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 December 2021 at 9.30 – 12.45
Venue: Microsoft Teams Meeting

	Item	Subject	Action	Lead	
01 Opening administration					
09.30	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	4
	1.4	Matters arising and action log	Review	All	12
09.35	Patient story: "Being on the other side"				
02 Strategy and Risk					
10.00	2.1	Chair's report	Inform	Chair	13
10.10	2.2	CEO's report including: • COVID-19 update • CQC inspection update	Inform	Chief executive	15
10.20	2.3	Significant risk register	Review	Medical director	21
10.30	2.4	Board assurance framework 2021-22	Review/ Approve	Head of corporate affairs	27
03 Patients					
10.40	3.1	Learning from deaths (Mortality)	Discuss	Medical director	40
10.50	3.2	Maternity SI report	Assure	Director of nursing and midwifery	43
11.00	3.3	Nursing, midwifery and care staff levels including nurse recruitment	Discuss	Director of nursing and midwifery	46
11.10	3.4	Nursing Establishment Review	Approve	Director of nursing and midwifery	58
11.25	3.5	Quality and Patient Safety Strategy	Approve	Director of nursing and midwifery	73
11.30	3.6	Nursing, Midwifery and AHP Strategy update	Note	Director of nursing and midwifery	99
04 People					
11.35	4.1	EDS 2	Approve	Director of People and OD	108
11.40	4.2	Vaccination as a condition of deployment (VCOD) for all healthcare workers	Inform	Director of People and OD	116

11.45	4.3	Healthcare worker flu vaccination best practice management checklist	Approve	Director of People and OD	122
05 Performance/pounds					
11.50	5.1	Integrated performance report	Discuss	Chief Information Officer	125
12.00	5.2	Elective Recovery Plan	Discuss	Chief Operating Officer	199
12.10	5.3	Response to NHSE/I letter regarding ambulance handovers	Note	Chief Operating Officer	206
12.20	5.4	H2 Financial Plan	Approve	Director of Finance	209
06 Governance					
12.30	6.1	Reports from committees: • Performance & Finance Committee 25.11.21 • Quality & Safety Committee 26.11.21 • Workforce Committee 29.11.21 • SMT.09.11.21 and 16.11.21	Inform	Chairs of committees	212 214 216 218
12.35	6.2	Corporate Trustee: • Report from Charitable Funds Committee meeting 19.11.21 and revised Terms of Reference • Charitable Funds Annual report and Accounts (including Independent Examination by External Auditors)	Inform/ Approve Approve	Chair of CFC/ Director of Finance	219 223
07 Questions from the public					
12.40	7.1	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
08 Closing administration					
	8.1	Summary of actions and decisions	-	Chair/All	
	8.2	New risks and issues Identified	Discuss	All	
	8.3	Any other business	Review	All	
12.45	8.4	Reflection on meeting	Discuss	All	

The Princess Alexandra Hospital NHS Trust

Public Board Meeting Dates 2021/22

01.04.21	07.10.21
03.06.21	02.12.21
05.08.21	03.02.22

Purpose:

The purpose of the Trust Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care. It determines strategy and monitors performance of the Trust, ensuring it meets its statutory obligations and provides the best possible service to patients, within the resources available.

Quoracy:

One third of voting members, to include at least one Executive and one Non-Executive (excluding the Chair). Each member shall have one vote and in the event of votes being equal, the Chairman shall have the casting vote.

Ground Rules for Meetings:

1. The purpose of the meeting should be defined on the day (set the contract).
2. Papers should be taken as read.
3. The purpose of a paper must be clearly explained and the decision/s to be made must be identified.
4. Members/attendees are encouraged to ask questions rather than make statements and are reminded that when attending meetings, it is important to be courteous and respect freedom to speak, disagree or remain silent. Behaviour in meetings should be in line with the Trust's Behaviour Charter.
5. Challenge should be constructive and a way of testing the robustness of information.
6. Members/attendees are encouraged to support the Chair of the meeting to ensure the meeting runs to time.
7. The use of mobile phones during meetings should be avoided; phones must be set to silent.
8. If the duration of a meeting is likely to exceed 2 hours a break should be taken at a convenient point.

Board Membership and Attendance 2021/22

Non-Executive Director Members of the Board (voting)		Executive Members of the Board (voting)	
Title	**Name**	**Title**	**Name**
Trust Chair	Hattie Llewelyn-Davies	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC) and Senior Independent Director	George Wood	Director of Nursing & Midwifery and Deputy CEO	Sharon McNally
Vice Chair and Chair of Quality & Safety Committee (QSC)	Dr. Helen Glenister	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Pam Court	Medical Director	Fay Gilder
Chair of Workforce Committee (WFC)	Helen Howe	Director of Finance	Saba Sadiq
Chair of Charitable Funds Committee (CFC)	Dr. John Keddie	**Executive Members of the Board (non-voting)**	
Non-Executive Director	Dr. John Hogan	Director of Strategy	Michael Meredith
NExT NED	Darshana Bawa	Director of People	Gech Emeadi
Associate NED	Anne Wafula-Strike	Director of Quality Improvement	Jim McLeish
		Chief Information Officer	Phil Holland
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Virtual Trust Board Meeting in Public
Thursday 7 October 2021 from 09:30 to 11:15

Present:	
Hattie Llewelyn-Davis	**Trust Chair (TC)**
Dr Amik Aneja	General Practitioner (GP-AA), Board Advisor
Helen Glenister	Non-Executive Director (NED-HG)
Darshana Bawa	NExT Non-Executive Director (NNED-DB)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Fay Gilder	Medical Director (MD)
John Hogan	Non-Executive Director (NED-JH)
Helen Howe	Non-Executive Director (NED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Lance McCarthy	Chief Executive Officer (CEO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Saba Sadiq	Director of Finance (DoF)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)
Pam Court	Non-Executive Director (NED-PC)
Phil Holland	Chief Information Officer (CIO)
In attendance:	
Amr Badawy	MTI Registrar - FAWS
Laura Warren	Associate Director - Communications
Members of the Public	
Clare Rose	Meditech
Apologies:	
None	
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Becky Warwick	Corporate Governance Officer (CGO)

01 OPENING ADMINISTRATION	
1.1	The Trust Chair (TC) Hattie Llewelyn-Davis introduced herself and welcomed all to the meeting. She requested members introduced themselves when speaking for the first time.
1.1 Apologies	
1.2	Dr Amik Aneja General Practitioner (GP-AA) and Associate Non-Executive Director Anne Wafula-Strike (ANED-AWS) would be joining the meeting late.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of the Meeting held on 11.06.21.	
1.4	These were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.5	No actions.
02 RISK/STRATEGY	
2.1 CEO's Report	
2.1	The CEO presented his report and key updates were as follows: <u>COVID and Current Pressures</u> The CEO drew members' attention to the graph on p17 and the rise in new positive COVID inpatients over the previous month, averaging just over 3 new positive patients per day for the last 3 months. He noted the separate 'red ED' and 'red ITU' remained in place to manage

	patients appropriately. The average age of admitted patients was lower than in the first or second wave. He noted in April 2020 the Trust had 36% more spells with COVID-19 than peer organisations. In December 2020 and January 2021, the Trust had 52% and 59% more spells respectively than peer organisations. He noted the backlog of elective cases and cancer activity was reducing and on track to ensure there were no patients waiting for more than 104 weeks by the end of this year. He stated that despite the easing of national lockdown measures no policies or ways of working had been changed within the Trust with continued compliance with NHS IPC guidance
2.2	CQC Formal Inspection The CEO noted the Trust was formally inspected by CQC colleagues between 6 July 2021 and 6 September. The draft reports from CQC were expected within the next few weeks, after which there would be a short period to check the reports for factual accuracy before the final consolidated report was published, likely to be in November. Key headlines relating to the core service inspections and the well led interviews were included in the report. He noted following the urgent emergency care core service review the Trust received a formal section 31 notice under the Health and Social Care Act and a series of actions had been put in place and were outlined in the report.
2.3	Non-Executive Director John Hogan (NED-JH) queried the sickness rate due to COVID-19 in the Trust and how it compared to that of the local community. The Director of Quality Improvement (DoQI) noted this was reviewed at Infection, Prevention and Control Cell and currently non-Covid sickness was higher than Covid related absences.
2.4	Non-Executive Director Helen Glenister (NED-HG) asked if there was a difference in demographics to the patients now being admitted for Covid. The CEO noted current admissions were younger than admissions in the first wave. He noted the admissions of very sick Covid patients were either those who were unvaccinated or had received a single dose. He noted there had been a significant increase in the number of paediatric patients.
2.5	Event in a Tent The CEO noted the success of the annual engagement event for all people at PAHT and gave his thanks to the teams that helped to facilitate and support the event. He noted the powerful first hand personal stories and reflections of the pressures over the last 18 months from a range of clinical colleagues heard in the COVID-19 Schwartz round. The AGM had taken place and there had been an opportunity to congratulate long service colleagues and the Amazing People Awards had taken place. He informed members PAHT 2030 and the Trust's new values had both formally been launched at Event in a Tent.
2.6	COVID booster and flu vaccinations The CEO informed members the annual flu vaccination programme for all colleagues across the Trust had started on Monday 4 October run in conjunction with the provision of the COVID-19 booster vaccination. He noted 675 staff had received the COVID booster and 698 had received the flu vaccination to date.
2.7	The Board was asked to ratify the appointment of Dr Sarah Babatunde, consultant anaesthetist with an interest in obstetrics, made through delegated authority to the AAC panel. The Board ratified the appointment.
2.8	The TC thanked the CEO for his report and took the opportunity to thank NED-HG for covering the Trust Chair position in the interim between substantive Chairs.
2.2 Significant Risk Register	
2.9	This update was presented by the Medical Director (MD) and was a snapshot of risks across the Trust at a specific point and included all risks scoring 15 and above. The overall number of significant risks on the register had reduced from 86 to 73 and the main themes for the risks scoring 20 were: • Six for operational pressures - 2 ED access standard compliance, 2 referral to treatment standard compliance, 1 Cancer-waiting and 1 bed pressures in medicine on Covid-19 register • Three for our patients covering: equipment for Dolphin ward, electronic storage of maternal CTG reports and delays for medical review in same day admissions unit

	• Two for our places - concerning the theatre roofs • Two medical consultant cover - for GI bleed rota and obstetric
2.10	The MD noted a score increase relating to delays to assessment in Same Day Emergency Care unit (SDEC) and as a result, a clinical navigator role had been introduced to address the challenges. She noted in relation to consultant cover in obstetrics, two posts were being advertised and further mitigating actions were in place pending recruitment. In regards to the risk for medical cover for GI bleed out of hours, she noted the rota would go live from the 16th October 2021. She thanked Dr Robert Ghosh, Associate Medical Director – Medicine and Urgent Care and his colleagues for their support in the creation of this rota.
2.11	She highlighted the increased risk score due to significant pressure on medical beds due to Covid-19 and ongoing increased non Covid-19 emergency demand. She asked members to note the new risks identified.
2.12	The CEO queried if the risk regarding the out of hour GI bleed rota would be removed now that the rota was going live. The MD noted the risk would remain on the register to allow the monitoring of the performance of the rota.
2.13	The MD updated members on the remaining three new risks; the first regarding mammography gaps due to vacancy and sickness absence, the second the nurse staffing on Kingsmoor ward and the last the financial cost to undertake refurbishment of Parndon Hall.
2.14	Non-Executive Director George Wood (NED-GW) queried the risk regarding the leaks in the theatres roof and whether this had been resolved. The Director of Strategy (DoS) noted this was an ongoing issue with the roofing due to the age of the building and was part of the backlog maintenance plan.
2.15	Non-Executive Director Helen Howe (NED-HH) asked if the scores were before or after mitigation and how the discussions regarding risk appetite were progressing. The MD noted the scores shown were after mitigation. The Director of Nursing and Midwifery (DoN&M) noted there was work underway in regard to risk appetite and the description of risks. She noted a paper would be brought to Board in quarter one on how this would addressed going forward.
ACTION **TB1.07.10.21/07**	**Provide an update to Trust Board (for Q1) on progress with revising the risk management approach and risk appetite.** **Lead: DoN&M/MD**
2.16	The TC thanked the MD for the report and noted the importance of further discussions to be had regarding risk appetite.
Staff Story – Amr's Story	
2.17	This item was presented by the Director of People (DoP). She introduced Amr Badawy, Registrar Family and Women's Services who had joined the Trust as part of the Medical Training Initiative (MTI). Amr introduced himself and gave an overview of his background before starting at the Trust. He informed members he had been working in Egypt in obstetrics and gynaecology and joined the Trust in December 2019.He gave an overview of the new skills he has acquired since working at the Trust and the differences in clinical practice from Egypt to the UK. He noted he had enjoyed the working environment at Trust and how supportive all his colleagues had been. He noted the induction period was challenging due to moving from a different country but he felt supported by his educational supervisor and other colleagues. He noted the MTI programme had opened up more opportunities for him in Egypt and would also make working in the UK easier for him in the future.
2.18	The DoP asked if there was anything that could have been better. Amr noted the challenges of the induction period due to there being only one registrar in Labour and Gynae although more registrars had now been appointed. The DoP queried if he was made to feel welcome when starting at the Trust. Amr noted when he started all the staff were helpful in getting him acquainted with the policies and procedures. As a final question, the DoP asked if Amr had any advice for future MTI doctors. Amr noted that being organised, and keeping up with training were key to succeeding in the programme and to gain more experience in other areas of the hospital, if possible.

2.19	The COO asked Amr if he had a takeaway message from his time with the Trust. Amr stated the supportive working environment and the people, his colleagues would be his best memory.
2.20	Non-Executive Director Pam Court (NED-PC) asked if there were any practices from Egypt that the Trust might want to adopt. Amr said there weren't any practices the Trust could adopt. He noted IVF was his specialty but this was not provided at the Trust.
2.21	NED-PC asked if there were any difference in expectations from patient's families. He noted any difference in expectation was a cultural difference but the level of care provided was the same.
2.22	NED-HH asked Amr if he had a formal induction when he started at the Trust and whether an exit interview had been planned. Amr noted he had an induction which was challenging due to staff shortages, He noted an exit interview had not yet been arranged as he did not leave the Trust until December 2021.
2.23	Associate Non-Executive Director John Keddie (ANED-JK) welcomed the information about the MTI programme and the investment in training professionals from overseas. .
2.24	The TC thanked Amr for his time in telling his story to the Board and noted the learning around the challenging induction period.
2.3 Board Assurance Framework 2021/22	
2.25	This paper was presented by the Head of Corporate Affairs (HoCA). She informed members the proposal was to increase one risk score that month (Risk 2.3 Inability to recruit, retain and engage) from 12 to 16. The risks had been reviewed at Committees in September and WFC had supported the change to the risk score for risk 2.3. Similarly, PAF had supported the revised risk score for risk 4.2 (Four Hour Emergency Department Constitutional Standard) from 16 to 20.
2.26	In line with the recommendation the Board approved the changes to the risk scores.
03 PATIENTS	
3.1 Learning from Deaths (Mortality)	
3.1	This update was presented by the MD. She noted there had been further updates since the report was produced. She noted for the first time in 36 months the Trust's standardised mortality ratio was as expected. She noted due to a failure of confidence in data transfer from HES to Telestra through their secure portal, the mortality indices for M2 and M3 were not available in the report. She highlighted the mortality improvement programmes, specifically sepsis, and the 6 month audit of ED compliance with sepsis 6 showed 94% of patients with sepsis were receiving antibiotics within one hour and 90% of patients were receiving all six elements of the Sepsis 6 bundle. She informed members that 3 new medical examiner posts were being recruited to. She highlighted the next steps in the report to the Board and noted the healthcare group restructure offered the opportunity to embed the learning from deaths into service and divisional patient quality and safety governance and learning.
3.2	She informed members the Trust' HSMR and SHMI had been 'as expected' since June 2021 which was good news.
3.3	The Chief Information Officer (CIO) noted the importance of the sustained downward trend and extended his congratulations to the MD for the achievement. The TC shared her congratulations and thanks to the teams who had made the improvements possible.
3.2 Maternity SI Report	
3.4	This update was presented by the DoN&M. She informed colleagues there had been two further SIs since the last Board meeting in August. Both had been referred to the Healthcare Safety Investigation Branch (HSIB). Whilst the investigations were not yet concluded it would be important for the organisation to undertake its own thematic analysis in order to learn from the incidents. The themes from both incidents related to how babies were monitored during birth and she highlighted that CTG training compliance figures were available in the IPR and were improving. Actions were noted under section four of the paper for the HCG in terms of

	CTG monitoring. She provided assurance that the organisation was not an outlier nationally but it would be incumbent upon it to take and embed the learning from the two incidents.
3.5	In response to the above NED-HH asked whether the new Director of Midwifery (DoM) might be able to undertake a gap analysis of the service and/or provide some thoughts from his own local and national experience. In response the DoN&M confirmed that the new DoM was undertaking a stock-take of the service and in addition she highlighted that the HCG also had a new Associate Medical Director (AMD). One action already in train was a review of the workforce strategy and Birth Rate+.
3.6	In response to a question from ANED-AWS the DoN&M confirmed that CTG training was required training for all midwives and clinical staff and was not used in terms of monitoring staff performance. Where staff needed support in terms of their own competency the organisation would step-in and facilitate that.
3.7	The TC congratulated the team on the progress to date and the assurance provided.
3.3 Nursing, Midwifery and Care Staff Levels	
3.8	This update was presented by the DoN&M who informed members that the organisation had sustained a good level of overall fill from plan for nursing and midwifery staff. There was however still some work to be done. Band 5 vacancy levels were reducing but there remained some sustained gaps in some areas – midwifery, Emergency Department (ED) and Paediatric ED. In those areas the organisation was waiting for staff to join from the pipeline. Another area of some concern was healthcare support worker vacancies. A new Recruitment & Retention nurse had just been appointed to work alongside the HR team to move that element forward and agree an appropriate trajectory.
3.9	The DoN&M continued that the nursing establishment review had just been completed and would be presented to Board in December with some recommendations. She emphasised there was significant pressure across the organisation particularly in terms of staff absence rates and the team would be meeting to review how to move forward in terms of 'safest care' and the deployment of staff with that focus in mind. In terms of ED staffing there would be a link-in nationally to 'track and trigger' tools to see whether that might add additional benefit to the organisation.
3.10	In response to the above NED-HG stated that she fully recognised the huge headway that had been made in recent years in terms of reducing nursing vacancies but also that once new staff joined the organisation it took a couple of months before those staff were fully inducted into the organisation. She then asked a question in relation to 'safest care' and whether or not that was also being looked at by other organisations. In response the DoN&M stated that across the whole of the East of England and nationally there were staffing pressures and staff resilience (nationally) was also down after the previous 18 months. It would be up to individual organisations to make a decision on how 'safest care' was taken forward. Guidance existed in terms of critical care and critical care escalation but not in terms of acute inpatient areas. She would be meeting with the senior nursing team later that day to discuss how to enable staff to make the right decisions in relation to priorities of care.
3.11	In response to the above NED-HH suggested that going forward the emphasis needed to be very much on retention in her view. In response the DoP stated that retention was a focus in terms of continued professional development, career development and staff engagement. Turnover rates were also reported and available in the IPR. The DoN&M added that retention had been an historical issue for nursing and midwifery however the turnover rate had significantly improved and was currently at around 11.5%. She reminded colleagues that the organisation had launched its Nursing & Midwifery Strategy the previous December and was driven to ensure the right levels of support and development opportunities were provided for staff.
3.12	In response to the above NED-HH stated it might be useful to ascertain from nursing and midwifery colleagues the four elements key to them remaining in the organisation. In response the DoP agreed and that was easily undertaken by walking the floors and asking. On-boarding and exiting interviews also supported that. It would also be key to ensure that managers had regular conversations with their teams to monitor how staff were feeling. As a

	final point NED-HH highlighted the excellent and on-going support for staff provided by the organisation's Health & Wellbeing team.
3.13	At this point the TC asked whether the ICS had plans in place for addressing retention. In response the DoP/DoN&M confirmed that planes were in place.
04 PEOPLE	
4.1 Annual Report on Medical Revalidation and Compliance Statement	
4.1	This paper was presented by the MD and was for noting and sign-off of the compliance statement. The report reflected the position to the end of March 2021 but she added that as of that day, there were now only two outstanding consultant appraisals. The paper had also been presented to Workforce Committee (WFC) and there had been no comments. The MD informed members that she was currently the responsible officer but Dr Fiona Hikmet, Deputy Medical Director would take on that role within the next six months.
4.2	The MD informed colleagues that some work was currently being undertaken around the Annual Leave and Job Planning policies in order to better understand the medical workforce and pressures they were under. The work would enable improvements in planning the medical workforce.
4.3	In line with the recommendation the Board approved the Annual Report on Medical Revalidation and the Compliance Statement.
05 PERFORMANCE/POUNDS	
5.1 Integrated Performance Report	
5.1	The TC noted that the IPR had already been presented to relevant Board Committees that month. She asked members whether they had any questions. In response the COO stated she would like to highlight to colleagues the work around elective recovery. Given on-going emergency pressures she provided assurance that elective recovery trajectories were still being closely monitored and teams were working closely with colleagues across the ICS to look at collaborative solutions to support patients over winter. The organisation was on trajectory to have no patients waiting more than 104 weeks by the end of December. In terms of cancer recovery she updated that clearance of those patients waiting longer than 62 days would be completed by the end of November. In summary some good progress despite the emergency pressures already discussed.
5.2	The CEO stated that in terms of performance there had been a number of conversations about how the Trust compared to other organisations. From page 79 of the pack it was evident that on the whole the organisation was middle of the pack for key performance indicators.
5.3	In response to a question from NED-HG in relation to elective recovery funding (ERF) the COO was able to confirm that the organisation was working hard with the ICS to ensure that targets were delivered. For the first part of the year the organisation was on trajectory and the details for the second half of the year were just being worked through.
5.4	The DoF was able to add that funding had been received from NHSE/I for April/May. Discussions were currently underway with the system in relation to funding for June and onwards. In the meantime the organisation would continue with its efforts to recover activity levels and reduce its backlog.
5.5	In relation to areas where the Trust was not meeting targets/standards ANED-JK asked members to consider the point at which the Board would be prepared to acknowledge that performance in these areas was not acceptable but was assured and content that the mitigating actions were sufficient to bring the organisation back to target and further, at what point those mitigations would be reviewed. In response the CEO thanked ANED-JK for his question and agreed that was something that needed to be undertaken across each of the performance indicators. The focus currently was on elective recovery but he agreed there needed to be a clear trajectory for each KPI with some clear plans to see what was achievable in a more planned manner. He agreed to consider how to undertake that.
ACTION **TB1.07.10.21/08**	**Review trajectories for each KPI in the IPR to understand what might be achievable.** **Lead: CEO/Executive Team**

5.6	In response to a question from NNED-DB, the CIO was able to confirm that some of the targets in the IPR were local targets and reviewed on a quarterly basis. There was also a set of national performance targets which were subject to national review.
06 GOVERNANCE	
6.1 Reports from Committees	
6.1	Updates from Committee Chairs were as follows: <u>Audit Committee – 06.09.21</u> NED-GW updated that the Committee's Terms of Reference (ToR) had been revised and were presented that day for approval. New external auditors had been appointed and the organisation was about to tender for Internal Audit services. Progress against the annual work plan was good. In line with the recommendation the Board approved the Committee's revised ToR. <u>Quality & Safety Committee – 24.09.21</u> In terms of the report, NED-JH reiterated the difficulties in recording COVID patient ethnicity at the time of admission, albeit the organisation was not an outlier in this regard. An ED deep dive had been presented which highlighted the current challenges but also new and innovative ways of treating patients. There had been some progress with the CQC 'must and should' actions but further work was still required. The BAF risk score for 1.1 would remain at 16, despite the recent good news in relation to HSMR. <u>New Hospital Committee – 27.09.21</u> The CEO updated that the organisation continued to work closely with the national New Hospital Programme and there were no escalations from the committee to the Board. <u>Workforce Committee – 27.09.21</u> NED-HH informed colleagues that the GMC Survey improvement plan had been received and there would be further updates in due course. The Guardian of Safer Working report had also been received with actions to take forward. The Committee had received and approved the Equality, Diversity and Inclusion (EDI) Report which provided assurance to the Board on the Trust's progress in EDI in respect of the Equality Act 2010 and summarised key actions for 2021-22. The Gender Pay Gap report had also been presented. <u>Performance & Finance Committee – 30.09.21</u> NED-PC informed members there had been a robust session with the new ICS Procurement team at the meeting. The M5 position, as stated, had been a small surplus and the capital programme was on target. There would be some more work on the CIP programme and the Vascular Services business case had been presented and endorsed for Board sign-off. <u>Senior Management Team – 14.09.21 and 21.09.21</u> The report was noted. Members had no comments/questions.
07 QUESTIONS FROM THE PUBLIC	
7.1	There were no questions from the public.
08 CLOSING ADMINISTRATION	
8.1 Summary of Actions and Decisions	
8.1	These are presented in the shaded boxes above.
8.2 New Issues/Risks	
8.2	The TC identified a potential risk in relation to the IPR, and looking at how progress was being presented in relation to performance.
8.3 Any Other Business (AOB)	
8.3	The DoS flagged there had been recent reports in the media about pressures on electricity and gas supplies in the UK. The hospital had reviewed its position in relation to supply and

	cost. There was currently good continuity of supply of both gas and electricity to the hospital. In terms of cost, the new framework had been presented to Board previously and there was flexibility on how costs were negotiated as part of that framework.
8.4	In response to a question from ANED-JK the DoS was pleased to confirm that the organisation's northern most generator had just been replaced and generators on site were diesel powered with sufficient supply for three continuous days in terms of back-up.
8.5	Following a comment in the chat box the TC thanked the Estates team for all their work and also staff for making efforts to get into the hospital during the recent fuel shortage.
8.4 Reflection on Meeting	
8.6	The MD stated that her suggestion would be (and had been at other meetings) to reflect on how the meeting had lived up to the organisation's new values. Members noted some examples of how the discussions and supporting papers had demonstrated the Trust's values.
8.7	ANED-AWS reflected on the low attendance from members of the public, and it was agreed to consider outside the meeting how other organisation's promoted their Board meetings.
ACTION **TB1.07.10.21/09**	**Consider how other organisations promote their Board meeting (with a view to increasing attendance from members of the public).** **Lead: CEO/HoCA**

Signed as a correct record of the meeting:	
Date:	02.12.2021
Signature:	
Name:	Hattie Llewelyn-Davis
Title:	Trust Chair

Trust Board Meeting in Public
Action Log 02.12.21

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.07.10.21/07	Risk Management Approach/Appetite	Provide an update to Trust Board (for Q1) on progress with revising the risk management approach and risk appetite.	DoN&M MD	Q1 2022/23	Item not yet due.	Open
TB1.07.10.21/08	IPR	Review trajectories for each KPI in the IPR to understand what might be achievable.	Exec Team	~~TB1.02.12.21~~ TB1.03.02.22	Focus on four key areas to begin with: Elective Recovery, Urgent Care Pathway, Quality Improvement and Staff Engagement. However, still to be agreed with the KPI owners but with a view to providing the first additions to the IPR in January 2022.	Open
TB1.07.10.21/09	Board Meeting Promotion	Consider how other organisations promote their Board meeting (with a view to increasing attendance from members of the public).	CEO HoCA	TB1.02.12.21	Actions agreed and in progress.	Closed.

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors 2nd December 20021.

Agenda item:	2.1
Presented by:	Hattie Llewelyn-Davies, Trust Chair
Prepared by:	Hattie Llewelyn-Davies, Trust Chair
Date prepared:	25th November 2021
Subject / title:	Chair's Report

Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	

Key issues: please don't expand this cell; additional information should be included in the main body of the report	To inform the Board and other colleagues about my role and to increase knowledge of the role and my accountability for what I do.
Recommendation:	The Board is asked to discuss the report, give feedback for future content and note it.

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:	Not applicable
Risk / links with the BAF:	Not applicable.
Legislation, regulatory, equality, diversity and dignity implications:	Not applicable
Appendices:	None

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1.0 Purpose/issue

This report outlines what is at the top of my agenda and what I have been doing in the last month. The aim of the report is to make my role as Chair more accountable to my colleagues and more transparent for our partners and local population.

2.0 Background

I was appointed as the new chair of PAHT following an external recruitment campaign and came into post in September 2021. I have a background in social housing and chaired two NHS Trusts before joining PAHT.

3.0 Update

I am very privileged to have been appointed as Chair of PAHT. I have been very impressed with what I have seen, read and learnt about the organisation over the last few months and am greatly looking forward to learning more. I would like to thank all the board members and other colleagues who have so generously given their time to me to help me learn more about the Trust and the way we work. I am very clear about the pressures on the organisation and so it has been really good to see the generous way I have been welcomed, despite the challenges we face at the moment.

The first priorities for me over the next six months will be:

a. To learn more about the Trust, and the system and region in which we work.
b. To work with the whole board to progress the recommendations from the reviews that the Trust has had over the last six months, including the recent CQC inspection.
c. To work with colleagues to lead the work arising from the Well Led Review undertaken by Deloitte and strengthen our governance as a consequence.

We have begun a lot of this work already, including undertaking a number of development sessions on a variety of governance issues and providing a greater knowledge of the system in which we work. We are in the process of setting up a development programme for the next six months.

We are also part way through the recruitment of a new NED. Sadly, Pam Court will leave us at the end of December and we are in the process of recruiting someone who, among other skills, is an accountant. We will appoint in mid-January. I know that everyone will miss Pam greatly and I would like to record my thanks to her for everything she has done for PAHT. I am sure we will not lose touch with her completely since she will remain an active member of our local population.

It is my intention that this report becomes more substantive as time goes on, but I hope this gives a flavour of its intentions. I welcome all questions and comments arising from it.

4.0 Recommendation

The Board is asked to discuss the report, give feedback for future content and note it.

Author: Hattie Llewelyn-Davies – Trust Chair
Date: 25.11.21

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 2 December 2021

Agenda item:	2.2							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	25.11.21							
Subject / title:	CEO Update							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report updates the Board on key issues since the last public Board meeting: - Current pressures - CQC inspection report - COVID vaccination programme - New hospital - National NHS and OD Plan - Consultant appointments							
Recommendation:	The Trust Board is asked to note the CEO report; note the progress made on key items and to ratify the offer of 4 consultant appointments, made through delegated authority to the AAC panels.							

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

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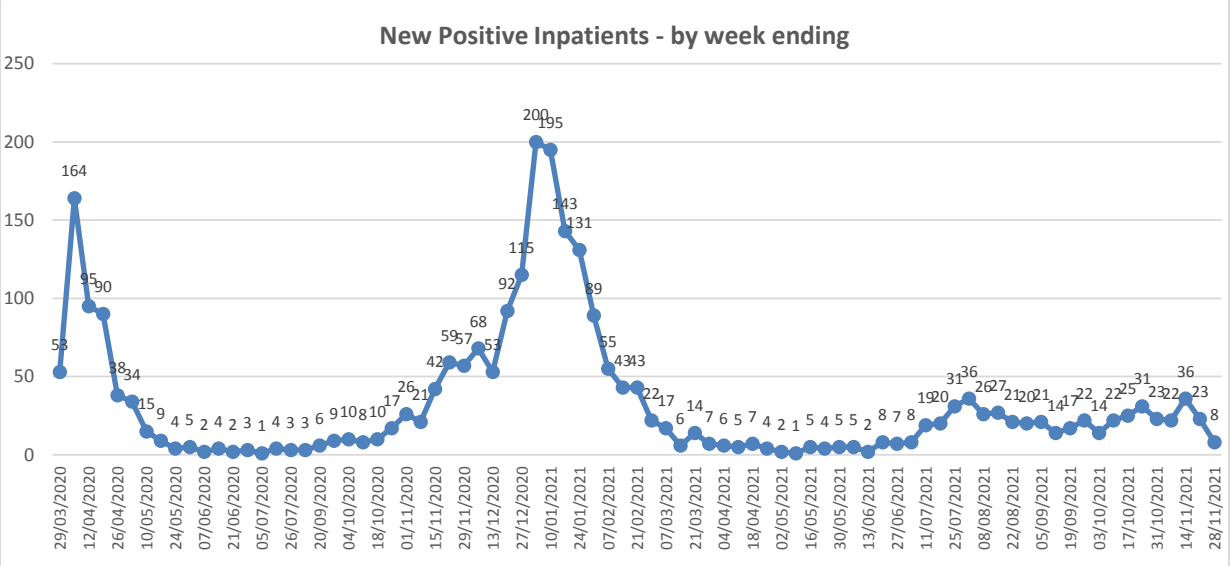
Chief Executive's Report
Trust Board: Part I – 2 December 2021

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

(1) Current pressures

I want to continue to reiterate my thanks to all my colleagues at PAHT for their hard work and amazing response to the COVID-19 pandemic, our recovery of elective activity and our response to the current unprecedented demand for urgent and emergency care services.

Despite most parts of the economy opening up and many aspects of life returning to pre-pandemic norms, we are still in the pandemic. The number of new COVID positive patients continues to fluctuate by week, averaging just over 3 new positive patients per day for the last 5 months.



As a result, we continue to run a separate 'red ED' and 'red ITU' to manage patients appropriately and have a defined COVID inpatient ward. This continues to put additional operational pressures on relevant teams.

The average age of new COVID positive admissions in recent weeks has increased from that at the end of the summer / start of the autumn, and the proportion of admissions requiring ventilation and ITU support has also started to increase. The number of hospital admissions as a proportion of new infections in the community however continues to be significantly lower than it was in the first 2 waves, aligned with the national evidence of the impact of the vaccination programme materially reducing severe illness in those infected.

All of our teams are continuing to work hard at recovering our non-covid services, significantly affected over the last year. We are continuing to work closely with NHSEI colleagues, ICS colleagues and the other acute providers across the ICS, local cancer alliance and our local independent sector colleagues to maximise every opportunity for our longest waiting and most urgent waiters to receive the interventions they require in a timely manner. We are on track to ensure there are no patients waiting for more than 104 weeks by the end of this year. Most of our diagnostic activity is now greater than pre-pandemic levels, however, our ability to restore our elective activity to pre-pandemic levels has been impacted on by the unprecedented demand for our urgent and emergency care services; October 2021 was the busiest month ever at PAHT in terms of attendances at our Emergency Department.

We continue to maintain high levels of vigilance within the hospital settings including strong compliance with the NHS IPC guidelines related to wearing masks at all times, maintaining 2m social distancing where possible and complying with good handwashing and ventilation. We have eased some of the restrictions on visiting and are continuing to run our 'Message for a Loved One' and virtual visits to support our patients. Thanks to our patients and visitors for continuing to comply with good IPC practices when on the hospital sites.

As discussed at previous Board meetings, the impact of the pandemic and the pressures and anxieties experienced by colleagues over the last 21 months cannot be underestimated. These are not subsiding, especially with our ongoing drive to recover our non-COVID services at the same time as meet the unprecedented demand for urgent and emergency care services. Running duplicate pathways in ED and ITU to support the safety of our patients and our people is also continuing to have a significant impact on our people. As a result of the pressures described, we continue to see an increased rate of sickness absence and a reduction in fill rates for shifts put out to bank and agency, further compounding the pressures on colleagues. We continue to enhance our health and wellbeing support for all colleagues who continue to remain under considerable strain and pressures.

(2) Care Quality Commission (CQC) inspection report

Since the last Board meeting, where I outlined the detail, initial feedback and Section 31 notice from the formal CQC inspection of our services between 6 July 2021 and 6 September, we have received the final formal report. CQC colleagues published this on 17 November.

The ratings scorecard by core service from this inspection is shown below.

Rating for The Princess Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← Nov 2021	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Requires Improvement →← Nov 2021	Requires Improvement →← Nov 2021
Services for children & young people	Good Jul 2019	Good Jul 2019	Outstanding 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
End of life care	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Outpatients and diagnostic imaging	Good Oct 2016	Not rated	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Good Oct 2016
Surgery	Requires improvement Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Urgent and emergency services	Inadequate →← Nov 2021	Good Mar 2020	Good Mar 2020	Requires Improvement →← Nov 2021	Inadequate →← Nov 2021	Inadequate →← Nov 2021
Maternity	Requires Improvement →← Nov 2021	Requires Improvement →← Nov 2021	Good Jul 2019	Good Jul 2019	Requires Improvement →← Nov 2021	Requires Improvement →← Nov 2021
Overall	Requires Improvement →← Nov 2021	Requires Improvement →← Nov 2021	Good →← Nov 2021	Requires Improvement →← Nov 2021	Requires Improvement →← Nov 2021	Requires Improvement →← Nov 2021

The black arrows show how relevant ratings have changed by domain for each of the core services inspected. CQC colleagues rated all 8 areas that they inspected as the same as they rated them in the last inspection for each of those areas.

Consequently, we have remained as 'Requires Improvement' overall as a Trust and our core services of medicine and maternity have remained 'Requires Improvement' and our Urgent and Emergency care (UEC) services have remained as 'Inadequate'.

The detailed report recognised the pressure that the pandemic has had on our people and also the positive approach that colleagues have within the organisation:

- "Staff we spoke with were passionate about delivering quality care and focussed on patients' needs"
- "All staff were committed to continually learning and improving services"
- "The service had an open culture where patients, their families and staff could raise concerns without fear"
- "Staff felt respected, supported and valued. They were focused on the needs of patients receiving care"

The patient panel and how it works and engages across the Trust was highlighted as excellent practice and unique across the region and aligns with their fantastic achievement of winning the Queen's Award for Voluntary Services last year.

Across all 3 of the core services inspected there were a number of consistent themes of good practice, outlined below, with other areas of good practice highlighted individually within each of the services:

- Commitment of staff
- Continuous learning and improving services
- COVID management
- Use of PPE
- Clinical waste disposal
- Establishment reviews
- Management of patient safety incidents
- Review of deaths

CQC colleagues outlined a number of areas for improvement in the report for each of the core services inspected, and the local teams are already addressing these with clear plans and actions; progress against which will be reported regularly through the Quality and Safety Committee (QSC).

As well as the specific improvements required in each service, there were some consistent themes for improvement across all areas, which will be addressed with a more Trustwide approach, including:

- Compliance with mandatory training (general); doctors particularly)
- Compliance with safeguarding training
- Timely completion of clinical risk assessments
- Actions taken as a result of the assessments
- Consistent and high-quality clinical documentation

The Board recently approved the implementation of Nervecentre electronic record solution in ED and this is due to start to be implemented in the spring. The Outline Business Case for a Trustwide Electronic Health Record that the Board approved recently, will be presented to the national Joint Investment Committee by our Regional NHSEI colleagues in January, after which we will go out to procurement for a suitable solution. These important IT initiatives will support significant improvements

in the final 3 of the above themes. Other interim solutions are being actioned until the IT initiatives are in place.

In regard to the Section 31 notice for our UEC services, we are providing monthly progress reports and updates to CQC colleagues to show how we are improving and meeting the requirements, as well as a range of weekly data returns, aligned with the clear plans for improving and transforming our services that the local team are leading.

UEC is however not just an ED issue. Continuing to improve the flow of patients out of the ED, through Same Day Emergency Care and our Acute Assessment Unit, in to and through the inpatient wards and safely out of the hospital is needed to continue to reduce the pressure in the ED department. To support both the Section 31 notice and the unprecedented increase in demand for our UEC services, the key focus of everyone in the Trust currently is on the safe management and care of our local population requiring urgent and emergency care.

In addition to this internal focus, the current pressures on UEC being experienced require a whole system approach including our health and care partners outside of PAHT and we continue to work with our system partners to address the increasing demand for our services and the support for safe and effective discharge and the management of suitable patients in the community. For the week of 22 November, we have also been running a Multi Agency Discharge Event (MADE) with our NHS and social care partner colleagues to support quality improvement and will be able to update on the output of this at the Board meeting.

We know that we have more to do to improve all our services and we continue to strive to provide 'good' and 'outstanding' services for all of our patients all of the time. I am confident that we have the fantastic people we need to do this and that our improvement journey, the speed of which has been impacted on by the pandemic, will gain the same momentum in forthcoming months that it had pre and post coming out of quality special measures in 2018.

All of the informal and the formal feedback from CQC colleagues has been added in to our Trustwide improvement programme that is aligned with the actions required to deliver out long term strategy; PAHT 2030.

(3) COVID vaccination programme

90% of PAHT colleagues have now had both doses of the COVID-19 vaccination and 77% of all colleagues have had the booster vaccination.

The government recently announced the plan that from 1 April 2022, all NHS staff and volunteers working in England who have face to face contact with service users will need to be doubly vaccinated unless medically exempt. This is in addition to the requirement for all care home staff to be fully vaccinated. This needs to be formally approved by parliament but is expected to come in to effect.

To be able to comply with this, any colleagues not medically exempt, will need to have their first COVID vaccination by the end of January. Our people and SHaW teams will work closely will all individuals who are not yet vaccinated to support them on an individual basis and will also work closely with union representatives and staff networks. All new adverts will include the need to prove vaccination status and the people team will continually assess the risk to each of the services from 1 April through a workforce planning approach.

Thank you to all colleagues who either helped to coordinate and run the vaccination programme or volunteered to be a vaccinator.

(4) New hospital

We continue to work at pace with the development of the new Princess Alexandra Hospital in conjunction with the national New Hospital Programme (NHP). Our Outline Business Case is continuing to be developed and we are expecting to be able to submit this in March 2022, subject to approval to proceed from the NHP.

(5) National NHS HR and OD Plan

On 22 November, Prerana Issar, NHSE Chief People Officer, launched a 10 year strategy for how the NHS HR and OD function will develop. Titled *The future of NHS human resources and organisational development,* it includes how people teams will develop to support the delivery of the NHS People Plan, recruit more colleagues, work differently, embrace digital, support colleagues' health and wellbeing and address equality, diversity and inclusion more effectively.

Our People team will work through this with colleagues locally, across the ICS and across the region and link into our transformation programme and PAHT 2030.

(6) Consultant appointments

Following an AAC panel on 11 November, 4 offers of appointment as a consultant at PAHT have been made to colleagues to work in our Emergency Department:

- Dr Nurdin Mohamed Hajinur
- Dr Zahidur Rahman
- Dr Rishi Gupta
- Dr Ranjit Ponnusamy

This is fantastic news for the department and the Board is asked to ratify the offer of these appointments, made through delegated authority to the AAC panel.

Author: **Lance McCarthy, Chief Executive**
Date: **25 November 2021**

The Princess Alexandra Hospital NHS Trust

2.3

Trust Board Meeting – 2 December 2021

Agenda item:	2.3
Presented by:	Fay Gilder - Medical Director
Prepared by:	Lisa Flack – Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Quality Governance
Date prepared:	23 November 2021
Subject / title:	Significant Risk Register

Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√

Key issues:	This paper presents the Significant Risk Register (SRR) for all our services. The Significant Risk Register (SRR) is a snapshot of risks across the Trust at a specific point and includes all items scoring 15 and above. The overall number of significant risks on the register has reduced from 69 to 62 (table 1 and section 2). The themes for the 11 risks scoring 20 on the SRR are: • Seven for operational pressures: two ED access standard compliance, two referral to treatment standard compliance, one Cancer-waiting times, and one bed pressures in medicine on Covid-19 register (unchanged). • Three for our people covering medical staffing vacancies in anaesthesia (new), medical consultant cover for obstetrics and nursing vacancies in paediatric emergency and urgent care unit (new). • One for our patients covering: electronic storage of maternal CTG reports Actions taken and mitigations in place in section 3 No new risks scoring 15 and 16 raised since 2 September 2021
Recommendation:	Trust board are asked to review the contents of the Significant Risk Register

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

Previously considered by:	Risk Management Group reviews risks on a rotation; each service is monitored quarterly as per annual work plan. This paper was reviewed by Senior Managers Team on 14 September 2021
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and the BAF

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Legislation, regulatory, equality, diversity and dignity implications:	Management of risk is a legal and statutory obligation
Appendices:	Nil

1.0 Introduction

This paper details the Significant Risk Register (SRR) across the Trust; the registers were taken from the web based Risk Assure system on 27 October 2021. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

There is an annual work plan (AWP) to ensure each areas register has a review in detail and on rotation. During Covid-19 wave 2, meetings focused on significant risks, new and emerging risks.

2.0 Context

The Significant Risk Register (SRR) is a snapshot of risks across the Trust at a specific point and includes all items scoring 15 and above. The risk score is arrived at using a 5 x 5 matrix of consequence x likelihood, with the highest risk scoring 25.
In line with the new quality governance structure we are reviewing how risk is managed as an organisation with additional training been provided to staff on how we to manage risks at a local level.

There are 62 significant risks on the risk register, decreased from 69 in the paper discussed in August Trust Board. The breakdown by service is detailed in the table below.

Table 1 – Significant risks by service	**Risk Score**				
	15	**16**	**20**	**25**	**Totals**
Covid-19	1 (1)	0 (0)	1 (1)	0 (0)	**2 (2)**
Cancer, Cardiology & Clinical Support	2 (2)	8 (8)	0 (0)	0 (0)	**10 (10)**
Communications	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Estates & Facilities	0 (0)	4 (3)	0 (0)	0 (0)	**4 (3)**
Finance	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Health Safety and Resilience **(formerly Non-Clinical Health & Safety)**	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Information Data Quality and Business Intelligence	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
IM&T	1 (1)	2 (2)	0 (0)	0 (0)	**3 (3)**
Integrated Hospital Discharge Team	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Learning from deaths	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Nursing	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Operational	2 (2)	1 (1)	4 (4)	0 (0)	**7 (7)**
Research, Development & Innovation	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Workforce	1 (0)	0 (0)	0 (0)	0 (0)	**1 (0)**
FAWs Child Health	2 (3)	0 (0)	1 (1)	0 (0)	**3 (4)**
FAWs Women's Health	5 (5)	3 (3)	2 (2)	0 (0)	**10 (10)**
Safeguarding Adults	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Medicine	2 (3)	0 (0)	0 (1)	0 (0)	**2 (4)**
Surgery	0 (3)	3 (3)	3 (4)	0 (0)	**6 (10)**
Urgent & Emergency Care	1 (1)	3 (4)	0 (1)	0 (0)	**4 (6)**
Totals	**20 (24)**	**31 (31)**	**11 (14)**	**0 (0)**	**62 (69)**

(The scores from paper presented at SMT in September and Trust Board in October 2021 are detailed in brackets)

3.0 Summary of risks scoring 20 and above

There are 11 risks with a score of 20, a summary of these risks is below and all new risks are detailed:

3.1 Our Patients

3.1.1 Electronic storage of Cardiotocography (CTG) for obstetrics

- The Trust needs electronic storage of CTG to cover antenatal and intrapartum care, (20202/06 raised in June 2020, score adjusted as software programme requires investment.
  Action: Currently all notes are available in paper and the team make copies where there is a known outcome that the CTG will be required for a review post-delivery. The team are awaiting an update to the server to ensure that all CTGs can be stored centrally.

3.2 Our People

3.2.1 Consultant cover in obstetrics

- Consultant cover achieves 82 hours per week including the extra four hours at the weekend associated with extra ward rounds as recommended in the Ockenden report, against the national requirement for availability at 98 hours a week for units with 4,000-5,000 deliveries per annum. There is a high potential for obstetric consultants needing to be called into the trust (2020/10/01 December 2020). Our unit delivers approx. 3,800 per annum, which means we should have 60 hours of cover, but we are aspiring to be better than the minimum.
  Action: All consultant job plans were reviewed. Recruitment is planned for two new WTE substantive roles, staff are due to come off the on call rota for health reasons, and so we are unlikely to be at 98 hours in the short term. Once the new Clinical Director is in post, the intention is to complete a work force review as part of the work on the Maternity Strategy. A hot week consultant role is in place, to ensure there are twice daily ward rounds on labour ward as per Ockenden recommendations.

3.2.2 Nursing cover for paediatric emergency and urgent care unit

- **NEW:** Paediatric ED nursing workforce has vacancies (4WTE) and high numbers of staff on maternity leave (8WTE), with further staff to go off over coming months (4WTE). This is impacting daily staffing cover (PED03/03/2021 raised in March with score increased in October as result of increasing numbers of staff off the rota).
  Action: Additional staff sourced through NHSP and agency, with rolling band 5 posts out to advert. Staff moved from Dolphin ward to cover ED so qualified workforce in both areas adjusted to meet the patient acuity and skill mix dependency. Paediatric ED attendance increased by 10% in last year but a reduction in the numbers of patients being admitted also seen so ward acuity can support the sharing of the team across both areas and not compromising safety.

3.2.3 Medical cover for the anaesthetic service

- **NEW:** Insufficient numbers of anaesthetists of all grades impacting the staffing rota and being able to flexibly cover during out of hours periods

(Anae001/2018 raised November 2018 and score increased in October as elective activity lists are restricted to six per weekday).
Actions: daily review of rota, shifts out to NHSP/locum agency, recruitment is ongoing with three consultants recently appointed, start date to be confirmed. Emergency and urgent elective workload is prioritised. Plan to develop business case to increase establishment based on increasing demands on the service

3.3 Our Performance

3.3.1 ED performance

Two risks regarding achieving the four-hour Emergency Department access standard

- Compliance with the statutory standard for the Emergency department (ED) (001/2017 on operations team register since April 2014)
- Achieving the standard of patients being in ED for less than 12 hours (002/2016 raised July 2016 on operational team register)
  Actions: Comprehensive ward bed plan and forecasts by speciality level demand and capacity in place. Internal professional standards agreed and trackers review compliance. Rapid assessment and treatment process monitoring flow through department. Increasing consultant presence in ED until 22.00 hours, opening of the new acute admissions unit to facilitate admissions, actions taken on safety rounds, timely escalation with clear trigger and daily patient tracking of discharges.

3.3.2 Cancer access standard

- Not achieving 85% of all patients referred by GP to receive treatment within the cancer 62 day standard (005/2016 on register since July 2016)
  Actions: Patient target list has granular information for oversight of individual patients on cancer pathway to monitor against escalation triggers. Recovery plan in place and trajectory monitored.

3.3.3 Referral to treatment standard

Two risks associated with performance against the national standard

- Risk of 52-week breaches because of the pandemic, pauses to OPD clinics and elective surgical activity. The numbers of patients waiting between 40 to 52 weeks is monitored (Nil over 52 weeks) and tracked by operational teams (Operational register 006/2017)
- Activity recovery to treat all patients within relevant time limits (S&CC004/2020B on register since January 2021)
  Action: Working with STP partners to manage paediatric urology, patients booked in order of clinical priority, monitoring of PTL continues weekly. Continue with use of independent sector. Cancer PTL reviewed daily, weekly for remainder of specialities. Monthly performance boards review performance and planned elective work.

- Achieve SCC 92% RTT standard, risk of non-compliance (S&CC002/2015 raised 2015 with score amended in March 21 due to worsening position)
  Action: patients are risk stratified as per NHSI guidance. Elective programme recommenced March 21.

3.3.4 Bed pressures in Medicine

- Significant pressure on medical beds due to Covid-19 and ongoing increased non Covid-19 emergency demand (C19-058 on Covid-19 register).
  Action: Close forecasting of Covid demand and review of elective activity and where necessary cancelling of elective surgery has enabled the Trust to have adequate capacity ahead of winter pressure. Acute Covid regional transfers can be completed as required to maintain safety.

3.4 Our Places: Nil

3.5 Our Pounds: Nil

4.0 New risks with a score of 15 and 16 raised since 1 September 2021

No new risks with a score of 15 or 16 have been raised in this time period

5.0 Recommendation

Trust board are asked to review the contents of the Significant Risk Register

Author: Lisa Flack – Compliance and Clinical Effectiveness Manager
Sheila O'Sullivan – Associate Director of Quality Governance

Date: 23 November 2021

The Princess Alexandra Hospital NHS Trust

2.4

Trust Board – 2 December 2021

Agenda item:	2.4
Presented by:	Heather Schultz – Head of Corporate Affairs
Prepared by:	Heather Schultz – Head of Corporate Affairs
Subject / title:	Board Assurance Framework 2021/22 – December update

Purpose:	**Approval**		**Decision**		**Information**		**Assurance**		
Key issues:	The Board Assurance Framework is presented for review and approval. The risks have been updated with executive leads and reviewed at the relevant committees during November. It is proposed to increase the score for one risk: BAF risk 3.5 New Hospital - risk score to increase from 16 to 20. An overview of all the risks is included in Appendix B and the full BAF is attached as Appendix C.								
Recommendation:	Review and approve the changes to the BAF and the risk score for Risk 3.5.								

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:	NHC, QSC, WFC, PAF and EMT in November 2021.
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance.
Appendices:	Appendix B – BAF dashboard Appendix C – BAF November 2021

Board Assurance Framework Summary 2021.22

Ref.	Risk description	Year- end score (Apr 21)	June 21	August 21	Oct 21	Dec 21	Feb 22	Year-end score (Apr 22)	Trend	Executive lead
Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population										
1.0	COVID-19: Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered.	16	12	*16 Increased score	16	16			↔	CEO/ DoN&M
1.1	Variation in outcomes resulting in an adverse impact on clinical quality, safety, patient experience and 'higher than expected' mortality.	16	16	16	16	16			↔	DoN&M/ MD
1.2	EPR: The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	16	16	16	16	16			↔	DoIMT/ CIO
Strategic Objective 2: Our People – we will support **our people** to deliver high quality care within a compassionate and inclusive culture that continues to improve how we attract, recruit and retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.										
2.3	Workforce: Inability to recruit, retain and engage our people	12	12	12	16* Increased score	16			↔	DoP
Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.										
3.1	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20	20	20			↔	DoS
3.2	Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	16	16	16	16	16			↔	DoS
3.5	There is a risk that the new hospital will not be delivered to time and within the available capital funding.	16	16	16	16	20* Increased score			↑	DoS
Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators										
4.2	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	16	16	16	20* Increased score	20			↔	COO
Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.										
5.1	Revenue: The Trust has established an indicative annual breakeven budget for 21/22. For the first half of the financial year (H1) income allocations are new and are linked to System envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement. For the second half of the year (H2) the national finance regime is under development and therefore allocations available to the Trust are uncertain.	New risk	12	12	12	12			↔	DoF
5.2	Capital: In year delivery of the Trust's Capital programme within the Capital Resource Limit and ICS allocations.	New risk	12	12	12	12			↔	DoF

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2021-22

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
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	Strategic Objectives 1-5													
BAF 1.0		**COVID-19:** Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on staffing levels, staff health and wellbeing, operational performance and patient outcomes.	Causes: i) Highly infectious disease with emerging new variants ii)Human Factors: Failure of public to adhere to Public Health messages and increasing Covid demand iii) Sustainability of supply chains during peak covid periods iv) Limitation and configuration of PAHT estate v) Vacancy and absence rates vi) Public perceptions around accessing services as normal	**5 X 5= 25**	Chief Executive /Deputy Chief Executive supported by Executive team QSC	i) Level 4 national incident declared by NHS England reduced to level 3 March 21st 2021 ii) PAHT incident co-ordination centre and incident management team established iii) COVID-19 incident management governance structure in place iv) Compliance with national directives v) Ongoing engagement with ICS and Local Resilience Forum, Local Delivery Board re-instated vi) COVID-19 patient pathways instigated vii) Staff being redeployed to provide additional support ix) Daily executive oversight of incident management x) Recovery and restoration planning (PAHT/ICP and ICS) xi) Separation of hospital into Covid and Covid free areas xii) Use of independant sector for elective patients xiii) Staff vaccination programme xiv) Engagement with critical care network xv) Back to Better Campaign launched xvi) Staff health and wellbeing initiatives introduced xvii) Nosocomial death review process in place	i) Incident Management Team Meeting ii) Strategic Incident Management Cell iii) IPC Cell and Infection Control Committee iv) Site Management Cell v) Communications Cell vi) People Cell viii) Clinical Cell ix) Incident management group	i) Incident management action and decision logs ii) QSC updates monthly from (March 2020 to November 2021) - ongoing iii) Trust Board updates (March, to December 2021) iv) Recovery Plans and submissions (Recovery paper to Board August 21 and paper being presented to PAF Nov, Trust Board Dec '21) v) Covid risk register	**4x4=16**	i) Adaptability and configuration opportunity of clinical areas	None.	Nov-21	Score to remain at 16.	**3x3=9 ~~September~~ February 2022**
			Effects: i) Increased numbers of patients and acuity levels ii) Shortages of staff, staff shielding and increased sickness; **staff fatigue and reduced resilience** 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							Actions: i) Critical network support ii) Surge planning: iii) Second Covid ward being prepared iv) Maximising elective daycases				

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	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population													
BAF 1.1		Variation in outcomes resulting in poor clinical quality, safety and patient experience ~~and 'higher than expected' mortality.~~	Causes: i) Unwarranted variation in care ii) System wide flow iii) Workforce gaps	**4 X 5 = 20**	Director of Nursing/ Medical Director **Quality and Safety Committee**	i) Quality and safety governance structures in place ii) Robust Appraisal/ medical and nursing iii) End of Life and deteriorating patient simulation programme for all staff, across ICP and ICS iv) Education & training in communication skills such as breaking bad news training. v) Sharing the Learning Programme vi) Commissioner reviews and engagement in quality and safety processes vii) Risk Management Training Programme and refresh of the risk management strategy 2021/22 viii) FTSUG's and 5 clinical FTSUG's appointed ix) Electronic handovers, Hospital at Night and E-Obs and observation compliance reports x) Schwartz Rounds xi) NHSI/NHSE Oversight xii) Patient Experience Strategy xiii) NED lead appointed for Mortality xiv) Mortality Strategy including dashboard in development , tracker, updates on work streams and learning from deaths. SMART software database implemented in July 21 xv) '15 steps' walkabouts (on hold over Covid and starting August 2021)- appreciate enquiry to commence August 21 xvi) Nursing Establishment review (bi-annually) and successful nursing recruitment campaign xvii) Safer Staffing policy and use of SafeCare to inform daily staffing xviii) Real time patient feedback implemented across all wards xix) Robust management of variations in neonatal outcomes xx) Engagement in external reviews MBRRACE,HSIB and LeDeR and Healthcare Safety Investigation Branch (maternity) xxi) Medical examiners (MEs) and Lead ME appointed and Strategic Learning from Deaths~established xxii) Complaints workshops held and development of PE strategy as part of Quality strategy (Sept 21) xxiii) Joint GIRFT and Model Hospital quality improvement programme xxiv) Appointment of medical PS&Q leads underway (July 21) xxv) Quality peer review process in place xxvi) Covid-19 governance structure/meetings in place xxvii) HCG restructure ~~cancelled~~ xxviii) Appointment of DMD (quality)	i) National Surveys and audits, national quality audits ii) Cancer Survey iii) CEO Assurance Panels iv) Incident Management Group meetings, SIAP 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 Optimisation Group xii) End of Life xiii) AKI & Sepsis Group xiv) Urgent Care Board xv) Deteriorating Patient Group xvi) Cardiac arrest review panels xvii) Twice weekly Long Length of Stay meetings xviii) Quality Compliance Improvement Group, Clinical Compliance Group xxix) ICS Oversight Meeting Monthly - section 31 notice)	i) CEO Assurance Panels (as required) ii) Reports to QSC on Patient Experience (bi-monthly), monthly Serious Incidents, monthly Safer Staffing, Patient Panel (bi-monthly) , Safeguarding, monthly Infection Control and Covid-19 updates Quality and safety data in the Integrated Performance Report iii) Monthly Mortality Improvement report to QSC including updates on ME reviews and monthly IPR report iv) ~~Dr Foster reports~~, CQC inspection reports (ED, Medicine, Maternity, Well-led inspection report November 21, Section 31 notice issued and IRMER May 21 (November 21 - notice lifted) and GIRFT reports) v) Dr Foster reports and engagement vi) Quarterly Coding reports to PAF vii) Freedom to Speak Up Guardians quarterly reports to WFC viii) Patient stories and learning from deaths reports to Public Board meetings (bi-monthly) ix) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) x) TARN review (March 21) xi) Current HSMR ~~104.27~~ 98.7 and TARN mortality 'better than expected' xii) Nervecentre business case for ED approved (November 21)	**4x4=16**	Lack of modernisation in some reporting processes including: i) Clinical audit plan developed and to be implemented - improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site footprint and bed constraints iv) NICE oversight and management of compliance with guidance v) Frequency and consistency of approach to M & M meetings vi) Clinical documentation not supported by existing infrastructure **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey 2020/21 action plan in place (Sept 2021) iii) Ongoing work with Dr Foster in relation to mortality iv) EPR development and OBC to PAF/Board September 2021 - approved v) Developing PAHT Quality Strategy vi) Medical records Committee leading programme of work to improve documentation vii) Review of Mortality Strategy viii) Review of departmental clinical governance meetings - agenda, attendance and frequency ix) QAS metrics to be included in PRMs x) Raising awareness of 5 patient safety priorities HCG governance structures and IPR reporting x) Prism working with UEC to improve safety and quality for patients	i) Demonstrating an embedded learning programme from Board to ward. ii) Inconsistent re-audit iii) Lack of data to support information on progress with some patient safety metrics.	01/11/2021	**Risk rating to remain at 16.**	**4x3=12 March 2022**
			Effects: i) Higher than expected Mortality rates ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Poor reputation and low staff morale v) Patient harm vi) Loss of confidence by external stakeholders											

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	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population **Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way**													
BAF 1.2		**EPR** The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	Causes: i) Poor clinical engagement with the system, due to lack of usability and limited functionality. ii) Timely system fixes/enhancements iii) Static functionality	**5 X 4= 20**	Chief Information Officer/Chief Operating Officer **Performance and Finance Committee**	i) Fortnightly DQ meetings held at ADO level ii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iii) Performance Mgt Framework in place. iv) User Training programme. v) Super users in place to deliver focused support. vi) Access Policy vii) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) viii) Development of capacity planning tools/information ix) Weekly ICT/COSMIC meetings ongoing x) New EPR Board established – chaired by CEO xi) EPR replacement programme established xii) EPR SOC developed and benefits realisation with link to HIMSS xiii) EPR OBC developed and to be presented to Board September 21 xiv) OBC reviewed and approved by Trust Board, submitted for regional and national approval. Anticipated Jan 22	i) Access Board ii) EPR Programme Board (to be chaired by CIO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews	i) Weekly Data Quality reports to Access Board and daily DQ reports to organisation ii) Quarterly E-Health reports to PAF October 21 DQ reports to PAF ~~and quarterly ICT updates to PAF~~ (21) iii) Reports to EPR Programme Board iv) EPR SOC approved by SMT, PAF and Board (March to April 21 and May 21 Trust Board). Regional team approval received to proceed straight to OBC. v) EPR OBC approved by SMT (02/09), considered by PAF and approved by Board September 21	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams to ensure completeness of data quality 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. Supplier requests to remove contractual requirement to comply with national standards e.g. ISNs - 2 risks associated 1) exposes PAH to technical compliance issue as supplier not compelled to comply and 2) financial risk – assurance PAH have declined supplier request on advice from NHSD.	Nov-21	**Risk rating unchanged**	**4x3=12** **end of 2022**
			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:** SOC approved and OBC developed to procure new EPR solution. Ongoing user training programme underway.				

