The Princess Alexandra Hospital NHS Trust

AGENDA

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

Date and time: Thursday 3 December 2020
09.30 – 12.30

Venue: Microsoft Teams Meeting

	Item	Subject	Action	Lead	
01 Opening Administration					
09.30	1.1	Apologies	-		
	1.2	Declarations of Interest	-	Chairman	
	1.3	Minutes from previous meeting	Approve	Chairman	4
	1.4	Matters Arising and Action Log	Review	All	14
02 Staff Story					
09.35	2.1	Patient Story	Inform		Pres
03 Risk					
10.00	3.1	CEO's Report including: • Covid-19	Inform	Chief Executive	15
10.20	3.2	Significant Risk Register	Review	Director of Nursing	19
10.30	3.3	Board Assurance Framework 2020-21	Review/ Approve	Head of Corporate Affairs	23
04 Patients					
10.40	4.1	New Hospital Programme update	Discuss/ Approve	Director of Strategy	38
10.55	4.2	Mortality	Discuss	Medical Director	44
11.05		**BREAK**			
11.15	4.3	Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	Discuss	Director of Nursing & Midwifery	52
11.25	4.4	Nursing, Midwifery and Allied Health Professionals Strategy	Approve	Director of Nursing & Midwifery	61
05 Performance and People					
11.35	5.1	Integrated Performance Report (IPR)	Discuss	Executives	71
11.50	5.2	Workforce Race Equality Standards	Discuss	Director of People	112
12.05	5.3	Healthcare Worker Flu Vaccination Best Practice Management Checklist	Approve	Director of Quality Improvement	136
06 Governance					
12.10	6.1	Reports from Committees: • NHC.23.11.20 • PAF.26.11.20 • QSC.27.11.20 • WFC.30.11.20 (verbal) • SMT.10.11.20	Inform/ Approve	Chairs of Committees	139 140 141 Verbal 143

12.20		Corporate Trustee: • Report to the Corporate Trustee from CFC.18.11.20 (including Terms of Reference) • The Princess Alexandra Hospital NHS Trust Charitable Fund Annual Report and Accounts 2019-20	Inform Approve	Chair of CFC	144 148
07 Questions from the Public					
12.25	7.1	Opportunity for Members of the Public to have a pre-submitted question answered.			
08 Closing Administration					
12.30	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	
	8.4	Reflection on Meeting	Discuss	All	

The Princess Alexandra Hospital NHS Trust

Public Board Meeting Dates 2020/21

02.04.20	01.10.20
04.06.20	03.12.20
06.08.20.	04.02.21

Purpose:

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

Quoracy:

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

Ground Rules for Meetings:

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

Board Membership and Attendance 2020/21			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chairman	Steve Clarke	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC) and Senior Independent Director	George Wood	Acting Chief Finance Officer	Simon Covill
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 Nursing & Midwifery	Sharon McNally
Chair of Charitable Funds Committee (CFC)	Dr. John Keddie	**Executive Members of the Board (non-voting)**	
Chair of Strategy Committee (SC)	Dr. John Hogan	Director of Strategy	Michael Meredith
		Director of People	Gech Emeadi
		Director of Quality Improvement	Jim McLeish
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Virtual Trust Board Meeting in Public
Thursday 1 October 2020 from 09:00 – 11:45

Present:	
Steve Clarke	**Trust Chairman (TC)**
Pam Court	Non-Executive Director (NED-PC)
Simon Covill	Acting Chief Financial Officer (ACFO)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Helen Howe	Non-Executive Director (NED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Lance McCarthy	Chief Executive Officer (CEO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Marcelle Michail	Acting Chief Medical Officer (ACMO)
George Wood	Non-Executive Director (NED)
In attendance:	
Dr. Amik Aneja (attended late)	General Practitioner (GP-AA), Board Advisor
Laura Warren	Associate Director - Communications
Members of the Public	
Trevor Arnold	Siemens Healthcare
Clare Rose	Crown Commercial Service
Apologies:	
None	
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chairman (TC) welcomed all to the virtual Board meeting.
1.1 Apologies	
1.2	No apologies were noted. It was noted that GP-AA would be slightly late joining.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Meeting held on 06.08.20	
1.4	These were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising. The action log was noted and that both items were closed.
02 STAFF STORY	
2.1 Staff Story (Monica Bose – Consultant Gastroenterologist)	
2.1	The Director of People (DoP) welcomed Monica Bose, Associate Medical Director for Cancer, Cardiology and Clinical Services (AMD-CCCS) and Consultant Gastroenterologist to the meeting, who took members through her experience of shielding during the COVID pandemic.
2.2	The AMD-CCCS informed members that on 23.03.20, the first day of lockdown, she had been 'consultant of the week' on Harvey Ward and had just been appointed the AMD for CCCS.
2.3	Her experience of being told she had to shield had been one of shock. She had felt guilty and remote from her patients and colleagues. She had experienced feelings of anxiety as to what she would be able to deliver clinically and, in her new role as AMD whether she would

	still be able to provide leadership and support for her colleagues. Further still, she was concerned about supporting her trainees.
2.4	Those feelings of anxiety had then turned to ones of opportunity and thoughts of new/agile ways of working. There would be opportunities in terms of using new technology for meetings and virtual patient contact, and benefits in terms of reduced carbon footprint (no commute) and reduced use of paper (sharing documents on screen in virtual meetings).
2.5	She acknowledged, as shielding staff had returned to work recently, that concerns had been raised in some areas that colleagues had felt unsupported by their managers during their time away. That had not been the case for her and she thanked colleagues present at the meeting for their support throughout the period.
2.6	The DoP thanked the AMD-CCCS for her reflections and acknowledged that not all staff experiences of shielding had been as positive as hers. Some had felt lonely and had been grateful for webinars where they could link in with other shielders. She acknowledged the organisation was acutely aware that some staff had less than optimal contact with line managers but she assured those present that lessons had been learned – the biggest of which had been there was no substitution for a manager picking up the phone and asking as to the welfare of colleagues.
2.7	The CEO thanked the AMD-CCCS for a very honest and open reflection and to hear that change could be an opportunity rather than a threat. He thanked her for her leadership in CCCS during a time of personal anxiety and as the DoP had acknowledged earlier, agreed that shielding experiences had been better for some staff than others. He encouraged the AMD-CCCS to share her story at one of the organisation's Schwartz Rounds.
2.8	In response to the comments above the TC emphasised it was important for all colleagues to look out for each other, not just managers.
2.9	The Chief Operating Officer (COO) thanked the AMD-CCCS for her leadership during the pandemic and for promoting new ways of working, particularly in relation to communicating with patients. She encouraged her to share her learning with colleagues across the organisation.
2.10	In response to a question from Non-Executive Director Helen Howe (NED-HH) it was confirmed that the AMD-CCCS was the organisation's only consultant 'mental health first aider', and more should be encouraged to take on that role. Around 30 members of staff had completed Mental Health First Aider training and TRIM training had also been launched.
2.11	The Director of Nursing & Midwifery (DoN&M) thanked the AMD-CCCS for reflecting on her journey. She emphasised the importance to all colleagues of not losing momentum and resilience when faced with challenges and new ways of working.
2.12	NED Helen Glenister (NED-HG) agreed with the above and asked the AMD-CCCS how her colleagues had responded to the challenges posed by the pandemic. In response the AMD-CCCS confirmed that the PAH ethos was about supporting each other. It had been comforting to receive a letter from the CEO during the shielding period acknowledging that colleagues were working from a distance. In her opinion the executive team had modelled excellent behaviour by working differently (at home or at Kao Park). Whilst she had been unable to work on her ward and be with colleagues face-to-face, she confirmed the majority of colleagues had been supportive. In terms of her patients she stated they had very much welcomed their virtual appointments which removed issues around waiting times and car-parking.
2.13	In terms of staff who had shielded, NED George Wood (NED-GW) stated there was a balance to be achieved. Some would require more support than others and he asked executive colleagues to consider that moving forward.
2.14	In response to the above NED John Hogan (NED-JH) asked in the event of a second wave, did the organisation now know exactly who would be shielding and how they could be contacted so that no-one fell through the net. The DoP confirmed that the organisation had reflected hard and was aware of what had worked (and what not) and what needed to be done to improve the position in the event of a second wave. Support was available for all staff, not just shielders, and particularly for those on the front line too.

2.15	As a final point the AMD-CCCS added that her experience would provide a platform for the move to a new hospital, and as one of the clinical leads working on the programme, that would be invaluable.
2.16	The TC thanked her for her honest and opinion reflection.
2.17	At this point in the meeting the TC welcomed two members of the public to the meeting (see attendance above).
03 RISK	
3.1 CEO's Report	
3.1	The CEO presented his report and informed members a potential second wave of COVID was starting with increased positive presentations to the hospital, albeit at a slightly slower rate than at the start of wave one. As of the previous day there had been nine positive inpatients, one of whom was on a ventilator and one on CPAP. As a result the decision had been taken the previous day to move the red ED back to the front of the hospital with Harold Ward now the nominated ward for COVID patients. Clear plans and thresholds were in place and cases in the community and through the front door would be closely tracked. He cautioned that if a second wave did materialise, that would severely impact the hospital's elective surgical pathway.
3.2	The CEO thanked the COO and DoN&M for their role in the ramping up of the restoration of services. There had been a huge amount of work undertaken over the last couple of months to provide speedy access to diagnostic, elective, and day case surgery. An additional CT and MRI scanner were supporting diagnostic capacity and a third Endoscopy room had been established. A huge amount of changes had been made to the way day case/elective surgery were untaken and activity was almost back to pre-COVID levels, however that could change over coming weeks if the increase in positive cases continued.
3.3	In response to a question from the TC, the CEO confirmed the organisation was absolutely safe for all patients and was now zoned to protect those patients coming in. The DoN&M added that in addition there was now rapid testing for patients on the emergency pathway who could then be appropriately zoned in a more timely manner. Track and trace at day five was in place for any hospital acquired cases and currently the organisation was seeing no nosocomial infections.
3.4	In response to a question from NED-HH it was confirmed that the capacity cap on ITU remained and work was underway around regional escalation for ITU capacity to ensure the sickest patients across the region were managed appropriately. The Acting Chief Medical Officer (ACMO) was able to add that the guidance around treating COVID patients was different for a second wave and there was now a threshold for when patients should be transferred out; capacity in ITU should not exceed 200%.
3.5	NED-GW asked whether the hospital was seeing the return of previous COVID patients now with respiratory issues. In response the ACMO stated she believed primary (not secondary) care was starting to see patients who had been impacted by the first wave. In her view winter was going to be very challenging.
3.6	The CEO continued that in terms of winter planning a two storey adult assessment unit was planned for the front of the building and ground works had begun. One floor would be open by Christmas and the other by January. In addition a Level 1 facility and ventilation service would soon be up and running to support patients and allow Level 3 facilities (critical care) to be split (red/green)in the event of an increase in COVID patients. The Trust's 'flu campaign had begun the previous week with 30% of staff already vaccinated.
3.7	In terms of the organisation's AGM and Events not in a Tent (ENIAT) he thanked all those who had participated in the virtual events, both of which had been a huge success. His thanks went to the Communications Team for their organisation of both. One of the highlights from the latter had been the session to celebrate nurses, midwives and AHPs into which Ruth May (the country's Chief Nursing Officer) had dialled. Two of the Trust's nurses had received a silver Chief Nurse award during the session, of which the organisation was very proud. He thanked NED colleagues for their input, some of whom had shared stories about their own careers.

3.8	The TC thanked the CEO for his update and colleagues for all their efforts in the AGM/ENIAT.
3.2 Significant Risk Register	
3.9	This paper was presented by the DoN&M and members noted, in line with the discussion at the last Board meeting, the number of risks scoring 16 or 20 was reducing in line with the work taking place as part of the capital/investment programme. There were no specific items to flag to the Board and she was able to confirm that some additional expertise would be available to the organisation over the coming three months to review and refresh processes.
3.10	NED-JH asked a question in relation to the risk around out of hours GI bleed. In response the DoN&M confirmed some work was underway to review the rota so that a service could be provided. All patients were reviewed by the huddle at 17:00 hours to ensure any patient at risk of requiring a scope out of hours would be picked up and actively managed for transfer out. The COO was able to add that the AMD for Medicine had reached an agreement with partners locally (Lister Hospital/West Herts Hospital) for out of hours emergency support. A service line agreement was being drafted (ambulance service being made aware) and it was hoped that would be finalised very soon. The ACMO confirmed there had been discussion around the issue at the Medical Director East of England network and the DoN&M added that patient safety was paramount and the new arrangement would address the CQC's Section 29 notice. NHSE/I had been kept fully updated along with the CQC.
3.3 Board Assurance Framework (BAF) 2020/21	
3.11	This item was presented by the Head of Corporate Affairs (HoCA). She updated there were no changes to the risk scores that month. The CEO stated that in his opinion the BAF should drive agenda items moving forward, provide assurance and initiate broader conversations such as the one above by NED-JH in relation to out of hours GI bleed.
3.12	The Board approved the BAF.
04 PATIENTS	
4.1 New Hospital	
4.1	This item was presented by the Director of Strategy (DoS). He thanked colleagues for their input to date in terms of the models of care, clinical model and demand and capacity analysis, particularly the ACMO. There had been huge clinical engagement across the organisation and also from operational teams. All documents presented that day had been approved by the New Hospital Committee, Senior Management Team (SMT) and the Executive Management Team (EMT). The Design Brief was a working document and would evolve overtime. Approval that day was sought on: demand and capacity modelling, models of care, technology and partnering strategy and design brief.
4.2	Demand & Capacity Modelling In terms of the demand and capacity analysis there had also been external sign-off by the ICS/CCG. A key area to note was the change in population estimates from the 2016 data in the PCBC - there was now a significant reduction in expectations and the team was working with the local authority to obtain the best estimates in relation to housing. He also drew members' attention to the significant demand management assumptions linked to the financial plan and models of care.
4.3	In response to the above NED-HH highlighted that the original case, and presumably the funding to be made available, had been predicated on much higher population growth – would there therefore be any impact with the smaller growth now predicted. In response the DoS confirmed the case had been predicated on a 'failed estate' – that had been the underlying case. He did however believe that a 25% increase in demand would still be seen.
4.4	In response to the above Associate NED John Keddie (NED-JK) stated, from what he had heard, residential growth levels were not predicted to be scaled back. In response the DoS stated there were a number of assumptions in the modelling. Those assumptions had to align with those of the Commissioner. However, in terms of the hospital design it was hoped to add some flex to allow for future growth of at least 20%.

4.5	ANED-JK reminded colleagues of his comment at the last New Hospital Committee that the assets (of any new hospital) must be sweated. In response the ACMO assured him that the model of care wouldn't change, it would be the SoA that would be reduced. . As an example (in terms of efficiency assumptions) she cautioned that in relation to the emergency pathway there would always be a theatre not in use, so it was available in an emergency.
4.6	In line with the recommendation, the Board approved the demand and capacity modelling.
4.7	Models of Care (MoC) There had been huge clinical engagement from within the organisation and some significant external engagement from GPs and national/international clinicians. The MoC recognised that healthcare did not stand still and that a new hospital needed to be fit for the future.
4.8	In line with the recommendation, the Board approved the models of care.
4.9	Technology & Partnering Strategy The DoS updated that the strategy had been designed to inform the MoC and the increase in demand – technology would be at the heart at everything. The strategy aligned with that of the national framework.
4.10	In line with the recommendation, the Board approved the technology and partnering strategy.
4.11	Design Brief The brief set out the ambition for the new hospital and would act as a checklist for the architects. It had been drawn up in conjunction with both staff and the public. It was a working document so was likely to change over time until it went out to the contractors. There had been some challenge from SMT so there was more to do on ward design moving forward.
4.12	In line with the recommendation the Board approved the design brief, but recognised it was a working document.
4.13	At this point in the meeting the DoS requested that the work of Chloe Atkinson, Head of Strategy & Development in his team on the new hospital be recognised.
4.14	Programme Risk The paper was taken as read. NED-HH asked whether any of the risks could be 'show stoppers'. In response the DoS confirmed that following previous Board discussions he believed the risks were all manageable and were ones expected at that stage of the programme. Mitigation was in place for all.
4.15	As a final point the CEO reminded colleagues that the Joint Investment Committee (JIC) was taking place that afternoon (prior to the PAH Board's private session).
4.2 Mortality	
4.16	This item was presented by the ACMO. The report had previously been discussed at QSC and the Learning from Deaths (LfD) Group. She updated that the LfD process was now well embedded at the Trust and was informing the work of the improvement programme. She reminded members a few months previously the organisation had been asking itself why it was an outlier in terms of HSMR and SHMI and was that a reflection of its quality of care.
4.16	The organisation had therefore commissioned a mortality expert (Richard Wilson) to undertake a deeper dive into its data. She was able to inform members that the first cut of the outputs of that work had come through the previous evening and early indications were that no marker stood out as directly attributing the mortality rate to the care provided to patients. She cautioned however there were a number of drivers/factors that drove mortality. She reminded members from previous work undertaken (in 2014) it had become clear that the hospital was seeing a higher than average number of elderly and sicker patients, it had been impacted by the closure of another local hospital (QEII) and over recent years its depth of coding had not been where it should be. In addition the provision of palliative care in the community had been an issue with insufficient nursing beds available locally.
4.17	In summary she hoped the work of Richard Wilson would start to reveal the complex drivers around mortality to support the ongoing system conversations and current HCG restructure. However, for now, the early signs of the work which had begun were indicating that higher than expected mortality was not a reflection on the care being provided to patients.

4.18	She agreed that once she had worked her way through all the outputs of the work she would present all the findings to the Board.
ACTION TB1.01.10.20/06	**Present to the Board and QSC the final output of the work undertaken by Richard Wilson around mortality. Lead: Acting Chief Medical Officer**
4.19	The DoQI informed members that he was pleased to see that early indications of the external work were endorsing that the organisation was on the right track to delivering good care. In terms of the recent work around mortality he was pleased to report that data sharing had significantly improved and there were daily reviews of all patients who died in hospital to identify any learning. His intention would be to finalise the programme of work for the second year and present that to both QSC and to the Board, to provide some assurance around mortality as the organisation moved into winter.
4.20	In response to a question from NED-GW in relation to avoidable deaths, the ACMO was able to confirm that learning was shared with other trusts and there were plans in place to undertake mortality reviews as a system (with primary care/community provider). In terms of trauma and vascular, the Trust was part of networks where mortality would be reviewed across that network.
4.21	In response to the above NED-HH stated she was surprised that the update had not included the recent very positive work around coding which involved the coders supporting clinical staff with their coding. In response the ACMO acknowledged that point and the huge amount of work undertaken in that area and the significant improvements made in coding over the last three to four years. There was still some way to go with the ambition being to get the primary diagnosis coded right first time. A pilot had been underway for the previous two weeks to understand how to record that correctly in the notes to support the improvements in coding and the impact would be audited.
4.22	
4.24	The TC thanked the ACMO for her update and that QSC would look forward to seeing the finalised outputs of the work undertaken by Richard Wilson.
Members took a 15 minute break	
4.3 Ophthalmology	
4.25	Members welcomed Board member Dr. Amik Aneja to the meeting.
4.26	The CEO presented this item and reminded members that a number of SIs had been raised in January that year and concerns expressed (by new consultants) that patients were being lost to follow-up. A significant amount of work had since been undertaken with the team to drive both change and improvement. Of circa 4000 patients on the follow-up list almost all had now been seen and any remaining would be seen within the next two weeks. A diagnostic centre had been opened on Gibberd Ward with huge success (and had since been copied by Moorfields). A set of internal professional standards had been established which the team had signed up to and some very positive feedback (both patient and staff) had been received on the new ways of working. There would be ongoing work to link in with the community service to develop a high quality pathway locally.
4.27	In response to the above the COO was able to update that the previous evening she had received some very positive feedback from a 'regular' patient who had offered his congratulations to staff on the way the unit had been reorganised and for a very positive patient experience. As she had informed QSC the previous week, some of the work/learning was now being mirrored in other specialties. In response to the above Dr. Amik Aneja was able to endorse the positive feedback, having had an appointment in the unit himself earlier that day.
4.28	In response to the above ANED-JK was pleased to see the progress made but asked whether assurance could be provided that similar issues were not being experienced in other specialties. The CEO was able to update that some conversations were taking place in relation to follow-up lists in a couple of other areas but concerns there were nowhere near the level they had initially been in Ophthalmology. QSC had received an update on this at the recent meeting and would be kept informed of progress going forward.

