

AGENDA

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

Date and time: **Friday 11 June 2021**

10.45 – 14.15

Venue: **Microsoft Teams Meeting**

	Item	Subject	Action	Lead	
01 Opening Administration					
10.45	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	14
10.55 Staff story: Role of the Mental Health First Aiders					
02 ANNUAL REPORT AND ACCOUNTS					
11.15	2.1	Final Accounts 2020-21 including: • Letter of Representation to External Audit	Approve	Director of Finance /External Audit	15
11.25	2.2	External Audit Findings: • Audit Report	Inform	External Audit	72
11.30	2.3	Annual Report 2020-21 including: • Annual Governance Statement	Approve	Chief Executive	120
03 Risk/Strategy					
11.40	3.1	CEO's Report including: • Covid-19 update	Inform	Chief Executive	210
12.05	3.2	Strategic objectives 2021-22	Approve	Chief Executive	216
12.20	3.3	Significant Risk Register	Review	Director of Nursing & Midwifery	219
12.30	3.4	Board Assurance Framework 2021-22	Review/ Approve	Director of Nursing & Midwifery	224
04 Patients					
12.40	4.1	Learning from Deaths (Mortality)	Discuss	Medical Director	237
12.50	4.2	Maternity SI report	Assure	Director of Nursing & Midwifery	246
13.00	4.3	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing & Midwifery	249
		BREAK			
05 Performance /Pounds					
13.20	5.1	Integrated Performance Report	Discuss	Executives	256
06 Governance					
13.30	6.1	Reports from Committees: • AC.25.05.21 • NHC.26.05.21 including terms of reference	Inform/ Approve	Chairs of Committees	297 298



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		- PAF.27.05.21 including terms of reference - QSC.28.05.21 including terms of reference - WFC.01.06.21 - SMT.11.05.21 and 18.05.21			302 310 318 319
07 Questions from the Public					
13.45	7.1	Opportunity for Members of the Public to ask questions about the Board discussions or have a question answered.			
08 Closing Administration					
14.00	8.1	Summary of Actions and Decisions	-	Chairman/All	
	8.2	New Risks and Issues Identified	Discuss	All	
	8.3	Any Other Business	Review	All	
14.15	8.4	Reflection on Meeting	Discuss	All	



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Public Board Meeting Dates 2021/22

01.04.21	07.10.21
03.06.21	02.12.21
05.08.21	03.02.22

Purpose:

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

Quoracy:

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

Ground Rules for Meetings:

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

Board Membership and Attendance 2021/22

Non-Executive Director Members of the Board (voting)		Executive Members of the Board (voting)	
Title	Name	Title	Name
Trust Chairman	Steve Clarke	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



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Minutes of the Virtual Trust Board Meeting in Public
Thursday 1 April 2021 from 09:00 – 12:30

Present:**Steve Clarke**

Dr. Amik Aneja (left early)
Darshana Bawa
Pam Court
Ogechi Emeadi (non-voting)
Helen Glenister
John Hogan
Phil Holland
Helen Howe
John Keddle (non-voting)
Stephanie Lawton
Lance McCarthy
Jim McLeish (non-voting)
Sharon McNally
Saba Sadiq
George Wood

In attendance:

Shikha Sharma
Blessing Asesho
John Candolesas

Observer:

John Murray

Members of the Public

Clare Rose

Apologies:

Michael Meredith (non-voting)
Darrel Arjoon
Laura Warren

Secretariat:

Heather Schultz
Lynne Marriott

Trust Chairman (TC)

General Practitioner (GP-AA), Board Advisor
NExT Non-Executive Director (NNED-DB)
Non-Executive Director (NED-PC)
Director of People (DoP)
Non-Executive Director (NED-HG)
Non-Executive Director (NED-JH)
Chief Information Officer (CIO)
Non-Executive Director (NED-HH)
Associate Non-Executive Director (ANED JK)
Chief Operating Officer (COO)
Chief Executive Officer (CEO)
Director of Quality Improvement (DoQI)
Director of Nursing & Midwifery (DoN&M)
Director of Finance (DoF)
Non-Executive Director (NED-GW)

Staff Story (International Nurse)
Staff Story (International Nurse)
Staff Story (International Nurse)

Deloitte

Crown Commercial

Director of Strategy (DoS)
NExT Non-Executive Director (NNED-DA)
Associate Director - Communications

Head of Corporate Affairs (HoCA)
Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chairman (TC) welcomed all to the virtual Board meeting
1.1 Apologies	
1.2	No apologies were noted as above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
2.0 Staff Story	
2.1	The Director of People (DoP) welcomed three international nurses (see names above) to the meeting. The nurses took members through their presentation which provided an insight into their arrival in the UK, the interview/recruitment process followed, and some of the challenges they experienced during that time as new nurses arriving from a foreign country.
2.2	In terms of why the nurses had chosen PAHT, its proximity to London had been an advantage along with its structured interview process. In terms of positive experiences the nurses spoke about the warm and welcoming environment, the structured and very supportive process for OSCE preparation, the huge support they had received from the Trust's Practice Development Team (PDT) and ward colleagues and the fact that there was a clear and structured career progression for them.

2.3	In terms of challenges that the team had experienced they spoke about issues with communication particularly in terms of the language, different dialects and idioms. They had not been used to some of the policies/procedures in places and indeed back home in some cases had used completely different processes. The Board was concerned to hear that on occasion the new nurses had encountered poor/wrong perceptions of themselves as new/overseas nurses which had been upsetting, particularly at a time when they were away from home and their family/friends.
2.4	Now being two or three years into their PAHT journey, the team had some words and wisdom for any future international colleagues which they detailed as follows: Always speak up and voice concerns, always ask questions, build a good network, be ready to take on challenges and keep striving to learn and grow.
2.5	The TC thanked the international nurses for their insightful story. He could see from comments posted in the chat-box how excited Board members were to hear of the positives, but also how concerned they were in terms of certain elements that had been relayed during the presentation. He thanked them for all their hard work and the contribution they were making on a daily basis to the organisation, of which they should be very proud.
2.6	In response to the above the CEO also thanked the nurses for the hard work, energy and effort they put into the organisation on a daily basis. He apologised for some of the negative experiences that had been relayed and gave his commitment (and that of Board members too) that that would not continue. He felt it would be useful for the nurses to attend one of the Executive Management Team meetings in an endeavour to focus on what could be done to improve the experience for overseas nurses. He stated he was pleased to hear of the huge support from the PDT who had been mentioned on more than one occasion during the presentation.
ACTION TB1.01.04.21/01	Invite the 'April Staff Story' international nurses to a future EMT. Lead: Head of Corporate Affairs
2.7	Associate Non-Executive Director John Keddie (ANED-JK) stated he had experience of working abroad himself and had only admiration for the team arriving alone in a foreign country about to start a new job. He emphasised the responsibility for integrating new colleagues into the organisation lay solely with the Board and senior colleagues and he would encourage new international starters to raise any concerns they may have so those could be addressed.
2.8	NED George Wood (NED-GW) reiterated comments made by colleagues in terms of thanks and difference the team were making on a daily basis. He stated he would strongly encourage the nurses to attend the EMT (as requested by the CEO) and to think about how the organisation could support them particularly in terms of COVID, health and wellbeing and also to think about a 'top 3 wish list' of items which would make life easier on a daily basis.
1.3 Minutes of Meeting held on 04.02.21	
1.4	These were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising and the action log was noted. In terms of action ref: TB1.04.02.21/13 (Health and Wellbeing) the DoP updated that a comprehensive report had been submitted and discussed at Workforce Committee (WFC) earlier that week. The health and wellbeing approach was focussing on 4Ps, practical, physical, psychological and professional. There was input from the Health & Wellbeing Steering Group, Staff Network and Staff Council. There was also some collaborative work underway with the the ICS, East of England region and the DoP informed members she was involved with the 'rest and recovery' programme in the EoE region. NED Helen Howe (NED-HH) had been asked to be the Health & Wellbeing Guardian for the Trust (in addition to chairing the WFC).
02 RISK	
2.1 CEO's Report	
2.9	This item was presented by the CEO. He drew members' attention to the table of key indicators which evidenced improvements in most since the previous meeting. The actual

	performance in a number of areas (ED and diagnostics) reflected the pressure that the Trust was under currently and the impact that COVID was having on the hospital's ability to maintain underlying services in the way it would wish to.
2.10	In terms of the organisation's COVID response the CEO reiterated his thanks to all colleagues for their hard work and amazing response to the pandemic. The organisation had seen a sustained reduction in the number of new COVID positive inpatient admissions on a daily and weekly basis since the peak of 219 new positive inpatient admissions in w/e 03.01.21 which had been almost twice as high as the peak week of the first wave (w/e 05.04.21). Since that point there had been a slow but steady decline in the number of new positive inpatient admissions, mirroring the reduction in the number of new COVID infections in the local community. At the time of paper submission there had been 11 COVID positive inpatients in the Trust, of which two were in critical care, and local/regional forecasts suggested admissions of between 0 and 19 new positive inpatients per week by Easter weekend.
2.11	The CEO continued that the reduction in the number of new transmissions in the community had also seen sickness absence rates amongst colleagues reduce significantly, with absence rates in February down to 4.2% (from more than 14% in some weeks in January). COVID wards had now reduced from nine back down to one currently.
2.12	The CEO continued that the impact of COVID on normal services had been significant. The amount of elective surgery provision had reduced to focus on maintaining the top two priorities of patients, including cancer surgery. A large number of patients had now been waiting more than 52 weeks for their routine surgery and there was also a significant pressure on the demand for diagnostic services, particularly for cancer. To support that endoscopy, CT and MRI capacity had been expanded and the hospital continued to work closely with independent sector colleagues at The Rivers Hospital to maximise access to key services. Discussions continued with The Rivers Hospital in terms of potential further support from 01.04.21. All patients who had been waiting for longer than they would do normally continued to be reviewed by the relevant clinical team and reprioritised where appropriate.
2.13	In terms of urgent care, demand had increased in recent weeks and was almost back to pre-COVID levels. Performance against the 4-hour standard remained challenged and lower than pre-COVID levels due to the reduction in available beds in the hospital. Despite a huge amount of hard work at all levels, the impact of COVID on services had been significant and it would be some time before services and performance could be fully recovered.
2.14	In relation to the vaccine the hospital vaccination hub had reopened and 6,829 health and care colleagues had been vaccinated with more than 80% of PAHT colleagues having taken up the vaccine. Work was underway to target those who had not yet taken the opportunity to have the vaccine. The hub had reopened on 17.03.21 for booster doses with currently 2,500 provided so far. Shielding staff would be able to return as of 01.04.21 and individual plans would be in place for that to ensure staff were fully supported.
2.15	In response to a question from Non-Executive Director John Hogan (NED-JH) the Medical Director (MD) informed colleagues that the view was that a third wave of COVID would hit in winter 2021/22.
2.16	NED-JH then asked whether, in terms of lateral flow testing, it was a legal requirement for staff or the organisation to undertake that and report the results. In response the Director of Quality Improvement (DoQI) agreed to clarify that outside the meeting and report back.
ACTION TB1.01.04.21/02	Confirm the legal responsibilities in terms of lateral flow testing (and reporting of results) and who that lies with. Lead: Director of Quality Improvement
2.17	NED Helen Howe (NED-HH) asked whether (in relation to the 505 COVID deaths noted in the paper) the organisation was an outlier compared to others. In response the CEO stated that depended on multiple factors but the hospital was 'middle of the pack' in terms of COVID deaths for both peaks combined.
2.18	The CEO continued that his report fully recognised the unannounced CQC visit of the ED on 14.02.21 following which a Section 29a warning notice had been served relating to four

	specific concerns. A draft report had now been received from the CQC and would be discussed in the private session later that day.
2.19	He continued that the new Adult Assessment Unit (AAU) was now fully open meaning facilities for frailty patients and general ward areas could now start to be improved. The Trust's ten year strategy PAHT 2030 was due to launch in May and significant progress had been made in terms of an outline business case (OBC) for a new electronic patient record (EPR).
2.20	As a final point the CEO stated that horizon-scanning was something that the Board had previously discussed as needing to improve. The three key areas at present that had the potential to impact on current thinking and strategy were: • The recent white paper – Integration and Innovation: working together to improve health and social care for all – published on 11.02.21. • Potential changes to ICS boundaries included within the white paper, aligning them with local authority boundaries. • National Planning Guidance for 2021/22.
2.21	In response to a comment made by NED-GW, the Chief Operating Officer (COO) was able to confirm that the development of a new cancer diagnostic centre would be something planned for the new hospital. There was also work underway to develop community diagnostic centres as part of the system-wide transformation programme.
2.22	In response to a question from the TC, it was confirmed that a decision around ICS boundaries was expected to be made by May. Concerns that the Trust had related to the relationships already formed in terms of the new hospital work and the future sign-offs required and also the progress made in terms of the One Health & Care Partnership work.
2.2 Significant Risk Register	
2.23	This paper was presented by the Director of Nursing & Midwifery (DoN&M) and taken as read. Members noted there were 19 risks with a score of 20 but it was anticipated a number of those would now reduce following progress made since paper submission. There were five new risks with a capital funding allocation and she was pleased to update that the theatre roof had now been repaired, significantly reducing that risk. Internal Audit's report on their review of the Board Assurance Framework and Risk Management had been reflected in the paper and reasonable assurance had been received from them.
2.24	The CEO updated at this point that in line with the recent CQC concern around out of hours GI bleed services, the issue was now being properly tracked as a risk.
2.25	In response to a question from NED-JH in terms of the timeline for recommended consultant cover in Maternity, the CEO was able to provide assurance that a business case had been established by the team and would be presented to Senior Management Team (SMT) later that month. The additional recruitment was expected to increase cover to 87 hours against the current recommendation of 96. In response NED-JH stated in his view the recommendation was non-negotiable. The COO agreed and confirmed that the team were being supported to move ahead with recruitment to some substantive posts as quickly as possible.
2.26	In response to the discussion above ANED-JK stated in his view, and on having studied the SRR, there was nothing that appeared to flag the current challenges in ED. He asked if an opportunity was being missed to capture a significant organisational risk. In response it was confirmed that ED had their own risk register which picked up their own individual risks. In addition a Corporate Risk Register (CRR) was now in the throes of being developed.
2.27	In response NED Helen Glenister (NED-HG) flagged that she would very much welcome a CRR. Staffing levels in particular areas were of concern and had been for a couple of years in terms of the CQC.
2.28	In response to a question from NED-HH the DoN&M updated that the SRR would pull together any organisational risks scoring 15 or above. A CRR would allow an assessment of organisational risks in different areas and an aggregate of those. In response to a question as to when the work on the CRR would conclude the DoN&M agreed to report back on that (as it relied on an interim appointment which had not yet been finalised).

ACTION TB1.01.04.21/03	Provide a timeline for the work to establish a Corporate Risk Register. Lead: Director of Nursing & Midwifery
2.29	In response to a question from Associate NED Anne Wafula-Strike (ANED-AWS) the DoN&M assured members that the Trust's Risk Management Group (RMG) undertook a huge amount of work in the background to review/validate risks and to feed those outputs into the SRR.
2.30	In response to the comments/questions above the CEO stated he felt it would be useful to run another Board session around risk, to include risk appetite and the management of risk. It would be particularly useful he felt for the new NEDs.
ACTION TB1.01.04.21/04	Schedule a Board development session on risk. Lead: Head of Corporate Affairs
2.31	Going back to the earlier discussion the CEO agreed that workforce in general was a significant BAF risk which impacted on the organisation's ability to deliver its strategic objectives. Work was underway to improve the approach going forward but he reminded members that 350-400 additional nursing posts had been created over the previous two years (some of which still needed to be filled).
2.32	In terms of medical staffing the organisation was understaffed in terms of consultant posts and overstaffed in terms of middle grades, which caused significant pressure on services. Cases were being built to recruit additional consultants and job/workforce planning would be required to achieve the correct balance moving forward. Areas of current concern were ED and Obstetrics & Gynaecology.
2.33	In response to the above NED-JH stated he fully agreed and workforce was a threat to the organisation's ability to deliver safe care to its patients. He would strongly encourage colleagues to rethink the position in terms of which services could be offered, particularly with the move to a new hospital.
2.34	In response to the above the CEO stated he fully agreed but the organisation was in a completely different place currently to where it had been three years previously. The quality of applicants had significantly improved and a position had been appointed to the previous day where all four applicants had been appointable. He provided assurance that work would continue in terms of workforce planning particularly at speciality level to ensure safe care.
2.3 Board Assurance Framework 2020-21	
2.35	This item was presented by the Head of Corporate Affairs (HoCA). Key points to note were: - BAF risk 1.0 Covid – the risk score to be reduced from 20 to 16. - BAF risk 3.3 Strategic change and organisational structure – the risk score to be reduced from 12 to 8, achieving the target risk score and consequently it was proposed to close the risk. - BAF risk 3.4 Sustainability of local services – the risk score was to be reduced from 16 to 12, achieving the target risk score and consequently it was proposed to close the risk.
2.36	In response to the above the DoP raised a concern around closing risk 3.3, bearing in mind the current uncertainty around ICS boundaries. The CEO reflected that was a good challenge. The risk was quite an historic one which had originally related to the risk around capacity and capability of leaders to develop the OHCP model several years back. After further discussion it was agreed the risk should be closed as a team was now in place to support this work and progress had been made but a new risk should be worked up which captured the uncertainty around ICS boundaries currently.
ACTION TB1.01.04.21/05	Work up a new risk to capture the current uncertainty and risk related to the potential change of ICS boundaries. Lead: Head of Corporate Affairs/Director of Strategy
2.37	In response to a question raised by NED-HH in relation to the link between the BAF and the organisation's strategic objectives, the CEO stated that the strategic objectives were aligned to the organisation's 5Ps and the BAF was the risk to the non-delivery of those strategic objectives. PAHT 2030 had the same five strategic objectives but with five key areas of work in order to achieve them to move the organisation forward, mitigate risk and deliver the strategic objectives.

2.38	In response to the discussion above ANED-JK reiterated his concern that not all risks were being captured. The risk around the achievement of the ED four hour standard was rated at 20 but at the same time was not being captured in the SRR. The DoN&M noted that it appeared in the SRR. In response the COO stated there would be further discussion at EMT on risks to emergency care and outputs would be shared with both QSC and PAF.
2.39	In response to a concern raised by NED-GW the CEO assured colleagues that whilst the organisation struggled to recruit medical staff in certain specialities, there were no concerns around the safety of those services.
2.40	The TC thanked colleagues for their update and summarised there had been agreement around the changes to the BAF and that a new risk would be worked up to capture current uncertainties around ICS boundaries.
<i>Break 1110-1120</i>	
03 PATIENTS	
3.1 ED CQC Inspection	
3.1	This item was presented by the CEO. He informed colleagues that the draft report had now been received from the CQC (for factual accuracy). In line with deadlines the Trust had already responded in terms of the risks around GI bleed and infection control and the remaining two issues (timely risk assessments for patients in the ED including mental health risk assessments) required a response by 01.06.21.
3.2	The DoN&M continued there had been a detailed discussion at QSC around the inspection and a number of external peer reviews would now take place. QSC had also requested a deep dive into the CQC 'must and should' actions for its next meeting.
3.3	NED-HG stated that outside of QSC she had also met with Executive colleagues and felt assured around the plans in place currently and moving forward. In her view there should be a clear focus on providing the evidence of change/improvement and being clear as to the targets being aimed for.
3.4	ANED-JK reminded colleagues of the disappointment he had expressed at the last meeting. His concern now would be how to address the root causes of the position in which the service had found itself, and that key elements such as leadership needed to be addressed. The CEO agreed with the comments and provided assurance that leadership (along with other elements) was being addressed.
3.5	In response to a point raised by NED Pam Court (NED-PC) the DoN&M confirmed that the senior team in ED had been very disappointed with the findings of the inspection and were keen to put things right. The service (Urgent & Emergency Care) had now been established as a HCG in its own right. A Head of Nursing had been appointed the previous year and the role of an Operations Lead was about to go out to advert. To put things in context the team had been hit hard by COVID but had coped well with that, possibly to the detriment of embedding the work they had started prior to the pandemic. She assured colleagues the team were fully committed to making improvements and moving forward. The team were being supported by Executive colleagues to rebuild their confidence, address issues around leadership and accountability and to move towards providing an improved and sustainable service. NED-HH added it would be important to ensure that staff morale was rebuilt and support was provided from all areas, particularly the Trust's Health & Wellbeing team.
3.6	The TC thanked colleagues for their update and it was noted the discussion would continue at the private session later that day.
3.2 Learning from Deaths (Mortality)	
3.7	This update was presented by the Medical Director (MD). She informed members it had recently come to light that the data submitted to Dr. Foster for August/September/October 2020 had been incorrect (due to a change in the way the data needed to be configured). She would not therefore discuss HSMR/mortality outliers that day as the position may not be truly accurate. She had been assured by Dr. Foster that the data would not affect SHMI which remained 'as expected'. It was hoped to be able to report again accurately in terms of HSMR

	in April/May. The plan was to resubmit data to Dr. Foster data from August-October as a bundle.
3.8	The discussion then turned to the risk register and four key risks on that were: • That the organisation was not learning from deaths. • HSMR was not rated as 'as expected' in an appropriate timeframe (6-12 months). • SJRs were not being undertaken within six weeks. • The infrastructure was not yet in place to deliver the learning from deaths programme appropriately.
3.9	In response to the above NED-HH stated it was important when discussing learning from deaths to also discuss embedding the learning but also the monitoring moving forward. The MD agreed and highlighted that a development session taking place that afternoon would reflect on the use of SPC charts to achieve early warning of special cause variation.
3.10	The TC thanked the MD for her update and looked forward to receiving the revised mortality data and seeing the changes to approach.
3.3 Maternity	
3.11	The DoN&M presented this item and reminded colleagues it was a requirement following the Ockenden Report for Board's to be sighted on Maternity SIs, themes and actions. A more detailed paper was presented to QSC which provided additional detail on individual cases.
3.12	The DoN&M drew members' attention to the section which detailed the outcome of the external review which had been commissioned into a cluster of incidents in Autumn 2020 and that no overarching themes had been found to link any of the cases, albeit there were some individual areas for improvement and learning.
3.13	The HCG had been fully engaged in the investigation process and were committed to learning and making improvements in the service.
3.14	As a final point she confirmed there had been an external stakeholder review of the cluster of incidents also at the beginning of March (including Commissioners, Regulators and the CQC) with a follow-up meeting to be held at the end of April when it was hoped actions could start to be closed down.
3.4 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
3.15	This update was also presented by the DoN&M and the paper was taken as read. She asked colleagues to note the organisation was returning to an improved fill rate (since January) after operating on minimum staffing levels during COVID. The ED had been in the region of 20% under-filled in February in line with the increase in nursing establishment in October and the separate footprint for Red ED and Samba. Overall, workforce vacancy figures were on trajectory to reduce down further and there remained a significant number of overseas nurses in the pipeline which it was hoped would support the organisation in achieving its 1% nursing vacancy rate over the coming year.
04 PEOPLE	
4.1 Staff Survey Results and Improvement Plan	
4.1	This update was presented by the DoP and the paper provided an overview of the 2020 PAHT NHS staff survey final results and an initial comparison to results from previous years. The final 2020 response rate for the Trust had been 38.2%, a 6.8% decrease to that of 2019. Medicine HCG was the only HCG to achieve a small increase in response. In terms of results: • Historical comparison: Only 1 question scored significantly better than last year, and 24 questions scored significantly worse. • Comparison with average: There were no questions that scored significantly better than last year, and 55 that scored significantly worse. • The national benchmarking report covered the 280 NHS organisations which took part in the 2020 survey, and showed how the Trust compared against 10 key 'themes'.

	The paper also set out the Trust's response plan, including the sharing of results, PAHT's three improvement priorities and development of corporate, HCG and divisional improvement/action plans.
4.2	In summary the results had been disappointing and improvements needed to be made, particularly in the area of staff health and wellbeing.
4.3	In response to the above NED-HH updated that the results had been discussed in detail at WFC and it had been hugely disappointing to note them, particularly (as stated above) in the area of staff health and wellbeing and all that had been provided to staff during the pandemic. NED-JH stated he had been surprised too and particularly that staff felt undervalued. It might be that the results were not a true reflection of the feeling, given so few had responded.
4.4	In response the DoP stated that staff too had been surprised by the results. It may have been the case that staff enjoying an average or good experience had not felt the need to complete the survey. The CEO agreed that was a possibility however, there were clearly a large number of people who had not had a good experience and that needed to be addressed.
4.5	In response to a comment from NED-PC in terms of the availability of an 'app' to support the receipt of real time data, the Chief Information Officer (CIO) confirmed that was something to be pursued and there were a number of initiatives the organisation was currently discussing not only in terms of feedback but also in terms of messaging to staff.
4.6	In response to the above NED-HG agreed that messaging was critical and often staff were sceptical that surveys were not anonymous. She felt it would be important to be clear to staff that the results were prompting actions/improvements and if technology could be used to support that then she would very much welcome it.
4.7	NED-GW commented that the request from the Staff Story earlier in the meeting for those nurses to attend an EMT would be useful in gaining a perspective on staff feeling and what could be done to make improvements.
4.8	The Board noted the staff survey results and approved response plans.
4.2 Gender Pay Gap	
4.9	This item was presented by the DoP and key headlines from the 31.03.20 report showed: - The average mean hourly rate was 27% lower for women (28% in 2019). - The average median hourly rate was 21% lower for women (22% in 2019) a continuous decrease year on year. - Agenda for change staff, (which excluded medical and dental, but included very senior managers (VSMs), mean gap showed women earned 5% less than men and median gap was in favour for women earning more. - Medical and dental mean and median gap was 13% and 20% in favour for men.
4.10	The discussion at WFC had centred around the organisation's people processes, efforts being made to attract women into jobs and flexible working. COVID had shown that services could still be delivered and in an agile way.
4.11	In response to a comment by NED-AWS the DoP agreed that absolutely flexible working would be key moving forward to attract more women into roles. In response to a question raised by NED-JH it was confirmed the report was not about equal pay for equal work but about looking at the causes of why women worked part-time or flexible hours. The mandatory requirement was for the Trust to report its gender pay gap. What the organisation now needed to do was to delve deeper into the data, particularly in terms of pay distribution by gender (table 7) to understand the driving force behind the data and why the majority of upper pay quartiles generally comprised men. In response NED-HH highlighted that many NHS staff were female which distorted the figures. In response to a further point made by NED-HH it was agreed that the DoP would reflect on staff members (who were carers) becoming part of the Trust's Carers' Group (to extend its support to staff). That would also align with some national work underway to support anyone who was a carer in the workplace.
ACTION TB1.01.04.21/06	Consider including staff members who are carers, in the Trust Carers Group. Lead: Director of People

4.12	The Board approved the report for publication on its website to include an addendum in terms of its actions to address the gap.
05 PERFORMANCE	
5.1 Integrated Performance Report M12	
5.1	By way of context the CIO informed colleagues that work was underway to revise the IPR and to move towards the use of SPC charts to represent performance against KPIs. He cautioned that SPCs would not work in all areas (e.g. complaints) and it would be the intention the following month to issue a shadow IPR in the new format. It was hoped moving forward that the IPR would better show the direction of travel and the better use of data to identify areas of risk.
5.2	The COO then took colleagues through the individual sections of the report. In terms of the Patient section NED-HG drew members' attention to the fact that hand hygiene compliance appeared to be evidencing 100% but that did not match the accompanying narrative and some wards had not submitted their data. She agreed that could be picked up at QSC.
5.3	In terms of the People section the DoP informed colleagues there would be a renewed focus on staff appraisal (a previous CQC concern). Members had no comments in relation to the Place section.
5.4	The COO updated colleagues on the Performance section and that with the full opening of the new AAU, teams would take the opportunity over coming weeks to review pathways, the Frailty Service and discharge/planning processes. There had been a detailed presentation to QSC the previous week around discharge, and following a conversation with NED-GW she would pick in more detail the following month in terms of the organisation's approach to length of stay and stranded patients.
5.5	The DoF then updated colleagues in terms of the Pounds section and that the M11 deficit had been £100k, which was £200k better than plan. The reason for that had been the receipt of more income than planned, with more to come in March too following a submission for lost income and annual leave accrual. Expenditure had shown a slight rise due to the opening of the new AAU. The Trust remained on track to achieve its year-end financial plan of £400k deficit. In terms of capital, spend to date was £27.8m with the organisation on track to spend the balance and its CRL by financial year-end. Cash balances remained buoyant but were likely to start to reduce moving into the new year.
5.6	In response to a question from NED-JH, members were informed that a decision had been taken at Strategic Cell/People Cell that staff would not be able to 'sell' back any accrued annual leave, but they would be able to carry over up to 20 days into the coming year.
06 PLACES	
6.1 New Hospital Programme	
6.1	The CEO presented this item and updated that the project team continued to make huge progress and the programme remained on track. There had been a significant amount of work and engagement with clinical teams to review the layout of the new building and a third iteration of the Schedule of Accommodation (SoA) had been drawn up with another likely in the next couple of weeks. Work continued with surveyors/engineers in terms of modern methods of construction (MMC) to ensure every bit of space was used effectively.
6.2	The CEO reminded colleagues the Board had committed funding for enabling works and the team would be working in conjunction with Essex Council County on that to ensure all works were aligned. Engagement continued at a national level in terms of the national programme team and a meeting had been scheduled for all HIP1 schemes to meet with national colleagues to talk through numbers and cost base. Work remained on target to submit the OBC in October following Board approval.
6.3	In relation to public engagement the CEO continued that two successful 'town hall' events had been held with more planned for May/June. It was evident from social media hits that engagement had been wide and successful in line with the organisation's previous commitment around that.

07 GOVERNANCE	
7.1 Reports from Committees	
7.1	The TC asked Committee Chairs whether they had anything additional to add following submission of their reports. In response NED-HG informed colleagues that QSC had requested a schedule of 'feeder group' meetings be established so that NEDs could dip in and out of the meetings (as observers).
7.2	As the meeting of the Workforce Committee (WFC) had only taken place that week, NED-HH provided a verbal update to colleagues. Topics that had been discussed had included the GMC Survey, from which a Medicines action plan had been drawn up. There had been some positive work undertaken by the junior doctors in terms of supporting each other (webinars/stress relieving sessions) and the gender pay gap report had also been discussed. The Committee had supported QSC in terms of agreement to reduce the COVID BAF risk score from 16 to 12 and a discussion had taken place around the Trust's refreshed values. The fantastic work of the SHAW team during COVID/vaccination roll-out had been recognised along with the recovery programme now in place for staff.
7.3	The remaining reports from committees were noted.
08 QUESTIONS FROM THE PUBLIC	
8.1	There were no questions from the member of public present.
09 CLOSING ADMINISTRATION	
9.1 Summary of Actions and Decisions	
9.1	These are presented in the shaded boxes above.
9.2 New Issues/Risks	
9.2	The risk in relation to the current uncertainty around ICS boundaries would now be drawn up.
9.3 Any Other Business (AOB)	
9.3	In response to a question from ANED-AWS, the CEO confirmed that members of the public were very welcome to attend the public session of the Board meeting and had the opportunity to submit questions in advance. Historically very few members of the public attended despite efforts to advertise meetings widely. He agreed to discuss with ANED-AWS outside the meeting how (as a local resident) she might support that work.
9.4 Reflection on Meeting	
9.4	Not undertaken.

Signed as a correct record of the meeting:

Date:	03.06.21
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

**Trust Board Meeting in Public
Action Log - 11.06.21**

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.01.04.21/01	International Nurses	Invite the 'April Staff Story' international nurses to a future EMT.	HoCA	TB1.11.06.21	Actioned.	Closed
TB1.01.04.21/02	Lateral Flow Testing	Confirm the legal responsibilities in terms of lateral flow testing (and reporting of results) and who that lies with.	DoQI	TB1.11.06.21	Verbal update to be provided.	Open
TB1.01.04.21/03	Corporate Risk Register	Provide a timeline for the work to establish a Corporate Risk Register.	DoN&M	TB1.11.06.21	End of July 2021.	Proposed for closure
TB1.01.04.21/04	Board Development Session - Risk	Schedule a Board development session on risk.	HoCA	TB1.11.06.21	Actioned. Session to be held on 01.07.21, hosted by NHS Providers.	Closed
TB1.01.04.21/05	New BAF Risk	Work up a new risk to capture the current uncertainty and risk related to the potential change of ICS boundaries.	HoCA DoS	TB1.11.06.21	Draft risk discussed at EMT.25.05.21 and to be discussed in private Board on 11.06.21.	Open
TB1.01.04.21/06	Trust Carers' Group	Consider including staff members who are carers, in the Trust Carers' Group.	DoP	TB1.11.06.21	Messages put out to staff in In-Touch and also via staff brief and in global emails inviting people to join virtual and in person carers' groups run by staff members.	Proposed for closure

Trust Board

11 June 2021

Agenda item:	2.1																
Presented by:	Saba Sadiq, Director of Finance																
Prepared by:	Adrian Buggle, Interim Deputy Director of Finance Colin Forsyth, Head of Financial Services																
Date prepared:	7 th June 2021																
Subject / title:	2020/21 Annual Report and Accounts for Approval																
Purpose:	Approval	x	Decision	x	Information	x	Assurance	x									
Key issues:	The purpose of this paper is to present, for approval, the audited 2020/21 Annual Report and Accounts to the Audit Committee and then the Trust Board. The document will need to be signed off by the Trust Chair, Audit Committee Chair, CEO and DoF once formal approvals have been obtained. Once signed these will be uploaded to the NHSE/I portal on 15th June 2021. The work that EY has completed on the annual report and accounts anticipates issuing a qualified audit opinion on the basis of a limitation of audit scope on the inventory balance as at 31 March 2020 which impacts on their 2020/21 opinion (as the comparator balance is included in the accounts). No other significant issues have been identified from the external audit process, although minor presentational issues have been identified (see appendix 2). The reported financial performance for the Trust in the audited accounts is: <table><tr><td>Revenue</td><td>£1,816k</td><td>surplus</td></tr><tr><td>Capital resource limit (CRL)</td><td>£0</td><td>breakeven</td></tr><tr><td>External financing limit (EFL)</td><td>£0</td><td>breakeven</td></tr></table>								Revenue	£1,816k	surplus	Capital resource limit (CRL)	£0	breakeven	External financing limit (EFL)	£0	breakeven
Revenue	£1,816k	surplus															
Capital resource limit (CRL)	£0	breakeven															
External financing limit (EFL)	£0	breakeven															
Recommendation:	The Audit Committee and the Trust Board approve the Trust's 20/21 Annual Report and Accounts so that designated Trust officers can sign the documents.																
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	 Patients x	 People x	 Performance x	 Places x	 Pounds x												
Previously considered by:	Extraordinary Audit Committee – 11.06.21																
Risk / links with the BAF:	BAF 5.1 require to breakeven and ensure sufficient cash resources																
Legislation, regulatory, equality, diversity and dignity implications:	The Board of Directors are required under the National Health Act 2006 to prepare Accounts for each financial year.																
Appendices:	Appendix 1 – Final Audited Accounts Appendix 2 – Amendments made to original draft accounts Appendix 3 – Letter of representation																

**The Princess Alexandra Hospital NHS Trust
Annual Accounts for year ended
31 March 2021**

**The Princess Alexandra Hospital NHS Trust
Annual Accounts 2020/21**

2.1

Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Chief Executive _____

Date _____

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

2.1

Statement of Directors' responsibilities in respect of the Accounts

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the Directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the Accounts; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The Directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Trust's performance, business model and strategy

By order of the Board

Chief Executive _____

Date _____

Finance Director _____

Date _____

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

2.1

Independent Auditor's Report To The Directors Of The Princess Alexandra Hospital NHS Trust

Qualified Opinion

We have audited the financial statements of The Princess Alexandra Hospital NHS Trust for the year ended 31 March 2021 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 36. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2020/21 HM Treasury's Financial Reporting Manual (the 2020/21 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2020/21 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion, except for the possible effects of the matter described in the basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of The Princess Alexandra Hospital NHS Trust as at 31 March 2021 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the Accounts Directions issued thereunder.

Basis for qualified opinion

Due to the restrictions on movement imposed as a result of the Coronavirus pandemic, in 2019/20 the Trust was unable to undertake, and we were unable to observe, the counting of physical inventories at the beginning of the year. We were unable to satisfy ourselves by alternative means concerning the inventory quantities held at 31 March 2020, which are included as comparatives in the balance sheet at £4.565 million, by using other audit procedures. Consequently, we were unable to determine whether any adjustment to this amount was necessary.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of 12 months to 30 June 2022 from when the financial statements are authorised for issue.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

2.1

Independent Auditor's Report To The Directors Of The Princess Alexandra Hospital NHS Trust (continued)

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

As described in the basis for qualified opinion section of our report, we were unable to satisfy ourselves concerning the comparative inventory quantities of £4.565million held at 31 March 2020. We have concluded that where the other information refers to the comparative inventory balance or related balances, it may be materially misstated for the same reason.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in these respects.

**The Princess Alexandra Hospital NHS Trust
Annual Accounts 2020/21**

2.1

**Independent Auditor's Report To The Directors Of The Princess Alexandra Hospital NHS Trust
(continued)**

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 3, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they either intend to cease operations, or has no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State and for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), as well as relevant employment laws of the United Kingdom. In addition, the Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.

We understood how The Princess Alexandra Hospital NHS Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Trust's board minutes, through enquiry of employees to verify Trust policies, and through the inspection of HR Policies and other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.

**The Princess Alexandra Hospital NHS Trust
Annual Accounts 2020/21**

2.1

Independent Auditor's Report To The Directors Of The Princess Alexandra Hospital NHS Trust (continued)

We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance (through improper recognition of revenue), inappropriate capitalisation of revenue expenditure and management override of controls to be our fraud risks.

To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue, we reviewed the Trust's manual year end receivable and payable accruals, challenging assumptions and corroborating the income and expenditure to appropriate evidence. We tested year-end cut-of arrangements by selecting samples of income and expenditure from either side of the 31 March 2021 balance sheet date and reviewing to supporting evidence to ensure these were recorded in the appropriate financial year. We also undertook cut-off testing of expenditure as at month 6 of the financial year to establish whether the Trust had incorrectly included expenditure relating to later months that would trigger Reimbursement and top-up funding for that period of the financial year that it would otherwise not be entitled to.

To address our fraud risk of inappropriate capitalisation of revenue expenditure we tested the Trust's capitalised expenditure to ensure the capitalisation criteria were properly met and the expenditure was genuine.

To address our fraud risk of management override of controls, we tested specific journal entries identified by applying risk criteria to the population of manual journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were appropriate.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at <https://www.frc.org.uk/auditorsresponsibilities>. This description forms part of our auditor's report.

To address our fraud risk of management override of controls, we tested specific journal entries identified by applying risk criteria to the population of manual journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were appropriate.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at <https://www.frc.org.uk/auditorsresponsibilities>. This description forms part of our auditor's report.

Independent Auditor's Report To The Directors Of The Princess Alexandra Hospital NHS Trust (continued)

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in April 2021, as to whether the Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of The Princess Alexandra Hospital NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Directors of The Princess Alexandra Hospital NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Debbie Hanson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Luton
XX June 2021

The Princess Alexandra Hospital NHS Trust
Annual Accounts 2020/21

Statement of Comprehensive Income

		2020/21	2019/20
	Note	£000's	£000's
Operating income from patient care activities	3	267,835	246,747
Other operating income	4	47,287	41,744
Operating expenses	6	(308,104)	(286,048)
Operating surplus from continuing operations		7,018	2,443
Finance income	11	-	85
Finance expenses	12	(18)	(2,032)
PDC dividends payable	22	(3,034)	-
Net finance costs		(3,052)	(1,947)
Surplus for the year from continuing operations		3,966	496
Other comprehensive income			
Revaluations		-	613
Other recognised gains and losses		1	117
Total comprehensive income for the period		1	730
Adjusted financial performance (control total basis):			
Surplus for the period		3,966	496
Net impairments not scoring to DHSC expenditure limit		341	-
Net impact of inventories received from DHSC for COVID response		(655)	-
Remove I&E impact of capital grants and donations		(1,836)	(78)
Remove 2018/19 post audit PSF reallocation		-	(368)
Adjusted financial performance surplus		1,816	50

The Princess Alexandra Hospital NHS Trust
Annual Accounts 2020/21

Statement of Financial Position

		31 March 2021 £000's	31 March 2020 £000's
	Note		
Non-current assets			
Intangible assets	14	7,169	7,633
Property, plant and equipment	15	137,845	117,405
Receivables	18	1,189	692
Total non-current assets		146,203	125,730
Current assets			
Inventories	17	5,697	4,565
Receivables	18	8,381	49,837
Cash and cash equivalents	19	65,242	1,144
Total current assets		79,320	55,546
Current liabilities			
Trade and other payables	20	(49,070)	(27,068)
Borrowings	22	(30)	(150,958)
Provisions	24	(1,142)	(1,186)
Other liabilities	21	(2,180)	(1,158)
Total current liabilities		(52,422)	(180,370)
Total assets less current liabilities		173,101	906
Non-current liabilities			
Borrowings	22	(10)	(40)
Provisions	24	(1,077)	(767)
Total non-current liabilities		(1,087)	(807)
Total assets employed		172,014	99
Financed by			
Public dividend capital		320,559	133,863
Revaluation reserve		591	19,343
Income and expenditure reserve		(149,136)	(153,107)
Total taxpayers' equity		172,014	99

The notes on pages 13 to 49 form part of these accounts.

Chief Executive

Date

The Princess Alexandra Hospital NHS Trust
Annual Accounts 2020/21

2.1

Statement of Changes in Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000's	£000's	£000's	£000's
Taxpayers' equity at 1 April 2020	133,863	19,343	(153,107)	99
Surplus for the year	-	-	3,966	3,966
Other transfers between reserves	-	(5)	5	-
Impairments	-	(18,748)	-	(18,748)
Revaluations	-	-	-	-
Other recognised gains and losses	-	1	-	1
Public dividend capital received	186,696	-	-	186,696
Taxpayers' equity at 31 March 2021	320,559	591	(149,136)	172,014
Taxpayers' equity at 1 April 2019	130,918	18,626	(153,616)	(4,072)
Surplus for the year	-	-	496	496
Other transfers between reserves	-	(13)	13	-
Revaluations	-	613	-	613
Other recognised gains and losses	-	117	-	117
Public dividend capital received	2,945	-	-	2,945
Taxpayers' equity at 31 March 2020	133,863	19,343	(153,107)	99

Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the Public Dividend Capital.

Income and Expenditure Reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Revaluation Reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

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Statement of Cash Flows

	Note	2020/21 £000's	2019/20 £000's
Cash flows from operating activities			
Operating surplus		7,018	2,443
Non-cash income and expense:			
Depreciation and amortisation	6	10,451	9,385
Net impairments	7	341	-
Income recognised in respect of capital donations	4	(1,857)	(98)
Decrease / (increase) in receivables and other assets		41,230	(30,746)
Increase in inventories		(1,132)	(50)
Increase in payables and other liabilities		11,374	3,989
Increase in provisions		273	1,015
Net cash flows from / (used in) operating activities		67,698	(14,062)
Cash flows from investing activities			
Interest received		4	85
Purchase of intangible assets		(446)	(522)
Purchase of PPE and investment property		(35,562)	(13,042)
Net cash flows from / (used in) investing activities		(36,004)	(13,479)
Cash flows from financing activities			
Public dividend capital received		186,696	2,945
Movement on loans from DHSC		(150,467)	26,511
Capital element of finance lease rental payments		(30)	(20)
Interest on loans		(461)	(1,937)
PDC dividend paid		(3,309)	-
Cash flows used in other financing activities		(25)	(11)
Net cash flows from financing activities		32,404	27,488
Increase / (decrease) in cash and cash equivalents		64,098	(53)
Cash and cash equivalents at 1 April		1,144	1,197
Cash and cash equivalents at 31 March	19	65,242	1,144

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis, in accordance with the definition as set out in section 4 of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) which outlines the interpretation of IAS1 'Presentation of Financial Statements' as "the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents".

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the Hertfordshire and West Essex Integrated Care System (ICS). The ICS has published its Strategic Delivery Plan and NHS Long Term Plan response for the five year period 2020/21 - 2024/25 and this plan includes the continued provision of services by the Trust. In addition, the Trust continues to develop an Outline Business Case to build a new hospital, which is being supported by a variety of stakeholders. No circumstances were identified causing the Directors to doubt the continued provision of NHS services.

For the 2020/21 financial year, the Trust achieved a surplus of £1.8m against a planned deficit of £0.4m. Income from our local Clinical Commissioning Groups was largely based on the adapted finance regime introduced in response to the COVID-19 pandemic and this provided predictability and improved cash flow with the Trust finishing the year with a £65.2m cash balance. Additional costs arising from the pandemic were reimbursed in the first half the year and incorporated into a block payment basis for the second half of the year.

In April 2020, the DHSC and NHS England and NHS Improvement (NHSE/I) announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow their repayment. Consequently, the Trust received PDC of £146.2m to repay these loans which had accumulated from prior year deficits. In addition, capital loans of £4.3m were also extinguished and replaced with PDC and therefore total net assets increased by £150.5m. This strengthened the value of the Trust's Statement of Financial Position and means that the Trust is no longer required to generate surpluses to service this historic debt.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

For 2021/22 the current financial funding arrangements will remain in place for the first half of the year, with additional funding to support elective recovery post COVID.

The going concern assessment is made up to 31 March 2022. The national financial arrangements for the second half of the year are not fully known at this stage and while the implications of COVID-19 should be greatly reduced, there is likely to be some ongoing effect and, potentially, additional funding for this. The Trust's income is largely based on commissioner block contracts which will continue throughout the second half of the year. Reducing the Trust's underlying cost base and increasing efficiencies is essential with the focus on delivering a cost-improvement programme of £6.7m (or 2.2%). In 2019/20, the Trust achieved £9.9m (or 3.4%) of cost improvements and therefore is reasonably assured of the achievability of this target.

The Trust has prepared a cash forecast modelled on the above expectations for funding during the going concern period to 30 June 2022. The cash forecast shows sufficient liquidity for the Trust to continue to operate during that period with no need to borrow. In addition, the Trust has access to working capital arrangements should the need for this arise. In conclusion, these factors, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

Note 1.2 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors considered relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which both the estimate is revised if the revisions affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- Adoption of the going concern basis (see note 1.1.2)
- Classification of leases as finance or operating leases. Leases have been reviewed to determine if they are classified as operating or finance leases in line with IAS17. Critical judgements include whether the ownership transfers at the end of the term, the level of risk transfer, whether the lease term is for a major part of the economic life of the asset and whether the present value of the minimum lease payment is substantially all of the fair value of the asset.

Department of Health and Social Care guidance specifies that the Trust's land and buildings should be valued on the basis of depreciated replacement cost, applying the Modern Equivalent Asset (MEA) concept. The MEA is defined as "the cost of a modern replacement asset that has the same productive capacity as the property being valued." Therefore the MEA is not a valuation of the existing land and buildings that the Trust holds, but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets. The MEA valuation approach continues to be adopted by the Trust (Note 1.7.2). The Valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. The valuation is not reported as being subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICS Valuation.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.2.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Provisions (Note 24)

Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date where the liability meets the recognition criteria of IAS 37. These are based on judgements and estimates of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made.

Public liability claims are based on information received from the NHS Resolution (NHSR, previously NHS Litigation Authority) which handles claims on behalf of the Trust. For cases not yet concluded, provision, or contingent liability, is made according to NHSR assessment of expected outcomes.

Pensions provisions are based on information received from NHS Pension Agency (part of NHS Business Services Authority).

Other provisions for legal and constructive obligations (including employment) are made by management, and informed by professional opinion. Provisions are made where past events are known and settlement by the Trust is probable and a reliable estimate can be made. As actual settlement is not known at the reporting date provisions are calculated on the best information available on likely settlement at the date the Accounts are approved.

Accruals

At the end of each accounting period management review expenditure items that are outstanding and estimate the amount to be accrued in financial statements. Accruals are generally based on estimates and judgements of historical trends and outcomes. Any variation in prior periods has not been material to the Accounts.

Inventories

In 2019/20 the Trust was unable to perform a complete stocktake of all inventory items, specifically the impact of COVID led to an inability to access some clinical areas e.g. Theatres. For those areas not counted in 2019/20 the Trust performed a mid year stocktake count during September 2021. In addition, during March 2021 the Trust has re-performed a full inventory count of all inventory held. To ensure completeness and accuracy of inventory verification this exercise was supported by a suitably qualified third party. The final value of the stockholding was £5.7m. This compares to the previous calculated stock value of £4.6m. The increase in inventory includes consumables and drugs increases totalling £0.5m. In addition during 2020/21, and as part of the response to COVID the Trust received 'Push' deliveries of Personal Protective Equipment (PPE). The cost of this PPE was funded centrally with the closing stock of PPE inventory recorded as held by the Trust. The value of this stock is £0.6m.

Note 1.3 Charitable funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. IAS 1 states that specific disclosure requirements as set out in individual standards or interpretations need not be satisfied if the information is not material, and on that basis the Trust has not consolidated its Charitable Funds.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.4 Revenue

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

Current Year (2020/21)

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient.

Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

For 2020/21 and 2019/20

Where the effects of practical expedients mandated by the GAM are material, these should be disclosed as accounting policies. These include: (1) As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. (2) The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date. (3) The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF)

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration. A revised financial regime was established for 2020/21 and PSF and PRF were not included within the revised regime.

Note 1.4.2 Other income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs - NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item costs at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually cost more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

The valuation exercise was carried out from 13 January 2021 to 31 March 2021 with the valuation date being 31 March 2021. Valuations were undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted, and applied by the HMT Treasury FReM compliant with Department of Health Group Manual for Accounts. They are also prepared in accordance with the professional standards of the Royal Institution of Chartered Surveyors: RICS Valuation - Global Standards 2017 and RICS UK National Supplement, commonly known together as the 'Red Book'.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Impact of COVID-19 on valuation

In applying the RICS Valuation Global Standards the valuer has recognised the outbreak of the COVID-19 pandemic on the 11 March 2020. The valuer recognises the pandemic, and the measures taken to tackle COVID-19 continue to affect economies and real estate market. Nevertheless, as at the valuation date some property markets have started to function again, with transaction volumes and other relevant evidence returning to levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly, and for the avoidance of doubt, the valuer's valuation is not reported as subject to 'material uncertainty' as defined by the RICS valuation - global standard.

In respect of the total value of estate, being the aggregate of current values, including depreciated replacement cost, of operating properties, the fair values of non-operational properties and excluding leased properties as at 31 March 2021 may be taken to be £89.985m. These values can be apportioned between land £8.150m and buildings £81.835m. On the basis, and for the reasons outlined above, the Board of Directors are content that the valuation used is reasonable and materially valid.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.7.5 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings	15	30
Plant & machinery	5	15
Transport equipment	3	7
Information technology	5	8
Furniture & fittings	5	15

Finance leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus, with no plan to bring it back into use, is valued at fair value where there are no restrictions on sale at the reporting date, and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	5	8
Development expenditure	8	8

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

In 2020/21, the Trust received push inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office of National Statistics (ONS).

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Note 1.11.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below:

- Financial assets are classified as fair value through income and expenditure.
- Financial liabilities classified as fair value through income and expenditure.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On de-recognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive Income.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to a 12 month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit loss if the credit risk assessed for the financial asset significantly increases (stage 2).

All outstanding non-NHS receivables over one year old are included in the credit loss allowance. Any receivable relating to prescription charges that are over six months old plus any receivable where the Trust considers there to be a high risk of being uncollectable are included. The amount included for Injury Cost Recovery receivables follows the DHSC GAM guidance (an allowance of 22.43% of outstanding receivables is included - was previously 21.79% in 2019/20).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.3 De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as Lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted as an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.12.1 The Trust as lessee

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.12.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating lease

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury. The discounted rate used by the Trust for Early Retirements is minus 0.95% in real terms (2019/20 rate was minus 0.50%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.14 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public Dividend Capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at

<https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.18 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

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Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.18 Foreign exchange (continued)

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the Accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the Accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

Notes to the Accounts

Note 1. Accounting policies and other information (continued)

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

In light of COVID-19 pressures, HM Treasury and the Financial Reporting Advisory Board (FRAB) have decided that IFRS 16 implementation in the public sector will be deferred until 2021/22.

Note 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

**The Princess Alexandra Hospital NHS Trust
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Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted (cont.)

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000's
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	18,492
Net impact on net assets on 1 April 2022	18,492
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(1,450)
Additional finance costs on lease liabilities	(216)
Lease rentals no longer charged to operating expenditure	1,484
Estimated impact on surplus / deficit in 2022/23	(182)

Note 2. Operating Segments

The nature of the Trust's services is the provision of healthcare. Similar methods are used to provide services across locations, since all policies, procedures and governance arrangements are Trust wide. As a Trust, all services are subject to the same regulatory environment and standards set out by our external performance managers. Accordingly the Trust operates one segment.

Note 3. Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Note 3.1 Income from patient care activities (by nature)	2020/21 £000's	2019/20 £000's
Acute Services		
Block contract / system envelope income*	255,169	222,400
High cost drugs income from commissioners (excluding pass-through costs)	1,631	14,077
Other NHS clinical income	1,923	912
All services		
Private patient income	175	290
Additional pension contribution central funding**	7,061	6,440
Other clinical income	1,876	2,628
Total patient income from activities	267,835	246,747

*As part of the COVID pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

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Note 3.2 Income from patient care activities (by source)

	2020/21 £000's	2019/20 £000's
Income from patient care activities received from:		
NHS England	29,662	29,937
Clinical commissioning groups	236,425	215,150
Department of Health and Social Care	22	27
Other NHS providers	955	490
NHS other	1	103
Local authorities	-	19
Non-NHS: private patients	175	290
Non-NHS: overseas patients (chargeable to patient)	100	93
Injury cost recovery scheme	495	638
Total income from activities	267,835	246,747

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2020/21 £000's	2019/20 £000's
Income recognised this year	100	93
Cash payments received in-year	92	43
Amounts added to provision for impairment of receivables	199	38
Amounts written off in-year	1	1

Note 4. Other operating income

	2020/21 £000's	2019/20 £000's
Other operating income from contracts with customers		
Research and development	543	632
Education and training	7,644	6,772
Non-patient care services to other bodies	2,782	2,706
Provider sustainability fund (2019/20 only)	-	5,787
Financial recovery fund (2019/20 only)	-	21,829
Marginal rate emergency tariff funding (2019/20 only)	-	548
Reimbursement and top up funding	27,454	
Other income	1,318	3,271
Other non-contract operating income		
Receipt of capital grants and donations	1,857	98
Charitable and other contributions to expenditure	4,888	-
Rental revenue from operating leases	801	101
Total other operating income	47,287	41,744

Note 5. Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21 £000's	2019/20 £000's
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	613	656

The Princess Alexandra Hospital NHS Trust
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Note 6. Operating expenses

	2020/21	2019/20
	£000's	£000's
Purchase of healthcare from NHS and DHSC bodies	2,426	4,741
Purchase of healthcare from non-NHS and non-DHSC bodies	4,768	3,880
Staff and executive directors costs	203,722	193,119
Remuneration of non-executive directors	114	94
Supplies and services - clinical (excluding drugs costs)	22,152	19,864
Supplies and services - general	3,133	3,395
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	21,087	20,189
Consultancy and professional services	3,419	3,532
Establishment	2,249	1,618
Premises	14,219	10,328
Transport (including patient travel)	652	816
Depreciation on property, plant and equipment	8,520	7,494
Amortisation on intangible assets	1,931	1,891
Net impairments	341	-
Movement in credit loss allowance: contract receivables / contract assets	526	158
Change in provisions discount rate	5	7
Audit fees payable to the external auditor		
audit services - statutory audit	138	73
Internal audit costs	89	104
Clinical negligence	13,010	9,924
Legal fees	382	416
Insurance	165	117
Education and training	710	741
Rentals under operating leases	2,624	2,292
Redundancy	35	11
Car parking & security	802	459
Hospitality	12	1
Losses, ex gratia & special payments	297	73
Other external services	199	276
Other	377	435
Total	308,104	286,048

During 2020/21 some items of operating expenditure were impacted by the response to COVID-19. For some items of expenses this led to comparative increases in expenditure and in some cases expenditure reduced when compared to 2019/20.

Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2 million (2019/20: £2 million).

**The Princess Alexandra Hospital NHS Trust
Annual Accounts 2020/21**

Note 7. Impairment of assets

	2020/21 £000's	2019/20 £000's
Net impairments charged to operating surplus		
Changes in market price	341	-
Total net impairments charged to operating surplus	341	-
Impairments charged to the revaluation reserve	18,748	-
Total net impairments	19,089	-

Note 8. Employee benefits

	2020/21 £000's	2019/20 £000's
Salaries and wages	136,950	124,956
Social security costs	12,456	12,319
Apprenticeship levy	606	605
Employer's contributions to NHS pensions	23,171	21,144
Pension cost - other	36	35
Temporary staff (including agency)	33,141	35,865
Total gross staff costs	206,360	194,924
Total staff costs	206,360	194,924
Of which, included above		
Costs capitalised as part of assets	2,603	1,794
Redundancy	35	11
Total staff and executive directors costs	203,722	193,119

Note 8.1 Retirements due to ill-health

During 2020/21 there were three retirements from the Trust agreed on the grounds of ill-health (three in 2019/20). The estimated additional pension liabilities of these ill-health retirements is £147k (£151k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

The Princess Alexandra Hospital NHS Trust Annual Accounts 2020/21

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Note 9. Pension costs (continued)

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the

NEST Pension Scheme

Where staff are not eligible for, or choose to opt out of, the NHS Pensions Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme.

NEST is a government-backed, defined contribution pension scheme set up to make sure that every employer can easily access a workplace pension scheme. The employer's contribution rate in 2020/21 was 3% (2019/20: 3%)

The Princess Alexandra Hospital NHS Trust
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Note 10. Operating leases

Note 10.1 The Trust as a lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor.

	2020/21 £000's	2019/20 £000's
Operating lease revenue		
Minimum lease receipts	801	101
Total	801	101
	31 March 2021 £000's	31 March 2020 £000's
Future minimum lease receipts due:		
- not later than one year;	311	101
- later than one year and not later than five years;	247	247
- later than five years.	146	146
Total	704	494

Note 10.2 The Princess Alexandra Hospital NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where The Princess Alexandra Hospital NHS Trust is the lessee.

	2020/21 £000's	2019/20 £000's
Operating lease expense		
Minimum lease payments	2,624	2,292
Total	2,624	2,292
	31 March 2021 £000's	31 March 2020 £000's
Future minimum lease payments due:		
- not later than one year;	1,881	2,089
- later than one year and not later than five years;	6,381	6,942
- later than five years.	8,606	9,320
Total	16,868	18,351

Note 11. Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21 £000's	2019/20 £000's
Interest on bank accounts	-	85
Total finance income	-	85

**The Princess Alexandra Hospital NHS Trust
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Note 12. Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21 £000's	2019/20 £000's
Interest expense:		
Loans from the Department of Health and	-	2,019
Total interest expense	-	2,019
Unwinding of discount on provisions	(7)	2
Other finance costs	25	11
Total finance costs	18	2,032

Note 12.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

There were nil interest charges on late payments in 2020/21 (nil in 2019/20)

Note 13. Other gains / (losses)

There were no gains or losses from disposals of assets in 2020/21 (nil in 2019/20)

Note 14.1 Intangible assets - 2020/21

	Internally generated information technology £000's	Development expenditure £000's	Total £000's
Valuation / gross cost at 1 April 2020	116	15,295	15,411
Additions	1,467	-	1,467
Valuation / gross cost at 31 March 2021	1,583	15,295	16,878
Amortisation at 1 April 2020	36	7,742	7,778
Provided during the year	3	1,928	1,931
Amortisation at 31 March 2021	39	9,670	9,709
Net book value at 31 March 2021	1,544	5,625	7,169
Net book value at 1 April 2020	80	7,553	7,633

Note 14.2 Intangible assets - 2019/20

	Internally generated information technology £000's	Development expenditure £000's	Total £000's
Valuation / gross cost at 1 April 2019	48	14,860	14,908
Additions	68	435	503
Valuation / gross cost at 31 March 2020	116	15,295	15,411
Amortisation at 1 April 2019	21	5,866	5,887
Provided during the year	15	1,876	1,891
Amortisation at 31 March 2020	36	7,742	7,778
Net book value at 31 March 2020	80	7,553	7,633
Net book value at 1 April 2019	27	8,994	9,021

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Note 15.1 Property, plant and equipment - 2020/21	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Valuation/gross cost at 1 April 2020	8,150	80,176	11,637	28,028	279	21,480	1,169	150,919
Additions	-	9,762	25,018	9,064	-	4,169	36	48,049
Impairments	-	(19,089)	-	-	-	-	-	(19,089)
Reclassifications	-	17,340	-	(17,404)	64	-	-	-
Valuation/gross cost at 31 March 2021	8,150	88,189	36,655	19,688	343	25,649	1,205	179,879
Accumulated depreciation at 1 April 2020	-	569	-	19,701	109	12,011	1,124	33,514
Provided during the year	-	3,192	-	2,243	27	3,046	12	8,520
Accumulated depreciation at 31 March 2021	-	3,761	-	21,944	136	15,057	1,136	42,034
Net book value at 31 March 2021	8,150	84,428	36,655	(2,256)	207	10,592	69	137,845
Net book value at 1 April 2020	8,150	79,607	11,637	8,327	170	9,469	45	117,405
Note 15.2 Property, plant and equipment - 2019/20	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Valuation / gross cost at 1 April 2019	8,150	80,445	1,849	26,520	76	18,068	1,169	136,277
Additions	-	1,772	9,854	1,739	132	3,412	-	16,909
Revaluations	-	(2,107)	-	-	-	-	-	(2,107)
Reclassifications	-	66	(66)	(71)	71	-	-	-
Disposals / derecognition	-	-	-	(160)	-	-	-	(160)
Valuation/gross cost at 31 March 2020	8,150	80,176	11,637	28,028	279	21,480	1,169	150,919
Accumulated depreciation at 1 April 2019 - as previously stated	-	535	-	17,783	28	9,440	1,114	28,900
Provided during the year	-	2,754	-	2,149	10	2,571	10	7,494
Revaluations	-	(2,720)	-	-	-	-	-	(2,720)
Reclassifications	-	-	-	(71)	71	-	-	-
Disposals / derecognition	-	-	-	(160)	-	-	-	(160)
Accumulated depreciation at 31 March 2020	-	569	-	19,701	109	12,011	1,124	33,514
Net book value at 31 March 2020	8,150	79,607	11,637	8,327	170	9,469	45	117,405
Net book value at 1 April 2019	8,150	79,910	1,849	8,737	48	8,628	55	107,377

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Note 16.3 Property, plant and equipment financing - 2020/21

	Land £000's	Buildings excluding dwellings £000's	Assets under construction £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Net book value at 31 March 2021								
Owned - purchased	8,150	84,428	19,251	13,071	143	10,592	69	135,704
Finance leased	-	-	-	71	-	-	-	71
Owned - donated/granted	-	-	-	2,070	-	-	-	2,070
NBV total at 31 March 2021	8,150	84,428	19,251	15,212	143	10,592	69	137,845

Note 16.4 Property, plant and equipment financing - 2019/20

	Land £000's	Buildings excluding dwellings £000's	Assets under construction £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Net book value at 31 March 2020								
Owned - purchased	8,150	79,607	11,637	8,110	170	9,469	45	117,188
Finance leased	-	-	-	83	-	-	-	83
Owned - donated/granted	-	-	-	134	-	-	-	134
NBV total at 31 March 2020	8,150	79,607	11,637	8,327	170	9,469	45	117,405

Note 16.4 Donations of property, plant and equipment

The Trust did not receive any donated assets from The PAH NHS Trust Charitable Fund (Registered Charity No 10547745) during 2020/21 (2019/20 £98k).

Note 16.5 Revaluations of property, plant and equipment

The Trust has undertaken a revaluation of land and buildings as at 31 March 2021 (see note 1.7.2). This work was performed by Mr Giles Awford BSc (Hons) MRICS, Principal Surveyor, District Valuer Services (DVS), the specialist property arm of the Valuation Office Agency (VOA). The valuation has been undertaken in accordance with International Finance Reporting Standard (IFRS) as interpreted by the HM Financial Reporting Manual (FReM) compliant with the DHSC Group Manual for Accounts (DHSC GAM). The valuation approach continues to adopt the Modern Equivalent Asset (MEA) concept. DHSC guidance specifies that land and buildings should be valued on the basis of depreciated replacement cost, applying the MEA concept. MEA is defined as 'the cost of a modern replacement asset that has the same productive capacity as the property being valued'. Therefore MEA is not a valuation of the existing land and buildings that the Trust holds but a theoretical valuation for accounting purposes of what the Trust could need to spend in order to replace the current assets.