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The Princess Alexandra Hospital Board
Assurance Framework 2021-22

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Positive/negative assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
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		Strategic Objective 2: Our People – we will support our people to deliver high quality care within a within a compassionate and inclusive culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**												
2.3		**Workforce:** Inability to recruit, retain and engage our people	**Causes:** i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels viii) Covid -19 **Effects**: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation. Covid-19 effects - delays in workforceplanning, recruitment programmes and additional health and wellbeing pressures on teams	**5 X 4 =20**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) Event in a Tent held annually viii) Staff recognition awards held locally and trust wide annually ix) Enhanced controls around temporary staffing x) Line Manager development programme underway xi) Behaviour workshops held xii) New consultant development programme launched xiii) Staff engagement groups and Staff Council xiv) International recruitment programme for nurses and ED doctors xv) Medical staffing review underway (Medical Safer Staffing) xvi) Additional recruitment ('Bring back staff') during Covid xvii) Provision of Health and Well-being support during Covid-19 including psychological support and absence line.Back to Better campaign launched March 21 xviii) Communications Strategy approved June 2020 xix) NHS People Plan and ICS People Plan xx) Webinars during Covid (BAME, Vaccination)	i) WFC, QSC, SC, PAF, SMT, EMT. ii) People board iii) JSCC, JLNC iv) PRMs and health care group boards v) People Cell established (Covid-19)	i) Workforce KPIs reported to WFC bi-monthly and inluded in IPR (monthly) ii) People strategy deliverables iii) Staff survey results 2020 (reported March 2021) iv) GMC survey (July 21) v) WRES and WDES reports 2021 (WFC and Board) vi) OD Framework approved (WFC June 2020) vii) Medical workforce plan update to WFC November 2020 and June 2021 viii) Dignity at Work report January 2021 ix) Culture and values refresh (EIAT, September 2021) x) Compassionate and inclusive leadership session (Board development session March 21) xi)Here to hear listening event and survey xii Deloitte well-led review survey xiii) NHSE/I pulse survey xiv) NHSE/I FTSU assessment xv) Anti-racism Board session xvi) Board seesion on leadership	**4 x4 = 16**	Pulse surveys targeted for all staff Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Roll out of e-rostering to all areas Safer Medical Staffing plan in development CV19 staff vaccination implementation plan Actions i) ~~P~~lans for medical staff Jan '22 ii) Extranet for staff - Q3 21/22 iii) Staff survey underway ~~action plan~~ iv) Review of raising concerns (increase in FTSUGs - completed, lead FTSUG Q3, senior inclusion lead Q3) vi CV19 staff booster implementation plan - Q3 vi) NHSE/I Health and wellbeing framework assessment - Q3 vii) Allocate rostering system review assessment and plans - Q2 vii) Review of management and leadership development provision - Q3 viii) Deloitte well-led review actions - Q3 to 2022/23 Q2	None identified.	01/11/2021	**Risk score to remain at 16**	**4 x2 = 8** **March 2023**

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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) Inability to undertake planned preventative maintenance viii) Lack of decant facility to allow for adequate repair/maintenance particularly in ward areas.	**5 X 5= 25**	Director of Strategy **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report received (£105m) iii) Potential new build/location of new hospital iv) Capital programme - aligned to red rated risks. v) STP Estate Strategy developed and approved. vi) Modernisation Programme for Estates and Facilities underway vii) Robust water safety testing processes viii) Annual asbestos survey –completed and red risks resolved. ix) Trust's Estate strategy being developed x) Annual fire risk assessment completed and final report received, compliance action plan being developed. xi) New estates and facilities leadership team in place with authorised persons in posts x) Sustainability Manager in post xi) Emergency Capital funding £4.3m xii) Compliance Manager appointed xiii) Significant capital programme for year c.£40m	I) PAF and Board meetings ii) SMT Meetings iii) Health and Safety Meetings iv) Capital Working Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings viii) Monthy Estates Board meeting	i) Reports to SMT (as required) ii) Signed Fire Certificate iii) H&S reports quarterly to PAF. iv) Ventilation assurance report v) Annual and quarterly report to PAF: Estates and Facilities quarterly report) vi) IPR monthly ix) Annual Sustainability report to PAF (May 2021 and update to PAF Sept 21) x) Capital projects report (PAF monthly, Trust Board Nov 2021 and weekly updates at EMT, reports to SMT in October 21)	**5x4=20**	i) Planned Preventative Maintenance Programme (time delay) ii) Sewage leaks and drainage iii) Electrical Safety/Rewiring - ongoing iv) Maintaining oversight of the volume of action plans associated with compliance. **ACTIONS:** i) EBME review underway ii) Green Plan in development (PAF in November 21 and Trust Board in December 21)	i) Estates Strategy /Place Strategy developing within ICS ii) Compliance with data collection and reporting iii) PPM data not as robust as required	01/11/2021	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

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BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iii) The resources required for delivery at a programme and workstream level have not been defined or secured iv) The current governance structure is under development given the shift in focus from planning to delivery. v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS Trust Board	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) STP Estates Strategy being developed. viii) STP Clinical Strategy in place ix) STP wide Strategy Group implemented x) Independant STP Chair and independant STP Director of Strategy appointed. xi) System agreement on governance and programme management xii) New ICS governance and structure meetings set up with PAH attending task-finish groups	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 (Board session on ICS governance Dec 21)	**4 X 4= 16**	Lack of ICS demand and capacity modelling. ~~Implications of white paper and statutory changes.~~ **ACTIONS:** System leadership capacity to lead ICS -wide transformation		01/11/2021	**No changes to risk rating.**	**4x3=12 March 2022**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership													
BAF 3.5		**New Hospital:** There is a risk that funding for the new hospital will not be sufficient to deliver the preferred way forward and that the new development can not be delivered to the timescale needed to meet increasing demand.	Causes: ii) Funding is not made available for the preferred way forward ii) enabling works are delayed iv) ~~there is a delay to approval of the business case~~ new design guidance from NHP results in a substantial redesign v) the required SoA can not be delivered within the agreed affordability envelope vi) the land purchase is not completed successfully and in a timely manner vii) Development of new standards and programme approach by NHP has delayed ~~may delay~~ OBC viii) Advisors stood down due to lack of funding Effects i) Hospital remains on existing site and continued investment in existing site will be required ii) Unable to deliver all of the service transformation iii) Unable to manage system demand due to lack of transformation iv) Digital transformation not complete v) Poor staff retention due to failing infrastructure vi) Unable to reach outstanding service provision due to failing infrastructure vii) New hospital~~, if delayed,~~ will be undersized because demand management is delayed viii) Loss of clinical engagement ix) loss of public confidence	**5 X 4= 20**	Director of Strategy ~~New Hospital~~ Strategic Transformation Committee from January 2022	i) Detailed programme of work ~~ii) Monthly meetings with national cash and capital team~~ ~~iii) Weekly meetings with regional team~~ ~~iv) Weekly meetings with landowners~~ ii) New national team appointed to provide transaction support and bi-weekly meetings with lead for scheme iii) ~~detailed review~~ continual monitoring of proposed solution to ensure it is deliverable within the available funding envelope iv) National Programme design convergence review initiated v) Regular meetings with stakeholders, MPs, Council leaders vi) Regular meetings with landowners	i) New Hospital Programme Board ii) Strategic Transformation Committee iii) Trust Board iv) External advisory meetings as required v) Reviews undertaken by NHP	i) Monthly reports to Trust Board and ~~New Hospital~~ Strategic Transformation Committee. ~~(November 2020)~~ Ii) Letters of support received from JIC. iii) confirmation received that programme management structure is appropriate. ~~iv) Expert advice received on procurement strategy.~~ v) Landowners have accepted offer in principle vi) Positive technical review feedback vii) Positive meeting between MP's and Secretary of State	**~~4x4=16~~ 4 x 5 = 20**	~~Negotiations with landowners~~ Extended delay to the DCR which is outside of the control of the Trust New lead for national programme appointed resulting in delay on issue of guidance ~~NHP Commercial strategy not agreed~~ Actions i) Support national team in areas such as ~~with~~ Design Convergence Review and commercial strategy ii) ~~Develop~~ Agree Heads of Terms for land transaction ~~iii) Complete clinical review of 1:200 drawings~~ iii) Paper on land to NHP and JIC	None.	Nov-21	**Risk score increased.**	**3x3=9** **March 2022**

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.2		**4 hour Emergency Department Constitutional Standard** Failure to achieve ED standard resulting in increased risk to patient safety and poor patient experience.	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Changes to working practice and modernisation of systems and processes iv) Delays in decision making, patient discharges and impacting on flow v) Lack of assesment and short stay capacity, lack of CDU space vi) Increase in volume of patients presenting to ED vii) Volume of ambulance patients and delays offloading patients	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) UEC improvement plans in place and monitored through the UCPB and workstreams ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Developing plans to expand the footprint and space of the Urgent Treatment Centre. vii) Local Delivery Board in place with system partners. UEC ICS Board in place with COO representation ix) ED action plan reported to PAF/Board x) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries increasing opportunities for re direction and more bookable appointments xi) Weekly Urgent Care operational meetings and Urgent Care Board in place xii) Focus on length of stay in ED for all patients xii) Think 111 First plans to be expaned, working with the national team	i) Operational meetings ii) Board, PAF and SMT meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) System Operational Group vii Urgent Care Board	i) Daily ED reports to NHSI ii) Monthly PRM reports from HCGS - development of Divisional IPR iii) Monthly IPR reported to PAF/QSC and Board reflecting ED performance (PAF, QSC Sept 21) iv) UEC deep dive presentation QSC Sept 21	**4x5=20**	i) Staffing (Trust wide) and site capacity ii) System capacity and demand pressures iii) Leadership changes being embeded and strengthened ahead of winter Actions: 1. All trust consultant escalations and awareness of current pressures 2. Review of capacity in UTC and SDEC to support attendance and walk in patients through ED 3. Review of weekly medical and nursing staffing 4. Capacity through inpatient wards and and application of red to green oversight in place 5. Daily review and panel of pathway zero patients and simple discharges 6. Executive oversight daily 7. Attendance from senior clinicans at the ED safety huddles and real time escalation of all specialty delays	None noted.	01/11/2021	**Risk score to remain at 20.**	**4x3 =12** **March 2022** **(on consistent delivery of standard - 95%)**
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.													
BAF 5.1		**Finance - revenue :** The Trust has established an indicative annual breakeven budget for 21/22. For the first half of the financial year (H1) income allocations are know and are linked to System envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement. For the second half of the year (H2) the national finance regime is under development and therefore allocations available to the Trust are uncertain.	**Causes:** The main causes of risk are : (i) The current financial regime operates under 'block contract' arrangements. There is limited capacity for Commissioner contracts to be varied. (ii) There is uncertainty of the financial regime to be operated in H2. (iii) Financial plans include a requirement to deliver CIPs with a step change in delivery required in H2 - the ability to control costs and the deliverability of CIPs will be influenced by COVID, restore and recover. (iv) The Trust has a number of cost pressures that will require mitigation. (v) Although the Trust has improved its vacancy rates it remains over reliant on temporary staffing which attracts premium costs - continued improvements in substantive recruitment is required. (vi)The CIP ask in H2 is being increased. This increases the potential for non-delivery of the CIP (vii) Elective Recovery Funding activity levels have been increased from M4. Therefore the system may not achieve the required activity levels. Consequently, this may put the reimbursement of ERF in jeopardy.	**4 X 4= 16**	**Exec leads:** DoF **Committee** : Performance and Finance Committee	**Key Controls include :** (i) Agreed H1 financial envelopes including continued levels of COVID funding. (ii) Health Care Group / Corporate performance review meetings are in place where performance is being monitored. (iii) Exec led vacancy control group. (iv) Oversight of the Trust's financial performance by the EMT, SMT, PAF, Workforce and Audit Committee. (v) Monthly monitoring of financial performance by NHSE/I through the submission of financial returns. (vi) Strengthening of financial control and governance including an improved governance process for business case investmentusiness case approval process. (vii) Development of CIP workshops and plans. (vii) Temporary staffing audit underway and focus on reduction in temporary staffing.	**Sources of Assurance :** (i) Performance review meetings - monitoring against plan and forecast (ii) Internal audit reports / Head of Internal Audit Opinion (iii) External audit opinion (iv) Cash management monitoring and adequate cash balances (v) CIP tracking (vi) Reduction in run rate spend on temporary staffing	**Positive Assurances :** (i) Delivery against YTD and forecasted plans. (ii) CIP delivery and forecast to plan. (iii) Substantial rating on internal audit reports. (iv) Unqualified value for money opinion	**4x3=12**	**Gaps in Control** : (i) Instances of non-compliance across the organisation in relation to SFIs i.e. non compliant waivers (ii) Activity and demand and capacity planning. (iii) CIP delivery (iv) Embedding management of temporary staffing costs (v) Existence of manual processes across the Trust	**Gaps in Assurance :** (i) National H2 Financial regime is under development and therefore uncertainty over allocations in H2. (ii) Fully integrated business and operational planning including demand and capacity plans. (iii) Business case benefits realisation process	01/11/2021	**Residual risk score not changed.**	**4 x 2 = 8 (Q4 2021/22)**
			Effects: (i) Challenges to meet financial control targets, including delivery of our CIP (ii) Delivery of revenue position may impact on future capital availability.							**ACTIONS:** (i) Transformational and modernisation work plans. (ii) Demand and capacity planning and modelling to be regularised. (iii) ~~Consideration being given to the~~ Introduction of a PMO. (iv) Review of Governance Manual/SFI's				

Risk Key															
Extreme Risk		15-25													
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**												
Medium Risk		4-6													
Low Risk		1-3													
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**							
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way													
BAF 5.2		Finance : In year delivery of the Trust's Capital programme within the Capital Resource Limit and ICS allocations.	**Causes:** The main causes of risk to delivery are (i) An over-subscribed capital programme. (ii) Operational pressures that may constrain the delivery of a capital scheme. (iii) Confirmation of external funding sources within a timeframe to allow projects to be completed including adequate planning and procurement preparation. (iv) Incomplete and/or untimely production of business cases that do not facilitate required approvals. (v) Single year funding settlements that do not support development of longer term / 5 year plans and management of a plan over financial years. (vi) As the ICS takes on increasing responsibilities for capital planning the Trust will be competing for capital resource across the ICS. (vii) The development of the New Hospital will continue to be a significant programme of work. (viii) Costs for building projects are increasing therefore adding pressure to the capital programme. (ix) The capital programme has an overplanning margin wich increases the risk of breaching the CRL if all projects deliver.	**4 X4 = 16**	**Exec leads:** DoF **Groups:** Capital Working Group, SMT, EMT and Performance and Finance Committee, New Hospital Committee	**Key Controls:** (i) The Trust has developed a 'Risk based' prioritised capital programme which is agreed through the capital working group, SMT, PAF and the Board. The CWG meets monthly to monitor progress on pre agreed schemes. (ii) The Risk Management Committee detail all risk that require capital investment. (iii) The Trust undertakes a six facet survey which informs of all backlog maintenance risks and how this element of capital is spent. (iv) Business cases are required for all capital investment. (v) All capital projects have a senior responsible officer and project lead and report into HCG/Corporate areas. (vi) Application of external funding for additional, ad hoc capital. (vii) Discussion with system partners to ensure that the Trust does not breach its CRL as capital allocations can be moved across the system.	**Sources of Assurance :** (i) Frontloaded capital trajectories that monitor expected performance against plans, including cashflow forecasts. (ii) YTD and forecast reports detailing progress. (including New Hospital) (iii) Internal audit reports. (iv) A prioritised capital programme that allows for flexibility and longer term planning. (vi) Business case review process verifies investments are strategic/operational and meet the Trust's requirements to achieve its objectives.	**Positive Assurances :** (i) Delivery against YTD and forecasted plans. (ii) Business cases approved timely. (iii) Substantial internal audit reports. (iv) Reduction in non-compliant waivers. (v) Approval of external funding and receipt of PDC/MoU	**4x3=12**	**Gaps in Control**: (i) Compliance to business case and approval process as this is a new process and is currently being embedded within the organisation.	**Gaps in Assurance:** (i) Improvements in forecasting trajectories and development of longer term capital programme.	13/11/2021	**Residual risk score not changed.**	**4 x 2 =8 (Q4 2021/22)**
			Effects: (i) Risk to under/overshoot of CRL.							**ACTIONS:** (i) Business Development Group is being initiated in line with the revised Capital and Revenue investment guidance				

The Princess Alexandra Hospital NHS Trust

Trust Board 2 December 2021

3.1

Agenda item:	3.1							
Presented by:	Dr Fay Gilder, Medical Director							
Prepared by:	Dr Fay Gilder, Medical Director							
Date prepared:	24 November 2021							
Subject / title:	Learning from deaths update							
Purpose:	**Approval**		**Decision**		**Information**	**x**	**Assurance**	x
Key issues: please don't expand this cell; additional information should be included in the main body of the report	No update for November from Telestra (Dr Foster) provided due to their concern regarding their own data quality. Most recent data included.							
Recommendation:	For noting and debate							

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

Previously considered by:	QSC
Risk / links with the BAF:	BAF 1.1 Variation in outcomes in clinical quality, safety, patient experience and "higher than expected mortality"
Legislation, regulatory, equality, diversity and dignity implications:	*'Learning from Deaths'* - National Quality Board, March 2017
Appendices:	

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The Princess Alexandra Hospital NHS Trust

3.1

1.0 Purpose

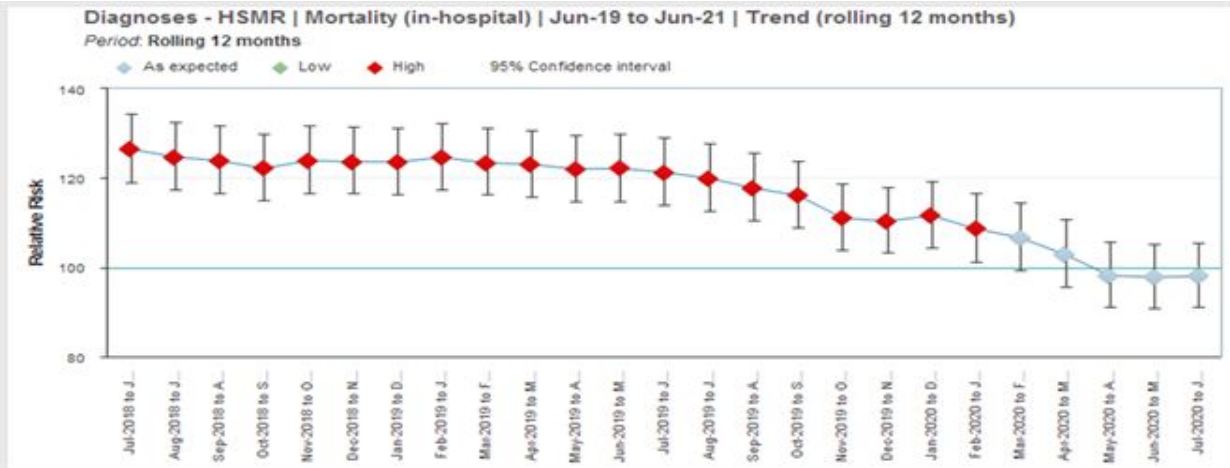
The purpose of this paper is to provide assurance on the implementation of the learning from death process, to highlight key pieces of learning and to provide progress updates on the current programme of work to improve clinical practice.

2.0 Context

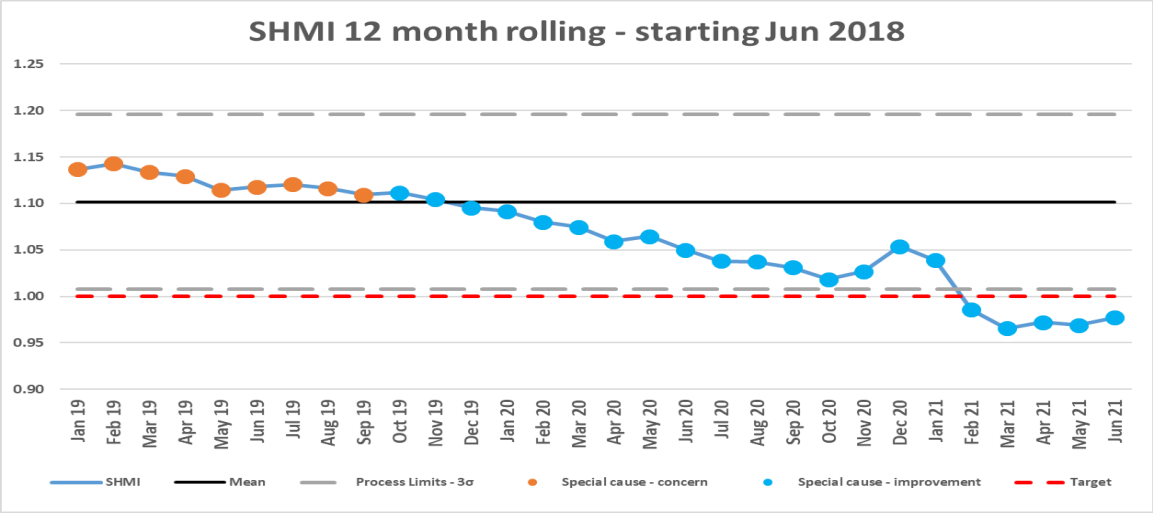
BAF 1.1 Variation in outcomes in clinical quality, safety, patient experience and "higher than expected mortality".

3.0 Key Points

3.1 Dr Foster (now known as Telestra) update



12 month rolling average – 5 data points showing as expected.
Data for august and September due in December



SHMI remains as expected.

3.2 Mortality Improvement Programmes (cyclical 3 monthly updates)

Fractured neck of femur -

The #NOF team have been re-established and are looking at a number of workstreams including:

- Identified trauma anaesthetists and the introduction of a trauma rota for anaesthetists
- Standardising trauma anaesthetic care, including the development of a set of guidelines
- MDT prioritisation of #NOF patients – standardised practice for trauma lists
- Time from ED to Tye Green – working with the team to understand root causes of delays of transfer of patients from ED and to develop a plan of targeted improvements.

End of Life

The EoL team are working on a number of streams on work including:

- The introduction of EoL training for the PAHT teams
- Sage & Thyme training, facilitators being training during September through to November to allow training of staff to start from December 2021
- The team are also working with a number of hospices to update the electronic ward folders with examples of best practice referrals. This will also form part of the training for wards.
- Quarterly audits are being undertaken of the individualised care plans, with improvements being targeted on the back of the results
  A task and finish group has also been established review use of the Treatment Escalation Plan at the trust and to understand how PPC\PPD could be incorporated within it

3.3 Medical Examiner Service

In October 94.7% of our MCCDs have been completed (national target 94.7%).

A Bereavement Officer, an additional MEO and 4 part time MEs have been appointed.

We initiated piloting community death scrutiny with St Claire Hospice on the 15th of November 2021.
Additionally we plan to roll out of GP death scrutiny with the assistance of the Clinical Director of NHS West Essex CCG as soon as our newly appointed staff have joined us

4.0 Next steps

The healthcare group restructure offers us the opportunity to embed the learning from deaths into service and divisional patient quality and safety governance and learning. This opportunity will be realised as part of the work of the Deputy Medical Director for Quality and Safety (in post January 2021 –), the Deputy Chief Nurse for Quality and the divisional patient safety and quality leads (medical and nursing).

SMART mortality software has now been in use for 3 months. A dashboard is being refined and the data will be used to support this report going forward.

5.0 Recommendation

For the Board to provide feedback on the contents of the paper to ensure a dynamic discussion and challenge of the information provided.

Author: Dr Fay Gilder, Medical Director
Date: 24 November 2021

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 02.12.21

3.2

Agenda item:	3.2								
Presented by:	Sharon McNally, Director of Nursing, Midwifery and AHPs								
Prepared by:	Erin Harrison, Lead Governance Midwife								
Date prepared:	9th November 2021								
Subject / title:	Overview of Serious Incidents within maternity services								
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x	
Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SIs) reports and a summary of the key issues be shared with Trust boards. There were 0 new maternity incidents declared since the last report. There were 0 maternity incidents closed since the last report. Maternity services currently have 6 SIs under investigation. The Maternity Improvement Board (MIB) was commenced in August this year and provides oversight of the thematic learning and actions. The work of MIB is included under section 5.								
Recommendation:	To provide assurance to the Board that the maternity service is continually monitoring compliance and learning from Serious Incidents.								
Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**				
	x	x	x	x	x				

Previously considered by:	PSQ: November 2021 QSC: November 2021
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the Ockenden report that was published in December 2020 with recommendations for maternity services.
Appendices:	N/A

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The Princess Alexandra Hospital NHS Trust

3.2

1.0 Purpose

This paper outlines the open and recently closed Serious Incidents within Maternity services with concerns, thematic analysis, areas of good practice and shared learning identified.
This is an abridged version of the report reviewed by both Patient Safety Group and the Quality & Safety Committee (patient identifiable information through case detail has been removed).

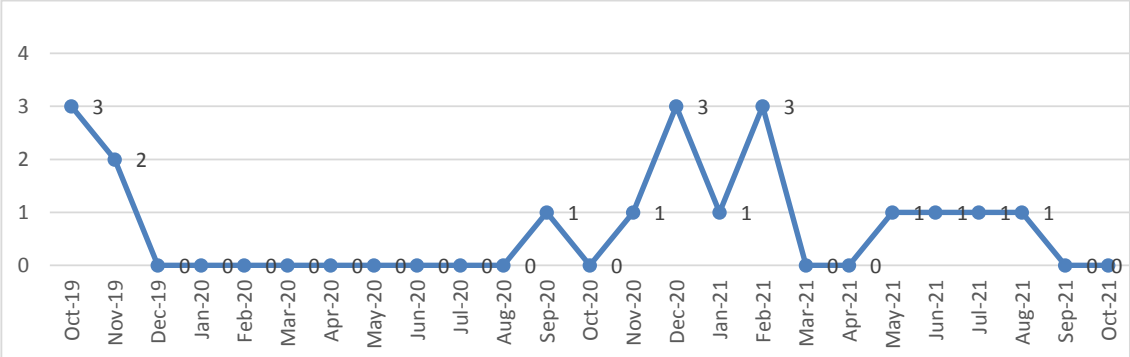
2.0 Background

The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards.

3.0 Analysis

Maternity currently have 6 SIs under investigation, 2 of which are being investigated by HSIB. Table 1 details the trend of declared SIs within the last 24 months to October 2021.

Table 1. Comparison of SIs reported for Maternity in last 24 months (to October 2021)



There were no new serious incident declared in October 2021.

4.0 Thematic Review

Table 2 details the top themes identified in maternity SIs within the last 24 months to October 2021.

Table 2. Top Themes

Total Number of SI's	Theme	Number
18	Obstetric Haemorrhage	6
	CTG interpretation	5
	Compliance with guidance	3
	Hypertension	3
	Delay in care	2
	Escalation	2

	Neonatal death	2
	Intrauterine death	2
	Hypoxic ischaemic encephalopathy	2
	Assisted delivery	2
	Perineal trauma	2
	Laceration at caesarean	1
	Fetal growth	1
	Fire	1
	Pseudomonas	1

5.0 Oversight

All highlighted concerns have been escalated at Divisional level. All incidents are discussed at the Divisional Patient Safety and Quality Group and Trust Incident Management Group and escalated where relevant for further investigation. A new executive maternity board is being established to provide assurance for quality and safety of the maternity services.

A Maternity Improvement Board was commenced on 12th August 2021 with 7 key work streams:

- Induction of Labour
- Post-Partum Haemorrhage
- Maternity Triage
- Documentation
- LocSSips
- Estates transformation and traditional care
- Handover, ward rounds and huddles

Each work stream has an identified lead and progress is reported back to the Maternity Improvement Board. This will feed into the Maternity Board/ Committee (governance framework TBA) once it has been established.

Due to operational pressure with Covid the MIB was temporarily suspended. This will be recommenced in December to ensure that improvement work continues and feeds through from floor to board.

6.0 Recommendation

It is requested that the Board accepts the report with the information provided and the ongoing work with the investigation process, learning and improvement.

Author: Erin Harrison – Lead Governance Midwife
Date: 09.11.2021

Trust Board (Public) – 02.12.21

3.3

Agenda item:	3.3
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery
Date prepared:	12.11.2021
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels and an update to Nursing and Midwifery Workforce Position – Hard Truths Report

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	Overall staffing risk rating in month: Amber ED, Paediatric and maternity staffing: Red The fill rate for overall RN/RM in month 95.9% Registered nurse and HCSW temporary staff demand have increased slightly but with a reduced fill rate. Enhanced care demand continues with a high demand for RMN specials due to the higher than normal number of patients with mental health needs or at risk being in our care The report reintroduces data on CHPPD following a pause on data collection during Covid and details information on nursing apprenticeships The vacancy rate for RN continues to reduce and is 0.5% however this masks the overall establishment demand due to Covid and elective recovery pathways
Recommendation:	The Board is asked to note the information within this report.

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

Previously considered by:	WFC.29.11.21
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: Registered fill rates by month against adjusted standard planned template. RAG rated. Appendix 2: Ward staffing exception reports. Appendix 3 : Ward Level CHPPD

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 October 2021. To provide an update on plans to reduce the nursing vacancy rate over 2020/21

2.0 BACKGROUND

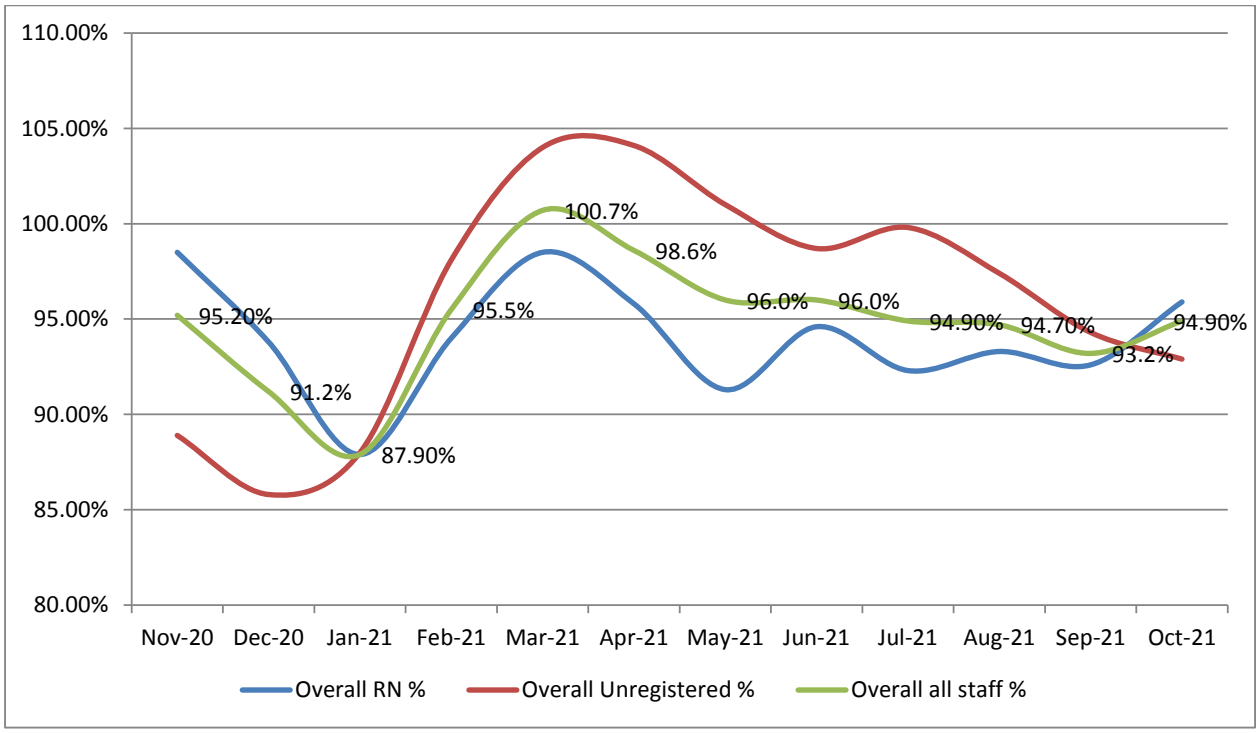
The report is collated in line with The National Quality Board recommendations (June 2016).

3.0 ANALYSIS

3.1 The Trust Safer Staffing Fill rates for October 2021 against the standard templates for overall RN/RM in month has increased to 95.9%, which is an increase of 3.3% against September 2021.

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

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
In Patient Ward average October 21	95.4%	85.5%	96.5%	103.6%	95.9%	92.9%	94.9%
In Patient Ward average September 21	89.0%	88.4%	98.1%	102.9%	92.6%	94.3%	93.2%
Variance October 21 – September 21	↑6.4%	↓2.9%	↓1.6%	↑0.7%	↑3.3%	↑2.6%	↑1.7%



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

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

Red <75%	Amber 75 – 95%	Green >95%

	Day		Night	
A&E Nursing	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
August 2021	93.1%	77.8%	94.3%	81.9%
September 2021	95.6%	89.4%	104.6%	81.1%
October 2021	99%	71%	106%	78.3%

ED fill rates are currently reported to the CQC as part of the requirements of the Regulation 31 notice. There is weekly Exec oversight of the information and mitigation worked through. Staffing huddles are focussed on prioritising ED to maintain numbers.

Recruitment of HCSW and RN's continues to be prioritised and will be supported by the Trusts new Recruitment and Retention Nurse

3.5 Fill rates by ward

Fill rates by ward have been produced against the standard planned templates (Appendix 1). 1 ward reported average fill rates below 75% for registered nurses against the standard planned template during August. This does not reflect the fluctuating patient numbers on this ward over the month due to bed closures and changes in patient acuity against the norm for this area following change of use.

3.6 Areas of concern

Paediatric ED and Dolphin Ward

Concerns remain with paediatric staffing due to impact of high rates of maternity leave and vacancies there are currently 25.95TWE vacancies equivalent to 25% vacancy within children's nursing workforce. In order to ensure safe staffing and to ensure there is adequate cover to Paediatric ED, who are seeing increased attendances up to 100% above norm, the children's nursing workforce is being supported to work across the service. The twice daily staffing huddles continue with a focus on reviewing acuity and dependency of patient's, available staff and local and national picture of children attendances and a plan to reduce in bed capacity in Dolphin to reflect the levels of staff available and the number of available beds is agreed 24 hours in advance by the senior children's nurse and consultant team at the

All alternatives including redeployment from ICS partners, international recruitment, redeployment of non-paediatric nurses to support workforce and enhanced NHSP rates to increase temporary staff fill are being considered and pursued. There are 8 new registered children's nurses who have been recruited and are in the pipeline to commence in the new year.

Maternity Service

Maternity services staffing remains challenged with high maternity leave and vacancies. Acuity and dependency are captured via the Birthrate Plus tool which is updated every four hours and captures managers escalation which is taken as a result. The 4 maternity areas labour ward, birthing unit, Samson and Chamberlain wards are seen as a single unit with staff moved to provide cover where most needed. They are supported by the continuity of carer midwives who come into the service to provide support for their caseload when required. There is are 2 on-call management posts at anyone time who are also available to provide cover if required.
The DDoN and Director of Midwifery are working closely to provide a standardised format for reporting maternity staffing however for October the following points are of note:

The Birthing Unit was closed on 18 days due to staffing issues. Staff were redeployed to other areas of the service and women were redirected to labour ward for their delivery

There were 17 red flags raised for labour ward in October, 11 of which were due to the labour ward co-ordinator unable to maintain supervisory/supernumerary status.

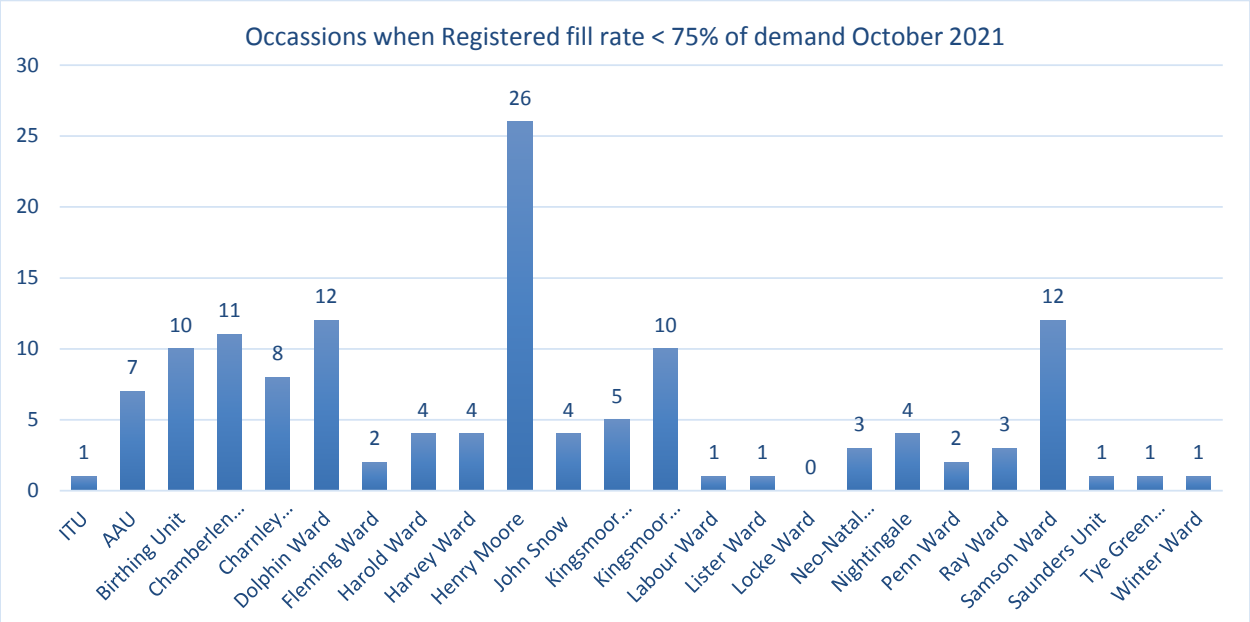
The unit has been able to maintain safety by utilising the escalation policy and pulling on on-call midwives and redeploying senior midwives to clinical shifts.

There are 2 new midwives started in October.

3.7 Red flag data:

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 following table provides information on mitigations for those areas reporting more than 10 occasion's in month were fill was <75%

Area	Speciality	Mitigation
Henry Moore	Elective surgery	Fluctuation in patient numbers means set template demand not always required on review at safe staffing huddle.
Kingsmoore Red	Covid	Fluctuation in patient numbers means set template demand not always required on review at safe staffing huddle.
Dolphin	Paediatrics	Beds reduced due to requirement to staff Paediatric ED
Birthing Unit, Chamberlen and Samson	Maternity	Maternity unit staffing under intensive pressure due to maternity leave and vacancies. Staffing is utilised flexibly across all maternity footprints to support safest staffing. Staffing reviewed for whole unit including community services and managers so not always reflective of staffing levels

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).

It is calculated every month by adding together the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants.
Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average.
Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day

CHPPD covers both temporary and permanent care staff but excludes student nurses and midwives. CHPPD relates only to hospital wards where patients stay overnight.

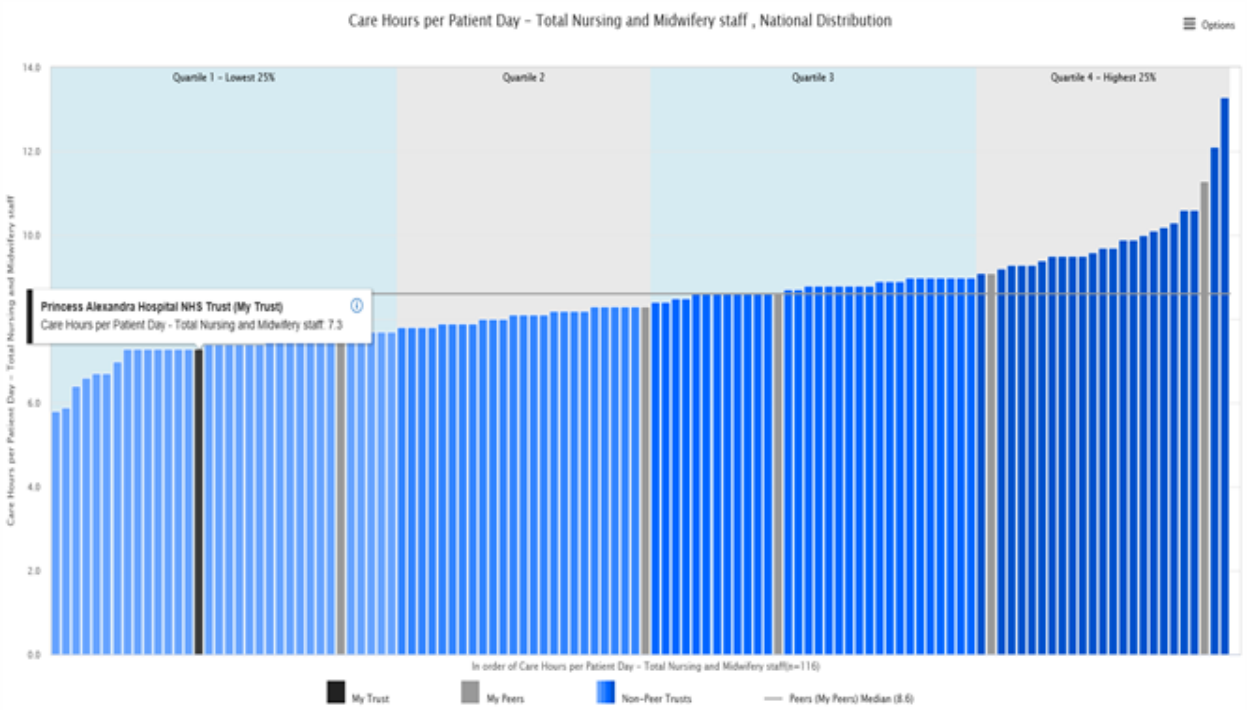
By itself, CHPPD does not reflect the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive. It should therefore be considered alongside measures of quality and safety.

The accuracy of this report is dependant of the rosters being up to date and accurate bed occupancy numbers.
Appendix 3 shows the CHPPD for each ward and the Trust total for October.

Work has been undertaken in month to ensure accurate bed occupancy data.

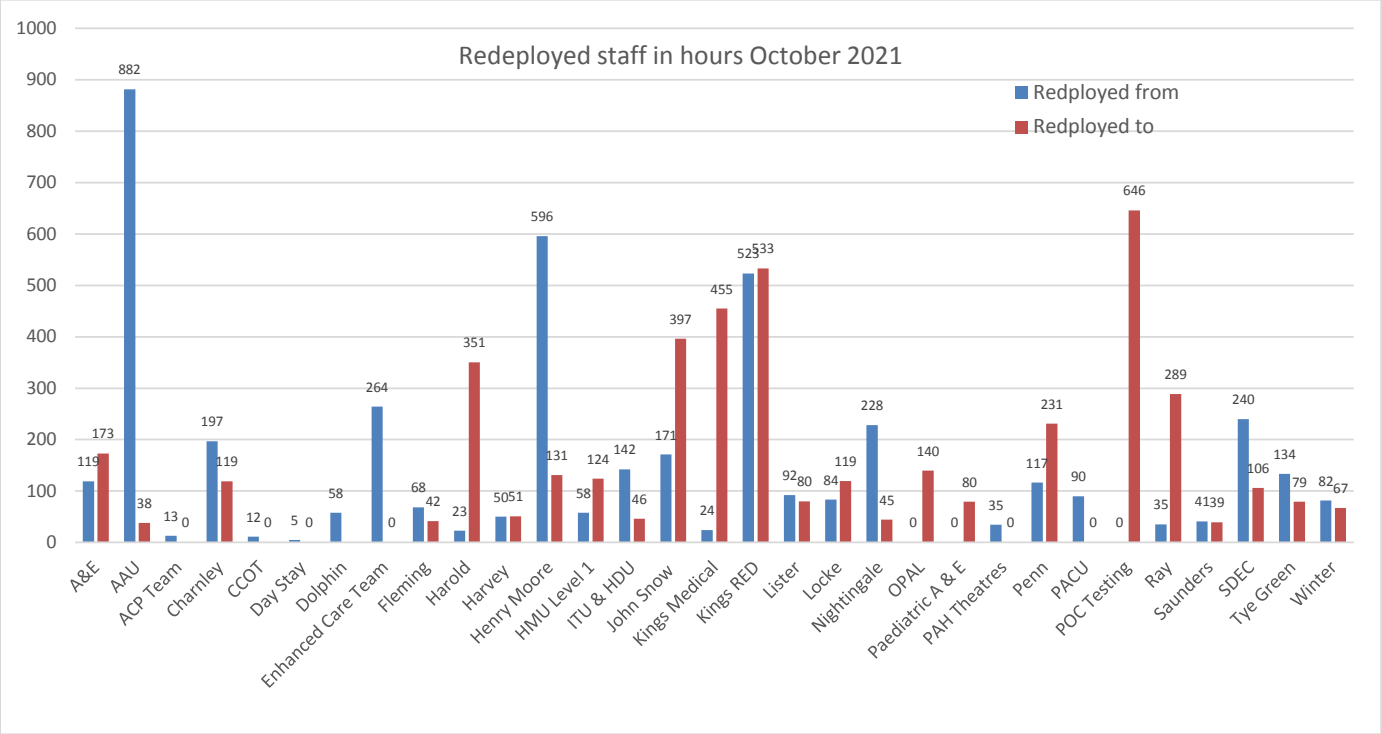
Trust comparative data via the Model Hospital portal is presented below based on August 2021 data

	August 2021 data	National Median (August 2021)	Variance against national median
CHPPD Total	7.3	8.3	-1.0
CHPPD RN	4.8	4.8	-
CHPPD HCSW	2.5	3.3	-0.8



3.9 Redeployment of staff:

The graph below shows how the Trust is supporting safe staffing through redeployment of staff to meet acuity and dependency. The graph does not capture the moves of bank or agency staff from the bank or rapid response pools. The graph shows the number of hours of staff redeployed from and to the wards to support safe staffing.



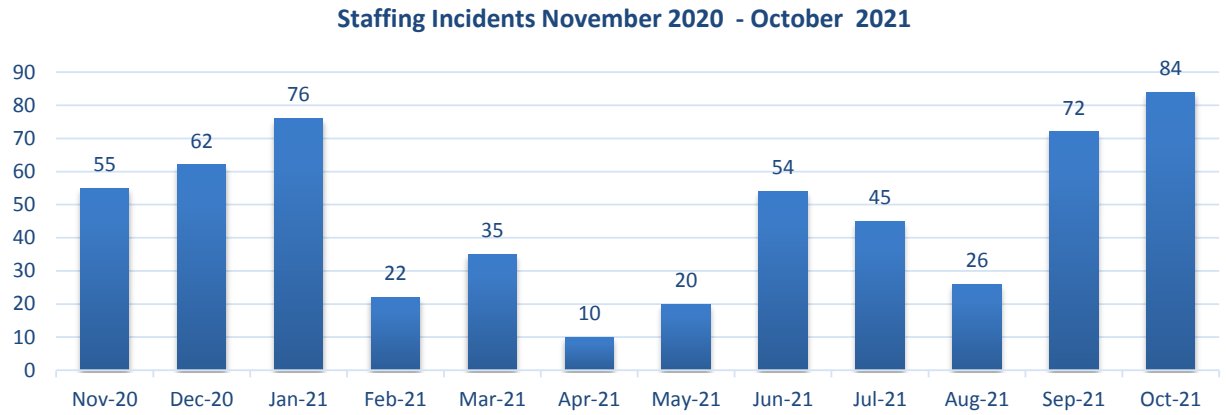
The accuracy of these reports continues to be dependent on the wards and site team redeploying staff, capturing and recording these moves in real-time in the e-Roster or SafeCare systems.

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.

A series of webinars were held for nursing staff in October to talk through staffing concerns in particular the impact on staff of redeployment.

3.10 Datix reports:

The trend in reports completed in relation to nursing and midwifery staffing is included below and shows that the number of incidents recorded there was a further increase in month to 84 total (↑12), ED and Tye Green remain the areas raising the most Datix reports in relation to staffing levels (ED 12 (12%)), with Tye Green raising 14 (16.5%).



Triangulation with patient safety incidents raised has not identified any patient safety issues as a direct result of the staffing concerns however the impact on staff with stress and anxiety is noted as well as delays in providing care or transfer of care.

3.11 Bank and Agency fill rates

The day-to-day management of safer staffing across the organisation is managed through the twice daily staffing huddles using information from SafeCare to ensure support is directed on a shift: by shift basis as required in line with actual patient acuity and activity demands

The use of NHSP continues to support the clinical areas to maximise safer staffing. The need for temporary staff is reviewed daily at the Safe Staffing daily meeting, staff redeployment along with a greater challenge continues and all shifts not required continue to be cancelled.

In October there was a large increase in registered requirements due to sickness, increased enhanced care pool and changes to the way the rapid response pool is set to try and attract ED trained agency nurses.

The main areas utilising agency staff continued to be A&E Nursing and critical care where specialist skills are required. There was an increase in registered demand (↑444 shifts) in October compared to September. October also shows an increase in agency usage (↑4 shifts). The overall fill rate decreased from 87.4% to 77.7%

RN temporary staffing demand and fill rates*: (October 2021 data supplied by NHSP 5.11.2021)*

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
May 2021	2787	1885	67.6%	310	11.01%	78.8%	592	21.2%
June 2021	2688	1761	65.5%	400	14.9%	80.4%	527	19.6%
July 2021	2792	1809	64.8%	498	17.4%	82.2%	498	17.8%
August 2021	2585	1880	72.7%	424	16.8%	89.5%	271	10.5%
September 2021	2538	1767	69.6%	452	17.8%	87.4%	319	12.5%
October 2021	**2982**	**1862**	**62.4%**	**456**	**15.3%**	**77.7%**	**664**	**22.3%**
October 2020	2807	1910	68%	267	9.5%	77.6%	630	22.4%

The HCSW demand shows a continued increase in unregistered demand (↑31 shifts), there was a increase in fill rate from 71.6% in September to 75.9% in October. There continued to be zero agency HCA filled shifts in October.

HCA temporary staffing demand and fill rates: ***(October 2021 data supplied by NHSP 5.11.2021)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
May 2021	1385	1170	84.5%	0	0	84.5%	215	15.5%
June 2021	1334	1143	85.7%	0	0	85.7%	191	14.3%
July 2021	1588	1353	85.3%	0	0	85.2%	235	14.8%
August 2021	1642	1456	88.7%	0	0	88.7%	186	11.3%
September 2021	1773	1271	71.6%	0	0%	71.6%	502	28.3%
October 2021	**1804**	**1359**	**75.3%**	**0**	**0%**	**75.9%**	**434**	**24.1%**
October 2020	1425	1040	73%	0	0%	73%	385	27%

B: Workforce:

4.0 Nursing Recruitment Pipeline

The overall clinical nursing vacancy rate in September was 0.5%. The vacancy rate for Band 5 RN's was -6.9%. The table below includes projections of starter including international nurses who are in the pipeline, nursing apprenticeships due to qualify and student nurses who have accepted offers of employment with the Trust. The vacancy rate is against funded establishment for clinical nursing posts and does not include additional posts required for support service or midwifery or the approximate additional 52WTE required to support Covid additional demand.

Nursing Establishment v Staff in post												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Funded Establishment WTE	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25
Staff in Post WTE	915.00	920.00	922.00	937.00	936.00	936.00	961.58	967.58	969.58	987.58	993.58	1000.58
Vacancy WTE	51.25	46.25	44.25	29.25	30.25	30.25	4.67	-1.33	-3.33	-21.33	-27.33	-34.33
Actual RN Vacancy Rate	5.3%	4.8%	4.6%	3.0%	3.1%	3.1%	0.5%	-0.1%	-0.3%	-2.2%	-2.8%	-3.6%
Forcast Vacancy Rate in Business Plan												

Band 5 Establisment V Staff in Post												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Funded Band 5 Establisment WTE	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2
Band 5 Staff in Post WTE	498	502	516	520	523	548	558	560	578	584	591	599
Band 5 Starters	12	16	16	8	11	30	17	9	25	13	14	15
Vacancy Band 5 WTE	24.2	20.2	6.2	2.2	-0.8	-25.98	-35.98	-37.98	-55.98	-61.98	-68.98	-76.98
Actual Vacancy Rate	4.6%	3.9%	1.2%	0.4%	-0.2%	-5.0%	-6.9%	-7.3%	-10.7%	-11.9%	-13.2%	-14.7%
Forcast Vacancy Rate in Business Plan												

Actual/Projected Starters Pipeline												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
RNs (not Band 5)	3	2	3	1	4	3	0	7	7	7	7	7
Band 5 Newly Qualified + Local	1	0	3	0	1	18	9	1	7	3	1	1
Band 5 International Recruitment	11	16	13	8	10	12	8	8	18	10	13	14
Band 5 Starters	**12**	**16**	**16**	**8**	**11**	**30**	**17**	**9**	**25**	**13**	**14**	**15**
Total Starters	15	18	19	9	15	33	17	16	32	20	21	22

Projected Leavers WTE												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
RNs (not Band 5) Leavers	4	4	2	6	7	2.6	4	7	7	7	7	7
Band 5 Leavers	6	12	2	4	8	4.82	7	7	7	7	7	7
Total Leavers	**10**	**16**	**4**	**10**	**15**	**7.42**	**11**	**14**	**14**	**14**	**14**	**14**
N&M Turnover %	8.65%	10.83%	10.43%	10.80%	11.51%	11.67%	12.04%					

The Trust receive support for recruitment of healthcare support workers from NHSE/I. The table below provides the pipeline and recruitment trajectory for HCSW. The vacancy rate has increased in month to 14.06%. Sustained reduction in the vacancy rate is proving problematic due to high turnover but it should be noted that some of the turnover is driven by HCSW commencing apprenticeship pathways to foundation degree and nursing degrees as part of a pathway to becoming a registered nurse. The DDoN has been working with the new nurse recruitment lead and recruitment team to refresh the selection and

on boarding process to ensure the right staff are recruited. Two successful recruitment session was held in October and November with 15 offers made. Further events are planned monthly.

Establishment V Staff in Post												
	Apr-21	May-21	Jun-21	Jul-21	Aug-20	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Funded Establishment WTE	419	419	419	419	419	419	419	419	419	419	419	419
Staff in Post WTE	366.00	375.00	376.00	368.00	365.00	370.00	358.00	363.00	368.00	373.00	378.00	383.00
Vacancy WTE	53	44	43	51	54	49	61	56	51	46	41	36
Actual B2/B3 Vacancy Rate	12.6%	10.5%	10.3%	12.2%	12.9%	11.7%	14.6%	13.4%	12.2%	11.0%	9.8%	8.6%
Forcast Vacancy Rate in Business Plan												

Actual/Projected Starters Pipeline												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Band 2 Starters	**0**	**19**	**9**	**3**	**9**	**11**	**2**	**10**	**10**	**10**	**10**	**10**
Total Starters	0	**19**	**9**	**3**	**9**	**11**	**2**	**10**	**10**	**10**	**10**	**10**

Projected Leavers WTE												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total Band 2/3 Leavers	**0**	**10**	**8**	**11**	**12**	**6**	**14**	**5**	**5**	**5**	**5**	**5**
HCSW Turnover %	11.59%	12.23%	12.45%	16.86%	15.98%	16.96%	18.73%					

4.1 Apprenticeships

The Trust has been working for some time on supporting HCSW to undertake apprenticeship's either as a Nursing Associate or via a 2+2 route to registered nurse in partnership with Anglia Ruskin University and direct entry degree nurse associates. In 2020/21 we will have 11 HCSW qualifying as RN via the apprenticeship route and 2 NA's.

Over 2020/21 this programme has been extended as part of the join work within the ICS to grow our own future nursing workforce. The now includes direct entry student nursing associates and degree nurse apprenticeships. The following table provides a breakdown of the numbers of HCSW currently undertaking an apprenticeship programme.

Apprenticeship Programme	**Number of Apprentices**
Degree Nurse Apprenticeship (2+2 or 4 year programme)	
Years 0-2	28
Years 2-4	22
Student Nursing Associate (2 year programme)	4
Total	**54**

Depending on the academic and clinical supernumerary time required by specific course's HCSW Apprentices are required to be off rota for between 2-3 days per week. There is back-fill funding for this which covers some temporary staffing backfill costs but the number of staff on apprenticeships is having an impact on HCSW fill rates in conjunction with ongoing vacancy rates.

5 RECOMMENDATION

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

Author: Sarah Webb, Deputy Director of Nursing and Midwifery

Date 12.11. 2021

Appendix 1

Ward level data: fill rates October 2021. *(Adjusted Standard Planned Ward Demand)*

Appendix 1 has captured the fill rate at ward level, the accuracy of this data is dependent on all ward / staff moves and redeployment being captured and recorded accurately in Health Roster.
Chamberlen Ward, Labour Ward, Samson Ward and Birthing Unit ward level data has been collated and reported as Maternity; this is gives a more accurate picture and reflects the way Maternity works.

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
ITU & HDU	88.0%	74.5%	86.6%	53.2%	87.3%	63.9%	84.0%
John Snow Ward	119.2%	100.5%	95.8%	82.0%	108.0%	91.7%	102.6%
Henry Moore Ward	73.2%	56.1%	97.1%	71.0%	82.2%	60.8%	74.2%
Harvey Ward	86.9%	67.1%	106.4%	112.7%	94.8%	84.4%	90.5%
Lister Ward	102.2%	95.4%	93.6%	105.3%	98.6%	99.4%	98.9%
Locke Ward	96.9%	86.2%	87.0%	114.6%	92.1%	97.0%	93.8%
Ray Ward	86.9%	79.3%	102.6%	135.9%	92.7%	97.1%	94.6%
Saunders Unit	93.6%	121.8%	91.1%	148.9%	92.5%	132.0%	106.7%
Nightingale Ward	91.4%	62.5%	97.9%	104.6%	94.1%	78.5%	87.6%
Tye Green Ward	91.7%	90.6%	102.6%	110.8%	96.4%	98.8%	97.4%
Winter Ward	96.6%	108.7%	105.8%	151.6%	100.5%	125.0%	109.2%
Charnley Ward	77.6%	84.1%	88.8%	97.6%	82.3%	89.6%	85.5%
AAU	97.2%	87.0%	88.2%	95.4%	92.9%	91.0%	92.3%
Kingsmoor Red	91.1%	92.9%	106.7%	136.0%	97.9%	108.3%	102.4%
Kingsmoor Medical	105.8%	85.3%	99.5%	97.6%	102.8%	91.2%	97.0%
Penn	106.4%	104.9%	116.4%	82.4%	110.4%	95.0%	104.4%
Fleming Ward	91.9%	68.0%	97.6%	119.4%	94.3%	87.5%	91.8%
Harold Ward	92.9%	81.5%	120.4%	101.1%	104.5%	89.5%	97.9%
Neo-Natal Unit	91.4%	102.2%	91.7%	84.2%	91.6%	93.2%	91.9%
Dolphin Ward	102.3%	67.8%	100.0%	96.6%	101.1%	77.4%	93.5%
Maternity	118.8%	107.2%	103.5%	84.6%	111.5%	96.5%	106.9%
Total	95.4%	85.5%	96.5%	103.6%	95.9%	92.9%	94.9%

Appendix 2

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

	Report from the Associate Director of Nursing for the HCG		
Ward	Analysis of gaps	Impact on Quality / outcomes	Actions in place
Henry Moore	RN fill on days was less than 73.2% Overall Fill 74%	Nil. The template for days is 3 RN and due to elective capacity and workflow the unit only required 2 plus ward manager for many days in October	Elective activity has relocated to Kingsmoor ward to make efficiencies in bed occupancy and staffing.

Appendix 3

The table below shows the CHPPD for each ward and the Trust total for October, based on the Trusts Unify submission for October 2021

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Total	**5.3**	**2.8**	**8.1**
ITU & HDU	26.7	3.3	29.9
John Snow Ward	5.5	2.3	7.8
Henry Moore Ward	6.5	2.9	9.4
Harvey Ward	4.8	3.1	7.9
Lister Ward	3.8	3.0	6.9
Locke Ward	4.0	2.1	6.1
Penn Ward	3.8	2.4	6.2
Ray Ward	4.2	3.2	7.3
Saunders Unit	2.1	1.7	3.7
Nightingale Ward	6.3	3.8	10.1
Tye Green Ward	3.4	2.8	6.2
Winter Ward	4.1	2.9	7.0
Charnley Ward	4.0	3.4	7.3
AAU	7.7	3.8	11.5
Kingsmoor Red	3.7	3.0	6.7
Kingsmoor Medical	4.2	3.7	7.9
Fleming Ward	4.1	2.1	6.2
Harold Ward	4.3	2.9	7.2
Neo-Natal Unit	11.4	2.3	13.7
Dolphin Ward	17.0	6.2	23.2
Labour Ward	8.1	1.9	9.9
Birthing Unit	29.1	8.4	37.5
Samson Ward	2.5	2.1	4.6
Chamberlen Ward	5.6	1.5	7.1

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board (Public) – 02.12.21

3.4

Agenda Item:	3.4							
Presented by:	Sharon McNally, Director of Nursing, Midwifery and AHPs							
Prepared by:	Sarah Webb, Deputy Director of Nursing							
Date prepared:	2nd November 2021							
Subject / Title:	Nursing Establishment Review							
Purpose:	Approval	x	Decision		Information	■	Assurance	■
Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The nursing establishment review (May 2021) undertaken in line with the NQB principles and internal nursing workforce intentions has resulted in recommended changes to the nursing workforce. These are an uplift in qualified nurses of 25.63WTE and a reduction in unqualified care staff of 16.79 WTE. Additional recommendation as part of the nursing workforce intentions is to substantiate a team of HCSW and RMN's who are able to provide enhanced care to patients who require 1:1 therapeutic care who at potential risk to themselves or others (falls, dementia, mental health etc). The overall increase in budget from 2022/23 will be £1.27M however £550k is already included in the current run rate.							
Recommendation:	The Board is asked to support the outcome and recommendations of the May nursing establishment review.							

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

Previously considered by:	EMT SMT 9th November 2021 – Approved. SMT noted funding for establishing substantive nursing team for Covid ward has also been agreed. PAF.25.11.21 and WFC.29.11.21
Risk / links with the	BAR Risk 2.1 Nurse Recruitment
Legislation, regulatory, equality, diversity and dignity implications:	NHSE: How to ensure the right people with the right skills in the right place at the right time (2014). Expectation one. NQB guidance (2013, 2016)
Appendices:	Appendix 1: Summary of Nurse Sensitive Indicators for each in-patient area Appendix 2: Emerging questions from 2019 review Appendix 3 Progress against Nursing Workforce Intentions 2020/21 Appendix 4: Enhanced care pool Appendix 5: CHPPD Appendix 6 Results of establishment review Bibliography

1.0 PURPOSE

The National Quality Board (NQB) in their publication 'Developing workforce safeguards' (2018), clearly sets out a requirement for the Board of Directors to receive a report outlining the assessment or resetting of the nursing establishment and skill mix by ward or service area at least annually.

Part A of this report details the results of the establishment review which was undertaken in May 2020 and provides assurance that the review was undertaken in line with regulatory requirements. It outlines a series of recommendations following the review and details the nursing workforce intentions for 2021/22.

Due to the Covid pandemic an establishment review was not conducted in 2020

Part B outlines the financial impact of the recommendations

Having completed a Birthrate+ and a midwifery staffing review, a report for maternity midwifery establishment will be presented to the Board early 2022.

Part A

2.0 BACKGROUND AND NATIONAL CONTEXT

The NQB guidance (2014, 2018) and NICE (2014) set out clear expectations for boards in relation to staffing:

> *Boards are required to take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Boards are required to ensure there are robust systems in place to assure themselves that there is sufficient capacity and capability to provide high quality care to patients on all wards, departments, services or environments day or night, every day of the week.*

This was reiterated in the RCN Nursing Workforce Standards (Supporting a safe and effective nursing workforce) 2021 Standard 1**:** Executive nurses are responsible for setting nursing workforce establishment and staffing levels. All members of the corporate board of any organisation are accountable for the decisions they make and the action they do or do not take to ensure the safety and effectiveness of service provision

Post publication of the Francis Report 2013 and Safe Staffing in adult inpatient wards in acute hospital (NICE, 2014) the National Quality Board (NQB July 2016) has defined a framework and set of expectations (July 2016) to achieve the "right staff, with the right skills, in the right place at the right time", including the responsibilities of Trust Boards.

The fundamental aims of each of the safe nurse staffing guidance are set out as three main principles, right care, minimising avoidable harm and maximising the value of available resources.

NHS organisations have a responsibility to undertake an annual comprehensive nursing and midwifery skill mix review to ensure that there are safe staffing levels and to provide assurance to the Board and stakeholders. The yearly skill mix review should be "followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate" (NQB 2016).

Lord Carter's report, 'Operational Productivity and Performance in English Acute Hospitals: Unwarranted variations' (revised February 2016), identified efficiency opportunities and the requirement for organisations to meet the challenges of maintaining and improving quality, operational performance, finance and efficiency. The latest CQC Consultation document outlines how effectively

a provider uses its resources is one of the factors that determines the quality and responsiveness of its care.

The principles set out by the NQB are further supplemented by a suite of nationally driven guidance documents, and speciality specific recommendations, which further inform the governance required to demonstrate the application and delivery of safe staffing in practice. A selection are included in the Bibliography

3. Process

The last establishment review was conducted in July 2019, gaining Board approval in January 2020. Due to the Covid pandemic (resulting in a number of ward closures and moves) a formal establishment review was not conducted in 2020 however there was high level of oversight of establishment templates, fill and outcomes by the senior nursing leadership team. This was reported to the Workforce Committee, the Quality and Safety Committee and in the public domain via the Board Hard Truths report.

The data collection for this nursing establishment review was commenced in May 2021 for the following areas utilising approved acuity and dependency tools.

Adult Inpatient Wards	Safer Nursing Care Tool Adult Inpatient Areas
AAU	Safer Nursing Care Tool Adult Inpatient Areas and Assessment Areas
Dolphin	Safer Nursing Care Tool Children's Inpatient Areas
ED Inc Children's ED	Baseline Emergency Staffing Tool

The Safer Nursing Care Tool (SNCT) multipliers are incorporated into the Safecare module of Allocate Healthroster, this is completed twice a day for each area by the nurse in charge. During the census period, results were validated on a daily basis by Matrons with additional validation by the Heads of Nursing and Associate Directors of Nursing. This validation showed that on average the acuity accuracy was at 94% across the trust, for the purpose of this review only the late census data was used.

The BEST data collection was completed on an hourly basis, 24 hours per day for a week as stipulated in the audit process.

The SNCT calculation is based upon a funded headroom allowance of 22% (leave allowance including annual, study, sickness etc.), our trust allowance is currently 20%, it should be noted that the Royal College of Nursing (RCN) recommends 25%.

The Ward Manager role has been fully supervisory since the last full establishment review in 2019.

Whilst the establishment reviews focus on the acuity/dependency results, these were not reviewed in isolation. Experience and best practice identify that a wider suite of quality indicators must be considered to allow more informed approaches in respect of assuring the Trust that staff are in place to provide high quality, safe and compassionate care. Therefore, in addition to the acuity/dependency results professional judgement, peer group validation, review of e-roster data and nurse sensitive indicators were incorporated into the review process.

A full breakdown of the nurse sensitive indicators that were reviewed when considering the SNCT results are in Appendix 1. Additional local information related to the ward layout, and professional judgement supplemented the outcome of the SNCT findings. Recommendations were then triangulated with the emerging themes from the 2019 establishment review (Appendix 2).

During wave one and two of the Covid pandemic the ward teams relocated numerous times as well as changed the case mix of patients as a result of ongoing requirements for separate red areas and

green elective recovery. In May when the review was undertaken the majority of wards had stabilised however some adjustments had to be made to accommodate these short-term changes

2.0 Workforce Intentions

The establishment review paper presented in January 2019 identified a series of workforce intentions. These were further refreshed in the establishment review paper of October 2020. Appendix 3 outlines progress to date.

A number of workforce intentions underpin the nurse staffing recommendations for 2021/22.

These are to:

- Continue to reduce our vacancy rate against establishment to less than 1%
- Improve the skill mix of the nursing teams to 70/30 for those wards with a higher level of acuity or requirement for nurse assessment including Fleming (cardiology), Charnley (short stay), AAU and Locke (respiratory/ NIV) and 60/40 for all other general wards as indicated in 2019 review.
- Continue the programme of inclusion of Nursing Associates within the skill mix on care of the elderly wards
- Continue with our programme of growing our own workforce in conjunction with the ICS and NHSE/I 50K target by supporting 10 new Nursing Associate Apprenticeships and providing ongoing support to 47 degree nurse apprenticeships which are in progress
- Expand the clinical practice educator team to include additional post for assessment and short stay (funded from establishment review)
- Develop Nurse/ Practitioner Consultant posts including a Nursing Professor post with ARU for older peoples care
- Develop a sustainable model for safe staffing of escalation areas including funding.
- Review how the new regulatory requirement for dedicated off rota time for Professional Nurse Advocates can be met.
- Establish an enhanced care team who are able to respond to meet patients' additional requirements for observation and support due to increased risk of fall, behaviour or mental health.

In 2021 in line with best practice data collection commenced via SafeCare of patients who were identified as having additional care needs requiring close observation or 1:1 care. An enhanced care policy was approved incorporating a risk assessment to guide and standardise the assessment of patient's risk and requirement. Where these additional needs cannot be met safety from the ward team additional bank or agency (RMN) are booked to meet the need. 24/7 cover with 4 HCSW and 1 RMN is required to meet current demand (12.43 WTE Band 2 and 4.14WTE Band 5).
Further detail in Appendix 4.

Data collection has identified there is a regular requirement across the Trust for one RMN and 4 HCSW per shift. Establishing these posts will enable us to develop the skill set of the team and reduce reliance on temporary staffing.

4. Care Hours Per Patient Day (CHPPD)

CHPPD has been a regular method of measuring available capacity for several years. It is a mandated monthly report and provides local and central information regarding the average amount of care delivery time each patient receives per day. Lord Carter (2016) as part of his unwarranted variation review indicated that an overall average CHPPD of 7.5 or less could contribute to increase risk of patient harm. Furthermore the patient to staff ratio's currently in place for general inpatient areas suggest that registered nurse establishment should provide approximately 3 hours CHPPD.

CHPPD collection during 2020 was difficult due to safest staffing and national reporting on the model hospital platform ceased. Data collection has recommenced and a review of the occupied bed capacity has been undertaken with the ICT team to ensure data accuracy for PAH.

Appendix 5 shows a breakdown by ward during the census period of CHPPD and identifies that no area was below 3 hours CHPPD of registered nurse during this time.

6. Findings:

A full breakdown of the findings from the establishment review can be found in Appendix 6. Wards which require a change in establishment are as follows:

Urgent and Emergency Care HCG

AAU: Reduce HCSW establishment from by 16 WTE HCSW, including 3 HCSW posts are a budget misalignment and should be within the SDEC establishment

New SNCT multipliers have been released for assessment areas. These were used for AAU despite the ward not running as assessment in May. This has provided a high level of confidence that the recommended changes to AAU are appropriate.

SDEC: Budget alignment with transfer of 3 HCSW posts from AAU (as above)

Charnley: Increase 2 WTE Band 5, reduce HCSW Band 2/3 by 5.13WTE. This is to take into account the bed reduction from transfer from Saunders and to improve skill mix to 60/40 in line to work force intentions on both days and nights.

