchases, the asset must be capable of being delivered within the expected duration of the outbreak; and

c) In the case of modifications to estate, the works must be capable of being completed within the expected duration of the outbreak.

Commissioner capital

We anticipate that individual claims for capital expenditure by commissioners will fall within the delegated budgetary limits for NHSE/I of £10m. Any requests for capital expenditure by commissioners including any assets being purchased on behalf of general practice should be relayed to NHSE/I regional teams for assessment with the national team, following which the required capital allocation will be issued.

Provider capital

We anticipate that individual claims for capital expenditure by providers will fall within the delegated budgetary limits for trusts of £15m. Any requests for capital expenditure by providers should be relayed to NHSE/I regional team for rapid assessment with the national team to enable swift decision making and disbursement of cash where appropriate. PDC charges will not be levied on any funding supplied in connection with COVID-19.

Summary

Group	Service line	Funding method
Revenue costs		
All NHS organisations	Contracting basis	All providers to move to block contract,
	Self-isolation of workers	To be directly reimbursed as required
	Increased staff costs in the event of sick or carer's leave	To be directly reimbursed as required
	Other additional operating costs	Reasonable costs to be reimbursed
Acute providers	Pod provision	Initial on-account payment based on submissions received so far Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
	Laboratory costs	To be directly reimbursed as required
CCGs	Purchase of step-down beds	Final 19/20 payment based on cost submissions Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
	Out of Hours (primary care) capacity increase	Additional allocations to be paid to CCGs to pass on to providers
Specialised services	Patient admissions	To be funded through block contractual payments
	Drugs costs	Payments for drugs not included in tariff will continue in the normal way
Ambulance providers	Additional PPE and cleaning	Initial on-account payment based on submissions received so far Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions
Community	Swabbing services	Final 19/20 payment based on updated cost template Ongoing 20/21 costs to be reimbursed monthly based on cost submissions

Group	Service line	Funding method
NHS 111	National CRS function	Costs to be reimbursed nationally
	Additional local 111 funding	Additional allocations to be paid via CCGs where agreed
Capital costs		
Acute providers	Equipment and estate modification as required	PDC allocation from DHSC to provider trust
CCGs (including primary care)	Equipment as required	NHS England allocation to CCGs funded via DHSC mandate adjustment

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 02/04/20 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM:	Workforce Committee
REPORT FROM:	Andrew Holden/Helen Howe – Committee Chair
DATE OF COMMITTEE MEETING:	23/03/20

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- BAF risks 2.1 and 2.3 were discussed; WFC agreed that the risk score for Risk 2.3 should remain at 12 but that the risk score for Risk 2.1 (Nurse Recruitment) should be reduced from 16 to 12.
- Freedom to Speak Up - the quarterly report from the guardians was discussed and it was agreed that the Committee would receive an action plan for the areas of concern highlighted in the report.
- Workforce indicators - the Committee requested a breakdown of consultant vacancies across all areas.
- Training and education - the update was noted; although apprenticeship activity has increased the Trust is reporting a loss of 'expired' funds from the apprenticeship levy. Actions are being taken to minimise this loss.
- Communications Strategy - the draft strategy was reviewed and members suggested that the final version include a 'forward look' and link to other relevant strategies.
- Staff Survey - progress against the action plan was discussed and members agreed that safety culture should be an area of focus.
- Gender Pay Gap - the report was approved for publication on the Trust's website by 31 March 2020. The report is on the Board agenda for information.
- Fit and Proper Persons Report - the report was reviewed and is on the Board agenda for discussion.

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

The following are highlighted for the Board's awareness and/or assurance:

The agenda was reduced to the items mentioned above due to the operational pressures relating to COVID-19.

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 agreed the workplan for 2020/21.

7.1

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 02.04.20 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Andrew Holden - PAF Chairman
DATE OF COMMITTEE MEETING: 26.03.20 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

Forecast Outturn (FOT): The Trust continues to forecast delivery of the control target supported by non-recurrent income and recovery of Covid-19 costs which are being captured separately.

COVID-19 Costs: The CFO reported that an internal Cost Recovery Unit was being set up to ensure the capture and recovery of all revenue and capital costs. The Chair emphasised the need for a dedicated team focussing on the identification and collation of all costs incurred across the Trust.

Draft Budget 2020/21: The Deputy Chief Financial Officer would circulate a briefing note to members covering points raised at the recent Regional DoFs meeting. An interim budget is being worked up in line with advice received and will include a line for costs associated with COVID-19. The intention is to present the interim budget to Board on 2 April. A communication would be provided to all budget holders, their establishments and non-pay budgets would roll-over for the start of the financial year.

MSK Contract: This would continue to be reviewed.

Patient Access Targets: Members noted that performance would reduce over coming months in response to the national directive to suspend all elective surgery. Assurance was provided that every patient was being tracked/risk stratified in terms of their individual pathway.

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

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

- M11 Integrated Performance Report
- Financial Implications of COVID-19
- BAF risks 5.1 (finance), 4.2 (4 hour ED standard), 1.2 (EPR) and 3.1 (Estate and Infrastructure) - all risk scores remain unchanged.

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

- The Committee continues to make good progress against the workplan although on this occasion agenda items were deferred by agreement with the Chair due to the current pressures in the hospital relating to COVID-19. The Committee focussed on key areas and areas of risk.