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Note 17. Inventories

	31 March 2021 £000's	31 March 2020 £000's
Drugs	1,668	1,451
Consumables	3,983	3,046
Energy	46	32
Other	-	36
Total inventories	5,697	4,565

Inventories recognised in expenses for the year were £34,467k (2019/20: £31,347k). Write-down of inventories recognised as expenses for the year were £0k (2019/20: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £4,888k of items purchased by DHSC, of which £655k was held as stock at 31 March 21. These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 18. Receivables

	31 March 2021 £000's	31 March 2020 £000's
Current		
Contract receivables	6,242	47,666
Allowance for impaired contract receivables / assets	(1,689)	(1,193)
Prepayments (non-PFI)	1,725	1,241
Interest receivable	-	4
PDC dividend receivable	275	-
VAT receivable	1,655	1,406
Other receivables	173	208
Total current receivables	8,381	49,332
Non-current		
Contract receivables	576	692
Other receivables	613	505
Total non-current receivables	1,189	1,197
Of which receivable from NHS and DHSC group bodies:		
Current	3,607	44,659
Non-current	613	505

Note 18.1 Allowances for credit losses

	2020/21 £000's	2019/20 £000's
Allowances as at 1 April - brought forward	1,193	1,066
New allowances arising	555	175
Reversals of allowances	(29)	(17)
Utilisation of allowances (write offs)	(30)	(31)
Allowances as at 31 March 2021	1,689	1,193

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Note 19. Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21 £000's	2019/20 £000's
At 1 April	1,144	1,197
Net change in year	64,098	(53)
At 31 March	65,242	1,144
Broken down into:		
Cash at commercial banks and in hand	12	22
Cash with the Government Banking Service	65,230	1,122
Total cash and cash equivalents as in SoFP / SoCF	65,242	1,144

Note 19.1 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	2020/21 £000's	2019/20 £000's
Bank balances	18	16
Total third party assets	18	16

Note 20. Trade and other payables

	31 March 2021 £000's	31 March 2020 £000's
Current		
Trade payables	7,545	8,598
Capital payables	18,407	6,757
Accruals	18,781	9,258
Social security costs	2,008	1,863
Other taxes payable	1,719	347
Other payables	610	245
Total current trade and other payables	49,070	27,068
Of which payables from NHS and DHSC group bodies:		
Current	3,562	4,663

Note 20.1 Early retirements in NHS payables above

There are no early retirements included in NHS payables (nil in 2019/20)

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Note 21. Other liabilities

	31 March 2021 £000's	31 March 2020 £000's
Current		
Deferred income: contract liabilities	2,180	1,158
Total other current liabilities	2,180	1,158

Note 22. Borrowings

	31 March 2021 £000's	31 March 2020 £000's
Current		
Loans from DHSC	-	150,928
Obligations under finance leases	30	30
Total current borrowings	30	150,958
Non-current		
Obligations under finance leases	10	40
Total non-current borrowings	10	40

Note 22.1 Reconciliation of liabilities arising from financing activities - 2020/21

	Loans £000's	Finance £000's	Total £000's
Carrying value at 1 April 2020	150,928	70	150,998
Cash movements:			
Payments and receipts of principal	(150,467)	(30)	(150,497)
Payments of interest	(461)	-	(461)
Carrying value at 31 March 2021	-	40	40

As part of the revised 2020/21 financial regime, all outstanding loans were converted to PDC and this has increased average net assets of the Trust. Interest was therefore not payable in 2020/21, but there was dividend payable of £3,034k.

Note 22.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans £000's	Finance £000's	Total £000's
Carrying value at 1 April 2019	124,335	-	124,335
Cash movements:			
Payments and receipts of principal	26,511	(20)	26,491
Payments of interest	(1,937)	-	(1,937)
Non-cash movements:			
Application of effective interest rate	2,019	-	2,019
Other changes	-	90	90
Carrying value at 31 March 2020	150,928	70	150,998

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Note 23. Finance leases

Note 23.1 The Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2021 £000's	31 March 2020 £000's
Gross lease liabilities	40	71
of which liabilities are due:		
not later than one year;	30	30
later than one year and not later than five years;	10	41
later than five years.	-	-
Finance charges allocated to future periods	-	(1)
Net lease liabilities	40	70
of which payable:		
not later than one year;	30	30
later than one year and not later than five years;	10	40
later than five years.	-	-

Note 24. Provisions for liabilities and charges analysis

	Pensions: early departure costs £000's	Legal claims £000's	Other £000's	Total £000's
At 1 April 2020	842	302	809	1,953
Change in the discount rate	2	-	3	5
Arising during the year	1	541	260	802
Utilised during the year	(70)	(10)	(134)	(214)
Reversed unused	(240)	(27)	(53)	(320)
Unwinding of discount	(4)	-	(3)	(7)
At 31 March 2021	531	806	882	2,219
Expected timing of cash flows:				
not later than one year;	67	806	269	1,142
later than one year and not later than five years;	266	-	613	879
later than five years.	198	-	-	198
Total	531	806	882	2,219

Note 25. Clinical negligence liabilities

At 31 March 2021 £121.1m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2020: £107.9m).

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Note 26. Contingent assets and liabilities

	31 March 2021 £000's	31 March 2020 £000's
Value of contingent liabilities		
NHS Resolution legal claims	(37)	(38)
Employment tribunal and other employee related litigation	(416)	(128)
Gross value of contingent liabilities	(453)	(166)

Note 27. Contractual capital commitments

	31 March 2021 £000's	31 March 2020 £000's
Property, plant and equipment	9,237	8,265
Total	9,237	8,265

Note 28. Financial instruments

Note 28.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking activities. Because of the continuing service provider relationship that the Trust has with Commissioners and the way Commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which financial reporting standards mainly apply.

The Trust's cash management operations are undertaken by the finance department within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust can borrow from the government for capital expenditure, subject to approval from NHS Improvement. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest charges at the national loans fund rate, fixed for the life of the loan.

The Trust can also borrow from the government for revenue support funding, subject to approval from NHS Improvement. Interest rates are confirmed by the lender (Department of Health and Social Care) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

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Note 28.1 Financial risk management (continued)

Credit risk

A majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk.

Liquidity risk

The Trust's operating costs are incurred under contracts with Commissioners, which are financed from resources voted annually by Parliament. The Trust mainly funds its capital from internally generated funds. The Trust is therefore not exposed to significant liquidity risks.

Note 28.2 Carrying values of financial assets

Carrying values of financial assets held at amortised cost	31 March 2021 £000's	31 March 2020 £000's
Trade and other receivables excluding non financial assets	5,915	47,377
Cash and cash equivalents	65,242	1,144
Total at 31 March	71,157	48,521

Note 28.3 Carrying values of financial liabilities

Carrying values of financial liabilities held at amortised cost	31 March 2021 £000's	31 March 2020 £000's
Loans from the Department of Health and Social Care	-	150,928
Obligations under finance leases	40	70
Trade and other payables excluding non financial liabilities	45,343	24,858
Total at 31 March	45,383	175,856

Note 28.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual

	31 March 2021 £000's	31 March 2020 £000's
In one year or less	45,373	175,816
In more than one year but not more than five years	10	41
In more than five years	-	-
Total	45,383	175,857

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 28.5 Fair values of financial assets and liabilities

The carrying value of financial liabilities is at book value (carrying value) as it is considered that this is a reasonable approximation of fair value.

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Note 29. Losses and special payments

	2020/21		2019/20	
	Total number of cases Number	Total value of cases £000's	Total number of cases Number	Total value of cases £000's
Losses				
Cash losses	-	-	2	4
Fruitless payments	2	126	-	-
Bad debts and claims abandoned	1,133	30	31	32
Stores losses and damage to property	3	47	3	33
Total losses	1,138	203	36	69
Special payments				
Compensation under court order or legally binding arbitration award	8	47	4	9
Ex-gratia payments	14	15	5	3
Total special payments	22	62	9	12
Total losses and special payments	1,160	265	45	81
Compensation payments received		0		0

Note 30. Related parties

In accordance with IAS 24 and paragraphs 5.179-5.183 of the GAM the Trust is required to disclose the main entities within the public sector that the Trust has had dealings with. The Department of Health and Social Care are regarded as a parent department. Related parties include:

- The Department of Health and Social Care
- Other NHS Providers
- CCGs and NHS England
- NHS West Essex
- NHS East and North Hertfordshire
- NHS England
- NHS Resolution
- NHS Business Service Authority
- Other Health Bodies and Government Departments
- HM Revenue and Customs
- NHS Blood and Transplant Service
- NHS Professionals
- NHS Pensions Agency
- NHS England and NHS Improvement
- Health Education England
- NHS Property Services
- Local Authorities

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Note 30. Related parties (continued)

All Board members and the most senior managers of the Trust with key controlling influence have been requested to confirm any material related party transactions, including any transactions of close family members. The Trust also maintains a hospitality and declaration of interest register.

Name of Related Party	Name of Trust Employee	Title of Trust Employee	Relationship with Related Party	Expenditure with related party £000's	Income from related party £000's	Amounts owed to related party £000's	Amounts due from related party £000's
Addenbrooke's Charitable Trust	Helen Howe	Associate Non-Executive Director	Trustee	0	0	0	0
Anglia Ruskin University	John Keddle	Non-Executive Director	Governor	145	24	142	0
Anglia Ruskin University	James McLeish	Director of Quality Improvement	Family member an employee	145	24	142	0
Care Quality Commission	Ahmed Soliman	Associate Medical Director - Urgent Care	Specialist Clinical Advisor	163	0	0	0
Holly House Hospital	John Hogan	Non-Executive Director	Private Practice	55	0	55	0
St Clare Hospice	Monica Bose	Consultant Gastroenterologist	Trustee	29	0	9	0
University of Suffolk	Steve Clarke	Chairman	Independent Director	0	0	0	0
East of England Ambulance Service	James McLeish	Director of Quality Improvement	Family member an employee	42	0	21	0
Barts Health NHS Trust	John Hogan	Non-Executive Director	Consultant Cardiologist	329	503	404	339

PAH NHS Trust Charitable funds (Registered Charity 10547745). The Trust receives revenue and capital payments from this charity and certain Trustees are also members of the Trust Board. The charity's objective is to provide support both generally and in certain areas of the Trust's activities. During the year the charity contributed £235k (unaudited) to the Trust (2019/20 £286k).

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Note 31. Prior Period Adjustments

There have been no prior period adjustments with IAS8 that has required restatement of comparative information due to either changes in accounting policy or material prior period error.

Note 32. Events after the reporting date

The Trust has no other adjusting events after the end of the reporting period. The Accounts were approved by the Board of Directors on 11 June 2021.

Note 33. Better Payment Practice code

	2020/21 Number	2020/21 £000's	2019/20 Number	2019/20 £000's
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	45,928	109,532	49,002	76,083
Total non-NHS trade invoices paid within target	39,957	92,948	43,722	64,320
Percentage of non-NHS trade invoices paid within target	87.0%	84.9%	89.2%	84.5%
NHS Payables				
Total NHS trade invoices paid in the year	2,296	53,313	2,227	56,446
Total NHS trade invoices paid within target	1,912	48,878	1,805	47,379
Percentage of NHS trade invoices paid within target	83.3%	91.7%	81.1%	83.9%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 34. External financing limit

The Trust is given an external financing limit against which it is permitted to underspend

	2020/21 £000's	2019/20 £000's
External financing limit (EFL)	(27,899)	30,083
Cashflow financing	(27,899)	29,489
Unadjusted EFL	-	594
Adjusted financial performance (management control total basis):		
CT Scanner funding deferred to 20/21 included in 19/20 limit		(447)
Underspend against EFL	-	147

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Note 35. Capital Resource Limit

	2020/21 £000's	2019/20 £000's
Gross capital expenditure	49,516	17,412
Less: Donated and granted capital additions	(1,857)	(98)
Charge against Capital Resource Limit	47,659	17,314
Capital Resource Limit	47,659	17,721
Unadjusted CRL	-	407
Adjusted financial performance (management control total)		
CT scanner funding deferred to 2020/21 included in 2019/20 limit	-	(447)
COVID CRL support for 2019/20 adjusted in 2020/21	-	509
Underspend against CRL	-	469

Note 36. Breakeven duty and financial performance

Note 36.1 Breakeven duty by Control Total

	Control Target £000's	Actual Outturn £000's	Under- spend £000's
Net Control Total - 2020/21	(391)	1,816	2,207
Net Control Total - 2019/20	(6,168)	50	6,218

Note 36.2 Breakeven duty financial performance

	2020/21 £000's
Adjusted financial performance surplus (control total basis)	1,816
Breakeven duty financial performance surplus	1,816

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Note 36.3. Breakeven duty rolling assessment

	1997/98 to £000's	2009/10 £000's	2010/11 £000's	2011/12 £000's	2012/13 £000's	2013/14 £000's	2014/15 £000's
Breakeven duty in-year financial performance		511	415	461	122	(16,403)	(21,998)
Breakeven duty cumulative position	1,536	2,047	2,462	2,923	3,045	(13,358)	(35,356)
Operating income		172,171	179,388	180,790	184,568	177,739	190,478
Cumulative breakeven position as a percentage of operating income		1.19%	1.37%	1.62%	1.65%	-7.52%	-18.56%

	2015/16 £000's	2016/17 £000's	2017/18 £000's	2018/19 £000's	2019/20 £000's	2020/21 £000's
Breakeven duty in-year financial performance	(37,714)	(26,715)	(28,435)	(16,542)	418	1,816
Breakeven duty cumulative position	(73,070)	(99,785)	(128,220)	(144,762)	(144,344)	(142,528)
Operating income	196,124	209,742	213,231	236,700	288,491	315,122
Cumulative breakeven position as a percentage of operating income	-37.26%	-47.58%	-60.13%	-61.16%	-50.03%	-45.23%

The amounts in the above tables in respect of 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

Appendix 2 – Schedule of changes: Draft to Final

Accounts and PFR				
Schedule of Changes from Draft Accounts				

TAC Ref	Accts Ref	Area	Impact on I&E / SoFP	Comment
			£000s	
TAC09 / STA0500	n/a	Capital Staff Numbers	0	Capital staff numbers updated (from 48 to 46)
TAC09 / STC0170	Note 8	Capital Staff Costs	0	Capital staff salaries updated (from £2,730k to £2,630k). Classification so nil overall impact on capital or revenue positions
TAC51	n/a	AGS	0	N/a at draft accounts. TAC51 AGS added for final submission. See AGS tab
n/a	Note 1.1.2 p12,13	Going Concern	0	Updated text
TAC 28 / CRL	Note 35	Capital Resource Limit	0	CRL Limit updated as per NHSI/E to bring the Trust to breakeven position
TAC 12	Note 15.1	PPE	0	Updated PPE classifications - transfers between categories included on revaluations row in error
TAC62 NPS033 Expenditure TAC08 EXP0220 A08CY10 and A08CY13	n/a	Agreement of Balances	0	Expenditure with NHS Propco amended (reduction by £782k (to £2,040k from £2,822k. Spend classified as non-NHS in error. Is TAC analysis only and nil impact on accounts or on total Premises expenditure.
n/a	n/a	All areas	0	Page numbers updated. Now commences at page 1 (revised Annual Report design)
TAC09 / STA0580 + STA0750	n/a	Exit Packages	0	1 package (£27k) reported originally in 20/21 but was agreed in 19/20. Removed from 20/21 and prior year restated. Annual Report amended



The Princess Alexandra Hospital NHS Trust

2.1

The Princess Alexandra Hospital Trust
Hamstel Road
Harlow
Essex
CM20 1QX

11th June 2021

Ms Debbie Hanson
Associate Partner
Ernst & Young LLP
400 Capability Green
Luton
Bedfordshire LU1 3LU

Dear Ms Hanson

The Princess Alexandra Hospital NHS Trust: Financial Statements for the Year Ended 31st March 2021

This letter of representation is provided in connection with your audit of the financial statements of The Princess Alexandra Hospital NHS Trust ("the Trust) for the year ended 31st March 2021. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to form an opinion as to whether the financial statements give a true and fair view of (or 'present fairly, in all material respects,') the financial position of The Princess Alexandra Hospital NHS Trust as of 31st March 2021 and of its financial performance (or operations) and its cash flows for the year then ended in accordance with the Secretary of State Directions and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM).

We understand that the purpose of your audit of our financial statements is to express an opinion thereon and that your audit was conducted in accordance with International Standards on Auditing (UK), which involves an examination of the accounting system, internal control and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor necessarily be expected to disclose - all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Chief executive: Lance McCarthy

Chairman: Steve Clarke



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A. Financial Statements and Financial Records

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated 5th March 2021, for the preparation of the financial statements in accordance with the Secretary of State Directions and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM).
2. We acknowledge, as members of management of the Trust our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position, financial performance (or results of operations) and cash flows of the Trust in accordance with Secretary of State Directions and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), and are free of material misstatements, including omissions. We have approved the financial statements.
3. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.
4. As members of management of the Trust, we believe that the Trust has a system of internal controls adequate to enable the preparation of accurate financial statements in accordance with the Secretary of State Directions and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) that are free from material misstatement, whether due to fraud or error. We have disclosed to you any significant changes in our processes, controls, policies and procedures that we have made to address the effects of the COVID-19 pandemic on our system of internal controls.
5. There are no unadjusted audit differences identified during the current audit and pertaining to the latest period presented.

B. Non-compliance with law and regulations, including fraud

1. We acknowledge that we are responsible for determining that the Trust's activities are conducted in accordance with laws and regulations and that we are responsible for identifying and addressing any non-compliance with applicable laws and regulations, including fraud.
2. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.
3. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
4. We have no knowledge of any identified or suspected non-compliance with laws or regulations, including fraud that may have affected the Trust's (regardless of the source or form and including without limitation, any allegations by "whistleblowers"), including non-compliance matters:
 - involving financial statements;
 - related to laws and regulations that have a direct effect on the determination of material amounts and disclosures in the Trust/CCG's financial statements;

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Chairman: Steve Clarke



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- related to laws and regulations that have an indirect effect on amounts and disclosures in the financial statements, but compliance with which may be fundamental to the operations of the Trust's activities, its ability to continue to operate, or to avoid material penalties;
- involving management, or employees who have significant roles in internal controls, or others; or
- in relation to any allegations of fraud, suspected fraud or other non-compliance with laws and regulations communicated by employees, former employees, analysts, regulators or others.

C. Information Provided and Completeness of Information and Transactions

1. We have provided you with:
 - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
 - Additional information that you have requested from us for the purpose of the audit; and
 - Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.
2. All material transactions have been recorded in the accounting records and all material transactions, events and conditions are reflected in the financial statements, including those related to the COVID-19 pandemic.
3. We have made available to you all minutes of the meetings of the Board, and Committees including Audit Committee and Performance and Finance Committee or summaries of actions of recent meetings for which minutes have not yet been prepared held through the year to the most recent meeting on the following date: 11 June 2021
4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Trust's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the period end. These transactions have been appropriately accounted for and disclosed in the financial statements.
5. We believe that the methods, significant assumptions and the data we used in making accounting estimates and related disclosures are appropriate and consistently applied to achieve recognition, measurement and disclosure that is in accordance with the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM).

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6. We have disclosed to you, and the Trust has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.
7. From the date of our last management representation letter through the date of this letter we have disclosed to you any unauthorized access to our information technology systems that either occurred or to the best of our knowledge is reasonably likely to have occurred based on our investigation, including of reports submitted to us by third parties (including regulatory agencies, law enforcement agencies and security consultants), to the extent that such unauthorised access to our information technology systems is reasonably likely to have a material impact to the financial statements, in each or in the aggregate.

D. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.
2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal counsel.
3. We have recorded and/or disclosed, as appropriate, all liabilities related to litigation and claims, both actual and contingent, and have disclosed in Notes 24, 25 and 26 to the financial statements all guarantees that we have given to third parties.

E. Going Concern

1. Note 1.1.2 to the financial statements discloses all the matters of which we are aware that are relevant to the Trust's ability to continue as a going concern, including significant conditions and events, our plans for future action, and the feasibility of those plans.

F. Subsequent Events

1. As described in Note 32 to the financial statements, there have been no events, including events related to the COVID-19 pandemic, subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

G. Agreement of Balances and Key Judgements

1. We have disclosed to you details of all transactions and judgments we have made on income and expenditure, payable and receivable balances with counter-parties irrespective of whether or not they have been included in the 2020/21 Agreement of Balances Exercise.
2. We have agreed balances, disputes and claims with all NHS bodies via the Agreement of Balances process and where not agreed, we have reported the matter to you.

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3. We have disclosed to you all of the risks and judgments we have made in arriving at the Trust's reported financial outturn for financial year ended 31 March 2021.

H. Other information

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises the Annual Report and Annual Governance Statement.
2. We confirm that the content contained within the other information is consistent with the financial statements.

I. Segmental reporting

1. We have reviewed the operating segments reported internally to the Board and we are satisfied that it is appropriate to aggregate these as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:
 - The nature of the products and services
 - The nature of the production processes
 - The type or class of customer for their products and services
 - The methods used to distribute their products

J. Use of the Work of a Specialist

1. We agree with the findings of the specialists that we engaged to value the Trust's land and buildings and have adequately considered the qualifications of the specialists in determining the amounts and disclosures included in the financial statements and the underlying accounting records. We did not give or cause any instructions to be given to the specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an effect on the independence or objectivity of the specialists.

K. Estimates

1. We believe that the measurement processes, including related assumptions and models, used to determine the accounting estimate for the Modern Equivalent Valuation of land and buildings have been consistently applied and are appropriate in the context of the Secretary of State Directions and the Department of Health (DH) Group Accounting Manual (GAM).
2. We confirm that the significant assumptions used in making the modern equivalent asset (MEA) valuation appropriately reflect our intent and ability to carry out the delivery of services from the sites valued.

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3. We confirm that appropriate specialised skills or expertise has been applied in making the MEA valuation.
4. We confirm that the disclosures made in the financial statements with respect to the accounting estimate are complete, including the effects of the COVID-19 pandemic on the valuations, and made in accordance with the Secretary of State Directions and the Department of Health (DH) Group Accounting Manual (GAM).
5. We confirm that no adjustments are required to the accounting estimate and disclosures in the financial statements due to subsequent events, including due to the COVID-19 pandemic.

Yours sincerely

Director of Finance

Chair, Audit Committee

Chief executive: Lance McCarthy

Chairman: Steve Clarke



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The Princess Alexandra Hospital NHS Trust Audit results report

Year ended 31 March 2021



Building a better
working world



Private and Confidential

4 June 2021

The Princess Alexandra Hospital NHS Trust

Dear Audit Committee Members

2021 Audit Results Report

We are pleased to attach our Audit Results Report, summarising the status of our audit for the forthcoming meeting of the Audit Committee. We will update the Audit Committee at its meeting scheduled for 11 June 2021 on further progress to that date and explain the remaining steps to the issue of our final opinion.

The audit is designed to express an opinion on the 2021 financial statements and address current statutory and regulatory requirements. This report contains our findings related to the areas of audit emphasis and our views on the Trusts' accounting policies and judgements. Each year sees further enhancements to the level of audit challenge and the quality of evidence required to achieve the robust professional scepticism that society expects. We thank the management team for supporting this process. We have also included an update on our work on value for money arrangements.

This report is intended solely for the information and use of the Audit Committee and other members of the Board of Directors and management. It is not intended to be and should not be used by anyone other than these specified parties.

We welcome the opportunity to discuss the contents of this report with you at the Audit Committee meeting on 11 June 2021.

Yours faithfully

Debbie Hanson

Associate Partner

For and on behalf of Ernst & Young LLP

Encl

Contents



The contents of this report are subject to the terms and conditions of our appointment as set out in our engagement letter of 5 March 2021.

This report is made solely to the Audit Committee, Board of Directors and management of The Princess Alexandra Hospital NHS Trust in accordance with our engagement letter. Our work has been undertaken so that we might state to the Audit Committee, Board of Directors and management of The Princess Alexandra Hospital NHS Trust those matters we are required to state to them in this report and for no other purpose. To the fullest extent permitted by law we do not accept or assume responsibility to anyone other than the Audit Committee, Board of Directors and management of The Princess Alexandra Hospital NHS Trust for this report or for the opinions we have formed. It should not be provided to any third-party without our prior written consent.



01 Executive Summary

Executive Summary

Scope update

In our Outline Audit Planning Report presented to the 8 March 2021 Audit Committee meeting, we provided you with an overview of our audit scope and approach for the audit of the financial statements. We carried out our audit in accordance with this plan, with the following exceptions:

- ▶ **Changes in materiality:** We updated our planning materiality assessment using the draft financial statements and have also reconsidered our risk assessment. Based on our updated assessment we revised our materiality level to 1.5% of gross expenditure to reflect the improved financial performance over 2019/20 and 2020/21 (previously set at 1%). This results in an updated overall materiality level of £4.6 million (Audit Planning Report – £2.86 million). This results in updated performance materiality, at 75% of overall materiality, of £3.47 million, and an updated threshold for reporting misstatements of £0.23 million. This change was communicated verbally at the 25 May 2021 Audit Committee.
- ▶ **New significant risks not identified at planning stage - Inappropriate capitalisation of revenue expenditure** (linked to the risk of management override and the fact that the Trust's operating environment continues to be challenging financially. There is inherent opportunity for the Trust to inappropriately capitalise revenue costs in order to improve its reported revenue position and performance against key financial targets. This risk is increased due to the new hospital project and significant capital spending with additions in 20/21 of £49.5 million. This change was communicated verbally at the 25 May 2021 Audit Committee.

Additional audit procedures as a result of Covid-19

Other changes in the entity and regulatory environment as a result of Covid-19 that have not resulted in an additional risk, but result in the following impacts on our audit strategy were as follows:

Information Produced by the Entity (IPE): We identified an increased risk around the completeness, accuracy, and appropriateness of information produced by the entity due to the inability of the audit team to verify original documents or re-run reports on-site from the Trust's systems. We undertook the following to address this risk:

- Used the screen sharing function of Microsoft Teams to evidence re-running of reports used to generate the IPE we audited; and
- Agree IPE to scanned documents or other system screenshots.

Executive Summary

Status of the audit

Our audit work in respect of the Trust opinion is ongoing. The following items relating to the completion of our audit procedures were outstanding at the date of this report (4 June).

- ▶ Debtors/creditors - small number of residual queries
- ▶ Income/expenditure - small number of residual queries
- ▶ Conclusion of work in respect property, plant and equipment valuation - particularly in respect of an increase gross internal area and static land value
- ▶ Clearance of queries in respect of capital additions testing
- ▶ Agency staff costs- small number of residual queries
- ▶ Annual leave accrual - conclusion of work
- ▶ Small number of disclosure notes
- ▶ Receipt and check of final set of financial statements and TACs
- ▶ Receipt of signed letter of representation
- ▶ Completion of work on Whole of Government Accounts

Given that the audit process is still ongoing, we will continue to challenge the remaining evidence provided and the final disclosures in the Annual Report and Accounts which could influence our final audit opinion, a current draft of which is included in Section 3.

As noted above, we are still in the process of completing a number of our audit procedures and are waiting for information from the Trust in some areas. Some of these delays are due to the fact that evidence provided in response to audit queries has been journals rather than source evidence and has therefore not provided sufficient support for the figures in the accounts. To further improve the audit process in future years the Trust should ensure that information provided to support entries in the financial statements is primary evidence (for example invoices or bank statements) rather than journals.

On the basis of our work performed to date, we anticipate issuing a qualified auditor's report in respect of the Trust accounts. The basis of the qualification, which relates to the prior year qualification is summarised below:

Inventory - Qualification - Limitation of audit scope - Further to the modification in the 2019/20 financial statements, and in consultation with NHS Improvement/England, the NAO and internally within EY, we are not able to gain sufficient retrospective assurance on the 31 March 2020 inventory balance. Therefore, our 2020/21 opinion will be qualified in relation to the prior year comparative balance.

Executive Summary

Auditor responsibilities under the new Code of Audit Practice 2020

Under the Code of Audit Practice 2020 we are still required to consider whether the Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. The 2020 Code requires the auditor to design their work to provide them with sufficient assurance to enable them to report to the Trust a commentary against specified reporting criteria (see below) on the arrangements the Trust has in place to secure value for money through economic, efficient and effective use of its resources for the relevant period.

The specified reporting criteria are:

- Financial sustainability
How the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance
How the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness:
How the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

Status of the audit - Value for Money

In the Outline Audit Plan and subsequent verbal update to the Audit Committee on the 25 May, we reported that we had substantially completed our value for money (VFM) risk assessment and not identified any risk of significant weakness against the three reporting criteria we are required to consider under the NAO's 2020 Code. We have now completed our risk assessment and are satisfied that we have not identified a risk of significant weakness. As a result, we have completed our planned VFM procedures and have no matters to report by exception in the auditor's report (see Section 03). We plan to issue the VFM commentary by the 15 June as part of issuing the Auditor's Annual Report.

A draft of our VFM Commentary will be shared with the Committee for consideration at the meeting on 11 June.

Executive Summary

Audit differences

Based on the work we have completed to date, there are no adjusted or unadjusted audit differences arising from our audit.

See section 4 for further details of differences identified during the audit.

As our audit work remains in progress, further audit differences may be identified. We will provide an update at the Audit Committee meeting on 11 June 2021.

Other reporting issues

We have reviewed the information presented in the Annual Report and Annual Governance Statement for consistency with our knowledge of the Trust. We have audited the parts of the remuneration and staff report disclosures that are required to be audited. We have no material matters to report as a result of this work.

We are in the process of completing the procedures requested of the National Audit Office with respect to the Trust's Whole of Government Accounts submission. We expect to issue an unqualified confirmation to the National Audit Office regarding the Trust's consolidation schedule submission.

We have no other matters we wish to report.

Executive Summary

Areas of risk and audit focus

In our Outline Audit Plan we identified a number of significant risks and key areas of focus for our audit of the financial accounts of The Princess Alexandra Hospital NHS Trust. This report sets out our observations and status in relation to these areas, including our views on areas which might be conservative and areas where there is potential risk and exposure. Our consideration of these matters and others identified during the period is summarised within the "Areas of Audit Focus" section of this report.

In each case, our work is ongoing at the time of writing this report. We will provide an update at the Audit Committee on 7 June 2021.

We request that you review these and other matters set out in this report to ensure:

- ▶ There are no residual further considerations or matters that could impact these issues
- ▶ You concur with the resolution of the issue
- ▶ There are no further significant issues you are aware of to be considered before the financial report is finalised

There are no matters, other than those reported by management or disclosed in this report, which we believe should be brought to the attention of the Audit Committee or Board of Directors.

Control observations

As we have adopted a fully substantive approach, we have not tested the operation of controls. Although our audit was not designed to express an opinion on the effectiveness of internal control we are required to communicate to you significant deficiencies in internal control.

We have not identified any significant deficiencies in the design or operation of an internal control that might result in a material misstatement in your financial statements of which you are not aware. We have however identified some areas for improvement related to inventory procedures.

See section 7 for further details identified during the audit.

Independence

Please refer to Section 8 for our update on Independence.



02

Areas of Audit Focus

Areas of Risk and Audit Focus

Significant risks

Risk of fraud in revenue and expenditure recognition

What is the risk?

Under ISA 240 there is a presumed risk that revenue may be misstated due to improper revenue recognition. In the public sector, this requirement is modified by Practice Note 10 issued by the Financial Reporting Council, which states that auditors should also consider the risk that material misstatements may occur by the manipulation of expenditure recognition.

We assess that the risk is particularly associated with:

- The valuation and completeness of non-NHS creditors including accruals and other creditors
- The existence and valuation of non-NHS debtors including trade and other receivables
- The completeness and measurement of operating costs not covered by the intra NHS agreement of balances, excluding payroll and depreciation
- The valuation and occurrence of other operating revenue not covered by the intra NHS agreement of balances.

In addition, for 2020/21 the Trust will receive significant sums from DH to support its response to Covid-19.

What areas and judgements are we focused on?

We focused on aspects of the financial statements where management could inappropriately inflate income or understate expenditure, primarily:

- ▶ Year-end accruals of income and expenditure
- ▶ Year-end cut off
- ▶ We also reviewed expenditure cut-off at month 6, to address the risk of expenditure being moved incorrectly into the first half of the year to obtain break-even funding.

What did we do?

In response to this risk, we:

- ▶ Tested revenue relating to accrued non-NHS income back to supporting documentation to confirm it had been recognised in line with the Trust's recognition policies.
- ▶ Tested expenditure relating to accrued other operating costs (excluding payroll and finance expenditure) back to supporting documentation.
- ▶ Tested the completeness of expenditure by completing cut-off procedures from 1 March 2021 through to 30 April 2021, and by testing for unrecorded liabilities from 31 March 2021 through to sign off.
- ▶ Reviewed in-year expenditure to assess any unusual patterns around the mid-year point when the funding regime changed, and perform cut-off testing at months 6 and 7.

Our work to date has not identified any instances of fraud in revenue and expenditure recognition. We will provide a further update at the Audit Committee on 11 June 2021.

Areas of Risk and Audit Focus

Significant risks

Misstatements due to fraud or error

What areas and judgements are we focused on?

We focused on aspects of the financial statements which are open to estimation and judgment, which would facilitate management overriding controls:

- ▶ Material accounting estimates.
- ▶ Journal entries.
- ▶ Unusual transactions.

What is the risk?

The financial statements as a whole are not free of material misstatements whether caused by fraud or error.

As identified in ISA (UK and Ireland) 240, management is in a unique position to perpetrate fraud because of its ability to manipulate accounting records directly or indirectly and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.

We identify and respond to this fraud risk on every audit engagement.

What did we do?

In response to this risk, we:

- Identified fraud risks during the planning stage.
- Inquired of management about risks of fraud and the controls put in place to address those risks.
- Obtained an understanding the oversight given by those charged with governance of management's processes over fraud.
- Considered the effectiveness of management's controls designed to address the risk of fraud and did not identify any significant deficiency.
- Reviewed material accounting estimates, with the valuation of property, plant & equipment identified as an area of higher inherent risk.
- Tested a sample of journal entries and other adjustments in the preparation of the financial statements.
- Confirmed there were no significant unusual transactions.

What are our conclusions?

Our audit work to date has not identified any material issues, inappropriate judgements or unusual transactions which indicated that there had been any misreporting of the Trust's financial position, or that management had overridden control.

We will provide a further update at the Audit Committee on 11 June 2021.

Audit risks

Significant risks

Inappropriate capitalisation of revenue expenditure *

What areas and judgements are we focused on?

We focused on aspects of the financial statements where management could inappropriately inflate capital expenditure, primarily:

- Additions testing

What is the risk?

The Trust continues to operate in an extremely challenging financial environment.

The Trust's capital indicative budget for 2020/21 was £43.7 million and additions in the draft financial statements were £49.5 million and is therefore material.

There is inherent opportunity for the Trust to inappropriately capitalise revenue costs in order to improve its reported revenue position and performance against key financial targets. This risk is increased due to the new hospital project and significant capital spending.

What did we do?

We addressed the risk of inappropriate capitalisation of revenue expenditure by:

- Testing property, plant and equipment additions, including assets under construction (AUC), using the lower end of the testing threshold range.
- Challenging the classification of additions under each property, plant and equipment category, including their inclusion as AUC.
- Checking the reasonableness of the total additions spend within the year compared to the budgeted spend at the start of the financial year.
- Testing specific journal entries around capitalisation of expenditure to identify any inappropriate capitalisation.

What are our conclusions?

Our audit work to date has not identified any material issues, inappropriate judgements or unusual transactions in respect of inappropriate capitalisation of revenue expenditure.

We will provide a further update at the Audit Committee on 11 June 2021.

Areas of Risk and Audit Focus

Other risks

Going concern disclosures

What areas and judgements are we focused on?

- Managements assessment of the going concern assumption.
- Cash flow projections and assumptions regarding future financial planning arrangements

What is the risk?

While the Trust is subject to the presumption of accounting as a going concern under the continuation of services approach, the Department of Health and Social Care Group Accounting Manual (GAM) requires Trusts to include in the overview section of the performance report of the annual report 'an explanation of the adoption of the going concern basis where this might be called into doubt (e.g. by the issue of a report under Section 30 of the Local Audit and Accountability Act 2014)'.

The GAM also requires disclosure of material events or uncertainties that cast significant doubt on the going concern of the entity. It is important that the Trust's management are aware of and comply with these requirements for assessing going concern as part of the preparation of the financial statements for the year ending 31 March 2021.

The Trust will need to undertake its annual going concern assessment to take into account NHSI/E's current financial framework, considering any potential future changes to funding arrangements, to demonstrate its liquidity over the future period of its going concern assessment which should extend for at least 12 months from the likely date of our audit report in June 2021. This assessment will need to inform the disclosure in the financial statements to explain why the Trust considers it appropriate to prepare the financial statements on a going concern basis, and to ensure sufficient disclosure is made of any material uncertainties in this regard.



Areas of Risk and Audit Focus

Other risks

What did we do?

In response to this risk, we:

- Obtained managements going concern assessment and reviewed it for any evidence of bias and consistency with the accounts;
- Reviewed the financial modelling and forecasts prepared by the Trust. This included considering key assumptions, stress testing applied to those assumptions and considering the risk to cashflows up to at least 12 months after the signing date of the accounts and opinion i.e. June 2022 as a minimum;
- Ensured that an appropriate going concern disclosure has been made within the financial statements consistent to management's assessment; and
- Considered the implications for our Audit Report under ISA (UK) 700 (Revised June 2016) Forming an Opinion and Reporting on the Financial Statements, and complied with EY consultation requirements.

What are our conclusions?

Our audit work to date has not identified any evidence that suggests the Trust's use of the going concern assumption is inappropriate, and there is no indication that government will curtail services that are provided by the Trust.

The Trust has not identified any material uncertainties through its assessment, including its cashflow forecast that shows sufficient liquidity through the going concern period through to June 2022.

We have reviewed the Trust's initial disclosure, and updates were made consistent with our feedback and requests which included additional information on the assumptions being made for the whole of 2021/22 that then feed into the cashflow forecast.

Our work to review the Trust's assessment of going concern and intended disclosure in the financial statements is substantially complete and we have commenced the internal consultation process regarding our audit opinion. This consultation was triggered due to the inclusion of a material uncertainty with regard to going concern in our prior year audit report. We will provide an update at the Audit Committee on 11 June 2021.

Areas of Risk and Audit Focus

Other risks

Valuation of property plant and equipment (PPE) land and buildings

What areas and judgements are we focused on?

We focussed on key inputs and assumptions within the valuations including:

- Depreciated replacement cost assets (specialised assets) - build costs, professional fees and external works
- Existing Use Value assets (valued with reference to market factors) - value per square metre, useful economic life and apportionment between land and buildings

What is the risk?

The value of land and buildings is a significant balance on the Trust's Statement of Financial Position.

The valuation of land and buildings is complex and is subject to a number of assumptions and judgements. A small movement in these assumptions can have a material impact on the financial statements.

The ongoing impact of Covid-19 is likely to continue to impact on the valuations of land and buildings.

What did we do?

In response to this risk, we:

- Reviewed the output of the Trust's valuer (District Valuer / Valuation Office Agency)
- We challenged the inputs (such as floor plans, applicable indices, etc.) and assumptions used by the Trust's valuer by reference to external evidence
- We agreed the valuer's report to the Fixed Asset Register and the Fixed Asset Register to the accounts. This confirmed the assets and valuation adjustments were accurately processed in the financial statements.
- Tested accounting entries have been correctly processed in the financial statements.

What are our findings and conclusions

Our work on the valuation of land and buildings is substantially complete, subject to internal review. We have reviewed the output of the Trust's valuer and challenged the inputs to the valuation. We are undertaking further work on the increase in gross internal area (GIA) and the static in year land values.

We agreed the valuer's report to the Fixed Asset Register and the Fixed Asset Register to the accounts. Accounting entries have been correctly processed in the financial statements.

We will provide any further updates at the Audit Committee on 11 June 2021.



03 Audit Report



Audit Report

Draft audit report

Draft opinion on the financial statements

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST

Qualified Opinion

We have audited the financial statements of The Princess Alexandra Hospital NHS Trust for the year ended 31 March 2021 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust's Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 36. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2020/21 HM Treasury's Financial Reporting Manual (the 2020/21 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2020/21 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion, except for the possible effects of the matter described in the basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of The Princess Alexandra Hospital NHS Trust as at 31 March 2021 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and the Accounts Directions issued thereunder.

Basis for qualified opinion

Due to the restrictions on movement imposed as a result of the Coronavirus pandemic, in 2019/20 the Trust was unable to undertake, and we were unable to observe, the counting of physical inventories at the beginning of the year. We were unable to satisfy ourselves by alternative means concerning the inventory quantities held at 31 March 2020, which are included as comparatives in the Statement of Financial Position at £4.565 million, by using other audit procedures. Consequently, we were unable to determine whether any adjustment to this amount was necessary.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.



Audit Report

Draft audit report

Our opinion on the financial statements

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of 12 months to 30 June 2022 from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the Trust's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

As described in the basis for qualified opinion section of our report, we were unable to satisfy ourselves concerning the comparative inventory quantities of £4.565 million held at 31 March 2020. We have concluded that where the other information refers to the comparative inventory balance or related balances, it may be materially misstated for the same reason.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued thereunder.



Audit Report

Draft audit report

Our opinion on the financial statements

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in these respects.

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 90, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they either intend to cease operations, or has no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State and for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.



Audit Report

Draft audit report

Our opinion on the financial statements

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant are the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), as well as relevant employment laws of the United Kingdom. In addition, the Trust has to comply with laws and regulations in the areas of anti-bribery and corruption, data protection and health & safety.

We understood how The Princess Alexandra Hospital NHS Trust is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, internal audit and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance. We corroborated this through our review of the Trust's board minutes, through enquiry of employees to verify Trust policies, and through the inspection of HR Policies and other information. Based on this understanding we designed our audit procedures to identify non-compliance with such laws and regulations. Our procedures had a focus on compliance with the accounting framework through obtaining sufficient audit evidence in line with the level of risk identified and with relevant legislation.

We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur by understanding the potential incentives and pressures for management to manipulate the financial statements, and performed procedures to understand the areas in which this would most likely arise. Based on our risk assessment procedures, we identified manipulation of reported financial performance (through improper recognition of revenue), inappropriate capitalisation of revenue expenditure and management override of controls to be our fraud risks.

To address our fraud risk around the manipulation of reported financial performance through improper recognition of revenue, we reviewed the Trust's manual year end receivable and payable accruals, challenging assumptions and corroborating the income and expenditure to appropriate evidence. We tested year-end cut-off arrangements by selecting samples of income and expenditure from either side of the 31 March 2021 and reviewing to supporting evidence to ensure these were recorded in the appropriate financial year. We also undertook cut-off testing of expenditure as at month 6 of the financial year to establish whether the Trust had incorrectly included expenditure relating to later months that would trigger Reimbursement and top-up funding for that period of the financial year that it would otherwise not be entitled to.

To address our fraud risk of inappropriate capitalisation of revenue expenditure we tested the Trust's capitalised expenditure to ensure the capitalisation criteria were properly met and the expenditure was genuine.



Audit Report

Draft audit report

Our opinion on the financial statements

To address our fraud risk of management override of controls, we tested specific journal entries identified by applying risk criteria to the population of manual journals. For each journal selected, we tested specific transactions back to source documentation to confirm that the journals were appropriate.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at <https://www.frc.org.uk/auditorsresponsibilities>. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in April 2021, as to whether the Trust had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.



Audit Report

Draft audit report

Our opinion on the financial statements

Certificate

We certify that we have completed the audit of the accounts of The Princess Alexandra Hospital NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Directors of The Princess Alexandra Hospital NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Directors, for our audit work, for this report, or for the opinions we have formed.

Debbie Hanson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Luton
XX June 2021



04 Audit Differences

Audit Differences

In the normal course of any audit, we identify misstatements between amounts we believe should be recorded in the financial statements and the disclosures and amounts actually recorded. These differences are classified as 'known' or 'judgemental'. Known differences represent items that can be accurately quantified and relate to a definite set of facts or circumstances. Judgemental differences generally involve estimation and relate to facts or circumstances that are uncertain or open to interpretation.

Summary of adjusted differences

To date, no adjusted differences exceeding our performance materiality of £3.466 million have been identified. A small number of disclosure differences were identified in the statutory accounts and annual report, which have been corrected by management.

Summary of unadjusted differences

To date, no unadjusted differences exceeding our reporting threshold of £230k have been identified.

As our audit work remains in progress, further audit differences may be identified. We will provide an update at the Audit Committee meeting on 11 June 2021.



05

Value for Money



Value for money

The Trust's responsibilities for value for money (VFM)

The Trust is required to maintain an effective system of internal control that supports the achievement of its policies, aims and objectives while safeguarding and securing value for money from the public funds and other resources at its disposal.

As part of the material published with its financial statements, the Trust is required to bring together commentary on its governance framework and how this has operated during the period in a governance statement. In preparing its governance statement, the Trust tailors the content to reflect its own individual circumstances, consistent with the requirements of the relevant accounting and reporting framework and having regard to any guidance issued in support of that framework. This includes a requirement to provide commentary on its arrangements for securing value for money from their use of resources.

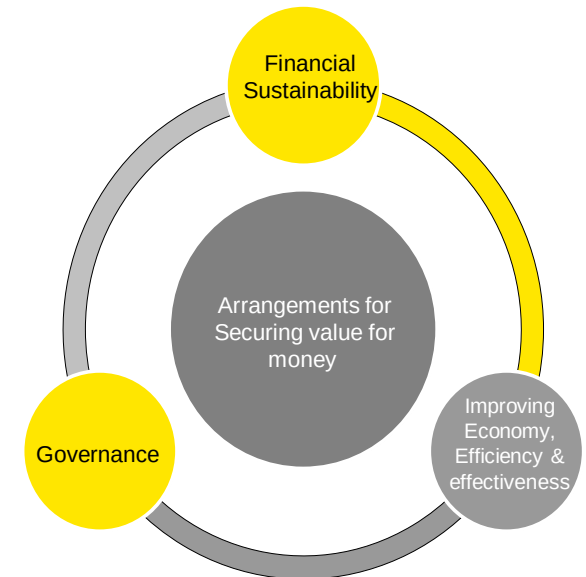
Risk assessment

In the Audit Plan and subsequent update to the Audit Committee in May 2021, we reported that our value for money (VFM) risk assessment was in progress and that we had not identified any risk of significant weakness against the three reporting criteria we are required to consider under the NAO's 2020 Code.

We can confirm that our planning procedures are now complete, and that no risks of significant weakness have been identified.

Status of our VFM work

We have sufficiently completed our planned VFM procedures to confirm that we have no matters to report by exception in the auditor's report (see Section 3). We plan to issue the VFM commentary by 15 June 2021 as part of issuing the Auditor's Annual Report





06

Other reporting issues



Other reporting issues

Annual Report including Annual Governance Statement

We are required to give an opinion on the consistency of the Annual Report and other information published with the financial statements and the parts of the remuneration report that are required to be audited. We are also required to review the Annual Governance Statement for completeness of disclosures, consistency with other information we are aware of from our work and whether it complies with relevant guidance. In reviewing the Annual Report and other information published with the financial statements we took account of updated guidance issued to bodies in the light of covid-19.

Financial information within the Annual Report and published with the financial statements was consistent with the Annual Accounts.

The remuneration and staff report was prepared properly and within the rules set and we had no matters to report.

We have reviewed the Annual Governance Statement and can confirm it is consistent with other information that we are aware of from our audit of the financial statements and we have no other matters to report

Whole of Government Accounts

Alongside our work on the financial statements, we also report to the Trust on differences, within a tolerance of £300,000, between the Trust's consolidation schedules and the audited financial statements. We report to the NAO under Whole of Government Accounts group audit instructions.

We are currently concluding our work in this areas and will report any matters that arise to the Audit Committee.



07

Assessment of Control Environment



Assessment of Control Environment

Financial controls

It is the responsibility of the Trust to develop and implement systems of internal financial control and to put in place proper arrangements to monitor their adequacy and effectiveness in practice. Our responsibility as your auditor is to consider whether the Trust has put adequate arrangements in place to satisfy itself that the systems of internal financial control are both adequate and effective in practice.

As part of our audit of the financial statements, we obtained an understanding of internal control sufficient to plan our audit and determine the nature, timing and extent of testing performed. As we have adopted a fully substantive approach, we have therefore not tested the operation of controls.

Although our audit was not designed to express an opinion on the effectiveness of internal control we are required to communicate to you significant deficiencies in internal control.

We have not identified any significant deficiencies in the design or operation of an internal control that might result in a material misstatement in your financial statements of which you are not aware.

Through our work on inventory, we note that the Trust is not aware of the stock position at any particular point in time, in order to effectively manage the Trust's maximum and minimum level of goods. Theatre staff record the use of a number of key items (Orthopaedic implants, Breast Implants, Stents, Mesh and Grafts) in separate manual log books, but not record the use other items. A manual weekly high level review is undertaken of stock levels for all other stock items. Although there are therefore records maintained of stock issues and levels, either on a daily or weekly basis, these are manual and are therefore subject to the risk of fraud or error.

We considered whether circumstances arising from Covid-19 resulted in a change to the overall control environment of effectiveness of internal controls, for example due to significant staff absence or limitations as a result of working remotely. We identified no issues which we wish to bring to your attention.



08 Independence

Relationships, services and related threats and safeguards

The FRC Ethical Standard requires that we provide details of all relationships between Ernst & Young (EY) and your company, and its directors and senior management and its affiliates, including all services provided by us and our network to your company, its directors and senior management and its affiliates, and other services provided to other known connected parties that we consider may reasonably be thought to bear on the our integrity or objectivity, including those that could compromise independence and the related safeguards that are in place and why they address the threats.

There are no relationships from 1 April 2020 to the date of this report, which we consider may reasonably be thought to bear on our independence and objectivity.

Services provided by Ernst & Young

The next page includes a summary of the fees that you have paid to us in the year ended 31 March 2021 in line with the disclosures set out in FRC Ethical Standard and in statute. Full details of the services that we have provided are shown below.

As at the date of this report, there are no future services which have been contracted and no written proposal to provide non-audit services has been submitted.

We confirm that we have not undertaken any non-audit work in 2020/21 due to the suspension of the requirement for assurance work to be undertaken on the Trust's Quality Account.

Independence

Relationships, services and related threats and safeguards

Services provided by Ernst & Young			
Description	Final Fee 2020/21 £	Planned Fee 2020/21 £	Final Fee 2019/20 £
Audit Fee per the engagement letter	115,250	115,250	61,000
Additional Fees:			
S30 Referral			1,000
Assessment of going concern, reassessment of materiality and value for money risks			1,334
Cost of consultation - Limitation of Scope on inventory, material uncertainty on going concern and emphasis of matter on property, plant and equipment			3,466
Further consultation and time taken to assess undertaking stock take after year end			1,500
Inefficiency due to Covid-19			516
Total Audit Fee	115,250	115,250	68,816

 Independence

Other communications

EY Transparency Report 2020

Ernst & Young (EY) has policies and procedures that instil professional values as part of firm culture and ensure that the highest standards of objectivity, independence and integrity are maintained.

Details of the key policies and processes in place within EY for maintaining objectivity and independence can be found in our annual Transparency Report which the firm is required to publish by law. The most recent version of this Report is for the year end 30 June 2020:

[EY UK Transparency Report 2020 | EY UK](#)



09 Appendices



Appendix A

Audit approach update

We summarise below our approach to the audit of the statement of financial position and any changes to this approach from the prior year audit.

Our audit procedures are designed to be responsive to our assessed risk of material misstatement at the relevant assertion level. Assertions relevant to the statement of financial position include:

- ▶ Existence: An asset, liability and equity interest exists at a given date
- ▶ Rights and Obligations: An asset, liability and equity interest pertains to the entity at a given date
- ▶ Completeness: There are no unrecorded assets, liabilities, and equity interests, transactions or events, or undisclosed items
- ▶ Valuation: An asset, liability and equity interest is recorded at an appropriate amount and any resulting valuation or allocation adjustments are appropriately recorded
- ▶ Presentation and Disclosure: Assets, liabilities and equity interests are appropriately aggregated or disaggregated, and classified, described and disclosed in accordance with the applicable financial reporting framework. Disclosures are relevant and understandable in the context of the applicable financial reporting framework

Appendix B

Required communications with the Audit Committee

There are certain communications that we must provide to the Audit Committees of UK entities. We have detailed these here together with a reference of when and where they were covered:

		Our Reporting to you
Required communications	What is reported?	When and where
Terms of engagement	Confirmation by the audit committee of acceptance of terms of engagement as written in the engagement letter signed by both parties.	Engagement letter 5 March 2021
Our responsibilities	Reminder of our responsibilities as set out in the engagement letter.	Audit planning report 8 March 2021
Planning and audit approach	Communication of the planned scope and timing of the audit, any limitations and the significant risks identified. When communicating key audit matters this includes the most significant risks of material misstatement (whether or not due to fraud) including those that have the greatest effect on the overall audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.	Audit planning report 8 March 2021
Significant findings from the audit	▶ Our view about the significant qualitative aspects of accounting practices including accounting policies, accounting estimates and financial statement disclosures ▶ Significant difficulties, if any, encountered during the audit ▶ Significant matters, if any, arising from the audit that were discussed with management ▶ Written representations that we are seeking ▶ Expected modifications to the audit report ▶ Other matters if any, significant to the oversight of the financial reporting process	Audit planning report 8 March 2021

Appendix B

		Our Reporting to you
Required communications	What is reported?	When and where
	▶ About the directors' explanation in the annual report as to how they have assessed the prospects of the entity, over what period they have done so and why they consider that period to be appropriate (in accordance with Code provision 31), and their statements: i. In the financial statements, as to whether they considered it appropriate to adopt the going concern basis of accounting in preparing them, including any related disclosures identifying any material uncertainties to the entity's ability to continue to do so over a period of at least twelve months from the date of approval of the financial statements (in accordance with Code provision 30); and ii. In the annual report as to whether they have a reasonable expectation that the entity will be able to continue in operation and meet its liabilities as they fall due over the period of the assessment, including any related disclosures drawing attention to any necessary qualifications or assumptions (in accordance with Code provision 31); ▶ Any other matters identified in the course of the audit that we believe will be relevant to the board or the audit committee in the context of fulfilling their responsibilities referred to above.	

Appendix B

		Our Reporting to you
Required communications	What is reported?	When and where
Going concern	Events or conditions identified that may cast significant doubt on the entity's ability to continue as a going concern, including: ▶ Whether the events or conditions constitute a material uncertainty related to going concern ▶ Whether the use of the going concern assumption is appropriate in the preparation and presentation of the financial statements ▶ The appropriateness of related disclosures in the financial statements	Audit results report 11 June 2021 Audit Committee
Misstatements	▶ Uncorrected misstatements and their effect on our audit opinion, unless prohibited by law or regulation ▶ The effect of uncorrected misstatements related to prior periods ▶ A request that any uncorrected misstatement be corrected ▶ Material misstatements corrected by management	Audit results report 11 June 2021 Audit Committee
Subsequent events	▶ Enquiry of the audit committee where appropriate regarding whether any subsequent events have occurred that might affect the financial statements.	Audit results report 11 June 2021 Audit Committee

Appendix B

		Our Reporting to you
Required communications	What is reported?	When and where
Fraud	▶ Enquiries of the audit committee to determine whether they have knowledge of any actual, suspected or alleged fraud affecting the entity ▶ Any fraud that we have identified or information we have obtained that indicates that a fraud may exist ▶ Unless all of those charged with governance are involved in managing the entity, any identified or suspected fraud involving: - Management; - Employees who have significant roles in internal control; or - Others where the fraud results in a material misstatement in the financial statements. ▶ The nature, timing and extent of audit procedures necessary to complete the audit when fraud involving management is suspected ▶ Any other matters related to fraud, relevant to Audit Committee responsibility.	Audit results report 11 June 2021 Audit Committee
Related parties	Significant matters arising during the audit in connection with the entity's related parties including, when applicable: ▶ Non-disclosure by management ▶ Inappropriate authorisation and approval of transactions ▶ Disagreement over disclosures ▶ Non-compliance with laws and regulations ▶ Difficulty in identifying the party that ultimately controls the entity	Audit results report 11 June 2021 Audit Committee
Independence	Communication of all significant facts and matters that bear on EY's, and all individuals involved in the audit, objectivity and independence. Communication of key elements of the audit engagement partner's consideration of independence and objectivity such as: ▶ The principal threats ▶ Safeguards adopted and their effectiveness ▶ An overall assessment of threats and safeguards ▶ Information about the general policies and process within the firm to maintain objectivity and independence	Audit Planning Report 8 March 2021 Audit Committee Audit results report 11 June 2021 Audit Committee

Appendix B

		Our Reporting to you
Required communications	What is reported?	When and where
	Communications whenever significant judgements are made about threats to objectivity and independence and the appropriateness of safeguards put in place. For public interest entities and listed companies, communication of minimum requirements as detailed in the FRC Revised Ethical Standard 2019: ▶ Relationships between EY, the company and senior management, its affiliates and its connected parties ▶ Services provided by EY that may reasonably bear on the auditors' objectivity and independence ▶ Related safeguards ▶ Fees charged by EY analysed into appropriate categories such as statutory audit fees, tax advisory fees, other non-audit service fees ▶ A statement of compliance with the Ethical Standard, including any non-EY firms or external experts used in the audit ▶ Details of any inconsistencies between the Ethical Standard and Group's policy for the provision of non-audit services, and any apparent breach of that policy ▶ Where EY has determined it is appropriate to apply more restrictive rules than permitted under the Ethical Standard ▶ The audit committee should also be provided an opportunity to discuss matters affecting auditor independence	
External confirmations	▶ Management's refusal for us to request confirmations ▶ Inability to obtain relevant and reliable audit evidence from other procedures.	Audit results report 11 June 2021 Audit Committee
Consideration of laws and regulations	▶ Subject to compliance with applicable regulations, matters involving identified or suspected non-compliance with laws and regulations, other than those which are clearly inconsequential and the implications thereof. Instances of suspected non-compliance may also include those that are brought to our attention that are expected to occur imminently or for which there is reason to believe that they may occur ▶ Enquiry of the audit committee into possible instances of non-compliance with laws and regulations that may have a material effect on the financial statements and that the audit committee may be aware of	Audit results report 11 June 2021 Audit Committee

Appendix B

		Our Reporting to you
Required communications	What is reported?	When and where
Significant deficiencies in internal controls identified during the audit	▶ Significant deficiencies in internal controls identified during the audit.	Audit results report 11 June 2021 Audit Committee
Written representations we are requesting from management and/or those charged with governance	▶ Written representations we are requesting from management and/or those charged with governance	Audit results report 11 June 2021 Audit Committee
Material inconsistencies or misstatements of fact identified in other information which management has refused to revise	▶ Material inconsistencies or misstatements of fact identified in other information which management has refused to revise	Audit results report 11 June 2021 Audit Committee
Auditors report	▶ Any circumstances identified that affect the form and content of our auditor's report	Audit results report 11 June 2021 Audit Committee

Appendix E

Management representation letter

Management Rep Letter

[To be prepared on the entity's letterhead]
[Date]

Debbie Hanson
Associate Partner
Ernst & Young LLP
400 Capability Green,
Luton
Bedfordshire
LU1 3LU

This letter of representations is provided in connection with your audit of the financial statements of The Princess Alexandra Hospital NHS Trust ("the Trust") for the year ended 31 March 2021. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to form an opinion as to whether the financial statements give a true and fair view of (or 'present fairly, in all material respects,') the financial position of The Princess Alexandra Hospital NHS Trust as of 31 March 2021 and of its financial performance (or operations) and its cash flows for the year then ended in accordance with the Secretary of State Directions and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM).

We understand that the purpose of your audit of our financial statements is to express an opinion thereon and that your audit was conducted in accordance with International Standards on Auditing (UK), which involves an examination of the accounting system, internal control and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor necessarily be expected to disclose - all fraud, shortages, errors and other irregularities, should any exist.

Accordingly, we make the following representations, which are true to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

A. Financial Statements and Financial Records

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated 5 March 2021, for the preparation of the financial statements in accordance with the Secretary of State Directions and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM).
2. We acknowledge, as members of management of the Trust our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair view of the financial position, financial performance (or results of operations) and cash flows of the Trust in accordance with Secretary of State Directions and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM), and are free of material misstatements, including omissions. We have approved the financial statements.
3. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements.
4. As members of management of the Trust, we believe that the Trust has a system of internal controls adequate to enable the preparation of accurate financial statements in accordance with the Secretary of State Directions and the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) that are free from material misstatement, whether due to fraud or error. We have disclosed to you any significant changes in our processes, controls, policies and procedures that we have made to address the effects of the COVID-19 pandemic on our system of internal controls.
5. There are no unadjusted audit differences identified during the current audit and pertaining to the latest period presented.

Appendix E

Management representation letter

Management Rep Letter

B. Non-compliance with law and regulations, including fraud

1. We acknowledge that we are responsible for determining that the Trust's activities are conducted in accordance with laws and regulations and that we are responsible for identifying and addressing any non-compliance with applicable laws and regulations, including fraud.
2. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.
3. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
4. We have no knowledge of any identified or suspected non-compliance with laws or regulations, including fraud that may have affected the Trust's (regardless of the source or form and including without limitation, any allegations by "whistleblowers"), including non-compliance matters:
 - involving financial statements;
 - related to laws and regulations that have a direct effect on the determination of material amounts and disclosures in the Trust/CCG's financial statements;
 - related to laws and regulations that have an indirect effect on amounts and disclosures in the financial statements, but compliance with which may be fundamental to the operations of the Trust's activities, its ability to continue to operate, or to avoid material penalties;
 - involving management, or employees who have significant roles in internal controls, or others; or
 - in relation to any allegations of fraud, suspected fraud or other non-compliance with laws and regulations communicated by employees, former employees, analysts, regulators or others.

C. Information Provided and Completeness of Information and Transactions

1. We have provided you with:
 - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
 - Additional information that you have requested from us for the purpose of the audit; and
 - Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.
2. All material transactions have been recorded in the accounting records and all material transactions, events and conditions are reflected in the financial statements, including those related to the COVID-19 pandemic.
3. We have made available to you all minutes of the meetings of the Board, and committees including Audit Committee and Performance and Finance Committee or summaries of actions of recent meetings for which minutes have not yet been prepared held through the year to the most recent meeting on the following date: *[list date]*.
4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Trust's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related balances due to or from such parties at the period end. These transactions have been appropriately accounted for and disclosed in the financial statements.
5. We believe that the methods, significant assumptions and the data we used in making accounting estimates and related disclosures are appropriate and consistently applied to achieve recognition, measurement and disclosure that is in accordance with the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM)

Appendix E

Management representation letter

Management Rep Letter

6. We have disclosed to you, and the Trust has complied with, all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance, including all covenants, conditions or other requirements of all outstanding debt.

7. From the date of our last management representation letter through the date of this letter we have disclosed to you any unauthorized access to our information technology systems that either occurred or to the best of our knowledge is reasonably likely to have occurred based on our investigation, including of reports submitted to us by third parties (including regulatory agencies, law enforcement agencies and security consultants), to the extent that such unauthorized access to our information technology systems is reasonably likely to have a material impact to the financial statements, in each or in the aggregate.

D. Liabilities and Contingencies

1. All liabilities and contingencies, including those associated with guarantees, whether written or oral, have been disclosed to you and are appropriately reflected in the financial statements.

2. We have informed you of all outstanding and possible litigation and claims, whether or not they have been discussed with legal counsel.

3. We have recorded and/or disclosed, as appropriate, all liabilities related to litigation and claims, both actual and contingent, and have disclosed in Note [X] to the financial statements all guarantees that we have given to third parties.

E. Going Concern

Note 1.1.2 to the financial statements discloses all the matters of which we are aware that are relevant to the Trust's ability to continue as a going concern, including significant conditions and events, our plans for future action, and the feasibility of those plans.