ED: Reprofile shift pattern to meet periods of demand as per recommendations of BEST. Increase skill mix of registered nurses by transitioning 7.6 WTE Band 5 and 6 posts to Band 7 posts via recruitment and natural wastage and increasing Band 7 WTE by 2.1WTE. Increase HCSW posts by B2 4.4

Increase 6.5 WTE

NB: there may be further recommendations when the model for CDU has been finalised as these patients were excluded from the BEST modelling. There continues to be cost pressures with the increased staffing demand for Red RD and POCT team for SAMBA testing

CCCS HCG

Fleming: Changes to the skill mix to achieve 70/30 in line with workforce intentions. Re-band Band 4 into Band 2 posts. Increase RN B5 by 2.32 WTE and reduce HCSW by 1.74WTE

Surgery HCG

No changes

Medicine HCG

Tye Green: Increase establishment in line with SNCT by 5 WTE registered nurses. It is recommended that these are Band 4 Nursing Associates in line with workforce intentions. This will enable the skill mix to meet 60/40

Harold: Increase establishment in line with SNCT by 4.5 WTE registered nurses. It is recommended that these are Band 5 Registered Nurses. This will enable the skill mix to meet 60/40

Winter: Increase establishment in line with SCNT by 2.5WTE Band 5 Registered Nurses. This will enable the skill mix to meet 60/40

Lister: Increase establishment in line with SCNT by 2.38WTE Band 5 Registered Nurses. This will enable the skill mix to meet 60/40

Harvey: Reduce establishment by 4.28WTE Band 2/3 HCSW posts. SNCT data correlated with 2019 review.

Locke: Increase establishment by 4.03WTE Band 5 and reduce HCSW Band 2/3 posts by 1.7WTE to achieve required skill mix of 70/30. This is to support NIV service on Locke.

Nightingale: The team on Nightingale will move onto Ray when the ward refurbishment programme has been completed. The team care for medical and endocrinology patients. SNCT data has been extrapolated from that undertaken in May to account for final bed complement of 28 (currently 17 beds on Nightingale).

Recommendation is to improve skill mix in line with workforce intentions and reduce HCSW Band2/3 by 2.67WTE and increase B5 3WTE.

FAWS HCG

Paediatric ED: No changes

Dolphin: No changes

NB Paediatric Ambulatory care is unfunded and a business case will be required by FAWS. Current staffing is pulled from the Children's ED budget but the ED budget is only sufficient to meet BEST safe staffing for Children's ED.

NICU and Maternity staffing will be presented in the Maternity Establishment review paper

Summary table of recommendations:

	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7
Fleming	0.26		-2	2.32		
AAU	-16					
SDEC	3					
Charnley		-5.13		2		
Harold				4.5		
Harvey	-3.29	-1				
Lister				2.5		
Winter				2.38		
Locke		-1.7		4.03		
Nightingale		2.67		3		
Tye Green			5			
ED	4.4			-4.3	-3.3	9.5
Total	**-11.63**	**-5.16**	**3**	**16.43**	**-3.3**	**9.5**

Emerging questions

Many of the ward budget names and correlating budgets have not been changed following the ward moves. It is recommended that when the final ward move has been completed with opening of refurbished Saunders ward in January 2022 that the budget name changes are completed to avoid further confusion.

Kingsmoor ward is currently running as escalation area for Covid and does not have a budgeted establishment

Once the ward refurbishments have been completed Nightingale will be an escalation ward and does not have a budgeted establishment

Part B

7. Financial Impact

Medical wards

Band	PAYE total 1 WTE	NI	Pension	Annual Cost	WTE	Total cost
Band 2	20,935	1,698	4,329	26,962	-16.03	- 432,204
Band 3	22,866	1,964	4,729	29,559	-5.16	- 152,523
Band 4	26,126	2,414	5,403	33,943	3	101,829
Band 5	33,111	3,378	6,847	43,336	20.73	898,356
Band 6	35,881	3,760	7,420	47,061		-
Band 7	43,882	4,865	9,075	57,821		-
						415,459

Emergency Department

Band	PAYE total 1 WTE	NI	Pension	Annual Cost	WTE	Total cost
Band 2	20,935	1,698	4,329	26,962	4.4	118,634
Band 3	22,866	1,964	4,729	29,559		-
Band 4	26,126	2,414	5,403	33,943	0	-
Band 5	33,111	3,378	6,847	43,336	-4.3	- 186,345
Band 6	35,881	3,760	7,420	47,061	-3.3	- 155,301
Band 7	43,882	4,865	9,075	57,821	9.5	549,302
						326,290

Enhanced care team

Enhanced Care Pool						
Band	**PAYE total 1 WTE**	**NI**	**Pension**	**Annual Cost**	**WTE**	**Total cost**
Band 2	20,935	1,698	4,329	27,771	12.43	345,194
Band 5	33,111	3,378	6,847	44,636	4.14	184,794
						529,988

Spend on additional shifts between M1-6 was £255K (see Appendix 4)

RECOMMENDATIONS

To note the recommendations within this report, and the methodology used to inform the establishment setting process:

- Overall increase of 20.73 WTE Band 5 and 3 WTE Band 4 qualified nurses and reduce 21.19 WTE Band 2/3 unqualified posts across adult inpatient wards
- Increase of 1.9WTE WTE registered nurses with increase in skill mix and 4.4 WTE unqualified in Emergency Department
- Establish Enhanced Care Team by 12.43WTE Band 2 and 4.14 Band 5

- To approve the uplift in templates for Winter, Harold, Tye Green and reduction in template for Harvey from November 2021

- To approve the establishment changes and budget increase for inpatient wards from 22/23 of £415k.

- To approve the net budget increase for ED of £326K which will be phased over 21/22 as staff are recruited into more senior posts

- To approve the recruitment of staff to the enhanced care pool from M10 recognising approx. £550k (full year effect) is already being incurred and included in the current runrate.

- It is recommended that the staffing templates are uplifted in the adult inpatient areas in line with the recommendations with immediate effect to support safe staffing.

- Given the current vacancy across nursing it is anticipated that recruitment to substantive posts will be phased throughout the remainder of the current financial year and therefore budgets would be realigned with effect from April 2022/23

- Nurse Sensitive Indicators will continue to be reviewed by exception reports on a monthly basis to ensure safe staffing levels

- A further establishment review will be completed in February 2022 in line with the NQB guidance and report to Board in May 2022. It is not anticipated that there will be any additional recommendations for Board from this report.

Appendix 1: Summary of Nurse Sensitive Indicators for each in-patient area

Ward	PALS (Inc bereavement , GP queries)	PALS Queries referred to complaints	Compliments	New complaints	Pressure ulcers	Falls	SI	Staffing levels	Medication errors
A&E	24	1	10	4		11		4	8
AAU	3	0	3	0	1	10			4
Charnley	8	0	2	1		9			1
Dolphin Ward	2	0	7	0				1	2
Fleming Ward	1	0	6	0	1	11			6
Harold Ward	0	0	0	0	5	8			6
Harvey Ward	4	0	4	0		16			1
Henry Moore Ward	0	0	1	0	1	1			1
John Snow ward	4	0	1	0					
Kingsmoor Red	0	1	0	1		3		2	7
Lister Ward	6	0	3	0	3				1
Locke Ward	3	0	1	0	2	7			2
Nightingale Ward	3	0	0	0	8				4
Penn Ward	0	0	0	0					
Ray Ward	5	0	2	0	2	6		1	5
Saunders Ward	5	0	0	0	1	2		4	3
SDEC	0	0	1	0					
Tye Green Ward	5	0	3	0	4	10		8	2
Winter Ward	8	0	0	0	3	10		3	1

Appendix 2 : Emerging questions from 2019 review

The data from this establishment review has identified a number of areas which require further review over the next 6 months where changes may be recommended. These areas will be therefore under 'watch'.

Trend data is suggestive of a change in rota template with a **reduction** in required establishment in the following areas:

Harvey Trend data is suggestive of a change in rota template with a reduction in required establishment.

Locke Trend data is suggestive of a change in rota template with a reduction in required establishment however the service model is to increase acuity and deliver NIV service through the acute respiratory unit located on Locke ward, the staffing model is supportive of this development

John Snow Trend data suggests there could be a decrease the establishment. However, applying professional judgement, the recommendation is to review the impact of the increase in the funded and recruited establishment and review the establishment against the next data set in 6 months in line with future service developments.

Paediatrics Trend data suggests there could be a decrease the establishment however paediatric acuity and demand is highly seasonal and monthly data for full 12 months should be reviewed.

Trend data is suggestive of a change in rota template with an **increase** in required establishment in the following areas:

Increased skill mix. There are currently 7 wards where the skill mix of qualified to unqualified staff is less than 60:40. In line with evidence of the impact of poor skill mix on nurse led outcomes including mortality a shift to a minimum 60:40 ratio on all inpatient wards will be phased into future reviews.

Appendix 3 Progress against Nursing Workforce Intentions 2020/21

Priority	Intention	Rationale	Progress
1.	Uplift nursing and midwifery establishment in line with Autumn 2019 establishment review	Uplift required to support acuity and dependency as evidenced by validated safe staffing process	Achieved
2.	Reduce and maintain nurse vacancy of less than 1% in 2020/21. To meet this it is anticipated that approx. 106 international nurses will be required to supplement domestic recruitment	Improve patient outcomes reducing mortality and better patient flow	Partial achieved. Vacancy rate 7.2% at end of 2020/21
3.	Recruit 5 Clinical Practice Educators and Additional WTE PDT Nurse	Make posts from overseas business case substantive to support development of skills and capability of nursing workforce and mentors and apprenticeships within the workplace Increase capacity of PDT team to support improvements in nursing practice including discharge planning across the Trust	Achieved
4.	Uplift Band 5 establishment to enable Ward Managers to be fully supervisory	Strengthen the ward leader's role, enabling them to demonstrate and use their transformational leadership skills. Evidence shows where this happens wards have fewer safety incidents, less staff absence and lower turnover.	Achieved
5.	Review Band 6 WTE establishment	Ensure equity across similar profiled wards whilst ensuring succession planning and adequate scope for career progression within nursing workforce	Achieved
6	Recruit x10 Apprentice Degree Nurses on 4 year programme	Grow our own nursing workforce	Partially achieved – 8 RDNA's recruited

Appendix 4: Enhanced care pool

In May 2021 the enhanced care policy was implemented. The policy sets out the how patients who are identified as having additional care needs should be managed. Patients who require enhanced care include some mental health patients, those at very high risk of falling and those have dementia and delirium and are restless or agitated. The policy is in line with evidence based best practice and work undertaken at other similar Trusts. The policy includes a standardised risk assessment and matrix for establishing need, definition of what enhanced care(amber) or 1:1 (red) care is, how and who can provide care and core care plans.

In many cases the ward establishment will be able to provide enhanced care or a 1:1 from their establishment but due to the unpredictability of the requirement additional staff are required to meet the need. This is currently sourced from NHSP or Agency staff but sustainability and quality of care can be better met by a substantive pool.
Analysis of acuity and dependency has included the requirement for enhanced care since February 2021

Number of patients per month who are identified as having an enhanced care need

	Day		Night	
	Amber	Red	Amber	Red
Feb-21	12.2	7.6	7.6	5.9
Mar-21	10.3	8.5	9.3	7.0
Apr-21	12.1	8.6	12.1	7.4
May-21	12.1	7.0	11.9	6.5
Jun-21	12.4	6.8	12.0	7.1
Jul-21	12.9	7.0	12.5	7.1

As enhanced care can be provided as cohorting or bay care and some demand can be met from within the existing establishments it is recommended that a substantive pool is established that provides 4 HCSW and 1 RMN per shift.

This is equivalent to 12.43WTE HCSW and 4.14 RMN

Temporary staff bookings broken down by filled and unfilled for additional shifts for ‘specialing’, ‘enhanced care’, ‘RMN special’ or ‘high acuity’

Count of Work Time								
Row Labels	High Patient Acuity	RMHN Required	Special	Grand Total Filled	Grand Total - unfilled	Total Demand		
Jul	12	66	135	213	56	269	Average per month	264.00
Aug	9	82	178	269	26	295	Average per Day	8.8
Sep	6	38	145	189	39	228	Average per shift	4.4
	27	186	458	671	121	792		

Current costs included in the pay spend for additional shifts from M1-6 are £250K as follows:

Count of Work Time	Column Labels							
Row Labels	gh Patient Acuity	HCS RMHN Required	ecial HC	Grand Total				
Apr	3	13	102	118				Month 1-6
May	8	5	80	93		RMN cost per shift	413.88	£100,986.72
Jun	3	40	48	91		HCA cost per shift	211.7	£154,329.30
Jul	12	66	135	213				**£255,316.02**
Aug	9	82	178	269				
Sep	6	38	145	189				
Grand Total	41	244	688	973				

Appendix 5: CHPPD

		Registered CHPPD	Unregistered CHPPD	
Unit	**Actual CHPPD**	**Registered**	**Unregistered**	**Actual RN:Patient Ratio**
AAU	13.1	8.9	4.2	1:2.69
Charnley Ward	7.3	3.9	3.4	1:6.05
Dolphin Ward	19.2	15.1	4.0	1:1.48
Fleming Ward	6.5	4.2	2.3	1:5.73
Harold Ward	6.6	3.7	3.0	1:6.62
Harvey Ward	7.8	4.3	3.5	1:5.55
John Snow Ward	17.1	14.0	3.0	1:1.71
Kingsmoor Orthopaedic	8.9	6.9	2.0	1:3.48
Kingsmoor Surgery	8.8	5.6	3.2	1:4.25
Lister Ward	6.6	3.5	3.1	1:6.70
Locke Ward	6.7	4.4	2.3	1:5.47
Nightingale	8.7	4.9	3.9	1:4.72
Ray Ward	6.4	4.0	2.4	1:6.12
Saunders Unit	6.3	3.9	2.4	1:6.20
Tye Green Ward	6.7	3.5	3.2	1:6.86
Winter Ward	7.4	4.3	3.2	1:5.56

Appendix 6 Results of establishment review

Ward Name - establishment review	HCG	Budget Name	Budget WTE RN (exc B7)	Budget HCSW	Total WTE	Currrent template		Template WTE	Skill Mix		SNCT Review RN	SNCT Review HCSW	SNCT WTE	Recommended		New Template		New Template WTE	New Skill Mix	
						Day	Night		Day RN%	Night RN%				RN	HCSW	Day	Night		Day	Night
Fleming	CCCS	Kingsmoor	22.68	12.44	35.12	5+3	4+2	36.28	62	67	25	10.7	35.7	25	10.7	**6+2**	**4+2**	36.3	75	66.7
AAU	UEC	AAU	39.42	27.1	66.52	8+3	8+3	56.67	72	72	35	15	50	38.8	10.3	**8+2**	**7+2**	49.1	80	78
Charnley	UEC	Saunders	23.3	15.46	38.76	5+4	4+3	41.44	55	57	25	10.7	35.7	26	10.3	**5+2**	**5+2**	36.3	71.4	71.4
Harold	Medicine	Harold	23.93	18	41.93	5+4	4+3	41.44	55	57	32.2	13.8	46	28.4	18.1	**6+4**	**5+3**	46.6	60	62.5
Harvey	Medicine	Harvey	18.14	14.59	32.73	4+3	3+3	33.6	57	50	17.4	7.4	24.8	18.1	10.3	**4+2**	**3+2**	28.4	66	60
Lister	Medicine	Lister	23.38	15	38.38	5+4	4+3	41.44	55	57	29.3	12.5	41.8	25.8	15.5	**5+3**	**5+3**	41.2	62.5	62.5
Locke	Medicine	Locke	24.37	12	36.37	5+3	4+2	36.3	62.5	67	26	11.1	37.1	28.4	10.3	**6+2**	**5+2**	38.8	75	71.4
Winter	Medicine	Ray	23.42	15.29	38.71	5+4	4+3	41.44	55	57	26.2	11.2	37.4	23.3	15.5	**5+3**	**5+3**	41.2	62.5	62.5
Nightingale	Medicine	Winter	20.5	12.97	33.47	4+3	3+2	31.1	57	60	25	10.7	35.7	23.3	10.3	**5+2**	**4+2**	33.6	71	66
Tye Green	Medicine	Tye Green	23.3	18.14	41.44	5+4	4+3	41.44	56	57	32.3	13.9	46.2	28.4	18.1	**6+4**	**5+3**	46.5	60	62.5
Henry Moore	Surgery	Henry Moore	12.6	8	20.6									no change						
John Snow	Surgery	John Snow	17.8	12	29.8									no change						
Ray	Surgery	Charnley	20.83	13	33.83	5+3	3+2	33.8	62	60	24.2	10.4	34.6	no change	no change					
Saunders	Surgery	Penn	20.83	13	33.83	5+3	4+2	36.3	62		23.6	10.1	33.7	no change	no change					
Kingsmoor	Medicine	Escalation																		

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The Princess Alexandra Hospital NHS Trust

Trust Board 2nd December 2021

3.5

Agenda item:	3.5
Presented by:	Sharon McNally, Director of Nursing, Midwifery and Allied Health Professionals
Prepared by:	Finola Devaney, Deputy Chief Nurse - Quality (Director of Clinical Quality Governance)
Date prepared:	Sarah Murphy, Assistant Strategy and Development Manager
Subject / title:	26.11.21 Quality and patient safety strategy

Purpose:	Approval		Decision		Information	X	Assurance		

Key issues:	This paper is to provide the Board oversight of the new Quality and Patient Safety strategy.
Recommendation:	Trust Board are asked to note the Quality and Patient Safety Strategy for information.

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:	PSG on 14.09.21, SMT on 21.09.21, QSC on 29.10.21 & 26.11.2021
Risk / links with the BAF:	This strategy links to BAF risks: • Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality, , • 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 • 3.3, Strategic Change and Organisational Structure. Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust. • 3.5 New Hospital. There is a risk that the delivery of the new hospital will be delayed because of failure to engage with a suitable contractor or that the additional funding is not forthcoming from the JIC even if the 3 conditions are met.
Legislation, regulatory, equality, diversity and dignity implications:	N/A
Appendices:	Quality and patient safety strategy

Clinical strategy

Quality and Patient Safety

The Princess Alexandra Hospital NHS Trust

2020 - 2030

Your future • Our hospital

patient at heart • everyday excellence • creative collaboration

Forward

The purpose of the Quality & Patient Safety Strategy is to support the delivery of the organisation's vision: *To deliver outstanding healthcare to the community.*

This strategy recognises the biggest areas of challenge within our organisation today and sets out our vision for the future, provide safe, high quality care to all patients in order to produce the best outcome for patients.

What do we mean by Quality and Patient safety?

The NHS defines quality in three parts:

- **The effectiveness of the treatment and care provided to patients** – measured by both clinical outcomes and patient-related outcomes. There is much evidence of wide variation in the clinical effectiveness of care delivered across the country;
- **The safety of treatment and care provided to patients** – safety is of paramount importance to patients and is the bottom line when it comes to what NHS services must be delivering. It has risen up the agenda over the last ten years following the publication of An Organisation with a Memory and Safety First: a report for patients, clinicians and healthcare managers; and
- **The experience patients have of the treatment and care they receive** – how positive an experience people have on their journey through the NHS can be even more important to the individual than how clinically effective care has been.

This definition demonstrates that high quality patient care is one which is safe, provides good patient outcomes and ensures the patient has the best possible experience while under our care. At The Princess Alexandra Hospital Trust, we strive to deliver high quality, safe care to all of our patients. We are developing this strategy in order to improve in all three areas highlighted in the quality definition. The development of our people and our technology will be paramount in delivering high quality patient care.

This Quality and Patient Safety Strategy will work alongside other strategies including:

- PAHT 2030 – our Trust wide strategy
- Our digital strategy
- Our people strategy
- Speciality level clinical strategies
- Quality accounts; annual operational business plans; health care group business plans

Developing our Quality and Patient Safety strategy.

Our Quality and Patient Safety strategy has been developed through a range of workshops with **our patients groups including our patient panel**, staff and 'in your shoes' events **where patients share their experience of care** at The Princess Alexandra Hospital Trust. We have also reviewed the following:

- The 2020 NHS Staff Survey results
- The 2019 National Inpatient survey,
- The 2019 Cancer survey,
- The 2018 Children and Young People's survey,
- The 2020 Maternity Patient Satisfaction survey
- The PAHT 2019-2022 Quality Improvement Strategy
- The 2020-2021 Quality Accounts

We are preparing to adopt the new **Patient Safety Incident Response Framework (PSIRF)** from April 2022. We are also developing a **mental health strategy** to improve care and treatment for all patients who need acute care who also have mental health needs. This strategy will also focus on the mental health and wellbeing of our people.

The feedback and data from these documents, alongside the engagement events with patients and staff have been paramount to creating this strategy and shaping our plans for the future.

The structure of our strategy

The Princess Alexandra Hospital Trust's quality strategy will focus on all three part of the NHS definition of quality.

- Patient safety
- Patient effectiveness
- Patient experience

Each section will detail why it is important, what we want to achieve and how, and what success will look like.

National picture – NHS England plan for Patient Safety Specialist.

NHS England have released a paper detailing the short to medium term priorities for Patient Safety Specialists (full plan available at appendix one). The areas for focus include:

National focus	Plan
Just Culture	Link with People Strategy and HR partners
National Patient Safety Alerts	Part of the patient safety specialist role is to ensure the Trust has a robust alert process within the Trust – this is already in place and lead by the central patient safety and quality team.
Improving quality of incident reporting	Revised incident management policy and serious incident policy 2020/21
Support transition from NRLS and StEIS to PSIMS	Working as part of a national and regional network and support the piloting of the new system.
Involvement in implementing the new Patient Safety Incident Response Framework (PSIRF)	Working as part of regional and ICS network to agreed PAHT prioritisation of incidents that will require investigations
Implementation of the Framework for Involving Patients in Patient Safety	Working with alongside our patient panel and agreeing with ICS partners on implementation date and oversight at Executive level regarding compliance and ensuring we are a learning organisation.
Patient safety education and training	Part of the patient safety specialist role to support Trust wide education and training in investigation and just culture and undertaking patient safety culture assessments.
National patient safety improvement programmes	Part of the patient safety specialist role to identify and support PAHT in national safety programmes.
COVID-19 recovery planning	Part of the Trust overarching recovery programme for both staff and patients.

National picture – Patient Safety Strategy 2021

Furthermore, in May 2021 the CQC released a patient safety strategy which includes these key headlines:

- Safety through learning – regulating for stronger safety culture across health and care, prioritising learning and improvement, and collaborating to value everyone's perspectives.
- Learning and improvement must be primary responses to all safety concerns in services and systems – we'll act quickly where improvement take too long or where change isn't sustainable.
- A sharper focus on checking for open and honest cultures and more focus on care settings where there's a greater risk of a poor culture going undetected.
- Work with others to agree and establish a definition and language about safety.
- Staff feel confident that we'll listen and act on their concerns, and intervene quickly where appropriate
- People can influence the planning and prioritisation of safe care and be truly involved in their care

Our quality and patient safety strategy aims to achieve these headlines outlined within the CQC strategy, and The Princess Alexandra Hospital Trust aims to improve our learning and safety culture to become a true learning organisation.

In order to achieve this, there is a national patient safety syllabus, run by Health Education England and will be available to all NHS staff from September 2021. It includes chapters on:

- Systems approach to patient safety
- Capability sets
- Learning from incidents
- Human factors, human performance and safety management
- Creating safe systems
- Being sure about safety

The Princess Alexandra Hospital Trust will encourage all staff to complete this online training as part of the effort to become a learning organisation.

National Picture – Framework for involving patients in patient safety 2021

The framework for involving patients in patient safety was announced as a priority in the NHS Patient Safety Strategy published in April 2021. It provides guidance on how the NHS can involve people in their own safety as well as improving patient safety in partnership with staff: maximising the things that go right and minimising the things that go wrong for people receiving healthcare. The framework is split into Part A and Part B.

Part A – involving patients in their own safety.

Approaches to involving patients in their own healthcare and safety can include:

- Encouraging patients to ask questions by:
  - asking them directly if they have any queries about their care
  - providing leaflets, videos and apps to encourage patients to ask questions or raise issues with professionals.
- Individual information-sharing sessions for patients, including proactively involving them in:
  - monitoring their symptoms
  - understanding their medications
  - following up on test results and appointments
  - making choices about their care, where appropriate.
- Information campaigns such as those encouraging people to be vigilant about staff, visitors and patients cleaning their hands.
- Reporting incidents by:
  - raising concerns through complaints systems
  - flagging them to staff them to the online national reporting system (currently the
    - National Reporting and Learning System, NRLS; to be replaced by the Learn from patient safety events (LFPSE)

• Individual involvement in incident investigation.

Whatever the approach, there is a need to ensure that:

• Individuals have enough information to participate in decision-making about their care; information should be consistently written in plain language without jargon

• Communication is effective, which may include the use of structured communication tools, so that individuals both understand the information they are given and feel safe in communicating their needs

• If individuals feel they need more information they are directed to this

• Individuals are trained when required in how to be involved in their own safety, e.g. in self-medication

• Individuals are helped or trained to use technology if required

• When individuals need access to wider support networks relating to their condition or another concern, they are directed to these, including local independent advocacy services.

Part B – Patient safety partner involvement in organisational safety

Patient safety partner (PSP) involvement in organisational safety relates to the role that patients and other lay people can play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety. Roles for PSPs can therefore include:

• Membership of safety and quality committees whose responsibilities include the review and analysis of safety data

• Involvement in patient safety improvement projects

• Working with organisation boards to consider how to improve safety

• Involvement in staff patient safety training

• Participation in investigation oversight groups.

PSPs can support effective safety governance at all levels in the organisation.

Local picture

The below table details the strategic priorities in our quality accounts and our plan of how to achieve them by March 2022:

Quality Account Strategic Priorities	Plan
To reduce trust mortality rate (improve Hospital Standardised Mortality Rate (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) continue with the work already started on learning from every death	As part of the Quality and Patient Safety Strategy, we have detailed our plan for improving mortality rates by the learning from deaths programme and learning from our unwarranted variation in care. We aim to see a continued reduction in HSMR and SHMI at PAHT.
Improve our performance for timeliness of treating patients requiring emergency and urgent care	We are developing an urgent care strategy which will detail our plan for improving the timeliness of treating patients requiring emergency and urgent care. Work with national partners on implementing the new urgent care standards when introduced.
Quality improvement projects to transform services	The Quality and Patient Safety Strategy details the model for improvement, which is PAHT's Quality First methodology used for transformation projects.
Theatre transformation	We are developing a surgery healthcare group strategy which will detail our plans for theatre optimisation and transformation
Medicines optimisation	Medicines optimisation is a one of the five priorities for patient safety in the Quality and Patient Safety strategy. There is a medicines optimisation strategy in place.
Harlow in partnership to improve our hospitals and health infrastructure.	The Princess Alexandra Hospital Trust is of six hospital trusts across the UK to be developed in HIP1 (2020-2025). As part of this, we are working with local partners through the New Hospital Development programme to improve local health infrastructure. Specific speciality level partnership working is detailed in each clinical strategy.

Local picture

Following our 2020 staff survey results, the Trust has also identified three priority areas of focus, which our quality and patient safety strategy will align to, and these are:

Priority One: Improving the physical and mental health and wellbeing of our people. Our people's mental health and wellbeing is a key factor of our mental health strategy.

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

Priority Three: Improving the effectiveness of line managers.

By focusing on creating a culture of wellbeing and psychological safety for our staff, and by improving the effectiveness of our managers, we will provide better quality and safer care to all our patients at The Princess Alexandra Hospitals Trust.

Our vision for the Quality and Patient Safety over the next 10 years:

Princess Alexandra Hospital will provide safe, high quality care to all patients in order to produce the best outcome for patients.

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
The experience and care our patients have will always be outstanding

Integrated
Together, we will work with system partners and our patient to ensure we will achieve safe, patient centred, well-coordinated care

Modern
We will use advances in technology to support our efforts to drive out inequalities and unwarranted variation in care as well as using data to target our improvement efforts.

Strategic objectives for 2021-2023

Our strategic priorities have been identified through strategy workshops with patients and staff, and through reviewing national priorities and looking at our benchmark performance compared with other Trusts. The following are areas of focus for our strategy:

Patient Safety

The patient safety team have identified the top five areas of patient safety which PAHT need to focus:

- Falls prevention: *to reduce falls with harm by 50%*
- Venous thromboembolism: *to become an exemplar trust for venous thromboembolism in the UK*
- Diabetes: *to run an outstanding service to all patients with Diabetes whether or not Diabetes is the reason for admission*
- Pressure ulcers: *to reduce all hospital acquired pressure ulcers that could not otherwise be avoided, and to reduce moderate and severe pressure ulcers by 50% by 2021/22 with the ambition of 0% preventable harms by 2023*
- Medicines optimisation: *to increase the reporting of medicine incidents while reducing the harm*
-

Patient Effectiveness

For patient effectiveness, our focus will be to improve on our mortality rates

- Mortality: *We will maintain 'as expected' for Hospital Standardised Mortality Rate and Summary Hospital-level Mortality Indicator rates (12 months rolling position).*

Patient Experience

The patient experience team have identified the top three areas which PAHT need to focus:

- Addressing harms related to communication, ensuring we develop a culture of learning and psychological safety: *reduction in proportion of complaints where communication is the primary cause in years 2-3.*
- Assessing and mediating the impact of technology on patient experience: *reduction in evidence of concerns raised by the implementation of new technologies through peer review as shown by PALS and complaints cases*
- Developing a culture of kindness and compassion to our patients and people which we can measure: *measurement of the number of times compassion and kind are mentioned in FFT results over the period of the strategy,* and*; monitor and improve our scores across CQC satisfaction and the FFT*

Patient Safety

Why is patient safety a top priority?

Reducing avoidable harm to patients is a key priority at The Princess Alexandra Hospital Trust.

The patient safety team have identified the top five areas on which PAHT need to focus:

Focus	Measures of success
Falls	To reduce falls with harm by 50%
Venous thromboembolism	To become an exemplar trust for venous thromboembolism in the UK
Diabetes	To run an outstanding service to all patients with Diabetes whether or not Diabetes is the reason for admission
Pressure ulcers	To reduce all hospital acquired pressure ulcers that could not otherwise be avoided, and to reduce moderate and severe pressure ulcers by 50% by 2021/22 with the ambition of 0% preventable harms by 2023
Medicines optimisation	To increase the reporting of medicine incidents while reducing the harm

How will we improve for patient safety at PAHT?

- Each priority safety area of falls prevention, VTE, diabetes, pressure ulcers and medicines optimisation will develop its own work plan to achieving the goals with 1 and 2 year milestones.
- We will review each year as we make progress to ensure we are sighted on emerging risks of avoidable harm
- We will ensure our staffing structure is best suited to achieve success of our strategy and staff are trained and developed.

What does success look like?

- We will see a year on year improvement to our key performance indicators, and improved clinical outcomes and achieve the measures highlighted in the table above for each of our priority areas.
- We will see an improvement in the prevention of avoidable falls and medication errors.
- We will achieve our work plans for each safety priority area by March 2023.
- We will promote a culture of safety and learning from mistakes.

Patient Effectiveness

Why is patient effectiveness a top priority?
Effectiveness of care is measured in both clinical and patient-related outcomes. The focus for PAHT in this quality and patient safety strategy is on mortality rates to improve our mortality position. We want to be an organisation that continuously learns from all deaths and has no unwarranted variation in care, so that every patient receives the best possible treatment they can receive.

Focus	Measures of success
Mortality	We will maintain 'as expected' for Hospital Standardised Mortality Rate and Summary Hospital-level Mortality Indicator rates (12 months rolling position).

How will we improve mortality rates at PAHT?

Mortality Improvement	**Programmes**	**Projects**
	Looking back (response)	1. Sepsis
		2. Acute Kidney Injury (AKI)
		3. Acute respiratory (COPD, Pneumonia and Aspiration Pneumonia
		4. Fracture of neck of femur
		5. End of life
		6. Using data and evidence base to better target improvement (SMART)
		7. Improved recording of care (documentation and coding)
	Looking forwards (prevention)	Develop and deliver a campaign for every specialty lead to engage with and lead in the delivery of clinical strategy and address unwarranted variation in care.

**The projects listed (1-5) relate to particular diagnosis where there have been outlier alerts. This may be subject to change if new outlier appears or come off. These are priorities as of April 2021 and will be constantly under review.*

What does success look like?

- We will maintain 'as expected' for Hospital Standardised Mortality Rate and Summary Hospital-level Mortality Indicator rates (12 months rolling position), and no more than three outlier alerts in any given year.
- Reduction in the risk rating of all known risks associated with mortality improvement.

Patient Experience

To develop the patient experience aims, the patient experience and strategy teams have held engagement sessions with patients and staff to help identify the areas of improvement. We have also used the results from the 2019 National Inpatient survey, the 2019 Cancer survey, and the 2018 Children and Young People's survey

Why is patient experience a top priority?
We understand that coming in to hospital and using our services can be daunting for patients. The experience a patient has in our service is as important as the outcome of their clinical treatment. We want to ensure that patients receive the best experience as well as the best care while at the Princess Alexandra Hospital.

Focus	Measures of success
Addressing harms related to communication, ensuring we develop a culture of learning and psychological safety	A reduction in proportion of complaints where communication is the primary cause in years 2-3
Assessing and mediating the impact of technology on patient experience	Reduction in evidence of concerns raised by the implementation of new technologies through peer review as shown by PALS and complaints cases
Developing a culture of kindness and compassion to our patients and people which we can measure	Measurement of the number of times compassion and kind are mentioned in FFT results over the period of the strategy. Monitor and improve our scores across CQC satisfaction and the FFT

How will we improve patient experience at PAHT?

Addressing harms related to communication, ensuring we develop a culture of learning and psychological safety

- We will train staff in SATFAC (Sage and Thyme) training as trainers
- We will train staff using sage and thyme model
- We will develop a patient panel-led communication tool based on patient experience scenarios
- We will implement Patient safety partners
- We will see an increased number of PALS cases as a balancing measure
- We will see an increase in the overall number of complaints as we promote the service to address communications issues
- We will report to the People and Workforce committee for oversight of our progress against creating a just culture and psychological safety
- Regular reports to Patient Experience Group and other governance committees will reflect the voices of our patient groups as a process measure

Assessing and mediating the impact of technology on patient experience

- We will assess and mediate the impact of technology on patient experience
- We will develop consistent impact assessments on patient experience
- We will implement partnership working to support the development of patient centred perspective in conversations about adoptions of new technologies such as EPR and new hospital services

Developing a culture of kindness and compassion to our patients and people which we can measure

- We will develop patient experience competency and training such as patient experience concepts which assess and develop skills related to kindness
- We will connect learning from complaints with kindness and compassion based outcomes
- We will develop a strategy to share learning from mistakes and complaints. Every quarter we will have an agenda item at Patient Experience Group to discuss learning from complaints.

What will success look like?
We will see year on year improvement in Friends and Family Test, inpatient survey results and a reduction in formal complaints.

How we will monitor patient quality and safety

Assuring our patients that the Princess Alexandra Hospitals Trust is committed to improving the quality and safety of our care is of paramount importance. Quality and safety will be measured through national data analytics, such as Doctor Foster, Get It Right First Time (GIRFT), the Summary Hospital-level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR) for mortality. We will also use our internal data dashboards, the risk register, the board assurance framework and trust board reports in order to monitor progress and assure our patients, staff, Board, commissioners and regulators of our commitment and progress to improving the quality and safety of our care at The Princess Alexandra Hospitals Trust.

We shall also publish our progress in our yearly Quality Accounts, which are public documents that assure the public of our commitment to improving the quality of our care.

We will also monitor progress against our delivery plans for each priority at our Quality and Safety Committee (QSC) meetings quarterly. These plans will be regularly reviewed and updated to ensure they remain relevant and reflect the current situation of the organisation.

Quality Improvement methodology at PAHT

The Quality and Patient Safety strategy highlights the Princess Alexandra Hospital Trust's quality improvement approach. Projects to achieve the Quality and Patient Safety strategy will use the Quality Improvement methodology. PAHT uses the Model for Improvement methodology for all quality improvement projects. The Quality Improvement (QI) approach for the Trust is called "Quality First" which includes a central Quality Improvement Team .The Trust has developed a QI education and development programme which includes Leading Change and Leading Projects.

The Model for Improvement is the Princess Alexandra Hospitals NHS Trust's quality improvement methodology of choice. The Model for Improvement, developed by Associates in Process Improvement, provides an intuitive framework for developing, testing and implementing changes that can better ensure improvement.

1. The model firsts asks you to define a **SMART** (specific, measurable, achievable, realistic and time bound) aim.

2. The second question asks you to identify what you will measure to understand whether a change leads to an improvement.

3. The final question asks you to develop change ideas that would lead to a measurable improvement.

The model then combines with the Plan Do Study Act (PDSA) cycle to test changes on a small scale before scaling up. Our quality improvement methodology is spread throughout the trust and further strengthened by learning and development gained via the Leading Change and Leading Projects learning and development sessions, which are facilitated by the Quality First team.

Summary

Summary: Our vision for Quality and Safety at The Princess Alexandra Hospital Trust

Quality and patient safety is at the heart of our Trust strategy PAHT2030 and our vision to: '*Deliver outstanding care to the community'.*

Through achieving this strategy, by 2023 The Princess Alexandra Hospital Trust will deliver excellent experience and improved outcomes for patients within a culture of continuous quality and safety improvement.

Next steps:

Implementation plans will be produced for each of the priority areas, setting out in detail the actions needed, clear targets, key performance indicators and an accountable owner.

Progress against each plan will be reported to Quality and Safety Committee and Trust Board.

Appendix one: Short – medium term priorities for Patient Safety Specialists

Patient Safety Strategy requirement	Role of Patient Safety Specialist	Timescale
Local systems to set out how they will embed the principles of a safety culture on an ongoing basis. These should include monitoring and response to NHS staff survey results and any other safety culture assessments, [and] adoption of the NHS England and NHS Improvement 'A Just Culture Guide' or equivalent*	• Work with your HR team to ensure the Just Culture Guide (or an equivalent guide*) is formally adopted and built into your organisation's HR policies; and that staff and staff representatives understand how and when it should be used which is for the minority of cases where there is good reason to consider the role of an individual. If the Just Culture Guide is new to your organisation, working through the training scenarios provided and other resources, including insights from trusts with the best staff survey results, will help colleagues understand the benefits. • Ensure the safety sections of the recently published NHS Staff Survey results for your organisation are reviewed and discussed, and agree any actions needed to improve patient safety culture.	Ongoing
An Alert was issued by the Central Alerting System (CAS) helpdesk in September 2019 (CHT/2019/001: The introduction of National Patient Safety Alerts) which set out actions for NHS organisations to support the introduction of the new NatPSAs: ➢ Identify appropriate escalation routes for National Patient Safety Alerts to ensure organisation-wide coordination and senior oversight.	Help ensure your organisation has a system for the receipt and actioning of NatPSAs. This must have an organisational-wide coordination of response, with executive oversight, led by appropriate senior healthcare professional(s); and that this system can respond to alerts designated as 'complex' and as 'straightforward'. Your local system for managing alerts must ensure: • your board is notified as new NatPSAs are issued; and the appropriate people who are involved in implementation are	Ongoing

➢ Note the dual running period and action all alerts in the appropriate manner. ➢ Embed process for ensuring senior oversight and actioning of NatPSAs within your internal SOPs. There is an existing contractual and regulatory requirement to complete actions required in NatPSAs and this is reinforced by the strategy requirement that '100% compliance declared for NatPSAs by their action complete deadlines'	contacted to ensure they understand their responsibilities, allowing actions to be completed in the identified timescale. • NatPSAs are only recorded as 'action completed' on CAS with executive authorisation and assurance that all actions are complete. The board should be aware that a record of non-compliance with alerts by their designated deadline is publicly available on the CAS website, Provision of feedback to the alert issuer may also be required.	
Improving the quality of incident reporting as one of the principles of improving safety culture	Use your organisation's NRLS explorer reports to help improve how incidents are captured locally and most effectively described to the board. Support patient safety leads to ensure free text information provided in local incident reports is sufficient to enable national learning in accordance with information provided in NHS England and NHS Improvement Review and Response Reports. Ensure that the degree of harm provided in local incident reports is in line with NRLS degree of harm FAQs and the NHS Improvement pressure ulcer reporting framework.	Ongoing

Local systems, including current non-reporters, to connect to the new system subject to local software compatibility.	• Being local champions for PSIMS adoption:
	  ○ Engage with your risk management/LRMS management team about the PSIMS project; directing them to online resources and info; and encouraging them to speak with your LRMS vendor about timescales for upgrading your local system to be PSIMS compatible
	  ○ Speak to senior management to check they are aware of the project and its benefits, and seek their support for any necessary local changes.
	• Work with your internal communications team to begin raising awareness of the project amongst all staff and provide information around the changes to expect and when.
		End of Q4 2021/22

Local systems to plan how they will prepare for and support implementation of the PSIRF. This should be informed by nationally shared early adopter experience. Initially local systems should:
• Identify PSIRF implementation lead(s) by beginning Q3 2021/22
• Review current resource (in terms of skills, experience, knowledge and personnel) and subsequent action required from beginning Q4 2021/22, to ensure organisations across the local system are equipped
	• Support the identification of your organisation's PSIRF lead(s) and support links/networking with others supporting this work within the local system
	• Ensure a gap analysis is conducted to understand current skills, capability, capacity within the organisation to undertake:
	  ○ good practice patient safety incident investigation (working with those with investigation expertise as required)
	  ○ other types of responses (reviews) following a patient safety incident
	• Support work to address any identified gaps.
		Q3 2021/22
		
		Can be initiated at any time (recommend Q2/3 to support action planning from beginning of Q4 2021/22)
		
		Can be initiated at any time – recommend Q2/3

to respond to patient safety incidents as described in the PSIRF, and to undertake patient safety incident investigation (PSII) as describe in the PSII standards: NB: leaders and staff must be appropriately trained in responding to patient safety incidents, including PSII, according to their roles, with delivery of that training from Q4 2021/22 onwards • Update quality governance arrangements (from Q4 2021/22) that: ○ support implementation and oversight of PSIRF requirements ○ eliminate inappropriate PSI/SI/patient safety performance measures from all dashboards/performance frameworks ○ monitor on an annual basis the balance of resources for patient safety incident investigation versus improvement across the	• Start to identify structures, systems and staff involvement in patient safety incident management to help inform where and how changes to support PSIRF implementation will be required.	(to support action planning from beginning of Q4 2021/22) Can be initiated at any time to support action from beginning of Q4 2021/22

local system and whether actions completed in response to patient safety incidents measurably and sustainably reduce risk.		
Local systems and regions aim to include two PSPs on their safety related clinical governance committees (or equivalent) by April 2022 and elsewhere as appropriate.	• Agree with the executive director with responsibility for patient safety how the initial board commitment to PSP involvement will be made, including a public statement. • Identify an operational lead, if appropriate, for implementation of the framework. • Work with the executive director and operational lead to develop the initial business case for PSP involvement and gain relevant executive and financial approval. • If appropriate, coordinate an organisation-wide safety culture assessment using a recognised tool to identify any immediate actions required to support the introduction of PSPs. • Work with the executive director and operational lead to develop a plan for implementing the framework which takes into account the outcome of the culture assessment.	Immediate Immediate From April 2021 From April 2021 From April 2021

Support all staff to receive training in the foundations of patient safety by April 2023	• Update the exec directors with responsibility for patient safety and education and training on the patient safety syllabus, and the requirements for all staff to be trained. • Lead on the development of an implementation plan with the relevant education and training teams for the delivery of 'essentials' training once available in July 2021. • Be the contact point for queries from within the organisation relating to the 'essentials' training. • Ensure the uptake of 'essentials' training across the organisation is measured.	Immediate April- July 2021 April 2021 onwards April 2021 onwards
Local systems to deliver key enablers of patient safety improvement with support from the national patient safety team and PSCs Local systems to deliver the safety improvement programmes supported by the national patient safety team and the PSCs	• Understand how your organisation can contribute to each programme's national programme ambitions, including key enablers for system safety. • Engage with the named patient safety lead at your local PSC • Familiarise yourself with the PSC Local Improvement Plan across all five programmes and support with delivery and planning as appropriate. • Through direct involvement with Patient Safety Networks, support the improvement approach and/or implementation at system level.	Ongoing

	• Identify interventions that are measurable and scalable and provide realistic feedback on testing and scale-up. • Support with positive programme engagement at system and organisational level. • Contribute insight and local intelligence to support the PSC/Patient Safety Network to undertake the inequalities scoping exercise. • Work with the local PSC to raise awareness of safety culture and appropriate interventions and behaviours to enable a safety culture to flourish. • Provide or identify leadership support (including clinical leadership), as agreed with the PSC Patient Safety Lead, to support the set up and maturity of Patient Safety Networks and specific programmes of work. • Support the PSC to enhance improvement leadership and build safety improvement capacity and capability. • Share insights and intelligence relating to individual programmes to inform future safety improvement work.	

The Princess Alexandra Hospital NHS Trust

Trust Board 2nd December 2021

3.6

Agenda item:	3.6							
Presented by:	Sharon McNally, Director of Nursing, Midwifery and AHPs							
Prepared by:	Sharon McNally, Director of Nursing, Midwifery and AHPs							
Date prepared:	15th November 2021							
Subject / title:	Nursing, Midwifery and AHP Strategy update							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The Nursing, Midwifery and AHP strategy was launched in the organisation in December 2020, bringing together the professions' priorities under a 3-year direction and focus. In 2020/21, despite significant impact of the pandemic there were only 5 priorities that were not fully achieved. The paper describes progress against these as well progress against the new priorities that have been set for 2021/22. The paper also notes the risk to delivery against 3 priorities in 2021/22.							
Recommendation:	The Board to note the continuing work being undertaken to deliver the objectives set out in the Nursing, Midwifery & AHP strategy							

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:	Nursing, Midwifery and Senior Leadership Team (SLT): 8th November 2021. EMT: 18th November 2021. Workforce Committee: 29th November. 2021.
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	1. Shared decision making 2. CNO fellow 3. Consultant practitioner 4. 3 year strategic priorities

1.0 Purpose

This paper provides an update position on the Nursing, Midwifery and Allied Health Professional strategy, with particular focus on the delivery of the partially achieved priorities in year one, and progress against the year two priorities.

2.0 Background

The Nursing, Midwifery and AHP strategy was launched in the organisation in December 2020, bringing together the professions' priorities under a 3-year direction and focus.

Whilst the delivery of the year one (20/21) objectives was slowed by the significant impact of covid-19, considerable progress was made across a number of the priorities. The year one priorities flow into the current 21/22 year where continued improvement against priorities can be seen.

The three-year priorities are included in appendix 4. The delivery of the strategy is overseen by the nursing, midwifery and AHP senior leadership team (SLT).

3.0 Progress

The partially achieved priorities and progress for year one (20/21), and progress against the current year (21/22) is detailed in the table below:

Priority (year one 20/21)	Update
Commence bespoke leadership programme for matrons	The programme was developed in the 20/21 year, but the launch was paused due to the pandemic and the priority to enable the ward managers programme to commence. The matron programme, with all our 15 participants, was launched June 2021 with the Myers Briggs Type Inventory (MBTI) and the first formal session with NHS Elect was held the first week of November.
Continue to reduce nursing and midwifery vacancies (qualified and unqualified) to less than 2%	Delivery of this priority was significantly affected by the reduction in global movement in line with the pandemic. However, over the 20/21 year we grew our registered workforce by 45 wte band 5 nurses. Since April we have continued to grow with an additional 21 wte (net of turnover) and we continue to have significant focus on our nursing and midwifery vacancy rate and we are on trajectory to be < 2% by end March 22. Our unregistered workforce vacancy rates remain challenging due to turnover and a number of our healthcare support workers (HCSW) commencing our 'grow your own' routes into nursing. Overall, we have 54 nursing apprenticeships currently in training. Significant focus is being given to reduce the HCSW vacancies, but there is risk to achieving the < 2% end year target.
Introduce ward dashboard to measure nurse sensitive indicators and measure how we are doing	The ward dashboard metrics have been agreed by nursing, midwifery and AHPs and includes nurse sensitive indicators. A draft dashboard with available metrics is to be tabled at the Senior Leadership Day on 13th December. It is acknowledged that the dashboard development is likely to be an iterative process due to data availability in electronic form. It is also noted that the ward accreditation programme will also inform this strategic priority for nursing, midwifery and AHPs.

Commence introduction of shared governance (decision making) framework across the Trust	We have been associated with the EoE programme for shared governance, however, the implementation of the programme was delayed in 20/21 due to the pandemic. In year we have appointed a new project lead, have refreshed the delivery programme and aim to launch the communication strategy by the end of November with a plan for a minimum of two councils by the end of 21/22. An overview of shared governance is included in appendix.1.
We will work with the Trusts Equality Diversity &Inclusion lead to build a development plan for nursing, midwifery and AHP leadership roles which are under represented by BAME staff	The proposal for enhancing the BAME representation will be tabled at the BAME network to enable further conversation and support (December) The proposal includes: International Recruits Shared Decision Making Council, Chief Nursing Fellowship programme, Reciprocal Mentorship and a purposeful review of the 'Face of the Professions' across our relevant media sites.

In year two we said we would focus on:

Priority (year two 21/22)	Update
Career development pathways in place maximising shared experience across STP and wider network	Shared rotations and outreaching services are being scoped -aligned to PAHT 2030 priorities and N, M & AHP priorities. Current pathways include: Shared apprenticeship programme with local Hospices, Acute/Community rotations with HCT Outward reach into LD pathways Workforce model for frailty includes plans for joint posts for AHP with ICS acute partner (ENHT)
Commence direct entry Nursing Associate Apprenticeship programme	Direct entry apprenticeship programme in place. Due to the success of our apprenticeship 'grow your own' model (54 currently on the programme); our direct entry programme for this module will February 2022.
Develop workforce model for extended practice roles for specific pathways	This priority has been scoped into a broader piece of work that includes: understanding the baseline for specialist nurse titles and banding across the organisation and consistent, effective job planning. This will identify opportunities for extended practice across the professions. This work is due to report progress at the SLT day on 13th December. Extended practice roles are embedded across the organisation in a number of specialities including: Advanced Clinical Practitioners in NICU and Emergency Nurse Practitioners with the UEC footprint.
Implement fast track development programme to grow our future leaders	A proposal for Chief Nurse Fellows has been developed and supported by the Senior Leadership Team. Please see appendix.2 for additional information.
Nurse, midwifery and AHP led discharge embedded	Midwifery led discharge is embedded within the labour pathways. Scoping of N,M & AHP led discharge is being undertaken and is in line with the discharge workstream identified within the Urgent Care Programme Board improvement programme

Enhanced care team in place and demonstrating improved patient outcomes and reduced patient safety incidents	Recruiting to the enhanced care team has commenced with 2.38WTE HCSW in post. They are undergoing extended training to include Namaste care and supporting mental health patients. The pool should be fully established with 12.43WTE HCSW by the end of the year which will provide 4 staff per shift to be deployed were required. In addition, the team is supported by an agency RMN night shift. Recruitment of a substantive team of 4.14 WTE RMN's is also underway.
Evidence based nursing/AHP research programme commences	This is linked to implementation of consultant practitioner roles (see below)
Implement Consultant Practitioner role at PAH.	Discussions are ongoing with Anglia Ruskin University (ARU) don joint a Professor of Nursing post. Scoping of consultant practitioner opportunities has identified key areas: Consultant practitioner in urgent and emergency care and, consultant practitioner in the care of the older person (Frailty). In addition, our maternity services have identified a role for a midwifery consultant with the portfolio for midwifery led care and public health Further information on consultant practitioners is include in appendix 3. A joint SLA in relation to the UEC post should be agreed with ARU by the end of December and recruitment commence in January 2022.

4. Risks to the programme

- HCSW vacancy rate: due to the current turnover of the HCSW, achievement of the < 2% end year vacancy rate is at risk. A strong focus on maximising our recruitment has been enhanced by the appointment of our recruitment and retention nurse. Oversight of the vacancy rate and tracking of progress will be reported via the Hard Truths: Safer Staffing report to the Workforce Committee and Board.
- Ward dashboard: whilst progress is being made with this priority, availability of a complete integrated dashboard is unlikely by end Q4, however visibility of metrics via the BI tool is progressing incl. Perfect Ward reporting.
- N, M & AHP led discharge: discharge pathways for maternity are in place, however optimising N,M & AHP led discharge is not likely to be deliverable in the current year and will roll over for embedding in 2022/23.

5. Governance of the programme

Work to further take forward the 2021/22 priorities are being overseen by the Nursing, Midwifery and AHP senior leadership team (SLT). The SLT reports to SMT.

6. Recommendation.

To note the progress of the N,M & AHP strategic priorities.

Appendix 1.

Shared Governance (Shared Decision Making)

The PAHT Nursing, Midwifery and Allied Health Professionals Strategy (2020/23) pledges to embed a model of shared governance that will ensure frontline staff are engaged in trust wide decisions. The goals are to improve experiences and clinical outcomes for patients and to strengthen staff engagement and satisfaction through empowerment and engagement.

Shared Governance places staff at the centre of the decision-making process with managers taking on a facilitative leadership role.

"Collective leadership is about everyone taking responsibility not just for their own job or role, but for the success of their team and their organisation as a whole. It is about ensuring that all voices are valued and contribute to the conversations where decisions are made" Ruth Many CNO England.

Shared Governance and the empowerment of frontline staff to engage in collectively leading improvements in quality of care is a crucial part of the continuous journey towards achieving excellent patient and staff experience and excellent patient outcomes.

LAUNCHING SHARED DECISION-MAKING COUNCILS

In order to facilitate shared governance at PAHT, the aim is to begin to establish Shared Decision-Making councils. Through shared decision-making councils, staff will take collective ownership for developing and improving practice; ensuring patients receive caring, safe and confident care.

NHS Organisations that have successfully implemented shared decision making councils refer to benefits such as

- Staff members feeling they have a voice in improving quality of care,
- Staff feeling empowered to take control and make decisions
- Staff feeling included in decision making across the organisation.

There are four underpinning principles to a successful shared decision making council:

1. **Responsibility** – Council members are given the responsibility to manage decisions (nursing/midwifery) at local level; contributing to the Trust vision and objectives
2. **Authority** – Council members have authority to act, supported by Leadership council
3. **Accountability** – Council members are accountable for their decisions in terms of delivering patient care, developing the professions and implementing change
4. **Equity** – Council members have an equal voice, no role more important than another

COUNCIL FUNCTIONS

Ward/Unit Practice Council – Focus upon one ward or department, with around 4 to 7 members recruited from bands 2 to 6 staff. Each council meets on a monthly basis and nominate one member to chair the meetings. The aim is to focus on projects that will

- Improve patient care or safety or
- Improve staff well-being or
- Improve the environment.

Councils will use measurable outcomes in order to evaluate impact. Each council will have access to a facilitator whose role is to ensure that professional decision making is meaningful for both patients and staff in the clinical area.

The chair of the council is invited to attend the Leadership Council where they will provide a progress update as well as having access to support when required.

Themed Council – Sitting cross PAHT as a whole, the council focuses upon a particular group of staff or a specific topic or theme. Using shared governance principles this type of council seeks to discuss and pursue actions to address improvements that will benefit the wider organisation (examples of topics include newly qualified nursing/midwifery staff, equality and diversity).

Speciality Council – This type of council includes members from a group of wards/departments with the same speciality. Members are recruited from all relevant areas (2 or 3 from each). The focus is on improvement using measurable outcomes that are collectively agreed and can be evaluated. The aim is to

demonstrate shared decision making that positively impacts upon patients and staff in the individual clinical areas. Regularity of meetings may be monthly.

Leadership Council – Chaired by the Director of Nursing, Midwifery & Allied Health professionals (DoN, M & AHP) or the Deputy Director of Nursing and midwifery. Other members include the lead nurse for ward accreditation, a member of the Patient Panel, senior nursing, Midwifery and AHP colleagues (such as a ward manager or matron). Representatives from relevant support services such as Human Resources, finance, estates and facilities, training and development, Patient Experience and Quality Governance shall all be invited when required where their expertise may be able to provide support and guidance, clearing obstacles to success.

All councils will nominate a member to attend the leadership council (initially alongside their facilitator) where there is an opportunity to discuss the work being undertaken, report back on progress and debate professional issues. This enables engagement in discussions about broader strategic decision making for the Trust and nationally.

The function of the leadership council is to

- Support frontline staff councils in the development and delivery of their improvement projects.
- Celebrate completed initiatives
- Report to the Trust Board via the DoN, M & AHP, all aspects of shared decision making undertaken by the councils with evidence of improvements for patients and staff.

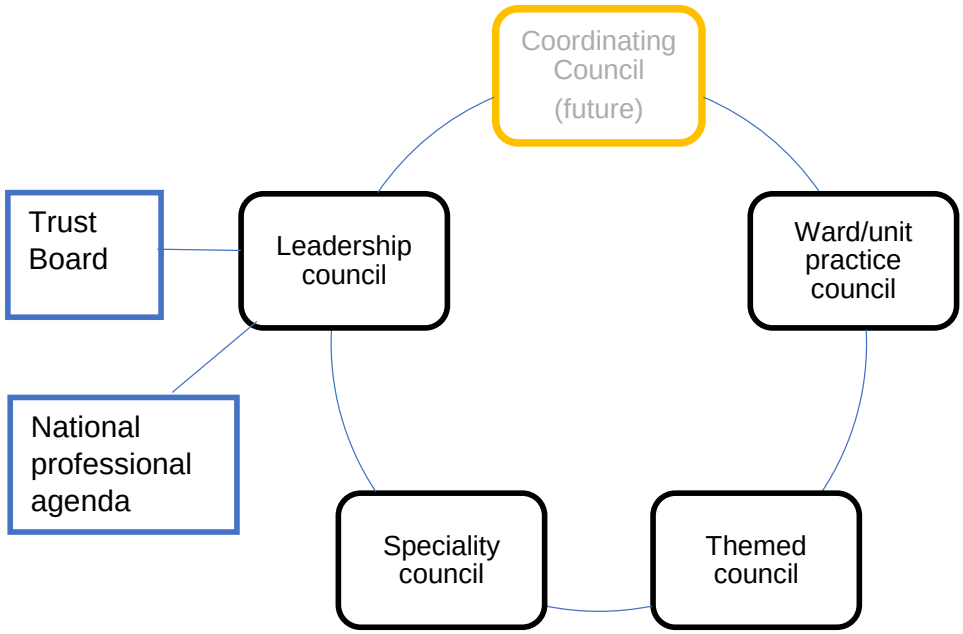
Coordinating Council – To be developed over time within health care groups/divisions once the roll out of Councils has been implemented. The purpose of the Coordinating council will be to bring together representatives from existing councils within the division on a quarterly basis. The Coordinating Council will provide support as well as oversight of projects being undertaken. Using an appreciative enquiry approach, the coordinating council will explore

- What projects are being pursued and how they are progressing
- Whether any support or help is required to enable success
- How the projects align with health care group/divisional or trust wide priorities
- How shared decision making around professional issues is impacting upon strategic objectives for the improvement of patient experience, clinical outcomes and staff well-being.

PROPOSED SHARED DECISION MAKING STRUCTURE FOR PAHT

Figure one is the proposed structure for shared decision making councils at PAHT and is based upon the successful model introduced at Nottingham University Hospitals NHS Foundation Trust (successfully rolled out in other organisations such as Northampton General Hospital NHS Trust).

Figure One



Appendix 2

CNO fellows.

The Chief Nurse Fellowship is an opportunity for nurses, midwives and Allied Health Professionals (AHP's) to be seconded for up to x days per week (TBC) for a 12-month programme. The secondment will enable the Chief Nurse Fellow to develop clinical leadership and service transformation skills through undertaking a specific service development.

The benefits of the programme are that it allows PAHT to:

1. Develop our staff through building a talent pool and identifying our rising stars
2. Showcase our Nursing/Midwifery and Allied Health Professionals (AHP's) excellence
3. Champion the role which Nurses/Midwives and AHP's play within patient care and experience
4. Promote the Trust as a positive place to have a nursing/midwifery and AHP career
5. Highlight the leadership influence of our Nurses/Midwives and AHP's
6. Expand our networks, learn from others and share best practice
7. Progress Nursing/Midwifery and AHP's careers
8. Maximise the creativity and innovation and passion within our Nursing/Midwifery and AHP workforce

This is a positive opportunity for a nurse, midwife or AHP with at least 18 months post registration experience to have access to a unique professional development programme which will provide a broader understanding of the organisation and the NHS and support future career aspirations.

Appendix 3

Consultant Practitioner

Introduced by the Department of Health in 2000, the nurse consultant role **aims to improve the quality of services, strengthen leadership and help retain experienced and expert nurses in clinical practice**.

There are 4 pillars to a nurse practitioner role*

- expert practice function (**clinical practice**)
- professional leadership and consultancy function (**leadership**)
- education, training and development function (**education**)
- practice and service development, research and evaluation function (**research**)

*Practitioner is used to describe a nurse, midwife or allied health professional.

NHS
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Appendix 4

2020/21	Lead	(end	ority No	2021/22 (* 21/22 priorities in bold)	Lead	Priority No	2022/23 new priorities
Ward managers move to supervisory	SMcN						
Commence bespoke leadership programme for ward managers	SMcN		2	ongoing	SMcN		
Implement matron review	SMcN						
Commence bespoke leadership programme for matrons	SMcN		4	ongoing	SMcN		
Review ward administrative support to ensure equity and increased ward clerk cover	SW						
Continue to reduce nursing and midwifery vacancies (qualified and unqualified) to less than 2%	SMcN/SW		6	Continue to drive	SW		
Commence Fundamentals of Care programme to improve nurse led outcomes and promote trust and confidence in nursing	SW		16	**Enhanced care team in place and demonstrating improved patient outcomes and reduced patient safety incidents**	SW		
Introduce ward dashboard to measure nurse sensitive indicators and measure how we are doing	FD		8	further develop and embed	FD		
Commence development of ward accreditation programme	SW		17	**Embed Ward Accreditation programme**	SW (JE)	28 29	1. PAHT part of national accreditation programme (ANA or similar) 2. At least one ward achieves exemplar status and at least 50% achieves accreditation
Commence introduction of shared governance framework across the Trust	PH		18	**Embed shared governance programme**	PH		
Commence Degree Nurse Apprenticeship programme	SW		19	**Commence direct entry Nursing Associate Apprenticeship programme**	SW		
Nursing, Midwifery and AHPs to be actively involved and engaged in developing the clinical pathways for the new hospital	ALL		20	**Nursing, Midwifery and AHPs to be actively involved and engaged in developing the clinical pathways for the new hospital**	SMcN (CNIO)		
Strengthening leadership to ensure nursing and therapies embrace digital technology	SMcN			CNIO to commence Q2			
Nursing, Midwifery and AHP's actively involved and engaged in development of EPR	SMcN		21	**Nursing, Midwifery and AHP's actively involved and engaged in development of EPR**	SMcN (CNIO)	30	Nursing, midwifery and AHP workforce will be prepared for ePR and digitalisation
We will work with the Trusts Equality Diversity &Inclusion lead to build a development plan for nursing, midwifery and AHP leadership roles which are under represented by BAME staff	SMcN		15	Implement plan	SMcN		
			22	**Career development pathways in place maximising shared experience across STP and wider network**			
			23	**Develop workforce model for extended practice roles for specific pathways**			
			24	**Implement fast track development programme to grow our future leaders**			
			25	**Nurse. midwifery and AHP led discharge embedded**			
			26	**Evidence based nursing/AHP research programme commences**			
			27	**Implement Consultant Practitioner role at PAH**			
						31	Comprehensive simulation training programme in place to support MDT learning to support improvements in communication for better outcomes
						32	Nursing, midwifery ad AHPs to be actively involved and engaged in developing the clinical pathways for the new hospital

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 02.12.21

Agenda item:	4.1
Presented by:	Ogechi Emeadi, Director of People
Prepared by:	Shahid, Sardar, Associate Director Patient Engagement & Experience Padraig Brady, Lead Strategic HR Business Partner
Date prepared:	9th November 2021
Subject / title:	Equality Delivery System Update

Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	

Key issues:	The **Equality Delivery System** (EDS2) is designed to help NHS organisations, in discussion with stakeholders, review and improve performance for patients, communities and staff in respect to all nine characteristics protected by the Equality Act 2010. The Trust assesses its performance against 18 outcomes (within 7 thematic goals) and assigns an assessment grade of Undeveloped- Developing – Achieving – Excelling against each outcome. The attached EDS2 report summarises the evidence collated to support the assessment ranking for each outcome: • **6** goals are assessed as developing • **10** goals are assessed as achieving • **2** goals are assessed as excelling The EDS2 report will be reviewed annually.
Recommendation:	This paper is presented for information.

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:	Senior Management Team, Equality, Diversity & Inclusion Steering Group and the People Board.
Risk / links with the BAF:	Risk of reputational damage and/or negative impact on employee relations and/or services to patients.
Legislation, regulatory, equality, diversity and dignity implications:	In accordance with relevant equality/employment legislation and best practice.
Appendices:	

Equality Delivery System for the NHS
EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

The Princess Alexandra Hospital NHS Trust

Organisation's Board lead for EDS2:

Ogechi Emeadi Executive Director of People, OD and Communication (workforce) Sl

Organisation's EDS2 lead (name/email):

Padraig Brady - padraigbrady@nhs.net (workforce) Shahid Sardar shahidsardar@nh

Level of stakeholder involvement in EDS2 grading and subsequent actions:

Equality, diversity and inclusion steering group represented by:
- Executive lead
- Patient panel
- Staff side
- EDI champions
- People division
- Patient experience team

Other groups/committees
-Workforce committee members
- Quality and safety committee members

Organisation's Equality Objectives (including duration period):

PAHT's Equality objectives 2017 - 2022 (revised in 2021)

1. We will ensure ongoing involvement and engagement of protected groups and 'local interests' including patients, carers, staff, the third sector, clinical commissioning groups and the local authority, improving access to NHS services for protected groups and enabling the most responsive, effective organisation we can be to support patients, carers and families at their times of greatest vulnerability as well as the most vulnerable patients.

