The Princess Alexandra Hospital NHS Trust

AGENDA

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

Date and time: Thursday, 5 August 2021
11.00 – 13.30

Venue: Microsoft Teams Meeting

	Item	Subject	Action	Lead	
01 Opening Administration					
11.00	1.1	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from previous meeting	Approve	Chairman	4
	1.4	Matters Arising and Action Log	Review	All	17
11.05		Patient story: 'David's Story'			
02 Risk/Strategy					
11.30	2.1	CEO's Report including: • COVID-19 update • CQC inspections	Inform	Chief Executive	18
11.45	2.2	Significant Risk Register	Review	Medical Director	39
11.55	2.3	Board Assurance Framework 2021-22	Review/ Approve	Head of Corporate Affairs	43
12.05	2.4	PAHT 2030 and new values – engagement and implementation plan	Discuss	Director of People/Director of Strategy	56
03 Patients					
12.25	3.1	Learning from Deaths (Mortality)	Discuss	Medical Director	87
12.35	3.2	Maternity SI report	Assure	Director of Nursing & Midwifery	103
12.45	3.3	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing & Midwifery	107
12.55	3.4	Elective Recovery	Discuss	Chief Operating Officer	115
04 People					
13.05	4.1	Freedom to Speak Up Guardian: Self- assessment tool	Approve	Director of People	122
05 Performance /Pounds					
13.10	5.1	Integrated Performance Report	Discuss	Executives	146
06 Governance					
13.20	6.1	Reports from Committees: • NHC. 26.07.21 • PAF. 29.07.21 • QSC. 30.07.21 • WFC.26.07.21 and revised Terms of Reference 2021/22 • SMT.13.07.21 and 20.07.21	Inform/ Approve	Chairs of Committees	204 205 207 214 219

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07 Corporate Trustee					
	7.1	Report from Charitable Fund Committee	Inform	Chair of Committee	220
	7.2	Policies: • Charitable Funds Policy • Investment Policy	Approve	Director of Finance	221 237
08 Questions from the Public					
	8.1	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.			
09 Closing Administration					
	9.1	Summary of Actions and Decisions	-	Chairman/All	
	9.2	New Risks and Issues Identified	Discuss	All	
	9.3	Any Other Business	Review	All	
13.30	9.4	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**
Acting Chairman	Dr. Helen Glenister	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC) and Senior Independent Director	George Wood	Director of Nursing & Midwifery and Deputy CEO	Sharon McNally
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 6 June 2021 from 10:45 – 14:15

Present:	
Steve Clarke	**Trust Chairman (TC)**
Darshana Bawa	NExT Non-Executive Director (NNED-DB)
Pam Court	Non-Executive Director (NED-PC)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Fay Gilder	Medical Director (MD)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Phil Holland	Chief Information Officer (CIO)
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)
In attendance:	
Michael Snares (Staff Story)	Staff Health & Wellbeing Administrator
Beverley Watkins (Staff Story)	Deputy Director of People
Laura Warren	Associate Director - Communications
Members of the Public	
John Wright	Member of the public
Christine Craven	CQC Rep
Jackie Westaway	Member of the public
Sultan Taylor	NELFT (Aspiring Chairman Programme)
Rishi Dhir	Trauma & Orthopaedic Consultant
Apologies:	
Dr. Amik Aneja	General Practitioner (GP-AA), Board Advisor
Heather Schultz	Head of Corporate Affairs (HoCA)
Secretariat:	
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chairman (TC) welcomed all to the virtual Board meeting, including members of the public. He updated colleagues that NExT Non-Executive Director Darrel Arjoon (NNED-DA) had taken the decision to leave the organisation but had been very positive about his placement at the Trust and the experience he gained which now placed him in a better position to explore future options.
1.1 Apologies	
1.2	Apologies were noted as above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
Staff Story	
2.1	This item was presented by the Director of People (DoP) who reminded colleagues that the focus for Staff Stories had been linked to the priorities from the recent Staff Survey action plan. She introduced Michael Snares, Health & Wellbeing Administrator/Mental Health First Aider (MHFA) and Beverley Watkins the Deputy Director of People (DDoP). The MHFA then introduced himself and took members through his presentation.

2.2	He informed colleagues that the principles of a MHFA were to have a skill set to spot triggers and signs of mental health issues, to step in, reassure and support a person in distress and to signpost staff for support. The role was not to provide clinical advice.
2.3	During the past 15 months there had been a significant change in the mental health support that the organisation's people had needed, across all staff groups and levels. Themes included stress, anxiety, depression and bereavement.
2.4	The MHFA then provided details of two case studies. The first related to an employee with financial and relationship issues and the second to a staff member who was struggling with symptoms of PTSD linked to their work in Critical Care during the pandemic. Both cases had been resolved successfully.
2.5	Throughout the previous 12 months the team had been able to develop and offer support services such as Staff Health & Wellbeing (SHaW), Employee Assistance (Vita Health), 'Here For You', Mental Health First Aiders and TRiM (trauma risk management) Practitioners.
2.6	To enable the team to continue to support staff, the SHaW team would continue to develop and implement the following: • Health and Wellbeing Steering Group. • Long COVID Support Group. • Clinical psychologist support through 'Here For You'. • Increased MHFAs across the Trust – aiming to have 5% (190) of its people trained by April 2022. • Health and Wellbeing Champions –ambassadors for health and wellbeing also trained as MHFAs. • REACT Mental Health conversation training for line managers.
2.7	The TC thanked the MHFA for his presentation and opened the item to questions. He asked the MHFA himself how he was supported when challenging cases presented. In response the MHFA confirmed that he had quarterly support meetings and when new members joined the team they were paired up with a more experienced 'buddy' for the first few months.
2.8	Associate NED Anne Wafula-Strike (ANED-AWS) commented that health and wellbeing encompassed not only physical health but also mental health. She asked whether consideration had been given to offering the same service to patients. In response the MHFA confirmed he did not know, but agreed that the two elements were equally important to aiding recovery.
2.9	The Chief Information Officer (CIO) stated he would be keen to get a view on the stigma which was still associated with mental health both in the organisation and nationally and what could be done to break down boundaries. In response the MHRA stated that in his view it was always best for people to keep talking and for there to be as many events as possible organised as a way to keep reminding people that it wasn't something that was just an issue for them alone. Making sure that new staff were aware of the support available to them was also key.
2.10	The Chief Operating Officer (COO) asked whether there were sufficient MHFAs in the organisation. In response the MHFA confirmed there were not, however 52 were currently being trained with one cohort due to start that month, and then two others mid-July and early August. That would have a significant impact.
2.11	At this point NED Helen Howe (NED-HH) highlighted the interface between patients and staff and that some staff were carers outside their day job at the hospital. The Trust currently had a Carers' Group and discussions were underway around staff being able to join that group or for additional support to be provided for them in another way.
2.12	NED George Wood (NED-GW) enquired as to what percentage of staff were referred to their GPs and what percentage could be 'self-contained' in the support provided by the team. In response the MHFA confirmed that he believed the percentage of staff referred to their GP was quite high but there was often a wait to be seen whereas with the employee assistance programme counselling was often available immediately.

	NED Helen Glenister (NED-HG) asked whether staff who had been referred to the team then returned for additional support. In response members were updated that a few cases sometimes required additional support from the team but the team was not there specifically for on-going support, more to keep staff safe in the immediate instance.
2.13	The TC thanked the MHFA for a very informative update.
1.3 Minutes of Meeting held on 01.04.21	
1.4	These were agreed as a true and accurate reflection of that meeting with one amendment: Minute 7.2: It was noted the reference to Medicine was in relation to the Healthcare Group (HCG) rather than to pharmaceuticals.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising. The action log was noted and that the risk around ICS boundary changes would be discussed at the private session later than day.
02 ANNUAL REPORT AND ACCOUNTS	
2.1 Final Accounts 2020-21 including Letter of Representation	
2.14	This item was presented by the Director of Finance (DoF) who updated colleagues that the accounts had just that morning been presented to Audit Committee. She reminded colleagues that in the previous financial year there had been an amended financial regime with a block contract and top-ups in the first six months of the year. The second half of the year also had block contracts with the tops subsumed into it. The organisation had been reimbursed for all COVID activity in the previous year and whilst the annual plan had been for a deficit of £0.4m, the year end financial position was a £1.8m surplus due to the receipt of late income. The accounts had been prepared on a going-concern basis.
2.15	She drew members' attention to the following notes: Note 1.2 – Critical Judgement: land and buildings had continued to be valued on a modern equivalent asset basis. Note 24 Provisions: management judgements had been used and professional advice received on disclosures. Note 20 – Trade and Other Payables: this contained accruals, for example annual leave. Statement of Financial Position: she drew members' attention to the £150m debt which had been replaced with public dividend capital. It was also noted the accounts in 2019/20 had been qualified on inventory balance (as the organisation had been unable to undertake stock-takes). Although thefinance team had worked hard to try to remove this qualification this had not happened. External Auditors had been supportive of that objective too but unfortunately had not been able to gain assurance on the closing balance of 19/20 and so the opening balance of 20/21 would be qualified. This issue had been raised at Audit Committee earlier that morning. EY, the Trust's external auditor, was considering the wording of its opinion and would issue this in due course.. Note 34: The external financing limit and capital resource limits had been achieved. £47.7m of capital had been spent which was a huge achievement, during the pandemic. The capital spent would support patient care. Annual Report element of accounts: The remuneration report contained a disclosure relating to the previous Medical Director. She had left the pension scheme and the Trust at the end of October 2020. Information from NHS Business Services Authority was required for completion of that note but their normal processes did not supply the requisite information (this is an issue across the NHS) so External Audit were still considering the impact of this and were taking advice from the National Audit Office. External audit were proposing to qualify their audit opinion on this issue. The conversation at AC had been that attempts should be made to obtain the missing

	information but it was unclear whether that could be achieved within the timeframe for accounts submission of 15.06.21. Changes to the accounts: these were noted as non-significant (and the finance team were commended).
2.16	In response to the above NED-GW highlighted that a physical stock check had been undertaken in September which had shown minimal variance but that had not been sufficient for external audit purposes. Colleagues should reflect on the challenging year with managing COVID but achieving a surplus and value-for-money on spending record levels of capital – a huge achievement for the organisation. The two technical issues were disappointing but outside the organisation's control and had no bearing on the accounts. He congratulated the team and was content to approve the annual report and accounts.
2.17	NExT NED Darshana Bawa (NNED-DB) requested additional detail on the increase in the audit fee. In response the DoF confirmed that the contract with external auditors had ended the previous year but unfortunately the subsequent tender process had been unsuccessful. The organisation had then had to revert to its original supplier, hence the increase in fee. In addition the Financial Reporting Council had mandated additional work for audit firms which had also increased the costs.
2.18	The TC summarised that the accounts represented a good result, albeit the pension element was disappointing as was the fact the stock-based qualification could not be removed.
2.19	In line with the recommendation the Board approved the Trust's 20/21 Annual Report and Accounts and Letter of Representation with the caveat there was some additional work to be undertaken in relation to the pension disclosure of the previous MD.
2.2 External Audit Findings	
2.20	External Audit colleagues were not in attendance so the item was presented by the DoF. She updated there had been no significant findings or adjustments to the accounts, other than those specified earlier. Some minor points had been made in relation to the controls framework relating to stock issues. The current process was very manual and the organisation recognised work was required to improve systems and a pilot stock system would now be rolled out across Theatres, EBME and IT. Their VfM assessments had also been undertaken, again with no issues. In summary it had been a robust process with no issues identified and no adjustments to the accounts or VfM. The two qualifications (inventory and remuneration report) had been discussed earlier.
2.21	The Board noted the External Auditor's report.
2.3 Annual Report 2020-21 including Annual Governance Statement	
2.22	The Trust's Annual Report 2020-21 was presented for approval by the CEO. The Trust's external auditors had reviewed the report and amendments had been made following receipt of their comments. The Board was asked to approve the Annual Governance Statement (from page 60 of the paper). The report had been approved earlier that morning at AC.
2.23	**The CEO flagged that NED-HH had raised a query at Audit Committee earlier and asked her to provide details to colleagues. In response NED-HH confirmed that the report, in her view, contained an excellent summary of HSMR but failed to describe SHMI in the same way. In response the Medical Director (MD) agreed she would be pleased to address that concern.**
ACTION **TB1.11.06.21/07**	**Revise the SHMI section of the Annual report prior to submission to NHSE/I on 15 June 2021.** **Lead: Medical Director/Head of Corporate Affairs**
2.24	NED-GW commented that the foreword in the report was excellent and thought should be given to publicising that as a standalone statement so it was not lost in the Annual Report. In response to a question he posed it was confirmed that in relation to staff lost to COVID, the People Team were supporting their relatives to ensure they understood

	and could access information in relation to death-in-service benefits. There had been a number of remembrance services for staff and the Chaplaincy and People Teams were currently reviewing how colleagues lost in service could continue to be remembered.
2.25	In line with the recommendation the Board approved the Annual Report and Annual Governance Statement ahead of submission on 15.06.21 with the caveat there would be some additional wording in the former in relation to SHMI.
03 RISK/STRATEGY	
3.1 CEO Report	
3.1	The CEO presented his report and updated colleagues on the following: COVID-19 The CEO reiterated his thanks to all colleagues at PAHT for their hard work and amazing response during the pandemic. The organisation continued to see a sustained reduction in the number of new COVID positive inpatient admissions on a weekly basis and had not experienced a significant impact from the delta variant of COVID which was having the largest impact on communities in other areas. It was however maintaining high levels of vigilance within the hospital and maintaining 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.
3.2	There had been a fantastic response in terms of activity recovery over the previous couple of months and the organisation was close to the same levels of activity as in April 2019. Activity in May had increased further and teams were working hard to recover the backlog which had built up during COVID. There had been a 12 week programme for staff recovery (Back to Better) which had been well received and in addition, he himself had had the pleasure of accepting a Harlow Council Civic Award on behalf of the hospital and its staff from Harlow Council's outgoing Chair.
3.3	At this point the Board referred back to an open action in the log in relation to lateral flow testing. The Director of Quality Improvement (DoQI) was able to update that in response to that action the organisation had reviewed its testing and statutory responsibilities and as a result had changed and reissued its communication to staff in the form of a fact sheet to encourage staff to have a better understanding of the rules and requirements for reporting. It was agreed the action could be closed.
3.4	The DoQI continued that the organisation was now in its third phase of testing and had asked staff whether they wished to access the test using its own platform or to continue using the national testing platform. Currently the uptake for phase 3 was relatively slow (due to lower prevalence of the disease) but Health and Wellbeing staff would continue to provide the correct advice and kits as and when required by staff.
3.5	In response to the above NED John Hogan (NED-JH) congratulated colleagues on the recovery work to date and the award. In terms of the latter he felt that was particularly well deserved given that the hospital's ITU had run at 700% above normal capacity during the peak of wave 1. He then asked for an update on PPE following indications in the national press that some had been found not fit for purpose. In response the CEO confirmed the organisation did receive notices to withdraw/change items. FFP3 masks had been withdrawn immediately and replaced and there was always a different range of those for people who could not tolerate certain masks. Over time three masks had proven not to be as effective as they should be. Two of those had been stopped and the third withdrawn ten days previously. To date there had not been any cases of colleagues being infected with COVID as a result of ineffective masks.
3.6	NED Pam Court (NED-PC) requested an update on visiting arrangements. In response the Director of Nursing & Midwifery (DoN&M) stated that needed to link in with guidance from ICS/East of Colleagues. There had been a cautious approach to visiting and communications had changed to be more permissive than restrictive. Currently the process was one visitor per patient by prior arrangement and no more than 25% of capacity (i.e. one visitor at a time in four bedded bays) so that was a huge change for

	staff. It was anticipated further guidance would be announced in line with the national changes due to take effect from 21.06.21.
3.7	Inspections and Visits The CEO reminded colleagues of the Section 29a notice which had been issued following the unannounced CQC visit to the ED in February that year. The organisation had now responded to the four concerns raised and was working closely with Prism to develop an action plan in response to the concerns. He was pleased to report that good progress had been made on that. A follow-up visit was now awaited.
3.8	In terms of other external visits the organisation was close to completing its diagnostic reference levels so that the IRMER concern could be closed down. Changes had been made following the HSE concerns in relation to infection control/social distancing and there had been a very positive letter from the Trauma Network review in terms of the quality of care and also good news from Environmental Health following a visit to the restaurant. A 'best guess' was provided in the paper in terms of anticipated future visits including a broader CQC well led review for the whole hospital at some point in the next few months. In addition an overdue review of Pathology services was expected in the autumn.
3.9	In terms of capital expenditure the CEO updated that a significant amount of investment had been made on the site in Q3/Q4 with a large number also about to come to fruition. He flagged that in terms of the new hospital and the work underway to get funding approved, some increasingly hard decisions would need to make on capital expenditure for the coming five/six years to ensure the site was safe and to continue to improve facilities for patients. The current year would most likely be the final year of major investment on the site. In terms of facilities for staff, the Green Zone was really developing with shower/changing facilities. There was now a secure cycle locking area and electric charging for cars. The foundations had been built under Charnley Ward for the new Training and Education Centre to enable the move from Parndon Hall and for patients, the first ward refurbishment was nearly completed (Penn Ward).
3.10	PAHT 2030 There had been a number of Board conversations already on the above. The latest version was still on track to launch in July and would be a significant part of that autumn's Event in a Tent. Despite not yet being formally launched, good progress continued to be made against each of the five areas of focus: Culture, Transforming our Care, Digital Health, Corporate Transformation and the New Hospital.
3.11	Strategic Objectives The following agenda item would request approval of the organisation's strategic objectives for the coming year in line with ongoing work on the Trust's values which would enable the launch of PAHT 2030.
	The TC thanked the CEO for a very comprehensive update.

3.2 Strategic Objectives 2021-22	
3.12	This item was presented by the CEO who reminded colleagues of the previous agreement that the organisation's strategic objectives should be based around its 5Ps, which in it turn it had agreed would remain for five years (from 2017). The strategic objectives were reviewed each year based on the current position and future direction of travel. The proposal that day was to maintain the objectives based around the 5Ps but to make changes to three of them as follows: • 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**.** • Our People – We will support **our people** to deliver high quality care within a culture that continues to improve how we attract, recruit and retain ~~engagement, recruitment and retention~~ all our people. Providing all our people with a better experience will be evidenced by improvements ~~with this reflected~~ in our staff survey results.

	• Our Pounds – we will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way.
3.13	The DoP flagged that in terms of the People objective it should say '… high quality care within a compassionate and inclusive culture …'.
3.14	NED-HG stated she had initially thought there should be a 'partners' objective to match the patient one but now that 'reducing inequality in the local population' had been built in she was content.
3.25	Associate NED John Keddie (ANED-JK) stated he found the objectives light on metrics and at some point there should be some clarity around how success would be measured. The CEO agreed and that the detail was available in the PAHT 2030 document and would be available also in the revised IPR.
3.26	NED-HH raised that the People objective should contain an element of 'caring for and supporting people to deliver services'. However it was then agreed the verbal amendment made by the DoP earlier covered that.
3.27	NED-PC stated that she fully supported the amendments and was pleased to see the addition in relation to health inequalities. She flagged that in future the organisation may need to employ some public health expertise to take that work forward.
3.28	In response to the above the MD updated she had spent time the previous day with Essex County Council colleagues who had commended the Trust for the impact they were having with the Continuity of Care Programme in Maternity – it was one of the top two performing trusts in the East of England. In addition she had been approached by the Chair of Harlow Council in terms of public health representation which she was currently discussing with the CEO.
3.29	In response the Director of Strategy (DoS) updated there had, over the last few years, been public health representation within the Strategy Team, although not currently. His view was the organisation should be working with its partners, which was where the expertise lay. In response NED-PC stated she was unsure whether that would provide all the expertise required but she was assured that it was being discussed currently with the CEO.
3.30	In response to the discussion above the CEO stated he would make the suggested changes in terms of the People objective and the confidence around health inequalities. He updated there was a sub-group of the ICP to address the latter within which the Trust had a significant role.
3.31	In line with the recommendation the Board approved the five proposed strategic objectives for the Trust for 2021/22, taking into account the discussion that day and the requirement for some additional minor revisions.
3.3 Significant Risk Register	
3.32	This item was presented by the DoN&M and included all the risks from all risk registers across the organisation, scoring 15 or above. The paper had been to the Risk Management Group and SMT that week. In relation to a previous Board action, it was anticipated the Corporate Risk Register would be ready by the end of July and there would be a Board development programme around risk, the organisation's risk appetite and risk statement on 1 July 2021.
3.33	The DoN&M then updated on some individual risks: 2.5.1 – Maternity Staffing – there had been some progress and a business case approved with the Royal College for approval of JDs for Registrar posts. 2.5.2 – Out of Hours GI Bleed Rota – as of that week policies were in place, the internal rota would go-live in August, cover was in place and there was an advisory out of hour on-call rota too which the AMDs were covering. The process had been tested across the ED with good response and understanding. 2.7.1 – The Theatre roof had now been fixed so that risk would come off the register. 3.1 – Anticoagulant management of patients who fall – that was now being managed and would also come off the register.

3.34	A new emerging risk was staffing in Paediatric ED due to maternity leave. A roundtable had been arranged to review options for mitigation.
3.35	NED-HH asked for some detail around the risk associated with the re-provision of the Pharmacy aseptic unit, the business case had been to the Performance & Finance Committee (PAF) but not approved. In response the COO updated there had been a long discussion at PAF but further clarifications were required which the team were now working to address. The case would be re-presented at PAF later that month along with the case for the Pharmacy robot.
3.36	In response to a question from NED-JH in terms of the GI Bleed rota - the current arrangement was that when a patient presented with a GI Bleed, the medical consultant on-call would speak to the consultant on-call for the GI Bleed Advice and Guidance rota to discuss the further management of the case. If between them, it was decided that the patient required transfer to another organisation, the consultant on call for the advice and guidance rota would contact the gastroenterology consultant at Mid and South Essex hospitals to make the referral. This was a temporary solution until August when PAH would have its own internal out of hours GI bleed service.
3.37	In response to a question from NED-GW in relation to the risk around baby cots the COO was able to update that the team had purchased new cots for NICU but through a testing process it had come to light they did not meet the requirements of staff (in terms of size). They were therefore being replaced.
3.4 Board Assurance Framework 2021-22	
3.38	This item was presented by the DoN&M. She informed colleagues that the strategic objectives for 2021-22 would be added once approved. The changes that month were that it was proposed to reduce the risk score for risk 1.0 COVID and to add two revised finance risks (Risks 5.1 and 5.2). For BAF risk 1.0 COVID the risk score was to reduce from 16 to 12 and the target risk score had been reduced from 12 to 9. BAF risks 5.1 Revenue and 5.2 Capital had been added to reflect the financial risks for 2021-22.
3.39	The DoN&M also added there had been some discussion around working up a risk to reflect proposed ICS boundary changes. Those discussions were ongoing and the Board would discuss that further in the private session later than day.
3.40	The Board approved the changes to the risk score for risk 1.0 and the addition of risks 5.1 and 5.2.
04 PATIENTS	
4.1 Learning from Deaths Update	
4.1	This item was presented by the MD. For the benefit of external attendees she reminded colleagues that the organisation had higher than expected HSMR. A huge amount of work had been undertaken over the previous two years and the Trust was now fully compliant with the Learning from Deaths process and Medical Examiners were scrutinising all deaths. Structured judgement reviews were undertaken and outcomes escalated where necessary.
4.2	Over the previous four months there had been some issues with the hospital's data submission however that had now been resolved and in May, the organisation had been able to make its annual data submission. It was anticipated therefore that judgements around HSMR/SHMI could most likely be made by August. In the meantime the SRJs and learning would continue.
4.3	She was pleased to update that some new software was about to go live which would provide a smarter way to look at mortality and the outcomes of the SJRs. It would also provide an improved database for the organisation.
4.4	She highlighted that the paper evidenced the hospital was an outlier in terms of COPD, aspiration pneumonia and end of life and improvement programmes would continue in those areas.
4.5	The MD continued that the team had an interest in an audit related to the cause of death for patients who had been vaccinated against COVID. A summary of 60 deaths was

	provided at appendix 2 and evidenced there were no common themes for those deaths but opportunities for the organisation to undertake further work around that.
4.6	As a final point the MD updated that as of 2022 Medical Examiners would become a statutory requirement and would scrutinise all deaths including community deaths. Numbers of MEs in the Trust would therefore be increased and support staff also appointed.
4.7	In response to a question from ANED-JK the MD stated that she could not currently provide an absolute position in terms of HSMR. SHMI however was as expected. The team would retain a focus on its mortality outliers. She could not say whether the organisation was currently under or over reporting deaths.
4.2 Maternity SI Report	
4.8	This update was presented by the DoN&M and she reminded colleagues this was a requirement following the Ockenden Report and was also discussed at QSC.
4.9	She updated there had been 11 overarching maternity SIs since April 2020 and six of those remained open. Some of the SIs open since the end of the previous year related to the cluster of ten from October/November 2020. The paper demonstrated there had been good oversight and improvements following external review and the list of improvements and learning that the HCG had taken forward were listed in the paper.
4.10	She drew members' attention to the risk on the SRR in relation to obstetric staffing and was able to provide assurance that a new consultant would start in May. She also flagged that the reintroduction of glucose tolerance tests for gestational diabetes had been planned for 31.05.2021 but had been delayed by two weeks.
4.11	The DoN&M then updated that a new SI would be reflected in the next report and related to a scalp laceration incurred during an emergency Caesarean section.
4.12	In terms of staffing changes in FAWS she was pleased to update that a new Director of Midwifery would join later that month, the current AMD had been appointed to a Deputy MD post and a substantive clinician in the HCG had been appointed to the post of AMD.
4.3 Hard Truths	
4.13	This item was also presented by the DoN&M who informed colleagues the position reported was favourable, compared to that reported during winter/COVID. She highlighted that the report was predicated on funded establishments but an establishment review had not been undertaken that year due to COVID. In its place there had been a data capture exercise during May, the results of which would come to September Board Committees and October Board. She drew members' attention to the fact that ED staffing had improved over the month and would continue to be monitored.
4.14	She then drew the Board's attention to final section which evidenced the workforce trajectories suggesting vacancy rates would be around 3% by the end of the year. There were currently 38 new starters in the pipeline. She cautioned however the establishment review would need to inform the correct baseline and did not take account of any increased activity/capacity over the year.
4.15	The DoN&M also updated that data around healthcare support workers would start to be added to the paper. She was able to update there were 44 new starters over the coming three months, the current vacancy rate was circa 15% and turnover around 14%. It was expected those rates would start to significantly reduce ahead of winter.
4.16	The TC thanked the DoN&M for her update and commended the team on the work over the prior two years to significantly reduce nurse vacancy rates.
Break 1245-1320	
05 PERFORMANCE/POUNDS	
5.1 Integrated Performance Report M1	

5.1	This item was presented by the CIO who updated colleagues that the IPR would now be presented in a different way going forward. He would provide a summary of KPIs by 5P section and the Executive Lead would then add any additional commentary.
5.2	<u>Patients</u> • Hand hygiene - sustained good performance but work was being undertaken around the audit tool. • Falls - an encouraging downward trend was noted since a high point in December. • Compliments - a downward trend so there would now be a focus on timely data entry. • Complaints - evidence of an upward trend but were still below target. That was possibly due to a seasonal effect but would remain a focus. • All other KPIs were at or near target.
5.3	In response to the above the DoN&M commented that the organisation reported good compliance with hand hygiene but from a self-audit. A significant amount of work was now underway to refresh the strategy and to run a quality improvement event to improve compliance. Complaints had been discussed at QSC and the organisation's quality strategy was now in draft.
5.4	<u>People</u> • Staff appraisal remained in special cause variation with some short-term improvement but outside where performance needed to be. The same was evident for statutory/mandatory training. • Temporary staffing spend was still below target but the trend was showing a gradual increase.
5.5	In terms of training the DoP updated that a review was underway around data quality and access to training modules.
5.6	<u>Places</u> • Food waste continued to reduce with further reductions expected. This was positive for the organisation's carbon neutral and environment sustainability positions.
5.7	<u>The DoS had nothing to add.</u>
5.8	<u>Performance</u> • Referral to treatment (RTT) performance had deteriorated but there were some strong recovery actions in place with an active response to delays. • Cancer 2 week wait performance was back at national target which was good news. • Cancer 62 day pathway performance was below target with plans in place to achieve improvements. • 4 hour ED standard performance was out of special cause variation but some indicators were still flagging with performance below the expected 95%. The service was currently being supported by external consultants Prism. • Diagnostic performance was in special cause variation with COVID having had a significant impact. However the last three months was showing some improvement and a continuation of that trajectory was expected. • 52 week waits continued to increase but the incline of that increase was starting to flatten. • Bed occupancy had seen a slowing increase in the past six months (reflected in patient volumes). That did not correlate with numbers of stranded/super stranded patients which was in a good position so most likely aligned to increased activity and acuity.
5.9	In response to the above the COO updated that the organisation was performing in the upper quartile of organisations in terms of stranded/super stranded patients over 7 days and around 21 days and numbers continued to reduce. There was a work-stream in place across the system to look at improving discharge ahead of winter. Internally the

	organisation would concentrate on 'red to green' and how to use NerveCentre to capture and facilitate swift discharge.
5.10	In terms of ED performance the COO continued that this remained a key focus but good progress was being made in relation to the improvement programme in place. There was a clear sense of ownership and accountability within the team which was pleasing. The Executive team that week had signed off Q2 insourcing/outsourcing plan to support recovery and the end of June should have no priority 2 patients waiting past their due dates.
5.11	Over 52 week wait patients were starting to reduce and over 78 weeks would clear with the exception of Orthopaedics and ENT. The speciality receiving additional support was Urology and the organisation was looking for support going forward with that from the ICS.
5.12	In response to a comment made by NED-GW, the COO updated there were ongoing national emergency pressures. Conversion rates for the Trust were not increasing significantly and the pathway through assessment and SDEC (same day emergency care) were supporting that. In terms of elective recovery that was being monitored weekly with operational and clinical colleagues to ensure sufficient capacity to support the programme.
5.13	NED-JH asked for some additional detail around the hospital's ED performance and its continued challenges. In response the COO updated that during COVID when attendances reduced, performance improved. The last two months had seen particularly high attendances but there was now a renewed focus on redirection, streaming and rapid assessment and there were early signs of improvement from that. The new assessment unit was now functioning and the SDEC was also taking some of the activity away. The Frailty Assessment Unit was about to be handed over which would alleviate the numbers coming into the ED. The medical staffing position was also starting to improve.
5.14	In response to a query from NED-HH around the data for diagnostics the COO was able to update that although the organisation was not currently performing at the national standard, the SPC chart was showing an upward trend. The diagnostic recovery programme was on track and all those waiting over six weeks were being clinically reviewed and prioritised.
5.15	Pounds • Month 1 had achieved a break-even position in line with the plan. • Capital programme of £49.2m to be delivered in 2021-22 which was significant.
5.16	The DoF had nothing additional to add.
06 GOVERNANCE	
6.1 Reports from Committees	
6.1	Audit Committee – 25.05.21. The report was noted and NED-GW had nothing additional to add.
6.2	New Hospital Committee – 26.05.21. The report was noted and members approved the Committee's revised terms of reference for 2021/22.
6.3	Performance & Finance Committee – 27.05.21. NED-PC flagged that the Committee's Effectiveness Review had been thorough and actions implemented at pace. Members approved the Committee's revised terms of reference for 2021/22.
6.4	Quality & Safety Committee – 28.05.21. NED-HG flagged that the Committee had felt it needed to be more forward facing. That was therefore reflected in the revised terms of reference for the current year, which the Board approved.
6.5	Workforce Committee – 01.06.21 NED-HH updated that the Health and Wellbeing Strategy was intended to be delivered by the end of the summer and listening events were being used to inform that. The

	medical staffing model presented had not included all doctors (just those in Medicine) so would be followed up.
6.6	Senior Management Team The CEO highlighted that key areas from SMT discussion had been followed up at Board Committees.
07 QUESTIONS FROM THE PUBLIC	
7.1	The TC informed those present that some questions had been submitted in advance of the meeting by member of the public John Wright. Those were as follows:
7.2	1) Is there an overarching national plan to tackle the unprecedented backlog of patients waiting elective surgery? 2) Are the Government providing any increase in funding to enable the NHS to expedite increased elective surgery? 3) Does the PAH have a plan in place to ramp up elective surgery to tackle our local backlog, if so will this plan be communicated to the many patients currently on a waiting list for a surgical intervention? 4) Will PAH be able to access any of the £160m funding provided? 5) What is the criteria for Elective Accelerator sites and will PAH qualify?
7.3	In response to Q1 the COO updated that there was an overarching plan for the recovery of elective services to clear the backlog of cases. The hospital also had its own internal plan across all specialties which had been shard with Commissioners and was being monitored across the ICS.
7.4	In terms of communications to patients the COO updated that she would be meeting with the Chair of the Patient Panel the following week as they had offered support in relation to the communications to patients and in particular a letter that would be sent out to all patients providing an estimated timeframe for recovery for their particular circumstances. The Trust was working with the independent sector to support additional elective capacity to try to reduce the backlog as quickly as possible.
7.5	It was noted that the organisation could access funding to support the work with the independent sector
7.6	The COO continued that many outpatient appointments during COVID had become virtual (via Attend Anywhere) and that would continue moving forward. Some face-to-face activity had also resumed on all three sites, maintaining social distancing and adhering to infection control guidelines.
7.7	In terms of accelerator sites this had been to try and reduce backlogs. The Trust had submitted an application but had been unsuccessful but that would not stop its drive to deliver recovery targets as soon as possible.
7.8	Member of the public John Wright thanked the COO for providing answers to his questions and in particular he was glad to hear of the intention to send a letter informing patients as to an estimated timescale for their own individual procedures. He then added that he himself had been on the waiting list for a hip replacement and was pleased to report that had recently been outsourced to Hatfield and his surgery should now take place within the next four to seven weeks.
7.9	Member of the public Sultan Taylor thanked the Board for a very informative session and for the opportunity to observe proceedings that day.
08 CLOSING ADMINISTRATION	
8.1 Summary of Actions and Decisions	
8.1	These are presented in the shaded boxes above.
8.2 New Issues/Risks	
8.2	No new risks or issues were identified.
8.3 Any Other Business (AOB)	
8.3	ANED-JK updated members he had received a letter that week from Robert Jenrick MP confirming that Harlow had been successful in its bid for the Towns' Fund (for

	regeneration of the town centre) and had received an award of £23.7m. The town had also been invited to bid against another fund (and had done so in the sum of £25m) for investment in the town by the following Friday – all great news for the town.
8.4	The DoN&M requested delegated authority for QSC to approve the final quality account for submission on 30.06.21. Most of the priorities had been set in the previous year were ongoing or had been achieved and priorities for the current year would mainly be 'rollovers'. She would ensure those met the revised strategic objectives. The Board was content to approve the request for delegated authority.
8.5	ANED-AWS highlighted to members that the following Thursday a webinar would be aired encouraging people from ethnic backgrounds to be receptive to the COVID vaccination. She had been invited by NHSE/I to provide a presentation as part of that webinar.
8.6	As a final point the CEO acknowledged it would be the TC's final public meeting and he thanked him on behalf of the Board for his work for the organisation over the previous two and half years and wished him well for the future.
8.4 Reflection on Meeting	
8.7	NED-HG commented that she had welcomed the revised presentation of the IPR that day.

Signed as a correct record of the meeting:	
Date:	05.08.21.
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log 05.08.21

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.11.06.21/07	Annual Report	Revise the SHMI section of the Annual Report prior to submission to NHSE/I on 15 June 2021.	MD/HoCA	05.08.21.	Actioned	Closed

The Princess Alexandra Hospital NHS NHS Trust

2.1

Trust Board – 5 August 2021

Agenda Item:	2.1
Presented by:	Lance McCarthy – CEO
Prepared by:	Lance McCarthy – CEO
Date prepared:	27 July 2021
Subject / Title:	CEO Update

Purpose:	Approval		Decision		Information		Assurance	

Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting: - COVID-19 response - CQC full inspection - ICS Boundary - New Chair - New hospital - PAHT 2030 / new values launches - Awards / recognition - 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 5 consultant appointments, made through delegated authority to the AAC panels.

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

Previously considered by:	n/a
Risk / links with the BAF:	CEO report links with all the BAF risks
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	1. Medicine Post Inspection Feedback Letter 2. PAH Response to Medicine Inspection Feedback 3. Maternity Post Inspection Feedback Letter 4. PAH Response to Maternity Inspection Feedback

2.1

Chief Executive's Report
Trust Board: Part I – 5 August 2021

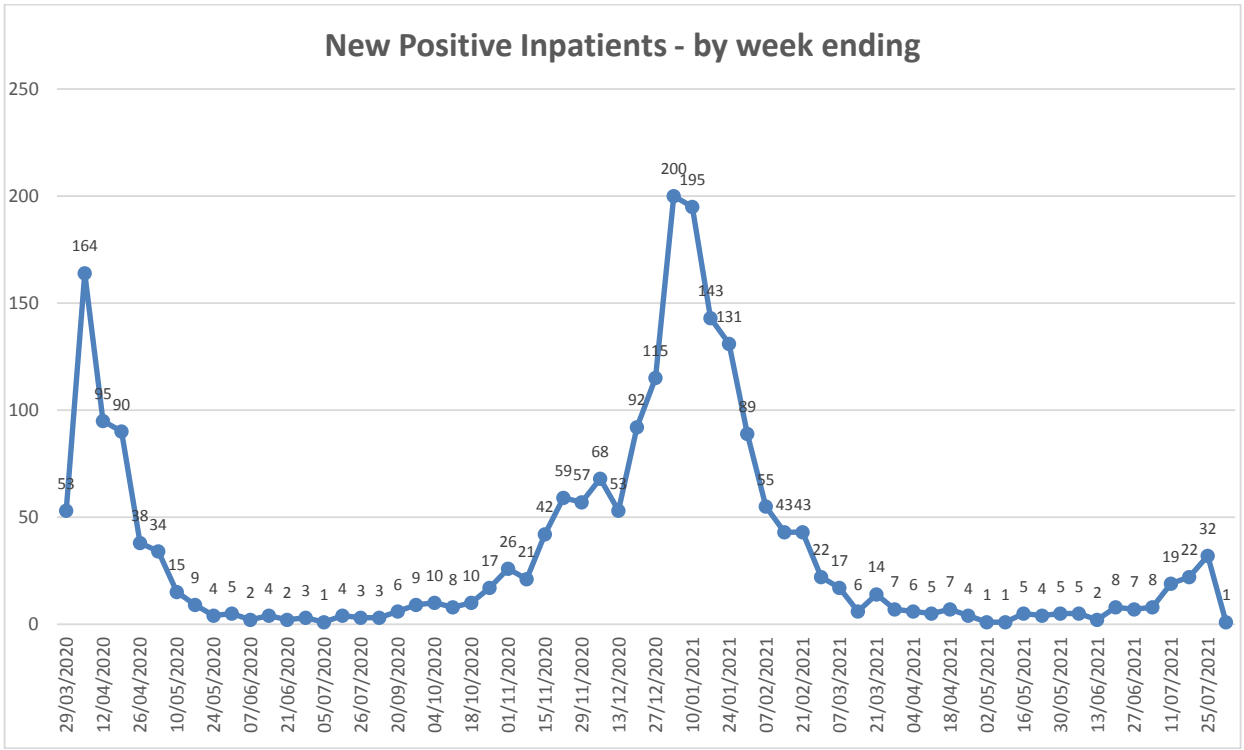
This report provides an update since the last Board meeting on the key issues facing the Trust.

(1) COVID-19 response

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

As you can see in the graph below, we have started to see a significant increase in the number of new COVID-19 positive inpatient admissions over the last 3 weeks. At the time of writing this report we have 34 COVID-19 positive patients in the organisation, 3 of whom are on Optiflow and 5 on critical care.

The increase is new positive inpatients is aligned with the increase in new infections in the local communities. As many of our colleagues live locally, the increase in the number of new transmissions has seen our sickness absence rates increase and our rates of absence as a result of both track and trace and being 'pinged' by the COVID app. Combined with annual leave being taken by colleagues at the start of the school holidays, this is causing some staffing pressures in some parts of the organisation and in some specialties.



Despite the easing of national lockdown measures, we have not changed any of our policies or ways of working within the hospital settings; maintaining high levels of vigilance within the hospital 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.

All of our teams have been fantastic with the speed with which they have started to recover our non-covid services, significantly affected over the last year.

The speed of our recovery relative to others has been recognised by regional and national NHSEI colleagues and as a result a number of our clinical colleagues have appeared on BBC, ITV and Channel 4 news programmes during July, supported by Steph Lawton, COO, describing our recovery programme for our patients.

The recovery of non-COVID services, together with the uptick in COVID-19 positive patients in recent weeks, on the back of the demands on all of my colleagues over the last 18 months, continues to put a huge amount of physical and mental stress on many colleagues. Our 12-week 'Back to Better' health and wellbeing support programme was well received and there are a number of actions and learning that have come out of this to continue to support colleagues in to the future.

(2) CQC full inspection

On 7 July CQC colleagues notified me that they were undertaking a full inspection of PAHT, with the well-led interviews to commence 5½ weeks later on 16 August. These interviews will be run via a combination of virtual and face to face sessions.

The new inspection process from the CQC means that all relevant core service reviews that they complete as part of the inspection, are undertaken and completed in advance of the well-led interviews.

At the time of writing the report, CQC colleagues undertook a core service review of our medicine services on 6 and 7 July, notifying us 30 minutes before their arrival on 6 July; and a core service review of our maternity services on 14 July. We are awaiting other core service reviews in advance of 16 August.

Initial written feedback from the medicine review was received on 9 July, with 53 information requests received on 12 July and responded to in full on 15 July, within the 72-hour timeframe requested. The initial written feedback is included as an Appendix to this paper, as is my response to this of 15 July. The main concern of CQC colleagues was in relation to the completion and management of the care prevention falls bundle and the ongoing management of patients at risk of falls on Harold ward. To assure ourselves of the safety of these patients we undertook an MDT review of all patients on the ward on 8 and 9 July in relation to the management of falls. The review concluded that all patients were assessed as safe and that no direct harm incidents were identified, although the MDT had concerns with regard to 3 patients out of the 32, but not serious enough for a safety alert. In response, the following two key actions were put in to place immediately:

- A refreshed safety huddle sheet used from that evening to provide an 'at a glance' list of patients who are at high risk of falls, those whose Waterlow scores are triggering high and very high pressure ulcer risk and those that require enhanced care in addition to other key safety metrics
- An additional HCA booked for both day and night shifts for Harold ward to provide the ward with headroom over and above the staffing levels indicated by SNCT and establishment review while the Enhanced Care programme is being embedded

Following the maternity review, 52 information requests were received on 16 July and responded to in full on 21 July, within the 72-hour timeframe requested. Initial written feedback from the maternity review was received on 19 July and is also included as an Appendix to this paper, as is my response to this on 21 July.

We are awaiting the individual core service draft reports from CQC colleagues for both of the above reviews and we will undertake the factual accuracy check and review on their receipt.
Given the timing of the well-led interviews, planned to be over the course of a week in mid-August, clashing with the main holiday period for colleagues, we have agreed with CQC colleagues for the well-led interviews to be undertaken over an extended time period. There will be a presentation on 11 August with interviews on 16, 17 and 24 August and 7 September. These will be a combination of virtual and face to face interviews.

(3) ICS Boundary

Early in 2021, DHSC asked NHS England and Improvement to set out options for potential boundary alignment between NHS Integrated Care System (ICS) boundaries and upper-tier local authority boundaries across the country (for us; Hertfordshire CC and Essex CC boundaries).

The expectation was for coterminosity, and for PAHT to be part of an Essex-wide ICS, moving from the current Hertfordshire and West Essex (HWE) ICS.

Following a review of the options by the Secretary of State and Minister of State for Health and discussions with other MP colleagues, a statement was made by Edward Argar MP on 22 July that the East of England would be an exception to the presumption of coterminosity and therefore no changes to ICS boundaries in the region would be made.

PAHT and West Essex CCG and the local Integrated Care Partnership, will therefore remain part of Hertfordshire and West Essex ICS and we will work closely with all colleagues in partnership organisations to support the transition of the ICS to a statutory body from April 2022. We will of course continue to work very closely with Essex CC colleagues to support our West Essex residents and ensure that we can maximise efficiency and effectiveness of health and care and support services across health and social care, and continue to work hard to reduce health inequalities locally.

Within HWE ICS there will be some changes to the Accountable Officers of two of our partner organisations. Nick Carver, Chief Executive of East and North Hertfordshire NHS Trust and Tom Cahill, Chief Executive of Hertfordshire Partnership NHS Foundation Trust both recently announced their retirement after many years in their roles. Adam Sewell-Jones has been appointed as the new Chief Executive at E&NHT and the CEO role at HPFT is being recruited to in August.

(4) New Chair

I'm delighted to formally let the Board know of the appointment of Hattie Llewelyn-Davies OBE as the new Chair of the Trust.

Hattie was appointed by NHSEI following an interview process on 13 and 14 July, and will start with the Trust on 13 September.

Hattie has extensive experience as chair of NHS organisations, having chaired Hertfordshire Partnership Foundation Trust (HPFT) for many years before spending the last seven years as chair at Buckinghamshire Health NHS Trust, where she will continue to remain the Chair until March 2022 when she is due to step down as her term of office completes.

Before joining the NHS, Hattie had a number of chief executive and senior management roles in the housing and homelessness sector; and was awarded an OBE for services to homeless people in 2004. Hattie was also recognised by the Sunday Times as Non-Executive for the Public and Not for Profit Sector in 2019 and is a Trustee on the board of NHS Providers.

I'd like to thank Helen Glenister, as the vice-Chair, for stepping into the interim Chair role on 2 July until Hattie starts with us.

(5) 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) and our Outline Business Case is continuing to develop well.

Subject to timings for the receipt of central design guidance and a decision on the most effective design platform on which to develop our plans, we are looking to complete our OBC in the winter. Our engagement programme is strong and continues well.

(6) PAHT 2030 / New organisational values launches and roll out

Following the discussion at 11 June Trust Board, we are in the process of developing 3 versions of our 10-year strategy, PAHT 2030 – a short summary version, a mid-sized version with detail for transformation projects for the first 2 years and a long full version.

The short summary version has been completed and approved, and soft launch of this will start on 2 August with a range of open, departmental specific and profession specific engagement sessions through August to further develop the transformation projects based on what our people are keen to see. These engagement sessions will enable us to develop the mid-sized version which will be formally launched at Event in a Tent on 14 September. PAHT 2030 will be the golden thread to run through the 3 days of Event in a Tent.

Despite not yet formally launched, we continue to make good progress against each of our 5 areas of focus:

- Our Culture
- Transforming our Care
- Digital Health
- Corporate Transformation
- Our New Hospital

One of the key elements of the 'Our Culture' priority is the refresh of our organisational values. The new values will be soft launched from 2 August also with a range of engagement sessions for colleagues to start to talk about the new values, what they mean to them and their teams, what poor behaviours may be and what and how they change behaviours to align with the values. The values and associated behaviours are fundamental to supporting the delivery and implementation of PAHT 2030 and will be formally launched also on 14 September at Event in a Tent.

(7) Awards / recognition

Since the last Board meeting a number of our amazing people and teams have received awards or recognition for the fantastic work that they undertake. These include:

- Mr Ashraf Patel, breast surgeon, has been awarded an MBE for services to funding and research for breast cancer
- Our Patient Panel were presented with their Queen's Award for Voluntary Service by HM The Queen's representative, the Lord Lieutenant of Essex, Jennifer Tolhurst, in a lovely ceremony on 20 July
- Our gastroenterology and pharmacy teams have been shortlisted for an HSJ Patient Safety Award for improving safety in medicines management in patients with IBD. The teams are being judged on 28 July.
- Donna Morris, one of our amazing biomedical scientists, was the winner of a national NHS Employers award for Outstanding Achievement by an AHP or Healthcare Science Apprentice, Support Worker of Technician.
- Our Communications team were shortlisted for two separate national awards for the innovative approach to online events and staff engagement with Events not in a Tent 2020.
- Our trauma and orthopaedic department was awarded 2nd place in the East of England T&O Training Programme's Trainee Led Training Hospital of the Year Awards for the 3rd year running
- Our Director of Midwifery, Guiseppe Labriola has just been re-elected as the Chair of the Royal College of Midwives.

(8) Consultant appointments

Following AAC panels in recent weeks, offers of appointment as a consultant at PAHT have been made to the following people:

- AAC on 17 June – Mr Rishi Dhir; consultant orthopaedic surgeon
- AAC on 15 July – Dr James Diss, consultant radiologist
- AAC on 21 July – Dr Kate Sherring, consultant histopathologist
- AAC on 21 July – Dr Roumina Hasan, consultant histopathologist
- AAC on 21 July – Dr Veronica Moyo, consultant histopathologist

The Board is asked to ratify the offer of these appointments, made through delegated authority to the AAC panels.

Author: **Lance McCarthy, Chief Executive**
Date: **27 July 2021**

By Email

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

For the attention of The Chief Executive
Lance McCarthy
The Princess Alexandra Hospital
Hamstel Road
Harlow
Essex
CM20 1QX

Date: 9 July 2021

CQC Reference Number: INS2-10959393211

Dear Lance

Re: The Princess Alexandra Hospital

Following your feedback meeting with Quentin Colley- Bontoft CQC inspector and Danny Mann CQC inspector on 7 July 2021. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues Sharon McNally, director of nursing and midwifery at the feedback meeting.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 7 July 2021 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

- We identified concerns in relation to the completion and management of the care prevention falls bundle and the ongoing management of patients at risk of falls within the service. Staff had not effectively recorded the risks around falls and these were not completed, or the risks had been wrongly categorized. This means that there is a risk that patients were being exposed to avoidable harm.

- We identified that five out of the six medicine wards we visited were below the planned staff establishment for nursing and health care assistants and that staff skills mix on wards was not appropriate for the patient group.

- On 6 July 2021, we shared our concerns in relation to the management of patients requiring one-to-one supervision due to the lack of suitably skilled and trained to supervise complex patients. We escalated our concerns to staff in relation to one specific patient during our inspection. On the 7 July 2021, we visited the ward and found that the patient was not being supervised by appropriately skilled and trained staff to provide one-to-one supervision, no updates had been made to the patients care prevention falls bundle and their medication had not been formally reviewed.

However, we also found:

- Staff were following the trust's infection, prevention and control policy and managing patients at risk of infection in appropriate side rooms.

- Throughout our inspection we observed staff having mutually respectful and positive interactions with patients and colleagues.

We are concerned that there appears to be a lack of progress in improving falls management processes to protect patients from avoidable harm. As you may be aware, since the inspection we have had a management review meeting in relation to these concerns and Antoinette has spoken with Sharon McNally today and outlined the seriousness of our concerns. Sharon has shared some of the actions the trust is already taking in relation to falls and one to one supervised care. We will be requesting this information and further assurances of how the trust is keeping patients safe in terms of harm-free care. This is in addition to the information that has already been requested about the patients on Harold Ward.

We will also be requesting information relating to other incidents that have occurred to review in line with our specific incident guidance.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to colleagues at NHS Improvement

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number to hand INS2-10959393211. It may cause delay if you are not able to give it to us.

Yours sincerely

Sarah Dunnett

pp Philippa Styles

Head of Hospitals Inspection

c.c. Steve Clarke Chair of Trust
Catherine Morgan NHSEI
Ann Radmore NHSEI
CQC regional communications manager

2.1

The Princess Alexandra Hospital
Hamstel Road
Harlow
Essex
CM20 1QX

Philippa Styles
Head of Hospital Inspections
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Via email

15 July 2021

CQC Reference Number: INS2-10959393211-

Dear Philippa

I am writing in response to your feedback letter dated 9 July 2021 following your visit on 6 and 7 July 2021 of our medicine core services at The Princess Alexandra Hospital.

Thank you for the valuable feedback which we have already started to address.

I have shared your letter with and meet with both Executive Director colleagues and our Senior Leadership Teams in medicine and across the Trust to discuss the content, the informal feedback received from Quentin and colleagues and agree how to address the concerns raised. I have also shared your letter with and discussed it with our non-executive directors, together with our actions, and I will ensure that it is discussed in our next public Trust Board meeting.

Thank you also for the data requests covering each of the domains, which we received on 12 July. We have responded to all 53 information requests and we have uploaded them to the CQC portal this afternoon. Please let me know if you or your team have any queries related to their content.

In addition to the specific information requested, I would also like to share some additional information to provide further context and assurance in relation to:

- our approach to falls management
- our recent patient safety work, underpinning our safety culture
- our management of safe staffing within the Trust

Falls management

- Our falls strategy and action plan have been shared with you as part of the information requests. We have developed, reviewed, tested and approved our current process and the strategy in partnership with our local commissioner colleagues at West Essex CCG.

- You will be aware than immediately following, and in response to the falls risk assessment concerns raised by CQC colleagues to myself and Sharon McNally, Director of Nursing, on the afternoon of 7 July, we undertook a comprehensive MDT review of all patients on Harold ward on the afternoon of 8 July and morning of 9 July. This included reviewing all the clinical documentation, specifically the falls risk assessments and the associated care plans that were in place and being delivered. The MDT, whilst they had some concerns with the documentation of 3 of the 32 patients reviewed, did not have concerns that were serious enough to raise a safety alert. The MDT were assured that all patients in Harold ward were safe and that no direct harm incidents were identified.

  Further to the immediate review, and keen to learn from any concerns raised with us, as a result of the inspection and our review, from Friday 9 July, we implemented:
  - A refreshed safety huddle sheet on Harold ward from that evening to provide an 'at a glance' list of patients who are at high risk of falls, those whose Waterlow scores were triggering high and very high pressure ulcer risk and those that require enhanced care in addition to other key safety metrics
  - An additional HCSW was booked for both day and night shifts for Harold ward to provide the ward with headroom over and above the staffing levels indicated by SNCT and establishment review while the Enhanced Care programme is being embedded

  CQC colleagues did not raise with me any concerns with our management of falls on any of the other medicine wards that they visited so we didn't feel the need to undertake a comprehensive review of patients on these wards. We found the MDT review on Harold ward very useful however and are planning to undertake similar reviews across other IP wards here.