E. Subsequent Events

1. Other than described in Note [X] to the financial statements, there have been no events, including events related to the COVID-19 pandemic, subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

F. Agreement of Balances and key judgments

1. We have disclosed to you details of all transactions and judgments we have made on income and expenditure, payable and receivable balances with counter-parties irrespective of whether or not they have been included in the 2020/21 Agreement of Balances Exercise

2. We have agreed balances, disputes and claims with all NHS bodies via the Agreement of Balances process and where not agreed, we have reported the matter to you.

3. We have disclosed to you all of the risks and judgments we have made in arriving at the Trust's reported financial outturn for financial year ended 31 March 2021.

G. Other information

1. We acknowledge our responsibility for the preparation of the other information. The other information comprises the Annual Report and Annual Governance Statement.

2. We confirm that the content contained within the other information is consistent with the financial statements.

Appendix E

Management representation letter

Management Rep Letter

H. Segmental reporting

1. We have reviewed the operating segments reported internally to the Board and We are satisfied that it is appropriate to aggregate these as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:

- The nature of the products and services
- The nature of the production processes
- The type or class of customer for their products and services
- The methods used to distribute their products

I. Use of the Work of a Specialist

1. We agree with the findings of the specialists that we engaged to value the Trust's land and buildings and have adequately considered the qualifications of the specialists in determining the amounts and disclosures included in the financial statements and the underlying accounting records. We did not give or cause any instructions to be given to the specialists with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an effect on the independence or objectivity of the specialists.

J. Estimates

1. We believe that the measurement processes, including related assumptions and models, used to determine the accounting estimate for the Modern Equivalent Valuation of land and buildings have been consistently applied and are appropriate in the context of the Secretary of State Directions and the Department of Health (DH) Group Accounting Manual (GAM)

2. We confirm that the significant assumptions used in making the modern equivalent asset (MEA) valuation appropriately reflect our intent and ability to carry out the delivery of services from the sites valued.

3. We confirm that appropriate specialized skills or expertise has been applied in making the MEA valuation.

4. We confirm that the disclosures made in the financial statements with respect to the accounting estimate are complete, including the effects of the COVID-19 pandemic on the valuations, and made in accordance with the Secretary of State Directions and the Department of Health (DH) Group Accounting Manual (GAM).

5. We confirm that no adjustments are required to the accounting estimate and disclosures in the financial statements due to subsequent events, including due to the COVID-19 pandemic.

Yours faithfully,

(Director of Finance)

(Chairman of the Audit Committee)

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ED None

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Trust Board - 11 June 2021

Agenda item:	2.3				
Presented by:	Lance McCarthy – Chief Executive				
Prepared by:	Head of Corporate Affairs/ Members of the finance team/Department leads				
Date prepared:	19 May 2021				
Subject / title	Annual Report 2020-21 including Annual Governance Statement (AGS)				
Purpose:	Approval		Decision		Information x Assurance
Key issues:	The Trust's Annual Report 2020-21 is presented for approval. The report is presented in word format with changes made since the Audit Committee Meeting on 25.05.21, highlighted in red font and summarised in the attached note. The Trust's external auditors have reviewed the report and amendments have been made following receipt of their comments. The Board is asked to approve the AGS, from page 60 of the report.				
Recommendation:	Trust Board is asked to: Approve the report and AGS ahead of submission on 15 June 2021.				
Trust strategic objectives:	 Patients ✓	 People ✓	 Performance ✓	 Places ✓	 Pounds ✓
Previously considered by:	Circulated to Board members via email on 14.05.21 and reviewed at Audit Committee on 25.05.21 and 11 June 2021.				
Risk / links with the BAF:	Linked to all BAF risks				
Legislation, regulatory, equality, diversity and dignity implications:	The report has been prepared in line with national guidance - DHSC Group Accounting Manual (DHSC GAM) for 2020/21.				
Appendices:	Nil				

Annual report including Annual Governance Statement 2020-21

The Annual report has been updated following the Audit Committee meeting held on 25th May to include feedback received from Audit Committee, Board members and the Trust's external auditors. A summary of the changes is detailed below:

- Pages 3 – 7 added: foreword and COVID-19 letter from Lance to staff
- Page 10: revised PAHT2030 graphic inserted reflecting the Trust's current values
- Page 40: revised wording in red font
- Page 60: revised wording in red font
- Page 62: revised wording in red font (last paragraph)
- Page 65 – revised wording in red font (second paragraph)
- Final page – section added for looking forward

Following feedback from the Trust's external auditors, the following amendments have been made:

Page 12: going concern note revised

Page 15: typo corrected

Page 74: revised wording – pay multiples

Page 75: revised numbers in table - employee benefits

Page 76: revised numbers in average staff numbers table

Page 77: revised numbers in exit packages table

Page 78: revised numbers and note in exit packages table

Page 80: table revised and note 2 added

Report author:

Heather Schultz

Annual Report 2020 - 2021



The Princess Alexandra
Hospital
NHS Trust

2.3



Your **future** • Our **hospital**

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The performance report 2020-21

Overview

The overview section provides a summary of our hospital, how we have performed over the year and the challenges we have faced.

Foreword from the chair and the chief executive officer

A year ago as we sat down to write the foreword for our annual report we had just come out of the intense first wave of the COVID-19 pandemic. We were facing the unprecedented challenges, having cared for hundreds of COVID-19 positive patients, of how we were going to support our colleagues through the impact that the previous few months had had on them and how we were going to continue to support our local community with the much needed ongoing care for COVID-19 and non-COVID-19 conditions that they required.

One year on, and we could not have predicted the severity of the second wave of the COVID-19 pandemic and the significant and profound impact this would have on all of us and all of our community.

It is vital that we keep our focus on managing the virus and its variants as we look to the future and we are in no doubt that our PAHT people will continue to meet the challenge and provide compassionate care to all of our patients and all of the people they work alongside.

With the pandemic as our backdrop, we are incredibly proud of the hard work and commitment of our people in their response and of the significant changes that our people have put in place and the many ways they have responded to and adapted the ways that patient care is delivered. Just one of these changes, which we will continue to enhance and provide to our patients are virtual appointments. Many of our patients have told us how helpful they find virtual appointments in terms of fitting them around their work and family commitments without the need to travel. As technology extends, we will be able to offer more video call appointments and bring the benefits of a virtual face-to-face appointment to a wider range of patients.

During the pandemic, in-line with national guidance, we had to pause visitors coming to the hospital. We recognise that this was a difficult change for many people and we thank our patients' friends, family and loved-ones for their understanding and support. To enable contact beyond a phone call, we introduced a new initiative, *Message to a loved one*, where colleagues have volunteered to ensure messages and cards have been delivered across the hospital and, additionally, that patients could connect with their loved ones through a video call on a PC tablet – enabling people to see each other too.

Throughout the last year, the improvement action plans within our PAHT 2030 strategy have continued. Aligned to the *NHS Ten Year Plan*, the strategy sets out five key areas of focus and the objectives that, together, we are striving to achieve. Many of the initial actions are set alongside the new hospital project and will put us in a position to provide improved levels of high quality care, implement changes and be ready to

transition into a new hospital. It is good to be part of the conversations and to see our people working collaboratively to ensure that the needs of all patients are considered and included in the changes and plans for the future.

The new Princess Alexandra Hospital project is also continuing at pace as the PAHT team bring together a very detailed and extensive outline business case that will be submitted to the national New Hospital Programme at the end of the year. Creating a plan to build a new hospital for the 21st century is a huge project to bring together and, as with any project, the progress is thanks to our team of skilled specialists who are working behind the scenes to ensure that every detail is being considered and included. It is fantastic to know that the outline business case continues to progress at pace and that we have many exciting stages ahead of us as we work towards building and welcoming our people and patients to our new hospital.

The past year has been a year unlike any other and a year of unprecedented demand on all of us. It is thanks to the hard work, compassion and commitment to patient care of each and every member of the PAHT team that we have achieved all that we have in the last twelve months. We have also been honoured to receive the generous support and kindness from local people from the very start of the pandemic to the present day, culminating in the award of a civic award from Harlow District Council to all of the staff at PAHT for their continuous commitment and contribution to the community of Harlow. The award was thanks to the nominations of many members of the local community and their appreciation, touching comments and positive feedback has meant so much to us.

The COVID-19 pandemic continues and we remain mindful of the impact on our people and making sure they have the help and support they need in terms of their health and wellbeing as, every day, they continue to high quality care to our patients and support their colleagues too. They are amazing.

Best wishes

Steve Clarke
Chair

Lance McCarthy
Chief executive

A final change to update you about is that I will be stepping down from his role and leaving PAHT. I took on the role of chair in December 2018 and will be leaving in June 2021. I have thoroughly enjoyed my time at PAHT and want to thank everyone for their hard work that they continue to give to patient care.

Steve Clarke
Chair

[pull-out box]

The year 2020-21 has been an unprecedented time, we are pleased to share with you a message from Lance McCarthy, chief executive, shared with all our people to mark the first 12 months of the COVID-19 pandemic.

Our year of COVID-19...

Dear all

The 29 January 2021 marked a year since the first COVID-19 patient was admitted to a UK hospital. We didn't admit our first patient until 15 March, but what a year. An unprecedented year in our lifetimes, an extraordinary year, an exhausting year, a sad year and a truly remarkable year in terms of what we have all done.

We have swabbed more than 23,000 patients for COVID; we have treated more than 1,800 positive patients; we have seen 1,200 of them discharged; but sadly we have seen nearly 500 die; too soon and from a virus we knew nothing about a year ago.

We have made hundreds of decisions about issues we would never have thought about a year ago; we have changed and transformed buildings, clinical pathways, teams and ways of working at a phenomenal pace; we have built things, moved things, lent things, borrowed things and procured things that we would never have dreamed of. We all now think differently.

We have a 'red ED' and a 'red ITU'; we have run at more than 600% critical care capacity; we have turned wards to COVID-19 wards, back to non-COVID-19 and back to COVID-19 again; we have rolled out 1,000s of laptops for virtual outpatient appointments and home working; we have moved colleagues off site; we have built a temporary mortuary; we have installed screens between bed spaces; we have run loads of new assays; we have set up a health and wellbeing hub and an absence line. We have all done things differently.

We have worked extra hours, in different teams, in different roles; used different drugs, in different ways; measured, monitored and tracked numbers like never before and we have developed a new vocabulary - COVID, lockdown, tiers, lateral flow test, PCR test, Samba, social distancing, hands face and space, stay safe, SIREN, furlough, shielding, clinically extremely vulnerable, surge levels.

We have experienced more anxiety, adrenaline and pride than usual but we have also been more scared, exhausted and traumatised than usual.

We've experienced the strangest Christmas and New Year in most of our lives; we've home schooled; we've worked from home and we've transitioned in to a virtual world; for families to speak to their loved ones in our care, for outpatient appointments, for meetings, or to speak to our family and friends. Zoom, Teams, WebEx... "you're on mute!"



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We have made new friends with colleagues that we never really knew a year ago and, sadly, we have lost old friends. Colleagues, family members, personal friends, gone too soon and leaving holes in our hearts.

We have also embraced diversity, equality and inclusion; George Floyd's death in Minneapolis and the realisation in the first wave of the increased vulnerability of our BAME colleagues and friends to COVID-19, affected us all. We have done and will always work together regardless of age, sex, sexual orientation, race, religion, disability and ethnicity.

Through all of this, we have built a new two-storey adult assessment unit, a sanctuary space and prayer room, a junior doctors' mess, a refurbished paediatric ward, a new fracture clinic and an EBME workshop. We have looked out for each other and others less fortunate and we have been looked out for by others and seen the generosity of many.

Infection prevention and control is more centre stage than ever, PPE guidance at the front of our minds, scrubs (raspberry especially) worn almost everywhere and face masks part of everyday life. We've celebrated, we've thanked, we've been kind and we've been recognised, with scientists, technicians, nurses and doctors all receiving national awards, including an MBE.

And as we welcomed in the new year, some of our amazing colleagues were busy setting up a vaccination hub in record time; administering more than 6,500 doses to local health and care workers in just four weeks, giving us all some hope and hopefully some immunity.

It has been a year of huge change and huge emotion. We've been tested and pushed to our limits and beyond. We've had good days and great days, bad days and terrible days.

It has been a year of huge contrasts, a year of opposites and a year that we wouldn't want to see the likes of again. Through it we have treated 1,000s of patients, cared for them, put their minds at rest and made them better.

The pandemic, the battle against COVID-19, is not over, but we're slowly winning it. We will all need more health and well-being and psychological support than ever and being civil and kind has never been more important; but we will get back to 'normal', we will stop wearing masks everywhere, we will get to go out again and we will keep caring for sick members of the community.

Thank you. Thank you to all the doctors, nurses, midwives, pharmacists, scientists, technicians, radiographers, physios, dieticians, OTs, SALTs, ODPs, all other AHPs, HCSWs, MCAs, MLSOs, PAs, optometrists, audiologists, phlebotomists, domestics, porters, caterers, housekeepers, drivers, estates team, librarians, chaplains, assistants, associates, students, volunteers and all our administrative and corporate colleagues from all professions. You have all been amazing.

#TeamPAHT

Best wishes

Lance McCarthy

Chief executive

The purpose and activities of the organisation

PAHT is a 414 bedded hospital with a full range of general acute services, including; a 24/7 Accident and Emergency Department (A&E), plus an Intensive Care Unit (ICU), a Maternity Unit (MU) and a Level II Neonatal Intensive Care Unit (NICU). During 2021 the Trust opened a new building on the main site that holds the Adult Assessment Unit & Same Day Emergency Care unit, both are services that improve patient experience for those patients requiring urgent care.

The trust serves a core population of around 350,000 and is the natural hospital of choice for people living in West Essex and East Hertfordshire. In addition to the communities of Harlow and Epping, the trust serves the populations of Bishop's Stortford and Saffron Walden in the North, Loughton and Waltham Abbey in the South, Great Dunmow in the East, and Hoddesdon and Broxbourne in the West. Its extended catchment incorporates a population of up to 500,000.

The trust owns the main hospital site in Harlow, and also operates outpatient and diagnostic services out of the Herts and Essex Hospital, Bishops Stortford and St Margaret's Hospital, Epping. The operation of these facilities forms part of the longer term strategy of bringing services closer to where patients live and making services, where appropriate, more accessible and easily available to patients.

The trust operates over forty different services to meet the needs of its patients (see service portfolio below):

Directory of our services			
Adult assessment services incorporating ambulatory care and same day emergency care.	Endocrinology	Maxillo-facial surgery	Radiology
Audiology	Ear Nose & Throat	Medical Oncology	Respiratory Medicine
Breast screening	Frailty service	Neonatal critical care – special care baby unit and neonatal community nurses	Rheumatology



Breast surgery	Gastroenterology	New-born Hearing Screening	Specialist palliative care
Cardiology	General medicine	Neurology	Speech and language therapy
Chemotherapy	General surgery	Obstetrics	Surgery – in-patients
Clinical Haematology	Genito-urinary medicine	Ophthalmology	Transfusion services
Clinical Oncology	Geriatrics	Oral surgery	Tongue tie service
Colposcopy and hysteroscopy services	Gynaecology: Including Termination of Pregnancy Services Gynaecology ambulatory service	Oncology services	Trauma and orthopaedics
Community midwifery	High Dependency Unit	Paediatrics – in-patients, out-patients, ambulatory care	Urology
Colorectal services	Intensive Care unit	Paediatric diabetic Medicine	Vascular services
Day surgery	Infection prevention & control services	Paediatric Emergency Department	Blood tests
Dermatology	Interventional radiology		End of life care
Diabetic medicine	Maternity comprising: • Antenatal clinic • Ultrasound scanning • Labour Ward • Antenatal Ward • Postnatal Ward • Maternal Foetal	Pathology	Mortuary & Bereavement services
Dietetics		Patient appliances	Patient at home
Early Pregnancy Unit		Pharmacy services	Research & Development
Emergency Department		Physiotherapy and occupational therapy	Tissue viability
Endoscopy services		Perioperative Medicine (Anaesthetics and ICU)	

	Assessment Unit • Breast feeding support • Birthing Unit • Community midwifery services		

Strategic objectives

The trust's vision is to deliver outstanding healthcare to the local community and the trust's mission is to put quality first in everything that is done.

Over the course of 2020-2021 the trust has been working towards the launch of PAHT2030. PAHT2030 provides our roadmap to 'outstanding' and delivery of services from a modern, fit for purpose new hospital through five strategic priorities:



Underpinning our five priorities and the way in which we achieve these ambitions are our trust goals, objectives and values.

Courageous Goals What will PAHT achieve by 2030?	Objectives PAHT have 5 objectives known as the 5P's.	Values What is important to PAHT?
Outstanding We will deliver healthcare that our patients deserve and makes us proud.	 Patients We will continue to improve the quality of care and experiences that we provide our patients , integrating care with our partners and improving our CQC rating	Respectful Treating others as we would wish to be treated
Integrated We will work as one to provide joined up healthcare that puts patients first.	 People We will support our people to deliver high quality care within a compassionate and inclusive culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results	Caring Always putting patients first
Modern We will always use up to date treatments, technology and facilities.	 Performance We will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators	Responsible Doing what we say we're going to do
	 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	Committed Striving to be the best
	 Pounds We will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2020/21 and our local system control total	

The development of PAHT2030 over 2020-2021 has been set against a challenging and changing NHS landscape which has emphasised the importance of a strong organisational strategy to provide our communities, staff and partners with the assurance that we can deliver our ambitions. PAHT2030 has been developed from the ground up, with input from over 300 members of our staff to understand where real change is required to deliver outstanding care.

The NHS Long Term Plan is an ambitious 10 year plan focussed on new service models; prevention and health inequalities; significant improvements in the quality of care and patient outcomes; strengthened workforce; digital transformation; financial efficiency and value for money for the taxpayer. The trust's one vision, three goals and five 'P's together with the strategic priorities all bring together our ambition and closely align it to the NHS Long Term Plan.

Our ambition was strengthened further in February 2021 when the Department of Health and Social Care published the White Paper 'Integration and innovation: working together to improve health and social care for all'. The paper proposes greater flexibility for local health and care organisations to work in partnership through Integrated Care Systems (ICS) to deliver localised models of care to support their populations which is exactly what we want to achieve with our partners for our local community.

Models of Care

Although integrated care has been a focus for the trust since 2015, in 2020-2021 we have worked in partnership with the newly formed Hertfordshire and West Essex Integrated Care System and more localised One Health & Care Partnership to develop new models of care and begin holding joint accountability for delivery of these models across our local health and care system. We are doing this because

we believe working together is the only way we can truly meet the holistic needs of our population.

Our ambitious care development programme took place over June-September 2020, working with a range of health and care professionals from across the trust and wider health and care system to develop models of care which push the boundaries of how healthcare is planned and delivered. Underpinned by place based planning and developed through innovative challenge sessions to understand how we and our system partners can collaborate and deliver real, evidence based integrated care and population health management.

Integrated Care Systems

Developed with and supported by our ICS and local One Health & Care Partnership our new models of care have provided a foundation to design our new hospital. 2020-2021 saw the trust and wider system partners set out a new and innovative approach to care delivery: the development of a Learning Health System culture, which will champion and develop a patient-centric and data driven health system that continually strives to improve with a relentless focus on outcomes.

Using the new Hospital Programme as a springboard we have developed a comprehensive Digital Strategy keeping us relentlessly focused on our ambition of becoming the most technological and digitally enabled hospital in the UK, allowing us to transform the care we deliver and the experience of our people.

This Digital Strategy outlines how PAHT will deliver world class care, in a paperless world supported and transformed through a digital culture that is right at our core.

New Hospital

Never before has the reality of a new hospital been so close having submitted our Pre-Consultation Business Case in September 2019, coinciding with the launch of the government's Health Infrastructure Plan (HIP) Programme. In October 2019 the Department of Health announced that PAHT would be one of 6 trusts in the first wave of the HIP Programme giving the go ahead for PAHT to develop its Outline Business Case, with a new hospital build on a greenfield site as the preferred way forward. With the development of a national New Hospital Programme we are one of the frontrunner 8 organisations working closely with the national team to deliver a new hospital for Harlow and surrounding areas.

Between January- March 2020 the trust built its New Hospital Programme Team consisting of a clinical leadership team, full PMO, health planners, and design team. Over 2020-2021 the New Hospital Programme Team have worked tirelessly to deliver the following elements of the Outline Business Case:

- A full demand & capacity modelling exercise determining the predicted population growth and capacity required over the next 20+ years,



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- A fully developed integrated and innovative model of care fit for the next 20+ years
- An ambitious Digital Strategy illustrating how the trust will become the most technically advanced hospital in the country
- A net zero carbon strategy for the new hospital
- A set of clinically designed 1:200 layouts for each department in the hospital that will support the delivery of care for the foreseeable future
- In support of our commitment to continual public engagement, a series of 'Virtual Town Hall' events with local communities outlining our vision for the new hospital and collecting feedback on a number of design ideas
- A staff engagement programme providing space for over 250 members of staff to influence the design of the new hospital

The Outline Business Case will be submitted to national regulators in autumn 2021.

Key risks

The trust has a Board Assurance Framework (BAF) which provides a mechanism for the Board to monitor risks to delivery of the trust's strategic objectives. The highest scoring risks on the BAF throughout 2020-21 were variation in clinical outcomes, our estate, delivery of the Emergency Department standard and our finances. The risks are reviewed monthly and progress is monitored by the relevant board committees and Trust board every other month. The BAF is published within the Board papers on the trust's website.

Going concern

The Trust Board has assessed the Trust's ability to continue for the foreseeable future in accordance with the Department of Health and Social Care (DHSC) Group Accounting Manual. Consequently, as in previous years, the Trust has prepared its 2020-21 Annual Accounts on a going concern basis.

In approving the trust's annual accounts the Board of Directors has satisfied itself that the Trust has prepared the accounts on the basis of going concern.

The Directors of the Trust have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the Hertfordshire and West Essex Integrated Care System (ICS). The ICS has published its Strategic Delivery Plan and NHS Long Term Plan response for the five year period 2020-21 to 2024-25 and this plan includes the continued provision of services by the Trust. In addition, the Trust continues to

develop an Outline Business Case to build a new hospital, which is being supported by a variety of stakeholders. No circumstances were identified causing the Directors to doubt the continued provision of NHS services.

For the 2020-21 financial year, the Trust achieved a surplus of £1.8m against a planned deficit of £0.4m. Income from our local Clinical Commissioning Groups was largely based on the adapted finance regime introduced in response to the COVID-19 pandemic and this provided predictability and improved cash flow with the Trust finishing the year with a £65.2m cash balance. Additional costs arising from the pandemic were reimbursed in the first half of the year and incorporated into a block payment basis for the second half of the year.

In April 2020, the DHSC and NHS England and NHS Improvement (NHSE/I) announced reforms to the NHS cash regime for the 2020-21 financial year. During 2020-21 existing DHSC interim revenue loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow their repayment. Consequently, the Trust received PDC of £146.2m to repay these loans which had accumulated from prior year deficits. In addition, capital loans of £4.3m were also extinguished and replaced with PDC and therefore total net assets increased by £150.5m. This strengthened the value of the Trust's Statement of Financial Position and means that the Trust is no longer required to generate surpluses to service this historic debt.

For 2021-22 the current financial funding arrangements will remain in place for the first half of the year, with additional funding to support elective recovery post COVID.

The going concern assessment is made up to 30 June 2022. The national financial arrangements for the second half of the year are not fully known at this stage and while the implications of COVID-19 should be greatly reduced, there is likely to be some ongoing effect and, potentially, additional funding for this. The Trust's income is largely based on commissioner block contracts which will continue throughout the second half of the year. Reducing the Trust's underlying cost base and increasing efficiencies is essential with the focus on delivering a cost-improvement programme of £6.7m (or 2.2%). In 2019-20, the Trust achieved £9.9m (or 3.4%) of cost improvements and therefore is reasonably assured of the achievability of this target.

The Trust has prepared a cash forecast modelled on the above expectations for funding during the going concern period to 30 June 2022. The cash forecast shows sufficient liquidity for the Trust to continue to operate during that period with no need to borrow. In addition, the Trust has access to working capital arrangements should the need for this arise. In conclusion, these factors, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

Performance Analysis

Financial Performance

As part of the national response to COVID-19, operational planning arrangements for 2020-21 were suspended. Operational planning was replaced with an 'adapted financial regime'. As part of these arrangements all NHS organisations were required to deliver financial balance over the first half of the financial year. This was achieved by a move away from commissioner contracts based on activity payments mechanism (Payment by Results) and replaced with block/fixed contract arrangements. In addition to block contract payments NHS providers received 'top-up' payments. These payments, along with a reimbursement process to recover costs associated with the response to COVID-19 ensured Trust's delivered financial balance. From 1 April to 30 September 2020 the Trust therefore delivered a breakeven position.

From September 2020 the block contract arrangements continued but the 'top up' payment mechanism ceased. For the second half of the financial year, September 2020 to March 2021, a control total was agreed with our Integrated Care System (ICS). Our financial plan was set at a £391k deficit. This became the basis on which our financial performance was measured.

The Trust delivered a £1.8m surplus against our deficit plan (a £2.2m improvement). This improved financial performance can be attributed to non-recurrent transactions.

Operating and Financial Review

The key financial results for 2020-21 are that the Trust delivered a surplus of £1,816k. This was an improvement on the 2019-20 financial performance.

Cost improvement

Even during the course of the pandemic, the Trust made efficiency savings of £6.2m during the year through our Cost Improvement Programme (CIP) without impacting the quality or safety of the care we provide.

Capital investment

As the Trust has been in deficit for a number of years, this had previously led to significant constraints on being able to generate sufficient internally funded capital to be able to invest in our estate and facilities.

In 2020-21 we secured additional capital funding. We had a strategic capital investment plan and associated cash management plan in line with our local investment priorities. As a result we have been able to make investments that improved our estate which has helped us to be able to deliver high quality care to our patients and provide a better working environment for our people.

The Trust has made capital investments of £47.7m. In 2020-21 our key capital projects have included

- the Adult Assessment Unit
- the Fracture Clinic Unit
- the mortuary and staff facilities
- a new training facility
- equipment to support the NHS COVID-19 response
- critical infrastructure developments
- ICT investment including further rollout of wireless technology
- new CT and MRI equipment
- continued investment in backlog maintenance to ensure our estate is safe
- the development of our New Hospital Outline Business Case

Looking forward to 2021-22 we are planning major capital investment projects which will continue to transform the care that we are able to provide with the purchase of a further CT scanner and other medical equipment. We will continue to seek more capital investment to provide the best possible care to our local population now and into the future.

Looking ahead

Looking ahead to 2021-22, the current national guidance is to continue the principles of the 'Adapted Financial Regime' into the first half of 2021-22. Block contract arrangements with commissioners will continue and will be uplifted for national inflationary uplifts offset by efficiency requirement. The ICS will receive additional funding allocations e.g. Growth and COVID-19 which will be distributed to ICS partners.

During the first half of the financial year the Trust will be eligible to receive additional funding from an 'Elective Recovery Fund'. This fund will be available to support the Trust in performing additional activity and accelerate the restoration of activity following COVID-19.

The Trust has also developed its capital plan for 2021-22. The plan is risk based inclusive of the continuation and the completion of capital commitments entered into during 2020-21. The plan also includes planned new strategic investments and continuation of progression towards our New Hospital. Our capital programme for next year is circa £49m which is funded by a combination of internal and external funding.

Key Financial Results

The following table shows a range of financial performance values taken from the accounts.

Accounts Highlights	2020-21 £000's	2019-20 £000's
Surplus for year	1,816	50
Public Dividend Capital Dividend Payable	3,034	0
Value of Property, Plant and Equipment	137,845	117,405



Value of borrowings (including loans)	40	150,998
Cash at 31 March	65,242	1,144
Creditors – trade and other	49,070	27,068
Debtors – trade and others	8,381	49,837
Revenue from patient care activities	267,835	246,747
Clinical negligence costs	13,010	9,924
Gross employee benefits	203,722	193,119

Better payment practice code

The code sets out the following obligations for NHS organisations in respect of the payments it makes to its suppliers - principally:

- payment terms are to be agreed with suppliers before a contract commences
- payment terms are not to be varied without prior agreement with a supplier
- by default, bills are to be settled within 30 days unless other terms have been agreed

During the COVID-19 pandemic, and where possible and appropriate the Trust accelerated payments to suppliers recognising its responsibility to support all businesses in sustaining cash flow. As such performance in 2020-21 was an improvement on 2019-20. Performance is summarised as follows:

	2020/21 Number	2020/21 £000's	2019/20 Number	2019/20 £000's
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	45,928	109,532	49,002	76,083
Total non-NHS trade invoices paid within target	39,957	92,948	43,722	64,320
Percentage of non-NHS trade invoices paid within target	87.0%	84.9%	89.2%	84.5%
NHS Payables				
Total NHS trade invoices paid in the year	2,296	53,313	2,227	56,446
Total NHS trade invoices paid within target	1,912	48,878	1,805	47,379
Percentage of NHS trade invoices paid within target	83.3%	91.7%	81.1%	83.9%

Anti-Fraud and Bribery

The Trust continues to work to maintain an anti-fraud, bribery and corruption culture and has a range of policies and procedures to minimise risk in this area. The Trust is committed to providing and maintaining an absolute standard of honesty and integrity in dealing with its assets. We are committed to the elimination of fraud, bribery and illegal acts within the Trust and ensure rigorous investigation and disciplinary or other

actions as appropriate if allegations are made. The Trust utilises best practice, as recommended by NHS Counter Fraud Authority.

Operational performance

The trust's operational performance against national and local standards is monitored and reviewed at:

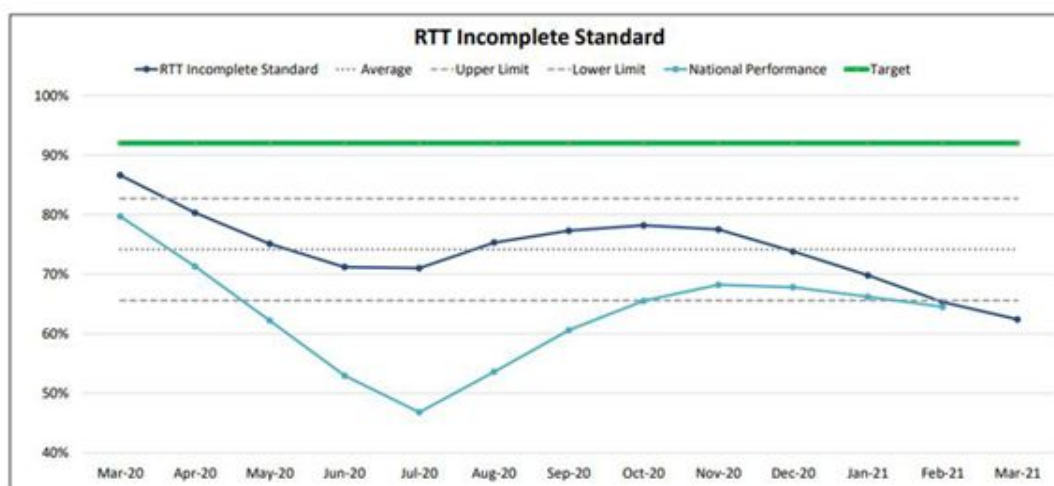
- Regular Performance Review Meetings between members of the executive team and each health care group
- The Urgent Care Board
- The Elective Access Board
- The Cancer Board
- Senior Management Team meetings
- The Performance and Finance Committee
- Trust board meetings

An Integrated Performance Report is presented to the Performance and Finance Committee, Quality and Safety Committee and Trust board meetings. Externally, the trust is held to account for its operational performance by NHS England/Improvement.

Targets and national standards

Delivery of all national standards has been significantly impacted by COVID-19 and the increased volume of emergency patients requiring care. The requirement to maintain separate urgent COVID-19 and non-covid pathways and flows through the hospital, the change of many wards to focus on emergency care and the transfer of theatre staff to critical care significantly reduced the volume of elective activity that could be delivered.

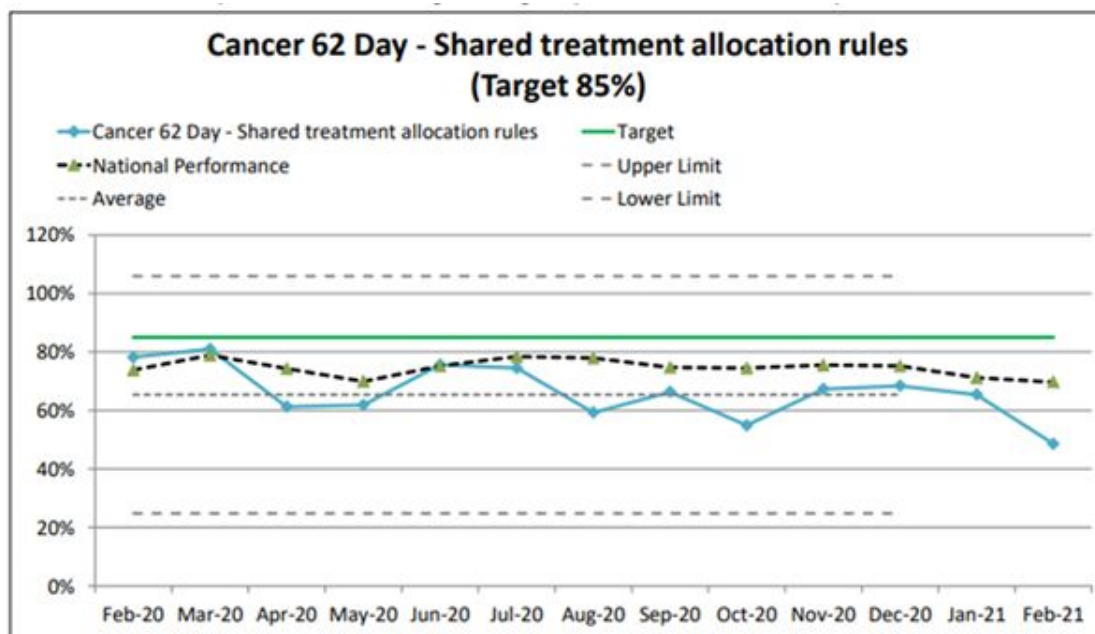
Full elective operating was paused on the PAH main site in March 2020 and did not recommence until July 2020. The local Independent Sector Provider hospital supported PAH by allowing activity to be carried out at their location which allowed PAH to continue cancer and urgent elective surgery, along with associated diagnostics.



The consequent impact on the 18 week RTT standard has been dramatic, although the trust has continued to deliver performance higher than the national average.

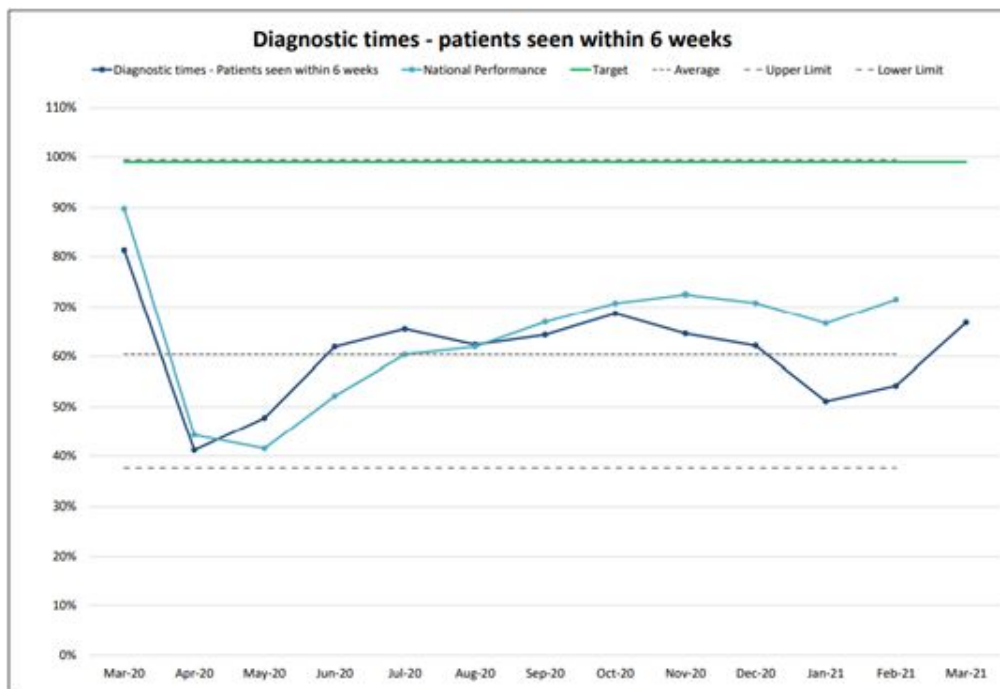
Delivery of the national cancer standards was also impacted by COVID-19, however the trust prioritised the maintenance of cancer services by transferring activity to the independent sector. After both waves of COVID-19, cancer recovery plans were implemented across all specialties and these led to sustained improvements in clearing the backlog of long waiting patients in the autumn which is reflected in the low 62 day performance seen as we treated more patients over 62 days than in previous years. The Trust's cancer performance was below the national average as it was more impacted by COVID-19 than other providers that had more flexible facilities to maintain elective activity during COVID-19 waves.

The trust continues to be committed to the delivery of all national cancer standards and plans are now in place to reduce the backlog from the first wave. The new 28 day faster diagnosis standard is coming into effect during 2021 and the trust has implemented a number of pathway changes in response to COVID-19 that sets up the achievement of the 28 day standard in 2021-22.



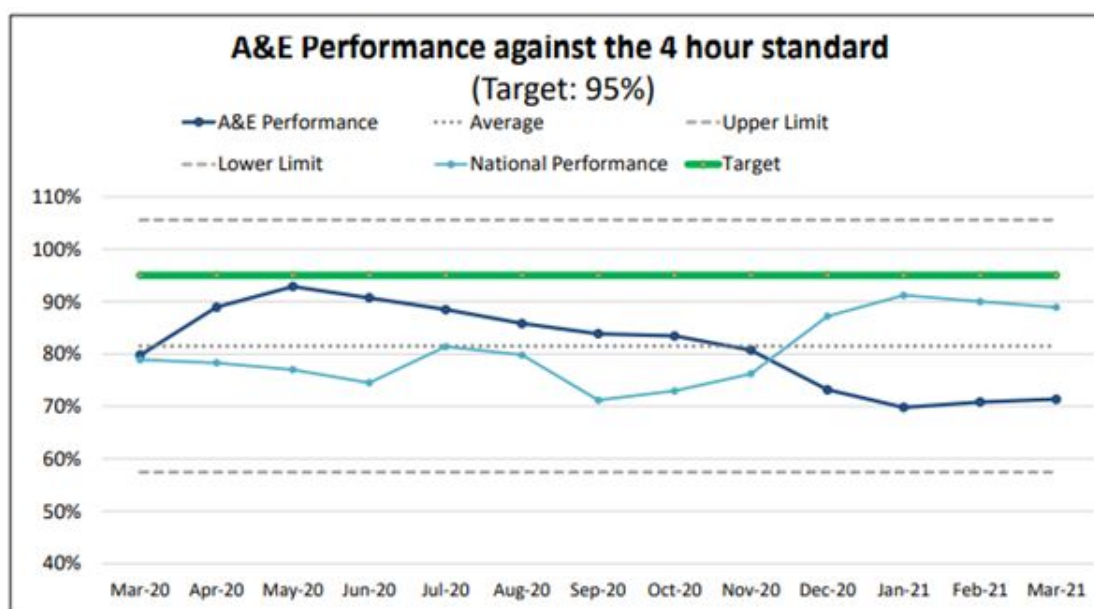
Diagnostic performance

Diagnostic performance was also impacted by COVID-19 demand as routine appointments were paused twice during 2020-21. Cancer and urgent diagnostics continued and despite considerable staff absence levels the diagnostics department delivered additional support to the emergency departments for COVID-19 patients. In between each wave of COVID-19 the diagnostic services recommenced routine work and increased capacity as far as possible with the use of CT vans on site, offsite additional working and patients travelling to independent providers for their diagnostic. The graph below shows clearly the drop in performance during COVID-19 and the rapid improvements in between.

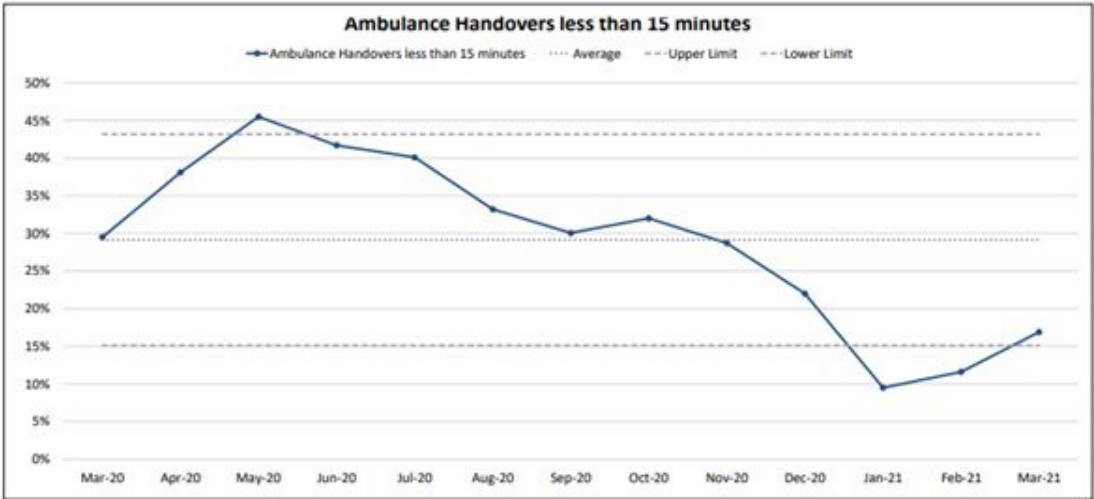


Urgent Care and ED performance

The urgent care attendances during the year have been untypical of an average year, with the waves of COVID-19 reducing non COVID-19 attendances, however attendances in March 2021 have shown an increase to pre-COVID-19 winter levels. The Emergency Department rapidly created a Respiratory Emergency Department to take COVID-19 attendances and ensure segregated non COVID-19 urgent care services. During the majority of 2020 the trust maintained performance against the 4 hour standard ahead of the national average however in the winter and early 2021

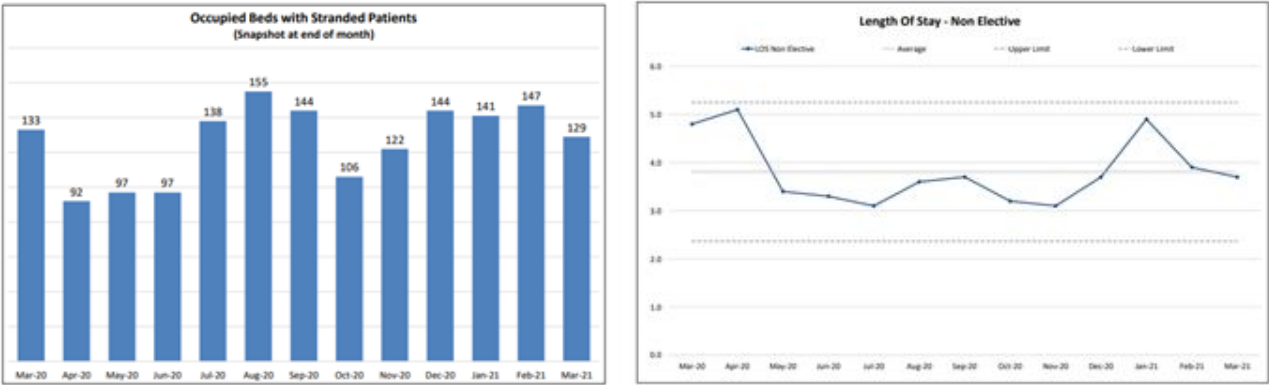


the increased COVID-19 admissions created huge pressure on bed capacity and the urgent care departments were unable to place patients on wards quickly to maintain the 4 hour standard. This also then impacted the ambulance handover performance and patients waited longer for handover to the emergency departments. The Rapid Assessment Treatment (RAT) pathways continued to be in place over the year but staff absence due to COVID-19 impacted the number of RAT teams available for this pathway.



We have continued to work with our system partners to further develop streamlined services that can be delivered in the most effective location and to prevent attendances and admissions to hospital. The Local Delivery Board has continued to forge close working relationships across organisations and enabled improved service provision such as increased intermediate care capacity and patient at home support for patients with existing care packages. Patient experience has been enhanced by the opening of the Adult Assessment Unit and Same Day Emergency Care in addition to improvements in the Frailty unit.

The trust has continued to focus on reducing long length of stays for patients through collaborative work with the community across the ICS. The length of stay of COVID-19 patients directly impacted the overall non elective length of stay, particularly as each wave of COVID-19 showed different average lengths of stay.



Responding in an emergency

Throughout 2020-21 the resilience team focused predominantly on supporting colleagues across the organisation with the response to the COVID-19 pandemic.

The response to COVID-19 has not been without its challenges, however, our people have gone above and beyond to demonstrate their ability to respond to challenges in a safe, coordinated and effective manner to ensure that our patients receive the best possible care.

From the end of January 2020 a full ‘command and control’ structure was implemented to ensure a robust response to what has been at times a rapidly changing situation. This structure comprised a Strategic Command Cell, with tactical cells managing operational response, clinical response, infection prevention and control, supporting our people, communications response and the management of our estate and infrastructure.

Along with our internal work we recognise the importance of multi-agency working, and continue to actively engage in the work of the local health resilience partnership, the Essex resilience forum and local organisations within our care system to provide a coordinated approach to emergency preparedness, resilience and response.

As required nationally we undertook an assessment against the NHS England emergency preparedness, resilience and response core standards for which we were able to provide full assurance to NHS England.

The coming year will see us working alongside our partners and a range of other organisations, as we face the continued challenges posed by the COVID-19 pandemic, and our work to recover, identify learning, and restore our services, in a way that reflects a dramatically different way of working. Further detail on how the Trust is managing this virus is included in the infection prevention and control section below.

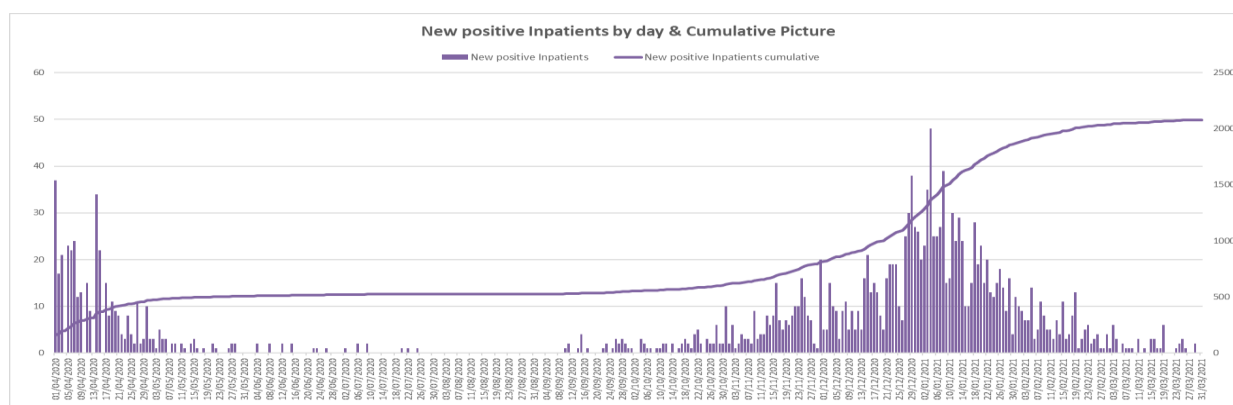
Clinical performance

Infection Prevention & Control

COVID-19:

The trust's Infection and Prevention Control (IPC) programme was in place well before our first COVID-19 admission on 15 March 2020. The IPC programme was supported and escalated using the Trust's 'command and control' structure, as the pandemic evolved. Numbers of COVID-19 positive inpatients are listed in the table below from the dates stated until 31 March 2021:

Table 1 – Data up to 31 03 21	Inpatient Spells since:	
	01 02 20 :First wave	01 09 20 : Second wave
TOTAL Inpatient Spells (with a Positive Swab):	2069	1542
Inpatients (Positive) - on 31 03 21:	5	5
Inpatients (Previously Positive)- on 31 03 21:	7	7
Discharged Home (with a positive Swab in Spell):	1249	1018
Discharged Other (with Positive Swab in Spell):	69	47
Inpatient deaths (with Positive Swab in Spell):	529	330
Transferred (with Positive Swab in Spell):	210	135



The above graph shows the number of new positive inpatients by day, and also the total cumulative number of positive patients admitted.

The table below shows numbers of nosocomial COVID-19 at PAHT, using national definitions:

01/04/20 – 31/03/21	Q1	Q2	Q3	Q4
Patients testing positive for the first time 3-7 days after admission (Indeterminate cases)	31	1	84	76
Patients positive for the first time 8-14 days after admission (Probable nosocomial infection)	19	0	57	56
Patients positive for the first time ≥ 15 days after admission (Definite nosocomial infection)	12	0	40	38

- Cases are 'indeterminate' as it is possible these are community acquired and not hospital associated cases.



- It is likely patients had the more transmissible Kent variant in Q3 and 4, as nosocomial infection rose steeply despite outbreak control measures

A variety of strategies were put in place to manage patients admitted with SARS CoV2 and control COVID-19 infections at PAHT. This was supported by the Trust Board.

- The Executive team had access to national and regional support and feedback, provided visible leadership and chaired all Trust meetings.
- There was acceleration of coordination, planning, monitoring, training including IPC training, staff resource and finance.
- Risk communication, Operational support and logistics, and supply chains were optimised.
- CCG and Public Health (Essex Health Protection Unit) engagement with the IPC team and Executive team occurred on a regular basis.
- Data management (COVID-19 data, mortality, and operational data), IT support and remote working was facilitated throughout the year.
- Constant review of national guidance took place with adherence in all aspects of IPC including uniform policy, linen and waste disposal.
- 27 COVID-19 associated outbreaks were noted at PAHT from 01 April 2020 to 31 March 2021; 22 associated with clinical areas and five with non-clinical areas. Regular reporting to East of England Regional leads took place.
- In order to reduce staff sickness and staff outbreaks, close contact between staff was minimised at work stations, ward rounds and handover sessions, moving to 'virtual' multi-disciplinary meetings, and staggering staff breaks.
- Mortality reviews of all probable and definite nosocomial COVID-19 cases took place. This helped us learn lessons and implement improvements in practice such as minimal ward transfers.

Changes made in March 2020 to the way the organisation and the IPC team functioned continued throughout 2020-21. The IPC cell, Clinical cell, People cell, and Strategic cell shared decisions with the Incident Management Team for onward action. Ten PPE safety marshals were appointed to work alongside the IPC team to support and monitor the PPE programme.

Other IPC measures continued including:

- ✓ Respiratory segregation and respiratory etiquette.
- ✓ PCR testing of in-patients every 48 hours for COVID-19, to detect cases early.
- ✓ Ward cleaning up to four times daily, using a neutral detergent and a chlorine-based disinfectant.
- ✓ Single use items were used where possible, including allocations for side rooms.
- ✓ Social distancing when possible, in-patients wearing masks (FRSM IIR) when possible, any visitors to wear masks.
- ✓ All staff in PPE appropriate to their assessed risk (FRSM IIR or FFP3, gloves, scrubs, aprons/ gowns, goggles/ visors), including in non-clinical areas.
- ✓ Staff support up to seven days a week, by Staff Health and Wellbeing and The People team.
- ✓ Robust IPC risk assessment processes and control practices including for non COVID-19 infections and pathogens.

The following measures were also implemented and escalated at the Trust:

- Epidemiological investigation and contact tracing within the hospital and via public health links in the community
- Adherence to all mandatory reporting systems, risk registers, board assurance framework.
- Individual risk assessments for all staff, redeployment and COVID-19 secure settings.
- Ventilation reviews, system modifications, and introducing air cleaning and disinfection devices to reduce airborne transmission.
- Isolation of immuno-compromised patients using a side room priority isolation list stratified by pathogen and infection risk.
- PPE supply and compliance monitoring, for low risk (green), medium risk (amber) and high risk (red) patient pathways.
- A significant expansion in Microbiology laboratory capacity and diagnostics: In-house PCR testing capacity increased to 252 tests per day on weekdays, with 126 tests per day during weekends.
- The introduction of Point of care (POC) tests, mainly Samba II nucleic acid amplification units with ED testing capacity of 72 samples a day, increasing to 96 samples per day.
- Daily meeting of the Infection Prevention and Control (IPC) cell including weekends when required, with roll out and monitoring of all IPC methods.
- Protection of the health workforce including monitoring of staff sickness, database of COVID-19 related staff illness, lateral flow testing and participation in the national PHE run Siren study.
- Case management, and improvements in therapeutics managed by the PAHT Clinical cell.
- Introduction of the COVID-19 care bundle at the Trust, which included protocols on use of antibiotics only for concurrent bacterial infections.
- A well-publicised vaccine programme made available to all staff from December 2020 with booster doses in March - April 2021.
- In line with national guidance, monitoring for Variants of Concern by isolating any patients with a travel history, and providing positive isolates for genome sequencing. Only the UK Kent variant B.1.1.7 has been detected at PAHT to date.
- Monitoring patients for COVID-19 re-infections, and more recently also being vigilant for COVID-19 infections post vaccination.

Alert Organisms

***Clostridium difficile* (C.difficile)** - There were a total of 43 hospital-onset and 11 community-onset healthcare associated (i.e. these patients were in-patients in the previous four weeks) *C.difficile* cases at the Trust during the year 2020-2021 (first two categories in table one below). This compares with 17 hospital-onset and five community-onset healthcare associated cases last year. The rise in cases is likely to be associated with the COVID-19 pandemic and the increase in broad spectrum antibiotic prescribing. Of the *C.difficile* cases in January to March 2021, at least half were known to have had COVID-19.

Community cases have also risen, and *C.difficile* in the whole population of West



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Essex CCG are higher; 73% compared to around 60% in the other two CCGs in the Integrated Care System (ICS).

Table 1: *C.difficile* – cases by month

<i>Clostridium difficile</i> (C.difficile)	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Hospital onset healthcare associated:	0	2	1	4	6	4	2	1	5	7	3	8
Community onset healthcare associated:	1	0	0	0	2	0	1	1	0	2	2	2
Community onset indeterminate association:	1	1	1	2	2	2	5	1	1	1	0	0
Community onset community association:	0	2	1	1	1	0	1	1	0	1	0	1

Control of *C.difficile* will be a top priority for our clinical teams, the IPC Committee, and the Antimicrobial Stewardship Group in the months to come.

MRSA Bacteraemia - There have been no Trust-attributable MRSA bacteraemia cases this year, which means the organisation remains in an excellent position nationally. Community cases have increased (four in 2020-2021) and are being investigated by the CCG.

MSSA Bacteraemia - There is no trajectory in place for MSSA bacteraemia. There were seven Trust-apportioned cases during the year which is a low number of cases. Case numbers are the same this year as for the previous year.

Gram Negative Blood Stream Infections (GNBSIs) - There is a whole health-care economy ambition for reducing healthcare associated GNBSIs by 50% by 2023-2024. Cases during 2020-21 were comparable with the number seen in 2019-20.

Total number of cases during the year 2020 - 2021

Gram Negative Blood Stream Infections	Pre 48 hour cases	Post 48 hour cases
<i>E.coli</i> bacteraemia	156	12
<i>Klebsiella spp.</i> bacteraemia	33	8
<i>Pseudomonas Aeruginosa</i> bacteraemia	14	3

Infection Incidents and Outbreaks

Norovirus. There were no outbreaks of norovirus.

Influenza and other respiratory viruses. From 28 September 2020 influenza A and B, and RSV testing was undertaken routinely. Just six of 20,000 patients tested were positive for Influenza A, nine were positive for Influenza B and ten were positive for RSV throughout the six month period. These are extra-ordinarily low numbers, showing the predominant role of SARS CoV 2, and the success of the influenza vaccination.

Audits and Surveillance

PPE compliance and hand hygiene audits continued throughout the year with actions plans implemented by Health Care Groups and monitored by the IPC cell/IPC Committee.

Conclusion

Together with our colleagues across the UK, we are reviewing lessons learned from the COVID-19 virus and our response, identifying gaps in our knowledge and anticipating potential challenges that may lie ahead. With global travel stopping and starting depending on the evolving epidemiological situation around the world, the COVID-19 vaccination programme and emergence of SARS-CoV-2 variants of concern, the virus is currently still being monitored very closely.

Learning from incidents

At PAHT, patient safety is a priority and we continuously work to ensure that incidents are managed effectively and most importantly that we learn and share the improvements from them.

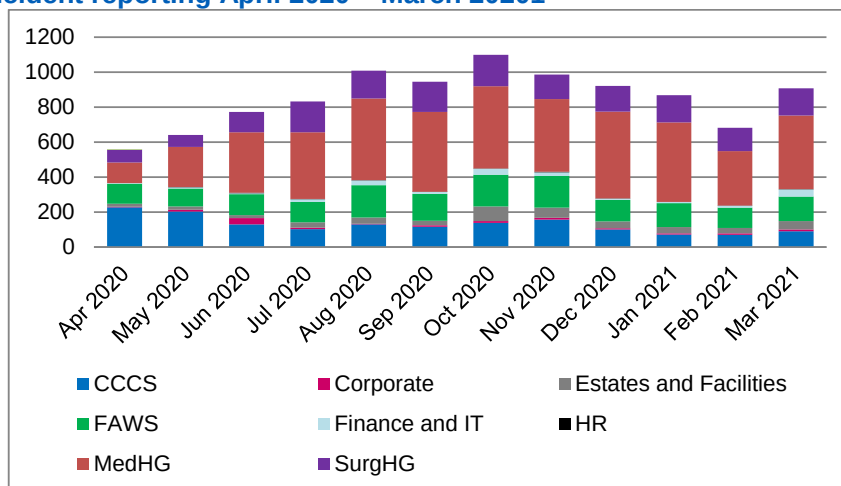
A patient safety incident or adverse incident is defined as 'any unintended or unexpected incident which could have, or did lead to harm for one or more patients receiving NHS funded care'. This includes all terms such as adverse incidents, adverse events and near misses, where an incident was recognised and averted.

This year saw changes in the incident management process in response to the impact of the pandemic. Twice weekly Incident Management Group meetings (IMG) took over from the historical daily oversight and serious incident group meetings. IMG reviews all incidents graded as moderate and above and makes a decision on the appropriate harm grading and the level of investigation. All moderate, severe and death graded harms were reviewed through this process.

IMG is chaired by the Director of Clinical Quality Governance, deputised by the Associate Director of Quality Governance. There is executive oversight of the incident management process through quality briefings and reports submitted to the Patient Safety Group and Quality and Safety Committee.

For the year 1 April 2020 to 31 March 2021, a total of 10,226 incidents were reported on the trust's Datix incident management system; this is a 0.8% increase from 2019/20.

Incident reporting April 2020 – March 2021



10,226 incidents were reported during 2020-21, 0.8% increase from 2019-20. 6902 were patient safety incidents (67%) reported this year, a decrease from 72% last year. Other incident reporting types were:

- 738 staffing shortage (7.4%)
- 652 staff related (6.4%)
- 564 equipment related (5.6%)
- 485 Security (4.8%)
- 463 environmental (4.6%)
- 369 monitoring (3.7%) not incidents but recorded on Datix for monitoring purposes
- 53 visitor related (0.5%)

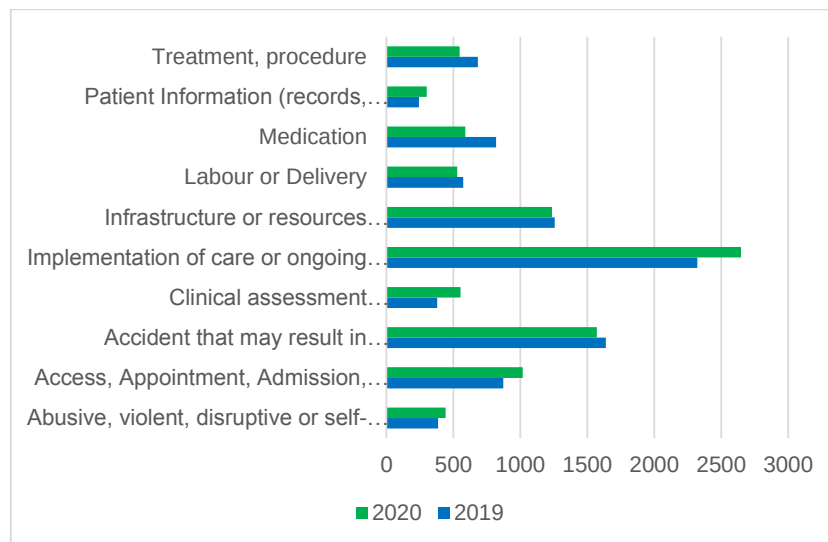
In comparison with last year there has been a rise in:

- Security incidents from 2% to 4.8%
- Staffing shortage from 5.8% to 7.4%

Both of these incident types saw an increase related to the social and organisational pressure of the pandemic. Other incident types have either seen congruent or decreased reporting numbers.

Top 10 Patient safety incidents

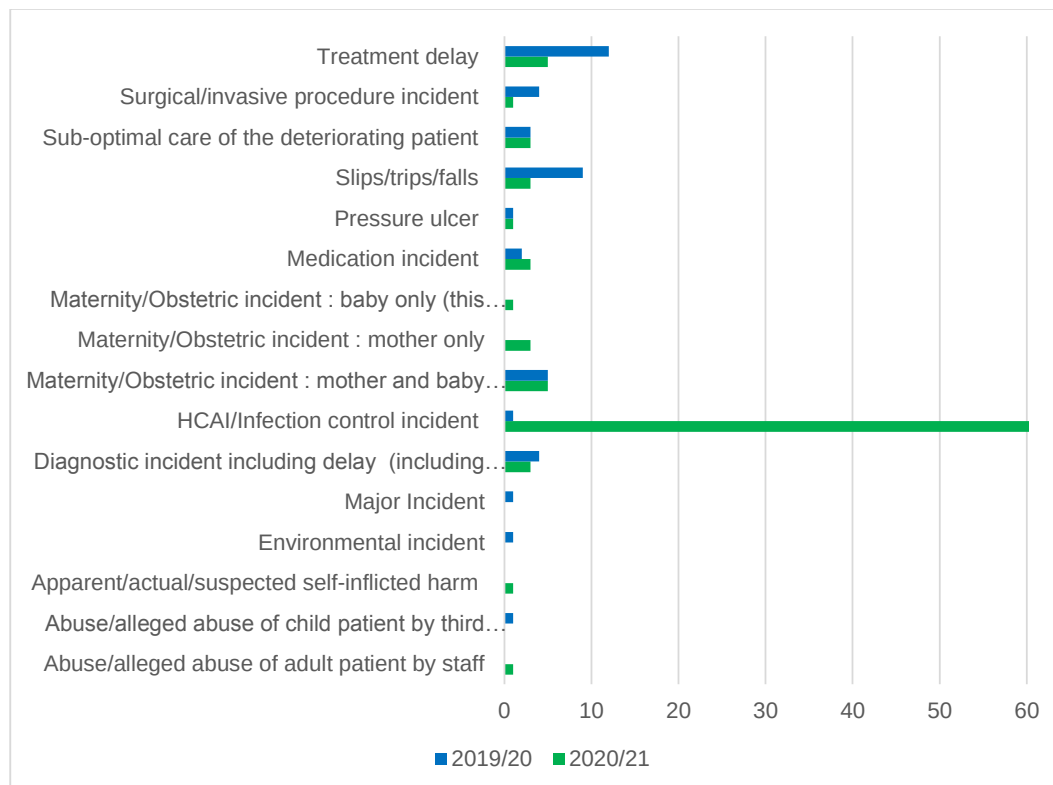
The top 10 categories of patient safety incidents reported in year are summarised in the table below. These are reported to the National Reporting and Learning System (NRLS) now part of NHS England to enable learning and comparison with similar sized organisations to occur.



Serious Incidents

94 serious incidents (SIs) were reported by the trust in 2020-21. In comparing the last two years with 2020-21, there has been a reduction in incidents for falls, treatment delays, surgical procedure, and diagnostic incidents meeting the criteria for SI. There was an increase in maternity incidents from 4 to 9, and an increase in health care associated infections related to the COVID-19 pandemic.

Serious incidents reported in year



Never Events

The trust reported one Never Event in 2020-21.