4.29	The DoQI was able to provide assurance that the work of the Outpatient Transformation programme now meant that a patient left their outpatient appointment with the date of their next follow-up. By the end of the year it was hoped 'patient initiated follow-up' would be fully rolled out. Both would, in future, negate the requirement for review lists. .
4.30	In response to the comments above the DoN&M reflected on the organisational learning form this and the way in which issues had been handled and the feedback from partners on the Trust's honesty and transparency. –
4.31	The TC thanked colleagues for their update and the assurance provided.
4.4 Nursing, Midwifery and Care Staff Levels including Nurse Recruitment	
4.32	This item was presented by the DoN&M. She acknowledged the variation month on month but overall a positive improvement had been sustained in terms of fill rate. She drew members' attention to the increase in staffing incidents reported on Datix (page 75) which were being tracked to understand the themes. What had been noticed was an increase in incident reporting in line with the number of staffing moves (undertaken to maintain safety where there were gaps) but this was not linked to any quality issues.
4.33	The vacancy rate had seen some improvement in-month with some new midwifery qualifiers and a small number of new starters from overseas. There remained 80 in the pipeline and in terms of the significant healthcare support worker vacancies, 70 offers had now been made.
4.34	In response to the above NED-GW congratulated the team on the significant progress that had been made in terms of nursing vacancies at the Trust. In response to a point raised by NED-HH in relation to a policy to manage sickness/maternity leave/additional workload the DoN&M confirmed the rostering policy would support that in addition to the daily staffing huddles. Temporary staff were now cancelled if no longer required and rostering KPIs were helping to drive down inefficiencies across rotas.
4.35	The COO also congratulated the Nursing and People teams on the progress made to date, from which there was learning that could be used across other professional groups, for example Medical recruitment.
05 PERFORMANCE	
5.1 Integrated Performance Report (IPR)	
5.1	This item was introduced by the COO and key headlines under the organisation's 5Ps were as follows: <u>Patients</u> Members' attention was drawn to the increase in C-difficile cases over the previous three months, which was unusual for the Trust. A root cause analysis had evidenced no gaps in care but work now needed to be undertaken around antibiotic stewardship. In terms of mental health a service line agreement was now in place with mental health partners which was a positive step forward for both patients and the hospital and evidence of good system working.
5.2	<u>Performance</u> The hospital was now in Phase 3 COVID recovery and plans had been submitted to the regulator with detailed trajectories for core services and managing emergencies pressures alongside both COVID and elective patients. There would be some challenges moving into winter but trajectories would be reviewed on a weekly basis.
5.3	Work had started on the new Adult Assessment Unit with the plan for the first floor to be open before Christmas.
5.4	The hospital was leading on a piece of work in the ICS in relation to a national project, Think 111, which would support patients in accessing appointments in the ED in a more planned way. Work was underway with GPs to have that up and running by 01.12.20.
5.5	In terms of length of stay (LoS) there had been a slight increase in the number of stranded patients in-month and steps had been taken to address that. In light of increasing capacity restraints the LoS meetings had reverted to daily and the Trust was working with community partners to look at additional capacity requirements there too.

5.6	In response to a question from NED-GW the COO agreed to revert after the meeting with the September status for bed occupancy.
ACTION TB1.01.10.20/07	**Revert to NED-GW with September bed occupancy data. Lead: Chief Operating Officer**
5.7	NED-JH asked whether Executive colleagues had the same concerns as he did in terms of the return of COVID and the move into winter. In response the COO stated she shared those concerns. Teams had started on the ground work and were building in contingency where possible. The hospital now had an additional MRI scanner and mobile CT unit which would support diagnostics and flow and would be working with the independent sector in terms of capacity until the end of the year. A piece of work was underway in the ICS with all acute providers for beds to be shared where organisations had spare capacity.
5.8	In response to an additional question from NED-JH it was confirmed that discussions had been had with the organisation's AMD for Surgery. The elective recovery plan was currently going well and additional wards could be ring-fenced if required.
5.9	The COO continued (in response to a question from NED-HH) that the hospital did run a patient at home service and was in discussion with community providers to expand that service to enable it to care for higher acuity patients.
5.10	People Members noted that compliance with statutory/mandatory training and appraisals was down (due to COVID) and there would now be a big focus in the organisation to address that. There had been a request (at WFC) for a deep dive into sickness absence in Estates & Facilities and a more detailed report on that would be provided in due course (to the next WFC meeting).
5.11	In response to a question from NED-HG the ACMO confirmed that medical appraisal was no longer suspended.
5.12	Pounds The Month 5 position showed the organisation was maintaining a breakeven position. There would be a continued focus on the reduction of temporary staffing and costs had reduced in-month to £200k. The capital programme for the current year was significant (£45k) with year to date spend at £7.6m, slightly behind plan. Cash resources remained sufficient with a continued focus to pay both national and local suppliers on time. Members noted that as of Month 7 the financial regime would change (with plans to revert back to break even across the system) and the Trust was awaiting final guidance around that.
5.13	Places The transformation of domestic services continued and the significant investment planned for the current estate as part of the capital programme was likely to be the last before the move to a new hospital. In response to a concern raised by NED-GW it was confirmed the Trust's Procurement team were adequately resourced, albeit stretched.
5.2 East of England Regional EPRR Annual Assurance Report 2021	
	This paper was presented by the COO and taken as read. The organisation was fully compliant with all core standards. The submission would now be signed off by the ICS.
06 GOVERNANCE	
6.1 Reports from Committees	
6.1	Audit Committee – 07.09.20 (Chair NED George Wood Manual stock takes were now underway (previously impacted by COVID at year end) which may give the organisation a chance to have its audit qualification lifted. The Trust would go out to tender for external audit services by the end of December. The Board approved the Committee's revised terms of reference and noted theannual effectiveness review had been undertaken .
6.2	New Hospital Committee – 22.09.20 (Chair Lance McCarthy, CEO) The CEO had nothing to add and members had no questions.
6.3	Performance & Finance Committee – 24.09.20 (Chair NED Pam Court)

	NED-PC took the opportunity to congratulate the Health & Safety team for their efforts during COVID and in particular to Alison Morris (Health & Safety Manager) who was now moving to a different position (within the same service).
6.4	Quality & Safety Committee – 25.09.20 (Chair NED Helen Glenister) Members noted the CQC had been in attendance at the meeting.
6.5	Workforce Committee – 28.09.20 (Chair NED Helen Howe) This update was verbal due to the timing of the meeting and key highlights were: • Reductions in temporary staff. • Agreement that the BAF risk should remain at 12. • Actions agreed following publication of the People Plan. • Deep dive for next meeting on vacancies in Estates & Facilities. • Work undertaken around bullying and harassment. • Some minor amendments to the Committee's ToR were agreed and would be presented to the next Board meeting. • Assurance provided around safe nurse staffing levels.
6.6	Senior Management Team – 08.09.20 (Chair Lance McCarthy CEO) The items were noted. Members were informed the Trauma Network would be visiting the organisation again the following day.
07 QUESTIONS FROM THE PUBLIC	
7.1	A question had been submitted in advance by member of the Public, Trevor Arnold in relation to how the new hospital team would ensure diagnostic specialist advice on optimum diagnostic department design and patient flow was incorporated in the very earliest stages of planning of the new hospital. The response provided by the clinical lead for the workstream/consultant radiologist (with 20 years' experience) was: *The Diagnostics Department Design & Patient flow has been a key part in the planning of the New Hospital. In fact, we have a dedicated work stream overseeing Diagnostics & Cancer with a Triumvirate (Clinical, Operational & Nursing representation). We had initial Model of Care workshops involving the wider team, followed by a session with the Health Planners (which included Prof Mark Emberton & Prof John Tooke). The future of Diagnostics & its Impact was discussed at length. There have been regular work stream meetings with the Clinical team & Architects in planning the Diagnostic Department Design and the Patient flows, including Clinical adjacencies and Schedule of Accommodation. The future Demand & Capacity data and the predicted growth in Diagnostics has also been taken into account. All key stakeholders have been involved in these workshops.*
08 CLOSING ADMINISTRATION	
8.1 Summary of Actions and Decisions	
8.1	These are presented in the shaded boxes above.
8.2 New Issues/Risks	
8.2	No new risks or issues were identified.
8.3 Any Other Business (AOB)	
8.3	There were no items of AOB.
8.4 Reflection on Meeting	
8.4	The CEO reflected there had been a different level of dialogue that day and excellent engagement from Board members. The TC reminded members that Black History month was about to start and encouraged colleagues to engage in events. Members noted it was the last meeting of the Board with Marcelle Michail in the position of ACMO. The TC thanked her for all her hard work, particularly since March and during the peak of COVID. The CEO also offered his personal thanks for the speed with which she had stepped into the role and for her huge energy and effort.

Signed as a correct record of the meeting:

The Princess Alexandra Hospital NHS
NHS Trust

Date:	03.12.20
Signature:	
Name:	Steve Clarke
Title:	Trust Chairman

Trust Board Meeting in Public
Action Log - 03.12.20

	A	B	C	D	E	F	G
1	**Action Ref**	**Theme**	**Action**	**Lead(s)**	**Due By**	**Commentary**	**Status**
28	TB1.01.10.20/06	Mortality Outputs	Present to the Board and QSC the final output of the work undertaken by Richard Wilson around mortality.	MD	QSC.22.01.21 TB1.04.02.21	Item not yet due.	Open
29	TB1.01.10.20/07	Bed Occupancy Data	Revert to NED-GW with September bed occupancy data.	COO	TB1.03.12.20	Actioned	Closed

The Princess Alexandra Hospital NHS Trust

3.1

Trust Board – 3 December 2020

Agenda Item:	2.1
Presented by:	Lance McCarthy – CEO
Prepared by:	Lance McCarthy – CEO
Date prepared:	25 November 2020
Subject / Title:	CEO Update
Purpose:	Approval ☐ Decision ☐ Information ☐ Assurance ☐
Key Issues: [please don't expand this cell; additional information should be included in the main body of the report]	This report updates the Board on key issues since the last public Board meeting: - Performance highlights - COVID-19 response and recovery and winter planning - New hospital - Executive Director appointments
Recommendation:	The Trust Board is asked to note the CEO report.

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

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

Chief Executive's Report
Trust Board: Part I – 3 December 2020

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

(1) Key performance headlines

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

Key Performance Indicator	Actual performance for latest month (October)	Comparison to last report
ED 4-hour performance	83.4%	↓ (worse); target = 95%
HSMR	119 (Jul 19 – Jun 20)	↑ (worse); higher than expected
C. Diff (hospital onset)	2	↓ (better)
Never Events	1	↑ (worse); first since 2016
Incidents reported	1,107	↑
No harm / minor harm incidents	97.5%	↑ (better)
Falls / 1,000 bed days	8.8	↓ (better)
Number of stillbirths	1	New indicator – below national rate / 1,000
PPH >1,500ml	4%	New indicator
6-week diagnostic standard	69.0%	↑ (better); target = 99%
Stat Man training	83.0%	↓ (worse)
Temporary staff % of pay bill	14.95%	↑ (worse)
Staff turnover	9.82%	↓ (better)

I have added 2 new indicators this month related to maternity services to track over subsequent months, and I have removed the MRSA bacteraemia indicator as it has been consistently low and within expected levels for more than 18 months.

The table of key indicators above shows the pressure that the Trust is under at the moment and the impact that the COVID-19 pandemic is having on our ability to maintain our underlying services in the way that we would wish to.

(2) COVID-19 response and recovery and winter planning

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. During the spring there was an enormous amount of change in a very short space of time, with a large number of people working differently, in different teams, different locations and undertaking different roles, all to support our patients. This has continued as we strove hard to get our elective and diagnostic services back to pre-pandemic levels and subsequently as we have seen a significant increase in COVID-19 cases in recent weeks.

Over recent weeks we have started to see an increase in the number of patients presenting to the Trust with COVID-19 symptoms and an increase in the number of confirmed positive COVID-19 cases, both on admission and from the day 5 swab. At the time of writing this paper, we are about to create a 3rd COVID-19 positive ward.

Our red ED moved back to the front of the hospital in September, having been working out of Harold Ward during the summer and we have separated out red ITU pathways, now running from Henry Moore Ward, which is also providing Level 1 care and optiflow for relevant patients.

To date we have treated 668 patients with a positive COVID-19 test. Sadly 237 patients have died in our hospital as a result of COVID-19.

Impact of COVID-19 on services

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

We also have significant pressure and demand for our diagnostic services so that we can ensure that we diagnose and treat suspected cancers in the timely manner that we have done for a number of years. We have expanded our endoscopy, CT and MRI capacity significantly to support the management of cancer patients.

In addition to our capacity, we are continuing to work closely and well with our independent sector colleagues at The Rivers and a number of other providers to maximise access to key services so that we can restore timely services to all of our patients.

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

Through the summer months, we developed detailed and clear plans to get back up to more than 90% of our usual day surgery capacity by the end of September and inpatient elective capacity by November. We have largely achieved this until w/b 16 November; since when we have restricted our elective programme to ensure that we can manage the increased number of COVID-19 positive patients and can maximise safety and social distancing on our inpatient wards through the reduction in the number of beds in the G bays of a number of our wards.

The demand for urgent care remains at approximately 85% to 90% of pre-COVID-19 levels. Our performance against the 4-hour standard has fallen in recent weeks with the reduction in available beds in the hospital impacting on the flow of patients requiring admission out of the ED.

We continue to communicate with the local population to try to provide assurance that our services and facilities are safe to use.

To support the restoration of services and the provision of care through the winter months, we continue to work closely with health and care colleagues across West Essex and East Hertfordshire. The build of our new 2-storey Adult Acute Assessment Unit continues at pace and is on track to be part open in December and fully open in January. We will then be reorganising the facilities on the ground floor next to our Emergency Department (ED) to provide enhanced frailty assessment space and support the speedier and better flow and care for our older people attending our ED. The work on our on-site fracture clinic is also nearing completion.

Despite a huge amount of hard work from many across the system, the impact of COVID-19 has been significant on our services and it will be some time before we have managed to recover our services fully and meet the access targets and waiting times that we achieved pre-COVID-19.

Staff support and testing

Whilst the number of patients attending the hospital fell significantly over the summer months, the demands of treating COVID-19 patients since February have been significant and have put a huge amount of physical and mental stress on many of our colleagues.

We have provided a range of health and wellbeing support for colleagues through this period and in particular I'd like to thank Essex Partnership University NHS Foundation Trust (EPUT) for the mental health and wellbeing support that they have provided for our colleagues.

To support the ongoing pandemic, we have tested our people for COVID-19 antibodies and vitamin D levels and we have in the last week rolled out the asymptomatic lateral flow testing kits for our front-line patient facing colleagues; just under 1.5% of whom have tested positive to date despite being asymptomatic. We are also making detailed preparations for the potential roll out of a COVID vaccination in future weeks and to support a mass vaccination programme for the local population.

Our colleagues have responded fantastically to the 'flu vaccination and to date 81.8% of all colleagues and 83.2% of front-line colleagues have been vaccinated.

All colleagues have been encouraged to complete a personal COVID-19 risk assessment to support decisions to maximise their health and wellbeing. At the time of writing this paper 95% of all colleagues had completed this with their line manager. Appropriate adjustments have been made to support relevant colleagues.

In response to feedback from colleagues about what would be useful to support them, we have also just started building work to expand out multi-faith space for colleagues and patients and will be starting work shortly to create a new large multi-professional and high quality staff rest facility.

(3) New hospital

Work continues to progress at pace on the development of the new hospital and detailed 1:200 drawings have been through 2 iterations.

Since the last Board meeting we have employed a second team or architects who are working closely with the original team, and we have also employed some specialist advisors in Modern Methods of Construction (MMC). All are working closely with each other and our clinical workstream leads at pace to redesign the layout and configuration of the new hospital to maximise the quality of patient spaces whilst taking the benefits of MMC to ensure we minimise costs and maximise replication potential for the wider HIP programme.

We have also been working closely with the new national team for the HIP programme and ensuring that our plans are aligned fully with the national programme, in particular the opportunity for systematic and repeatable platform design.

Our engagement programme is developing well and further focus groups and innovative engagement methods are planned for the winter and spring.

We remain in regular fortnightly formal discussions with regional NHSE/I colleagues and frequent formal discussions with national NHSE/I and DHSC colleagues and our timeline to completion remains challenging and ambitious, enabling us to have built relevant new facilities by the end of 2025.

(4) Executive Director appointments

I'd like to extend a warm welcome to Dr Fay Gilder, who started in the Trust as our Medical Director on 2 November 2020.

Saba Sadiq, currently Deputy Director of Finance at East Sussex Healthcare NHS Trust, starts as our Director of Finance on 14 December 2020 and by the time of the Trust Board we will have interviewed for our vacant Chief Information Officer role; I will update on the appointment at the meeting.

Author: **Lance McCarthy, Chief Executive**
Date: **25 November 2020**

The Princess Alexandra Hospital NHS Trust

3.2

TRUST BOARD
3 DECEMBER 2020

Agenda item:	3.2
Executive Lead:	Sharon McNally - Director of Nursing, Midwifery and Allied Health Professionals
Prepared by:	Lisa Flack - Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Governance & Quality Finola Devaney – Director of Clinical Quality Governance
Date prepared:	23 November 2020
Subject / title	Significant Risk Register

Purpose:	Approval		Decision		Information	√	Assurance	√

Key issues:	This paper presents the Significant Risk Register (SRR) for all our services. The Significant Risk Register (SRR) is a snapshot of risks across the Trust at a specific point and includes all items scoring 15 and above. There are no risks scoring 25. The overall number of significant risks continues to show a reduction with 88 currently on the register. The three main themes for the risks scoring 20 are relating to Operational issues (6), backlog maintenance (6) and need for new equipment/staffing (2 each). See section 2.4 to 2.8, detailing actions and mitigations. In line with the new quality governance structure, we are undertaking a focused review of how risk is managed as an organisation, with a proposed way forward expected to report to SMT in December 20.
Recommendation:	Trust Board is asked to note the content of the Significant Risk Register

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

Previously considered by:	Risk Management Group reviews risks monthly as per annual work plan Executive Management Team
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

The Princess Alexandra Hospital NHS Trust

3.2

1.0 INTRODUCTION

1.1 This paper details the Significant Risk Register (SRR) across the Trust; the registers were pulled from the web based Risk Assure system on 03 November 2020. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

There is an annual work plan to ensure each areas register can be reviewed in detail on a rotation. However during the Covid-19 risk period the focus of the group has been on significant risks and new and emerging risks

2.0 CONTEXT

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

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

2.2 There are 88 significant risks on our risk register which is a decrease from 96 in the previous paper discussed in October Trust Board. The breakdown by service is detailed in the table below.