- We have a good, open and honest relationship with our colleagues in the quality team at NHS England and Improvement (East of England). Following your recent inspection, we discussed all of your colleagues' concerns with them. They have undertaken a comparative data analysis for us with regard to the number of slips, trips and falls that met the SI criteria over each of the last 7 years, comparing PAHT to other healthcare organisations in our ICS (Herts and West Essex) and also how HWE compares with other ICSs across the East of England Please find this attached Appendix 1. For PAHT, the data shows our known problem and concerns in 2019 and the spike that we had in the number of falls during the 2nd COVID-19 wave in 2020 (slide 3). The data also shows the reduction in 2021 to date, as a result of our increased focus on risk assessments, and shows that our relative numbers of serious fallers are aligned with or better than other organisations within the ICS (slide 3) and how HWE ICS compares favourably to most other ICSs

across the Region (slide 4). Whilst recognising that we need to continue to improve our management of falls within the Trust and that we need to continue to implement and embed our falls strategy and processes, the regional data provides me with further assurance that our focus and approach to falls management is working and provides me with further assurance of the safe management of our patients.

- As you will be aware, falls is one of our top patient safety priorities in our Patient Safety and Quality Strategy, 2020-2030, which will be formally launched in conjunction with our new Trustwide strategy (PAHT 2030) in our 'Event in a Tent' celebration in mid-September. (The management of the pandemic has unfortunately delayed the launch of our Trustwide and important supporting and underpinning strategies). For information, 'Event in a Tent' is our annual event of celebration, recognition, leadership and engagement for all of our colleagues in the Trust, where colleagues receive protected time to attend and partake in events over the period. This will be our 5th annual event and will help to further embed our safety culture and focus on the management of falls.

- Our patient safety week (w/b 20 September) follows directly on from 'Event in a Tent' and has a number of keynote speakers now confirmed. Falls improvement will be a topic for the week, aligned with our Patient Safety and Quality Strategy priorities and will enable us to build on the discussions from the previous week.

Safety Culture and enhancement of the governance structure

As part of our ongoing commitment to continuing to progress the safety and care provided to our patients we continue to develop and enhance our governance structure, particularly with regard to supporting the safety culture and processes and oversight within the Trust:

- In late 2019 we strengthened our senior leadership in this area with the appointment of a Director of Clinical Quality & Governance. This role is also the Trust nominated Patient Safety Specialist.

- In early 2021 we created a new Deputy Medical Director role for Quality and recently appointed to this role.

- In line with our Divisional restructure, which we were planning to launch in autumn 2020, but were delayed as a result of preparations for the 2nd wave of COVID-19, we have created patient safety and quality lead roles in each Division to support and complement the existing local Divisional teams and the corporate quality and safety team. These appointments will be made in the summer and further enhance the Trustwide focus on quality and safety.

- Appendix 2 shows our Quality Governance meeting structure and how information and assurance flows up and down the organisation and the seniority of the chairs of the sub Board committee meetings.

A strong safety culture is well recognised as being key to high quality service provision and the safety of patients. This need to enhance and improve this was evident when

we went into quality special measures 5 years ago. Every year since we have enhanced and developed our approach to quality and safety and enhanced and developed our learning approach and now our formal drive in conjunction Anglia Ruskin University colleagues to become a formal learning organisation. Furthermore:

- Our Patient Safety and Quality Strategy reflects the national patient safety strategy.

- We a have a strong report culture and our National Reporting and Learning System (NRLS) data confirms this (please see information in Appendix 3)

- We support an open and transparent reporting culture to ensure staff feel psychologically supported when things go wrong, which is reflected in our staff satisfaction results with score of 6.8 (national average 6.5).

- Our named patient safety specialist will be holding a Board session in September as part of our commitment to achieving compliance against the national patient safety priorities.

Safe staffing

With regards to our assurance for safe staffing, we have daily safe staffing reviews and adjust ward teams according to the acuity of patients. This is also discussed at the safety huddles in each care setting. In addition, we are in the process, as your colleagues are aware and as we discussed with them last week, of rolling our our enhanced care programme across the Trust to further support all colleagues in all clinical areas and ensure where possible that our staffing levels match the acuity of our patients locally.

Other regional data

In addition to the falls information in Appendix 1, our Regional colleagues have also provided some comparative data on the number of serious pressure ulcers in organisation in the ICS and ICS comparators, and also on the number of Never Events by organisation across the ICS.

- You can see on slides 3 and 5 that we compare favourably to both other acute providers in our ICS and that our ICS compares favourably to others in the region in terms of the number of serious hospital acquitted pressure ulcers.

- Slide 1 shows PAHT's relative good performance in terms of Never Events compared with other acute providers across the ICS and our relative performance in responded effectively to our outstanding SIs over recent months.

Whilst recognising that we can always enhance the safety of our patients and the quality of the care we provide and that CQC colleagues found some areas of concern that they escalated to me, these slides and information provide me with further assurance that we have a strong approach to and culture of safety across the Trust

and assurance that we aren't outliers compared with other acute providers in terms of incidents, pressure ulcers or falls.

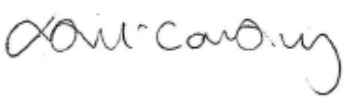
Since your inspection, our teams have met a number of times with Christine Craven to provide further assurances around our process. We are working with improvement partners from the national NHSEI improvement team and with colleagues from MSE Partnership to further enhance our Project management office function to continue to drive our quality improvement plan. We have also recently undertaken an external well led review with Deloitte, supported by Regional NHSEI colleagues, which has been presented and shared at Trust Board in July, with actioning of the recommendations already in place.

Thanks again for yours and your team's time in our recent medicine core service review. I hope that this letter provides some helpful context and background to support the information provided this afternoon. If you have any queries in relation to any of the information or anything that I have written above, please don't hesitate to contact me.

I hope that my responses provide assurance that we have a strong safety culture and also a strong responsive approach to learning and addressing issues raised, and that we have put immediate actions in place to address the concerns raised following your visit last week.

Best wishes

Yours sincerely



Lance McCarthy
Chief Executive Officer

cc: Antoinette Smith, CQC Inspection Manager
Christine Craven, CQC Relationship Manager
Ann Radmore NHS England and NHS Improvement

Care Quality Commission
Citygate
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Newcastle Upon Tyne
NE1 4PA

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By Email

Our reference: INS2-10959393211
For the attention of The Chief Executive
Lance McCarthy
The Princess Alexandra Hospital
Hamstel Road
Harlow
Essex
CM20 1QX

Date: 16 July 2021

CQC Reference Number: INS2-10959393211

Dear Lance McCarthy

Re: The Princess Alexandra Hospital

Following our unannounced inspection of the maternity service using our focused methodology, Beth Houston, inspector and Christine Colbourne, CQC specialist advisor provided feedback to you and your colleagues Giuseppe Labriola, Alexander Field, Stephanie Lawton and Sarah Webb on 14 July 2021.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on 14 July 2021 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

- We thanked you and asked that staff were thanked for welcoming us and taking time to speak with us.
- We were concerned that the service had not implemented a robust triage tool or have a guideline in place for triage to help staff safely assess women.

- Medical staffing was a concern. Medical staff told us they were concerned about the excessive use of locums, and changes to the rota including cancellation of leave.
- There was no structured induction for locum doctors and consultants told us they did not receive one to one job planning. This was particularly concerning due to the involvement of locums in two recent serious incidents.
- Medical staff told us they did not always receive feedback regarding serious incidents and did not have the opportunity to learn lessons as a result.
- Midwifery staff reported being burnt out, fatigued, and sometimes working without safe staff numbers.
- Overall, we were concerned that the safety culture in the service was under-developed. There were no dedicated maternity safety huddles in line with national guidance. Handovers doubled up as safety huddles. During our observations of handovers, we saw that staff did not discuss safety issues and the format was not safety focused. Maternity safety champions were not yet in place and staff were unclear about their role and function.
- On 14 July we escalated our concern that an emergency c-section was being performed without the correct equipment available to monitor the mother. Specifically, the ECG machine was not available, and this had not been checked after the previous procedure.
- Women's care records were not always fully completed and this might impact on their care and treatment. For example, swab counts were not always recorded, WHO checklists were not always completed and Cardiotocographs were not always fully completed with appropriate annotations.
- Medicines were not always managed appropriately. For example, we saw lidocaine was not appropriately stored to ensure access was limited to those authorised to access it.
- Medicine fridge temperatures were not consistently checked and were not acted upon when out of range. Staff did not acknowledge that this might affect the efficacy of medication stored in the fridge.
- Not everyone knew who the freedom to speak up guardian was.

However we also found:

- Staff having mutually respectful and positive interactions with women and colleagues.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Frances Bolger and Amba Murdamatoo at NHS Improvement

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number to hand INS2-10959393211. It may cause delay if you are not able to give it to us.

Yours sincerely

Philippa Styles

Head of Hospitals Inspection

c.c. Frances Bolger **-** NHS Improvement representative
Amba Murdamootoo - NHS Improvement representative
Jonathan Davies - CQC regional communications manager

The Princess Alexandra Hospital
Hamstel Road
Harlow
Essex
CM20 1QX

Philippa Styles
Head of Hospital Inspections
Care Quality Commission
Citygate
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Newcastle upon Tyne
NE1 4PA

Via email

22 July 2021

CQC Reference Number: INS2-10959393211

Dear Philippa

I am writing in response to your feedback letter dated 16 July 2021 following your visit on 14 July 2021 of our maternity core services at The Princess Alexandra Hospital.

I have shared your letter and the informal feedback received on the day with both Executive Director colleagues and our Senior Leadership Teams to agree how to address the concerns raised. I have also shared and discussed the letter with our non-executive directors, along with immediate actions. In addition, I will ensure that it is discussed in our next public Trust Board meeting.

Thank you also for the PIR covering each of the domains, which we received on 16 July. I would like to confirm that we have responded to all 54 information requests and we have uploaded them to the CQC portal late yesterday (21st July). Additional data requests were also requested and returned by noon on the 16 July and I understand Beth had a follow up conversation with our Director of Midwifery (Giuseppe) on the same day. Please let me know if you or your team have any queries related to their content.

In addition to the specific information requested, I would also like to share some additional information to provide further context and assurance in relation to:

- You were concerned that the service had not implemented a robust triage tool or have guideline in place to help staff safely assess women. We have been working on our triage process and introduced a new telephone triage tool on 21 June. This was the first stage of our improvement work and further steps are being undertaken to facilitate dedicated space to enable face to face triage in MAFU (which requires estate reconfiguration). The improvement has also

included ensuring we have access to appropriate medical cover to support the midwifery team with triaging our high/low risk patients.

- You heard that medical staff were concerned about the excessive use of locums, and changes to the rota including cancellation of leave. I would like to confirm that staffing is reviewed daily to ensure safe staffing and, following the feedback, we provided weekend staffing of all groups to Beth (16th July). Within the PIR data we have provided the evidence against permanent v locum use. In addition, we have approved business cases for 2 consultants and 5 registrars to further enhance our substantive establishment with appointments anticipated to start from September 21.

- You were concerned that we have no structured induction for locum doctors and consultants told you they did not receive one to one job planning. This was particularly concerning due to the involvement of locums in two recent serious incidents. We have been reviewing our locum induction following the two recent serious incidents and working across the LMNS to ensure we follow best practice. I can assure you that in both these cases we did have clear induction and supervision in place and have evidenced this within the root cause analysis undertaken as part of the SI process.
  In relation to job planning - this is a significant focus and part of the 2021/22 aims for all care groups. To facilitate this within the HCG, we have a planned away day on 30th July to review this with our consultants.

- Medical staff told you they did not always receive feedback regarding serious incidents and did not have the opportunity to learn lessons as a result. The HCG share learning and key messages though 'Feedback Monday'. In addition, learning is shared though the departmental audit meeting. However, we recognise that we can make further steps to improve on how we share the learning wider in a sustained way. This is included within our draft Quality and Patient Safety Strategy which will be launched formally in September.

- We acknowledge that our staff reported being burnt out, fatigued, and sometimes working without safe staff numbers. We will all recognise the impact the last 18 months has had across the NHS and for our amazing staff. To help recover and rebuild resilience, we have a focused health and wellbeing programme with has included a 12 week Back to Better campaign to support staff have time to rest, reflect and recover. Within maternity specifically, we have aimed to be responsive to needs and this has included (external) psychological and wellbeing support earlier this year. The health and well-being of staff continues to be a priority and we continue with our focus and to be responsive to this need.

- You were concerned that the safety culture in the service was underdeveloped (maternity safety huddles, observations of handovers, Maternity safety champions). Our strategic approach to safety has included the appointment of a Director of Quality and Clinical Governance (late 2019) and, within the HCG – a consultant with responsibility for safety and quality (Q3 19/20), consultant with responsibility for obstetric risk (Q3 20/21) and a Governance and Risk midwife (Q4 20/21) and a Director of Midwifery (June 21). Following your visit

we have taken immediate actions to introduce four times per day safety huddles. I can assure you that we have maternity safety champions (Sharon McNally, Executive Director of Nursing, Midwifery and Allied Health Professionals and Helen Glenister, Non-Executive Director and Chair of the Quality and Safety Committee) who have been visible within the department. Our NED has attended the maternity healthcare board and both appointments can be evidence in the Trust Board papers. I am sorry that the staff on the wards were not able to name them and we will look at how we can further strengthen and promote the roles.

- You escalated concern that an emergency c-section was being performed without the correct equipment available to monitor the mother. Specifically, the ECG machine was not available, and this had not been checked after the previous procedure – I am pleased this was addressed immediately and the teams are now aware how to access equipment both in and out of hours.

- It was noted that not all women's care records were fully completed and acknowledge that this may impact on their care and treatment. As you are aware, the Trust is undertaking a focused programme to improve our documentation - including a review of the compliance with WHO checklist (99.89% June 21) and Local Safety Standards for invasive procedure (LoSSip).

- I was disappointed that not everyone was able to name who the Freedom to Speak Up Guardians are, although I have confidence that they would be able to describe the existence of the Freedom to Speak up Guardian service. We have taken steps to increase the visibility of this role over the last 12-15 months and I have made 5 additional clinical appointments to the Freedom to Speak Up Guardian service recently to aid access and broaden the professional mix of the Guardians. I would like to assure you that on the staff intranet there is clear signpost about how to access/contact our Freedom to Speak up Guardians and there is also a life size poster on display outside the staff restaurant (which has remained there throughout the pandemic). We can demonstrate that we are committed to further improving the awareness and access to this important service.

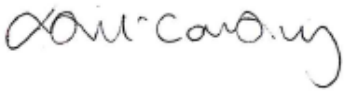
In addition, our maternity services are part of and have embraced the Maternity Improvement Programme. We have worked closely with our Maternity Improvement Partner and with the East of England midwifery team. The feedback has recognised our open transparent culture and our focus on improvement. As an organisation we are committed to learning, improving and transforming – we have engaged with improvement partners from the national NHSEI improvement team and with colleagues from MSE Partnership to further enhance our Project Management Office function to continue to drive our quality improvement plan. We have also recently undertaken an external well led review with Deloitte, supported by Regional NHSEI colleagues, which has been presented and shared at Trust Board in July, with actioning of the recommendations already in place.

Thank you again for your team's time in our recent maternity core service review. I hope that this letter provides some helpful context and background to support the PIR

information provided yesterday. I hope that my response provides assurance that we have a strong safety culture and also a strong responsive approach to learning and addressing issues raised, and that we have put immediate actions in place to address the concerns raised following your visit last week.
If you have any queries in relation to any of the information or anything that I have written above, please don't hesitate to contact me.

Best wishes

Yours sincerely



Lance McCarthy
Chief Executive Officer

cc: Antoinette Smith, CQC Inspection Manager
Christine Craven, CQC Relationship Manager
Wendy Matthews, EoE Director of Midwifery
Frances Bolger - NHS Improvement representative
Amba Murdamootoo - NHS Improvement representative
Jonathan Davies - CQC regional communications manager

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board
4 August 2021

Agenda item:	2.2
Executive Lead:	Fay Gilder - Medical Director
Prepared by:	Lisa Flack – Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Quality Governance
Date prepared:	2 July 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 86 to 73 (section 2.1). The main themes for 13 risks scoring 20 on the SRR are: • Seven for operational pressures - 3 for referral to treatment standard compliance, 3 for ED standard compliance and 1 for cancer waiting times. • Three for our places - research facility, and theatre roof (2) • Two medical consultant cover - for GI bleed and obstetrics. Actions and mitigations detailed in sections 2.4 to 2.7 One new risk raised, with score of 15 • Women are waiting greater than four hours to be seen by obstetrician in MAFU and mitigating actions detailed in 3.1
Recommendation:	Board are asked to review the contents of the Significant Risk Register and to approve all new risks added and those with amended scores.

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

Previously considered by:	Risk Management Group reviews risks on a rotation so each service is monitored quarterly as per annual work plan, most recently on 9 June 2021. EMT and SMT July 21.
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and the BAF
Legislation, regulatory, equality, diversity and dignity implications:	Management of risk is a legal and statutory obligation
Appendices:	Nil

1.0 INTRODUCTION

1.1 This paper details the Significant Risk Register (SRR) across the Trust; the registers were taken from the web based Risk Assure system on 30.06.21. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

There is an annual work plan to ensure each areas register 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

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

2.2 There are 73 significant risks on the risk register, decreased from 86 in the paper discussed in June Trust Board. The breakdown by service is detailed in the table below.

	Risk Score				
	15	**16**	**20**	**25**	**Totals**
Covid-19	2 (2)	1 (1)	0 (0)	0 (0)	**3 (3)**
Cancer, Cardiology & Clinical Support	4 (6)	8 (7)	0 (0)	0 (0)	**12 (13)**
Communications	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Estates & Facilities	1 (4)	2 (4)	0 (1)	0 (0)	**3 (9)**
Finance	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Health Safety and Resilience **(formerly Non-Clinical Health & Safety)**	0 (2)	1 (1)	0 (0)	0 (0)	**1 (3)**
Information Data Quality and Business Intelligence	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
IM&T	1 (1)	2 (1)	0 (0)	0 (0)	**3 (2)**
Integrated Hospital Discharge Team	1(1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Learning from deaths	0 (0)	2 (2)	0 (0)	0 (0)	**2 (2)**
Nursing	2 (1)	0 (0)	0 (0)	0 (0)	**2 (1)**
Operational	2 (2)	1 (1)	4 (4)	0 (0)	**7 (7)**
Research, Development & Innovation	0 (0)	1 (1)	1 (1)	0 (0)	**2 (2)**
Resilience	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
FAWs Child Health	3 (2)	0 (0)	1 (0)	0 (0)	**4 (2)**
FAWs Women's Health	6 (7)	3 (4)	2 (2)	(0)	**11 (13)**
Safeguarding Adults	1 (0)	0 (1)	0 (0)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Medicine	3 (4)	0 (3)	1 (1)	0 (0)	**4 (8)**
Surgery	3 (5)	2 (4)	4 (3)	0 (0)	**9 (12)**
Urgent & Emergency Care	1 (0)	1 (1)	0 (0)	0 (0)	**2 (1)**
Totals	**31 (38)**	**29 (36)**	**13 (12)**	**0 (0)**	**73 (86)**

(The scores from paper presented at Trust Board in June 2021 are detailed in brackets)

2.3 There are 13 risks with a score of 20: increasing by one from the previous paper. A summary of these risks is below and all new risks are as detailed: -

2.4 Our Patients

2.4.1 Baby cots for paediatrics

- **NEW:** The Favero 300 cots on Dolphin do not lower enough to allow staff below 5ft 5in to reach a child to perform CPR and the head of the cot is not close enough to allow intubation (Dolph01/2021 risk raised February 2021 and score increased on 28/6/21 following receipt of a government alert regarding expected surge in respiratory viruses affecting babies and toddlers within the UK and several Datix incidents of inadequate numbers of cots on the ward in the preceding two weeks.
  Action: to develop an ATI for acquisition of new cots. The ward have 5 cots they can use and can access addition cots from NICU.

2.5 Our People

2.5.1 Consultant cover in obstetrics

- Consultant cover currently achieves 87 hours per week, against the national requirement for availability at 98 hours a week. There is a high potential for consultants needing to be called into the trust (2020/10/01 December 2020).
  Action: All consultant job plans are reviewed. Further recruitment is planned for cover of 2.0WTE and working towards appointments starting by October 2021. A hot week consultant role is in place, to ensure there are twice daily ward rounds on labour ward as per Ockenden recommendations.

2.5.2 Medical cover for GI bleed out of hours

- Trust does not have an out of hours GI bleed rota (Endo 08 initially raised October 2016, score amended after discussion within September Medicine Board meeting and increased to 20 in September 2020).
  Action: Completed the upper GI bleed proforma and policy. A Consultant is available 24/7 to provide advice and support to teams managing a patient during out of hours period, will liaise with partner trust North & East Herts, to facilitate transfer for immediate endoscopy. The Trust has agreed to fund an out of hour's endoscopy service and consultation is in progress to have staffing cover for out of hours GI bleed rota by end of Q2 2021/2.

2.6 Our Performance

2.6.1 ED performance

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

- Compliance with the statutory standard for the Emergency department (ED) (001/2017 on operations team register since April 2014)
- Achieving the standard of patients being in ED for less than 12 hours (002/2016 raised July 2016 on operational team register)
- Ensuring patients wait less than 12 hours from time of decision to admit (003/2016 on register since July 16) for operational team register.
  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. PRISM team supporting ED with flow and processes.

2.6.2 Cancer access standard

- Not achieving 85% of all patients referred by GP to receive treatment within the cancer 62 day standard (005/2016 on register since July 2016)

Actions: PTL has granular information for oversight of individual patients on cancer pathway to monitor against escalation triggers. Recovery plan in place and trajectory monitored.

2.6.3 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 and S&CC004/2020B)
  Action: Working with STP partners to manage paediatric urology, patients booked in order of clinical priority, monitoring of PTL continues weekly. Cancer PTL reviewed daily, weekly for remainder of specialities. Monthly performance boards review performance and planned elective work.

- **Score Increased**: 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. Patients operated in private sector, elective programme recommenced March 21.

2.7 Our Places

2.7.1 Environment: Surgery

- **Score Increased Two risks for Theatres:**
  Water ingress in theatre 1 and theatre 7 due to structure of the roof and rain water ingress impacting the use of theatres for surgery. (THE 006/2019 and THE 008/201, initially raised on 31/10/19, score increased on 22/6/21 as result of new roof leaks).
  Action: Weather forecast checked prior to commencing surgery, staff are vigilant, lists are moved to another theatre if possible or not commenced.

2.7.2 Research team require a clinical space

- Research and development require a location to conduct clinical trials as the Trust intends to grow the research conducted in the Trust (Risk raised R&D15/12/2017 with score amended January 2021 as required to move locations)
  Action: Working in OPD at Wych Elm currently and plan to move to outpatients on main site in August. Working with the new hospital team to ensure a location is available in the new site. In addition to telehealth versus face-to-face contacts.

2.8 Our Pounds: No finance risks detailed

3.0 NEW Risks on the Significant Risk Register Scoring 15

3.1 Our Patients

- Women are waiting greater than four hours to be seen by obstetrician in MAFU (2021-06-04) raised May 2021)
  Action: Any delay will be escalated initially to the labour ward team, if they are unable to attend then to the gynaecology team. These two groups of staff will attend MAFU and will review ladies. The team are going through a recruitment process for five registrar roles and these appointments will in turn increase the cover for MAFU. The posts are anticipated to commence in post from Sept 21 & throughout Q3.

4.0 RECOMMENDATION

Board are asked to review the contents of the Significant Risk Register and to approve all new risks added and those with amended scores.

The Princess Alexandra Hospital NHS Trust

Trust Board – 5 August 2021

Agenda item:	2.3
Presented by:	Heather Schultz – Head of Corporate Affairs
Prepared by:	Heather Schultz – Head of Corporate Affairs
Date prepared:	30.07.21
Subject / title:	Board Assurance Framework 2021/22

Purpose:	Approval	x	Decision		Information		Assurance	

Key issues:	The BAF 2021/22 is presented for review. It is proposed to increase one risk score this month (Risk 1.0 Covid) from 12 to 16 and amend the risk descriptions for risk 1.1 Variation in outcomes and risk 4.2 Emergency Department. The risks have been reviewed at committees in July and QSC supported the change to the risk score for 1.0 and the revised risk description for risk 1.1. PAF supported the revised risk description for risk 4.2. Appendix 1 summarises the risks and the scores.
Recommendation:	The Board is asked to approve the changes to the risk score for Risk 1.0 and revised for wording for risks 1.1 and 4.2.

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, QSC, IPC Committee, NHC and WFC in July 2021. EMT on 28 July 2021.
Risk / links with the BAF:	All BAF risks as attached.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with Healthcare legislation.
Appendices:	Appendix 1 – 2021- 22 summary Appendix 2 – BAF 2021-22

Your future • Our hospital

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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					↑	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					↔	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					↔	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					↔	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					↔	DoS
3.2	Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	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					↔	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					↔	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					↔	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					↔	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)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objectives 1-5													
BAF 1.0		**COVID-19:** Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on 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 ~~viii) Non COVID Priority Business Cell established for business as usual matters~~ ix) Daily executive oversight of incident management x) Recovery and restoration planning (PAHT/ICP and ICS) xi) Separation of hospital into Covid and Covid free areas xii) Use of independant sector for elective patients xiii) Staff vaccination programme xiv) Engagement with critical care network 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 July 2021) iii) Trust Board updates (March, to July 2021) iv) Recovery Plans and submissions (Recovery paper to Board August 21) v) Covid risk register	~~4 x 3 = 12~~ **4x4=16**	i) Loss of staff with key skills and training due to virus; shielding/isolating or sickness - cross out ~~ii) Reliance on national supply chain~~ ~~iii Modelling information for next peak (local, regional and national) dependant on lock down and public behaviour~~ v) Plans for use of the private sector ~~vi) Limitation with PAHT estate configuration and supply of oxygen~~ Adaptability and configurations opportunity of clinical areas		Jul-21	Proposed to increase score from 12 to 16.	**3x3=9 September 2021**
			Effects: i) Increased numbers of patients and acuity levels ii) Shortages of staff, staff shielding and increased sickness iii) Shortages of equipment, medicines and other supplies iv) Lack of system capacity v) Staff concerns regarding safety and well-being vi) Changing national messaging vii) Potential for patient harm due to cancellation of elective surgery							Actions: i) Critical network support ii) Surge planning: red ITU moving to Henry Moore 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 an adverse impact on clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Unwarranted variation in care ii) System wide flow iii) Workforce gaps	**4 X 5 = 20**	Director of Nursing/ Medical Director **Quality and Safety Committee**	i) ~~Robust~~ quality and safety governance structures in place ~~including infection control~~ ii) Robust Appraisal/ medical and nursing iii) End of Life and deteriorating patient simulation programme for all staff, across ICP and ICS (suspended due to Covid) 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) Escalation prescribing processes~~ 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 ~~Mortality Surveillance~~ Strategic Learning from Deaths established xxii) Complaints workshops held and development of PE strategy as part of Quality strategy (Sept 21) xxiii) Joint GRFT and Model Hospital quality improvement programme xxiv) ~~Patient flow module~~ ~~xxv) Electronic fluid prescribing~~ xxvi) Appointment of medical PS&Q leads underway (July 21) xxvii) Complaints process being revised and grading system introduced ~~xxviii) Fab Change accreditation~~ xxix) Quality peer review process in place xxx Covid-19 governance structures/meetings in place ~~xxxi) OD Plan agreed at WFC (June 2020)~~ xxxii) HCG restructure consultation xxxiv) Appointment of DMD (quality)	i) National Surveys 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 ~~and Mortality Surveillance and Strategic Learning from Deaths Groups~~ Group xiii) AKI & Sepsis Group xiv) Urgent Care ~~Improvement~~ Board xv) Deteriorating Patient Group xvi) Cardiac arrest review panels xvii) Twice weekly Long Length of Stay meetings xviii) Quality Compliance Improvement Group, Clinical Compliance Group	i) CEO Assurance Panels (as required) ii) Reports to QSC on Patient Experience (bi-monthly), monthly Serious Incidents, monthly Safer Staffing, Patient Panel (bi-monthly) , Safeguarding, monthly Infection Control and Covid-19 updates 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 inspection report April 21 and IRMER May 21 and GRFT reports) v) Dr Foster reports and engagement ~~vi) GMC Survey results and~~ WFC report March 2021 ~~vii) Clinical Audit internal audit report 18/19 - tiaa (limited assurance)~~ viii) Quarterly Coding reports to PAF ~~ix) Positive staff survey outcomes (2019) measuring safety culture and engagement~~ x) Freedom to Speak Up Guardians quarterly reports to WFC xi) Patient stories and learning from deaths reports to Public Board meetings (bi-monthly) xii) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) ~~xiii) Critical care network review peer review April 2020~~ xiv) TARN review (March 21) xv) Dr.Foster report received July '21 indicating HSMR of 104.27 'as expected'.	**4x4=16**	Lack of modernisation in some reporting processes including: i) Clinical audit plan developed and to be implemented - improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site footprint and bed constraints iv) ~~Access to Qlikservie~~ v) NICE oversight and management of compliance with guidance vi) Frequency and consistency of approach to M & M meetings ~~vii) Recruiting Lead ME~~ v) CLinical documentation not supported by existing infrastructure **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey 2020/21 action plan in place iii) Ongoing work with Dr Foster in relation to mortality ~~ii) NHS Patient Safety Strategy 2019 published. Trust to review and align to best practice~~ iii) EPR development and business case to PAF/Board March 2021 iv) Developing PAHT Quality Strategy v) Medical records COmmittee leading programme of work to improve documentation vi) Review of Mortality Strategy vii) Review of departmental clinical	~~i) Clinical evidence of improvements made following compliance with national audits. NICE,NCEPOD.~~ ii) Demonstrating an embedded learning programme from Board to ward. iii) Inconsistent re-audit iv) Lack of data to support information on progress with some patient safety metrics.	01/07/2021	Risk rating not changed	**4x3=12 September 2021**
			Effects: i) Higher than expected Mortality rates ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Poor reputation and low staff morale ~~v) Recurrent themes in complaints involving communication failure.~~ Patient harm 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 HIMMS	i) Access Board ii) EPR Programme Board (to be chaired by CCIO) 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 DQ reports to PAF and quarterly ICT updates to PAF (August21) 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.	**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.	Jul-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 being developed to procure new EPR solution. Ongoing user training programme underway.				

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

The Princess Alexandra Hospital Board
Assurance Framework 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 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. **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
2.3		**Workforce:** Inability to recruit, retain and engage our people	**Causes:** i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels viii) Covid -19 **Effects**: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation. Covid-19 effects - delays in workforceplanning, recruitment programmes and additional health and wellbeing pressures on teams	**4 X 4 =16**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) Event in a Tent held annually viii) Staff recognition awards held locally and trust wide annually ix) Enhanced controls around temporary staffing x) Line Manager development programme underway xi) Behaviour workshops held xii) New consultant development programme launched xiii) Staff engagement groups and Staff Council xiv) International recruitment programme for nurses and ED doctors xv) Medical staffing review underway (Medical Safer Staffing) xvi) Additional recruitment ('Bring back staff') during Covid xvii) Provision of Health and Well-being support during Covid-19 including psychological support and absence line.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 (WFC March 21) v) WRES and WDES reports 2020 (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 (SMT March 21) 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	**4 x3 = 12**	Pulse surveys targeted for all staff Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Roll out of e-rostering to all areas Safer Medical Staffing plan in development Actions i)-Recruitment plans for medical staff led by AMD (medicine) ii) Extranet for staff - Q2 21/22 iii) Staff survey action plan v) Review of raising concerns (FTSUG's, champions for bullying and harassment, senior inclusion lead) vi) CV19 staff vaccination implementation plan - completed vii) NHSE/I Health and wellbeing framework assessment - Q2 viii) Allocate rostering system review assessment and plans - Q2 ix) Review of management and leadership development provision - Q2	None identified.	01/05/2021	**Risk score not changed.**	**4 x2 = 8** **March 2022**

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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) Under-investment in training of estate management & site development.~~ viii) Inability to undertake planned preventative maintenance ix) Lack of decant facility to allow for adequate repair/maintenance particularly in ward areas. ~~x) Key workforce gaps in compliance, energy and engineering.~~	**5 X 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) ~~x) Internal Audit report (tiaa) – review of PPM (limited assurance report) - Audit Committee Dec 2019, action plan in place~~ xi) Capital projects report (PAF May 2021, Trust Board April 2021 and weekly updates at EMT)	**5x4=20**	i) Planned Preventative Maintenance Programme (time delay) ii) Sewage leaks and drainage iii) Electrical Safety/Rewiring (gaps - recent power failure March 21) iv) Maintaining oversight of the volume of action plans associated with compliance. **ACTIONS:** i) EBME review underway ~~i) Review of estates function complete.~~	i) Estates Strategy /Place Strategy developing within ICS ii) Compliance with data collection and reporting iii) PPM data not as robust as required	21/05/2021	**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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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iii) The resources required for delivery at a programme and workstream level have not been defined or secured iv) The current governance structure is under development given the shift in focus from planning to delivery. v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS 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	STP CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) STP Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and STP updates (CEO report August and Development sessions in October/November 2020)	**4 X 4= 16**	Lack of ICS demand and capacity modelling. Implications of white paper and statutory changes. **ACTIONS:** System leadership capacity to lead ICS -wide transformation		21/05/2021	**No changes to risk rating.**	**4x3=12** **July 2021**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 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)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership													
BAF 3.5		**New Hospital:** There is a risk that the new hospital will not be delivered to time and within the available Capital funding.	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 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 vi) Development of new standards and programme approach by NHP may delay OBC Effects i) Hospital remains on existing site ii) Unable to deliver 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	**5 X 4= 20**	Director of Strategy New Hospital Committee	~~i) Soft market testing postponed (contractors)~~ ii) Detailed programme of work iii) Monthly meetings with national cash and capital team iv) Weekly meetings with regional team v) Weekly meetings with landowners ~~vi) HOSC meetings held and agreement reached that consultation is not required~~ vii) New national team appointed to provide transaction support viii) detailed review of proposed solution to ensure it is deliverable within the available funding envelope ~~ix) Engagement events underway~~ ix) National Programme design convergence review initiated	i) New Hospital Committee ii) Trust Board iii) External advisory meetings as required. Iv) New Hospital SMT meetings	i) Monthly reports to Trust Board and New Hospital Committee. (November 2020) Ii) Letters of support received from JIC. iii) ~~Verbal~~ 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	**4x4=16**	Negotiations with landowners Actions i) Support national team with Design Convergence Review ii) Develop Heads of Terms for land transaction iii) Complete clinical review of 1:200 drawings	None.	Jul-21	**Risk score not changed.**	**3x3=9** **September 2021**

Risk Key														
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High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
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		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 risks 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	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) revised Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Developing new models of care vii) Local Delivery Board in place ix) ED action plan reported to PAF/Board x) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries xi) Weekly Urgent Care operational meetings and Urgent Care Board in place xii) Focus on length of stay in ED for all patients xii) Think 111 First ~~- went live December 2020~~ xiii) Paeds ED now relocated back into ED with Executive oversight meeting weekly	i) Access Board meetings ii) Board, PAF and SMT meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) System Operational Group vii Weekly Length of Stay meetings viii) Urgent Care Board	i) Daily ED reports to NHSI ii) Monthly PRM reports from HCGS iii) Monthly IPR reported to PAF/QSC and Board reflecting ED performance (PAF, QSC July 21)	**4x4=16**	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues **Actions:** i) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings and weekly Urgent Care Board review iv) Revised internal professional standards introduced v) Prism team supporting delivery of CQC actions	None noted.	01/07/2021	**Risk score not changed.**	**4x3 =12** **~~July~~ 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 :** 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) QIA of CIP schemes has been delayed due to operational pressures. (vii) Elective Recovery Funding levels may be reduced from M4 onwards therefore may not meet the costs of the recovery activity thereby adding a financial pressure to the revenue position.	**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	14/07/2021	**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				

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
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Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
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	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.	**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.	**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.	01/07/2021	**Residula 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

2.4

Public Board: 5 August 2021

Agenda item:	2.4
Presented by:	Ogechi Emeadi, director of people, organisational development and communications Michael Meredith, director of strategy and estates
Prepared by:	Laura Warren, associate director of communications
Date prepared:	29 August 2021
Subject / title:	PAHT 2030 and new values – engagement and implementation plan

Purpose:	Approval	X	Decision		Information	X	Assurance			
Key issues:	The report provides details on the engagement and implementation plan for both the PAHT 2030 strategy campaign and, alongside that, the introduction of the new corporate values.									
Recommendation:	The report is provided as an update for members of 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		

Previously considered by:	Executive team meeting Senior management team meeting
Risk / links with the BAF:	Transformation of PAHT through the PAHT 2030 strategy; its goals and what this means for our people and patients. The introduction of our new values, co-produced with our people.
Legislation, regulatory, equality, diversity and dignity implications:	CQC well-led
Appendices:	Engagement and implementation plan **I** Graphics package **I** Core narrative

Your future • Our hospital

respectful · caring · responsible · committed

PAHT 2030 and values

NHS
The Princess Alexandra Hospital
NHS Trust

Modern, integrated, outstanding

patient at heart • everyday excellence • creative collaboration

Your future • Our hospital

respectful • caring • responsible • committed

Purpose

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- To seek the views and ideas of our people on the PAHT 2030 strategy and how they will take it forward in their roles
- To introduce our new values ahead of full launch at Event in a tent and how they will support our goals, culture and standards of behaviour
- To share the outcome of the values co-production and engagement that has resulted in a set of three new values being developed and agreed by our people

Your involvement is critical

PAHT 2030 strategy and our values are the responsibility of everyone at PAHT. Senior leaders and managers have a critical role in promoting, championing and delivering the strategy and team members have a critical role in working together.

PAHT 2030 - engagement

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The development of the PAHT 2030 strategy, its content and direction has been extensive and has benefitted from the input and commitment of many clinicians and colleagues from across PAHT.

Ahead of its launch at Events in a tent (14 – 16 September) the strategy will be shared more extensively to ensure that our people have the opportunity to engage and contribute to the final version. This version will then underpin all that we do as we work towards our vision to be integrated, modern and outstanding.

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Phase one - awareness

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For senior leaders of the organisation:

What we will provide

- The four page strategy document and guidance for discussions with teams.

What we need from you

- **Familiarisation** with the strategy and understanding the implications for your team.
- **Champion** the strategy to teams and diarise opportunities to discuss and get feedback.
- **Connect strategy** with CQC, awareness of progress and plans within specialities.
- **Recommend** the most appropriate ways for Lance and Michael to hold listening events with your teams **by 20th July.**
- **Tell us other ways** we can engage staff with strategy objectives **by 20th July**
- **Tell us** how you are going to engage your team with the strategy **by 27th July**

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Phase two - engagement

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Internal launch of the four page document followed by engagement events, briefings and meetings: 2 August – 23 August

What we will provide

- A teaser campaign to raise awareness.
- Launch event with as many our people as possible e.g. exec briefing 3/8/21.
- Free breakfast / refreshment drop-in / virtual events.
- Events across all sites in PAHT.
- Corridor graphics.
- Teams background images.
- Information on digital screens and screensavers.
- Feature articles in InTouch magazine and briefings
- Virtual suggestions box.

What we need from you

- **Tell us how** we can reach as many of our people as possible.
- **Encourage maximum cooperation** and attendance from our people at events.

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Phase three - feedback

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Collate all feedback to incorporate into and finalise the full version of PAHT 2030 and a delivery plan: 23rd August – 14th September

What we will provide

- Provide a framework for collecting feedback.
- Edit the full PAHT 2030 document and pull together the action plan from feedback in the listening events.

What we need from you

- **Collate feedback** from your teams, deliver edited summary back to the strategy team inbox before 23rd August.
- **Read** the full version of the strategy before launch in Event in a Tent

Phase four - launch

The Princess Alexandra Hospital NHS Trust

Launch full strategy in event in a tent: 14 – 16 September

What we will provide

- Final draft of PAHT 2030 the full version and the action plan built from feedback.
- A slide deck for the event in a tent launch.
- Provide attendees with a pin badge, pens, and a new lanyard, and printed marketing material at the event.
- Exhibition stands as people come in to the event.

What we need from you

- **Encourage** people to attend event in a tent.
- **Encourage** people to engage with the recordings if they are unable to attend live.
- **Plans and commitment for embedding the strategy** in to teams.

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Values - engagement

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The development and engagement with our people on a refreshed and new set of values has been completed and agreed as:

- Patient at heart
- Everyday excellence
- Creative collaboration

The most valuable part of our new values and what they mean to everyone is that they reflect the thoughts and thinking of our people and what is important to them.

patient at heart • everyday excellence • creative collaboration

Values - implementation

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The Princess Alexandra Hospital
NHS Trust

Our new values will be formally launched at Events in a tent and given context to our people in terms of the full introduction schedule as they replace our current values in our appraisal, PDPs; 1:1's and recruitment. The values will underpin a new set of standards in our behaviour charter.

Our people will be supported with guidance and updates to enable them to bring the values into the way we work and deliver across the organisation.

The many people who were involved in the development and framing of the new values will be encouraged to share the values and support the communications messages and promotion.

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Values - implementation

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What we will provide

- Briefing materials and slide deck
- Teaser campaign
- Marketing materials
- Launch presentation

What we need from you

- **Familiarisation** with the values and their meanings and how this fits with your individual and team objectives
- **Champion** the values to teams and embed into 1:1 conversations and PDP reviews
- **Connect values** with culture and standards of behaviour

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Timeline

The Princess Alexandra Hospital NHS Trust

July

- 6 July – PAHT 2030 strategy shared with AMDs
- 13 July - PAHT 2030 strategy shared with SMT

September

- 9 September – sign off final version of PAHT 2030 strategy at EMT.
- 14 - 16 September – PAHT 2030 and new values launched in Event in a Tent and AGM

Phase one **Phases two and three** **Phase four**

August

- 3 August – PAHT 2030 and values engagement events begin with executive briefing
- 23 August – Compile feedback into full version of PAHT 2030

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Patient at heart

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Both the strategy and values will provide a focus that encourages collaboration.

Our PAHT 2030 strategy frames everything that we are planning and developing and is strongly connected and supported by our new values, which put our patients at the heart as we continue our journey to outstanding.

patient at heart • everyday excellence • creative collaboration

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PAHT 2030 campaign development: Stage 1a

Version 9: 30 July

JULIA WOOLLAMS **31%WOOL** JULY 2021

Contents

Updated objectives '5Ps' graphic

Updated objectives '5Ps' graphic

White background version to sit on colour

NB: This gradient background should only be used for PAHT2030 campaign materials

Presenting the new values

Presenting the new values

patient at heart • everyday excellence • creative collaboration

patient at heart • everyday excellence • creative collaboration

patient at heart • everyday excellence • creative collaboration

patient at heart • everyday excellence • creative collaboration

NB: This gradient background should only be used for PAHT2030 campaign materials

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

2.4

Summary of brand elements

Summary of brand elements

Updated objectives (5Ps) graphic

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PAHT2030 campaign logo

PAHT2030

modern • integrated • outstanding

PAHT logo

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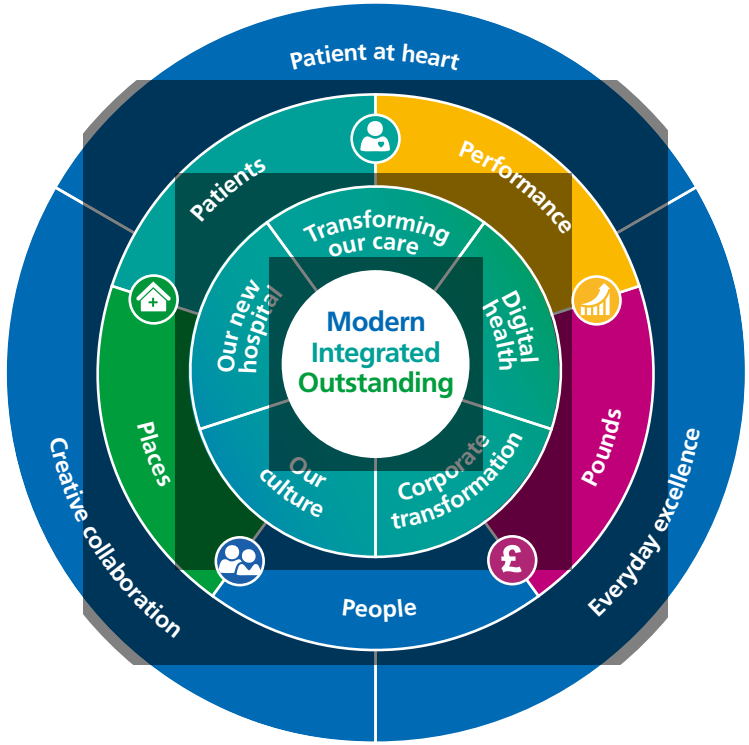
NHS Trust

Values

patient at heart • everyday excellence • creative collaboration

PAHT2030 campaign diagram



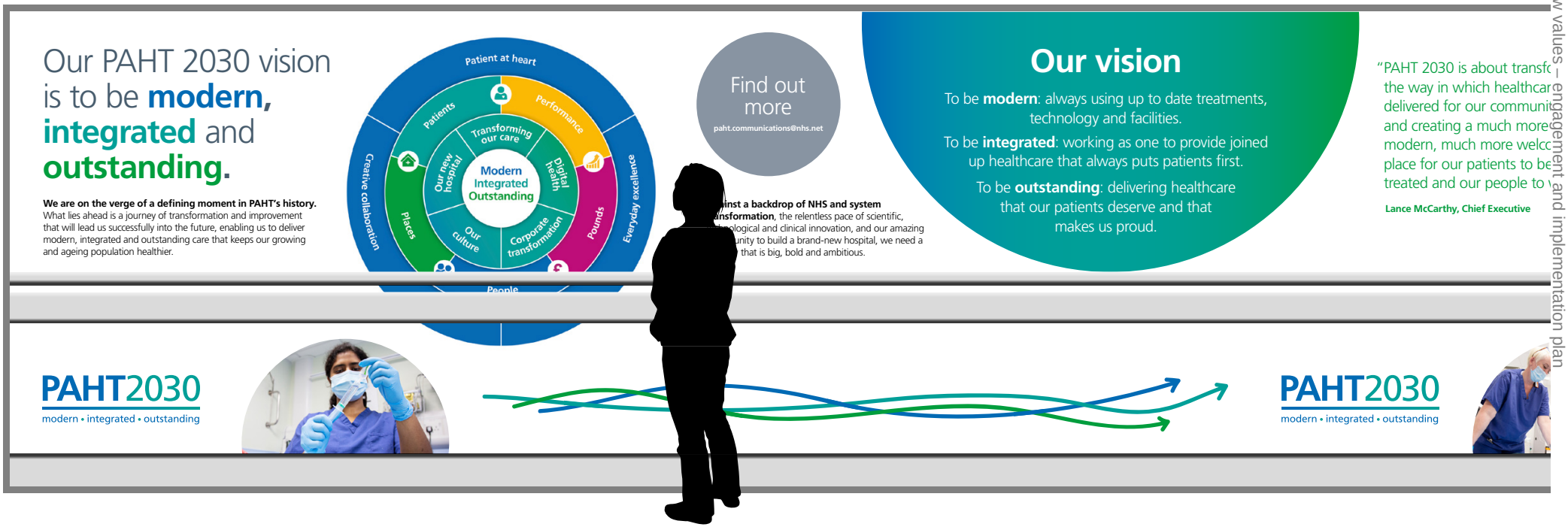
Modern, integrated, outstanding

The New Hospital campaign logo

The *New* Princess Alexandra Hospital

Corridor design

Corridor design



NB: This design will alter slightly when final wall dimensions and positions are confirmed.

2.4

Corridor design

Our PAHT 2030 vision is to be **modern, integrated** and **outstanding.**

We are on the verge of a defining moment in PAHT's history. What lies ahead is a journey of transformation and improvement that will lead us successfully into the future, enabling us to deliver modern, integrated and outstanding care that keeps our growing and ageing population healthier.

Find out more
paht.communications@nhs.net

Against a backdrop of NHS and system transformation, the relentless pace of scientific, technological and clinical innovation, and our amazing opportunity to build a brand-new hospital, we need a strategy that is big, bold and ambitious.

Our vision

To be **modern**: always using up to date treatments, technology and facilities.

To be **integrated**: working as one to provide joined up healthcare that always puts patients first.

To be **outstanding**: delivering healthcare that our patients deserve and that makes us proud.

"PAHT 2030 is about transforming the way in which healthcare is delivered for our communities and creating a much more modern, much more welcoming place for our patients to be treated and our people to work."

Lance McCarthy, Chief Executive

Our priorities

Our five priorities provide the focus to achieving that vision over the next 10 years: **transforming our care, our culture, digital health, corporate transformation** and **our new hospital.**

Have your say
paht.communications@nhs.net

Our objectives

Our five core objectives: **patients, people, performance, places** and **pounds** hold us to account, keeping us grounded in reality and challenging us to keep improving the experience for our patients, visitors and people.

Tell us how we're doing
paht.communications@nhs.net

PAHT 2030 is that strategy. Our organisational roadmap for the next 10 years, designed to inspire and challenge us, guide and unite us in working smarter and better to achieve our vision.

Our values

And throughout everything we do, we are guided at all times by our values: **patient at heart, everyday excellence** and **creative collaboration.**

"I have never been in a hospital where I have witnessed such teamwork. They say laughter is the greatest medicine, if that's the case then PAHT staff must be overflowing with it." **Patient**

We have already made great progress, thanks to the hard work of our amazing people. But there is much more to do. We will work together with our local, regional and national partners, our patients and our communities to make PAHT the centre of excellence we know it can be.

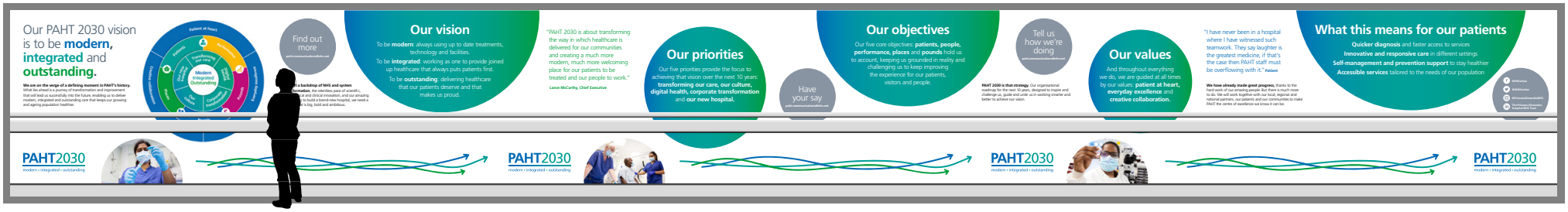
What this means for our patients

Quicker diagnosis and faster access to services
Innovative and responsive care in different settings
Self-management and prevention support to stay healthier
Accessible services tailored to the needs of our population

NHSHarlow
@NHSHarlow
@PrincessAlexandraNHS
The Princess Alexandra Hospital NHS Trust

PAHT2030
modern • integrated • outstanding

Corridor design



Merchandise

Lanyards

NB: These designs are notional, as merchandise items need sourcing and costing before creating the artwork for production.

31% WOOL

CONTACT DETAILS

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NHS
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NHS Trust

Appendix 1. Values Implementation Plan

Action#	Description	Task dependant	Owner	Length of time	Open date*	Est complete date
	Pre go live					
	Communications					
1	Finalise graphics	No	Communications	6 weeks	15/06/21	27/07/21
2	Create teaser campaign	Yes - 1	Communications	3 weeks	27/07/21	17/08/21
3	Staff messages ready for issue	No	Communications	1 week	15/06/21	22/06/21
4	Create graphics slides for digital information screens	Yes - 1	Communications	2 weeks	27/07/21	10/08/21
5	Create Extranet page and upload content	Yes - 1	Communications	1 week	27/07/21	03/08/21
6	Create screen savers	Yes - 1	Communications	2 weeks	27/07/21	10/08/21
7	Filming & editing of promotional videos	Yes - 1	Communications	3 weeks	27/07/21	17/08/21
8	Message drafted and agreed with Board		Communications	3 weeks	27/07/21	17/08/21
9	Content for InTouch magazine special edition	Yes - 8	Communications	1 week	27/07/21	03/08/21
10	Slide deck ready for Exec launch	Yes - 8	Communications	1 week	27/07/21	03/08/21
12	Update website and social media platforms		Communications	1 week	27/07/21	03/08/21
	Merchandise					
13	Merchandise (pens, pins, lanyards color coded by value) agreed, purchased and in hand		L&OD	5 weeks	27/07/21	31/08/21
	Documentation					
14	Update PAHT 2030 strategy		Jill Hogan	6 weeks	15/06/21	27/07/21
15	Update all L&OD materials	Yes - 1	L&OD	7 weeks	27/07/21	14/09/21
16	Update appraisal forms	Yes - 1	L&OD	7 weeks	27/07/21	14/09/21

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17	Update recruitment materials	Yes - 1	People	7 weeks	27/07/21	14/09/21
18	Update onboarding materials	Yes - 1	L&OD, People	7 weeks	27/07/21	14/09/21
19	Update behavioural charter	Yes - 1	L&OD	7 weeks	27/07/21	14/09/21
	Go live day - Tuesday, 14 September 2021					
20	Exec reveal		Communications			14/09/21
21	Posters, motivational quotes go up		Communications			14/09/21
22	Unveiling of behavioural charter		Communications			14/09/21
23	Hand out merchandise		Communications			14/09/21
	Post go live					
24	Share Executive and Senior Team 'Embed the Values Guide'		L&OD	1 day		07/09/21
25	Finalise content of staff and manager guide(s)		L&OD, Quaity First	6 week	15/06/21	27/07/21
26	Pre Huddle managers briefing session		L&OD, Quaity First	1 week	20/09/21	27/09/21
27	Patient at Heart team discussions		L&OD, Quaity First	2 weeks	27/09/21	11/10/21
28	Patient at Heart live team discussions for sharing		L&OD, Quaity First	3 days	30/09/21	01/10/21
29	Patient at Heart Intouch discussion		Communications	2 days	06/10/21	08/10/21
30	Everyday Excellence team discussions		L&OD, Quaity First	2 weeks	11/10/21	25/10/21
31	Everyday Excellence live team discussions for sharing		L&OD, Quaity First	3 days	13/10/21	15/10/21
32	Everyday Excellence Intouch discussion		Communications	2 days	21/10/21	22/10/21
33	Creative Collaboration team discussions		L&OD, Quaity First	2 weeks	25/10/21	08/11/21
34	Creative Collaboration live team discussions for sharing		L&OD, Quaity First	3 days	27/10/21	29/10/21
35	Creative Collaboration Intouch discussion		Communications	2 days	04/11/21	05/11/21
36	Staff photograph / art competition		Quality First			
37	Cartoons to demonstrate our values		Quality First			
38	Patient panel feedback - indicators of values in practice		Quality First			
39	Community engagement event supported by patient panel		Quality First			
40	Managers commence weekly or monthly 'embed the values challenge' with their teams		L&OD		03/11/21	Ongoing

41	Launch peer to peer recognition of a value behaviour demonstrated by a colleagues (virtual , nurture intrinsic motivation)		L&OD		03/11/21	Ongoing

- Start dates being reset in-line with revised dependency dates eg graphics sign-off

The Princess Alexandra Hospital NHS Trust

Trust Board - 5 August 2021

3.1

Agenda item:	3.1
Presented by:	Dr Fay Gilder
Prepared by:	Dr Fay Gilder
Date prepared:	30 July 2021
Subject / title:	Mortality indices update

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	HSMR (12 monthly rolling trend April 2020-March 2021) 104.27 (as expected) – first time PAH has been as expected for >36 months SMR (incl covid) 115.73 (higher than expected) SMR (excl covid) 90.39 (better than expected) SHMI 98.56 (as expected)
Recommendation:	Board is asked to note and celebrate the updated mortality indices

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:	Quality and Safety Committee
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	None
Appendices:	None

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The Princess Alexandra Hospital NHS Trust

3.1

1.0 Purpose

To inform the Board of the current mortality indices position for Princess Alexandra Hospital

2.0 Background

The Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths over expected deaths for a hospital. It adjusts for factors that affect in-hospital mortality rates such as patient age, sex, diagnosis, population demographics, comorbidities and admission status. It is an important measure by which the quality and safety of care at a hospital is judged. It is calculated for 56 diagnostic groups which cover 80% of the primary diagnoses at admission.