Friends and Family Test (FFT)

The use of the Friends and Family test was suspended at PAHT as the approach to gathering data presented a risk of infection for patients and staff. National returns of this data were also suspended for much of 2020-21 due to the pandemic. As a result, although some evidence was gathered electronically this section of the report focusses on the wider patient experience metrics.

The year in patient experience

We closed 2020-21 with 204 complaints received, the first increase in complaints year on year since 2011 (176 in 2019-20) and 3112 PALS cases received (vs. 3462 2019-20).

The top trending theme is medical care expectations and communication issues which continue to be the most significant issue.

A richer picture of communication issues

As we develop plans to renew our patient safety, experience and quality strategy we have been taking a closer look at the issues underlying our communication challenges. As a result of this analysis we now have a richer, more complex picture of the people who are most concerned about communication.

We see that caregivers and relatives play the most significant role in raising concerns about the quality of care and communication, confusion about the correct information from professionals to both patients and relatives appears to be a systemic issue and in addition to this telephone contact with relatives is significant issue.

Some examples of our operational response to these issues:

Existing support projects continue with 1542 family video calls completed through our 7 day service in the last year, over 1533 carers messages distributed and 128 ITU patients' carers and relatives provided with ITU information.

- The team developed new inpatient visiting guidance which has restarted based on the national guidance, supports open visiting for high risk groups as well as visiting at the ward managers discretion for those for whom this would 'enhance the care experience' so that family carers are fully supported.
- Repatriated patient property for over 200 families who may otherwise not have received their family member's belongings, refreshing our policy in the process, introducing securely tagged, colour coded bags for elements of property, a night safe and centralised control.
- New communication channels for carers with a group operating the first and third Monday of the month, being publicised through local voluntary sector groups and Trust communications.

- Work on health inequalities as a result of funding from the East of England Cancer Alliance who funded a cancer information film from a patient perspective translated into five community languages on video and information card. The languages are Polish, Romanian, Italian, Urdu and Punjabi.

Mortality

Some of the statistical markers for mortality have been higher than expected for 2020-21. This year a change in requirements for the configuration of the data submitted to HES has led to incomplete data submission affecting the HSMR and SHMI from September 2020-November 2020. Resolution is expected by May 2021 and a data bundle will be submitted which will enable correction of the SHMI and HSMR for that period.

Hospital Standardised Mortality Ratio (HSMR) and Standardised Mortality Ratios (SMR)

HSMR

The Hospital Standardised Mortality Ratio is the ratio of observed deaths to expected deaths for a basket of 56 diagnosis groups, which represent approximately 80% of in hospital deaths.

The trust's rolling HSMR and SMR reported for the last 12 months have been higher than expected. For the period December 2019 to November 2020 (including a time lag of one month) the trust's HSMR was 116 (higher than expected) but improved from 2018-2019 (122).

It is anticipated that the HSMR will continue to improve.

PAHT is 1 of 6 trusts within the peer group of 15 that sit within the 'higher expected' range.

Summary Hospital-Level Mortality Indicator (SHMI)

SHMI for the period December 2019 to November 2020 is 101.85 (as expected).

Progress over the past year

Mortality governance is a key priority for the trust board. The medical director has executive responsibility for the learning from deaths agenda and a non-executive director has responsibility for oversight of progress.

A trust wide improvement programme and Mortality Improvement Board was established in 2019-20 utilising quality improvement methodology to deliver improvements in patient outcomes and mortality rates.

Over the past year the national medical examiners system has been fully implemented and 100% of all inpatient deaths are reviewed and scrutinised. The national system of structured judgement reviews has also been rolled out across the



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trust. Themes identified from these reviews inform the quality improvement projects to be undertaken and learning from mortality reviews is shared across the organisation.

A lead nurse for mortality and quality was also appointed to facilitate the mortality review process.

The COVID-19 pandemic has increased the actual and the expected number of deaths both nationally and at PAHT. The first COVID-19 death at PAHT was reported on 18 March 2020. All deaths related to COVID-19 are included in the structured judgement review process with the learning shared rapidly through the IPC reporting infrastructure.

Going forward a new software system (SMART) is being implemented to enable a 'live' and 'visible to all staff' view of the trust status in terms of learning from deaths. Go Live is anticipated to be May 2021 and the benefits expected include more timely insights in to the effectiveness of the care we give.

The healthcare groups will be appointing medical patient safety and quality leads who will work with all the clinical specialties to ensure learning from deaths across the organisation and support a continuing improvement in mortality indices.

Quality improvement



The trust is registered with the Care Quality Commission (CQC) and our current status is 'registered without condition'.

Our staff used the CQC Inspection outcomes as the foundation upon which to critically examine our services and focus on how we plan and deliver the fundamental aspects of safe care and have taken decisive action to change everyday activities which have led to significant improvements.

The last full trust inspection conducted by the CQC was completed in March and April 2019 with the report published in July 2019, this showed improvements, with five of the trust's core services rated as **Good**. The trust received an **outstanding** rating for caring for children and young people. The overall quality rating for the trust remained the same at **Requires Improvement**. However, the trust received an overall rating of **Good** for both the well-led assessment and also for the use of resources assessment.

The current CQC ratings received in July 2019:

Ratings	
Overall rating for this trust	Requires improvement 
Are services safe?	Requires improvement 
Are services effective?	Requires improvement 
Are services caring?	Good 
Are services responsive?	Requires improvement 
Are services well-led?	Good 
Are resources used productively?	Good 

1 The Princess Alexandra Hospital NHS Trust Inspection report 31/07/2019

During the 2019 inspection, the CQC identified areas where the trust was performing well and had made improvements from previous inspection in 2017, these were:

- Safety incidents reported well
- Pain management regularly monitored
- Patients treated with compassion, kindness, privacy and dignity.
- Services were inclusive and complaints treated seriously
- Positive culture where staff felt respected, supported and valued
- Clear vision for the trust and embedding of large amounts of change over the last 3 years
- 72% of all ratings are now 'good' or 'outstanding'
- Caring rated as 'good' for the third consecutive inspection

Within this inspection report, the CQC identified areas where the trust needed to improve performance and these were:

- Mandatory training not completed (doctors) and insufficient nursing staff
- Poor and incomplete record keeping
- Limited audit activity (national and local)
- 4-hour standard for urgent and emergency care not achieved
- Slow response to issues of risk and poor performance

The report detailed 42 recommendations for the trust;

- 22 MUST do actions
- 20 SHOULD do actions.

The recommendations were collated into 14 individual projects based on themes, using our Quality Improvement methodology to enable a consistent and sustained approach to the achievement of these objectives. Each project has a designated executive, a senior responsible officer (SRO) and may have a small project team appointed.

The trust is using the quality improvement plan as a dynamic document; with additional topics added over time, as we identify areas that require further improvement.



The quality improvement plan is monitored monthly through the Clinical Quality Improvement Group and reports into the Trust Compliance group and Quality and Safety Committee.

2020

The CQC undertook an unannounced winter assurance visit to the Urgent and Emergency care department on 3 February 2020. Their report was published in April 2020 and rated the service **Requires Improvement** with two areas receiving a regulation notice:

- The trust must ensure sufficient provision of out of hours endoscopy service to minimise risk of treatment delay to patients who require to access the service
- The trust must ensure detailed up to date records are kept in relation to provision of care and treatment and it is reflective of reflective of each patient's full clinical pathway and include actions taken in response to individual risks.

The Trust implemented a quality improvement plan to address recommendations raised and strengthen the leadership team with the service areas.

2021

The CQC conducted an unannounced inspection of the emergency and urgent care department on 14 February 2021. Their report was published on 27 April 2021, giving the department a rating of inadequate and the trust received a section 29A warning notice.

The concerns identified by the CQC from their inspection was-

- Risk assessments were not being completed for all patients within the emergency department.
- Not assured that patients presenting with acute mental health illness were receiving timely assessments.
- There was a lack of adherence to infection, prevention and control procedures.
- The process for the provision of the out of hour's endoscopy service for patients presenting with acute upper gastrointestinal bleeding was not embedded.

Immediate actions were implemented following receipt of the warning notice, with further actions underway. We have undertaken a review of these findings across the trust, for all core services to ensure the learning is shared widely and improve services across the whole trust.

The trust is confident that the actions undertaken and planned in the coming weeks will ensure we continue to improve the safety of patients in our emergency department.

The CQC will complete a further unannounced inspection of the emergency department after 1 June 2021 to monitor our progress against the action plan and we look forward to the opportunity to show them the improvements we have made.

Quality first team

The quality first team defines their purpose as:

‘Inspiring our people to put quality first for the benefit of our patients, staff and wider community by building confidence and capability in quality improvement’

The past year has been a very different year for everyone especially those working and receiving care in the NHS.

The Trust’s and NHS’s response to the COVID-19 pandemic has seen some quality improvement initiatives and transformation projects not progress at the pace that had been hoped for or anticipated. However, in other areas our response to the pandemic has seen some changes occurring at an exponentially increased pace, due to the necessity to keep patients safe. This is evidenced by the ability of our teams to introduce non face to face outpatient services within two weeks. Our learning from such changes has supported the ability to sustain and enhance this change for the benefits of our patients, people, performance, places and pounds.

The Quality First team responded at pace to the necessary changes to activity the pandemic has necessitated. This included redeployment of members of the team to high risk areas such as critical care, introduction and delivery of the lateral flow tests for staff and key patient groups and leading the COVID-19 vaccination service to circa 7000 local health and social care staff.

The improvement partnership

The ‘Improvement Partnership’ is our programme for enrolling, engaging, involving and developing our staff in quality improvement. The quality first team runs leading change and leading projects learning and development sessions with the objective of enabling them to deliver successful quality improvement projects. When the staff member completes a quality improvement project (capturing project outcomes in poster), they become PAHT improvement partners:



The improvement partnership is an enabler addresses the leadership, culture and organisational development required to embed quality improvement at PAHT.

We continue to develop our people with quality improvement skills, knowledge and capability with a focus on leading change and leading projects. 385 staff members have completed Leading Change, with 198 completing Leading Projects. We now have 52 Improvement Partners at PAHT.



Improving patient outcomes

Our work to improve outcomes (mortality rates) for our patients has continued throughout the COVID-19 pandemic. Original plans were amended as many of the clinical and operational leads had to prioritise supporting our response to the pandemic; however here are some notable achievements from the previous year.

We have significantly improved our learning from death processes and standardised the mortality and morbidity meetings that happen in our speciality teams giving us greater ability to address lessons learnt as well as celebrate our successes. Our focus will continue to be on the areas where we know we have an opportunity to improve, namely the following diagnosis areas, sepsis, acute kidney injury (AKI), acute respiratory (COPD, Pneumonia and Aspiration Pneumonia), fracture of neck of femur and our end of life pathways, which will continue to do in partnership with our wider health and care system colleagues.

Every specialty has a clear clinical strategy in place and a big part of delivering these will address unwarranted variation in care and ultimately improve patient outcomes.

A significant milestone achievement for PAHT was being able to provide non-invasive positive pressure ventilation in our respiratory ward in addition to critical care. We know beginning non-invasive positive pressure ventilation quickly can improve patient outcomes, reduce length of stay in hospital and reduce the need for admission to critical care. Thank you to the respiratory, Locke Ward, critical care, emergency department and clinical site teams for their support with developing the pathway.

Theatre utilisation

The development of a QlikView dashboard to show performance in theatres to help identify opportunity for improvement was completed and went live on 15th September 2020. This development will support focus for the surgical teams to improve theatre utilisation to achieve 85% utilisation by March 2022. The focus is now on improving utilisation within three clinical specialties, Ophthalmology, ENT and Maxillofacial. If we reach 85% within these specialties it will increase the trust's utilisation by 10%.

Outpatients

Patient initiated follow up (PIFU) allows patients to determine whether their condition requires clinical intervention and allows access to the specialist when it is needed. In turn this reduces the number of follow up appointments needed. The first pilot for Fracture went live on 22nd February 2021 and as at 25th March 2021 38 patients have been discharged onto this pathway. Prior to PIFU these patients would have been booked for a follow up appointment. Plans are in place for a pilot in Neurology to go live on 12th April 2021. We will be working with specialties to determine the roll out plan for PIFU across the Trust.

“Doctor Dr” was introduced and enabled paperless communication for patients. A text message generates a link for correspondence to be viewed. This is in place for

all appointments in outpatients with outcome letters due to go live in April 2021. There has been a 71% uptake in patients choosing to view their letters electronically which has both cost savings, due to reduction in postage, and environmental saving, as less paper is used.

We moved away from a one-way messaging flow provider to a new provider enabling two way messaging with our patients. We have gone live with Paediatric and Paediatric diabetes as a two way messaging flow for appointments. Other main outpatient services will be live by October 2021 and pilots are due to commence for gynaecology elective activity in April 2021 before roll out to all elective activity.

Telemedicine was rolled out rapidly, using the Attend Anywhere platform, as part of the national response to COVID-19 in April 2020 with 70% of specialties trained to use the system. Template letters and processes have been established to support the delivery of telemedicine. We are now engaging with operational teams to identify opportunities to increase non-face to face capacity in line with new hospital ambitions.

National Careers Week

Over 150 students took part in virtual work experience as part of National Careers week, where they looked at 3 of the NHS's wicked problems (recruitment and retention, patient flow and patient experience) they then presented their ideas on how these problems could be solved to the board of directors during national careers week.

Our values

The Quality First Team worked with the People team to lead a review of the Trust values. As part of this review 433 surveys were completed which included 807 stories shared by staff. 35 people attended the workshop and 100 people gave permission for their stories to be shared. In the second survey, requesting staff to order the new values, 442 responses were received. Our new values are:

Patient at Heart (PAH)	always holding the patient and their wellbeing at the centre of our thoughts and efforts
Everyday Excellence	sharing and celebrating our successes, being honest when we get it wrong, giving us the ability to learn from both
Meaningful Connections	building trust and mutual understanding through empathetic conversations
Purposeful Curiosity	using our imagination and creativity to improve experiences and outcomes
Creative Collaboration	knowing strength comes from diversity, we combine our experiences, skills and talents,



working together to find new and better ways to care

The Culture Steering Group has been established to support embedding the values and other work streams to improve the culture at PAHT and this will continue to develop into 2021-22.

Strategic realisation and system partnership

The Quality First Team works in partnership with PAHT's Strategy Team to support the facilitation of Clinical Strategy workshops and the quality improvement methodology is embedded into each of specialty level strategies ensuring that our plans have clear aims, measurable deliverables and achievable actions (tests of change).

We also work with system partners in the development and delivery of the ICP/S and transformation plans and support expert oversight groups (EOGs) in the delivery of quality improvement.

People performance

In 2020-21 our people faced many challenges in response to the COVID-19 pandemic. Staff were required to work in significantly different ways through skill development and redeployment in management of unprecedented levels acute patients as well as COVID-19 related staff absences. The trust has continued to recruit throughout the year to both substantive posts and temporary recruitment to support is increase and pressure in the services.

The key workforce indicators are reflected in the table below:

People KPI	2019-20 target	Year to date performance
Vacancy rate	8.6%	8%
Sickness absence	4.3%	3.6%
Voluntary turnover	10.7%	9.7%
Statutory and mandatory training	92%	87%
Appraisal	89%	71%
Flu	80.1%	81%
Time to hire	31 days	Average 41 days

The below key themes highlight the outputs that form our people framework and clarifies the five key pillars of the people strategy:

- Culture, health and wellbeing
- Workforce resourcing and planning

- Learning, leadership and team development
- New service and workforce models
- Optimising technology

It is acknowledged that the last year has been a challenge for our workforce, in addition to PAHT's people strategy the NHS 2020-21 people plan also set out practical actions for employers and systems in light of the challenges faced by organisations in their response to COVID-19, as outlined below:

- **Looking after our people** – with quality health and wellbeing support for everyone
- **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

The trust focused on how we continue to look after each other and foster a culture of inclusion and belonging, as well as taking action to grow and develop our workforce, and work together differently to deliver patient care.

Health and Wellbeing

One of the key priorities during 2020-21 was to implement and embed a sustainable health and wellbeing offer to our staff in response to the impact of COVID-19 and the challenges that have been faced.

The trust had 160 staff who were required to shield under government rules. Laptops were distributed to enable staff to work from home where possible. This included some redeployment into roles that could continue to provide support remotely from home.

A seven day week first line absence reporting service was set up during the peak of the pandemic to take calls from staff reporting their absence either through their own sickness or a requirement to self-isolate. This captured live absence data throughout the day and enabled clinical staff to reviewing staffing levels on an ongoing basis.

Individual risk assessments were carried out on staff working on all hospital sites which assessed any underlying conditions that may affect the level of risk of becoming seriously unwell if tested positive for COVID-19. Advice and coaching was provided to staff and managers on undertaking the risk assessment and managing outputs. Where required, action plans were then agreed between the staff member, their manager and the trusts staff health and wellbeing service (SHaW).

Project wingman was a national initiative resourced voluntarily by pilots and cabin crew who were grounded at the time of the pandemic. The purpose of the initiative was to provide a first class style socially distanced breakout area where drinks and refreshments were served to staff. An additional key element of this initiative was



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that all of the cabin crew were mental health first aiders. This was well received by staff.

The winter flu campaign saw 81% of staff vaccinated, a slight increase on 19/20 figures.

Webinars took place within the trust to provide staff with updated information and advice about the virus, a number of these were facilitated specifically for our BAME staff to address emerging themes and concerns.

The trust has developed a range of health and wellbeing support initiatives for our staff whether at the front line or in supporting services. A number of these services have been developed on a national and ICS level and additional support implemented locally in partnership with SHaW (staff health and wellbeing) - our occupational health service, the trust's employee assistance programme, the Red Cross and Essex partnership university NHS foundation trust (EPUT).

Work was undertaken to support both shielding staff and their managers in returning to work and psychological and physical support was made available. The trust delivered an ongoing series of webinars for both staff and managers throughout the COVID-19 period.

Lateral flow testing was implemented across the trust in October 2020, initially to frontline staff and in December this was rolled out to all staff.

January 2021 saw the first dose of the COVID-19 vaccination delivered to staff, students and volunteers working within the trust. This programme was led by the trusts occupational health department with the support of the quality first team. The second vaccination dose programme commenced in March and completed in April. 85% of staff received their first vaccination through the trust, those staff who were unable to receive their vaccinations were supported to book their vaccination through the community provider in Harlow.

The trust introduced a peer support initiative called "time to talk". This initiative is supported by substantive staff from within the trust who are trained as either mental health first aiders or are trauma and risk management practitioners. The concept is to provide immediate intervention with face to face drop in support to staff across the trust at designated times and places such as at the end of each shift. This support has been well received by staff and will continue as part of the trust's recovery plan going forward

A 12 week "back to better" people focused campaign was launched by the trust with the aim of supporting our people to develop and drive refreshed approaches to delivering services following the significant challenges that have been faced over the last 12 month and will continue to face going forward. There are four themes underpinning this campaign:

- Health and Wellbeing
- Compassionate and inclusive leadership
- Civility
- Operational leadership

The trusts intranet ALEX, has a page dedicated to the health and wellbeing offer available to our staff. This includes signposting staff to the services which offer both psychological and physical wellbeing and support, as well as online resources, toolkits and self assessments.

In line with the NHS people plan the trust has appointed a non-executive director as a health and wellbeing guardian. This role will work closely with the people division and wellbeing leads across the organisation to encourage a model of wellbeing leadership.

Workforce, resourcing and planning

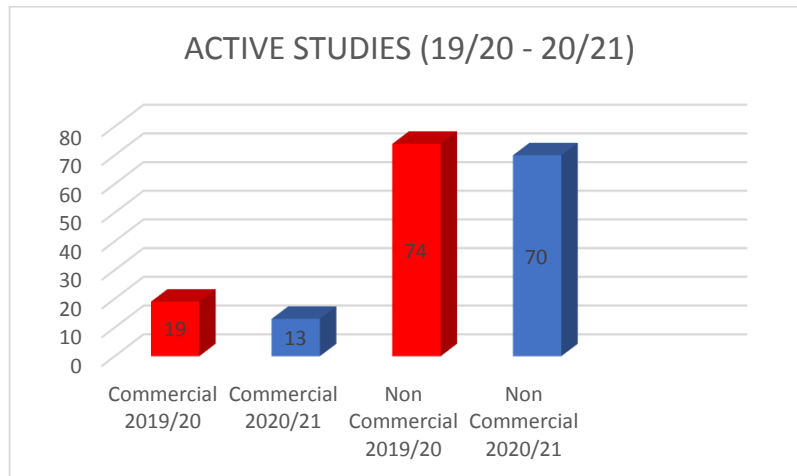
The trust implemented agile working across the organisation including working from home. The wide use of laptops and digital telephone systems enabled the trust to implement social distancing rules and decrease footfall across our working sites. The impact of agile working/ working from home has enabled greater productivity efficiencies through re-evaluation of current processes and systems and has enabled specific objectives and targets to be set and measured more efficiently.

- We continued to welcome international nursing staff into the trust, facilitating the required isolation period with designated hospital accommodation. The nursing staff group now has a vacancy rate of 7.8%. The overall trust vacancy rate is less than 10%
- 2020-21 saw a drive to increase healthcare support workers across the organisation. The current vacancy rate is and there are ongoing recruitment pipeline to bring this down to 0%
- There were been a number of national initiatives to support staff groups in being deployed across the NHS in response to the pandemic. These included medical student aspirant nurses and staff deployed from other organisations, both private and public sector
- The trust has continued to support NHS management graduates placed within the organisation
- Following a pause during the pandemic, pre-registration students restarted placement with the trust in March 2020
- Whilst apprenticeships were paused in a number of areas during wave 1 and wave 2 of the COVID-19 pandemic, we have continued to support this scheme where possible and currently have 65 apprentices working across the trust
- The trust management and leadership development programmes were paused for most of 2020-21, the ward managers leadership programme commenced in March 2020



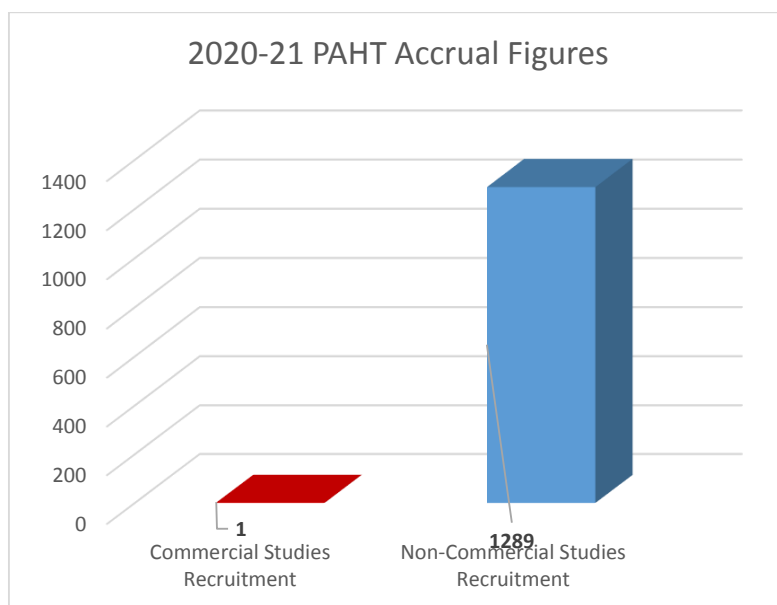
- Non statutory training was paused during the pandemic to maximise availability of staff. All training was reinstated in March 2021, a majority of which is either online or via MS teams
- Appraisals were also paused during the pandemic, these were also reinstated in March 2021

Research, development and innovation



There were 13 Commercial Portfolio studies throughout 2020-21. 5 were open with 1 having a significant delay/suspension due to the COVID-19 Pandemic (Diamond Study). 8 of the studies were In Follow Up.

We had 70 Non Commercial Portfolio studies in 2020-21. Out of the 50 Open studies, 15 were significantly suspended or delayed due to the COVID-19 Pandemic. There was 1 COVID-19 Non UPH study and 9 COVID-19 UPH studies. 17 were closed to recruitment and had moved to In Follow up only and 3 were closed following the conclusion of Follow Up.



Recruitment per Speciality

Recruitment	Speciality	Directorate	Commercial/Non Commercial
Portfolio Activity			
777	Cancer	C,C & CSS	Non-Commercial
5	Gastroenterology	Medical	Non-Commercial
3	Emergency Dept.	Urgent & Ambu	Non-Commercial
16	Critical Care	Surgery	Non-Commercial
369	People	Corporate	Non-Commercial
64	Respiratory	Medical	Non-Commercial
10	Maternity	F & W,S	Non-Commercial
3	Ophthalmology	Medical	Non-Commercial
35	Musculoskeletal	Medical	Non-Commercial
6	Diabetes	Medical	Non-Commercial
1	Cancer	C,C & CSS	Commercial

Improving our estate

The trust has invested substantially in remodelling and maintaining the estate with the following initiatives and priorities progressing at pace over 2020-21.



- Improving the management of buildings and engineering systems.
- Providing excellent facilities.
- Ensuring safety and security.

The approved capital programme was significant including £7.7m backlog maintenance and £17m investment in improving the estate. The programme was made up of three elements, these include:

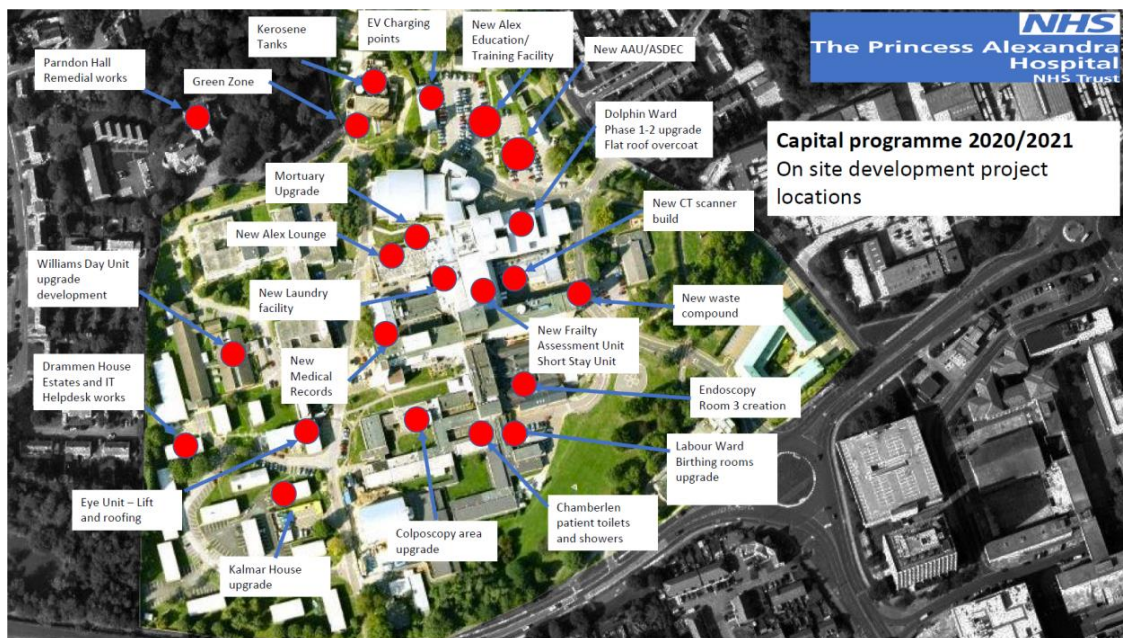
- Emergency backlog and critical infrastructure maintenance schemes (£7.7m).
- Capacity schemes (£11.3m).
- Development schemes (£5.7m).

2020-21 saw the Trust implementing agile working, reducing office accommodation onsite to enable maximising the availability for clinical space in line with the emerging demand from increased patient activity.

Completed schemes include:

- Fracture Clinic.
- Kao Park (administrative hub)
- Adult Assessment Unit (AAU).
- Multi-faith facility
- Alex Study (Consultants Office)
- Dolphin Ward upgrade.
- Drammen House upgrade
- Kalmar House upgrade

The locations of the projects are shown on the site plan below. Included are schemes initiated in 2020-21 but due for completion in early 2021-22.

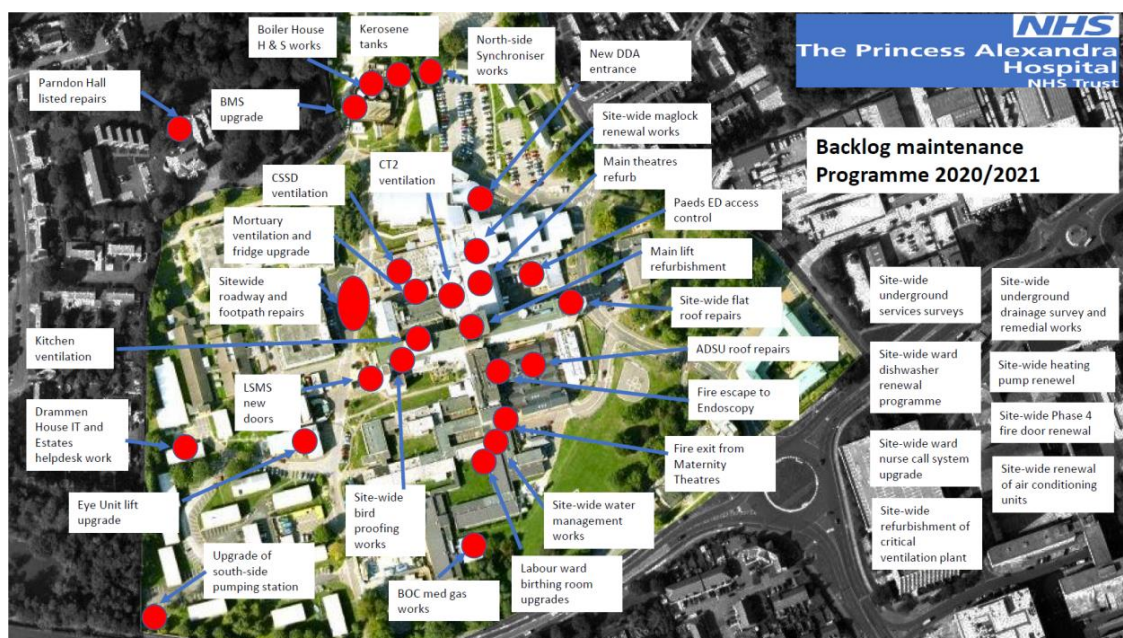


In addition we completed a total of 54 schemes (90 individual projects) ranging from £10k to £500k to manage maintenance backlog and the Trust's critical infrastructural risks. These included:

- Asbestos - encapsulation/removal works.
- Fire damper remedial works - Trust wide.
- Replacement of kerosene tanks located in Boiler house compound.
- Water Management remedial works from audit.
- Labour ward corridor and room upgrade.
- Upgrade of Bereavement Suite.
- Bird proofing to roof mounted AHU/Chiller plant.
- Site underground services survey update and required remedial works.
- New external door sets to meet LSMS audit report.
- Upgrade of main block (3No.) and Eye Unit lift
- Obsolete switchgear replacement - North and south side.
- Medical gas plant remedial works identified in BOC audit.
- CSSD - ventilation replacement.

- New UPS/IPS to ED, theatres and ITU dept. on critical equipment.
- Basement fabric, electrical, mechanical repairs required for compliance and business continuity.
- Refurbishment of main sewerage stack.
- Site-wide Roadway and Footpath Repairs.

The locations of the projects are shown on the site plan below.



Sustainability

The Clinical Senate Council (South West) acknowledged that climate change should be treated as a healthcare emergency and that there is much that can be done both in the short and medium term to make the NHS more sustainable, at provider, organisational, procurement, estates and individual levels. In light of this the trust has continued to pursue its commitment to ensure delivery of high quality health care service with minimal negative impact on the environment.

We reported significant progress on our Sustainable Development Management Plan (SDMP) for 2019-20 financial year; where we achieved 28% energy related carbon footprint reduction in compliance with set regulatory target by the Environmental Agency on our Carbon Reduction Commitment (CRC) on 2013 baseline figures. This success was replicated in our waste management practices where we laid emphasis on processes and methodology to support waste hierarchy and circular economy and in water management with reduction in water usage.

Despite the impact of COVID-19 pandemic in 2020-21 financial year, the Trust continued to embark on environment and sustainability driven projects to realise set

actions on its SDMP and to comply with requirements set by the Sustainable Development Unit (SDU), NHSI and the government. The projects focused on include:

- Completion of the LED lighting project to actualise the projected carbon and cost savings.
- The 'Green Zone' project:
 - Implementing the 'Green Travel Plan' – installation of Electric Vehicle (EV) charging infrastructure.
 - Cycle rack installation
 - Changing facilities for cyclists and runners
 - Waste recycling area
- 'Green Plan' requirement – review of SDMP activities and timelines to align them to the new Green Plan guideline introduced by the SDU, NHS England and NHSI
- Delivering net zero by 2045

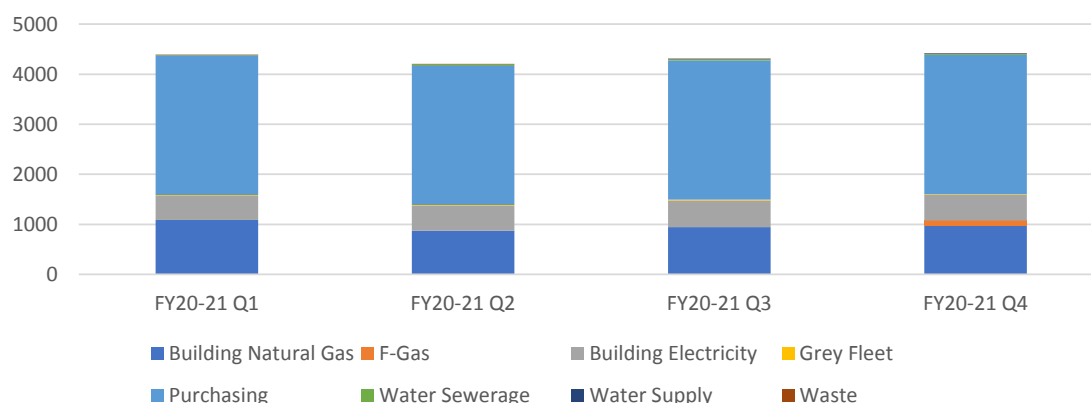
Carbon Footprint Statement

To refresh our SDMP in line with new SDU guidance the Trust is working with a Net Zero consultancy firm to establish our baseline emission data and to set measurable targets and a pathway to achieve net zero by 2045. The analytics method is based on the tools proposed by the Intergovernmental Panel on Climate Change (IPCC) for compilation of Greenhouse Gas (GHG) emissions. The data stream includes limited emissions under Scope 1 and 2 (purchased electricity, gas & fuel used in transport) and limited emissions under Scope 3 (fuel used in personal/hire cars for business purposes, purchasing, generated waste and water supply/sewerage).

The interim report (using data available as at February 2021) shows total carbon emission of 17,321.77tCO₂e and the following percentage breakdown by category:

- Purchasing (scope 3) – 64.21%
- Natural Gas (scope 1) – 22.42%
- Electricity (scope 2) – 11.65%
- Others (scope 1&3) – 1.72%

Quarterly GHG Emissions by Category (tCO₂e)



The 2020-21 GHG emissions data indicates that a high percentage of our carbon footprint is from purchasing i.e. supply chain contributors, so key action of the



updated SDMP (Green Plan) will be to collaboratively work with our supply chain partners to fully integrate sustainable and ethical procurement practices into our procurement strategy/processes for all goods and services.

Sustainability Activities Update

Light-Emitting Diode (LED) lighting project

The Estates & Facilities team along with the installation contractor worked through the challenges of COVID-19 pandemic to deliver the first and second phases of the LED project to programme in December 2020.

The total number of installations across the site and the benefits are listed below:

- Total number of LED luminaires / lamps installed – 4,144 units
- Annual cost savings – £150,068.74
- Annual energy savings – 1,005,016.35 kWh
- Annual carbon savings – 384.18 Tonnes of CO₂

Green Zone Project

The green zone construction phase works started in February 2021 (delayed due to COVID-19 pandemic). The scheme is split into two major elements – the installation of Electric Vehicle (EV) charging points and the cyclist and runners welfare scheme. In addition to the reduction of travel related carbon footprint, these projects also support staff welfare and travel modal shift as indicated in staff response to travel survey conducted in 2019.

Electric Vehicle (EV) charging point

The EV charging point works have completed. This scheme will enhance modal shift to use of electric vehicles rather than fossil fuelled vehicles. The installation provides the following:

- Capability to charge up to 22kW (“Fast charging”) to ensure the system is future proofed ready for improvements in vehicle battery
- Load-balancing between multiple vehicles to optimise available supply capacity
- MID-approved (Measuring Instrument Directive) compliant meters fitted to each charge point connection ensures accurate consumption monitoring
- Integrated Wi-Fi to enable remote monitoring and fault resolution

Changing facilities for cyclist and runners

The planned completion date for this work is May 2021. Deliverables from this element of the green zone scheme are:

- Fully refurbished changing facilities with external cladding
- Installation of cycle storage facilities
- Improved landscape around the changing facilities, providing outdoor garden space for staff
- Improved lighting and footpath with benches.

Provision of waste recycling area and receptacles

The provision of recycling area and receptacles will enable the Trust to embark on recycling more domestic waste streams as well as supporting the local community with recycling of clothing and glass bottles.

Net Zero strategy project scope

The trust is undertaking this project to align its carbon emission reduction commitments to NHS and UK government goal of achieving net zero by 2050. The output will be a defined and measurable Net Zero Strategy to be adopted by the trust and will include high-level cost-benefit analysis and action plan pathway to Net Zero carbon emission. This project involves:

- Comprehensive assessment of the current major greenhouse gas (GHG) emission sources and emissions across the Trust aligning to the NHS Carbon Footprint guidance including access to the Net Zero Hub for ongoing carbon reporting
- Baseline and technical audits including data capture, assessment of the energy performance of the hospital to inform the strategy and behavioural surveys to understand employee influence
- Assessment of climate-related risks and opportunities available to the Trust including PESTLE analysis of climate change relating to Operation and Value Chain carbon and assessment of the Trust's strengths, weaknesses, opportunities and threats
- Assessment of existing and known potential climate-related legislation and compliance schemes that the Trust are to be aware of
- Scenario modelling using government, national and local data sets to assess various technical and financials approaches to Net Zero and informing other works, namely objective settings workshop
- Objective setting workshop to collaborate with the Trust to set reasonable and achievable target for the Net Zero journey
- Production of a Net Zero Strategy in line with the NHS's Green Plan guidance bringing together all data sources and work completed to compile an adoptable document supported by various technical workbooks.

Low Carbon Skill Fund (LCSF) and Public sector decarbonisation scheme (PSDS)

The Trust's application for the public sector LCSF grant was successful. We received a grant of £19,140 through Salix and the department of Business Energy & Industrial Strategy (BES). The funding enabled the Trust to carry out surveys for applicable sustainability technologies to reduce its carbon footprint and deliver an effective PSDS grant scheme application, however the £1bn fund made available by the government was oversubscribed and the Trust's £450k grant application was not successful. The trust is in a better position to put in another application once the government provides further funding opportunities; this is deemed to be imminent due to government's commitment to sustainability.



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Waste management

Due to the pandemic, clinical waste generated across all healthcare settings had increased significantly; PAHT produced 608 tonnes in 2020, an increase of 128 tonnes over 2019 data. This unprecedented increase in waste generation happened across the country and impacted on the national clinical waste treatment infrastructure leading to regular service disruptions and the cabinet office established a national emergency logistic cell to manage the situation.

The trust managed to remain compliant with the 'COVID-19 waste management standard operating procedure (SOP) issued by the NHSE/I for the management of waste during the pandemic. We have implemented the guidance to ensure our waste is managed in a safe manner using appropriate receptacles and waste bags for infectious and non-infectious waste consignments so that our activities do not negatively affect critical national waste disposal resources during the emergency response period.

Procurement (Supply Chain)

Through working collaboratively with our supply chain partners we currently have 75% of our electricity supply from renewable sources (not fossil) that are REGOS certified. The aim is to fully integrate sustainable and ethical procurement practices into our procurement strategies and processes for all goods and services. This is being incorporated into the procurement of our environment and sustainability related contract agreements. We will continue to specify environmentally friendly practises to our supply chain partners to ensure that our contract arrangements for services that have direct or indirect impact on the environment are managed with climate risk elements mitigated

Look-ahead

In addition to making visible the Trusts commitment to work towards the national goal of keeping the global average temperature increase below 2°C and achieving 'Net Zero' by 2050. We will continue to review the carbon footprint of our estates and its impact on the environment, our staff, patients and our finances in line with our strategy to decarbonise our facilities.

To achieve this we will:

- Produce achievable and measurable Green Plan (SDMP) from established site specific baseline data, pestle analysis and defined net zero pathway scenarios i.e. with outlined programme of goals where we can keep track of planned actions and progress. The actions will include:
 - Proposal to change fleet and estate vans to electric vehicles
 - Further removal of single use plastic from our restaurant
 - Switch over to low power laptops where reasonably practical
 - Collaboration to positively influence our supply chain partners.
- Drive further energy, water and carbon reductions in owned buildings and rented buildings.
- Achieving the BREEAM (Building Research Establishment Environmental Assessment Method) standard for all our capital projects and new builds.

- Maintain comprehensive measurement and reporting systems with external verification and publish our annual report.
- Challenge building contractors to propose cost-effective, low carbon solutions when undertaking refurbishment projects and monitor the benefits.
- Work with waste contractors to implement the waste hierarchy, achieve zero waste to landfill and turn residual waste into a resource opportunity wherever possible.
- Aim to increase the amount of electricity we purchase from the national grid is generated from renewable energy sources.
- Produce a Net Zero Strategy alongside partners to understand the Trust's current position and actions required to work towards Net Zero within the NHS's timeframe no later than 2045.
- Implementation of the trusts green travel plan to ensure that all travel options and impacts are taken into consideration when planning new premises and for off-site/local community healthcare services.

Conclusion – Sustainable Development Goals

The Trust is constantly striving to understand fully and reduce the environmental impact created through delivering quality healthcare services. We are also looking at how sustainable principles can help provide a better environment for our staff, patients and the local and global community. We will continue to analyse the environmental, social and economic impacts of our activities; covering the three approved global Greenhouse Gas (GHG) emission scope protocols (scopes 1, 2 & 3) with the aim of fully embedding sustainability themes throughout the whole organisation in compliance with the target set by the Climate Change Act (2008), Net Zero by the year 2045 and to fulfil our moral responsibilities of ensuring better environment for future generations.

Lance McCarthy

Chief executive officer

The Accountability Report 2020-21

Corporate governance report

Our board

The Trust board meets bi-monthly in public. The times and venues are advertised on the hospital's website (www.pah.nhs.uk) and board papers are published ahead of each meeting.

The role of the trust board is to determine strategy and policy for the trust, to monitor in-year performance against its plans and ensure the trust is well governed.

The trust board formally operates in accordance with its governance manual comprising the standing orders, standing financial instructions and scheme of delegation.

Name	Position	Voting	From	To
Executive directors:				
Lance McCarthy	Chief Executive Officer	Y	03.05.17	Current
Trevor Smith	Chief Financial Officer	Y	15.07.13	31.08.20
Simon Covill	Acting Chief Financial Officer	Y	01.09.20	13.12.20
Saba Sadiq	Director of Finance	Y	14.12.20	Current
Stephanie Lawton	Chief Operating Officer	Y	02.03.16	Current
James McLeish	Director of Quality Improvement	N	01.04.16	Current
Sharon McNally	Director of Nursing & Midwifery	Y	01.10.18	Current
Ogechi Emeadi	Director of People, OD and Communications	N	01.08.18	Current
Michael Meredith	Director of Strategy	N	04.06.18	Current
Marcelle Michail	Acting Chief Medical Officer	Y	30.03.20	31.10.20
Fay Gilder	Medical Director	Y	01.11.20	Current
Phil Holland	Chief Information Officer	N	01.02.21	Current
Non-Executive Directors:				
Steve Clarke	Chairman	Y	03.12.18	Current
George Wood	Senior independent director	Y	01.07.19	30.06.21

	(Chair of Audit Committee)			
Pam Court	Non-executive director (Chair of CFC until 01.01.20 and Chair of PAF from 01.01.20)	Y	28.09.15	27.09.21
John Hogan	Non-executive director (Chair of QSC until 01.01.20 and Chair of Strategy Committee from 01.01.20)	Y	01.08.17	03.07.23
Helen Glenister	Non-executive director (Chair of CFC until 01.01.20 and Chair of Quality and Safety Committee from 01.01.20)	Y	01.04.18	31.03.23
Helen Howe	Non-executive director (Chair of Workforce Committee from 01.04.20)	Y	11.06.18	31.03.23
John Keddle	Associate non-executive director (Chair of Charitable Funds Committee from 01.01.20)	N	01.07.19	30.06.21
Darrel Arjoon	NExT NED	N	04.01.21	6-12 month placement
Darshana Bawa	NExT NED	N	11.01.21	6-12 month placement
Anne Wafula- Strike	Associate NED	N	15.02.21	14.02.23

Attendance at board meetings

Number of board members present at board meetings in 2020-21:

	02.04.20	07.05.20	04.06.20	19.06.20	02.07.20	06.08.20	03.09.20	01.10.20	05.11.20	03.12.20	05.01.21	14.01.21	11.02.21	04.03.21
	Public	Private Board	Public & Private	Extraordinary	Private Board	Public & Private	Private Board	Public & Private	Private Board	Public & Private	Extraordinary	Private Board	Public & Private	Private Board
Public	14/15	15/15	15/15	5/5	13/15	15/15	14/15	15/15	15/15	15/15	14/16	16/17	17/17	18/19
Private	No private meeting held due to COVID-19		15/15			15/15		15/15		15/15			17/17	

Committees

The trust board has established the following committees to discharge its responsibilities on Board assurance:

Audit Committee

The Audit Committee provides the board of directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the trust's activities (clinical and non-clinical) both generally and in support of the annual governance statement. In addition it oversees the work programmes for external and internal audit and receives assurance of their independence, monitoring the trust's arrangements for corporate governance.

Remuneration and nominations committee

The remuneration and nominations committee determines the remuneration and terms of service of the trust's directors and senior managers; it also considers the overall skill mix and balance of the board of directors.

Performance and Finance Committee

The purpose of the Performance and Finance Committee is:

- Consider, challenge and recommend the trust's operating plan to the board
- Scrutinise operational and financial performance and monitor achievement of national and local targets and recommend any re-basing or re-forecasting of operational and financial performance trajectories to the board
- Assure the board of directors that the trust has robust processes in place to prioritise its finance and resources and make decisions about their deployment to ensure that they best meet patients' needs, deliver best value for money and are efficient, economical, effective and affordable
- Recommend the trust's cost improvement programme to the board and monitor its delivery including investigating reasons for variance from plan and recommend any re-basing or re-forecasting of the plan to the board
- Monitor the management of the trust's asset base and the implementation of the trust's enabling strategies in support of the trust's clinical strategy and clinical priorities
- Review and monitor the management of finance, performance and contracting risks



Quality and Safety Committee

The Quality and Safety Committee (QSC) functions as the trust's umbrella clinical governance committee. It enables the trust board to obtain assurance that high standards of care are provided by the trust and that adequate and appropriate governance structures, processes and controls are in place throughout the trust to enable it to deliver a quality service according to each of the dimensions of quality set out in High Quality Care for All and enshrined through the Health and Social Care Act 2012.

Workforce Committee

The purpose of the Workforce Committee is:

- 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 trust 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 trust 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 trust board that legal and regulatory requirements relating to workforce are met

New Hospital Committee

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

Charitable Funds Committee

The Charitable Funds Committee was established by the trust board to make and monitor arrangements for the control and management of the trust's charitable funds.

Statement of board members' interests 2020-21

Name	Title	Interests/Memberships declared
Steve Clarke	Chairman	- Trustee and honorary treasurer of Dementia UK - Independent director, University of Suffolk - Trustee and honorary treasurer of Young Dementia UK - Wife employed by NHS England (EoE Regional Office)
Pam Court	Non-executive director	- Chief executive officer of Saint Francis Hospice - Daughter employed by Princess Alexandra Hospital Trust
Helen Glenister	Non-executive director	- Chair of Accelerate CIC Limited - Chief Executive of Isabel Hospice - Chair of Saffron Walden Orchestral Society
Helen Howe	Non-executive director	- Trustee of Addenbrooke's Charitable Trust - Honorary professor pharmacy/chairman of pharmacy pre-registration training advisory group (HEE funded) for East of England - Member UEA undergraduate Pharmacy advisory group - Chair of Governors at Great Abington Primary School

John Hogan	Non-executive director	• Consultant cardiologist at Barts Health NHS Trust • Non-Executive Director Whitfield Academy Trust
George Wood	Non-executive director	• Chairman of the King George's Hospital Charity • Associate Non-Executive Director BHRUT
John Keddle	Associate non-executive director	• Governor, Anglia Ruskin University • Trustee, Anglia Trust • Chair, Harlow Growth Board • Chair, Discover Harlow Board • Deputy Chair, London Stansted Cambridge Consortium • Chair, ARU Direct Ltd
Darrel Arjoon	NExT Non-executive director	• Executive Chair for Reuse Technology Group Ltd
Darshana Bawa	NExT Non-executive director	• Finance Director for Micro Scooter Ltd • Company Secretary at Kit Imports Ltd
Anne Wafula-Strike	Associate non-executive director	• Founder of Olympia-Wafula Foundation • Non-Executive Director for UK Athletics • Non-Executive Director for British Paralympic Association • Non-Executive Director for Dimensions UK • Non-Executive Director for Active Essex
Lance McCarthy	Chief executive officer	• Trustee, NHS Providers

Saba Sadiq	Director of Finance	No Interests Declared
Ogechi Emeadi	Director of people, organisational development and communications	No Interests Declared
Michael Meredith	Director of strategy and estates	No interests declared
Sharon McNally	Director of nursing, midwifery and allied health professionals	No interests declared
Stephanie Lawton	Chief operating officer	No interests declared
James McLeish	Director of quality improvement	- Spouse is a paramedic for East of England Ambulance Service - Daughter is student nurse, Anglia Ruskin University
Fay Gilder	Chief medical officer	Director, Gilder Medical Ltd
Phil Holland	Chief Information Officer	No interests declared

Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken “all the steps that he or she ought to have taken” to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Statement of director's responsibilities

The full statement of director's responsibilities is included in the financial statements.

The statement of accounting officer's responsibilities

The chief executive of NHS Improvement, in exercise of powers conferred on the NHS trust development authority, has designated that the chief executive should be the accountable officer of the trust. The relevant responsibilities of accountable officers are set out in the NHS trust accountable officer memorandum. These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- Value for money is achieved from the resources available to the trust
- The expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- Effective and sound financial management systems are in place
- Annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

Signed

Lance McCarthy

Chief executive officer

Date: 31 May 2021

The Princess Alexandra Hospital Annual Governance Statement 2020-21

My Annual Governance Statement (AGS) has been written describing the governance arrangements in place at the Trust during 2020-21. During the year, we continued to review and strengthen our governance arrangements and took into account the findings of our CQC inspections together with continuing feedback and support from NHS England and Improvement.

At the same time, we have taken a full and active role within the Hertfordshire and West Essex Integrated Care System (ICS) and the West Essex Integrated Care Partnership system (ICP). Delivering high quality, timely and cost effective care to our local community are core components of our strategic objectives, and the ICS and ICP both give clear clinically led focus on improving standards, financial stability and adapting services to a growing and changing community across West Essex and Hertfordshire.

The Trust has received from the External Auditors a **qualified** opinion on its financial statements in that the accounts present a true and fair view on the Trust's financial position for the 2020-21 financial year.

The key financial results for 2020-21 are that the Trust delivered a surplus of £1,816k.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Princess Alexandra Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Princess Alexandra Hospital NHS Trust for the year ended 31 March **2021** and up to the date of approval of the annual report and accounts.

The Governance Framework of the Organisation

The Governance Framework describes the structure and systems that are in place for the direction and control of the Trust to fulfil the functions as set out in the Statutory

Instrument 1994 No. 3179. These mechanisms include the Board, its Committees, management arrangements, Governance Manual and Risk Management Strategy.

The Trust Board is responsible for making sure we provide safe, effective and compassionate care to our patients at the same time as supporting their families, relatives and carers. It does this by making the key decisions that affect our hospital and setting the values, aims and strategic direction for the Trust. It also reviews performance against our objectives, as well as against national standards and targets. It has overall responsibility for the effective control of the Trust and is accountable, through its Chairman, to NHS Improvement and the Secretary of State for Health and Social Care. The Trust Board consists of:

- a Chairman
- five voting Non-Executive Directors and two non-voting Associate Non-Executive Directors
- two non-voting NExT Non-Executive Directors (NHSEI placement scheme)
- five voting Executive Directors (Chief Executive Officer, Director of Finance, Medical Director, Chief Operating Officer and Director of Nursing, Midwifery and AHPs) and four further Executive Directors without voting rights; the Director of People, OD and Communications, the Director of Strategy and Estates, the Director of Quality Improvement and the Chief Information Officer .

The following Non-Executive Director appointments were made in the year:

- Helen Howe, previously an Associate Non-Executive Director was appointed as a substantive Non-Executive Director in Andrew Holden's vacant post; Andrew Holden's term of appointment ended on 31 March 2020.
- Two NExT Non-Executive Directors, Darshana Bawa and Darrel Arjoon joined the Board in January 2021.
- Anne Wafula-Strike joined the Board as an Associate Non-Executive Director in February 2021.

The following executive appointments were made in the year:

- The Chief Medical Officer, Andy Morris was seconded to NHSEI to support COVID-19-19 planning and the deputy Chief Medical Officer (strategy), Marcelle Michail was appointed as the Acting Chief Medical Officer, with effect from 30 March 2020 until 31 October 2020.
- The Medical Director, Fay Gilder was appointed on 1 November 2020.
- The Chief Financial Officer, Trevor Smith left the Trust on 31 August 2020 and Simon Covill was appointed as acting Chief Financial Officer from 1 September to 13 December 2020.
- The Director of Finance, Saba Sadiq was appointed on 14 December 2020.
- The Chief Information Officer, Phil Holland was appointed on 1 February 2021. This was a new role.

Attendance at Board and Committee meetings throughout 2020-21 has been monitored and is recorded in the Annual Report.

The Trust Board has established the following Committees to discharge its responsibilities in relation to Board assurance:

- Audit Committee
- Quality & Safety Committee

- Performance and Finance Committee
- Workforce Committee
- New Hospital Committee
- Remuneration & Nominations Committee
- Charitable Funds Committee
- Senior Management Team Meeting.

An annual effectiveness review of each committee is undertaken to ensure they continue to meet their terms of reference. The outcomes of the reviews are reported to the Trust Board.

Following each meeting of the committees the Committee Chairs present written and verbal reports to the next Board meeting. These reports provide a summary of the matters discussed at the meetings, areas of risk or concern as well as areas of good news or positive performance. Progress against the Committees' work plans is also included in each Committee report to Board.

In response to the pandemic a full 'command and control' structure was implemented from the end of January 2020. This consisted of a Strategic Command Cell, with tactical cells managing operational response, clinical response, infection prevention and control, supporting our people, communications response and the management of our estate and infrastructure. In the peak of the pandemic, the cells met daily and as the number of COVID-19 patients reduced, the frequency of the meetings also reduced.

Capacity to Handle Risk

As Chief Executive Officer, I am accountable for the overall risk management activity within the Trust. Committed leadership in the area of risk management is essential to maintaining sound systems of internal control required to manage risks associated with the achievement of the corporate goals of the Trust. The Trust's Risk Management Strategy details my overall accountability to the Trust Board for risk management and makes it clear that managing risk is a key responsibility for the Trust and all staff employed by it. The Trust Board receives regular reports that detail quality, financial and operational performance risk, and, where required, the action being taken to reduce identified high-level risks.

I am responsible for ensuring that the Trust is in a position to provide overall assurance that the organisation has in place the necessary controls to manage its risk exposure. In discharging these responsibilities I was assisted by the following Directors during 2020-21:

- The Director of Finance has delegated responsibility for co-ordinating the management of financial and business related risk and assisted me in ensuring that the Trust's resources were managed efficiently, economically and effectively.
- The Director of Nursing, Midwifery and AHPs has delegated authority and responsibility for the professional leadership of the Nursing, Midwifery and Allied Health Professions. The role is also the executive lead for infection prevention and control with the Director of Infection Prevention and Control reporting to them. The role has delegated responsibility for reporting to the Trust Board on **medicines**

management, the achievement of quality and patient experience standards and complaints and claims management and is the Trust's Safeguarding Lead.

- The Medical Director has overall accountability for operational and clinical risk and incident management. This includes the establishment and monitoring of assurance mechanisms and provision of associated risk reports to the Trust Board. The Medical Director also has delegated responsibility for co-ordinating and monitoring the Trust's revalidation programme for Medical Staff in line with the 'Maintaining High Professional Standards' system for the NHS. The Medical Director is also the Caldicott Guardian for the Trust.
- The Chief Operating Officer has delegated authority for managing the Trust's performance delivery both against national operating standards and key performance indicators together with local contractual standards set by the Clinical Commissioning Groups (CCGs).
- The Director of People, OD and Communications has delegated responsibility for overseeing all People functions across the Trust including recruitment, staff training and managing absence as well as embedding the Trust's People Strategy and OD and Culture programme.
- The Director of Quality Improvement has delegated responsibility for managing the Trust's transformation and modernisation programme as well as the Quality 1st Team and implementing the Quality Improvement Strategy.
- The Director of Strategy has delegated responsibility for managing the development of the New Hospital, the Estates Strategy and the Capital Programme for the Trust.
- The Chief Information Officer has delegated responsibility for ensuring that Information Governance arrangements at the Trust are suitable, is the Trust's Senior Information Risk Owner (SIRO) and is responsible for the development and implementation of the Digital Strategy for the Trust.

As Chief Executive I also hold responsibility for managing the strategic development and leadership of the Trust's quality improvement agenda; ensuring the implementation of the quality management improvement agenda; and ensuring the safety and quality of the care provided to our patients.

All our people receive risk management and related training at induction and further updates as required. The training covers topics such as risk assessments, Health & Safety at work, moving and handling, fire safety, incident reporting, information governance as well as infection prevention and control. In addition to providing staff with skills and knowledge to carry out their work safely, staff are actively encouraged to report incidents and escalate any identified risks in a timely manner. In addition, thematic learning from incidents is shared through newsletters, internal safety alerts, simulation sessions and/or case scenarios through the Trust's sharing the Learning sessions. We also support a programme of Counter fraud training and awareness provided by the Local Counter Fraud Specialist team.

The Risk and Control Framework

The role of the risk and control framework is to identify, evaluate and prioritise clinical and non-clinical risks and gain assurance that these are properly controlled to ensure safe and effective care.

Within the Trust, there are systems and processes in place for identifying, managing and monitoring risks. These include:

- A Risk Management Strategy (for the effective management of clinical and non-clinical risk)
- A Board Committee structure with clear reporting lines to the Trust Board
- A Risk Management Group reporting to the Trust Board via Senior Management Team Meetings
- A Significant Risk Register and Board Assurance Framework, both of which are reviewed by the Risk Management Group and Trust Board.
- Monitoring systems for incidents and complaints.

Risk is managed at different levels of the organisation. Each Health Care Group and Corporate Department has a risk register that is regularly reviewed, ensuring that risk scores are accurate and that risks are appropriately mitigated, managed and escalated. Each risk on the register has a risk owner accountable for that risk.

The Risk Management Group meets on a monthly basis to review risks across all Health Care Groups as well as corporate departments. The Group's objectives are:

- To champion and promote the identification, proactive management of risks and sound risk management practices across the Trust, facilitating and embedding a strong risk management process and culture
- To ensure the identification of the burden of risks across the Trust by providing a critical review of risks on all risk registers.
- To offer constructive challenge, serving as risk moderators in the Trusts risk escalation process and ensuring that significant risks are appropriately escalated.
- To support the delivery of the Trust's objectives by obtaining assurance on the effectiveness of controls and actions identified to minimise risks.
- To improve the standard of decision making on risk management.

The Trust has a Board Assurance Framework (BAF) which provides a mechanism for the Board to monitor the risks to delivery of the Trust's strategic objectives as well as the effectiveness of the controls and assurance processes. The risks reflect the Trust's in-year and future risks.

Each risk on the BAF has an executive lead and a designated responsible Committee. The risks are reviewed monthly with executive leads and are reviewed by the relevant Committees and the Trust Board bi-monthly. The Risk Management Group reviews the BAF by exception.

The highest scoring BAF risks throughout 2020-21 were the risks relating to our Estate/Infrastructure, delivery of the ED standard and our financial position. Further detail on these risks and their management is outlined in the annual report.

Following the annual review of the Trust's risk management processes and BAF by the Trust's Internal Auditors an overall assessment of reasonable assurance was provided.

Quality Governance Arrangements

There is clear accountability at Board level for patient safety and clinical quality outcomes along with structured reporting of performance against these objectives. Executive oversight of quality improvement is through the Director of Nursing, Midwifery and AHPs who, with the Medical Director ensures an organisation-wide approach to the integrated delivery of the quality governance agenda. For any transformational change required, they are supported by the Trust's Quality 1st Team.

Each of the Trust's four Health Care Groups has a Patient Safety and Quality group where themes and trends from reviews of incidents and complaints and learning are reported. Performance is reviewed at monthly performance review meetings and at the Quality & Safety Committee each Health Care Group presents a quarterly overview of its performance on a rolling programme, in line with the CQC key lines of enquiry. Throughout 2020-21, the Quality & Safety Committee continued to receive updates on progress against the Quality Improvement Plan developed to address concerns raised by CQC during their inspection. Regular 'Sharing the Learning' reports providing an overview of themes, trends and learning arising from incidents, serious incidents and on-going quality improvement initiatives for topics such as falls, dementia and pressure ulcers are also received. **The Chief Pharmacist provides regular reports to the committee on medicines management.** Following a review of the quality governance framework in quarter 4 of 2019-20 a new structure for the meeting groups reporting to the Quality and Safety Committee was agreed and implemented during 2020-21.

Mortality is monitored by the Quality and Safety Committee as well as the Trust Board. The statistical markers for mortality have been higher than expected for 2020-21. The Trust's rolling HSMR for the last 12 months has been 'higher than expected'. The SHMI has been 'as expected'. For the period December 2019 to November 2020 (including a time lag of one month) the Trust's HSMR was 116 (higher than expected) but improved from 2018-2019 (122). It is anticipated that the HSMR will continue to improve. PAHT is 1 of 6 trusts within the peer group of 15 that sit within the 'higher than expected' range.

A Trust-wide Mortality improvement programme was established which utilised QI methodology to deliver improvements in patient outcomes across a number of identified work streams. Medical examiners have been appointed and structured judgement reviews are undertaken. The Quality and Safety Committee receives monthly reports on mortality and learning from deaths whilst the Trust Board receives an update at every public Board meeting (held bi-monthly).

The Quality and Safety Committee and Trust Board receive monthly reports on Nurse and Midwifery Staffing levels in line with guidance received from NHS England and the Care Quality Commission on the delivery of the 'Hard Truths' commitments associated with publishing staffing data regarding nursing, midwifery and care staff levels.

CEO Assurance Panels have been convened to provide enhanced oversight and assurance where high risk areas have been identified in relation to quality.

In October 2020 the Trust reported its first Never Event since 2016. It related to unintentional connection of a patient requiring oxygen to an air flowmeter. This was reported as a serious incident and a full root cause analysis was undertaken with immediate learning noted and actions taken.

Well-Led Reviews

The Board commissioned an external review of the Well-led framework in March 2021 and the outcome of that review will be reported to the Board in June 2021. The Board's own self-assessment against the CQC's well-led framework resulted in an overall rating of 'Good' being assigned. The CQC rated the Trust as 'good' for well-led at its last inspection.

Compliance with NHS Provider Licence

The Trust is compliant with the following NHS provider licence conditions:

- The provider has taken all precautions necessary to comply with the licence, NHS acts and NHS Constitution (Condition G6 (3)).
- The provider has complied with required governance arrangements (Condition FT4 (8)).

In relation to General Condition 4 (Fit and proper persons) of the Provider Licence the Trust has a robust process for monitoring the Trust's compliance with the regulations. Annual compliance checks, by way of annual self-declarations are undertaken and reported to the Workforce Committee.