	Risk Score				
	15	16	20	25	Totals
Covid-19	2 (3)	0 (0)	0 (2)	0 (0)	**2 (5)**
Cancer, Cardiology & Clinical Support	5 (10)	4 (3)	0 (3)	0 (0)	**9 (14)**
Estates & Facilities	10 (10)	10 (10)	0 (0)	0 (0)	**20 (20)**
Finance	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Information Data Quality and Business Intelligence	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
IM&T	0 (0)	2 (2)	0 (0)	0 (0)	**2 (2)**
Integrated Hospital Discharge Team	1 (0)	0 (0)	0 (0)	0 (0)	**1 (0)**
Learning from deaths	0 (0)	3 (0)	0 (0)	0 (0)	**3(0)**
Non-Clinical Health & Safety	2 (2)	1 (1)	0 (0)	0 (0)	**3 (3)**
Operational	1 (1)	0 (0)	4 (4)	0 (0)	**5 (5)**
Patient Safety & Quality	0 (1)	0 (0)	0 (0)	0 (0)	**0 (1)**
Research, Development & Innovation	0 (0)	2 (2)	0 (0)	0 (0)	**2 (2)**
Resilience	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Workforce	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Child Health	0 (1)	0 (1)	2 (2)	0 (0)	**2 (4)**
Safeguarding Adults	0 (0)	0 (0)	1 (1)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1(1)**
Women's Health	6 (4)	0 (1)	0 (0)	0 (0)	**6 (5)**
Medicine	4 (2)	6 (7)	3 (3)	0 (0)	**13 (12)**
Surgery	4 (4)	4 (4)	6 (6)	0 (0)	**14 (14)**
Totals	**37 (40)**	**35 (34)**	**16 (21)**	**0 (0)**	**88 (96)**

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

2.3 There are 16 risks with a score of 20; this has decreased from 33 in the July 2020 and 21 in October. A summary of these risks is below and all new risks identified since the October paper are detailed:-

2.4 Our Patients

2.4.1 Equipment

2.4.2 Ophthalmology

- Purchase additional Medisoft modules to have one for each of the ophthalmology specialities cared for in the Trust (OPH005/2019 initially raised May 2019, score adjusted May 2020)
  Action: Business case accepted in May 2020, order raised. Company will build the system to fully integrate with Cosmic and other Trust IT systems. Anticipate delivery in approx. 6 months and aiming for use by February 2021. The current software will continue to be used until the new system is available.

2.4.3 FAWS: Paediatrics

- **NEW:** Additional demand on Dolphin ward requires a High Dependency area and an increase in numbers of cubicles to provision isolation, (Dolphin03/2020 on register June 2020). Score increased in September since moving to Nightingale ward for the refurbishment as there is a reduced number of cubicles available down to 3 from 7.
- **Action**: Refurbishment in progress, anticipate completion by end of February 2021. If more than 3 children require a cubicle the team will either cohort a small group in a bay or complete non clinical transfer.

2.5 People

2.5.1 Medical staffing

- Paediatric registrar rota is not compliant with national standards as there is 1.5 WTE posts vacant. (CH02/2020 on register since March 2020, score adjusted April 2020)
  Action: Associate Nurse Practitioner and Locums are in place to ensure rota achieves compliance. Recruitment is ongoing

- 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). Despite support from NHS England the Trust was not successful in obtaining a formal partner engagement for an out of hours SLA.
  Action: Completed the upper GI bleed proforma, care bundle and SOP. The Trust has agreed to fund an out of hour's endoscopy service. A consultation will be undertaken and the plan is to have an out of hours GI bleed rota by Q4 2020.

2.6 Performance

2.6.1 ED performance

Five risks regarding achieving the four hour Emergency Department access standard

- Compliance with the statutory standard for the Emergency department (ED) (001/2017 on operations team register since April 2014)
- Achieving the standard of patients being in ED for less than 12 hours (002/2016 raised July 2016 on operational team register)
- Ensuring patients wait less than 12 hours from time of decision to admit (003/2016 on register since July 16) for operational team register.
- Two risks for Medicine about achievement of the ED four hours standard (MED57 on Medicine register since July 2016) and (ED012 on Medicine register since July 2016)
  Actions: Rapid assessment and treatment process monitoring flow through department. Daily patient tracking of discharges to facilitate admissions, actions taken on safety rounds, timely escalation with clear triggers. CDU and ENP pathways being rewritten. ED remedial action plan monitored through Urgent Care Programme Board.

2.6.2 Cancer access standard

- Not achieving 85% of all patients referred by GP to receive treatment within the cancer 62 day standard (005/2016 on register since July 2016)
  Actions: Daily patient tracking of cancer list at meetings attended by Head of Performance & Planning. Cancer Board monitors recovery action plan and trajectory.

2.7 Places - Environment

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

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

- **Safeguarding:** Refurbishment required to the portacabin office location (ASG/04/2019 on Safeguarding register initially raised July 2019 and score amended July 2020).
  Action: Space utilisation group identifying staff groups that can relocate to Kao Park, in turn this will free up space to relocate the safeguarding team to different location at PAH.

- **Penn ward**: requires refurbishment. (Penn001/2020 raised January 2020)
  Action: Capital funding requested for completion of work during 20/21. Awaiting confirmation of the date this is planned for completion.

2.8 Pounds and Information Technology

No finance risks detailed

3.0 New Risks on the Significant Risk Register

3.1 Risks Scoring 16: No new risks raised

3.2 Risk Scoring 15: one risk raised since the last report

Endoscopy: NEW: Ensure patients listed for an endoscopy investigations receive a timely procedure, (Endo151020 raised September 2020).
Action: Performance and activity discussed weekly at access board, risk stratification of patients on cancer waiting target pathway currently in place. Working to create an additional endoscopy room and increase the size of the endoscopy team to meet the demand.

4.0 RECOMMENDATION

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

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The Princess Alexandra Hospital NHS Trust

Trust Board - 3 December 2020

3.3

Agenda Item:	3.3							
Presented by:	Head of Corporate Affairs - Heather Schultz							
Prepared by:	Head of Corporate Affairs - Heather Schultz							
Date prepared:	25 November 2020							
Subject / Title:	Board Assurance Framework 2020/21							
Purpose:	Approval	x	Decision		Information		Assurance	
Executive Summary: [please don't expand this cell; additional information should be included in the main body of the report]	The Board Assurance Framework 2020/21 is presented for review. Risks, risk ratings and outcomes of Committee reviews in month are summarised in the attached appendix and detailed BAF risks as at the end of November 2020 are also attached. There are no changes to the risk scores this month however each risk has been reviewed and updated where relevant. As the Strategy Committee has been dis-established, Risks 3.2, 3.3 and 3.4 have been allocated to the Board for consideration. The wording for BAF risk 5.1 Finance has been revised to include the risk relating to the capital programme for the current financial year.							
Recommendation:	The Board is asked to approve the Board Assurance Framework.							

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

Previously considered by:	WFC, PAF, QSC, New Hospital Committee in November 2020.
Risk / links with the BAF:	As reflected in the attached BAF.
Legislation, regulatory, equality, diversity and dignity implications:	Compliance with national legislation and regulations and the Code of Governance.
Appendices:	Appendix A summary, and Appendix B - Board Assurance Framework 2020/21

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5P	Executive Lead	Committee	BAF Risks 2020/21 (December update)	Current risk score	Trend
	Chief Executive	QSC	1.0 Covid-19: Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered.	16	
	Chief Nurse/Chief Medical Officer	QSC	1.1 Outcomes:Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	16	
	Chief Finance Officer/DoI&IT	PAF	1.2 EPR Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes	16	
	DoP	WFC	2.3 Workforce: Inability to recruit, retain and engage our people	12	
	DoS	PAF	3.1 Estates & Infrastructure Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	
	DoS	Trust Board	3.2 Financial and Clinical Sustainability across health and social care system Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system.	16	
	DoS	Trust Board	3.3 Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	12	
	DoS	Trust Board	3.4 Sustainability of local services Failure to ensure sustainable local services continue whilst the new hospital plans are in development and funding is being secured.	16	
	DoS	Trust Board/ New Hospital Committee	3.5 New Hospital: There is a risk that the delivery of the new hospital will be delayed because of failure to engage with a suitable contractor or that the additional funding is not forth coming from the JIC even if the 3 conditions are met	16	
	COO	PAF	4.2 4 hour Emergency Department Constitutional Standard Failure to achieve ED standard	16	

	CFO	PAF	5.1 Finance Concerns around ability to meet operating financial plan including revenue and capital plans.	20	

The Princess Alexandra Hospital NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2020-21

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/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 the standard of care delivered.	Causes: i) Highly infectious disease ii) Failure of public to adhere to Public Health messages and increasing Covid demand iii) National issues regarding supply chains iv) Configuration of PAHT estate v) Current vacancy rates vi) Public perceptions around accessing services as normal	**5 X 5= 25**	Chief Executive supported by Executive team QSC	i) Level 4 national incident declared by NHS England ii) PAHT incident co-ordination centre and incident management team established iii) COVID-19 incident management governance structure in place iv) Compliance with national directives v) Ongoing engagement with STP and Local Resilience Forum, Local Delivery Board re-instated vi) COVID-19 patient pathways instigated vii) Staff being redeployed to provide additional support viii) Non COVID Priority Business Cell established for business as usual matters ix) Daily executive oversight of incident management x) Recovery and restoration planning (PAHT/ICP and ICS) xi) Separation of hospital into Covid and Covid free areas xii) Use of independant sector for elective surgery	i) Incident Management Team Meeting ii) Strategic Incident Management Cell iii) IPC Cell and Infection Control Committee iv) Site Management Cell v) Communications Cell vi) People Cell vii) Recovery Cell viii) Clinical Cell	i) Incident management action and decision logs ~~(daily)~~. ii) QSC updates (March, to November 2020) iii) Trust Board updates (March, to November 2020) iv) Recovery Plans and submissions v) Covid risk register	**4x4=16**	i) Loss of staff with key skills and training due to virus; shielding/isolating or sickness ii) Reliance on national supply chain iii Modelling information for next peak (local, regional and national) dependant on lock down and public behaviour v) Plans for use of the private sector		Nov-20	No change to risk score.	**5x2=10 (April 2021)**
			Effects: i) Increased numbers of patients and acuity levels ii) Shortages of staff, staff shielding and increased sickness iii) Shortages of equipment, medicines and other supplies iv) Lack of system capacity v) Staff concerns regarding safety and well-being vi) Changing national messaging vii) Potential for patient harm due to cancellation of elective surgery											

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High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
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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			
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	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients, integrating care with our partners and improving our CQC rating													
BAF 1.1		Variation in outcomes in clinical quality, safety, patient experience and 'higher than expected' mortality.	Causes: i) Unwarranted variation in care ii) System wide flow iii) Workforce gaps	**4 X 5= 20**	Director of Nursing/ Chief Medical Officer **Quality and Safety Committee**	i) Robust quality and safety governance structures in place including infection control ii) Robust Appraisal/ medical and nursing iii) End of Life and deteriorating patient simulation programme for all staff, across ICP and ICS iv) Education & training in communication skills such as breaking bad news training. v) Sharing the Learning Programme vi) Commissioner reviews and engagement in quality and Safety processes vii) Risk Management Training Programme viii) Escalation prescribing processes ix) Electronic handovers, Hospital at Night and E-Obs and observation compliance reports x) Schwartz Rounds xi) NHSI/NHSE Oversight xii) Red2 Green Board rounds supported by ECIST xiii) Patient Experience Strategy xiv) NED lead appointed for Mortality xv) Mortality Strategy including dashboard, tracker, updates on workstreams and learning from deaths. xvi) '15 steps' walkabouts xvii) Nursing Establishment review (bi-annually) and succesful nursing recruitment campaign xviii) Safer Staffing policy xix) Real time patient feeback implemented across all wards xx) Robust management of variations in neonatal outcomes xxi) Engagement in external reviews MBRRACE,HSIB and LeDeR and Healthcare Safety Investigation Branch (maternity) xxii) Medical examiners (MEs) and Lead ME appointed and Mortality Surveillance Group established xxiii) Complaints workshops held xxiv) Joint GIRFT and Model Hospital quality improvement programme xxv) Patient flow module live xxvi) Electronic fluid prescribing pilot live xxvii) Appointment of medical PS&Q leads xxviii) Complaints process being revised and grading system introduced xxix) Fab Change accreditation xxx) Quality peer review process in place xxxi) Covid-19 governance structure/meetings in place xxxii) OD Plan agreed at WFC (June 2020)	i) National Survey ii) Cancer Survey iii) CEO Assurance Panels iv) Incident Management Group meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings, PRMs and Patient Experience meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings/ Vulnerable Patient Group x) PLACE Inspections xi) Medicines Management Committee xii) End of Life and Mortality Surveillance Group xiii) AKI & Sepsis Group xiv) Urgent Care Improvement Board xv) Deteriorating Patient Group xvi) Cardiac arrest review panels xvii) Twice weekly Long Length of Stay meetings xviii) Quality Compliance Improvement Group	i) CEO Assurance Panels (as required) ii) Reports to QSC on Patient Experience (bi-monthly), monthly Serious Incidents, monthly Safer Staffing, Patient Panel (bi-monthly) , Safeguarding, monthly Infection Control and Covid-19 updates iii) Monthly Mortality Improvement report to QSC including updates on ME reviews and monthly IPR report iv) Dr Foster reports, CQC inspection reports (March 18 and June 19) and GIRFT reports v) Real time Dr Foster reports and engagement vi) GMC Survey results (July 2019) and WFC report June 2020 vii) Clinical Audit internal audit report 18/19 - tiaa (limited assurance) viii) CMO/CFO Coding Meetings and quarterly Coding reports to PAF ix) Positive staff survey outcomes (2019) measuring safety culture and engagement x) Freedom to Speak Up Guardians quarterly reports to WFC ~~and Guardian of Safe Working reports to Trust Board (Dec18)~~. xi) Patient stories and learning from deaths presentations to Public Board meetings (bi-monthly) xii) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) ~~xiii) International Nurse Recruitment business case to SMT/PAF and Board (June/July 19)~~ ~~xiv) Presentation to QSC on documentation and strategic direction to having one electronic system (QSC February 20)~~ xv) Critical care network review peer review April 2020 xvi) TARN review (QSC September and October 2020)	**4x4=16**	Lack of modernisation in some reporting processes including: i) Clinical audit plan developed and to be implemented - improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site footprint and bed constraints iv) Access to Qlikview v) NICE oversight and management of compliance with guidance vi) Frequency and consistency of approach to mortality reviews vii) **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey action plan in place iii) Ongoing work with Dr Foster in relation to mortality ii) NHS Patient Safety Strategy 2019 published. Trust to review and align to best practice ~~iii) Structured Judgment Review champions appointed~~ iii) EPR development	i) Clinical evidence of improvements made following compliance with national audits, NICE,NCEPOD. ii) Demonstrating an embedded learning programme from Board to ward.	14/11/2020	Risk rating not changed	4x3=12 March 2021
			Effects: i) Increase in complaints/ claims or litigation ii) Persistent poor results in National Surveys iii) Poor reputation iv) Recurrent themes in complaints involving communication failure v) Loss of confidence by external stakeholders vi) Higher than expected Mortality rates											

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	Strategic Objective 1: Our Patients - we will continue to improve the quality of care and experiences that we provide our patients, integrating care with our partners and improving our CQC rating **Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2020/21 and our local system control total**													
BAF 1.2		**EPR** Concerns around availability of functionality for innovative operational processes together with data quality and compliance with system processes.	Causes: i) Poor engagement with the system, usability, time/skills ii) Timely system fixes/enhancements	**5 X 4= 20**	Chief Financial Officer/Chief Operating Officer/Chief Medical Officer **Performance and Finance Committee**	i) Weekly DQ meetings held at ADO level ii) Programme management arrangements established with Data Quality Recovery Programme to 'Health Group Challenge' meetings, EMB and Trust Board. Governance via Performance and Finance Committee to Trust Board. iii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iv) Performance Mgt Framework in place. v) Training programme. vi) Super users in place to deliver focused support. vii) Transformation function extended to ensure high level issues affecting delivery of benefits and reporting are captured and managed through to process review, fix and system enhancement to improve usability viii) Access Policy ix) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) x) Development of capacity planning tools/information xi) PWC review and actions identified xii) ICT Newsletter issued xiii) Daily ICT/COSMIC meetings ongoing xiv) Real time data now available xv) CDS 011 now live xvi) Maternity MDS configuration completed. xvii) Monthly Contract Performance monitoring meeting with supplier established. xviii) New EPR Board established – chaired by CEO xix) EPR replacement programme established and EPR requirements being gathered, 5 Business Change Managers in post and other EPR Trust resources being recruited xx) EPR Options appraisal development to complete mid December 2020 xxi) EPR FBC being developed and benefits realisation with link to HIMMS commissioned	i) Access Board ii) ICT Programme Board (chaired by CFO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews ~~vii) Monthly EPR Board to Board meetings~~	i) Weekly Data Quality reports to Access Board and EDB ii) Monthly DQ reports to PAF and quarterly ICT updates to PAF (September 2020) ~~iii) EPR outline business case developed and presented to SMT and PAF September 19.~~ iii) Reports to EPR Programme Board	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Compliance with refresher training vii) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training - monitoring process being developed. Responsiveness and quality of delivery of PFM - testing processes and actions identified by tiaa internal audit (limited assurance). Supplier requests to remove contractual requirement to comply with national standards e.g. ISNs - 2 risks associated 1) exposes PAH to technical compliance issue as supplier not compelled to comply and 2) financial risk as uncapped liability – assurance PAH have declined supplier request on advice from NHSD	Nov-20	Risk rating unchanged	**4x3=12 end of March 2021 (subject to monthly review of progress)**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** i) Ongoing training and support ii) Re-establishing relationship/engagement with Cambio iii) Refresher training underway iv) Revised roadmap to incorporate new statutory/legal requirements e.g GDPR v) Recruitment of CIO				

Risk Key		
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The Princess Alexandra Hospital Board
Assurance Framework 2020-21