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

- Implementation of agile working/ increased flexible working
- Reverse executive mentoring
- Management and leadership development in place for clinicl and non clinical staff
- EDI/ people team representation on interview panel 8a and above (Aug 2021)
- Unconscious bias training
- EDI activities taking place throughout the year - webinars, Q&A sessions, staff briefings
- BAME support line in respinse to COVID
- COVID Risk assessment for all staff, all EIA

Publication Gateway Reference Number: 03247

Date of EDS2 grading August 2021 **Date of next EDS2 grading** August 2022

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: PAHT works closely with commissioners to ensure that patients are, consistent with our values, at the heart of the design and delivery of our services while working towards the realisation of a single accountable care organisation in the area, One Health & Care Partnership. PAHT has systems in place to provide opportunities for patients to	✓
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: The Trust proactively assesses the individual needs of patients and supports reasonable adjustments to meet their needs. Individual needs are assessed prior to attendance where possible (e.g. additional slots are provided at outpatient appointments for people with learning disabilities, we use the TEACH acronym to support reasonable adjustments based on a user led model designed by our Hertfordshire PWLD groups such as Purple Stars, Grove	✓
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Admission processes lead to appropriate pathways being followed for patients, and patients are kept informed and involved through multi-disciplinary teams who work to enable smoother transitions between services across the Trust. Collaborative working with the community and other Trusts enables regional transitional care for patient groups, and ensures referrals	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: The safety of our patients is a priority for our organisation, our pathways promote safety and we work within a safety reporting culture, implementing our duty of candour so patients know when something has gone wrong and are aware of our plans to address the consequences in terms of harms, systemic issues and a Safety II perspective.	✓
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: The pandemic has highlighted the role of acute hospitals in supporting vaccinations of our staff population, in addition to public screening and vaccinations delivered during antenatal appointments and vaccination checks. The Trust routinely ensures that health screening programmes are available (e.g. cancer screening, eye screening, antenatal	✓
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: PAHT recognises the need for all our patients to access our hospital and its services without barriers, to ensure high quality health care. We acknowledge there are potential barriers regarding communication, physical access and location access – and that steps must be taken to mitigate the risk of these barriers preventing access to our services.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Patients are informed about their care to enable their involvement in decision making, and PAHT surveys assess patient satisfaction of this, for example we run a bereavement survey by telephone led by patients which have identified year on year improvements over the last 3 years, as well as Paediatric Hospital at Home, Nutrition Surveys, patient initiated follow up surveys, the Friends and Family test and the Maternity Survey.	✓
	2.3	**People report positive experiences of the NHS** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Our Friends and Family Test (FFT) results show that 97% of respondents reported having a 'Very Good' or 'Good' experience of our services between January-August 2021, with <2% reporting a 'Poor' or 'Very Poor' experience. Over 500 compliments were recorded for the Trust over the same period during wave 3 of the COVID-19 pandemic.	✓
	2.4	**People's complaints about services are handled respectfully and efficiently** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** People's complaints about services are handled respectfully and efficiently through our PALS service, complaints and legal services as well as the clinical teams involved. Service users are encouraged to speak with ward/ departmental staff to resolve any informal concerns at the time, with the PALS team available to process all concerns in collaboration with patients	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: - Implentation of unconscious bias training for all managerial posts - New managers induction including recruitmenr and selction training - Recruitment and selection training for EDI steering group members - From Aug 21, EDI/ People team representation on all interviews 8a and above	✓
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: - PAHT follow agenda for change guidelines on appointment of staff - Job descriptions are assessed by management and staff side - PAHT report annually on the gender pay gap which can be found on the trust website	✓
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: - Leadership development programmes developed for all taff, matron and new consultants - 2019 appraisal policy updated to include discusions around talent conversations and career development - New manager incuction programme (open to existing manager) embedded and positively received by attendees	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: - Development of a trust culture steering group as part of the people division governance structure - Here to Hear program delivered in response to staff survey outcomes with local action plans developed to address themes - Recruitment of additional 5 freedom to speak up guardians, bringing the total to 7, representing both clinical and non clinical workforce	✓
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: - The trust embraced and implemented agile working in April 20 following the first COVID wave. Laptops and mobile telephone systems were implemented in most work areas where applicable with a continues roll out across all teams and sites where possible - Health and wellbeing conversations take place as part of the annual appraisal - Flexible working policy in place and actively promoted	✓
	3.6	**Staff report positive experiences of their membership of the workforce** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: - Staff report positive feedback on developmental training sessions such as new managers induction - Staff engagement has increased significantly following implementation of virtual events such as executive briefing, in touch briefings on key topics	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: - Board development sessions on inclusion an compassionate leadership - Equality initiatives supported by the bord - staff story delivered to board bi monthly covering equality topics - WRES, WDES and annual equality reports dvivered to workfoce committee and board - Director People SRO for ICS workforce ICS - NED attendance at staff networks and engagemen events	✓
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: - Equality impact assessments are in place where relevant	✓
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: - New managers induction cover key people policies - Implementation of a refreshed disciplinary pre assessment following NHS I/E review guidance. Ensuring that a full and fair assessment of cases takes place prior to formal intervention - EDI champions for protected characteristics - EDI awareness webinars take place with bespoke sessions on specific characteristics such as disability - hearing loss	✓

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 02.12.21

4.2

Agenda item:	4.2
Presented by:	Ogechi Emeadi – Director of People, OD and Communications
Prepared by:	Ellie Manlove, Health and wellbeing lead, Beverley Watkins, Deputy director of people
Date prepared:	24 November 21
Subject:	Vaccination as a condition of deployment (VCOD) for all healthcare workers

Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**		

Key issues: please don't expand this cell; additional information should be included in the main body of the report	• The Department of Health and Social Care (DHSC) formally announced (9 November) that individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19 by no later than 1 April 2022 to protect patients, regardless of their employer, including secondary and primary care. • The government regulations are expected to come into effect from 1 April 2022, subject to parliamentary process. This means that unvaccinated individuals will need to have had their first dose by 3 February 2022, in order to have received their second dose by the 1 April 2022 deadline. • Organisations await further information or guidance on this matter • The trust will be taking a number of steps in preparation of this regulation whilst we await further information. This will include: continued education and promotion of being vaccinated, promoting the regulation on vaccination to all new starters through advert and the on-boarding process - specifically O/H clearance), webinars and education through staff networks • 86% of our staff are fully vaccinated (both doses). 77% have received the booster
Recommendation:	Trust Board are asked to note the 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			

Previously considered by:	People cell Executive Management Team
Risk / links with the BAF:	NHS People plan BAF Risk 2.1 Workforce Capacity 3.2 Ability to recruit, retain and engage KLOE 4 – Good governance
Legislation, regulatory, equality, diversity and dignity implications:	Equality Act 2010 CQC well led *Pending VCOD regulation
Appendices:	Appendix one – Letter from Amanda Pritchard re: Vaccination as a condition of deployment (VCOD) for all healthcare workers

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

4.2

Vaccination as a condition of deployment (VCOD) for all healthcare workers

1.0 Purpose/issue

The Department of Health and Social Care (DHSC) has formally announced (9 November) that individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19 no later than 1 April 2022 to protect patients, regardless of their employer, including secondary and primary care.

2.0 Context

The government regulations are expected to come into effect from 1 April 2022, subject to parliamentary process. This means that unvaccinated individuals will need to have had their first dose by 3 February 2022, in order to have received their second dose by the 1 April 2022 deadline.

Current vaccination rates for staff at the Trust who have fully vaccinated (1st and 2nd doses) is currently 90% (at second dose)

*Booster vaccination is at 77%, it should be noted however that staff were only eligible for a booster 6 months after the second vaccination and therefore may have missed the timeframe of when the trust were administrating this. Staff are sign posted to their nearest vaccination sites.

Staff who have been vaccinated outside of the trust are asked to confirm their vaccination status with SHaW, this is then recorded on their health record.

NHSI/E have advised that the parliament will need to agree the proposal by 15 December 2021 for the current timeline to be met.

Once agreed and in law, the 12 week period of consultation will commence from 6th January with 1st dose required by 3rd February. If it is not agreed by Parliament by 15th December, then the timeline will change.

The trust record vaccination status's via a system called NIVS (National Immunisation and Vaccination System)

3.0 Proposal

Appendix 1 outlines the proposals for vaccinations being a condition of employment however at present no further information has been released.

At present there is no definition of who will be directly affected by these proposals but it is anticipated to be any CQC registered organisation and those staff who are patient facing. With this in mind, the trust will be applying the same criteria to that of the flu vaccination, therefore all roles considered front line/ patient facing will be the primary focus. Communication will focus on active education and promotion to all staff on the importance and benefits of being vaccinated

In order to prepare for vaccination being a condition of employment the trust will Continue with a programme of promotion and education including:

- Refreshed FAQ's
- Webinars to all staff and networks led our IPC and SHaW teams
- Job adverts will advise on the requirement to be fully vaccinated by 1 April 2022
- Vaccination status monitored and recorded at pre-employment by SHaW.
- Data review of staff who may have been vaccinated locally but have not updated SHaW
- Information and education sessions planned with staff groups / divisions where there is a low uptake vaccination numbers.
- Links with Staff networks to specific tailored information sessions regarding vaccinations.
- Discussions with Trade unions regarding implementation plan once details are known.
- Managers to discuss vaccination with all staff in a compassionate way.
- Discussions with NHSP/Agencies regarding recording of workers vaccination status and assurance processes

4.0 Risks and mitigation

There is a potential risk that we might need redeploy front line staff if they are not fully vaccinated by the government implementation date of the new legislation. This risk will be added to the risk register. New candidates into the trust will be advised on the requirement to be fully vaccinated by. 1st April 2022.

5.0 Recommendation

Trust Board are asked to note the report for information. Further updates will be reported to Trust board in the coming months

Author: Ellie Manlove – Health and wellbeing lead
Date: 24 November 2021

Classification: Official
Publication approval reference: C1451

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

10 November 2021

4.2

To:
- ICS leads
- All Trust (acute, community, ambulance, mental health):
  - Chief Executives
  - Chief Operating Officers
  - Chief AHPs
  - Chief Nursing Officers
  - Medical Directors
  - Chief People Officers/HR Directors
  - Chief Dental Officers
  - Chief Pharmaceutical Officers
- CCG accountable officers
- CCG HR Directors
- Regional Directors of Primary Care
- Regional Directors of Public Health
- PCN Clinical Directors and GP providers
- All NHS Primary Care Dental Contract Holders

CC:
- Regional Directors
- Regional Directors of Commissioning
- Regional Directors of Primary Care and Public Health Commissioning
- Regional Directors of Performance and Improvement
- Regional Chief AHPs
- Regional Chief Nurses
- Regional Medical Directors
- Regional Chief People Officers
- ICS chairs
- Chairs of NHS Trusts and Foundation Trusts
- CCG Chairs

Dear colleague

Vaccination as a condition of deployment (VCOD) for all healthcare workers

Policy announcement by the Department of Health and Social Care

The Department of Health and Social Care (DHSC) has formally announced (9 November) that individuals undertaking **CQC regulated activities in England must be fully vaccinated against COVID-19 no later than 1 April 2022 to protect patients**, regardless of their employer, including secondary and primary care.

The government regulations are expected to come into effect from 1 April 2022, subject to parliamentary process. This means that **unvaccinated individuals will need to have had their first dose by 3 February 2022,** in order to have received their second dose by the 1 April 2022 deadline.

This government policy takes into account specific exemptions, including those who are medically exempt; under 18 years of age; do not have contact with patients; or are a participant in a clinical trial investigating COVID-19 vaccination. Further details on exemptions will be detailed within the DHSC Code of Practice which the NHS is

expecting to be published imminently. The policy applies to the first and second dose of the COVID-19 vaccination, and not to boosters or the flu vaccination at this stage.

Next steps from NHS England and NHS Improvement

The NHS has always been clear that individuals should get the life-saving COVID-19 vaccination to protect themselves, their loved ones and their patients; the overwhelming majority have already done so. We will continue to support individuals who have not yet received the vaccination to encourage them to take up the offer of the 1st and 2nd doses, which will always be made available to them (the 'evergreen' offer).

NHS England and NHS Improvement is working with NHS Employers, DHSC and wider stakeholders to develop detailed implementation guidance, which will be issued in due course. This will give clarity and confirm specifically which individuals are in scope of this policy. We will work with you to minimise service disruption and ensure patient care and safety continues to be our core priority.

We ask local commissioners and systems to support primary care organisations, particularly where uptake is lower. NHS England and NHS Improvement will continue to work with local, regional, and national vaccination teams providing support to increase vaccination uptake. Targeted information is available to tackle misconceptions around vaccinations. For example, we are engaging with clinical, BAME networks and faith leaders through our advisory groups to ensure we provide appropriate support across the workforce; and have created videos with experts around fertility and pregnancy to reassure staff of the safety and importance of being vaccinated against COVID-19.

Next steps for the service

We know that one-to-one conversations have been the most effective way to support colleagues to make an informed choice, often leading to vaccination uptake. Therefore, we ask organisations to ask line managers to have supportive one-to-one conversations with unvaccinated staff members to identify reasons for vaccine hesitancy and provide information that will support them to make an informed decision about the vaccine. Resources to assist with this can be found here.

Other actions which have been found to be especially effective in increasing vaccination rates include:

- Making it as simple and convenient as possible to receive the vaccine and to make the most of walk-ins, pop-ups, and other delivery models, such as hospital hubs, vaccinations centres and local vaccination services.
- Engagement with targeted communities where uptake is the lowest, including extensive work with BAME and faith networks to encourage healthcare workers to receive the vaccine.
- Senior leaders and clinicians to proactively encourage vaccination uptake for all individuals through concerted communication campaigns and proactive engagement with individual colleagues.
- One-to-one follow up with unvaccinated individuals to offer structured support and access to expert clinical advice.

Please encourage individuals who have not yet been vaccinated to use the resources available and discuss with their own GP or trusted healthcare professional if they wish to have a further conversation or have any questions around vaccination.

Staff can access their COVID-19 vaccine from their place of work, from a community pharmacy, or a local vaccination centre using the National Booking Service. Frontline healthcare workers working outside of the NHS, including clinical and non-clinical staff, students, volunteers, and laboratory or mortuary staff, can use the National Booking Service to book their vaccine.

Support for staff

NHS England and Improvement has put in place a comprehensive package of wellbeing support for health and social care staff which includes:

- a dedicated health and care staff support service including confidential support via phone and text message
- free access to a range of mental health apps
- a range of counselling and talking therapies
- online resources, guidance, and webinars.

We would like to take this opportunity to thank all those who have already been vaccinated and to emphasise how important it is that every person who is eligible to do so also takes up COVID-19 boosters and flu vaccinations in the lead up to winter.

Thank you for your continued support throughout the vaccination programme and for everything you are doing to care for patients and support your colleagues at this time.

Yours sincerely

Amanda Pritchard	**Prerana Issar**	**Professor Stephen Powis**	**Ruth May**	**Dr Nikita Kanani MBE**
NHS Chief Executive	Chief People Officer for the NHS	National Medical Director	Chief Nursing Officer for England	Medical Director for Primary Care

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 December 21

4.3

Agenda Item:	4.3
Presented by:	Gech Emeadi – Director of People
Prepared by:	Ellie Manlove – People Lead Transformation
Date prepared:	23 November 2021
Subject	Healthcare worker flu vaccination best practice management checklist

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary:	In July 21 national clinical and staff side professional leaders wrote to Chief Executives requesting that the best practice management checklist for healthcare worker vaccination was completed. It is a requirement that the self-assessment against these measures is published in Trust Board papers for public assurance
Recommendation:	For Trust board to approve the Self-Assessment

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:	EMT.26.11.21
Risk / links with the BAF:	n/a
Legislation, regulatory, equality, diversity and dignity implications:	n/a
Appendices:	n/a

Healthcare worker flu vaccination best practice management checklist

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**	**RAG Rating**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated,	All staff members to be offered the vaccination	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	This has been ordered and delivered into the Trust w/c 27 September 2021	
A4	Agree on a board champion for flu campaign (3,6)	Ogechi Emeadi - Director of People, Organisational Development and communications. Helen Howe – Health and Wellbeing Guardian	
A5	Agree how data on uptake and opt-out will be collected and reported	This information is being collated by the SHaW team and recorded on ESR. Self-reporting is also requested by individuals to SHaW due to external vaccination services as an ongoing action.	
A6	All board members receive flu vaccination and publicise this (4,6)	Board members to be captured at the vaccination clinic	
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6)	Flu champions have all been trained, these are mainly nursing staff. Additional banks nurses have been booked to support vaccinations	
A8	Flu team to meet regularly from August 2021 (4)	Monthly meetings in place and planning meetings from Summer 21 with weekly meetings from September 2021	
B	**Communications plan**		
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions (3,6)	Posters, regarding why you should get the flu vaccination posted around the hospital, screen savers	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4)	All published on Alex and in the daily communication briefings	
B3	Board and senior managers having their vaccinations to be publicised (4)	As per A6	

B4	Flu vaccination programme and access to vaccination on induction programmes (4)	All new staff are offered immunisation as part of pre-employment checks	
B5	Programme to be publicised on screensavers, posters and social media (3, 5,6)	Flu plan agreed with communications to include screensavers, posters, social media and internal communications	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6)	Uptake is discussed at EMT /Divisional meetings / Health and Wellbeing Group / People PRM/ People Board and Workforce committee	
C	**Flexible accessibility**		
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	Flu champions trained Flu will be given at the vaccination hub during October 21and then roaming vaccination models	
C2	Schedule for easy access drop in clinics agreed (3)	Roaming clinic times to be advertised. All drop ins and bookable appointment welcome during SHaW working hours	
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6)	Night and weekend clinics, Outpatient nurse at Herts and Essex and St Margaret's trained as flu champions and have agreed to take responsibility of vaccinating all staff based there.	
D	**Incentives**		
D1	Board to agree on incentives and how to publicise this (3,6)	Incentives for Flu Champions	
D2	Success to be celebrated weekly (3,6)	Via InTouch, weekly briefing.	

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 02.12.21

5.1

Agenda item:	5.1
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	22 November 2021
Subject / title:	M7 2021/22 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:

Patients		
Patients	**Mental Health**	Oversight of mental health continues through the mental health qulaity forum and continues to be a significant focus for the organisation due to increasing complexity and activity. The development of the mental health strategy is making good progress following three workshops with good stakeholder and partner engagement
	Infection Control	In month we have reported an MRSA bacteraemia. This is under investigation to ensure the root cause and learning is identified. More detail will be reported in the December IPR.
People		
People	**Appraisals**	In common cause variation. Performance has plateaud for the previous five
	Statutory and Mandatory Training	Whle in common cause variation, performance has dropped slighlty to 87%, and below the target of 90%. However, when the new training centre opens towards the end of the year we expect to see an upturn in training compliance
	Sickness Absence	In common cause variation however, we have seen two months of increasing sickness
Performance		
Performance	**RTT**	Performance remains in special cause variation, recovery actions continue, with patients being treated in clinical priority
	Cancer 2 week wait	Performance in special cause variation with a large reduction. This has been largely caused by a significant increase in skin and breast referral due to increased media coverage.
	Cancer 62 day pathway	Performance remains in common cause variation and a second consecutive month of improved performance and back to near the mean
	Four hour standard	Has returned to special cause variation for under performance with a number of indicators still flagging. Attendances for October exceeded the higher volumes experienced since May and are the highest for over 6 years.
	Diagnostics	Still in special cause variation with performance plateauing. Focus is being placed on the booking of the longest waiting patients. Trajectories and plans in place across all modalities to increase capacity and return to the standard by mid 2022
	52 week waits	Still is special cause variation and volume is increasing. There remains a continued focus on clinical priority patients and no 104 week waiting patients.
	Super Stranded Patients	Remains in common cause variation, and performing well compared to peers across the midlands and east region
Places		
Places	Catering Food Waste and Meals Served	Food waste has dropped below the mean and target last month, despite the second consecutive month of increased meals served, and the highest since February
Pounds		
Pounds	Surplus	The Trust has achieved financial break even at M7 in line with its financial plan. To deliver this finanical performance the Trust has utilised its M6 surplus of £127k & £3.8m of its COVID-19 financial envelope. Key factors driving this deterioriation in finanical performance are receiving less income for elective recovery activity & CIP under delivery. The Finance Department is supporting Divisions to reduce their run rate.
	CIP	The Trust has delivered £1.826m of savings against a year to date plan of £3.049m. The CIP is being delivered non-recurrently. A concerted effort is being made to find CIPs that deliver recurrently.
	Capital Spend	The capital profile has been reprofiled after discussion with NHSE/I. YTD capital spend is £13.491m against a revised capital plan of £15.528m. The underspend is a timing difference. There is currently an overplanning margin of c.£1.4m. The Trust continues to forecast achieving its Capital Resource Limit.
	Cash	The Trust cash balance is c.£49m. There is a continued push to reduce aged payables & improve the Trust's performance against the Better Payment Practice Code. The Trust is also working on reducing its aged receivables to ensure that it is collecting all of its debts.

The Princess Alexandra Hospital NHS Trust

Recommendation:	The Board is asked to discuss the report and note the current position and further action being taken in areas below agreed standards.				
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	Patients	People	Performance	Places	Pounds
	x	x	x	x	x

Previously considered by:	PAF.25.11.21 and QSC.26.11.21
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	

5.1

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report for October 2021

Performance Summary

Patients		
Patients	**Mental Health**	Oversight of mental health continues through the mental health qulaity forum and continues to be a significant focus for the organisation due to increasing complexity and activity. The development of the mental health strategy is making good progress following three workshops with good stakeholder and partner engagement
Patients	**Infection Control**	In month we have reported an MRSA bacteraemia. This is under investigation to ensure the root cause and learning is identified. More detail will be reported in the December IPR.
Pounds		
Pounds	Surplus	The Trust has achieved financial break even at M7 in line with its financial plan. To deliver this finanical performance the Trust has utilised its M6 surplus of £127k & £3.8m of its COVID-19 financial envelope. Key factors driving this deterioriation in finanical performance are receiving less income for elective recovery activity & CIP under delivery. The Finance Department is supporting Divisions to reduce their run rate.
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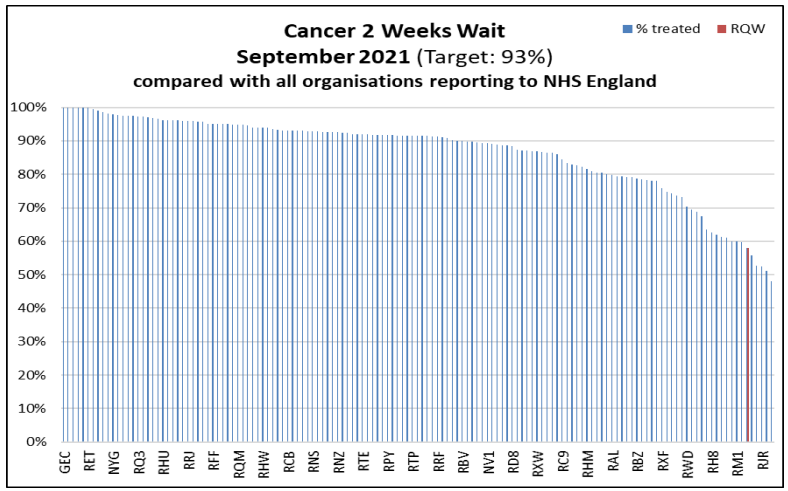
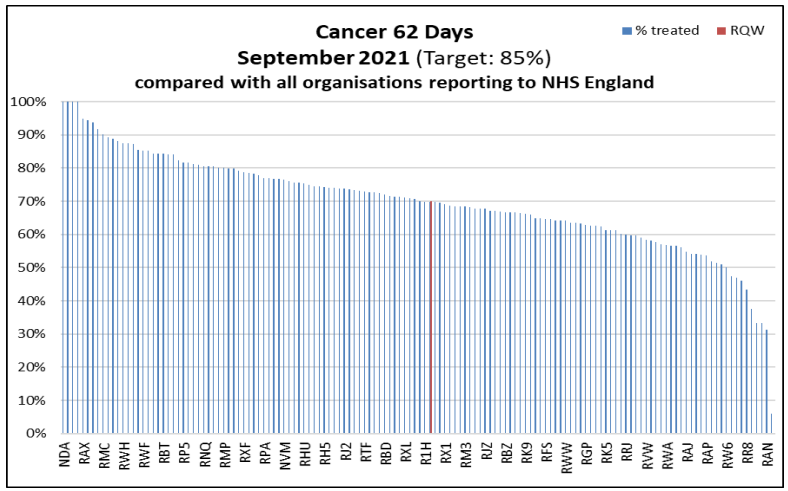
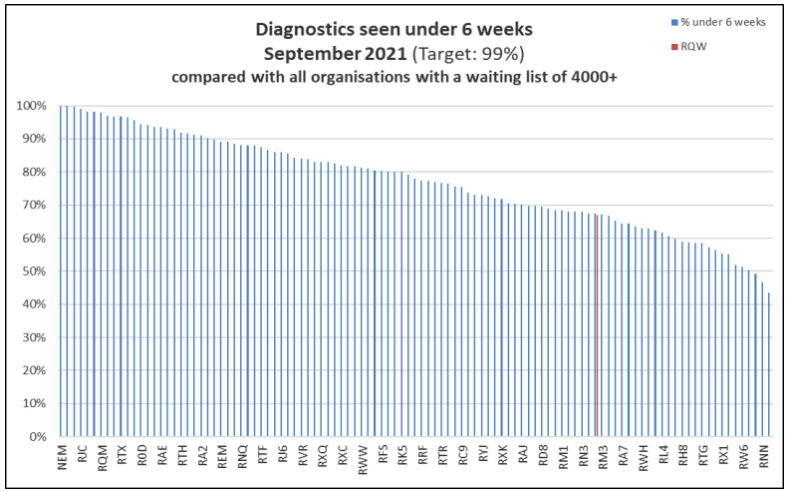
Pounds	Capital Spend	The capital profile has been reprofiled after discussion with NHSE/I. YTD capital spend is £13.491m against a revised capital plan of £15.528m. The underspend is a timing difference. There is currently an overplanning margin of c.£1.4m. The Trust continues to forecast achieving its Capital Resource Limit.
Pounds	Cash	The Trust cash balance is c.£49m. There is a continued push to reduce aged payables & improve the Trust's performance against the Better Payment Practice Code. The Trust is also working on reducing its aged receivables to ensure that it is collecting all of its debts.
Places		
Places	Catering Food Waste and Meals Served	Food waste has dropped below the mean and target last month, despite the second consecutive month of increased meals served, and the highest since February

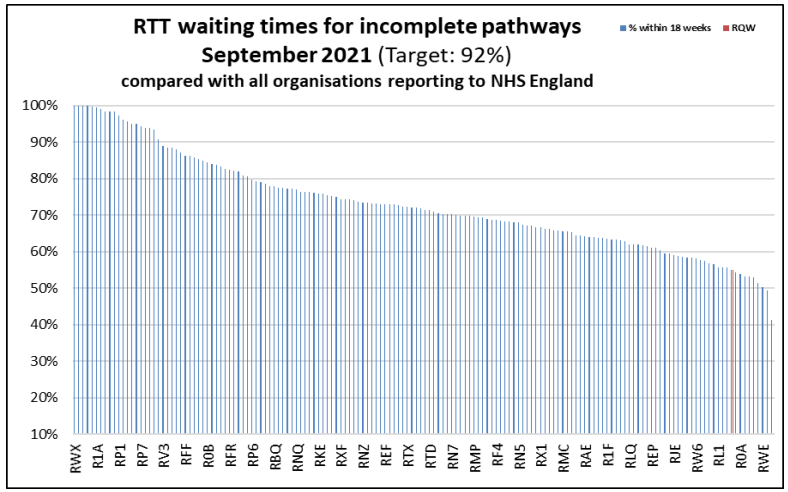
People		
People	**Appraisals**	In common cause variation. Performance has plateaud for the previous five months
People	**Statutory and Mandatory Training**	Whle in common cause variation, performance has dropped slighlty to 87%, and below the target of 90%. However, when the new training centre opens towards the end of the year we expect to see an upturn in training compliance
People	**Sickness Absence**	In common cause variation however, we have seen two months of increasing sickness
Performance		
Performance	**RTT**	Performance remains in special cause variation, recovery actions continue, with patients being treated in clinical priority
Performance	**Cancer 2 week wait**	Performance in special cause variation with a large reduction. This has been largely caused by a significant increase in skin and breast referral due to increased media coverage.
Performance	**Cancer 62 day pathway**	Performance remains in common cause variation and a second consecutive month of improved performance and back to near the mean
Performance	**Four hour standard**	Has returned to special cause variation for under performance with a number of indicators still flagging. Attendances for October exceeded the higher volumes experienced since May and are the highest for over 6 years.
Performance	**Diagnostics**	Still in special cause variation with performance plateauing. Focus is being placed on the booking of the longest waiting patients. Trajectories and plans in place across all modalities to increase capacity and return to the standard by mid 2022
Performance	**52 week waits**	Still is special cause variation and volume is increasing. There remains a continued focus on clinical priority patients and no 104 week waiting patients.
Performance	**Super Stranded Patients**	Remains in common cause variation, and performing well compared to peers across the midlands and east region

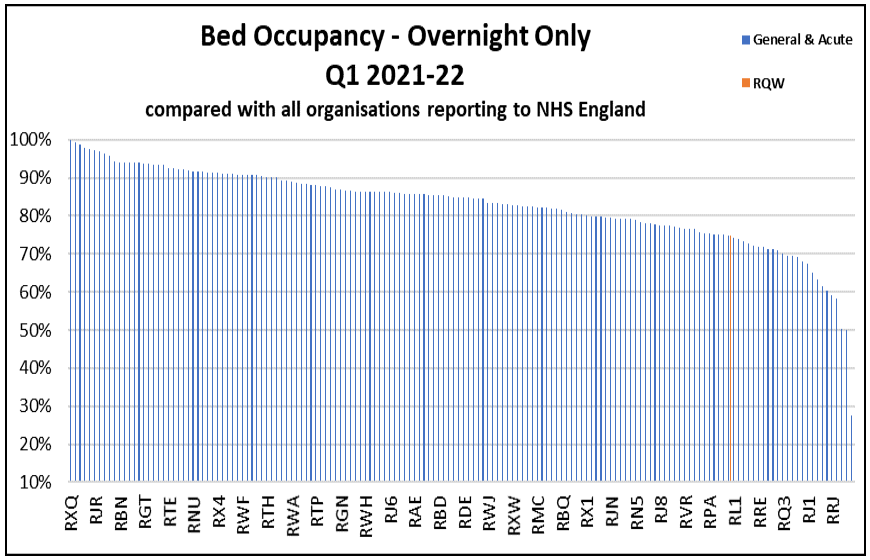
National Benchmarking

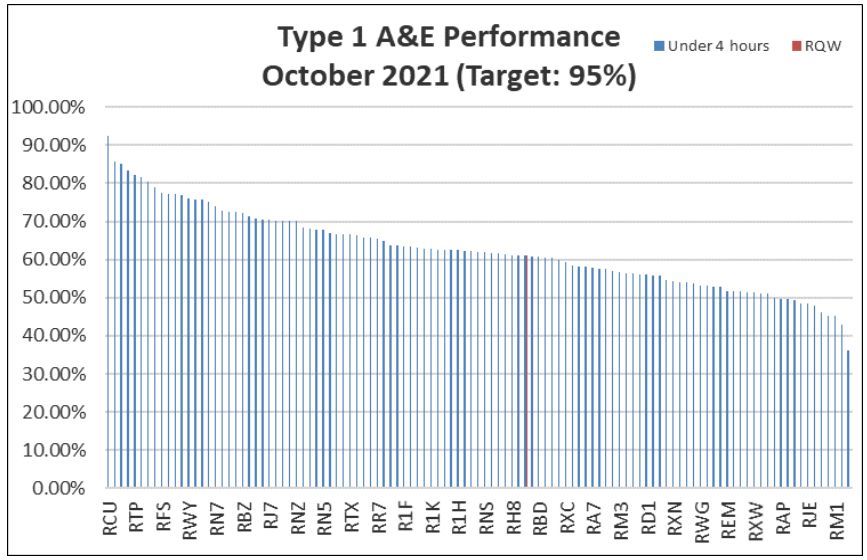


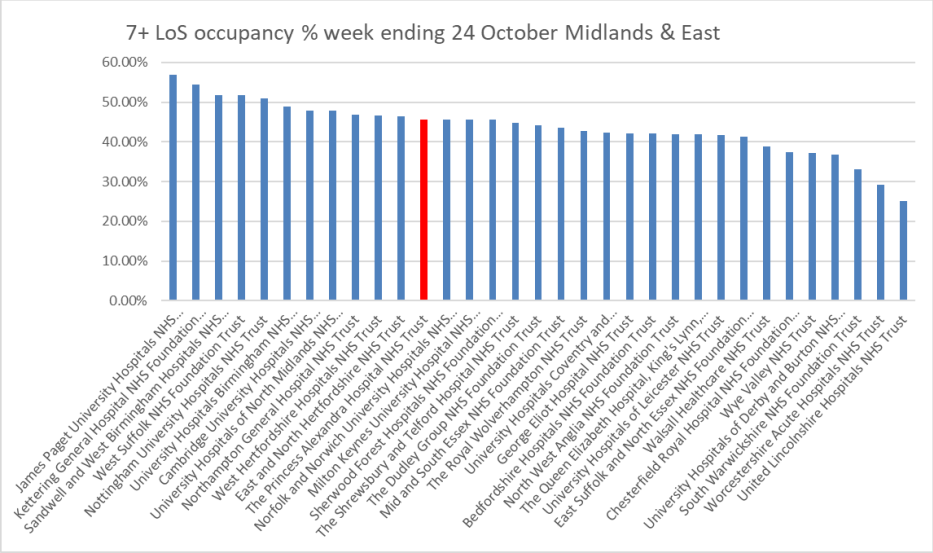


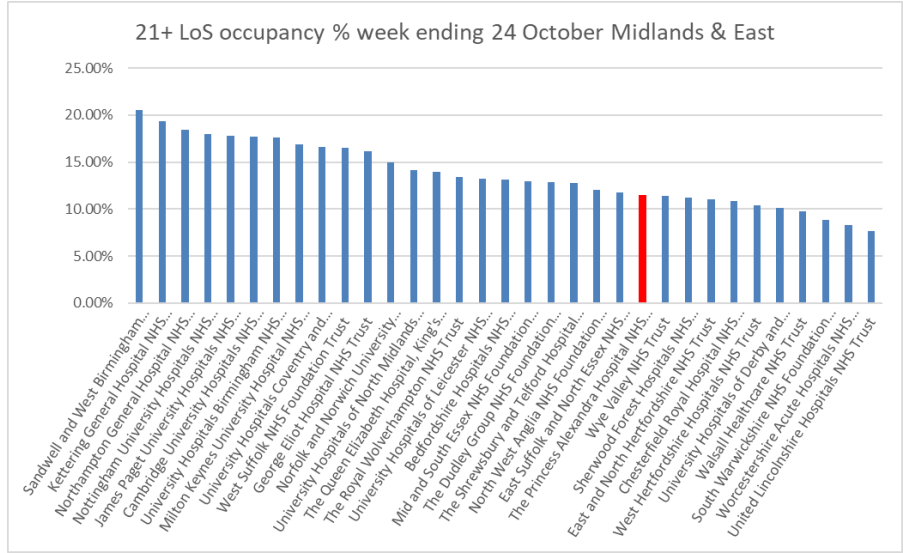





Bed Occupancy - Overnight Only
Q1 2021-22
compared with all organisations reporting to NHS England
General & Acute
RQW
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
RXQ RJR RBN RGT RTE RNU RX4 RWF RTH RWA RTP RGN RWH RJ6 RAE RBD RDE RWJ RXW RMC RBQ RX1 RJN RN5 RJ8 RVR RPA RL1 RRE RQ3 RJ1 RRJ


Type 1 A&E Performance
October 2021 (Target: 95%)
Under 4 hours
RQW
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
RCU RTP RFS RWY RN7 RBZ RJ7 RNZ RN5 RTX RR7 R1F R1K R1H RNS RH8 RBD RXC RA7 RM3 RD1 RXN RWG REM RXW RAP RJE RM1


7+ LoS occupancy % week ending 24 October Midlands & East
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
James Paget University Hospitals NHS...
Kettering General Hospital NHS Foundation...
Sandwell and West Birmingham Hospitals NHS...
West Suffolk NHS Foundation Trust
Nottingham University Hospitals NHS Trust
University Hospitals Birmingham NHS...
Cambridge University Hospitals NHS Trust
University Hospitals of North Midlands NHS...
Northampton General Hospital NHS Trust
West Hertfordshire Hospitals NHS Trust
East and North Hertfordshire NHS Trust
The Princess Alexandra Hospital NHS Trust
Norfolk and Norwich University Hospitals NHS...
Milton Keynes University Hospital NHS Trust
Sherwood Forest Hospitals NHS Foundation...
The Shrewsbury and Telford Hospital NHS Trust
The Dudley Group NHS Foundation Trust
Mid and South Essex NHS Foundation Trust
The Royal Wolverhampton NHS Trust
University Hospitals Coventry and...
George Eliot Hospital NHS Trust
Bedfordshire Hospitals NHS Foundation Trust
North West Anglia NHS Foundation Trust
The Queen Elizabeth Hospital, King's Lynn...
University Hospitals of Leicester NHS Trust
East Suffolk and North Essex NHS Foundation...
Chesterfield Royal Hospital NHS Foundation...
Walsall Healthcare NHS Trust
Wye Valley NHS Trust
University Hospitals of Derby and Burton NHS...
South Warwickshire NHS Foundation Trust
Worcestershire Acute Hospitals NHS Trust
United Lincolnshire Hospitals NHS Trust


21+ LoS occupancy % week ending 24 October Midlands & East
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Sandwell and West Birmingham...
Kettering General Hospital NHS...
Northampton General Hospital NHS...
Nottingham University Hospitals NHS...
James Paget University Hospitals NHS...
Cambridge University Hospitals NHS...
University Hospitals Birmingham NHS...
Milton Keynes University Hospital NHS...
University Hospitals Coventry and...
West Suffolk NHS Foundation Trust
George Eliot Hospital NHS Trust
Norfolk and Norwich University...
University Hospitals of North Midlands...
The Queen Elizabeth Hospital, King's...
The Royal Wolverhampton NHS Trust
University Hospitals of Leicester NHS...
Bedfordshire Hospitals NHS...
Mid and South Essex NHS Foundation...
The Dudley Group NHS Foundation...
The Shrewsbury and Telford Hospital...
North West Anglia NHS Foundation...
East Suffolk and North Essex NHS...
The Princess Alexandra Hospital NHS...
Wye Valley NHS Trust
Sherwood Forest Hospitals NHS...
East and North Hertfordshire NHS Trust
Chesterfield Royal Hospital NHS...
West Hertfordshire Hospitals NHS Trust
University Hospitals of Derby and...
Walsall Healthcare NHS Trust
South Warwickshire NHS Foundation...
Worcestershire Acute Hospitals NHS...
United Lincolnshire Hospitals NHS Trust


Benchmarking

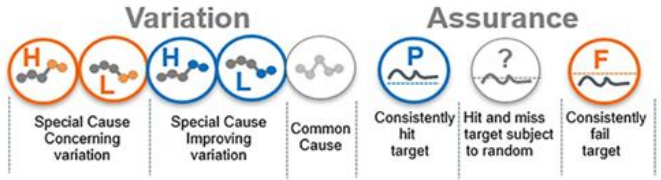
Patients

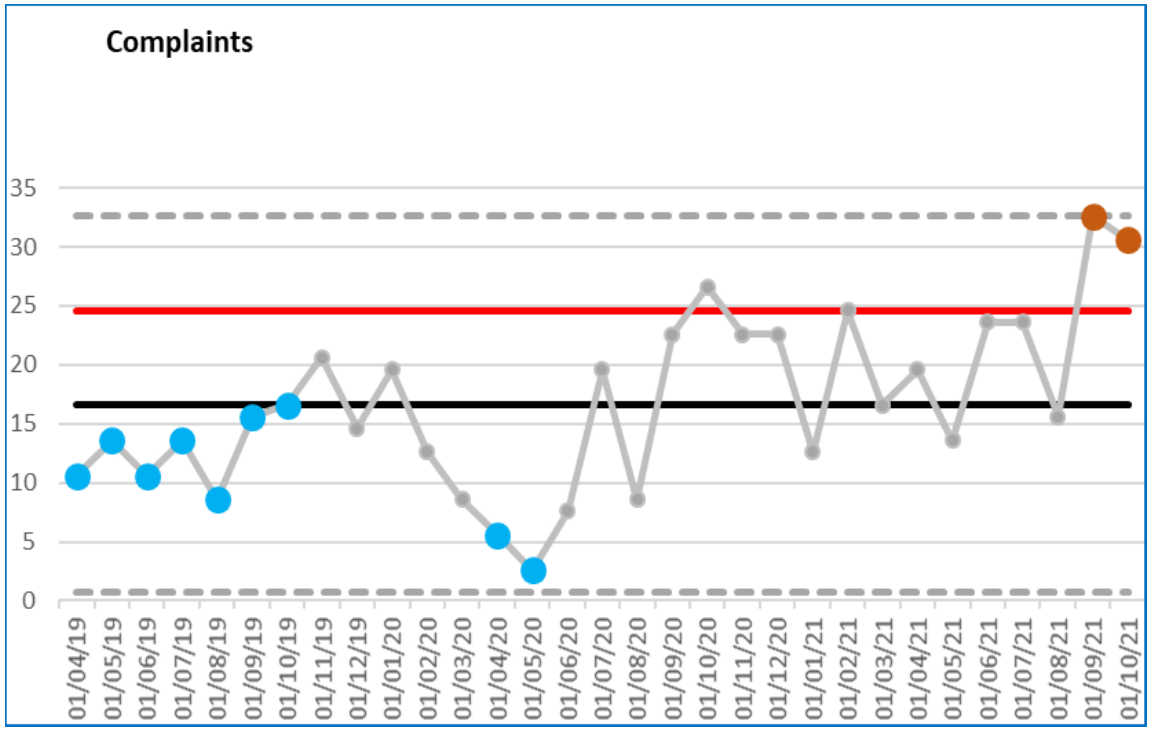
*We will continue to improve the quality of care, outcomes & experiences that we provide **our patients**, integrating care with our partners & reducing health inequity in our local population*

Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Mental Health	Oversight of mental health continues through the mental health qulaity forum and continues to be a significant focus for the organisation due to increasing complexity and activity. The development of the mental health strategy is making good progress following 3 workshops with good stakeholder and partner engagement	For information	NA
Infection Control	In month we have reported an MRSA bacteraemia. This is under investigation to ensure the root cause & learning is identified. More detail will be reported in the December IPR.	For information	NA

KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
Complaints	Oct 21	31	25			17	1	33
Compliments	Oct 21	76	50			136	-108	380
PALS	Oct 21	265	none			284	145	422
Complaints closed within target	Oct 21	9	none			5	-4	14
% of complaints where an extension has been agreed	Oct 21	39%	none			41%	3%	80%
Mixed Sex Accommodation Breach	Oct 21	1	0	L		7	-4	19
Serious Incidents	Oct 21	3	none	L		5	-5	15
MSSA	Oct 21	1	none			1	-1	3
CDIFF	Oct 21	4	none			5	-2	13
Hand Hygiene	Oct 21	99%	none	H		92%	73%	110%
eColi	Oct 21	2	none			1	-2	4
Klebsiella	Oct 21	1	none			1	-2	3
Pseudomonas	Oct 21	1	none			0	-1	1
Falls per 1000 bed days	Oct 21	8	9			9	6	11
Falls total minor, moderate & severe	Oct 21	29	13			25	12	39
Pressure Ulcers per 1000 bed days	Oct 21	5	3			4	1	8
Pressure Ulcers: grade 3, 4 & unstageable	Oct 21	5	3			3	-3	10
Total number of mothers delivering in birthing unit/home	Oct 21	8%	20%			11%	0%	22%
Number of mothers delivering in Labour Ward/Theatres	Oct 21	91%	75%		P	89%	77%	100%
Number of women due to deliver at PAH adjusted for misc/TOPs	Oct 21	348	375			335	278	391
Smoking rates at booking	Oct 21	8%	none			9%	5%	14%
Smoking rates at delivery	Oct 21	9%	6%	L		10%	5%	15%
Breast feeding rates at delivery	Oct 21	77%	74%			75%	66%	85%
Total Planned C-Sections	Oct 21	19%	none			15%	8%	22%
Total Unscheduled C-Sections	Oct 21	18%	none			18%	12%	24%

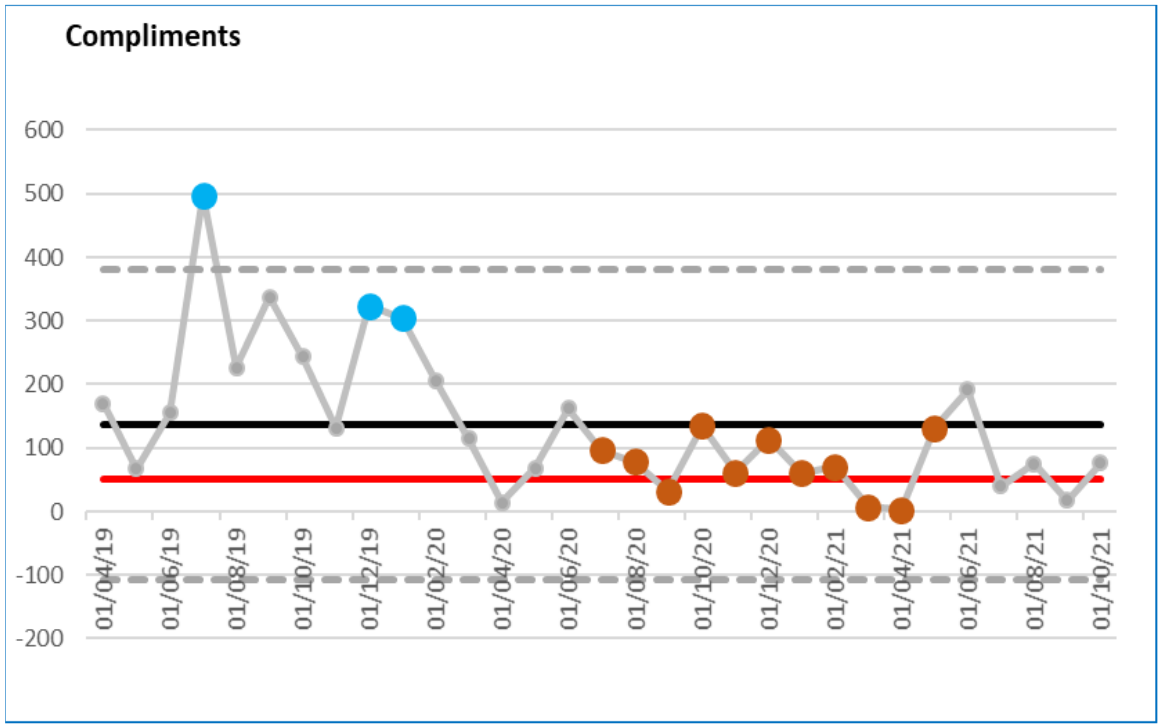
KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
PPH over 1500mls	Oct 21	3%	none			4%	1%	7%
CTG training compliance midwives	Oct 21	61%	85%			67%	46%	88%
CTG training compliance doctors	Oct 21	87%	85%			74%	51%	97%
Still births	Oct 21	2	none			1	-1	3
Patients detained under MHA	Oct 21	1	none			0	-1	2
Patients detained under section 136	Oct 21	0	none			1	-2	3
Mental health patient incidents	Oct 21	6	none			11	0	22
Mental health patient complaints	Oct 21	1	none			0	-1	1
Mental health patient PALS	Oct 21	6	none			1	-1	4
Patients with LD and Autism accessing inpatient services	Oct 21	27	none			25	2	48
Patients who died in their preferred place of death	Oct 21	50%	none			56%	19%	93%
C-DIFF Hospital onset healthcare associated	Oct 21	0	none			2	-3	7
C-DIFF Community onset healthcare associated (Acute Admissio	Oct 21	3	none			1	-1	3
C-DIFF Community onset indeterminate association (Acute Adm	Oct 21	0	none			1	-1	3
C-DIFF Community onset community associated (No acute conta	Oct 21	1	none			1	-3	5
Covid-19 new positive inpatients	Oct 21	108	0			127	-154	408
MRSA	Oct 21	0	0			0	0	0





Oct-21
31
Variance Type
Common cause variation
Target
25
Target Achievement
Hit & miss target subject to random variation

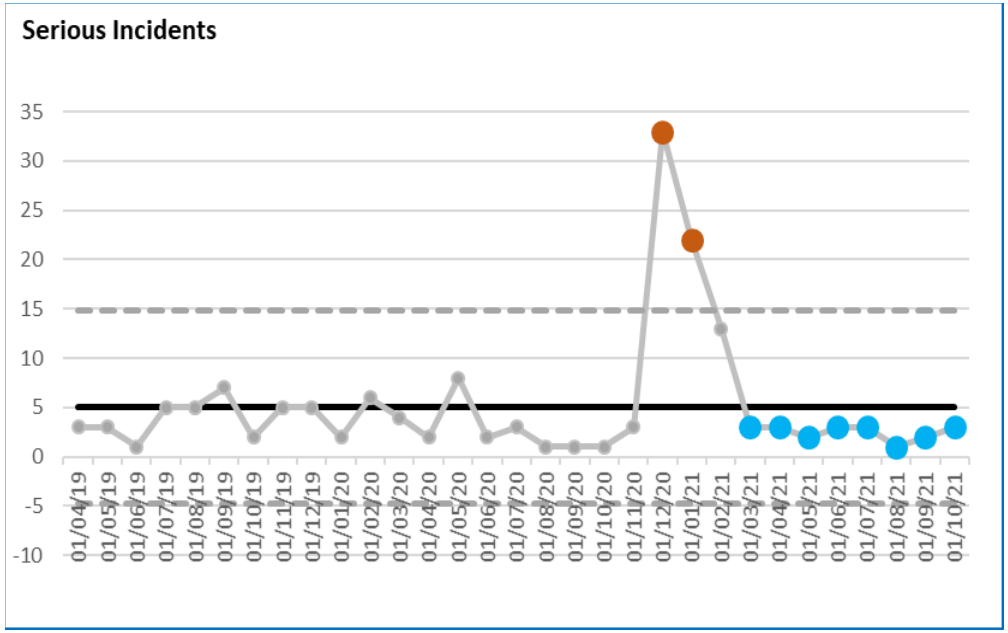
Background	What the chart tells us	Issues	Actions	Mitigation
Complaints	Common cause concerning variation while hitting & missing the target, on LCL.	Complaints increase reflects operational pressures.	Support being offered to urgent care and FAWS teams to optimise reponse times and maintain standards. Thematic overview of complaints static with communication being the significant trend. Patient Qulaity and Safety Strategy provides strategic response to enable improvement.	No further action required.



Oct-21
76
Variance Type
Common cause variation
Target
50
Target Achievement
Hit & miss target subject to random variation

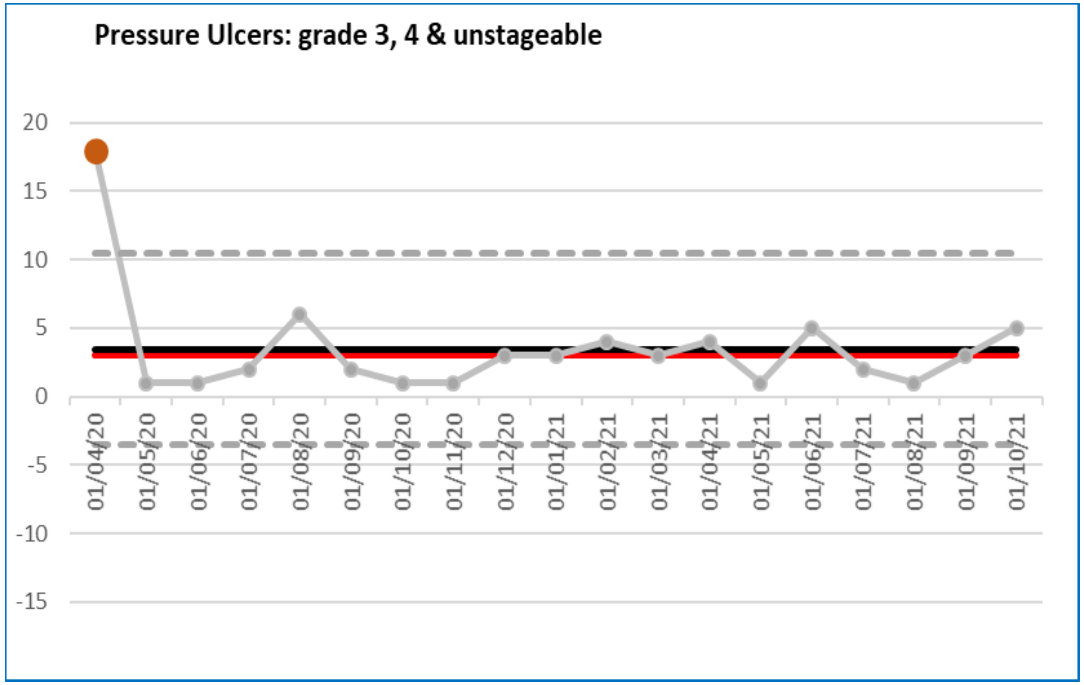
Background	What the chart tells us	Issues	Actions	Mitigation
Compliments	Common cause variation while hit & missing the target	During the last 12 month compliments have seen a decline, now stabilised.	None needed	None needed at present.

Patients



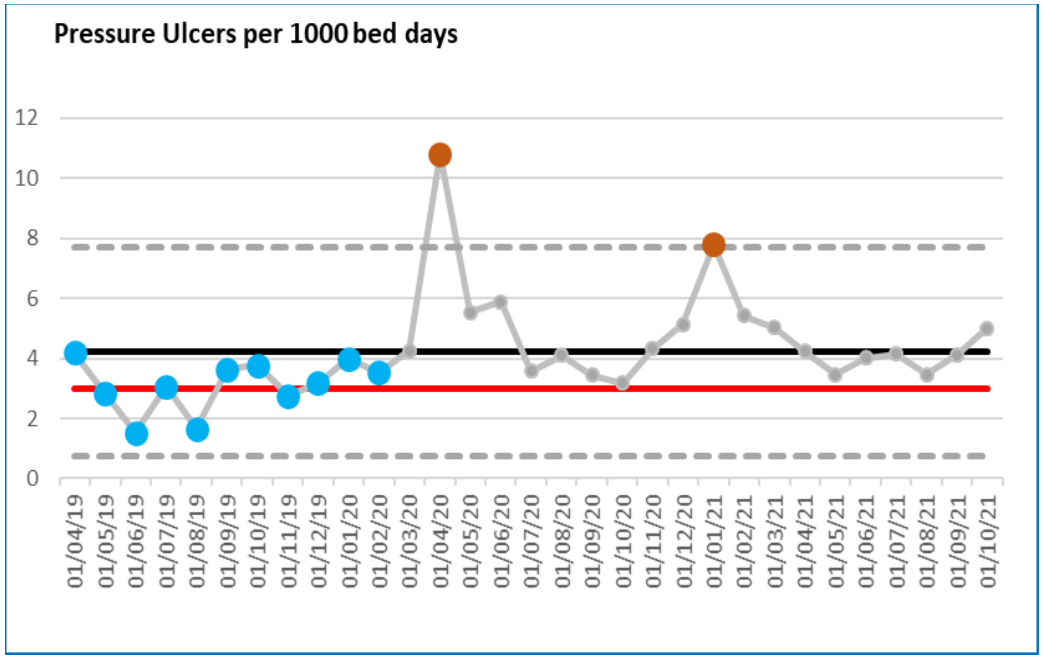
Oct-21
3
Variance Type
Special cause improving variation
Target
The trust does not have a target submission no. for SIs each month
Target Achievement
Our level of serious incidents reported per month is consistent & within our tolerance range

Background	What the chart tells us	Issues	Actions	Mitigation
Serious Incidents (SIs)	Trust reporting numbers for serious incidents raised each month is consistent & within the internally set tolerance range	The significant spike seen during the winter months 20/21 was associated with nosocomial Covid-19 hospital infections during wave 2 of the pandemic. We do not expect to see this replicated in future months.	Incident management group meets twice a week to review new incidents & those with completed investigations. Where an incident meets the national reporting criteria to be raised externally as a serious incident it will be raised. During October the trust raised three SIs & closed one. The trust has an overall of 21 open SIs	Daily local review of incidents by each divisional team is completed with appropriate second stage review at the incidents management group. IMG submits a monthly report on both incident themes & serious incidents onto the Patient Safety Group.



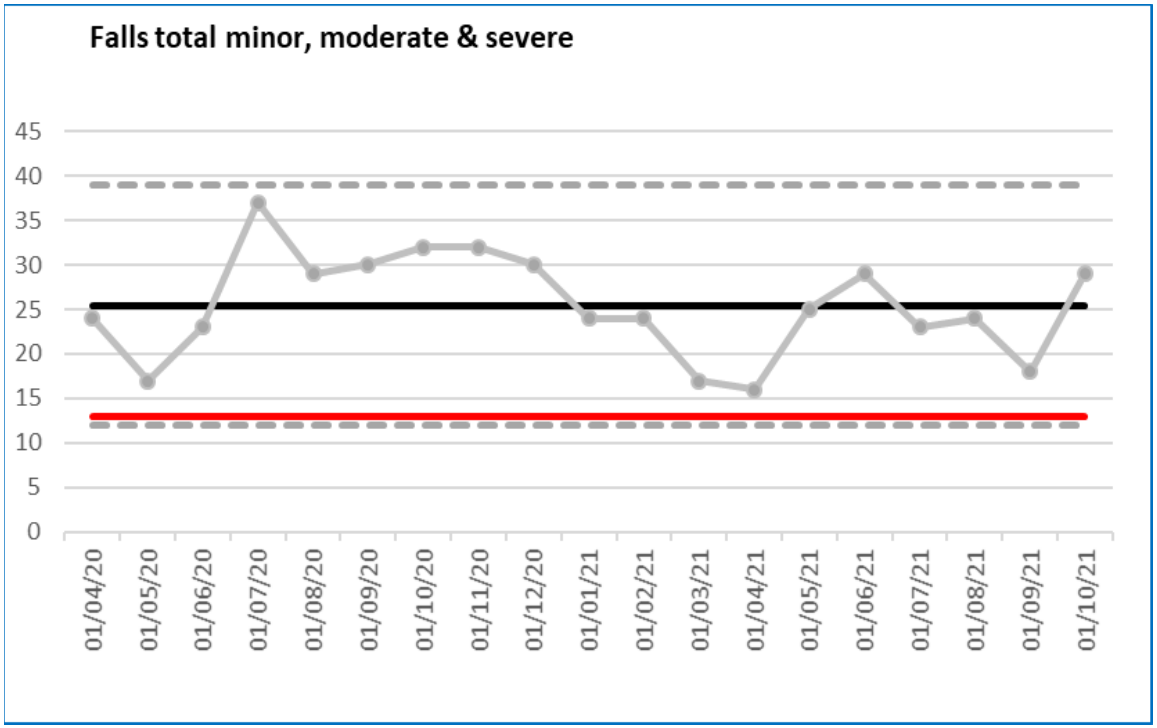
Oct-21
5
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers: grade 3, 4 & Unstageable	Common cause variation while hit & missing the target	One severe harm, four moderate harms & all remaining were minor harms.	The severe harm is currently under investigation & safeguarding is under consideration. One moderate harm was deemed to be patient's clinical condition as the main root cause. Remaining 3 are currently being investigated. TVNs continue to conduct SSKIN audits & feedback will be provided to the ward managers & matrons/ADDON for action planning.	We have now trained 42 staff. Link practitioners are starting to develop projects in their area around pressure ulcer prevention.



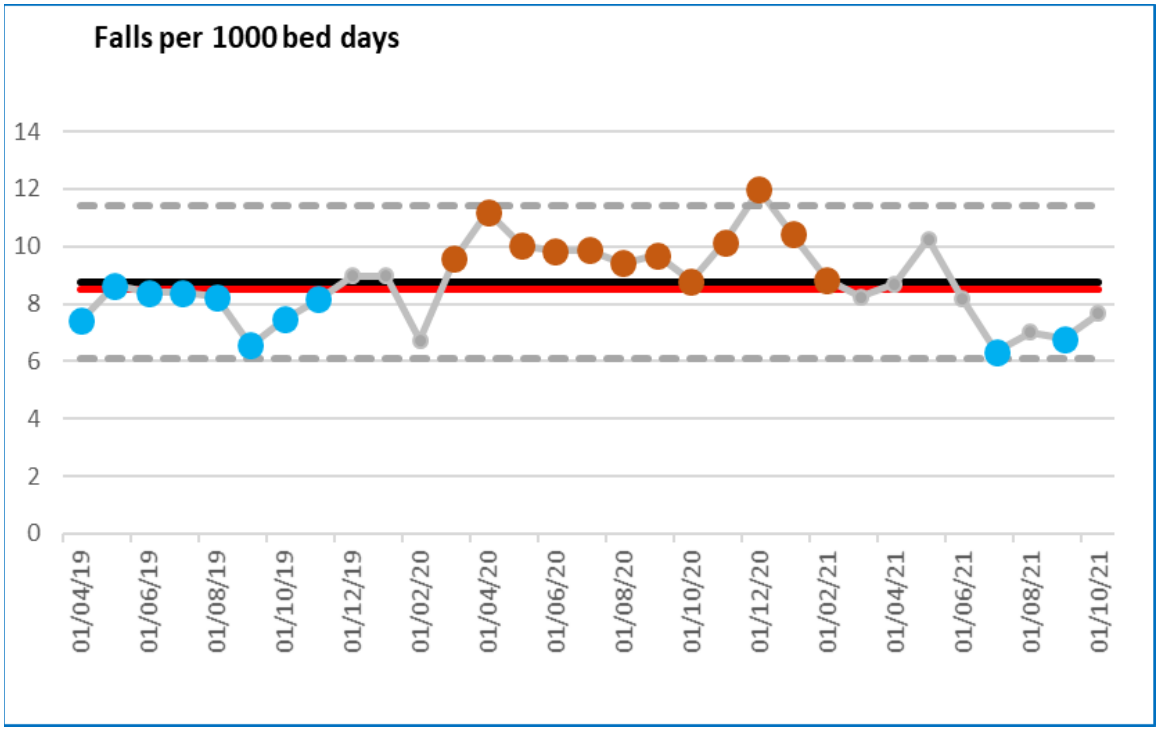
Oct-21
5.01
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers per 1000 bed days	Common cause variation while hit & missing the target	There were a total of 66 pressure ulcers in October, 15 more than September. Of those 66 PUs, there were a total of 48 patients injured, meaning 10 patients sustained more than one pressure ulcer during admission, the higher being one patient with 6 pressure ulcers (COVID pneumonitis patient due to prolonged hours of proning). One severe harm that is under investigation, four moderate harms & all remaining were minor harms. Twelve pressure ulcers were medical device related, attributable to O2 devices, ET tube, stockings & bandages. The majority of PUs have developed on sacrum.	The highest number of hospital acquired pressure ulcers were covid related with a total of 18 pressure ulcers (8 patients injured). These were mainly caused due to prolonged hours of proning. Tye Green and Locke ward followed with 7 and 6 pressure ulcers respectively. TVNs will conduct an SSKIN audit on both wards & feedback will be provided to the ward managers & matrons/ADDON for action planning.	TVNs have now introduced tissue viability link practitioners across the Trust. We have now trained 42 staff. Link practitioners are starting to develop projects in their area around pressure ulcer prevention. All pressure ulcer prevention resources are available via Intranet, Youtube, ward folders & X drive.