Developing Workforce Safeguards

The Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which provide assurance to the Trust Board that staffing processes are safe, sustainable and effective. Compliance with the 'Developing Workforce Safeguards' recommendations is demonstrated through the following systems:

- The Integrated performance report (IPR) is received at each public Trust Board meeting and details a range of staffing metrics including vacancy rates, sickness absence, turnover, appraisal rates, friends and family test results, statutory and mandatory training compliance
- A workforce report is presented to the Workforce Committee bi-monthly where the metrics listed above are scrutinised
- The safer nurse staffing report is presented to the Quality and Safety Committee monthly and bi-monthly to the Workforce Committee and Trust Board; this details the actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff as well as providing an update on nursing vacancy rates, and in 2020-21, the plans to further reduce the vacancy rate to achieve the target vacancy rate.
- Trust Board reporting is underpinned by monthly performance review reports which detail a range of performance indicators including vacancy rates, sickness absence, turnover, maternity leave, training and average absence
- Freedom to Speak Up Guardians and Guardian of Safe Working reports are presented to the Trust Board and Workforce Committee
- Electronic job planning processes are in place for medical staff

- Bi-annual nursing and midwifery establishment reviews are undertaken and reported to the Workforce Committee, Quality and Safety Committee and the Trust Board. The reviews utilise the Safer Nursing Care Tool (SNCT) for adult ward areas, the Baseline Emergency Staffing Tool (BEST) for the Emergency department and Birth-rate plus for the maternity department.
- The Trust's workforce plan underpins the Trust's annual operating plan which is reviewed by the Performance and Finance Committee and approved by the Trust Board.
- The Trust remains focussed on increasing and retaining its core nursing workforce, utilising new roles such as Nursing Associates, Paramedics and Physician Associates whilst continuing to further develop and embed new workforce models. Working with our ICS partners we will continue to explore opportunities for joint roles as we identify workforce models that support integrated working and the implementation of our new models of care.

Managing Conflicts of Interest

The Trust has published an up-to-date register of interests, including gifts and hospitality for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance. The Trust's Audit Committee monitors and approves the registers of interest.

Care Quality Commission

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The last full inspection conducted by the CQC was completed in March and April 2019 with the report published in July 2019. This showed improvements, with five of the trust's core services rated as Good. The trust received an outstanding rating for 'caring' for children and young people. The overall quality rating for the Trust remained the same at 'Requires Improvement'. However, the Trust received an overall rating of 'Good' for both the well-led assessment and also for the use of resources assessment.

Following the CQC Winter Assurance visit on 14th February 2021, the CQC issued a Section 29a warning notice in relation to a lack of effective governance processes including:

1. Risk assessments were not being completed for all patients within the emergency department.
2. A lack of assurance that patients presenting with acute mental health illness were receiving timely assessments.
3. A lack of adherence to infection, prevention and control procedures.
4. The process for the provision of the out of hour's endoscopy service for patients presenting with acute upper gastrointestinal bleeding was not embedded

Immediate actions were implemented following receipt of the warning notice, with further actions underway. Formal progress against these concerns is due to be reported to the CQC by 1 June 2021. A review of all core services across the Trust is being undertaken to ensure this learning is shared widely and improves the safety and quality of care our patients receive.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Carbon Reduction

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Trust has a Governance Manual comprising standing orders and standing financial instructions, which provide the framework for ensuring appropriate authorisation of expenditure commitments in the Trust. The Board's processes for managing its resources include approval of annual budgets for both revenue and capital, reviewing financial performance against these budgets, and assessing the results of the Trust's cost improvement programme on a monthly basis. The Trust has a process for the development of business cases for both capital and revenue expenditure and, depending on the level of investment, these are reviewed by the Senior Management Team, Performance and Finance Committee and Trust Board. The Performance and Finance Committee reviews productivity, operational and financial performance and use of resources both at Trust and Health Care Group level.

The Trust was rated 'good' following the use of resources assessment in March 2019. More details of the Trust's performance and some specific Trust projects aimed at increasing efficiency are included in the annual report. The Trust's external auditors are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. They report the results of their work to the Audit Committee.

Information Governance/Data Security Risks

The Trust has reported two Information Governance (IG) data security breaches to the Information Commissioners Office (ICO) during 2020-21 and both have been closed.

The first breach related to a member of bank staff accessing a patient record inappropriately in breach of Trust policy. The ICO has investigated and closed this incident with no further action taken.

The second breach occurred due to human error, where documents from a vacated room were left unsecured in a space outside the back of a building for a limited time. The ICO has investigated and closed this incident with no further action taken.

Elective Waiting Time Data

Patients who have been referred to the Trust on a Cancer Waiting Time or Referral to Treatment (RTT) pathway are managed daily by the clinical and operational teams, in line with the hospital's Access Policy and the national addendum relating to COVID-19. These pathways are reviewed at weekly Patient Tracker List (PTL) meetings, chaired by the Performance Manager where pathway trigger points are reviewed and remedial actions taken, if required. The PTL meetings report to the weekly Access Board meetings which are chaired by the Head of Performance & Planning. The Access Board also reviews RTT Data Quality reports and determines required actions to ensure that processes maintain accurate data recording.

In addition, a number of Data Quality reports are produced to enable the service management teams to monitor patients on non-RTT pathways. These are reviewed through the Data Quality Steering Group. Both the Access Board and the Data Quality Steering Group report to the Senior Management Team and then onto Performance & Finance Committee and the Trust Board.

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, the Executive Team, managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board and Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust has an annual clinical audit programme in place including mandated audits addressing national and local issues, targets and performance.

The Trust's Internal Auditors provide an opinion on the overall arrangements for gaining assurance as part of the risk-based Annual Internal Audit Plan. During the year, the following internal audit report received a limited assurance rating:

- Supply Chain and EROS – Authorisation Controls

The Trust's Internal Auditors undertook a detailed follow up exercise of the recommendations in relation to the limited assurance reports and concluded that all

high priority recommendations had either been implemented by the Trustor were not yet due for implementation.

Action plans are in place to address Internal Audit's recommendations for all audits undertaken. The Internal Auditors provide a progress report to the Executive Management Team, Senior Management Team and Audit Committee. The Executive Team as well as the Audit Committee continues to focus on the implementation of recommendations to ensure the Audit Committee is receiving adequate assurance that control weaknesses are being addressed.

Head of Internal Audit Opinion (HoIA) on the Effectiveness of the System of Internal Control for the Year Ended 31 March 2021:

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Board in the completion of its Annual Governance Statement (AGS).

My opinion is set out as follows:

1. Overall opinion;
 2. Basis for the opinion; and
 3. Commentary.
1. My overall opinion is that **Reasonable** assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.
 2. The basis for forming my opinion is as follows:
 - i. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
 - ii. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. any reliance that is being placed upon Third Party Assurances.

Significant Issues

The following is a summary of significant issues which were and will continue to be the focus of the Trust Board's attention and direct the Trust's management efforts during 2021 (and beyond); these issues are also reflected on the Board Assurance Framework:

Operational Performance – A&E Standard

The Trust has struggled to deliver against this standard throughout the year. Year to date the Trust achieved 83.2% for all attendances. The urgent care attendances during the year have been untypical of an average year, with the pandemic reducing non COVID-19 attendances. During most of 2020 the Trust maintained the 4 hour standard ahead of the national average however in the winter and early 2021 the increase in COVID-19 attendances and admissions created pressure on bed capacity across the Trust and the urgent care department was unable to place patients on wards quickly enough to maintain the 4 hour standard. The Rapid Assessment Treatment (RAT) pathways continued to be in place over the year but staff absence due to COVID-19 impacted the number of RAT teams available for this pathway. Patient experience and the flow of patients in to and through the hospital has been enhanced by the opening of the Adult Assessment Unit and Same Day Emergency Care in addition to improvements in the Frailty unit.

The Urgent Care Improvement Board meets on a weekly basis to review actions being taken to improve performance against the standard. Recovery plans remain in place to address performance issues both internally and across the health and social care system. There is also a system wide Local Delivery Board supporting the management of urgent care patients across all parts of the health and care sectors. The Urgent Care Board and governance structure beneath has been enhanced following the CQC unannounced Winter Assurance visit on 14 February 2021.

COVID-19: Recovery and Restoration

The impact of the COVID-19 pandemic on the Trust's services has been significant. As elective procedures were reduced during the pandemic, there has been an increase in the number of patients waiting for more than 52 weeks for routine surgery and a rise in demand for diagnostic services. The intensity of the response to the pandemic has had a marked impact on the Trust's people. The same group of staff who worked through the pandemic are stepping up to recover elective backlogs and the Trust has launched a number of health and well-being initiatives to support colleagues. The Trust has expanded endoscopy, CT and MRI capacity to support the management of cancer patients and has continued to work closely with independent sector colleagues to maximise access to key services and maintain timely services for patients. All patients who have been waiting for longer than they would do normally continue to be reviewed by the relevant clinical team and reprioritised where relevant.

The Trust acknowledges the scale of the challenge that lies ahead and continues to work with partners across the local health and care system to bring waiting lists down in a way that is transparent and equitable, that provides equity for patients and looks after the workforce. Despite a huge amount of hard work from everyone it will be some time before the Trust's services are restored to pre-pandemic levels.

Estate

The quality and safety of the estate remain significant challenges for us at a time of financial constraint. It has been well communicated that the current hospital estate has reached its limit in terms of capacity and development. A significant portion of the hospital site is more than 60 years old and falls short of modern day expectations with areas of key infrastructure in need of replacement. Our ability to keep up with the changing clinical landscape, technological advances and delivery of new models of care is limited by our current estate.

These key risks and concerns drive our long term estate strategy which includes building a new hospital to address these challenges and enable the Trust to be successful in delivering integrated care as part of an Integrated Care Partnership. However we still need to deliver high quality, efficient services from the current estate for at least the next 5 years.

Conclusion

As Accountable Officer, I receive information and assurance from a wide range of sources about the Trust's internal control systems and structures in place to ensure the effective operation of the Trust. These facilitate the identification of strengths and areas in need of attention enabling appropriate action plans to be established and acted on. Although some significant issues have been identified, my review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and statutory duties. I and the Trust Board remain committed to achieving continuous improvement and enhancement of the systems of internal control.

Lance McCarthy

Chief executive officer
(31 May 2021)

Remuneration and staff report

Background

This report includes details regarding “senior managers” remuneration in accordance with paragraphs 3.31 to 3.78 of the DHSC (Department of Health and Social Care) Group Accounting Manual 2020-21. The Remuneration Report set out below is subject to audit by our external auditors.

The Trust has established a Remuneration and Nominations Committee to advise and assist the Board in meeting its responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief executive officer, executive directors and very senior managers. The Remuneration Committee is chaired by the Trust’s chairman and meets at least annually. Membership of the committee consists of Trust chairman and all non-executive directors with the director of people and others in attendance. The chief executive officer and directors remuneration is determined on the basis of reports to the Remuneration and Nominations Committee taking account of any independent evaluation of the post, national guidance on pay rates and market rates. Pay rates for the chair and non-Executive directors of the Trust are determined in accordance with national guidance.

The Trust does not operate any system of performance related pay and no proportion of remuneration is dependent on performance conditions. The performance of non-executive directors is appraised by the chair. The performance of the chief executive officer is appraised by the chair. The performance of Trust executive directors is appraised by the chief executive officer. Annual pay increases are implemented in accordance with national pay awards for all other NHS staff.

Staff report

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation’s workforce.

- The banded remuneration of the highest paid director in PAHT in the financial year 2020-21 was £185k-£190k (£235k- £240k in 2019-20). This was 5.7 times the median remuneration of the workforce which was £33.1k (in 2019-20 the ratio was 7.5 times with the median remuneration being £31.8k)
- In 2020-21, 19 employees received remuneration in excess of the highest paid director (this was 2 employees in 2019-20). Remuneration ranged from the bands £0k-£5k to £270k-£275k (in 2019-20 these were £0k-£5k to £255k-£260k).

- Total remuneration includes salary, benefits-in-kind, golden hellos and compensation for loss of office. It does not include employer pension contributions, termination payments and the cash equivalent transfer value of pensions

Consultancy and professional services spend

2020-21 total expenditure on consultancy and professional services was £3,419k (2019-20 £3,532k).

Employee benefits and staff numbers (subject to audit)

Employee benefits

Gross expenditure	Permanently employed	Other	2020-21 Total	2019-20 Total
	£000's	£000's	£000's	£000's
Salaries and wages	136,406	544	136,950	124,956
Social security costs	12,456	-	12,456	12,319
Apprenticeship levy	606	-	606	605
Employer's contributions to NHS pensions	23,171	-	23,171	21,144
Pension costs - other	36	-	36	35
Temporary Staff	-	33,141	33,141	35,865
Total employee benefits	172,675	33,685	206,360	194,924
Less: Employee costs capitalised	1,197	1,406	2,603	1,794
Redundancy	35	-	35	11

Gross employee benefits excluding capitalised costs	171,444	32,279	203,722	193,119

Average staff numbers

	Permanent Number	Other Number	2020-21 Total	2019-20 Total
Medical and dental	507	60	567	563
Ambulance staff	0	0	0	0
Administration and estates	591	46	637	617
Healthcare assistants and other support staff	354	58	412	422
Nursing, midwifery and health visiting staff	976	123	1,099	1,029
Nursing, midwifery and health visiting learners	403	63	466	510
Scientific, therapeutic and technical staff	239	0	239	240
Healthcare science staff	79	0	79	0
Social care staff	0	0	0	80
Other	147	0	147	139
Total	3,296	350	3,646	3,600
Staff engaged on capital projects (included in above)	21	25	46	34

Staff sickness and ill health retirements

Annual references for staff sickness absence relate to calendar years. For ill health retirements, year references relate to financial years.

Staff sickness absence data can be accessed via NHS Digital using the following link:
[NHS Digital Staff Sickness Data](#)

Ill Health Retirements	2020-21	2019-20
	Number	Number
Number of persons retired early on ill health grounds	3	3
	£000's	£000's
Total additional pensions liabilities accrued in the year	147	151

Reporting of compensation schemes - exit packages 2020-21 (subject to audit)

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Less than £10,000	0	0	0
£10,000 - £25,000	0	0	0
£25,001 - £50,000	0	0	0
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
> £200,000	0	0	0
Total	0	0	0
Total resource cost (£)	£0	£0	£0

Redundancy and other departure costs have been paid for in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Reporting of compensation schemes - exit packages 2019-20 (subject to audit)

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Less than £10,000	0	0	0
£10,000 - £25,000	0	0	0
£25,001 - £50,000	1	1	2
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
> £200,000	0	0	0
Total	1	1	2
Total resource cost (£)	£44,000	£27,000	£71,000

Exit packages: other (non-compulsory) departure payments (subject to audit)

	2020-21		2019-20	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000's	Number	£000's
Contractual payments in lieu of notice	-	-	1	27
Exit payments following Employment Tribunals or court orders	-	-	-	-
Total	-	-	1	27

Note: the prior year exit packages figure has been restated for 1 case ("other" £27k) identified during 20/21 as relating to 19/20.

Off payroll arrangements

No individual holding a Board position was paid directly through an associated limited company. During 2020-21 there were no executive posts covered by off-payroll arrangements.

Table of salaries - non-executive directors (subject to audit)

		2020/21							2019/20						
Name	Title	Period	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Period	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
			£000's	£'s	£000's	£000's	£000's	£000's		£000's	£'s	£000's	£000's	£000's	£000's
Steve Clarke	Chairman	All Year	35 - 40	-	-	-	-	35 - 40	All Year	35 - 40	4,500	-	-	-	35 - 40
Andrew Holden	Non-Executive Director	-	-	-	-	-	-	-	All Year	5 - 10	1,900	-	-	-	5 - 10
Pam Court	Non-Executive Director	All Year	10 - 15	-	-	-	-	10 - 15	All Year	5 - 10	200	-	-	-	5 - 10
Dr John Hogan	Non-Executive Director	All Year	10 - 15	-	-	-	-	10 - 15	All Year	5 - 10	-	-	-	-	5 - 10
Helen Howe	Non-Executive Director	All Year	10 - 15	300	-	-	-	10 - 15	All Year	5 - 10	1,400	-	-	-	5 - 10
Dr Helen Glenister	Non-Executive Director	All Year	10 - 15	-	-	-	-	10 - 15	All Year	5 - 10	1,000	-	-	-	5 - 10
John Keddie	Associate Non- Executive Director	All Year	10 - 15	-	-	-	-	10 - 15	01.07.19 - 31.03.20	5 - 10	300	-	-	-	5 - 10
George Wood	Non-Executive Director	All Year	10 - 15	-	-	-	-	10 - 15	01.07.19 - 31.03.20	5 - 10	-	-	-	-	5 - 10
Darrel Arjoon	NEXT NED	04.01.21 - 31.03.21	-	-	-	-	-	-	-	-	-	-	-	-	-
Darshana Bawa	NEXT NED	11.01.21 - 31.03.21	-	-	-	-	-	-	-	-	-	-	-	-	-
Anne Wafula-Strike	Associate Non- Executive Director	15.02.21 - 31.03.21	0-5	-	-	-	-	0-5	-	-	-	-	-	-	-

Table of salaries - executive directors (subject to audit)

		2020/21							2019/20						
Name	Title	Period	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performanc e pay and bonuses (bands of £5,000)	Long term performanc e pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Period	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performanc e pay and bonuses (bands of £5,000)	Long term performanc e pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
			£000's	£'s	£000's	£000's	£000's	£000's		£000's	£'s	£000's	£000's	£000's	£000's
Lance McCarthy	Chief Executive	All Year	185 - 190	-	-	-	42.5 - 45	235 - 240	All Year	190 - 195	-	-	-	45 - 47.5	235 - 240
Sharon McNally	Director of Nursing and Midwifery	All Year	125 - 130	-	-	-	55 - 57.5	185 - 190	All Year	120 - 125	-	-	-	112.5 - 115	230 - 235
Dr. Andy Morris ²	Chief Medical Officer	01.04.20 - 30.06.20	50 - 55	-	-	-	-	50 - 55	01.04.20 - 30.03.20	235 - 240	-	-	-	90 - 92.5	325 - 330
Marcelle Michail ²	Interim Chief Medical Officer	01.04.20 - 31.10.20	115 - 120	-	-	-	-	115 - 120	30.03.20 - 31.03.20	0 - 5	-	-	-	-	0 - 5
Trevor Smith	Chief Financial Officer	01.04.20 - 31.08.20	65 - 70	-	-	-	22.5 - 25	85 - 90	All Year	145 - 150	-	-	-	7 - 7.5	150 - 155
Stephanie Lawton	Chief Operating Officer	All Year	135 - 140	-	-	-	35 - 37.5	170 - 175	All Year	130 - 135	-	-	-	0 - 2.5	135 - 140
James McLeish	Director of Quality Improvement	All Year	110 - 115	-	-	-	10 - 12.5	125 - 130	All Year	105 - 110	-	-	-	2.5 - 5	110 - 115
Michael Meredith	Director of Strategy	All Year	120 - 125	-	-	-	25 - 27.5	145 - 150	All Year	115 - 120	-	-	-	25 - 27.5	145 - 150
Ogechi Emeadi	Director of People, Comms & OD	All Year	120 - 125	-	-	-	20 - 22.5	140 - 145	All Year	115 - 120	-	-	-	42.5 - 45	160 - 165
Saba Sadiq	Chief Financial Officer	14.12.20 - 31.03.21	35 - 40	-	-	-	5 - 7.5	45 - 50	-	-	-	-	-	-	-
Fay Gilder ¹	Medical Director	01.11.20 - 31.03.21	70 - 75	-	-	-	-	70 - 75	-	-	-	-	-	-	-
Phil Holland	Chief Information Officer	01.02.21 - 31.03.21	15 - 20	-	-	-	7.5 - 10	25 - 30	-	-	-	-	-	-	-
Simon Covill	Acting Chief Financial Officer	01.09.20 - 13.12.20	35 - 40	-	-	-	12.5 - 15	45 - 50	-	-	-	-	-	-	-

1. Not a member of the NHS Pension Scheme
2. Where calculations of pension related benefits returns a negative figure, this has been replaced with a zero as per national guidance. Negative balances can be returned where a member retires, or leaves the pension scheme, during the year.

Salary pension entitlement of senior managers (subject to audit)

Name and title	Real increase / (decrease) in pension at pension age (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2020 (£000's)	Real increase in Cash Equivalent Transfer Value (CETV) (£000's)	Cash Equivalent Transfer Value at 31 March 2021 (£000's)	Employer's contribution to stakeholder pension (£000's)
Lance McCarthy ²	2.5 - 5	(2.5) - 0	65 - 70	135 - 140	1,044	64	1,108	0
Sharon McNally	2.5 - 5	7.5 - 10	50 - 55	155 - 160	1,070	97	1,167	0
Dr Andy Morris ^{2 3}	(45) - (40)	(65) - (62.5)	65 - 70	200 - 205	2,216	(2,216)	0	0
Marcelle Michail ^{1 2}	(60) - (55)	(137.5) - (135)	-	-	1,123	(1,123)	0	0
Trevor Smith	2.5 - 5	2.5 - 5	70 - 75	155 - 160	1,276	85	1,361	0
Stephanie Lawton ²	2.5 - 5	0 - 2.5	50 - 55	110 - 115	828	51	879	0
James McLeish	0 - 2.5	2.5 - 5	25 - 30	80 - 85	609	42	651	0
Michael Meredith ²	0 - 2.5	(2.5) - 0	10 - 15	20 - 25	197	32	229	0
Ogechi Emeadi ²	0 - 2.5	(2.5) - 0	45 - 50	95 - 100	823	41	864	0
Saba Sadiq ²	0 - 2.5	-	10 - 15	-	104	29	133	0
Phil Holland ²	0 - 2.5	0 - 2.5	20 - 25	35 - 40	316	31	347	0
Simon Covill	2.5 - 5	0 - 2.5	45 - 50	100 - 105	772	61	833	0

1. Member opted out of pension scheme during 2019-20.
2. Real increase to lump sum may be low/zero or negative as now a member of 2008/2015 scheme which does not provide automatic lump sum.
3. Member retired in 2020-21.

There are no entries in respect of pensions for Non-Executive members as they do not receive pensionable remuneration.

CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

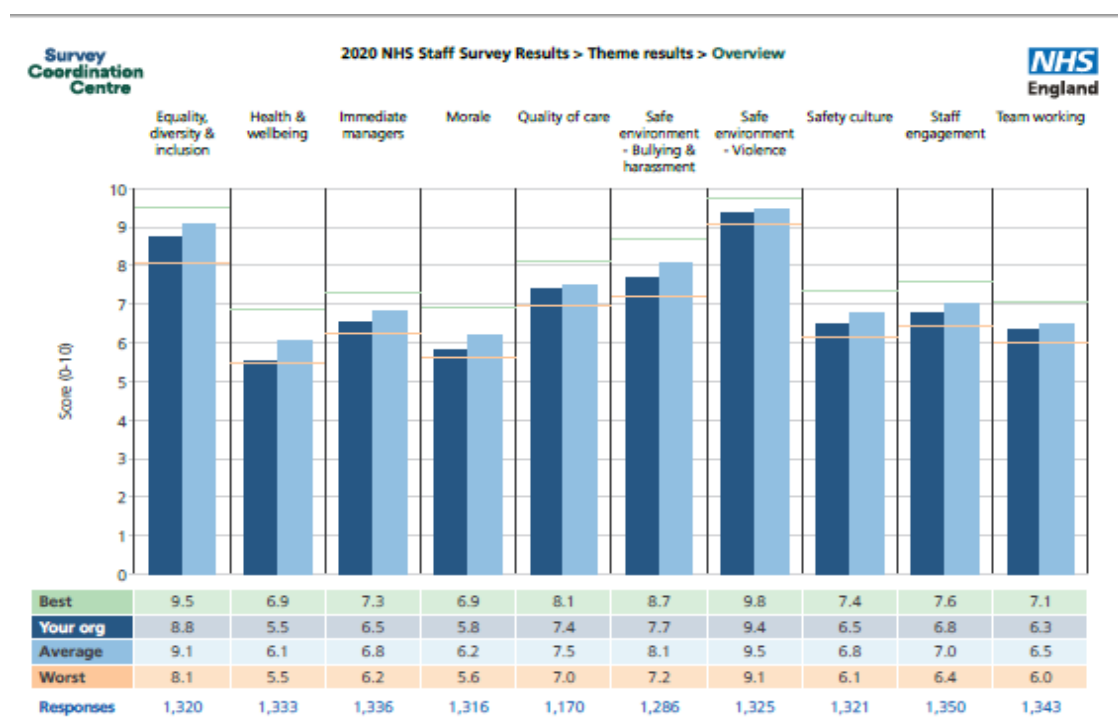
Real Increase / (Decrease) in CETV - This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The National NHS staff survey

The annual NHS National Staff Survey (NSS) is recognised as an important tool for ensuring that the views of people working in the NHS are used to help inform local improvements. The feedback is useful in helping highlight strengths, and determine improvements that will make the hospital a better place to both work and be treated.

A full census was held in the Trust between 28th September and 27 November 2020 with all our people employed on 1 September 2020 having the opportunity to take part. In total 1368 (38.2%) completed and returned their survey questionnaire, which was 6.8% lower than 2019, and 6.8% lower than the average 2020 response rate (there are 128 acute and acute and community trusts within our benchmarking group).

The table below summarises the survey results by the key national themes, benchmarked against the 128 other trusts.



The full findings report of the 2020 NSS were presented to the Workforce Committee in March 2021 and to the full Trust Board in April 2021. Action plans are being developed by each of the health care groups to address those areas most requiring improvement, which will align to three priority actions identified by the Trust:

Priority 1: Improving the physical and mental health and wellbeing of our people

Priority 2: Improving our learning and safety culture, encouraging people to openly raise concerns and ensure they are acted upon (improving psychological safety)

Priority 3: Improving the effectiveness of line managers

Action plan progress will be monitored by the Executive team at monthly performance review meetings, with bi-monthly assurance reporting to the Workforce Committee and updates to Trust Board. These are particularly important as we continue to deliver our quality improvement plan, which focuses on enabling outstanding care for *all* of our patients, *all* of the time.

2020-21 Staff Friends and Family Test

Due to the pandemic, NHSE/I issued new guidance pausing the quarterly Staff Friends and Family Test (SFFT) survey's from quarter 1 (April to June 2020) to quarter 4 (January to March 2021).

PAHT COVID-19 Staff Survey

Following a recommendation from the PAHT COVID-19 People Cell a decision was taken by the Strategic Cell to replace the formal SFFT quarter 1 survey with a specifically designed COVID-19 survey. The survey ran from 26 May to 21 June 2020, and a total of 3529 questionnaires were issued (via e-mail and QR codes). PAHT received 739 full completions and 387 partial completions, with an overall response rate (full and partial) of 31.91%.

A full report was made available to all PAHT staff, and a summary of the findings was presented to Workforce Committee in September 2020. Responses ranged from issues initially with PPE supply and the impact of ward moves, to positive feedback from our people feeling supported by the organisation, and appreciation for the daily COVID-19 communications updates.

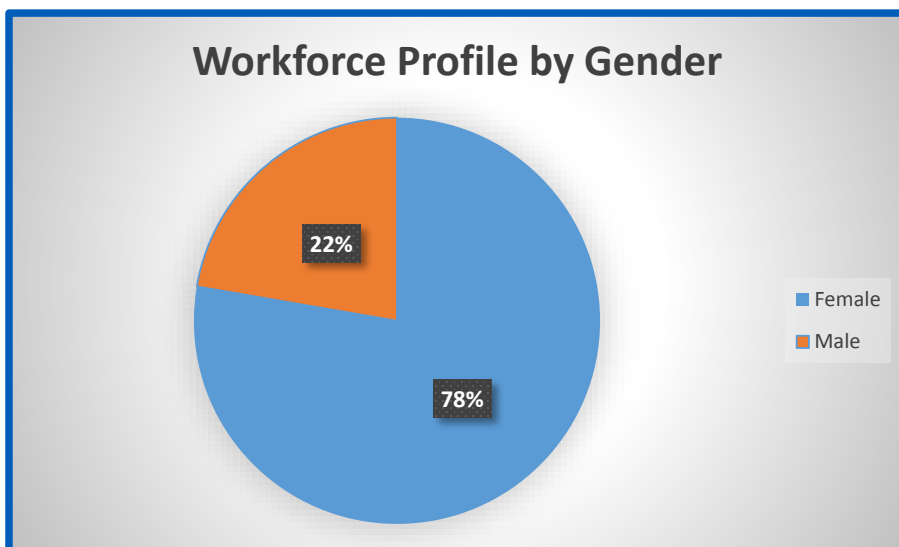
Our staff breakdown

Mar 2021 staff composition	Male	Female
Executive directors	4	4
Other employees	825	2921
Total	829	2925

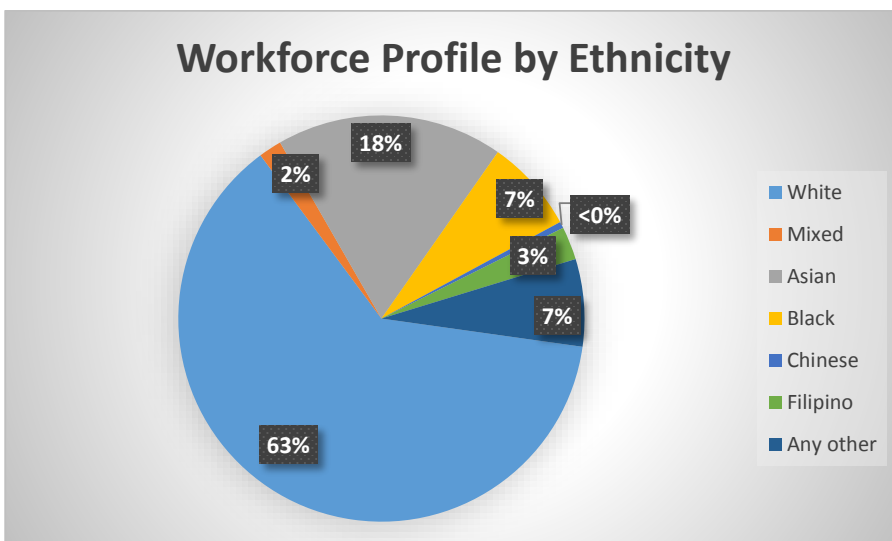
Turnover rate

Turnover rate	2019-20	Mar 20- Feb 21
Overall staff turnover	12.96%	12.13%
Voluntary turnover	10.74%	9.89%

Our workforce – gender profile



Our workforce – ethnic profile



Equality and diversity: significant achievements during 2020-21

The equality, diversity and inclusion steering group meets monthly to review activities and initiatives to promote and support awareness and education of equality, diversity and inclusion (EDI) at PAHT.

Due to the COVID-19 pandemic, the monthly meetings have been successfully held virtually. It has also required the steering group to review the ways it can highlight EDI activities, predominately through virtual events.

Black, Asian and Minority Ethnic (BAME) staff are an identified group that is disproportionately more likely to be impacted by COVID-19. In collaboration with other Trusts within the Integrated Care System (ICS), we have developed a number of initiatives to support our BAME staff:

- Establishment of a BAME staff support line
- Agreed consistent risk assessment and outcomes for **all** COVID-19 identified vulnerable groups
- Research methods were explored to understand BAME staffing needs and views on the COVID-19 response
- Creation of system-wide EDI network and BAME chairs network for ongoing transformation

The steering group agreed a calendar of events for 2020-21, to promote protected characteristics throughout the year. Some activities focused on celebrations, others on awareness and education. These events have included:

- Working in partnership with the staff health and wellbeing (SHaW) team and infection prevention control (IPC) colleagues on the content for InTouch briefings. The aim of these briefings was to raise awareness of the importance of completing COVID-19 risk assessments and to give colleagues an opportunity to ask questions of a panel of experts on COVID-19 vaccinations.
- We celebrated Black History Month in October 2020, supported by a calendar of webinars and a social media campaign with engaging content throughout the month.
- We marked International Men's Day in November 2020, with a variety of content across our internal and external communications channels to promote the work of our #PAHTPeople.
- We recognised Armed Forces Day on 27 June 2020 with a special feature in our staff newsletter, InTouch weekly.
- Linking with Essex Pride, we celebrated LGBT+ Pride in June 2020, developing bespoke graphics with quotes from our #PAHTPeople, which we promoted across our internal and external communications channels.
- We celebrated International Women's Day on 8 March 2021 and this year's theme of 'choose to challenge' across our internal and external communications channels. This included an InTouch briefing with a panel of inspirational women from PAHT sharing their experiences.

Looking forward

As we reflect on the past year and raise our eyes to view the year to come, we must pay respect to all that we have learnt from the last year and make sure that we continue to make a difference to our patients and care for each other and those around us.

Currently (May 2021), the COVID-19 pandemic remains with us and the Government has a roadmap to the easing of lockdown restrictions. Of course, the significant difference that 12 months has brought us are the COVID-19 vaccines and the delivery of many thousands of vaccinations across our people and local communities. We will continue to support the vaccination programme and work with our system partners in ensuring people have all the information they need about the vaccination options available to them.

Back to better

As an organisation, we have been focussing in recent months on the learning from the pandemic and on resetting how we work and provide care differently in to the future, building on the many changes that we put in place at great speed over the last year. Although we will, and need, to get back to a more familiar routine and deliver business as usual we must make sure that we continue to improve and make sure that in moving back to a new normal that this is better for our patients and for our people.

For our patients, this will mean maximising the improvements we have made to further enhance the care we provide.

For our people, this will mean a continued focus on the changes we make and the guidance, assistance and health and wellbeing support that is available.

Working together

Aligned to the NHS Long Term Plan's ambitions around more collaboration and integration in local health and social care settings, we are proactively involved in strengthening existing partnership working. We are also at the forefront of seeking the greater efficiencies that will come from combining how services are delivered and using the time released for patients and continued improvements.

PAHT 2030

Our vision to deliver outstanding healthcare to our community underpins our PAHT 2030 strategy and improvement plans to achieve our three goals, to be:

- ✓ Modern
- ✓ Integrated
- ✓ Outstanding

Our **PAHT 2030** plans are based on five key strategic priorities:

1. Our Culture
2. Transforming our care
3. Digital health
4. Corporate modernisation



Your future • Our hospital

5. New hospital

The business case development, design and build of a new hospital for local people will continue with a focused attention on ensuring we have a hospital fit for the 21st century that maximises technology to deliver the very best care for our patients,

Our focus on our journey to outstanding, delivered through the detailed plans in place for **PAHT 2030**, remains clear. Our amazing people are our greatest asset and with their passion and energy we will continue to work together with our health and social care partners to make a difference to our patients and the people living and working in the communities we serve.

Lance McCarthy

Chief executive

Trust Board – 11 June 2021

3.1

Agenda Item:	3.1							
Presented by:	Lance McCarthy – CEO							
Prepared by:	Lance McCarthy – CEO							
Date prepared:	3 June 2021							
Subject / Title:	CEO Update							
Purpose:	Approval		Decision		Information		Assurance	
Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting: - Performance highlights - COVID-19 response - Harlow Council Civic Award - CQC section 29a warning notice - External visits and inspections - New hospital progress - Capital developments - PAHT 2030 - Pathology procurement update							
Recommendation:	The Trust Board is asked to note the CEO report and note the progress made on recovery of services and other key items.							
Trust strategic objectives: [please indicate which of the 5Ps is relevant to the subject of the report]								
	Patients	People	Performance	Places	Pounds			
	X	X	X	X	X			
Previously considered by:	n/a							
Risk / links with the BAF:	CEO report links with all the BAF risks							
Legislation, regulatory, equality, diversity and dignity implications:	None							
Appendices:	None							

Chief Executive's Report
Trust Board: Part I – 11 June 2021

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

(1) Key performance headlines

I am not providing key performance headlines in my report this month for the first time in a number of years.

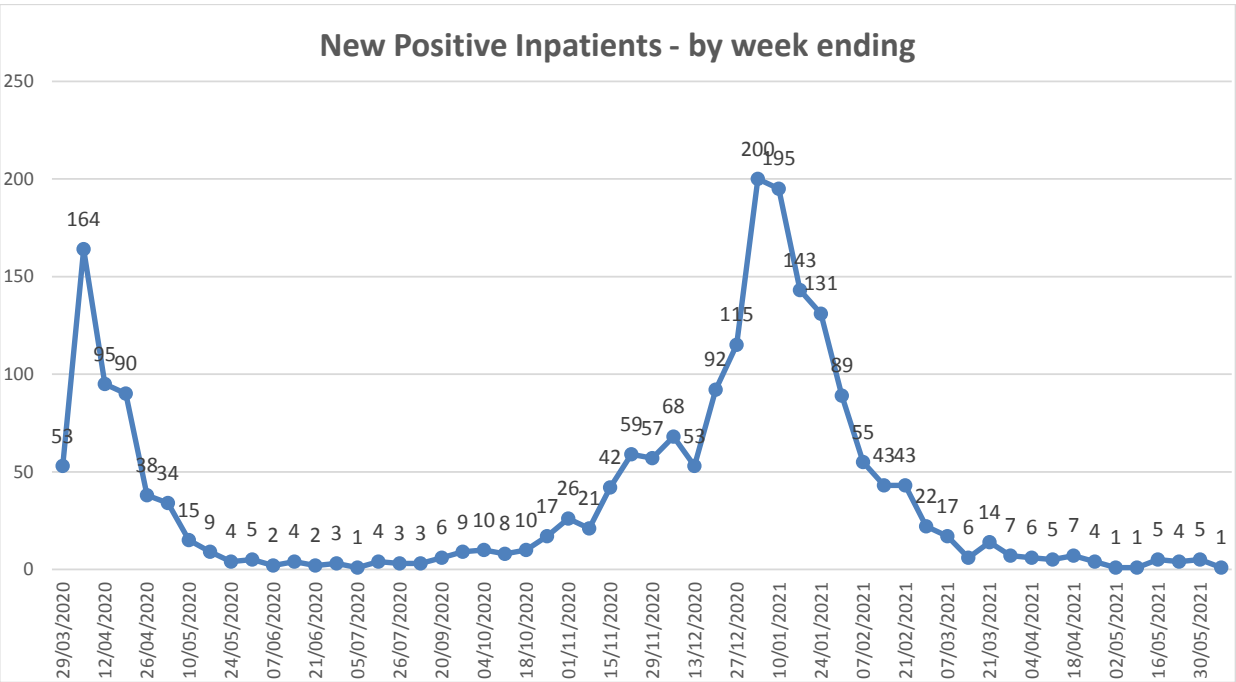
This is as a result of recent discussions that we have had as a Board over the last few months about how to better measure ourselves and report our data so that we can be more effective in getting to the things that matter. Our Integrated Performance Report is in the process of having a complete face lift and will be completed in the next few weeks, focussed on Statistical Process Control (SPC) charts and understanding variation and causes for variation as well as assurance.

(2) COVID-19 response

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

As you can see in the graphs below, we have seen a sustained reduction in the number of new COVID-19 positive inpatient admissions on a weekly basis since our peak of new positive inpatient admissions in w/e 3 January 2021, mirroring the reduction in the number of new COVID infections in our local communities. At the time of writing this paper, we have 5 COVID-19 positive inpatients in the Trust.

As many of our colleagues live in the local communities that we serve, the reduction in the number of new transmissions in the community has also seen our absence rates amongst colleagues reduce significantly, with sickness absence in February down to <4% (from more than 14% in some weeks in January).



We have not experienced a significant impact from the delta variant of COVID-19 which is more virulent than other variants and is having the largest impact on communities in the North West of the country and, with the EoE region, in Bedfordshire. We are 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.

The reduction in demand on our services for managing COVID-19 has enabled us to start to recover our elective services. Our teams have been fantastic at restoring these services quickly. Compared with April 2019 activity numbers, we undertook:

- 77% of daycases and 97% of elective IPs in April 2021
- Diagnostic services in April were at between 98% and 113% of April 2019 levels
- new outpatient attendances were at 101% of April 2019 levels with FUs at 129%
- ED attendances have been high in the last few months, with April levels the highest April we have experienced and May volumes the highest month ever at PAHT
- Our performance against the cancer targets continues to improve rapidly and is now back to pre-pandemic levels for 2ww and 31-day standard.

Despite a huge amount of hard work from everyone across the local health and care system, the impact of COVID-19 on our services and our people has been significant and it will be some time before we can reduce our backlogs down to the levels of waiters and consistent waiting times that we achieved pre pandemic.

The demands of treating COVID-19 patients over the last year, and particularly through the 2nd wave has put a huge amount of physical and mental stress on many of our colleagues. As part a comprehensive package of health and wellbeing support for colleagues we have completed a 12-week 'Back to Better' programme including a range of different types of event, webinars and information for colleagues, coordinated across 4 themes of:

- Health and wellbeing
- Compassionate leadership
- Civility, values and behaviours
- Operational changes and pressures

This has been well received by colleagues and supported further learning from things that went well and things that didn't go so well in our response to the pandemic.

In addition to this, we have continued to invest some of our capital in schemes and ideas that colleagues said would be helpful to make their working days better and support their health and wellbeing further. More information on this is in section 7 below.

(3) Harlow Council Civic Award

It was with great delight, pride and humility that I was invited to the Harlow Civic Centre recently to receive a Civic Award from the outgoing Chair of the Council, Maggie Hulcoop on behalf of all colleagues at PAHT.

As a result of the volume of and the strength of nominations made by members of the local community for the Trust, for individual departments and for specific individuals, it was felt by council colleagues that the best way to recognise this was to present a civic award at their Annual Council meeting on 20 May to all staff at PAHT for their continuous commitment and contribution to the community of Harlow.

I'd like to take this opportunity to reiterate my thanks to all in the local community for their support, gifts, donations and kind words over the last 12-15 months for all of my colleagues at PAHT and to thank the Chair, CEO and all at Harlow Council for their continued and ongoing support for the hospital.

It really was humbling to receive the award on behalf of my amazing colleagues and I'm sure that they will be delighted to know that they have been recognised in this way by members of the local community and council colleagues.

(4) CQC Section 29a warning notice

As I reported in my April CEO report to Board, following an CQC unannounced assurance visit to our ED on Sunday 14 February, we were issued with a Section 29a warning notice on 2 March due to concerns from inspectors related to:

- Risk assessments not being completed for all patients within the emergency department.
- Timely risk assessment for patients presenting with acute mental health illness
- Concerns regarding full adherence to infection, prevention and control procedures.
- Lack of embedding of the process for the provision of the out of hours endoscopy service for patients presenting with acute upper gastrointestinal bleeding

We responded to CQC colleagues at the end of March outlining the significant progress made against the IPC and GI bleed concerns and responded at the end of May outlining the substantial progress made in relation to the documentation and risk assessment concerns.

Supported by a third party, Prism, we have a comprehensive action plan and oversight process in place to support ED colleagues to make the necessary changes to address the concerns raised by CQC colleagues and to ensure that all of our patients receive the best and safest care.

We continue to report progress against the plan through a weekly oversight meeting and in to the monthly Quality and Safety Committee and we continue to meet with our local and regional CQC inspection managers as part of our regular engagement meetings to ensure full openness in all that we do.

(5) External visits and inspections

In addition to the CQC Winter Assurance visit of 14 February, we have had a number of other external visits / regulator inspections since the last Board meeting, as the pandemic has started to subside. These include:

- IRMER inspection – good report recognising many areas of strength and no significant concerns, other than an improvement notice for incomplete diagnostic reference levels. Updated DRLs will be available from our external Radiation Protection Advisor in the coming weeks, which will address the notice in its entirety.
- HSE virtual visit re: IPC – contravention letter due to belief of inadequate social distancing compliance as a result of some photographs of some empty rest facilities. We have continued to reiterate to all colleagues the importance of complying with good IPC procedures and social distancing where possible and we have provided further evidence of improvements and compliance to HSE colleagues
- Regional Trauma Network review – strong and good visit and the network team are very happy with our processes and procedures for managing trauma patients effectively and the review of deaths post trauma. Many of our indicators and data collection is amongst the best in the region and our excess deaths from trauma have moved from being a significant outlier a few years ago to being slightly less than expected for the last 12-month period.
- Environmental Health Officer visit to our restaurant – again a good visit and we have maintained our 5* rating for catering and the restaurant

We are expecting further visits and inspections over the next few months including:

- CQC to return to ED for a well-led review of UEC – probably in June
- CQC well-led review / full inspection for the whole hospital in the autumn

- UKAS review of pathology – expected in the autumn

(6) New hospital

We continue to work at pace with the development of The new Princess Alexandra Hospital in conjunction with the national New Hospital Programme (NHP).

Our Outline Business Case is developing well and we received strong and positive feedback from the recent deep dives undertaken by NHP colleagues reviewing progress we have made. We continue to work closely with NHP colleagues to support the maximum benefit to the whole programme as well as to our scheme for local residents, through repeatability of design, use of modern methods of construction to maximum effect and underpinning our new models of care and clinical strategies with a comprehensive digital and technology strategy.

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 remain on track to complete our OBC in the autumn and bring to the Trust Board for decision in October.

Our engagement programme is strong and continues to develop well and we continue to have regular conversations with all local MPs, local district councillors, Essex CC colleagues and our internal colleagues.

More information is provided in the places section of the agenda later.

(7) Capital developments

As we continue to develop our plans for the new hospital, we need to ensure that our current facilities remain safe and suitable for our people and our patients. Consequently we continue to invest our capital to support the highest risk areas to patient safety and care and also use some of our capital funds to support requests from our people in terms of what would make their working days better and support their health and wellbeing more effectively, especially as we recover from the COVID-19 pandemic.

Key schemes that are in progress at the moment include:

Improvements for our patients:

- Refurbishment of Penn Ward – turning our 16-bedded bay in to 4 x 4-bedded bays; creating high quality toilet and washing facilities for patients; improving the look and feel of the whole ward; enhancing safety through improved lines of sight and improved gases stacks
- Additional CT scanner (in ED) - new building adjoining ED to house a new CT scanner dedicated to support the speedier flow of and decision making for our urgent care patients
- Enhanced, refurbished and expanded frailty unit – complete overhaul of facilities next to ED to better support the management of our frail older population and ensure timelier and specialist assessment
- Renovation of the delivery suite corridor and rooms, including a new birthing pool, in the obstetric corridor
- Creation of a 3rd endoscopy room providing much needed additional physical capacity to meet the increasing demand for endoscopy, and supported by a new recovery facility for endoscopy patients
- Renovated colposcopy facilities providing the highest-grade facility

Improvements for our people:

- Development of a 'green zone' for our people and our patients to enjoy some rest and relaxation
- New changing and showering facilities and secure bicycle locking facilities for our colleagues who cycle or wish to cycle to work
- New electric car charging points, supporting our sustainability work
- Development of a new training, education and development facility enabling colleagues to learn in a much enhanced environment and for us to decommission the Grade II listed Pardon Hall

Over the next few months we will start a number of other key projects including:

- Two further ward refurbishments
- Creation of a large multi-professional, high quality staff rest facility
- Ongoing refurbishment and improvement of our mortuary, post mortem and viewing facilities

(8) PAHT 2030

As a result of further consultation on our 10-year strategy, PAHT 2030, we have made a number of developments and enhancements to it before we launch it across the organisation and with local stakeholders in July. PAHT 2030 will be a core theme running through our Event in a Tent 2021 in the autumn.

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

As soon as the revised Strategic Objectives for the Trust are approved (agenda item later today) and our refreshed values are approved (early July), we will launch PAHT 2030 and track progress through a regular monthly report and a report to every Board meeting.

(9) Pathology procurement update

The procurement of pathology services across the ICS have regained momentum as the impact of the COVID-19 pandemic has started to reduce.

The procurement is almost exactly a year behind where we expected it to be as a direct result of managing the pandemic. Currently we are part way through the dialogue phase of the procurement with the bidders and are on track to issue the Best and Final Offer (BAFO) documentation in mid-July. We are still expecting, together with the other acute providers and CCGs in the ICS, to get to contract award in October and contract signature in December.

Author: Lance McCarthy, Chief Executive
Date: 3 June 2021

Trust Board – 11 June 2021

Agenda Item:	3.2					
Presented by:	Lance McCarthy – CEO					
Prepared by:	Lance McCarthy – CEO					
Date prepared:	3 June 2021					
Subject / Title:	Strategic Objectives for 2021/22					
Purpose:	Approval	X	Decision	X	Information	Assurance
Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	Attached are the proposed strategic objectives for the organisation for 2021/22 As with previous years they are aligned with the 5Ps and will be aligned with our 3 goals of being modern, integrated and outstanding. PAHT 2030, our 10-year plan aligned with the long-term plan will be published shortly.					
Recommendation:	The Trust Board is asked to approve the 5 proposed strategic objectives for the Trust for 2021/22					
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:	Failure to achieve any of the strategic objectives is a risk to the organisation. The BAF by definition of outlining the risks to the non-deliver of the strategic objectives is integrally linked to this paper.					
Legislation, regulatory, equality, diversity and dignity implications:	None specifically.					
Appendices:	None					

Strategic Objectives for 2020/21 Trust Board – 11 June 2021

3.2

1.0 PURPOSE

- 1.1 The Trust Board is asked to discuss and approve the proposed strategic objectives for the organisation for 2020/21.

2.0 BACKGROUND

- 2.1 The Trust's strategic objectives underpin the working of the organisation for the year.
- 2.2 From the strategic objectives the Health Care Group objectives and individual objectives are set, ensuring they are aligned with the direction of the Trust.
- 2.3 The strategic objectives need to reflect the key risks faced by the organisation.
- 2.4 The Trust Board agreed, in June 2017, 5 Strategic Objectives, based around our 5Ps, and supporting our ambition to provide outstanding care for our local population. The Board agreed to maintain the strategic objectives for 5 years to ensure consistency of direction.
- 2.5 Our Board Assurance Framework (BAF), reviewed at every Board meeting, will identify the risks, and mitigations in place, of achieving our strategic objectives.

3.0 5Ps

- 3.1 We have been developing PAHT 2030 over the last year and we will be launching this soon. This will be an organisational plan for the next 10 years, aligned with the NHS Long Term Plan, to support our drive towards delivering 'outstanding' services to our patients and secure our future with a new building.
- 3.2 It has 5 priorities of our culture; transforming our care; digital health; corporate transformation and the new hospital and it will be focussed around the 5 'Ps' of:
- Patients
 - People
 - Places
 - Performance
 - Pounds
- underpinned by working in partnership with all our health and social partners.
- 3.3 This will be linked closely to our 3 goals of being modern, integrated and outstanding and our organisational values.
- 3.5 In line with the proposed changes to the business planning process for the second half of this financial year and annually going forward, all Healthcare Groups will have clear plans for how their services will develop in line with the 5 priorities and support delivery against the 5P strategic objectives. During the year, all specialties, clinical departments and corporate departments will also develop their local plans, linked with their clinical strategies and new models of care to drive the transformation and modernisation agenda across the whole organisation. These will be interlinked with the actions from the Getting it Right First Time (GiRFT) programme and our Model Hospital data, supporting the improved use of our resources, and will be overseen and managed by a project management office including our quality improvement resource.

- 3.6 All plans will have clear milestones identified for delivery within each specific year and achievement of the 2021/22 milestones will support the achievement of the Trust's strategic objectives.

4.0 PROPOSAL

- 4.1 Consequently we need to update the 5 strategic objectives to both reflect the move to a new financial year and the increased rigor of a greater project management approach to the implementation and delivery of local plans aligned with PAHT 2030.

- 4.2 The 5 proposed strategic objectives for approval are outlined below, being less focussed on the financial year as a result of the above, progress being tracked against the delivery of the specific items outlined in PAHT 2030 by year:

- 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 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 development of our local Integrated Care Partnership
- Our Performance – we will meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators
- Our Pounds – we will manage **our pounds** effectively **to ensure that high quality care is provided in a financially sustainable way**

- 4.3 It is proposed that the Trust Board monitors progress throughout the year against PAHT 2030 and the strategic objectives on a 2-monthly basis.

5.0 RECOMMENDATION

- 5.1 The Trust Board is asked to approve the 5 proposed strategic objectives for the Trust for 2021/22.

Author: Lance McCarthy, Chief Executive
Date: 3 June 2021

TRUST BOARD
11 JUNE 2021

3.3

Agenda item:	3.3							
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:	25 May 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 is 86 reduced from the previous paper (section 2.1). The main themes for 12 risks scoring 20 on the SRR are: • 7 relating to operational pressures: 3 for referral to treatment standard compliance and three for ED standard compliance. • 3 for our places: research facility, waste removal and theatre roof • 2 medical staffing for consultant cover for GI bleed and Maternity. Actions and mitigations detailed in sections 2.4 to 2.7 Three new risks raised, with scores of 15 • Need for 9 replacement NICU baby cots • Management of patients who sustain head injury following a fall and are on anticoagulation • Band 5 staffing constraints in paediatric emergency department. Details of full risk and mitigating actions in section 3.							
Recommendation:	Trust board are asked to review the contents of the Significant Risk Register.							
Trust strategic objectives:	 Patients √	 People √	 Performance √	 Places √	 Pounds √			
Previously considered by:	Risk Management Group reviews risks on a rotation so each service is monitored quarterly as per annual work plan, April meeting Senior Management Team on 11 May 2021							
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 23 April 2021. 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.

Work in refreshing our risk management strategy and a corporate risk register is being supported by additional resource; a corporate risk register is expected to be in place by end July 2021.

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.

There are 86 significant risks on the risk register, decreased from 108 in the paper discussed in April's Trust Board. The breakdown by service is detailed in the table below.

	Risk Score				Totals
	15	16	20	25	
Covid-19	2 (1)	1 (4)	0 (1)	0 (0)	3 (6)
Cancer, Cardiology & Clinical Support	6 (6)	7 (10)	0 (0)	(0)	13 (16)
Communications	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Estates & Facilities	4 (7)	4 (8)	1 (1)	(0)	9 (16)
Finance	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Information Data Quality and Business Intelligence	0 (1)	1 (0)	0 (0)	0 (0)	1 (1)
IM&T	1 (1)	1 (2)	0 (0)	0 (0)	2 (3)
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)
Non-Clinical Health & Safety	2 (2)	1 (1)	0 (0)	0 (0)	3 (3)
Nursing	1 (0)	0 (0)	0 (0)	0 (0)	1 (0)
Operational	2 (2)	1 (0)	4 (4)	0 (0)	7 (6)
Research, Development & Innovation	0 (0)	1 (2)	1 (1)	0 (0)	2 (3)
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	2 (0)	0 (2)	0 (0)	0 (0)	2 (2)
FAWs Women's Health	7 (6)	4 (5)	2 (6)	0 (0)	13 (17)
Safeguarding Adults	0 (0)	1 (0)	0 (1)	0 (0)	1 (1)
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	1 (1)
Medicine	4 (5)	3 (4)	1 (2)	0 (0)	8 (11)
Surgery	5 (7)	4 (5)	3 (3)	0 (0)	12 (15)
NEW Register: Urgent & Emergency Care (risks reassigned from Medicine)	0 (0)	1 (0)	0 (0)	0 (0)	1 (0)

Totals	38 (40)	36 (49)	12 (19)	0 (0)	86 (108)

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

2.3 There are 12 risks with a score of 20: a decrease from the previous paper. A summary of these risks is below and all new risks are detailed:-

2.4 Our Patients

- The Trust needs electronic storage of CTG to cover antenatal and intrapartum care, (2020/06 raised in June 2020, score adjusted as software programme requires investment.
Action: Currently all notes available in paper copy. ATI completed and submitted to capital programme group.

2.5 Our People

2.5.1 Consultant cover on rota in Maternity

- Consultant cover currently achieves 77 hours per week, with 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: One new consultant starts May which takes hours covered up to 87. All consultant job plans are on track for review by end of April. Further recruitment is planned.

2.5.2 Medical Staffing cover for GI bleed

- 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, care bundle and SOP. The Trust has agreed to fund an out of hours endoscopy service. A consultation is in progress to have staffing cover an out of hours GI bleed rota by end of Q2 2021/2. In the interim the consultant gastroenterology team are starting an advice and guidance out of hours rota. All acute GI bleed cases will be discussed with the gastroenterologist, further discussion made for appropriate management, including referrals to other centres.

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: 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. External 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: Daily patient tracking of cancer list at meetings attended by Head of Performance & Planning. Cancer Board monitors recovery action plan and trajectory.

2.6.3 Referral to treatment standard

Three risks associated with performance against the national standard

- 52-week breaches because of the pandemic and pauses to OPD clinics and elective surgical activity. The numbers of patients waiting over 52 weeks is 1227 (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 elective work continues at the Rivers.

- **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

- **Theatres for Surgery:**
The theatre roof has been fixed and this will be removed from the significant risk register.

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 location twice)

Action: Space allocation group asked to provide a location for use, currently working out of the new fracture clinic. Working with the new hospital team to ensure a location is available in the new site. Looking at telehealth versus face-to-face contacts.

2.7.3 Waste Management

- As a result in shortages of the capacity to manage clinical waste in the south east if England, the trust is at risk of breaching waste regulations as not all waste is secured all clinical waste bins (EFMwaste-01 raised December 2020)

Action: Porters continue to collect waste and store it in cages within a locked compound. Trust discusses daily the position with current contractor and resolve issues locally where possible. Looking to source a third party provider to assist clearing the site.

2.8 Our Pounds: No finance risks detailed

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

3.1 Our Patients

- Requirement of nine replacement Kanmed baby cots for neonatal unit (NICU08/2021 scoring 15, raised March 21)

Action: Completion of ATI

- To prevent further deaths resulting to patients that fall and on anticoagulation (Fall/2021/12/24, scores 15)

Action: Strategic falls management action plan in place, amended falls management policy with protocol for those who sustain head injury, discussed at clinical group meetings in February 21, internal safety bulletin published March 21, micro teaching on MS Teams commenced and falls lead nurse reviews all incidents daily.

3.2 Our People

- Recruitment of vacant nursing band 5 posts in ED (4WTE), and gain cover for staff shortly to commence maternity leave (4) for funded 10.74WTE roles. (PRD03/2021, score of 15, raised March 21)

Action: out to agency for short-term cover, not able to fill all shifts. Rolling band 5 adverts and rotate staff from other children's area where acuity allows supporting ED.

4.0**RECOMMENDATION**

Trust board are asked to review the contents of the significant risk register.

Trust Board – 11 June 2021

3.4

Agenda item:	3.4				
Presented by:	Sharon McNally – Director of Nursing, Midwifery and AHP's				
Prepared by:	Heather Schultz – Head of Corporate Affairs				
Date prepared:	03.06.21				
Subject / title:	Board Assurance Framework 2020/21				
Purpose:	Approval	x	Decision		Information
Key issues:	The BAF 2021/22 is presented for review. The strategic objectives for 2021-22 will be added once approved at Board (agenda item on 11 June). It is proposed to reduce one risk score this month (Risk 1.0 Covid) and add two revised finance risks (Risks 5.1 and 5.2). BAF risk 1.0 Covid – the risk score is to reduce from 16 to 12 and the target risk score has been reduced from 12 to 9. BAF risks 5.1 Revenue and 5.2 Capital have been added to reflect the financial risks for 2021-22. 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 addition of Risks 5.1 and 5.2.				
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 May 2021. EMT on 28 May 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				

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 and experiences that we provide our patients, integrating care with our partners and improving our CQC rating										
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						↓	CEO/ DoN&M
1.1	Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	16	16						↔	DoN&M/ MD
1.2	EPR: Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes.	16	16						↔	DoIMT/ CIO
Strategic Objective 2: Our People – we will support our people to deliver high quality care within a within a compassionate and inclusive culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results										
2.3	Workforce: Inability to recruit, retain and engage our people	12	12						↔	DoP
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.										
3.1	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	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						↔	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						↔	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 the ED standard.	16	16						↔	COO
Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2020/21 and our local system control total										
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						New risk	DoF
5.2	Capital: In year delivery of the Trust's Capital programme within the Capital Resource Limit and ICS allocations.	New risk	12						New risk	DoF

The Princess Alexandra Hospital Board Assurance Framework

2021-22

Risk Key														
Extreme Risk		15-25	The Princess Alexandra Hospital Board Assurance Framework 2021-22											
High Risk		8-12												
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 independent 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 vii) Clinical Cell ix) Incident management group	i) Incident management action and decision logs ii) QSC updates monthly from (March 2020 to March 2021) iii) Trust Board updates (March, to April 2021) iv) Recovery Plans and submissions 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 - in Modelling information for next peak (local-regional-and-national-dependant on lock-down-and-public-behaviour) iii) Plans for use of the private sector iv) Limitation with PAHT estate configuration and supply of oxygen Adaptability and configurations opportunity of clinical areas	May-21	Proposed to reduce score from 16 to 12.	4 x 3 = 12 (June-2021) 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								Target risk score revised.			

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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		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective					
								Evidence should link to a report from a Committee or Board								
Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients, integrating care with our partners and improving our CQC rating																
Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2020/21 and our local system control total																
BAF 1.2		EPR Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes. The current EPR has limited functionality that does not always support 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) Programme management arrangements established with Data Quality Recovery Programme to Health Group iii) Challenge meetings SMT and Trust Board Governance with Performance and Finance Committee to Trust Board iv) Increased training application support, mobile training support, RTT validators & staff awareness sessions. v) Performance Mgt Framework in place. vi) User Training programme. vii) Super users in place to deliver focused support. viii) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability. ix) Access Policy x) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) xi) Development of capacity planning tools/information xii) SMC review and actions identified xiii) ICT Newsletter issued xiv) Weekly ICT/CSMIC meetings ongoing xv) Real-time data now available xvi) CDG 614 review xvii) Maternity MDS configuration completed xviii) Monthly Contract Performance monitoring meeting with supplier established. xix) New EPR Board established – chaired by CEO xx) EPR replacement programme established xxi) EPR Options appraisal development to complete mid-December 2020 xxii) EPR SOC developed and benefits realisation with link to HMMS	i) Access Board ii) EPR Programme Board (to be shared by CCO) iii) Board and PAF meetings iv) Weekly meetings with Cambio v) Weekly DQ meetings vi) Monthly performance reviews	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/interim/junior doctors with the system and uptake of refresher training. Responsiveness and quality of delivery of SMC – testing processes and actions identified by risk internal audit – limited to emergency – Supplier requests to remove contractual requirement to comply with national standards e.g. SNE - 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 NHS. ACTIONS: SOC being developed to procure new EPR solution Ongoing user training programme	May-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: i) Ongoing training and support ii) Re-establishing relationship/engagement with Cambio iii) Refresher training underway iv) Revised roadmap to incorporate new statutory/legal requirements e.g. GDPR v) CIO in place						

Risk Key														
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	What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered Evidence should link to a report from a Committee or Board.		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				
Strategic Objective 2: Our People – we will support our people to deliver high quality care within a within a compassionate and inclusive culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results														
Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators														
23	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 included 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) Hire 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 iv) Review of raising concerns (FTSUG's, champions for bullying and harassment, senior inclusion lead) v) CV19 staff vaccination implementation plan - completed vi) NHSE/i Health and wellbeing framework assessment - Q2 vii) Allocate rostering system review assessment and plans - Q2 viii) Review of management and leadership development provision - Q2	None identified.	01/05/2021	Risk score not changed.	4 x2 = 8 March 2022	

Risk Key														
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Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.														
BAF 3.1	Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	Causes: i) Limited NHS financial resources (Revenue and Capital) ii) Lack of capital investment, iii) Current financial situation, iv) Inherited aged estate in poor state of disrepair v) No formal assessment of update requirements, vi) Failure to comply with estates refurbishment/ repair programme historically, vii) ~~Under investment in training of estate management & site development~~ viii) Inability to undertake planned preventative maintenance ix) Lack of decant facility to allow for adequate repair/maintenance particularly in ward areas. x) ~~Key workforce gaps in compliance, energy and engineering~~	5 x 5= 25	Director of Strategy Performance and Finance Committee	i) Schedule of repairs Six-facet survey/ report received (£105m) ii) Potential new build/location of new hospital iii) Capital programme - aligned to red rated risks. iv) STP Estate Strategy developed and approved. v) Modernisation Programme for Estates and Facilities underway vi) Robust water safety testing processes vii) 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 xii) Sustainability Manager in post xiii) Emergency Capital funding £4.3m xiv) Compliance Manager appointed xv) 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) Monthly 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 vii) Annual Sustainability report to PAF (May 2021) viii) ~~Internal Audit report (Iaa) – review of PDM (limited assurance) report – Audit Committee Dec-2020, action plan in place~~ ix) 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 ii) ~~Review of estates function complete~~	i) Estates Strategy /Place Strategy developing within ICS ii) Compliance with data collection and reporting iii) PPM data not as robust as required	21/05/2021		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 PFC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.												