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Positive/negative assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
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	Strategic Objective 2: Our People – we will support our people to deliver high quality care within a within a compassionate and inclusive culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
2.3		**Workforce:** Inability to recruit, retain and engage our people	**Effects:** i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels	**4 X 4 =16**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) Event in a Tent held annually viii) Staff recognition awards held locally and trust wide annually ix) Enhanced controls around temporary staffing x) Line Manager development programme underway xi) Behaviour workshops held xii) New consultant development programme launched xiii) Staff engagement groups and Staff Council xiv) International recruitment programme for nurses and ED doctors xv) Medical staffing review underway xvi) Additional recruitment ('Bring back staff') during Covid xvii) Provision of Health and Well-being support during Covid-19 including psychological support. xviii) Communications Strategy approved June 2020	i) WFC, QSC, SC, PAF, SMT, EMT. ii) People board iii) JSCC, JLNC iv) PRMs and health care group boards v) People Cell established (Covid-19)	i) Workforce KPIs reported to WFC bi-monthly and inluded in IPR (monthly) ii) People strategy deliverables iii) Staff survey results 2019 (WFC March 2020) iv) Staff friends and family results (WFC March 2020) v) Medical engagement surveys, action plans and GMC surveys (WFC November 2019 and June 2020) vi) WRES and WDES reports 2020 vii) OD Framework approved (WFC June 2020) viii) Culture update (WFC June 2020)	**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 ~~Management of staff health and well-being during and post Covid~~ Actions ~~i) Implementation of communication strategy - Q3 2020/21~~ i) Recruitment plans for medical staff ii) Extranet for staff - Q1 20/21 iii) Staff survey action plan:health and well being, manager development and learning culture (Q2 20/21) iv) Completion of risk assessments (target of 100%) - Q2 v) Review of raising concerns (FTSUG's, champions for bullying and harassment, senior inclusion lead) vi)Board level Health and wellbeing guardian vii) CV19 staff vaccination implementation plan	None identified.	01/11/2020	**Risk score not changed.**	**4 x2 = 8 (at end of 5 year People Strategy but to be reviewed in December 2020)**
			Effects: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation											

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	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.1		**Estates & Infrastructure** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Lack of capital investment, iii) Current financial situation, iv) Inherited aged estate in poor state of disrepair v) No formal assessment of update requirements, vi) Failure to comply with estates refurbishment/ repair programme historically, vii) Under-investment in training of estate management & site development viii) Inability to undertake planned preventative maintenance ix) Lack of decant facility to allow for adequate repair/maintenance particularly in ward areas. x) Key workforce gaps in compliance, energy and engineering.	**5 X 4= 20**	Director of Strategy **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report received (£105m) iii) Potential new build/location of new hospital iv) Capital programme - aligned to red rated risks. v) STP Estate Strategy developed and approved. vi) Modernisation Programme for Estates and Facilities underway vii) Robust water safety testing processes viii) Annual asbestos survey –completed and red risks resolved. ix) Trust's Estate strategy being developed x) Annual fire risk assessment completed and final report received, compliance action plan being developed. xi) New estates and facilities leadership team in place x) Sustainability Manager in post xi) Emergency Capital funding £4.3m xii) Compliance Manager appointed xiii) Significant capital programme for year c.£40m	i) PAF and Board meetings ii) SMT Meetings iii) Health and Safety Meetings iv) Capital Working Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings	i) Reports to SMT (as required) ii) Signed Fire Certificate iii) Annual H&S reports to Trust Board and quarterly to PAF. iv) Ventilation assurance report v) Annual and quarterly report to PAF: Estates and Facilities September 20 - quarterly report) vi) IPR monthly ix) Annual Sustainability report to PAF (June 20 an dupdate in October 2020) x) Internal Audit report (tiaa) - review of PPM (limited assurance report) - Audit Committee Dec 2019, action plan in place xi) Capital projects report (PAF June 20, October 2020 and weekly updates at EMT)	**5x4=20**	i) Planned Preventative Maintenance Programme (time delay) ~~ii) Ventilation systems~~ ii) Sewage leaks and drainage iii) Electrical Safety/Rewiring (gaps) 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 STP ii) Compliance with data collection and reporting iii) PPM data not as robust as required	01/11/2020	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

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	Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iii) The resources required for delivery at a programme and workstream level have not been defined or secured iv) The current governance structure is under development given the shift in focus from planning to delivery. v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS Trust Board	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) STP Estates Strategy being developed. viii) STP Clinical Strategy in place ix) STP wide Strategy Group implemented x) Independant STP Chair and independant STP Director of Strategy appointed. 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) ~~iii) STP report to Strategy Committee (Oct 2019)~~	**4 X 4= 16**	Lack of ICS demand and capacity modelling. **ACTIONS:** System agreement on governance and programme management System leadership capacity to lead ICS -wide transformation		01/11/2020	**No changes to risk rating.**	~~4x3=12~~ ~~**December**~~ **March 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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BAF 3.3		**Strategic Change and Organisational Structure** Capacity & capability of senior Trust leaders to work in partnership to develop an Integrated Care Trust.	**Causes:** i) Staff and stakeholders lack of awareness and/or understanding of drivers and issues cross the system ii) Scale, pace and complexity of change required. iii) Infrastructure (IT, buildings) not supportive of change iv) Financial resources lacking to support change v) Focus on immediate operational and financial priorities versus the longer term strategic planning vi) Lack of clarity regarding contracting and organisational models in support of ICP vii) Management resource and team with relevant capability and skills to drive change and strategy development to be developed. viii) Uncertainty around future CCG structure and relationships	**4 X 4= 16**	DoS Strategy Committee	i) Good relationships with key partner organisations ii) CEO chairing ICP Board iii) CEO and Chair attending STP meetings iv) Clinical Strategy being developed. v) Strategy Committee established and Strategy team in place vi) Development of MSK service and engagement of senior clinicians. vii) One Health and Care Partnership established viii) Financial principles for integrated working developed, allocative contract and due diligence underway ix) NHSE/I assurance process underway x) Legal advice sought on governance and staff transfers xi) Transformation plan in development	i) ICP Board and STP meetings ii) Expert Oversight Groups and workstreams (finance,people, IT) iii) ICP senior leaders meetings iv) Executive to executive meetings and Board to Board meetings (as required)	i) ICP Reports to Strategy Committee ii) CEO report to Board (bi-monthly) iii) ICP update Board development session August 2020.	**4x3=12**	i) Data quality impacting on business intelligence (SLR) **ACTIONS:** PAH long term strategy being developed and PAHT 2030 to be presented to Board for approval in January 2021	Development of governance structures for integration and legislation CCG Accountable Officer process completed and new management structures.	01/11/2020	**Risk rating not changed.**	4 x 2= 8 **March 2021**
			Effects: i) Poor reputation ii) Increased stakeholder and regulator scrutiny iii) Low staff morale iv) Threatened stability and sustainability v) Restructuring fails to achieve goals and outcomes vi) Impact on service delivery and quality of care vii) Poor staff survey viii) Failure to fully implement the transformation agenda required e.g. increase in market share, following restructure ix) Undermines regulatory confidence to invest in hospital/system solutions											

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		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,			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3 : Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.4		**Sustainability of local services** Failure to ensure sustainable local services continue whilst the new hospital plans are in development.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Long periods of underinvestment in backlog maintenance iii) Lack of capital investment, iv) Current financial situation, v) Inherited aged estate in poor state of disrepair vi) Complexity of STP vii) Insufficient quantity and expertise in workforce capability	**4 X 4= 16**	Director of Strategy Trust Board	i) Potential new build/location of new hospital ii) STP Footprint and Estate Strategy developed. iii) Herts & West Essex STP Estates workstream iv) Pathology workstream led by CEO v) Estates and Facilities Infrastructure subgroup for West Essex vi) SOC affordability model vii) SOC approved and submitted to NHSI viii) Detailed analysis of current site option commissioned ix) Master planning work being aligned to Six Facet Survey and Health Planning, phasing of development on PAH site or off site. x) Alignment of strategic capital and tactical capital plans xi) MSK service developments underway xii) Funding confirmed xiii) PAH part of HIP 1 funding programme for capital investment xiv) PCBC completed, submitted and reviewed by NHSI xv) New members of strategy team appointed xvi) OBC in development (completion date is March 2021)	i) PAF, Strategy Committee and Board meetings ii) SMT Meetings iii) Capital Planning Group iv) Weekly Estates and Facilities meetings v) Stakeholder group vi) New Hospital Committee established	~~i) STP reports to Strategy Committee (bi-monthly).~~ ii) Reports to SMT iii) STP work plans ~~iv) Our New Hospital reports to Strategy Committee (Oct 2019 and updates to Board (August and September 20).~~ v) PAHT 2030 report to Trust Board (April 2020) vi) PCBC approved at Trust Board (September 2019)	**4 x 4 = 16**	i) Balancing short term investment in the PAH site vs the required long term investment **ACTIONS:** Clinical strategy being developed and underpinned by 5P plans PAHT 2030 to be presnetd to Board for approval in January 2030	i) Clinical strategy in development	01/11/2020	**No change to residual risk rating.**	**4 x 3 =12** **March 2021 (on completion of OBC)**
			Effects: i) Failure to deliver strategy and transformation project and service changes required for service and performance enhancement ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant vii) Poor patient experience, viii)Backlog maintenance ix) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health. x) Lack of integrated approach xi) Increased risk of service failure xii) Impact on throughput of patients												

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/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 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 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 delivery of the new hospital will be delayed because of failure to engage with a suitable contractor or that the additional funding is not forthcoming from the JIC even if the 3 conditions are met.	Causes: i) Challenged contractor market/insufficient skills and capability ii) Competition in the market due to large number of HIP schemes iii) High profile failures in hospital construction	**5 X 4= 20**	Director of Strategy New Hospital Committee	i) ~~Soft market testing underway~~ postponed (contractors) ii) Detailed programme of work iii) Monthly meetings with national cash and capital team iv) Weekly meetings with regional team v) Weekly meetings with landowners vi) HOSC meetings held and agreement reached that consultation is not required vii) New national team appointed to provide transaction support viii) Meeting with national team on 3.11.20	i) New Hospital Committee ii) Trust Board iii) External advisory meetings as required. Iv) New Hospital SMT meeting (November 2020)	i) Monthly reports to Trust Board and New Hospital Committee. (November 2020) Ii) Letters of support received from HOSCs. Iii) Verbal confirmation received that programme management structure is appropriate. Iv) Expert advice received on procurement strategy.	**4x4=16**	Negotiations with landowners Actions: Soft market testing postponed ~~progressing and a bidders day planned.~~	None.	Nov-20	**Risk score not changed.**	3x~~3=9~~ **(~~Nov 2020~~)** March 2021
			Effects: i) Significant delay/failure to deliver hospital by 2025 deadline ii) Increase in Capital costs through inflation iii) Delivery of a suboptimal hospital											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**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 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 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) Skill mix gaps in nursing workforce ~~medical and nursing workforce~~ iv) Lack of public awareness of emergency and urgent care provision in the community. v) Attendances continue to rise annually (5.1% over the last 2 years). vi) Changes to working practice and modernisation of systems and processes vii) Delays in decision making, patient discharges and impacting on flow ~~viii) Increases in minor attendances~~	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) Performance recovery plans in place ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Developing new models of care vii) Local Delivery Board in place viii) System reviewing provision of urgent care ix) ED action plan reported to PAF/Board x) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries xi) Weekly Urgent Care operational meetings and Urgent Care Board in place xii) Focus on length of stay in ED for all patients xiii) Improved ambulance handover process and improved staffing levels xiv) Assessment unit ~~build commenced 2020~~ opening December 2020 xv) Think 111 First - go live date December 2020	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 **Actions:** i) Local Delivery Board monitoring ED performance iii) Monthly Performance review meetings and weekly Urgent Care Board review	None noted.	01/11/2020	**Risk score not changed.**	**4x3 =12 March 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		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2020-21**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively and modernise our corporate services to achieve our agreed financial control total for 2019/20 and our local system control total													
BAF 5.1		**Finance** Concerns around ability to meet operating financial plan including revenue and capital plans.	Causes: i) The Trust has now agreed its operating plan for M7-M12. This is a requirement to deliver a deficit of £0.4m. Although the plan provides greater certainty on the level of income to be received from block contract arrangements some variables in delivery of the financial position remain. The main risks include the delivery of efficiencies (including reductions in temporary staffing) and containing covid costs within funding envelopes at the backdrop of increase covid activity. ii) The Trust's capital programme is significant at c£45m and contains a significant number of Estates, equipment and ICT initiatives. A number of programme s are scheduled for delivery in Q3. Ability to deliver schemes coud be impacted by Covid and the Trust awaits confirmation of some external funding associated with planned schemes.	**5 X 4= 20**	**Exec leads :** ACFO **Committee** : Performance and Finance Committee	i) Cash Management Group ii) Capital Working Group - increased frequency and membership iii) Exec led Temporary staffing group iv) SMT, PAF, Workforce and Audit Committee v) Health Care Group PRM meetings vi) Covid cost sign off process vii) Approved Governance Manual iix) Operating plan m7-m12 approved ix) Two Weekly Cashflow Reporting to NHSI/E x) Monthly Regulatory returns xi) STP Capital oversight group	i) Internal Audit Reports ii) External Audit opinion. ii) External reviews iii) NHSI/E reporting iv) Internal Trust reporting v) Cash Forecasts vi) CIP Tracker vii) Estates project plans	i) Monthly reports including bank balances and cash flow forecasts to PAF and Board ii) CIP reports iii) Internal Audit reports: Financial Reporting and Budget Monitoring (substantial assurance) Key Financial Systems (substantial assurance) iv) FAM reports monthly v) PRM packs monthly vii) Recovery plans and trajectories reported to Recovery cell viii) Temporary staffing action plan (Board July 20)	**5 x 4 = 20**	i) Organisational and Governance compliance e.g. waivers ii) Activity and capacity planning iii) CIP delivery and PMO function iv) Embedding management of temporary staffing costs	Demand and Capacity Workforce planning	18/11/2020		4 x 3 =12 (Q4 2020)
			Effects: i) Ability to meet future financial control target and recovery Financial Recovery Funds. ii) Impact to pay supplies within 7 days iii) Impact on Going Concern opinion iv) Impact on capital availability v) Unfavourable audit opinion (VfM,Section 30, UoR)							**ACTIONS:** Modernisation business case complete - approval sought. Recovery and restoration cell, Demand and Capacity Planning and Modelling to be regularised Clinical and operational forums in place to review QIPP schemes. Intensive support for job planning, rota and roster management. Review of CIP/PMO processes Collective Executive targetting of temporary staffing				

The Princess Alexandra Hospital NHS Trust

Meeting of Board of Directors – 3 December 2020

4.1

Agenda item:	4.1
Presented by:	DoS
Prepared by:	Richard Robinson
Date prepared:	26 November 2020
Subject / title:	New Hospital Update

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:	The New Princess Alexandra Hospital is progressing well; we are increasingly seen as an exemplar within the Government's `40 Hospital Programme'. Work is ongoing to ensure Modern Methods of Construction (MMC) are fully implemented in the design. Land acquisition negotiations continue.
Recommendation:	To note.

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

Previously considered by:	
Risk / links with the BAF:	BAF risk (3,5) "New Hospital"
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	1. High Level Programme

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1.0 Purpose/Issue

To update members on the New Hospital programme generally, including programme key risks and milestones.

2.0 Discussions with Central Team

Since announcement of the `40 Hospitals Programme', PAH joined an introductory meeting held 3rd November and followed up with a further phone call 24th November. We received a strong steer on priorities for the Programme. A platform approach is being adopted for hospital design, including a suite of standard elements and 'ubiquitous' components. A programme wide commercial strategy is being developed.

3.0 Discussions with CCGs

ICP and CCGs have been regularly briefed in order to ensure their continued support. Capital and revenue affordability were shared on 18th November. Work is ongoing with CCGs on detailed modelling assumptions, including impact of the system's transformational plans and Trust's role as the system "nerve centre".

4.0 Progress Updates

a. **Finance**

Updated assessments on affordability and project running costs were provided to NHC on 23 Nov 20. In summary, work towards finalising the affordability position is ongoing, and the programme is running within approved limits.

b. **Clinical**

- Second of three clinical sessions with the architect took place 18-20 November, resulting in requests for change that were presented to Change Control Board on 24 Nov 20. The final sessions are planned for the week commencing 30th November 2020.
- Clinical delivery for BAU options is being prepared. Clinical Leads have been engaged to confirm continuing working through FBC.
- Work started on developing the `Patient Journey'.

c. **Estates**

- **Land**. Landowners are reviewing evidence we provided regarding valuation; we are pushing to reach agreement before the end of 2020. Update has been prepared for the DHSC/NHSEI Joint Investment Committee.
- **Design**. Drawings at 1:200 scale are under development. 2 out of 3 design meetings have been completed, but some key issues have still to be resolved eg:
  - Oncology access
  - Single room design
  - Theatre design

d. **St Margaret's Hospital**.

Currie & Brown is planning to move straight to Outline Business Case starting in January 2021, but it is not yet clear how this will be taken forward. PAH is discussing with NHS PS regarding the high level programme. Meetings with NHS PS are scheduled for 3rd December 2020 - longlist of options. 17th December 2020 for the fully costed shortlist.

e. **IMT & Digital.**
- **Strategic case and Economic Case**: Second draft of Strategic Case completed. Getting good responses from industry on costing and produced first pass report.
- **Commercial case and Management Case**: Commercial case in now under development which will also fully consider the phasing and planning of the digital implementation and lifecycle management of the new hospital.

f. **HR & Workforce.**
- Initial modelling has been completed, based on inputs from the clinical and non-clinical workforce workshops held. This breaks down the workforce projections into 5-year intervals until 2040, now on circulation for comment.
- HR & Finance models being updated using Model Hospital assumptions, benchmarked against a range of new build hospitals including Papworth and Chase Farm.
- Associate Director of Nursing is working with the programme team to further develop staff ratios for various ward types to build into the model, and a time and motion study of current staff is being organised to fully understand benefits of both the new models and the innovative use of technology.

g. **Comms & Engagement.**
Stakeholder group meeting on 17th November was well attended by representatives from local council, healthcare providers and CVS. As well as the regular programme update this month's meeting focused on giving them greater detail on the models of care. We were asked to schedule a series of briefing sessions with members of local councils. Comms & Engagement Strategy was approved by NHC on 23 Nov 20 and a range of Town Hall events will be held in the New Year.

h. **Procurement.**
- Current OBC supplier performance assessments are being undertaken in accordance with NHC paper approved on 23rd November 2020. This will inform the procurement route from OBC to FBC.
- Package specifications / scopes are currently being drafted in preparation for FBC ITTs and Contract execution
- Current package budgets are being reviewed ensuring each package has sufficient funds for the design options being considered in line with procurement governance procedures.
- Currently in high level discussions regarding main contractor appointment options, which will inform the main contractor procurement strategy and the potential for early supplier involvement to inform and input into the design phases.

i. **PMO**
A first assurance review on the New Hospital programme was conducted in October 20, and findings presented to DoS.