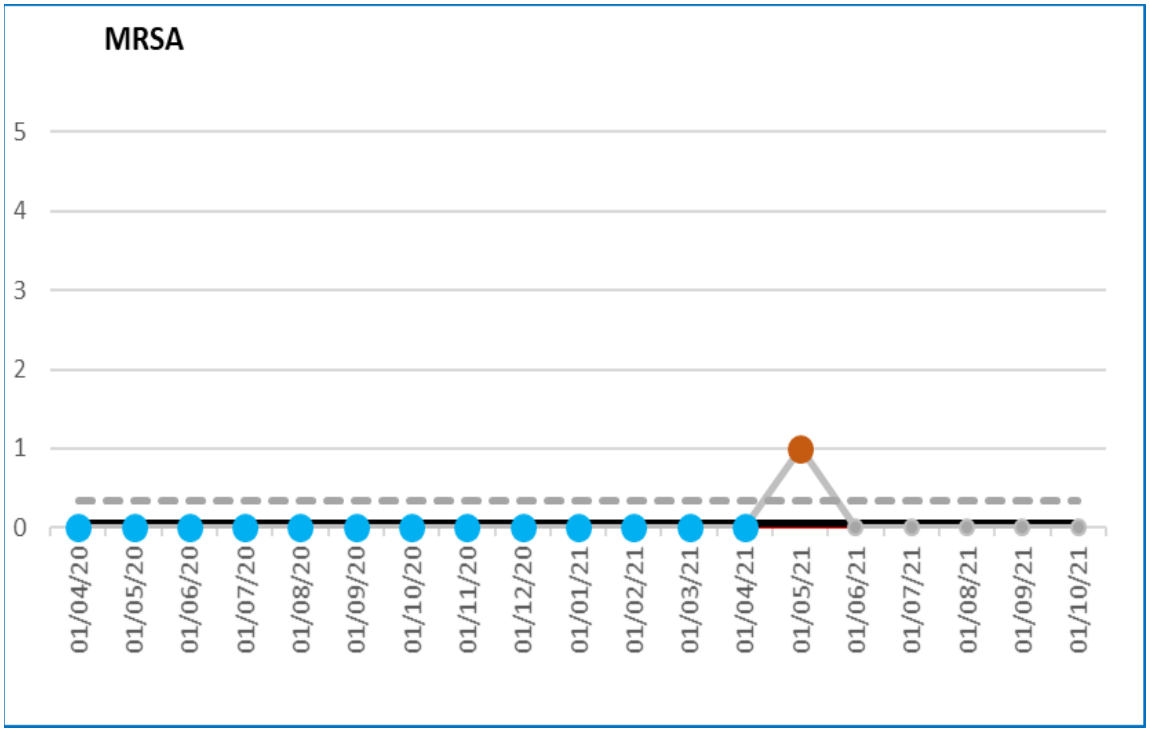
Oct-21
29
Variance Type
Common cause variation
Target
13
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Falls total minor, moderate & severe	Common cause variation & hit and miss target subject to random variation	The Trust's falls action plan aim is to reduce falls with harm by 50% by the end of March 2022	1. Strategic falls action plan is in place 2. The Enhanced Care programme is being embedded across the Trust 3. Falls awareness training is mandatory for all nursing, care and AHP staff and current compliance is 86% 4. The STOPIT initiative is being rolled out across the Trust ((initiative to de-prescribe culprit medications)	No mitigating factors at this time



Oct-21
7.67
Variance Type
Common cause variation
Target
8.5
Target Achievement
Hit & miss target subject to random variation

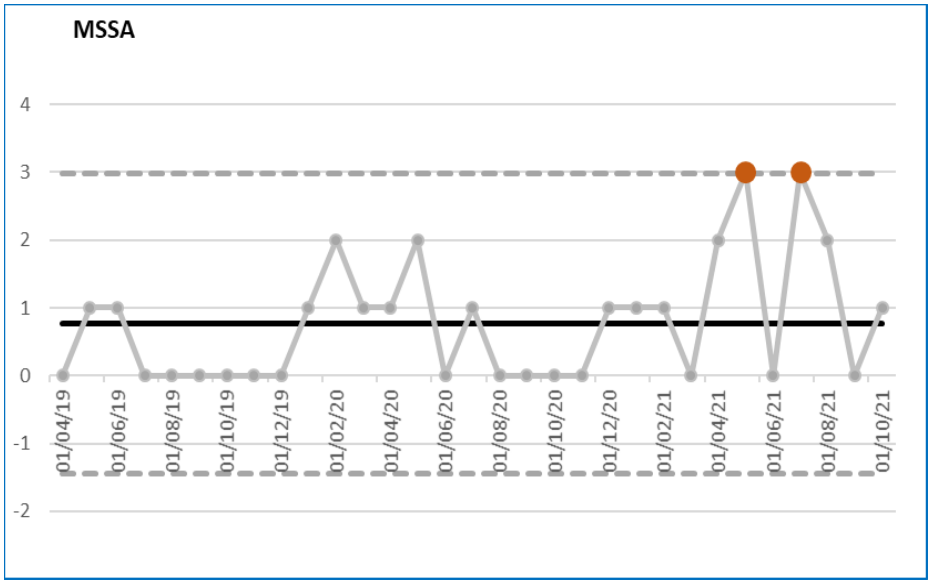
Background	What the chart tells us	Issues	Actions	Mitigation
Falls per 1000 bed days	Common cause variation & hit and miss target subject to random variation		Please see Falls by Harm narrative	



Oct-21
0
Variance Type
Common cause variation
Target
0
Target Achievement

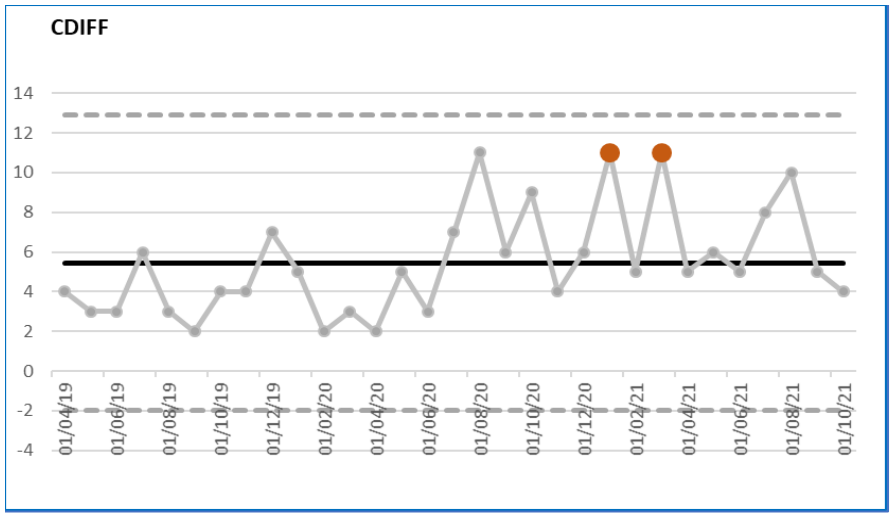
Background	What the chart tells us	Issues	Actions	Mitigation
MRSA	Common cause variation			

Patients



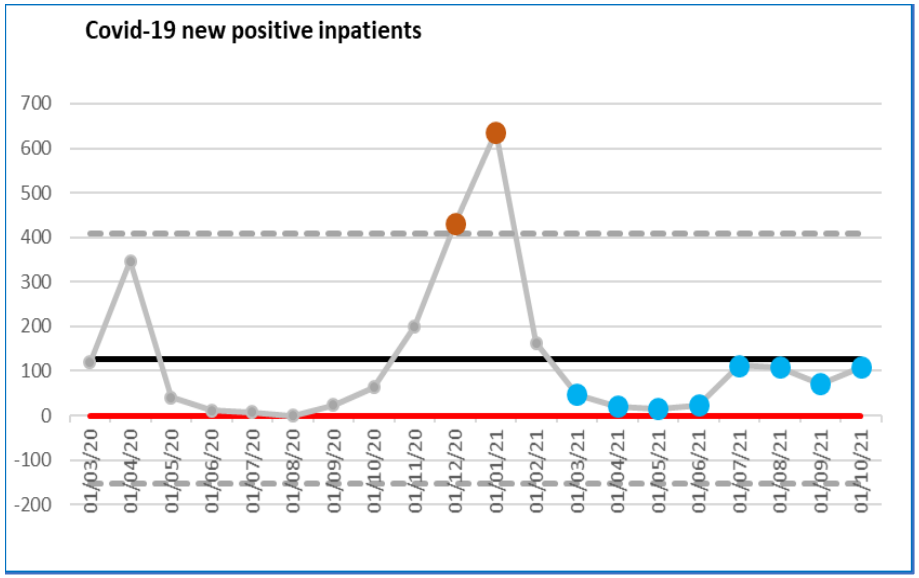
Oct-21
1
Variance Type
Common cause variation
Target
None
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
MSSA	Common cause variation	During 2021-2022 there has been a significant rise in hospital-onset, healthcare associated (HOHA) cases of MSSA bacteraemia. In 2020-2021, there were a total of seven cases for the year, compared with 11 cases to date between April - October 2021.	RCA meetings have taken place to identify source. Some of cases appear to be linked to IV devices - therefore actions are being taken to focus on line care practice. This will include enhancing the existing training by working with the PDP team & Clinical Skills leads, additional refresher training for staff, prioritising ED initially, introduction of new online tool (clinicalskills.net, intorduction of nursing documentation used for inpatient areas with the same Visual Infusion Phlebitis (VIP) scoring, provision of pre-recorded IPC presentation including a focus on accurate documentation & VIP scores for invasive devices, support from company representative for re-training on Octenasin wash & sharing of learning through HCGs.	1. Use of Octenisan body wash to reduce risk of skin colonisation 2. Safety alert to all staff regarding appropriate siting of cannulas, e.g avoid ante-cubital fossa where possible 2. Body map documentation 3. Surveillance & review of all cases to identify sources & share learning 4. Refresher training



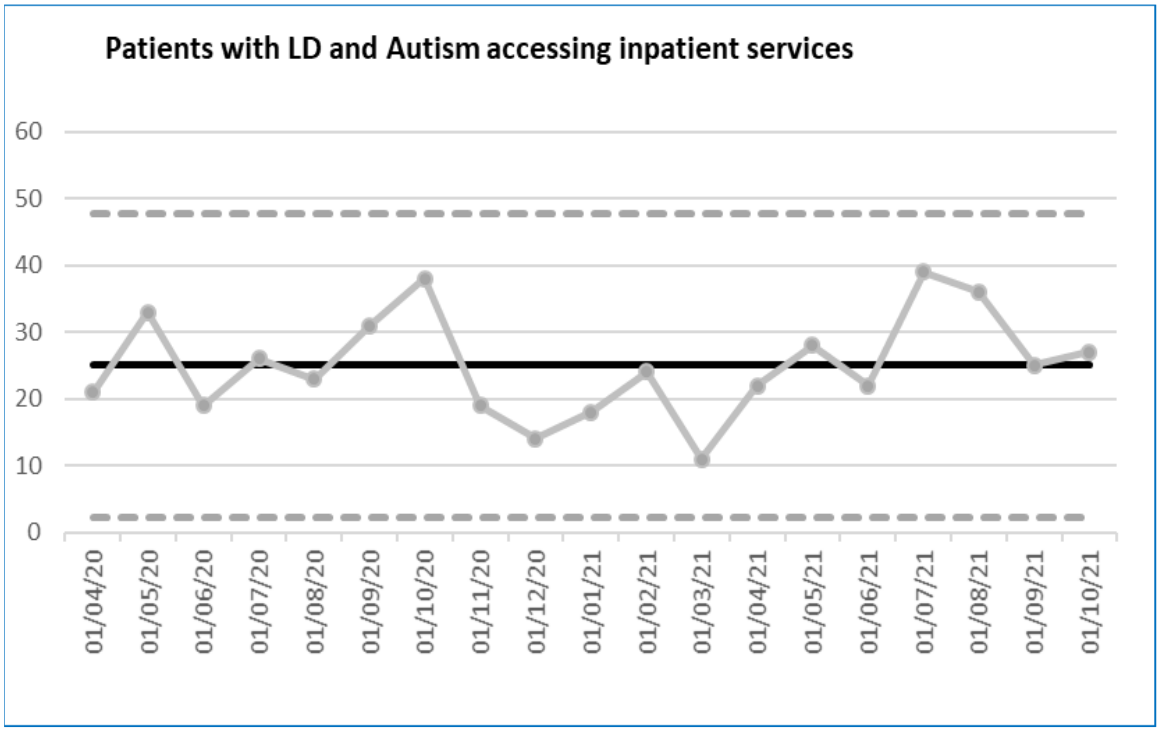
Oct-21
4
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
C.difficile	Common cause variation	1. The Trust had a significant increase in cases since July 2020 2. The rise in cases is almost certainly associated with the pandemic & the increase in broad spectrum antibiotic prescribing (Cephalosporins); however there are likely to be a combination of factors involved including cleaning & hand hygiene / PPE. 3. Since July this year we have started to see a reduction in the Hospital Onset Health Care Associated (HOHA) cases, in comparison to the same time last year; the Community Onset Health Care Associated cases (COHA) are higher. 4. The Trust has now been set a threshold of 23 for 2021-22 (to include both HOHA and COHA cases); currently there has been a total of 26 at end of October.	A C.difficile recovery action plan implemented which focuses on ensuring compliance with: 1.Antimicrobial prescribing 2.Environment /cleanliness 3.Prompt isolation 4.Hand hygiene 5.PPE 6.Prompt stool specimen collection 7.Commode & dirty utility audits 8.Increased teaching / cascading of key messages /attending ward manager meetings/ PPE Champions 7.Introduction of sporicidal wipes for commode cleaning in all clinical areas 8.Ribo-typing of C.difficile specimens to support in detecting possible outbreaks or clusters of infection 9.RCA process to review cases and shared learning	1. Monitoring of cases (Infection Prevention & Control Committee & Trust Dashboard) 2. RCA reviews of all cases; this is undertaken by the IPC Team, DIPC/Microbiology Consultant, Antimicrobial pharmacist, senior medical & nursing colleagues caring for the patient - shared learning is achieved through the reviews 3. Antimicrobial Stewardship Committee is responsible for the monitoring of antibiotic prescribing 4. IP&C Associate team in place who are supporting the IPC team in delivering the key messages 5. Appeals panel in place (led by CCG) to appeal against cases that have been considered to be 'unavoidable' 5. Although cases have increased, severity of infection has not; there have not been any deaths where C.difficile has been the cause of death



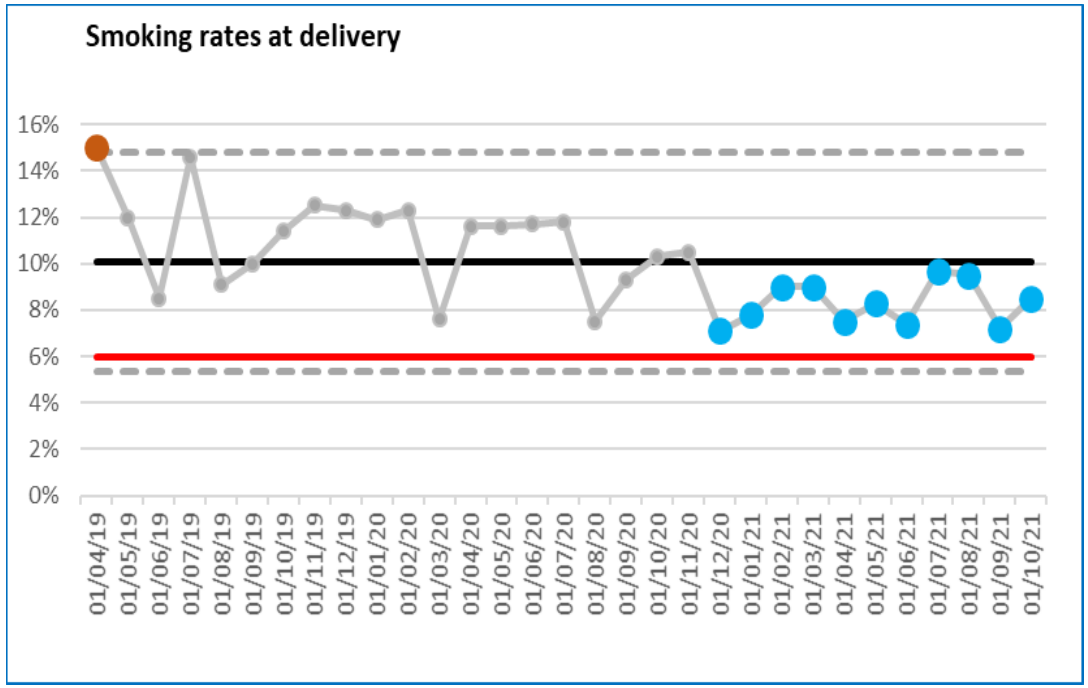
Oct-21
108
Variance Type
Special cause improving variation
Target
0
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Covid-19 new positive inpatients	Special cause improving variation & inconsistently hit & missing target	Nosocomial cases remained low in October (five indeterminate, five probable and two definite) There was one outbreak in October on a ward within the Medicine HCG, with four patients affected.	IPC Team collecting data on all cases related to vaccination status. Information relating to non-vaccinated cases shared with colleagues in the CCG / NHSE/I /PHE to review how this can be addressed in the community. Outbreak meetings held wth representation for regional and CCG colleagues. The outbreak has now been declared over as 28 days have passed since the last admission.	1. All measures in place relating to screening on admission & every 48 hours thereafter & monitoring for signs & symptoms of COVID-19 2. All other IPC measures in place, e.g screens between beds, patients encouraged to wear masks, standard precautions, restricted visiting, cleaning protocols 3. Regular outbreak meetings following declaration of outbreak to agree & monitor actions including: Screening of staff and patients, increased observations/audits of practice, emphasis on hand hygiene, decontamination, cleaning & restricted visiting.



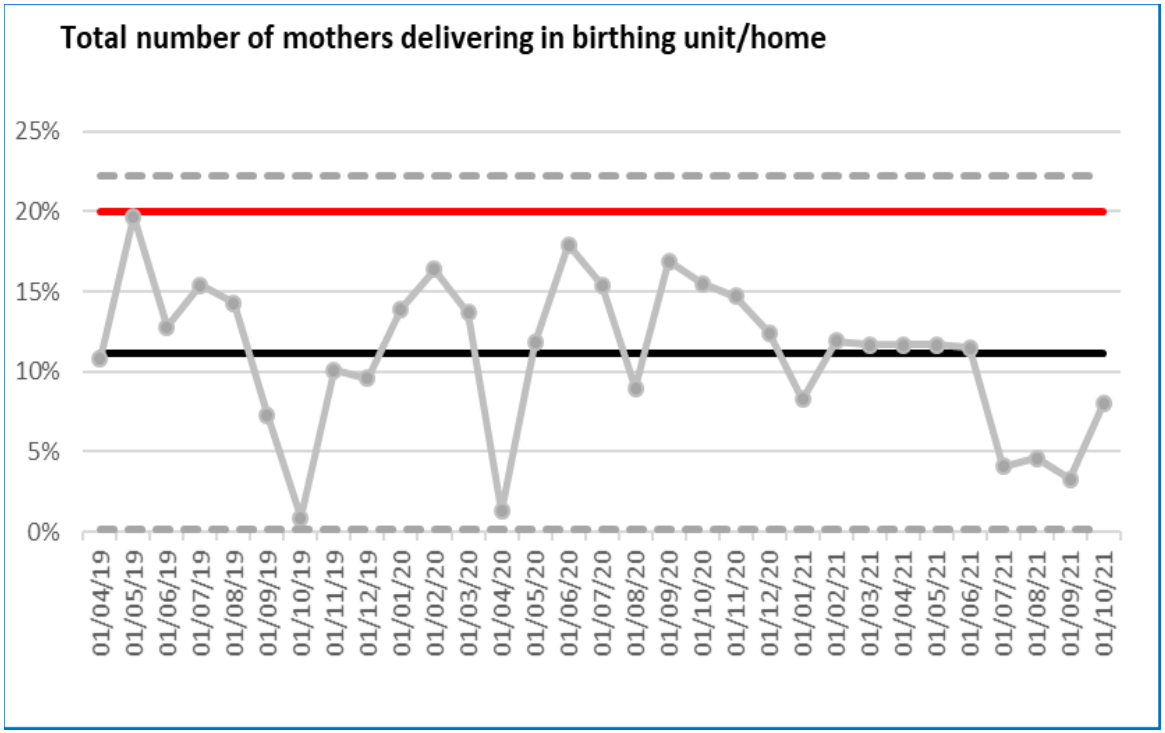
Oct-21
27
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
Patients with learning disabilities & autism accessing inpatient services	Common cause variation	The number of patients with LD will continue to fluctuate especially as the recovery programme continues. Work continues to ensure LD patients are able to access services & provide feedback on their experience.	A group of young people with LD attended our ED department in October to review the provision for LD & provide feedback on the environment. The visit was very positiive with many suggestions including improved wayfinding, creating a calm room & easier to read updates on wait times.	Nil required



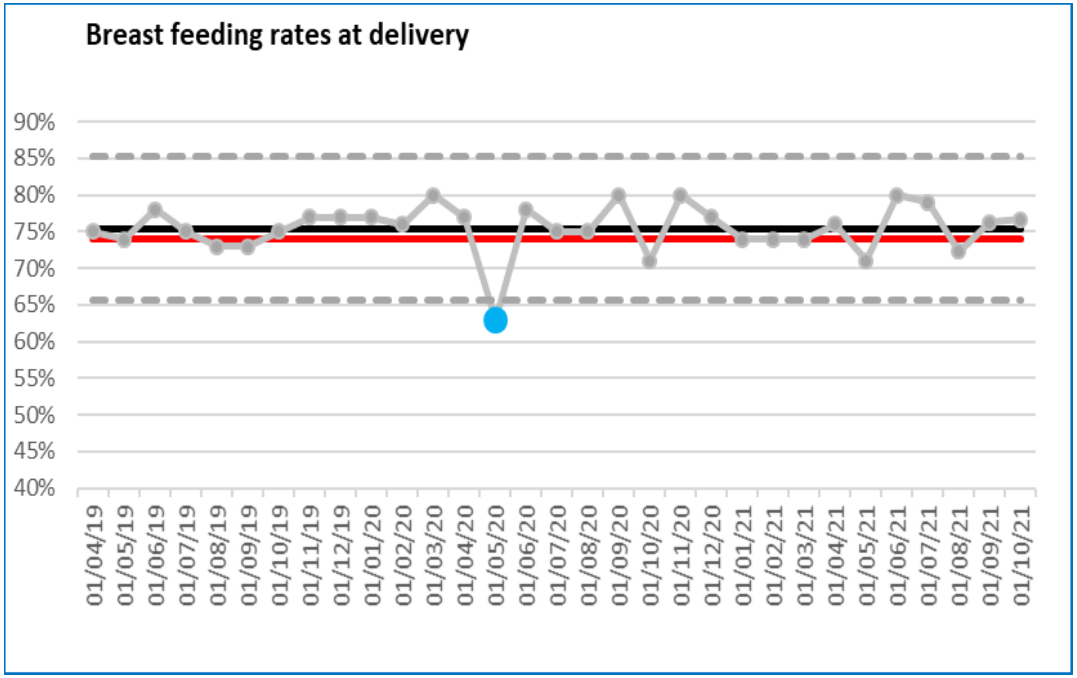
Oct-21
8%
Variance Type
Special cause variation
Target
6%
Target Achievement
Hit and miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Smoking rates at delivery	Special cause variation and inconsistently hit & missing target	Smoking rates at delivery	The smoking at delivery rate for October '21 was 8.5%. The Healthy Lifestyles midwife, with the remit, of improving services & pathways for smoking in pregnancy, has ordered new Co monitors for all CMWs & all Antenatal & Postnatal clinical areas. The role out of the new Co monitors will ensure each user has up to date training around Very Brief Advice for smokers, training on CO monitor post COVID, & thorough knowledge of the referral pathways.	Work has started on providing Nicotine Replacement Therapy to women whilst inpatients on AN/PN ward rather than waiting for referral to external agencies



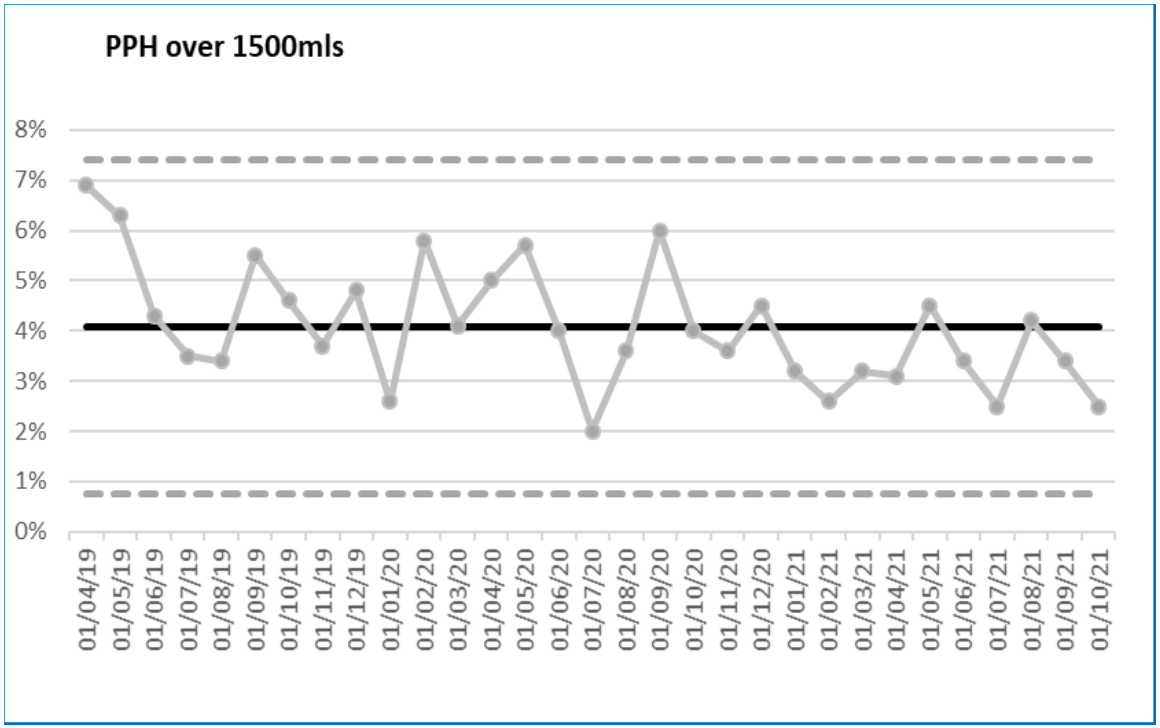
Oct-21
8%
Variance Type
Common cause variation
Target
20%
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Total no. of mothers delivering in birthing unit/home	Common cause variation & hit & missing target	Mothers delivering in birthing unit/home	5.8% of women delivered in the birth unit in October 2021 & 2.2% had a home birth. The rate of Birth Unit Deliveries is below the target but is much improved compared to September (0.8% Birth Unit deliveries in September 21).	Midwives are being deployed to the most appropriate area in terms of maintaining safe staffing levels. The Midwife led Unit has recently fully re-opened & the number delivering in the Birth Unit is expected to continue to increase for November.



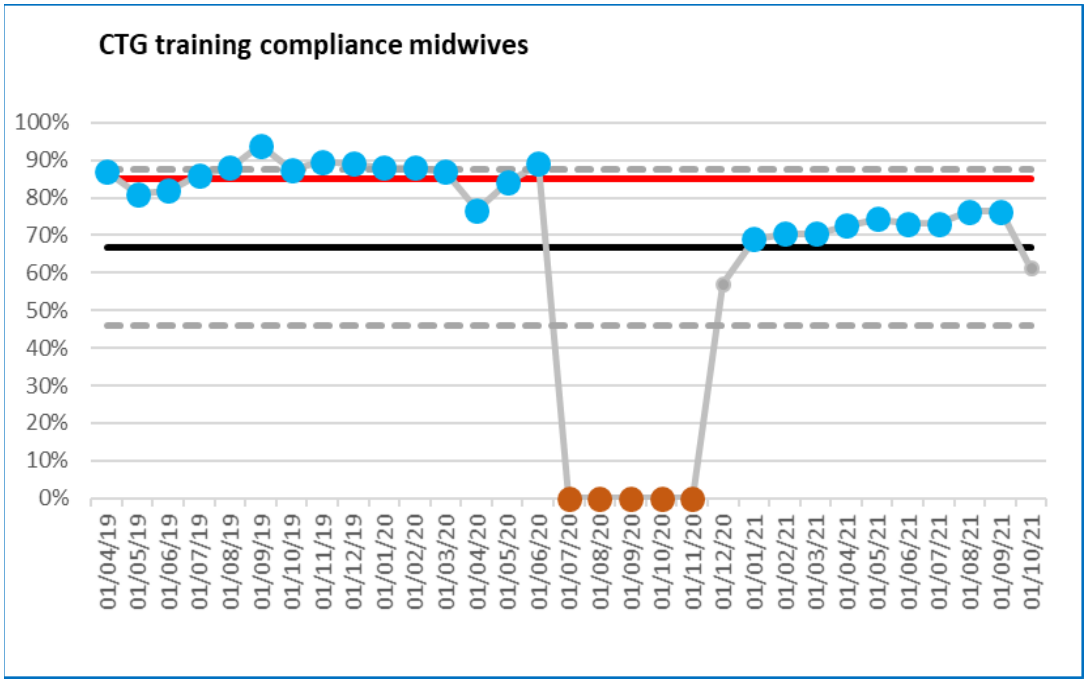
Oct-21
77%
Variance Type
Common cause variation
Target
74%
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Breast feeding rates at delivery	Common cause variation & inconsistently hit & missing target	Breast feeding rates at delivery	PAH's BFI Assessment is due to take place in November. Women have been consented for Unicef to do phone call interviews as part of this assessment & are being routinely contacted in the Antenatal period by a member of the Specialist Breast Feeding Team to discuss their planned baby feeding method. These 'Antenatal conversations', are as recommended by the 'Baby Friendly Initiative'.	76.7% of PAH delivered women are breast feeding at delivery, which is above the latest National Average rate of 73.6% (NMPA Audit 2019)



Oct-21
3%
Variance Type
Common cause variation
Target
Not set
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
PPH over 1500mls	Common cause variation	PPH over 1500mls	A massive obstetric haemorrhage action plan, developed in partnership with Watford & Lister Hospitals, is in place & the rate is continuously monitored. A new work stream group has been commenced to look at any further actions that may be applied.	The massive PPH rate has reduced in recent months from 4.2% in August to 3.4% in September & 2.5% in October 2021, which is below the latest reported National Average of 2.9%.



Oct-21
61%
Variance Type
Common cause variation
Target
85%
Target Achievement
Hit & miss target subject to random variation

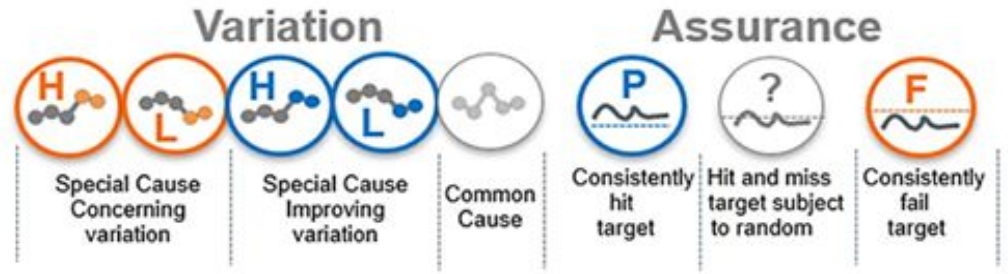
Background	What the chart tells us	Issues	Actions	Mitigation
CTG training compliance midwives	Common cause variation & inconsistently hit & missing target	Compliance with CTG training for midwives below trajectory	The Midwives CTG Training compliance rate has gone down to 61.1% % for October. This is due to a large number of midwives' competencies expiring in November 2021. 33 Midwives have attended their Fetal Monitoring Study Day but have not yet passed the competency. Midwives are given a week following the Study Day attendance to complete the assessments.	The CTG Specialist Midwife has a plan in place, including trajectory targets to achieve full compliance by December 2021

Places

*We will maintain the safety of & improve the quality & look of **our places** & will work with our partners to develop an OBC for a new hospital, aligned with the development of our local Integrated Care Partnership.*

Places Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Faciliites	NSC very high and high risk standards are both above the national cleanliness standards Sickness still an issue however now have a dedicated member of the HR team based in with the managers to assist with sickness Car parking charging reinstated for patients and visitors with effect from 01.11.2021	For information	
Capital	**Schemes completed** Williams Day unit refurbishment ED CT scanner build Winter Ward refurbishment STM MRI turnkey works OPAL unit completion and HCG operational Dolphin Ward – Phase 1 additional works completed **Schemes progressing:** Alex training and education facility build by 30/11/2021 Domestic Transformation upgrade for new Laundry by end of October 2021 Clinical agile office (mortuary corridor) by early November 2021 Alex lounge / clinical agile office by early November 2021 Saunders ward refurbishment by 22/12/2021	For information	
Estates	The Estates team continue to address jobs reported through the helpline with a 98% reponse rate for emergency call & 95% rate for urgent calls	For information	

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Estates Responsiveness (Priority 2 - Urgent)	Oct 21	95%	95%			95%	92%	99%
Meals Served	Oct 21	37898	42120			37044	27069	47018
Catering Food Waste	Oct 21	3%	4%			5%	-1%	11%
Domestic Services (Cleaning) Very High Risk	Oct 21	99.0%	98.0%			97.6%	93.8%	101.3%
Domestic Services (Cleaning) High Risk	Oct 21	96.9%	95.0%			96.5%	93.1%	100.0%



Performance

*We will meet & achieve **our performance** targets, covering national & local operational, quality & workforce indicators.*

Performance		Board Sub Committee:	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
52 Week waits	The number of long waiting patients continues to increase and is forecast to increase until March 2022, a further forecast is being developed to ascertain when the overall numbers will start to decrease. Patients are being booked in clinical priority order - emergency (P1), urgent &cancer (P2), then the longest waiting patients to ensure we have no patients waiting more than 104 weeks and no overdue P3 patients at 31st December 2021. A clinical review process for patients over 52 weeks has been implemented and will continually be reviewed by the clinical leads. Capacity across the ICS and IS is actively been sourced to support the flow of patients. Clear, visible trajectories for all specialities have been agreed and are monitored weekly. Accountability for clearing the backlog and adhering to the trajectory sits with the divisional directors.	For increased visibility and awareness	Date being forecast
DM01	The overall DM01 performance is slowly improving & has a recovery trajectory forecasted to reach the national standard in April 2022. Particular modalities are nearly at the 99% standard, Ultrasound = 98.92%, CT 95.7%, others due to increase in demand and staffing challenges have further to go, MRI 56% with a new scanner coming on line next month, Echocardiograms have insourcing support now & further capacity is being sought. Workforce challenges across radiography continue. Action to address this includes a proactive overseas recruitment campaign, local and national recruitment advertising, review of support and development and incentives to assist recruitment. The divisional team are proactive and are fully sighted on the challenges and actions required.	For increased visibility and awareness	30/04/2022

Performance cont.

*We will meet & achieve **our performance** targets, covering national & local operational, quality & workforce indicators.*

Performance			Board Sub Committee:
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
4 hour standard	The Urgent Care improvement work is continuing through the "In", "Out" & CQC workstreams reporting to the Urgent Care Board. Data shows PAHT type 1 performance is in the top half of the country. Unprecedented pressures continue across PAHT and the NHS. System working across the ICS is strong and continues to support flow on a daily basis for all 3 acute trusts. The Urgent Care Programme Board has been reshaped and refocussed to concentrate on the key metrics and areas to support patient experience and flow. There are a small number of key winter schemes under rapid development to support increased demand. The expansion of the Urgent Treatment Centre is on track for go live 1st December. Additional streaming and redirection to alternative pathways in on trajectory for 1st December. Direct access into SDEC and OPAL for EEAST will commence 1st December. A review of capacity and flow through the OPAL unit is scheduled for 30 November. Enhancing further operational and nursing support to Emergency care over winter has been approved as part of the winter resilience funding.	For information	Ongoing
Stranded patients	A Multi-Agency Discharge Event is scheduled for w/c 22/11/21 to highlight discharge process improvements across the system & ensure that the West Essex system has an efficient base to work from over winter 21/22. The objective is to use the week as a catalyst to reset assessment and support flow both in and out of the hospital. The week is being led by the Divisional Medicine Director with full internal and external partner support.	For information	31/12/2021
2 week wait	2 week wait referral numbers increased significantly in breast & skin in September (39% & 14%). Breast due to national media focus & skin appears to be a shift of referrals from routine to cancer. This impacted overall 2ww performance as both these tumour sites have high numbers of referrals. Referral levels have returned to more usual levels in October & breast performance is recovering in October & November. Skin has significant capacity issues & high numbers of patients being booked beyond 14 days, the service are increasing insourcing to support routine capacity to release PAH capacity for cancer activity. The CCG are supporting with GP communications about appropriate referrals & the roll-out of dermatoscopes to enable photographic triage. Lower GI referrals are also improving in 2ww performance in November as both the triage, Infoflex recording & endoscopy booking processes are improved. Current partial November performance shows an improving picture for all tumour sites except skin. A review of the structure to support cancer services has been undertaken with a role for a Trust Cancer Lead under discussion with the aim to advertise by December.	For information	30/11/2021

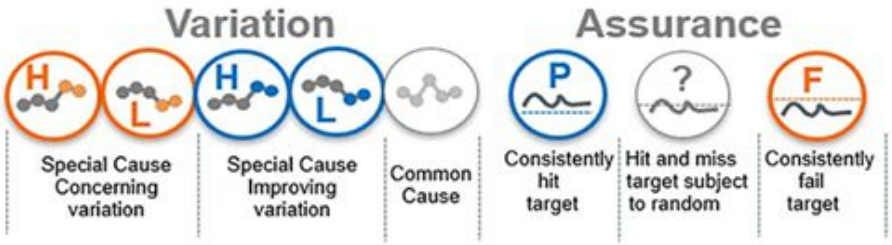
Performance cont.

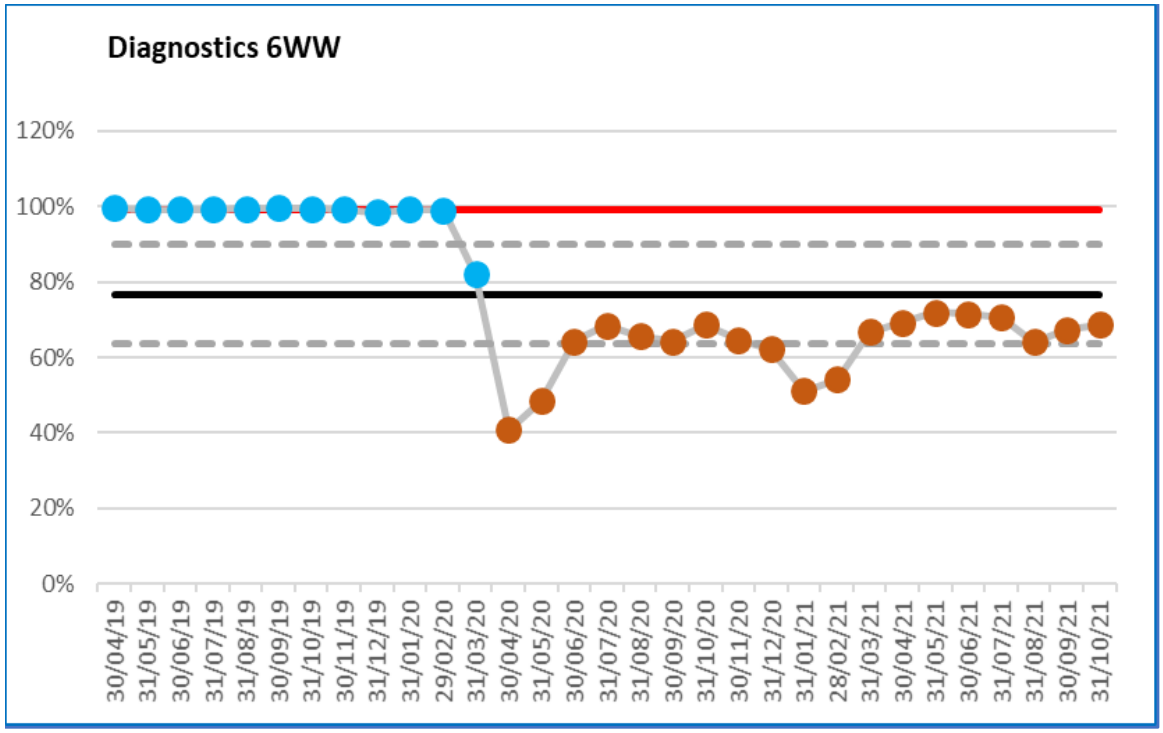
*We will meet & achieve **our performance** targets, covering national & local operational, quality & workforce indicators.*

62 Day Standard	The 62 day performance is starting to improve in line with the trajectory set with the tumour site teams who mapped the recovery of the backlog of long waiting patients to create the trajectory. The number of long waiting patients is decreasing as their diagnoses and treatments are being delivered. At the October month end the Trust was slightly better than the snapshot month end trajectory at 277 patients over 62 days, trajectory 284. The recovery is being actioned by: Improved data quality & better contemporaneous tracking to ensure next steps are expedited. Close senior review & escalation process of the patients on the cancer patient list. Focus on diagnosing & treating the longest waiting patients in addition to ensuring patients between 31 & 62 days are treated within target (do not "tip-in" to the backlog). Work on the 2ww standard and 28 day diagnosis standard in each tumour site. Prioritisation of theatre and out-patient capacity for cancer (and other P2) procedures Commitment from whole Trust to support continuation of elective services whenever possible.	For information	31/01/2022

KPI	Latest month	Measure	Target	Performance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 1 metrics								
RTT incomplete	Oct 21	52%	92%			76%	71%	81%
RTT admitted	Oct 21	43%	90%			54%	26%	82%
RTT Non admitted	Oct 21	85%	95%			88%	86%	91%
RTT PTL vs RTT PTL & ASIs	Oct 21	87%	none			95%	93%	97%
Cancer 31 days First	Sep 21	87%	96%			94%	87%	101%
Cancer 31 days Subsequent Drugs	Sep 21	100%	98%			99%	95%	104%
Cancer 31 days subsequent surgery	Sep 21	86%	94%			93%	65%	120%
Cancer 2WW	Sep 21	58%	93%			84%	68%	101%
Cancer 62 day shared treatment	Sep 21	70%	85%			71%	51%	91%
Cancer 62 day screening	Sep 21	63%	90%			67%	12%	122%
Cancer 62 Day Consultant Upgrade	Sep 21	94%	90%			86%	65%	106%
Cancer 28 day faster diagnosis	Sep 21	63%	none			67%	51%	82%
4 Hour standard	Oct 21	61%	95%			76%	68%	84%
ED attendances	Oct 21	10780	none			8698	6787	10610
ED Admitted performance	Oct 21	27%	95%			51%	34%	69%
ED non admitted performance	Oct 21	69%	95%			84%	76%	92%
ED Arrival to Triage	Oct 21	79	15			43	26	60
ED Triage to examination	Oct 21	131	60			90	69	111
ED Examination to referral to specialty average wait	Oct 21	123	45			97	85	109
ED referral to be seen average wait	Oct 21	96	30			77	59	96
Seen by specialty to DTA	Oct 21	127	60			94	71	116
DTA to departure	Oct 21	361	30			175	64	285
Ambulance handovers less than 15 minutes	Oct 21	12%	100%			28%	15%	42%
Ambulance handovers between 15 and 30 mins	Oct 21	29%	0%			43%	34%	51%
Ambulance handovers between 30 and 60 mins	Oct 21	29%	0%			21%	11%	32%

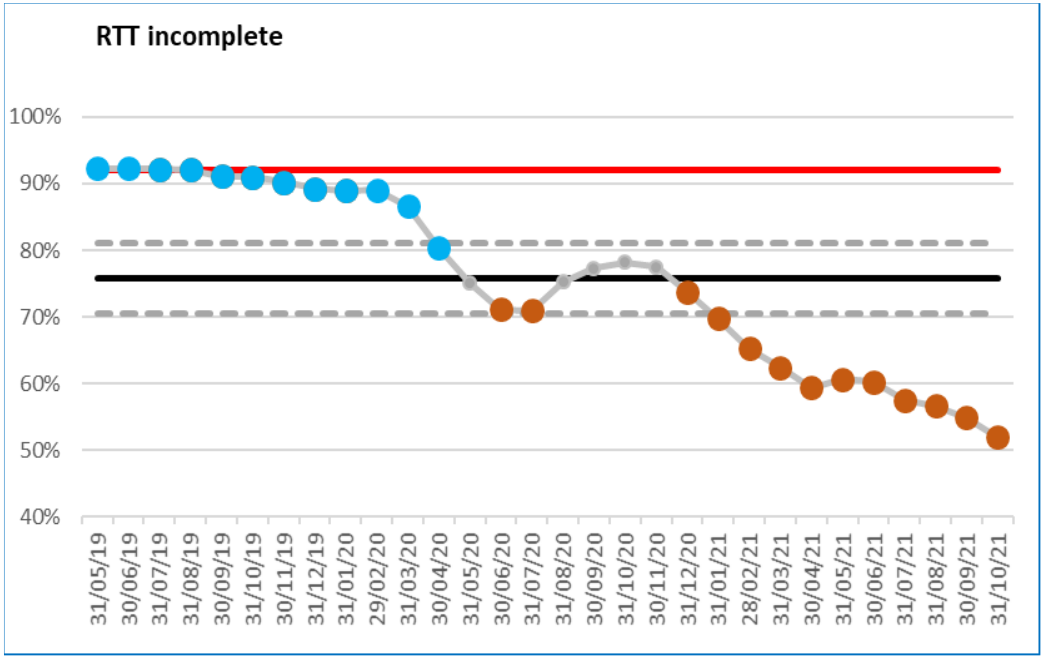
KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 2 metrics								
Ambulance handovers > 60 mins	Oct 21	30%	0%			8%	-1%	17%
Diagnostics 6WW	Oct 21	69%	99%			77%	64%	90%
Occupied beds with stranded patients	Oct 21	157	80			144	91	197
Bed occupancy	Oct 21	75%	85%			88%	78%	97%
Discharges between 8am and 5pm	Oct 21	687	none			730	472	989
Discharges between 5pm and 8am	Oct 21	769	none			702	436	968
LOS non elective	Oct 21	3.8	5.1			3.7	2.8	4.7
LOS elective	Oct 21	3.3	4.2			2.2	0.6	3.9
Short Notice clinical cancellations	Oct 21	38	none			44	-32	121
OP new to follow up ratio	Oct 21	2.1	2.3			2.1	1.8	2.5
OP DNA Rate	Oct 21	6%	8%			5%	3%	6%
52 Week waits	Sep 21	1536	0			464	290	637
Proportion of Majors Patient treated within 4 hours in ED Paeds	Oct 21	50%	95%			83%	68%	98%
Super stranded patients	Oct 21	51	25			40	14	66
12 Hour waits in ED from Arrival	Oct 21	1171	0			399	94	703
12 Hour Trolley waits in ED from DTA	Oct 21	220	0			31	-29	90





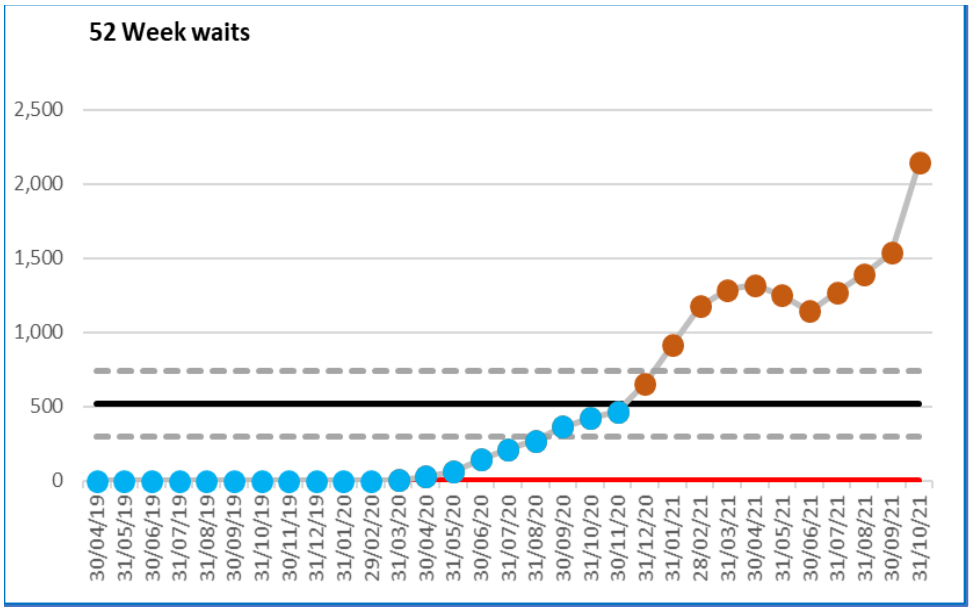
Oct-21
68.67%
Variance Type
Special cause variation
Target
99.00%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Diagnostics 6 week wait	Special cause concerning variation and consistently failing target	There is a backlog of diagnostic requests which have built up as a result of covid restrictions. The delay in the replacement of the MRI scanner is reducing capacity. Increased referral levels (+20%) continuing.	Additional capacity is being delivered as extra sessions & use of independent sector providers. "Smart" booking of longest waiting patients. Additional temporary staff being sourced to support additional capacity.	Clinical prioritisation (99%) of waiting list & review of long waiting patients on DM01 waiting list. A number of modalities are improving month by month, eg Ultrasound should achieve standard next month



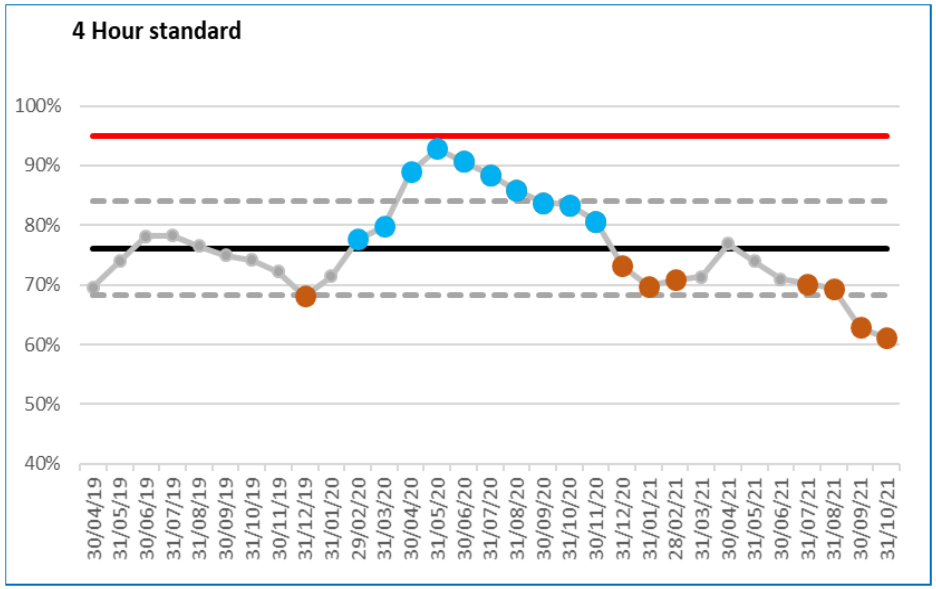
Oct-21
52%
Variance Type
Special cause variation
Target
92%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
RTT Incomplete	Special cause concerning variation and consistently failing target	The performance against the RTT standard has been below the target and statistical mean for 12 months as a result of covid activity pressure pausing elective activity which created a backlog of patients waiting longer than 18 weeks for first definitive treatment. The balance of emergency, elective and recovery remains an ongoing challenge	Admitted backlog being booked & treated in clinical order not chronological. Virtual & face to face clinics and additional sessions being put on. Extensive outsourcing to Independent Sector & insourcing at PAH to increase capacity. Weekly oversight from healthcare groups. Trajectory to ensure no 104week breaches and no overdue P2&3s by 31/12/21 in place. All specialties remain under constant review	Admitted backlog clinically prioritised. Non admitted - clinical priority booking at sub specialty level. Clinical Reviews of long waiting patients & harm reviews being in place



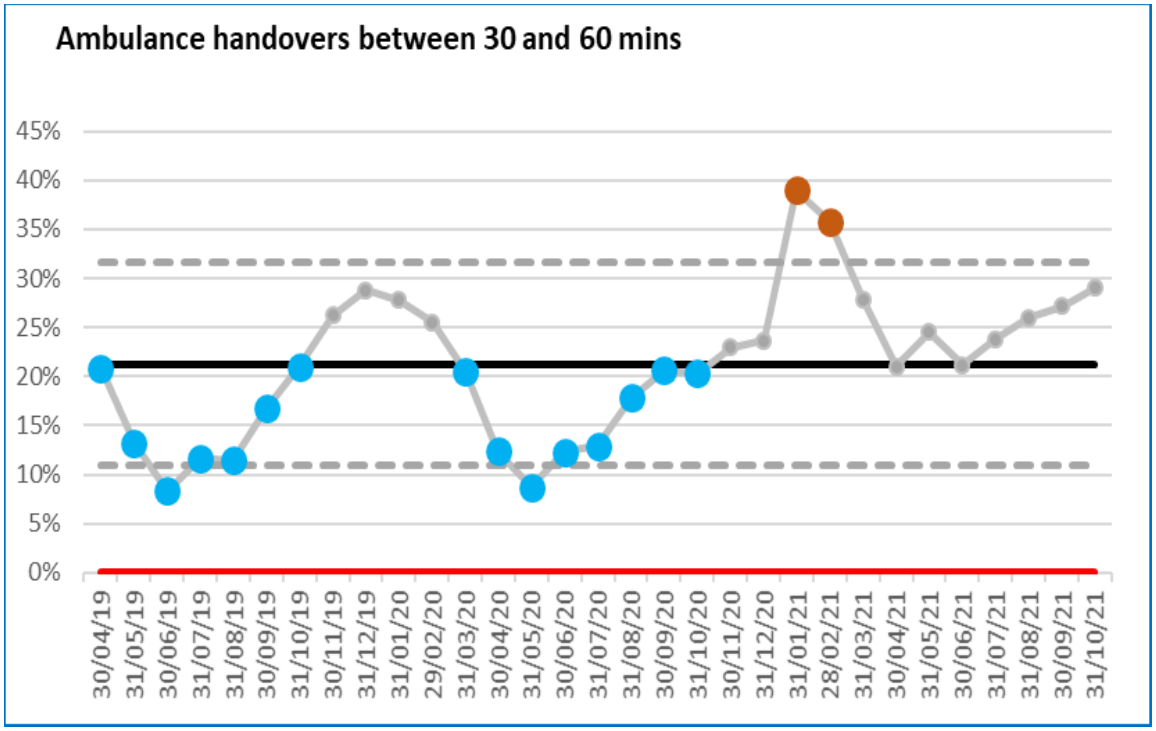
Oct-21
2141
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
52 week waits	Special cause concerning variation and consistently failing target	Booking in clinical priority order instead of chronological order has led to increasing numbers of long waiting lower priority patients. Modelling indicates number of 52 week patients will increase until March 2022. Balance between emergency & elective capacity is an ongoing challenge. Challenge of inpatient capacity and space, anaesthetic workforce availability and ongoing covid pressures will and has impacted on the speed of recovery	All patients over 78 weeks increased in priority to P3. RTT Recovery trajectory developed to ensure that the Trust has no patients waiting over 104 weeks by 31/12/21. Additional aim to ensure no overdue Priority P3, 2 or 1 patients by 31/12/21. Ongoing outsourcing of lower priority patients to Independent sector. Working with ICS colleagues to develop a sustainable winter solution to support elective surgery utilising the IS. Elective ward capacity moved to single ward to protect as far as possible from emergency pressures on bed capacity	Review of theatre capacity to support recovery. Deelopment of a enhanced post op recovery area. Clinical review of long waiting patients being implemented with interim & treatment harm review process to monitor for potential harm.



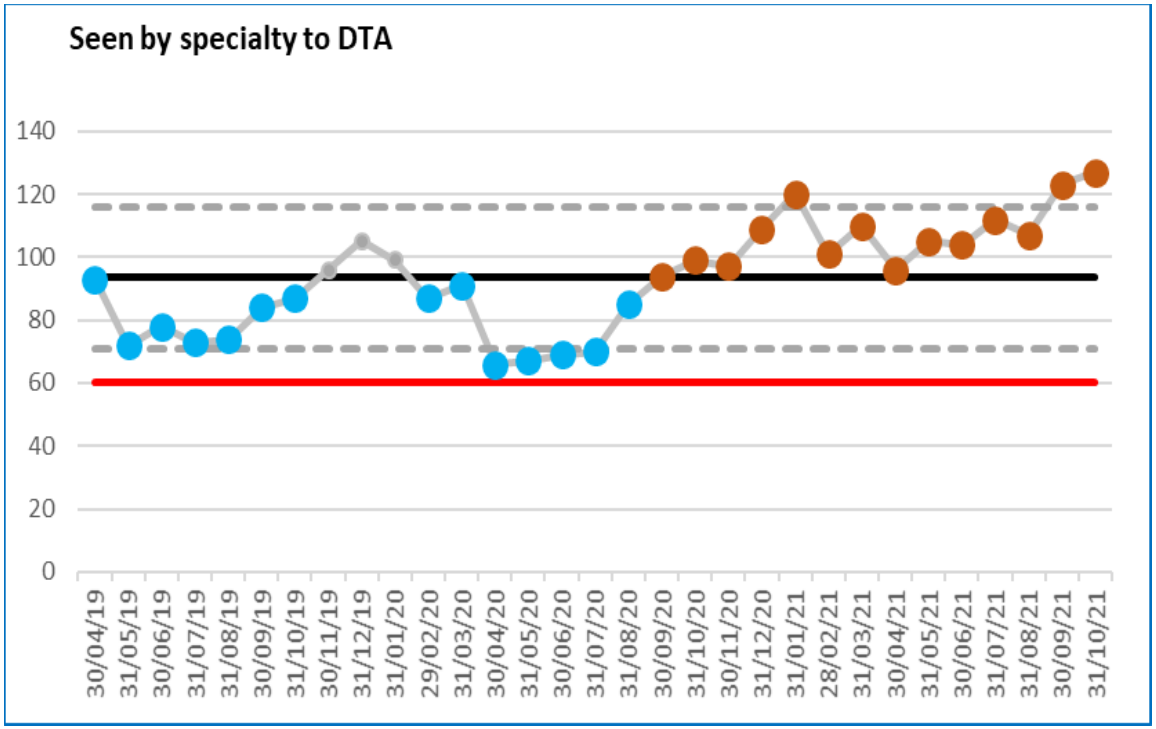
Oct-21
61%
Variance Type
Special cause variation
Target
95.00%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Four hour standard	Special cause concerning variation and consistently failing target	The performance against the four hour standard has been consistently below the statistical mean for four months & close to the lower control limit. Significant increases in attendances has exacerbated the pressure on the emergency pathways.	Executive and Healthcare group oversight continues through theUrgent Care Board & CQC Quality Project workstream. Internal, ICS, Regional and national discussions taking place to support the increase in patients. Work to extend the Urgent Treatment Centre is underway to reduce crowding in the main ED area. Cohorting SOPs with ED and EEAST colleagues are in place and under regular review. The volume of patients continues to increase. Multi-Agency Discharge Event w/c 22/11 to improve flow out of hospital & through the urgent care departments, returning AAU to an assessment unit.	Safety huddle in ED 3 times a day to review safety and pressure in the department and to escalate where additional support is required. Additional support in place for the UTC with extended hours in GP. SDEC unit developed OPEL status and reviewing demand and capacity to support urgent care. Weekly regional discussion on pressure points. Evening ICS system call to support emergency areas out of hours.



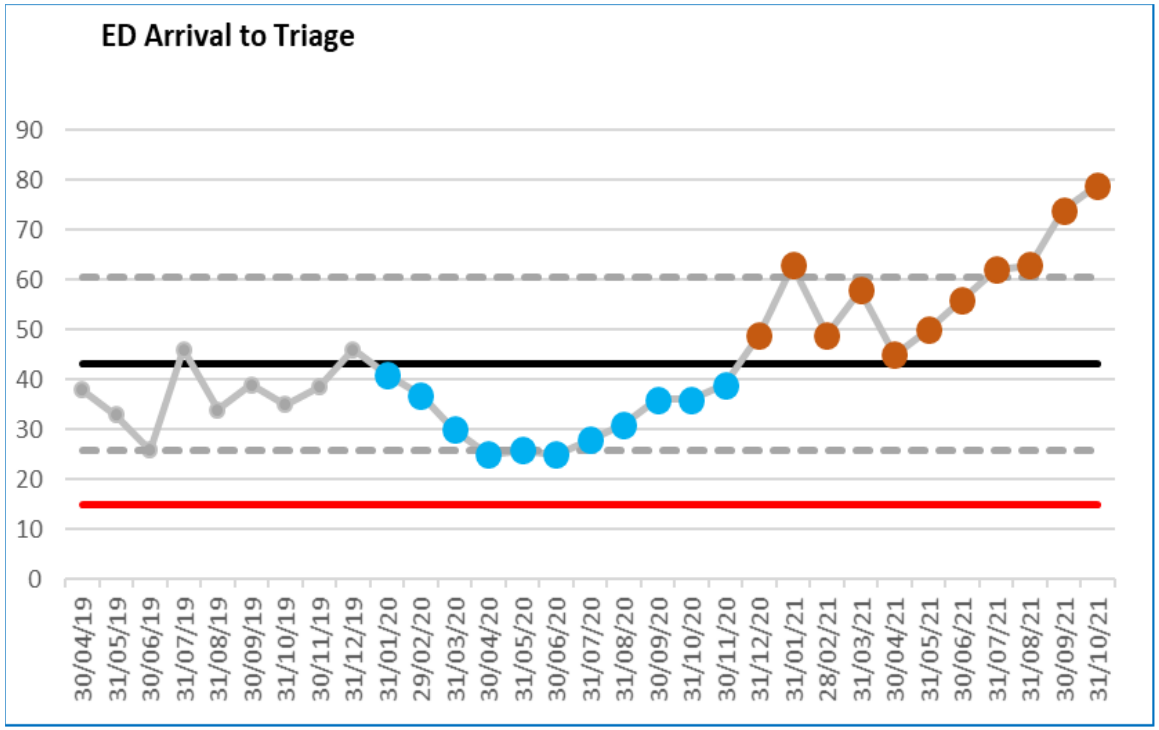
Oct-21
29%
Variance Type
Common cause variation
Target
0.00%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Ambulances handovers between 30 and 60 minutes	Common cause concerning variation and consistently failing target	The % of ambulance conveyances over 30 minutes has increased above the statistical average. Increased ambulance activity, delays in bed availability for admissions in emergency department.	Improvement programme has delivered a revised Standard Operating Process for Ambulance handovers, creating a cohorting area that enables ambulances to offload & return to the community. Daily system call with EEAST to enact load levelling and manage volume across the acute Trusts. Winter resilience plan being developed with EEAST and NHSI colleagues.	Safety huddle led by EPIC and NIC to review entire department 6 times a day. SOP in place for ambulance patients. Ongoing review of capacity across the emergency department



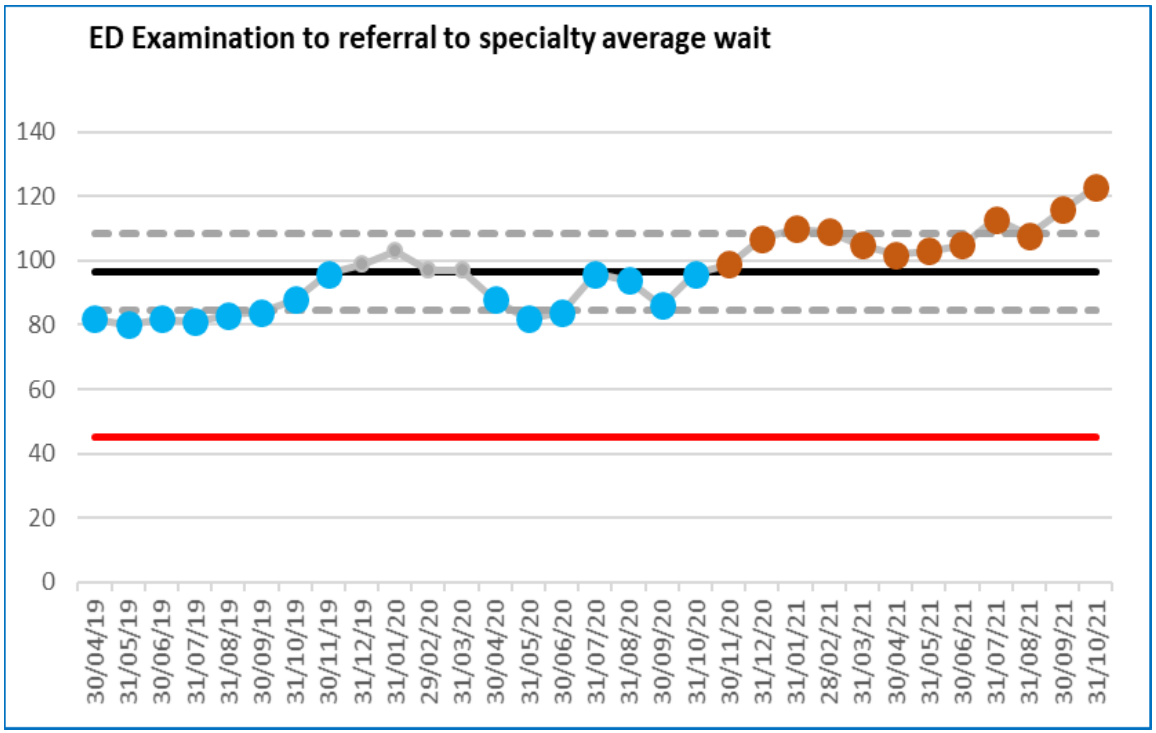
Oct-21
127 minutes
Variance Type
Special cause variation
Target
60 minutes
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Seen by specialty to DTA	Special cause concerning variation and consistently failing target	The average time from being seen by specialty to decision to admit has been consistently increased over the statistical average for 9 months	Internal Professional Performance Standards being monitored by Urgent Care Board and actions to improve being developed. Focus on increasing attendance at Emergency Department huddles from specialities to ensure clear & rapid communication of delays. Divisional directors accountable for direct discussions across clinical teams	Close review through breach analysis &at Urgent Care Board



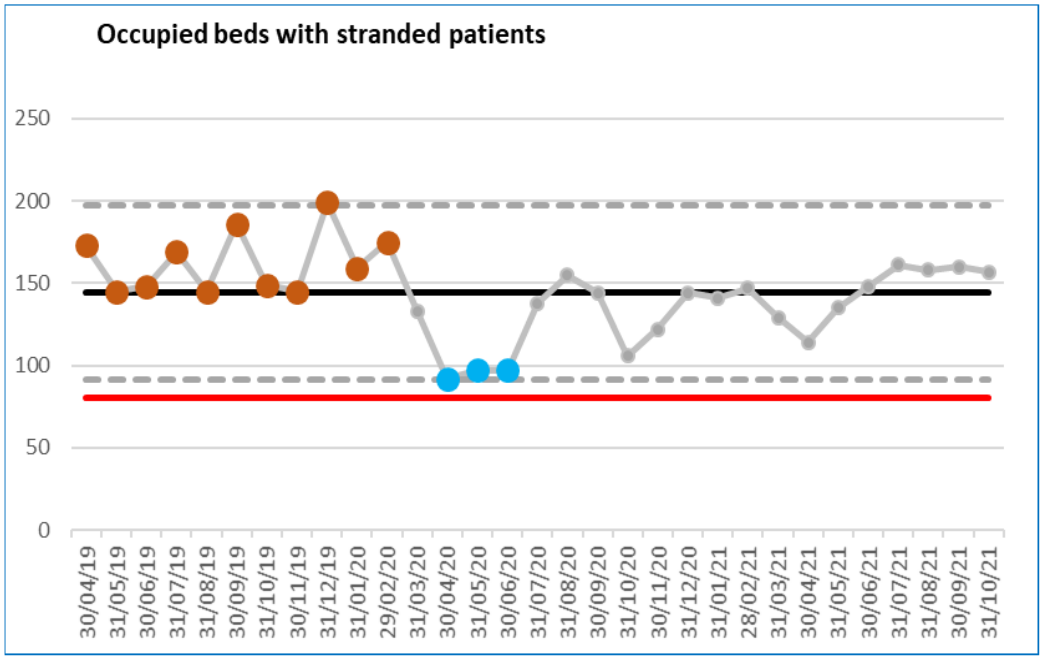
Oct-21
79 minutes
Variance Type
Special cause variation
Target
15 minutes
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Seen by specialty to DTA	Special cause concerning variation and consistently failing target	The average time from being seen by specialty to decision to admit has been consistently increased over the statistical average for 8 months	IPPS measurements of time to straeming & triage through Urgent Care Board. Ongoing review of the streaming processes and redirection to the UTC to manage & support demand increases.	Close review through breach analysis at Urgent Care Board



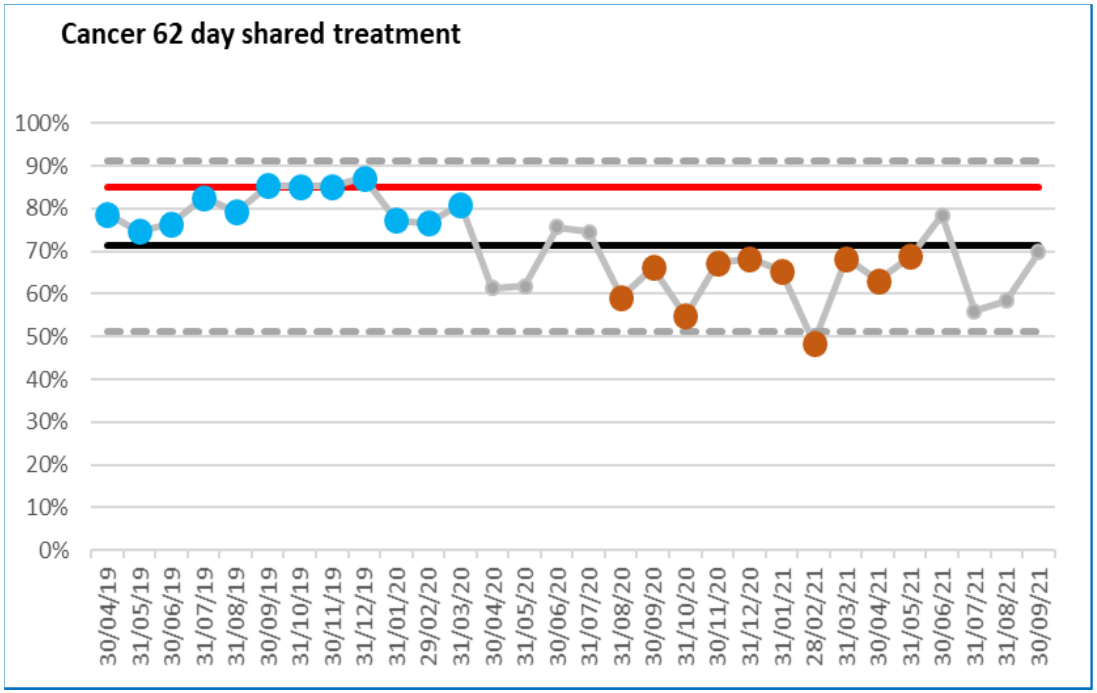
Oct-21
123 minutes
Variance Type
Special cause variation
Target
45 minutes
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
ED examination to referral to specialty average wait	Special cause concerning variation and consistently failing target	The average time from being seen by specialty to decision to admit has been consistently increased over the statistical average for 9 months	IPPS measurements of performance through Urgent Care Board. Divisional attendance at ED Huddles being monitored and escalated.	Close review through breach analysis at Urgent Care Board



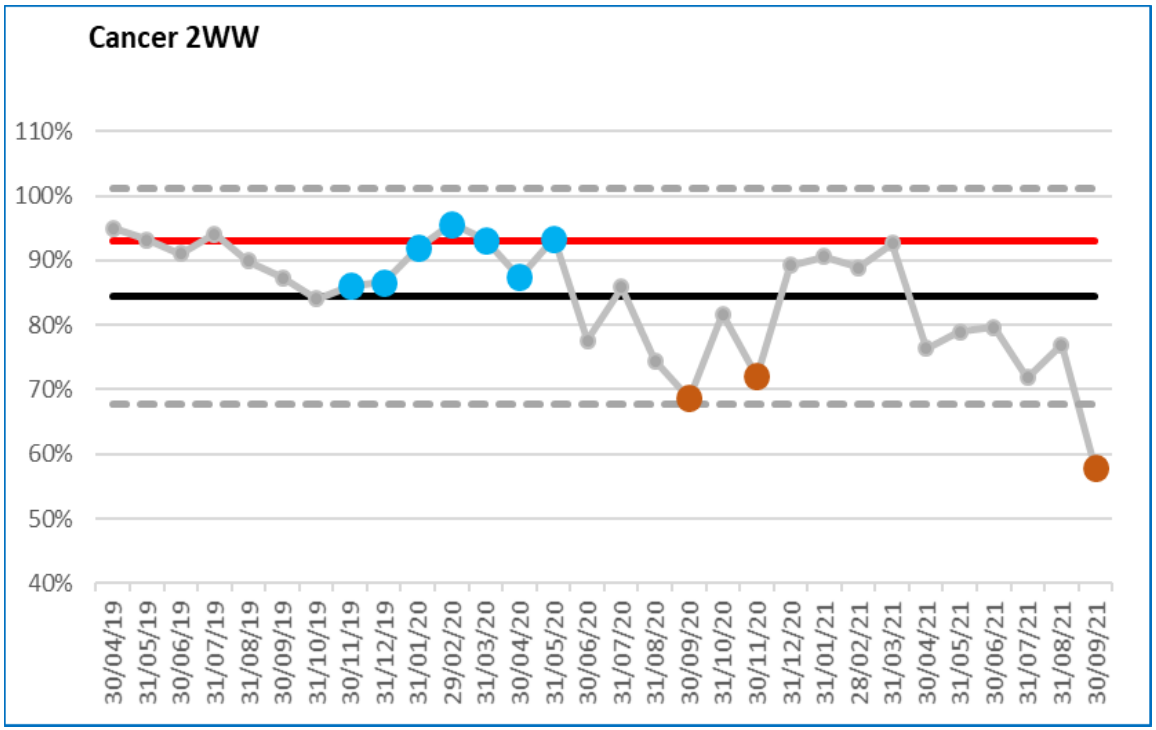
Oct-21
157
Variance Type
Common cause variation
Target
80
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Occupied beds with stranded patients	Common cause variation and consistently failing target	The performance against the target for stranded patients has failed consistently, however, we have shown common cause variation for the last 12 months	Safer and Red 2 Green refresh underway to support robust discharge planning. Daily patient panel review to understand discharge constraints. HIT Team review of patients appropriate for discharge at the weekends. Additional community capacity is being considered and options worked through with social care and community partners. External senior national consultant support secured to work alongside consultant and nursing teams on the inpatient wards.	Review via daily bed meetings, daily system meetings & weekly capacity planning meetings. EDD review underway. Use of nerve centre to track patient EDDs and support for discahrge in place.