Princess Alexandra Hospital (PAH) has been a negative outlier for the HSMR (12 month rolling average) for > 36 months. A comprehensive programme of mortality improvement has been in place for over 2 years. The work has included a focus on the SMR diagnostic outliers, quality of clinical coding, quality of clinical documentation, structured judgement review themes and the learning from death programme supported by the medical examiner service.

3.0 Analysis

REPORT HEADLINES

Data Period: Apr 2020 - Mar 2021

Metric	Result
HSMR	**104.27 – 'As Expected'**
HSMR position vs. peers	The HSMR for the entire regional acute peer group – **107.9 – 'Higher than expected'**
SMR outlying groups	Other liver diseases – 173.5 Cancer of head and neck – 1129.8 Viral infection (COVID-19) – 154.9
All Diagnosis SMR	**SMR – 115.73 – 'Higher than Expected'** **SMR (exc. COVID-19) – 90.39 – 'Lower than expected'**
CUSUM breaches ***(exc. Viral Infection due to COVID-19)***	**99% threshold: (New alerts in bold)** • Allergic Reactions (alerted Jan-21) • Cancer of head and neck (alerted Jul-20 & Jan-21) • **Cancer of other female genital organs (alerted Mar-21)** • Other injuries and conditions due to external causes (alerted May-20) • Senility and organic mental disorders (alerted Jun-20) • Transient cerebral ischaemia (alerted Apr-20) **99.9% threshold: (New alerts in bold)** • Acute and unspecified renal failure (Apr-20)
SHMI position	98.56 – 'Band 2 – As Expected'

The table above summarises the most recent mortality indices position for Princess Alexandra Hospital (PAH) for the data period April 2020 – March 2021. The following figures and text explains the indices above in more detail.

Figure 1 – HSMR Monthly Trend

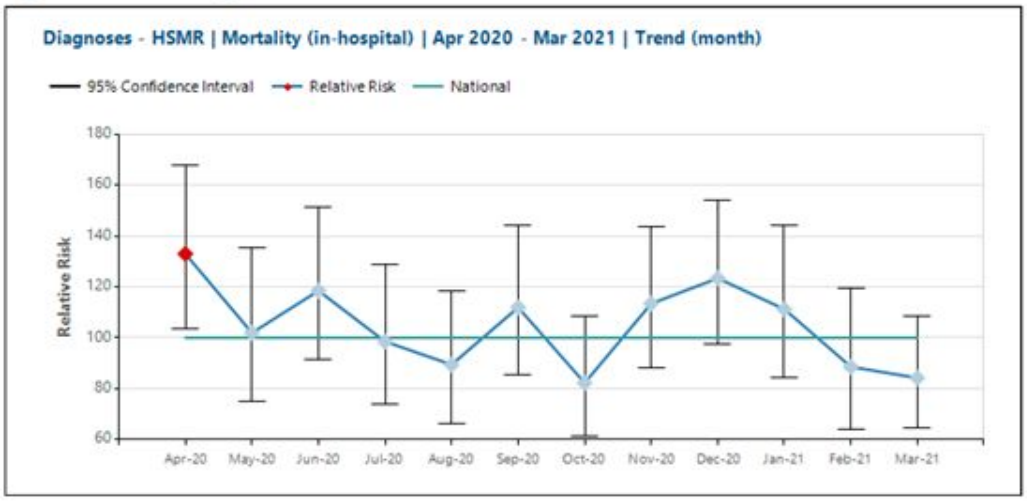


Fig 1 details the monthly HSMR position. Note that the monthly HSMR has been 'as expected' for the last 10 months.

Figure 2 – HSMR 12 Month Rolling Trend (Last 12 Months)

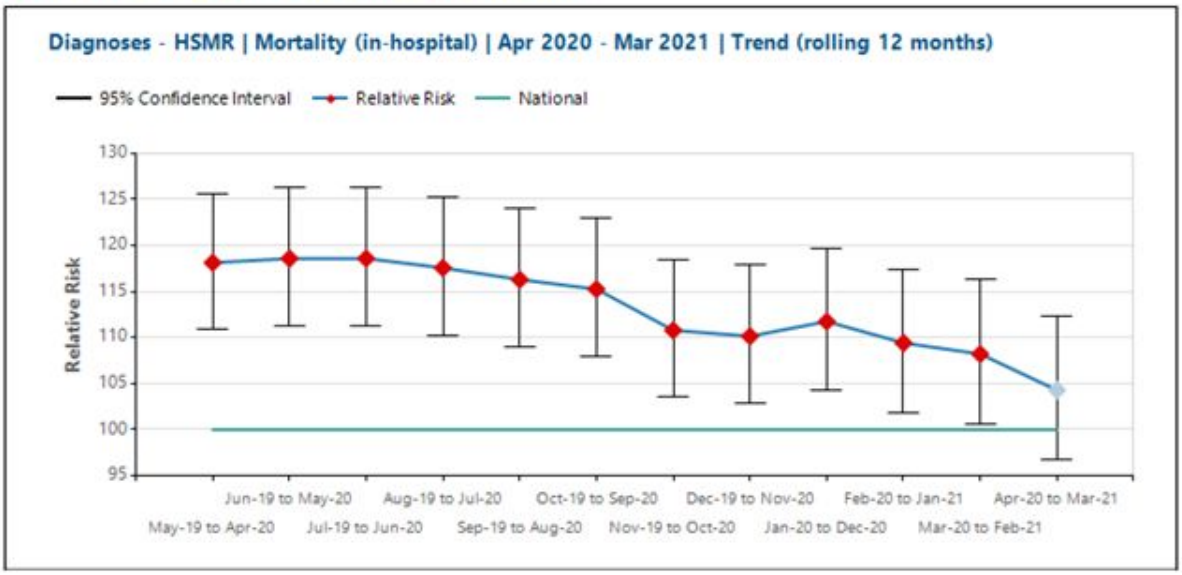


Figure 2 shows a sustained downward trend in the rolling 12 monthly HSMR with the figure for April 2020 - March 2021 of 104.27 (as expected). **This is the first time that PAH has had an HSMR in the 'as expected range' for > 36 months.**

Figure 2.1 – HSMR 12 Month Rolling Trend (Last 36 Months)

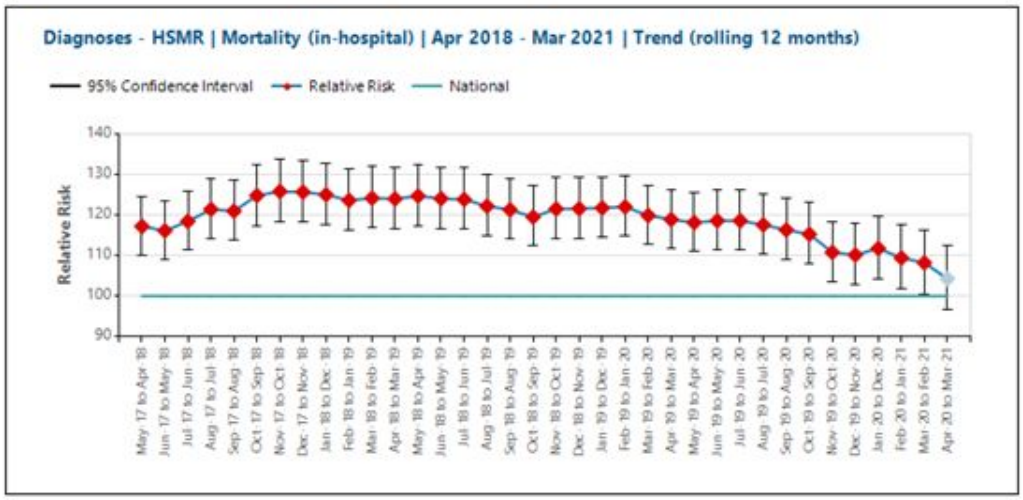


Figure 2.1 shows the HSMR 12 month rolling trend for the last 36 months.

Figure 2.3 – Changes in Superspells, Observed Deaths and Expected Deaths (Last 5 Years)

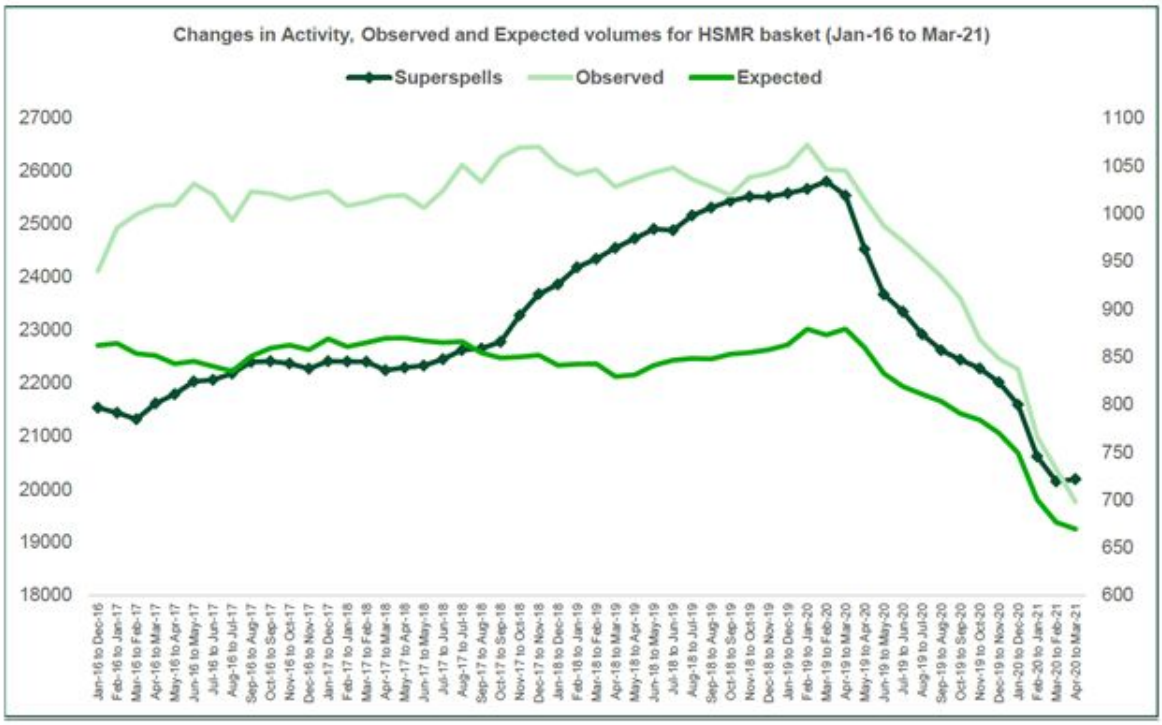


Figure 2.3 (numbering from the Dr Foster report) shows the number of superspells (scale on the RHS) , observed deaths and expected deaths (scale on the LHS) for the 12 month rolling period commencing January 2016. Of note is the increasing superspell activity without a parallel increase in observed deaths (from November 2018) , and the narrowing of the gap between observed deaths and expected deaths over the last 12 months.

Figure 3 – HSMR 12 Month Peer Comparison

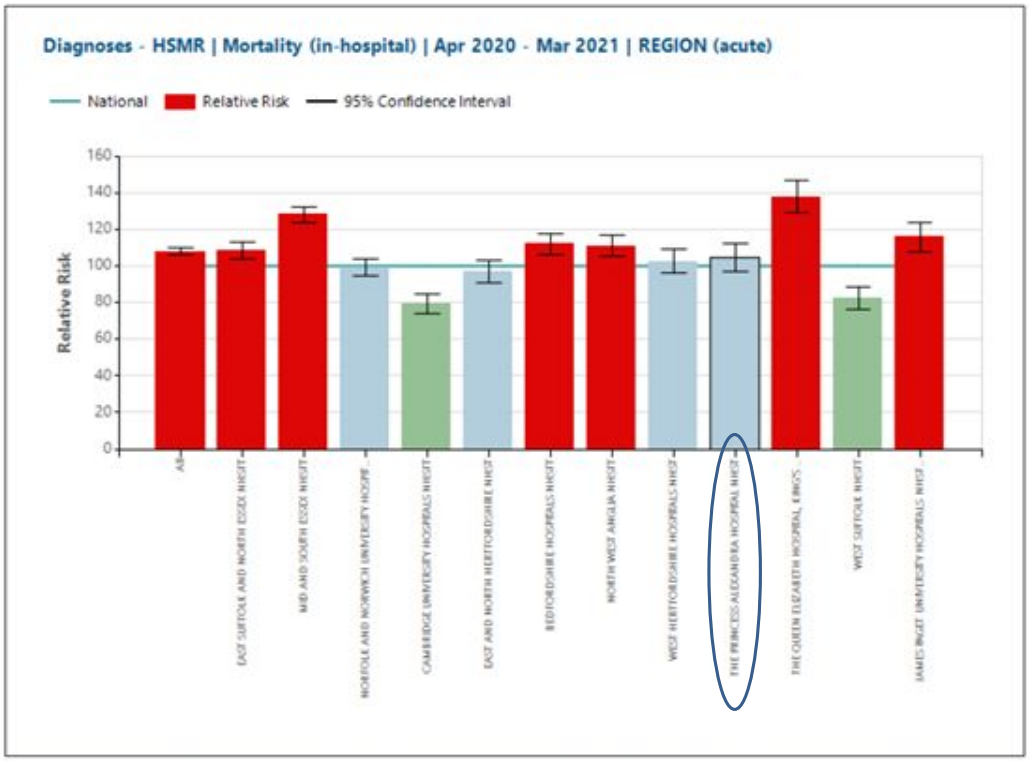


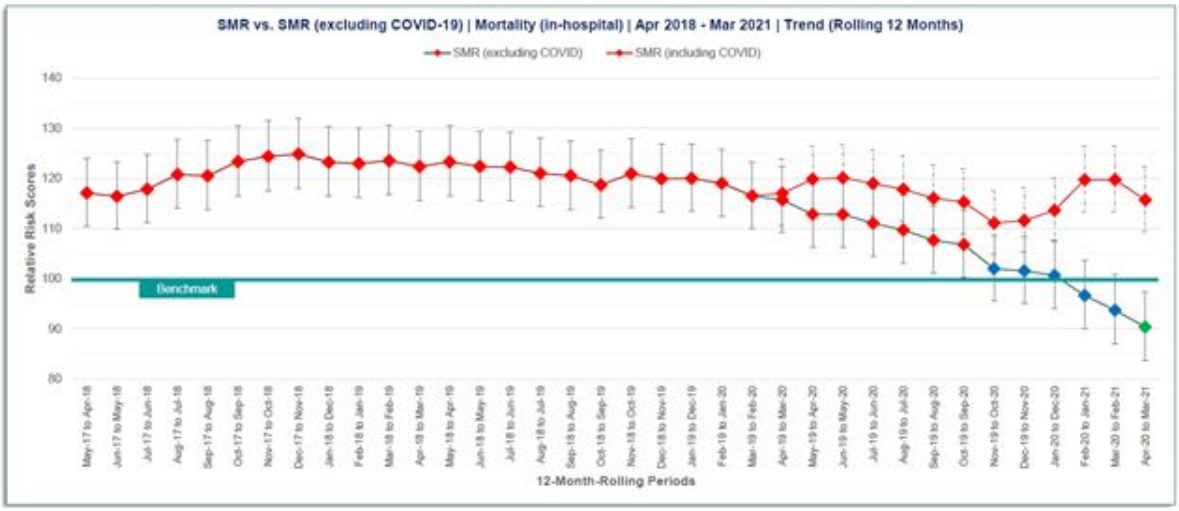
Figure 3 shows the comparison between PAH and our East of England regional peers. We are 1 of 6 Trusts with an HSMR in the 'as expected/better than expected' range.

SMR

The Standardised Mortality Ratio (SMR) is the ratio of observed deaths over expected deaths and is the figure calculated for all diagnostic groups encompassing the primary diagnosis for 100% of admissions.

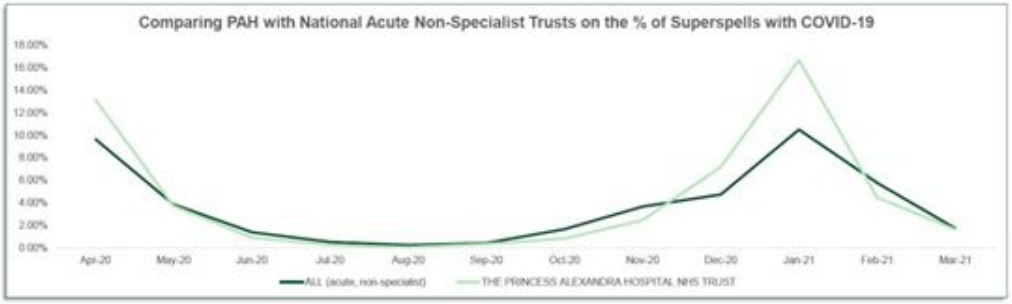
Over the last 12 months, comparing relative risk scores when COVID is and isn't included in the SMR model demonstrates the impact of COVID at PAH

Health UK



The figure above shows the SMR all diagnosis rolling trend for the last 36 months with the impact of covid and excluding covid. The figure for April 2020-March 2021 is 115.73 'higher than expected' when deaths due to covid are included and 90.39 'better than expected' when the impact of covid is excluded.

PAH have had a higher proportion of COVID-19 patients in Dec-20 and Jan-21 than the national average



% of Superspells with COVID-19	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
ALL (acute, non-specialist)	9.65%	3.87%	1.41%	0.54%	0.26%	0.44%	1.68%	3.67%	4.75%	10.51%	5.79%	1.75%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	13.17%	3.72%	0.94%	0.27%	0.07%	0.35%	0.84%	2.47%	7.21%	16.68%	4.50%	1.65%

This final figure shows that PAH was disproportionately affected by Covid compared to the national average which is likely to explain the elevated SMR.

Quality of clinical care

Much of the mortality improvement work has focussed on the diagnostic outliers of fractured neck of femur, acute kidney injury, sepsis, chronic obstructive pulmonary disease, aspiration pneumonia and fluid and electrolyte balance. PAH is no longer an outlier for any of these diagnostic groups implying improved quality of care. Figure 2.3 evidences a reduced number of observed deaths compared to the expected -providing further support to the fact that the care for patients has improved at PAH over the last 3 years.

Clinical coding

The quality of clinical coding has much improved and this can be evidenced by the fact that palliative care coding has increased (as a percentage of cases – figure not included in this report) and 'senility and organic mental disorders' is no longer a diagnostic group outlier.

SHMI

The SHMI is 98.56 'as expected'. PAH has not been an outlier since April 2019.

4.0 Recommendation

For the Board to note the significant achievement of the many teams who have contributed to the current mortality position.

Author: **Dr Fay Gilder Medical Director**
Date: 30 July 2021

REPORT HEADLINES

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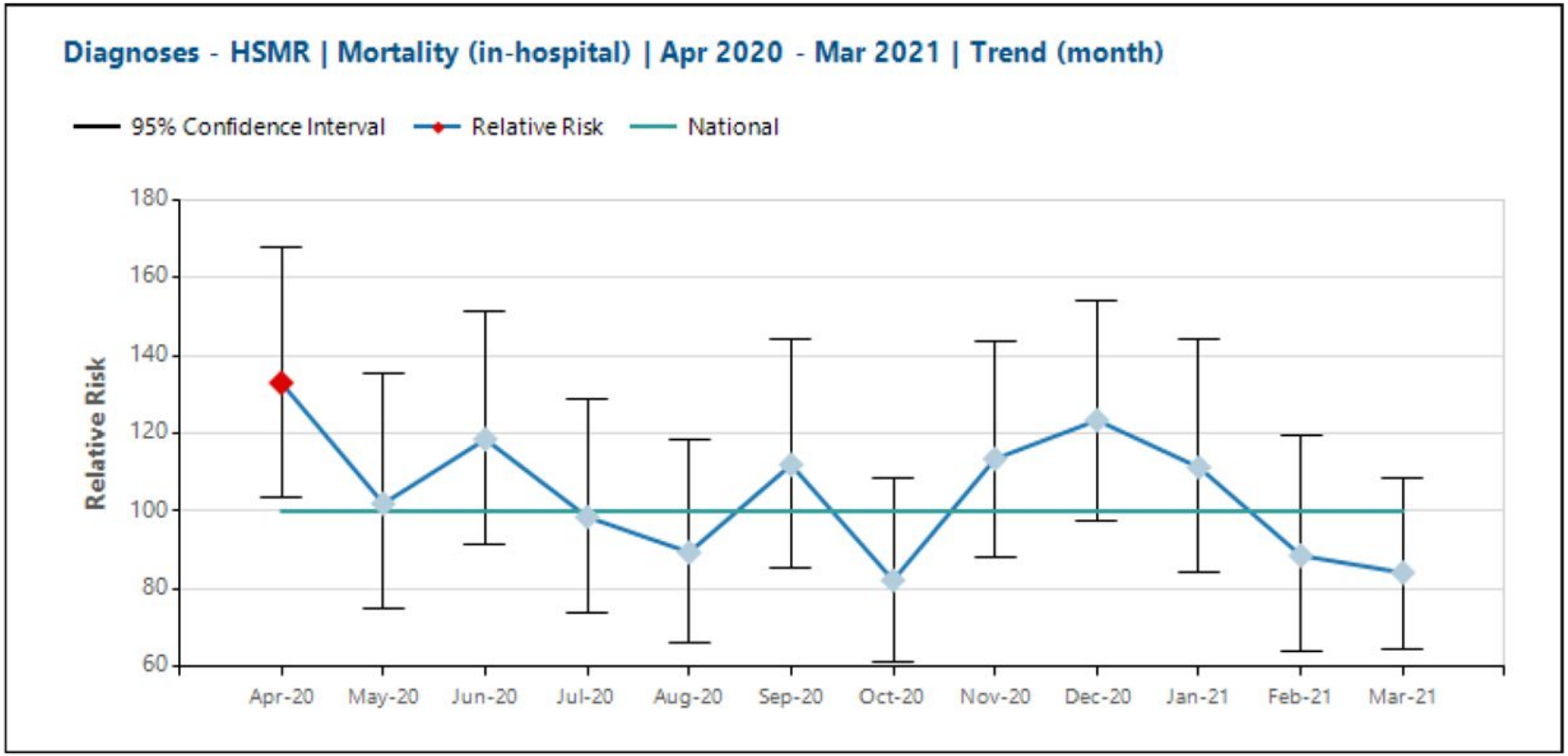
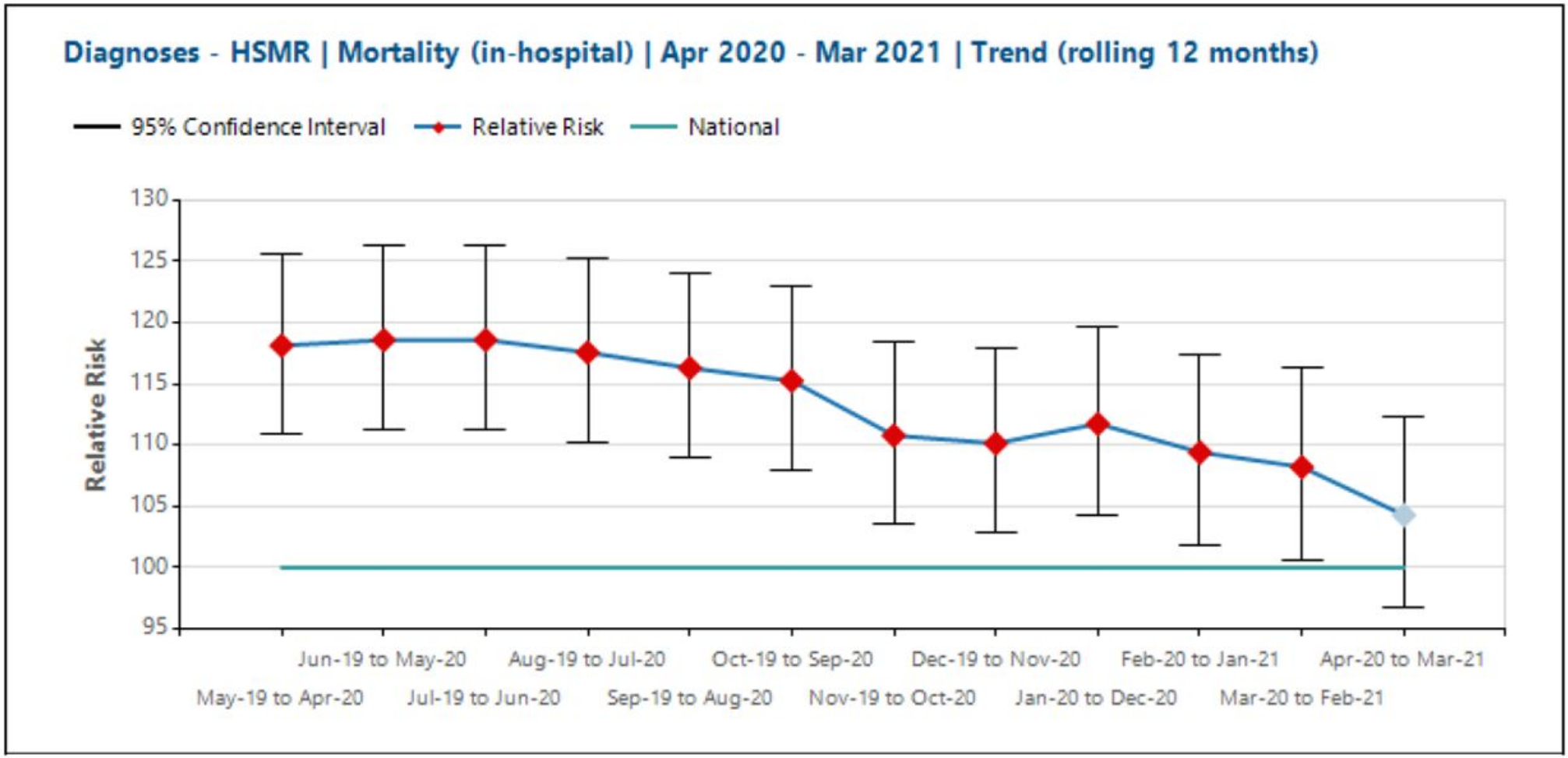


Figure 2 – HSMR 12 Month Rolling Trend (Last 12 Months)



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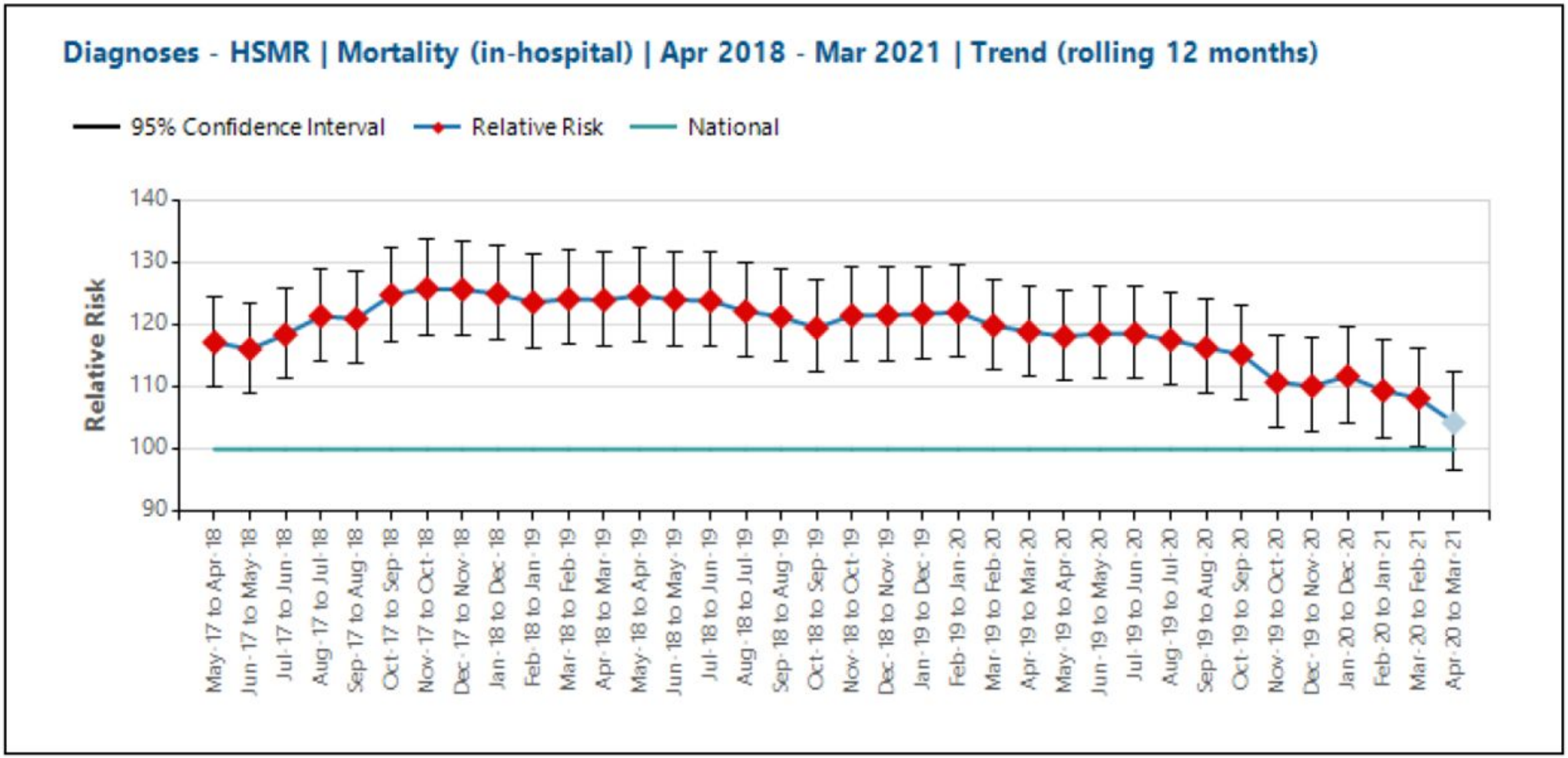
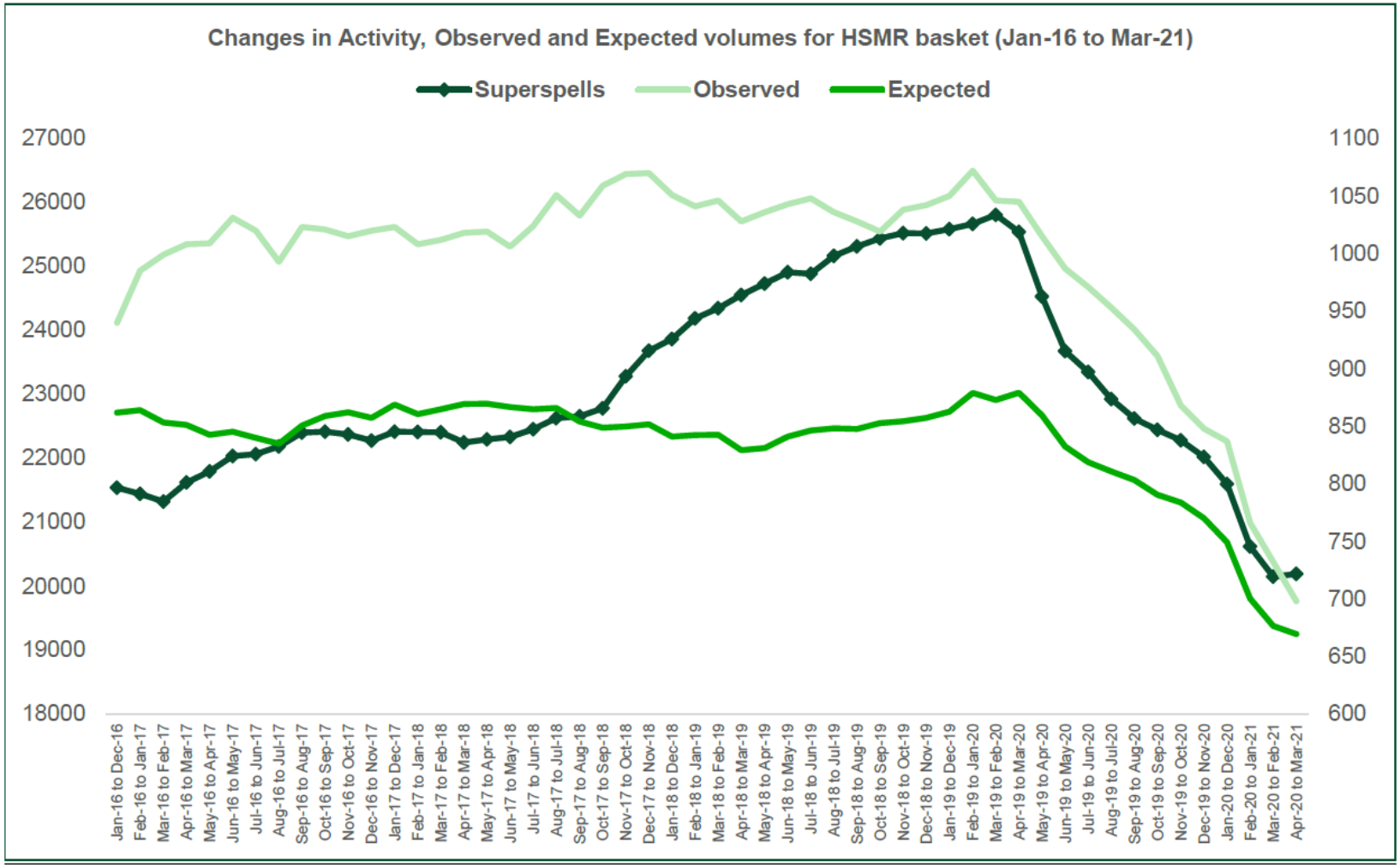


Figure 2.3 – Changes in Superspells, Observed Deaths and Expected Deaths (Last 5 Years)



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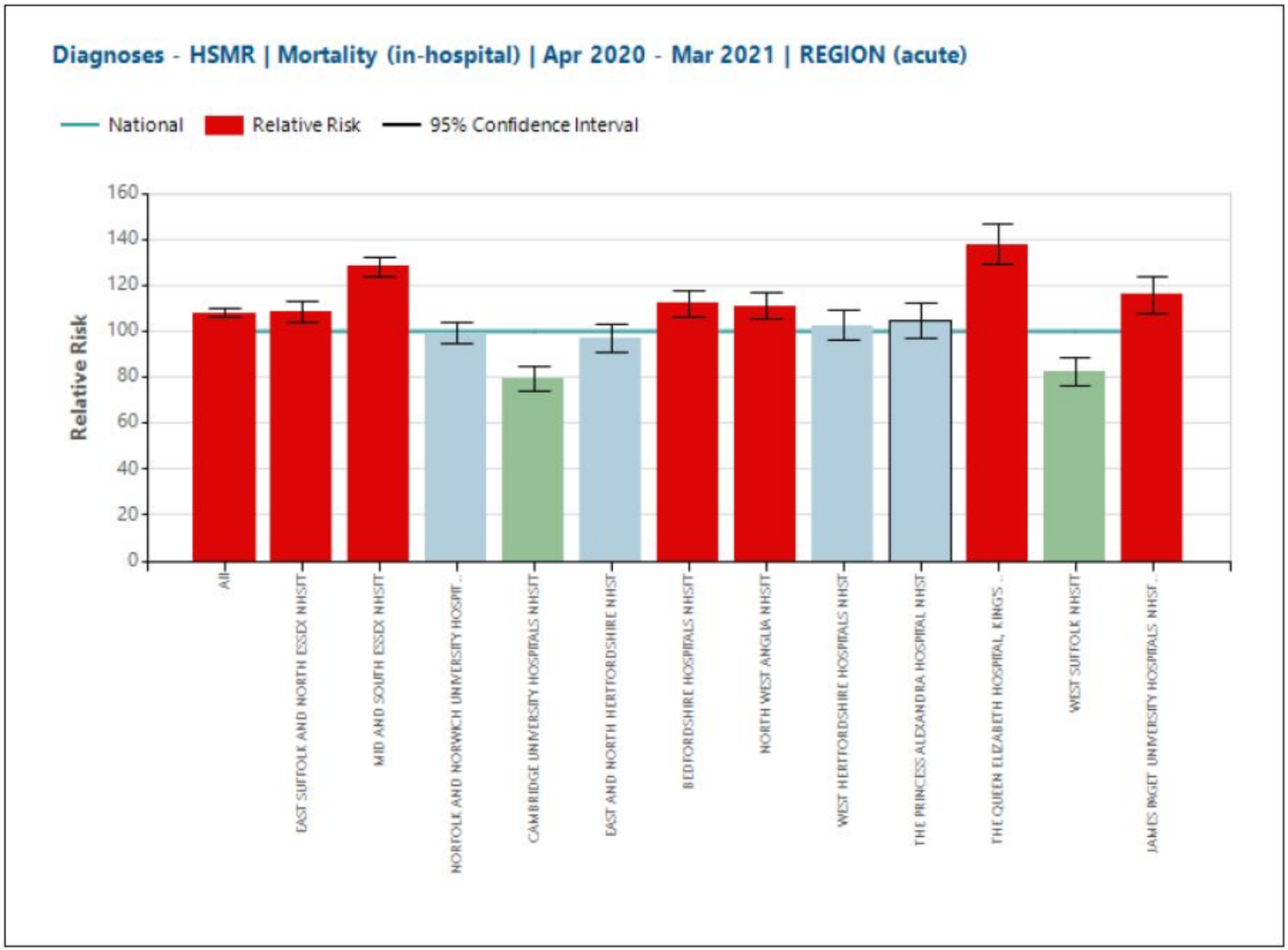


Figure 5.1 – SMR All Diagnoses Rolling Trend (Last 36 Months)

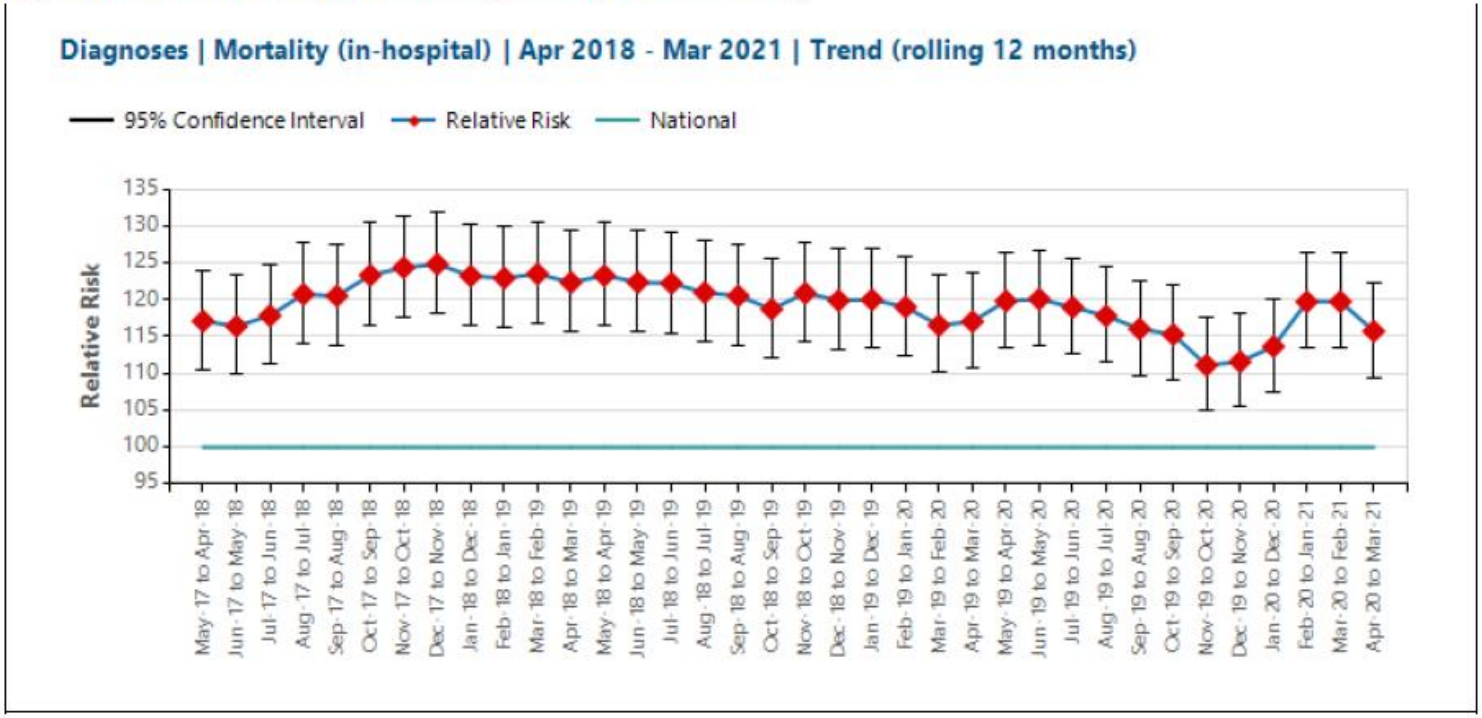
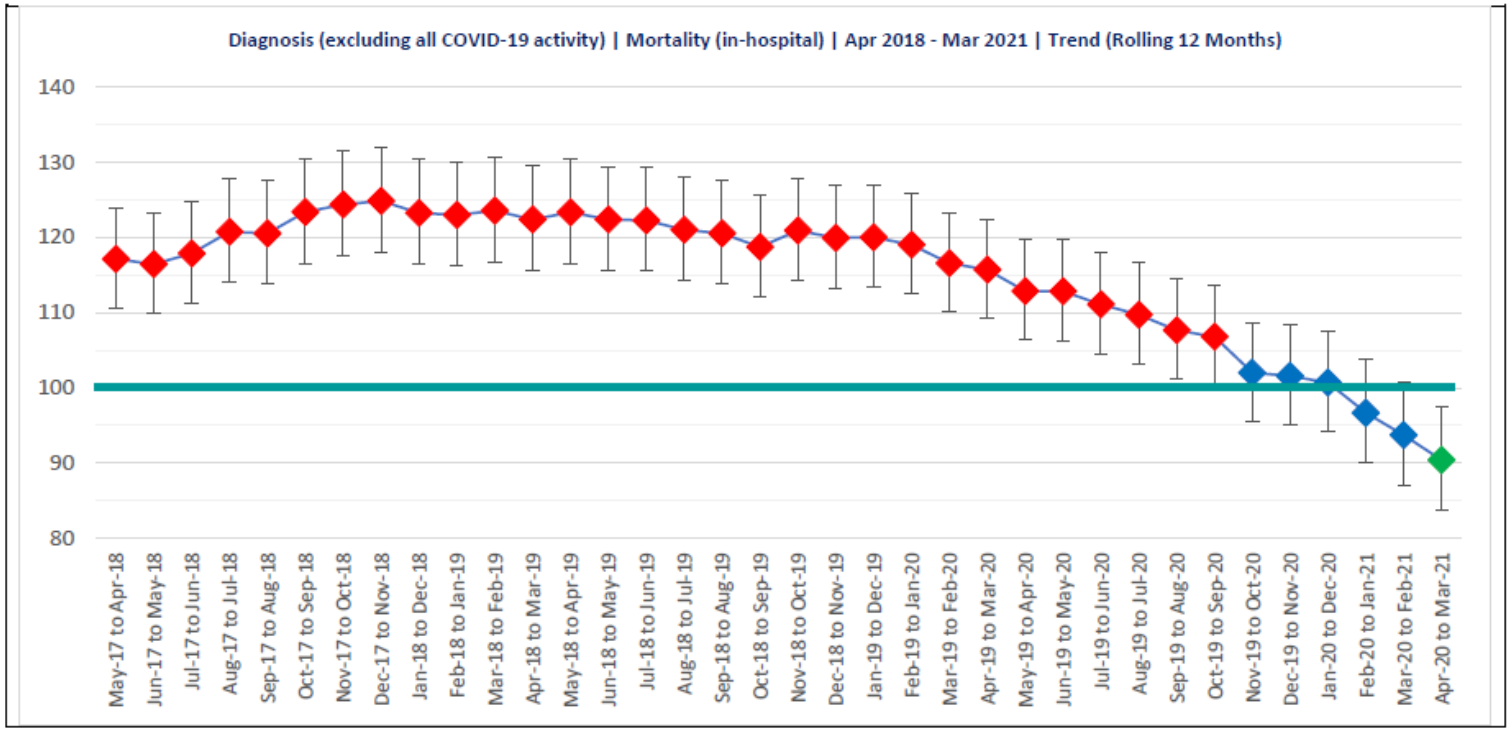
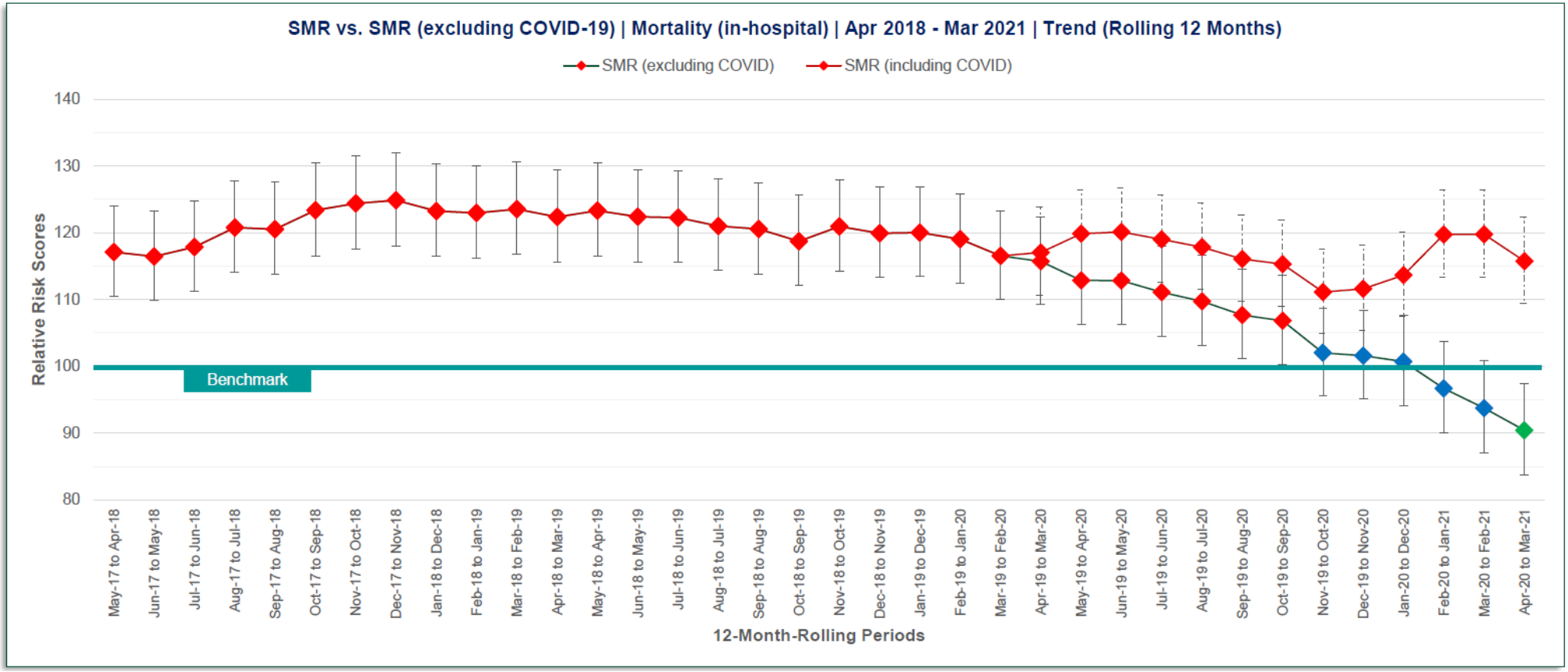


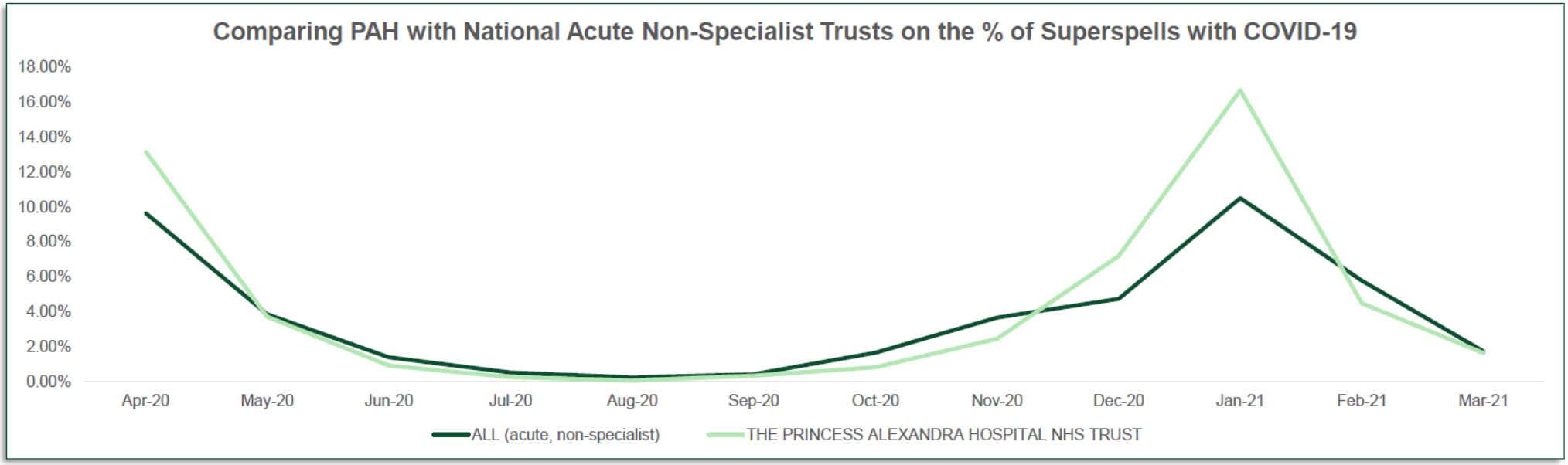
Figure 5.3 – SMR (excluding COVID) All Diagnoses Rolling Trend (Last 36 Months)



Over the last 12 months, comparing relative risk scores when COVID is and isn't included in the SMR model demonstrates the impact of COVID at PAH



PAH have had a higher proportion of COVID-19 patients in Dec-20 and Jan-21 than the national average



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The Princess Alexandra Hospital NHS
NHS Trust

Trust Board (Public) – 05.08.21

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:	28/07/2021
Subject / Title:	Overview of Serious Incidents within maternity in Family And Women's Services

Approval		Decision		Information	X	Assurance	X

Executive Summary: [	Following the Ockenden report published in December 2020, one of the essential actions from enhanced safety was that all Maternity Serious Incident's (SI's) with a summary of key issues must be sent to the Trust Board and at the same time to the Local Maternity and Neonatal System (LMNS) for scrutiny oversight and transparency. There has been 1 new incident declared since the last report. The Maternity Services Health currently have 6 Serious Incidents (SI's) under investigation.
Recommendation:	To provide assurance to the Board that Family and Women's Services Health Group are continually monitoring compliance and learning from serious incidents

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

Previously	QSC 30/7/21
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity	To be compliant with the recent Ockenden report that was published in December 2020 with recommendations for maternity services.
Appendices:	N/A

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1.0 PURPOSE

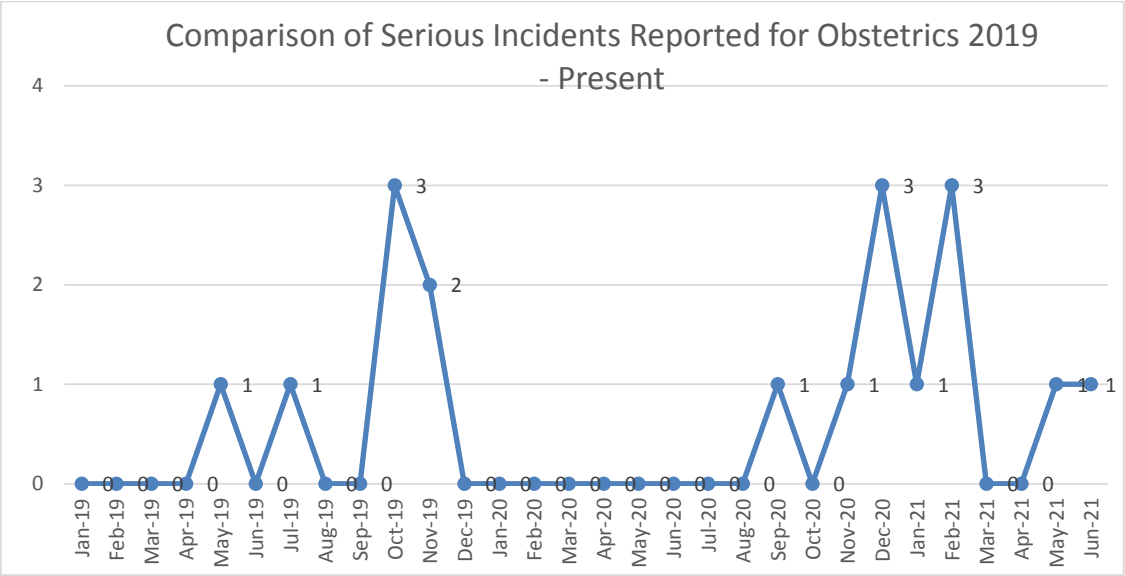
This paper outlines the open Serious (SI's) within Women's Health (Obstetrics and Gynaecology) with concerns, areas of good practice and shared learning identified.