5.0 Programme Risk

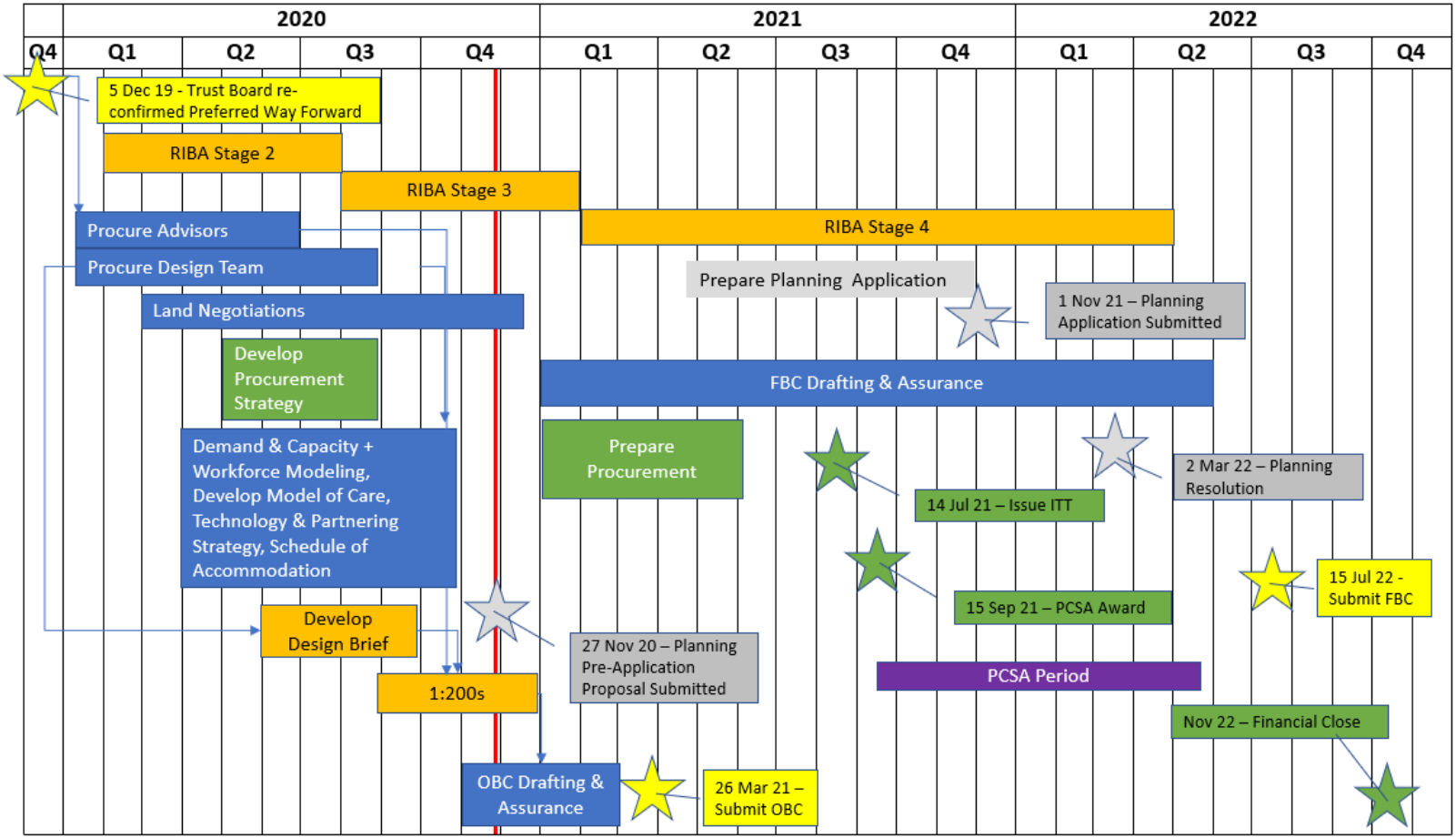
The new hospital BAF risks remains at 16 following detailed review at the New Hospital Committee.

6.0 Programme

Please see Appendix 1 for updated high-level programme view.

The Princess Alexandra Hospital NHS Trust

NEW HOSPITAL PROGRAMME – HIGH LEVEL VIEW (AS AT 26 NOV 20)



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NHS Trust

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4.1

Trust Board – 03.12.20

4.2

Agenda item:	4.2
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 End of Life Nick Kroll – Graduate Trainee – Informatics Information Team
Date prepared:	November 2020
Subject / title:	Learning From Deaths Update – Oct 2020 Information

Purpose:	Approval		Decision	X	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. The paper provides details of the key learning identified from the reviews and this month provides a focus on the Pneumonia Quality Improvement programme. It also provides an updated improvement programme for Sepsis							
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 and QSC.27.11.20
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 – Updated Sepsis Improvement Driver Diagram

1.0 Purpose/issue

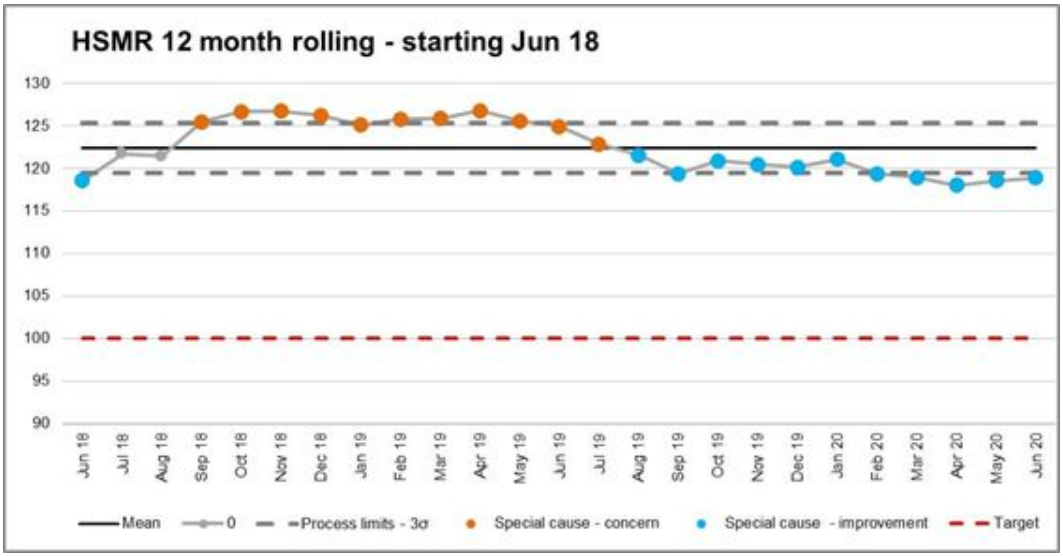
The purpose of this paper is to provide assurance on the implementation of the Learning from Death process, to highlight key pieces of learning and to provide progress updates on the current programme of work to improve clinical practice.

2.0 Background

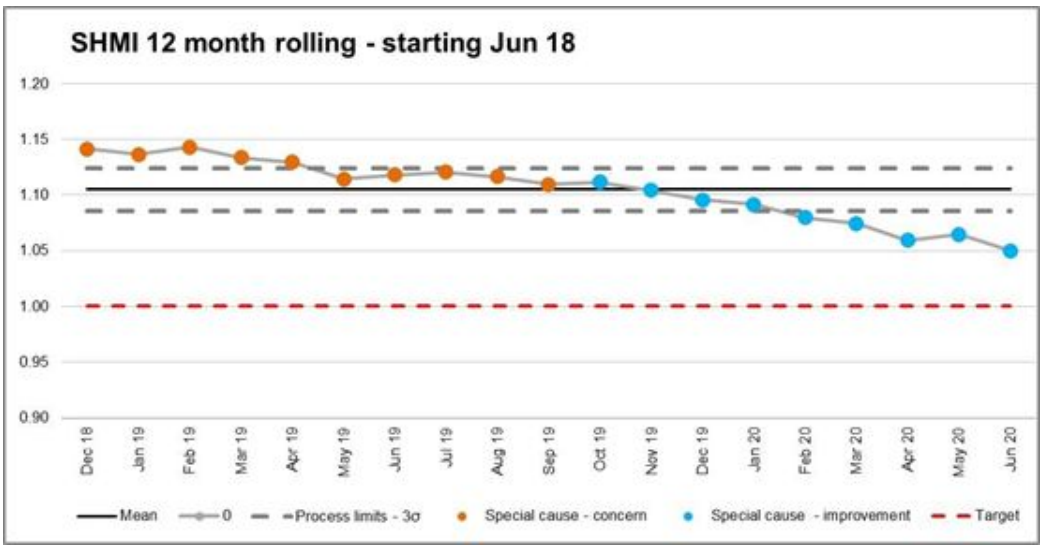
PAHT now has a Learning from Death process that meets the National requirements. Every death has a level one review by a Medical Examiner, at least 25% of all deaths are referred for a Structured Judgement Review (SJR) to be undertaken including all the mandatory reviews and those of our local outliers, and all other deaths are reviewed through the local Mortality and Morbidity process using a standardised level 2 review template. For any death that has an avoidability score of 1 or 2 (definitely avoidable or strong evidence of avoidability) these cases are referred to the Second Review Panel.

3.0 Current Dr Foster/ NHS D Data Headlines

3.1 Tables



PAHT has shown significantly high HSMR since November 2016. The SPC chart above shows the most recent 12 month rolling data point is 118.9. While the previous months show special cause improvement, this should be taken with caution as the trust is still a significant outlier in our HSMR.



The most recent SHMI value is 1.05. We have not alerted since April 2019.

There are 4 diagnostic groups that are significantly higher than expected (HSMR only) (appendix 1):

- Acute and unspecified renal failure
- Aspiration pneumonitis
- Senility and organic mental disorders
- Septicaemia

Of the 10 diagnostic groups that have SHMI values calculated, all 10 are “As expected”.

3.2 There is a decision taken to replace the existing learning from deaths software with an alternative system that meets all of PAHT’s requirements. A paper will be going to the Capital Working Group for approval and ICT Programme Board for information.

3.3 There is also need to develop an automated dashboard that allows the user to see the big picture as well as deep dive into the detail (e.g. consultant, speciality and diagnosis) as close to real-time as possible. Increasing visibility and accessibility to this data and information will increase accountability if used as part of the accountability framework going forwards. Work will commence on this once the new learning from deaths software is in place.

4.0 Summary of Learning from Death Data

4.1 From the SJRs completed from last month the following have been identified as key pieces of learning:

- Missed opportunities to discuss patients preferred place of death
- Patients developing aspiration pneumonia during admission
- Delays in starting end of life care

4.2 Positive aspects of care from SJR’s include:

- Good care and treatment

- Good communication with families

4.3 There were no cases referred to the second review panel and therefore no avoidable deaths identified.

4.4 5 x incidents were logged following SJR completion. 4 of these are for local learning and 1 is for community learning and feedback.

4.5 Within Family and Women's Health, there was 1 still birth at 26 weeks gestation and one neonatal death at 32+3 weeks gestation. There are no direct learning opportunities initially highlighted but one of the cases is being reviewed externally to provide third party insight to reduce the risk of anything being missed. Both cases will be discussed at paediatric mortality review group and any learning from the incident will be shared locally.

There were no paediatric deaths within Dolphin ward but 1 from Paediatric Emergency Department where the patient attended dead on arrival.

5.0 Current Learning from Deaths and Improving Patient Outcome programme

5.1 The data, from the Learning from Death process has been amalgamated to inform our improvement programme going forward. The following are the programmes of work currently being taken forward by the Trust to address the key pieces of learning:

End of Life Quality Improvement Programme

- Focus on identification and referral to correct pathway.
- Training and development for all staff involved to improve confidence and capability.
- Assessment and recording of individualised plans of care.
- Initiation of early conversations with patients and families and recording of preferred place of death (PDD)

AKI/Sepsis

- Focus on early recognition and early intervention.
- Review of Sepsis improvement programme with updated driver diagram – see Appendix 2
- Lead clinician reviewing all sepsis recorded deaths with coders to target areas for improvement
- Sepsis 6 pathway updated to meet National recommendations and being shared with staff
- Business Case being prepared to purchase AKI/Sepsis Safety Track and Trigger tool on NerveCentre.

Speciality Assessment Tool

- Associate Medical Director for Unplanned Emergency Care taking forwards ongoing monitoring and compliance as business as usual.

Acute Respiratory Pathway including aspiration pneumonia

- Implementation of Non-Invasive Ventilation outside of Critical Care. Patients are now receiving NIV on Locke ward feedback is very positive to date.
- Project group set up and have completed Root Cause Analysis to inform focus for QI work for aspiration pneumonia.
- Developing solutions for better communication regarding patients feeding at risk and those with dysphagia.
- Focus on compliance with Pneumonia and COPD admission care bundle with early identification and interventions.

Fractured neck of femur

- Focus on expediting patients safely and in a timely manner from ED to Hip Fracture ward and ensuring escalation bed on ward always available.

5.2 The Learning from Death process is dynamic and will inform the need for further additions to this programme of work.

5.3 Following the SJR findings of a number of patients being admitted at the end stage of their oncology pathway, all in-patient deaths are now being reviewed by the Acute Oncology Service to ensure learning is shared with the appropriate teams. No incidents or errors have been identified; however missed opportunities for oncology input for advice has been noted. Individual specialties are contacted with this information for their learning.

5.4 A review of the notes coded as 'Senility and organic mental disorders', as flagged in the latest Dr Foster report, is being undertaken. The findings and recommendations from this will be presented at the December Strategic Learning from Deaths Group.

5.4 A significant amount of work has been undertaken over the past few months to standardise the M&M process and relaunch these meetings in areas that had lapsed due to COVID. A compliance report will be presented on a monthly basis to the operational Learning from Death group for escalation and actions for each specialty.

5.3 On a monthly basis a more detailed focus will be on one aspect of the key learning from the review process. This report will provide an update on the Pneumonia Quality Improvement programme

6.0 Pneumonia Improvement Programme

6.1 A deep dive was undertaken with the Lead Respiratory Consultant to explore the causes of our high pneumonia HSMR. The following actions are taking place to address the findings.

6.2 Exploration with the Urgent Care Leadership team is planned to explore causes of non-compliance with elements of the pneumonia care bundle so that improvements can be targeted to address these.

6.3 Inaccurate recording of first episodes of care is to be addressed through respiratory review with coders to identify areas of development that can be shared with clinicians. Learning from Structured Judgement Reviews and Mortality and Morbidity meetings should also be targeted to inform learning

6.4 Under-reporting of co-morbidities is to be addressed through the continued use of the Speciality Assessment tool and training to improve compliance with the use of this.

7.0 Summary of External Consultants Analysis

The Trust has also engaged an external consultant to analyse our HSMR and SHMI historical data to identify trends and root causes for our HSMR deterioration and make recommendations to address this. In Summary his findings were:

7.1 The impact of wider (external) local health and care provision changes, leading to more patients coming to PAHT, leading to an increase in overcapacity also remains unclear.
7.2 The impact of changes in the Trusts role in the end of life pathway remains unclear.

7.3 Concerns over our poor depth of coding not capturing the complexity of our patients, including the fact that palliative care coding, did not keep pace with the increase in hospital deaths (driven by an ageing population) is likely to be deflating the expectation of death.
7.4 Mortality outlier status is driven by a small number of diagnosis of which pneumonia, aspiration pneumonia and septicaemia are predominate.
7.5 There are no stand out markers of the increase in mortalities being directly attributable to the care being provided as the mortality rate for the WECCG population does not change, as it might be expected to.

8.0 Risks for Escalation

The Trust has now developed 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.

The Committee is asked to note a rise in the risk level for delivery of the standardised M&M process in all specialities due to varied engagement and some variation in compliance with medically led SJR completion. This is being addressed by the Associate Medical Directors. Compliance is being monitored and gaps will be escalated in the first instance to the AMDs. The aim of this is to ensure continuous learning from deaths and near misses that are shared and influence the Trust's improving patient outcome strategy.

8.0 Recommendations

8.1 To note the progress with the Learning from Death process and the key actions being taken to embed the learning and to improve clinical practice.

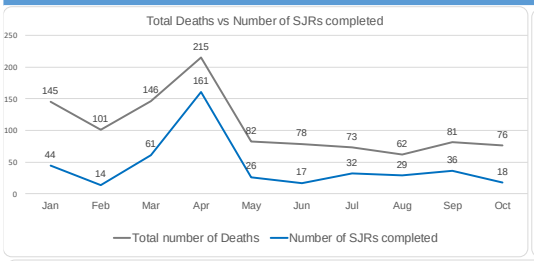
8.2 For the Group/Board to provide feedback on the contents of the paper to ensure a dynamic development of the information provided so that assurance can be provided.

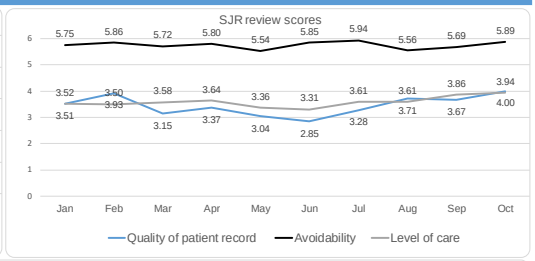
Appendix 1 – Mortality dashboard

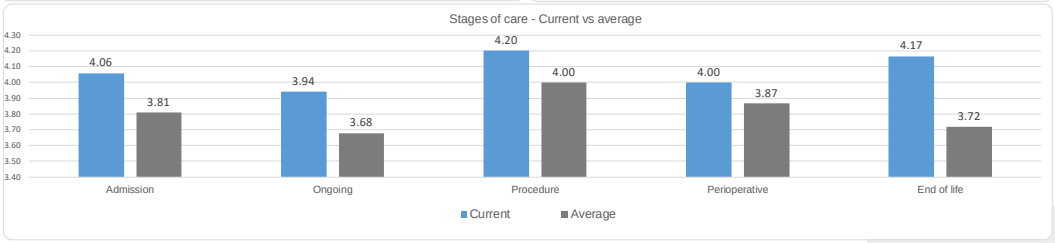
Mortality Dashboard

NHS The Princess Alexandra Hospital NHS Trust

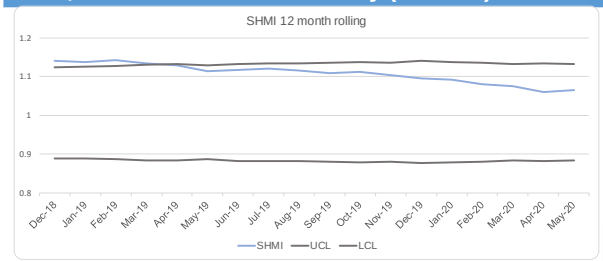
Learning from deaths

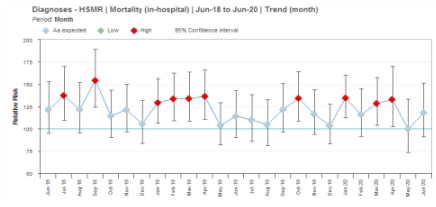


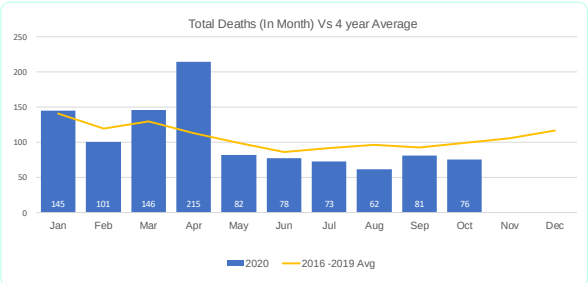




SHMI, HSMR and crude mortality (Cosmic)