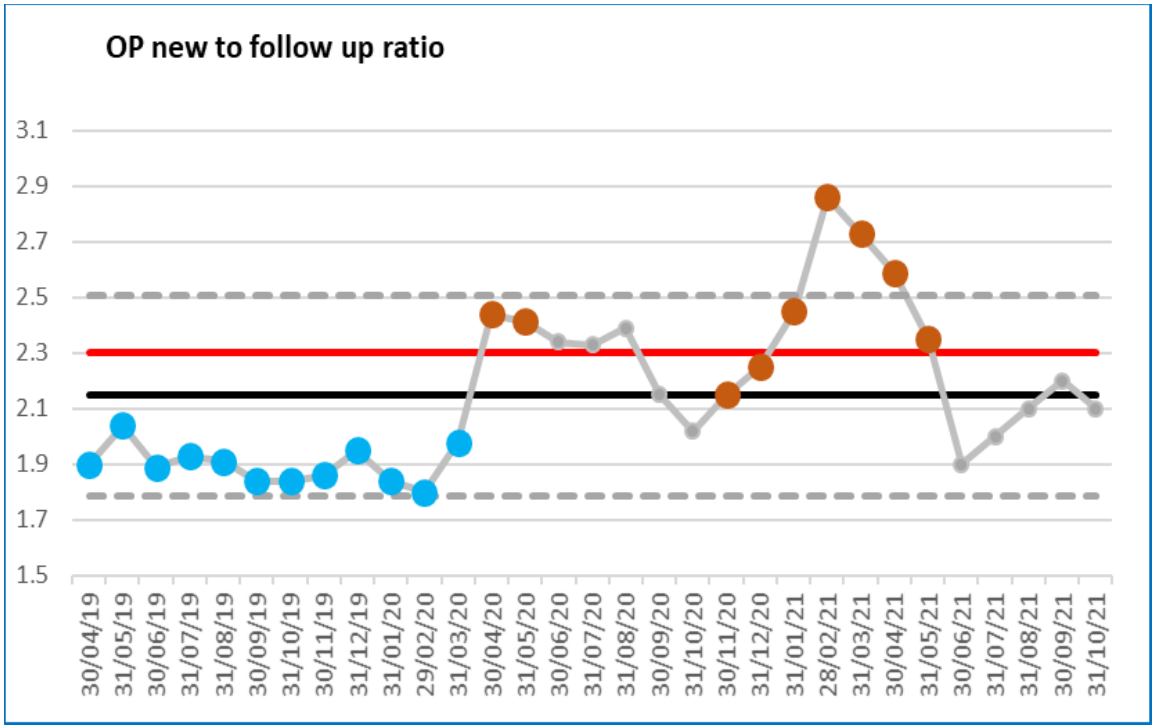
Sep-21
70%
Variance Type
Common cause variation
Target
85%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 62 day shared treatment	Common cause variation and hitting and missing target radomly	The performance against the target has failed for over 12 months.	The Trust has continued to focus on diagnosing & treating the backlog of patients that developed over the Covid period & the 62 day performance reflects the increased numbers of patients treated after 62 days in their pathway. Additional diagnostics & treatments are being delivered to clear the backlog & the Trust has a recovery trajectory that aims to return to national performance in February 2022.	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting. Priortisation of cancer patients in booking diagnostics & treatments. Clinician discussions at cancer Board to escalate actions required to assist.



Sep-21
58%
Variance Type
Special cause concerning variation
Target
93%
Target Achievement
Inconsistently passing and falling short of target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 2 week wait	Special cause concerning variation & inconsistently passing and falling short of the target	Ongoing increased referrals and capacity issues due to staff absence in conjunction with clinic booking issues. Dermatology has seen significant increases in 2ww referrals and has staffing issues	Clinic booking processes being refined, additional clinic capacity implemented wherever possible, including using insourcing for routine appointments. Support from commissioners to improve dermatology referral pathway.	Close review of 28 day diagnosis standard & maintenance at national standard. Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to Cancer Board & executive reporting.



Oct-21
2.1
Variance Type
Common cause variation
Target
2.3
Target Achievement
Inconsistently passing and falling short of target

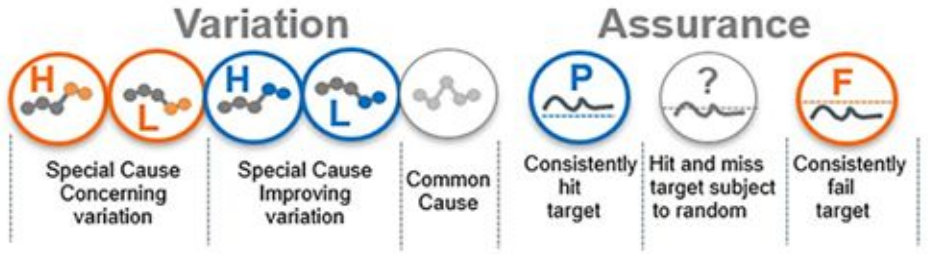
Background	What the chart tells us	Issues	Actions	Mitigation
OP new to follow up ratio	Common cause variation and inconsisrtently passing and falling short of the target	Additional insourcing to clear the overdue follow-up appointments is impacting the ratio.	Ongoing monitoring & increased volumes of activity to support recovery.	Not required - clearance of additional follow-up activity expected to increase ratio.

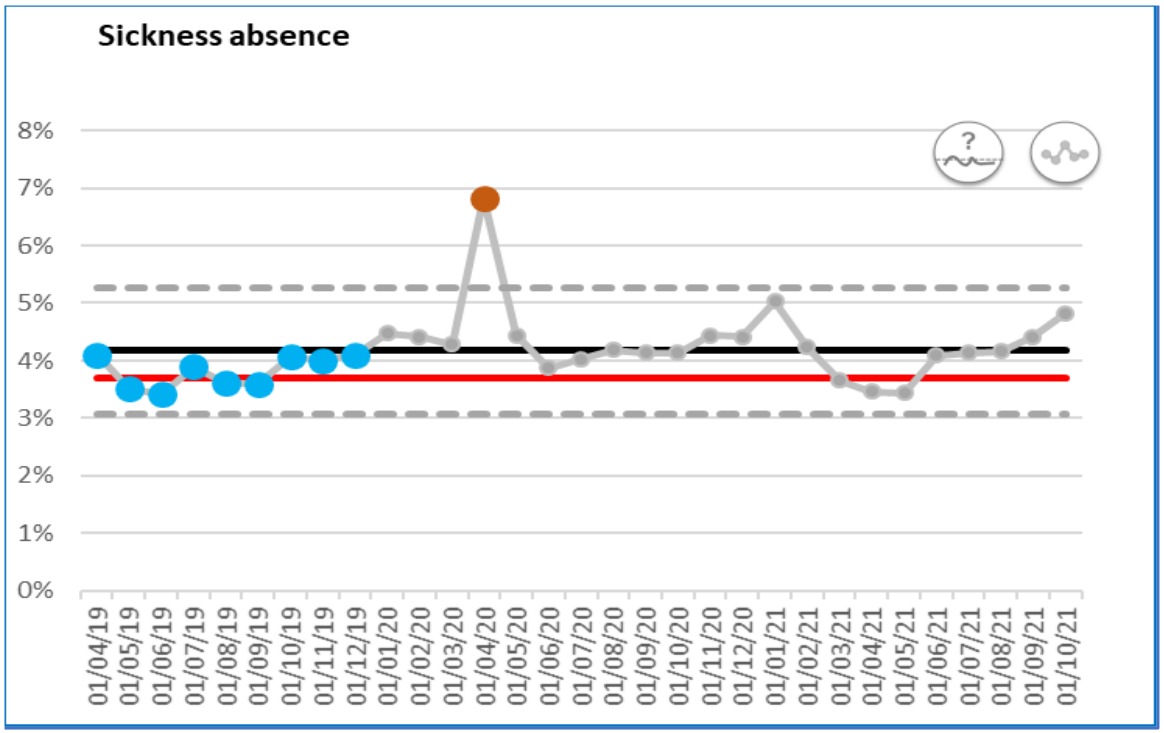
People

*We will support **our people** to deliver high quality care within a culture that continues to improve how we attract, recruit & retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.*

People Summary		Board Sub Committee: Worforce Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Appraisals	Divisional feedback indicated that staff workplace moves over the last year have compounded appraisals being completed by the appropriate manager. Advice is being provided by the Learning & OD team and the HRBPs with regards to this and support with planning provided by HRBPs at divisional board meetings. Service level compliance reports provided to managers on a monthly basis	For information	Q3/4
Sickness	Sickness absence continues to sit just above the trust KPI for October. Absences relate to mental health and MSK and cold & flu. Health & wellbeing initiatives in place to actively signpost to the trust psychological support service "Here for you" & physiomed, the physiotherapy support service	For information	Q3/4
Statutory and Mandatory training	LOD & HRBP teams continue to support divisions with action plans to support the release of staff to undergo training. There will be training facilities on the main hospital site in the autumn	For information	Q3/4
Vacancy	International recruitment plans remain on track & medical staffing posts within Surgery are actively being recruited to. Rolling adverts are in place for housekeeper roles.	For information	Q3/4

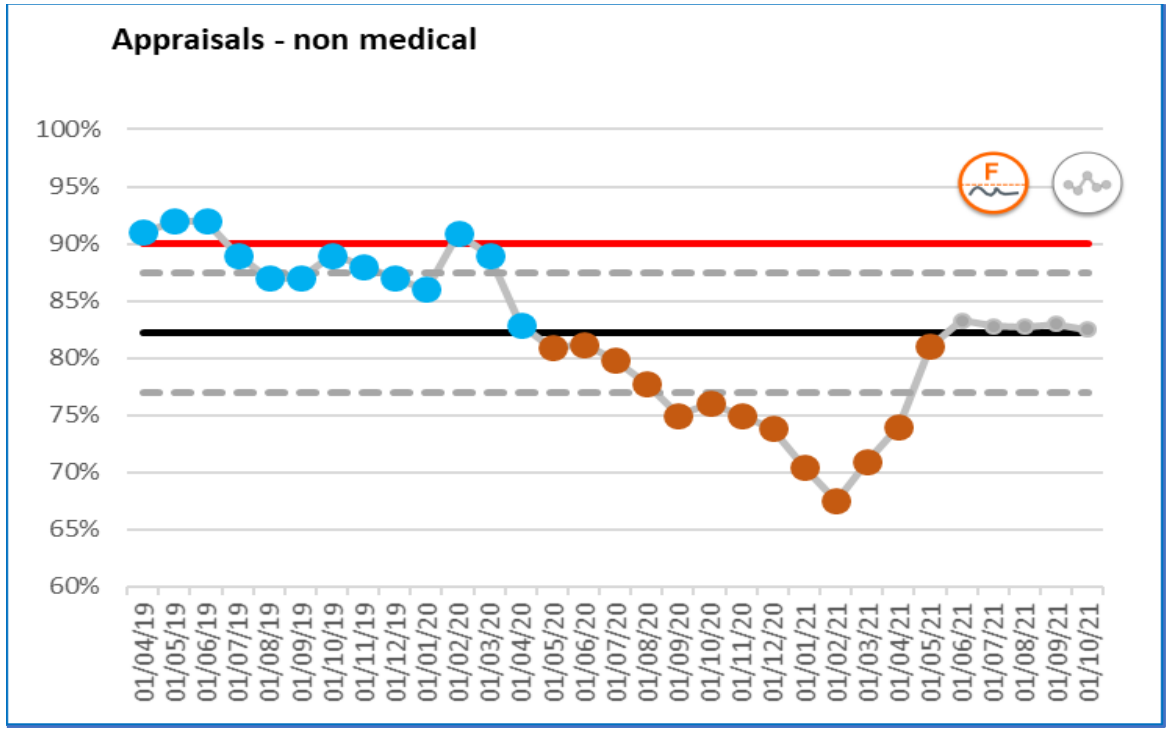
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Appraisals - non medical	Oct 21	83%	90%		F	82%	77%	87%
Agency staffing spend	Oct 21	4%	15%	L	P	5%	2%	8%
Bank staffing spend	Oct 21	12%	15%		P	12%	9%	14%
Vacancy Rate	Oct 21	8%	8%	L	F	10%	8%	11%
Staff turnover - voluntary	Oct 21	11%	12%		P	11%	10%	12%
Sickness absence	Oct 21	5%	4%		?	4%	3%	5%
Statutory and Mandatory training	Oct 21	87%	90%		?	89%	86%	92%





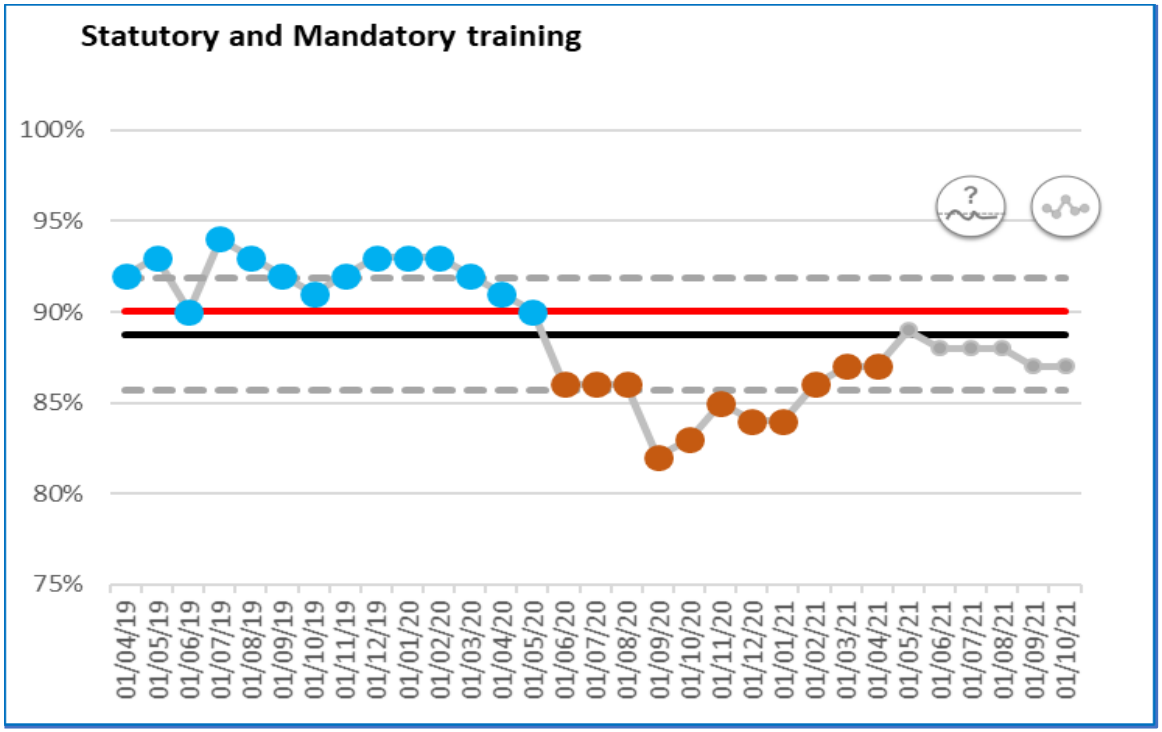
Oct-21
4.82%
Variance Type
Common cause variation
Target
4%
Target Achievement
Inconisistently passing & falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Sickness absence	Variation indicates inconsistently passing & falling short of the target	Sickness absence remains above the trust KPI for October. The top three absence reasons remain mental health & MSK and cold and flu	Action plans are in place and regularly reviewed to support all long term sickness absence cases to include staff health and wellbeing interventions both through the trust psychological support service and physiomed.	Absence rates are discussed at monthly divisional board meetings & performance review meetings



Oct-21
82.5%
Variance Type
Common cause variation
Target
90%
Target Achievement
Consistently failing target

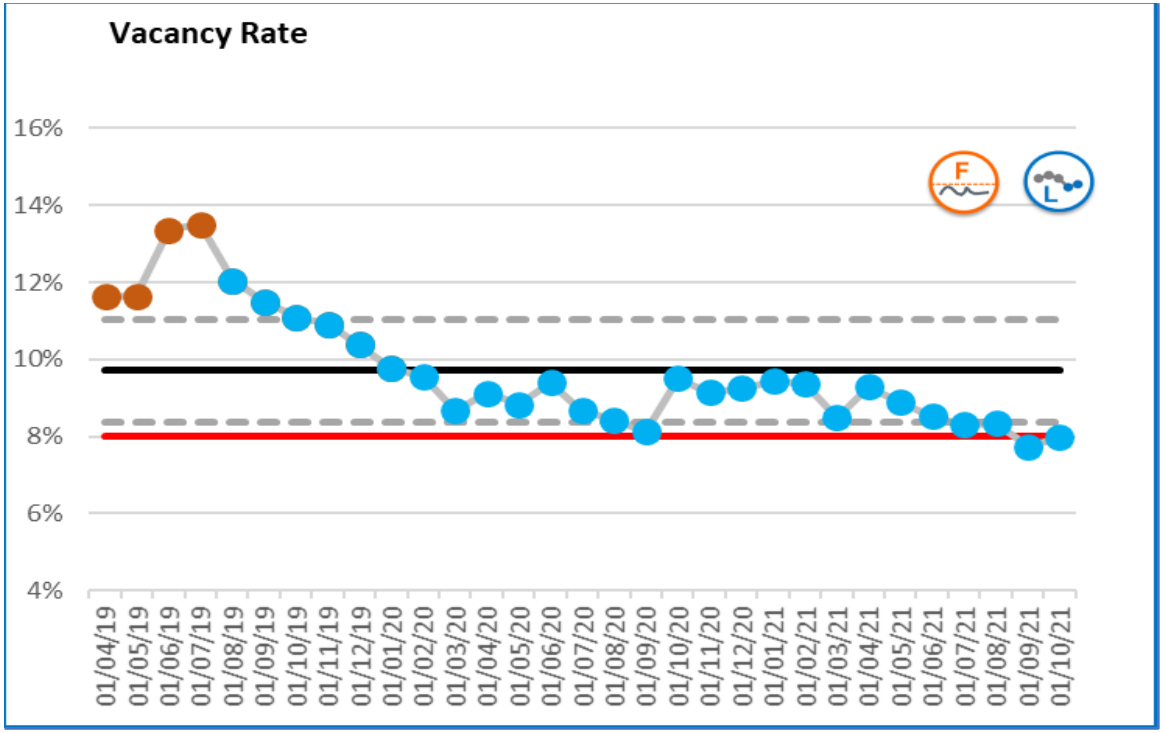
Background	What the chart tells us	Issues	Actions	Mitigation
Appraisal non medical	Common cause concerning variation & consistently falling short of target	Staff workplace moves and redeployment over the last year continue to compound appraisals being completed by the correct manager	Support with planning appraisals continues to be provided by HRBPs & LOD teams at divisional board meetings. Service level compliance reports provided to managers on a monthly basis. Support provided by the people information team on uploading appraisal data to ESR	Compliance rates discussed at monthly HCG board meetings & performance review meetings with actions agreed



Oct-21
87%
Variance Type
Common cause variation
Target
90%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Statutory and Mandatory Training	Common cause concerning variation & consistently failing target	Reported challenges of protected time to complete training	LOD team supporting HCG with action plans to support the release of staff to undergo training. The new training centre based on the main hospital site is due to open late autumn which will improve access to on site training	Training data discussed at divisional board meetings on a monthly basis. New training venue based on site planned for autumn

People



Oct-21
7.97%
Variance Type
Special cause variation
Target
8.00%
Target Achievement
Consistently failing

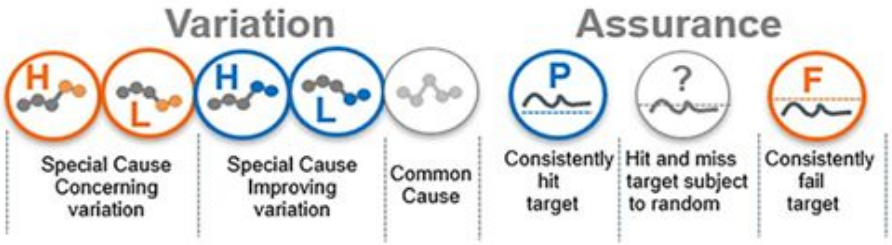
Background	What the chart tells us	Issues	Actions	Mitigation
Vacancy Rate	Special cause improving variation & consistently failing target	The trust vacancy rate has incresed in October. There is a focus on vacancy rates within allied health professonals, housekeeper roles and medical staff within surgery	International nurse recruitment continues as per plan, advertising of estates & facilities domestic & housekeepers roles takes place on a rolling basis. Medical staffing vacancies currently within the recruitment pipeline with candidates due to start in Q3 & Q4	Recruitment plans for divisions reviewed at divisional board meetings & at monthly performance review meetings.

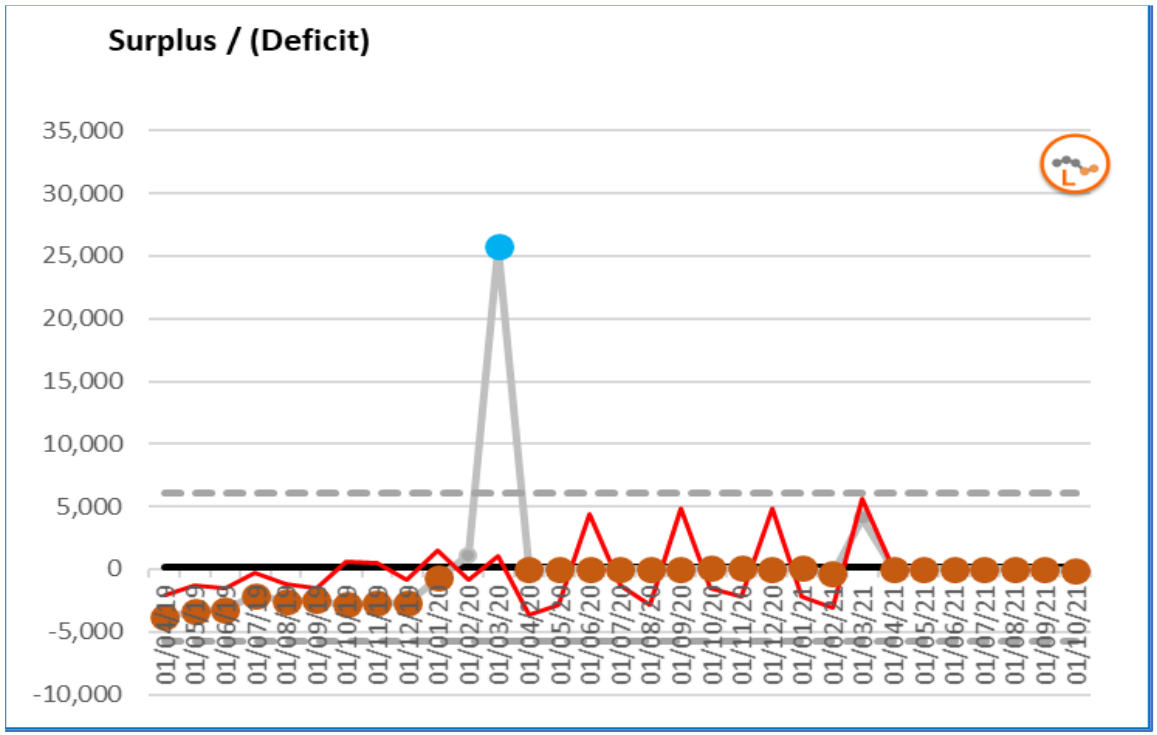
Pounds

*We will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way*

Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Surplus	The Trust has achieved financial break even at M7 in line with its financial plan. To deliver this finanical performance the Trust has utilised its M6 surplus of £127k & £3.8m of its COVID-19 financial envelope. Key factors driving this deterioriation in finanical performance are receiving less income for elective recovery activity & CIP under delivery. The Finance Department is supporting Divisions to reduce their run rate.	For information	
CIP	The Trust has delivered £1.826m of savings against a year to date plan of £3.049m. The CIP is being delivered non-recurrently. A concerted effort is being made to find CIPs that deliver recurrently.	For information	
Capital Spend	The capital profile has been reprofiled after discussion with NHSE/I. YTD capital spend is £13.491m against a revised capital plan of £15.528m. The underspend is a timing difference. There is currently an overplanning margin of c.£1.4m. The Trust continues to forecast achieving its Capital Resource Limit.	For information	
Cash	The Trust cash balance is c.£49m. There is a continued push to reduce aged payables & improve the Trust's performance against the Better Payment Practice Code. The Trust is also working on reducing its aged receivables to ensure that it is collecting all of its debts.	For information	

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Surplus / (Deficit)	Oct 21	-127	0			144	-5763	6051
EBITDA	Oct 21	1323	0			1279	-4694	7253
CIP	Oct 21	60	0			579	-297	1456
Income	Oct 21	26749	0			25648	14183	37113
Operating Expenditure	Oct 21	26902	0			25510	19730	31289
Bank Spend	Oct 21	3038	0			2022	1326	2718
Agency Spend	Oct 21	938	0			829	411	1246
Capital Spend	Oct 21	2599	0			2594	-3405	8593

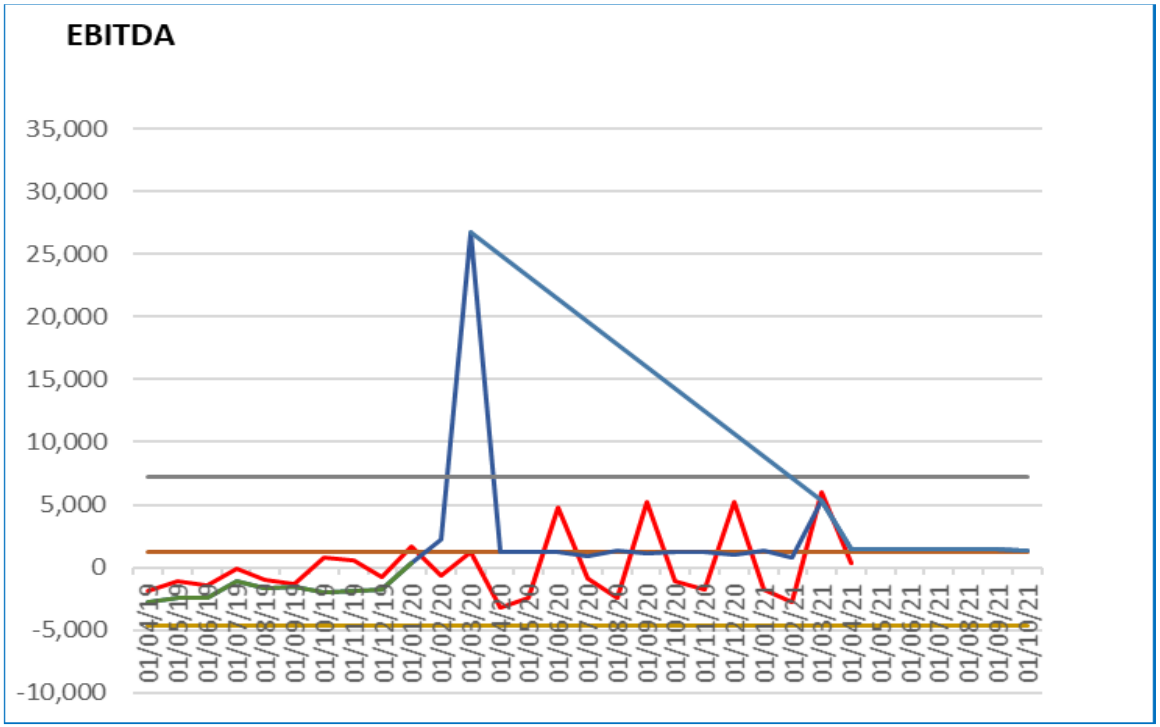




Oct-21
-127
Variance Type
Special cause concerning variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Surplus/Deficit	Special cause concerning variation & inconsistently passing and falling short of the target	The Trust has delivered a breakeven finanical performance at M7. This was achieved utilising surplus & the COVID-19 envelope due to receiving less income relating to elective recovery activity.	The Trust is focusing on recovering elective activity. The Finance Department is working with Divisions to help them reduce their run rate.	N/A

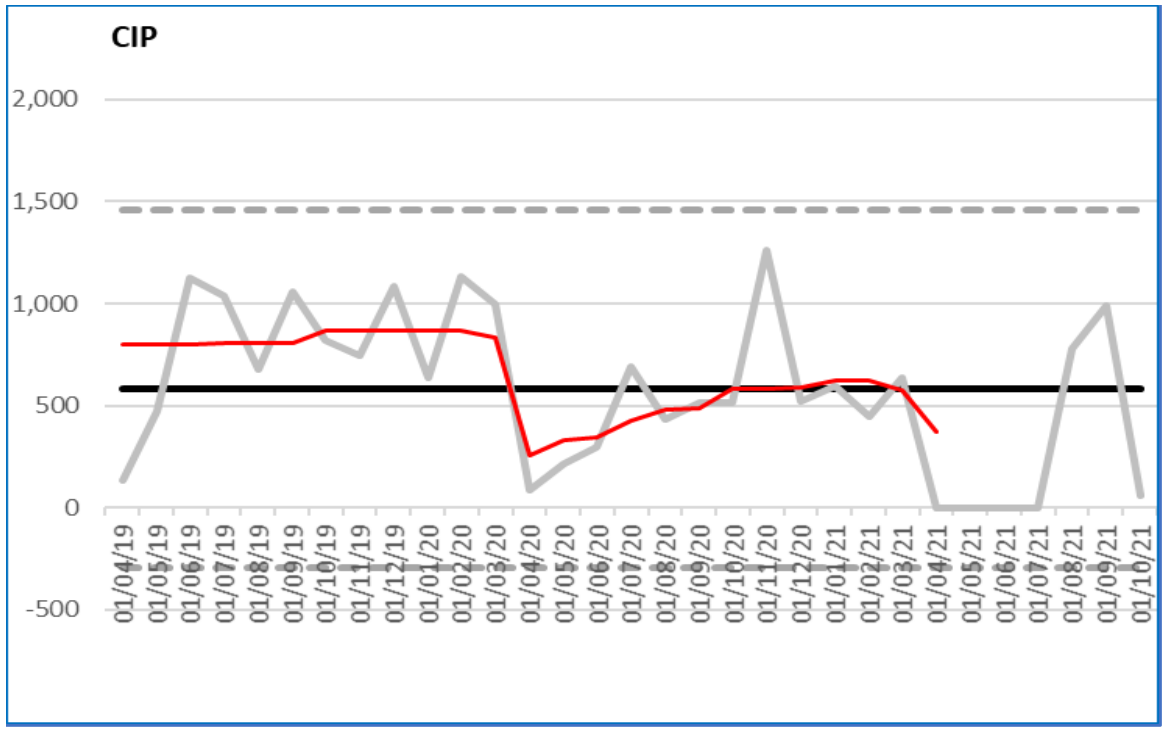
Pounds



Oct-21
1323
Variance Type
Special cause concerning variation
Target
362
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
EBITDA	Special cause concerning variation & inconsistently passing and falling short of the target	N/A	N/A	N/A

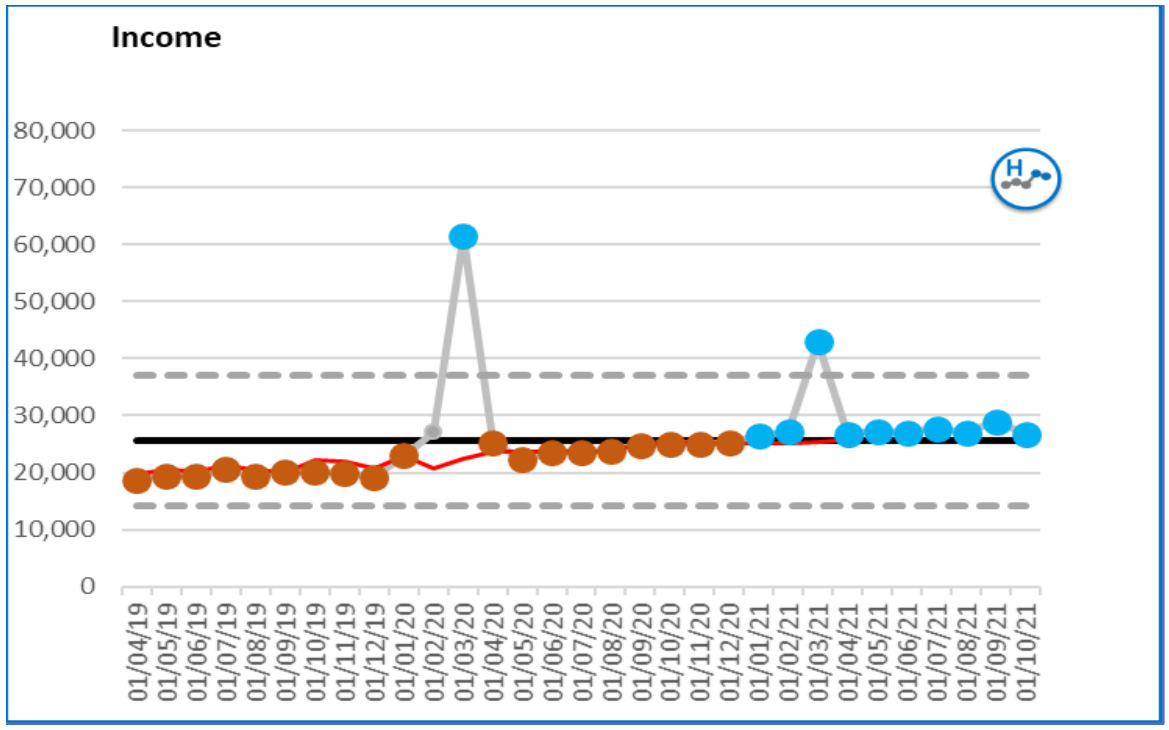
Pounds



Oct-21
60
Variance Type
Common cause variation
Target
375
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
CIP	Common cause variation and inconsistently passing and falling short of the target	CIP delivery is behind plan as at M7 (£1.2m) and is being delivered non-recurrently.	Divisions are being supported to develop their cost improvement plans.	N/A

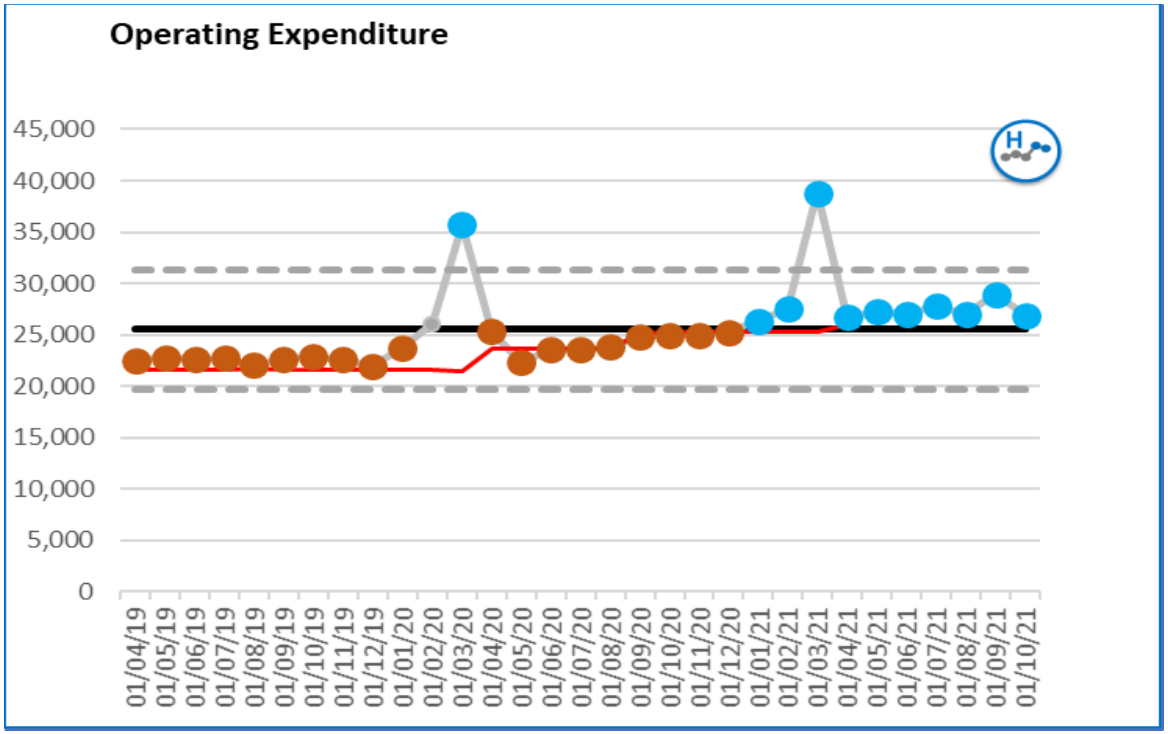
Pounds



Oct-21
26749
Variance Type
Special cause improving variation
Target
26097
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
Income	Special cause improving variation	More elective activity was performed therefore increasing the amount of ERF the Trust was entitled to hence the overperformance against this target.	N/A	N/A

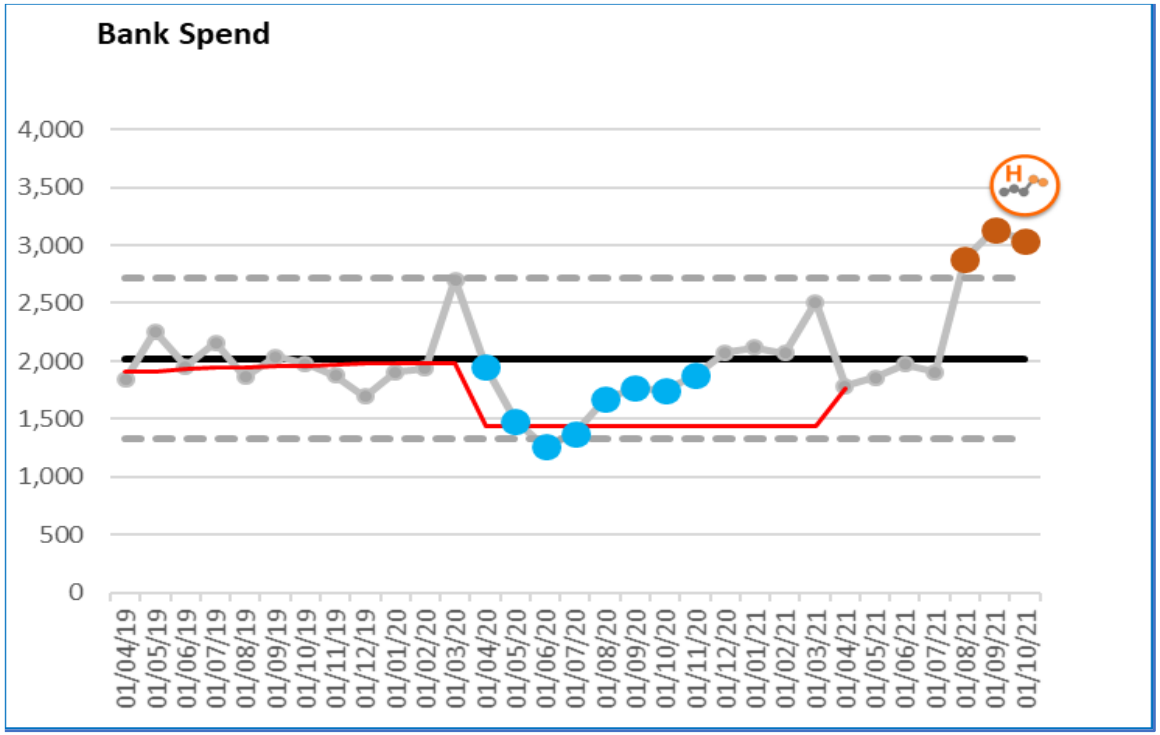
Pounds



Oct-21
26902
Variance Type
Special cause improving variation
Target
26710
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
Operating Expenditure	Special cause improving variation	Expenditure is, in the main, on plan. Cost increases relate to a continued focus on elective recovery activity.	The Finance Department is working with Divisions to help them reduce their run rate.	N/A

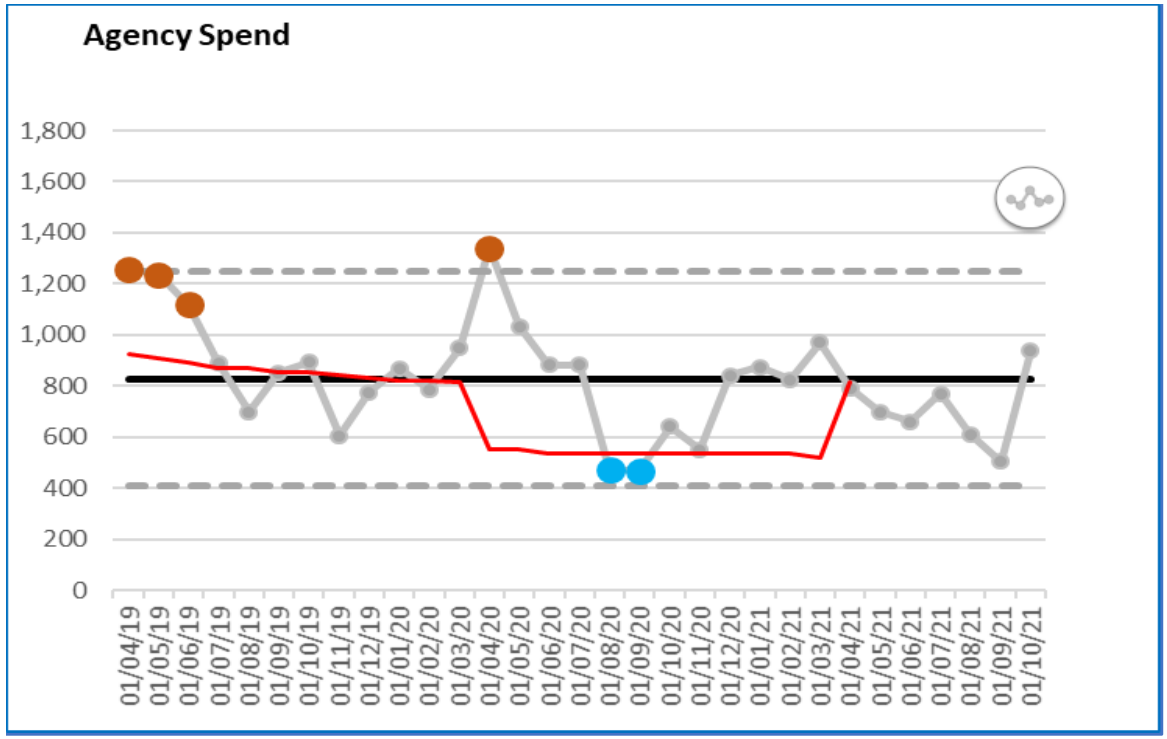
Pounds



Oct-21
3038
Variance Type
Special cause concerning variation
Target
1863
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Bank Spend	Special cause concerning variation & inconsistently passing and falling short of the target	Bank usage is increasing.	The bank & agency review meeting is supporting Divisions to reduce this expenditure category. Recruitment plans are being developed to support longer term sustainability of clinical services.	N/A

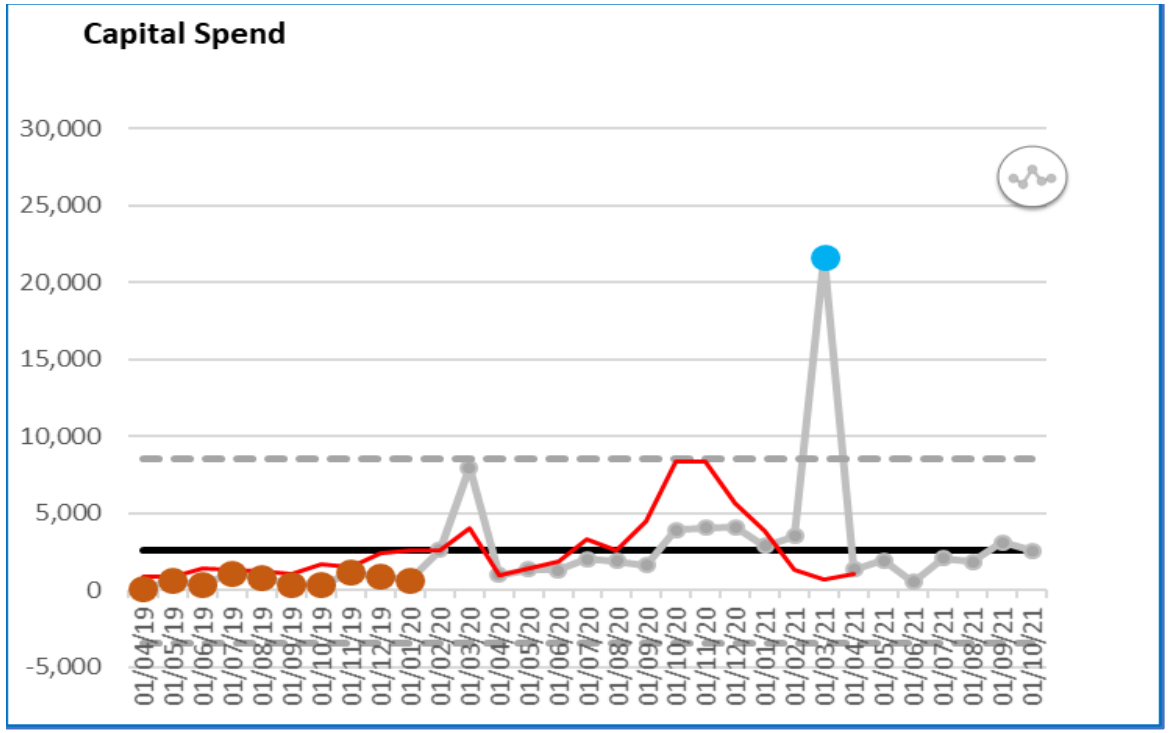
Pounds



Oct-21
938
Variance Type
Common cause variation
Target
886
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Agency Spend	Common cause variation and inconsistently passing and falling short of the target	Agency spend is below plan for M7 as more bank staff have been utilised	The bank & agency review meeting is supporting Divisions to reduce this expenditure category. Recruitment plans are being developed to support longer term.	N/A

Pounds



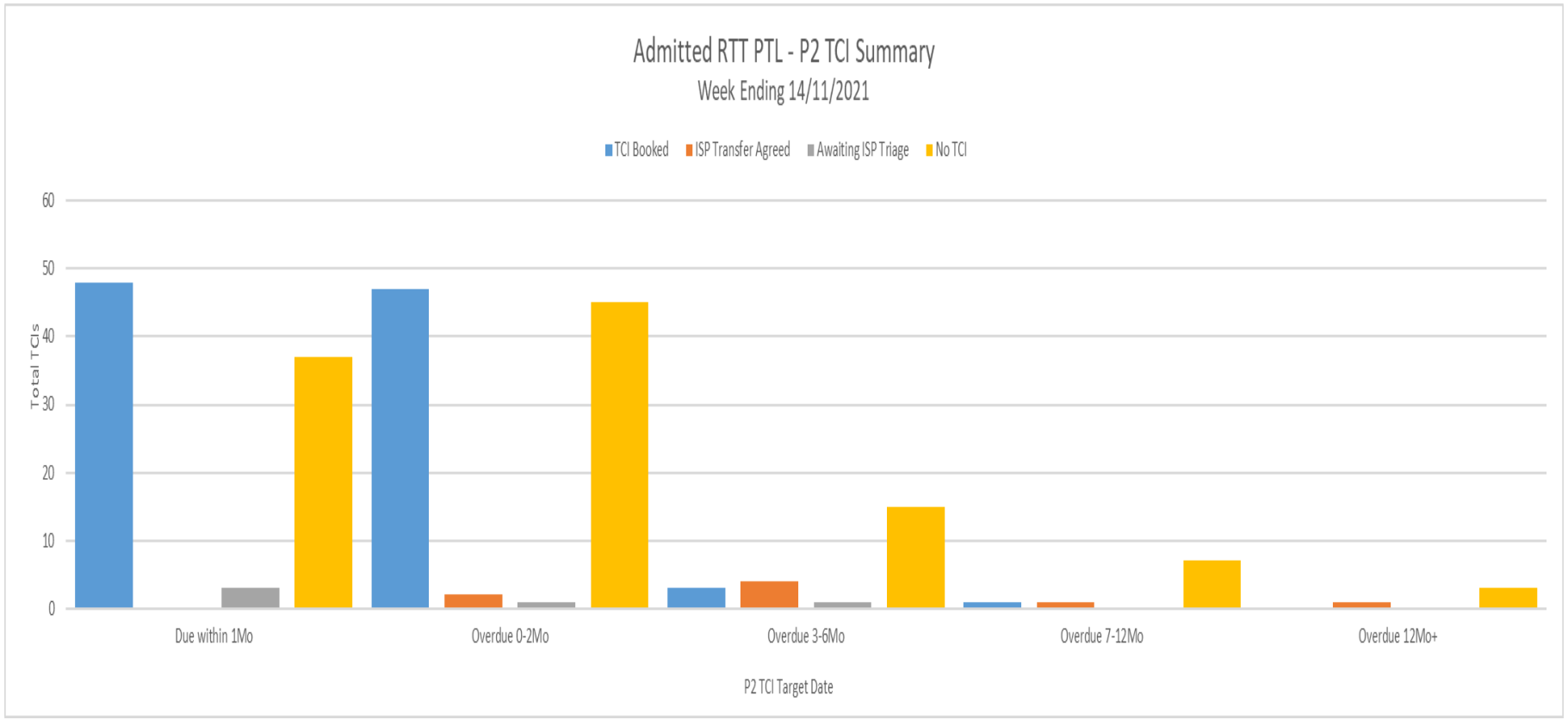
Oct-21
2599
Variance Type
Common cause variation
Target
7873
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Capital Spend	Common cause variation and inconsistently passing and falling short of the target	The capital plan has been reprofiled. Spend is currently behind schedule - this is a timing issue. The capital programme includes an over planning margin. The Trust forecasts achieving its Capital Resource Limit.	The CWG monitors the capital programme & will take the necessary action to achieve the CRL.	N/A

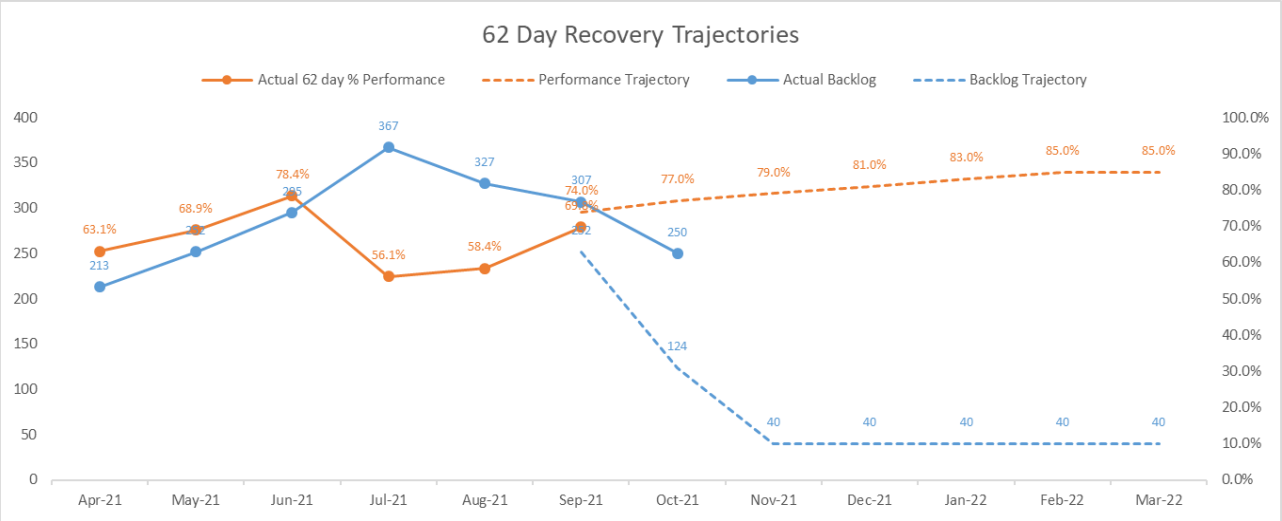
Pounds

Appendix A – Recovery Dashboard

Clinical Prioritisation

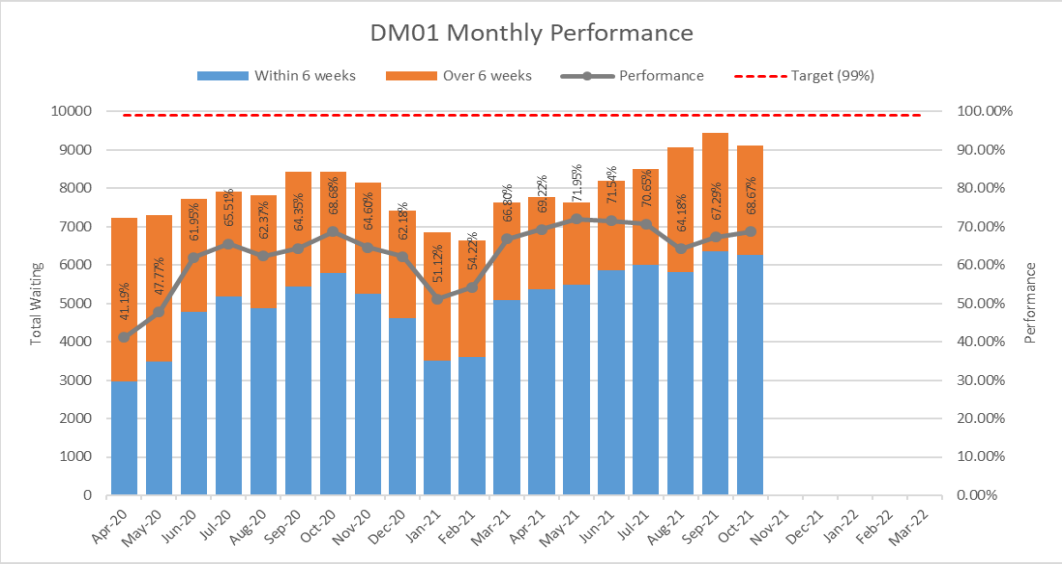


Cancer

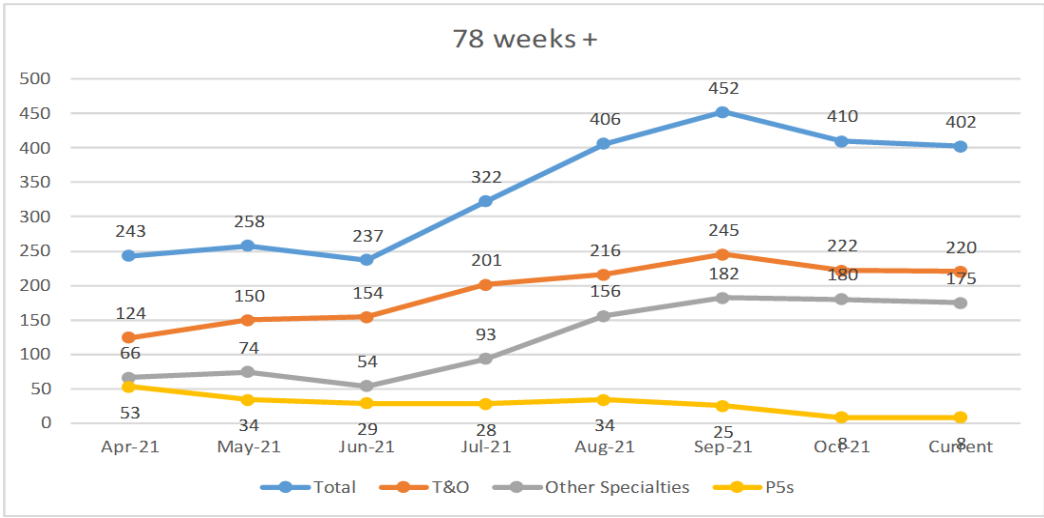


Month	Cancer Performance			
	2WW Performance	28 Faster Diagnosis Performance	31 Day Performance	62 Day Performance
Apr-21	76.4%	71.5%	93.5%	63.1%
May-21	79.0%	74.1%	100.0%	68.9%
Jun-21	79.7%	62.5%	96.2%	78.4%
Jul-21	71.9%	77.1%	92.6%	56.1%
Aug-21	76.9%	75.9%	88.4%	58.4%
Sep-21	57.9%	62.8%	86.9%	69.8%

DM01


DM01 Monthly Performance
Within 6 weeks
Over 6 weeks
Performance
Target (99%)
Total Waiting
Performance
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
41.19%
47.77%
61.95%
65.51%
62.37%
64.35%
68.68%
64.60%
62.18%
51.12%
54.22%
66.80%
69.22%
71.95%
71.54%
70.65%
64.18%
67.29%
68.67%
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22

RTT


78 weeks +
500
450
400
350
300
250
200
150
100
50
0
243
258
237
322
406
452
410
402
124
150
154
201
216
245
222
220
66
74
54
93
156
182
180
175
53
34
29
28
34
25
8
8
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Current
Total
T&O
Other Specialties
P5s

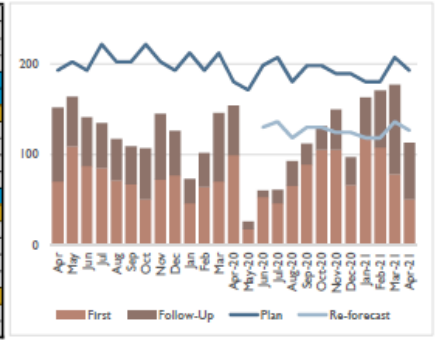
Appendix B – MSK Pathway

MSK Activity vs Plan (19/20, 20/21 & YTD 21/22)

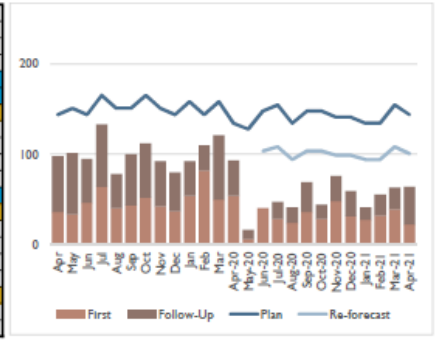
PRIMARY CARE - Stellar Healthcare Limited

PRIMARY CARE - SHL

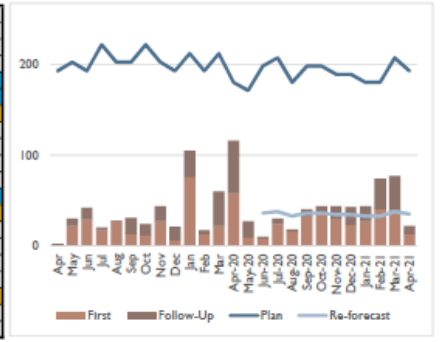
GPSI T&O		2019/20	Financial Month																												
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
First	Actuals	868	70	109	87	85	71	67	50	72	77	46	64	70	99	17	53	46	65	89	105	105	66	117	108	78	50		
	Plan	1,534	121	127	121	139	127	127	139	127	121	133	121	133	113	107	124	130	113	124	124	119	119	113	113	130	121	115	133
	Rebased plan														73	70	73	76	70	73	73	70	76	70	67	76	73	70	73
	Re-forecast	60%															75	78	68	75	75	71	71	68	68	78	72	69	80
	Var	-666	-51	-18	-34	-54	-56	-60	-89	-55	-44	-87	-57	-63	-14	-90	-71	-84	-48	-35	-19	-14	-53	4	-5	-52	-71		
Follow-Up	Actuals	649	82	55	54	50	46	42	57	73	49	27	38	76	55	9	7	15	28	23	26	45	31	46	63	99	63		
	Plan	917	72	76	72	83	76	76	83	76	72	79	72	79	68	64	74	78	68	74	74	71	71	68	68	78	72	69	79
	Rebased plan															52	55	57	52	55	55	52	57	52	50	57	55	52	55
	Re-forecast	75%															56	58	51	56	56	53	53	51	51	58	54	51	60
	Var	-268	10	-21	-18	-33	-30	-34	-26	-3	-23	-52	-34	-3	-13	-55	-67	-63	-40	-51	-48	-26	-40	-22	-5	21	-9		
Total	Actuals	1,517	152	164	141	135	117	109	107	145	126	73	102	146	154	26	60	61	93	112	131	150	97	163	171	177	113		
	Plan	2,451	193	203	193	222	203	203	222	203	193	212	193	212	180	171	198	207	180	198	198	189	189	180	180	207	193	183	212
	Re-forecast																130	136	118	130	130	124	124	118	118	136	127	120	139
	Var	-934	-41	-39	-52	-87	-86	-94	-115	-58	-67	-139	-91	-66	-26	-145	-138	-146	-87	-86	-67	-39	-92	-17	-9	-30	-80		



GPSI Spine		2019/20	Financial Month																												
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
First	Actuals	579	36	33	46	64	40	43	52	42	37	54	82	50	54	6	40	28	24	36	28	48	31	27	32	39	22		
	Plan	926	73	77	73	84	77	77	84	77	73	80	73	80	68	65	75	78	68	75	75	72	72	68	68	78	73	69	80
	Rebased plan														49	47	49	51	47	49	49	47	51	47	44	51	49	47	49
	Re-forecast	66%															50	52	45	50	50	47	47	45	45	52	48	46	53
	Var	-347	-37	-44	-27	-20	-37	-34	-32	-35	-36	-26	9	-30	-14	-59	-35	-50	-44	-39	-47	-24	-41	-41	-36	-39	-51		
Follow-Up	Actuals	633	62	68	49	69	38	57	60	50	43	38	28	71	39	10		19	17	33	16	28	28	14	23	24	42		
	Plan	902	71	75	71	82	75	75	82	75	71	78	71	78	66	63	73	76	66	73	73	70	70	66	66	76	71	67	78
	Rebased plan															51	53	56	51	53	53	51	56	51	49	56	53	51	53
	Re-forecast	74%															54	56	49	54	54	52	52	49	49	56	53	50	58
	Var	-269	-9	-7	-22	-13	-37	-18	-22	-25	-28	-40	-43	-7	-27	-53		-57	-49	-40	-57	-42	-42	-52	-43	-52	-29		
Total	Actuals	1,212	98	101	95	133	78	100	112	92	80	92	110	121	93	16	40	47	41	69	44	76	59	41	55	63	64		
	Plan	1,828	144	151	144	166	151	151	166	151	144	158	144	158	135	128	148	155	135	148	148	141	141	135	135	155	144	137	158
	Re-forecast																104	108	94	104	104	99	99	94	94	108	101	96	111
	Var	-616	-46	-50	-49	-33	-73	-51	-54	-59	-64	-66	-34	-37	-42	-112	-108	-108	-94	-79	-104	-65	-82	-94	-80	-92	-80		



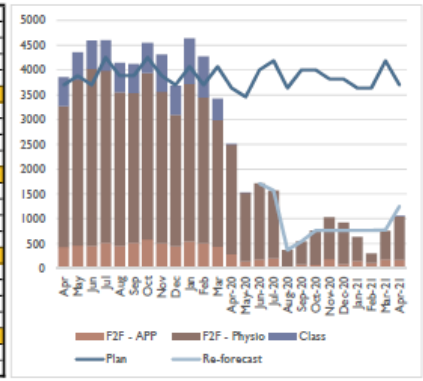
GPSI Rheumatology		2019/20	Financial Month																												
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
First	Actuals	263		22	29	17	27	13	11	27	6	76	13	22	58	9	8	24	16	32	36	30	23	27	40	39	13		
	Plan	1,534	121	127	121	139	127	127	139	127	121	133	121	133	113	107	124	130	113	124	124	119	119	113	113	130	121	115	133
	Rebased plan														22	21	22	23	21	22	22	21	23	21	20	23	22	21	22
	Re-forecast	18%															22	23	20	22	22	21	21	20	20	23	22	21	24
	Var	-1271		-105	-92	-122	-100	-114	-128	-100	-115	-57	-108	-111	-55	-98	-116	-106	-97	-92	-88	-89	-96	-86	-73	-91	-108		
Follow-Up	Actuals	161	2	8	13	3	1	18	13	17	15	29	4	38	58	18	2	6	2	8	8	14	20	17	34	38	9		
	Plan	917	72	76	72	83	76	76	83	76	72	79	72	79	68	64	74	78	68	74	74	71	71	68	68	78	72	69	79
	Rebased plan														14	13	14	14	13	14	14	13	14	13	12	14	14	13	14
	Re-forecast	18%															14	14	12	14	14	13	13	12	12	14	13	13	15
	Var	-756	-70	-68	-59	-80	-75	-58	-70	-59	-57	-50	-68	-41	-10	-46	-72	-72	-66	-66	-66	-57	-51	-51	-34	-40	-63		
Total	Actuals	424	2	30	42	20	28	31	24	44	21	105	17	60	116	27	10	30	18	40	44	44	43	44	74	77	22		
	Plan	2,451	193	203	193	222	203	203	222	203	193	212	193	212	180	171	198	207	180	198	198	189	189	180	180	207	193	183	212
	Re-forecast																36	38	33	36	36	34	34	33	33	38	35	33	39
	Var	-2027	-191	-173	-151	-202	-175	-172	-198	-159	-172	-107	-176	-152	-64	-144	-188	-177	-162	-158	-154	-145	-146	-136	-106	-130	-171		