2.0 BACKGROUND

Following the Ockenden report published in December 2020, one of the essential actions from enhanced safety was that all Maternity SI's with a summary of key issues must be sent to the Trust Board and at the same time to the local LMNS for scrutiny, oversight and transparency.

3.0 ANALYSIS

Serious and Internal Incidents



Overview of Incidents

Obstetrics currently have 6 Serious Incidents (SI's) under investigation, these are within the agreed timeframe with root cause analysis investigations on going.
The areas of focus within the open SI's are:

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

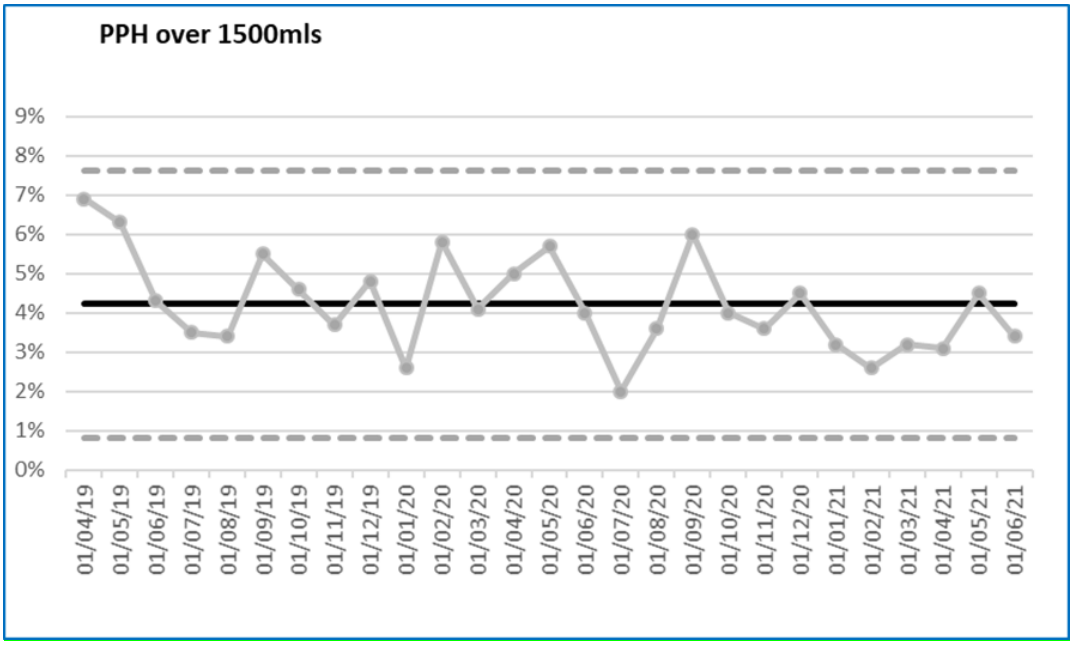
The new incident declared in month is detailed below:

23.05.2021 Massive Obstetric Haemorrhage 3200mls. Patient was transferred to there for a manual removal under general anaesthetic. The patient received 4 units of RBC. Concerns with possible delay of transfer and blood products. **Investigation ongoing – Round-table to be arranged**. Immediate changes and actions:

- Rapid review undertaken
- Review by Consultant Anaesthetist and Obstetrician
- Debrief with staff involved
- Post-Partum Haemorrhage (PPH) proforma updated to encourage the use of O Negative blood and prompt earlier transfer to theatre

- Review of Registrar rota to be undertaken by Labour Ward Lead Consultant

The board will note that PPH has been a significant focus for the HCG and there has been significant improvement. The PPH rate for June 2021 was 3.3%, with a national target rate of 2.9%.



Information is shared through the LMNS including Watford General Hospital and Lister Hospital for shared learning and improvement initiatives. The LMNS range for PPH is between 2.9% - 3.4%, demonstrating the rate for PAH (3.3%) remains similar to other comparable trusts.

The Health Care Group continues to ensure PPH is a focus of improvement and is monitored through the PPH rolling audit, weekly PPH thematic reviews and a PPH working group. This is also shared through the patient safety and quality meetings.

Healthcare Safety Investigation Branch (HSIB)

There are no active cases with HSIB

4.0 OVERSIGHT

All highlighted concerns have been escalated at Health group board. All incidents are discussed at the Health Group Patient Safety and Quality Group and Trust Incident Management Group and escalated where relevant for further investigation. There has been good transparency and openness from the service relating to a cluster of maternity incidents which are currently under external review. This has been discussed at Trust level, CCG, CQC, NHSI/E and with the Regional Chief Midwifery Officer.

5.0 RECOMMENDATION

It is requested that the board accept the report with the information provided and the ongoing work with the investigation process.

Author: Erin Harrison: Lead Governance Midwife **Date:** 22/07/2021

Trust Board (Public) – 05.08.21

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:	15 July 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:	Staffing risk rating in month: GREEN The fill rate for overall RN/RM in month 94.6% Temporary staff demand has decreased across the Trust and agency usage continues to be restricted to ED and ITU or where specialist nursing skills are required. There has been an increased use of RMN specials due to the higher than normal number of patients with mental health needs being in our care The overall nursing vacancy rate is 4.6%. The report details our pipeline of starters and summarises international recruitment activity which is supported by additional investment from NHSE.							
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.26.07.21
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.

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

2.0 BACKGROUND

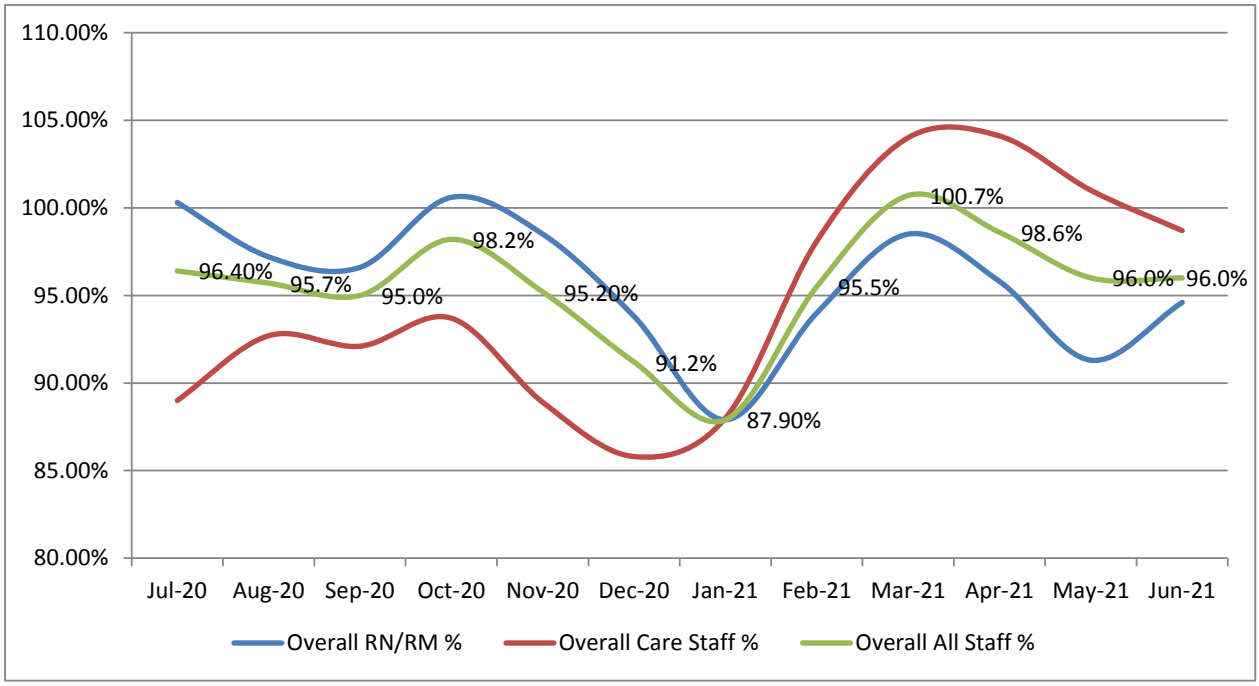
The report is collated in line with The National Quality Board recommendations (June 2016).

3.0 ANALYSIS

3.1 The Trust Safer Staffing Fill rates for June 2021 against the standard templates for overall RN/RM in month has increased to 94.6%, which is an increase of 1.3% against May 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 June 21	89.9%	94.8%	98.3%	104.3%	94.6%	98.7%	96.0%
In Patient Ward average May 21	91.3%	97.1%	97.3%	106.7%	93.4%	101.1%	96.0%
Variance May 21 – June 21	↓1.4%	↓2.3%	↑1.0%	↓2.4%	↑1.3%	↓2.4%	-



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 (%)
April 2021	87.2%	92.6%	104.8%	89.2%
May 2021	89.1%	94.6%	100.9%	88.9%
June 2021	85.3%	96.2%	107.5%	74.1%

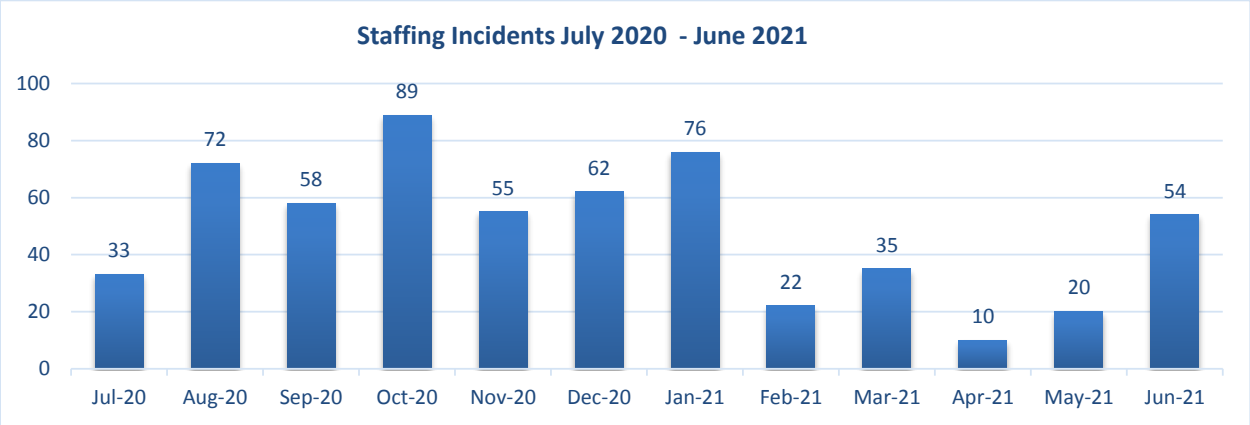
There has been a decrease in registered staffing levels within ED, availability of skilled and experienced senior ED RN's remained a risk despite additional actions that have been taken to increase temporary staffing cover. Monitoring of risk and the potential impact on patient safety continues by the Urgent and Emergency Care team supported by the Executive Team.

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 June. This does not reflect the fluctuating patient numbers on these wards over the month due to bed closures and changes in patient acuity against the norm for these areas following change of use.

3.6 Datix reports:

The trend in reports completed in relation to nursing and midwifery staffing is included below and shows that the number of incidents recorded increased in month to 54 total (↑34), though Tye Green (17) remains the main ward raising Datix reports in relation to staffing levels. Staff on Tye Green are being supported to analyse and report where care has been affected by safe staffing rather than when below template. Triangulation with patient safety incidents raised has not identified any patient safety issues as a direct result of the staffing concerns however close monitoring of trends in patient safety issues is identifying an increase in month of incidents relating to essential care e.g. pressure ulcers, falls with harm etc.



3.9 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 June there was a decrease in registered requirements, the main areas utilising agency staff continued to be A&E Nursing and critical care where specialist skills are required. There was a decrease in registered demand (↓99 shifts) in June compared to May. June also shows an increase in agency usage (↑90 shifts). The overall fill rate increased from 78.8% to 80.4%

RN temporary staffing demand and fill rates*: (May 2021 data supplied by NHSP 5.7.2021)*

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
February 2021	3086	1739	56.4%	345	11.2%	67.5%	1002	32.5%
March 2021	3294	1892	69.0%	380	11.05%	69%	1022	31%
April 2021	2666	1642	61.6%	340	12.08%	74.3%	684	25.07%
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%**
June 2020	975	750	76.9%	73	7.5%	84.4%	152	15.6%

The HCSW demand shows a reduction in unregistered demand (↓51 shifts), there was also an increase in fill rate from 84.5% in May to 85.7% in June. There continued to be zero agency HCA filled shifts in June demonstrating the impact of HCSW recruitment.

HCA temporary staffing demand and fill rates: ***(May 2021 data supplied by NHSP 5.7.2021)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
February 2021	1539	972	63.2%	151	9.8%	73.0%	416	27.0%
March 2021	1635	911	55.7%	131	8.0%	63.7%	593	36.6%
April 2021	1397	1007	72.01%	33	2.04%	74.04%	357	25.06%
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%**
June 2020	650	539	82.9%	0	0	82.9%	111	17.1%

B: Workforce:

Nursing Recruitment Pipeline

The overall nursing vacancy rate in June was 4.6% a reduction of 0.2% from May The vacancy rate for Band 5 RN's was 1.2% (3.9% in May). 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 and does not include additional posts 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	938.00	945.00	968.00	987.00	980.00	973.00	966.00	959.00
Vacancy WTE	51.25	46.25	44.25	29.25	28.25	21.25	-1.75	-20.75	-13.75	-6.75	0.25	7.25
Actual RN Vacancy Rate	5.3%	4.8%	4.6%	3.0%	2.9%	2.2%	-0.2%	-2.1%	-1.4%	-0.7%	0.0%	0.8%
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	517	524	547	566	561	556	551	546	541
Band 5 Starters	12	16	16	7	13	29	25	1	1	1	1	1
Vacancy Band 5 WTE	24.2	20.2	6.2	5.2	-1.8	-24.8	-43.8	-38.8	-33.8	-28.8	-23.8	-18.8
Actual Vacancy Rate	4.6%	3.9%	1.2%	1.0%	-0.3%	-4.7%	-8.4%	-7.4%	-6.5%	-5.5%	-4.6%	-3.6%
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	4	4	4	4	2	2	2	2	2
Band 5 Newly Qualified + Local	1	0	3	1	1	16	12	1	1	1	1	1
Band 5 International Recruitment	11	16	13	6	12	13	13					
Band 5 Starters	**12**	**16**	**16**	**7**	**13**	**29**	**25**	**1**	**1**	**1**	**1**	**1**
Total Starters	15	18	19	11	17	33	29	3	3	3	3	3

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	4	4	4	4	4	4	4	4	4
Band 5 Leavers	6	12	2	6	6	6	6	6	6	6	6	6
Total Leavers	**10**	**16**	**4**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
N&M Turnover %	8.65%	10.83%	10.42%									

The Trust receive support for recruitment of healthcare support workers from NHSE/I. The following is the pipeline and recruitment trajectory. The recruitment team are working closely with the practice development team, department leads to support the recruitment and on boarding of this group of staff

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	381.00	391.00	401.00	411.00	411.00	411.00	411.00	411.00	411.00
Vacancy WTE	53	44	43	38	28	18	8	8	8	8	8	8
Actual B2/B3 Vacancy Rate	12.6%	10.5%	10.3%	9.1%	6.7%	4.3%	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%
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**	**15**	**20**	**20**	**20**	**10**	**10**	**10**	**10**	**10**
Total Starters	0	**19**	**9**	**15**	**20**	**20**	**20**	**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**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**	**10**
HCSW Turnover %	11.59%	12.23%	12.45%									

The Trust have appointed a new Recruitment and Retention Nurse who will join the Trust next month.

4.0 RECOMMENDATION

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

Author: Sarah Webb, Deputy Director of Nursing and Midwifery

Date 15 July 2021

Appendix 1

Ward level data: fill rates June 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.

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

	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	89.5%	91.7%	88.2%	65.0%	88.8%	78.4%	87.3%
John Snow Ward	138.0%	129.8%	102.1%	150.0%	120.8%	131.2%	123.2%
Henry Moore Ward	84.9%	80.9%	118.3%	83.3%	97.6%	81.7%	91.6%
Harvey Ward	91.4%	81.1%	105.6%	85.4%	97.1%	83.2%	90.7%
Lister Ward	88.5%	98.0%	94.2%	103.3%	90.9%	100.1%	94.9%
Locke Ward	94.6%	93.9%	108.3%	126.0%	100.4%	106.1%	102.4%
Ray Ward	96.4%	79.0%	123.3%	109.8%	106.5%	88.7%	99.0%
Saunders Unit	95.5%	114.9%	125.8%	126.2%	136.8%	119.1%	130.1%
Nightingale Ward	79.9%	70.0%	100.0%	104.7%	88.1%	83.2%	86.0%
Tye Green Ward	86.4%	90.3%	100.3%	111.9%	92.3%	99.1%	95.3%
Winter Ward	85.1%	86.4%	104.9%	104.8%	93.5%	93.9%	93.6%
Charnley Ward	83.0%	97.2%	96.7%	107.7%	88.8%	101.5%	94.3%
AAU	76.7%	109.2%	75.9%	134.3%	76.3%	121.2%	88.6%
Kingsmoor Red	49.9%	49.8%	93.3%	53.0%	66.4%	50.8%	60.5%
Kingsmoor Covid	55.6%	46.4%	100.0%	100.0%	72.4%	63.2%	69.0%
Kingsmoor Surg	77.9%	75.1%	94.7%	72.9%	84.3%	74.1%	79.8%
Fleming Ward	83.9%	88.8%	100.0%	103.0%	90.7%	94.1%	92.0%
Harold Ward	93.9%	117.9%	103.4%	102.2%	98.4%	110.4%	103.6%
Neo-Natal Unit	87.3%	130.4%	82.9%	143.3%	85.1%	136.9%	93.7%

Dolphin Ward	71.8%	60.3%	100.0%	100.6%	84.3%	73.7%	81.7%
Maternity	97.6%	103.4%	90.5%	89.6%	94.2%	96.8%	95.0%
Total	89.9%	94.8%	98.3%	104.3%	94.6%	98.7%	96.0%

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
Kingsmoor RED / COVID	Data Quality due to the ward being split into two nursing teams.	Nil	

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 05.08.21

3.4

Agenda item:	3.4							
Presented by:	Stephanie Lawton Chief Operating Officer							
Prepared by:	Elizabeth Podd, Head of Performance and Planning							
Date prepared:	July 2021							
Subject / title:	Update on the Elective Recovery Programme							
Purpose:	Approval		Decision		Information	X	Assurance	X
Key issues:	• Supporting patients and staff throughout the recovery and restoration of all patient services. • clinical risk stratification and prioritisation • patient communication is an important part of recovery and choice of provider is included where feasible. • Additional activity is being delivered both at PAH and at alternative independent providers to reduce the built up waiting lists. • Pathway innovations are assisting in the efficient delivery of activity • Activity is monitored and recovery trajectories are in place. • PAH & HWE ICS are one of the top achievers in elective recovery in the country. • Covid modelling and capacity planning • Critical care capacity							
Recommendation:	The board are asked to note the progress in recovery of activity and the complex planning and mitigations to ensure recovery can continue over 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:	N/A
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:	None

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1.0 Introduction

This paper details the approach to and the outcome of elective recovery following the first and second wave of Covid between March 2020 and April 2021.

The Trust approached Elective Recovery using the following principles:

- Staff Recovery
- Clinical Risk Mitigation
- Patient Communication
- Accurate data
- Planning
- Recovery trajectories
- Monitoring
- Transparency

2.0 Staff Recovery

The Trust directed staff recovery as a primary aim after the peak of Covid. An extensive 3-month programme, “Back to Better” was commenced including webinars, one to one and group counselling & support services and manager discussions with staff. This was supported with a number of feedback process including Here to Hear and workshops looking at the Staff Survey results. The elective staff were redeployed throughout Covid and required a period of recuperation and up-skilling to support their return to elective work. This staff recovery process, along with the gradual change over of wards from Covid to more usual specialty work, necessitated a gradual switch-on of elective services.

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.

During the waves of Covid-19 the Trust implemented that cancer stratification and elective prioritisation processes to ensure that patients on elective waiting lists were clinically prioritised to enable the booking teams to identify the most urgent patients for booking. This required system changes and all patients added to the elective waiting list now have a clinical priority added by the listing clinician:

- P1 – emergency
- P2 – requires procedure within 1 month
- P3 –up to 3 months
- P4 – up to 6 months
- P5 – patient wishes to wait until after Covid

The changes in booking to the clinical prioritisation has ensured that over the period to 30th June 2021 the Trust has booked all overdue P2 patients and is booking P2 patients within the target period and performance monitoring this. The Trust has set an aim to replicate this for P3 patients by 30th September.

Out-patient waiting lists were too large for individual patient prioritisation but specialty & sub specialty prioritisation of clinics was implemented to ensure that the most urgent out-patient appointments were made, along with the continuation of cancer appointments.

The Trust continued to offer out-patient appointments on a virtual basis until June 2021 (with clinically required exceptions for clinically essential face to face appointments) when face to

face appointments were expanded to a wider cohort. The Trust aims to maintain a minimum 50% virtual appointment performance.

At no point during the Covid-19 period has the Trust paused referrals as it was considered better to receive a referral & triage it for urgency than leave the referring clinicians with an unplaced referral. This has created a large build of Appointment Slot Issues (ASIs or unbooked first appointments) however these are being triaged & booked now that face to face clinics are being implemented.

A process to review long waiting patients is being implemented in individual specialities and linked with a refreshed Harm Review process to ensure that we have full knowledge of the impact of the waits on individual patients and cohorts of patients. We will then be able to implement mitigating actions to prevent further deterioration.

The Diagnostic Waiting Lists are also undergoing a clinical review and prioritisation similar to the admitted waiting lists, (D1-5), and since commencing the national programme in June 2021 we have prioritised 89% of the diagnostic waiting list and new referrals are being prioritised on receipt & clinical triage. The Trust aims to have the diagnostic waiting list completely prioritised by 31st August, this will require a number of individual patient reviews in service led diagnostic modalities.

The Trust has also developed an alert flag on the Patient Administration System (Cosmic) for patients that are Clinically Extremely Vulnerable to Covid or other conditions. The national list of “shielding” patients are flagged on Cosmic and this will enable the Trust to ensure that patients have appropriate arrangements in place to mitigate their risk, e.g. minimise face to face appointments, ensure vaccination offered quickly, enhanced Covid secure environment. Over 2000 patients have the alert registered on Cosmic along with the condition that links to the clinical vulnerability and an agreed process for the 7000 patients without the known condition is being implemented.

System Access Board proposed an application to Essex County Council to join their Essex Wellbeing Service (EWS) which will support patients with their Emotional and Physical Wellbeing whilst they are awaiting an operation. The outcome of these calls will allow patients to access the services to help them become fitter, healthier and more prepared for their surgery thus resulting in less delays to surgery, quicker post-operative recovery and a quicker discharge.

4.0 Patient Communication & Choice

During 2020 patients on the admitted waiting list were written to and updated on the delay in accessing elective surgery. Patients were offered the option of contacting and speaking to a member of staff to provide further information on when they were likely to be offered an appointment. Patients were offered a choice of a virtual appointment to address any ongoing concerns.

Following discussion with the patient panel further communication has been designed to be sent to all patients waiting for a date for surgery. A letter has been approved through the System Access Board to be sent to all long waiting un-booked patients this summer. The letter will be sent out in cohorts, overdue P3, long waiting P3, then P4 & non-admitted patients. The letter apologises for the delay in the patients’ appointments and explains the additional capacity that the Trust has implemented in order to book patients as quickly as possible. System Access Board has proposed to follow this letter up with a second questionnaire for patients to feedback on their condition so that a further clinical prioritisation can be undertaken. It is hoped that this can be by two way text messaging for a majority of patients with paper letters for those that do not/cannot respond electronically.

Additional services are being delivered in alternative providers and patients are offered choice whenever possible. Support from the CCG to offer transport to patients if they are willing to travel assists in the uptake of offers.

Patients are able to choose to “wait until after Covid-19” and their response is recorded on the waiting list, this replaces previous Access Policies where a refusal to accept two reasonable appointments would result in discharge to the GP.

5.0 Activity Delivery

During the Covid waves the Trust has maintained some high priority elective work using facilities in the Independent sector hospitals and by commissioning teams of additional staff to deliver out-patient services at the Trust. As the winter wave of Covid started to reduce the operational teams pro-actively negotiated with a large number of independent sector providers to deliver elective operating, both day case and in-patient, out-patient appointments and procedures and a wide range of diagnostics from March 2021 onwards. The Trust commissioned over 1200 elective procedures to 30th June to reduce the admitted waiting list. Additional staff have been employed to contact patients to offer alternative providers for their procedures, appointments and diagnostics.

Six providers are delivering

- Dermatology O/Ps & minor procedures
- Rheumatology
- Gastroenterology
- Glaucoma reviews
- Ophthalmology
- Endoscopy
- Flexi-cystoscopies
- Orthopaedic, General surgery, operating
- MRI

Further contracts are being developed for MRI & CT capacity and Echocardiogram diagnostics.

Out-patient appointments continued throughout the Covid waves albeit majority virtually and face to face appointments were re-established in June which has increased capacity for specialities that required face to face assessment. Some specialties implemented super Saturday clinics with 40-50 patients seen in a day by a team of consultants and registrars. The Trust also continues to focus on clearing the 2020 Review lists (un-booked follow-ups). The IS contracts noted above are supporting this activity with considerable successes with 8 specialities having cleared their 2020 Review list and 15 specialities on track for clearance this year as planned.

Day case operating recommenced in late March using four theatres and initially reduced lists to enable staff to upskill and reach capacity. Careful booking of the lists to ensure high levels of theatre utilisation was reviewed clinically.

PAH elective bed capacity opened at the end of April 2021 with one ward initially, operating increased to six theatres in May and nine from June onwards. Weekly booking meetings with the cancer team and elective performance manager ensured that booking focussed on the Priority 2 patients and the target to have no overdue P2 patients by the end of June was achieved. Additional weekend lists were also delivered to increase capacity and to help clear the long waiting patients.

6.0 Innovations

Third endoscopy room, identified in recovery phase after wave 1, has been built & opened in July 2021. An independent sector provider delivered weekend endoscopy sessions during the

first quarter is supporting the delivery of the third room and surgery staff are supporting in July – September.

Lower GI have implemented a triage & straight to test pathway for cancer referrals which has ensured that patients are directed to the most appropriate intervention on referral, endoscopy, out-patient referral, FIT testing or advice & guidance. This is being closely linked to the development of a "care of the elderly" triage service for colorectal referrals.

The development of the Vague Symptoms pathway has created a more efficient process for patients with no obvious pathway and Cytosponge is being piloted for O/P diagnosis of upper GI conditions.

Patient Initiated Follow Up (PIFU) appointments are being piloted in fracture clinic & neurology with 3 more specialities being developed. The implementation of PIFU is a requirement for access to Elective Recovery Funding.

Orthopaedics are piloting a virtual follow up pathway for arthroplasty patients, which combines a patient questionnaire, Xray and letter or virtual appointment for ongoing monitoring of hip & knee replacements.

The use of Advice & Guidance is being encouraged and numbers are increasing including the implementation of the e-RS upgrade enabling advice & guidance requests to be converted direct to an appointment if required. In addition, the ICS is establishing a pilot to use the "Consultant Connect" advice service using a national list of consultants for GP advice.

Two way text messaging has been implemented and enables the Trust to communicate more efficiently with patients and receive feedback. In addition a pilot to send letters digitally is progressing well.

The Quality 1st team are continuing to support the theatre improvement project with the help of the AMD for Surgery & Critical Care and also encouraging the development of more O/P minor operations capacity.

7.0 Data, planning, trajectories & monitoring

The 18 week and cancer validation teams have adapted their work programmes to support the change in focus to book patients in a clinically prioritised manner moving away from some of the previous work focussing on performance data quality to clinical priority data quality.

Over the recovery period the Trust has set recovery trajectories for both cancer and long waiting elective patients:

- Reach a sustainable level of P2 patient volume & No overdue P2 patients by 30th June – achieved
- No overdue P3 patients by 30th September
- No patient over 78 weeks by 30th September
- Sustainable levels of >62 day cancer patient volume by 30th June – not achieved, new trajectory being developed to share with Exec team & SMT 31/7.
- DM01 6 week performance – trajectory to 99% by 31/12/21 overall with individual modalities achieving at different dates within the period.
- Endoscopy – trajectory to achieve sustainable 2ww volumes by June – achieved early July, no overdue surveillance patients by 30th November, overall DM01 compliance 31/08/21, on track.

The Herts & West Essex ICS Planned Care group has been supporting and developing planned care recovery across all providers in the area, primary, community & acute. As part of this the group swiftly developed a system waiting list view including

prioritisation which has been used to identify areas of focus for the system. In addition mutual aid has been implemented wherever possible and PAH has received support through these processes. In addition the system PTL enables a review of potential health inequalities across cohorts such as ethnicity, gender & social deprivation. No significant inequalities have been identified but a monthly review continues to ensure we have early escalation of any unintended consequences of recovery planning.

8.0 Achievements

The national Elective Recovery programme has a funding commitment to enable systems to commission additional activity to support recovery. The funding is allocated at ICS level on ICS achievements and therefore the close working relationships across the system have been key in developing a robust recovery plan and adequate financial compensation.

The initial requirements were:

Activity levels of:

- April 70%, May 75%, June 80%, July, August & September 85% of 19/20 value of activity at 21/22 tariff
- On 9th July the target was increased to 95% for July, August & September.

Gateway requirements to request funding:

- Reduction in P2 patents more than 3 weeks overdue
- %tage of PTL with P code
- Reduction in long waiting patients 52-104 weeks and over 104 weeks
- Increase in advice & guidance requested & answered
- Increase in number of patients discharged to PIFU pathway
- Increasing proportion of virtual consultations
- Analysis of health inequalities

To date the ICS has received confirmation that we have achieved all the Gateway criteria for April – June 2021, with July being submitted in August.

April Freeze data shows the system meeting the activity value target, with allocated ERF funding calculated at £4,461k for the system. We are awaiting confirmation of the final values for May, and June data will be made available after 24th August.

PAH's individual achievements are shown below in the recovery dashboard table. The HWE system has been identified by the national team as one the highest performing in the country and PAH achieved the highest recovery activity levels in the system. This resulted in discussions with the national team to share our approach and two television news pieces filmed on site.

9.0 Future Challenges

The Trust is currently experiencing significant emergency demand and increased Covid-19 attendances and admissions. The Covid-19 admissions are above the mean forecast for PAH and due to the clinical nature of the patients more are requiring high flow oxygen than in previous waves. This has required the Trust to use Henry Moore ward for patients requiring high flow oxygen and critical care which was previously the elective critical care area. The Trust has made the difficult decision to pause elective in-patient operating from July 15th but day cases are continuing. Additional support from ICS partner trusts and independent sector hospitals is being arranged to be able to deliver in-patient operating for P2 admitted patients. The clinical & operational teams are continuing to work together to find an alternative sustainable in-house capacity for elective operating. Clinical and operational teams are working hard to resume some elective operating as numbers of covid admissions start to stabilise again.

The Princess Alexandra Hospital NHS Trust

Author: Elizabeth Podd, Head of Performance & Planning
Date: 29th July 2021

3.4

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 05.08.21

Agenda item:	4.1
Presented by:	Ogechi Emeadi. Director of people, organisational development and communications
Prepared by:	Ogechi Emeadi. Director of people, organisational development and communications
Date prepared:	20 July 2021
Subject / title:	Freedom to Speak Up Review Tool for NHS Trusts and Foundation Trusts – Annual Review and Case Review

Purpose:	Approval	X	Decision		Information		Assurance	X

Key issues:	This self assessment tool highlights the current position and the improvement needed to meet the expectation of NHSE/! and the National Guardian's Office to encourage speaking up. A previous assessment template was last completed in December 2019. This new template focuses on the SMART objectives to support the implementation. The key areas of improvement centre around The Board 'beng assured your FTSU culture is healthy and effective' NHSE/! are supporting the Trust with this plan and at the time of writing was awaiting the outcome of its review which will be incorporated into the Board submission. The Trust has recruited a further 5 FTSUG to support this work.
Recommendation:	The Committee is asked to: contribute to and approve the self assessment tool ahead of its approval at Trust Board. To note NGO case review report (Appendices 1-3)

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:	WFC.26.07.21
Risk / links with the BAF:	2.3 inability to attract, recruit and retain our people
Legislation, regulatory, equality, diversity and dignity implications:	CQC Well Led KLOEs Equality Act 2000 Employment Rights Act

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respectful • caring • responsible • committed

Appendices:	Case reviews 1. https://nationalguardian.org.uk/wp-content/uploads/2021/04/2019-casereview-whittington.pdf 2. https://nationalguardian.org.uk/wp-content/uploads/2021/04/20190909-North-West-Ambulance-Service-NHS-Trust.pdf 3. 20190619-Brighton-and-Sussex-University-Hospitals-NHS-Trust.pdf (nationalguardian.org.uk) Data report 1. 201920_ftsuq_su_data_report.pdf (nationalguardian.org.uk)

Freedom to Speak Up review tool for NHS trusts and foundation trusts

The Princess Alexandra Hospital NHS Trust

July 2021- Annual review

NHS England and NHS Improvement

NHS England and NHS Improvement:

"This is a tool for the boards of NHS trusts and foundation trusts to accompany the Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts (cross referred with page numbers in the tool) and the Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the Board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the Board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the Board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The Executive lead should take updates to the Board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of Executives and the Board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the Board's perception of itself. The Board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net"

The Princess Alexandra Hospitals NHS Trust

Summary of the expectation	*Ref for complete detail* *Pages refer to the guidance and sections to supplementary information*	**How fully do we meet this now?**		**Evidence to support a 'full' rating**	**Principal actions needed in relation to a 'not' or 'partial' rating**	**Progress Update**
		Insert review status	**Insert review date**			
Behave in a way that encourages workers to speak up						
Individual Executive and Non-Executive Directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • *understand the impact their behaviour can have on a trust's culture* • *know what behaviours encourage and inhibit workers from speaking up* • *test their beliefs about their behaviours using a wide range of feedback* • *reflect on the feedback and make changes as necessary* • *constructively and*	*Section 1* *p5*	**Fully met**	Annual review date July 2022	1. **Appraisals and 360 feedback:** Executives are appraised using the PAHT's values and behaviour charter. One of our values; committed which includes the behaviour 'speaking up' . Executive and non-executive directors (NED) appraisals additionally include 360 feedback, which further supports the identification of development needs, enablesconsideration of feedback and evidence, and importantly provides an opportunity to constructively and compassionately challenge one another. 2. **Concerns raised:** Directors virtually meet with individuals who have raised concerns.		

compassionately challenge each other when appropriate behaviour is not displayed				3. **Senior visibility:** Senior visibility is a priority across corporate communications. This has been continued virtually (in person where appropriate) and innovatively throughout COVID, using methods such as live weekly executive brief to all staff with live virtual Q&As, Intouch briefings, Ask the Experts' live virtual Q&As, team meeting visits, walking the floor at Kao Park to maintain effective visibility. 4. **Corporate Induction:** The CEO presents at the monthly corporate induction, highlighting the importance of the Trust's values, behaviours, and speaking up. Promoting the different routes available to staff, and asking for staff to feed back if senior leaders are not living up to the Trust values. This has continued as the induction has moved to a virtual platform. 5. **Manager's Induction's and Leadership Programmes:** All new managers are asked enrolled on manager's induction. The CEO or director of people additionally asks the managers to hold the executives to account with regards to the Trust values and behaviours, and provide them with feedback when appropriate. All internal leadership development programmes have an element 'meet the leaders' providing an opportunity to meet the executive team. The CEO again encourages participants to challenge poor behaviours. 6. **Values and behaviours:** Executives and Non-Executives along with staff and patient feedback supported the refreshing of the Trust values and will support the accompanying behaviours which will	7.	

				continue to have behaviours of speaking up. 7. **PAHT People Strategy and PAHT 2030 strategy Culture Theme:** PAHT's people strategy has a pillars which encourages speaking, living the trust values and specific measures relating to FTSU. PAHT 2030 has a pivotal theme of culture which includes implementing and embedding the trust new values and behaviours and continue to encourage speaking up and acting the concerns raised and learning the lessons. 8. **Workforce Committee:** The Workforce Committee, consisting of executive and NED, (including the executive FTSU Lead) provides a governance structure and assurance across the People strategy outlined above, and therefore theFTSU measurements and actions. Accountability between members is additionally upheld here, with NEDs are asked to positively challenge process and action. 9. **PAHT Improvement Method (Quality First): and Quality Strategy** PAHT's Quality First and Quality Strategy strengthens and encourages a culture of learning, which requires all staff to be open and honest about aspects that are not where we want them to be; speaking up and utilising the Quality First to continually improve. 10. **NHS Staff Survey:** The annual NHS Staff Survey results of questions related to FTSU and the Trust's speaking up culture, are utilised to measure progress, and highlight areas for improvement at senior		

management team, Board, and Workforce Committee meetings

Summary of the expectation	*Ref for complete detail* *Pages refer to the guidance and sections to supplementary information*	**How fully do we meet this now?**		**Evidence to support a 'full' rating**	**Principal actions needed in relation to a 'not' or 'partial' rating**	**Progress Update**
		Insert review status	**Insert review date**			
Demonstrate commitment to FTSU						
The Board can evidence their commitment to creating an open and honest culture by demonstrating: • *there are a named Executive and Non-Executive leads responsible for speaking up* • *speaking up and other cultural issues are included in the Board development programme*	*p6* *Section 1* *Section 2* *Section 3*	**Partially met**	Annual review date July 2022	1. **Executive and NED leads:** appointments have been made to both positions. 2. **Regular 1:1 meetings**: take place between the CEO, Executive and NED lead for FTSU 3. **Reports to Board:** Regular reports are required to the Board to ensure clear sighting and accountability is upheld, as well as contributing to the Board's own development.	1. **NHSE/I Process and Reporting Reviews** NHSE/I currently undertaking a review of the FTSUS reporting to Workforce Committee and Board to identify areas of improvement including case review and theme and learning.	**1. In Progress:** NHSE feedback due at the end of July 2021

Summary of the expectation	*Ref for complete detail* *Pages refer to the guidance and sections to supplementary information*	**How fully do we meet this now?**		**Evidence to support a 'full' rating**	**Principal actions needed in relation to a 'not' or 'partial' rating**	**Progress Update**
		Insert review status	**Insert review date**			
• *they welcome workers to speak about their experiences in person at Board meetings* • *the Trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility* • *there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made* • *the Trust continually invests in leadership development* • *the Trust regularly evaluates how effective its FTSU Guardian and champion model is* • *the Trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.*				4. **Staff Stories:** Staff stories are presented at Board meetings, inviting a member of staff to share an experience ofworking for PAHT - both positive and negative stories are heard. 5. **Leadership development:** Leaders are supported and encouraged to continually develop. Several formal senior level development opportunities have been undertaken including, Board development (2019) Executive development (2018-19) Executive and divisional directors (2021) Board to Board (2020). Internal leadership development programmes all include an element of values and behaviours and speaking up. Manager's induction includes FTSU content. Informal development is available and encouraged, including coaching and mentoring. HEE/NGO training package forms part of PAHT's training. Human Factors training was delivered to senior leaders (2019) 6. **Bullying and Harassment:** The NHS Staff Survey results are used to monitor and measure progress. These results are discussed during the HCG boards and HCG monthly performance review meetings (PRMs). Relevant connections and actions are also established with the sub-committees, staff networks, EDI, culture steering group, staff side to ensure all issues and opportunities are identified	3. **Identified Trust-wide Improvement:** The 2020 survey results identified improvement required regarding encouraging staff to speak up and acting on concerns raised. The FSUG are part of the culture steering group Recruit clinical FTSUGs Lead CEO/DoP Refresh the Trust's values and supporting behaviours, to further enhance speaking up routes, addressing concerns and learning from the concerns. Lead: DoP A review of leadership programmes to ensure inclusion of FTSU content, human factors training, listening skills including giving and receiving feedback. Lead: DoP/AD for LOD Review of the Disciplinary policy using NHSE/I best practice template to ensure the principles of a just culture is followed.	4. **In Progress:** FTSUG are members of the EDI steering group, the culture steering group. 5 clinical FTSUG have been recruited 4 awaiting the NGO training. The Board have approved new Trust values and SMT have approved the implementation plan with a formal launch in Event in Tent in September 2021 **Completed.** Agreed by Workforce Committee and published on PAHT website.

				and appropriately managed. 7. **FTSU is widely promoted** across PAHT via various methods including InTouch briefings on raising concerns, speak up months. However we wish to develop this further by promoting'speaking up' in relation to all routes available to staff.	**3. Communications campaign:** actions have been established to launch a campaign to promote the different routes of escalation available to staff. The campaign will support the Trust's communication	4. **In Progress**: Key messages communicated in thisyear's 'Speak Up' month. Key messages were incorporated within 2020 speak up. Back to Better programme included InTouch briefing held jointly the FTSUG and NGO engagement lead
					strategy, with actions to ensure it is creative and engaging in its approach. Progress will be measured using the Staff Survey results, and the number of cases. Lead: DoP/AD for CommsC	. In addition, the FTSUG and CEO will once again be joining new starters in the Corporate induction.
					4. **Exranet Development:** Actions are underway to implement a new extranet and to ensure clear and accessible information is available to staff. This aims to support theTrust's communication strategy further. Lead: DoP/ADComms	**4. In Progress:** The extranet contract has been awarded and work continues to develop and enhance FTSU page with plans for it to be launched in Q3 of 2021/22

Summary of the expectation	*Ref for complete detail* *Pages refer to the guidance and sections to supplementary information*	**How fully do we meet this now?**		**Evidence to support a 'full' rating**	**Principal actions needed in relation to a 'not' or 'partial' rating**	**Progress Update**
		Insert review status	**Insert review date**			
Have a strategy to improve your FTSU culture						
The Board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • *as a minimum – the draft strategy was shared with key stakeholders* • *the strategy has been discussed and agreed by the Board* • *the strategy is linked to or embedded within other relevant strategies* • *the Board is regularly updated by the Executive lead on the progress against the strategy as a whole* • *the Executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.*	*P7* *Section 4*	**Fully met**	Annual review date July 2022	1. **Regular strategy updates are provided to the Board**; supported by the Executive Lead and approved by the Board. 2. The overarching Trust **People Strategy** contains specific measures relating to FTSU. 3. The strategy's progress is assured via the **Workforce Committee**, consisting of Executive and Non-Executive members, (including the Executive and Non-Executive FTSU Leads). This Group also ensure required links are made with other relevant strategies sub-committees/networks/groups, and reviews quantitative and qualitative data in relation to FTSU.		

Summary of the expectation	*Ref for complete detail* *Pages refer to*	**How fully do we meet this now?**	**Evidence to support a 'full' rating**	**Principal actions needed in relation to a 'not' or 'partial' rating**	**Progress Update**

	the guidance and sections to supplementary information					
		Insert review status	**Insert review date**			
Support your FTSU Guardian						
The Executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • *they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively* • *the Guardian has been given time and resource to complete training and development*	*p7* *Section 1* *Section 2* *Section 5*	**Fully met**	Annual review date July 2022	1. The Executive team supported the increasing of the number of FTSUGs from 2 to 7. 2. The Guardian attends Regional and National training events and conferences. 3. The Board supported FTSU Leads to receive refresher training 4. Regular coaching and psychological Support sessions are provided to the Guardian.	1. Appoint Lead Guardian With 7 FTSUG it is critical that a lead guardian is appointed. Lead CEO/DoP Q3 of 2021/22	

• *there is support available to enable the Guardian to reflect on the emotional aspects of their role* • *there are regular meetings between the Guardian and key Executives as well as the Non-Executive lead.* • *individual Executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner* • *they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes* • *the Guardian is enabled to develop external relationships and attend National Guardian related events*				5. 1:1 meetings take place between the Guardian, the CEO, Director andNED. 6. Open access is provided to relevant Directors when dealing with individual concerns. 7. The Guardian has regular access to Regional and National training events. 8. The FTSUG Guardian has open access to anonymised patient safety and employeerelations data for triangulation purposes. 9. The Guardian is able to raise issues directly with the relevant strategic HR business partner, the medical director, director nursing, midwifery and allied health professionals, the director of people/FTSU executive Lead and any other relevant executives.		
Be assured your FTSU culture is healthy and effective						

Summary of the expectation	*Ref for complete detail* *Pages refer to the guidance and sections to supplementary information*	**How fully do we meet this now?**		**Evidence to support a 'full' rating**	**Principal actions needed in relation to a 'not' or 'partial' rating**	**Progress Update**
		Insert review status	**Insert review date**			

Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • *that the policy is up to date and has been reviewed at least every two years* • *reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.*	*P8* *Section 8* *National policy*	**Partially met**	Annual review date July 2022	1. The PAHT policy is modelled on NGO policy,contained in PAHT policy review cycle. 2. All policies are reviewed by Staff Side.	1. To review the policy. Lead: DoP/DDoP – August 2021	**1. In Progress:** Currently being reviewed before submitting to staffside. Additionally we will incorporate feedback from NHSE/I review.

Summary of the expectation	*Ref for complete detail* *Pages refer to the guidance and sections to supplementary information*	**How fully do we meet thisnow?** **Insert review status**	**Insert review date**	**Evidence to support a 'full' rating**	**Principal actions needed in relation to a 'not' or 'partial' rating**	**Progress Update**
Evidence that you receive assurance to demonstrate that thespeaking up culture is healthy andeffective. Evidence should demonstrate: • *you receive a variety ofassurance* • *assurance in relation to FTSU is appropriately triangulated with assurancein relation to patient experience/safety and worker experience.* • *you map and assess yourassurance to ensure there*	*P8* *Section 6*	**Partially met**	Annual review date July 2022	1. **Regular updates are provided to the** Board with regards to the improvement strategy, supported by the executive lead. 2. The overarching **Trust People Strategy** consists of specific measures relating to FTSU). These measures are informed by the NHS Staff Survey. 3. The PAHT people strategy deliverables are assured via the **Workforce Committee**, consisting of executive and NED members, (including the executive FTSU leads). This therefore includes assurance of FTSU, and is the forum to triangulate FTSU action with all areas of thepeople strategy deliverables to ensure there are no gaps	1. **NHSE/I Process and Reporting Reviews** NHSE/I currently undertaking a review of the FTSUS reporting to Workforce Committee and Board to identify areas of improvement including case review and theme and learning.	**1. In Progress:** NHSE feedback due at the end of July 2021

Summary of the expectation	*Ref for complete detail* *Pages refer to the guidance and sections to supplementary information*	**How fully do we meet this now?**		**Evidence to support a 'full' rating**	**Principal actions needed in relation to a 'not' or 'partial' rating**	**Progress Update**
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are no gaps and you flex the amount of assurance you require to suit your current circumstances. • *you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection.* • *you evaluate gaps in assurance and manage any risks identified, adding them to the Trust's risk register where appropriate.*				. 4. **The Culture steering group and the EDI steering group** are a sub groups of the people board where FTSU matters are addressed. 5. **Staff Side assurance:** All action is shared with Staff Side for consultation, as well as with other relevant networks/sub-groups (of theWorkforce Committee) for continual supportand progress. 6. **Risks** are added to the Trust's risk register where appropriate. 7. **Quarterly data submissions** take place between the Guardian and the national office, who write back to the CEO with the results. **8. Additional assurance** has is gained/flexed under certain circumstances: for example, following the 2020 Staff Survey results, PAHT introduced Here to hear listening events, online survey as part of Back to Better programme. Analysis of social media comments including internal electronic message boards.	5. **Identified Trust-wide Improvement:** The 2020 survey results identified improvement required regarding encouraging staff to speak up and acting on concerns raised. The FSUG are part of the culture steering group Recruit clinical FTSUGs Lead CEO/DoP Refresh the Trust's values and supporting behaviours, to further enhance speaking up routes, addressing concerns and learning from the concerns. Lead: DoP A review of leadership	6. **In Progress:** FTSUG are members of the EDI steering group, the culture steering group. 5 clinical FTSUG have been recruited 4 awaiting the NGO training. The Board have approved new Trust values and SMT have approved the implementation plan with a formal launch in Event in Tent in September 2021

					programmes to ensure inclusion of FTSU content, human factors training, listening skills including giving and receiving feedback. Lead: DoP/AD for LOD	
					3. Communications campaign: actions have been established to launch a campaign to promote the different routes of escalation available to staff. The campaign will support the Trust's communication	5. **In Progress**: Key messages communicated in thisyear's 'Speak Up' month. Key messages were incorporated within 2020 speak up. Back to Better programme included InTouch briefing held jointly the FTSUG and NGO engagement lead

					4. **Exranet Development:** Actions are underway to implement a new extranet and to ensure clear and accessible information is available to staff. This aims to support theTrust's communication strategy further. Lead: DoP/ADComms	**4. In Progress:** The extranet contract has been awarded and work continues to develop and enhance FTSU page with plans for it to be launched in Q3 of 2021/22

Summary of the expectation	*Ref for complete detail* *Pages refer to the guidance and sections to supplementary information*	**How fully do we meet this now?**		**Evidence to support a 'full' rating**	**Principal actions needed in relation to a 'not' or 'partial' rating**	**Progress Update**
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					3. Ensure the presence of the FTSUG is maintained within the Corporate Induction process throughout changes due to COVID. 4. following the reduction in concerns raised (reflected nationally also), encourage 'speaking up' on the whole range of workplace issues, assuring staff that Covid does not negate our continuing commitment to improving patient care and staff experience.	. The inclusion of FTSU within the Corporate Induction was temporarily interrupted as the process moved to a virtual format, but has now been restored. . FTSUG has included important messages in all Champion training opportunities (FTSU/Dignity at Work/H&W Champions) to ensure immediate action and message sharing takes place across the Trust.
The Board can evidence the Guardian attends Board meetings, at least every six months, and presents a comprehensive report.	*P8* *Section 7*	**Partially met**	Annual review date July 2021	Reports are presented at Workforce Committee, with attendance from the Guardian every four months, which can be evidenced by meeting minutes and papers.	5. Once a lead FTSUG is appointed, the lead FTSUG will present a comprehensive report to the Trust Board. Lead:DoP/lead FTSUG Q4 of 2021/22	
Summary of the expectation	*Ref for complete detail* *Pages refer to the guidance and sections to supplementary*	**How fully do we meet this now?**		**Evidence to support a 'full' rating**	**Principal actions needed in relation to a 'not' or 'partial' rating**	**Progress Update**

	information					
		Insert review status	**Insert review date**			
The Board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other	*Section 1* *NGO JD*	**Fully met**	Annual review date July 2022	All FTSUG were recruited in accordance with the example job profile. The CEO led the recruitment process.		
guidance published by the National Guardian.				and example job description.		
The Board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	*Section 7*	**Partially met**	Annual review date July 2022	Review of data reports and themes are completed quarterly.	Case Reviews, published by NGO, to be included in Workforce Committee and Trust Board. Lead: FTSUG/DoP – July 2021	No new Case Reviews available since Covid restrictions. Relevant material published by NGO to be included as it is released. However, 2020 case review report will be included in July 2021 Workforce Committee
Be open and transparent						

The Trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • *discussion with relevant oversight organisation* • *discussion within relevant peer networks* • *content in the Trust's annual report* • *content on the Trust's website* • *discussion at the Public Board* • *welcoming engagement with the National Guardian and her staff*	*P9*	**Fully met**		1. Regular reports are submitted to Board, and information shared with CQC and the CCG. 2. Discussions take place with relevant oversight organisation- the National Guardians Office and CQC upon their visits, with attendance at national meetings by FTSUGs. 3. Discussion within relevant peer networks take place as described above. 4. FTSU content is present within the Trust's annual report. 5. FTSU discussion takes place at the Public Board. 6. The National Guardian engagement lead attended the Trust and co led a InTouch briefing for all staff about speaking up to ensure welcoming engagement. 7. The Trust website highlights the NED's additional role and duties as FTSU Lead, alongside membership on theBoard.		

Summary of the expectation	*Ref for complete detail* *Pages refer to the guidance and sections to supplementary information*	**How fully do we meet this now?**		**Evidence to support a 'full' rating**	**Principal actions needed in relation to a 'not' or 'partial' rating**	**Progress Update**
		Insert review status	**Insert review date**			
Individual responsibilities						

The Chair, Chief Executive, Executive lead for FTSU, Non-Executive lead for FTSU, HR/OD Director, Medical Director and Director of Nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	*Section 1*	**Fully met**	Annual review date July 2022	1. **Appraisals and 360 feedback:** Executives are appraised using the PAHT behaviour charter which underpins the values which includes speaking up. Executive and NEDs appraisals additionally include 360 feedback, which further supports the identification of development needs, enables consideration of peer feedback and evidence, and importantly provides an opportunity for peers to constructively and compassionately challenge one another. 2. **Regular 1:1 meetings**: which take place between the CEO, Executive and NED supports the above considerations additionally taking place for NEDs also.		