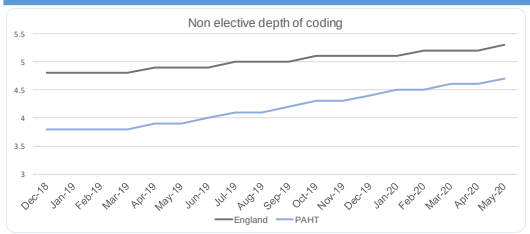


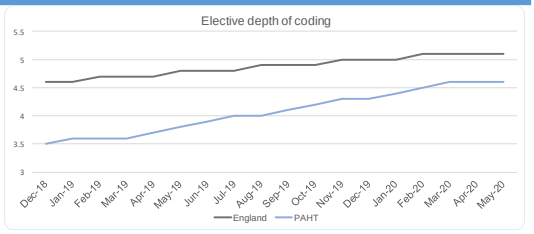


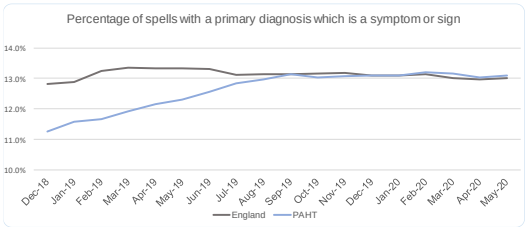


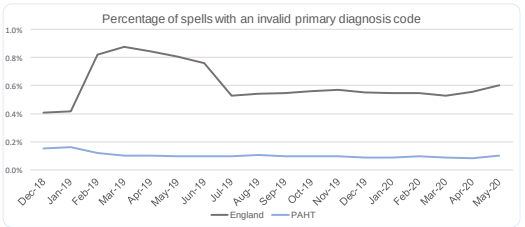
Diagnostic groups with alert status	Observed Deaths	Expected deaths	Excess deaths	HSMR
Acute and unspecified renal failure	48	31	17	156.7
Aspiration pneumonitis	70	53	17	132.6
Senility and organic mental disorders	19	11	8	178.4
Septicaemia	142	111	31	128.4

Coding









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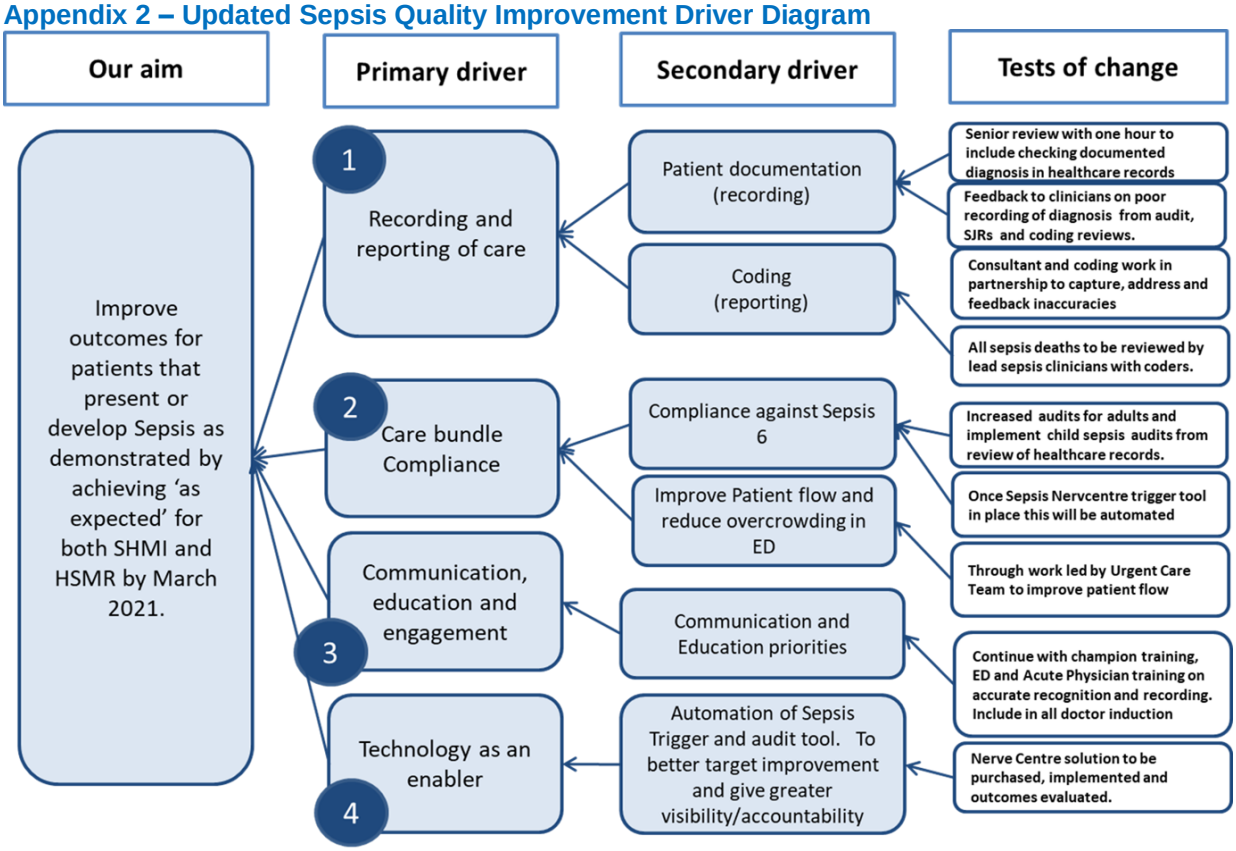
respectful | caring | responsible | committed

Appendix 2 – Updated Sepsis Quality Improvement Driver Diagram



Trust Board 03.12.20

4.3

Agenda item:	4.3
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery
Date prepared:	November 2020
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels (Hard Truths) and an Update to Nursing and Midwifery Workforce Position

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	Staffing risk rating in month: Green This paper provides the regular nursing and midwifery retrospective staffing report for the month of October 2020 and provides an update to the workforce position (part B). While every effort has been made to ensure the overall information is accurate due to the number of moves of wards across the month there remains a risk that some of the individual ward data remains inaccurate. The fill rate for overall RN/RM in month has increased to 100.6%, which is an increase of 4.0% against September 2020. Temporary staff usage has increased with the reopening of capacity across the Trust and the requirement for additional staffing across ITU and endoscopy to support covid pathway recovery. The overall nursing vacancy position has fallen slightly in month to 8.5% and Band 5 to 9.8%. The establishment data and workforce plan have been amended with the uplift in staff agreed as part of the establishment review approved in January 2020 and confirmed at SMT in September. The international recruitment pipeline has reopened supported by the NHSE/I programme.
Recommendation:	The Board is asked to note the information within this report

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

Previously considered by:	WFC.30.11.20
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	Appendix 1: Ward level fill rates Appendix 2: Registered fill rates by month. RAG rated.

1.0 PURPOSE

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

2.0 BACKGROUND

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

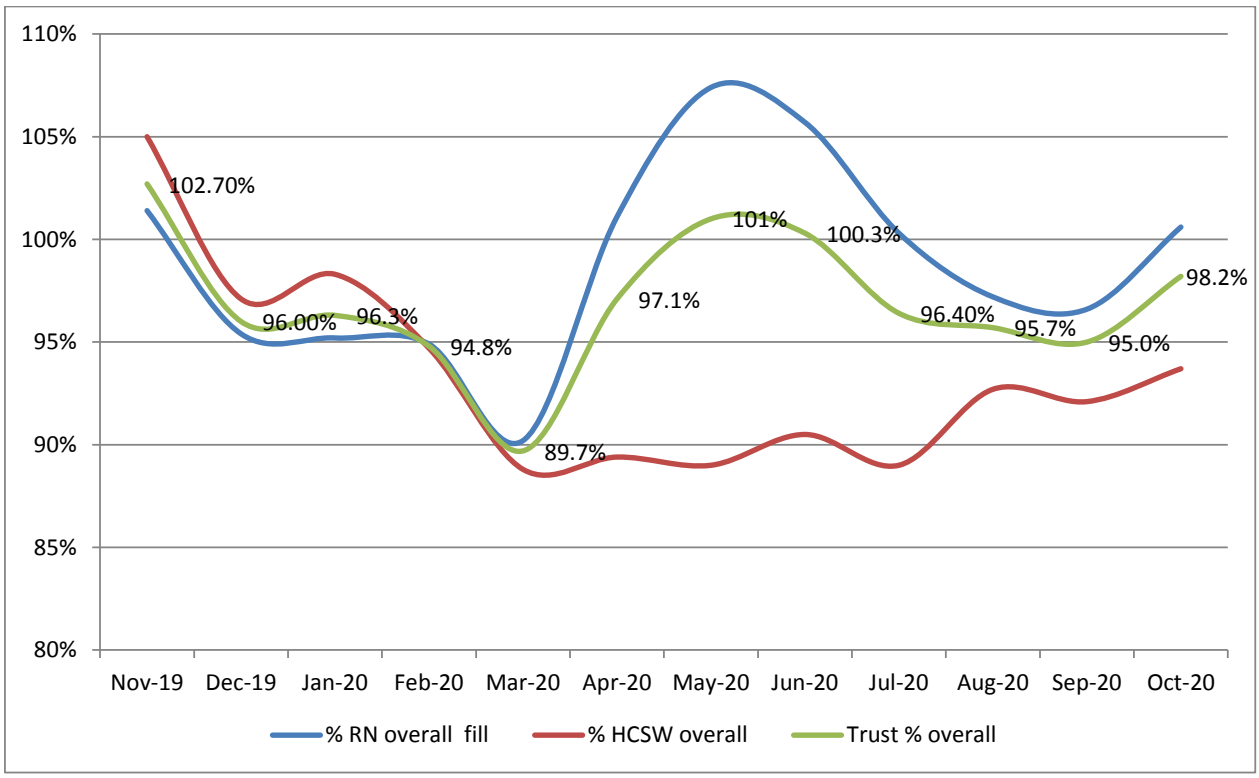
3.0 ANALYSIS

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

3.2 The summary position for the Trust Safer Staffing Fill rates for November 2020. The fill rate for overall RN/RM in month has increased to 100.6%, which is an increase of 4.0% against September 2020.

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

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
In Patient Ward average October 20	99.7%	91.3%	101.7%	97.1%	100.6%	93.7%	98.2%
In Patient Ward average September 20	95.2%	86.2%	98.4%	100.7%	96.6%	92.1%	95.0%
Variance September - October 2020	↑4.5%	↑5.1%	↑3.3%	↓3.6%	↑4.0%	↑1.6%	↑3.2%



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

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

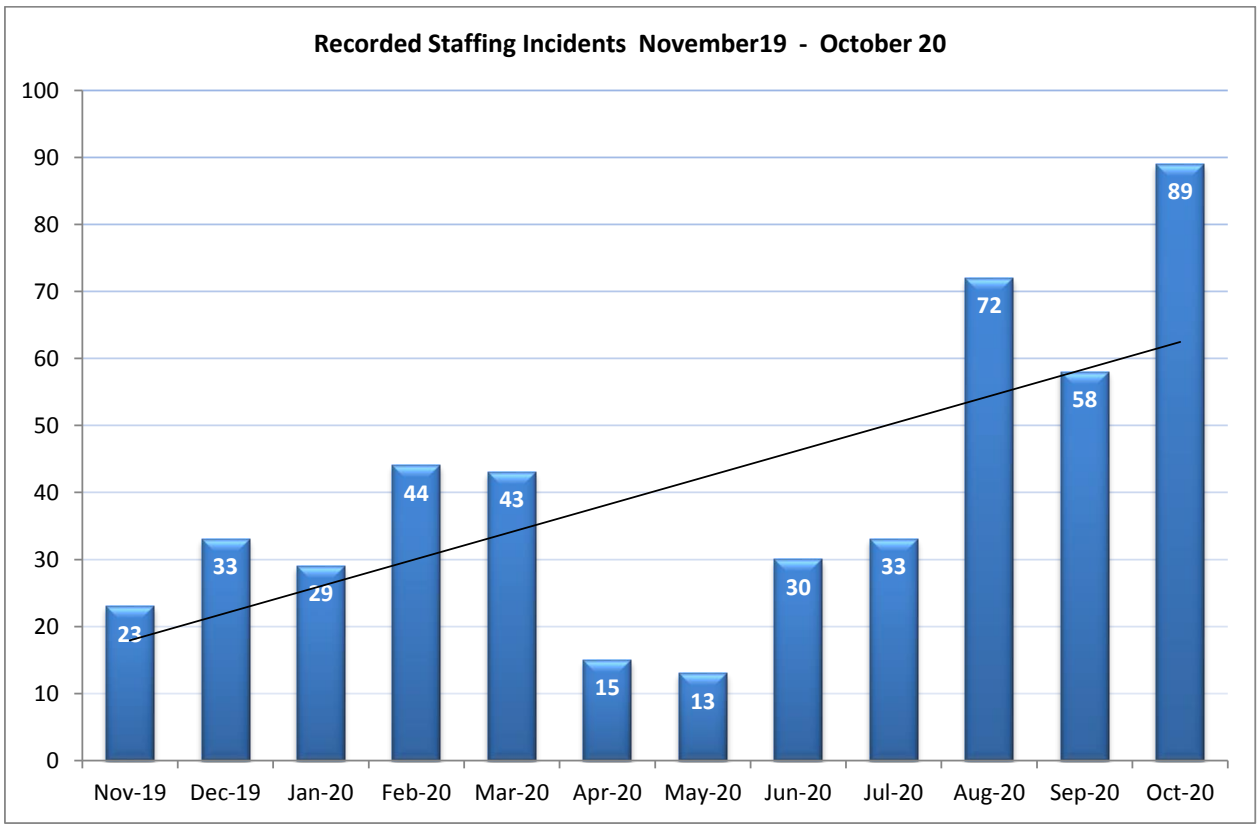
Red <75%	Amber 75 – 95%	Green >95%

	Day		Night	
September 2020	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
A&E Nursing	89.8%	71.5%	91.7%	69.7%
PAH Theatres *	118.5%	43.8%	127.1%	93.7%
Endoscopy Nursing	81.5%	80.6%		

**Registered Nurse demand and fill, ODP demand and fill excluded.*

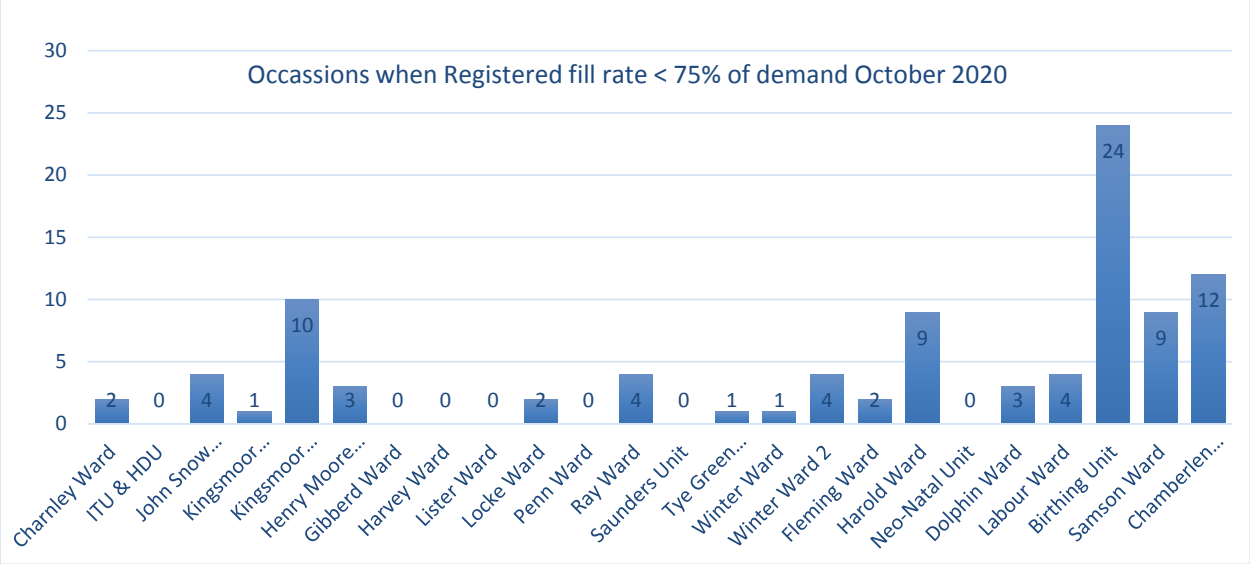
The demand template for theatres fluctuates according to recovery plan and is difficult to establish a fixed baseline template as changes daily due to the number of areas open and responding to the requirement for a red and green pathway for elective surgery.

3.5 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 has increased. The increase in datix reports is driven by 2 areas: ED (39) and Tye Green (19). There are no patient safety issues that have been identified as a result of the datix incidents raised. The skill mix of substantive staff within ED remains challenging as well as staffing to cover Red ED. Regular meetings have been held with the ED staff to ensure all actions are in place to support staffing and ensuring safety plans are in place. Tye Green are using datix to flag shifts where they are unable to fully meet the enhanced care needs of patients. This is part of the Trust Enhanced Care Pilot.



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

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



3.7 Care Hours per Patient Day* (CHPPD) has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018). The table below shows the Trust data from the Model Hospital. Current model hospital data for national median is based on latest available data. This shows the Trust and National data from August 2020, this shows that the Trust is now just under the National median for Registered CHPPD; as well being below the national median for overall CHPPD and HCA CHPPD.

	Trust August 2020 data	National Median (August 2020)	Variance against national median
CHPPD Total	8.0	9.7	↓1.7
CHPPD RN	5.4	5.5	↓0.1
CHPPD HCA	2.7	3.8	↓1.1

Data checked on Model Hospital 4.11.2020

3.8 Bank and Agency fill rates:

The day-to-day management of safer staffing across the organisation is managed through the 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.

The data for October shows there has been an increase in registered requirements This is in response to opening additional ward areas: Gibberd and Kingsmoore with expanded elective surgery capacity. The main areas utilising agency staff are A&E Nursing and Maternity. The table below shows that

there was an increase in registered demand (↑ 377 shifts) in October compared to September. October shows a corresponding increase in agency usage (↑84 shifts).

The HCSW demand shows a decrease in unregistered demand (↓ 72 shifts).

RN temporary staffing demand and fill rates*: (October 2020 data supplied by NHSP 5.11 .2020)*

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
May 20	1857	1401	75.4%	337	18.1%	93.6%	119	6.4%
June 20	982	748	76.2%	75	7.6%	83.8%	159	16.2%
July 20	1594	1139	71.5%	172	10.8%	82.2%	283	17.8%
August 20	2259	1598	70.7%	219	9.7%	80.4%	442	19.6%
Sept 2020	2438	1630	66.9%	204	8.4%	75.2%	604	24.08%
October 2020	**2815**	**1862**	**66.1%**	**288**	**10.2%**	**76.4%**	**665**	**23.6%**
October 2019	3889	1801	46.3%	1016	26.1%	72.4%	1072	27.6%

HCA temporary staffing demand and fill rates: ***(October 2020 data supplied by NHSP 5.11 .2020)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
May 20	1314	1095	83.3%	0	0%	83.3%	219	16.7%
June 20	642	532	82.9%	0	0%	82.9%	110	17.1%
July 2020	856	650	75.9%	0	0%	75.9%	206	24.1%
August 20	1357	1038	76.5%	0	0%	76.5%	319	23.5%
Sept 2020	1516	1023	67.5%	0	0%	67.5%	493	32.5%
October 2020	**1444**	**1049**	**72.6%**	**0**	**0%**	**75.3%**	**613**	**24.7%**
October 2019	2486	1873	75.3%	0	0%	75.3%	613	24.7%

B: Workforce:

Nursing Recruitment Pipeline

The overall nursing vacancy rate in October has fallen to 8.5% as a result of the reopening of the international pipeline and students entering the NMC register. The team are working to bring offer holders over in line with Covid requirements. The table below shows the increase in establishment in September 2020 following confirmation at SMT of the allocations of the agreed additional nursing posts from the 2019/20 establishment review.