- PAF approved the workplan for 2020/21.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 02/04/2020 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: George Wood – Chair of Audit Committee

DATE OF COMMITTEE MEETING: 26/03/2020

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION
The following are highlighted for the Board to note or to take action:
COVID-19 Financial Governance: The Trust has considered whether to review delegated authority limits but at this stage amendments are not being suggested. However, the Committee supported a recommendation that virtual arrangements are put in place in order for the Board to approve amendments to limits. **Accounts 2019/20 and audit timetable:** The challenges around completion of accounts and required stocktakes within the timescales were noted. **Annual Governance Statement:** a draft was received and reviewed. **Registers of interests, gifts and hospitality:** The Committee received the registers and approved them subject to one minor amendment. **Terms of reference 2020/21:** The revised Terms of Reference were approved and recommended to Board for approval. **(Appendix 1)**
The following reports were noted: Internal Audit Progress report, Head of Internal Audit Opinion and Annual report, Counter Fraud Progress Report and Plan 20/21, External Audit Plans, Debt write offs and special payments, Caldicott Guardian Annual report.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee's progress against its Annual Work Plan is set out below:
The AC is making good progress against its annual work plan and approved the workplan for 2020/21.

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

PURPOSE:

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

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

DUTIES:

The following comprise the Committee's main responsibilities:

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

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

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

Internal Audit
The Committee shall ensure that there is an effective internal audit

7.1

function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

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

External Audit

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

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

Annual Report and Accounts Review

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

1. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
2. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
3. Changes in, and compliance with, accounting policies, practices and estimation techniques.
4. The meaning and significance of the figures, notes and significant changes.
5. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
6. Explanation of estimates or provisions having material effect.

7. The schedule of losses and payments.
8. Any unadjusted (mis)statements.
9. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
10. The letter of representation.

Annual Quality Account
The Committee shall seek assurance that:

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

Governance Manual

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

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

Counter Fraud/Bribery/Corruption Arrangements
The Committee shall ensure that the Trust has in place:

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

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

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

The following comprise the Auditor Panel's main responsibilities:

Procurement of External Audit
In its capacity as Auditor Panel, the Committee shall:
1. Agree and oversee a robust process for selecting the external auditors in line with the Trust's procurement processes and rules.

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

ACCOUNTABLE TO: Trust Board.

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

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

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

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

CHAIRMAN Non-Executive Director.

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

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

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

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

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

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

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

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

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

DEPUTISING ARRANGEMENTS

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

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

QUORUM:

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

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

DECLARATION OF INTERESTS

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

MEETING FREQUENCY:

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

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

MEETING ORGANISATION

Audit Committee

- Meetings of the Committee shall be set before the start of the financial year.
- The meeting shall be closed and not open to the public.

The Princess Alexandra Hospital NHS Trust

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

Auditor Panel

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

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

AUTHORITY

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

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

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

TERMS OF REFERENCE

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

DATE APPROVED

By Committee: 26 March 2020~~5 September 2018~~
By Trust Board:

TO BE REVIEWED ANNUALLY

Next review due: ~~September 2019~~September 2021

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The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE 20~~18~~20/~~19~~21: MEMBERSHIP

Membership and Those in Attendance	
Members	
~~Stephen Bright~~George Wood	**Non-Executive Director and Committee Chair**
Helen Howe	~~Associate~~ Non-Executive Director
~~Andrew Holden~~	~~Non-Executive Director~~
Pam Court	Non-Executive Director
In Attendance (Board)	
Trevor Smith	Chief Financial Officer (Lead Exec)
Andy Morris	Chief Medical Officer
In Attendance (Internal & External Audit)	
Neil Abbott	tiaa
Thanzil Khan	tiaa
Kevin Limn	tiaa
~~Gareth Robins~~	~~tiaa~~
Hannah Wenlock	tiaa
Debbie Hanson	Ernst & Young
Natalie Clark	Ernst & Young
Invited	
Simon Covill	Deputy Chief Finance Officer
~~Nick Ryan~~	~~Deputy Chief Finance Officer~~
Secretariat	
Heather Schultz	Head of Corporate Affairs
Lynne Marriott	Board and Committee Secretary

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The Princess Alexandra Hospital NHS
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BOARD OF DIRECTORS

MEETING DATE: 02.04.20 **AGENDA ITEM NO: 7.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)
REPORT FROM: Helen Glenister – QSC Chair
DATE OF COMMITTEE MEETING: 27.03.20 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

COVID-19: QSC learned of the immense pressures that the hospital was currently under. The Committee understood that there were a number of key issues and staff anxiety, including PPE guidance, which were aligned with concerns being raised across the wider NHS. It recognised that the Trust continued to work across its networks, and was linked into the national forums ensuring it was in line with national guidance and responsive to the changing picture. It was noted a new risk was being added to the organisation's Board Assurance Framework (BAF) and over coming months (if meetings were still to go ahead) the Committee's agenda would continue to be reduced.

Quality Governance Review: The proposal was approved in principle, albeit timeframes for implementation would now be pushed back to due current clinical/operational pressures.

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

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

- Mortality Update
- M11 Integrated Performance Report
- Monthly Quality, Safety & Effectiveness Report
- Research & Development Annual Report
- Report on Nursing, Midwifery and Care Staff Levels
- Update on CQC Section 29 Notice and Trust Response
- Infection Control Update
- Review of BAF Risk Allocated to QSC

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

- The Committee continues to make good progress against the workplan although on this occasion agenda items were deferred by agreement with the Chair due to the current pressures in the hospital relating to COVID-19. The Committee focussed on key areas and areas of risk and safety.

- QSC agreed not to approve the workplan for 2020/21 until such time as clinical/operational pressures had reduced.