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report for June 2021

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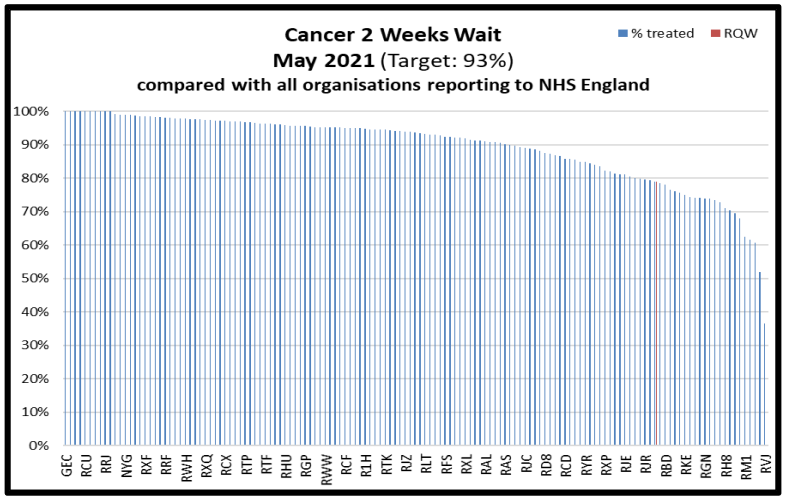
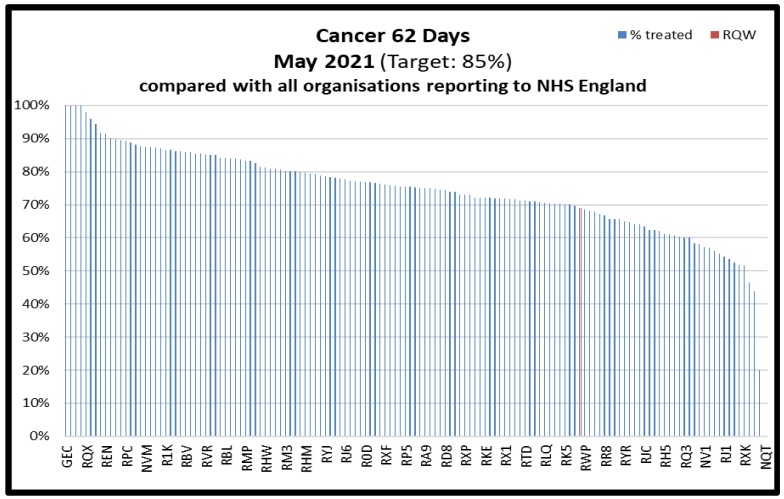
Performance Summary

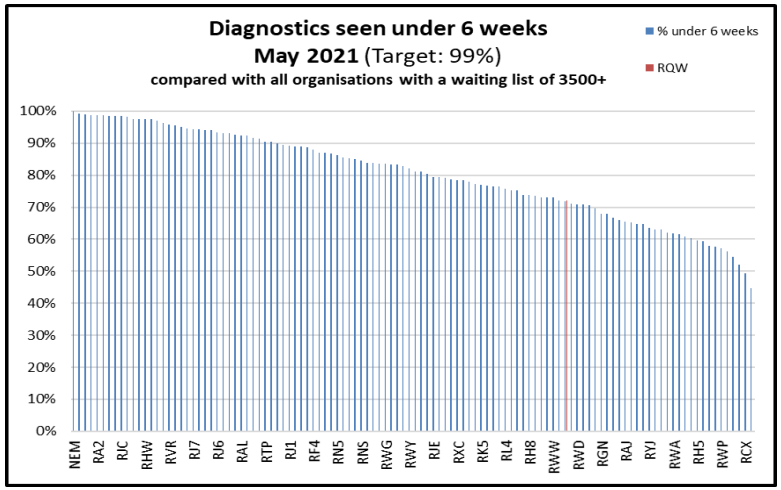
Patients		
Patients	**CTG Training**	Midwifery training is 73% against a target of 85%. The HCG have a focused improvement plan to achieve compliance following a move to Physiological interpretation.
Patients	**Mental Health Metrics**	Of note, the organisation had one detained patient under the mental health act in June, and eleven patient under mental health care. The Mental Health Quality Forum (MHQF) are working with the Strategy team to develop our mental health strategy. The MHQF are also working with our mental health partners on improvement .
Patients	**Compliments**	Logging has recommenced, with the volume the highest since February2020
Pounds		
Pounds	**Year to Date**	The Trust's financial performance at M3 is a surplus of £83k against a break-even plan. A significant amount of activity recovery has been achieved during the first quarter with the additional costs of this being matched by additional income provided through the Elective Recovery Fund (ERF).
Pounds	**Year to Date**	The Trust's YTD capital expenditure is £3.9m against a plan of £6.3m. The shortfall is mainly due to timing issues. The capital programme is under significant pressure. Mitigations are being developed to balance the value of schemes within the available funding.
Places		
Places	Categorty 2 Responsiveness	Three months of continued increase in performance has seen it near the upper control limit
People		
People	**Appraisals**	Now out of special cause variation and showing continued improvement over the last four months
People	**Statutory and Madatory Training**	Whilst still not in special cause variation, there has been a small reduction in performance in June
People	**Sickness Absence**	In common cause variation with a small increase on May, but still performing at or under the target
Performance		
Performance	**RTT**	Performance remains in special cause variation, but recovery actions are in place. The downward trend appears to have plateaud over the last two months
Performance	**Cancer 2 week wait**	Whilst performance remains in common cause variation with no significant change, it has dropped below the target and mean for May
Performance	**Cancer 62 day pathway**	Remains in special cause variation and below the mean
Performance	**Four hour standard**	In special cause variation, and very near the lower control limit for performance. Attendances exceeded the upper control limit for June. We also saw an increase in ambulance handover > 60 mins, and patients spending more than 12 hours in ED from arrival
Performance	**Diagnostics**	Still in special cause vairation. Performance has plateaud after 3 months on an upward trajectory
Performance	**52 week waits**	Still in special cause variation, but volume has potentially plateaud with a reduction over the last two months
Performance	**Bed occupancy**	Bed occupancy has continued to increase for 6 months, and more sharply over the last two, and now at the upper control limit. However, this continues to not correlate with beds occupied with stranded patients, which remains around the mean

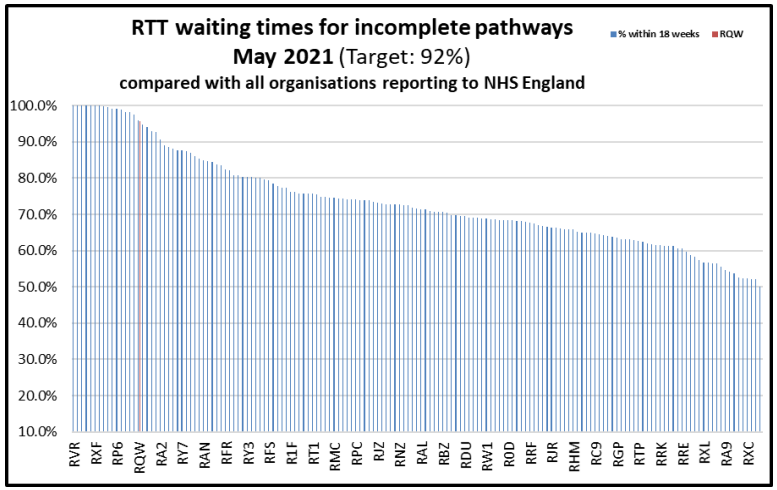
Summary

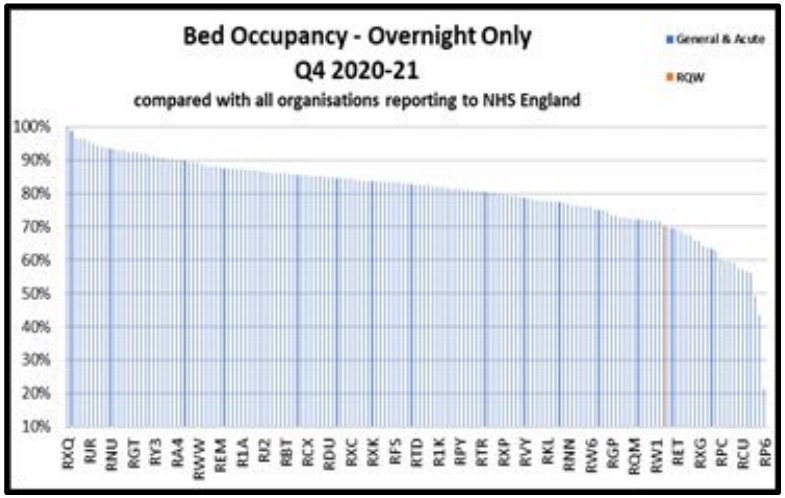
National Benchmarking

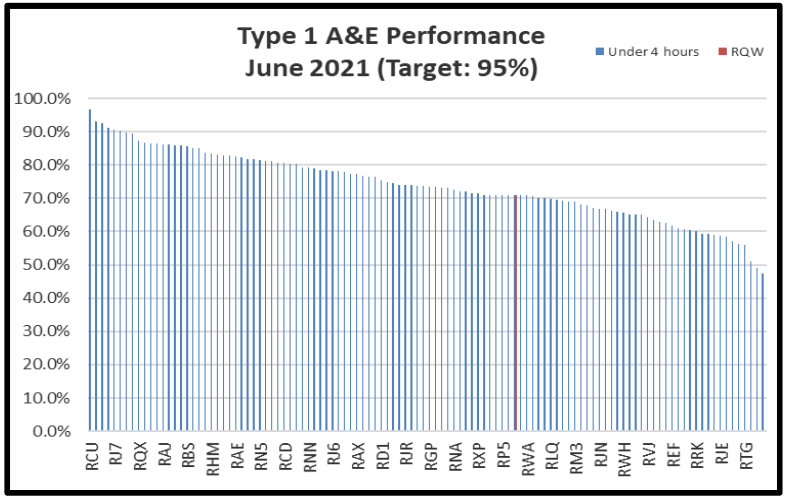


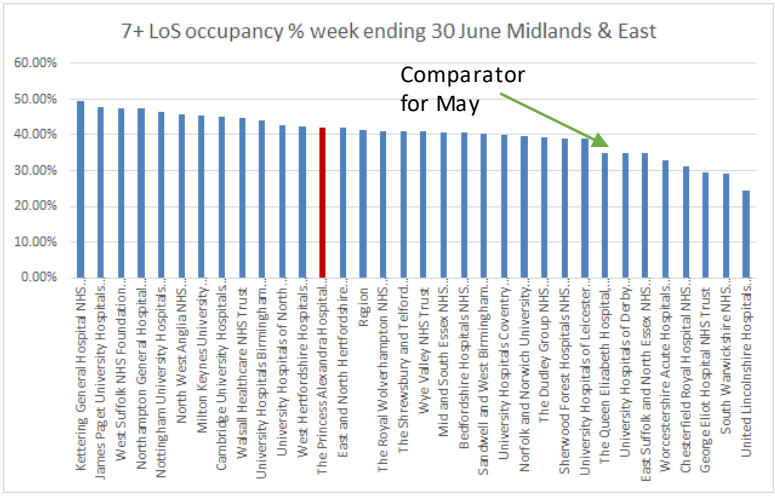


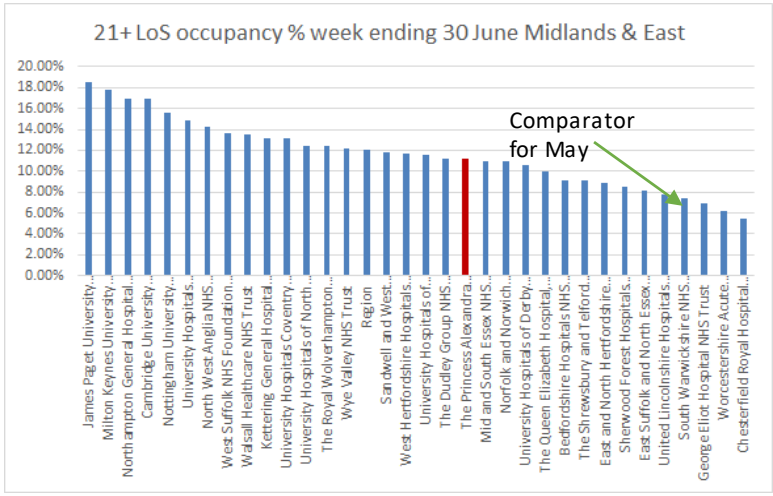





Bed Occupancy - Overnight Only
Q4 2020-21
compared with all organisations reporting to NHS England
General & Acute
RQW
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
RXQ RJR RNU RGT RY3 RA4 RWW REM R1A RJ2 RBT RCX RDU RXC RXK RFS RTD R1K RPY RTR RXP RVY RKL RNN RW6 RGP RQM RW1 RET RXG RPC RCU RP6


Type 1 A&E Performance
June 2021 (Target: 95%)
Under 4 hours
RQW
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
RCU RJ7 RQX RAJ RBS RHM RAE RN5 RCD RNN RJ6 RAX RD1 RJR RGP RNA RXP RP5 RWA RLQ RM3 RJN RWH RVJ REF RRK RJE RTG


7+ LoS occupancy % week ending 30 June Midlands & East
Comparator for May
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Kettering General Hospital NHS...
James Paget University Hospitals...
West Suffolk NHS Foundation...
Northampton General Hospital...
Nottingham University Hospitals...
North West Anglia NHS...
Milton Keynes University...
Cambridge University Hospitals...
Walsall Healthcare NHS Trust
University Hospitals Birmingham...
University Hospitals of North...
West Hertfordshire Hospitals...
The Princess Alexandra Hospital...
East and North Hertfordshire...
Region
The Royal Wolverhampton NHS...
The Shrewsbury and Telford...
Wye Valley NHS Trust
Mid and South Essex NHS...
Bedfordshire Hospitals NHS...
Sandwell and West Birmingham...
University Hospitals Coventry...
Norfolk and Norwich University...
The Dudley Group NHS...
Sherwood Forest Hospitals NHS...
University Hospitals of Leicester...
The Queen Elizabeth Hospital...
University Hospitals of Derby...
East Suffolk and North Essex NHS...
Worcestershire Acute Hospitals...
Chesterfield Royal Hospital NHS...
George Eliot Hospital NHS Trust
South Warwickshire NHS...
United Lincolnshire Hospitals...


21+ LoS occupancy % week ending 30 June Midlands & East
Comparator for May
20.00%
18.00%
16.00%
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
James Paget University...
Milton Keynes University...
Northampton General Hospital...
Cambridge University...
Nottingham University...
University Hospitals...
North West Anglia NHS...
West Suffolk NHS Foundation...
Walsall Healthcare NHS Trust
Kettering General Hospital...
University Hospitals Coventry...
University Hospitals of North...
The Royal Wolverhampton...
Wye Valley NHS Trust
Region
Sandwell and West...
West Hertfordshire Hospitals...
University Hospitals of...
The Dudley Group NHS...
The Princess Alexandra...
Mid and South Essex NHS...
Norfolk and Norwich...
University Hospitals of Derby...
The Queen Elizabeth Hospital...
Bedfordshire Hospitals NHS...
The Shrewsbury and Telford...
East and North Hertfordshire...
Sherwood Forest Hospitals...
East Suffolk and North Essex...
United Lincolnshire Hospitals...
South Warwickshire NHS...
George Eliot Hospital NHS Trust
Worcestershire Acute...
Chesterfield Royal Hospital...


Benchmarking

Patients

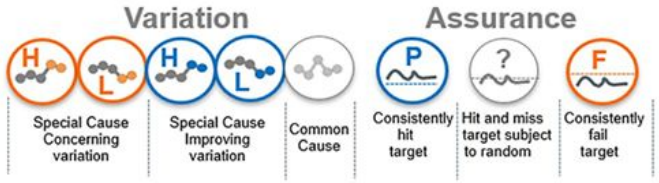
*We will continue to improve the quality of care, outcomes & experiences that we provide **our patients**, integrating care with our partners & reducing health inequity in our local population*

Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
CTG Training	Midwifery training is 73% against a target of 85%. The HCG have a focused improvement plan to achieve compliance following a move to Physiological interpretation. Trajectory: 161/179 = 89.9% by 9/7/2021 (missed Trajectory) 167/179 = 93.2% by 30/7/2021 (back on target) 172/179 = 96.0% by 17/9/2021 179/179 = 100% by 15/10/2021	For information	
Mental Health Metrics	Of note, the organisation had one detained patient under the mental health act in June, and eleven patient under mental health care. The Mental Health Quality Forum (MHQF) are working with the Strategy team to develop our mental health strategy. The MHQF are also working with our mental health partners on improvement .	For information	NA

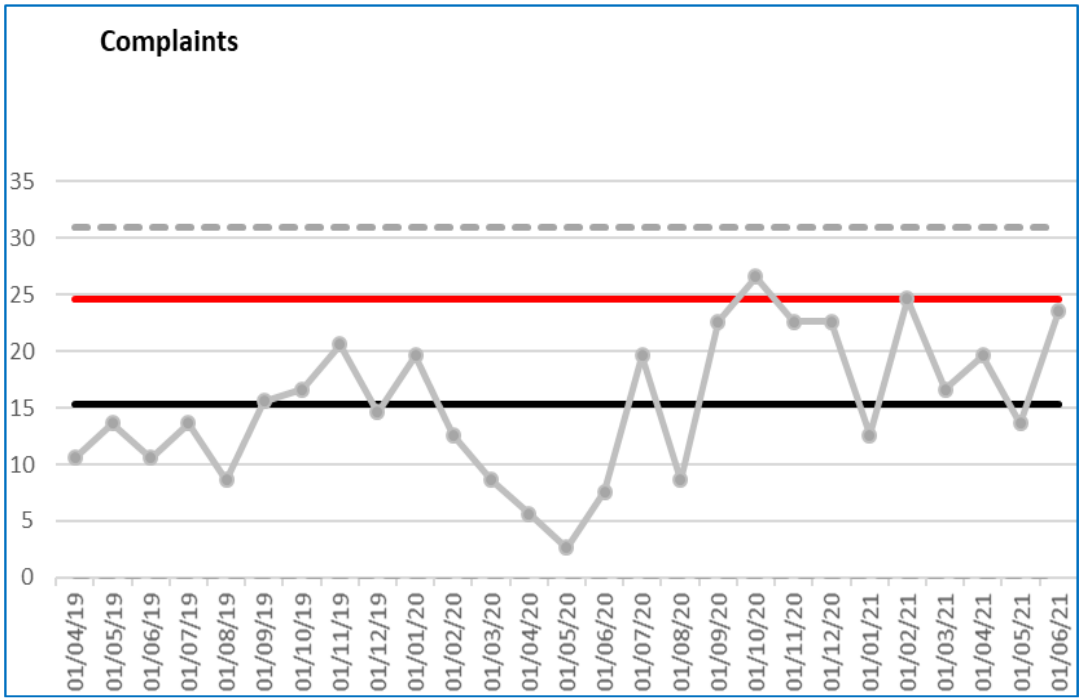
KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Patients metrics								
Complaints	Jun 21	24	25			16	0	31
Compliments	Jun 21	191	50			148	-102	399
PALS	Jun 21	353	none			280	130	429
Complaints closed within target	Jun 21	5	none			5	-5	14
% of complaints where an extension has been agreed	Jun 21	70%	none			41%	1%	81%
Mixed Sex Accommodation Breach	Jun 21	6	0			8	-5	21
Serious Incidents	Jun 21	3	0			5	-5	16
MSSA	Jun 21	0	none			1	-1	3
CDIFF	Jun 21	5	none			5	-2	13
Hand Hygiene	May 21	99%	none			90%	68%	112%
eColi	Jun 21	1	none			1	-2	4
Klebsiella	Jun 21	0	none			0	-1	2
Pseudomonas	Jun 21	1	none			0	-1	1
Falls per 1000 bed days	Jun 21	8.2	none			9.0	6.3	11.7
Falls by Harm - None	Jun 21	66	none			78	45	110
Falls by Harm - Minor	Jun 21	27	none			25	10	40
Falls by Harm - Moderate	Jun 21	2	none			2	-2	5
Falls by Harm - Severe	Jun 21	0	none			1	-2	3
Total number of mothers delivering in birthing unit/home	Jun 21	12%	20%			12%	1%	23%
Number of mothers delivering in Labour Ward/Theatres	Jun 21	88%	75%			88%	76%	100%
Number of women due to deliver at PAH adjusted for misc/TOPs	Jun 21	349	375			332	281	384
Smoking rates at booking	Jun 21	9%	none			9%	4%	14%
Smoking rates at delivery	Jun 21	7%	6%			10%	5%	15%
Breast feeding rates at delivery	Jun 21	80%	74%			75%	65%	85%
Total Planned C-Sections	Jun 21	19%	none			15%	7%	22%

Patients

KPI	Latest month	Measure	National target	Performance	Assurance	Mean	Lower process limit	Upper process limit
Patients metrics								
Total Unscheduled C-Sections	Jun 21	20%	none			18%	12%	24%
PPH over 1500mls	Jun 21	3%	none			4%	1%	8%
Hospital Acquired Category 4 pressure ulcers	Jun 21	0	0			0	-1	1
Hospital Acquired Category 3 pressure ulcers	Jun 21	2	0			1	-3	5
Hospital Acquired Category 2 pressure ulcers	Jun 21	24	4			21	0	41
Hospital Acquired Category 1 pressure ulcers	Mar 21	6	8			8	-2	18
Hospital Acquired Deep tissue injury	Jun 21	18	none			24	1	48
Hospital Acquired Unstageable pressure ulcers	Jun 21	3	none			2	-3	8
CTG training compliance midwives	Jun 21	73%	85%			66%	44%	88%
CTG training compliance doctors	Jun 21	89%	85%			71%	46%	97%
Still births	Jun 21	0	none			1	-1	3
Patients detained under MHA	Jun 21	1	none			0	-1	2
Patients detained under section 136	Jun 21		none			1	-2	4
Mental health patients as inpatients at PAHT	Mar 21	11	none			10	-1	20
Mental health patient complaints	Jun 21	2	none			0	-1	1
Mental health patient PALS	Jun 21	3	none			1	-1	3
Dementia patient falls	Jun 21		none			28	7	50
Dementia patient pressure sores	Jun 21		none			11	2	20
Patients with LD and Autism accessing inpatient services	Jun 21	22	none			16	-2	34
Patients who died in their preferred place of death	Jun 21	56%	none			56%	16%	97%
C-DIFF Hospital onset healthcare associated	Jun 21	0	none			2	-2	7
C-DIFF Community onset healthcare associated (Acute Admissio	Jun 21	1	none			1	-1	3
C-DIFF Community onset indeterminate association (Acute Adm	Jun 21	1	none			1	-2	3
C-DIFF Community onset community associated (No acute conta	Jun 21	3	none			1	-3	5

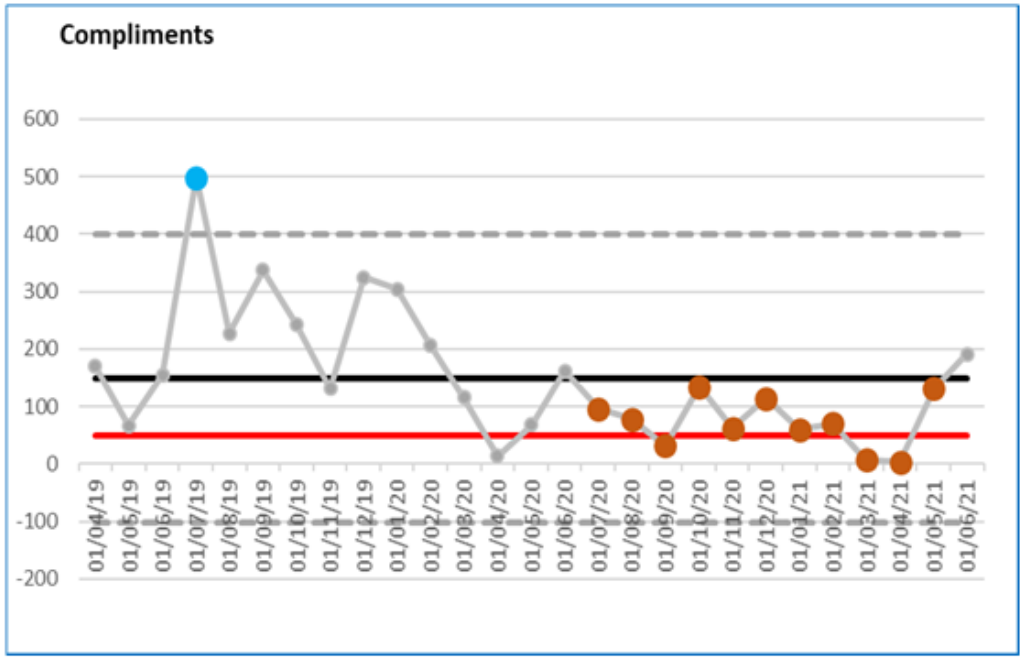


Patients



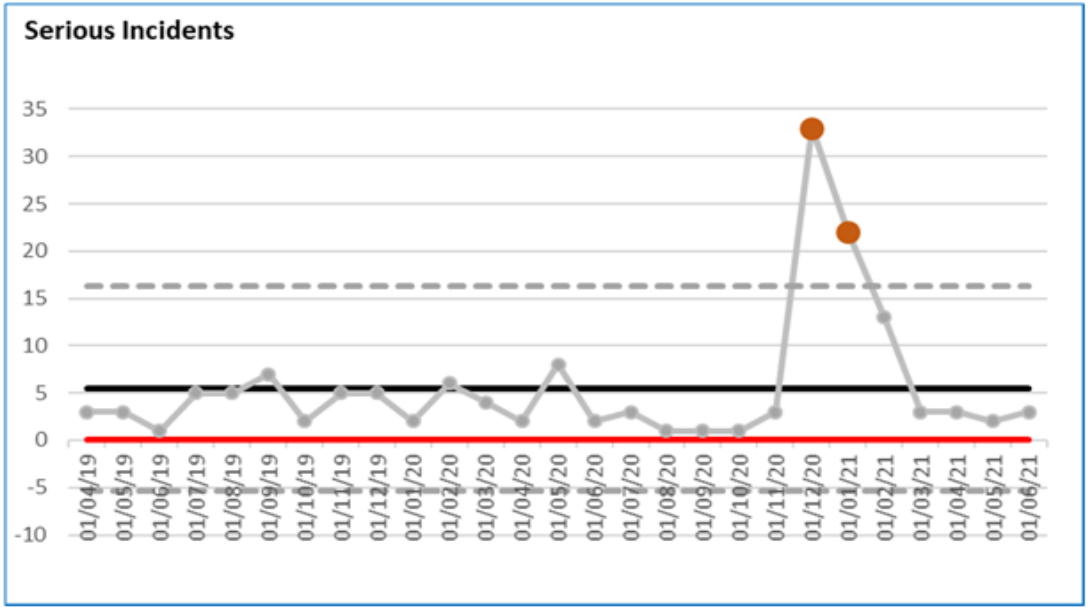
Jun-21
24
Variance Type
Common cause variation
Target
25
Target Achievement
Hit and miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Complaints	Common cause concerning variation while hit and missing the target	Numbers remain at a consistent level since beginning of pandemic.	HCG have weekly catch ups with the pateint experience team & 85% of all cases are investigated & closed within time, therefore reducing the number of open cases at one time. Action plans are also discussed & shared with staff for learning.	None needed at present.



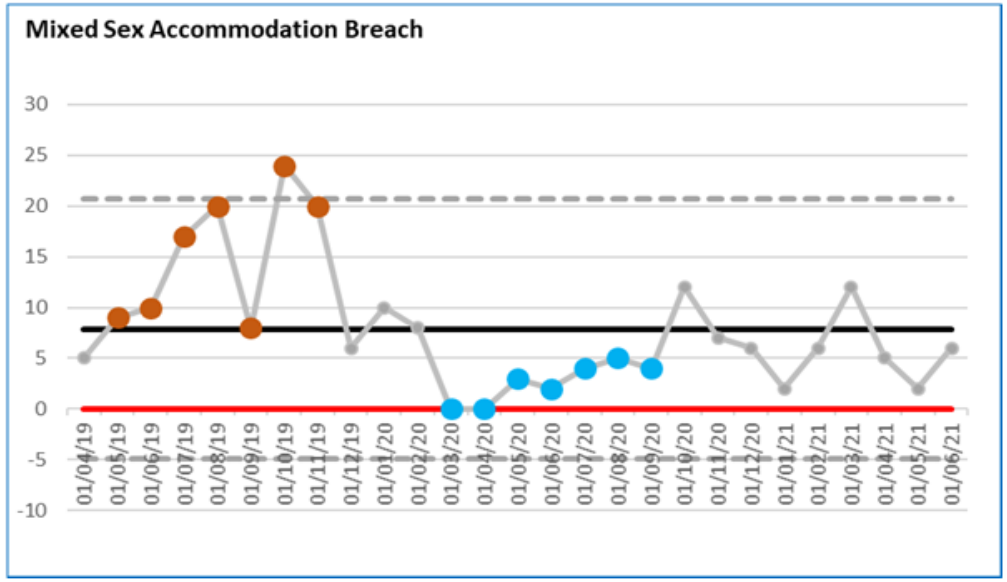
Jun-21
191
Variance Type
Special cause variation
Target
50
Target Achievement
Hit and miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Compliments	Special cause concerning variation while hit and missing the target	During the last 12 month compliments have seen a decline. Since the beginning of June 2021 the PE team have indenitified a member of staff to input this data daily & encourage teams to forward their	Continue logging all compliments daily & encourage departments, wards, units & areas to regularly share their compliments via email or photocopy with the PE team.	None needed at present.



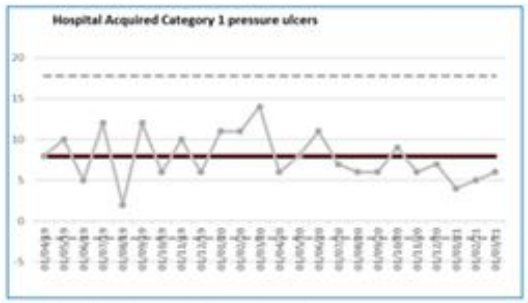
Jun-21
3
Variance Type
Common cause variation
Target
0
Target Achievement
Inconsistently passing and falling short of the target

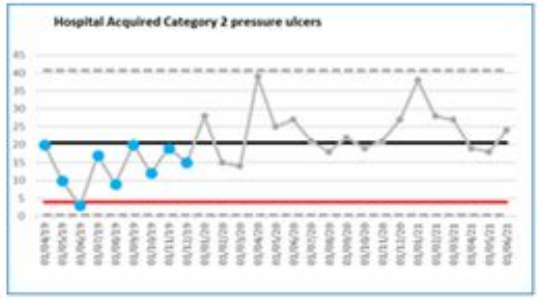
Background	What the chart tells us	Issues	Actions	Mitigation
Serious Incidents	Common cause variation and inconsisrtently passing and falling short of the target	We continue to focus on improving performance regarding closing serious incident investigations within the national 60 day standard. Progress has made in the last six months with improvements seen.	Serious Incident Assurance Panel (SIAP) meeting review all completed draft SI reports at 30 days to provide author & HCG feedback on quality, provide supportive suggestions for inclusion in the body of the report, analysis and action plan. Meetings increased to weekly since May 2021 to ensure sufficient time is available. As a learning organisation, we have in draft a learning from incidents strategy to ensure consistency and to further drive improvement.	Trust changed incident review process during 2020 and there are 2 meetings a week. Incidents resulting in harm have a rapid review investigation completed as part of our process to determine level of harm. This generally occurs before a serious incident is declared. As a result a substantial part of the investigation process is completed at the time the incident is raised, shortening the timeframe needed for completion of the final SI RCA report.

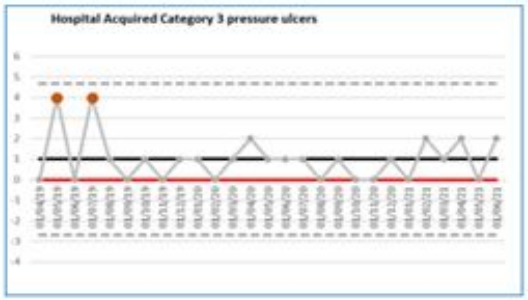


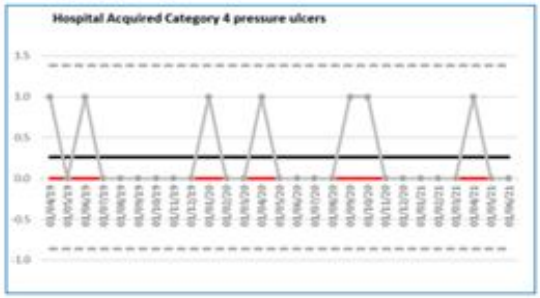
Jun-21
6
Variance Type
Common cause variation
Target
0
Target Achievement
Inconsistently passing or falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Mixed sex accommodation breach	Common cause concerning variation and hitting and missing target randomly	Critical care is exempt from the single sex guidance if the patient requires care in a ICU or HDU. The group of patients that breach this standard are all patients who are now well enough to leave ICU/HDU & cannot move to a ward bed within the 4 hour timeframe. Breaches occur when a) flow through the trust is poor b) patient requires care on a specific ward c) patient requires a side room d) a high number of patients are well enough to move out of ICU to wards on the same day	The ICU team will inform the duty site manager the day before for long term patients to give as much notice as possible of discharge as specific ward is required. Duty team organise transfers & give critical care patients priority over other ward moves. Patients moving into ICU can be swapped with those who are leaving to speed up a discharge. The duty team will ensure patients who have specific requirements go to the right bed on right ward, with the trust accepting this may mean a breach in the critical care unit occurs.	Critical care team have a side room in the HDU, if not required for isolation and clinically appropriate, it is used for those patients well enough to step down & to maintain privacy and dignity to prevent patients waiting for a ward bed.





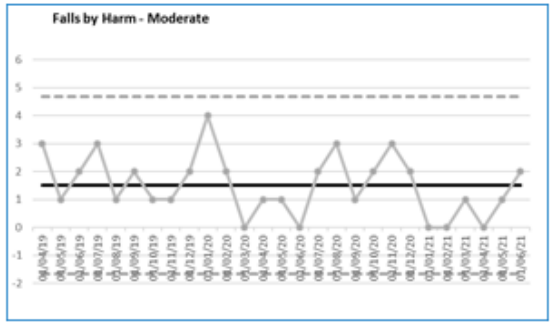


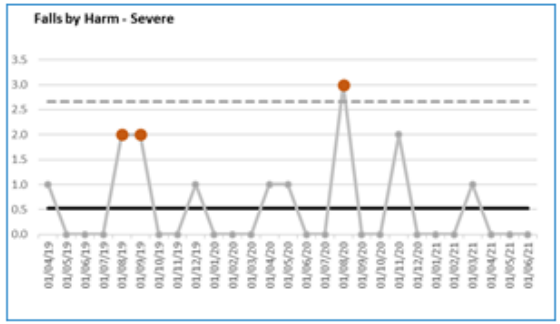


Jun-21
32
Variance Type
Common cause variation
Target
12
Target Achievement
Inconsistent passing and failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers grades 1 - 4	Common cause variation and inconsistently hitting and missing the target	There were a total of 47 pressure ulcers in June, 7 more than May. Of those 47 PUs, there were a total of 33 patients injured, meaning 9 patients sustained more than one pressure ulcer during admission, the higher being one patient with 5 pressure ulcers (all developed on both feet, vascular compromised with evident ischemia). Five moderate harms, the remaining were minor harms. Two pressure ulcers were medical device related, attributable to oxygen device & ET tube. The highest number of hospital acquired pressure ulcers were from Tye Green & Harold with 7 pressure ulcers in total.	Tye Green ward has put in place an action plan to reduce hospital acquired pressure ulcers, as well as regular internal audits around correct surface for patients. TVNs \re working with the ward manager & matron from Harold for action planning.	We are performing audits to all concerning wards on a weekly basis, in order to identify gaps in care & work with ward managers, matrons & practice development team forimprovement action plans.

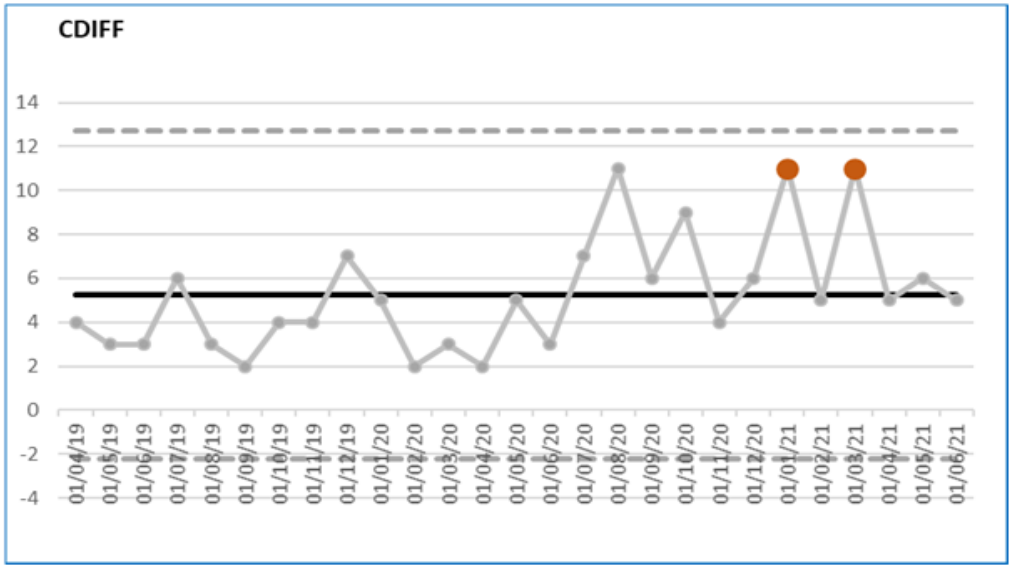
Patients





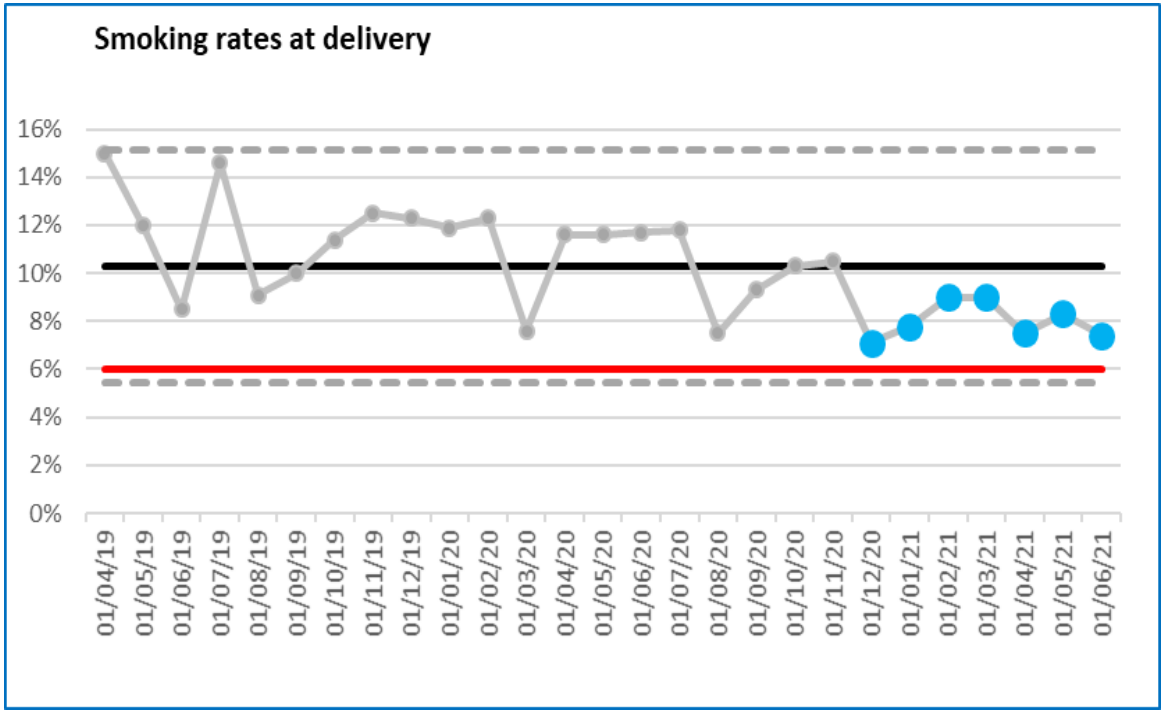
Jun-21
2
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
Falls by harm	Common cause variation	There are not sufficient data points to show a consistent decrease month on month yet. The Trusts' falls action plan aim is to reduce falls with harm by 50% by the end of 2021/22	1. Falls prevention strategic action plan in place 2. Enhanced care programme is being rolled out across the Trust 3. Training programme is being rolled out across the Trust 4. STOPIT initiative (to deprescribe culprit medications) is being rolled out across the Trust. 5. Falls risk assessment moved to Nervecentre.	All mitigations included in the falls strategic action plan, increased support from Falls Specialist Nurse to our high risk wards to suport roll out of enhanced care and accuracy of falls risk assessements.



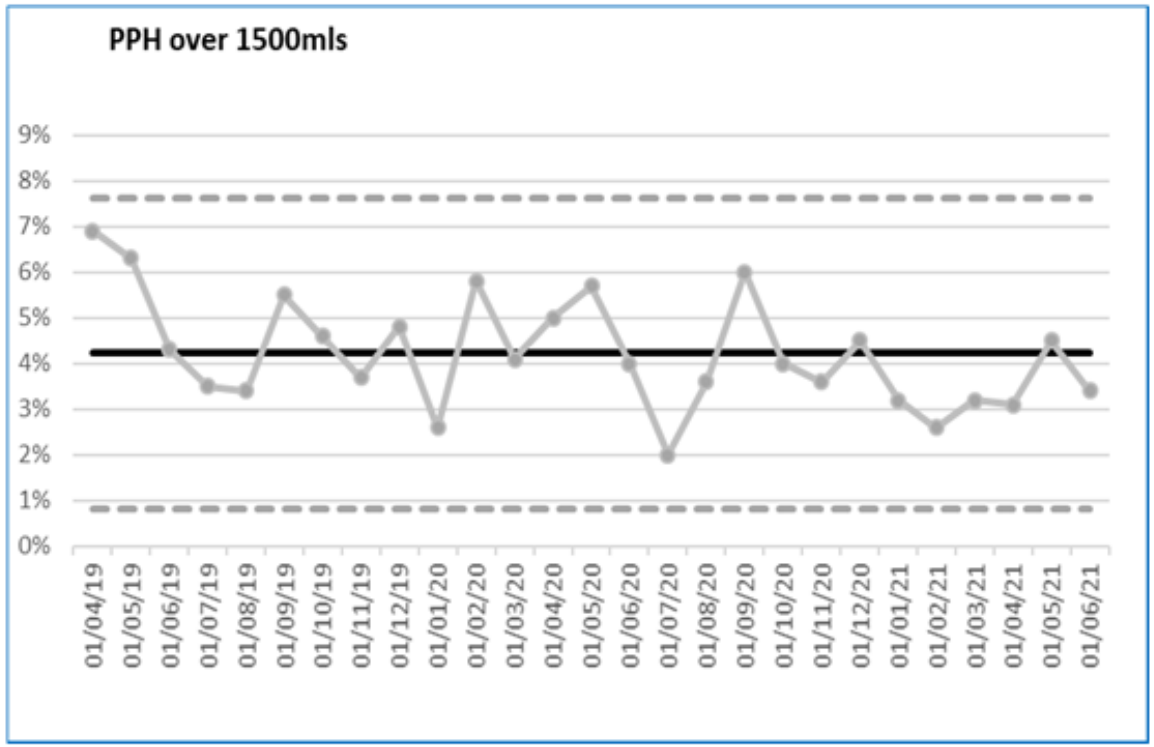
Jun-21
5
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
C.difficile	Common cause variation	1. The Trust has seen a significant rise in C.difficile cases over the last year (a total of 54 cases in 2020-2021; 145% increase from 2019-2020 when there were 23 cases). Community cases also rose. 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 April this year we have started to see a reduction in the Hospital Onset Health Care Associated cases; the Community Onset Health Care Associated cases	A review of the key control measures required to reduce the cases are being addressed through a C.difficile recovery action plan which focuses on ensuring compliance with: 1. Antimicrobial prescribing 2. Environment /increased cleaning 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 Ribo-typing of C.difficile specimens to support in detecting possible outbreaks or clusters of infection	1. Monitoring of cases (Infection Prevention & Control Committee and 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 meets monthly & is responsible for the monitoring of antibiotic prescribing 4. PPE Champion 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



Jun-21
9%
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 is discussed at every contact & all the midwives have a smokerlyser device	Nicotine Patches are being offered to all pregnant women who smoke & smoking is discussed at every contact	There has been a gradual reduction in the trendline for the number of women smoking at delivery



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

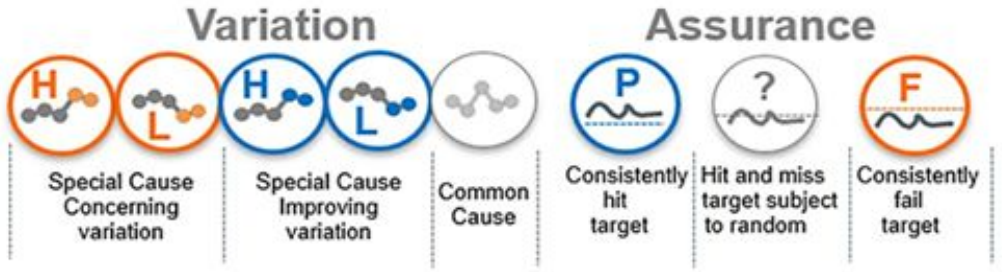
Background	What the chart tells us	Issues	Actions	Mitigation
PPH over 1500mls	Common cause variation	PPH measurement is subjective but measures have been put in place, e.g. to weigh swabs to help with the estimated amount	A Massive PPH Action Plan is in place in conjunction with the LMNS. This includes a labour admission risk assessment	There has been a gradual reduction in the trendline of PPH over 1500mls

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**
Catering	There is now a new & refreshed menu being offered for patients. Team have received great positive feedback & compliments so far. The new menu follows clear guidelines & ensures allergens or any special dietary requirements are listed. The team also cater for allergen free meals for patients needed dysphasia, gluten free & halal meals. Under new guidelines, packaged & in date goods are only allowed to be sold at charity & cake sales on site. This is to ensure the safety of patients, staff & visitors.	For information	N/A
Housekeeping	Rolling recruitment continues, in additional on-going training for all newly recruited & existing staff. Return to work plans are also in progress for members of staff who have been on long term sick leave. House-keeper vacancy position reduced significantly down to 13 WTE.	For information	N/A
Portering	Electronic portering system introduced on 17th May. Portering supervisor & manager rolled out training to ward staff. All areas have received SOP. Despite some early teething issues, the new system is working well for the team & to benefit the Trust. There has been a great response from all areas on requesting the porter service.	For information	N/A
Domestic	Following the consultation & introduction of the domestic transformation programme, all staff are now working to their new personal patterns & new cleaning equipment implemented & rolled out at pace across the trust. Successful recruitment drive, has reduced domestic vacancy position down to 2WTE.	For information	N/A
Estates Capital Projects	Below schemes completed & handed over during June. • Labour ward birthing rooms • Green Zone • Frailty Assessment and Short Stay (newly named OPAL) • Colposcopy refurbishment • Endoscopy 3rd room • Penn ward refurbishment	For information	N/A
Estates	• VIE Oxygen plant works have commenced (Friday 25th June) will be complete by Monday 28th June. This will significantly reduce the risk of plant failure & increase resilience in the event of increased usage. • Site wide fire door inspection progressing with remedial works required to be presented to the team in 2 weeks (capital funding identified for most urgent/high risk items). • External site works – in house team carrying our focused works externally across site on Saturday/Sunday each weekend. This was requested by the team to return the site to its former condition following extensive capital works & contractors working on site. • Remedial works complete on the main water softening plant which was causing hard water & presenting a risk of failure to CSSD equipment. Pipework alterations planned in order to prevent a reoccurrence should the main water softening plant fail in the future. All CSSD water to be diverted through the local water softening plant allocated to CSSD. • Two staff members achieved an excellent pass of 95% on their electrical low voltage Authorised Person course. Formal assessment scheduled for August following site familiarisation. • Completed upgrade to the AIR plant to the Kent wing areas. This will prevent any major callout we have been experiencing with plan failure.	For information	N/A

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Estates Responsiveness (Priority 2 - Urgent)	Jun 21	98%	95%			95%	91%	99%
Meals Served	Jun 21	34598	42120			37232	26337	48127
Catering Food Waste	Jun 21	5%	4%			5%	-2%	12%
Domestic Services (Cleaning) Very High Risk	Jun 21	99.0%	98.0%			97.5%	93.9%	101.1%
Domestic Services (Cleaning) High Risk	Jun 21	97.0%	95.0%			96.5%	93.1%	100.0%



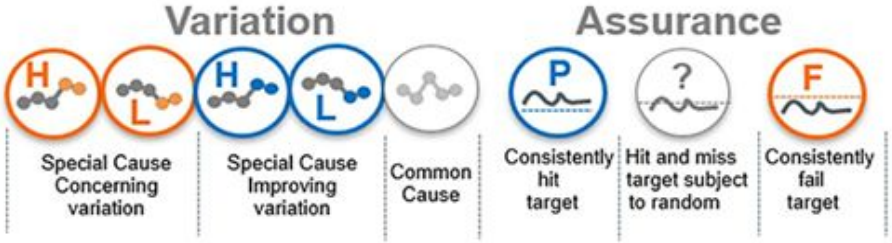
Performance

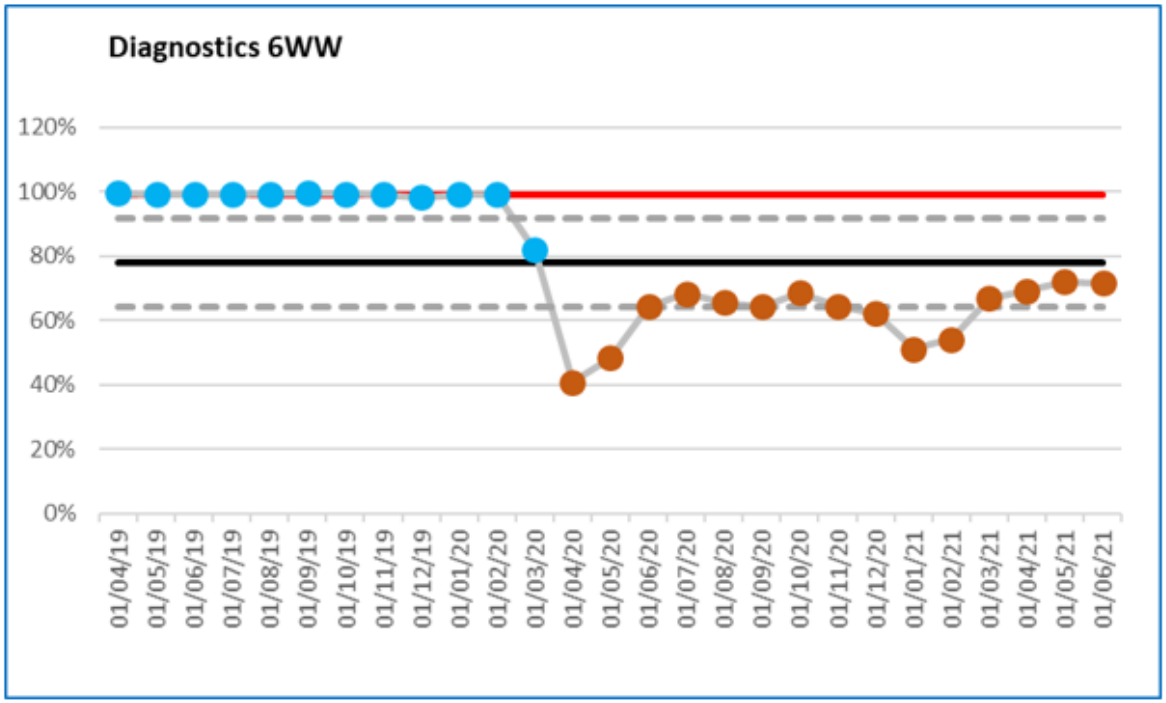
*We will meet & achieve **our performance** targets, covering national & local operational, quality & workforce indicators.*

Performance Summary		Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
RTT	Continued focus on booking patients in clinical priority order, reached sustainable P2 levels by target date 30/6 & very few overdue. Next target 30/9 for sustainable P3s, no P3 overdue & no patient over 78 weeks. Long term trajectory being developed.	For increased visibility and awareness	Ongoing review
52 week waits	Continued focussed outsourcing & insourcing additional capacity is resulting in 3 months of reduced 52 week breaches.	For recognition	Ongoing review
DM01 Diagnostics	Significant increases in referrals combined with reduced MRI & CT capacity due to equipment replacements have slowed down recovery but it is still within the trajectory.	For information	01/12/2021
Cancer 2ww	Increased referrals & staffing issues have impacted some tumour sites. All clinic capacity has been reviewed & 28 day diagnosis standard that supports early diagnosis is performing well as assurance.	For increased visibility and awareness	01/09/2021
Cancer >62 day	Continued focus on reducing number of long waiting patients with diagnosis & treatment means this measure remains low as a higher number of patients treated in month have breached. New performance trajectory being developed.	For increased visibility and awareness	01/10/2021
ED 4 hour standard & Seen by Specialty to DTA	ED 4 hour standard struggling under continued increased demand reflecting nationwide increases in emergency activity. Improvement programme continues & has developed strong foundation actions such new pathways, increased focus on Rapid Assessment & Internal Professional Performance standards.	For increased visibility and awareness	Ongoing review
ED Arrival to Triage	Improvement project focussing on this part of pathway with pre booking in assessment & redirection to more suitable services along with transfer into most appropriate UEC area.	For information	Ongoing review
Ambulance Handovers	Improvement project continues to focus on ambulance handovers, Rapid Assessment & Triage, correct flows into AAU & SDEC, collaborative working with EofE Ambulance Trust.	For information	Ongoing review
Out-patient new to follow-up	This ratio is decreasing down to more usual levels as more new patients are being booked into clinic now face to face appointments are recommencing.	For increased visibility and awareness	Ongoing review
Elective Recovery	Continued achievement of overall elective recovery activity targets with outpatients over 116% & 26% virtual, with all bar two activity types over the 80% target. PAH & ICS highlighted as one of the best in England & asked to feedback areas of good practice to national team. July national target recently been increased to 95% which will be a significant challenge.	For recognition	Ongoing review

KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
RTT incomplete	Jun 21	60%	92%			79%	74%	84%
RTT admitted	Jun 21	30%	90%			55%	25%	84%
RTT Non admitted	Jun 21	84%	95%			89%	86%	91%
RTT PTL vs RTT PTL & ASIs	Apr 21	94%	none			96%	94%	98%
Cancer 31 days First	May 21	100%	96%			95%	88%	101%
Cancer 31 days Subsequent Drugs	May 21	100%	98%			99%	94%	104%
Cancer 31 days subsequent surgery	May 21	88%	94%			93%	66%	120%
Cancer 2WW	May 21	79%	93%			86%	70%	102%
Cancer 62 day shared treatment	May 21	69%	85%			72%	54%	90%
Cancer 62 day screening	May 21	100%	90%			67%	12%	122%
Cancer 62 Day Consultant Upgrade	May 21	78%	90%			85%	68%	102%
Cancer 28 day faster diagnosis	May 21	74%	none			66%	53%	80%
4 Hour standard	Jun 21	71%	95%			78%	70%	86%
ED attendances	Jun 21	10589	none			8441	6398	10485
ED Admitted performance	Jun 21	38%	95%			54%	35%	73%
ED non admitted performance	Jun 21	79%	95%			86%	78%	94%
ED Arrival to Triage	Jun 21	56	15			39	22	57
ED Triage to examination	Jun 21	116	60			85	63	107
ED Examination to referral to specialty average wait	Jun 21	105	45			94	83	105
ED referral to be seen average wait	Jun 21	79	30			75	56	95
Seen by specialty to DTA	Jun 21	104	60			90	67	113
DTA to departure	Jun 21	211	30			160	48	272
Ambulance handovers less than 15 minutes	Jun 21	23%	100%			30%	15%	44%
Ambulance handovers between 15 and 30 mins	Jun 21	38%	0%			44%	36%	52%
Ambulance handovers between 30 and 60 mins	Jun 21	21%	0%			20%	9%	32%