Turnover rates continue to remain static at 10.12%.

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Funded Establishment WTE	942.61	942.61	942.61	942.61	942.61	966.25	966.25	966.25	966.25	966.25	966.25	966.25
Staff in Post WTE	871.00	868.00	866.00	858.00	862.00	856.00	884.00	884.00	889.00	891.00	915.00	939.00
Vacancy WTE	71.61	74.61	76.61	84.61	80.61	110.25	82.25	82.25	77.25	75.25	51.25	27.25
Actual RN Vacancy Rate	7.6%	7.9%	8.1%	9.0%	8.6%	11.4%	8.5%	8.5%	8.0%	7.8%	5.3%	2.8%
Forcast Vacancy Rate in Business Plan												

Band 5 Establisment V Staff in Post												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Funded Band 5 Establisment WTE	487.93	487.93	487.93	487.93	487.93	522.2	522.2	522.2	522.2	522.2	522.2	522.2
Band 5 Staff in Post WTE	447	446	446	450	446	471	471	472	470	486	502	518
Band 5 Starters	1	0	2	7	1	28	3	7	4	22	22	22
Vacancy Band 5 WTE	40.93	41.93	41.93	37.93	41.93	51.2	51.2	50.2	52.2	36.2	20.2	4.2
Actual Vacancy Rate	8.4%	8.6%	8.6%	7.8%	8.6%	9.8%	9.8%	9.6%	10.0%	6.9%	3.9%	0.8%
Forcast Vacancy Rate in Business Plan												

Actual/Projected Starters Pipeline												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RNs (not Band 5)	2	0	0	0	0	4	6	6	6	10	10	10
Band 5 Newly Qualified + Local	1	0	1	7	1	7	3	1	0	2	2	2
Band 5 International Recruitment	0	0	0	0	0	21	0	6	4	20	20	20
Band 5 Starters	**1**	**0**	**1**	**7**	**1**	**28**	**3**	**7**	**4**	**22**	**22**	**22**
Total Starters	3	0	1	7	1	32	9	13	10	32	32	32

Projected Leavers WTE												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
RNs (not Band 5) Leavers	3	1	7	0	2	1	6	2	2	2	2	2
Band 5 Leavers	3	1	2	3	5	3	3	6	6	6	6	6
Total Leavers	**6**	**2**	**9**	**3**	**7**	**4**	**9**	**8**	**8**	**8**	**8**	**8**
N&M Turnover %	10.53%	10.18%	10.12%	10.17%	10.17%	9.68%	10.12%					

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: **13th November 2020**

Appendix 1.

Ward level data: fill rates October 2020.

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

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

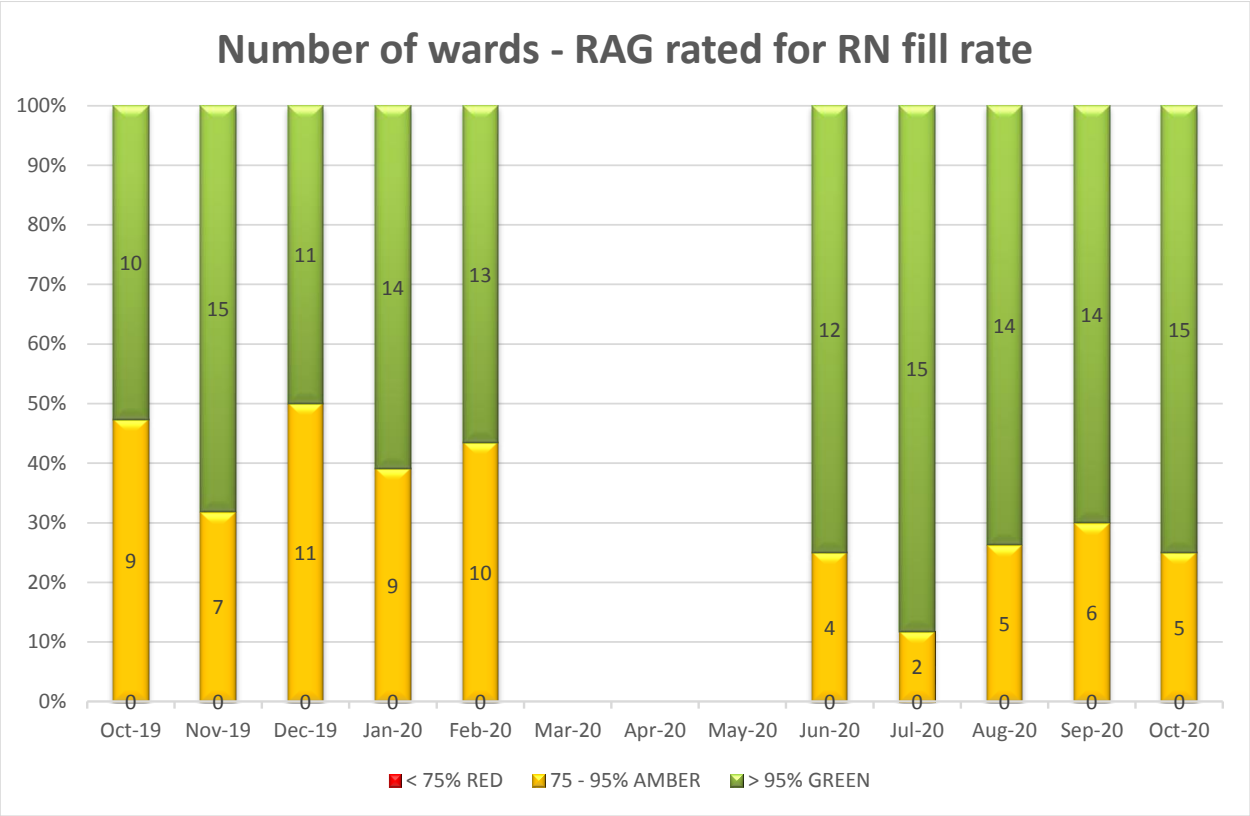
Analysis of areas with red fill rates has not been undertaken this month as there is still several DQ issues with the data due to the number of ward moves across the month.

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
Charnley Ward	95.4%	93.3%	79.2%	109.7%	88.6%	99.5%	92.5%
ITU & HDU	112.9%	127.9%	120.5%	109.7%	116.7%	118.8%	116.9%
John Snow Ward	93.0%	100.9%	99.0%	96.9%	95.4%	99.0%	96.7%
Kingsmoor Ward	105.3%	79.0%	116.1%	112.9%	109.4%	89.6%	102.0%
Kingsmoor Orthopaedic	90.9%	109.0%	96.9%	45.2%	93.2%	78.5%	88.8%
Gibberd Ward	119.3%	89.7%	100.0%	95.5%	110.1%	91.9%	101.7%
Harvey Ward	93.6%	77.4%	104.4%	76.5%	98.0%	76.9%	88.3%
Lister Ward	89.0%	89.8%	94.7%	97.9%	86.8%	93.1%	89.6%
Locke Ward	101.0%	70.0%	95.9%	98.4%	98.6%	80.7%	92.5%
Penn Ward	94.3%	93.7%	103.3%	111.3%	98.1%	100.4%	98.9%
Ray Ward	94.4%	84.4%	110.0%	109.1%	101.0%	92.1%	97.4%
Saunders Unit	93.1%	91.3%	100.2%	93.6%	96.1%	92.3%	94.4%
Tye Green Ward	96.3%	94.2%	97.1%	104.9%	96.6%	98.6%	97.5%
Winter Ward	107.8%	87.9%	125.2%	115.0%	114.0%	98.2%	107.9%
Winter Ward 2	112.2%	91.5%	100.0%	100.8%	107.3%	95.2%	102.4%
Fleming Ward	95.9%	84.5%	104.0%	97.1%	99.3%	89.2%	95.7%
Harold Ward	85.0%	95.7%	102.3%	93.9%	92.1%	95.0%	93.2%
Neo-Natal Unit	103.5%	118.9%	106.2%	100.0%	104.9%	109.4%	105.6%
Dolphin Ward	90.6%	76.2%	91.7%	92.7%	91.1%	81.7%	88.7%
Maternity	109.3%	106.3%	95.1%	92.2%	102.5%	99.6%	101.7%
Total	99.7%	91.3%	101.7%	97.1%	100.6%	93.7%	98.2%

Appendix 2

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

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



The Princess Alexandra Hospital NHS Trust

Trust Board – 03.12.20

4.4

Agenda item:	4.4
Presented by:	Sharon McNally – Director of Nursing, Midwifery and AHPs
Prepared by:	Sharon McNally Sarah Webb – Deputy Director of Nursing, Midwifery and AHPs.
Date prepared:	2nd November 2020
Subject / title:	Nursing, Midwifery and AHP Strategy 2020 – 2023.

Purpose:	Approval		Decision	x	Information		Assurance	
Key issues:	Developed following consultation across nursing, midwifery and allied health professionals (AHPs), the strategy launches our vision to lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes and sets three goals which link to the Trust goals of Outstanding, Integrated and Modern. The strategy sets out an underpinning programme of work to be undertaken over the next 3 years. Work in year one (2020/21) has already commenced and achievements delivered.							
Recommendation:	To approve the nursing, midwifery and AHP strategy.							

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

Previously considered by:	EMT (August 2020) PAH professional consultation period September 2020. Nursing, Midwifery and AHP Senior Leadership Group (approved Oct 2020) WFC.30.11.20
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	
Appendices:	NMAHP Strategy

Nursing, Midwifery and Allied Health Professionals

The Princess Alexandra Hospital NHS Trust

4.4

Strategy 2020-2023

Introduction from Director of Nursing, Midwifery and AHPs

At the start of 2020, the International Year of the Nurse and the Midwife, it was anticipated that across the nation there would be a chance to showcase and celebrate the professions. By March the country was in the grip of a global pandemic, all NHS staff were in the spotlight and public opinion was very much focused upon celebrating the hard work, dedication and commitment of all staff, especially nurses and midwives. I am proud to have worked alongside all of you during this difficult time and thank you for your professionalism, compassion and hard work.

At some point in all of our personal lives we shall come into contact with nurses, midwives and AHP's and the confidence of the public and their perception of our professions are crucial. Likewise, as we continue to address the workforce challenges and shortfalls, our professions need to be seen as high value career opportunities.

In 2019 the Chief Nurse for England, Ruth May, set out three goals for nurses and midwives; to address workforce shortfalls, to enhance pride in the professions, strengthening the perception of nursing and midwifery as high value careers and to influence and lead change at every level across the NHS.

At The Princess Alexandra Hospital NHS Trust (PAHT) we have a highly skilled nursing, midwifery and Allied Health Professional (AHP) workforce delivering complex patient care across a broad range of roles. Whilst our professions are the most trusted by the public, there is more to do if we are to realise our true value in delivering the PAHT ambition to be an outstanding organisation.

Central to the achievement of the Trust goals of Outstanding, Integrated and Modern will be the delivery of transformational change which is supported and influenced by evidence based practices.

Over the next 2-4 years the Trust will have a new electronic patient record (EPR) system and we will move into a digitally enabled new hospital with new pathways of care for our patients. These enormous and exciting changes provide us with a wonderful opportunity to shape the nursing, midwifery and AHP workforce, fully recognising and valuing the contribution of everyone, regardless of background and ensuring equal and fair treatment for all staff. I am confident that we will strengthen the leadership opportunities across all roles within nursing, midwifery and AHP's, enabling effective decision making that ensures care that is fit for the future.

This Strategy document launches our three goals which link to the Trust goals of Outstanding, Integrated and Modern, the details are described in the body of the document. To ensure we achieve our vision and meet our goals our strategy has been developed with an underpinning a programme of work to be undertaken over the next 3 years.

'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

I look forward to working with all of you to ensure that we realise our vision to lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes.

Goals

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

Outstanding

We will strive to deliver excellence through evidence based practice demonstrating our positive contribution to patient outcomes

Integrated

We will provide the right staff, with the right skills to deliver the right care in the right place

Modern

We will be innovative and adaptive to create a dynamic environment where research and technology enhances patient outcomes

'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

Alignment with the national framework

Chief Nurse and NHS LTP Priorities

Renew the reputation of our profession for the future

Stereotypes around the profession need to be removed and the profile of their integral role within healthcare need to be raised. The workforce is highly skilled and works in a breadth of roles, something which is not widely understood. These extraordinarily skilled people and leaders need to be recognised for their ability.

A collective voice that is powerful and heard

It is vital that the workforce knows to speak with confidence, understand their value and know the importance of their contribution. A collective voice enables collective leadership and ensures the professions are heard and valued in all decision-making conversations.

Workforce fit for the future

There is a national shortage of nurses, midwives and AHPs which need to be tackled. Steps to be taken include building a workplace which is rewarding and full of opportunity, developing the quality of management and leadership skills, breaking down inequality barriers and creating an infrastructure for volunteers to provide more support to front-line staff.

PAHT Nursing, Midwifery & AHP 2025 Vision

To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes

PAHT Nursing, Midwifery & AHP Objectives aligned to 5Ps

PAHT Nursing, Midwifery & AHP Courageous Goals

Outstanding

we will strive to deliver excellence through evidence based practice demonstrating our positive contribution to patient outcomes

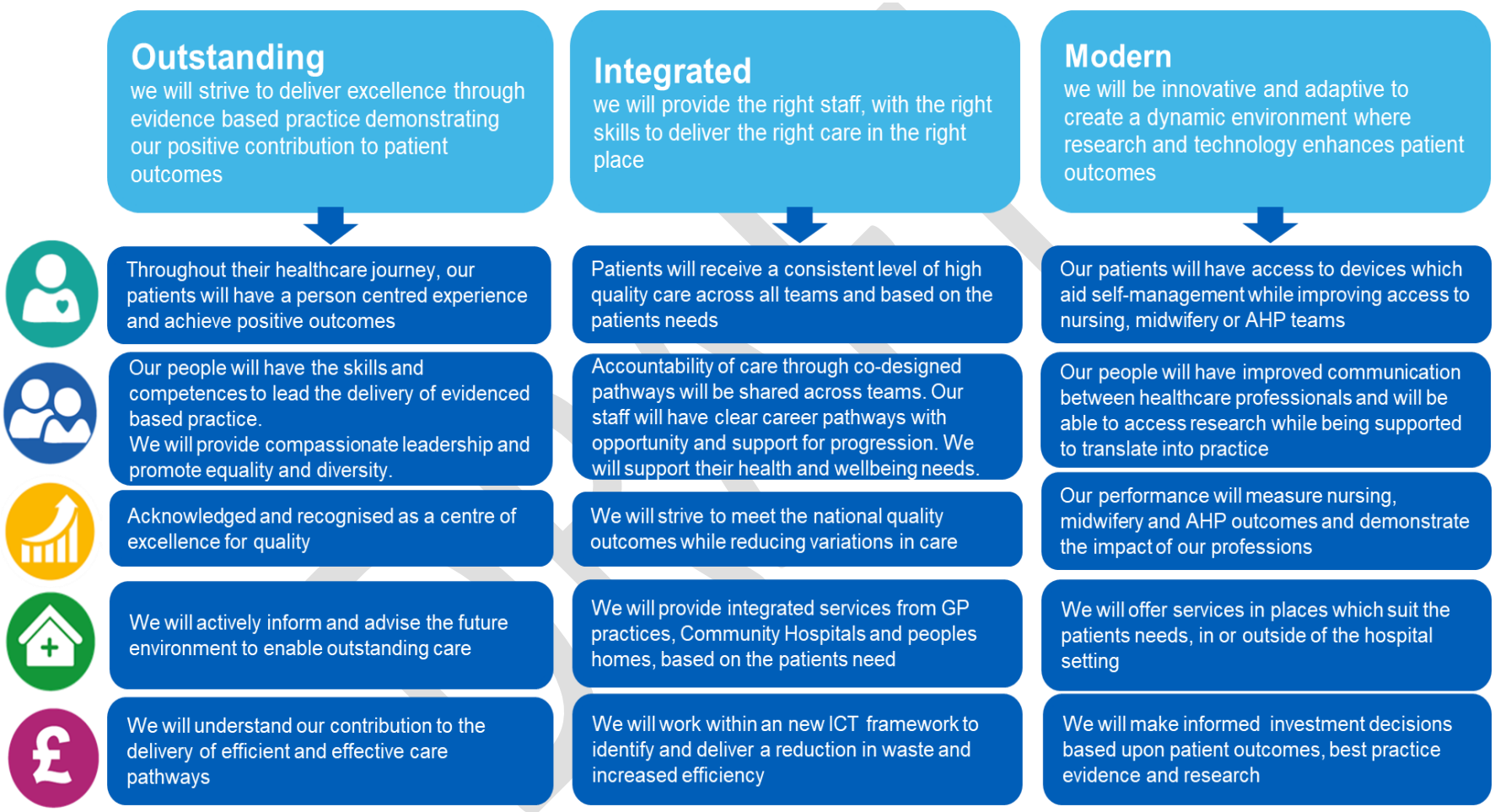
Integrated

we will provide the right staff, with the right skills to deliver the right care in the right place

Modern

we will be innovative and adaptive to create a dynamic environment where research and technology enhances patient outcomes

What do these goals mean to our patients, people, performance, places and pounds?