Risk Key														
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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) Independent STP Chair and independent STP Director of Strategy appointed. xi) System agreement on governance and programme management ICS meetings focussing on management of Covid-19	STP CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) STP Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and STP updates (CEO report August and Development sessions in October/November 2020)	4 X 4= 16	Lack of ICS demand and capacity modelling. 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											

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		Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership												
BAF 3.5		New Hospital: There is a risk that the new hospital will not be delivered to time and within the available Capital funding.	Causes: i) 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 NHF may delay OBC	8 X 4= 28	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) ~~HQSC 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~~	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 HQSC-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: ~~Soft-market-testing postponed-~~ ~~progressing and a bidders day planned-~~	None.	May-21	Risk score not changed.	3x3=9 September 2021

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								Evidence should link to a report from a Committee or Board.						
Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators														
BAF 4.2		4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	Causes: i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Changes to working practice and modernisation of systems and processes iv) Delays in decision making, patient discharges and impacting on flow v) Lack of assessment 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 vi) Local Delivery Board in place vii) ED action plan reported to PAF/Board x) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries xi) Weekly Urgent Care operational meetings and Urgent Care Board in place xii) Focus on length of stay in ED for all patients xiii) Think 111 First - went live December 2020 xiv) 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	4x4=16	i) Staffing (Trust wide) and site capacity ii) System Capacity iii) Leadership issues <u>Actions:</u> i) Local Delivery Board monitoring ED performance ii) Monthly Performance review meetings and weekly Urgent Care Board review	None noted.	20/05/2021	Risk score not changed.	4x3 =12 March-July 2021 (on consistent delivery of standard - 95%)
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels											

Risk Key														
Extreme Risk		15-26												
High Risk		8-12												
Medium Risk		4-6												
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		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Positive Assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
Strategic Objective 5: Our Pounds – We will manage our revenue financial resources to deliver our agreed financial control targets within System envelopes.														
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 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.	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 deliver CIPs will be influenced by COVID, recovery and restoration. (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.	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 Trusts 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 investment/business case approval process. (vii) Development of CIP workshops and plans. (viii) Temporary staffing audit underway and focus on reduction in temporary staffing.	Sources of Assurance : (i) Performance review meetings - monitoring against to 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	21/05/2021		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		15-26												
High Risk		8-12	The Princess Alexandra Hospital Board Assurance Framework 2021-22											
Medium Risk		4-6												
Low Risk														
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 capital financial resources to deliver our agreed Capital Resource Limit (CRL)														
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. The development of the New Hospital will continue to be a significant programme of work.	4 x 4 = 16	Exec leads: DoF: Groups: Capital Working Group, SMT, EMT and Performance and Finance Committee, New Hospital Committee	Key Controls: 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. 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.	(i) 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. (v) 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.	21/05/2021			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				

Learning From Death and Mortality Paper for Board – 11 June 2021

4.1

Agenda item:	4.1				
Presented by:	Fay Gilder Medical Director				
Prepared by:	Nicola Tikasingh Matron for Quality and Mortality Lindsay Hanmore ADON Quality improvement Robert Ayers Deputy Director Quality Improvement Kevin Jennings Programme Manager Bola Shoneye Information Team Alex Schosland Head of Information				
Date prepared:	May 2021				
Subject / title:	Learning from deaths: April 2021 data and information				
Purpose:	Approval		Decision		Information X Assurance X
Executive Summary	This paper provides an update on our learning from death process to the Quality and Safety Committee with assurance of PAHT compliance with National requirements. It highlights the progress on actions to mitigate risks associated with mortality and learning from deaths.				
Recommendation:	To note the progress being made on the learning from death process and the improvement work to address this.				
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	 Patients	 People	 Performance	 Places	 Pounds
	X	X	X		
Previously considered by:	This paper is also shared at the Strategic Learning From Death Group. QSC.28.05.21.				
Risk / links with the BAF:	BAF 1.1 Variation in outcomes in clinical quality, safety, patient experience and "higher than expected mortality"				
Legislation, regulatory, equality, diversity and dignity implications:	'Learning from Deaths' - National Quality Board, March 2017				
Appendices:	Appendix 1 – Mortality Dashboard Appendix 2 – Audit results of deaths after Covid 19 vaccine				



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1.0 Purpose/issue

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

2.0 Background

PAHT now has a learning from death process that meets the national requirements. The risks associated with this are captured on the learning from death risk register.

3.0 Current Dr Foster/ NHS D Data Headlines

Linked to risks:

LFR 2020 03: *'To improve the HSMR level at the Trust and eliminate outlying mortality groups.'*

LFD 2020 09: *'To improve outcomes for patients that present or develop sepsis as demonstrated, by achieving 'as expected' for both SHMI and HSMR by March 2021.'*

LFD 2020 10: *'To improve outcomes for patients that present or develop acute kidney Injury as demonstrated, by achieving 'as expected' for both SHMI and HSMR by March 2021.'*

LFD 2020 04: *'To ensure that our mortality data is available and accurate in order to facilitate learning from deaths.'*

Data Submission

The fault in the data submission process has been identified. The IT team at PAH are working closely with the two organisations involved (System C and NHSD) to resolve the problem. This means our data from October 2020 is erroneous. Until this is corrected we will not be able to focus our mortality improvement resources appropriately. The data submission has been completed (31 May 2021) which will enable Dr Foster to provide analysis from August 2021.

Hospital Standard Mortality Rate (HSMR)

We are pausing sharing HSMR data in this paper until issues with Secondary Uses Service (SUS) reporting are resolved as per the update provided in March's paper.

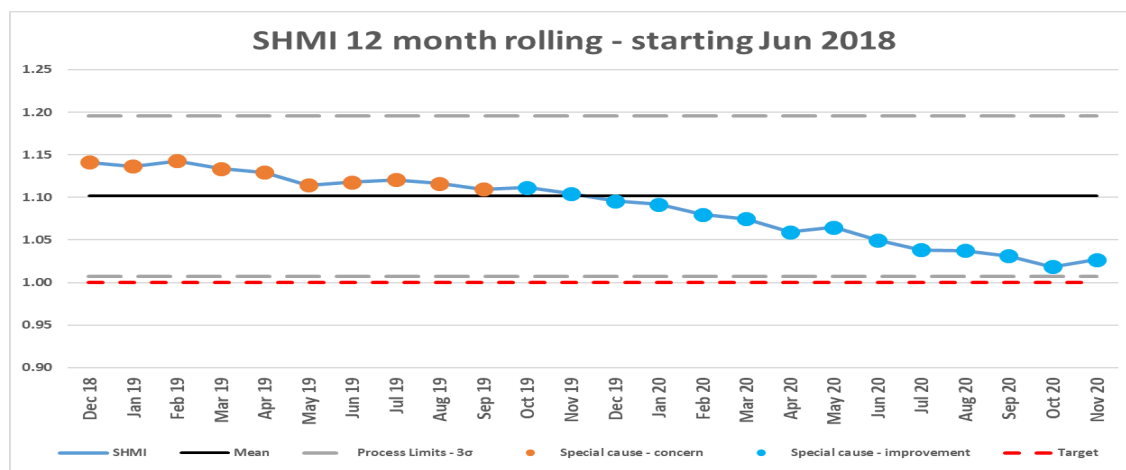
Summary Hospital-level Mortality Indicator (SHMI)

The most recent SHMI value is 1.0269 (November 2020). We have not alerted since April 2019.



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4.1

3.1 Deep dive into outliers – linked to risk LFD 2020 03: *‘To improve the HSMR level at the Trust and eliminate outlying mortality groups’*

The imminent SMART system for mortality reviews, will be able to incorporate reviews for deep dives of Dr Foster outlier cases. The management team from Acadian Limited will be able to work on providing specific forms for these deep dive cases. Plans will be in place over the next month with the specialist leads for Sepsis and AKI, so that a trial can take place for these outliers initially. This will ensure that all mortality reviews are held on the same system and the individualised forms will assist with pulling out specific themes so that gaps can be identified in order for learning to be taken.

4.0 Mortality Improvement Programme – linked to risk LFD 2020 04

The mortality improvement programme workshop has been organised for 29th June 2021 and will be facilitated by the Quality First Team. Scoping is currently taking place with clinical leads to understand what we can learn from the past, where we are now, where do we want to be and how do we get there.

Following the workshop a formal programme of work will be established with clear leads and accountability in place, which will report through to operational/strategic learning from deaths and quality and safety committee (Q&SC) to ensure governance is place and action/measures are tracked effectively.

4.1 SMART implementation update -linked to risk LFD 2020 04

The team are currently working on the implementation of the SMART system in the trust. The system will provide the Medical Examiners and Structured Judgement reviewers with the ability to record their reviews and provide the trust with the ability to identify the opportunities to celebrate care and where improvement is required.

The project is led by the Lead Medical Examiner, working with the supplier Acadian, informatics and IT to implement the system.

- UAT Server (based at PAHT) – implemented
- PRD Server (based at PAHT) – implemented
- Interface between Cosmic & SMART – developed and currently in test
- Integration testing – scheduled for May (dependency interface completion)



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- User Acceptance Training – (dependency successful Integration testing)
- Acadian and IT/informatics teams currently working on inbound/outbound data requirements from data warehouse
- The informatics team are working with our current mortality system (Clarity) to obtain historic data to populate SMART - Initial data load to be received – w/e 21/05
- Updated ME form B currently being reviewed by medical examiners
- NHSX data feed request submitted to enable more real time understanding of mortality indices

4.2 Acute Respiratory

4.2.1 Non-invasive ventilation (NIV) - restart on Locke ward

Key updates

A project group has been set-up to plan and implement the restarting on NIV on Locke ward. The team are currently running through the specific items including equipment, training and staff rotas (both medical & nursing) that are required in order to restart.

The team are currently working to re-implement NIV on Locke ward, the start has been delayed while we finalise a number of items – restart date to be agreed.

4.2.2 Aspiration pneumonia

Key progress updates:

- A mouth care audit took place on both Lister & Locke wards – March 2021. The results were disappointing revealing that 50% of patients did not have clean mouths. The presentations were shared with the teams to agree improvement approaches. The mouthcare assessment went live on nervecentre 18 May. High risk patients are given a red mouthcare pack. There are mouthcare champions on both wards and mouthcare is discussed for each patient at the daily huddles. The ward managers/matrons do weekly observations of practice and validation of assessment tool completion. A re-audit on both wards will be conducted in July.
- A deep dive is being conducted to understand how many patients who have been discharged with a 'feeding risk' diagnosis have been readmitted with aspiration pneumonia. The speech and language team are working with the information team to obtain the data.

4.3 End of Life (EoL)

4.3.1. Education – ward-based teaching has been reintroduced. An EoL on line module is on track for roll out in the next month. EoL training will be provided to all clinical staff on induction, and on the preceptorship and healthcare support worker programmes. Measures of success – appropriateness of referrals and improved compliance with recording in Individualised end of life care plans.

4.3.2 Preferred Place of Death (PPD) is now recorded on NerveCentre to increase number of patients with PPD recorded in a consistent place. The specialist palliative care team all have access to SystemOne to determine PPD for those patients recorded there by GPs. Measure of success will be increased number of patients with PPD recorded on NerveCentre.



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4.3.3 Hospice Pathways – all local hospices now involved with an aim to stream line referral process and access to other hospice services. Measure of success will be to monitor improvements in time from referral to time to transfer of care.

5.0 Learning from deaths process update

- 5.1 In the reporting month of April 2021 there have been 69 adult deaths, with 12 cases referred for a SJR.
- 5.2 There were 4 SJR's completed in April.
- 5.3 There were no COVID related deaths in April.
- 5.4 During the second wave (September 2020 to April 2021), there have been 322 COVID deaths with 59 of these listed as nosocomial deaths in total. All of these cases have now had a review and have been presented to the second review panel. The investigation report for this aggregated serious investigation is in the process of being completed; pulling the themes and learning from all of these cases.
- 5.5 There was one incident raised following a SJR. This case was scored as an avoidable death which has been escalated as a serious incident and due for discussion at the second review panel in May 2021. This case is in relation to a surgical patient, deemed medically fit for discharge; however the patients' blood sugars were not appropriately monitored which caused the patient to develop hypoxic brain injury / hypoglycaemia; which led to the patient's death.
- 5.6 There were 16 nosocomial cases presented to the second review panel. 2 of these cases were deemed avoidable due to multiple bed moves. All nosocomial cases for the second wave have now been presented to the second review panel, with avoidability of death scores determined.
- 5.7 Mortality reviews have also taken place for patients who had their first vaccine and were admitted and died (regardless of whether the patient had COVID or not). The audit has looked at deaths from December 2020 to beginning of March 2021. There were 60 cases in total reviewed. The outcome and learning from the audit can be seen in the Appendix 2. This has been shared with the HCG's and a request has been made to share this with the CCG and identify any learning primary care may have taken from deaths after COVID vaccine that can be shared.

6.0 Risks for Escalation

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

7/0 Recommendations

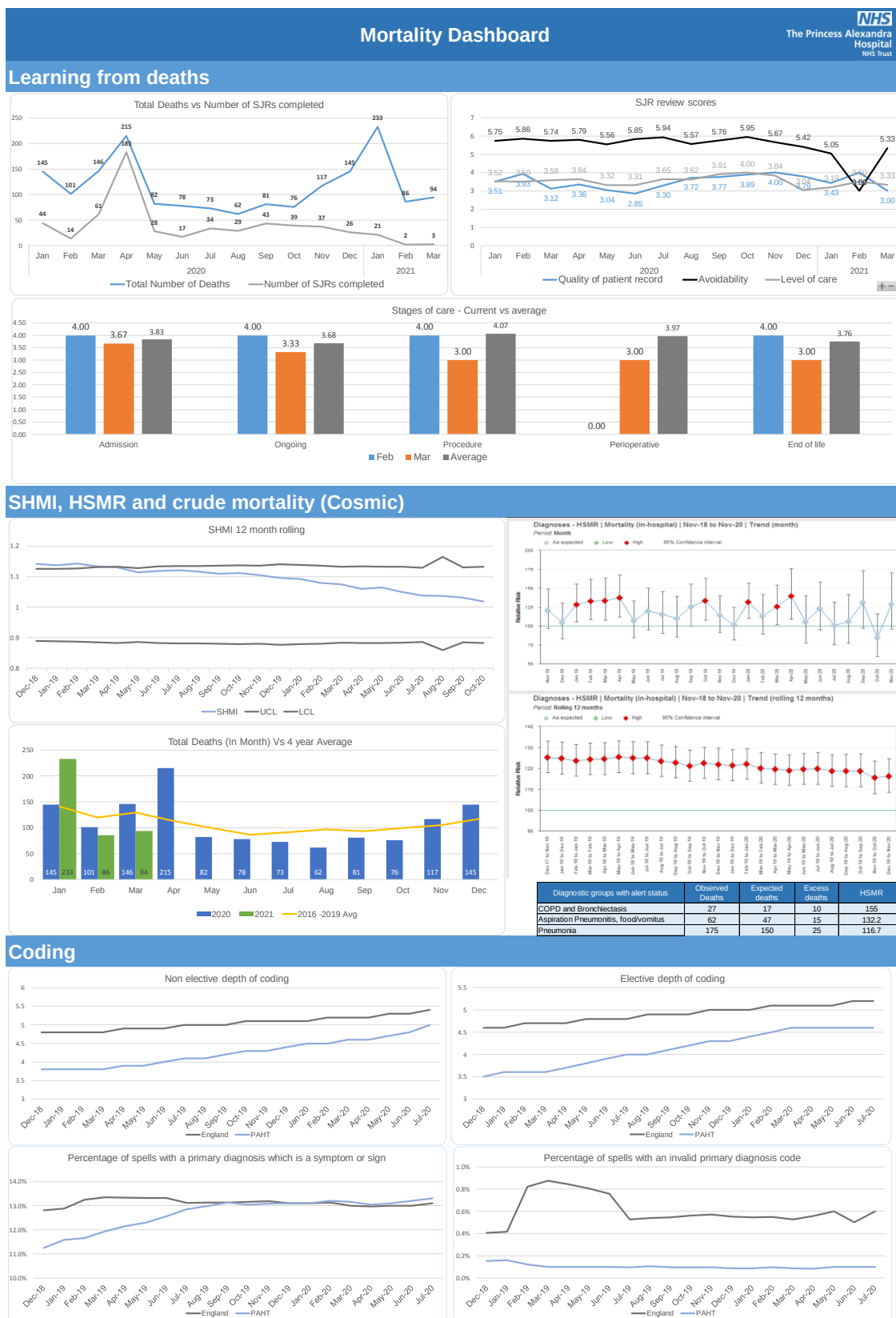
For the Group/Board to provide feedback on the contents of the paper to ensure a dynamic development of the information provided so that assurance can be provided.



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Appendix 1: Mortality and learning from deaths dashboard



SHMI 12 month rolling

Total Deaths (In Month) Vs 4 year Average

Diagnoses - HSMR | Mortality (in-hospital) | Nov-18 to Nov-20 | Trend (month)

Diagnoses - HSMR | Mortality (in-hospital) | Nov-18 to Nov-20 | Trend (rolling 12 months)

Diagnostic groups with alert status	Observed deaths	Expected deaths	Excess deaths	HSMR
COPD and Bronchiectasis	27	17	10	155
Aspiration Pneumonitis, food/vomitus	62	47	15	132.2
Pneumonia	175	150	25	116.7

Non elective depth of coding

Percentage of spells with a primary diagnosis which is a symptom or sign

Elective depth of coding

Percentage of spells with an invalid primary diagnosis code

Appendix 2: Audit of Deaths after COVID-19 Vaccination

Brief summary of the findings from the audit of deaths after COVID-19 vaccination:

Background Information

- National COVID-19 vaccination program started in December 2020
- Groups who were amongst the first to be vaccinated:
 - Residents in a care home for older adults and their carers.
 - All those 80 years of age and over and frontline health and social care workers.
 - All those 75 years of age and over.
 - All those 70 years of age and over and clinically extremely vulnerable individuals.
- This learning summary discusses the results of 60 patients who received their COVID vaccine and were admitted to hospital and died (admissions and deaths of any cause).

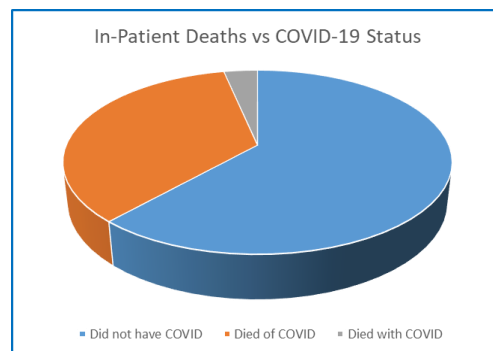
Findings

60 x In-Patients (December 2020 – March 2021)

37 x Did not have COVID-19
 21 x Died of COVID-19
 2 x Died with COVID-19

53 Patients received their 1st vaccine
 7 Patients received 1st and 2nd vaccine

(Died with COVID is based on COVID being listed on part 2 of the death certificate or patients who were COVID +ve but did not contribute towards death. Died of or from COVID is based on patients who were COVID positive and COVID is listed on 1a or 1b of the death certificate)



Deaths of Non-COVID patients

There were two suspicious death post vaccine:

- Patient developed Posterior Reversible Encephalopathy Syndrome (PRES) – case referred to coroner and treated as an adverse event.
- ?underlying cause for deterioration - linked to vaccine, when patient's symptoms started. Possibility of cancer, unable to confirm. Chest infection unlikely caused death and heart failure alone is not feasible. Causes of death yet to be issued.

Pfizer Vaccine issued. Yellow card system followed.

COVID-19 Positive Patients

23 patients in total
 16 x COVID +ve on admission
 1 x Community Onset
 5 x Indeterminate
 1 x Hospital Onset Probable (nosocomial)

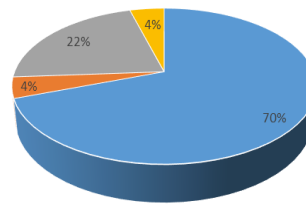


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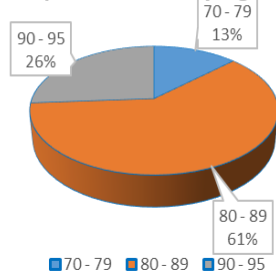
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Reference:
 Community onset, days 1-2 with day 1
 being the day of admission.
 Days 3-7 Indeterminate.
 Day 8-14 Probable
 Day 15 + Definite

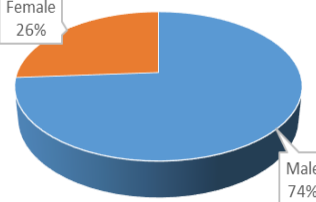
Status of COVID +ve Patients



■ COVID on Admission ■ Community Onset ■ Indeterminate ■ Hospital Onset

Number of COVID related Deaths
post Vaccine by Age

■ 70 - 79 ■ 80 - 89 ■ 90 - 95

COVID Related Deaths Post Vaccine
by Sex

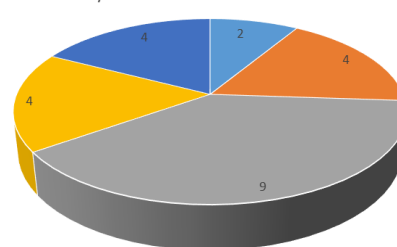
■ Male ■ Female

Days from Vaccination to Death

0 – 6 days = 2 patient
 7 – 14 days = 4 patients
 15 – 21 days = 9 patients
22 – 28 days = 4 patients
29 days + = 4 patients

The cases in red are cause for concern, as these patients should have built up a substantial amount of immunity from the vaccine.

Days from Vaccination to Death



■ 0 – 6 days ■ 7 – 14 days ■ 15 – 21 days ■ 22 – 28 days ■ 29 days +

Conclusions So Far:

- There were no themes associated with these deaths and the vaccinations centres that patients attended
- No themes from vaccine batch numbers
- These admissions and death were in line with the height of second wave
- High number of patients contracted COVID in the community
- Majority of patients, elderly, frail with multiple comorbidities
- High number of patients admitted following a fall in the community

Other Issues Identified:

- Patients perception and/or compliance with shielding and knowledge of how the virus can be spread
- Unable to transfer patients back to care homes when they are COVID positive
- Patient admitted for end of life care
- Yellow card scheme not followed – re-education and formal local process required

Next Steps



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To review all vaccinations that patients received
To establish the cause of death for the two yellow card cases
To set up a formal process for yellow card scheme

4.1



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Trust Board
11 June 2021

4.2

Agenda Item:	4.2							
Presented by:	Erin Harrison: Lead Governance Midwife							
Prepared by:	Erin Harrison: Lead Governance Midwife;							
Date prepared:	02/06/2021							
Subject / Title:	Overview of Serious Incidents within maternity in Family And Women's Services							
	Approval		Decision		Information	X	Assurance	X
Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	Following the Ockenden report published in December 2020, one of the essential actions from enhanced safety was that all Maternity serious incidents (SIs) with a summary of key issues must be sent to the Trust Board and at the same time to the local maternity and neonatal system (LMNS) for scrutiny oversight and transparency. Maternity currently have six Open Serious Incidents (SI's). There have been 10 maternity cases reviewed by external investigators, the report has been completed, HCG have an associated action plan which is making good progress. The plan has executive oversight.							
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 28/05/21							
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							

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. It was suggested 3 monthly however this report will come monthly to QSC with abridged version via the Integrated performance report in the maternity dashboard to Board.

3.0 OVERSIGHT AND GOVERNANCE

All reported patient safety incidents are reviewed daily by healthcare group patient safety and quality group as per Trust Incident Management policy and bi weekly at the Trust wide Incident Management Group which agree actions and any escalations or external reporting in the form of serious incidents required.

All incidents are reported to the Patient Safety and Quality Group as well as the Quality and Safety Committee and reported serious incidents shared on the Trust Maternity dashboard.

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

4.0 SERIOUS INCIDENTS

Since April 2020/21 the Trust have reported 11 serious incidents, of these, 6 remain open and are within the agreed timeframe with root cause analysis investigations on going.

The themes within the open SIs are:

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

5.0 MATERNITY EXTERNAL REVIEW

In addition, following a cluster in incidents over Autumn 2020, an external review was sought of 10 cases to identify if any overarching theme could be identified. The initial report has been received and is currently being checked for factual accuracy

No over-arching themes were found by the external reviewers that connected all the cases and for the majority they noted the care in a series of very disparate clinical situations was good.

Actions undertaken following report:

- Fortnightly meetings with Executive oversight
- Stakeholders event on 01.03.2021 (CCG, CQC, NHSI/E)
- Further stakeholder 19.04.2021 to review action plan
- Implemented weekly Maternity Risk Meeting as of 03.02.2021
- Interim Governance Lead Consultant and Lead Governance Midwife Appointed
- Audit undertaken on small for gestational age babies over timeframe of incidents occurring
- Work commenced to implement electronic e-obs – Currently using paper charts to mitigate this risk
- Serious incidents under investigation
- The health group met with stakeholders on 19.04.2021 with colleagues present from the CCG and NHSI/E, the CQC were invited however there was no presence at the meeting.

Actions in progress:

- Business case completed 30.04.2021 and agreement for an increase in obstetric staffing to match acuity of unit. Jobs are now out to advert and projection is that as of 31.10.2021 full obstetric staff on rota enabling two registrars to provide 24 hour cover 7 days a week.
- Glucose Tolerance Tests to be reintroduced to screen women for gestational diabetes was planned for 31.05.2021, however, this has been delayed by 2 weeks.
- Pathways are being reviewed to ensure a MDT approach to maternal diabetes care. A joint business case with medicine is to be presented to improve pathways and ensure endocrinology input. Fortnightly meetings are arranged to monitor the progress of this action.

6.0 AREA OF IMPROVEMENT

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

Key area of improvement;

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

7.0 RECOMMENDATION

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

Author: Erin Harrison: Lead Governance Midwife

Date: 02/06/2021

Trust Board (Public) – 11 June 2021

Agenda item:	4.3					
Presented by:	Sharon McNally – Director of Nursing & Midwifery					
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery					
Date prepared:	18 th May 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 fill rate in month was 98.6%. Temporary staff usage has decreased across the Trust and agency usage continues to be restricted to ED and ITU where specialist nursing skills are required The overall nursing vacancy rate is 5.3%. 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						
	x	x	x			x
Previously considered by:	WFC.01.06.21					
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 April 2021. To provide an update on plans to reduce the nursing vacancy rate over 2020/21

2.0 BACKGROUND

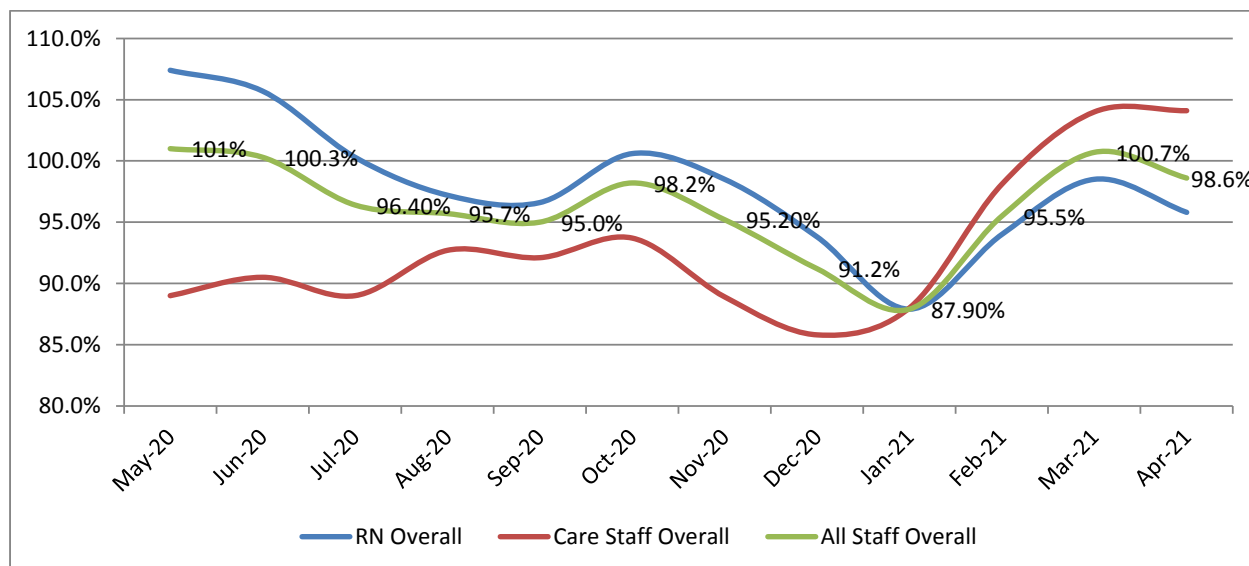
The report is collated in line with The National Quality Board recommendations (June 2016).

3.0 ANALYSIS

3.1 The Trust Safer Staffing Fill rates for April 2021 against the standard templates for overall RN/RM in month has decreased to 95.8%, which is a reduction of 2.7% against March 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 April 21	93.6%	100.9%	96.9%	108.5%	95.8%	104.1%	98.6%
In Patient Ward average March 21	96.6%	96.9%	102.5%	116.4%	98.5%	104%	100.7%
Variance March 21 – April 21	↓3.0%	↑4.0%	↓5.6%	↓7.9%	↓2.7%	↑0.1%	↓2.1%



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 (%)	
March 2021	83.4%	77.6%	105.9%	75.9%	
April 2021	87.2%	92.6%	104.8%	89.2%	

4.3

There has been an increase 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 Medicine and Urgent care teams supported by the Executive Team.

3.5 Critical care

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

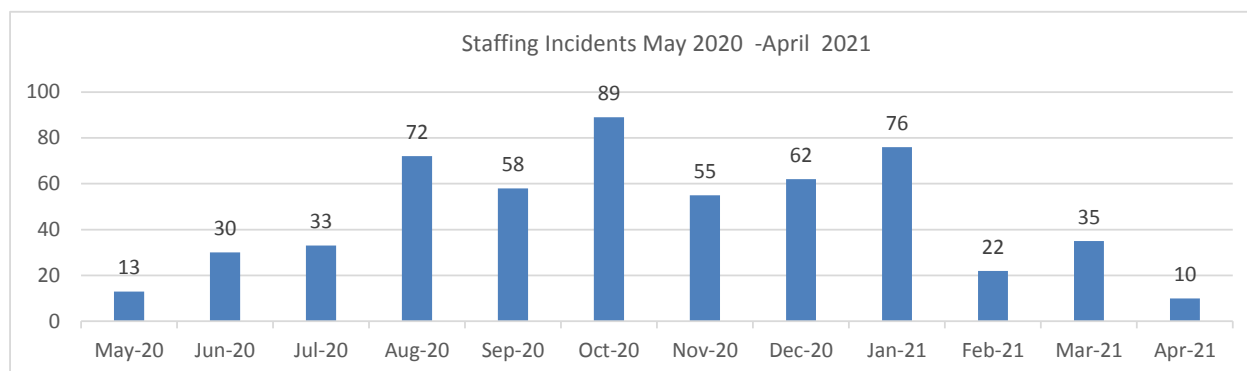
Across April the unit critical care activity reduced to below surge level 2 and critical care nurse to patient ratio was 1:1 across all shifts.

3.6 Fill rates by ward

Fill rates by ward have been produced against the standard planned templates (Appendix 1). No wards reported average fill rates below 75% for registered nurses against the standard planned template during April. 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.

3.7 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 decreased in month (10 in total), though Tye Green (6) remains the main ward raising Datix reports in relation to staffing levels. 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 April there was a reduction 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 (↓628 shifts) in April compared to March. April also shows a decrease in agency usage (↓40 shifts). The overall fill rate increased from 69% to 74.3%

RN temporary staffing demand and fill rates: (April 2021 data supplied by NHSP 5.5.2021)

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
December 2020	3621	1888	52.1%	440	12.2%	64.3%	1293	35.7%
January 2021	4210	2414	50.9%	360	8.6%	59.4%	1709	40.6%
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%
April 2020	3438	1733	50.04%	678	19.07%	70.01%	1029	29.07%

The HCSW demand also shows a reduction in unregistered demand (↓238 shifts), there was also an increase in fill rate from 63.7% in March to 74.04% in April. There was a significant reduction in the number of agency HCA filled shifts (↓98 shifts) demonstrating the impact of HCSW recruitment.

HCA temporary staffing demand and fill rates: (April 2021 data supplied by NHSP 5.5.2021)

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
December 2020	2031	1032	50.8%	40	2.0%	52.8%	959	47.2%
January 2021	2026	1082	53.4%	70	3.5%	56.9%	874	43.1%
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%
April 2020	2475	1539	62.02%	0	0%	62.02%	936	37.08%

B: Workforce:**Nursing Recruitment Pipeline**

The overall nursing vacancy rate in April was 5.3% a reduction against 7.2% in March. The vacancy rate for Band 5 RN's was 4.62% (5.8% in March). There are 38 nurses in the pipeline who hold offers, of which almost all are international nurses. There continues to be NHSE funding to cover costs of international recruitment and support to reduce nurse vacancies to < 1% in year.

The Trust has received an offer of further financial support from NHSE to escalate international recruitment for 2021/22 and will receive £7,000 per international nurse recruited from the end of October 2022.

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	927.00	945.00	944.00	943.00	943.00	939.00	939.00	939.00	939.00	939.00
Vacancy WTE	51.25	46.25	39.25	21.25	22.25	23.25	23.25	27.25	27.25	27.25	27.25	27.25
Actual RN Vacancy Rate	5.3%	4.8%	4.1%	2.2%	2.3%	2.4%	2.4%	2.8%	2.8%	2.8%	2.8%	2.8%
Forcast Vacancy Rate in Business Plan												

Band 5 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 Band 5 Establishment 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	505	523	522	521	521	517	517	517	517	517	517
Band 5 Starters	12	14	25	6	6	7	3	7	7	7	7	7
Vacancy Band 5 WTE	24.2	17.2	-0.8	0.2	1.2	1.2	5.2	5.2	5.2	5.2	5.2	5.2
Actual Vacancy Rate	4.6%	3.3%	-0.2%	0.0%	0.2%	0.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
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	7	7	7	7	7	7	7	7	7	7	7
Band 5 Newly Qualified + Local	1	1	5	1	1	7	3	3	3	3	3	3
Band 5 International Recruitment	11	13	20	5	5			4	4	4	4	4
Band 5 Starters	12	14	25	6	6	7	3	7	7	7	7	7
Total Starters	15	21	32	13	13	14	10	14	14	14	14	14

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	7	7	7	7	7	7	7	7	7	7	7
Band 5 Leavers	6	7	7	7	7	7	7	7	7	7	7	7
Total Leavers	10	14	14	14	14	14	14	14	14	14	14	14
N&M Turnover %	8.65%											

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: 17 May 2021

Appendix 1

Ward level data: fill rates April 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 gives a more accurate picture and reflects the way Maternity works.

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

4.3

Ward name	Day		Night		% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)			
ITU & HDU	86.9%	121.3%	86.2%	95.0%	86.6%	108.2%	89.7%
John Snow Ward	108.3%	105.3%	118.0%	96.2%	112.5%	100.9%	108.8%
Harvey Ward	107.4%	64.0%	98.9%	90.7%	104.0%	76.8%	91.4%
Lister Ward	99.3%	103.7%	107.8%	107.6%	102.9%	105.3%	103.9%
Locke Ward	98.1%	101.1%	113.0%	125.7%	104.4%	110.4%	106.5%
Ray Ward	97.9%	84.2%	120.6%	109.7%	106.4%	92.2%	100.4%
Saunders Unit	97.4%	101.7%	132.4%	117.1%	109.9%	107.5%	109.0%
Nightingale Ward	90.1%	87.2%	104.4%	120.5%	115.2%	99.8%	108.8%
Tye Green Ward	98.1%	104.0%	100.0%	138.2%	98.9%	117.9%	107.3%
Winter Ward	100.0%	87.5%	111.8%	103.1%	105.0%	93.8%	100.1%
Charnley Ward	85.0%	96.3%	100.0%	103.1%	91.3%	99.1%	94.7%
AAU	84.2%	133.1%	80.6%	126.6%	82.5%	130.0%	95.4%
Kingsmoor Orth	75.6%		75.1%		75.4%		91.8%
Kingsmoor Surg	77.1%	127.6%	77.3%	75.2%	77.2%	101.4%	83.8%
Fleming Ward	89.9%	84.1%	100.8%	103.2%	94.5%	91.3%	93.4%
Harold Ward	105.6%	129.4%	103.4%	106.7%	104.5%	118.6%	110.6%
Neo-Natal Unit	96.0%	131.7%	90.0%	120.0%	93.0%	125.9%	98.5%
Dolphin Ward	91.2%	75.2%	95.8%	99.1%	93.2%	83.2%	90.7%
Maternity	96.9%	111.3%	89.9%	93.4%	93.6%	102.8%	96.3%
Total	93.6%	100.9%	97.0%	108.5%	95.8%	104.1%	98.6%

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
Harvey	64% Care staff on days	Nil	Increased fill >100% RN on days so stronger skill mix

Trust Board (Public) – 11 June 2021

5.1

Agenda item:	5.1
Presented by:	Stephanie Lawton – Chief Operating Officer
Prepared by:	Elizabeth Podd - Head of Performance & Planning
Date prepared:	26 th May 2021
Subject / title:	M1 2021/22 Integrated Performance Report (IPR)
Purpose:	Approval Decision Information x Assurance
Key issues:	This month's IPR shows the detail of the performance for April 2021. Patients: There has been an increase in PALs enquiries which is similar to the prior year post Covid period. The reporting of SIs has decreased as the rate of nosocomial infections has reduced. There has been a rise in C Difficile cases and a shared learning panel with the CCG to investigate. The rate of falls and pressure injury per 1,000 bed days has continued to show a reduction. There were no SIs declared in Maternity in April. People: The Trust's vacancy rate is slightly above the target of 9.3%. International nurse recruitment is continuing along with Healthcare Support Worker recruitment. Staff turnover is below the target of 12% and sickness has reduced. Statutory & mandatory training and appraisals are slightly improved and all areas in the Trust are focussed on increasing compliance. Departmental meetings in response to the Staff Survey along with listening events are taking place to inform the improvement plan actions. Places: Estates projects progressing well and 100% of staff booked onto Authorised Persons training. Capital/ Projects workshop completed to improve governance standards setting out clear roles and responsibilities, permits, systems and processes. Staff survey action plan developed. New capital works plan for 21/22 in progress with a dashboard being developed to monitor progress. Positive feedback from patients regarding the new food menu and food waste has decreased. Housekeeping vacancies are being recruited to as a priority. Performance: The booking of Priority 2 patients continues to improve and the transfer of routine patients to the independent sector for treatment is ensuring that patients are offered treatment dates as quickly as possible. Cancer 2week wait performance achieved the national standard this month and the 28 day diagnostic standard was just 0.5% under the national target. The treatment of patients over 62 days is behind plan but individual tumour sites have actions to create improvement. Endoscopy recovery is close to sustainable for 2ww referrals and a number of radiology modalities are showing considerable improvement. Pounds: The Trust has agreed its income and expenditure budgets which have been jointly established to deliver a breakeven position. The M1 results record achievement of a breakeven position and are in line with plan. The results also include an improvement in the level of temporary staffing costs which have reduced to £2.6m from average levels over the last quarter of £3.1m. The Trust's indicative capital programme for 21/22 totals £49.2m and include strategic and operational developments. Strategic initiatives include the continued development of the New Hospital and progression of a digital agenda.



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

Previously considered by:	PAF.27.05.21, QSC.28.05.21 and WFC.01.06.21.
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	

5.1



The Princess Alexandra
Hospital
NHS Trust

Integrated Performance Report

April 2021

The purpose of this report is to provide the Board of Directors with an analysis of quality performance.
The report covers performance against national and local key performance indicators.



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Contact:

Lance McCarthy, Chief Executive Officer

Sharon McNally, Director of Nursing

Stephanie Lawton, Chief Operating Officer

Jim McLeish, Director of Quality Improvement

Ogechi Emeadi, Director of People

Michael Meredith, Director of Strategy

Saba Sadiq, Chief Finance Officer

Fay Gilder, Chief Medical Officer

Phil Holland, Chief Information Officer

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Trust Objectives



Our Patients

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



Our People

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



Our Places

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



Our Performance

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

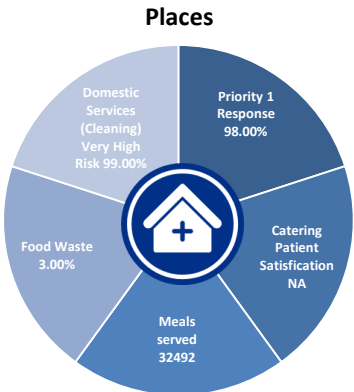
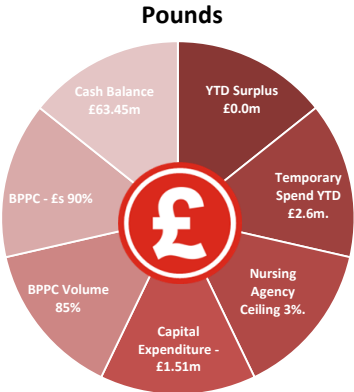
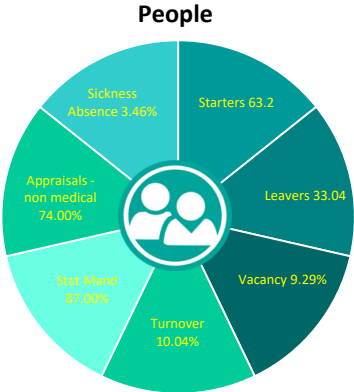
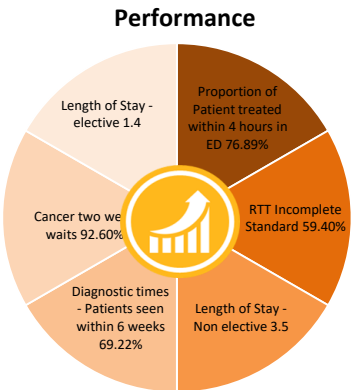
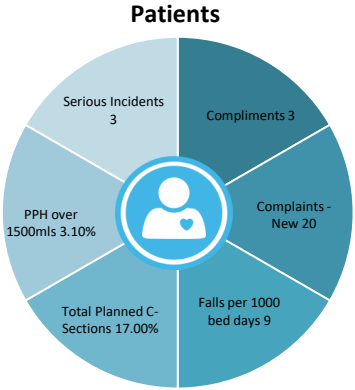


Our Pounds

Manage **our pounds** effectively to achieve our agreed financial control total for 2020/21.

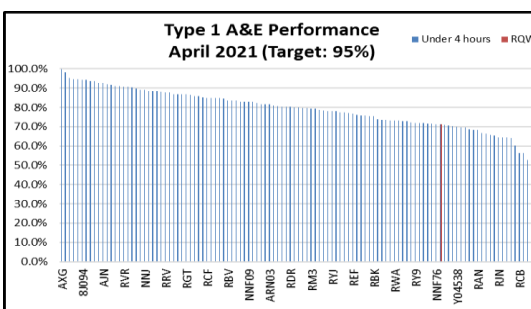
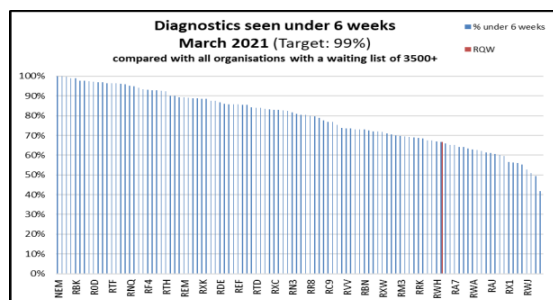
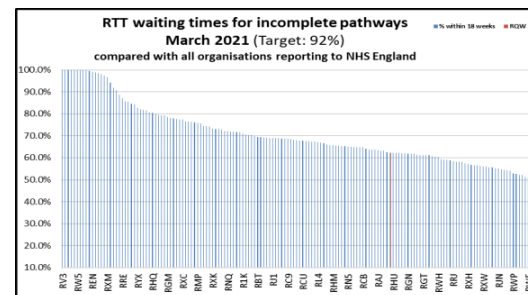
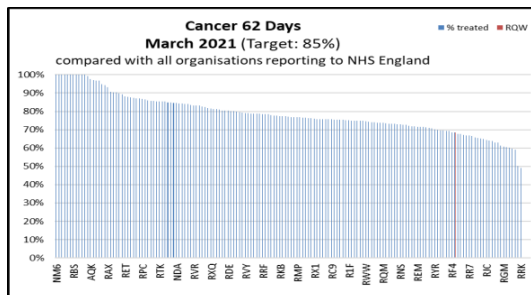
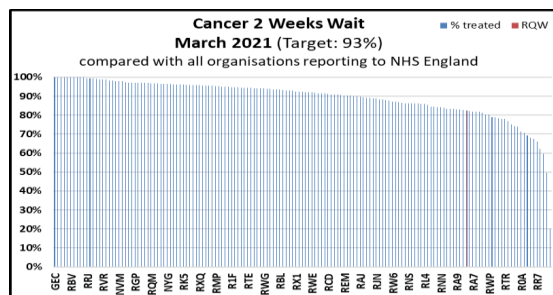
In this month

SP5



National Benchmarking

Compared with all organisations reporting to NHS England



Data Source: NHS England Statistics

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Executive Summary Our Patients

Patient experience: Of note is the sustained level of increase of PALs enquiries, which was also seen in the post covid period last year. Through the prm reviews with the HCGs, a number of these relate to appointments - with work underway to enhance appointment letters and pathways. In addition, a series of listening events with patients and staff has commenced which will inform the patient experience element of the Patient Safety, Experience and Quality Strategy.

Patient safety: the reporting of SIs has reduced following the peak of nosocomial related reports at the beginning of the year.

Infection Control: The Trust has seen a significant rise in the number of C.difficile cases over several months. The rise in cases is almost certainly associated with the pandemic and the increase in broad spectrum antibiotic prescribing (Cephalosporins); however there are likely to be a combination of factors . The Trust has invited CCG and NHSE/I IPC colleagues to attend a review panel of cases to encourage shared learning opportunities. PPE Audits During April, this audit was performed in 24 areas and the overall Trust wide score completed by Champions was 94% which is a significant improvement, particularly in relation to doffing procedures.

Harm free care: the rate of falls and pressure injury per 1,000 bed days has continued to show a reduction. The harm free care strategy continues to drive towards sustained reduction and improvement.

Maternity: There were no Serious Incidents (SI), or HSIB cases, declared in April 2021



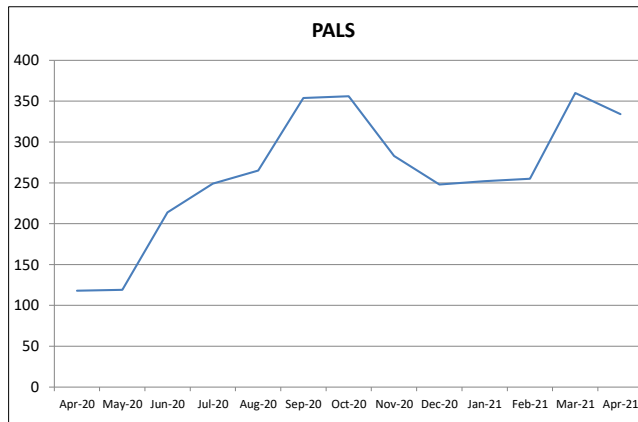
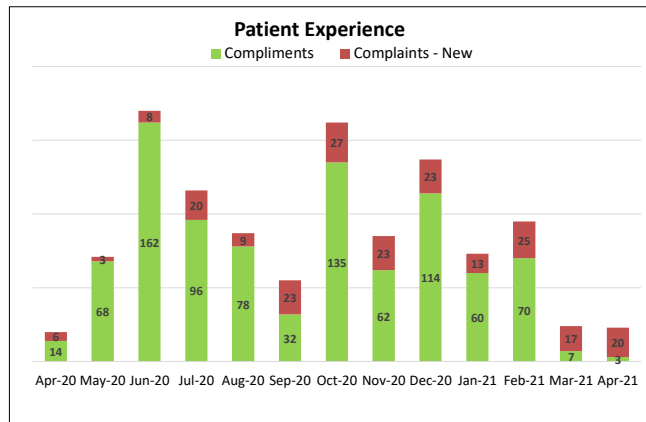
334 PALS cases received in April reflects the continuing higher level of public concern being raised about appointments, telephone systems and communications issues in general. We can expect this volume of activity to begin to subside once these issues begin to be resolved in a sustained way. Top trending formally recorded themes are communication 101, delays 59 and appointments issues.

20 complaints received with the top three themes of communication and medical care and then jointly nursing and attitude of staff. The team has worked closely with communications to respond to media enquiries for one complaint case in particular and a significant amount of work remains to be done to ensure patient belongings are consistently appropriately handled. Strategy development and mitigating actions such as the ICU information service, virtual visiting, family messaging and rebalancing of our resources to support PALS activity continues. In addition, a series of listening events with patients and staff has commenced which will inform the patient experience element of the Patient Safety, Experience and Quality Strategy.

Communication sub themes remain a lack of relative telephone contact, a lack of and conflicting information provided to patients and relatives by healthcare professionals. The gradual, carefully calibrated reintroduction of visiting may have a positive impact here, as well as the restart of key initiatives such as butterfly volunteers and ward level volunteering.

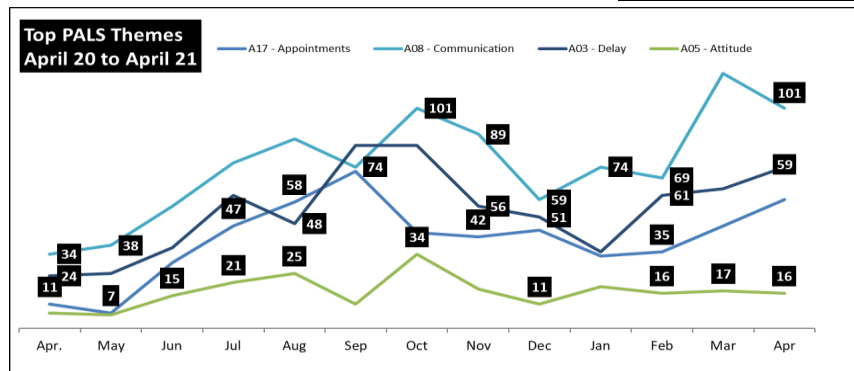
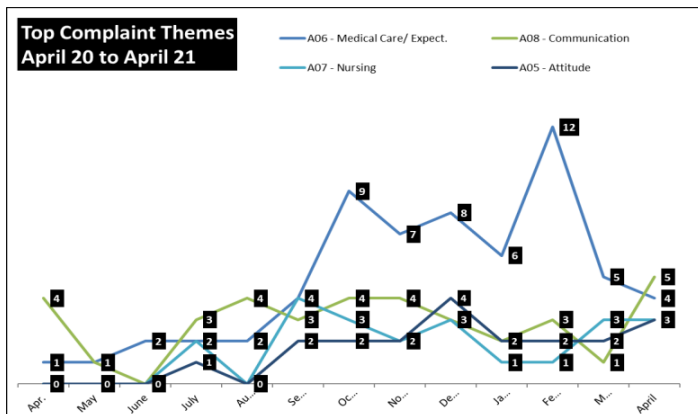
Commentary on performance.

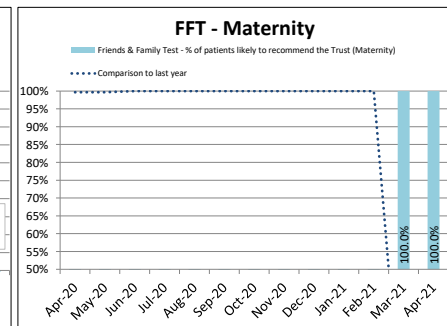
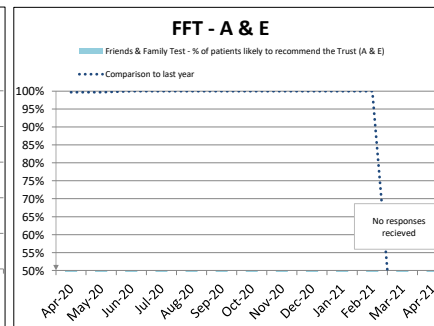
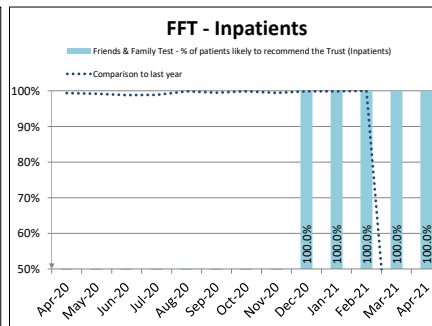
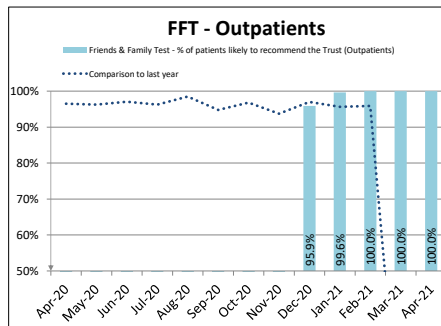
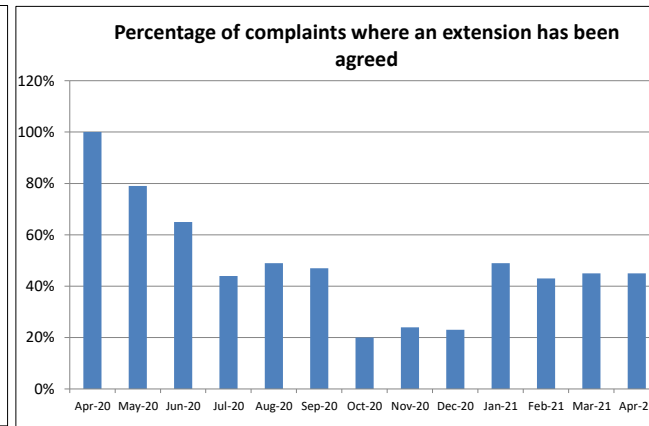
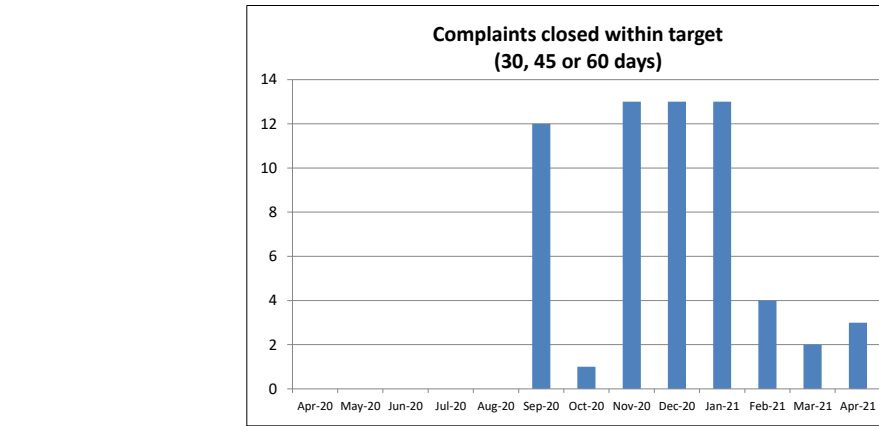
Of 106 open complaints (vs 90 last month), the oldest complaint case remains a CCCSS case 9516 from September 2019 related to a pending inquest and incident investigation (PAWEB75752). There are 222 open PALS cases up from 145 at last report.



PALS converted to Complaints

Apr-20	0
May-20	0
Jun-20	1
Jul-20	6
Aug-20	4
Sep-20	3
Oct-20	8
Nov-20	4
Dec-20	4
Jan-21	0
Feb-21	8
Mar-21	6
Apr-21	15





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



1 Our Patients Summary 1.3 Patient Safety

915 incidents were reported in April. 627 no harm and 275 minor (98.6%), 12 moderate (1.3%), and 1 severe (0.1%) graded harm.

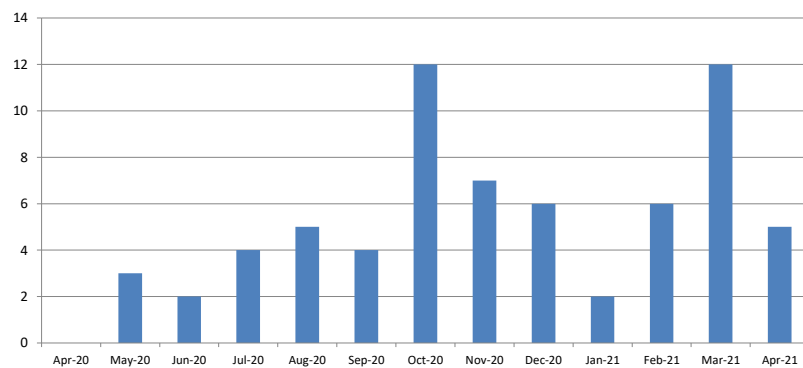
Three SI's were reported in April
2 incidents for Family and Womens: A delayed diagnosis and a safeguarding concern
1 incident for Surger: management of patient care

Two National Safety Alert remain in a breached status.

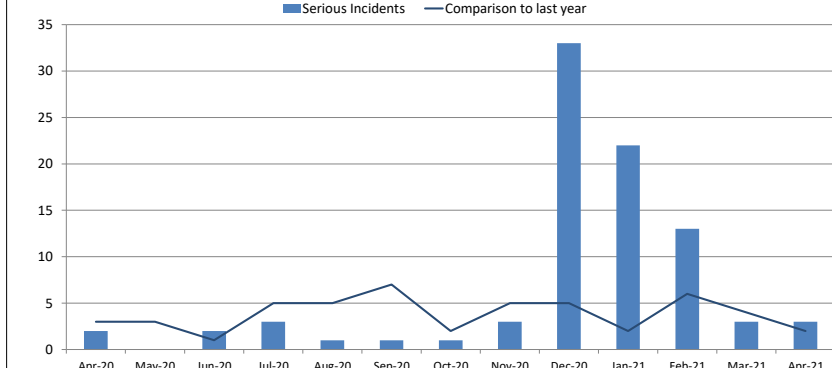
EFA.2020.001: Food Safety in the NHS has a deadline of 12/02/2021. We are still working through our Trust compliance against 2 action points. Working towards compliance by end of June.

EFA.2019.005 Doorstops/Door Buffers Alert has a deadline of the 30/04/2021. All works have been completed to remove/review doorstops/Buffers. A Risk assessment is required for the 2 doorstops that have been left in place as they protect radiology equipment from damage caused by the doors. Working towards compliance by the end of May.