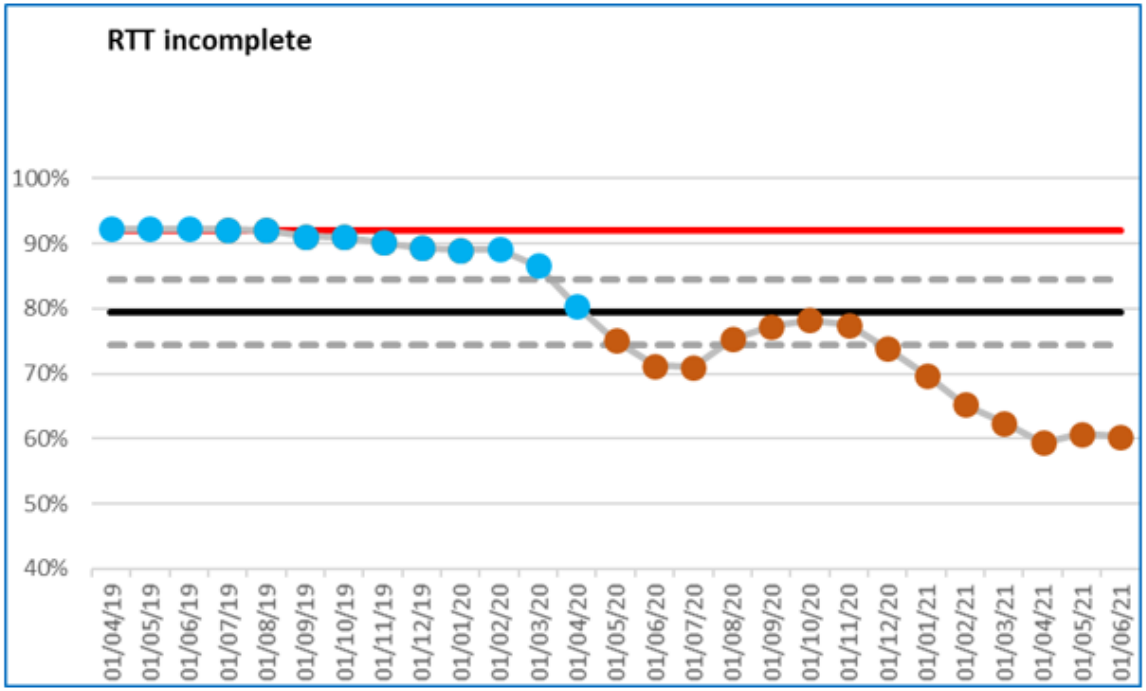
KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
Ambulance handovers > 60 mins	Jun 21	18%	0%			6%	-3%	14%
Diagnostics 6WW	Jun 21	72%	99%			78%	64%	92%
Occupied beds with stranded patients	Jun 21	148	80			142	83	201
Bed occupancy	Jun 21	97%	85%			88%	79%	96%
Discharges between 8am and 5pm	Jun 21	729	none			747	476	1018
Discharges between 5pm and 8am	Jun 21	869	none			695	420	971
LOS non elective	Jun 21	3.5	5.1			3.7	2.7	4.7
LOS elective	Jun 21	2.2	4.2			2.2	0.8	3.6
Short Notice clinical cancellations	Jun 21	12	0			45	-36	127
OP new to follow up ratio	Jun 21	1.9	2.3			2.2	1.8	2.5
OP DNA Rate	Jun 21	5%	8%			5%	3%	6%
52 Week waits	Jun 21	1143	0			360	207	513
Proportion of Majors Patient treated within 4 hours in ED Paeds	Jun 21	80%	95%			87%	75%	99%
Super stranded patients	Jun 21	48	25			39	11	67
12 Hour waits in ED from Arrival	Jun 21	569	0			331	44	617
12 Hour Trolley waits in ED from DTA	Jun 21	19	0			13	-19	46





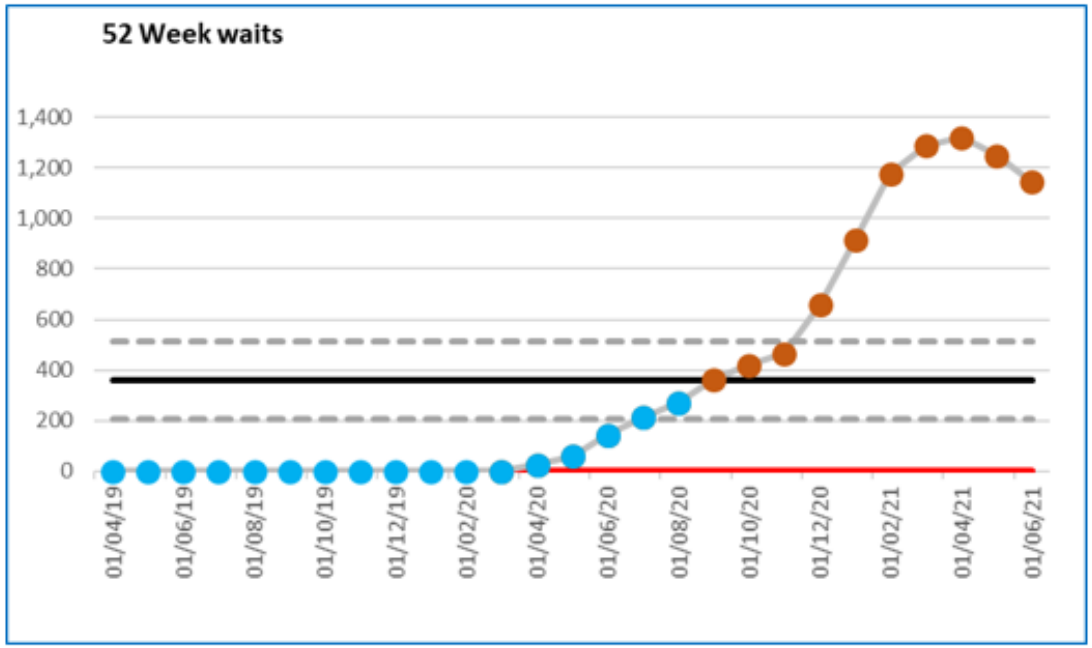
Jun-21
72.00%
Variance Type
Special cause variation
Target
99.00%
Target Achievement
Consistently failing

Background	What the chart tells us	Issues	Actions	Mitigation
Diagnostics 6 week wait	Special cause concerning variation and consistently failing target	There is a significant backlog of diagnostic requests which have built up as a result of covid restrictions.	Additional capacity is being delivered as extra sessions & use of independent sector providers. "Smart" booking of longest waiting patients.	Clinical review of long waiting patients on DM01 waiting list



Jun-21
60%
Variance Type
Special cause variation
Target
92%
Target Achievement
Consistently failing target

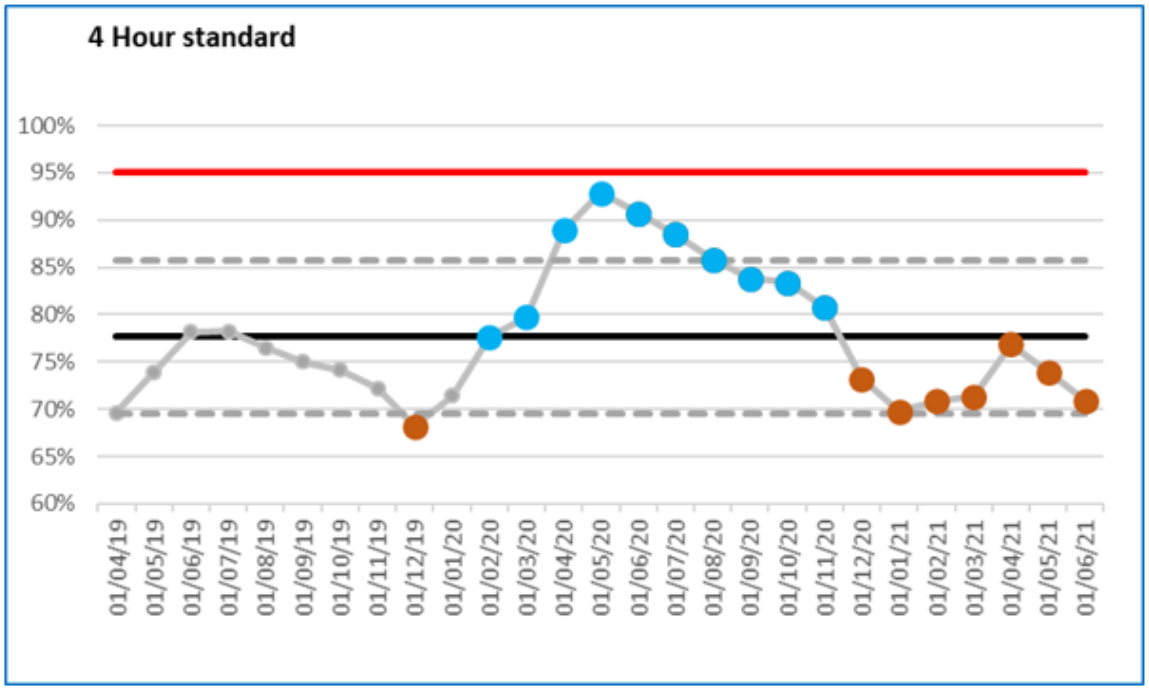
Background	What the chart tells us	Issues	Actions	Mitigation
RTT Incomplete	Special cause concerning variation and consistently failing target	The performance against the RTT standard has been below the target and statistical mean for 12 months as a result of covid activity pressure pausing elective activity. Elective work has resumed and a higher number of patients are being treated that have breached	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 to increase capacity.	Admitted backlog clinicaly prioritised. Non admitted - clinical priority booking at sub specialty level. Clinical Reviews & harm reviews being undertaken. Diagnostic waiting list clinically prioritised.



Jun-21
1143
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

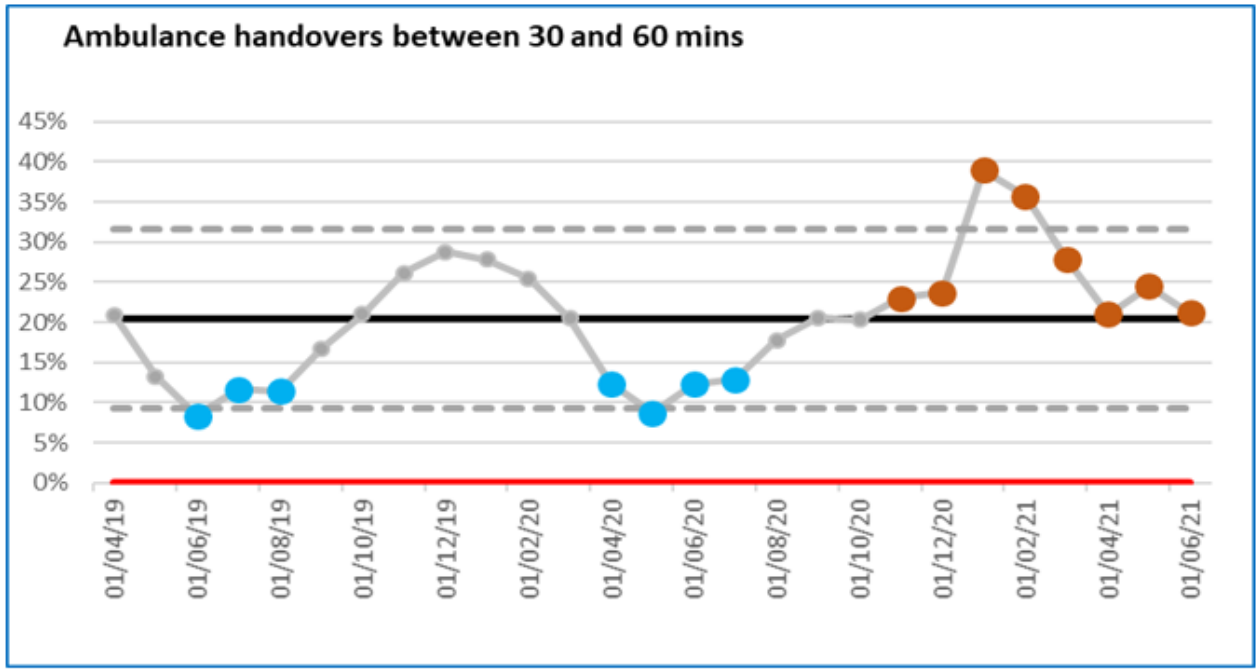
Background	What the chart tells us	Issues	Actions	Mitigation
52 week waits	Special cause concerning variation and consistently failing target	The volume of patients waiting over 52 weeks continues to increase due to the impact of covid restrictions over the last 14 months	Outsourcing & insourcing to increase capacity. Prioritising long waiting P4 admitted patients upgrading any >78 weeks to P3. Recovery trajectory being developed - clear all >78 weeks by 30/9/21 and no overdue P3 patients at 30/9/21.	Achieved goal of sustainable levels of P2 patients by 30/6 and very close to no overdue P2s by 30/6. Admitted backlog clinicaly prioritised. Non admitted - clinical priority booking at sub specialty level. Clinical Reviews & harm reviews being undertaken. Diagnostic waiting list clinically prioritised.

Performance



Jun-21
71%
Variance Type
Special cause variation
Target
95.00%
Target Achievement
Consistently failing target

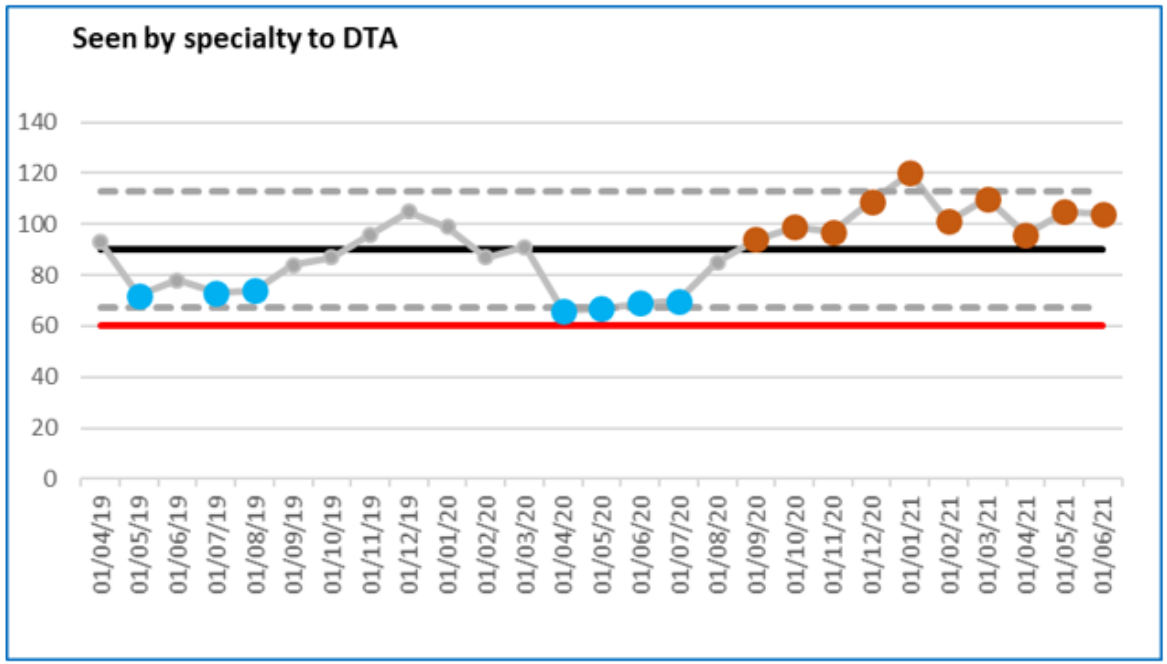
Background	What the chart tells us	Issues	Actions	Mitigation
Four hour standard	Special cause concerning variation and consistently failing target	The performance against the four hour standard has been consistently below the statistical mean for four months and close to the lower control limit. Significant increases in attendances has exacerbated the pressure on the	The Trust has implemented an improvement programme supported by external consultants Prism to improve the pathways and performance across all Urgent Care pathways. The 5 workstreams report to a delivery group & Executive Oversight group. Overall trajectory for 4 hour target improvement being developed.	Close review of daily processes by senior management team and executive directors.



Jun-21
21%
Variance Type
Special cause variation
Target
0.00%
Target Achievement
Consistently failing target

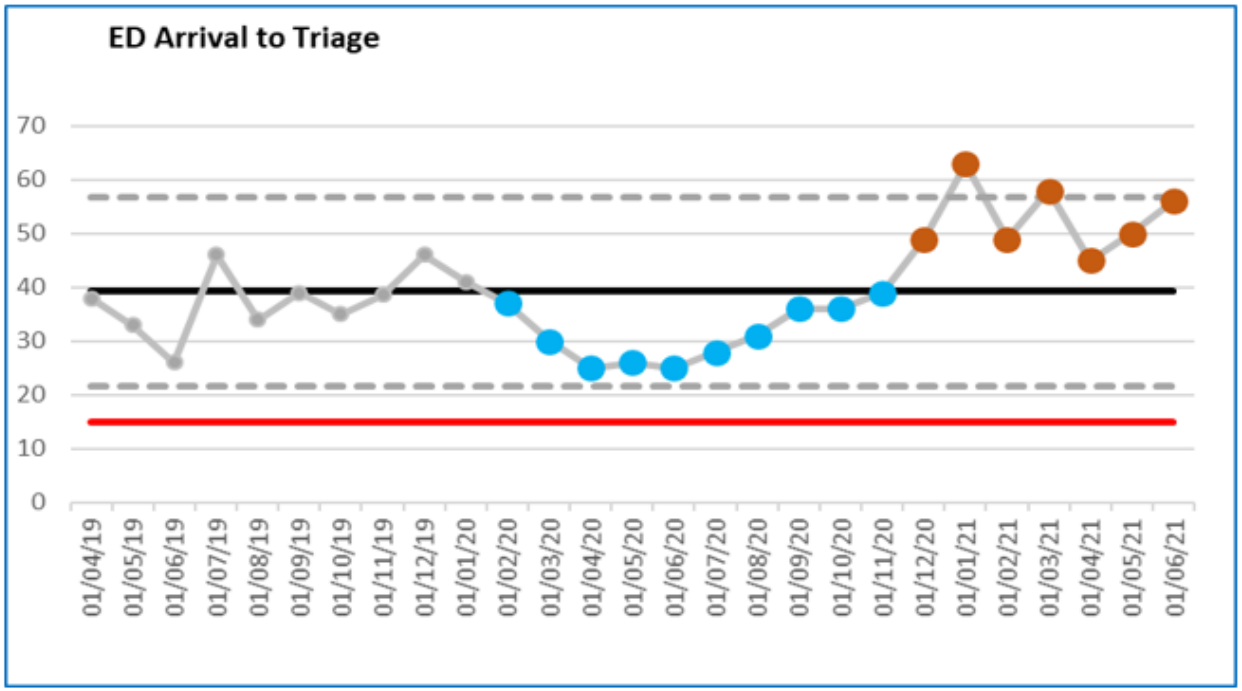
Background	What the chart tells us	Issues	Actions	Mitigation
Ambulances handovers between 30 and 60 minutes	Special cause concerning variation and consistently failing target	The % of ambulance conveyances over 30 minutes has increased above the statistical average	Workstream 1 and 2 of the Urgent Care Improvement programme supported by Prism is focusing on improving ambulance handovers by improving the Rapid Assessment & Triage pathway, improving communication between Ambulance & ED staff and improving flow through the department by correct use of AAU & SDEC.	Close review of daily processes by senior management team and executive directors.

Performance



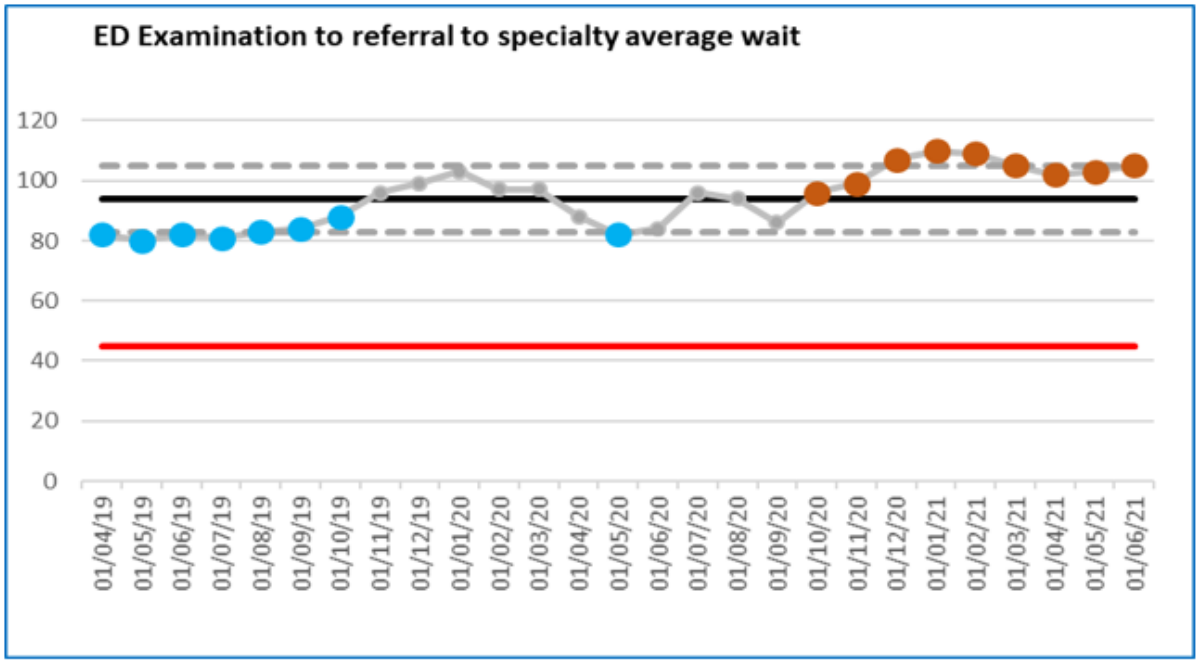
Jun-21
104 minutes
Variance Type
Special cause variation
Target
60 minutes
Target Achievement
Consistently failing target

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 7 months	We are working with an expert partner on urgent care pathway management to support the identification of areas of improvement	Close review through breach analysis PRISM supported improvement work.



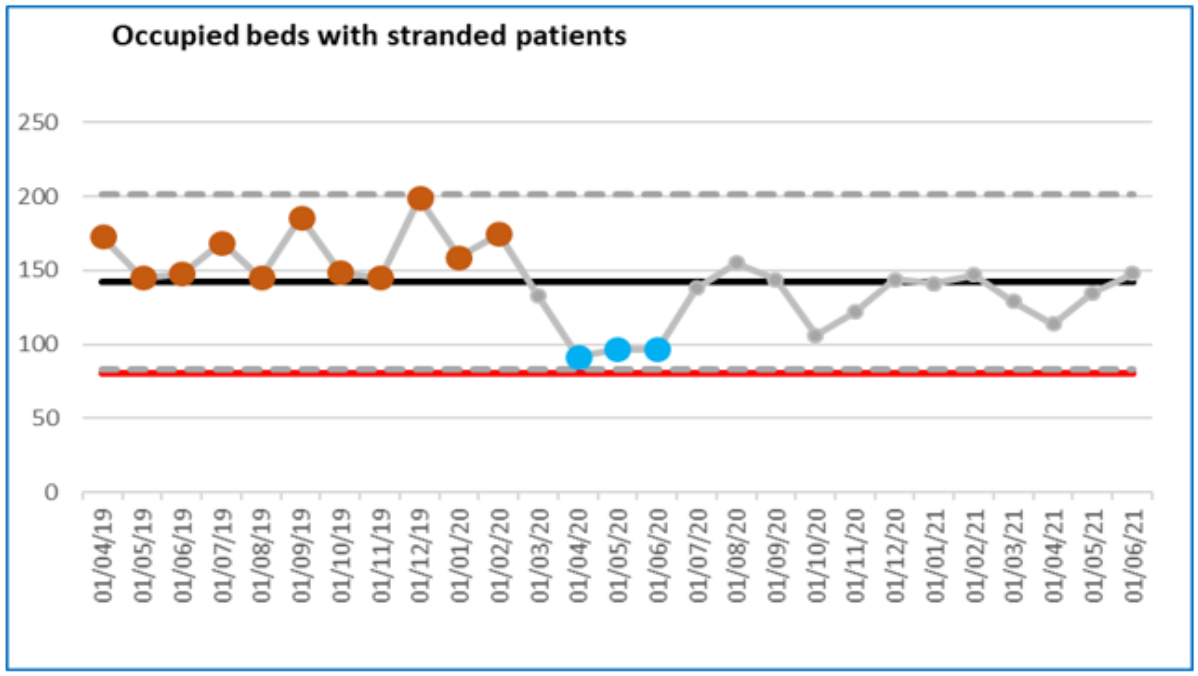
Jun-21
56 minutes
Variance Type
Special cause variation
Target
15 minutes
Target Achievement
Consistently failing target

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 7 months	We are working with an expert partner on urgent care pathway management to support the identification of areas of improvement	Close review through PRISM supported improvement work, reporting to Executive team weekly.



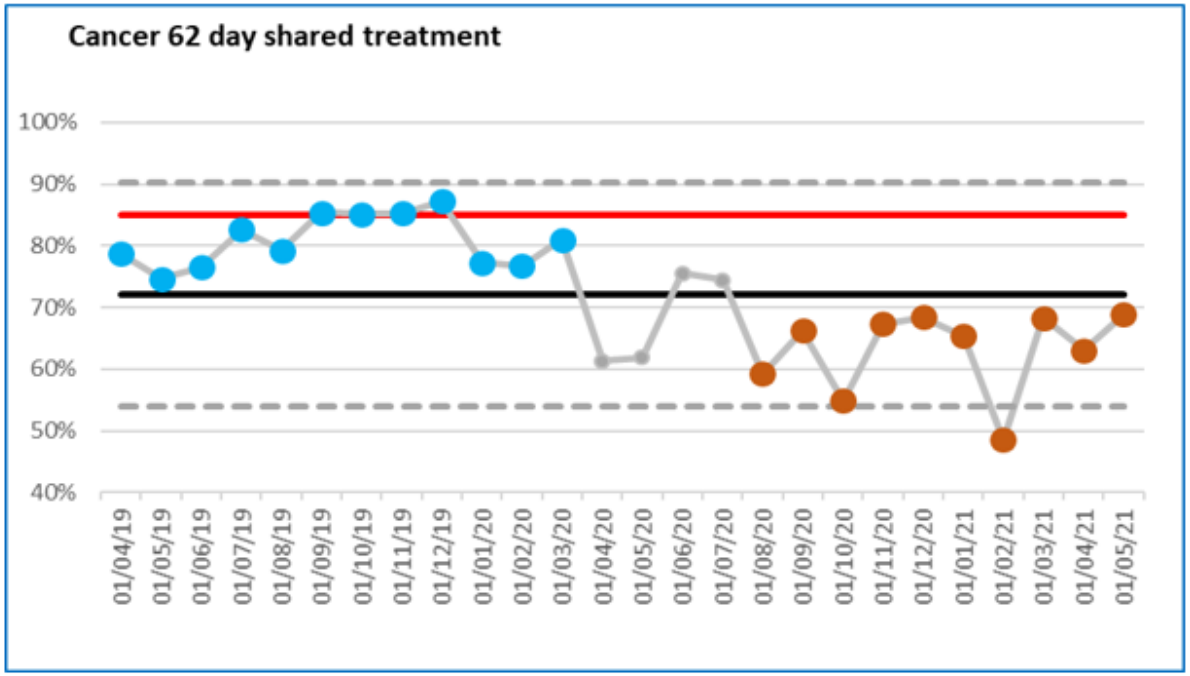
Jun-21
105 minutes
Variance Type
Special cause variation
Target
45 minutes
Target Achievement
Consistently failing target

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 7 months	We are working with an expert partner on urgent care pathway management to support the identification of areas of improvement, particularly on implementing refreshed Internal Profession & Performance Standards	Close review through PRISM supported improvement work, reporting to Executive team weekly.



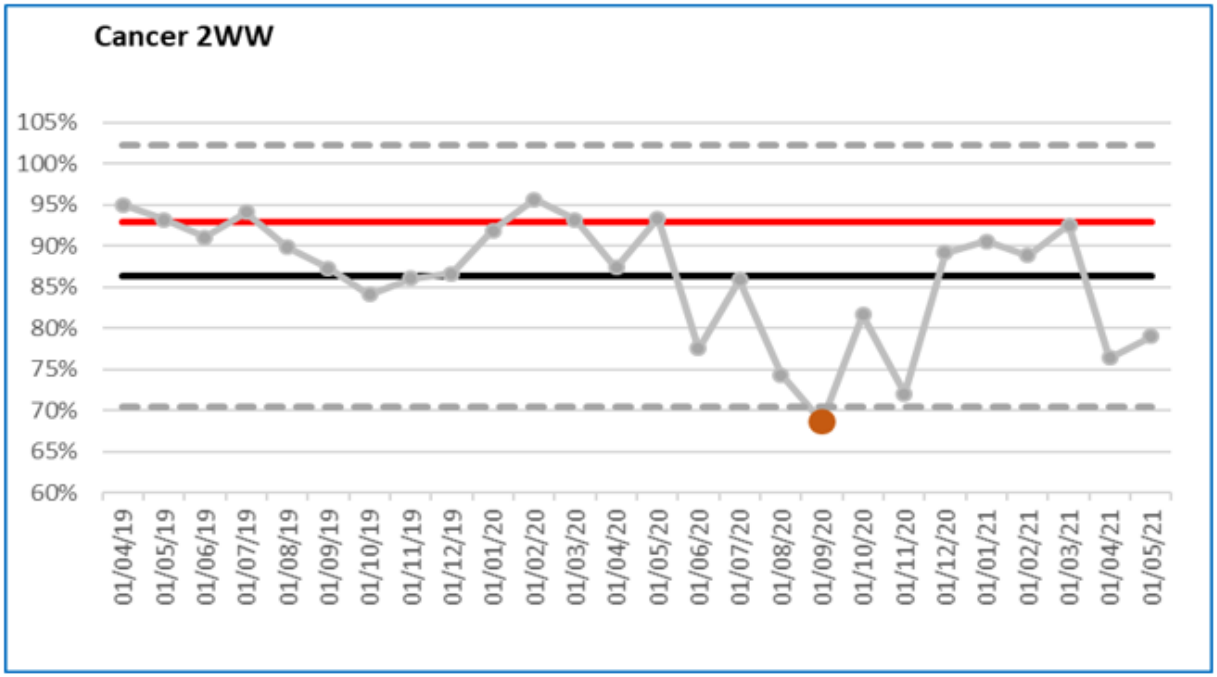
Jun-21
148
Variance Type
Common cause variation
Target
80
Target Achievement
Consistently failing target

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	Length of stay reviews have recommenced and concentrate on top 10 LOS issues. New member of staff commenced working on LOS project.	Review via daily bed meetings & weekly capacity planning meetings.



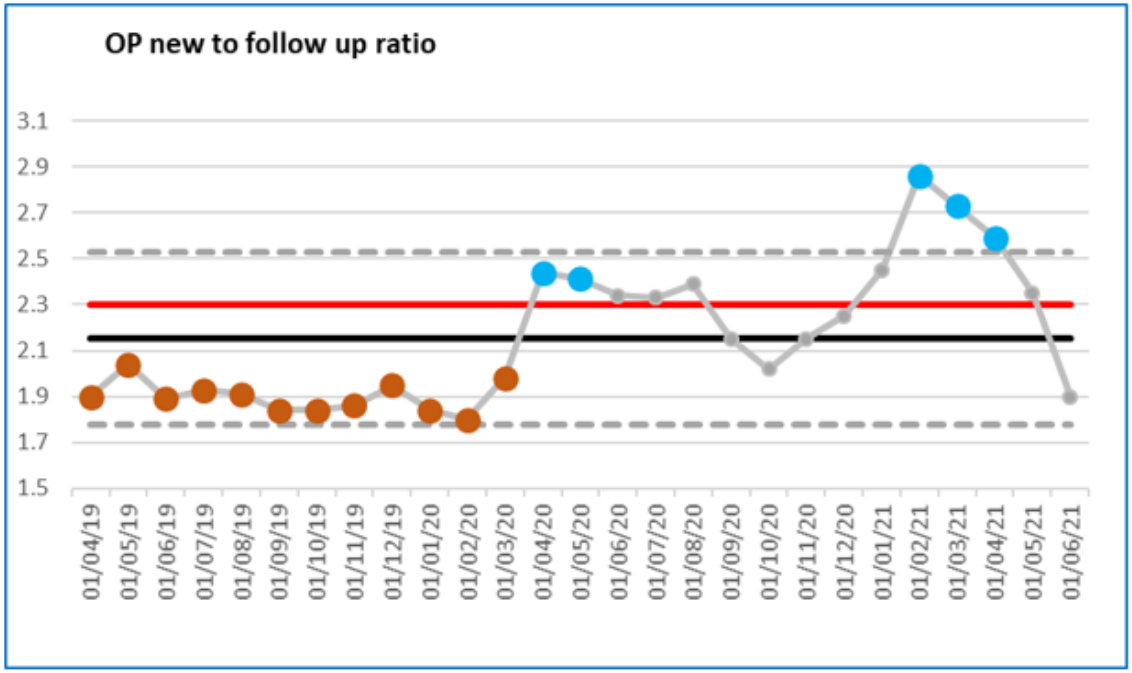
May-21
69%
Variance Type
Special cause variation
Target
85%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 62 day shared treatment	Special cause concerning variation and hitting and missing target radomly	The performance against the target has failed for over 12 months, and performance has been below the statistical mean for 9 months	The Trust has continued to focus on diagnosing & treating the backlog of patients that developed over the Covid period and the 62 day performance reflects the increased numbers of patients treated after 62 days in their pathway. Additional diagnostics and treatments are being delivered to clear the backlog and the Trust is refreshing the recovery trajectories to monitor performance against.	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting.



May-21
79%
Variance Type
Common cause 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	Common cause variation and inconsisrtently passing and falling short of the target	Increased referrals plus bank holidays in the month impacting clinic capacity, particularly in Breast & Skin Cancer. In addition the requirement to swab patients for Covid going straight to test lengthens the time to first appointment.	All tumour sites have reviewed their clinic capacity to ensure it is sufficient for the current increased referrals. Further straight to test pathways and closer scrutiny of booking of patients.	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting. 28 day diagnostic standard very close to national standard



Jun-21
1.9
Variance Type
Common cause variation
Target
2.3
Target Achievement
Inconsistently passing and falling short of target

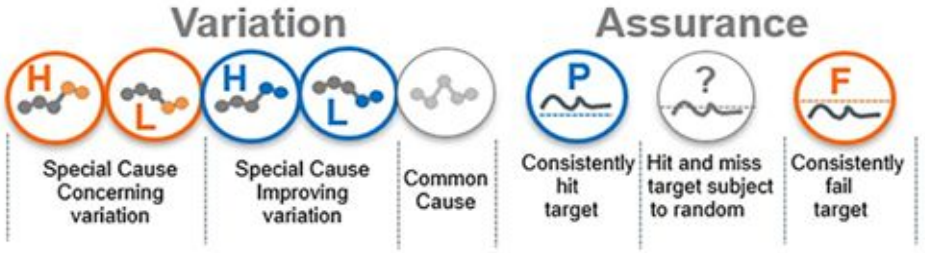
Background	What the chart tells us	Issues	Actions	Mitigation
OP new to follow up ratio	Common cause variation and inconsisrtently passing and falling short of the target	During Covid period only virtual clinics were in place with very few clinically necessary face to face appointments. Therefore majority of activity delivered was overdue follow-up appointments (review lists).	Continued in & outsourcing is being used to deliver additional clinic capacity for review list clearance in addition to new appointments being seen face to face.	Not required - returning to normal values

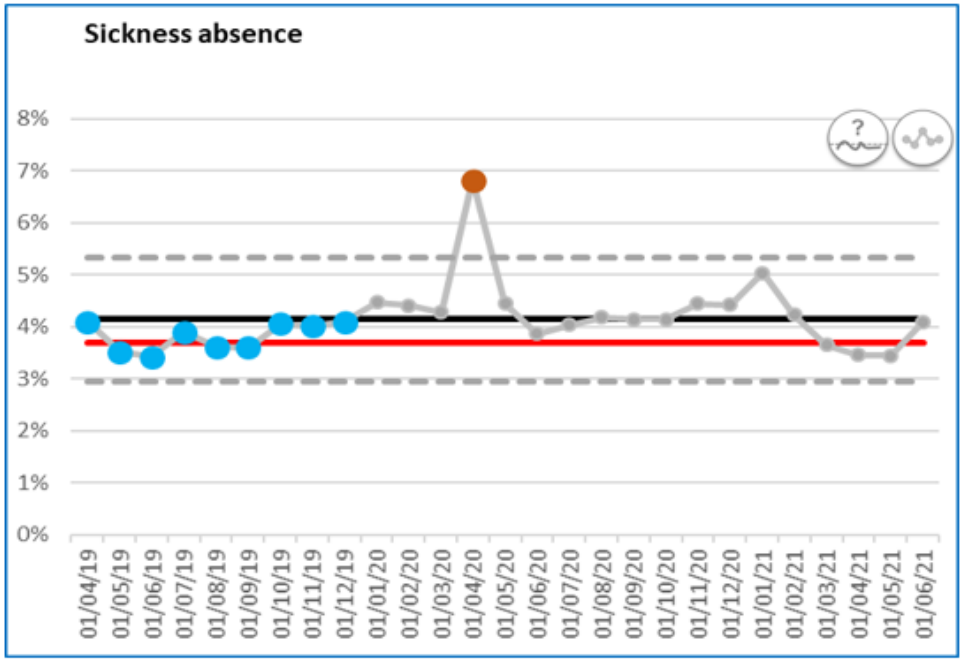
People

*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	Appraisal rates are increasing across all divisions & are monitored at divisional board meetings & monthly PRMs	For information	Q2
Sickness	Overall improvement in sickness absence with some local increase in short term absences related to COVID & self isolation	For information	Q2
Statutory and Mandatory training	Statutory & mandatory training has ben below the trust target. Some improvements made & compliance is monitored in divisional board meetings & monthly PRMs	For information	Q2
Vacancy	Vacancy rates are improving trust wide, international recruitment continues on plan following a pause on recruitment from India. Recruitment plans agreed for Estates & Facilities.	For information	Q2/3

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Appraisals - non medical	Jun 21	83%	90%		F	82%	76%	88%
Agency staffing spend	Jun 21	4%	15%	L	P	5%	2%	8%
Bank staffing spend	Jun 21	12%	15%		P	12%	9%	14%
Vacancy Rate	Jun 21	9%	8%	L	F	10%	9%	11%
Staff turnover - voluntary	Jun 21	11%	12%		P	11%	10%	12%
Sickness absence	Jun 21	4%	4%		?	4%	3%	5%
Statutory and Mandatory training	Jun 21	88%	90%		?	89%	85%	92%

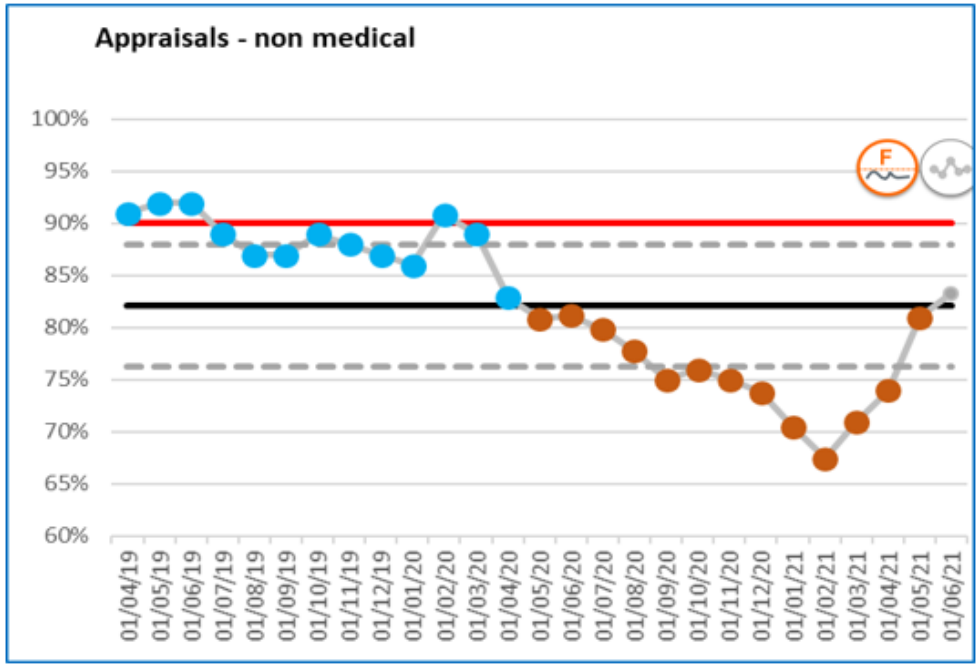




Jun-21
4%
Variance Type
Common cause variation
Target
4%
Target Achievement
Inconisistnently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Sickness absence	Variation indicates inconsistently passing & falling short of the target	Overall trust KPI remains on target. Increase from last month on short term absence related to COVID & self isolation	Active support around management of both short & long term cases with plans in place where required including occupational health interventions. Active promotion of health & wellbeing initiatives including "Here for you"	Peak in short term absence expected due to COVID & self isolation. Sickness data reviewed daily

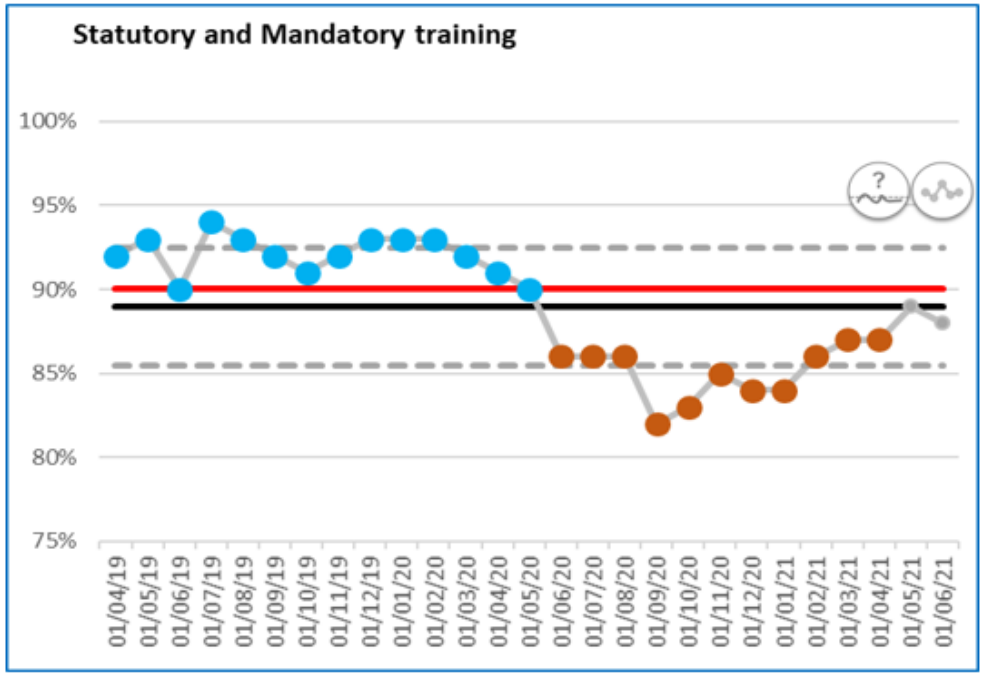
People



Jun-21
83%
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 and consistently falling short of target	There are low appraisal rates across the organisation following a pause in appraisals over the last year. Improvements have been seen month on month.	Webinars are being delivered to staff & managers & staff reminded of the link to pay progression for AfC staff.	Compliance is monitored at divisional meetings & monthly performance review meetings.

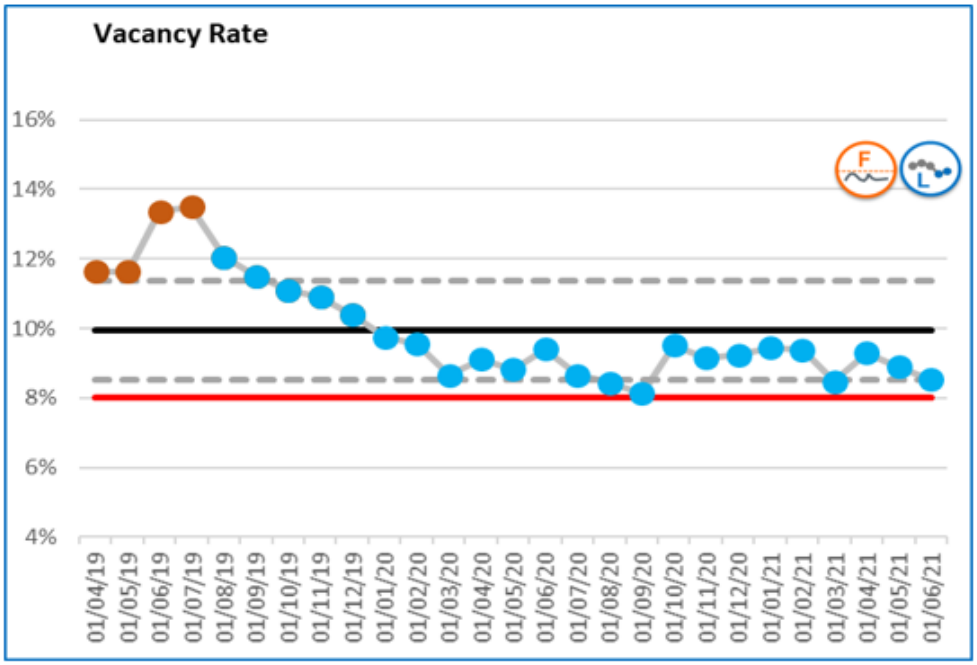
People



Jun-21
88%
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 and consistently failing target	There are low rates across the organisation following a pause on training over the last year. Analysis undertaken by the L&OD team have identified a number of key themes including ability to be released to attend training &	L&OD & people team working with divisions to agree an action plan to release staff to attend training.	Action plans monitored at divisional meetings & monthly performance review meetings. Training facilities will be moved to the new onsite training facility when this opened in Q2.

People



Jun-21
9.00%
Variance Type
Special cause variation
Target
8.00%
Target Achievement
Consistently failing

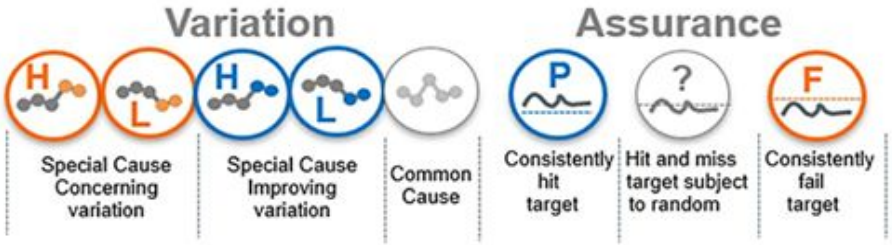
Background	What the chart tells us	Issues	Actions	Mitigation
Vacancy Rate	Special cause improving variation & consistently failing target	Overall vacancy rate continues to reduce. International recruitment from India was paused over the last 2 months due to COVID which has seen a lower than expected pipeline. High vacancy rates in Estates & Facilities.	International recruitment pipeline continues. Rolling recruitment for Estates & Facilities posts including domestics & housekeepers.	Recruitment plans agreed which are monitored at divisional boards & PRMs.