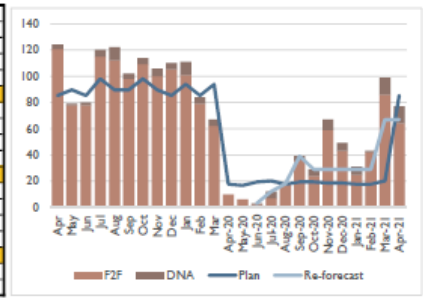
PRIMARY CARE - EPUT (Essex Partnership University NHS Trust)

COMMUNITY CARE - EPUT

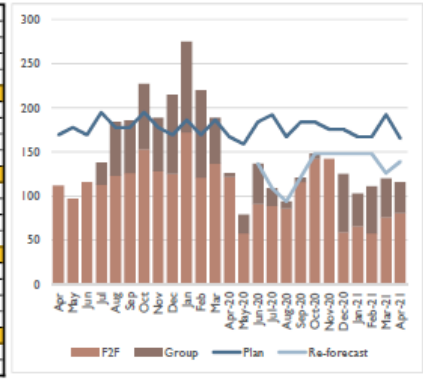
		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
			Financial Month																										
F2F - APP	Actuals	5,854	435	457	455	513	451	518	583	509	444	541	509	439	287	139	177	198	23	78	69	184	92	144	105	179	170		
	Plan	12,342	972	1020	972	1118	1020	1020	1118	1020	972	1069	972	1069	956	908	1051	1099	956	1051	1051	1003	1003	956	956	1099	972	923	1069
	Re-forecast																177	198	23	78	69	69	69	69	69	152	201	250	300
	Var	-6488	-537	-563	-517	-605	-569	-502	-535	-511	-528	-528	-463	-630	-669	-769	-874	-901	-933	-973	-982	-819	-911	-812	-851	-920	-802		
F2F - Physio	Actuals	37,083	2842	3343	3570	3472	3103	3014	3361	3053	2651	3181	2942	2551	2211	1385	1534	1371	348	467	695	847	826	489	201	578	876		
	Plan	28,925	2278	2391	2278	2619	2391	2391	2619	2391	2278	2505	2278	2505	2240	2128	2464	2576	2240	2464	2464	2352	2352	2240	2240	2576	2278	2164	2505
	Re-forecast																1534	1371	348	467	695	695	695	695	695	625	1050	1475	1900
	Var	8158	564	952	1292	853	712	623	742	662	373	676	664	46	-29	-743	-930	-1205	-1892	-1997	-1769	-1505	-1526	-1751	-2039	-1998	-1402		
Class	Actuals	7,640	584	559	568	617	594	589	605	754	584	923	828	435	17	3											17		
	Plan	5,732	451	474	451	519	474	474	519	474	451	496	451	496	444	422	488	510	444	488	488	466	466	444	444	510	451	429	496
	Re-forecast																												
	Var	1908	133	85	117	98	120	115	86	280	133	427	377	-61	-427	-419											-434		
Total	Actuals	50,577	3861	4359	4593	4602	4148	4121	4549	4316	3679	4645	4279	3425	2515	1527	1711	1569	371	545	764	1031	918	633	306	757	1063		
	Plan	49,628	3701	3886	3701	4256	3886	3886	4256	3886	3701	4071	3701	4071	3639	3457	4003	4185	3639	4003	4003	3821	3821	3639	3639	4185	3701	3516	4071
	Re-forecast																1711	1569	371	545	764	764	764	764	764	777	1251	1725	2200
	Var	949	160	473	892	346	262	235	293	430	-22	574	578	-646	-1124	-1930	-2292	-2616	-3268	-3458	-3239	-2790	-2903	-3006	-3333	-3428	-2638		



		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
			Financial Month																										
Pod Surg F2F	Actuals	1,158	121	78	78	115	112	98	109	100	105	101	79	62	10	6	2	7	18	36	24	59	43	25	42	86	64		
	Plan	1,083	85	90	85	98	90	90	98	90	85	94	85	94	18	17	19	20	18	19	19	18	18	18	18	20	85	81	94
	Re-forecast																2	7	18	36	24	24	24	24	24	59	59	59	59
	Var	75	36	-12	-7	17	22	8	11	10	20	7	-6	-32	-8	-11	-17	-13	0	17	5	41	25	7	24	66	-21		
DNA	Actuals	61	3	1	2	5	10	4	5	6	5	10	5	5			1	5		3	5	8	6	6	1	13	13		
	Plan	-																											
	Re-forecast																1	5		3	5	5	5	5	5	8	8	8	8
	Var	61	3	1	2	5	10	4	5	6	5	10	5	5			1	5		3	5	8	6	6	1	13	13		
Total	Actuals	1,158	121	78	78	115	112	98	109	100	105	101	79	62	10	6	2	7	18	36	24	59	43	25	42	86	64		
	Plan	1,083	85	90	85	98	90	90	98	90	85	94	85	94	18	17	19	20	18	19	19	18	18	18	18	20	85	81	94
	Re-forecast																3	12	18	39	29	29	29	29	29	67	67	67	67
	Var	75	36	-12	-7	17	22	8	11	10	20	7	-6	-32	-8	-11	-17	-13	0	17	5	41	25	7	24	66	-21		



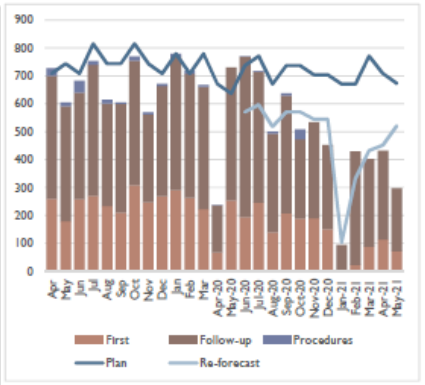
		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
			Financial Month																										
Pain service F2F	Actuals	1,523	112	97	116	113	123	126	153	128	125	172	121	137	122	58	91	89	86	116	142	142	59	66	58	76	81		
	Plan	1,029	81	85	81	93	85	85	93	85	81	89	81	89	80	76	88	92	80	88	88	84	84	80	80	92	79	75	87
	Re-forecast																91	89	86	116	142	142	142	142	142	70	80	90	100
	Var	494	31	12	35	20	38	41	60	43	44	83	40	48	42	-18	3	-3	6	28	34	58	-25	-14	-22	-16	2		
Group	Actuals	625				25	61	60	74	61	90	103	99	52	4	21	46	20	8	5	6		66	37	53	44	35		
	Plan	1,121	88	93	88	102	93	93	102	93	88	97	88	97	87	83	96	100	87	96	96	92	92	87	87	100	86	82	95
	Re-forecast																46	20	8	5	6	6	6	6	6	56	59	62	65
	Var	-496				-77	-32	-33	-28	-32	2	6	11	-45	-83	-62	-50	-80	-79	-91	-90		-26	-50	-34	-56	-51		
DNA	Actuals	761	15	27	32	44	66	80	88	93	78	86	80	72	46	22	29	35	16	33	160	109	62	66	55	55	44		
	Plan	58	5	5	5	5	5	5	5	5	5	5	5	5	5	4	5	5	5	5	5	5	5	5	5	5	5	4	5
	Re-forecast																29	35	16	33	160	160	160	160	160	57	59	61	63
	Var	703	10	22	27	39	61	75	83	88	73	81	75	67	41	18	24	30	11	28	155	104	57	61	50	50	39		
Total	Actuals	2,148	112	97	116	138	184	186	227	189	215	275	220	189	126	79	137	109	94	121	148	142	125	103	111	120	116		
	Plan	2,150	169	178	169	195	178	178	195	178	169	186	169	186	167	159	184	192	167	184	184	176	176	167	167	192	165	157	182
	Re-forecast																137	109	94	121	148	148	148	148	148	126	139	152	165
	Var	-2	-57	-81	-53	-57	6	8	32	11	46	89	51	3	-41	-80	-47	-83	-73	-63	-36	-34	-51	-64	-56	-72	-49		



SECONDARY CARE - The Princess Alexandra Hospital NHS Trust - OUTPATIENTS

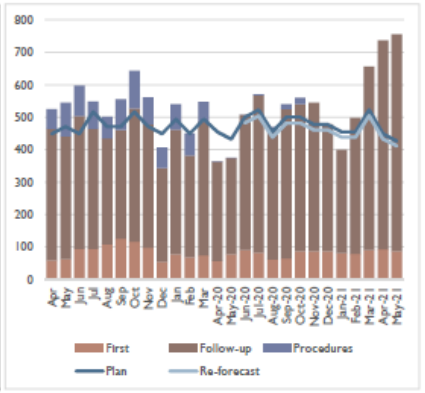
Orthopaedics

		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
		Financial Month																											
First	Actuals	3,010	259	179	258	271	233	210	308	247	269	291	263	222	67	253	194	246	140	207	189	190	150	1	22	88	113	71	
	Plan	3,127	246	259	246	283	259	259	283	259	246	271	246	271	233	221	256	268	233	256	256	245	245	233	233	268	246	234	271
	Re-forecast	80%															205	214	186	205	205	196	196			50	100	187	217
	Var	-117	13	-80	12	-12	-26	-49	25	-12	23	20	17	-49	-166	32	-62	-22	-93	-49	-67	-55	-95	-232	-211	-180	-133	-163	
Follow-up	Actuals	4,978	441	412	381	469	368	390	447	315	394	478	444	439	169	477	575	470	353	423	285	344	302	94	408	314	319	226	
	Plan	5,534	436	458	436	501	458	458	501	458	436	479	436	479	412	392	453	474	412	453	453	433	433	412	412	474	436	414	479
	Re-forecast	80%															363	379	330	363	363	346	346	100	330	379	349	331	383
	Var	-556	5	-46	-55	-32	-90	-68	-54	-143	-42	-1	8	-40	-243	85	122	-4	-59	-30	-168	-89	-131	-318	-4	-160	-117	-188	
Procedures	Actuals	176	27	14	43	13	14	5	15	8	9	9	12	7	2		1	1	7	8	35	27	9				23		
	Plan	337	27	28	27	31	28	28	31	28	27	29	27	29	25	24	28	29	25	28	28	26	26	25	25	29	27	25	29
	Re-forecast	10%															3	3	3	3	3	3	3	3	3	3	3	3	3
	Var	-161	0	-14	16	-18	-14	-23	-16	-20	-18	-20	-15	-22	-23		-27	-28	-18	-20	7	1	-17				-4		
Total	Actuals	8,164	727	605	682	753	615	605	770	570	672	778	719	668	238	730	770	717	500	638	509	561	461	95	430	402	455	297	
	Plan	8,998	709	744	709	815	744	744	815	744	709	779	709	779	670	637	737	771	670	737	737	704	704	670	670	771	709	673	779
	Re-forecast																571	596	519	571	571	545	545	103	332	432	451	521	603
	Var	-834	18	-139	-27	-62	-129	-139	-45	-174	-37	-1	10	-111	-432	93	33	-54	-170	-99	-228	-143	-243	-575	-240	-369	-254	-376	



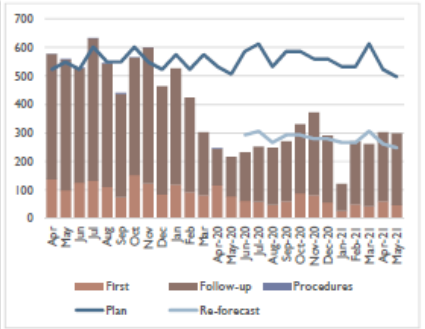
Rheumatology

		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
		Financial Month																											
First	Actuals	1,027	59	62	94	94	107	125	116	97	54	77	68	74	56	77	91	82	61	65	86	87	86	81	79	90	92	87	
	Plan	825	65	68	65	75	68	68	75	68	65	71	65	71	66	63	72	76	66	72	72	69	69	66	66	76	65	62	71
	Re-forecast	100%															72	76	66	72	72	69	69	66	66	76	65	62	71
	Var	202	-6	-6	29	19	39	57	41	29	-11	6	3	3	-10	14	19	6	-5	-7	14	18	17	15	13	14	27	25	
Follow-up	Actuals	4,417	404	379	409	369	328	336	412	380	289	385	314	412	307	297	416	485	399	460	454	458	391	319	418	566	644	668	
	Plan	4,647	366	384	366	421	384	384	421	384	366	402	366	402	371	352	408	426	371	408	408	389	389	371	371	426	366	348	402
	Re-forecast	100%															408	426	371	408	408	389	389	371	371	426	366	348	402
	Var	-230	38	-5	43	-52	-56	-48	-9	-4	-77	-17	-52	10	-64	-55	8	59	28	52	46	69	2	-52	47	140	278	320	
Procedures	Actuals	976	62	104	95	86	66	94	115	84	63	78	68	61	1	1	1	3	9	15	20	26	15	15	9	12	5		
	Plan	226	18	19	18	20	19	19	20	19	18	20	18	20	18	17	20	21	18	20	20	19	19	18	18	21	18	17	20
	Re-forecast	10%															2	2	2	2	2	2	2	2	2	2	2	2	2
	Var	750	44	85	77	66	47	75	95	65	45	58	50	41	-17	-16	-19	-18	-6	-5	0	7	-4	-3	-9	-9	-13		
Total	Actuals	6,420	525	545	598	549	501	555	643	561	406	540	450	547	364	375	508	570	469	540	560	571	492	415	506	668	741	755	
	Plan	5,698	449	471	449	516	471	471	516	471	449	494	449	494	454	432	500	523	454	500	500	477	477	454	454	523	449	426	494
	Re-forecast																482	504	438	482	482	460	460	438	438	504	433	411	476
	Var	722	76	74	149	33	30	84	127	90	-43	46	1	53	-90	-57	8	47	15	40	60	94	15	-39	52	145	292	329	



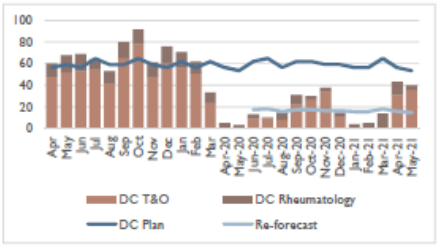
Physiotherapy

		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
		Financial Month																											
First	Actuals	1,328	137	99	126	131	111	74	152	123	84	118	92	81	117	77	62	58	48	60	88	82	57	27	50	42	60	47	
	Plan	1,479	116	122	116	134	122	122	134	122	116	128	116	128	119	113	131	137	119	131	131	125	125	119	119	137	116	111	128
	Re-forecast	50%															65	68	59	65	65	62	62	59	59	68	58	55	64
	Var	-151	21	-23	10	-3	-11	-48	18	1	-32	-10	-24	-47	-2	-36	-69	-79	-71	-71	-43	-43	-68	-92	-69	-95	-56	-64	
Follow-up	Actuals	4,826	439	459	401	501	432	363	412	476	381	408	332	222	127	139	170	194	200	211	243	290	234	95	220	220	243	252	
	Plan	5,161	406	427	406	467	427	427	467	427	406	447	406	447	414	384	456	476	414	456	456	435	435	414	414	476	406	386	447
	Re-forecast	50%															228	238	207	228	228	217	217	207	207	238	203	193	224
	Var	-335	33	32	-5	34	5	-64	-55	49	-25	-39	-74	-225	-287	-255	-286	-282	-214	-245	-213	-145	-201	-319	-194	-256	-163	-134	
Procedures	Actuals	14	1	2	2	1	3	3	1	1					3							1					1		
Total	Actuals	6,168	577	560	529	633	546	440	565	600	465	526	424	303	247	216	232	252	248	271	331	373	291	122	270	262	304	299	
	Plan	6,640	523	549	523	601	549	549	601	549	523	575	523	575	533	506	586	613	533	586	586	560	560	533	533	613	523	497	575
	Re-forecast																293	306	266	293	293	280	280	266	266	306	261	248	288
	Var	-472	54	11	6	32	-3	-109	-36	51	-58	-49	-99	-272	-286	-290	-354	-361	-285	-315	-255	-187	-269	-411	-263	-351	-219	-198	



SECONDARY CARE - The Princess Alexandra Hospital NHS Trust - INPATIENTS

INPATIENTS			Financial Month																										
ELECTIVE		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
T&O	Actuals	640	51	39	36	30	30	30	64	52	54	54	69	31		1	19	16	40	30	68	25	3				22	21	
	Plan	714	56	59	56	65	59	59	65	59	56	62	56	62	56	54	62	65	56	62	62	59	59	56	56	65			
	Re-forecast	80%															50	52	45	50	50	47	5						
	Var	-74	-5	-0	-0	-13	-9	-9	-1	-7	-2	-8	13	-31		-53	-43	-49	-16	-12	6	-34	-56				22	21	
DC T&O	Actuals	631	48	52	53	54	42	65	78	48	60	56	51	24			9	9	8	22	27	34	10				31	36	
	Plan	581	46	48	46	53	48	48	53	48	46	50	46	50	46	44	51	53	46	51	51	48	48	46	46	53	46	43	50
	Re-forecast	25%															13	13	11	13	13	12	12	11	11	13	11	11	13
	Var	50	2	4	7	1	-6	17	25	-0	14	6	5	-26			-42	-44	-38	-29	-24	-14	-38				-15	-7	
DC Rheumatology	Actuals	158	12	16	16	10	11	15	14	13	16	15	11	9	5	3	4	1	7	9	3	4	5	4	5	14	12	4	
	Plan	133	10	11	10	12	11	11	12	11	10	12	10	12	11	10	12	12	11	12	12	11	11	11	11	12	10	10	12
	Re-forecast	40%															5	5	4	5	5	4	4	4	4	5	4	4	5
	Var	25	2	5	6	-2	0	4	2	2	6	3	1	-3	-6	-7	-8	-11	-4	-3	-9	-7	-6	-7	-6	2	2	-6	
Day Case Total	Actuals	789	60	68	69	64	53	80	92	61	76	71	62	33	5	3	13	10	15	31	30	38	15	4	5	14	43	40	
	DC Plan	714	56	59	56	65	59	59	65	59	56	62	56	62	56	54	62	65	56	62	62	59	59	56	56	65	56	53	62
	Re-forecast																17	18	16	17	17	16	16	16	16	18	16	15	17
	Var	75	4	9	13	-1	-6	21	27	2	20	9	6	-29	-51	-51	-49	-55	-41	-31	-32	-21	-44	-52	-51	-51	-13	-13	



Appendix C
Quality Improvement Plan

QIP Project Reference	Quality Programme	QIP Action	Executive Oversight	Rating
Urgent and Emergency Services				
M1	Urgent Care	The trust must ensure detailed up to date records are kept in relation to provision of care and treatment and it is reflective of reflective of each patient's full clinical pathway	Chief Nurse	On track for delivery against the set timescales
M2	Urgent Care	The service must ensure that medical staff training meets the compliance target of 90%. [Nursing compliance >90%]	Medical Director	On track for delivery against the set timescales
M3	Urgent Care	The service must ensure it has enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Skill gap	Chief Nurse	On track for delivery against the set timescales
M23	Urgent Care	The trust must ensure all appropriate risk assessments for patients attending the department are completed in a timely way to ensure appropriate mitigating actions can be taken	Chief Nurse	On track for delivery against the set timescales
m24	Urgent Care	The trust must ensure all risk assessments for patients presenting with a mental health crisis are completed in a timely way in order to identify and mitigate any risks to patient and staff safety.	Chief Nurse	On track for delivery against the set timescales
m25	Urgent Care	The trust must ensure all staff comply with all trust infection prevention and control (IPC) guidance in order to minimise the risk of the spread of infection.	Chief Nurse	Implemented and awaiting confirmation of embedding
m26	Urgent Care	The trust must ensure that staffing resources are used efficiently throughout the ED to reduce delays to patient	Chief Nurse	Implemented and awaiting confirmation of embedding
m27	Urgent Care	The trust must ensure that there is robust oversight of the clinical decisions unit (CDU) including that patients cared for there meet the inclusion criteria	Chief Operating Officer	On track for delivery against the set timescales
m28	Urgent Care	The trust must ensure the triage process is robust and accurately identifies those patients who are the most sick.	Chief Operating Officer	On track for delivery against the set timescales
m29	Urgent Care	The trust must ensure the monitoring of the time to specialist review and total time spent in the department is accurate.	Chief Nurse	Implemented and awaiting confirmation of embedding
M30	Urgent Care	The Registered Provider must operate an effective system which will ensure that every patient attending the Emergency Department has an initial assessment of their condition to enable staff to identify the most clinically urgent patients	Chief Operating Officer	On track for delivery against the set timescales
M31	Urgent Care	The Registered Provider must devise a process and undertake a review of current and future patients clinical risk assessments, care planning and physiological observations, and ensure that the level of patients' needs are individualised, recorded and acted upon. This must include, but not limited to skin integrity, falls, and mental health assessments.	Chief Nurse	On track for delivery against the set timescales
M32	Urgent Care	The registered provider must ensure that it implements an effective system with the aim of ensuring all patients who present to the emergency department at the Princess Alexandra Hospital patient observations are completed within 15 minutes of arrival and as appropriately thereafter in line with trust policy.	Chief Nurse	On track for delivery against the set timescales
S2	Urgent Care	The trust should ensure that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.	Chief Operating Officer	On track for delivery against the set timescales
S21	Urgent Care	The trust should ensure resuscitation equipment in the CDU is checked in line with trust guidelines.	Chief Nurse	Implemented and awaiting confirmation of embedding
S22	Urgent Care	The trust should continue to recruit registered nursing and health care staff in order to meet establishment guidelines	Chief Nurse	On track for delivery against the set
S23	Urgent Care	The trust should continue to recruit consultants in order to meet Royal College of Emergency Medicine (RCEM) guidelines.	Medical Director	Implemented and awaiting confirmation of embedding
S24	Urgent Care	The trust should ensure the minutes of the Urgent and Emergency Care meetings are detailed.	Director of Quality improvement	Implemented and awaiting confirmation of embedding
T4	Urgent Care	The trust must ensure the out of hours endoscopy process is embedded and understood by all appropriate staff in the department.	Medical Director	On track for delivery against the set timescales

Medical Care (including older people's care)				
M4	Medical care (including older people's care)	The service must ensure it has enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment	Chief Nurse	On track for delivery against the set timescales
M5	Medical care (including older people's care)	The service must ensure that systems and processes to identify risk at ward level are embedded.	Chief Nurse	On track for delivery against the set timescales
M6 Falls	Medical care (including older people's care)	The service must ensure that staff keep detailed records in relation to risk assessments and care plans for patient falls	Chief Nurse	On track for delivery against the set timescales
M6 Ulcers	Medical care (including older people's care)	The service must ensure that staff keep detailed records in relation to risk assessments and care plans for patient pressure ulcers.	Chief Nurse	On track for delivery against the set timescales
M7	Medical care (including older people's care)	The service must ensure broken crockery and glass is safely disposed of on all wards.	Director of Strategy and Estates	Implemented and awaiting confirmation of embedding
M8	Medical care (including older people's care)	The service must ensure that medical staff training meets the trust compliance target of 90%.	Medical Director	On track for delivery against the set timescales
M9	Medical care (including older people's care)	The service must ensure that hazardous chemicals are kept in a locked cupboard.	Chief Operating Officer	On track for delivery against the set timescales
S3	Medical care (including older people's care)	The service should ensure all staff complete safeguarding training in line with national guidance.	Chief Nurse	On track for delivery against the set timescales
Surgery				
M10	Surgery	The service must ensure that actions to protect patient safety are put in place in a timely manner.	Chief Nurse	Implemented and awaiting confirmation of embedding
M11	Surgery	The service must continue to monitor and actively recruit to ensure staffing with the appropriate skill mix is in line with national guidance	Chief Nurse	Implemented and awaiting confirmation of embedding
M12	Surgery	The service must ensure that assessments are updated in patient records and that there is oversight of NEWS2 observation timeliness for deteriorating patients.	Chief Nurse	Implemented and awaiting confirmation of embedding
M13	Surgery	The service must ensure that policies are reviewed in a timely manner and that they are shared with staff	Medical Director	Implemented and awaiting confirmation of embedding
S5	Surgery	The service should consider revising the consenting of patients on the day of surgery in line with best practice. ***(Looking at consent)***	Medical Director	On track for delivery against the set timescales

Family and Women's Services				
M14	Maternity	The service must ensure staff accurately complete women's care records with all necessary assessments required to safely monitor mothers and their babies.	Chief Nurse	On track for delivery against the set timescales
M15	Maternity	The service must ensure staff complete fetal growth charts at each appointment.	Chief Nurse	On track for delivery against the set
M16	Maternity	The service must ensure staff complete and annotate cardiotocograph traces in line with national guidance	Chief Nurse	On track for delivery against the set
M17	Maternity	The service must ensure policy and guidance documents are reviewed in a timely way and reflect current working practices to enable staff to be able to give women the most up to date information.	Medical Director	Evidence of implementation and embedding
M18	Maternity	The service must ensure staff compliance with basic life support training meets the trust's compliance target of 90%.	Director Of People Organisational Development &	On track for delivery against the set timescales
M19	Maternity	The service must ensure medicines and hazardous substances are stored securely.	Chief Operating Officer	On track for delivery against the set
M20	Maternity	The service must ensure all incidents are reviewed in a timely way to promote learning and service improvement	Chief Nurse	Implemented and awaiting confirmation of embedding
M21	Maternity	The service must ensure risk registers accurate reflect the risks identified, are updated in a timely way and risks are closed appropriately once all actions are completed.	Medical Director	Evidence of implementation and embedding
M22	Maternity	The service must ensure that staff complete mandatory training to meet the trust's compliance target.	Director Of People Organisational Development &	On track for delivery against the set timescales
S6	Maternity	The service should ensure there is an arrangement in place for a dirty utility in the antenatal clinic.	Chief Nurse	Action underreview
S7	Maternity	The trust should ensure staff circulating in theatres wear personal protective equipment in line with national guidance to prevent health care associated infections.	Chief Nurse	Action underreview
S8	Maternity	The trust should ensure reusable equipment is cleaned appropriately after its use.	Chief Nurse	On track for delivery against the set
S9	Maternity	The trust should ensure that electrical equipment is up-to-date with safety testing.	Director of Strategy and Estates	Implemented and awaiting confirmation of embedding
S10	Maternity	The trust should ensure senior midwives and consultants participate in skill simulation training.	Chief Nurse	On track for delivery against the set
S11	Maternity	The trust should ensure maternity services have access to designated maternity physiotherapy practitioners.	Chief Nurse	Implemented and awaiting confirmation of embedding
S12	Maternity	The trust should ensure improved sustainability and transformation partnership working in maternity services.	Chief Nurse	Evidence of implementation and
S13	Maternity	The trust should ensure managers use effective change management processes to facilitate required improvements in a timely way.	Director Of People Organisational Development &	Implemented and awaiting confirmation of embedding
S14	Maternity	The trust should ensure detailed minutes of meetings are recorded to accurately reflect discussions, actions and responsibilities.	Chief Nurse	On track for delivery against the set timescales
S19	Services for children and young people	The service should improve access to allied health professionals, specifically in the Neonatal Intensive Care Unit.	Chief Nurse	On track for delivery against the set timescales
Trust				
S1	Trust	The trust should ensure that structures and processes for governance are fully embedded at all levels throughout the trust to enable a timely response to risk and safety issues.	Chief Nurse	Implemented and awaiting confirmation of embedding
S4	Trust	The service should monitor national audits and use the results to improve outcomes for patients	Medical Director	Implemented and awaiting confirmation of embedding
Services for Children and Young people				
S15	Services for children and young people	The service should continue to ensure staff complete safeguarding training, in line with national guidance	Chief Nurse	On track for delivery against the set timescales
S16	Services for children and young people	The service should ensure there is a nurse trained in advanced paediatric life support (APLS) or European paediatric advanced life support (EPALS) on every shift, in line with guidelines from the Royal College of Nursing.	Chief Nurse	On track for delivery against the set timescales
S17	Services for children and young people	The service should ensure discharge summaries are sent to GPs within 72 hours of discharge.	Chief Operating Officer	Evidence of implementation and embedding
S18	Services for children and young people	The service should continue to improve transitional arrangements for young people moving to adult services – QI team supporting update project	Chief Operating Officer	On track for delivery against the set timescales
End of Life Care				
S20	End of life Care	Continue to work towards a 7 day service to support patients at end of life	Medical Director	Evidence of implementation and embedding

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 02.12.21

5.2

Agenda item:	5.2
Presented by:	Stephanie Lawton, Chief Operating Officer
Prepared by:	Elizabeth Podd, Head of Performance and Planning
Date prepared:	19th November 2021
Subject / title:	Elective Recovery

Purpose:	**Approval**	X	**Decision**		**Information**		**Assurance**		
Key issues:	The Trust continues to support staff recovery from the waves of Covid-19 pandemic to date. Clinical risk mitigation and patient communication are prioritised processes. The Trust aims to deliver at least the national minimum elective activity however there are considerable risks from emergency demand on capacity.								
Recommendation:	This report gives an update on elective recovery processes & delivery and is provided for assurance.								

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

Previously considered by:	PAF.25.11.21
Risk / links with the BAF:	1.0 Covid-19 1.1Variation in outcomes 3.2 Financial & clinical sustainability 5.1 Finance
Legislation, regulatory, equality, diversity and dignity implications:	Health inequalities due to revised priority for appointments and admissions
Appendices:	Recovery Performance & trajectories.

1.0 Introduction

This paper details an update on the progress of elective recovery during the ongoing Covid-19 pandemic.

The Trust approached Elective Recovery using the following principles:

- Staff Recovery, health and well being
- Clinical Risk Mitigation
- Patient Communication
- Accurate data
- Planning
- Recovery trajectories
- Monitoring

Staff Recovery

The staff health and wellbeing team have continued to provide support and advice to our people including webinars to our staff and managers. “Here for you” is an ICS collaborative psychological service available for our staff, who work alongside our staff health and wellbeing team and Vita health, our employee assistance programme, to deliver a wide range of health and wellbeing interventions. This service will continue into 2022.

The Trust health and wellbeing steering group launched at the beginning of the year, represented by staff from across the services, a non-executive director and the health and wellbeing guardian. The aim of the steering group is to support the implementation of wellbeing initiatives that arise from a number of avenues including staff surveys, listening events and feedback from our health and wellbeing champions

The health and wellbeing steering group have:

- Developed a monthly health and wellbeing newsletter
- Recruited and embedded Health and Wellbeing (H&W) champions across the trust
- Finalised plans for the opening of the Alex lounge – the staff breakout lounge due to open in late November
- Increased the number of mental health support workers, supporting colleagues across the trust
- Implemented the carers passport
- Supporting a number of wellbeing campaign including Stoptober, mental health awareness, flu and COVID booster

Following feedback from the staff survey and “Here to hear” staff sessions, the health and wellbeing steering group have identified six health and wellbeing priorities and are working to finalise the trust health and wellbeing strategy to support the implementation of these

1. We will ensure that any H&W initiatives have visible support from the Trust board and also from all staff that are in supervisory/management/leadership roles.
2. Our People feel safe to raise concerns and encourage others and that they have the tools to look after psychological wellbeing.
3. Staff have the access and information to support them to lead a healthy lifestyle
4. Our staff have access to local, high quality, accredited occupational health services.
5. To use local and national evidence to develop and influence plans.
6. Staff have access to adequate facilities for rest and physical activities during shifts

3.0 Clinical Risk Mitigation

The Trust's approach to elective recovery is firmly rooted in clinical risk mitigation and ensuring that patients with the most urgent conditions are booked for appointments and treatments first. All patients waiting for a diagnostic or procedure have been prioritised in line with the national process and continue to be prioritised as they are added to the waiting list:

- P1 – emergency
- P2 – requires procedure within 1 month
- P3 –up to 3 months
- P4 – up to 6 months

Previous recovery reports informed that the Trust had an aim to continue to book all P2 patients within their time period and to ensure that P3 patients are booked within their time period by 30th September. Unfortunately, the Trust experienced an increased surge of Covid activity which paused elective operating in July and set these aims back to 31st December 2021. Further increases in covid positive patients has resulted in disruption to the recovery programme with a need to temporarily relocate the ITU again onto Henry Moore Ward which impacted on elective capacity and resulted in further ward changes.

The Trust is liaising with Integrated Care System (ICS) partners to develop a unified clinical risk assessment process for long waiting patients. For PAH this will include contacting long waiting patients to identify if their conditions have changed, booking into virtual clinics for re-prioritisation, and completion of a harm review process & duty of candour if required. Outcomes of these risk assessments will be collated and ICS level actions to mitigate further clinical risk to patients will be established.

Outpatients continue to be delivered in a combination of virtual & face to face appointments, booking appointments at sub-speciality level to ensure the most urgent appointments have priority booking.

4.0 Patient Communication & Choice

All patients waiting longer than 18 weeks for an appointment or procedure have been written to by letter to apologise for the long wait, to assure them that the Trust knows they are waiting and to explain the clinical priority booking process. This method of communication was agreed with the patient panel.

The priority option P5 – patient wishes to wait until after Covid-19 - is being removed from 1st December 2021 and therefore the Trust is contacting all P5 (& D5 Diagnostic) patients to ask if they wish to have their procedure/diagnostic and re-prioritise clinically. If patients do not wish to continue with their procedure, they are booked into a telephone clinic to discuss their condition & discharged back to their referrer.

The Trust has worked closely with Independent Provider partners and transferred patients to other hospitals for their procedures. Patients with suitable conditions/procedures are contacted to be offered this option and if willing, are transferred to the private provider for the remainder of their treatment & follow-up.

5.0 Activity Delivery

The Trust has committed to continued working with the private sector in the second half of 21/22 to deliver additional activity to PAH's patients. This includes diagnostics, out-patient appointments & procedures and operations. Approximately 1,200 patients have been transferred to independent sector hospitals for treatment during 2021 with further being planned and 23,000 units of out-patient and diagnostic activity has been commissioned from healthcare providers for PAH patients in the next six months.

The Trust has submitted its second half of the year activity & finance plan and aims to achieve or exceed the national minimum activity levels of 89% of first definitive treatments for patients each month over the next 6 months. The elective operating has been planned at only the 89% level due to uncertainties surrounding the impact of winter emergency & Covid-19 pressures. Out-patient and diagnostic levels are higher as these services are less likely to be directly impacted by seasonal fluctuations. The Trust ambition is to exceed the plan and to treat as many of the longest waiting patients as quickly as possible. The Trust's aims, in line with the ICS aims, are:

- Ensure that no P2 patient waits longer than a month for their procedure by 31/12/21
- Ensure that the Trust has treated **all** patients that have waited longer than 2 years by 31/12/21
- Ensure that no P3 patient waits longer than 3 months for their procedure by 31/12/21

The Trust has planned for significant winter pressures, and where possible the plans aim to mitigate the impact on elective services such as

- Releasing bed capacity for covid & emergency demand by tight control, & efficient use of, elective bed capacity
- Setting up mutual aid processes with other providers in the ICS and independent sector for back-up elective capacity if emergency demand requires the elective bed capacity or additional critical care resources

In addition the trust has set a recovery trajectory for cancer services performance to return to national standards by February 2022.

Diagnostic recovery also has a trajectory to achieve overall 99% national standards by April 2022, with some modalities expected to achieve national standards by the end of 2021.

6.0 Innovations

The Trust has continued to develop new ways of working to support more efficient use of clinical capacity and improve patient care which included:

- Re-building out-patient clinic templates to ensure clear distinction between virtual and face to face appointments
- Increased number of specialities using Patient Initiated Follow-up service
- Plans to expand GP Advice & Guidance capacity
- Ongoing Cytosponge diagnostic pilot
- Opened fracture clinic building & expansion of virtual fracture clinic services
- New MRI to be opened in St Margaret's hospital before end of 2021

- 3rd CT available for emergency demand, increasing CT capacity for elective September 2021
- Developing the Older Peoples' cancer referral pathways
- Two way text messaging to confirm appointments and use of electronic appointment & clinic letters for patients.

8.0 Data Quality & Performance

The Trust has regular monitoring of recovery performance by a weekly snapshot data table reviewed by the Executive Team and Senior Management Team and a monthly Recovery Dashboard, which is shown below and included in the Integrated Performance Report. The Trust aims to exceed the national requirement of 89% of definitive treatments (clock stops) which equates to 95% of the 19/20 activity levels. If emergency pressures allow, the Trust aims to exceed this level of activity and fund the additional activity with the Elective Recovery Funding allocated to the ICS. The Trust has also applied for additional one-off winter elective funding to support additional outsourcing activity, increased data quality support and 7-day management support to extend service support across weekends and make more efficient use of scarce capacity.

The financial elements of the recovery programme are being managed with the directors of finance across the ICS. Detailed discussions have continued to be held internally through executive directors, senior management team and board committees. At present there is a financial gap between the funding received and the expenditure. Discussions internally have supported continued active planning to support our patients on their recovery trajectories.

9.0 Conclusion

PAH is committed to recovering the backlog of elective activity as quickly as possible and ensuring that patients receive clear communication and support whilst they wait for their appointments. Emergency winter demand is likely to affect the timeliness of recovery however mitigations have been designed & implemented to ensure limited impact.

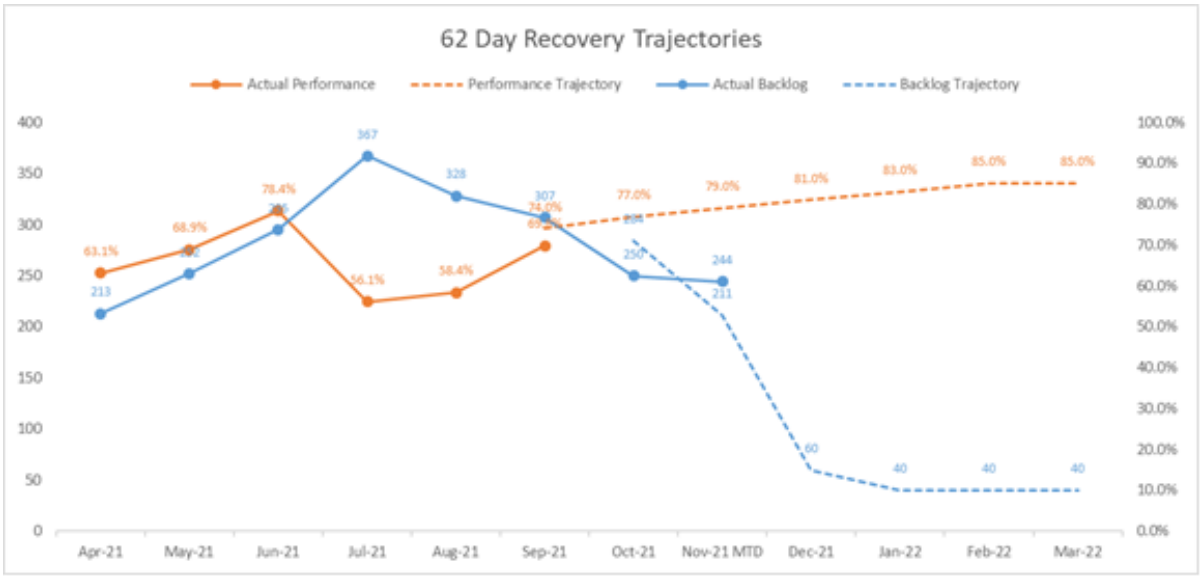
Author: Elizabeth Podd, Head of Performance & Planning
Date: 19th November 2021

The Princess Alexandra Hospital NHS Trust

Appendix: Recovery Dashboard

	Metric	Oct-19 Actuals	Oct-21 Target (% of 2019 Actuals)	Oct-21 Actuals	Oct-19 vs Oct-21	Monthly Trend 20/21 & 21/22
Outpatients	First appointments	9,832	95%	9,181	93.4%	
	Follow up appointments	14,110	95%	14,977	106.1%	
	Procedures	7,222	95%	5,826	80.7%	TBC
	Face to face	94.8%	N/A	67.5%	N/A	TBC
	Virtual	5.2%	N/A	32.5%	N/A	TBC
Inpatients	Day cases	2,200	95%	1,839	83.6%	
	Elective	388	95%	281	72.4%	
	Non-elective	3,472	95%	3,058	88.1%	
ED	A&E attendances	9,561	N/A	10,780	112.7%	
Diagnostics	MRI	1,500	95%	1,428	95.2%	
	CT	2,894	95%	2,980	103.0%	
	Non-Obstetric Ultrasound	4,161	95%	3,838	92.2%	
	Colonoscopy	263	95%	331	125.9%	
	Flexi Sigmoidoscopy	87	95%	91	104.6%	
	Gastroscopy	226	95%	201	88.9%	
	Echocardiography	801	95%	899	112.2%	

Cancer 62 day backlog trajectory (snapshot month end with 14/11/21 actual)



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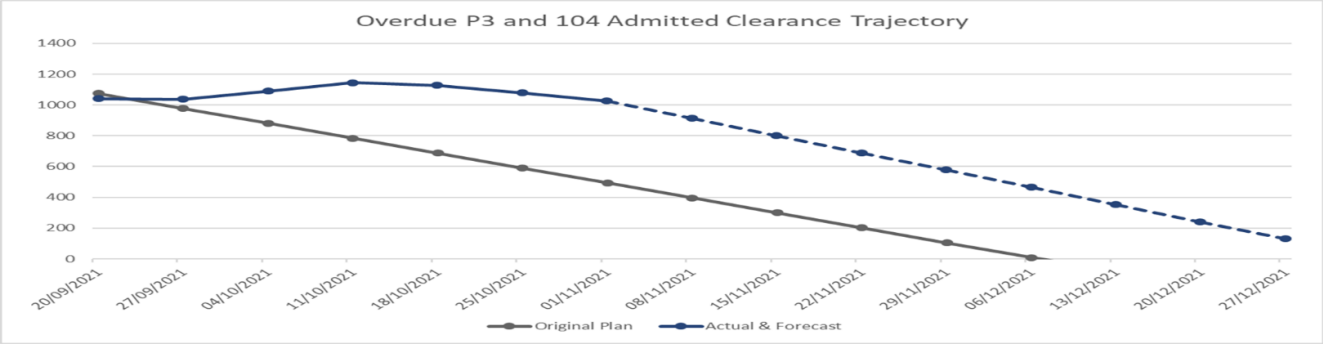
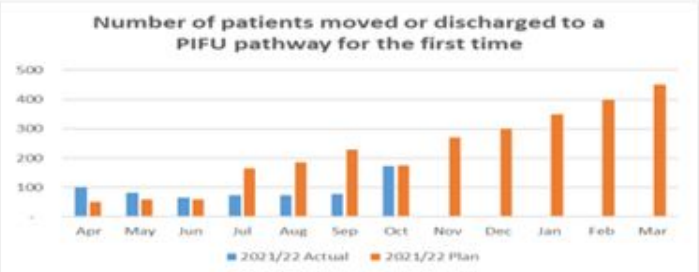
5.2

Routine long waiting patient recovery trajectory





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Trust Board (Public) – 02.12.21

5.3

Agenda item:	5.3
Presented by:	Stephanie Lawton, Chief Operating Officer
Prepared by:	Stephanie Lawton, Chief Operating Officer
Date prepared:	25 November 2021
Subject / title:	Response to the NHSE Ambulance Handover Letter

Purpose:	**Approval**		**Decision**		**Information**		**Assurance**	X
Key issues:	NHSE wrote to all Trusts requiring additional measures to be considered to assist in the improvement in Ambulance handovers for patients. This paper summaries the actions taken within the Trust and wider health economy. Work continues to be progressed with oversight through the Urgent Care Programme Board, Senior Management Meetings, Local Delivery Board and ICS Urgent Care Board. Capacity within Emergency care is being expanded through the Urgent Treatment Centre to support both adults and paediatric attendances. Additional support into paediatric emergency department including an additional GP, streamer and paramedic support is underway.							
Recommendation:	The Board are asked to note the actions taken to support improvement in ambulance handover delays with additional internal and external capacity being utilised ahead of winter							

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:	Local Delivey Board
Risk / links with the BAF:	Emergency Care
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	1

Update on the Trust response to the ambulance handover delays

NHSE/I wrote to all Trusts and ICs regarding the delay in handover of ambulances in October 2021. The letter set out a number of initiatives for Boards to consider and work through. Below is a brief summary and update on the actions undertaken at PAH to address the ongoing surge and delay for patients.

1. Establish surge capacity / priority admission unit to care for patients out with ED following a decision to admit; this may require conversion of existing space, or temporary accommodation, within the acute trust to accommodate patients prior to admission to the appropriate ward

   The Trust have established a standard operating procedure for patients to be cohorted and supported in the OPAL unit assessment area during times of extreme pressure. This is reviewed on a daily basis with the Nurse in Charge and Consultant in Charge of each shift. All patients are clinically assessed as suitable for transfer into this area pending admission into the Trust. The area is staffed by registered nurses and HCA with clear oversight and support from the site team out of hours.

2. Wherever practical implement "fit-to-sit" for patients that do not require a trolley
   In place and implemented 24/7 in discussion with the HALO, EEAST crews and nurse in charge. The Trust will utilise a corridor in the emergency department and the waiting area with clinical oversight to support patients who arrive by ambulance but who are clinically suitable to sit in a chair and do not require a trolley pending assessment.

3. Ensure early access to clinical decision-makers to enable prompt admission / discharge
   Nurse and Consultant in charge of very shift. Clear roles and responsibilities in place. Access to specialty review and internal professional standards for escalation have been rolled out and are monitored through the urgent care programme board on a weekly basis.

4. Establish additional community capacity to enable earlier discharge for patients no longer requiring acute medical care
   Winter funding has been received to support additional community capacity. A task and finish group has been developed to explore opportunities for Gibberd Ward, community and social care workforce. In addition pending the potential to open inpatient beds, a further option is being worked through with community colleagues across West Essex and East and North Hertfordshire to enhance the discharge support and support for additional carers in individual homes to enable earlier and safe discharge home. This includes the potential for community and social care teams to employ "night carers" out of hours.

5. Increase capacity of discharge lounge to free beds earlier in the day, accompanied by rapid support from non-emergency patient transport services
   Additional support to extend the opening hours of the discharge lounge through bank workforce has been implemented. Utilising winter funding to support extended hours. Discharge lounge are overseeing the process of booking transport to support clinical teams.

6. Increase direct access to GP streaming, SDEC, acute frailty services and medical / surgical assessment units from ambulance crews to reduce direct ED conveyance
   Additional space within the Urgent Treatment Centre has been developed and will open on 1st December 2021. Additional consulting rooms for GP colleagues will be expanded. OPAL (Frailty) service has now expanded to operate 8am – 8pm 7 days a week. Recruitment is underway for substantive staff within OPAL unit. The Multi-Disciplinary Agency Event (MADE) has operated from the 22nd November - 28th November to maximise flow through the hospital and to support a reset of assessment capacity.
   The Same Day Emergency Care (SDEC) unit is now fully operational 7 days a week. The unit has developed an OPEL status on a daily basis to monitor activity through the unit.

7. Match community and mental health service capacity and demand to enable reduced conveyance to ED for appropriate patients
   Collaborative work with mental health colleagues is undertaken on a daily basis. The mental health quality forum is developing and bringing partners together to ensure the care of patients with a mental health need is recognised and treated with parity. PAH have a seat at the Essex Mental Health Crisis Concordant.

8. Work with two-hour community crisis response teams to offer appropriate alternative pathways to an ambulance response
   Community partners are taking this forward and will monitor the impact of the service through the local delivery board.

9. Making use of HALO staff to support handover of care, or working with ambulance services to explore whether Community First Responders are available to take on additional roles to support care for patients
   HALO is onsite 7 days a week currently 12 hours per day. Additional winter funding has been received to extend the HALO hours to 24 hours a day, 7 days a week. EEAST are currently recruiting to the additional hours to support urgent and emergency care.

10. Work with Provider Collaboratives and ambulance services to support boundary changes and diverts, where this will help to decompress a site 3
   EEA**ST go live with Intelligent Conveyancing is scheduled for the 1st December 2021. Current system supports load levelling between acute organisations. This is managed a local acute, CCG and ICS level. Formal trust divert process requires Gold to Gold agreement and formal documentation to enact a full divert.**

The Princess Alexandra Hospital NHS Trust

Trust Board
25 November 2021

5.4

Agenda item:	5.4
Presented by:	Saba Sadiq – Director of Finance
Prepared by:	Saba Sadiq – Director of Finance James Thirgood, Deputy Director of Finance Paul McAuliffe, Head of Income & Contracting Leke Adebisi, Interim Head of Financial Management
Date prepared:	22 November 2021
Subject / title:	H2 Financial Plan

Purpose:	**Approval**	**X**	**Decision**		**Information**		**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This paper provides an update on the financial plan. The Trust has developed its H2 financial break even plan in line with NHSE/I guidance. A key component of achieving the financial break even plan is its H2 CIP target of £4,803k. The plan includes cost pressures which will be mitigated against during the remainder of H2 to ensure the delivery of the break even plan**.**							
Recommendation:	The Board is asked to formally approve the H2 financial plan which will be used as the basis of budget setting for H2 across the Trust (PAF had approved the plan on 25th November with delegated authority from the Board).							

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:	
Risk / links with the BAF:	BAF 5.1 requires the Trust to breakeven and ensure sufficient cash
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	

The Princess Alexandra Hospital NHS Trust

5.4

1.0 Purpose

This paper provides an update on the recent planning guidance and the effect that this has on the 2021/22 H2 financial plan.

A key component of delivering the break even H2 financial plan is delivery of the CIP target of £4,803k. The CIP target is higher in H2 than it was in H1 due to the Trust receiving less than forecast elective recovery activity income.

2.0 Update

Since the previous Committee meeting, the Trust has submitted workforce and activity plans. The financial plan is the last submission and reflects the other already submitted plans (workforce and activity). Key elements of H2 financial arrangements are as follows:

- H1 and H2 will be treated as a single financial period to deliver a break-even position for the full financial year
- The utilisation of H1 surplus (PAH reported a H1 surplus of £127k) to manage winter demands and go further on elective recovery
- H2 system funding envelopes, including system top-up and COVID-19 fixed allocation, have been calculated based on the H1 2021/22 envelopes adjusted for inflation, efficiency requirements and policy priorities
    - The system top-up and COVID-19 allocation will be distributed to our lead CCG for the system and will be distributed to providers by mutual agreement via block payment arrangements
- The block payment approach between NHS commissioners and NHS providers remains in place for H2
- The H2 block payment to providers included a general efficiency requirement of 0.82% applied to growth
- H2 other income support will be 75% of the H1 income support
- System funding envelopes will be uplifted to account for the 3% pay award recurrently and non-recurrently for back pay
    - COVID-19 fixed allocation has been reduced and will continue to be further tapering of the COVID-19 allocation will take place in 2022/23
- Signed 2021/22 contracts between NHS commissioners and NHS providers are not required for H2
    - Signed contracts will be required for 2022/23 and therefore work will need to be performed to ensure a common understanding of existing service requirements leading into 2022/23
- Provider to provider billing for Trusts to be based on average of 2019/20 billing plus a series of specified uplifts less non-recurrent items plus new services/changes
- The maximum targeted efficiency is 1.50%. Individual system positions will be higher or lower than the national average depending on their individual targeted efficiency requirement.

3.0 H2 Planned Budget

The Trust has developed a budget that reflects the Trust's H1 position and meets the national expectation that all NHS organisations will break even for FY21/22. In order to achieve the break even performance, the Trust needs to make CIP savings of £4,803k for the six months in 'H2' (October – March 2022). The summary of the budget is set out in the table below:

	H2 Budget Oct 21 to Mar 22 £000
Income	
Commissioning Income	157,583
Other Income	7,351
Total income	**164,934**
Expenditure	
Pay	(107,590)
Non-Pay	(53,298)
Financing & Depreciation	(8,849)
Total expenditure	**(169,737)**
Net Deficit	**(4,803)**
CIP target to achieve break even	**4,803**
Break even finanical plan	**-**

The proposed H2 plan includes

- creating a contingency of £0.5m to be used to help deliver the break even position;
- meeting known cost-pressures;
- allocating funding for the full-year effect of agreed developments;
- the continuation of COVID and growth funding at 2021/22 levels; and
- approved ICS winter pressures of £2.220m.

The H2 plan does not include activity recovery plans which will be subject to separate funding or any potential revenue consequences of business cases under development but not yet approved.

The key risk to delivering the financial plan is the Trustwide delivery of the H2 CIP. However, work is underway to mitigate this risk.

4.0 Recommendation

The Board is asked to formally approve the H2 financial plan which has been used as the basis of budget setting for H2 across the Trust (PAF approved the plan with delegated authority on 25th November 2021).

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS – 02.12.21 **Agenda Item: 6.1**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Pam Court - PAF Chairman
DATE OF COMMITTEE MEETING: 25.11.21 (virtual meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **M7 Update - Income and Expenditure**: The Trust is required to breakeven across the 2021/22 financial year and has set a financial plan to achieve this. The Trust posted an in-month deficit of £1.5m (the majority of this related to elective recovery activity) prior to the use of reserves which enabled a YTD break-even position, in line with plan.

- **Capital:** The capital resource limit (CRL) is £19.9.m. YTD spend is £13.5m and is behind the re-profiled plan of £15.5m by £2.0m.

- **HSE Health & Safety Action Plan:** The plan was presented and reviewed. It was noted that many actions were already in train and it was agreed that PAF would review the plan on a monthly basis going forward.

- **Nursing Establishment Review:** The nursing establishment review (May 2021) had resulted in recommended changes to the nursing workforce which were an uplift in qualified nurses of 25.63WTE and a reduction in unqualified care staff of 16.79 WTE. An additional recommendation was to substantiate a team of HCSW and RMNs to provide enhanced care to patients. The overall increase in budget from 2022/23 would be £1.27m however £550k was already included in the current run rate. The Committee supported the outcome and recommendations of the May nursing establishment review.

- **Financial Plan:** The Trust had developed its H2 financial break-even plan in line with NHSE/I guidance. It was noted that a key component of achieving the plan was its H2 CIP target of £4,803k. The plan included cost pressures which would be mitigated against during the remainder of H2 to support delivery of the plan. The Committee approved the plan on behalf of the Board in-line with the previously agreed request for delegated authority.

- **BAF Risks:** The risk scores for BAF Risk 5.1 (Revenue) and 5.2 (Capital) to remain at 12 but to reviewed on a monthly basis for the remainder of this financial year. BAF Risk 4.2 (ED 4 hour emergency standard) to remain at 20. BAF Risk 1.2 (EPR) score to remain at 16 and BAF Risk 3.1 (Estate & Infrastructure) score to remain at 20. Actions in progress for each of the risks were noted in the supporting papers.

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

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

- Planning Update
- Community Diagnostic Centre Business Case
- Better Payment Practice Code Update
- M7 Integrated Performance Report
- Recovery Update
- Monthly EPR Update
- Procurement Update
- New Hospital Update
- Estates & Facilities Quarterly Update
- Green Plan
- Report from Capital Working Group
- Report from Health & Safety Group
- Temporary Staffing Contract Update

The Princess Alexandra Hospital NHS
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SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee continues to make progress against its work plan.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS – 02.12.21 **Agenda Item: 6.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)
REPORT FROM: Helen Glenister (Chair)
DATE OF COMMITTEE MEETING: 26.11.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **Infection Prevention & Control/COVID-19:** The Committee heard of three emerging concerns in the organisation: 1) there had been a small increase in asymptomatic patients who test COVID positive on day 3-7 (rather than on day 1-2), this is a significant consideration for elective surgery pathways and also for the NIV (non-invasive ventilation) service. 2) further scoping of point-of-care testing options was underway to deliver the fastest result turnaround times. 3). The learning from the SI nosocomial cluster included the challenges of isolating those patients that are clinically extremely vulnerable (CEV) patients (due to limited siderooms across the site). All issues would continue to be reviewed at the Infection Prevention & Control Cell. Going forward it was agreed that in January the Committee would see a deep dive into the outcome and learning rom the SI cluster report in relation deaths related to nosocomial covid infection.

- **CQC 'Must & Should' actions:** The most recent data (w/c 01.11.21) was showing that of the 57 actions, 20 were moving to business as usual with only two rated as red. The Committee was assured in terms of processes and monitoring and in particular of the evidence process for moving an action to business as usual. Assurance was also provided that in terms of the transition to the Trust's own PMO, oversight/project management/and senior responsible officers would all remain the same.

- **Cancer, Cardiology & Clinical Support Quarterly Performance Review:** A very positive report was presented by the Healthcare Group and QSC was pleased to note the emphasis on system working, particularly in relation to recovery.

- **Quality & Patient Safety Strategy:** This was endorsed for Board approval.

- **Patient Panel:** The Panel would be recruiting three additional members, to meet the current demand for its services.

- **Review List/ASI Update:** The Committee noted the work being undertaken across all specialities to clear the outstanding review list patients. It also noted the update on ASIs (appointment slot issues).

- **BAF Risks:** BAF Risk 1.0 (COVID): It was agreed the risk score would remain at 16. BAF Risk 1.1 (Variation in Clinical Outcomes): It was agreed the score would remain at 16.

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

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

- Report from Clinical Effectiveness Group
- Mortality Update
- Report from Patient Safety Group
- Report from the Patient Experience Group
- Patient Safety, Quality & Effectiveness Update
- Maternity SI Report

The Princess Alexandra Hospital NHS
NHS Trust

• Maternity Incentive Scheme Update • M7 Integrated Performance Report • Nutrition & Hydration Annual Report • Clinical Ethics Annual Report • Horizon Scanning
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
• The Committee continues to make good progress against its work plan. .

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 02/12/21 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: Workforce Committee (WFC)
REPORT FROM: Helen Howe (Committee Chair)
DATE OF COMMITTEE MEETING: 29/11/21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

The future of NHS human resources and organisational development report: The report outlined a vision for 2030 and actions that support the delivery of the four pillars of "We are NHS: People Plan" and embeds the seven elements of our People Promise. The focus on the digital agenda was noted and the aim was to create a baseline for people services across the NHS. This was a 10 year strategy for HR in the NHS. It was noted there would be a further Board Development session regarding the future of HR and OD.

Nursing Establishment Review: The nursing establishment review (May 2021) had resulted in recommended changes to the nursing workforce which were an uplift in qualified nurses of 25.63WTE and a reduction in unqualified care staff of 16.79 WTE. An additional recommendation was to substantiate a team of HCSW and RMNs to provide enhanced care to patients. The overall increase in budget from 2022/23 would be £1.27m however £550k was already included in the current run rate. The Committee supported the outcome and recommendations of the May nursing establishment review. It was noted the midwifery establishment review was still in development.

Draft Health and Wellbeing Strategy: The Committee noted the draft strategy and the strategy would continue to be review to align with the NHS Health and Wellbeing framework launched in November 2021.

Recruitment of Healthcare Support Workers: The Committee welcomed the successful recent open day where 40 healthcare support workers were recruited.

Apprenticeships: The Committee noted the expired apprenticeship levy value of £0, down £16,055.76 from September; this means that we successfully spent our allocation in this period..

Staff Survey: The Committee noted the final response rate of 44.3% to the annual staff survey. An increase from last year's response rate of 38.2%

Urgent and Emergent Care Staffing: The Committee agreed for a deep dive to be conducted into staffing within urgent and emergent care, specifically the emergency department. This was in response to concerns regarding the levels of assurance the Committee would be receiving when closing down of the section 31.

BAF Risk 2.3 Workforce: Inability to recruit, retain and engage our people: It was agreed the risk score would remain at 16.

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

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

- Communications Update
- Safer Nurse Staffing
- People Board update
- Staff Survey Response Plan
- Temporary Staffing Contract
- Equality Delivery System Update

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

The Princess Alexandra Hospital NHS
NHS Trust

The Committee continues to make progress against its work plan and will meet again on 31th January 2022.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 2 December 2021 **Item No: 6.1**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Sharon McNally – Acting Chairman
DATE OF MEETINGS: **09.11.21 and 16.11.21**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

- The following items were discussed at SMT meetings in November:

9 November 2021:

- Significant Risk Register
- Multi-Agency Discharge Event (MADE)
- Extranet Update; including presentation from provider (FRANK)
- Nursing Establishment Review
- Kingsmoor Substantive Staff Funding
- HCG Change Management Workshops
- Draft H2 Activity Submission
- Sustainability – Green Plan development
- Integrated Performance Report (IPR)

16 November 2021:

- Draft Integrated Performance Report (IPR)
- Quality Briefing
- Multi Agency Discharge Event
- Maternity Safety Champions
- Sage and Thyme© Communication Training
- Equality Delivery System 2
- Anti-racism presentation
- Extranet Update
- Quality PMO report
- Recovery Dashboard
- Sustainability – Green Plan development
- H2 Financial Plan

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 02.12.21 **AGENDA ITEM NO: 6.2**

REPORT TO THE CORPORATE TRUSTEE FROM:
CHARITABLE FUNDS COMMITTEE (CFC)

REPORT FROM: John Keddie – Associate Non-Executive Director

DATE OF COMMITTEE MEETING: 19.11.21

SECTION 1 – MATTERS FOR THE CORPORATE TRUSTEE/TRUST BOARD'S ATTENTION
Items recommended to the Corporate trustee for approval: • The annual report and accounts for the charity were reviewed and recommended to the Corporate Trustee for approval (this includes the letter of representation). Final submission to the Charity Commission is required by 31 January 2022. The Annual Report and Accounts are being presented to the Corporate Trustee for approval on 2 December 2021. • CFC discussed the annual effectiveness review and noted areas for improvement including quality and timeliness of papers. The composition of the committee will be reviewed again June 2022. The Terms of Reference were reviewed and changes to the membership of the committee were agreed. **The revised Terms of Reference are attached as Appendix 1.** The following items are escalated for noting: • The financial position was noted; total fund balances at M6 were £783k with activity restarting after the pandemic. At the next meeting the Committee will receive a briefing on VAT and Gift Aid. • CFC approved the following: ▪ Two future events for the Breast Fund; the Royal Berkshire Shoot and the Snowball. ▪ Funding in the sum of £35k from the Just Giving for Covid 19 charitable fund to fit out the Alex Lounge for staff. The following reports were received: • Fundraising update (risk register reviewed) • Butterfly hub update.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The CFC is making good progress against its annual work plan.

The Princess Alexandra Hospital NHS Trust

CHARITABLE FUNDS COMMITTEE
2021/22

TERMS OF REFERENCE

CONSTITUTION: The Princess Alexandra Hospital NHS Trust ("the Trust") appointed as Corporate Trustee of the Trust's charitable funds by virtue of SI 2001 (2271), hereby resolves to establish a Committee to the Board to be known as the Charitable Funds Committee. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

PURPOSE: The Charitable Funds Committee ("the Committee") has been established by the Board to make and monitor arrangements for the control and management of the Trust's charitable funds and fundraising activities.

SCOPE AND DUTIES:

1. Within the budget, priorities and spending criteria determined by the Trust as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) seek assurance that charitable funds have been managed and spent in accordance with their respective governing documents and in line with the Standing Financial Instructions.
2. To ensure that the Trust's policies and procedures for charitable funds investments are followed. To make decisions involving the sound investment of charitable funds in a way that both preserves their capital value and produces a proper return consistent with prudent investment and ensuring compliance with:
   - Trustee Act 2000
   - Charities Act 1993
   - Charities Act 2006
   - Charities Act 2011
   - Terms of the funds' governing documents
3. On behalf of the Board, review the accounts of the Charity and receive the external auditor's report and commend the accounts to the Board once considered by the Committee.
4. To develop, monitor and review progress against the Trust's Charitable Funds Strategy, agree any new appeals to be supported by the Trust and monitor the progress of these appeals.
5. To appoint investment advisors (where appropriate) and agree their terms of appointment and monitor investment progress.
6. To receive regular reports on fund balances and performance.
7. To approve any arrangements for the day-to-day running of the Trust's charity.
8. To review and approve the acceptance of restricted funds
9. To approve charitable fund expenditure over £10000; if approval is required between meetings the Chair and CFO can approve the request with ratification by the Committee at the next meeting.
10. To maintain oversight of and receive regular reports on fundraising activities.

ACCOUNTABLE TO: Corporate Trustee/Board of Directors

REPORTING ARRANGEMENTS: A regular report from the Committee shall be produced for the Board of Directors by the Committee Chairman and Lead Executive.

CHAIRMAN: Non-Executive Director.

COMPOSITION OF MEMBERSHIP:	Committee Chairman, another Non-Executive Director, Director of People, OD and Communications, Director of Strategy, ~~Deputy Chief Financial Officer~~Director of Finance, ~~Head of Financial Services and Associate Director of Communications.~~
ATTENDANCE:	Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee meetings within each reporting year. An attendance record shall be taken at each meeting and an annual register of attendance will be included in the Committee's annual report to the Board.
INVITED TO ATTEND:	In addition to the members of the Committee, the following may be invited to attend the Committee to provide advice, support and information: • Head of Financial Services • Associate Director of Communications. • Charitable Funds & Income Assistant • Fundraising Coordinator • Fund Raisers/Managers within the Trust/representative from the Breast Fund • External Audit (as required). • Investment Advisors (as required).
DEPUTISING ARRANGEMENTS:	In the absence of the Chairman of the Committee, another Non-Executive Director member shall chair the meeting. If any substantive member is unable to attend, a nominated deputy should be in attendance at the committee meetings and should have delegated authority from the executive member
QUORUM:	The quorum for any meeting of the Committee shall be two members, one of whom shall be the Lead Executive and the other shall be a Non-Executive Director.
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.
LEAD EXECUTIVE:	Director of People, OD and Communications
MEETING FREQUENCY:	Meetings shall be held not less than ~~three~~ four ~~-~~times per year.
MEETING ORGANISATION:	• Meetings of the Committee shall be set before the start of the financial year. • The meeting shall be closed and not open to the public. • The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee. • A draft agenda shall be developed by the Head of Corporate Affairs and the Lead Executive and agreed by the Committee Chairman at least ten clear days* before the next Committee meeting. • All final Committee reports must be submitted six clear days* before the meeting. • The agenda and supporting papers shall be forwarded to each member of the committee and planned attendees five clear days* before the

date of the meeting and not less than three clear days* before the date of the meeting.

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

AUTHORITY: The Committee is empowered with the responsibility for the day to day management of investments of the charitable funds in line with Trust, regulatory and statutory procedures and appropriate professional advice. The Committee shall also have the power to appoint an investment manager to advise it on investment matters and may delegate day to day management of some or all of the investments to that investment manager.