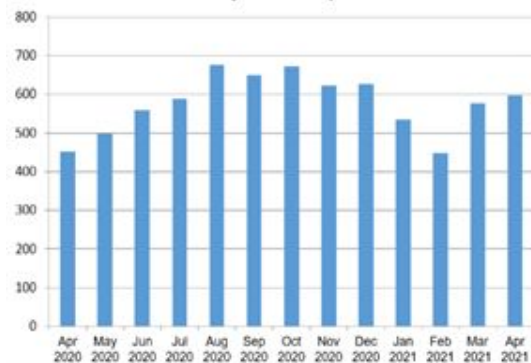
Mixed Sex Accommodation breach



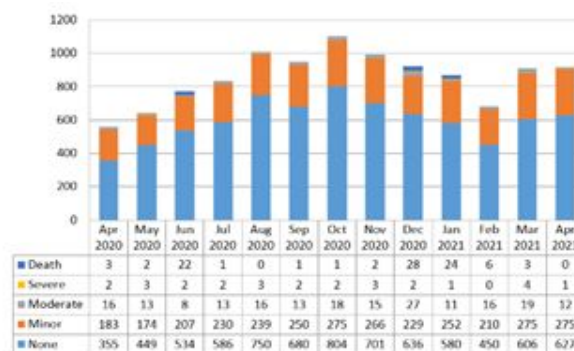
Serious Incidents



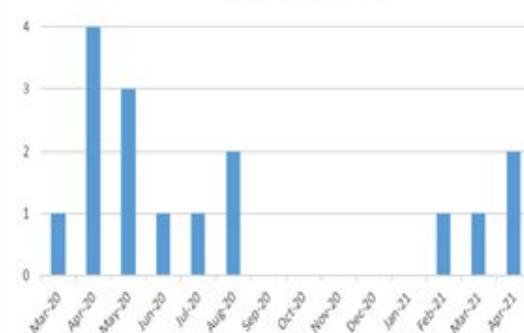
Patient safety incidents reportable to NRLS



Severity of reported Incidents on Datix

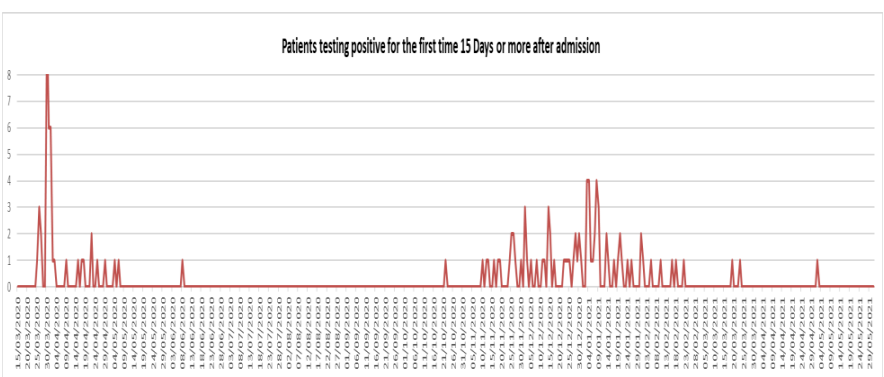
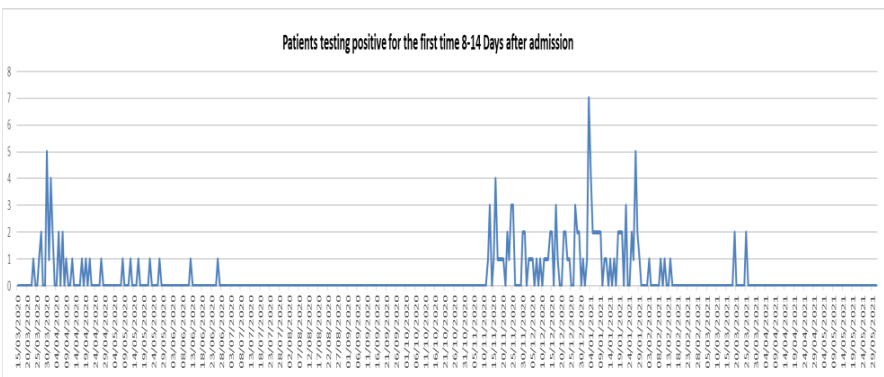
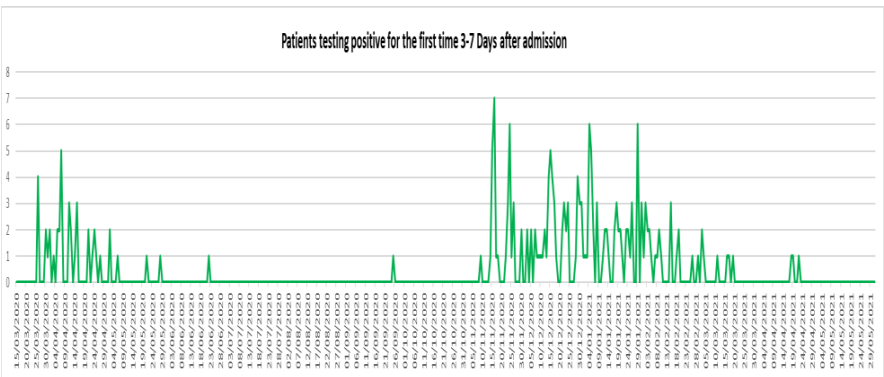
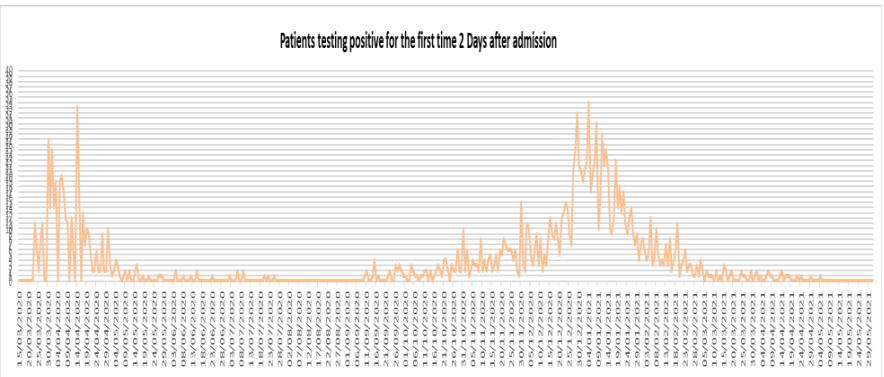
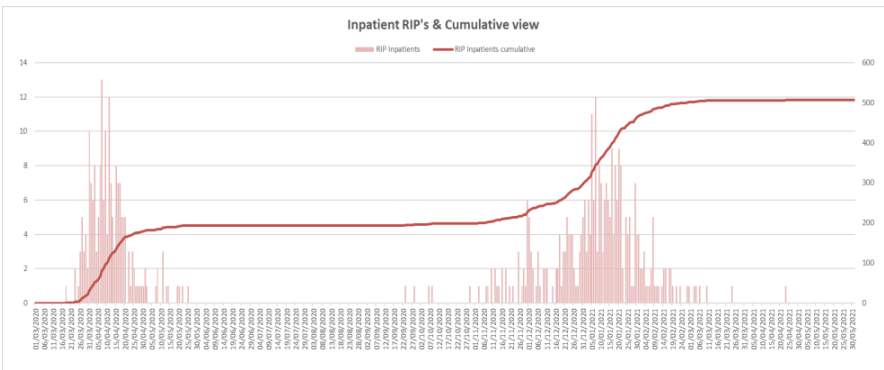
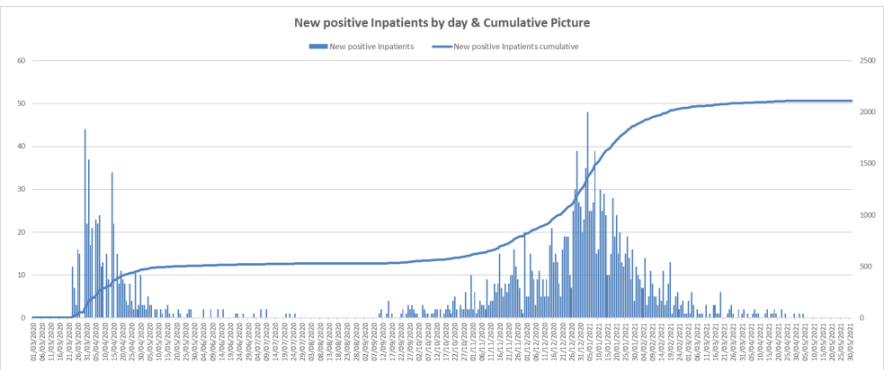


Breached Safety Alert





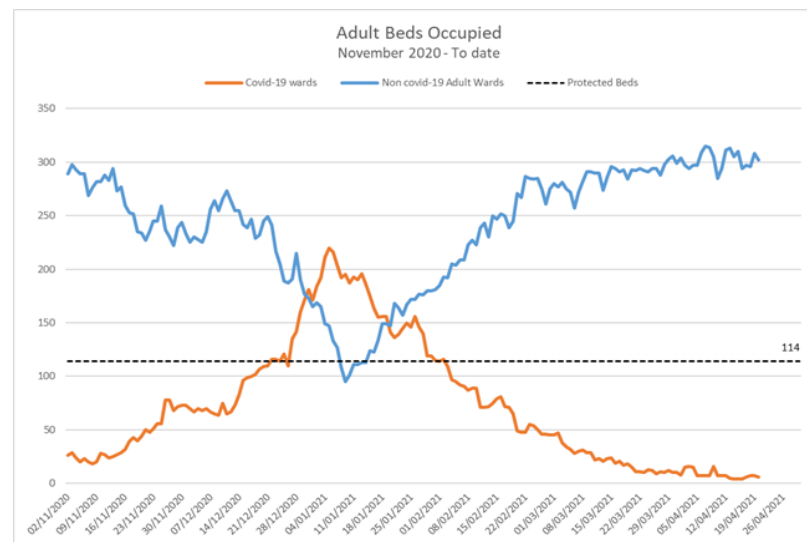
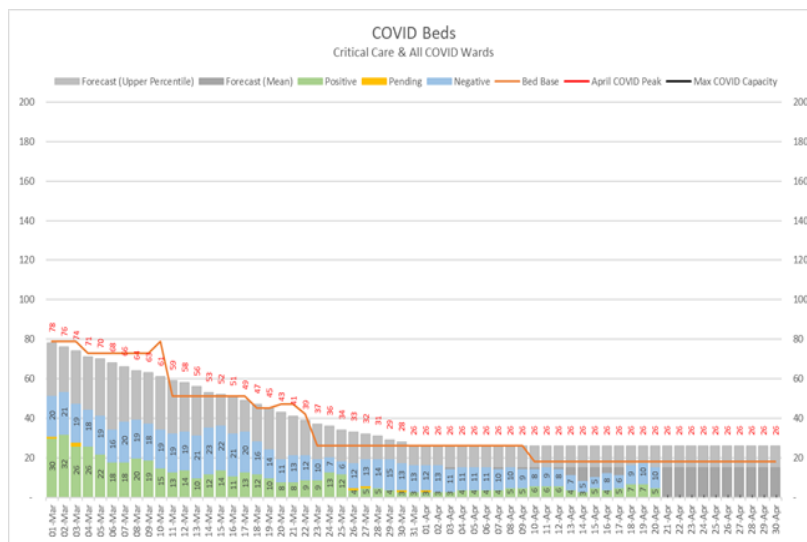
Infection Control





Please note re nosocomial infection: due to the timeliness of reporting, the dataset included within this report may include previously positive covid patients within the nosocomial figures. Data quality work is underway to ensure that we are able to capture any previous covid positive patient in a timely way to ensure accuracy of reporting.

Covid-19





1 Our Patients Summary 1.6 Infection Control

MRSA

There were no cases of Trust-apportioned MRSA bacteraemia cases in April.

MSSA

There was two cases of Trust-apportioned MSSA bacteraemia cases in April (Fleming and Lister ward). The Root Cause Analysis investigations are currently in progress.

C.difficile

During April there were five cases; two Hospital Onset Healthcare Associated infections, and three Community Onset Healthcare Associated infections.

The Trust has seen a significant rise in the number of C.difficile cases over several months. The rise in cases is almost certainly associated with the pandemic and the increase in broad spectrum antibiotic prescribing (Cephalosporins); however there are likely to be a combination of factors involved including cleaning and hand hygiene / PPE. There were five cases of C.difficile in April. The cases are currently being reviewed to identify any learning and/or links between them. The Trust has invited CCG and NHSE/IPC colleagues to attend a review panel of cases to encourage shared learning opportunities

Gram Negative Blood Stream Infections (GNBSIs)

The Trust remains in a good position when compared nationally with other hospitals; During April, there was one Trust-apportioned GNBSIs (Escherichia coli) bacteraemia.

MRSA Screening

MRSA screening data is not available for elective or non-elective from the Information Team for March:

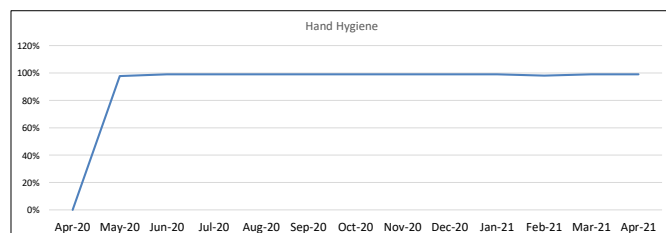
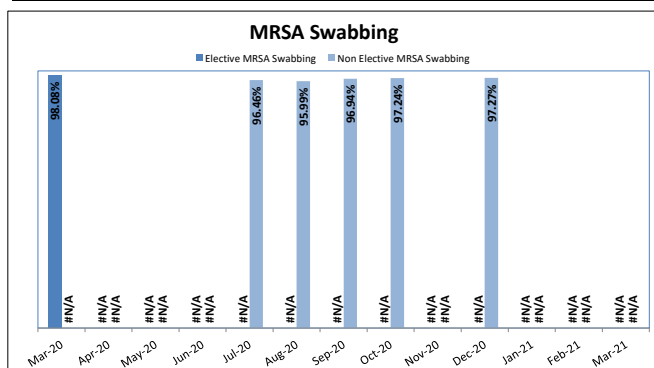
- NEL MRSA – we received Dec 2020 validation back from ED so that figure is below (97.27%)
- EL MRSA – no further progress – re-write still ongoing

Hand Hygiene Audits

All wards/clinical department are expected to participate in monthly audits. Pre-COVID-19, these were undertaken as 'cross-over' audits, meaning staff did not audit themselves. However, this has now changed to wards undertaking their own hand hygiene audits to reduce unnecessary visits to clinical areas during the pandemic. The expectation is that 100% of clinical areas participate and the performance standard is 95% compliance. During April, the overall Trust wide score was 99% compliance; however, there were three areas that did not submit their audits (93% submission compliance). Wards/departments are expected to discuss their results and agree appropriate actions within their Health-Care Group.

PPE Audits

The PPE Champions undertake a monthly PPE audit which addresses six key areas (Awareness, Availability and Storage, Appropriate use of PPE, Doffing, Hand Hygiene and social distancing in MDT rooms). In areas where practice scores below expected compliance, a re-audit is performed. During April, this audit was performed in 24 areas and the overall Trust wide score completed by Champions was 94% which is a significant improvement, particularly in relation to doffing procedures. Audit compliance is reviewed weekly at the IPC cell and at the IPC Committee; Health Care Groups are expected to take appropriate measures to improve compliance in



No data for March & April.

MSSA	
Apr-20	1
May-20	2
Jun-20	0
Jul-20	1
Aug-20	0
Sep-20	0
Oct-20	0
Nov-20	0
Dec-20	1
Jan-21	1
Feb-21	1
Mar-21	0
Apr-21	2

C-DIFF (New categories including community from April 2019)					
Month	Hospital Responsible		Community Responsible		Total
	Hospital onset healthcare associated	Community onset healthcare associated (Acute Admission within last 4 wks)	Community onset indeterminate association (Acute Admission within last 12 wks)	Community onset community associated (No acute contact within 12 wks)	
Apr-20	0	1	1	0	2
May-20	1	0	0	4	5
Jun-20	1	0	1	1	3
Jul-20	4	1	2	0	7
Aug-20	6	2	2	1	11
Sep-20	4	0	2	0	6
Oct-20	2	1	5	1	9
Nov-20	1	1	1	1	4
Dec-20	5	0	1	0	6
Jan-21	7	2	1	1	11
Feb-21	3	2	0	0	5
Mar-21	8	2	0	1	11
Apr-21	2	3	0	0	5

E Coli	
Apr-20	1
May-20	1
Jun-20	1
Jul-20	2
Aug-20	0
Sep-20	2
Oct-20	1
Nov-20	1
Dec-20	0
Jan-21	1
Feb-21	1
Mar-21	0
Apr-21	1

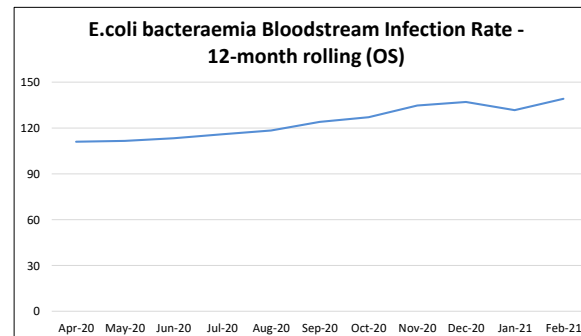
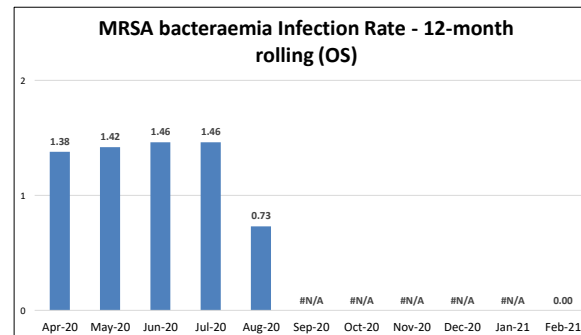
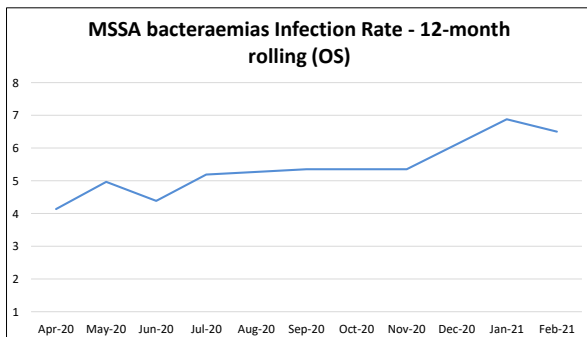
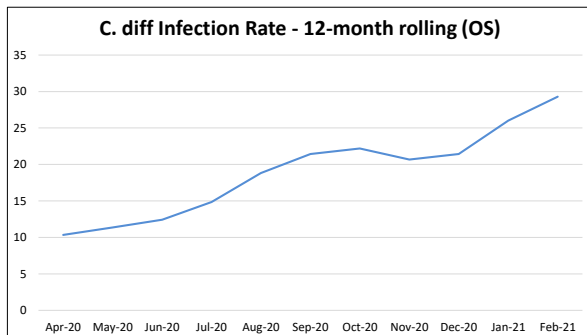
Klebsiella	
Apr-20	1
May-20	0
Jun-20	2
Jul-20	0
Aug-20	0
Sep-20	1
Oct-20	0
Nov-20	1
Dec-20	0
Jan-21	1
Feb-21	1
Mar-21	1
Apr-21	0

Pseudomonas	
Apr-20	0
May-20	1
Jun-20	0
Jul-20	0
Aug-20	0
Sep-20	1
Oct-20	0
Nov-20	0
Dec-20	1
Jan-21	0
Feb-21	0
Mar-21	0
Apr-21	0



The following are the latest published data available - 2 month time lag

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



Infection Control



1 Our Patients Summary 1.8 Patient Safety

Please note as of this month we are no longer including category 1 pressure ulcers on the IPR figures, in line with NHS Improvement PU recommendations (NHSI, 2018)

There were a total of 46 pressure ulcers in April (as opposed to 61 incident reports (including cat1)). Of those 46 PU's, there were a total of 38 patients injured, meaning 6 patients sustained more than one pressure ulcer during admission, the higher being two patients with 3 pressure ulcers each.

Four were moderate harms, unfortunately one category 4 from an ITU patient, and the remaining were minor harms. Four pressure ulcers were medical device related, attributable to oxygen devices and stockings.

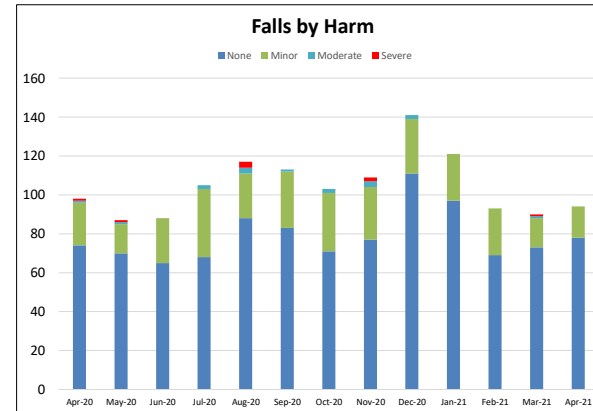
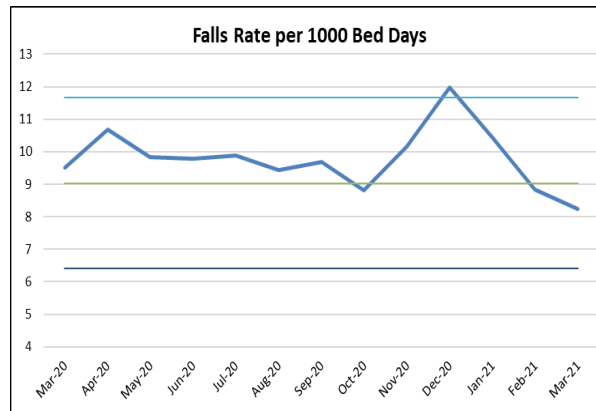
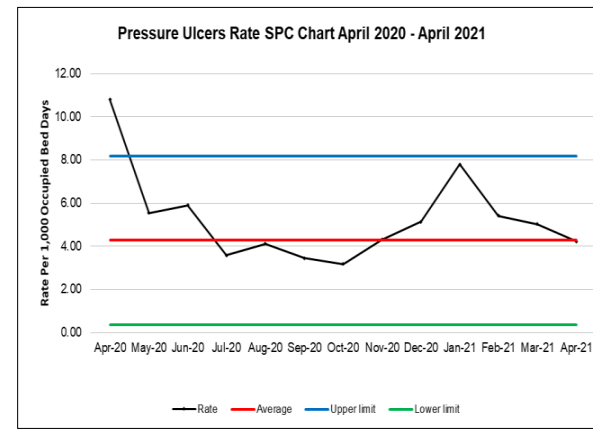
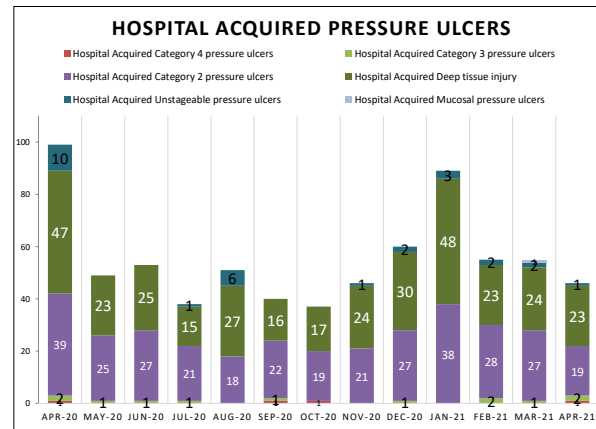
The highest number of hospital acquired pressure ulcers were from Tye Green with 10 pressure ulcers in total. Henry Moore/ITU followed with 7 pressure ulcers in total.

We are undertaking audits to all wards that have highest incidence on a weekly basis, in order to identify gaps in care and work with ward managers, matrons and practice development team for action plans.

We have available resources online such as Intranet and YouTube, as well as ward folders with relevant information about pressure ulcer prevention and management. We have recently updated our Pressure ulcer strategy, which is ready for sign off with IEC group for PU's this month.

Falls

Falls with harm continued to fall in month. No severe harms reported. All actions in line with Falls prevention strategy continue





2 Our Patients Summary 1.9 Family & Women's Service

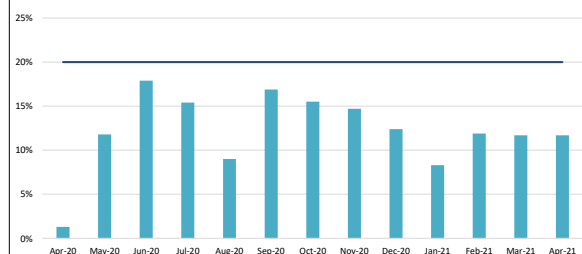
The number of women, delivering in the Midwife Led Birthing Unit, in April 2021 was 9.3%, i.e. 30 women. This is lower than expected due to the Midwife Unit having to close on occasions, due to staff shortages, but nevertheless represents a gradual recovery in the number of women delivering in the Midwife Unit over the first few months of 2021 (16 women in January, 26 women in February, and 26 women in March).

The Emergency C Section rate at PAH has increased in April 21, to 20%, contributing significantly towards an overall C Section rate of 37.0% (up from 34.5% in March 21). A continuous Audit of all Emergency C Sections is in place to check that every Emergency C Section is clinically appropriate and the indications for performing an Emergency C Section are regularly discussed at the FAWs Audit Meetings.

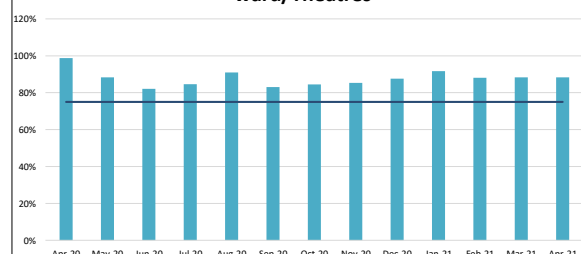
The rate of Post-partum Haemorrhage (PPH), over 1.5L, was 3.1% in April compared to 3.2% in March 2021 and continues to be closely monitored. An Action Plan, developed in partnership with Watford and Lister Hospitals, is in place. The latest National Rate is 2.8% (NMPA Clinical Report 2019).

There were no Serious Incidents (SI), or HSIB cases, declared in April 2021

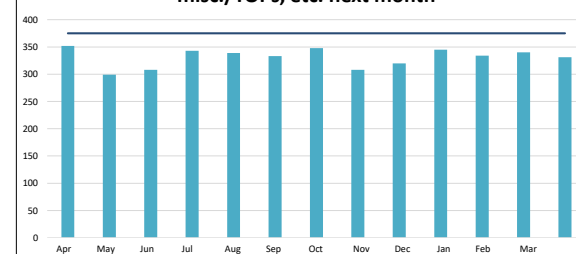
Total no. of mothers delivering in Birthing Unit/home (target 20%)



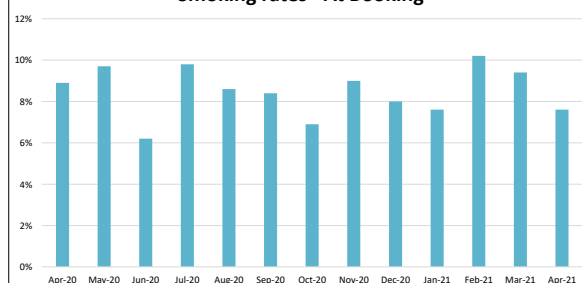
No. of mothers delivering in Labour ward/Theatres



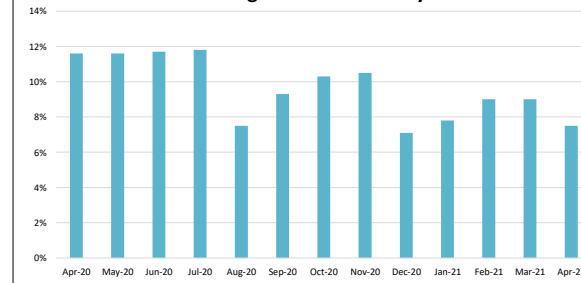
No. of women due to deliver at PAH adjusted for misc./TOPs, etc. next month



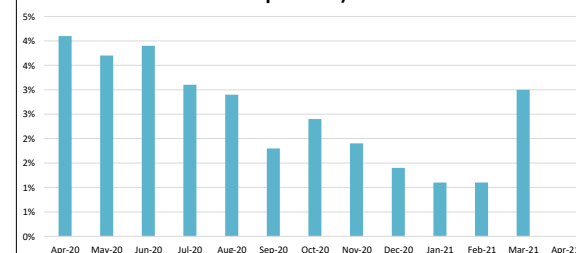
Smoking rates - At Booking



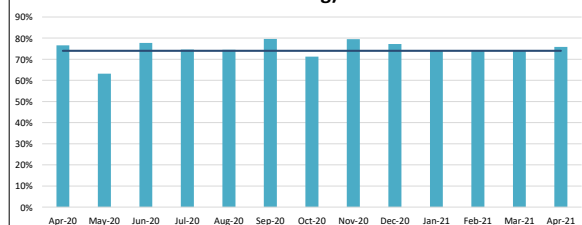
Smoking rates - At Delivery



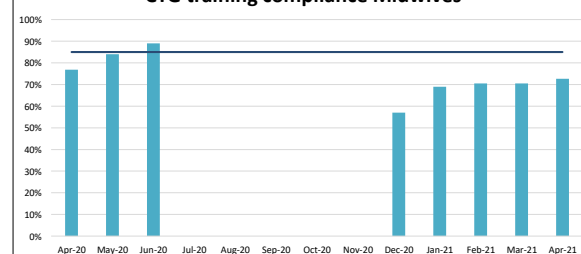
Low birth weight (<2.5kg) at fullterm (excluding preterm)



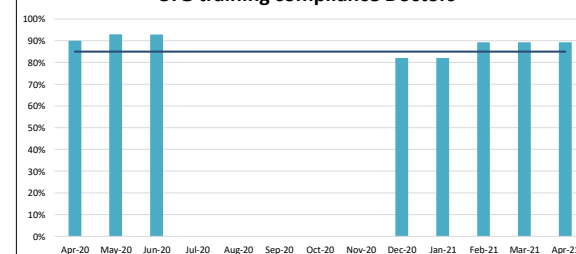
Breast feeding rates - At Delivery (incl. mixed feeding)



CTG training compliance Midwives



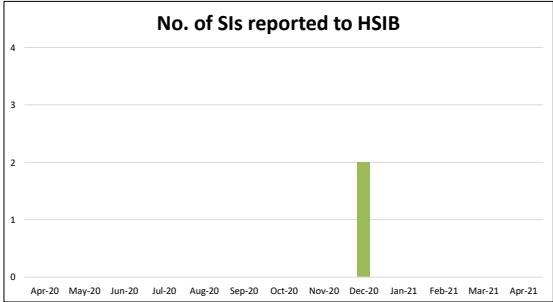
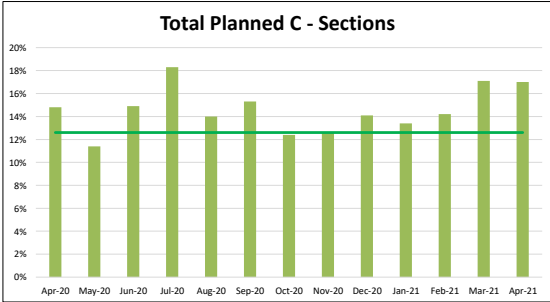
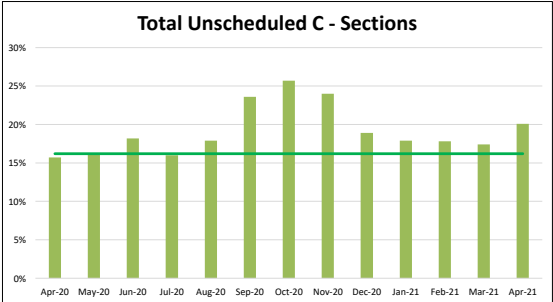
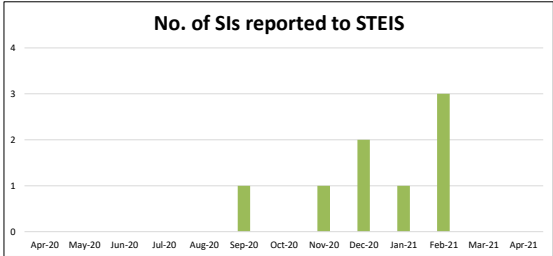
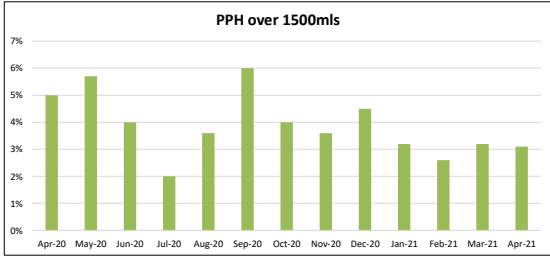
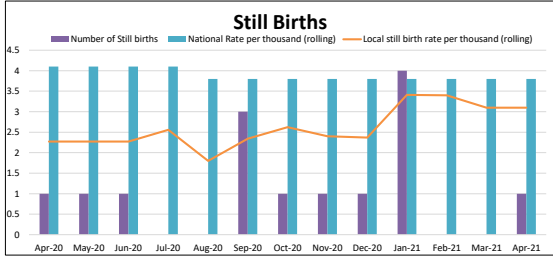
CTG training compliance Doctors



Family & Women's Service



2 Our Patients Summary 1.10 Family & Women's Service

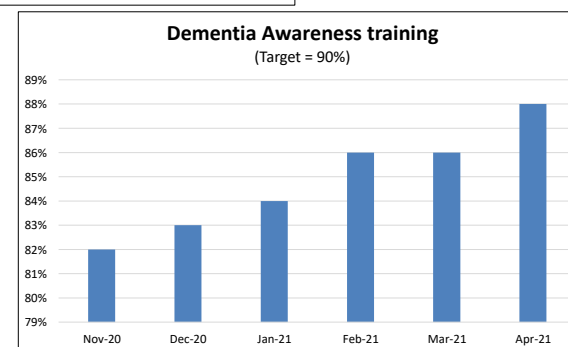
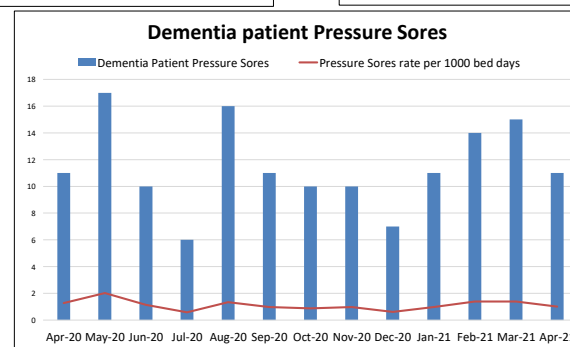
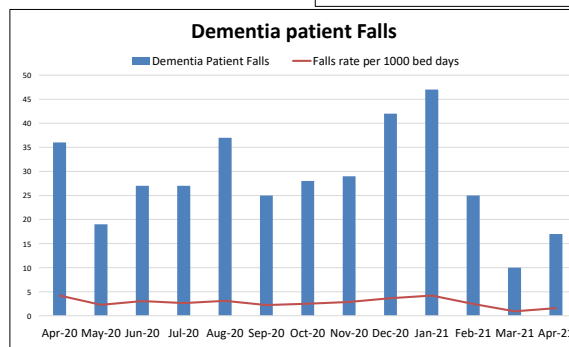
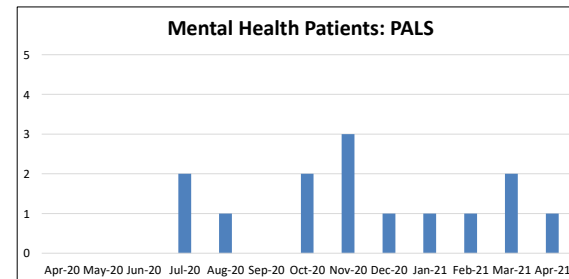
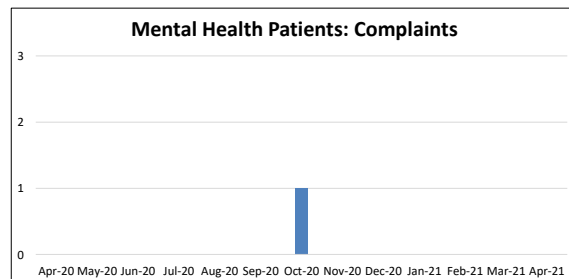
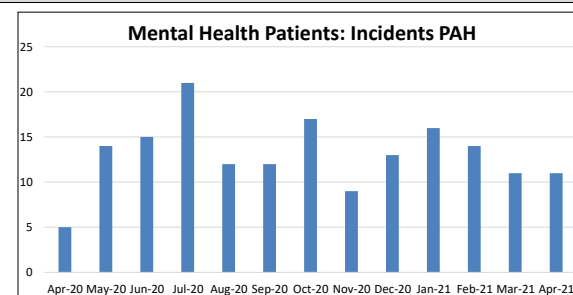
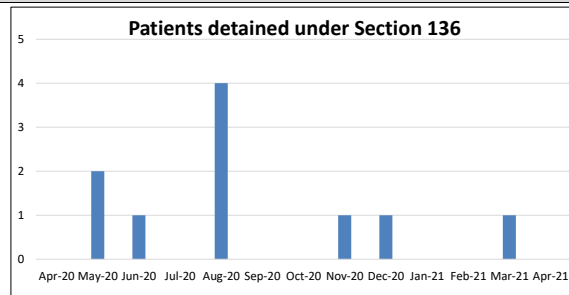
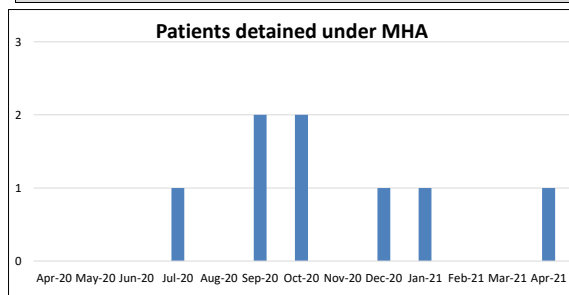




1 Our Patients Summary 1.11 Mental Health

This section details the trends relating to Mental Health and our Vulnerable Patients. The work is overseen by a number of groups, all of which have oversight at the new quarterly Vulnerable Person Group chaired by Director of Nursing.

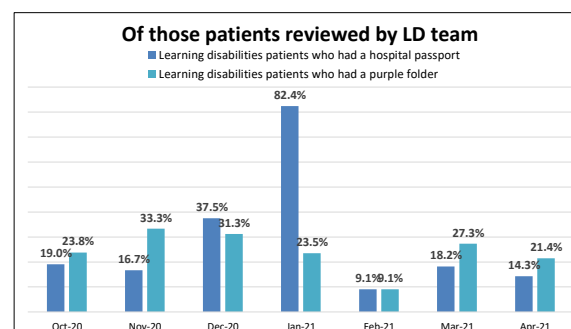
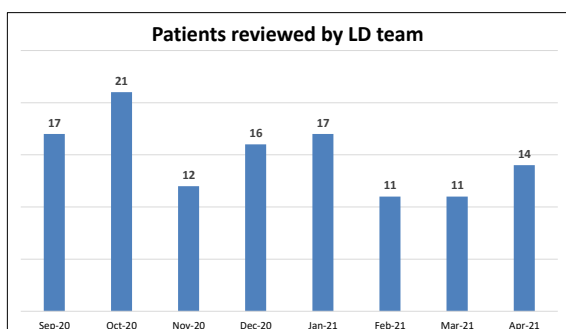
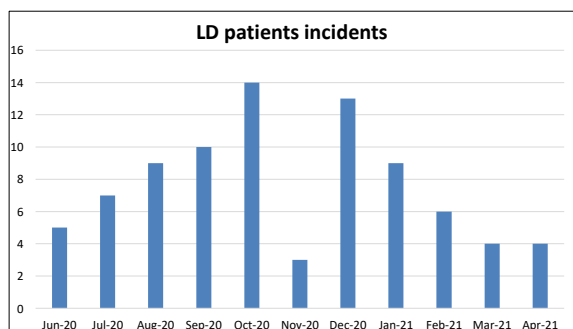
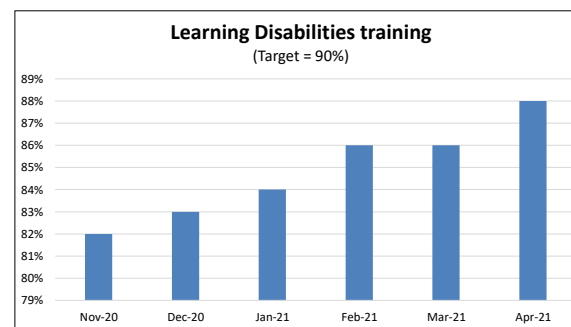
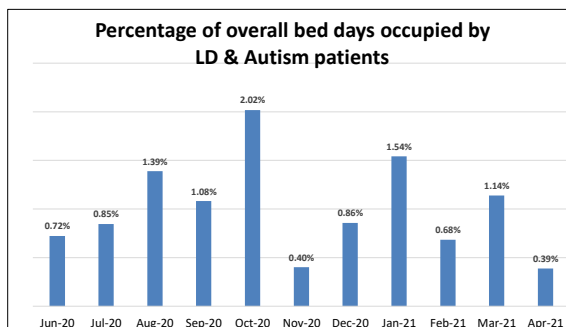
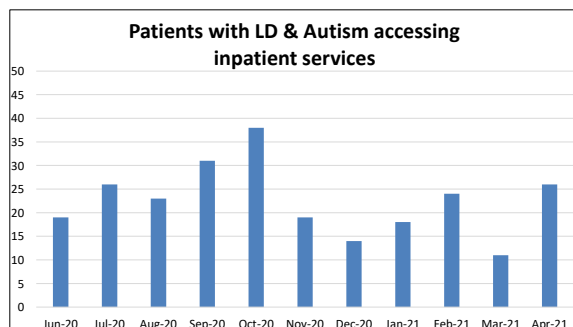
Dementia training rates have increased to 88% (target 90%) Data unavailable at point of report for PU and Falls in patients with Dementia.





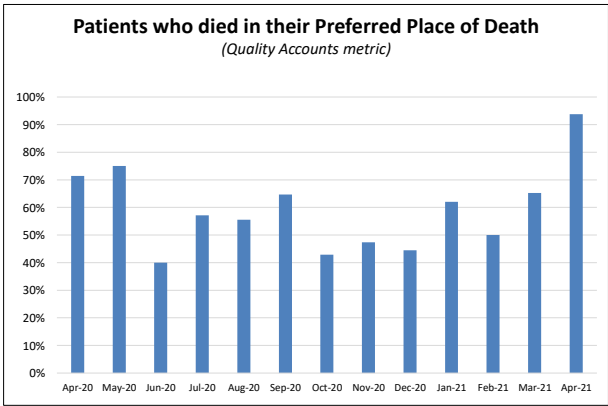
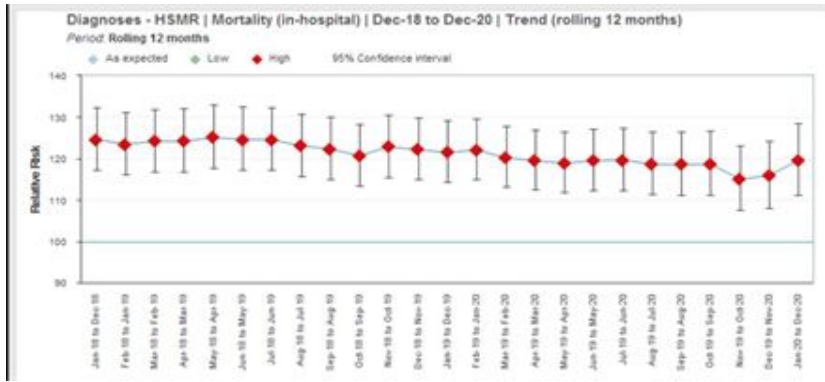
Learning Disabilities

Data unavailable at the time of the report for patients accessing services. Overall bed days and LD patient incidents. LD training rates have improved in month to 88% (target 90%)





Mortality



People measures

The trust vacancy rate is sitting just above the trust KPI of 9.3%. This increase relates to an increase in establishment of approx. 20 posts across the healthcare groups

- The trust continue to have a pipeline of international nurses due to join the trust over the coming months pending changes to government guidelines
- The trust is continuing with our HCSW recruitment pipeline and also working with colleagues within the ICS to share best practice and retention initiatives.
- Time to hire days within estates and facilities this month are significantly higher this month due to two posts where clearance checks have taken longer than expected.
- A “Step into Work” programme in collaboration with job centre plus will continue to focus on estates and facilities in the first instance.
- Staff turnover continues to sit under the trust KPI of 12%. Staff survey results and staff survey action plans are being developed by the HCGs
- Overall sickness absence has reduced and sits under the trust target in all HCG with the exception of estates and facilities. There continues to be focused support to estates and facilities and this month has seen a decrease in absence rate.
- Overall KPI for statutory and mandatory and appraisal have slightly improved this month (87%), appraisal rates have slightly increased to 74%. Pay progression has restarted and should see an improvement in these figures as having met both standards is a key criteria for progressing through the pay steps. Each of these KPIs is discussed at HCG performance review meetings
- HCG led action planning meetings are taking place across the organisation in response to the staff survey results. Listening events will form part of these action plans. The focus being on some of the areas for improvement particularly health and wellbeing.

Health and Wellbeing

- The trust is continuing with the trusts people focused recovery plan called “back to better”. This 12 week programme is based on four key topics:
 - health and wellbeing
 - Compassionate leadership
 - Civility and leadership
 - Leadership and values and behaviours
- A trust wide “here to hear” campaign will start in May which will include a series of listening events and comments boxes distributed across the hospital sites in which staff will be asked to comment on a number of set questions



Workforce Indicators Summary



Agency Spend 4.78%
Bank Spend 10.77%

Target: 15%



Staff In Post
3420
WTE



Sickness
3.46%

Target: 3.7%



Training
87%

Target: 90%



VACANCIES
9.29%

Target: 8%



Turnover
10.04%

Target: 12%



Medical
Non-Medical

Suspended
74%

Target: 90%

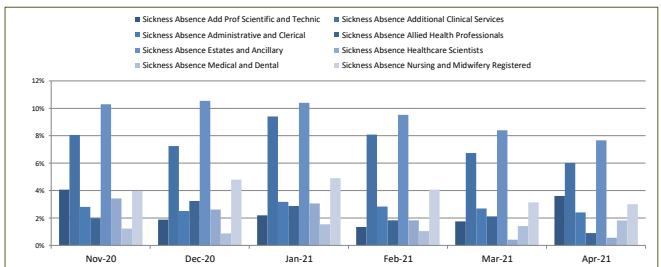
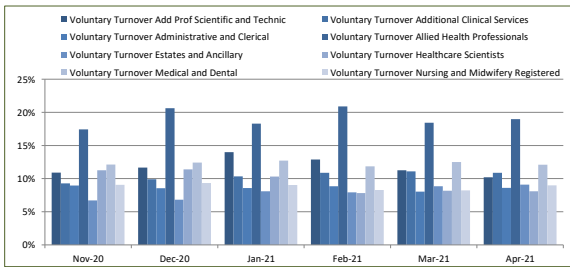
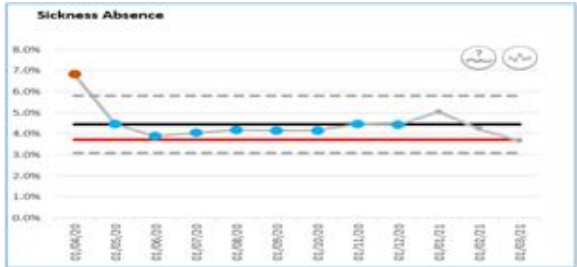
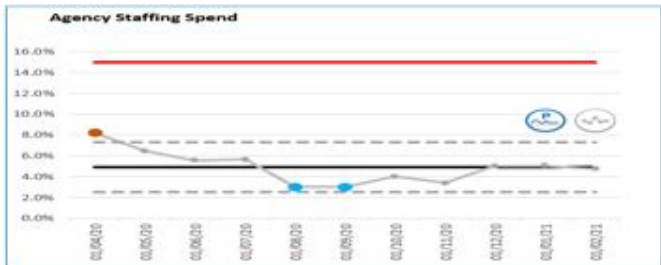
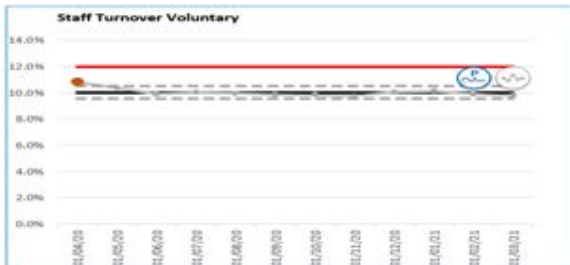
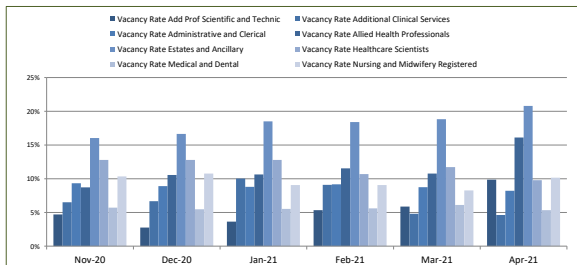
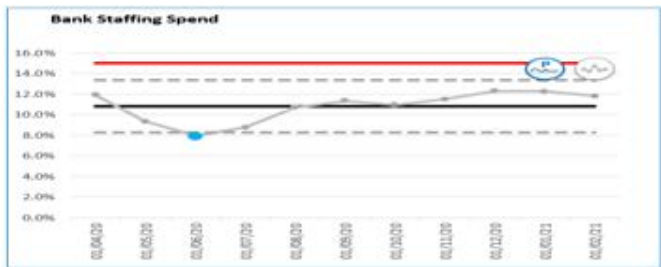
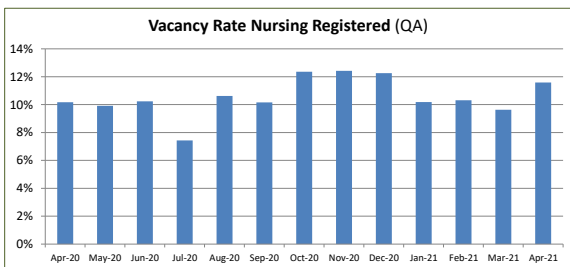
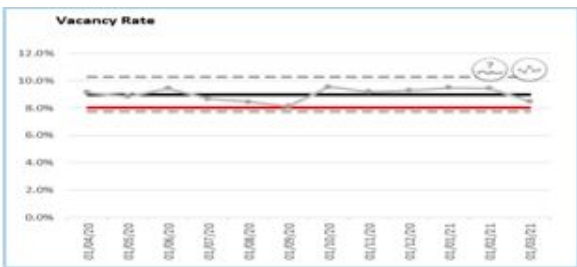
Scorecard

People Measures as at 30 April 2021	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3809.87	926.04	487.08	944.11	759.93	319.54	155.95	52.68	164.54
Vacancy Rate	8.0%	9.32%↑	10.35%↑	7.77%↑	10.74%↑	9.19%↓	22.68%↑	0%↔	0%↔	9.57%↑
Agency % of paybill	7.0%	4.8%↓	2.8%↑	2.8%↑	4.1%↓	6.8%↓	22.6%↓	1.9%↑	0%↔	4.7%↓
Bank Usage - wte	n/a	322.00	33.33	43.56	129.08	50.66	36.93	10.10	4.92	13.31
Agency Usage -wte	n/a	106.93	16.47	7.01	22.65	21.82	34.33	1.00	0.00	3.65
April 2021 Sickness Absence	3.7%	3.46%↓	3.21%↑	3.13%↓	3.68%↑	3.49%↓	6.76%↓	2.5%↑	0.73%↓	1.22%↓
Short Term Sickness	1.85%	1.70%	1.49%	1.40%	2.34%	1.54%	1.77%	1.97%	0.73%	0.88%
Long Term Sickness	1.85%	1.76%	1.72%	1.73%	1.35%	1.95%	5.00%	0.52%	0.00%	0.34 %
Rolling Turnover (voluntary)	12%	10.04%↑	11.24%↑	9.35%↑	10.26%↑	9.43%↑	7.94%↓	8.35%↑	18.76%↑	9.38%↓
Statutory & Mandatory Training	90%	87%↔	92%↓	84%↓	83%↓	82%↓	91%↑	89%↑	93%↓	96%↓
Appraisal	90%	74%↑	83%↑	70%↑	75%↑	67%↑	66%↑	55%↑	79%↑	79%↓
Starters (wte)		63.20	12.67	4.80	7.00	10.64	13.00	12.00	0.40	2.69
Leavers (wte)		31.04	9.37	3.80	7.40	5.39	3.08	1.00	1.00	0.00
Time to hire (Advert to formal offer made)	31Days	49	48	40	40	44	71	48	0	0

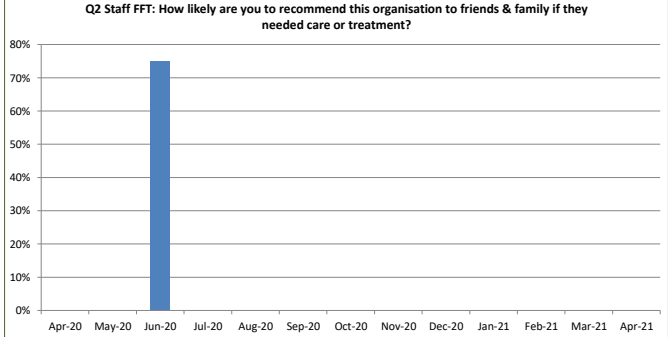
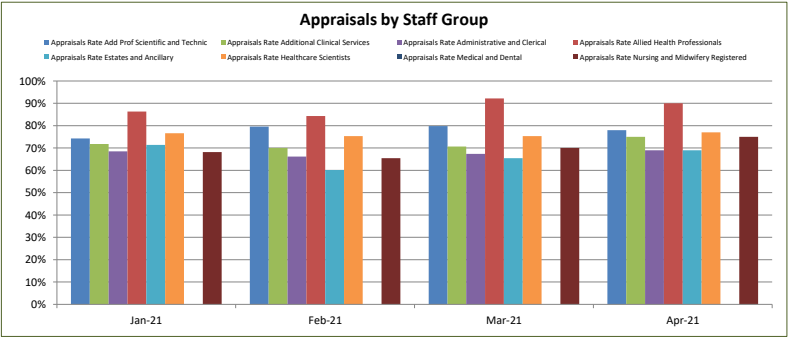
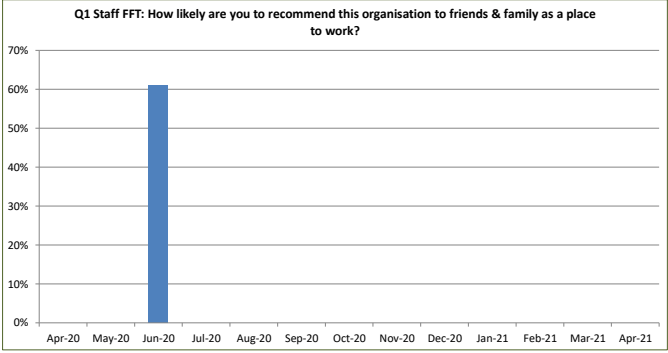
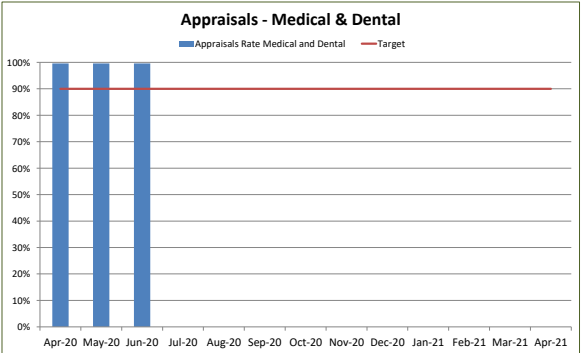
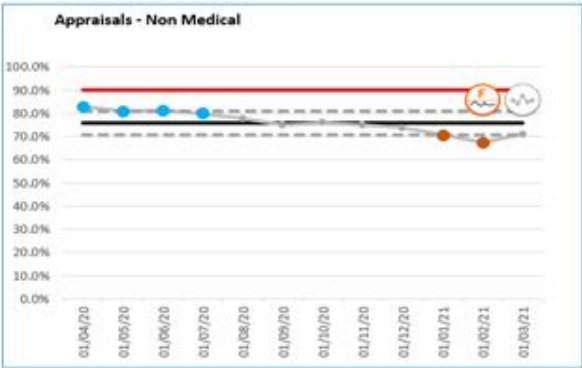
3.3 Well Led

 3 Our People Summary

Workforce Indicators



Workforce Indicators





Annual Staff Survey 2020 & Workforce Race Equality Standard (WRES) Latest Available

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

Measure	Average rating of:	Percentage
Support & Compassion	% experiencing harassment, bullying or abuse from staff in the last 12 months*	23.08%
	% not experiencing harassment, bullying or abuse at work from managers in the last 12 months	84.10%
Teamwork	% agreeing that their team has a set of shared objectives	69.00%
	% agreeing that their team often meets to discuss the team's effectiveness	53.20%
Inclusion (1)	% staff believing the trust provides equal opportunities for career progression or promotion	78.70%
	% experiencing discrimination from their manager/team leader or other colleagues in the last 12 months**	10.19%

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

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

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

Executive Summary Our Places

Estates:

- Estates tender for the planned and preventative maintenance contract at award recommendation stage (report due next week)
- Electricity infrastructure works progressing – project initiation meeting scheduled between ETA and GWF (12th May)
 - Contract instruction issued to ETA to realign existing UKPN contract (700kVA) in line with actual site electrical load requirements (additional 3150kVA)
 - Transfer of ownership of the UKPN application from Axiom Utilities to Eta Projects (completed) and progressing urgent G99 agreement
- EBME advisory audit by Tadd facilities near completion
- Backlog maintenance business case agreed to include 10 schemes with overall value £3.38m net of recoverable vat
 - Contingency or variations to be managed through business case change control form (revised) or via a separate business case
- Parndon hall remedial works approved and progressing – order for new boiler raised
- Trust's authorized person (AP) – 100% staff booked on training
- Preparedness works underway ahead of Saunders refurbishment following Penn completion – works to commence in accordance with approved business case
- Capital/ Projects workshop completed to improve governance standards setting out clear roles and responsibilities, permits, systems and processes.
- E&F dashboard being developed to monitor all estates KPI's
- Staff survey action plan 21_22, developed and implemented

Capital :

- Clinical agile working space (mortuary corridor) business case being developed
- ED CT Scanner project delayed by 4 weeks due to supplier lead times
- Penn ward refurbishment delayed by further 1 week due to additional water safety remedial works and supplier lead times
- Williams Day Unit delayed (TBC) due to significant change in scope (*additional works arising from approved variations*)
- Medical records is scheduled for completion by end of May
- Alex Education & Training center is scheduled for completion early Aug
- Fire doors phase-4 delayed due to supplier lead time
- Colposcopy refurbishment is due completion 19th May (on track)
- Endoscopy room-3 is due for completion 9th June (on track)
- Labour ward birthing rooms is due for completion 4th June (on track)
- Frailty assessment due completion 4th June (on track)
- Green zone is due for completion by 11th June (cycle lockers lead times)
- E&F dashboard being developed to monitor all capital projects
- Staff survey action plan 21_22, developed and implemented

Catering:

- **Patient Satisfaction:** we received positive feedback about the new Patients Food Menu since its launch from the 19th April 2021, this feedback was received by the various Housekeepers working on the various Patient Wards. One of the comments made from a patient at Ray Ward was, "the food has tremendously improved and is delicious too, looking forward for my next meal at the dinner time"
- **Catering Food Waste:** the food waste has decreased a lot but still much work needs to be done in this area, which hopefully will also be minimised with the introduction of patient meal electronic system as it will not allow a housekeeping assistant to order any extra food against total number of beds on a given Patient ward along with accounting for Nil By Mouth Patients and empty bed spaces.

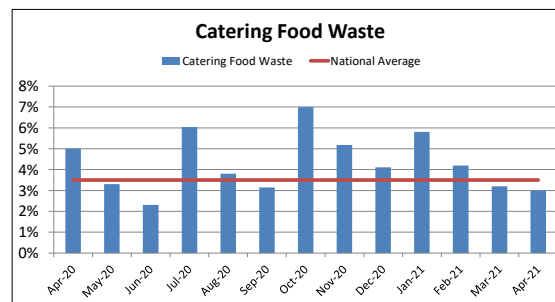
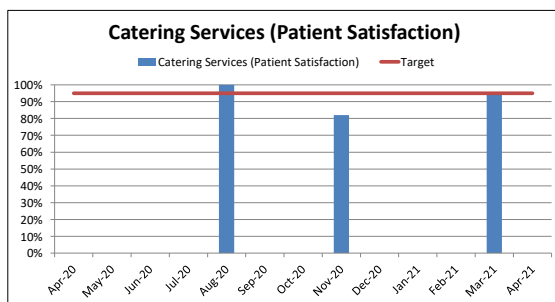
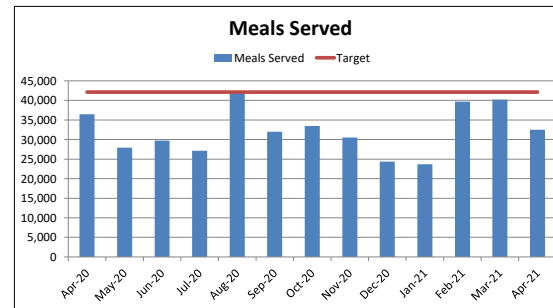
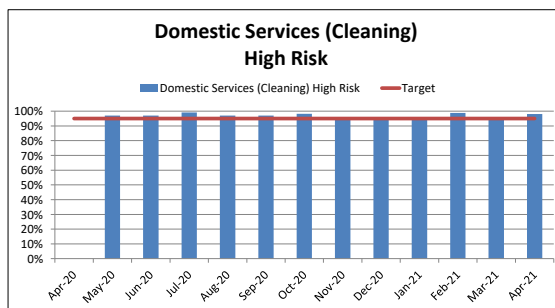
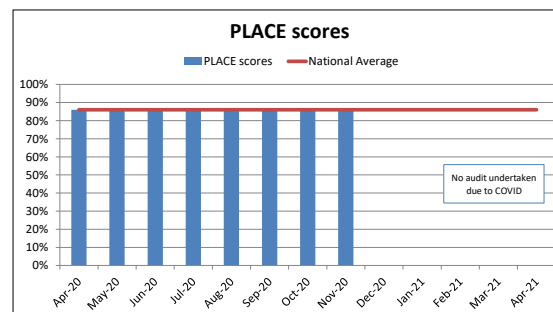
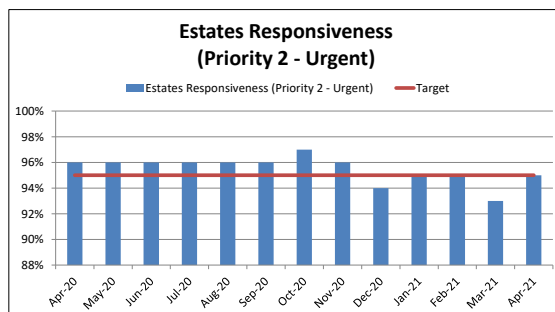
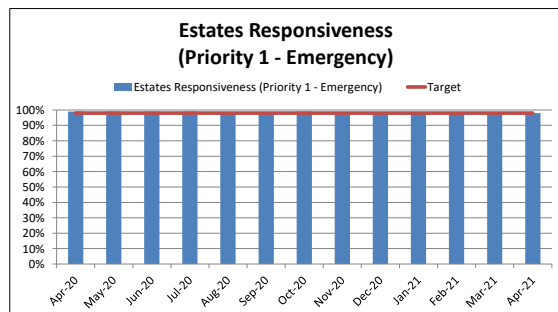
Facilities:

- Housekeeping vacancies are progressively being sent out to aim to fill the 25 available, these are currently a priority. The reason for so many vacancies is that staff who have been working with the trust since before the domestic modernisation have either not applied for the revised job role or have been offered job positions elsewhere. Furthermore, some staff are off on long term sickness due to anxiety and Covid related illness.
- New patient menu has now gone live, there has been positive feedback and compliments to the team which means the menu has been successful and is effective.
- New HPV machines have been ordered.
- Security contracts are currently under review and being worked on.
- Portering modernisation is underway and the new rotas are being created.
- E&F dashboard being developed to monitor all facility KPI's
- Staff survey action plan 21_22, developed and implemented



4 Our Places Summary

4.1 Cleanliness & Catering



Places

Executive Summary Our Performance

The RTT performance indicators continue to decline as the Trust books patients for appointments and treatments in a clinically prioritised order rather than chronological. The booking of Priority 2 patients continues to improve and the transfer of longer waiting Priority 3&4 patients to independent sector hospitals is ensuring patients are being offered dates as efficiently as possible. Comparison of national RTT performance for March illustrates that PAHT is in the top quartile for the percentage of 52 week breaches compared to the size of the PTL, 6%. We continue to focus on ensuring that all Priority 2 patients receive their treatment within the 4 week requirement and all long waiting patients are offered appointments thereafter.

Cancer 2 week wait performance achieved the national standard in March 2021 and the 28 day diagnosis standard also improved to 74.5% against the new national standard of 75%. This reflects the continued focus on early diagnosis of newly referred patients in addition to concentrating on diagnosing & treating the patients over 62 days. The 62 day standard performance continues to be low due to treating the longest waiting patients first. Most tumour sites are in line with their >62 day patient trajectory however Urology is significantly under performing due to a number of issues and the tumour site is receiving additional support and focus to develop a recovery action plan.

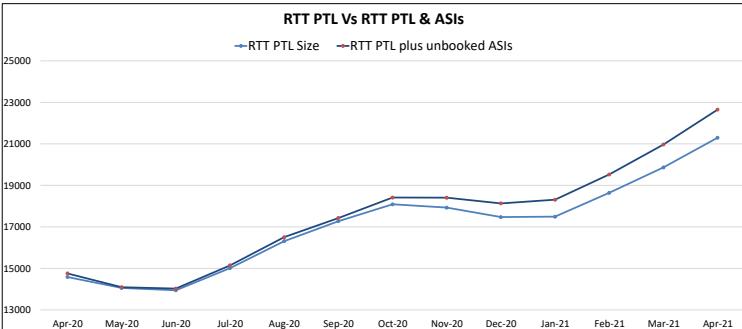
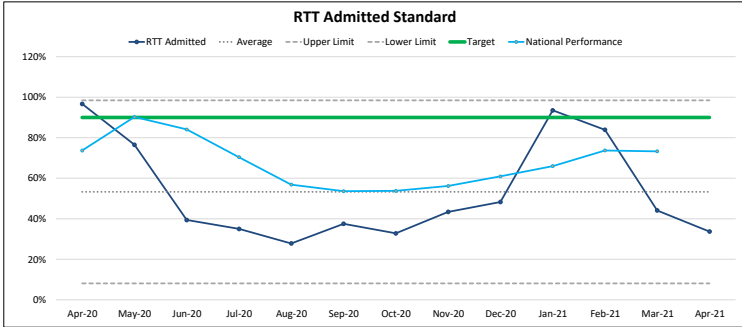
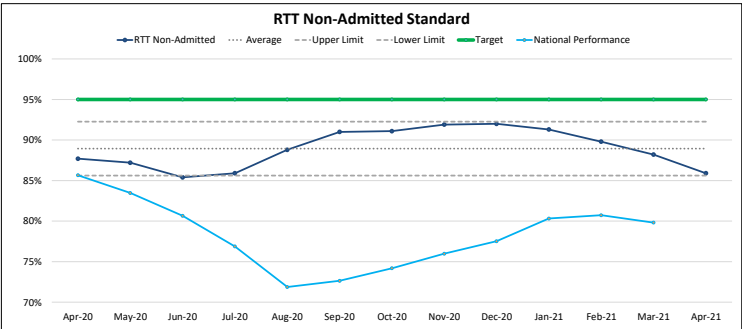
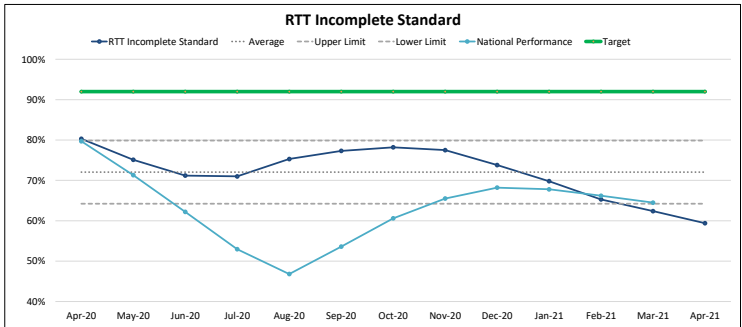
A&E performance of the 4 hour arrival to discharge has slightly improved despite significant increases in attendances over March & April. Paediatric A&E have also struggled with performance due to increased attendances. The cross-system initiative "A day in the life of ED" has collated valuable intelligence to support the redesign of urgent care services both within the hospital and out and along with the Prism Improvement team a comprehensive set of workstreams has been devised to deliver improvements across the emergency floor.

DM01 recovery is continuing to improve across most modalities and there is a recovery trajectory for each type of diagnostic. Echo cardiograms have the largest backlog and this is also seen across the ICS. The Trust has recently started weekend sessions with a locum consultant and is negotiating with an independent sector provider to offer additional capacity.