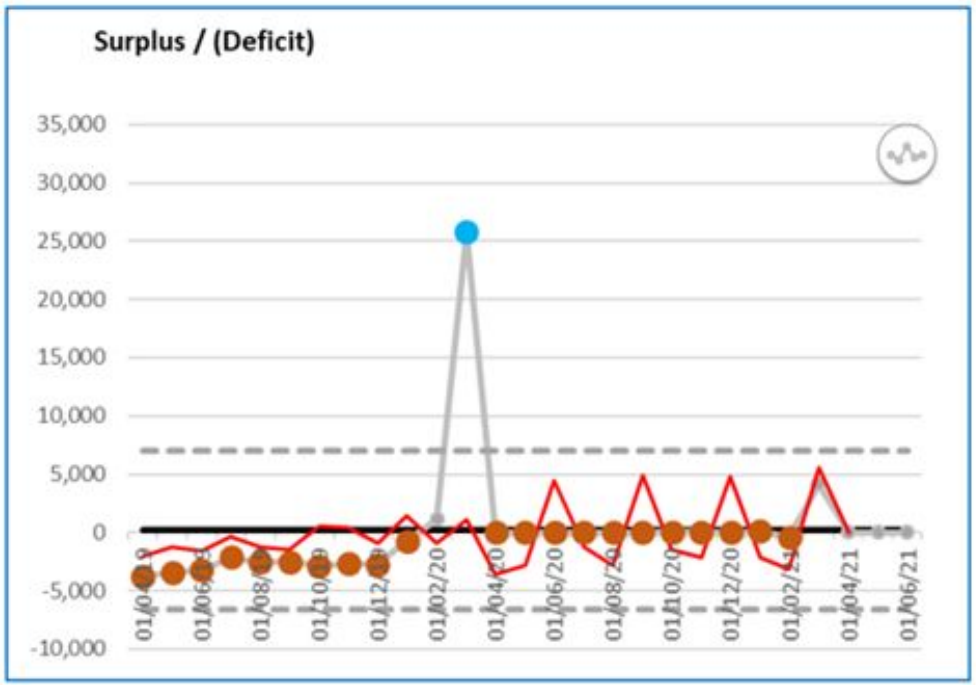
People

Pounds

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

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Surplus / (Deficit)	Jun 21	15	0			168	-6632	6969
EBITDA	Jun 21	1465	0			1257	-5618	8132
CIP	Jun 21	0	0	L		598	-218	1413
Income	Jun 21	26996	0			25357	12706	38008
Operating Expenditure	Jun 21	25531	0	H		25081	18920	31242
Bank Spend	Jun 21	1956	0			1914	1255	2574
Agency Spend	Jun 21	660	0			847	447	1246
Capital Spend	Jun 21	562	0			2645	-4044	9333

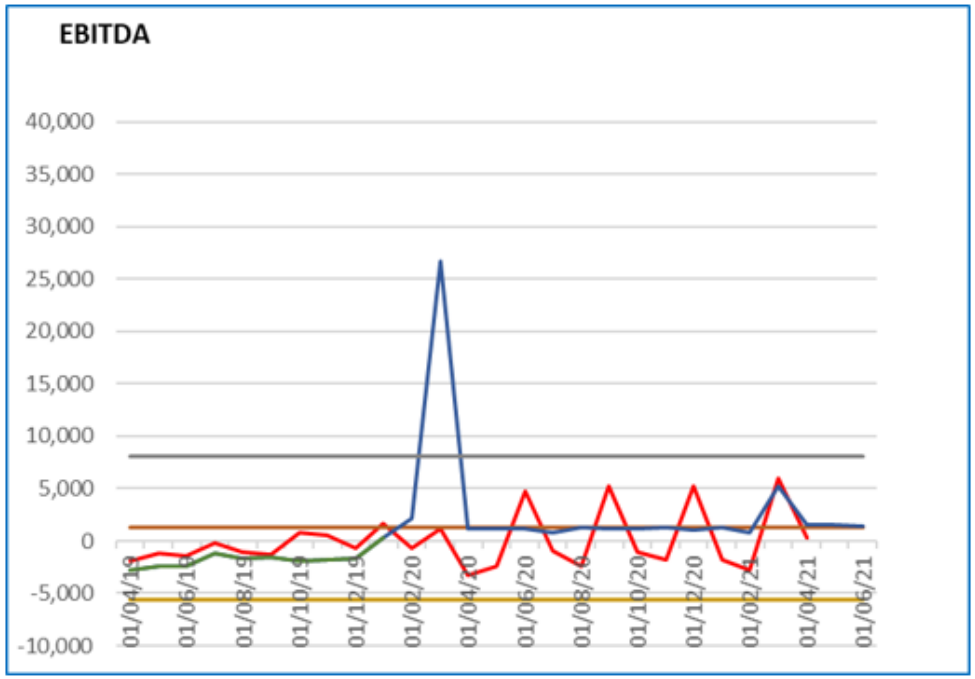




Jun-21
15
Variance Type
Common cause variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Surplus/Deficit	Common cause variation and inconsistently passing and falling short of the target	The Trust has successfully achieved a surplus for the first quarter of 20/21	N/A	N/A

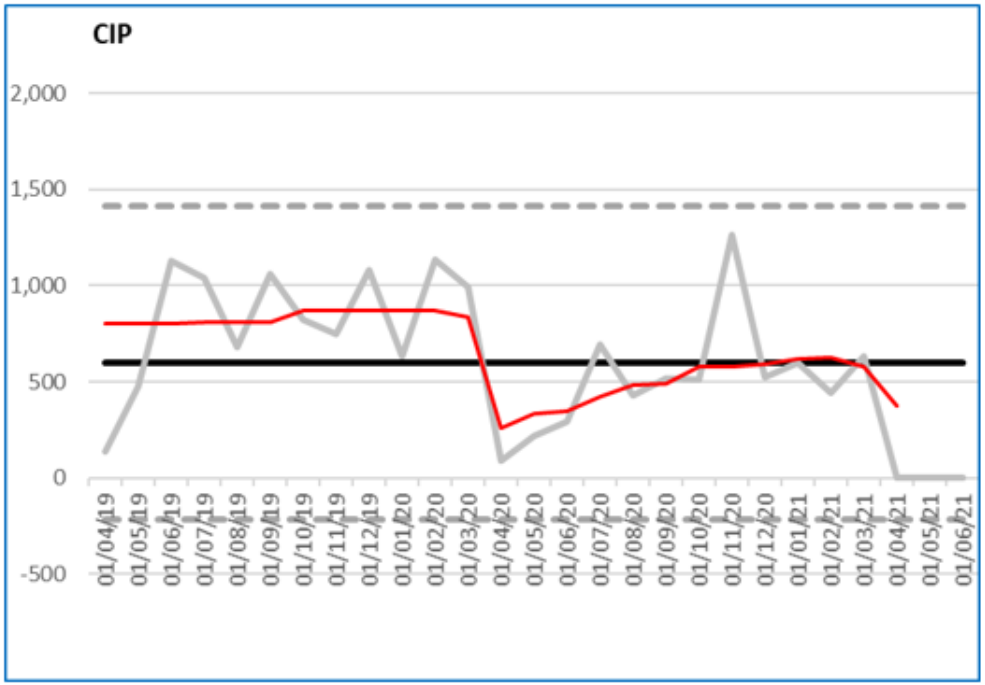
Pounds



Jun-21
1465
Variance Type
Common cause variation
Target
362
Target Achievement
Inconsistently passing and falling short of the target

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

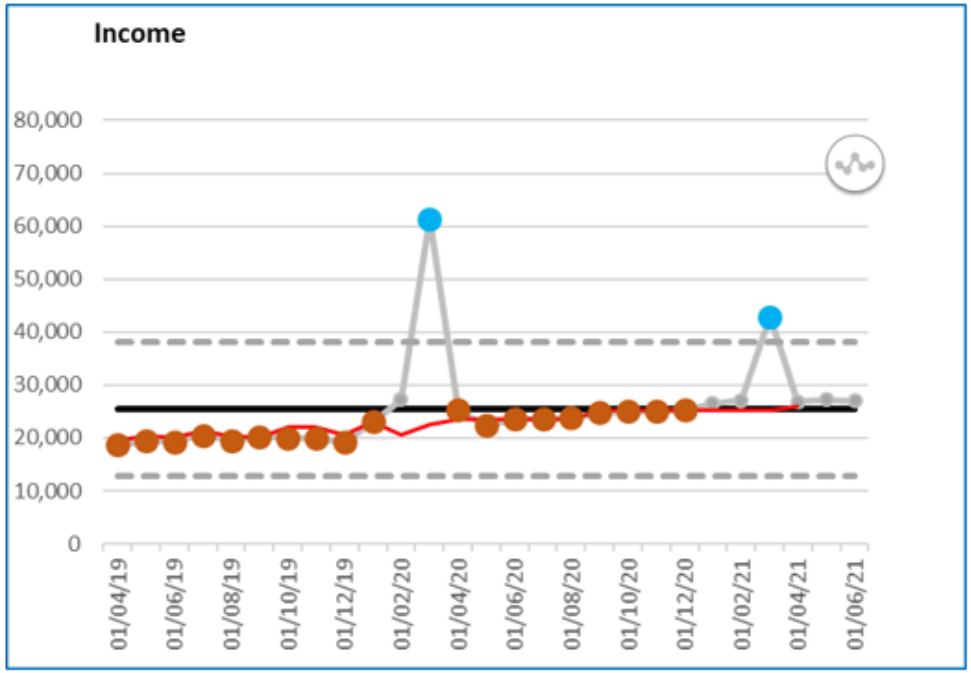
Pounds



Jun-21
0
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	Potential CIPs have yet to go through the QIA process. Therefore no CIP has been reported.	QIA process is taking place	N/A

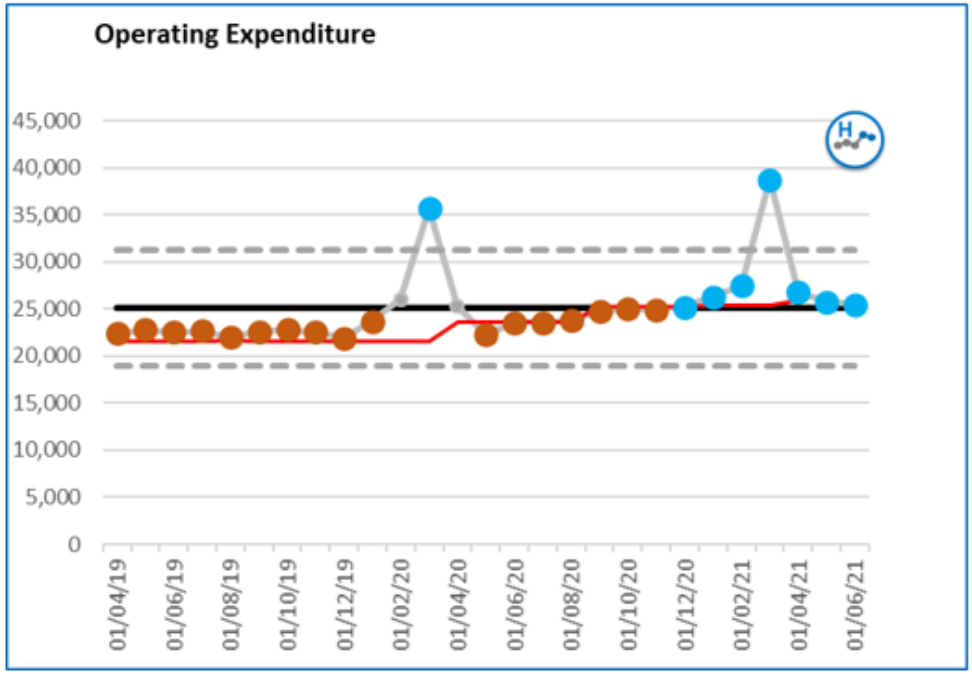
Pounds



Jun-21
26996
Variance Type
Common cause variation
Target
25930
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Income	Common cause variation and inconsistently passing and falling short of the target	ERF income has recognised to offset recovery activity expenditure hence the Trust has overperformed compared to income target	N/A	N/A

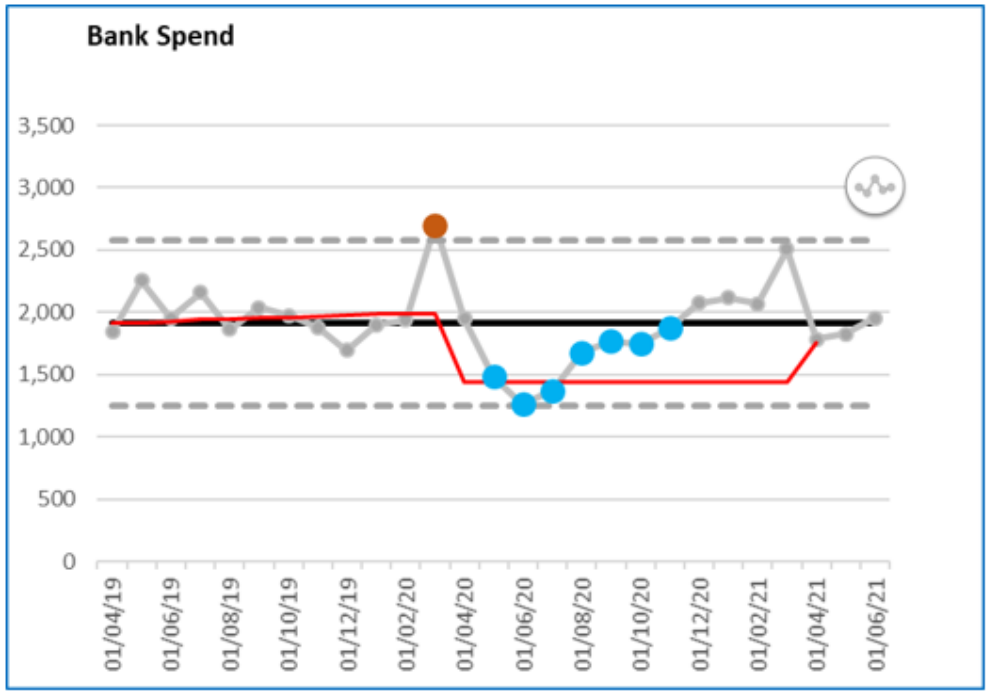
Pounds



Jun-21
25531
Variance Type
Special cause variation
Target
25531
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Operating Expenditure	Special cause improving variation and inconsistently passing and falling short of the target	The Trust remains on track in relation to its expenditure plan	N/A	N/A

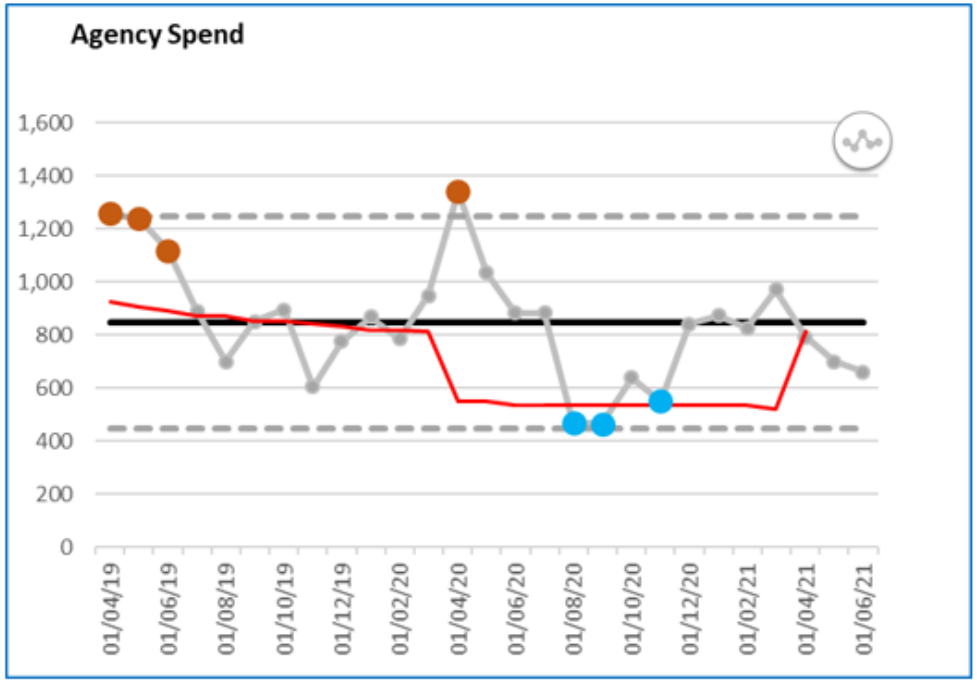
Pounds



Jun-21
1956
Variance Type
Common cause variation
Target
2185
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Bank Spend	Common cause variation and inconsistently passing and falling short of the target	Bank spend is higher than this month's target	The bank and agency Trustwide group has been reconstituted and is meeting on a monthly basis	N/A

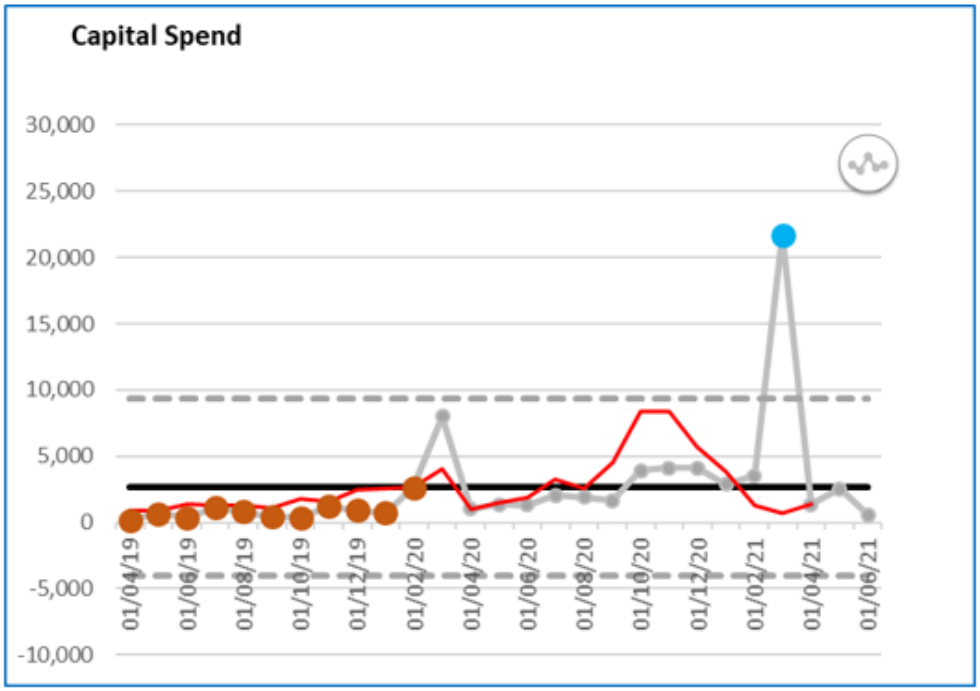
Pounds



Jun-21
660
Variance Type
Common cause variation
Target
1088
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 the target for this month.	Meeting on agency spend with HCGs have been set to manage bank and agency spend.	N/A

Pounds



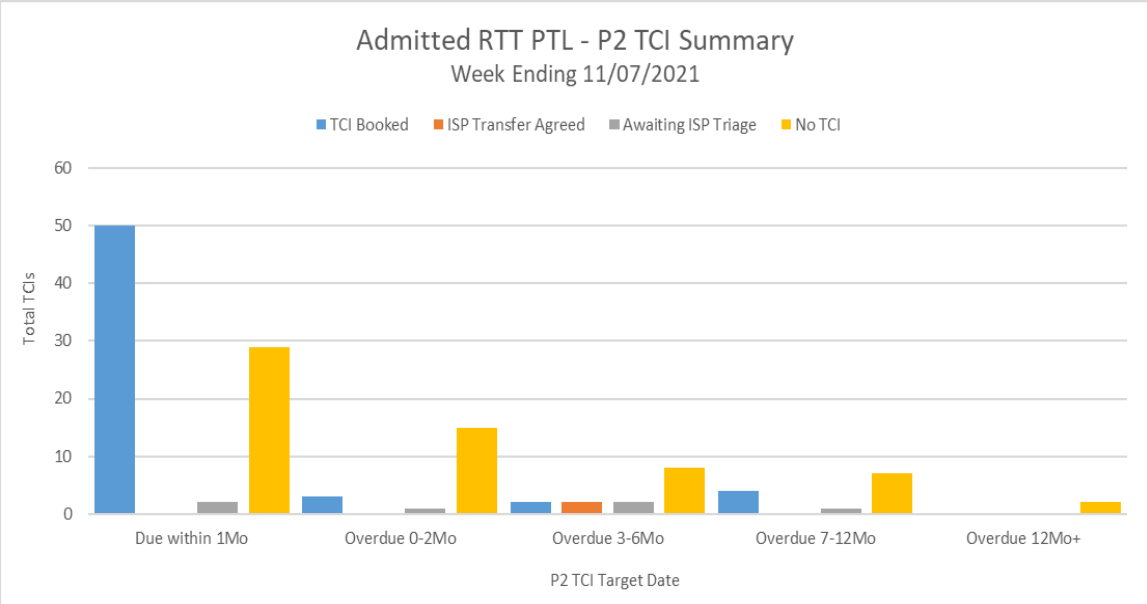
Jun-21
562
Variance Type
Common cause variation
Target
2521
Target Achievement
Inconsistently passing and falling short of the target

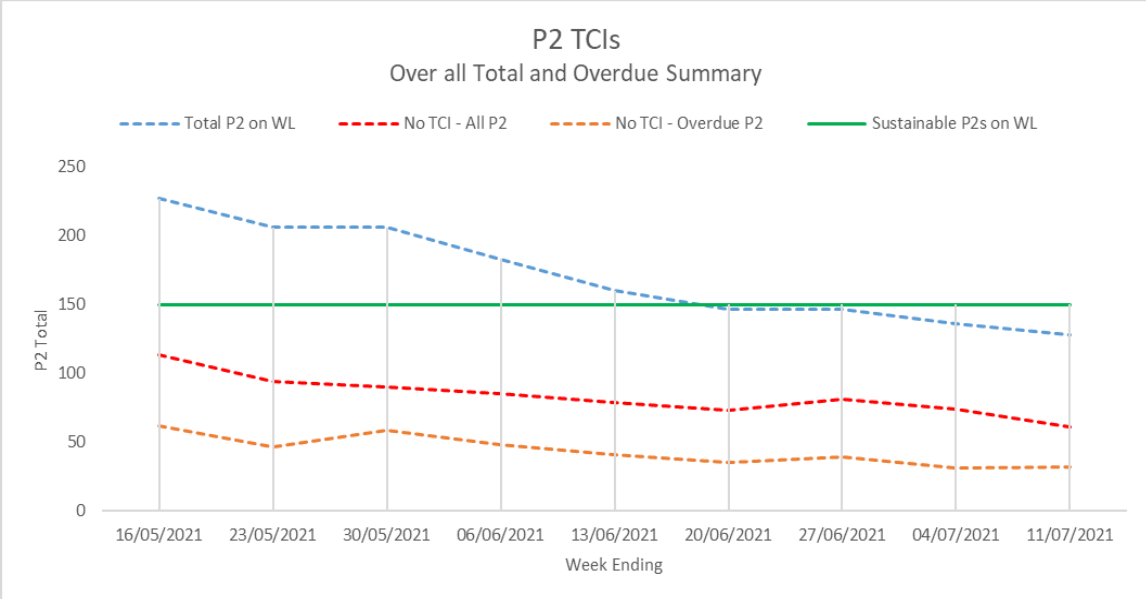
Background	What the chart tells us	Issues	Actions	Mitigation
Capital Spend	Common cause variation and inconsistently passing and falling short of the target	Spend is below the target but the capital programme is oversubscribed	The Trust's YTD capital expenditure is below target mainly due to timing issues which will catch up over the next few months.	Mitigations are being developed to balance the value of schemes within the available funding.

Pounds

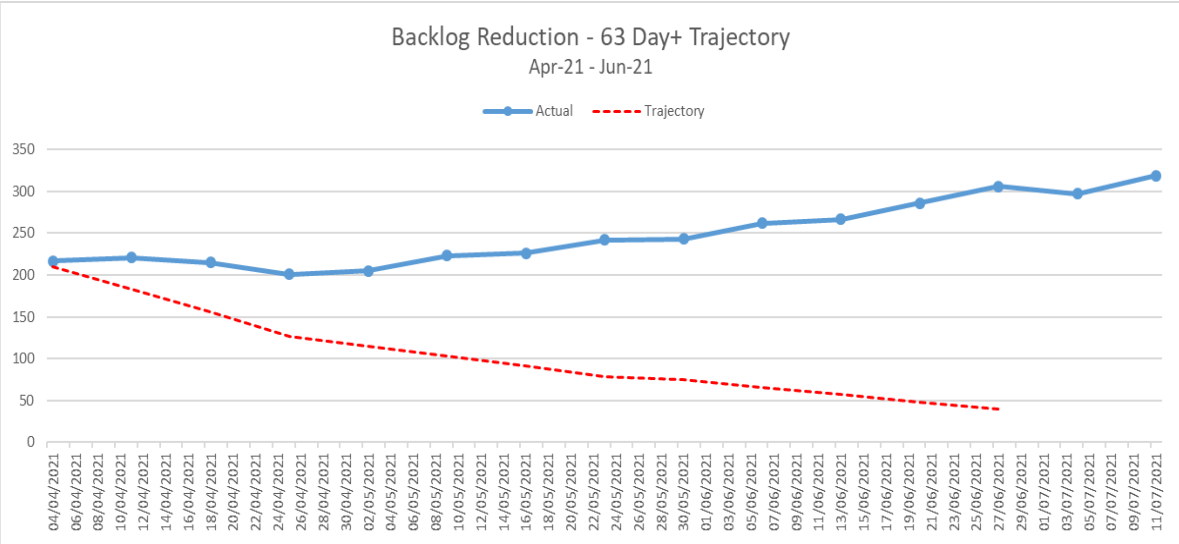
Appendix A – Recovery Dashboard

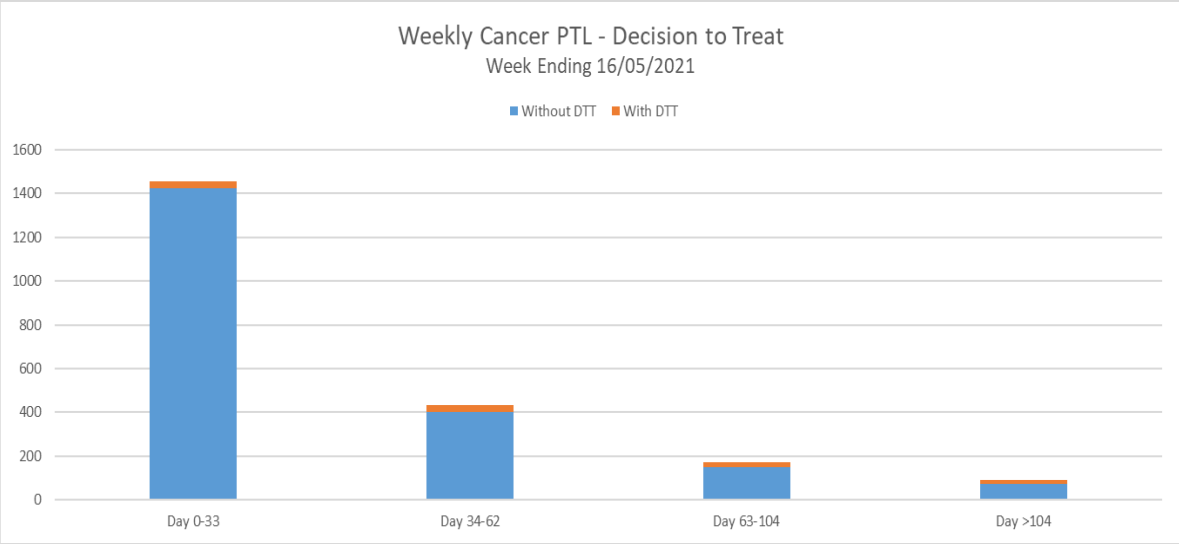
Clinical Prioritisation





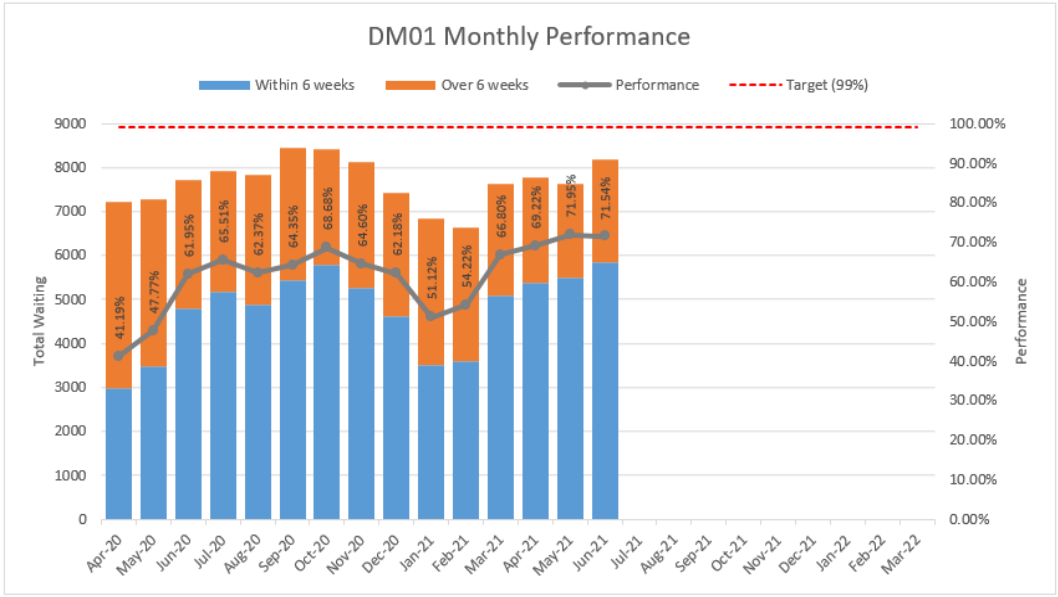
Cancer



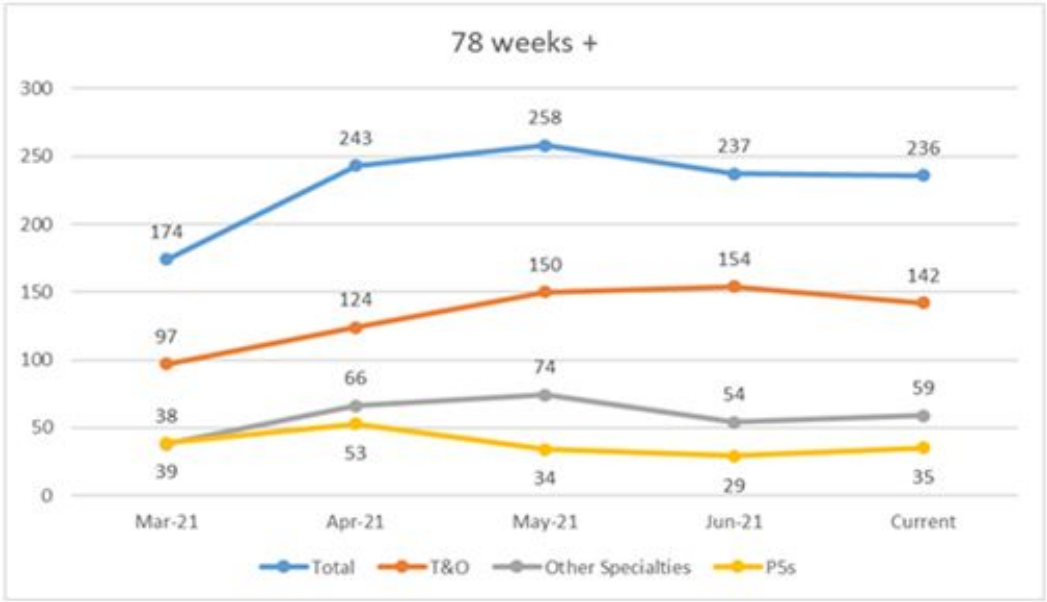


Month	Cancer Performance			
	2WW Performance	28 Faster Diagnosis Performance	31 Day Performance	62 Day Performance
Apr-19	91.0%	68.9%	100.0%	78.7%
May-19	92.6%	57.0%	97.8%	74.7%
Jun-19	91.1%	73.2%	98.1%	76.5%
Jul-19	94.1%	68.6%	99.0%	82.6%
Aug-19	89.9%	69.6%	98.9%	79.3%
Sep-19	87.3%	65.2%	99.1%	85.4%
Oct-19	84.1%	66.0%	100.0%	85.2%
Nov-19	86.1%	65.7%	100.0%	85.3%
Dec-19	86.7%	63.2%	97.9%	87.2%
Jan-20	91.9%	64.4%	94.4%	77.3%
Feb-20	95.7%	70.9%	96.9%	76.7%
Mar-20	93.2%	60.9%	97.1%	81.0%
Apr-20	87.4%	47.9%	95.1%	61.3%
May-20	93.4%	64.5%	90.7%	61.9%
Jun-20	77.6%	62.5%	86.9%	75.6%
Jul-20	85.9%	68.4%	91.1%	75.4%
Aug-20	74.4%	69.7%	87.1%	59.3%
Sep-20	68.7%	65.7%	90.2%	66.3%
Oct-20	81.7%	62.0%	87.4%	54.9%
Nov-20	72.1%	66.2%	92.6%	67.3%
Dec-20	89.2%	65.4%	93.7%	68.4%
Jan-21	90.6%	64.5%	89.3%	65.4%
Feb-21	88.9%	69.5%	87.5%	48.6%
Mar-21	97.5%	74.5%	93.3%	68.3%
Apr-21	76.4%	71.5%	93.5%	63.1%
May-21	79.0%	74.1%	100.0%	68.9%

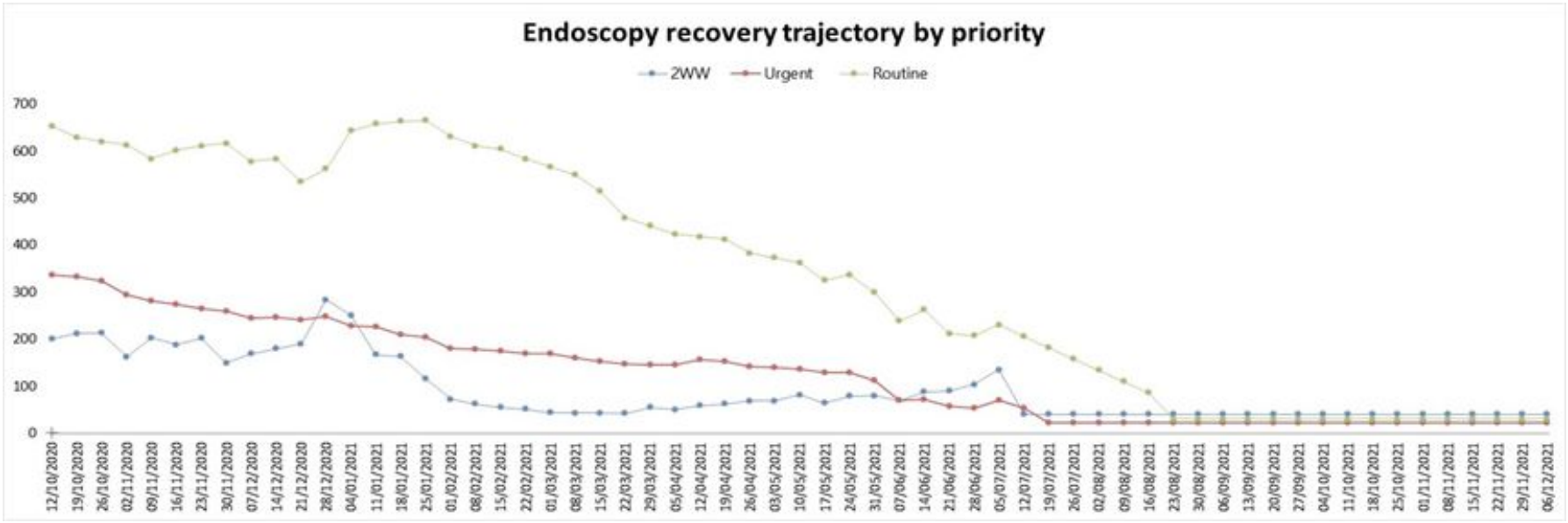
DM01


DM01 Monthly Performance
Within 6 weeks
Over 6 weeks
Performance
Target (99%)
Total Waiting
Performance
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%
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 +
300
250
200
150
100
50
0
174
243
258
237
236
97
124
150
154
142
38
66
74
54
59
39
53
34
29
35
Mar-21
Apr-21
May-21
Jun-21
Current
Total
T&O
Other Specialties
P5s

Endoscopy


Endoscopy recovery trajectory by priority
2WW
Urgent
Routine
700
600
500
400
300
200
100
0
12/10/2020
19/10/2020
26/10/2020
02/11/2020
09/11/2020
16/11/2020
23/11/2020
30/11/2020
07/12/2020
14/12/2020
21/12/2020
28/12/2020
04/01/2021
11/01/2021
18/01/2021
25/01/2021
01/02/2021
08/02/2021
15/02/2021
22/02/2021
01/03/2021
08/03/2021
15/03/2021
22/03/2021
29/03/2021
05/04/2021
12/04/2021
19/04/2021
26/04/2021
03/05/2021
10/05/2021
17/05/2021
24/05/2021
31/05/2021
07/06/2021
14/06/2021
21/06/2021
28/06/2021
05/07/2021
12/07/2021
19/07/2021
26/07/2021
02/08/2021
09/08/2021
16/08/2021
23/08/2021
30/08/2021
06/09/2021
13/09/2021
20/09/2021
27/09/2021
04/10/2021
11/10/2021
18/10/2021
25/10/2021
01/11/2021
08/11/2021
15/11/2021
22/11/2021
29/11/2021
06/12/2021

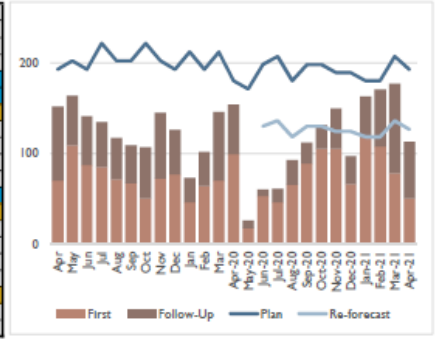
Appendix B – MSK Pathway

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

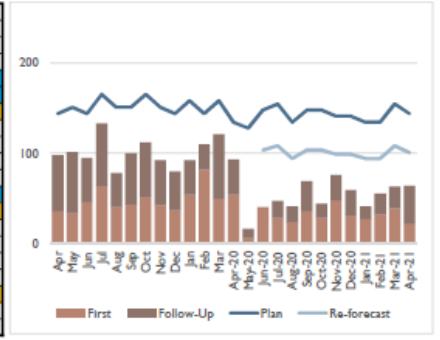
PRIMARY CARE - Stellar Healthcare Limited

PRIMARY CARE - SHL

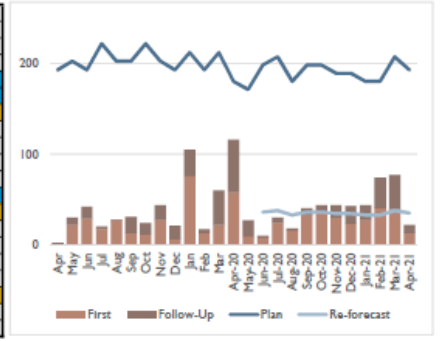
GPSI T&O		2019/20	Financial Month: Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
First	Actuals	868	70	109	87	85	71	67	50	72	77	46	64	70	99	17	53	46	65	89	105	105	66	117	108	78	50		
	Plan	1,534	121	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		



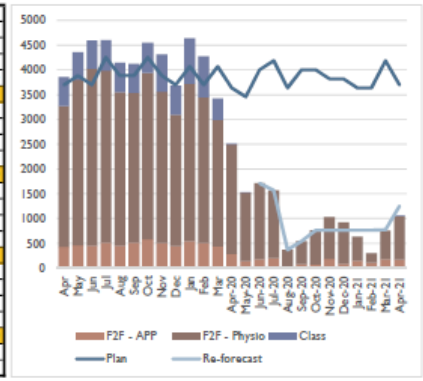
GPSI Rheumatology		2019/20	Financial Month: Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
First	Actuals	263		22	29	17	27	13	11	27	6	76	13	22	58	9	8	24	16	32	36	30	23	27	40	39	13		
	Plan	1,534	121	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	19%															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		



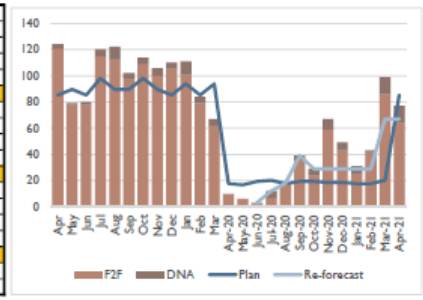
PRIMARY CARE - EPUT (Essex Partnership University NHS Trust)

COMMUNITY CARE - EPUT

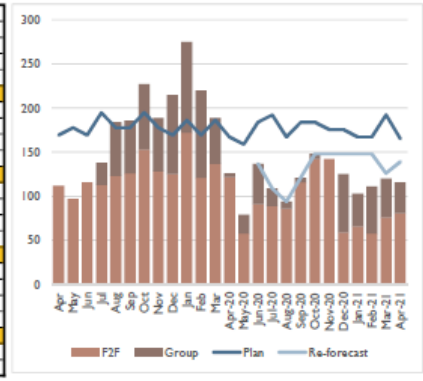
		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
			Financial Month																										
F2F - APP	Actuals	5,854	435	457	455	513	451	518	583	509	444	541	509	439	287	139	177	198	23	78	69	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		



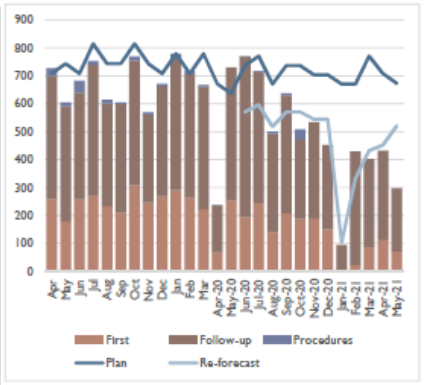
		2019/20	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
			Financial Month																										
Pain service F2F	Actuals	1,323	112	97	116	113	123	126	153	128	125	172	121	137	122	58	91	89	86	116	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	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	54	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	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

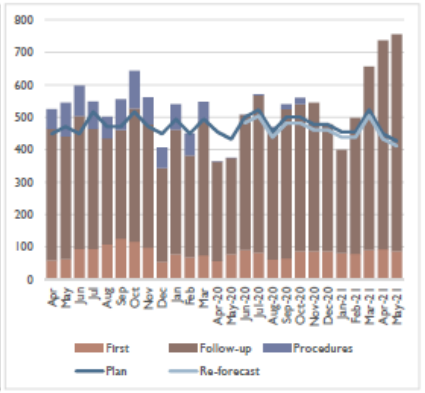
Orthopaedics

		2019/20	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	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	



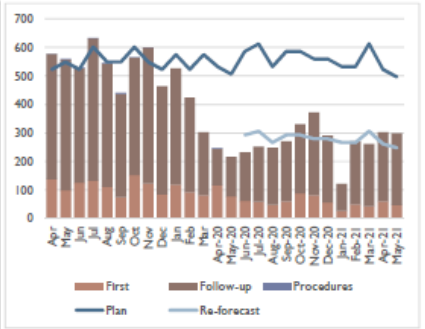
Rheumatology

		2019/20	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	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	-9	-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	



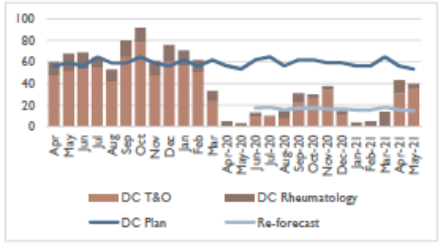
Physiotherapy

		2019/20	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	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	59	56	50	50	50	64	52	54	54	69	31		1	19	16	40	50	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	-15	-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	



The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 05.08.21 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: New Hospital Committee (NHC)
REPORT FROM: Lance McCarthy (Committee Chair)
DATE OF COMMITTEE MEETING: 26.07.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

New Hospital Programme (NHP) Update:

- The National Design Convergence Review (DCR) continues with the outputs (design requirements) anticipated by September. The risk of a delay to the Trust's programme and potential impact on the current design of the hospital were discussed.
- Further information has been requested on the Trust's preferred way forward, the part rebuild and part refurbishment and the new build on the existing site options. This information will be used to determine the overall capital envelope required for the national new hospital programme and to support discussions with HMT.
- All 1:200 departmental layouts with the exception of ED assessment, have been signed off by each department lead and the Trust Board.
- A first draft of the OBC workforce strategy section has been developed in discussion with the Trust HR and New Hospital project team.

Land Purchase:

- Negotiations for the purchase of the land continue.

New Hospital BAF Risk (3.5):

- In line with the recommendation it was agreed that the risk score should remain at 16.

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

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

- Standing agenda items including programme risks
- Finance Update

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

The Committee is making good progress against its AWP.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS – 01.07.21 **Agenda Item: 6.1**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Pam Court - PAF Chairman
DATE OF COMMITTEE MEETING: 29.07.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

Business cases:

- Vascular Services Outline Business Case: PAF endorsed (for Board approval in the private session on 5.08.21):
  1) That option 2 is progressed to create the HWE Vascular network.
  2) The recommendation to utilise STP wave 4 funds (£7.2m capital), subject to external approvals, to build a new hybrid theatre, improve IR recovery facilities and develop a dedicated ward for the vascular network hub at the Lister Hospital site.
  3) The development of a Full Business Case based on this Outline Business Case for submission to NHS England and Improvement to secure capital investment (to be presented to October Trust Board).

- **Winter Ward Refurbishment:** Additional funding of £274k for Winter Ward refurbishment was endorsed (for Board approval) to support changes which had been identified as being critical for business continuity and resilience. Those additional works have been identified from learning from COVID and from the works that had been undertaken.

CIPs: The Committee noted the progress on the CIP programme, the identification of schemes and current delivery against the plan.

EPR Update: PAF noted that initial stakeholder benefit workshops had completed and the statement of requirements was being consolidated along with the embedding of scripts in anticipation of procurement. Workshops were underway to develop documentation to support the procurement process and the data migration strategy was being developed. The plan was for the OBC to be complete for Trust Board in September 2021.

M3 Update – Income and Expenditure: At the April PAF a deficit plan of £2.2m, for the first half of the financial year (H1) had been presented. Subsequent discussions with the ICS had led to a breakeven plan for H1. The revised plan reconciled to ICS funding envelopes. The YTD position for June was a surplus of £0.1m against a break-even plan. That position had been delivered by a combination of income over-performance (income of £1.5m has been recognised to offset 'restore and recover' activity expenditure) and pay and non- pay underspends. Temporary staffing costs had shown a small increase to £2.6m compared to May's £2.5m.

Capital: The Trust's capital resource limit was clarified as being c.£20m. YTD spend was £3.9m and was under plan by £2.5m.

Data Security Protection Toolkit: Members noted submission of the on-line self-assessment tool that enabled organisations to measure and publish their performance against the National Data Guardian's ten data security standards. The Trust had received a 'Substantial Assurance' outcome following its audit.

BAF Risks: There were no changes proposed to the scoring of the BAF risks assigned to PAF. BAF Risk 5.1 (Revenue) and 5.2 (Capital) to remain at 12. BAF Risk 4.2 (ED 4 hour emergency standard) score to remain at 16. 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:

- M3 Integrated Performance Report
- Quarterly e-Health Update
- Bi-monthly New Hospital Update
- Quarterly Estates & Facilities Update
- AAU Benefits Realisation – further update to be presented at end of calendar year.
- Report from Health & Safety Committee
- Report from Capital Working Group

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 – 05.08.21 **Agenda Item: 6.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)
REPORT FROM: Helen Glenister – QSC Chair
DATE OF COMMITTEE MEETING: 30.07.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

COVID-19: The Committee was informed that in July, 92 patients had been admitted to the hospital with COVID. It was noted that half of that cohort had not been vaccinated. Patients had presented in varying age groups (up to those in their 50s/60s) and the organisation was working with colleagues at Public Health England to address the gaps in COVID vaccination in Essex. The Committee was given reassurance that arrangements had been put in place to manage an increase in COVID-19 patients.

Clostridium difficile (C.difficile): A significant rise in the number of C.difficile cases in 2020-21 had been reported over recent months, however during the last three months the organisation appeared to be seeing a reduction of the Hospital-Onset Healthcare Associated (HOHA) cases. In June there had been no hospital-onset healthcare associated cases of C.difficile and one Community-Onset Healthcare Associated (COHA) case.

Infection Control Annual Report: The Committee had sight of this report which outlined Infection Prevention and Control activity at the Trust during 2020/21. It included the Infection Prevention and Control Annual Work Programme, and Audit Programme for 2020/21. (Please see attached Executive Summary at appendix 1).

Quality PMO (QPMO) Update: The first report was provided from the QPMO and was received for assurance in terms of the QPMO approach, oversight and new methodology in relation to rag rating progress. It also updated on the progress made to date against CQC findings (must & should), any new arising quality projects or issues, and risks to the programme and the projects. The introduction and implementation of the QPMO would drive forward the evidence base and progress against the organisation's Quality Improvement Plan. QSC welcomed the approach and the weekly reporting the Deputy CEO/Director of Nursing and Allied Health Professionals.

Patient Experience Annual Report: The paper was structured against the organisation's Listening, Responding and Improving approach to improvement of Patient Experience. QSC noted the Trust had ended the year having received 204 complaints vs 172 in 2019-20, an increase of 18% with 10.4% more PALS cases received with 3778 closed. Communication continued to be the main theme, and it was noted that a strategic approach to address this issue was now being taken.

Mortality: Some preliminary data was showing the Trust's HSMR at 104.27, and for the first time in 36 months 'as expected', with the average in terms of East of England peers (11 organisations) at 107.9. The continued efforts of the organisation over the previous two and half years to reduce mortality were fully recognised. An update would be provided in the public Board session.

BAF Risks: BAF Risk 1.0 (COVID): It was agreed the risk score should increase again to 16 (from 12) given the current position in terms of infections. BAF Risk 1.1 (Variation in Clinical Outcomes): It was agreed the score would remain at 16 (despite the good news around HSMR) and would be reviewed again in September following further anticipated CQC inspections. Some minor changes to the risk narrative were also approved.

Maternity SI Report: The committee heard of the challenging staffing levels anticipated over August in relation to the service, and the mitigations in place to manage the risk.

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

The Princess Alexandra Hospital NHS
NHS Trust

In addition to the above, QSC received reports on the following agenda items: • CQC Visit – Outcomes/Action Plan • Report from Quality Compliance Group • Report from Clinical Effectiveness Group • Report from Strategic Learning from Deaths Group • Report from Patient Safety Group • Patient Safety, Quality & Effectiveness Update • Update from Patient Panel • Maternity SI Report • Surgery Quarterly Performance Update • M3 Integrated Performance Report • Horizon Scanning
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
• The Committee continues to make good progress against its work plan. .

2.0 Executive Summary:

2.1 The Trust has robust infection prevention and control (IPC) measures in place; this is part of a safety culture that helps control healthcare associated infections (HCAIs). The prevention and control of infection is part of the Trust's risk management strategy and is embedded into clinical care. This year has brought both challenges and successes, but IPC undoubtedly, now more than ever, remains a top priority for the organisation.

2.2 COVID-19 Pandemic:

The arrival of the COVID-19 pandemic in the early part of 2020 brought new and significant challenges, not only to the Trust, but the whole health care economy in the UK and globally. It has dominated and tested every aspect of infection prevention and control, including our ability to control droplet spread, contact spread and airborne spread across all clinical areas in the organisation. The work of the IPC team was significantly impacted by the emergence of the pandemic; however, managing COVID-19 has given a new perspective on organisational IPC, and shown the Trust to be versatile and responsive.

2.3 The IPC Team (IPCT) have been a resilient and integral part of the Trust's response to COVID-19, having been actively involved in all decisions relating to the management of the pandemic including patient placement, continuous development of pathways with the regular emergence of new guidance from Public Health England (PHE), training of staff on Personal Protective Equipment (PPE) and changing guidelines, development of PPE competencies for staff and the management of COVID-19 outbreaks. Additionally the IPC Team have been responsible for the appointment of a PPE Champion team who have been an invaluable resource for the Trust and have been responsible for supporting the IPCT with our fit testing programme, the training of staff and undertaking regular audits in clinical and non-clinical areas. A summary of the COVID-19 activity is included in the main report.

2.4 Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia:

The Trust has maintained its excellent position with no Trust-apportioned cases this year against a trajectory of zero.

2.5 *Clostridiodes difficile* (*C.difficile*):

The Trust has unfortunately seen a significant increase in *C.difficile*, with a total of 54 cases (a combination of hospital-onset and community-onset health care associated cases) for the year (compared to 23 the previous year). It is very likely that the COVID-19 pandemic has contributed to the rise in cases due to the prescribing of broad spectrum antibiotics, however, IPC practices are also key. A combination of factors, including lessons learned from our internal investigations, are being reviewed as part of our recovery plan.

2.6 Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia:

The Trust remains in a good position as one of the top performing NHS organisations in the country in terms of low MSSA blood infections. This year there have been seven cases which is directly comparable with the previous year.

2.7 Gram negative blood stream infections (GNBSIs):

Cases of *Escherichia coli* (*E.coli*), *Klebsiella spp*. and *Pseudomonas aeruginosa* are similar in numbers to the cases observed last year (an increase in *Klebsiella spp*. hospital-onset cases has occurred this year, but numbers are still small). There are no locally set objectives; there is however a national ambition of reducing GNBSIs by 50% by 2023-24 and it is expected that local trajectories will be set in 2021-22.

2.8 Other Multi-resistant organisms

Carbapenem-resistant and Carbapenemase- producing gram negative rods (GNR).

Recent taxonomy changes have included the family *Enterobacteriaceae* within the order Enterobacterales. Enterobacterales are a large family of bacteria that usually live harmlessly in the gut e.g. *Escherichia coli, Klebsiella* spp. and *Enterobacter* spp.

Incidences have been low this year with just three cases, a reduction from the nine cases last year and none of which were clinical infections. However, compliance with screening processes need to be improved upon for the Trust to have a full oversight of the rate of cases. This is being supported by auditing, education and the development of a new screening tool to reflect changes in national guidance.

Glycopeptide (Vancomycin) Resistant *Enterococci* (GRE / VRE)

There has been a gradual increase in VRE cases over the years with 92 cases associated with clinical samples this year compared to 70 last year. In addition there were also eight cases of VRE bacteraemia, compared to three cases last year. The rise may be attributed to the increased use of broad spectrum antibiotics and vancomycin, an antibiotic reserved for the treatment of serious infections, and also for the management of *C.diff* infection.

2.9 Surgical Site Surveillance

Mandatory surveillance has continued for knee and hip arthroplasty surgery this year with no infections identified; however due to the COVID-19 pandemic, in comparison to previous years, low numbers of elective procedures were performed. Previously the Trust has been highlighted as an outlier for hip replacement surgery (1.3% rate of infection); due to there being minimal procedures this year, this previous data continues to be the benchmark for the Trust.

2.10 MRSA Screening

Screening data is not fully available this year, mainly due to the constraints of the pandemic and that the validation process was not possible for the Emergency Department (ED) to undertake. For the data that is available (July-October 2020 and December 2020), compliance is above target. For elective screening, capacity has also been an issue for the Information Team, with further difficulties caused by a migration of servers. As a result of this, there are no finalised figures for elective swabbing compliance for 2020/21. The Information Team are working towards finalising the review/re-write to enable compliance reporting re-commence.

2.11 MRSA Transmissions

There are robust monitoring processes in place to identify MRSA transmissions which includes weekly screens of patients. There were 239 new MRSA isolates in 2020-2021, with a transmission occurrence of 20%. Two wards were of particular concern in relation to clusters of transmissions; in all cases, patients were colonised only and did not have clinical infections; however, incident meetings were held and a number of measures were implemented to reduce transmissions. Whilst there were no further cases on one of the wards, the other has continued to have cases and further measures are being taken to address this.

2.12 Tuberculosis (TB)

The TB audit undertaken in 2020 has shown a slight increase in TB notifications from the previous year; however, the cases in 2019 were particularly low and the 13 cases seen in 2020-21 is actually consistent or lower than previous years. Nationally, there has been a reduction in both active and latent cases as a result of the COVID-19 pandemic.

A new TB Action Plan for England, 2021 – 2026 has recently been developed. The aim of this is to improve prevention, detection and control of TB nationally. The Action Plan will focus on the needs of those affected by TB and TB services whilst recognising the impact and learning from the COVID-19 pandemic. The key points in the plan are being progressed through the Trust's TB MDT meetings, of which the Director of IPC (DIPC) is a core member of.

2.13 Influenza

This year has seen very low numbers of influenza with 15 cases (six influenza A and nine influenza B) in the six month reporting period. This is a reflection of the predominant role of COVID-19 and the success of the influenza vaccination programme.

2.14 Staff Influenza and COVID-19 Vaccination Programme

The staff vaccination programme for influenza commenced in September 2020; between then and January 2021, 86% of front line health care workers were vaccinated.

The COVID-19 vaccination programme for staff commenced in January 2021 and at the time of writing, 86% of staff (directly employed by the Trust) have received their first vaccination.

2.15 IPC Audits

Auditing of practice and compliance this year has been a key priority for IPC in response to the challenges of the pandemic, but also as part of our overall management of the control of infections. The appointment of the PPE Champion Team has provided us with the opportunity to ensure there are regular and impartial audits in progress to monitor compliance against our key standards; hand hygiene, PPE compliance, social distancing in clinical and non-clinical areas, patient compliance with the wearing of surgical face masks (and other audits as required). Alongside these, the routine auditing undertaken at ward/department level has continued (hand hygiene and the Saving Lives High Impact Intervention audits).

Audits undertaken by the PPE Champion Team have demonstrated a significant improvement in most areas from when these commenced in December 2020 until now. Focussing specifically on the hand hygiene and PPE audits, whilst compliance has not been at the expected 95% standard for all elements in every audit, progress has been made and the data (in the main report) demonstrates areas of compliance and areas that need to be improved upon. The addition of the PPE Champion Team has been influential in supporting, educating and challenging staff around IPC practices and behaviours.

2.16 Antimicrobial Stewardship

The Antimicrobial Stewardship (AMS) Committee meets monthly to monitor antibiotic usage in the Trust and consumption of specific broad spectrum antibiotics (e.g. carbapenems, ceftriaxone and piperacillin/tazobactam), the aim of which is to improve patient outcomes, while minimising the effects of antimicrobial use. Antibiotic consumption is higher at PAH, compared to average use in England.

The Antibiotic Audit is undertaken bi-annually, monitoring indication, compliance against the antibiotic guidelines and documentation of duration. The audit was last performed in August 2020 and results showed that compliance against the PAH antibiotic guidelines had decreased to 41% since the last audit in 2019, whilst documentation of indication and duration had increased on JAC (from 29% and 38% to 68% and 52% respectively). There has been a significant volume of AMS work that has been undertaken after the height of COVID-19 and it is anticipated that an improvement will be observed following the next audit which is in May 2021.

2.17 Cleanliness and Environment

The Facilities Team have continued to support the IPC agenda over the last year, providing a cleaning service in line with National Specification of Cleanliness (NSC) and this has included the implementation of COVID-19 two-tier cleans, following PHE guidelines. Deep cleans,

incorporating hydrogen peroxide vaporiser (HPV) machines (where possible), have been undertaken on all wards following COVID-19 outbreaks.

The team have continued to undertake NSC audits over the year, however during the pandemic, this significantly reduced audits due to staffing levels in the audit team. Standards of cleanliness continued to be met with the support of increased staff levels of domestics (and porters) in all areas where possible and on-going monitoring from the domestic supervisors.

2.18 Water Safety

The Estates Team have supported the Trust in all matters pertaining to water safety and ventilation over the year. The Water and Ventilation Safety group is established and meets bi-monthly, and reports to the IPC Committee (IPCC).