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

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

DATE APPROVED: By Charitable Funds Committee: 19 November 2021
By Corporate Trustee/Trust Board: 2 December 2021

NEXT REVIEW DATE: November~~July~~ 202~~1~~

Membership and Those in Attendance	
Members	
Chairman - Non-Executive Director	John Keddie
Non-Executive Director	Helen Glenister
Director of People, OD and Communications	Ogechi Emeadi
Director of Strategy	Michael Meredith
~~Deputy Chief Finance Officer~~Director of Finance	Saba Sadiq
~~Head of Financial Services~~	
~~Associate Director of Communications~~	~~Laura Warren~~
In Attendance/Invited as Required	
Head of Financial Services	Samuel Owusu-Ansah
Associate Director of Communications	Laura Warren
Head of ~~Fundraising~~ Charity	Gary Taylor
Charitable Funds & Income Assistant	TBC
Fund Raisers/Managers within the Trust	As identified
Representative of Breast Fund (Associate Specialist Surgeon)	Ashraf Patel
Secretariat	
Head of Corporate Affairs	Heather Schultz
Committee Secretary	Lynne Marriott/~~member of secretariat~~
Corporate Governance Officer	Becky Warwick

The Princess Alexandra Hospital Charity

NHS
The Princess Alexandra Hospital
NHS Trust

Trust Board
2 December 2021

6.2

Agenda Item:	6.2
Presented by:	Saba Sadiq – Director of Finance
Prepared by:	Saba Sadiq – Director of Finance Marion Mullins – Deputy Head of Financial Services
Date prepared:	25th November 2021
Subject / Title:	2020/21 Charitable Fund Annual Report and Accounts

Purpose:	**Approval**	X	**Decision**		**Information**		**Assurance**		
Key issues:	The 2020/21 Charitable Fund Annual Report and Accounts have been to the Charitable Fund Committee and have been approved. Trust Board approval is now sought. An independent examination has been performed by EY. No significant issues have been identified from their work.								
Recommendation:	The Trust Board formally approves the 2020/21 Charitable Fund Annual Report and Accounts which have already been approved by the Charitable Fund Committee.								

Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	✓	✓	✓	✓	✓

Previously considered by:	Annual Report and Accounts have been approved by the CFC on 19th November 2021
Risk / links with the BAF:	Failure to comply with Charity Commission requirements, insufficient funds to meet liabilities, reputational damage from lack of financial control over charitable funds.
Legislation, regulatory, equality, diversity and dignity	As a condition of its registration, the Charity is required to comply with Charity Commission guidance and reporting requirements.
Appendices:	Appendix 1 – Findings from EY Independent Examination Appendix 2 – Annual Report and Accounts 2020/21 Appendix 3 – Letter of Representation Appendix 4 – Charity Commission Publication Questions

The Princess Alexandra Hospital Charity

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1.0 PURPOSE

The purpose of this report is to present, for final approval, the 2020/21 Charitable Fund Annual Report and Accounts to the Trust Board, and to provide details of the summarisation of works undertaken by EY as part of their independent examination.

2.0 KEY POINTS RELATING TO THE ACCOUNTS

Key points in relation to the accounts are:

- The financial statements have been prepared under the historic cost convention and in accordance with the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

- The accounts have been prepared on a going concern basis. Fund balances are stable, with growth predicted for the future year. There are no material uncertainties about The Princess Alexandra Hospital NHS Trust Charitable Fund therefore preparing the accounts on a going concern basis is appropriate.

- The overall level of funds has increased, although there has been a fall in both income and expenditure. In 2020/21 fundraising events were postponed as a result of the pandemic, and general funds were not spent as staff concentrated on operational activities.

3.0 EY INDEPENDENT EXAMINATION

One point which required the accounts to be amended related to the independent examination fee disclosure. The independent examination fee value disclosed was incorrect. This had the consequent impact that the audit fee had to reanalysed across all funds therefore although the bottom line did not change the split between funds did.

Statement of Financial Activities		Pre amendment			Post amendment		
		2020/21 Restricted Funds	2020/21 Unrestricted Funds	2020/21 Total Funds	2020/21 Restricted Funds	2020/21 Unrestricted Funds	2020/21 Total Funds
Total Income		165	239	**404**	165	239	**404**
Total expenditure		(67)	(205)	**(272)**	(68)	(204)	**(272)**
Net income/(expenditure)		98	34	**132**	97	35	**132**
Net movement on funds		98	34	**132**	97	35	**132**
Fund balances brought forward at 1 April		0	(642)	**(642)**	0	(642)	**(642)**
Fund balances carried forward at 31 March		**(98)**	**(676)**	**(774)**	**(97)**	**(677)**	**(774)**

Balance Sheet		Pre amendment			Post amendment		
		2020/21 Restricted Funds	2020/21 Unrestricted Funds	2020/21 Total Funds	2020/21 Restricted Funds	2020/21 Unrestricted Funds	2020/21 Total Funds
Total current assets		98	765	**863**	97	765	**863**
Total current liabilities		0	(89)	**(89)**	0	(88)	**(88)**
Total net assets		**98**	**676**	**774**	**97**	**677**	**775**
Funds of the Charity							
Restricted		98	0	**98**	97	0	**97**
Unrestricted		0	676	**676**	0	677	**677**
Total Funds		**98**	**676**	**774**	**97**	**677**	**774**

6.2

EY have presented a note summarising their work and findings (Appendix 1) – no significant issues have been identified. The Annual Report and Accounts are at Appendix 2.

4.0 LETTER OF REPRESENTATION

The Letter of Representation is recommended for approval (Appendix 3). The 20/21 Annual Report and Accounts independent examiner's report will be formally received once EY are in receipt of the signed LoR, although the draft is included in the accounts.

5.0 CHARITY COMMISSION

Along with submitting the annual report and accounts, the Charity Commission requires that charities answer a series of questions to summarise the charity's (Appendix 4).

6.0 RECOMMENDATION

It is recommended that the Charitable Funds Committee:

- approves the 20/21 Annual Report and Accounts;
- approves the Letter of Representation;
- notes EY's Summary of Findings from their independent examination; and
- approves the responses to the Charity Commission submission questions relating to the charity's activities.

Ernst & Young LLP
400 Capability Green
Luton
Bedfordshire
LU1 3LU

Tel: + 44 1582 643 476
Fax: + 44 1582 643 001
ey.com

External memorandum

Summary of Findings from Independent Examination of:

Princess Alexandra Hospital NHS Trust Charitable Fund

EY has been engaged as the independent examiner of the charitable fund. There are no identified independence issues.

We have assessed and confirmed the continued eligibility of the charitable fund for independent examination (IE).

Materiality for the IE has been set at £4,040 based on 1% of income.

The accounting records have been reviewed. They were found to provide the information from which the financial position could be ascertained on any selected date, and were up to date and readily accessible. The Statement of Financial Activity and Balance Sheet were agreed to underlying records, which were assessed to contain sufficient detail to allow more detailed testing to be carried out if required. The trial balance and financial statements have been agreed.

Analytical review has been performed. Findings are:

- Assets and liabilities appear consistent with the size and scale of the charity and of understanding of charity activities and structure.
- Satisfactory explanations for variances obtained where appropriate and reasonable.

The following primary procedures have been performed:

- Review of the bank reconciliation
- Confirmation of investment/cash balances
- Testing of donations received and fundraising income
- Expenditure testing
- We have reviewed related parties disclosed within the financial statements.

We have no matters to report.

Charity minutes have been reviewed, with no issues to note for the examination.

A disclosure checklist has been completed to confirm the accounts have been prepared in accordance with the SORP.

We identified one amendment in respect of the audit fee disclosed within the Charity accounts. The Trust have amended for this. The agreed audit fee for the independent examination is £4,000 excluding VAT.

No reportable failures have been identified in the course of the independent examination.

We thank the Trust staff for their help and assistance in supplying information to complete this audit.

The Princess Alexandra Hospital Charity

Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
NHS Trust

The Princess Alexandra Hospital NHS Trust Charitable Fund

6.2

Annual Report and Accounts

Year ended 31 March 2021

Registered charity number 1054745

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital Charity

Registered Charity Number: 1054745

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The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

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Trustee's report

Report of the trustees for the year ended 31 March 2021

The trustees are pleased to present the annual report together with the financial statements of the charity for the year ended 31 March 2021.

The annual report and financial statements comply with the accounting and reporting by charities: statement of recommended practice applicable to charities preparing their accounts in accordance with the financial reporting standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2019), the Charities Act 2011 and the UK generally accepted accounting practice.

Chair's report

As chair of The Princess Alexandra Hospital NHS Trust Charitable Fund, I am pleased to welcome you to the 2020/21 Annual Report and Accounts. We hope you find this a useful guide to the important role our charity plays in supporting NHS patients, their carers, families and staff.

The charity's work is only possible thanks to the generous support of patients, staff and local people. Thanks to your efforts, we received £404,000 of income over the last year. Key highlights of our year include provision of:

- Reclining chairs and clinical trolleys for the benefit of patients in the Neonatal Intensive Care Unit;
- Project Wingman, to provide refreshments and a quite area to support staff during the COVID-19 pandemic;
- Replacement of furniture within the visitors room within the Intensive Care Unit; and
- Pamper gifts for nurses to recognise International Nurses Day.

I would like to take this opportunity to thank those individuals who have served as trustees during the last year and to welcome those who will play an important role going forward.

I would also like to thank all of our supporters – including everyone who has helped raise money for the charity or given their energy, time and skills to make a difference during this financial year. I hope that, like me, you will be inspired by our plans to help and want to be part of our story. Your donations made this work possible and your future donations are the key to our continued success.

If you would like to donate, details about how to do this are on page 29.

On behalf of the many patients who have benefitted from your generosity, thank you for your continued support.

Chair **Date**

Our objectives and activities

The Princess Alexandra Hospital NHS Trust Charitable Fund (the Charity), was formed under a trust deed dated 21 March 1996, and is registered with the Charity Commission, registration number 1054745.

Through fundraising activities, events and appeals, we will further improve the provision of high-quality patient care through the use of cutting-edge technology throughout the trust, focusing on areas not covered or fully supported by central NHS funds.

The trust board confirm that they have referred to the guidance contained in the charity commission's general guidance on public benefit when reviewing the charity's activities and objectives and in planning future activities.

The trust board shall hold the charitable fund, and use the income where applicable, and at their discretion the capital, for any charitable purpose or purposes relating to the National Health Service. Within the single registered charity, there are a number of funds, each managed by a fund manager. Specific criteria document that funds should only be spent in line with the purposes of the fund. This criterion is for internal guidance only, and has no legal standing.

However, expenditure from funds given by the public must be seen as being appropriate and in line with their wishes. The receipt given for donations is in line with charity commission guidelines and states that the funds will be used for the general purposes of the charity, and I desire they use such sum to....". This means that the charity will spend the cash in accordance with the donor's wishes, but retains the right to use discretionally. Unless raised for a specific object, charitable funds should be spent within a three-year time period, and should not be built up for future years.

Financial review

These financial statements have been prepared under the historic cost convention and in accordance with the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland (FRS102), the Charities Act 2011 and UK Generally Accepted Practice. The detailed statements can be found on pages 18 to 20 of this report.

The charity is constituted of 86 individual funds as at 31 March 2021 (100 in 2019/20).

COVID-19 and NHS Together

Our community kindly rallied to support us in the fight against COVID-19.

Our dedicated COVID-19 charity appeal launched in April 2020 and by March 2021 we had £222k of donations, which included £165k of grants very kindly provided from NHS Charities Together (www.nhscharitiestogether.co.uk).

Our teams are extremely grateful and delighted by this hugely generous outpouring of support for our amazing people who work so hard to deliver outstanding care and to keep people safe.

During these unprecedented times in the fight against COVID-19, the help and support of patients, visitors, family and friends has been crucial. We received many gifts to share with our people, which have been really appreciated. We were also asked by many if they could make donations to our hospital.

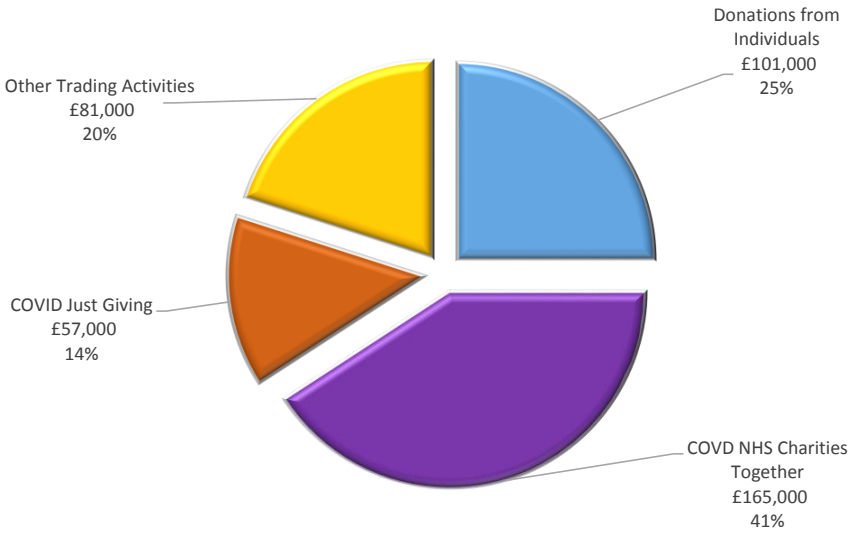
In response to these requests, we created a JustGiving page, as a simple and fast way to donate. We will soon be opening a new staff area with bright, modern space and facilities due to the level of funding received. This project was designed in response to staff feedback about how important a new staff area is to support their health and wellbeing. Contributions have also been made partly via the COVID-19 charity appeal, in recognition of the hard work and dedication of our people.

Donations we received

The charity received income for the year totalling £404,000, a decrease of £282,000 compared to 2019-20. As described above, this can be attributed to reduced activity, especially as regards to fundraising activities, due to the COVID-19 pandemic.

This income is comprised of donations and legacies, other income from fundraising activities, dividends, and interest, of which the largest elements related to donations in relation to COVID-19, grant funding from NHS Charities Together and donations from individuals. There was minimal income from fundraising as apart from some residual monies received from events that had taken place before lockdown measures were introduced. There were no fundraising events run during 2020-21 (in 2019-20 fundraising income totalled £484,000).

The income received is described in the chart below:



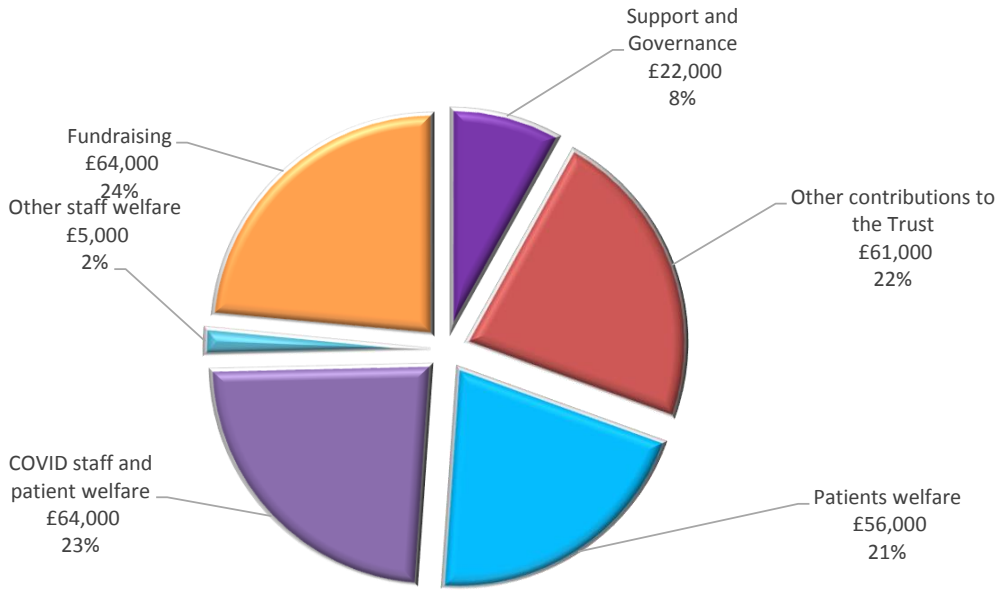
How we spent our funds

During the year, the charity provided support to users of The Princess Alexandra Hospital NHS Trust in many forms, including education and training for staff and the supply of medical equipment for patient treatment. In total, resources expended were £272,000. This is a considerable reduction from the previous year (£700,000 in 2019-20), and can be attributed to the reduced activity across the charity, especially in relation to fundraising, due to the COVID-19 pandemic.

The Charity has spent £64,000 on fundraising activities which generated £404,000 of income (£227,000 on fundraising which generated £686,000 of income in 2019-20).

The majority of the contributions to The Princess Alexandra Hospital NHS Trust were in relation to COVID activity as described above.

Total expenditure across the charity is depicted in the chart below.



The Princess Alexandra Hospital Charity

NHS
The Princess Alexandra Hospital
NHS Trust

Reference and administration details

Registered charity number: 1054745

Address of charity:
The Princess Alexandra Hospital NHS Trust Charitable Fund
Hamstel Road
Harlow
Essex CM20 1QX

Banker:	**Banker:**	**Auditor:**
Barclays Bank plc	RBS	Ernst & Young LLP
Water Gardens	280 Bishopsgate	400 Capability Green
Harlow	London	Luton
Essex CM20 1AN	EC2M 4RB	LU1 3LU

Trustee arrangements:
The trustee of the charity is The Princess Alexandra Hospital NHS Trust as sole corporate trustee, governed by the law applicable to trusts, principally the Trustee Act 2000 and the Charities Act 2011. This responsibility is managed by the Board members (with voting rights) of the trust.

Board members for the period 1 April 2020 to 31 March 2021 were as follows:

Chair:

Steve Clarke	Chair

Non-executive directors:

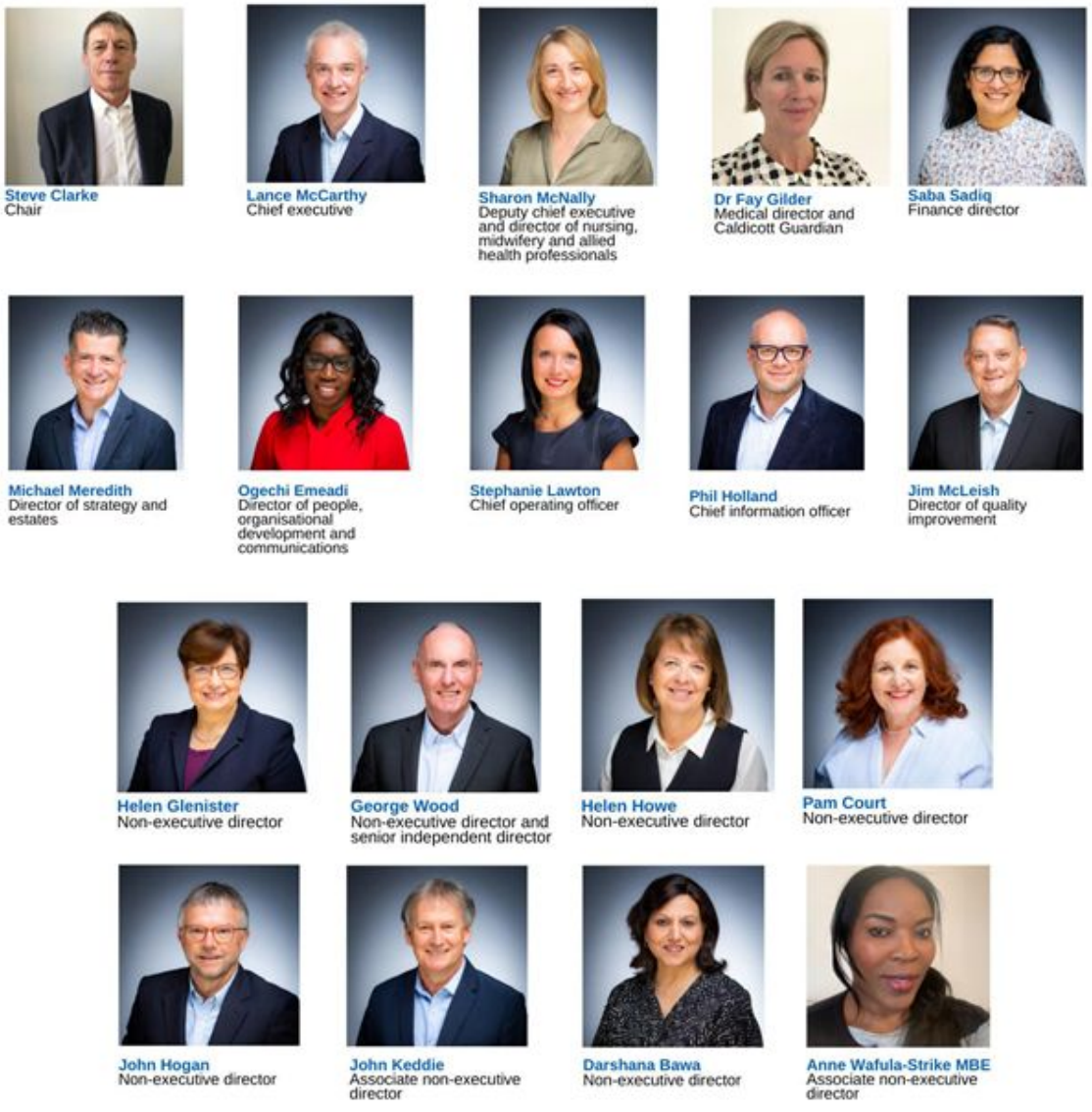
George Wood	Senior independent director
Pam Court	Non-executive director
John Hogan	Non-executive director
Helen Glenister	Non-executive director
Helen Howe	Non-executive director
John Keddie	Associate non-executive director
Anne Wafula-Strike	Associate non-executive director (from 15.02.2021)
Darrel Arjoon	NExT non-executive director (6-12 month placement from 04.01.2021)
Darshana Bawa	NExT non-executive director (6-12 month placement from 11.01.2021)

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
NHS Trust

Executive directors:

Lance McCarthy	Chief executive officer
Trevor Smith	Chief financial officer (to 31.08.2020)
Simon Covill	Acting director of finance (01.09.2020 – 13.12.2020)
Saba Sadiq	Director of finance (from 14.12.2020 onwards)
Stephanie Lawton	Chief operating officer
James McLeish	Director of quality improvement
Sharon McNally	Director of nursing, midwifery and allied health professionals
Ogechi Emeadi	Director of people, OD and communications
Michael Meredith	Director of strategy and estates
Marcelle Michail	Acting chief medical officer (to 31.10.2020)
Fay Gilder	Medical director (from 01.11.2020 onwards)
Phil Holland	Chief information officer (from 01.02.2021)



modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Highlights and case studies

During the year, the funds continued to support a wide range of charitable and health related activities benefiting both patients and staff. In general, they are used to purchase additional goods and services that the NHS is unable to provide. Charitable funds were used to purchase much needed equipment across the Trust, the case studies below provide further details on how charitable funds have been used within the Trust, and the significant difference this has made to the quality of care and the services provided.

Project Wingman at PAHT

The Project Wingman team departed PAHT on 3 July 2020, after more than two months providing a first-class airport lounge service to our hard-working people.

To thank the volunteers from Stansted Airport for their kind contributions during the COVID-19 pandemic, we held a socially distanced closing party in the restaurant and the Project Wingman lounge.

This was an all-day Spanish holiday themed celebration of the fantastic Project Wingman service to support the health and wellbeing of our people over the last few months.

The event gave staff an opportunity to say thank you to our fabulous furloughed flight-crew friends who served us refreshments provided by our catering team, with contributions from charitable funds of £52k, and helped us to unwind between shifts seven days a week from 27 April 2020.

Breast Unit Charity report 2020-2021

The breast unit team are extremely thankful to all supporters who sent donations to the Breast Unit Charity in such a difficult year.

The money is used to fund research nurses for clinical trials and the provision of Fabulous and Beautiful, Moving On and exercise programmes to support patients during their breast cancer treatment and recovery. Access to charitable funds have enabled the Breast Unit to carry out 44 breast cancer research trials, enhancing the care available to patients at The Princess Alexandra Hospital NHS Trust (PAHT). Due to the pandemic, alternative ways of safe working have sadly meant these programmes are on hold.

During the period 2020 – 2021 No fundraising events were held due to the pandemic. Supporters held their own events raising money for the Breast Unit Charity.

Roberto Zeolla – December 2020

In December 2020, Roberto Zeolla from The Chequers at Matching Green rode 100km around the village for PAHT Breast Unit Charity

Robert Zoella started the challenge on Monday 14 December 2020

Roberto said: “Whilst the likes of Captain Tom Moore have raised millions for the NHS, smaller charities such as the breast cancer unit run by Mr Ashraf Patel that supports women in the aftercare stages of breast cancer have seen a 95% reduction in donations.

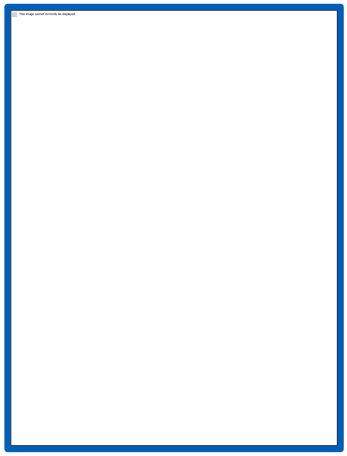
“In any ordinary year we would run three charity balls at The Chequers raising more than a hundred thousand pounds for much needed care. With the pub being closed and under restrictions this year we have been unable to raise money as we normally would.”

Roberto raised £9,085 via JustGiving.

Mel Fordham - August 2020

On 15 August 2020, Mel Fordham rode 103 miles solo to raise money for Princess Alexandra Hospital Brest Cancer Research Unit. Additionally, Mel also committed to riding a further 5,000 miles during the year. Mel raised a total of £2,056.00 for the charity.

A great photograph of Mr Patel with Mel Fordham after he rode the Prudential MYRIDE London. Mel raised a total of £2,056.00 for the Breast Unit Charity.



Nicky George – August 2020

Nicky George who was the 2020 Lady Captain for Theydon Bois Golf Club held a Ladies Captain Day on the 27 August 2020.

Nicky raised a total of £5,000 in what was the most difficult year to be a Ladies Captain. Nicky held a number of events to raise as much money for the charity as possible including a Yuletide Golf day, an email/text raffle with the final draw on WhatsApp and a joint Captains Charity day. Nicky really was a star supporter in 2020.

The Princess Alexandra Hospital Charity

NHS
The Princess Alexandra Hospital
NHS Trust

Neonatal Unit

Recliner chairs and trolleys

NICU were very pleased to be able to use their charitable funds to purchase reclining chairs and clinical trolleys for the unit.

Reclining chairs are recommended to allow parents to form close and loving relationships with their babies. Bliss supports skin to skin and kangaroo cares, and recommends that parents have the facilities to stay at their baby's cot side for as long as they like.

Research evidence shows that skin to skin, kangaroo cares, breastfeeding and bonding promotes the neurological development of infants brains and supports long-term neurological and developmental outcomes. It also promotes the mental health and wellbeing of mothers and fathers through skin-to-skin contact and kangaroo cares.

The recliner allows us to be able to offer ease of these interactions for parents making their experience a positive one, and was especially supportive for parents during the pandemic as it enabled them to remain comfortable whilst visiting their babies in NICU.

The clinical trolleys are closed trolleys which are on metal castors therefore sturdier than their predecessors, better from an infection control point of view and allow medical teams to more easily carry out procedures. These replacements are also colour coordinated to match the chairs and provide a safer, cleaner way of storing our consumables.

Structure, governance and management

The Princess Alexandra Hospital NHS Trust Charitable Fund was formed under a trust deed dated 21 March 1996. The charity is registered with the Charity Commission under registration number 1054745.

The responsibility for the identification, implementation and monitoring of the strategic direction of the charity is performed by the trust board of directors, along with the day to day running of the charity.

The Trust Board consists of a chair person, nine executive directors (four non-voting) including the chief executive officer, five non-executive directors, two associate non-executive directors (non-voting) and two NeXT non-executive directors (non-voting).

Appointment to executive director posts, including that of the chief executive officer, follow a common process. Posts are normally advertised nationally and short-listed candidates meet with senior trust and local health economy staff prior to formal interview. An interview panel, chaired by the trust chair, which includes executive level staff from NHS England/Improvement and local Clinical Commissioning Groups (CCGs), other trust non-executive directors and an external assessor, makes the final decision on appointments.

There are no formal training procedures in place for members of the trust board relating specifically to the charity. However, the non-executive directors, who are members of the Charitable Funds Committee, regularly attend sessions provided by the Association of NHS Charities that include a variety of relevant topics. Briefings from the Association are included in the papers for each meeting of the Charitable Funds Committee.

The trust board have adopted policies which achieve the objects stated in the trust deed by ensuring funds are used for the purpose for which the donor intended and are not accumulated unless part of a greater project or fundraising scheme.

The Trust Board has established a Charitable Funds Committee to manage and monitor arrangements for the control and management of the trust's charitable funds and fundraising activities.

The Trustees have delegated day-to-day administration of the Charity to the charitable funds finance lead, with the Trust's Director of Finance having responsibility for financial control. The Charitable Fund has adopted the internal controls of The Princess Alexandra NHS Trust.

Charitable Funds Committee (CFC)

The Charitable Fund Committee (CFC) is a formally established committee accountable to the corporate trustee/board of directors, to provide assurance to the board (the corporate trustee) on the arrangements for control and management of the charity. A non-executive director chairs the committee.

Members are expected to make every effort to attend all meetings of the CFC and it is expected that they shall attend the majority of Committee meetings within each reporting year. Attendance of CFC members at meetings is detailed below:

Name and position	Attendance
John Keddie Non-executive director and chairman	3/3
Helen Glenister Non-executive director	3/3
Ogechi Emeadi Director of people	3/3
Michael Meredith Director of strategy and estates	2/3
Colin Forsyth Head of financial services	3/3
Simon Covill Deputy director of finance	3/3
Saba Sadiq Director of finance (in post from 14/12/21)	1/1

Financial management

The charity manages its charitable activity spending through appointed fundholders for the individual funds. These fundholders manage the funds on a day-to-day basis with agreed authorisation limits, and in accordance with the trust's standing financial instructions and orders. Each fund holder receives a monthly financial statement of their fund which details income, expenditure and fund balances for the period.

The charity receives expenditure applications from staff throughout the year that are authorised by the fund holder and submitted to the charitable funds finance lead, who reviews all applications to ensure that they meet the objectives of the charity. Where an application exceeds £10,000, the fundholder is required to present the application to the Charitable Funds Committee for approval. Where any expenditure is considered inappropriate, feedback is given to the fund manager.

The charity does not directly employ any staff; where staff are employed by The Princess Alexandra Hospital NHS Trust and provide day to day operational support for areas such as financial management and reporting, and for fundraising, these costs are recharged to the charity. The charity is not financially dependent upon the support of any individuals, corporations or specific classes of donors. No funds are held by the charity on behalf of individuals.

Risk management

The major risks to which the charity is exposed have been identified and reviewed with systems established to mitigate them. The charity relies on and benefits from the financial control framework of PAHT.

The most significant risk identified was:

1. reputational damage leading to a sudden and dramatic fall in donations

Risks have been carefully considered and mitigating procedures put in place. The trustees are confident that reliance can be placed on the management arrangements in place which include independent examination to minimise any risk to the Charity. The Charity has no investment assets so there is no associated risk with an investment portfolio. Procedures are in place to ensure that both spending and financial commitments remain in line with income. The committee on a quarterly basis monitors both income and expenditure in order that any trends can be identified at an early stage in order to avoid unforeseen calls on reserves. Governance of income and expenditure follows the Trust's Standing Financial Instructions.

Future plans

The Charity continues to regularly review spending plans to reflect the changing needs of the NHS in Essex and the surrounding counties. The objective is to enhance facilities for patient care, ensuring that both the needs of the service and the objectives of the charitable fund are met.

In future, the trust will continue to:

- Review options for future specific fundraising opportunities
- Ensure the effective utilisation of monies received by the charity as a share of the COVID-19 national fundraising
- Develop annual expenditure plans across all funds
- Ensure the maintenance of adequate resource across funds whilst seeking to maximise the use of the resources
- Review of the trust's fund-raising strategy

The trust has a strategic vision for the redevelopment of its hospital. It has a master plan to provide modern facilities that are fit for purpose and underpin the objective of delivering high quality, effective and efficient patient care.

To maintain the quality of care provided at the trust the charity actively contributes to:

The education and continuing professional development of staff by supporting relevant courses and conferences.

Continued investment in research to ensure continued improvement in patient care.

Our strategic priorities are aligned to the trust's commitment to delivering the Long Term Plan and will provide additional resources above and beyond that provided by the NHS.

We will continue to work hard to support the needs of our patients, staff and carers, enhancing the care that they are able to receive from the NHS. We are hugely grateful for the support that we receive from our donors and our local population; their support makes everything that we do possible. Your support makes these plans possible and to help us please do consider making a donation (see page 29).

Statement of trustee's responsibilities

Under charity law, the trust board are responsible for preparing the trustee's Annual Report and Accounts for each financial year that show a true and fair view of the state of affairs of the charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice requires that the board of directors:

- Select suitable accounting policies and apply them consistently
- Make judgements and estimates that are reasonable and prudent
- State whether the recommendations of SORP have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the trust deed, subject to any material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to assume that the charity will continue its activities

The trust board are required to act in accordance with the trust deed and the rules of the charity within the framework of trust law. The trust board are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trust board to ensure that, where any statements of accounts are prepared by the trust board under section 132(1) of the Charities Act 2011. Those directors have general responsibility for taking such steps as are reasonably open to the trust board to safeguard the assets of the charity and detect fraud and other irregularities.

The trust board confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 18 to 20 attached have been compiled from, and are in accordance with the financial records maintained by the trust board.

Approved by the trustees on 2 December 2021, and signed on their behalf by:

John Keddie
Chair of charitable funds committee
Date:

Saba Sadiq
Director of finance
Date:

Independent examiner's report to the trustee of The Princess Alexandra Hospital NHS Trust Charitable Fund

I report on the accounts of the Trust for the year ended 31 March 2021, which are set out on pages 19 to 28

Respective responsibilities of trustees and independent examiner

The charity's trustees are responsible for the preparation of the accounts. The trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.
It is my responsibility to:

► examine the accounts under section 145 of the Charities Act;
► to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act; and
► to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no material matters have come to my attention which gives me cause to believe that in, any material respect:

► the accounting records were not kept in accordance with section 130 of the Charities Act; or
► the accounts did not accord with the accounting records; or
► the accounts did not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give 'true and fair' view which is not a matter considered as part of an independent examination.

I have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Independent examiner's report to the trustee of The Princess Alexandra Hospital NHS Trust Charitable Fund (continued)

Use of our report

This report is made solely to the trustees, as a body, in accordance with our engagement letter dated 16 April 2018. The examination has been undertaken so that we might state to the trustees those matters that are required to be stated in an examiner's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the trustees as a body, for this examination, for this report, or for the statements made.

Debbie Hanson
For and on behalf of Ernst & Young LLP
Relevant professional qualification or body: CIPFA
Address: 400 Capability Green, Luton, LU1 3LU
Date:

The Princess Alexandra Hospital Charity
Registered Charity Number: 1054745

NHS
The Princess Alexandra Hospital
NHS Trust

Statement of financial activities for the year ended 31 March 2021

		Restricted Funds	Unrestricted Funds	Total Funds	Total Funds
		£000	£000	£000	£000
Income and endowments from					
Donations and Legacies	3	165	158	323	198
Other income	4	0	81	81	484
Investments	5	0	0	0	4
Total Income		165	239	404	686
Expenditure on					
Raising funds	6	(3)	(61)	(64)	(227)
Charitable activities	7				
- Contributions to the Trust		0	(82)	(82)	(174)
- Medical Research		0	0	0	(130)
- Patient welfare and amenities		0	(56)	(56)	(154)
- Staff welfare and amenities		(65)	(5)	(70)	(15)
Total expenditure		(68)	(204)	(272)	(700)
Net income/(expenditure)		97	35	132	(14)
Transfers between funds		0	0	0	0
Net movement on funds		97	35	132	(14)
Reconciliation of funds					
Fund balances brought forward at 1 April		0	(642)	(642)	(656)
Fund balances carried forward at 31 March		(97)	(677)	(774)	(642)

All gains and losses recognised in the year are included in the statement of financial activities.

The Princess Alexandra Hospital Charity

NHS
The Princess Alexandra Hospital
NHS Trust

Balance sheet as at 31 March 2021

	Note	2020/21 Restricted Funds	2020/21 Unrestricted Funds	2020/21 Total Funds	2019/20 Total Funds
		£000	£000	£000	£000
Current assets					
Debtors	13	0	0	**0**	**82**
Cash and cash equivilents	14	98	765	**863**	**742**
Total current assets		**98**	**765**	**863**	**824**
Liabilities					
Creditors falling due within one year	15	0	(89)	**(89)**	**(182)**
Net current liabilities		98	676	**774**	**642**
Total net assets		**98**	**676**	**774**	**642**
Funds of the Charity					
Restricted		98	0	**98**	**0**
Unrestricted		0	676	**676**	**642**
Total Funds		**98**	**676**	**774**	**642**

The notes at pages 22 to 28 form part of these accounts.

Approved and authorised for issue by the trustees on 2 December 2021 and signed on their behalf.

John Keddie
Chair of charitable funds committee
Date:

Saba Sadiq
Director of finance
Date:

6.2

The Princess Alexandra Hospital Charity

NHS
The Princess Alexandra Hospital
NHS Trust

Statement of cashflows for the year ended 31 March 2021

	Note	2020/21 Total Funds	2019/20 Total Funds
		£000	£000
Cash flows from operating activities			
Net expenditure for the reporting period	16	**132**	**(10)**
Adjustments for:			
Dividends, interest and rents from investments	5	**0**	**(4)**
Decrease in debtors	13	**82**	**93**
(Decrease)/Increase in creditors	15	**(93)**	**151**
Net cash used in operating actvities		**121**	**230**
Change in cash and cash equivilents in the reporting period		**121**	**230**
Cash and cash equivilents at 1 April 2020		**742**	**512**
Cash and cash equivilents at 31 March 2021	14	**863**	**742**

The Princess Alexandra Hospital Charity

The Princess Alexandra Hospital NHS Trust

Notes to the accounts

1. Accounting policies

1.1. Accounting convention

The financial statements have been prepared under the historic cost convention. The financial statements have been prepared in accordance with the Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Charities Act 2011, and UK Generally Accepted Accounting Practice as it applies from 1 January 2015.

The trustees consider that there are no material uncertainties about the charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts.

1.2. Structure of funds

The Princess Alexandra Hospital NHS Trust Charitable Fund is registered as an umbrella fund, encompassing three unrestricted special funds whose names and objects are:

The Princess Alexandra Hospital general fund

For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by The Princess Alexandra Hospital.

The St Margaret's Hospital general fund

For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the St Margaret's Hospital.

The Herts and Essex Hospital general fund

For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the Herts and Essex Hospital.

1.3. Income recognition

All income is recognised and included in full in the Statement of Financial Activities as soon as the following three factors can be met:

- Entitlement: control over the rights or other access to the economic benefit has passed to the charity.
- Probable: it is more likely than not that the economic benefits associated with the transaction or gift will flow to the charity.
- Measurement: the monetary value or amount of both the income and the costs to complete the transaction can be measured reliably.

Income from legacies are accounted for as incoming resources once the receipt of the legacy becomes probable. This will be once confirmation has been received from the representatives of the estates that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled or are within the charity's control to fulfil.

The charity received no gifts in kind.

1.4. Expenditure recognition

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- there is a present legal or constructive obligation resulting from a past event
- it is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- the amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

Grants payable are payments made to third parties (including NHS bodies) in the furtherance of the charitable objectives. They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant. This includes grants paid to NHS bodies.

Support costs are those costs that do not relate directly to a single activity. These include some staff costs, costs of administration and internal and external examination/audit costs. Support costs have been apportioned between fundraising costs and charitable activities based on fund balances. Support and governance costs are apportioned across all funds based on the average fund balance for the year.

Costs of charitable activities comprise all costs in the pursuit of the charitable objects of the Charity. These costs, where not wholly attributable, are apportioned between the categories of expense in addition to the direct costs. The total costs of each category of expense include an apportionment of support costs as shown in note 9.

1.5. Realised gains and losses

There are no realised gains or losses in 2020-21 (nil in 2019-20).

1.6. Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

1.7. Cash and cash equivalents

Cash at bank and in hand is held to meet the day-to-day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments.

1.8. Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the Charity expects to have to pay to settle the debt. There are no amounts which are owed in more than a year.

1.9. Events after the end of the reporting period

No events (either adjusting or non-adjusting) occurred after the end of the reporting period for 2020-21 (nil in 2019-20).

2. Related party transactions

The Princess Alexandra Hospital NHS Trust manages the Princess Alexandra Hospital NHS Trust Charitable Fund, a corporate body established by order of the Secretary of State for Health. As such, the trust is the ultimate controlling party and the trust board of the charity are the directors of the trust, as detailed in page 12 of this Annual Report and Accounts.

Details of The Princess Alexandra Hospital NHS Trust are:

	2020/21		2019/20	
	Turnover	Adjusted Financial Performance	Turnover	Adjusted Financial Performance
	£000	£000	£000	£000
Nature of business				
Provision of healthcare	**315,122**	**1,816**	**288,491**	**50**

The trust's auditors (Ernst & Young LLP) confirmed that the trust's accounts gave a true and fair view of the financial performance and were prepared in accordance with the National Health Service Act 2006 and associated accounts directions. However, because of the COVID-19 pandemic, the auditors were not able to gain sufficient retrospective assurance on the 31 March 2020 inventory balance. Therefore, their 2020-21 opinion is qualified in relation to the prior year comparative balance.

The main beneficiaries of the charity are the patients, staff and visitors of The Princess Alexandra Hospital NHS Trust. The charity has provided grant funding for items purchased on behalf of these beneficiaries totalling £187,000 as detailed in note 8 of these accounts.

Expenditure of the charity is considered to be a grant to The Princess Alexandra Hospital NHS Trust, as the staff, patients and visitors of the trust are the ultimate beneficiaries.

The trust board received no remuneration or re-imbursement of expenses from the charitable fund during 2020-21 (nil in 2019-20).

3. Details of income

	2020/21 Restricted Funds	2020/21 Unrestricted Funds	2020/21 Total Funds	2019/20 Total Funds
	£000	£000	£000	£000
Donations	165	158	**323**	**167**
Legacies	0	0	**0**	**31**
Total	**165**	**158**	**323**	**198**

The Princess Alexandra Hospital Charity

NHS
The Princess Alexandra Hospital
NHS Trust

4. Income from other trading activities

Income relates to funds received from fundraising events (and where VAT is not chargeable). The charity receives no income from "trading" (i.e. from the sale of merchandise), nil trading income in 2019-20.

	2020/21 Restricted Funds	2020/21 Unrestricted Funds	2020/21 Total Funds	2019/20 Total Funds
	£000	£000	£000	£000
Long Live Liver Appeal	0	1	**1**	**22**
Gibberd Ward Garden Appeal	0	0	**0**	**9**
My Life Memory Software Appeal	0	0	**0**	**2**
Covid Campaign	0	52	**52**	**0**
Improving Cancer Service	0	0	**0**	**9**
Breast Unit Fundraising Team events	0	28	**28**	**442**
Total	**0**	**81**	**81**	**484**

5. Investment income

	2020/21 Restricted Funds	2020/21 Unrestricted Funds	2020/21 Total Funds	2019/20 Total Funds
	£000	£000	£000	£000
Interest from cash and cash equivalents	0	0	**0**	**4**
	0	**0**	**0**	**4**

6. Expenditure on raising funds

	2020/21 Restricted Funds	2020/21 Unrestricted Funds	2020/21 Total Funds	2019/20 Total Funds
	£000	£000	£000	£000
PAH Fundraising	3	16	**19**	**3**
Long Live Liver Appeal	0	1	**1**	**1**
Covid Campaign	0	1	**1**	**0**
Improving Cancer Services	0	1	**1**	**0**
Breast Unit Fundraising Team events	0	42	**42**	**223**
Total	**3**	**61**	**64**	**227**

7. Charitable expenditure

All charitable expenditure is classified as grant funded activities

	2020/21 Grant funded activity	2020/21 Support Costs	2020/21 Total	2019/20 Total
	£000	£000	£000	£000
Contributions to the Trust	67	15	**82**	**174**
Medical Research	0	0	**0**	**130**
Patient welfare and amenities	56	0	**56**	**154**
Staff welfare and amenities	70	0	**70**	**15**
Total	**193**	**15**	**208**	**473**

8. Analysis of grants

		2020/21 Number of Grants paid	2020/21 Total £000	2019/20 Total £000
The Princess Alexandra Hospital NHS Trust		1	187	455
		1	187	455

There were no grants made payable to individuals during 2020-21 (nil in 2019-20). All grants are made to The Princess Alexandra Hospital NHS Trust to provide for the care of NHS patients, and the welfare of its staff and visitors. The total cost of making grants, including support costs, is disclosed on the Statement of Financial Activities and the actual funds spent on each category of charitable activity is disclosed in note 7.

9. Allocation of support costs and overheads

	2020/21 Raising Funds £000	2020/21 Charitable Activities £000	2020/21 Total Funds £000	2019/20 Total Funds £000
Charitable activity				
Administration - staff costs	6	9	15	14
Other - bank charges	0	1	1	1
Governance fee				
Independent Examination fee	2	3	5	3
Fundraising Regulator levy charge	0	1	1	0
Total support and governance costs	8	14	22	18

The financial administration costs have been allocated between governance and charitable activity on the basis of staff time. External audit costs were wholly allocated to governance. The basis of apportionment of support costs is disclosed in note 1.4.

10. Trustee's remunerations, benefits and expenses

The trust board give their time freely and receive no remuneration for the work that they undertake as trustees.

11. Analysis of staff costs

The charity does not employ any staff.

12. Independent examiner's remuneration

The Independent examiner's remuneration of £4,800 inclusive of VAT (2019-20 £3,600) related solely to the independent examination with no other additional work undertaken.

13. Analysis of debtors

	Balance 31 March 2021	Balance 31 March 2020
	£000	£000
Debtors under 1 year		
Debtors (host Trust)	0	20
Accrued income	0	12
Prepayments	0	50
Total	0	82

14. Analysis of cash and cash equivalents

	Total 2020-21	Total 2019-20
	£000	£000
Cash held as short term investments and deposits	832	700
Cash at bank and in hand	31	42
Total	863	742

15. Analysis of liabilities

	Balance 31 March 2021	Balance 31 March 2020
	£000	£000
Creditors due within 1 year		
Trade creditors	71	72
Creditors (host Trust)	18	110
Total creditors	89	182

16. Reconciliation of net expenditure/income to net cashflow from operating activities

	2020/21 Total Funds £000	2019/20 Total Funds £000
Net (expenditure) / income *(as per the statement of finaincial activities)*	132	(14)
Adjustments for:		
Dividends, interest and rents from investments	0	(4)
Decrease in debtors	82	94
(Decrease)/ increase in creditors	(93)	150
Net cash used by operating actvities	121	226

17. Analysis of unrestricted and restricted fund movements

	Balance 1 April 2020 £000	Income £000	Expenditure £000	Balance 31 March 2021 £000
Restricted funds				
Princess Alexandra Hospital	0	165	(67)	98
Total	0	165	(67)	98
Unrestricted funds				
Herts & Essex Hospital	1	0	(1)	0
Princess Alexandra Hospital	483	181	(101)	563
St Margaret's Hospital	158	58	(103)	113
Total	642	239	(205)	676
Total Funds	642	404	(272)	774

18. Funding commitments

As at 31 March 2021 the trustees had not made commitments other than those shown as creditors, note 12.

Ways in which to support our charity

Our staff and the public can help to raise funds for the charity, by:

- Fundraise with your school, local club or group. We have many great ideas for fundraising for groups, including some fun socially distanced ideas.
- Fundraise with your workplace or company. Whether or not your business has worked with a charity before, we can tailor a partnership specifically for you and your colleagues. From a one-off fundraising event, to a charity of the year partnership, your support will make a huge difference and we will support you every step of the way.
- Do you have your own ideas of how you would like to raise money for The Princess Alexandra Hospital Charity? If so, we would love to hear all about it. Please email **paht.fundraising@nhs.net**.
- Donate to your local hospital charity. You can donate online (www.justgiving.com/pahnhs) or set up a direct debit to donate to your local hospital (Donate - Donation amount - JustGiving).
- You can also donate via cheque. Cheques can be sent to The Princess Alexandra Hospital Charity, Hamstel Road, Harlow, Essex, CM20 1QX and should be made payable to The Princess Alexandra Hospital Charity. Please include your name and address so we can send a thank you letter for your support.
- Follow us on Facebook (The Princess Alexandra Hospital Charity) or Twitter (@PAHCharity) to find out about our latest events.

Donations can be made in the following ways:

Direct into bank account

Bank:	Barclays
Sort code:	20-37-06
Account number:	50113999
Account name:	The Princess Alexandra Hospital NHS Trust Charitable Funds
Reference:	Please state the General Fund

By post

Cheques payable to: The Princess Alexandra Hospital NHS Trust Charitable Funds. Please write on the back of the cheque which fund you would like to donate to, e.g. General Fund, and send to:

The Princess Alexandra Hospital NHS Trust Charitable Funds
Finance Department
Kao Business Park
1st Floor Kao 2
London Road
Harlow
Essex CM17 9NA

By a donation on our Just Giving page, via this link.

As well as making a general donation, you can also open a page in celebration of and in memory of a loved one. If you are a group or an organisation who is interested in raising money on behalf of the Charity, we would love to hear from you too. For more information and for support if you are holding your own event, please contact or fundraising team:

Gift Aid

Gift Aid is a simple, government initiative which allows us to increase the value of your donations at no extra cost to you. For every pound you give to us we can get an extra 25 pence from HM Revenue and Customs helping your donation go further to help patients and their families. The only condition is that you are a UK tax payer. When making a donation simply let us know that you wish to Gift Aid your donation, to do this all we need is your name and address.

The Princess Alexandra Hospital NHS Trust

The Princess Alexandra Hospital Trust
Hamstel Road
Harlow
Essex
CM20 1QX

2nd December 2021

Ernst & Young LLP
400 Capability Green
Luton
LU1 3LU

Dear Sirs

This representation letter is provided in connection with your examination of the financial statements of The Princess Alexandra Hospital NHS Trust Charitable Fund ("the Charity") for the year ended 31 March 2021. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to complete your examination as to whether there are matters to which attention should be drawn to enable a proper understanding of the financial statements to be reached.

We understand that the purpose of your examination of our financial statements is to report whether any matter has come to your attention which gives you reasonable cause to believe that in any material respect the requirements to:

- keep accounting records in accordance with section 130 of the 2011 Act;
- prepare accounts which accord with the accounting records; and
- prepare accounts which comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008.

We understand that this examination is substantially less than an audit and involves an examination of the accounting records and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor necessarily be expected to disclose – all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

The Princess Alexandra Hospital NHS Trust

A. Financial Statements and Financial Records

1. The Trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

2. We have fulfilled our responsibilities, as set out in the engagement letter, for the preparation of the financial statements in accordance with the Charities SORP and UK Generally Accepted Accounting Practice.

3. We acknowledge, as Trustees of the Charity, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position and financial performance of the Charity in accordance with UK GAAP, and are free of material misstatements, including omissions. We have approved the financial statements.

4. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements. We have disclosed to you any significant changes in our processes, controls, policies and procedures that we have made to address the effects of the COVID-19 pandemic on our system of internal controls.

B. Fraud

1. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.

2. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

3. We have no knowledge of any fraud or suspected fraud involving management or other employees who have a significant role in the Charity's internal controls over financial reporting. In addition, we have no knowledge of any fraud or suspected fraud involving other employees in which the fraud could have a material effect on the financial statements. We have no knowledge of any allegations of financial improprieties, including fraud or suspected fraud, (regardless of the source or form and including without limitation, any allegations by "whistleblowers") which could result in a misstatement of the financial statements or otherwise affect the financial reporting of the Charity.

C. Compliance with Laws and Regulations

1. We have disclosed to you all known actual or suspected noncompliance with laws and regulations whose effects should be considered when preparing the financial statements.

The Princess Alexandra Hospital NHS Trust

D. Information Provided and Completeness of Information and Transactions

1. We have provided you with:

   - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters.

   - Additional information that you have requested from us for the purpose of the examination; and

   - Unrestricted access to persons within the entity from whom you determined it necessary to obtain evidence.

2. All material transactions have been recorded in the accounting records and are reflected in the financial statements, including those related to the COVID-19 pandemic.

3. We have made available to you all minutes of the meetings of Trustees or subcommittees of Trustees (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the period to the most recent meeting on the following date, 19th November 2021.

4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Charity's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the year end. These transactions have been appropriately accounted for and disclosed in the financial statements.

5. We have disclosed to you, and the Charity has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

E. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.

2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal advisers.

3. We have recorded and/or disclosed, as appropriate, all liabilities related litigation and claims, both actual and contingent, and have not given any guarantees to third parties.

F. Subsequent Events

1. There have been no events subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

G. Other information

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises the Annual Report.

2. We confirm that the content contained within the other information is consistent with the financial statements.

H. Reporting to regulators

1. We confirm that we have reviewed all correspondence with regulators, in England and Wales, which has also been made available to you, and the serious incident report guidelines issued by the Charity Commission (updated in 2017). We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the signing of the balance sheet.

Yours faithfully

_____ _____

Trustee Director of Finance

Signed on behalf of the Trustees

Charity annual return questions

This document is to help charities prepare for their annual return by gathering the required information.

Submit your annual return online, once you have the information you need.

There is more guidance on the questions in the online service.

During the pandemic, any money provided by the government's furlough programme must be declared individually as 'income from government grants'.

If your income is under £10,000 you only need to report your income and spending.

Section: Financial period	Proposed Response
You will be asked to confirm the charity's financial period. If the financial period end dates displayed are incorrect, you can change them in the Change the charity financial period service.	1st April 2020 to 31st March 2021
Section: Income and spending	
You will be asked to enter the charity's income and spending in the financial period for this annual return in the boxes provided. Please round all figures to the nearest pound (do not enter decimal points or commas). If your charity is part of a group and has prepared group accounts, then please use the group figures to complete the annual return. (Group accounts are only required where group income is more than £1million).	Income: £404293 Expenditure: £272463
Section: Confirm income and spending	
In the financial details section you will be asked to enter key financial information from your accounts, including total income. For charities with an income greater than £500,000. The total income from your Statement of Financial Activities should match the gross income you have entered here, unless your charity has received endowments during the year, or made transfers from your endowment to your income funds. If this is the case you should exclude these amounts from the total income you enter here. Please check the gross income figure you have entered here is correct.	Correct - No endowment funds held by the Charity
Section: Serious incidents	
If gross income is more than £25,000 you will be asked if there were any serious incidents in your charity that have not been reported to the Charity Commission, for the period of this return.	None
Section: Fundraising	
Did your charity raise funds from the public?	Yes
If you answer 'Yes', you will be asked:	
Did the charity work with any professional fundraisers?	No
Did your charity have a written agreement with each of its professional fundraisers?	N/A
Did your charity work with any commercial participators?	No
Did your charity have a written agreement with each of its commercial participators?	N/A
Section: Grant making	
Was grant making the main way your charity carried out its purposes?	Yes
Section: Income from government contracts	
During the financial period for this annual return, did the charity receive income from contracts (other than grant agreements) with central government or local authorities?	No
If you answer 'Yes', you will be asked:	
How many contracts did your charity have with central government or local authorities?	N/A
Enter total value of contracts. Please round all figures to the nearest pound (do not enter decimal points or commas). What was the total value of these contracts?	N/A
Section: Income from government grants	
During the financial period for this annual return, did the charity receive income from grants from central government or local authorities? During the pandemic, any money provided by the government's furlough programme must be declared individually as 'income from government grants'.	No
If you answer 'Yes', you will be asked:	

How many grants did your charity receive from central government or local authorities? If you received any furlough payments, each payment received needs to be recorded individually as single grants.	N/A
Enter total value of grants. Please round all figures to the nearest pound (do not enter decimal points or commas). What was the total value of these grants?	N/A
Section: Income from outside the UK	
Did your charity receive income from outside the UK?	No
If you answer 'Yes', you will be presented with a table of countries. Select countries or territories the charity received income from. Then answer the following questions.	
What is the value of income from each country? Please round all figures to the nearest pound (do not enter decimal points or commas). If your charity did not have any income from the source, please enter 0 (zero). Specify the source and amount of income from the options below: - Overseas government or quasi government bodies - Overseas charities, NGOs or NPOs - Other overseas institutions - Individuals resident overseas (for example school fees and memberships) - Unknown/Do not know **Notes on income from other overseas institutions and individuals resident overseas** 1. If your gross income is less than £25,000, only include payments that make up more than 80% of the charity's income. If your gross income is more than £25,000, only include payments of more than £25,000. 2. If you are completing a 2018 annual return, these categories are optional.	N/A
Section: Operating and spending outside England and Wales	
Did your charity operate outside England and Wales?	No
If you answer 'Yes', you will see a table of countries. Select countries or territories the charity operated in during the financial period covered in the annual return. Then answer the following questions.	
Record the total expenditure by country or territory. Please round all figures to the nearest pound (do not enter decimal points or commas). If your charity did not spend any money in the country, please enter 0 (zero). Note: If your charity operated in Northern Ireland or Scotland, you are not required to provide a value for spending for either of these countries.	N/A
When spending money or working outside England and Wales, did your charity transfer money other than using the regulated banking system? Note: if you are completing a 2018 annual return, this question is optional.	N/A
What methods to transfer money did your charity use? - Cash courier - Other charities or NGOs/Non-Profits - Money Service Business (e.g. Western Union) - Informal Money Transfer Systems - Online payment methods (e.g. PayPal) - Other Note: if you are completing a 2018 annual return, this question is optional.	N/A
How much money did your charity send outside the regulated banking system in total? Please round all figures to the nearest pound (do not enter decimal points or commas).	N/A
Did your charity have procedures and controls in place to monitor expenditure outside England and Wales? Note: if you are completing a 2018 annual return, this question is optional.	N/A
Are the trustees satisfied that your charity's risk management policies and procedures adequately covered activities and spending outside England and Wales? Note: if you are completing a 2018 annual return, this question is optional.	N/A
Section: Subsidiaries	
Did the charity have any subsidiaries?	No
If you answer 'Yes', you will be asked: Were any of the trustees also directors of the charity's subsidiaries?	N/A
Section: Trustee payments	
Did any of the trustees receive any remuneration, payments or benefits from the charity other than refunds of legitimate trustee expenses?	No

If you answer 'Yes', you will be asked: Did any of the trustees receive payments or benefits for: - being a charity trustee? - providing services to your charity (such as specialist services or advice provided by trustees who are builders, electricians, graphic designers, lawyers, for example)? - any other benefit from the charity (for example, accommodation, car, holiday)? Also include any payments and benefits given to trustees who are paid members of staff	N/A
Did any of the trustees resign and then take up employment with the charity?	No
Section: Employees	
Did any of your charity's staff receive total employee benefits of £60,000 or more?	No
If you answer 'Yes', you will be asked: Enter the **number of staff** whose total employee benefits were in each of the following bands: £60,000 to £70,000 £70,001 to £80,000 £80,001 to £90,000 £90,001 to £100,000 £100,001 to £110,000 £110,001 to £120,000 £120,001 to £130,000 £130,001 to £140,000 £140,001 to £150,000 £150,001 to £200,000 £200,001 to £250,000 £250,001 to £300,000 £300,001 to £350,000 £350,001 to £400,000 £400,001 to £450,000 £450,001 to £500,000 Over £500,000	N/A
For your highest paid member of staff only, what was the total value of their employee benefits?	N/A
Section: Volunteers	
How many UK volunteers, excluding trustees, did the charity have during the financial period?	Nil
Section: Financial controls	
Did your charity review its internal financial controls?	Yes
Section: Safeguarding	
Note: only charities with particular classifications and not regulated by certain organisations will be asked this question. Has the charity obtained a standard, enhanced or enhanced with barred lists DBS check on all trustees, employees and volunteers who are in roles that are eligible for these checks?	Yes

Only charities with annual income over £500,000 need to answer the following financial questions.

At this point, other charities will be asked to provide copies of their trustee annual report and annual accounts.

Section: Account type	
IMPORTANT - You will need a final version of the published accounts to fill in the financial details section. The trustees should ensure that this section is completed by a competent person who is familiar with the charity's accounts. The information you need to complete this section will generally be found in the statement of financial activities (SoFA). When completing this section you may wish to look at Charities SORP. Please indicate whether the information that you are giving is based on group accounts or charity-only accounts by clicking on the relevant account type. If you have prepared group accounts, please use these to complete the following section.	
Does your charity prepare: Group accounts Charity only accounts	N/A
Section: Income and Endowments	
All fields are mandatory - Enter 0 (zero) if the field does not apply to your charity. Fields that are indented provide additional information and are included in the figures for the field above. The indented fields may not represent the whole amount. The information you need to complete this section will generally be found in the Statement of Financial Activities (SoFA). Enter figures to the nearest pound and restate them in pounds if the accounts have, for example, been prepared to the nearest thousand. Do not enter decimal points or commas.	N/A

Donations and legacies	N/A
Of the total donations and legacies what amount is Legacies	N/A
Of the total donations and legacies what amount is Endowments received	N/A
Other trading activity	N/A
Investment income	N/A
Income from charitable activities	N/A
Other income	N/A
Total income and endowments	N/A
Note: The amount entered for 'Total income and endowments' minus 'Endowments Received' should be equal to the figure entered for 'Income' on the charity Information page. If the charity controls subsidiary undertakings, consolidated figures should be used from group accounts where these have been prepared.	N/A
Section: Expenditure	
The information you need to complete this section will generally be found in the Statement of Financial Activities (SoFA). All fields are mandatory - Enter 0 (zero) if the field does not apply to your charity. Fields that are indented provide additional information and are included in the figures for the field above. The indented fields may not represent the whole amount. Enter figures to the nearest pound and restate them in pounds if the accounts have, for example, been prepared to the nearest thousand. Do not enter decimal points or commas.	N/A
Expenditure on raising funds	N/A
Of total expenditure on raising funds what amount is Investment management costs	N/A
Other expenditure	N/A
Expenditure on charitable activities	N/A
Of the total expenditure on charitable activities what value is Grants to institutions	N/A
Of the total expenditure on charitable activities what value is Governance costs	N/A
Total expenditure	N/A
Section: Other recognised gains/(losses)	
The information you need to complete this section will generally be found in the Statement of Financial Activities (SoFA). All fields are mandatory - Enter 0 (zero) if the field does not apply to your charity. Fields that are indented provide additional information and are included in the figures for the field above. The indented fields may not represent the whole amount. Enter figures to the nearest pound and restate them in pounds if the accounts have, for example, been prepared to the nearest thousand. Do not enter decimal points or commas.	N/A
This figure should be prefixed with the minus symbol if it is a negative value. Gains/(losses) on revaluation of fixed assets	N/A
This figure should be prefixed with the minus symbol if it is a negative value. Actuarial gains/(losses) on defined benefit pension schemes	N/A
This figure should be prefixed with the minus symbol if it is a negative value. Net gains/(losses) on investments	N/A
This figure should be prefixed with the minus symbol if it is a negative value. Other gains/(losses)	N/A
Section: Assets	
All fields are mandatory - Enter 0 (zero) if the field does not apply to your charity. Fields that are indented provide additional information and are included in the figures for the field above. The indented fields may not represent the whole amount. The information you need to complete this section will generally be found in the Balance Sheet. Enter figures to the nearest pound and restate them in pounds if the accounts have, for example, been prepared to the nearest thousand. Do not enter decimal points or commas.	N/A
Total fixed assets	N/A
Of the total fixed assets what value is Fixed asset investments	N/A
Total current assets	N/A
Of the total current assets what value is Current asset investments	N/A

Of the total current assets what value is Cash at bank and in hand	N/A
Section: Liabilities	N/A
All fields are mandatory - Enter 0 (zero) if the field does not apply to your charity. Fields that are indented provide additional information and are included in the figures for the field above. The indented fields may not represent the whole amount. The information you need to complete this section will generally be found in the Balance Sheet. Enter figures to the nearest pound and restate them in pounds if the accounts have, for example, been prepared to the nearest thousand. Do not enter decimal points or commas.	N/A
Creditors due within one year	N/A
Creditors falling due after one year and provisions	N/A
Defined benefit pension scheme asset/(liability)	N/A
Total net assets/(liabilities)	N/A
Section: Funds	
The information you need to complete this section will generally be found on the Balance Sheet or in the notes to the accounts. All fields are mandatory - Enter 0 (zero) if the field does not apply to your charity. Fields that are indented provide additional information and are included in the figures for the field above. The indented fields may not represent the whole amount. Enter figures to the nearest pound and restate them in pounds if the accounts have, for example, been prepared to the nearest thousand. Do not enter decimal points or commas.	N/A
Endowment funds	N/A
Restricted funds	N/A
Unrestricted funds	N/A
Total funds	N/A
Section: Additional information	
The information you need to complete this section will generally be found in the notes to the accounts. All fields are mandatory - Enter 0 (zero) if the field does not apply to your charity. Enter figures to the nearest pound and restate them in pounds if the accounts have, for example, been prepared to the nearest thousand. Do not enter decimal points or commas.	N/A
Support costs	N/A
Depreciation charge for the year	N/A
Level of reserves	N/A
Average number of employees	N/A
Section: Send Trustees' Annual Report and Accounts	
You are required to submit your Trustees' Annual Report and accounts for this financial period. You will be asked if you want to attach this at the time of completing the annual return.	
Section: Submit Trustees' Annual Report, external scrutiny and accounts	
You are required to submit your Trustees' Annual Report and accounts for this financial period. You can attach files in any of the following formats: .docx and family, .xlsx and family, .ODF, .CSV, PDF and each file cannot exceed 25MB. You must attach a complete set of accounts which is comprised of the Trustees' Annual Report, accounts and appropriate independent examiners' / auditor's report. Privacy Notice This privacy notice explains how the Charity Commission processes personal data when a charity completes the annual return service including uploading the charity's accounts and trustees' annual report. The charity's accounts and trustees' annual report are published in full on the Commission's website. In completing the annual return 21 (AR21) service, your charity will be processing personal data and in some instances personal data which is special category personal data. This personal data may be processed in response to the question set in the AR21 service or it may be included in the accounts and trustees' annual report.	Files to be attached once signed by Board and Auditors
Some personal data is required to be included by SORP but other personal data may be included because it is relevant to the charity's financial performance or governance such as the names and other personal data about trustees, employees, donors, volunteers and beneficiaries. The charity as the data controller is responsible for ensuring that its response in the AR21 service and the accounts and trustees' annual report meet its obligations under the General Data Protection Regulations 2016 and the Data Protection Act 2018 for all the personal data processed. You will need to take particular care if you are including personal data about children, adults at risk, special category personal data or your charity's trustees have a dispensation from including their name in the accounts.	

By continuing to upload the accounts you certify that you have read this privacy notice and are authorised by the charity trustees to submit information. Select this option if you want to attach one file for all reports - file must not exceed 25MB Do not use special characters when naming the file. For example do not use these characters < > : " / \ | ? * @ By selecting this option you confirm that the file includes all of the following: Trustees' annual report Accounts Examiner's / auditor's report Select this option if you want to attach a separate file for each report - each file must not exceed 25MB Do not use special characters when naming the files. For example do not use these characters < > : " / \ | ? * @	
Does your independent examiners/auditors report identify any areas where accounting rules were not followed, disclosures not fully made or accounting records incomplete? Note: charitable incorporated organisations (CIOs) with income of £25,000 or less will not be asked this question.	No
Section: Check and submit your annual return	
Before you complete the declaration and submit the annual return, you should check the content and accuracy of the information you have provided.	