The out-patient short notice cancellation rate continues to improve and the new to follow up ratio is high due to the increased follow-up appointments delivered due to the majority of appointments being virtual. The recent agreement to open up routine and face to face clinics will change the ratio of new and follow-up in June/July and support the reduction in long waiting non admitted patient waiting.



RTT

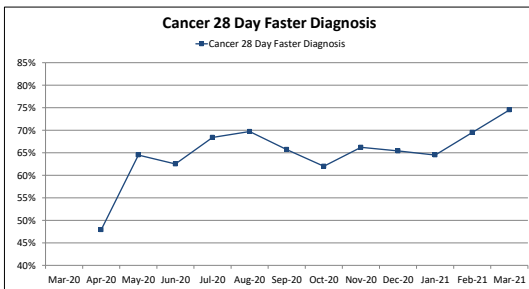
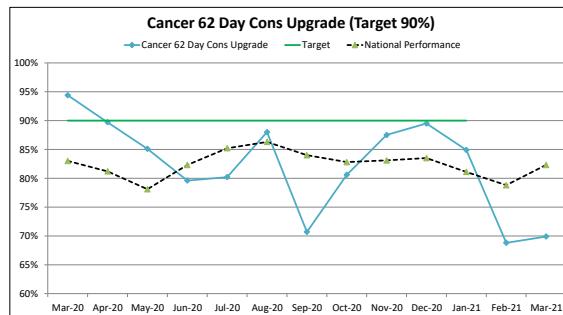
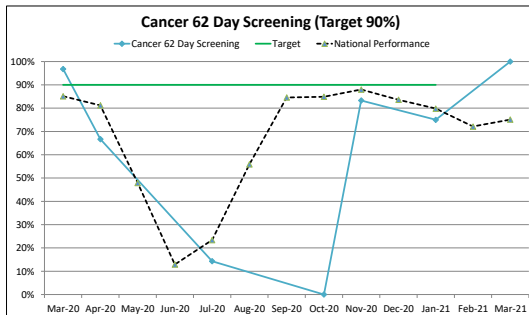
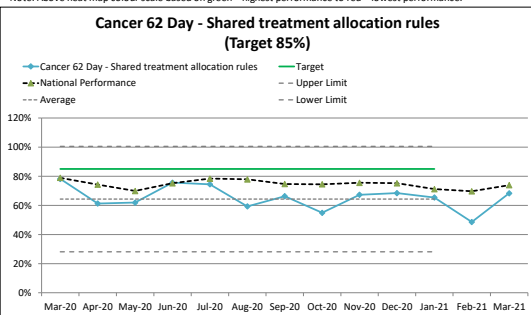
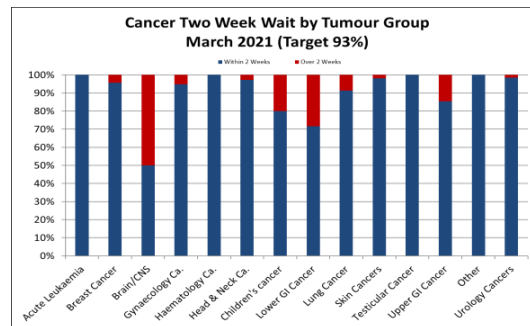
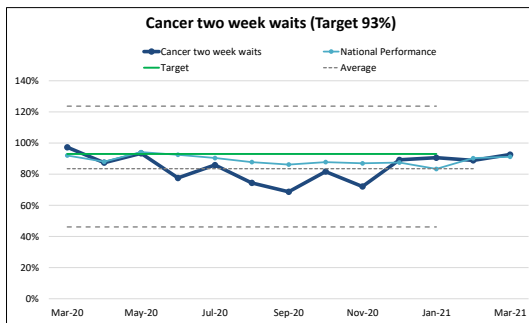


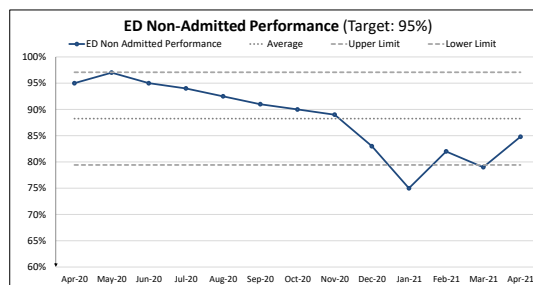
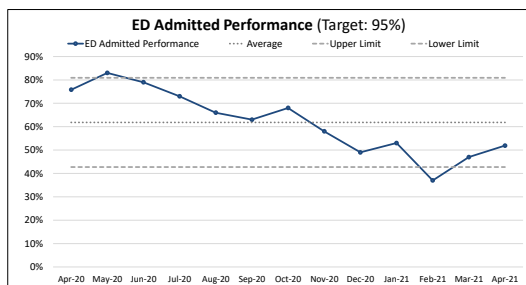
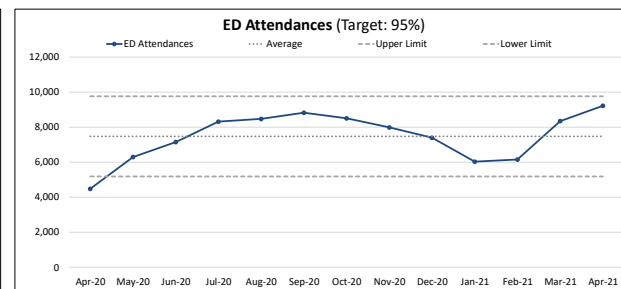
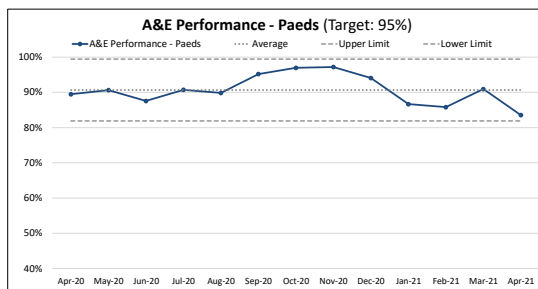
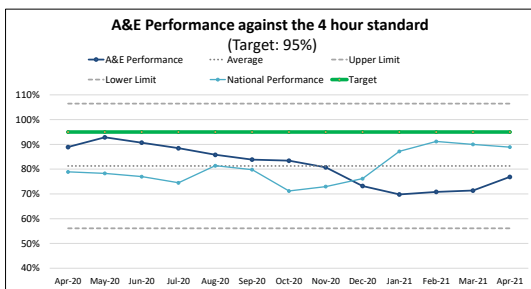
Cancer



	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Mar-20	97.70%	97.40%	100.00%	100.00%
Apr-20	91.90%	95.10%	100.00%	90.00%
May-20	97.50%	90.70%	100.00%	100.00%
Jun-20	89.80%	86.90%	100.00%	66.70%
Jul-20	82.50%	91.10%	100.00%	85.70%
Aug-20	92.30%	87.10%	100.00%	66.70%
Sep-20	92.90%	90.20%	100.00%	100.00%
Oct-20	91.10%	87.40%	100.00%	100.00%
Nov-20	61.50%	92.60%	100.00%	80.00%
Dec-20	79.90%	93.70%	100.00%	83.30%
Jan-21	86.80%	89.30%	88.00%	100.00%
Feb-21	96.00%	87.50%	100.00%	100.00%
Mar-21	97.50%	93.30%	100.00%	100.00%

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

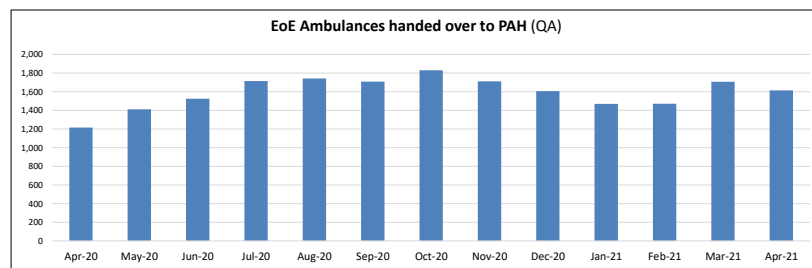
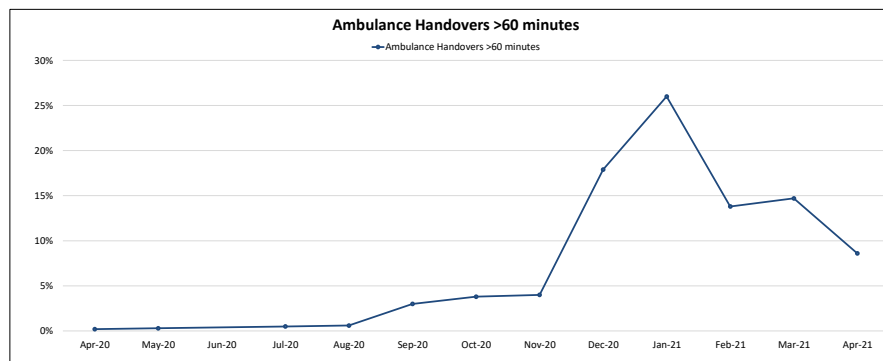
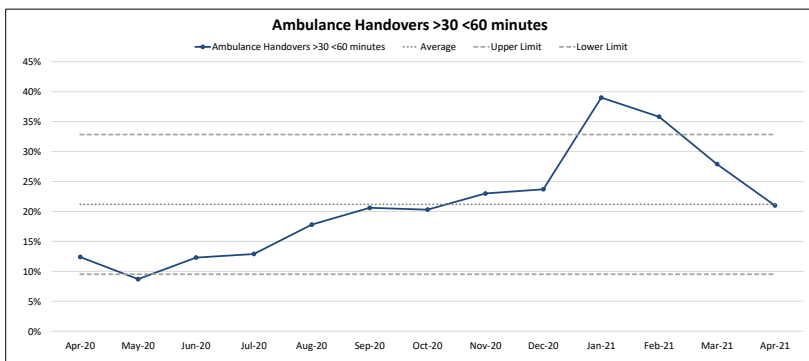
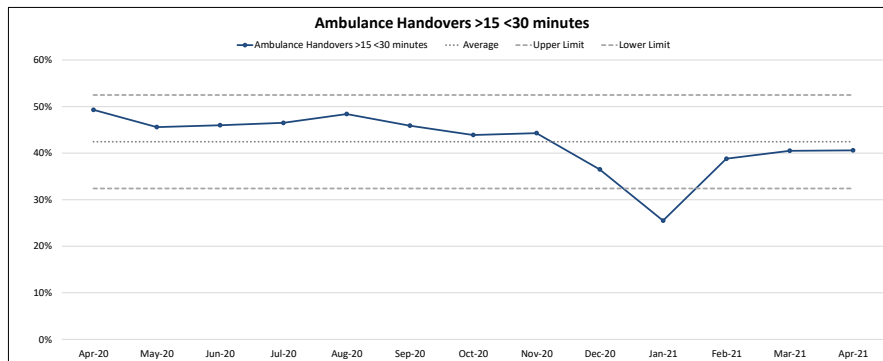
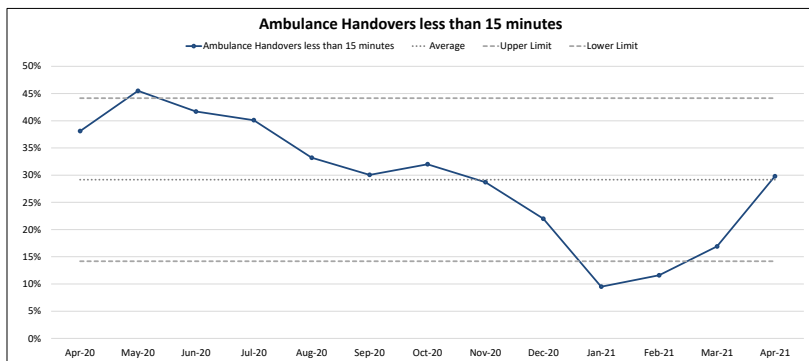


**ED Internal Professional Standards**

	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	Target
Arrival to Triage - Average Wait (Minutes)	25	26	25	28	31	36	36	39	49	63	49	58	45	15
Triage to Exam - Average Wait (Minutes)	41	44	56	78	68	79	80	73	79	80	76	97	97	45
Exam to Referral to Specialty - Average Wait (Minutes)	88	82	84	96	94	86	96	99	107	110	109	105	102	90
Referral to Seen by Specialty - Average Wait (Minutes)	54	48	51	64	70	73	75	88	94	98	80	80	80	30
Seen by Specialty to DTA - Average Wait (Minutes)	66	67	69	70	85	94	99	97	109	120	101	110	96	30
DTA to Departure - Average Wait (Minutes)	110	55	74	134	111	132	100	178	254	319	273	233	144	30

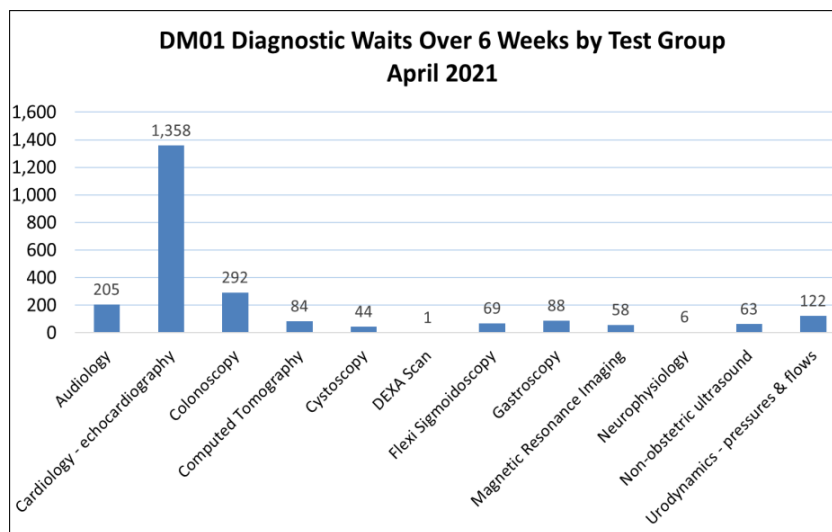
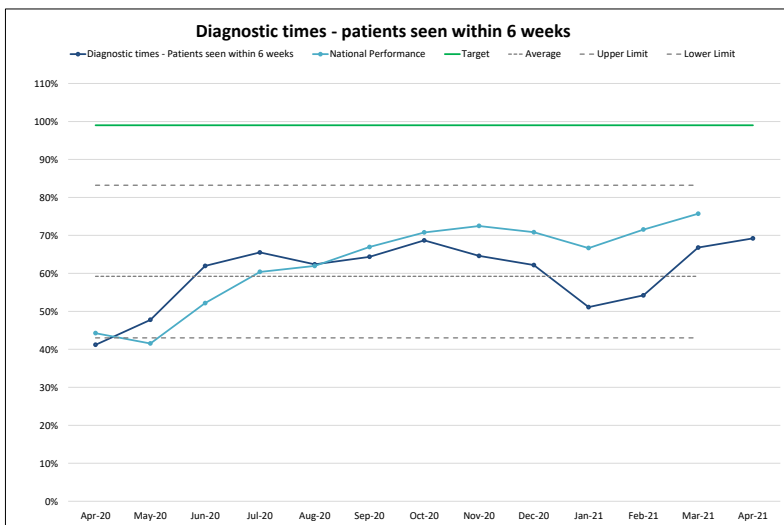
Average timeline for breach patients showing excess minutes over the standard.

Ambulance



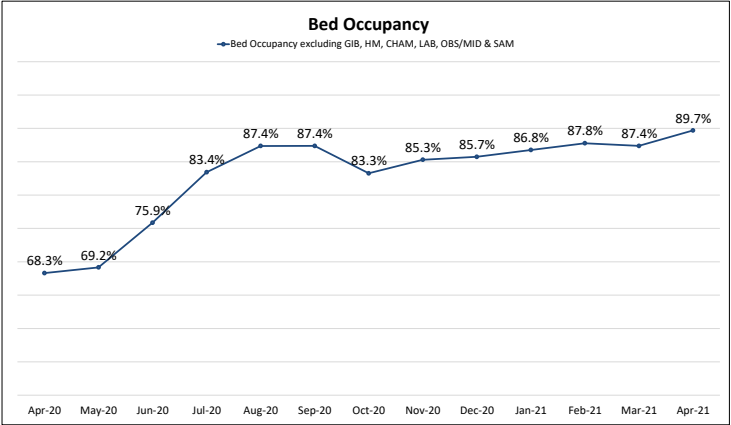
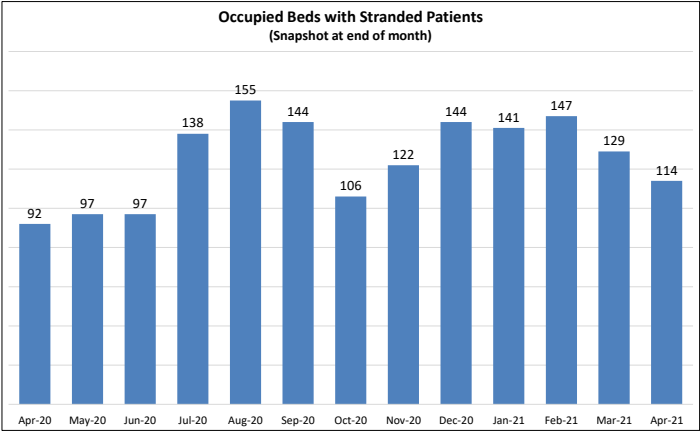


Diagnostics



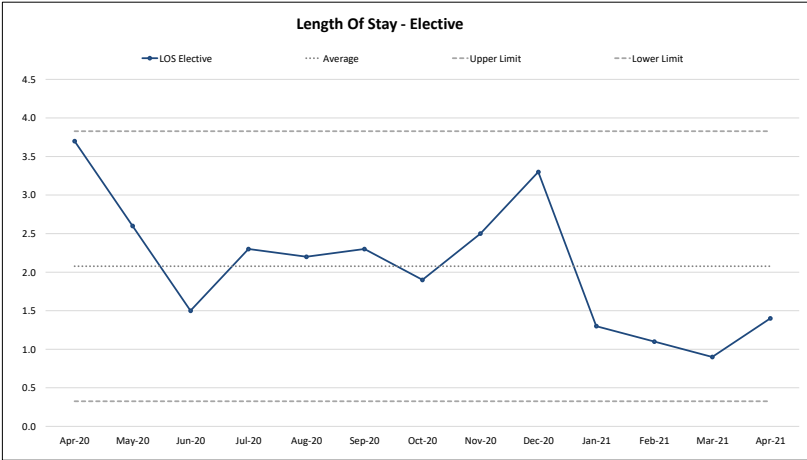
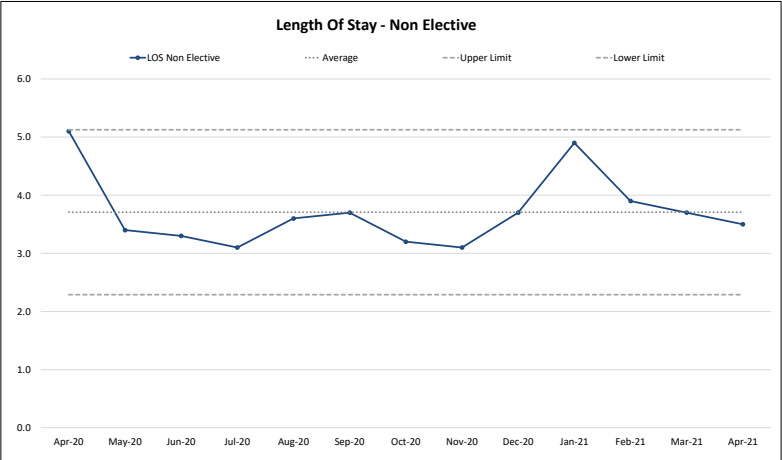
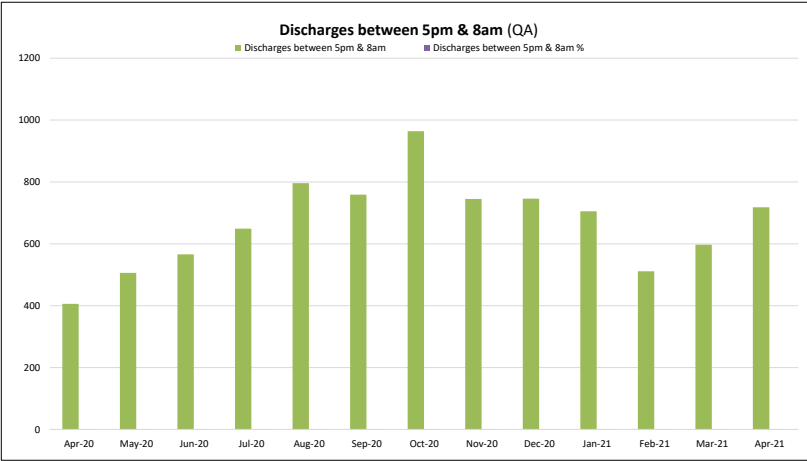
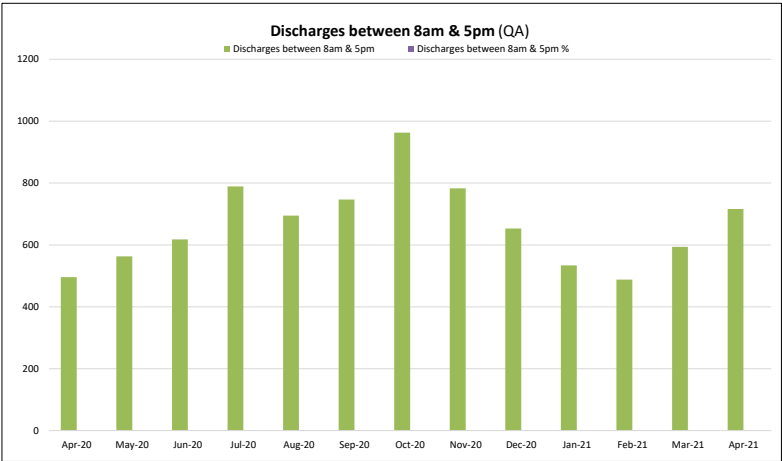
Test	% of Total Cohort - April 2021	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Magnetic Resonance Imaging (MRI)	15%	33.52%	38%	59%	79%	79%	74%	89%	81.85%	97.51%	82.68%	77.81%	92.19%	94.87%
Computed Tomography (CT)	6%	58.75%	61%	77.37%	80.00%	79%	89%	90%	91.78%	83.91%	79.03%	78.40%	83.92%	83.03%
Non-Obstetric Ultrasound	34%	39.20%	65.86%	92.61%	96.79%	93.18%	96%	97%	92.40%	95.27%	85.74%	84.37%	95.04%	97.59%
DEXA	0%	100%	100.00%	78%	88%	85%	93%	93%	97.56%	86.26%	51.83%	50.00%	50.00%	0.00%
Audiology - Audiology Assessments	5%	23.42%	11%	11%	25%	24%	25%	30%	23.79%	16.84%	12.57%	19.09%	35.01%	48.10%
Cardiology - Echocardiography	28%	38%	40.29%	55.46%	53.62%	52%	52%	54%	50.23%	47.43%	39.24%	39.21%	41.16%	36.63%
Neurophysiology	0%	42%	5%	36%	32%	28.41%	30%	47%	65%	74%	56%	81%	76%	84.21%
Urodynamics	2%	30%	30.30%	24.39%	16.30%	3.26%	11%	6%	3.74%	6.48%	7.96%	7.63%	10.24%	14.08%
Colonoscopy	6%	62.56%	38.41%	42.69%	40.42%	34.46%	39%	46%	44.24%	45.42%	25.48%	13.18%	23.75%	31.62%
Flexi Sigmoidoscopy	1%	49%	54%	55.66%	43.85%	31.45%	39%	40%	44.35%	38.14%	22.52%	9.18%	13.68%	14.81%
Cystoscopy	2%	48.16%	38.52%	34%	34.08%	29%	26%	35%	32.02%	32.11%	28.11%	57.00%	74.86%	76.22%
Gastroscopy	1%	58.37%	40.15%	44.88%	40.05%	28.94%	30%	38%	25.65%	24.37%	15.88%	10.13%	10.67%	22.81%

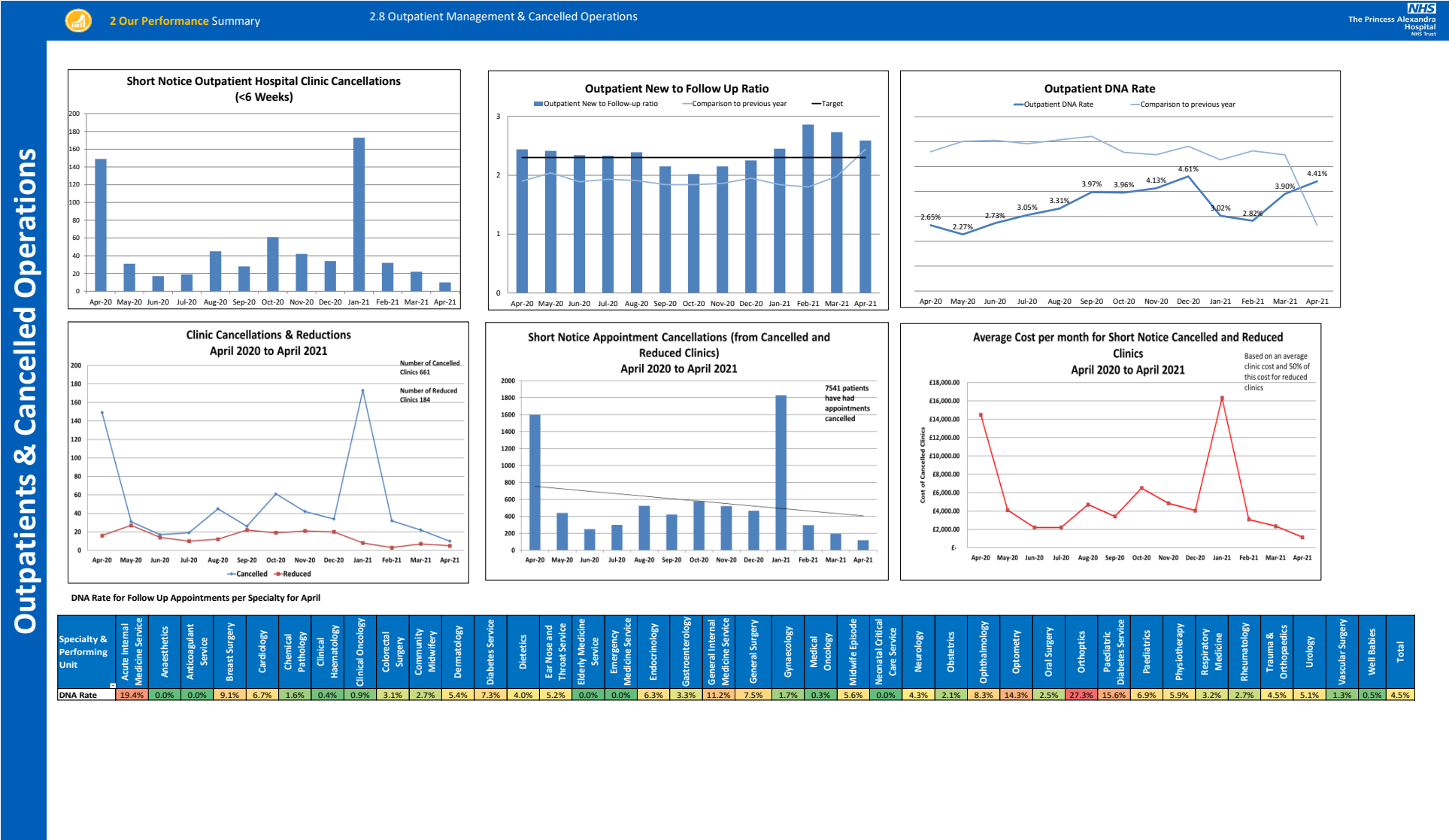
Stranded Patients





Discharges & LOS

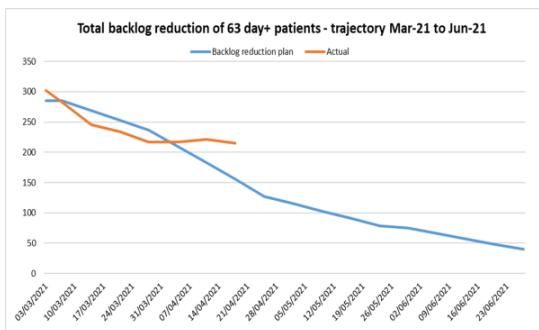
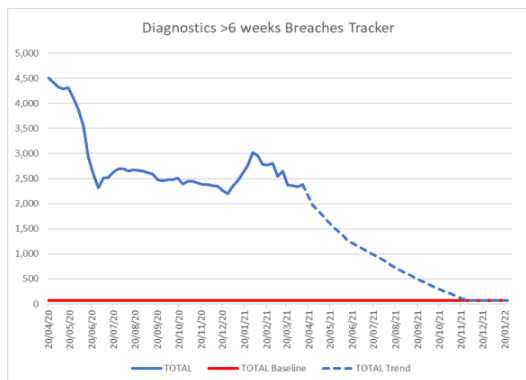
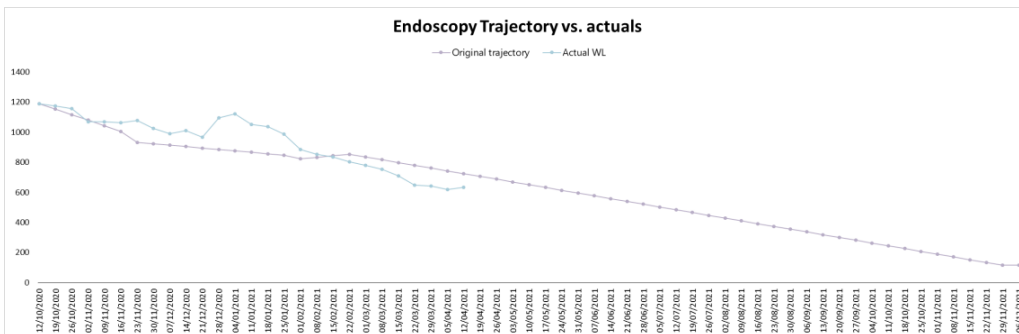
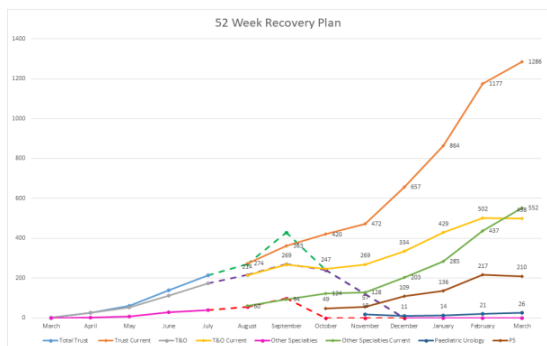




Outpatients & Cancelled Operations



Recovery Trajectories



	Metric	Mar-20 Actuals	Mar-21 Actuals	Mar-20 vs Mar-21
Outpatients	First appointments	10,398	8,686	83.5%
	Follow up appointments	18,154	23,733	130.7%
	procedures	TBC	TBC	TBC
	Face to face	TBC	TBC	TBC
	Virtual	TBC	TBC	TBC
Inpatients	Day cases	2,088	1,559	74.7%
	Elective	340	257	75.6%
	Non-elective	2,870	2,857	99.6%
ED	A&E attendances	9,328	8,348	89.5%

Executive Summary **Our Pounds**

For the first half of the financial year 21/22, and as part of the continued response to Covid an 'adapted financial regime' will remain in place. This means that the Trust's income from Commissioners will continue to be based on 'block contract' arrangements supplemented by allocations from the ICS. The Trust has agreed its income and expenditure budgets which have been jointly established to deliver a breakeven position. The financial plan does not currently reflect the additional activity associated with 'restore and recover' and there will be additional income made available for this (via the 'System') to meet the Trust's additional costs.

For the second half of the financial year the Trust has set an indicative breakeven budget. National guidance relating to the financial arrangements for the second half of the financial year are being finalised. Once this guidance is received the Trust will be reassessing budgets relating to the second half of the financial year.

The M1 results record achievement of a breakeven position and are in line with plan. The results also include an improvement in the level of temporary staffing costs which have reduced to £2.6m from average levels over the last quarter of £3.1m.

The Trust's indicative capital programme for 21/22 totals £49.2m and include strategic and operational developments. Strategic initiatives include the continued development of the New Hospital and progression of a digital agenda. The Trust's capital programme has been developed on a risk based approach with a concentration of schemes being planned to be delivered in the earlier part of the financial year.

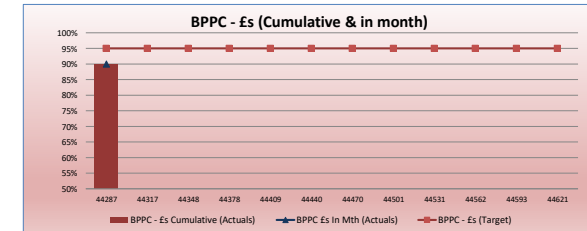
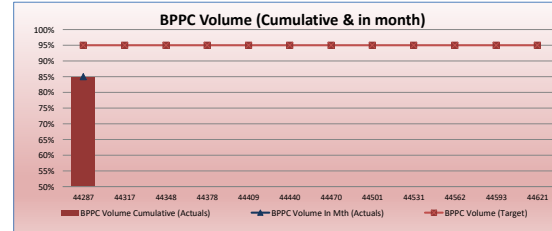
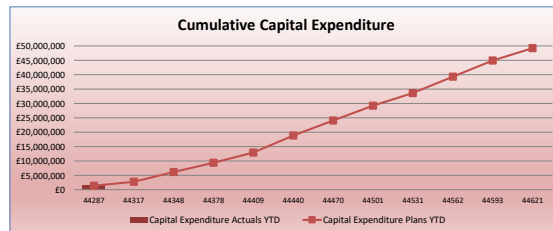
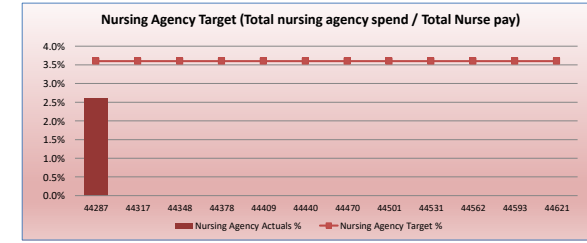
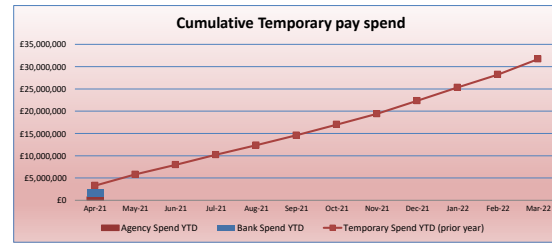
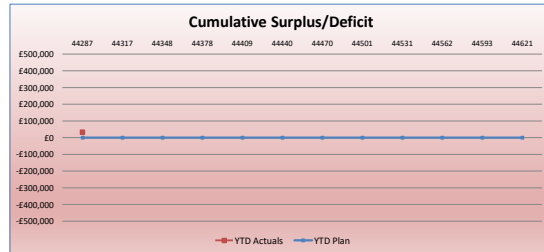


5 Our Pounds Summary

5.1 Overall financial position

OUR POUNDS

Metric	Annual Plan	YTD Actuals
Surplus/(Deficit)	£0	£32,551
Agency Spend £s	£10,292,000	£791,926
Bank Spend £s	TBC	£1,786,150
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3.6%	2.6%
Capital Expenditure	£49,226,000	£1,505,000
BPPC Volume	95%	85%
BPPC - £s	95%	90%
Cash Balance	£46,300,000	£63,450,000



Pounds

CQC Rating

CQC

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

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

CQC Inpatient Survey (OS)

20 June 2019

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

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

respectful | caring | responsible | committed

BOARD OF DIRECTORS**MEETING DATE:** 11/06/2021**AGENDA ITEM NO:** 6.1**REPORT TO THE BOARD FROM:** Audit Committee (AC)**REPORT FROM:** George Wood – Chair of Audit Committee**DATE OF COMMITTEE MEETING:** 25/05/2021**SECTION 1 – MATTERS FOR THE BOARD’S ATTENTION**

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

IA Annual report: Ten audits had been completed, one assigned a limited assurance opinion. This was for an audit of supply chain and EROS system authorisation controls and had been completed at the request of the DoF to address known concerns.

Head of Internal Audit Opinion: A reasonable assurance opinion has been assigned to the Trust.

External audit update: The external audit is in progress. Planning has been completed and the level of materiality increased from 1% to 1.5%. The only significant issue that had been identified so far in the audit process was that the inventory opening balance would be qualified as this had rolled forward from the prior year closing balance which had been qualified. Value for money planning had been completed by Ernst & Young.

Annual Report and accounts 2020-21: The Annual Report and Accounts including the Annual Governance Statement were reviewed by the Committee and recommended to the Board for approval subject to minor amendments suggested by committee members.

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

The Committee’s progress against its Annual Work Plan is set out below:

The AC will be meeting on Friday 11th June 2021 to approve the 2020/21 Annual Report and Accounts before they come to the Board for approval. In addition, this Audit Committee will appoint the external auditor following the completion of a tender process.

The AC is making good progress against its annual work plan and will meet again on Thursday 9 September 2021.

6.1

BOARD OF DIRECTORS**MEETING DATE:** 11.06.21**AGENDA ITEM NO:** 6.1**REPORT TO THE BOARD FROM:**

New Hospital Committee (NHC)

REPORT FROM:

Lance McCarthy (Committee Chair)

DATE OF COMMITTEE MEETING:

24.05.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD’S ATTENTION

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

Committee’s Annual Effectiveness Review 2020/21 – Members noted the areas for improvement highlighted in the review which were:

- 1) Quality of papers – request for papers to be high level and concise, front sheets to be clearer/more ‘tightly’ written.
- 2) Timeliness of papers – on occasions papers are circulated late with little time for members to read in advance of the meeting. It was noted however that the pace of the programme is such that information is often available at the last minute.

NHC also approved the Committee’s revised Terms of Reference (see appendix 1).

New Hospital Programme (NHP) Update: Members noted that the NHP had undertaken a deep dive review of the front runner trusts in the programme and a detailed report was now being prepared (on the Trust’s scheme) by the review team and would be shared with committee members once available. PAH was the only Trust on the programme to have not received a red against any of the design criteria. The Committee was then taken through a presentation that set out the developing context of the new hospital programme and future requirement for repeatable design elements. It was agreed that the team should align the Trust’s OBC programme to the emerging new hospital programme’s timeline.

Land Update: Negotiations with the land owners and their agents continue and an update would be shared with the Board on 11.06.21.

Design and Capital costs: Work continued to reduce the gross internal floor area whilst balancing the requirements for modern methods of construction and ensuring future flexibility.

Finance: The OBC programme costs incurred in April had been £342k, which left a remainder of £1.7m to OBC.

BAF Risk 3.5 New Hospital The risk was discussed and members 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:

- Affordability
- Enabling Works
- Standing agenda items including programme risks

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

The Committee discussed and approved an annual work plan for 2021/22.

6.1

PAH NEW HOSPITAL COMMITTEE (NHC)

TERMS OF REFERENCE - 2021-2022

INTRODUCTION:

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

Significant investment is required to:

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

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

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

PURPOSE:

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

DUTIES:

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

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

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

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

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

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

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

DATE APPROVED: By Committee: ~~9 July 2020~~ 24 May 2021
By Trust Board: ~~6 August 2020~~ 11 June 2021

6.1

PAH New Hospital Committee Membership	
Members	
Chair	Lance McCarthy
Director of Strategy	Michael Meredith
Non-Executive Director	John Hogan
Associate Non-Executive Director	John Keddie
~~CFO~~ Director of Finance	~~Trevor Smith~~ Saba Sadiq
~~CMO~~ Medical Director	~~Marcelle Michail~~ Fay Gilder
Chief Operating Officer	Stephanie Lawton
Attendees	
NHSE/I Land and Planning Advisor – Kevin Hopkinson Deputy Programme Director – Helen Davis ~~Senior Estates Advisor – Mark Cammies~~ Hospital Construction Specialist - Andrew Panniker CCG Representative - ~~TBC~~ Peter Wightman Representative from NHSE/I - Simon Wood/Nigel Littlewood Deputy Medical Director - Jon Keene	
Secretariat	
Corporate secretariat	

BOARD OF DIRECTORS – 11.06.21

Agenda Item: 6.1

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Pam Court - PAF Chairman
DATE OF COMMITTEE MEETING: 27.05.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **Committee's Annual Effectiveness Review 2020/21** – Members noted the areas for improvement highlighted in the review which were:
 - Quality of papers – request for papers to be high level and more concise, front sheets to be clearer
 - Timeliness of papers – on occasions papers are circulated late with little time for members to read in advance of the meeting.
 - Composition/skill of committee members – when the Chairman leaves the Trust the committee will be without a NED with a financial qualification (post meeting note: this has been addressed).
 - Agenda and timings – on occasion the agenda is too full which has resulted in discussions on some items being curtailed.
 - Follow up of outstanding actions – actions are not always completed by the next meeting.

PAF also approved the Committee's revised Terms of Reference (see appendix 1), following revisions to the sections relating to CQUIN and oversight of temporary staffing spend.

- **Business cases:** PAF reviewed and endorsed the case for Backlog Maintenance and requested some additional work on the case for an Aseptic Unit.
- **M1 Update** - At 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 which reconciled to ICS funding envelopes. The position for April was break-even which was consistent with that plan. YTD capital spend was £1.4m and in-line with plan and cash balances were £63.4m and sufficient for trading operations.
- **BAF Risks** – The following were agreed: BAF Risk 5.1 (Finance) to be split into two risks (5.1 revenue and 5.2 capital) and both risks to be scored 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 with approval on the revised risk narrative. BAF Risk 3.1 (Estate & Infrastructure) score to remain at 20.
- **EPR Update** – approval had now been received to proceed to Outline Business Case (OBC).
- **Estates & Facilities Annual Report** – Despite a challenging year, some good progress had been made in terms of the modernisation of services and delivery of the capital plan. PAF noted the recent five star hygiene rating for the Trust's catering service.
- **New Hospital Update** – Work continued on OBC development.

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

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

- Capital Programme 20/21 and 21/22
- Annual Operating Plan
- Business Planning Proposal
- M1 Integrated Performance Report

6.1

• EPR Update • Procurement Reports • Estates Strategy • Health & Safety Update • Annual Report into the Trust's Sustainable Development Management Plan and Carbon Reduction and Sustainability Strategy
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The Committee continues to make progress against its work plan.

PERFORMANCE AND FINANCE COMMITTEE

TERMS OF REFERENCE 20210/221

PURPOSE:

The purpose of the Performance and Finance Committee (PAF):

- Consider, challenge and recommend the Trust's Operating Plan to the Board.
- Scrutinise operational and financial performance and monitor achievement of national and local targets and recommend any re-basing or re-forecasting of operational and financial performance trajectories to the Board;
- Assure the Board of Directors that the Trust has robust processes in place to prioritise its finance and resources and make decisions about their deployment to ensure that they best meet patients' needs, deliver best value for money and are efficient, economical, effective and affordable.
- Recommend the Trust's Cost improvement programme to the Board and monitor its delivery including investigating reasons for variance from plan and recommend any re-basing or re-forecasting of the Plan to the Board;
- Monitor the management of the Trust's asset base and the implementation of the Trust's enabling strategies in support of the Trust's clinical strategy and clinical priorities;
- Review and monitor the management of finance, performance and contracting risks.

DUTIES:

The following comprise the PAF's main duties as delegated by the Board of Directors:

Financial Management

1. Consider the content of, planning assumptions, key risks and principles underpinning the Operating Plan prior to submission to the Board for approval.
2. Where there is variance against plan, agree any re-base or re-forecast and ensure appropriate actions are put in place for recovery.
3. Approve the Capital Programme as part of the budget setting process and monitor progress against the plan.
4. Approve the process for the submission of the National Reference Cost Return prior to submission and review the results.
5. Review the implementation of the Trust's plans for Service Line Management.
6. Review compliance with agency cap and spend.
7. Review financial performance and forecast against income, expenditure, working capital and capital and seek assurance that the position is in line with approved plans, targets and milestones and that any corrective measures that are being taken are effective
8. Review significant risks associated with the forecast outturn.
9. Review the Treasury Management Policy, receive reports in accordance with the Policy and approve institutions.
10. Review arrangements for effective compliance reporting in respect of loans and other requirements

Operational Performance

1. Agree the annual operational performance plan including annual trajectories for each local and national target, including CQUINs.
2. Scrutinise operational performance and including the investigation of reasons for variance from plan.
3. Recommend any re-basing or re-forecasting of annual performance trajectories to the Board.
4. Advise the Board of any penalties likely/due to be incurred as a result of performance variance.
5. Monitor the strategic and operational systems and processes to ensure the competent performance management of the organisation

Cost Improvement

1. Agree the level of the Cost Improvement Programme and recommend the /Cost Improvement Programme to the Board.
2. Monitor delivery of the Trust's Cost Improvement Programme including the investigation of reasons for any variance from plan.
3. Recommend any re-basing or re-forecasting of the Programme to the Board and advise of the reasons why this is necessary;
4. Provide the Board with assurance on the progress and delivery of the programme.

Contract Management

1. Review the Trust's negotiating position prior to annual contracting round with commissioners.
2. Review financial and performance activity against contracts and if corrective action is required, receive assurance that the measures being taken are effective.
3. Consider any tender opportunities with an annual income value exceeding £1m.

Workforce

1. Maintain oversight of expenditure on temporary staffing.
- 1-2. [Ensure that there is a link between recruitment and the reduction in temporary staffing costs.](#)

Procurement

1. Oversee the implementation of the Trust's Procurement Strategy.
2. Receive an annual report in respect of the Annual Procurement Plan.
3. Receive regular updates on the Procurement pipeline

Business Cases, Benefits Realisation and Return on Investment

On behalf of the Board:

1. Undertake a robust appraisal of new business cases and re-investment business cases valued at over £1m, ensuring that the outcomes and benefits are clearly defined, measurable, support the delivery of key objectives for the Trust and that they are affordable.
2. Review benefits realisation and return on investment of major projects.

Capex

1. Consider any significant infrastructure investment prior to proposals being put to the Board for consideration/approval.

2. Monitor the implementation of the Trust's Information Technology strategy and Estates Strategy.
3. Consider any estate disposal, acquisition or estate change of use in accordance with the Trust's Strategy and recommend to the Board.

Estates, Facilities & Sustainability

1. Oversee the implementation of the Trust's Carbon Reduction and Sustainability Strategy.
2. Receive an annual report in respect of the Trust's Sustainable Development Management Plan.
3. Review the Trust's arrangements for estates and facilities management

Health and Safety:

Maintain oversight of Health & Safety including radiation use and protection guidelines (IR(ME)R), fire safety and decontamination.

Information Management, Data Quality and Coding

1. Oversee the Trust's information management, coding and data quality arrangements and review progress against key metrics.
2. Monitor the implementation of the annual Information Management Plan.

Resilience & Business Continuity

1. Undertake an annual review of the Trust's resilience & business continuity arrangements,
2. On behalf of the Board, review how the Trust is upholding its duties to fulfil its duties as a Category 1 responder under the Civil Contingencies Act 2004 and recommend a report to the Board in respect of these.

Risk

1. Monitor and review any risks allocated to the PAF.
2. Review and monitor finance, performance and contracting risks and seek assurance that plans/actions are in place to mitigate identified risks.

Annual Work Plan and Committee Effectiveness

1. 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 PAF meeting and advise of progress against the PAF's Annual Work Plan.

CHAIRMAN:

Non-Executive Director.

COMPOSITION OF MEMBERSHIP:

The PAF 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
- ~~Chief Financial Officer~~ Director of Finance
- Chief Operating Officer
- Director of Strategy
- Chief Information Officer

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

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

At least one of the Non-Executive Director/ members of the PAF shall also be a member of the Trust's Audit Committee.

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

All members will have one vote. In the event of votes being equal, the Chairman of the PAF will have the casting vote. Deputies attending the PAF 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 PAF. An attendance register shall be taken at each meeting and an annual register of attendance included in the PAF's annual report to the Board.

The Chairman and Chief Executive in their capacity as ex officio members are expected to attend five out of eleven meetings in each reporting period.

In addition to the members of the Board, the following shall be expected to attend each PAF meeting:

- Deputy Director of Finance ~~Chief Finance Officer/s~~
- Director of Information & IT

To ensure appropriate accountability, others will be invited to attend when the PAF is discussing areas of risk or operation that are their responsibility.

Internal Auditors to attend meetings by exception, as required to present reports of any audits conducted by them in respect of issues within the scope of the PAF.

DEPUTISING ARRANGEMENTS

In the absence of the Committee Chairman, another Non-Executive Director member of the PAF 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 of the PAF shall be the attendance of a minimum of two Non-Executive members and two Executive members or their deputies (who may attend with the permission of the Chief Executive Officer).
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:	~~Chief Financial Officer.~~ <u>Director of Finance</u>
MEETING FREQUENCY:	Meetings of the PAF shall be held 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 PAF 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 PAF 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 PAF. The PAF 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 PAF shall be reviewed at least annually and presented to the Trust Board.
DATE APPROVED:	By PAF: ~~30 April 2020~~ <u>27 May 2021</u> By Trust Board: ~~7 May 2020~~ <u>11 June 2021</u>

PERFORMANCE & FINANCE 2021/22 MEMBERSHIP

Membership and Those in Attendance	
Members	
Chairman - Non-Executive Director	Pam Court
Non-Executive Director	George Wood
Associate Non-Executive Director	John Keddle
~~Chief Financial Officer~~ Director of Finance	~~Trevor Smith~~ Saba Sadiq (Lead Exec)
Chief Operating Officer	Steph Lawton
Director of Strategy, <u>Estates & Facilities</u>	Michael Meredith
<u>Chief Information Officer</u>	<u>Phil Holland</u>
<u>NEXT NED</u>	<u>Darshana Bawa</u>
In Attendance	
Deputy <u>Director of Finance</u> ~~Chief Financial Officer~~	~~Simon Covill~~ TBC
Director of Information and IT	Lynne Fenwick
In Attendance (right to attend reserved)	
Trust Chairman (to attend 5 out of 11 meetings)	~~Steve Clarke~~ TBC
Chief Executive (to attend 5 out of 11 meetings)	Lance McCarthy
Secretariat	
Head of Corporate Affairs	Heather Schultz
Board & Committee Secretary	Lynne Marriott

6.1

BOARD OF DIRECTORS – 11.06.21

Agenda Item: 6.1

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)
REPORT FROM: Helen Glenister – QSC Chair
DATE OF COMMITTEE MEETING: 28.05.21 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **Committee's Annual Effectiveness Review 2020/21** – Members noted the areas for improvement highlighted in the review which were:
 - Timeliness of papers – on occasions verbal updates are provided.
 - Composition/skill of committee members – medical input representing Health Care Groups had improved, however not all HCGs had medical representation, so could be improved further.
 - Is the Committee challenged or constrained in any way in discharging its duties – It was noted that there was some overlap with other committees, and sometimes further clarification was required. Also NEDs were attending feeder groups to further understand and inform the framework for items that are raised and escalated at QSC.
- QSC also approved the Committee's revised Terms of Reference (see appendix 1), with the caveat that some thought should be given to how 'forward-facing/strategic' the Committee was.
- **Infection Control Update** – Members noted that cases of *C-difficile* continued to remain higher than normal. Antibiotic stewardship would be a continued area of focus and there were plans for a round table discussion to understand further areas for reducing the risk. The hospital continued to have low numbers of new positive patients. Consideration was being given to options for managing an on-going small cohort of positive patients. Due to the emerging variants, teams would need to remain vigilant in isolating patients arriving from abroad. Data to date was showing there had been no new variants present in any patients cared for at PAH. An area of focus for clinicians would be continued vigilance around the vaccination status of patients. A gap analysis for the management of COVID-19 was presented to the Committee which demonstrated the Trust had effectively undertaken a self-assessment of its compliance in the management of COVID-19, and specifically in relation to the seven domains that the Health and Safety Executive (HSE) had used to measure compliance in other Trusts. The gap analysis identified areas of good practice as well as gaps/risks to current practice and the steps required to rectify those.
 - **Mental Health Deep Dive:** Partners (EPUT/NELFT) presented a deep dive into mental health services which highlighted the challenges around the availability of Tier 4 beds for patients and the plans in place to try to address that.
 - **IRMER Report** - The Committee received a copy of the report setting out the key findings from the recent CQC inspection of compliance with Ionising Radiation (Medical Exposure) Regulations 2017 IR(ME)R. An action plan would now be submitted to address requirements.
 - **BAF Risks:** The following were agreed: BAF Risk 1.0 (COVID) risk score to reduce from 16 to 12 and the target risk score to reduce to 12. BAF Risk 1.1 (Clinical Outcomes) risk score to remain at 16.

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

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

- Report from Clinical Effectiveness Group
- Report from Strategic Learning from Deaths Group (verbal)
- Learning from Deaths Update

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|--|
| <ul style="list-style-type: none">• Report from Patient Safety Group• Annual Report: Patient Safety, Quality & Effectiveness• Maternity SI Report• Update from Patient Panel• Cancer, Cardiology & Clinical Services – Quarterly Performance Update• M1 Integrated Performance Report (IPR) |
| |
| SECTION 3 – PROGRESS AGAINST THE COMMITTEE’S ANNUAL WORK PLAN |
| <ul style="list-style-type: none">• The Committee continues to make good progress against its work plan. . |

QUALITY & SAFETY COMMITTEE

TERMS OF REFERENCE 2021/22

6.1

PURPOSE:

The Quality & Safety Committee (QSC) functions as the Trust's umbrella clinical governance committee. It enables the Board to obtain assurance that high standards of care are provided by the Trust and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to enable it to deliver a quality service according to each of the dimensions of quality set out in *High Quality Care for All* and enshrined through the Health & Social Care Act 2012:

- **Clinical Effectiveness** – consistently achieving good clinical outcomes and high levels of productivity through evidence-based clinical practice.
- **Safety** – achieving high and improving levels of patient and staff safety and identifying, prioritising and managing risk arising from the delivery of clinical care.
- **Patient Experience** – promoting safety and excellence to deliver an excellent patient experience as measured by direct interaction with, and feedback from, those using the Trust's services.

DUTIES:

The following comprise the QSC's main duties as delegated by the Board of Directors:

Evidence-Based Clinical Practice

1. To receive assurance on action taken to improve mortality rates as part of the Trust's mortality review process and to receive a monthly update on Learning From Deaths.
2. To ensure there is a well-functioning and effective process for considering and implementing guidance from the National Institute for Health and Clinical Excellence (NICE) and National Service Frameworks, recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and responding to National Patient Safety Agency (NPSA) Alerts.
3. To receive assurance in respect of the delivery of any action plans arising from reviews or investigations into safety and or quality by healthcare regulators, inspectorates, accrediting bodies or Royal Colleges.

Compliance

1. To monitor the Trust's compliance with the Care Quality Commission's (CQC) registration criteria and oversee any remedial action required
2. To ensure the Trust complies with the NHS Litigation Authority (NHS LA) **Resolution** risk management standards and the **Clinical Negligence Scheme for Trusts (CNST)** maternity **Maternity Incentive Scheme** standards.
3. To undertake quarterly "deep-dives" into the work of each Healthcare Group via a Quality & Safety Performance Report to review quality and safety performance according to the CQC domains with the Triumvirate in attendance for their presentation.

4. To ensure the Trust complies with recommendations from the National Quality Board.
5. To receive regular reports on the Trust's infection control arrangements and receive assurance on remedial measures taken to handle the outbreak of infection.
6. To receive regular reports on the Trust's compliance with Safeguarding requirements and matters concerning **Liberty Protection Safeguards** ~~Deprivation of Liberty~~, **Mental Health** and Mental Capacity Act.
7. To receive recommendations on the Trust's annual Quality Account priorities and monitor their in-year progress.

Audit

1. To receive the annual Clinical Audit Programme and ensure that it is in line with the audit needs of the Trust prior to commencing it for approval by the Board. Monitor its in-year progress including actions taken to address audit concerns.
2. To make recommendations concerning the annual programme of Internal Audit work to the extent that it applies to matters within the remit of the QSC and consider the major findings of quality related Internal Audit reports (including the management response).
3. To be assured that recommendations from all clinical audits are robustly implemented in practice and desired outcomes are achieved.

Research and Development

1. To ensure the Trust has an effective Research and Development Strategy in place and produces an annual Research and Development Report to the Trust Board.
2. To review governance arrangements for Research and Development activity within the Trust including Clinical Ethics.
3. To receive six monthly reports from the Research & Development Group.

Learning when Things Go Wrong

1. To review the risks allocated to the QSC from the Board Assurance Framework and receive assurance that actions are in place to effectively manage and control the risks identified.
2. To ensure there are clearly defined and well understood processes for escalating safety and quality issues and meeting the Trust's obligations in respect of Duty of Candour with patients and families.
3. To consider regular reports identifying the trends and themes arising from claims, litigation, incidents (including STIs) and complaints and the management actions being taken to reduce risks and learn lessons.

Records and Confidentiality

1. To oversee the Trust's policies and procedures in respect of the use of clinical data and patient identifiable information to ensure that this is in

accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act.

2. To review, on an annual basis, the Trust's systems for the Management of Medical Records.

Patient Experience

1. To review the Trust's arrangements for managing complaints and PALS contacts.
2. To ensure the Trust has an effective system for patient feedback (including Friends and Family Test, patient environment and amenities) and patient involvement.
3. To undertake a review of the findings of any national patient surveys including any relevant action plans.

General Governance

1. To consider matters referred to the QSC by the Board or by the groups which report to it.
2. Every year, to set an annual Work Plan and conduct a review of the Committee's effectiveness (including the achievement of the Work Plan and a review of the Committee's terms of reference) and report this to the Board.
3. To ensure a system is in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest.
4. ~~As required, to~~ review any relevant Trust strategies relevant to the Committee's terms of reference (e.g. those associated with clinical quality, clinical effectiveness, health and safety, patient experience) prior to approval by the Board and monitor their implementation and progress.
5. To consider the arrangements for the assessment by the ~~Chief Medical Director Officer~~ and Director of Nursing, Midwifery & Allied Health Professionals on the safety and quality impact of the schemes within the Trust's Cost Improvement and Transformation Programme.
6. On behalf of the Performance & Finance Committee, to consider the clinical and safety aspects of all business cases worth more than £1m prior to their consideration by the Trust Board.

6.1

ACCOUNTABLE TO:

Trust Board.

REPORTING:

A highlight report prepared by the QSC Chairman supported by the Director of Nursing, Midwifery & Allied Health Professionals will be presented to the next meeting of the Board. The report shall set out areas requiring the Board's attention and report on the level of assurance provided by the QSC meeting; it shall also demonstrate progress against the QSC Annual Work Plan.

CHAIRMAN:

Non-Executive Director.

COMPOSITION OF MEMBERSHIP:

The QSC is comprised of Executive and Non-Executive Directors appointed by the Board. The agreed membership is:

- Chair - Non-Executive Director
- Non-Executive Director
- Non-Executive Director
- Director of Nursing & Midwifery and Allied Health Professionals
- Medical Officer-Director
- Chief Operating Officer
- Director of Quality Improvement
- Director of Clinical Quality Governance
- Deputy Chief Medical Officer-Director (Quality)
- Deputy Director of Nursing

The Chairman of the QSC shall be appointed by the Chairman of the Trust Board; ideally s/he shall have recent and relevant experience of NHS quality and safety.

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

The Chairman and Chief Executive of the Trust shall be ex officio members and will be invited to all meetings.

One of the NED members of QSC shall also be a member of the Trust's Audit Committee.

Other members of the Executive Team or management may be called to attend the meeting if required.

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

ATTENDANCE:

Members are expected to make every effort to attend all meetings of the QSC and it is expected that they will attend nine out of eleven Committee meetings within each reporting year. An attendance register shall be taken at each meeting and an annual register of attendance will be included in the QSC's annual report to the Board.

The Chairman and Chief Executive in their capacity as ex officio members are expected to attend five out of eleven Committee meetings in each reporting year.

The Chair of the Patient Panel will be a lay member of the QSC.

In addition to the members identified above, the following will be invited to attend when there is a deep dive into relevant Health Care Group or topic discussion

- Associate Medical Directors
- Associate Directors of Nursing
- Associate Director of Governance & Quality
- Associate Director, Patient Engagement & Experience Team
- ~~AMD for Quality First~~

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 QSC.

DEPUTISING ARRANGEMENTS:	In the absence of the Chair of the Committee, another Non-Executive Director appointed by the members of the Committee will chair the meeting. Other deputies may attend on behalf of executive members but must be suitably briefed and, where possible, designated and notified in advance.
QUORUM:	The quorum for any meeting of the QSC shall be the attendance of a minimum of two members of which one shall be a Non-Executive Director and one shall be either the Director of Nursing, Midwifery & Allied Health Professionals or the Medical Director Officer.
DECLARATION OF INTERESTS:	All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.
LEAD EXECUTIVE	Director of Nursing, Midwifery & Allied Health Professionals.
MEETING FREQUENCY:	Meetings of the QSC shall be held: • Monthly • Usually on the fourth Friday of Board cycle from 09.30 to 12.30 • At such other times as the Chairman of the QSC shall require.
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 (though lay members will be permitted to attend). • The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee. • A draft agenda shall be developed by the Head of Corporate Affairs and Lead Executives and agreed by the Committee Chair at least ten clear days* before the next Committee meeting. • All final Committee reports must be submitted six clear days* before the meeting. • The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees three clear days* before the date of the meeting. *'clear day' means any day which is not a Saturday or Sunday or a public or bank holiday.
AUTHORITY:	The QSC 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 QSC 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 QSC. The QSC is authorised by the Trust Board to request the attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this necessary.
TERMS OF REFERENCE:	The terms of reference of the QSC shall be reviewed at least annually and presented to the Trust Board for approval.

DATE APPROVED:

By QSC: 28 May 2021
By Trust Board:

6.1

BOARD OF DIRECTORS**MEETING DATE:** 11/06/2021**AGENDA ITEM NO:** 7.1**REPORT TO THE BOARD FROM:**

Workforce Committee (WFC)

REPORT FROM:

Helen Howe (Committee Chair)

DATE OF COMMITTEE MEETING:

01/06/2021 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD’S ATTENTION

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

Workforce report: The workforce metrics were reviewed and an update was received on improvement in Trust vacancies, reduction in agency spend and overall improvement in sickness absence.

Health and Wellbeing: A health and wellbeing steering group had its first meeting and agreed a health and wellbeing strategy would be developed.

Disciplinary Process: The Trust Disciplinary Policy was being reviewed and updated, in accordance with guidance received from NHSE/I.

Medical Staffing Model: An update was provided on the medical staffing model for medicine and noted an investment ('business') case was planned for Health care group board approval and then onward using a newly refined corporate investment process. Issues were identified regarding the plan not addressing the medical staffing issue Trust wide.

BAF risk 2.3 Inability to recruit, retain and engage our people: Recommended that risk score remain 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
- People, organisational development and communications (PODC) governance structure
- 100% compliance of the annual Fit and Proper Person Test
- Staff Survey 2020 results response plan: To note the 3 priorities identified from the staff survey

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

The Committee continues to make progress against its work plan and will meet again on Monday 26 July 2021.

6.1

BOARD OF DIRECTORS – 11.06.21

Item No: 6.1

REPORT TO THE BOARD FROM:

Senior Management Team (SMT)

CHAIR:

Lance McCarthy - Chairman

DATE OF MEETINGS:

4, 11 and 18 May 2021

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

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

4th May 2021:

- HGC Structures
- CIP Opportunities

11th May 2021:

- Quality Briefing
- Patient Initiated Follow Up Process
- Workforce Strategy Development – New Hospital
- Staff Survey results
- CQC Inspection Report to ED
- Half Year 2021/22 Planning Submission
- CIP Workshop Update
- Business case governance process
- Financial Update: M1 update and Capital Programme

18th May 2021:

- PAHT 2030
- Cause of Death Process SoP
- New Hospital: Anaesthetic Rooms Proposal
- H1 Operating Plan
- Capital & Revenue Investment
- M1 Financial Planning
- Business Planning
- Aseptic Unit Business Case
- Pharmacy Robot Business Case
- Backlog Maintenance Business Case

6.1