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 5/08/21 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: Workforce Committee (WFC)
REPORT FROM: Helen Howe (Committee Chair)
DATE OF COMMITTEE MEETING: 26/07/21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

Committee effectiveness review: The committee discussed the effectiveness review which was positive overall with improvements required in follow-up of actions, timeliness of papers and quality of papers (presentation of data) although improvements in this regard were noted. The Terms of Reference were reviewed and are recommended to the Board for approval with some minor amendments to membership noted in red font. **(Appendix 1)**

Freedom to Speak up guardians report and self- assessment: cases reported externally to the National Guardians Office for Quarter 4 of 2020/2021 and Quarter 1 of 2021 as well as internally to the Executive Team, including the Non-Executive Directors were noted. Themes were discussed and actions being taken to address the themes were noted. The appointment of five clinical Freedom to Speak up guardians was confirmed. The self-assessment tool is on the Board agenda for discussion.

Healthcare Group re-structure: The committee received an update on the re-structure and outcome of the consultation; a phased implementation is being adopted with the transfer of services and appointment of clinical directors taking place in phase 1.

Disciplinary Process: The Trust's Disciplinary Policy has been reviewed, updated and published on the Trust's website, in accordance with guidance received from NHSE/I. All Trusts were required to review their disciplinary policies to ensure they were consistent with recommendations arising from an independent enquiry.

Staff survey response: the committee received an update the 'Here to hear' events that were run specifically in relation to the staff survey 2020 results. A summary of feedback voiced through the events and an outline of how concerns raised are being addressed was noted.

BAF risk 2.3 Inability to recruit, retain and engage our people: Members discussed whether the risk score should be increased but recommended the score remain at 12. It was agreed that whilst there are some 'hotspot' areas where recruitment is challenging, on a Trust wide basis the level of risk is appropriately assessed as a 12.

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 – extranet to launch in Q3.
- NHSP contract update and KPI's
- ICS update
- Safer Nurse Staffing
- People Board update
- New Hospital – Workforce work stream update

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 Trust

WORKFORCE COMMITTEE

TERMS OF REFERENCE

PURPOSE: The purpose of the Workforce Committee:

- Maintain oversight of the development and design of the Workforce and ensure it is aligned with the strategic context within which the Trust is required to operate.
- Assure the Board on all aspects of Workforce and Organisational Development and provide leadership and oversight for the Trust on workforce issues that support delivery of the Trust's annual objectives.
- Assure the Board that the Trust has adequate staff with the necessary skills and competencies to meet both the current and future needs of the Trust and ensure delivery of efficient services to patients and service users.
- Assure the Board that legal and regulatory requirements relating to workforce are met.

DUTIES: The following comprise the Workforce Committee's main duties as delegated by the Board of Directors:

1. To promote the trust's values and behaviours
2. Provide assurance on the development and delivery of a people and OD strategy that supports the Trust plans and ensure an appropriate workforce culture is in place and monitor their implementation.
3. Keep under review the Trust's plans in relation to its workforce including recruitment and retention of staff, Organisational Development, learning, and employee engagement and wellbeing.
4. Review workforce performance and oversee the development of a balanced scorecard for all workforce indicators.
5. Review the outcomes of national and local staff surveys and monitor the progress of action plans.
6. Monitor staff engagement initiatives and outcomes
7. Ensure the Trust meets its statutory obligations regarding Diversity and Inclusion.
8. Oversee the Trust's relationship with educational partners to maximise the benefits of these relationships to the Trust.
9. Review and monitor workforce, organisational development and education and training risks including those reflected on the Board Assurance Framework and seek assurance that plans/actions are in place to mitigate identified risks.
10. The Committee shall request and review reports from other sub groups as deemed necessary
11. Other Workforce/OD/Training activity as requested by the Board.
12. Keep under review the development of a Communications Strategy and monitor its implementation.
13. Review and monitor the portfolio of volunteer activities and services.
14. Provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that these are dealt with in policy and national guidance including receiving regular reports from the Freedom to Speak up Guardians.

WORKPLAN: **Annual Work Plan and Committee Effectiveness**

Every year, set an Annual Work Plan and conduct an effectiveness review (which will include the achievement of the Annual Work Plan and a review of the terms of reference) and report this to the Board.

ACCOUNTABLE TO: Trust Board.

REPORTING A Committee report shall be provided to the next meeting of the Board of Directors. The report shall set out areas requiring the Board's attention and report on the level of assurance provided by the Workforce Committee and advise of progress against the Annual Work Plan.

CHAIRMAN: Non-Executive Director.

COMPOSITION OF MEMBERSHIP: The Workforce Committee is comprised of Executive and Non-Executive Directors appointed by the Board. The agreed membership is:

- Chair - Non-Executive Director
- Non-Executive Directors/Associate Non-Executive Directors
- Director of People, Organisational Development & Communications
- Director of Nursing, Midwifery & Allied Health Professionals
- Chief Operating Officer
- ~~Director of Medical Education~~

The Chairman of the Workforce Committee shall be appointed by the Chairman of the Trust Board; s/he shall have recent and relevant finance or business or workforce experience.

If not already a member of the Workforce Committee, the Audit Committee Chairman may attend any meeting.

The Chairman and Chief Executive of the Board reserve the right to attend meetings and will attend alternate meetings of the Committee.

All members will have one vote. In the event of votes being equal, the Chairman will have the casting vote. Deputies attending the meeting on behalf of a member of the Committee are not entitled to exercise a vote.

ATTENDANCE: Members are expected to attend all meetings of the Committee. An attendance register shall be taken at each meeting and an annual register of attendance included in the Trust's annual report.
In addition to the members of the Board, the following shall be expected to attend each meeting:

- Deputy Director of People
- Associate Director of Learning and OD
- Associate Director of Communications

The following shall attend meetings as required:

- Medical Education Manager
- Director of Medical Education

To ensure appropriate accountability, others will be invited to attend where areas of risk or operation are being discussed within their areas of responsibility.

Where considered appropriate and necessary, the Internal Auditors may be invited to attend meetings to present reports of any audits conducted by them in respect of issues within the scope of the Committee.

The Princess Alexandra Hospital NHS Trust

DEPUTISING ARRANGEMENTS	In the absence of the Committee Chairman, another Non-Executive Director member of the Workforce Committee will chair the meeting. Other deputies may attend but must be suitably briefed and, where possible, designated and notified in advance. In the absence of an Executive member his/her designated deputy may attend with the permission of the Chief Executive Officer.
QUORUM:	The quorum for any meeting shall be the attendance of a minimum of one Non-Executive member, and one other Executive member.
DECLARATION OF INTERESTS:	All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.
LEAD EXECUTIVES:	Director of People, OD and Communications
MEETING FREQUENCY:	Meetings of the Workforce Committee shall be bi-monthly.
MEETING ORGANISATION:	• Meetings of the Committee shall be set before the start of the financial year. • The meeting will 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. • 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' is a day which is not a Saturday or Sunday or a public or bank holiday.
AUTHORITY	The Workforce Committee is constituted as a Committee of the Trust Board. Its constitution and terms of reference shall be as set out above, subject to amendment by the Board as necessary. The Workforce Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the Workforce Committee. The Workforce 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 Workforce Committee shall be reviewed at least annually and presented to the Trust Board.
DATE APPROVED:	By Workforce Committee: 26 July 2021 By Trust Board: 5 August 2021

The Princess Alexandra Hospital NHS Trust

6.1

MEMBERSHIP

Membership and Those in Attendance	
Members	
Chair: Non-Executive Director	Helen Howe
Non-Executive Director	George Wood
Associate Non-Executive Director	John Keddie
Associate Non-Executive Director	Anne Wafula-Strike
Director of People, OD and Communications	Ogechi Emeadi
Chief Operating Officer	Stephanie Lawton
Director of Nursing, Midwifery & Allied Health Professionals	Sharon McNally
In Attendance	
Associate Director of Learning and OD	~~Martin Smith~~ Mandi Osoba
Medical Education Manager	Margaret Short
Deputy Director of People	Beverley Watkins
Associate Director of Communications	Laura Warren
Director of Medical Education	Jonathan Refson
In Attendance (right to attend reserved)	
Trust Chairman	Hattie-Llewellyn-Davies
Chief Executive	Lance McCarthy
Secretariat	
Head of Corporate Affairs	Heather Schultz
Corporate Governance Officer	Becky Warwick

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS – 5.08.21 **Item No: 6.1**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy - Chairman
DATE OF MEETINGS: 13.07.21 and 20.07.21

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at the SMT meetings held during July 2021:

13.07.21 - four key areas were discussed:

- Deloitte Well Led Review – outcome and actions
- Outcome of HGC Consultation
- Values Implementation
- PAHT 2030

20.07.21:

- Quality Briefing
- Communication Project: Alertive
- Internal Professional & Performance Standards for UEC
- Significant Risk Register
- Benefits Realisation of Q3 Business case 2019/2020– increase in medical establishment
- Learning & Organisational Development Team Consultation – June 2021
- Here to Hear outcomes
- Values Implementation plan
- Data Security and Protection Toolkit submission
- Capital Programme and M3 & H2 Updates
- Frailty Business Case - approved
- Vascular Outline Business Case - supported

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 05.08.21 **AGENDA ITEM NO: 7.1**

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

REPORT FROM: John Keddie – Associate Non-Executive Director

DATE OF COMMITTEE MEETING: 09.07.21

SECTION 1 – MATTERS FOR THE CORPORATE TRUSTEE/TRUST BOARD'S ATTENTION
The following items are escalated for noting: • The financial position was noted; total fund balances at M2 were £770k (£790k as at 31st March 2021). There has been limited activity regarding fundraising other than in some quite specific areas, although this is expecting to increase as the year progresses and COVID restrictions are lifted. • The draft annual report and accounts for the charity were reviewed ahead of the External Auditor's Independent review (scheduled for September/October 2020) with final submission of documents to the Charity Commission required by 31 January 2022. • CFC discussed return on investment and supported a 1 in 4 return with a case by case review over the next 12 month period. • Charitable Funds Policy and Procedure and Investment Policy were reviewed and recommended to the Corporate Trustee for approval. Both policies are attached for approval and going forward will be reviewed annually. • The committee supported the Head of Fundraising post. The following reports were received: • Fundraising update (risk register to be reviewed at all future meetings) • Butterfly hub funding discussed and requirement for further capital to be explored • Breast fund update (CFC approved the increase in costs for Camino Trek)
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The CFC is making good progress against its annual work plan.

7.1

Your future | Our hospital

The Princess Alexandra Hospital NHS Trust

Trust Board
5 August 2021

Agenda Item:	7.2
Presented by:	Saba Sadiq- Director of Finance
Prepared by:	Colin Forsyth – Head of Financial Services
Date prepared:	30 June 2021
Subject / Title:	Charitable Funds Policy

Purpose:	Approval	✓	Decision	✓	Information		Assurance	

Executive Summary:	Trustees of The Princess Alexandra Hospital Charity have a duty to ensure charitable funds are raised and spent in accordance with the Charity's objectives and that all charitable activity complies with the Charities Acts and Charity Commission guidance. This responsibility is laid out in the Trust's "Policy for the Management of Charitable Funds". The current Charitable Funds Policy was last reviewed by CFC in July 2018. It is understood that the Trust is intending to develop a detailed strategy for charitable funds, and once this has completed, a more detailed update will need to be undertaken.
Recommendation:	The Charitable Funds Committee is asked to: • Review and approve/amend the Management of Charitable Funds Policy; • Recommend to the Charity's Corporate Trustee that the Management of Charitable Funds Policy be approved; and • Note that the development of the Charitable Funds Strategy (including fundraising) may identify that the Policy requires further amendment before the next designated formal review date.

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

Previously considered by:	n/a
Risk / links with the BAF:	Failure of comply with Charity Commission requirements, loss of income /funds from poor investment decisions, reputational damage from inappropriate investment decisions
Legislation, regulatory, equality, diversity and dignity implications:	As a condition of its registration, the Charity is required to comply with Charity Commission guidance and reporting requirements.
Appendices:	Appendix 1 – Policy for the Management of Charitable Funds

1.0 PURPOSE

Trustees of The Princess Alexandra Hospital Charity have a duty to ensure charitable funds are raised and spent in accordance with the Charity's objectives, and that all charitable activity complies with the Charities Acts and Charity Commission guidance. This responsibility is laid out in the Trust's Policy for the Management of Charitable Funds" Policy.

2.0 CONTEXT

The current Charitable Funds Policy was last reviewed by CFC in July 2018 and now requires updating and review.

2.2 RESPONSIBILITY OF TRUSTEES

Guidance issued by the Charity Commission for England and Wales details the duties of Trustees as ("The essential trustee: what you need to know, what you need to do", May 2018). This includes that Trustees must:

- Ensure your charity is carrying out its purposes for the public benefit
- Comply with your charity's governing document and the law
- Act in your charity's best interests
- Manage your charity's resources responsibly
- Act with reasonable care and skill
- Ensure your charity is accountable

The Trust's Charitable Fund's Policy forms part of the arrangements in place to ensure that the above requirements are met and that the charity complies with Charity Acts and Charity Commission guidance.

3.0 REVIEWS AND CHANGES MADE

The policy has been reviewed by the Trusts Internal Audit and Counter Fraud Leads

The changes made to the policy are detailed below.

Section 2	Additional detail on the Trust's approach to fraud, and on raising queries and suspicions
Sections 6.2.1 and 6.7	Amend "Chief Financial Officer" to "Director of Finance"
Sections 1.9 and 6.13	Updating contact details for Finance and Fundraising

In addition, some formatting has been updated to ensure consistency across the document

4.0 RECOMMENDATION

The Charitable Funds Committee is asked to:

- Review and approve/amend the Management of Charitable Funds Policy;
- Recommend to the Charity's Corporate Trustee that the Management of Charitable Funds Policy be approved; and
- Note that the development of the Charitable Funds Strategy (including fundraising) may identify that the Policy requires further amendment before the next designated formal review date.

Author: Colin Forsyth – Head of Financial Services
Date: 30 June 2021

Appendix 1

Policy for the Management of Charitable Funds

Table of Contents

Section

1. QUICK REFERENCE GUIDE

This Quick Reference Guide is intended to provide the headlines for how to manage Charitable Funds. It is not intended as an alternative to reading the full Policy which follows, but more as a refresher once this full Policy has been digested. Fund Managers must also ensure full compliance with the Standard Operating Procedures (SOPs) for Charitable Funds. These are available from the Trust Finance Directorate (see 1.9 below).

1.1. A new Charitable Fund will only be set up in if no appropriate fund already exists. Wherever possible, an existing Fund should be utilised. See section 6.

1.2. Cheques should be made payable to The Princess Alexandra Hospitals Charity.

1.3. There are many ways that patients, family members, friends and staff can fundraise for the Charity and the Charity Team is able to offer support, advice and guidance. See section 6.

1.4. Donations should, wherever possible, be made at the Cashiers Office or online. Where donations are made on the Ward, an official Donation Envelope must be used. This is to safeguard staff and to ensure donors are issued with an immediate receipt (each Donation Envelope includes a tear-off receipt section). See section 6.

1.5. It is imperative that donors' details (name, address etc.) are captured at the point of donation to maximise gift aid and ensure every donor is thanked for their support. See section 6.5.

1.6. Wherever possible, donors should be encouraged to make an unrestricted donation to The Princess Alexandra Hospital's Charity rather than to a specific ward or department. This allows charitable funds to be spent where they are needed most. See section 6.5.4.

1.7. Charitable monies must be spent in line with the Charity's objectives, namely to:

'support a wide range of charitable and health related activities benefiting both patients and staff of The Princess Alexandra Hospital NHS Trust. In general, they [charitable funds] are used to purchase the very varied additional goods and services that the NHS is unable to provide'.

See section 6.9.

1.8. All expenditure is subject to authority limits. See section 6.9.4.

1.9. If you are in any doubt about accepting or spending charitable monies, please contact the Charity Office. See section 6.13 and below:

For all charity finance-related matters, such as obtaining a fund balance, purchasing or paying for goods or services or seeking advice on VAT, contact: Grazi Maddalozzo, Charitable Funds & Income Assistant, ext. 7962, Graziana.Maddalozzo@nhs.net.

For fundraising advice and support and information about non-finance charity matters, contact: ext.8782, paht.fundraising@nhs.net.

2. INTRODUCTION

This Policy has been produced primarily to support staff members who are Fund Holders for The Princess Alexandra Hospitals Charity but also to provide information for any staff member wishing to know more about the Charity.

The Princess Alexandra Hospitals Charity (The PAH Charity) is a registered charity in England and Wales (no. 1054745) and its aims are to benefit patients, staff and visitors of The Princess Alexandra Hospital NHS Trust. The NHS Trust Board is the Corporate Trustee for the Charity and is therefore legally responsible for ensuring charitable donations are managed effectively and efficiently and spent in accordance with donors' wishes. However, the Trust and the Charity operate separately and their funds are clearly demarcated. The Trust Board (as Corporate Trustee) has delegated day-to-day responsibility for the Charity to the Charitable Funds Committee.

Like all NHS charities, the Charity hosts several separate Funds which each support different wards and departments. Each Fund has a Fund Manager who has day-to-day responsibility for the management of funds within the parameters outlined in this Policy.

Donations to the Charity can be received from many sources, but the main one will be individuals, particularly patients and relatives. Where possible, staff are advised to encourage supporters to donate online or via the Cashiers Office. However, where monies are received by the ward or department, it is the responsibility of the Fund Manager to ensure donations are banked swiftly, that the donor is thanked promptly and that the donor's details are recorded in full (even if stored anonymously). The Finance and Charity Teams are able to provide support and guidance in this area, and will also issue day-to-day procedures to fund managers to assist them in managing charitable funds.

The success of the Charity is dependent on all members of staff meeting each donor's needs and adhering to this Policy. This Policy explains how the charitable systems operate, clarifies duties and responsibilities and provides details of the support available.

The Trust is committed to treating people with dignity and respect in accordance with the Equality Act 2010 and Human Rights Act 1998. Throughout the production of this Policy due regard has been given to the elimination of unlawful discrimination, harassment and victimisation (as cited in the Equality Act 2010).

The Trust has a zero tolerance approach to fraud, bribery and corruption. if you have a suspicion of fraud or bribery at the Trust, or need fraud-related advice, please contact the LCFS for the Trust, Dean Docherty, Support LCFS / Senior Fraud Manager on dean.docherty@nhs.net or 07717 801006.

Suspicions of fraud may also be reported to Saba Sadiq, Finance Director or to the NHS Counter Fraud Authority's fraud reporting line – https://cfa.nhs.uk/reportfraud

3. PURPOSE

This policy has been created to ensure charitable funds are raised and spent in accordance with the Charity's objectives and that all charitable activity complies with the Charities Acts and all Charity Commission guidance.

The Management of Charitable Funds Policy is subject to regular review and approval by the Charitable Funds Committee.

4. DEFINITIONS

Charitable Fund (the Funds)	A fund held for a designated purpose, for example to hold donated monies to be spent to benefit a particular ward or department or to purchase a specific piece of equipment. There is also a general Fund which can be spent at the discretion of the Trustee
Charity Commission	The independent regulator for charities in England and Wales.
Corporate Trustee	The body which has legal responsibility for the charity.
Donation	Monies given voluntarily by individuals or organisations to support the charitable aims of the Charity.
The Charity	The Princess Alexandra Hospital Charity.
The PAH Charity	A short hand way of referring to the charity, usually used in internal documents only.
The Princess Alexandra Hospitals Charity	The working name for The Princess Alexandra Hospitals NHS Trust Charitable Fund.
PAH	The Princess Alexandra Hospital NHS Trust
Special Fund	A charity set up to recognise the specific properties of a fund. E.g. where the charity has different sites or where legal restrictions are placed on a fund such as via a legacy.
Ultra Vires	A transaction or decision that is beyond the powers or rights of the officers or of the body to enter into.

5. DUTIES

The NHS Trust Board (The Board)	Acts as the Corporate Trustee on charitable matters.
Charitable Funds Committee (The Committee or CFC)	The body set up by the Trust Board to provide advice on all charitable matters.
Head of Financial Services	The person who line manages the Charity team and is responsible for implementing, disseminating and annual review of this policy.
Fund Manager	A designated individual who manages the day-to-day running of a specific Charitable Fund.

Charitable Funds & Income Assistant	The person responsible for financial processing of charitable fund transactions and the dissemination of this Policy via email and intranet.
Head of Fundraising	The person responsible for supporting Fund Managers and members of the public to support the Charity.

6. POLICY

6.1. Statutory Requirements

The Trust has a statutory duty to ensure effective and efficient management of charitable monies. It must ensure funds are used appropriately and as the donor intended. It must provide donors and potential donors with confidence in the operation of the Charity.

6.1.1.Charity Commission

The statutory body that monitors the Trust's performance is The Charity Commission. Charities have a requirement to register funds with the Charity Commission. This register is open to the public for general inspection and provides basic information on the charity (such as main purpose and accountable officers). The Princess Alexandra Hospitals Charity supports projects across the Trust, wherever they are located. It has also registered three special funds with the Charity Commission: Princess Alexandra, St. Margaret's and Herts and Essex Hospitals. Each fund has the registered purpose of applying monies for the general benefits of patients and staff at that hospital. In addition an umbrella fund has been registered which reflects the management of the Trust and allows the funds to be managed as a single entity.

The role of the Charity Commission is to preserve the integrity of charity. It achieves this through the application of the Charities Acts. Commissioners are appointed by the Home Secretary to ensure the effective performance of the Commission. The powers of the commission can be summarised as:

- to keep a register of charities which is open to public inspection;
- to promote the effective use of charitable resources;
- to provide advice and information on charitable matters, to change charitable trusts where necessary;
- to investigate and check abuse.

The commission provides guidance on the management of charitable funds. How this is applied within the Trust is covered in section 6.3.3.

6.1.2 Accounting Guidance

Guidance is issued by the Accounting Standards Board in the form of a Statement of Recommended Practice (FRS 102). In addition, the Department of Health and Social Care will issue NHS reporting guidance through the Group Manual for Accounts on an annual basis. . The finance directorate ensures that systems are in place to be able to meet these requirements. These systems and reports are subject to scrutiny by both Internal and External auditors and reports on performance are provided to the Audit Committee and the Charitable Funds Committee.

6.1.3 Trust Revenue Budgets

The management of charitable monies should complement the use of the Trust's revenue funds whilst maintaining independence. Charitable monies cannot be used

to subsidise Trust performance.

6.2. Management arrangements

In order to provide a framework for the Charity, the following structure has been implemented.

6.2.1 Charitable Funds Committee

The Charitable Funds Committee (CFC) has been established by the Board to make and monitor arrangements for the control and management of the Trust's charitable funds. The CFC is chaired by a non-executive director. Membership of the committee consists of: Committee Chairman, another Non-Executive Director, Director of Finance, Head of Financial Services. Meetings shall be held not less than three times per year. Full details are held in the Terms of Reference for the CFC.

6.2.2 Fund Managers

Fund Managers are responsible for the day to day management of the Funds, ensuring compliance with all processes in this Policy and that monies are used legally and appropriately. In particular, monies must be expended as per the wishes of the donor and spent in a timely manner.

6.2.3 Charity Team

The Charity Team should be the first point of contact for any charitable queries from members of the public or staff. It comprises two functions - Fundraising and Finance:

Fundraising: Responsible for promoting the Charity as a whole to Trust staff, patients, visitors, donors and the general public. This includes support with promoting your event, activity or fundraising appeal on the website, intranet and in the local press. They support donors who choose to fundraise for the Charity and provide fundraising advice and support to Fund Managers and other Trust staff looking to raise funds for the Charity. They also make proactive approaches to individuals and organisations for support – both in cash and in kind – and ensure all donations are thanked. A central database of all donors to the Charity - whether their donations are received by a ward or department, by post or directly to the Charity's office - is currently being developed. This will reduce duplication of approaches and provide one, central reference point for all charitable enquiries.

Finance: Responsible for banking, monitoring and reporting on charitable income and expenditure, The Head of Financial Services provides financial advice to the CFC and the Board whilst the Charitable Funds & Income Assistant provides advice and support to Fund Managers regarding financial matters. In summary, Finance undertake the following tasks:

- record financial details of transactions on Charitable Funds for both receipts and payments;
- make payments on invoices as required;
- provide financial advice and information on fund balances to Fund Managers and the Charitable Funds Committee;
- produce statutory reports as required;
- provide advice to Fund Managers and the Committee on day to day issues and on the interpretation of guidance;
- manage the Fund's cash, investments and other working capital balances;
- ensure systems are in place to ensure effective and efficient management of the charitable funds;
- liaise with the Trust's external auditors and the Charity Commission on charitable matters;
- ensure the tax implications on payments through the funds are correctly

accounted for.
- submit claims to HMRC for Gift Aid recovery as and when necessary.

6.3.

The Charity Finance Team provides the following information on a regular basis:

6.3.1 Fund Balances
Details of current Fund balances are available from the Charitable Funds and Income Assistant on request from the Fund Manager. Details are not provided to non-Fund Managers unless deemed appropriate.

6.3.2 Monthly Statements
Statements of the financial position for each fund are produced monthly. The statements will include information about all income and expenditure received up to the end of that month, including items committed through the raising of an order even where the goods have yet to be received. This ensures the balances reported reflect the monies available.

6.3.3 Annual Accounts and Return
Annual reports are required for the Charity Commission. The timetable for completion of the Accounts is set by Finance. The Accounts and the Annual Return must be submitted to the Charity Commission by the 31st January each year. The Annual Return provides summarised details on the charity's operations over the previous 12 months.

Other information is available, such as queries on VAT status, and any requirements should be directed to the Charitable Funds and Income Assistant.

6.4. Fundraising

The Princess Alexandra Hospitals Charity relies on donations from, and fundraising by, individuals and organisations to fund its work. Staff will often be approached by patients, friends and family members wishing to support the Charity and it is vital that you have a single point of contact that you can refer to – or refer the donor to – in these instances. If you need any help, support, guidance or advice about the Charity, please contact The Charity Team (see 6.13).

The main ways in which people may choose to support The PAH Charity are:

6.4.1 Donations.
These can be made online, by post or in person. They can be made as a 'thank you' to staff or in memory of a loved one. They can be one-off donations or a longer term fundraising goal can be set. See section 6.5 for details.

6.4.2 Organise an event
From cake bakes and jumble sales to Black Tie Balls and Corporate luncheons, the Charity Team can provide collection tins and buckets, letters of authority and guidance on how to organise an event which complies with Charity Law and best practice.

6.4.3 Join a PAH event. We have a number of overseas treks that people can join and have organised abseiling and skydiving in the past.

6.4.4 Community Ambassador. We need members of the local community to spread the word about the Charity, place collection tins in high footfall areas and represent the Charity at cheque presentations and events. All

will help raise the profile of, and funds for, the Charity.

6.4.5 Corporate support. Many companies have a Corporate Social Responsibility budget to support national, regional and local causes. They may make a donation, provide volunteers to support a charity or choose a cause as their Charity of the Year.

6.4.6 Shop and Give. The Charity is affiliated with a number of online shopping sites which makes donations every time you buy something through them. See our webpages (www.pah.nhs.uk/charity) for more details.

6.5. Receipt of donations

Anyone who enquires about making a donation to the Charity should be encouraged to do so online at **www.justgiving.com/pahnhs**. This is a quick, easy and secure way of making a donation, it captures gift aid declarations and it avoids the need for PAH staff to handle money.

However, when donations are made offline, all staff must ensure that monies are recorded properly, receipts are issued, the donor's details are fully documented and the monies are banked promptly and allocated to the appropriate fund. By capturing the donor's details, you are increasing your chances of the Charity being able to claim gift aid on their donation – this can increase the donation by 25% at no cost to the Charity (see section 6.10.2). The most straightforward way of recording this information is to use the Donation Envelope.

Cheques should be made payable to *The Princess Alexandra Hospitals Charity*.

The process of donating to the Charity is as follows:

6.5.1 Non Postal Donations

In order to safeguard staff, if a donor wishes to make a donation in person, they should be directed to the Cashiers Office which is open during office hours. Where the ward, department or Fund Manager feels this is inappropriate or not practical, they can receive and process the monies themselves by following the *Donation Processing Procedure* This involves the use of the Donation Envelope and all donations should be processed, via the Cashier's office, within 48 hours of receipt.

Unless the donor has indicated otherwise, the Charity Team will send a thank you letter to all donors and log this on the database. This ensures the donor is aware their donation has been received centrally. If a ward or department also wishes to thank a donor, they are welcome to do so.

6.5.2 Postal Donations

Donations should be sent directly to either the Cashiers' Office or Finance Department at Princess Alexandra Hospital. All donations received will be processed as outlined in the *Charitable Funds procedure documents,* including a thank you letter being sent by the Charity Team. If a ward or department also wishes to thank a donor, they are welcome to do so.

When donations are received by post direct to the Ward or Department, these should also be processed in line with the *Charitable* Funds Procedure. Again, wards and departments are welcome to thank the donor directly if they choose to do so.

6.5.3 Online Donations

Donations can be made online via www.justgiving.com/pahnhs. These are processed by JustGiving and paid electronically (via BACS) to the Charity monthly. All donors will receive an automatic email acknowledging their donation and, unless otherwise indicated by the donor, the Charity Team will send a thank you letter by post or email once payment from JustGiving has been received.

If the donor is making a donation or fundraising in support of a specific ward or department, they should include details of this in their JustGiving description and/or inform the Charity Team. This donation will then be allocated in line with the donor's wishes.

6.5.4 Restricted donations

The wishes of the donor must be followed in the management of the donation. Where this is not possible, the donor will be contacted and agreement on an alternative course of action will be reached.

Wherever possible, donors should be encouraged to make an unrestricted donation. This allows charitable funds to be spent where they are needed most. However, where a donor is clear that they wish the donation to benefit a particular ward, department or piece of equipment, this must be adhered to.

6.6. Opening a new Charitable Fund

Fund Managers should avoid setting up a new Charitable Fund it if can be avoided; some NHS Charities have hundreds of Funds which are confusing and time consuming to manage. When a donation is made, it should be allocated, where possible, to an existing Fund in line with the donor's wishes. If the donor's wishes are such that this is not possible, e.g. a donation for a specific, large scale purpose, then a new Fund may be required. Advice must be sought from the Charity Finance Team. Where it is agreed a new Fund is required, a *Request for New Charitable Fund Form* (as per Charitable Funds procedure) must be completed and forwarded to the Charitable Funds and Income Assistant. This form will be assessed and, if passed, forwarded for final approval to the Head of Financial Services before the Fund is set up.

Once approved, an *Authorised Signatory Form* (as per Charitable Funds procedure) must be completed and returned to the Charitable Funds and Income Assistant. A Fund must have at least two signatories in order to safeguard those signatories and to ensure the Fund can be managed during periods of absence.

A Fund cannot be set up in the following instance:

Funds to avoid taxation

Monies held as charitable can benefit from certain tax advantages (see section 6.10). To protect individuals against any charge of tax evasion, where a member of staff donates monies to a Fund, they are not permitted to be a Fund Manager for those funds. Nor can the monies be used to provide any personal benefit to that individual.

6.7. Bank Accounts and cash management

The Director of Finance is responsible under the Trust's Standing Financial Instructions for the management of all bank accounts relating to charitable monies. All income and expenditure must be accounted for through the Trust's designated

bank accounts. These are completely independent of the Revenue accounts as the charity and the Trust are separate legal entities. The Director of Finance must:

- ensure there are sufficient funds in the account to meet the liabilities;
- manage the accounts to maximise interest receivable but with due regard to risk and costs;
- only place monies with organisations where there is no risk to the funds, such as UK clearing banks;
- ensure all monies held are reconciled to the fund balances, to the Charity's records and to the bank statements.

The bank accounts currently held are:

- Barclays Current Account
- Barclays Business Premium Account (BPA) - interest bearing
- RBS Account -- interest bearing

All monies will be paid in or out through the current account. Immediate cash needs will be met via the BPA with surpluses or deficits being transferred to or from the RBS Account. The BPA account is to be maintained at an average balance of approximately £20,000. A report on all cash investments is provided to the Charitable Funds Committee quarterly meetings. The committee has responsibility for investment strategies.

6.8. Internal Financial Controls

The charity trustees have a responsibility to ensure that there are strong financial controls over the operation of the charity. This is also an individual responsibility and is achieved through various methods:

- Procedures
- Standing Financial Instructions, Standing Orders and Scheme of Delegation
- Budget manual
- Audit

The Charity Commission has produced guidance on the controls they would expect to see in a charity. Not all the guidance is applicable, however it indicates the nature of the controls that must exist.

6.9. Charitable Expenditure

It is imperative that donated monies are spent in line with The Princess Alexandra Hospitals Charity's charitable objectives, in accordance with the donor's wishes and in a timely manner. Where a donation cannot be spent as per the donor's wishes, they must be consulted and a mutually agreeable alternative course of action taken. If the CFC believes Funds are not being spent in a timely manner or are being accumulated unnecessarily, they can request a spending plan from the Fund Manager at any time and will ensure monies are spent appropriately.

As stated on the Charity Commission website, the charitable activities of the Charity are to:

'support a wide range of charitable and health related activities benefiting both patients and staff of The Princess Alexandra Hospital NHS Trust. In general, they [charitable funds] are used to purchase the very varied additional goods and services that the NHS is unable to provide'.

Charitable Funds must not be used to replace NHS funding – either because NHS budgets have been exhausted or because Charitable Funds may seem more

straightforward or quicker to access. All funds must be spent in line with the Charity's stated objectives. The CFC reviews charitable spend at each meeting and any unauthorised or improper use of funds will be investigated and action taken.

6.9.1 Ordering of goods and services

Goods and services funded through charitable monies must be purchased through the Trust's Supplies EROS system. The requirement to ensure value for money applies as much to Charitable Funds as it does to the Trust's revenue budget. For equipment purchases, unless income has been identified in advance from the Trust's revenue budget, there must be sufficient charitable funds available to cover the cost of the equipment and any staff training. This will ensure no immediate cost pressure is placed on the Trust through this purchase.

All expenditure of £10,000 or more must be authorised **in advance** by the CFC. Please note the CFC will meet not less than three times per year.

All purchases must be made in accordance with the Trust's authorised Purchase Order procedures and follow the Trust's Standing Financial Instructions, Scheme of Delegation. All purchases are to be discussed with the Charity Finance team to ensure that:

- purchases meet the Charity's objectives
- correct authorisation has been sought and obtained
- expenditure is correctly recorded
- VAT implications have been checked.

6.9.2 Receipt and Payment of Invoices

Invoices should be received directly by the Accounts Payable team. All expenditure must be supported by an official Purchase Order including the Fund code and Fund Manager's authorisation. When no official order number is supplied, payment will be delayed until an order is received.

Where payment is required in advance, such as for courses or books, the request is to be sent to the Charity Finance Team together with full supporting details including the source of funding. For courses, this includes the course programme, application form or equivalent and a non-stock requisition to enable an official order to be sent with payment. If an invoice cannot be obtained in advance, a Payment Request Form ((see Charitable Funds local procedures) must be completed and authorised in line with Fund signatories. The Payment Request form is also available on Public Folders.

Advances for purchases can be made only in exceptional circumstances. If agreed, then full receipts must be provided.

6.9.3 Petty Cash and Floats

Purchases can be made using Petty Cash from the Cashiers Office. Petty Cash slips must be appropriately authorised and provide details of the Fund and the purchase(s) together with receipts. There is a reimbursement limit of £25 for all Petty Cash claims, unless in exceptional circumstances.

If a Fund requires a Petty Cash float, then this can be requested from the Charitable Funds and Income Assistant. Please give as much advance notice as possible. Receipts for all expenditure must be retained and submitted using the *Petty Cash Receipt Sheets* For guidance, Petty Cash floats rarely exceed £150. For sums larger than this, please contact the Charity Team, giving as

much advance notice as possible.

6.9.4 Expenditure limits (Scheme of delegation)

The Scheme of Delegations details the expenditure limits available to Fund Managers. The limits are:

Up to £1,000 per request	Fund Manager
£1,001 to £10,000 per request	As above plus Financial Representative on the Charitable Funds Committee
Over £10,000 per request	as above plus Director of Finance and Chair of Charitable Funds Committee (or nominated Deputy) after approval by Charitable Fund Committee

6.10. Tax implications including Gift Aid and VAT

6.10.1 Individual Fund Managers

Individual Fund Managers will have no personal income tax liabilities so long as there is no personal benefit that can be gained from the Fund.

Personal liability can occur where a Fund is used to provide a benefit to a Trust or Charity employee. An example would be a gift or payment made to an individual at an awards ceremony. The only exception would be if the benefit was made available to **all** members of staff. Charitable Funds cannot be used to fund departmental functions, such as parties or gifts for people who are leaving or retiring.

6.10.2 Gift Aid

Charities can reclaim income tax on certain donations. HMRC provides detailed guidance, but the main category is:

Gift Aid - a scheme enabling registered charities to reclaim tax on a donation made by a UK taxpayer, effectively increasing the amount of the donation at no cost to the donor. The current rate of gift aid is 25p in every £1. To qualify, the donor must be a UK taxpayer and have paid enough income tax and/or capital gains tax in the financial year. The donor must complete and return a *Gift Aid Declaration Form*

To claim gift aid, it is vital that a core amount of donor information is captured. This includes the donor's initial, surname, house number, postcode and signature as well as the date of their donation and the amount donate. The quickest and easiest way to capture this information is by using the Donation Envelope.

Some donations, such as payroll giving and donations from companies, Trusts and Foundation, do not qualify for gift aid. The Charity Finance Team can advise on these matters and will ensure all sums reclaimable are claimed and received in a timely manner.

6.10.3 VAT

Purchases made from Charitable Funds are not all exempt from VAT; it is the nature of the purchase that determines VAT status. A general guide is that to qualify for VAT exemption, purchases must be made solely from charitable

monies and must be for a category of purchase approved by HMRC e.g. advertising.

To obtain zero rating, a VAT exemption certificate must be provided with an official order. These can be obtained from the Charity Finance Team. VAT guidance does change continually and, as such, any queries should be referred to the Charity Finance Team for investigation.

6.11. Investment income and management costs

Investment income and management costs are distributed across all Funds in proportion to the monthly average fund balances. The management cost charge is made up of the following:

* All direct costs such as bank charges and audit fees
* £100 charge for variable costs such as stationery and postage
* 40% of the Charitable Funds and Income Assistant's salary cost
* 10% of the Charitable Funds and Income Assistant's line manager salary cost

This is to reflect the time spent by Finance staff in administering the Funds. Over time, as the Charity's income increases as a direct result of increased activity, a proportion of fundraising costs may also be charged to each Fund.

Management costs are reviewed on an annual basis.

6.12. Guidance for other charitable activity within the Trust

Many PAH staff choose to organise fundraising activities and/or take part in events to fundraise for the Trust's Charity. Many raise money to fund improvements in their own ward or department. The Charity team is on hand to help with fundraising advice and to ensure all activities comply with Charity Law and abide with the guidance from the Charity Commission.

Whilst we are hugely grateful for the support PAH staff give the Charity in handling donations, providing information to patients and relatives and fundraising themselves, we appreciate some may choose to support other worthy causes both at home and abroad. In these circumstances, the Trust is able to provide the following guidance:

- Posters can be displayed in your own ward or department (subject to infection control restrictions) to promote your fundraising activity. Please do not place posters in communal areas e.g. lifts, corridors etc.
- Donations must never be actively solicited from patients or relatives.
- If a patient or relative hears about your activity/events or see your poster and asks about your fundraising activity, you are able to provide them with the information they request.
- You can email individual colleagues, who are already known to you, to ask them to support your fundraising. Please do not send blanket emails to whole departments or Directorates or to anyone you do not know.
- It is not permissible to display a collection tin or bucket on Trust property other than for The Princess Alexandra Hospital's Charity.
- Once your event or activity has ended, details can be emailed to path.communications@nhs.net for inclusion in InTouch Weekly and/or InTouch magazine. Pre-event articles will only be published for the Trust's Charity.

6.13. Contact details

For all charity finance-related matters, such as obtaining a fund balance, purchasing or paying for goods or services or seeking advice on VAT, contact: Grazi Maddalozzo, Charitable Funds & Income Assistant, ext. 7962,

Graziana.Maddalozzo@nhs.net.

For fundraising advice and support and information about non-finance charity matters, contact: ext.8782, paht.fundraising@nhs.net

7. TRAINING

There is no mandatory training associated with this policy.

8. MONITORING COMPLIANCE WITH THIS DOCUMENT

The table below outlines the Trust's monitoring arrangements for this document. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Aspect of compliance or effectiveness being monitored	Method of monitoring	Individual responsible for the monitoring	Monitoring Frequency	Group or committee who receive the findings or report	Group or committee or individual responsible for
The process for managing Charitable Funds including both income and expenditure	Regular feedback from Charitable Fund Managers and regular activity reports to CFC	Head of Financial Services	Quarterly, at CFC meetings	Charitable Funds Committee (CFC)	Charitable Funds Committee
Where a lack of compliance is found, the Charitable Funds Committee will identify required actions, allocate responsible leads, target completion dates and ensure an assurance report is represented showing how any gaps have been addressed.					

9. REFERENCES

Guidance on the statutory and accounting framework for the management of charitable funds is available at:

- **Charity Commission:** https://www.gov.uk/government/organisations/charity-commission
- **NHS Accounting Manual:** https://www.gov.uk/government/publications/department-of-health-group-accounting-manual-2017-to-2018
- **Gift Aid:** https://www.gov.uk/donating-to-charity/gift-aid

10. RELATED TRUST POLICIES

The following polices/policy areas are relevant and must be adhered to as part of the application of the Management of Charitable Funds Policy:

- Governance Manual
- Information Governance policies
- Data Protection policies
- Social Media Policy

The Princess Alexandra Hospital Charity

NHS
The Princess Alexandra Hospital
NHS Trust

Trust Board
5 August 2021

Agenda Item:	7.2
Presented by:	Saba Sadiq – Director of Finance
Prepared by:	Colin Forsyth – Head of Financial Services
Date prepared:	30 June 2021
Subject / Title:	Charitable Funds Investment Policy

Purpose:	Approval	✓	Decision	✓	Information		Assurance	

Executive Summary:	The Charitable Funds Investment Policy was reviewed and approved by the Charitable Funds Committee (CFC) in July 2018. The Investment policy formalises trustees' responsibilities and supports trustees in making decisions about investments that comply with their duties.
Recommendation:	The Charitable Funds Committee are asked to: • Review and approve/amend the investment policy; and • Recommend to the Charity's Corporate Trustee that the Investment Policy be approved

Trust strategic objectives:	Patients	People	Performance	Places	Pounds
			✓		✓

Previously considered by:	n/a
Risk / links with the BAF:	Failure of comply with Charity Commission requirements, loss of income /funds from poor investment decisions, reputational damage from inappropriate investment decisions
Legislation, regulatory, equality, diversity and dignity implications:	As a condition of its registration, the Charity is required to comply with Charity Commission guidance and reporting requirements.
Appendices:	Appendix 1 – Investment Policy

1.0 PURPOSE

The purpose of the Charitable Funds Invest Policy is to formalise the responsibilities of the Trustees in respect of the management of The Princess Alexandra Hospital NHS Trust Charitable Funds, and ensure that it complies with relevant legislation, and with Charity Commission guidance.

2.0 CONTEXT

The Charitable Funds Investment Policy was last reviewed and approved by the Charitable Funds Committee (CFC) in July 2018 and now requires updating and review.

2.2 RESPONSIBILITY OF TRUSTEES AND SCOPE OF THE POLICY

Guidance issued by the Charity Commission for England and Wales details the responsibility of Trustees as regards Financial Investments (Charities and investment matters: a guide for trustees (CC14)).

This guidance identifies that trustees should "decide on the overall investment policy and objectives for the charity", and that the policy should cover, where applicable:

- the scope of its investment powers
- the charity's investment objectives
- the charity's attitude to risk
- the amount available for investment, timing of returns and the charity's liquidity needs
- the types of investment it wants to make (this might include ethical considerations)
- who can take investment decisions (for example, trustees, an executive, an investment adviser or manager)
- how investments will be managed and benchmarks and targets set by which performance will be judged
- reporting requirements for investment manager

3.0 REVIEWS AND CHANGES MADE

The policy has been reviewed by the Trust's Internal Audit lead, and the Counter Fraud lead.

The changes made to the policy are detailed below.

Section 2 (parts v and vi)	Additional detail on the Trust's approach to fraud, and on raising queries and suspicions;
Sections 6.3 and 13	Amend "Chief Financial Officer" to "Director of Finance";
New Section 12	New section to include explicit reporting of investments and performance at each CFC meeting. Subsequent sections re-numbered

In addition, some formatting has been updated to ensure consistency across the document.

4.0 RECOMMENDATION

The Charitable Funds Committee is asked to:

- Review and approve/amend the investment policy; and
- Recommend to the Charity's Corporate Trustee that the Investment Policy be approved

Author: Colin Forsyth – Head of Financial Services
Date: 30 June 2021

Appendix 1

Charitable Funds Investment Policy

Table of Contents

1. FUND STRUCTURE

1.1 The Princess Alexandra Hospital NHS Trust Charitable Fund (Registered Number 1054745) is an Umbrella Fund with three funds affiliated under this umbrella group, namely:

- The Princess Alexandra Hospital General Fund
- The St Margaret's Hospital General Fund
- The Herts and Essex Acute Services General Fund

1.2 The Board of The Princess Alexandra Hospital NHS Trust are the Corporate Trustees of the Charitable Funds.

2. PURPOSE

2.1 The purpose of this Policy is formalise the responsibilities of the Trustees in respect of the management of The Princess Alexandra Hospital NHS Trust Charitable Funds and to translate these responsibilities into an investment strategy which complies with the Trustees Act 2000 and incorporates best established practice by:

2.1.1 Ensuring that when investing charitable funds Trustees invest on a basis that is consistent with the investment objectives set out in this policy, achieving an appropriate balance for the charity between the two objectives of:

2.1.1.1 Providing an income to help the charity carry out its purposes effectively in the short term; and

2.1.1.2 Maintaining and, if possible, enhancing the value of the invested funds, so as to enable the charity effectively to carry out its purposes in the longer term.

2.1.2 Ensuring that the following standards as defined in the Trustee Act are followed, whether they are using the investment powers in that Act or not:

2.1.2.1 That the Charity is discharging its general duty of care (as described in section 1 of the Trustee Act), which is the duty to exercise such care and skill as is reasonable in the circumstances. This applies both to the use of any power of investment and to the discharge of the specific duties which the Act attaches to the use of investment powers. A higher level of care and skill is expected of a trustee who is, or claims to be knowledgeable about, or experienced in investments, or who is paid.

2.1.2.2 Secondly, that the Charity is complying with the following specific duties:

i. Trustees must consider the suitability for their charity of any investment. This duty exists at two levels:
   - The trustees must be satisfied that the type of any proposed investment (e.g. a common investment fund or a deposit account) is right for their charity (including whether it is consistent with an ethical investment policy if the charity has one).
   - They also have a duty to consider whether a particular investment of that type is a suitable one for the charity to make.

   - Trustees should, at both levels, try to consider the whole range of investment options which are open to them.

ii. Trustees must consider the need for diversification, i.e. having different types of investment, and different investments within each type. This will reduce the risk of losses resulting from concentrating on a particular investment or type of investment.

iii. Trustees must periodically review the investments of the charity. Reviews will be carried out annually (or more frequently if decided by the trustees. The nature and frequency of these reviews is up to the trustees to decide, but the reviews should be proportionate to the nature and size of the charity's investment portfolio. To review too infrequently may result in losses or missed opportunities; chopping and changing investments too frequently may incur unnecessarily high levels of transaction charges. It is recommended that a review of the investments should be carried out at least once a year.

iv. Before exercising any power of investment, and when reviewing the charity's investments, trustees must obtain and consider proper advice from a suitably qualified adviser (who may be one of the trustees), unless the size of the funds available for investment is so small that seeking investment advice would not be cost effective.

v. The Trust has a zero tolerance approach to fraud, bribery and corruption. If you have a suspicion of fraud or bribery at the Trust, or need fraud-related advice, please contact the LCFS for the Trust, Dean Docherty, Support LCFS / Senior Fraud Manager on dean.docherty@nhs.net or 07717 801006.

vi. Suspicions of fraud may also be reported to Saba Sadiq, Finance Director or to the NHS Counter Fraud Authority's fraud reporting line – https://cfa.nhs.uk/reportfraud

3. INVESTMENT OBJECTIVES

3.1 The Trustees have agreed that The Trusts Charitable Funds investment objective is to

3.1.1 Optimise investment income received whilst maintaining or increasing the capital value of the funds.

3.1.2 Maintain a sufficient cash balance to meet the fund's ongoing working capital requirements.

4. SCOPE OF POLICY APPLICATION

4.1 The policy applies to the Corporate Trustee and all employees of the Corporate Trustee who are engaged in charitable fund activity

5. IMPACT OF POLICY APPLICATION

5.1 Implementation of this policy will ensure that:

5.1.1 The management of charitable funds investments meets the requirements of the Charity Commission; and

5.1.2 The investment objective is achieved

6. RESPONSIBILITIES

6.1 The Trust Board as the Corporate Trustee

6.1.1 The Trust Board as the Corporate Trustee recognises its overall responsibilities for investment decisions and the need to demonstrate that they have retained overall control of decision-making and have complied with their duties regarding investing The Princess Alexandra Hospitals NHS Trust Charitable Funds. The Terms of Reference for the Charitable Funds Committee is included at Appendix 5.

6.2 Role of the Charitable Funds Committee

6.2.1 The members of the Charitable Funds Committee are responsible for

6.2.2 Acting on behalf of the Corporate Trustee for the organisation's charitable funds;

6.2.3 Having the general control and management of the administration of the Trust's charitable funds; and

6.2.4 Approving the spending on behalf of the Corporate Trustee.

6.2.5 Investments can be amended at the discretion of the Charitable Funds Committee.

6.3 Role of the Director of Finance

6.3.1 The Director of Finance is responsible for:

6.3.2 Controlling the administration of the Trust's charitable funds and their day to day management, through delegated authority as outlined in the Trust's Standing Orders ; and

6.3.3 Ensuring the policies and procedures for managing and reporting the spending of the Trust's charitable funds are robust.

7. PAYMENT OF INCOME

7.1 Investment income (including any dividends received as a result of investments made) will be apportioned across the accumulated balances of the individual funds on a quarterly basis.

8. MAINTENANCE OF LIQUIDITY LEVELS

8.1 The Trustees shall require that a proportion of Trust Fund assets equivalent to the level of reserves required as identified in the Reserves Policy be held in immediate and short-term liquid forms. These shall be:

8.2 Current accounts with a minimum balance equivalent to the minimum reserves level, paying a nominal interest rate holding an operational level of cash.

8.3 The balance of funds above the reserves policy level being held in a format that is consistent with the Trust Funds financial position and long term investment strategy but which may include:

- interest bearing deposit accounts,
- term deposits; or

- Common Investment Funds

9. ARRANGEMENTS FOR INVESTMENT OF FUNDS AND MONITORING INVESTMENTS

9.1 The Trust, in its capacity as Corporate Trustee, has the general duty of properly managing and protecting the funds of the Charities. In particular it should:

9.1.1 invest money not needed immediately, or place it on deposit to earn interest if expenditure is expected in the near future;

9.1.2 invest the funds in a way which aims to both preserve their capital value and produce a proper return consistent with prudent investment;

9.1.3 not place the fund at risk by speculative investment; and

9.1.4 invest only as permitted by the investment powers of the Charity.

9.2 In order to carry out these duties:

9.2.1 The Trust must be aware and take into account, advice and guidance given in respect of investments and investment management by the Charity Commission.

9.2.2 The Charitable Funds Committee is responsible for reviewing the performance of any investments,

9.2.3 In order to achieve its investment objectives, the Trustees may invest in a Common Investment Fund.

10. INVESTMENT RISKS

10.1 The Trustees must attempt to maximise the investment return on the charitable funds whilst minimising the risk to the funds themselves. Furthermore, the Trustees have a legal duty to avoid speculative forms of investment.

10.2 The Trustees recognise that all investments involve an element of risk. The level of risk that is appropriate for the Trust will be influenced by various factors, including the Trustees' attitude to risk, the Trust's capacity to afford potential investment losses and its investment objectives.

10.3 Trustees determine the level of risk and assess, that in broad terms, the risk level that is acceptable is a low-mid risk level.

10.4 What does Low-mid risk mean:

10.4.1 In general, low-mid risk investors would prefer not to take risk with their investments, but they can be persuaded to do so to a limited extent. They would prefer to keep their money in the bank, but they may realise that other investments might be better over longer term.

10.4.2 Low-mid risk investors may have some limited experience of investment products, but will be more familiar with bank accounts than other types of investments.

10.4.3 Low-mid risk investors can often suffer regret when decisions turn out badly.

10.4.4 Low-mid risk investors with time horizons of ten or more years typically have portfolios with a majority of bonds and cash, but with some exposure to equities and other higher risk investments.

11. INVESTMENT RESTRICTIONS

11.1 The Trustees reserve the right to exclude companies that carry out activities contrary to their aims or from holding particular investments which damage the Charity's reputation.

11.2 The Trustees do not wish to invest in companies connected with products which solely cause harm (e.g. Tobacco and Arms) rather than products which have harm as a side effect.

12. INVESTMENT REPORTING

12.1 The Charitable Funds Committee is to receive, at each meeting, details of investments made, and the performance of those investments (to be included within the regular finance report).

13. MONITORING COMPLIANCE WITH AND THE EFFECTIVENESS OF THE POLICY

13.1 Monitoring compliance with this policy will be the responsibility of the Director of Finance.

Aspect of compliance or effectiveness being monitored	Method of monitoring	Individual responsible for the monitoring	Monitoring Frequency	Group or committee who receive the findings or report	Group or committee or individual responsible f completing a actions
Duties	To be addressed by the monitoring activities below.				
Levels of liquidity	Reporting to the Charitable Funds Committee on cash and investment balances	Director of Finance, Head of Financial Services	Quarterly, at CFC meet	Charitable Funds Committee	Charitable Funds Committee
Appropriateness of investment decisions and investments made	Reporting to the Charitable Funds Committee on cash and investment balances	Director of Finance, Head of Financial Services	Quarterly, at CFC meet	Charitable Funds Committee	Charitable Funds Committee
Investments made within identified restrictions	Reporting to the Charitable Funds Committee on cash and investment balances	Director of Finance, Head of Financial Services	Quarterly, at CFC meet	Charitable Funds Committee	Charitable Funds Committee
Where a lack of compliance is found, the identified group, committee or individual will identify required actions, allocate responsible leads, target completion dates and ensure an assurance report is represented showing how any gaps have been addressed.					

14. TRAINING

14.1 There is no mandatory training associated with this policy.

15. REFERENCES

15.1 Guidance on the statutory and accounting framework for the management of charitable funds is available at: Charity Commission

https://www.gov.uk/government/organisations/charity-commission

16. RELATED TRUST POLICIES

16.1 Information Governance policies
16.2 Data Protection policies
16.3 Governance Manual
16.4 Management of Charitable Funds