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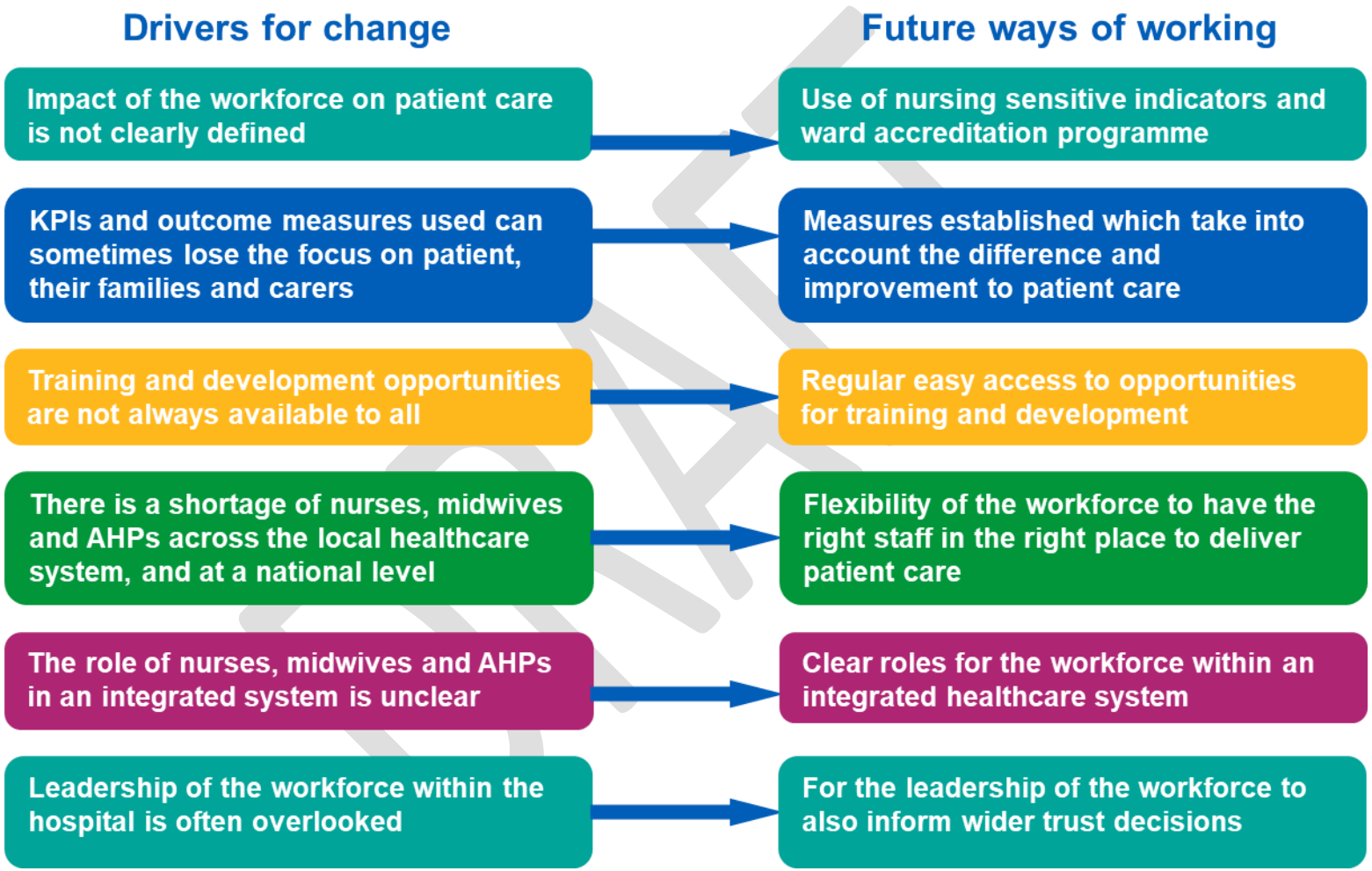
'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

What needs to change and how will it be different?



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'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

Work plan to achieve our goals

2020-21

- Ward managers move to supervisory
- Commence bespoke leadership programme for ward managers
- Implement matron review
- Commence bespoke leadership programme for matrons
- Review ward administrative support to ensure equity and increased ward clerk cover
- Continue to reduce nursing and midwifery vacancies (qualified and unqualified) to less than 2%
- Commence Fundamentals of Care programme to improve nurse led outcomes and promote trust and confidence in nursing
- Introduce ward dashboard to measure nurse sensitive indicators and measure how we are doing
- Commence development of ward accreditation programme
- Commence introduction of shared governance framework across the Trust
- Commence Degree Nurse Apprenticeship programme
- Nursing, Midwifery andAHPs to be actively involved and engaged in developing the clinical pathways for the new hospital
- Strengthening leadership to ensure nursing and therapies embrace digital technology
- Nursing, Midwifery and AHP's actively involved and engaged in development of EPR
- We will work with the Trusts Equaliiy Diversity &Inclusion lead to build a development plan for nursing, midwifery and AHP leadership roles which are under represented by BAME staff

'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

2021-22

- Career development pathways in place maximising shared experience across STP and wider network
- Commence direct entry Nursing Associate Apprenticeship programme
- Develop workforce model for extended practise roles for specific pathways
- Implement fast track development programme to grow our future leaders
- Nurse. midwifery and AHP led discharge embedded
- Enhanced care team in place and demonstrating improved patient outcomes and reduced patient safety incidents
- Evidence based nursing/AHP research programme commences
- Implement Consultant Practitioner role at PAH
- Embed Ward Accreditation programme
- Embed shared governance programme
- Nursing, Midwifery and AHPs to be actively involved and engaged in developing the clinical pathways for the new hospital
- Nursing, Midwifery and AHP's actively involved and engaged in development of EPR

'To lead the delivery of compassionate healthcare to achieve outstanding person centred outcomes'

2022-23

- PAHT part of national accreditation programme (ANA programme or similar)
- At least one ward attains exemplar ward status and at least 50% of wards attain accreditation status
- Nursing, midwifery and AHP workforce will be prepared for EPR and digitalisation
- Comprehensive simulation training programme in place to support MDT learning to support improvements in communicating for better outcomes
- Nursing, Midwifery and,AHPs to be actively involved and engaged in developing the clinical pathways for the new hospital
- Nursing, Midwifery and AHP's actively involved and engaged in development of EPR

The Princess Alexandra Hospital NHS Trust

Trust Board – 03.12.20

5.1

Agenda item:	5.1
Presented by:	Stephanie Lawton
Prepared by:	Elizabeth Podd Head of Performance & Planning & Information Team
Date prepared:	18th November 2020
Subject / title:	M7 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	

Key issues:

Patients:
Note the complaints and PALs data trend, themes and the improvement work underway
A Never Event (NE) reported in month, the first NE reported by the organisation since 2016
The C. Difficile rate has seen a reduction in October to 2 cases
Maternity: the emergency C - section rate has shown an increase over the last few months.
After the increase reported in September, the number of still-births reported in October reduced to 1
The number of reported pressure ulcers and falls has shown a continued positive downward trend over the last 2 months.
Please note the addition of KPIs relating to dementia and learning disability.
Performance:
RTT incomplete performance is head of national average however the number of 52 week breaches are higher than trajectory
Cancer backlog clearance is continuing slowly and the numbers over 104 days have continued to decrease.
Diagnostic recovery is continuing slightly ahead of trajectory despite increased referrals from outside the STP.
A&E Performance continues to be under pressure caused by high non Covid bed occupancy.
People:
Trust vacancy rate a little behind target at 8.4% and staff turnover is at 10%, ahead of the 12% target. Sickness themes emerging as musculoskeletal and stress/anxiety. Mandatory training rates improving and expected to continue. Psychological & physical health & wellbeing work continues, with Trauma & Risk training being carried out this month to enable staff to support colleagues.
Pounds:
Nursing agency spend continues to be under Trust target. CIP delivery increased and revised targets being assessed for HealthCare Groups & departments. Capital spend behind plan however focussed work from Estates team to ensure maintain ability to deliver.
Places:
19/20 emergency backlog maintenance schemes now completed. 20/21 schemes continue to progress and risks to delays being mitigated wherever possible. Main delay risks caused by decant space availability. Completed projects – EBME facility & Alex Study. Domestic Modernisation programme progressing well and Electronic Portering scheme being trialled.

The Princess Alexandra Hospital NHS Trust

Recommendation:	The Committee 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.26.11.20 and QSC.27.11.20
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
October 2020

The purpose of this report is to provide the Board of Directors with an analysis of quality performance.
The report covers performance against national and local key performance indicators.

Your future | Our hospital

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

Simon Covill, Acting Chief Financial Officer

Fay Gilder, Chief Medical Officer

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Trust Objectives

NHS
The Princess Alexandra Hospital
NHS Trust

Our Patients

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

Our People

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

Our Places

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

Our Performance

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

Our Pounds

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

5Ps

In this month

The Princess Alexandra Hospital NHS Trust

Patients

Performance

People

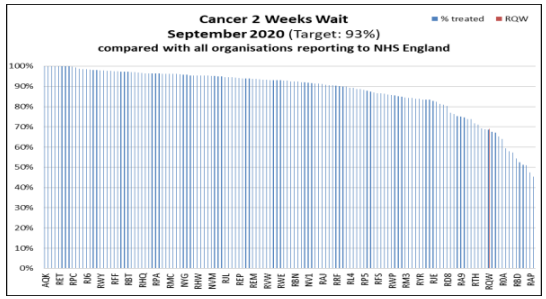
Pounds

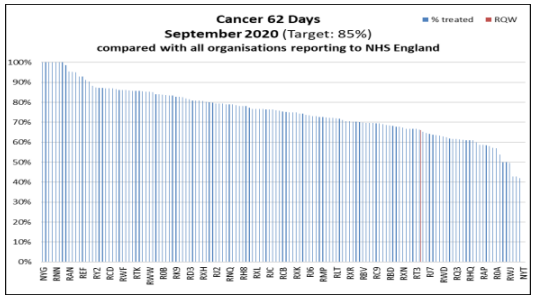
Places

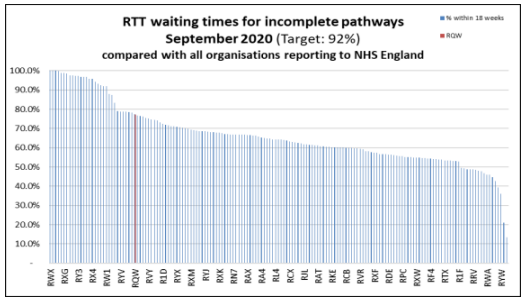
5.1

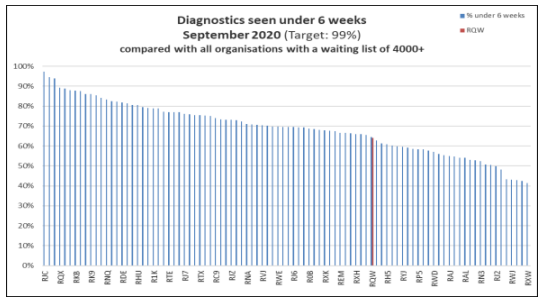
National Benchmarking
Compared with all organisations reporting to NHS England

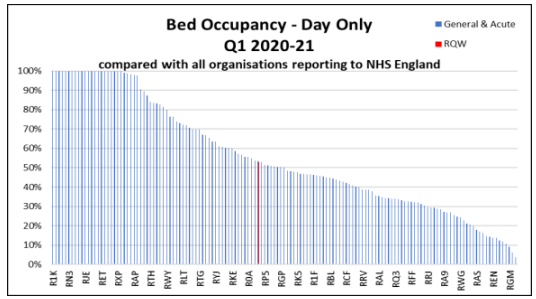
NHS
The Princess Alexandra Hospital
NHS Trust

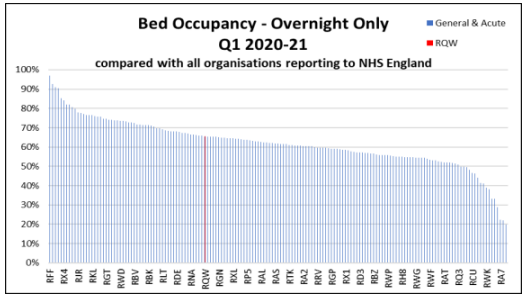


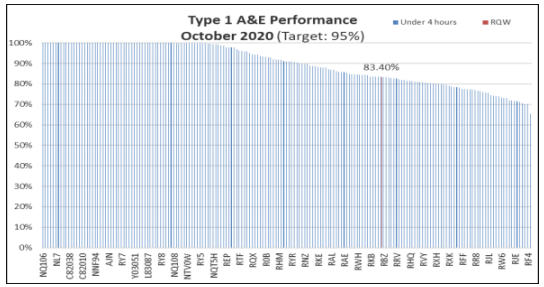


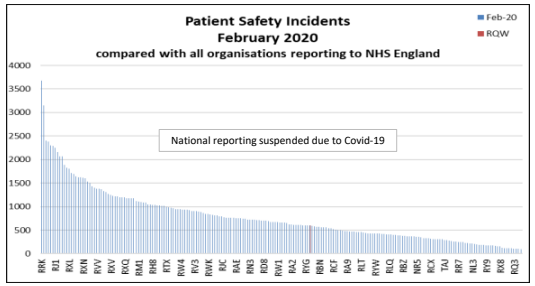


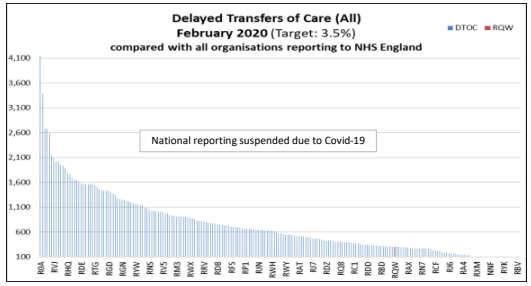












Your future | Our hospital

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

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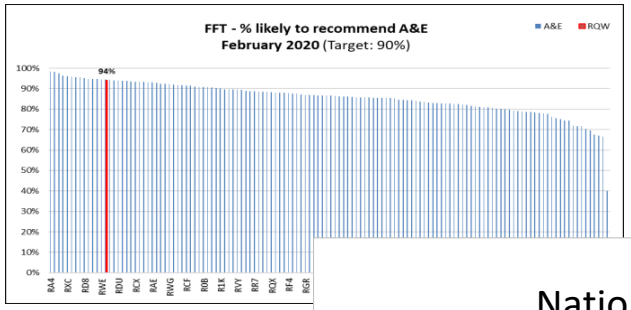
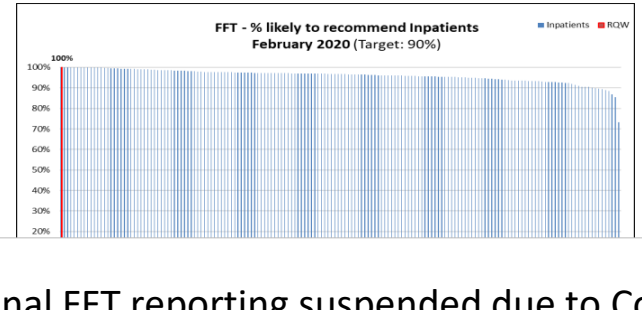
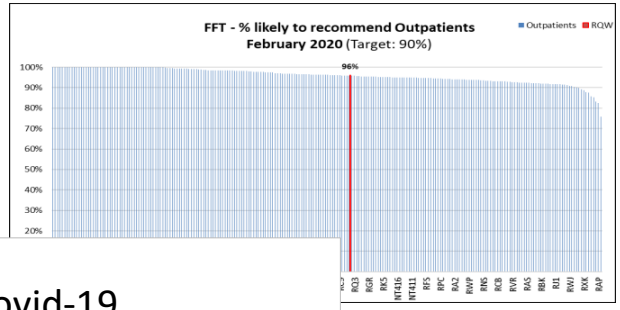
National Benchmarking
Compared with all organisations reporting to NHS England

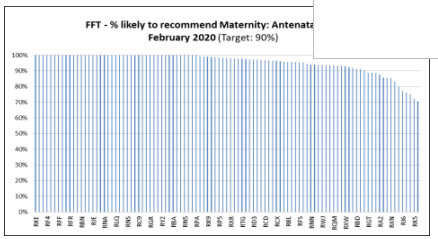
NHS
The Princess Alexandra Hospital
NHS Trust

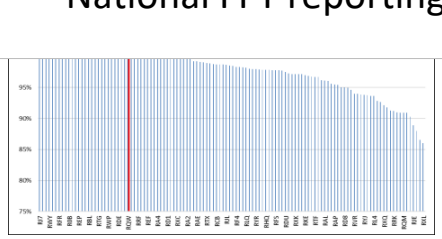


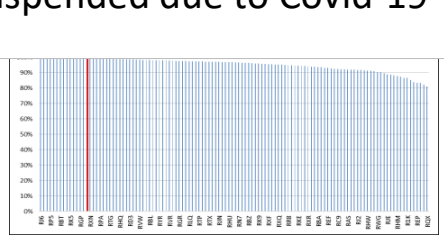


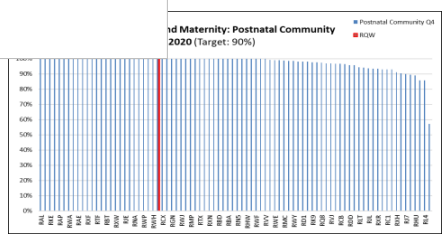


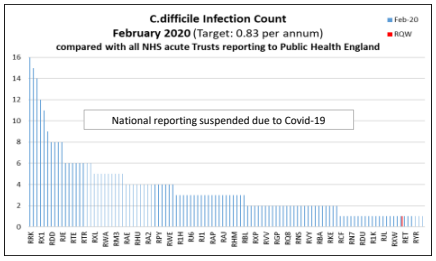
National FFT reporting suspended due to Covid-19

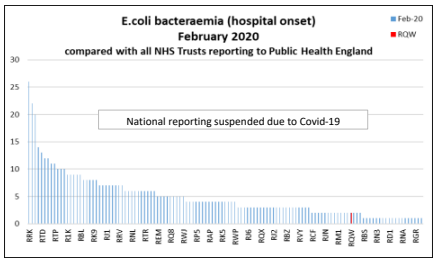


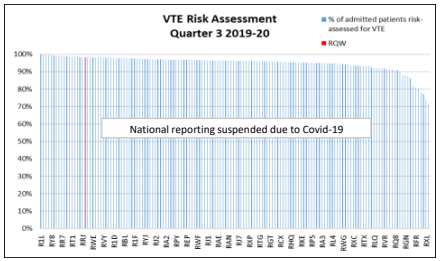


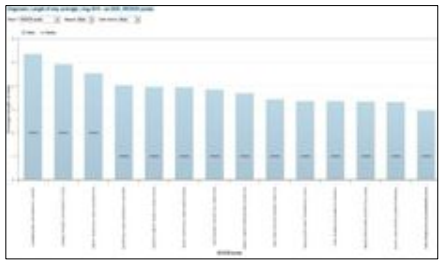












Data Source: NHS England Statistics/Public Health England/Dr Foster

Your future : Our hospital

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Executive Summary Our Patients

The Princess Alexandra Hospital NHS Trust

Patient experience: of note the complaints and PALs data trend, themes and the improvement work underway.

Patient safety: of note the Never Event (NE) reported in month. This is the first NE reported by the organisation since 2016.

Infection control: The C. Difficile rate has seen a reduction in October to 2 cases following and increase seen in August and September. Covid information is included in the data set.

Maternity: the emergency C - section rate has shown an increase over the last few months. This trend is being reviewed by the maternity team to identify causation and any resulting actions. After the increase reported in September, the number of still-births reported in October reduced to 1 - a review of the September increase is being undertaken to understand any underlying themes and expected to report in December.

Harm free care: the number of reported pressure ulcers and falls has shown a continued positive downward trend over the last 2 months.

Mental health: please note the addition of KPIs relating to dementia and learning disability.

Patient Experience

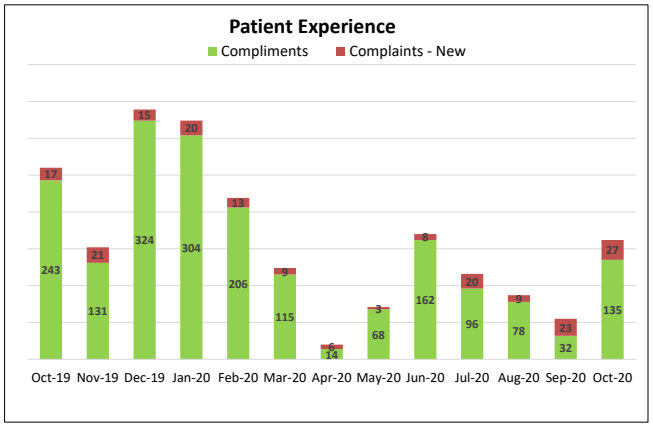
1 Our Patients Summary 1.1 Patient Experience

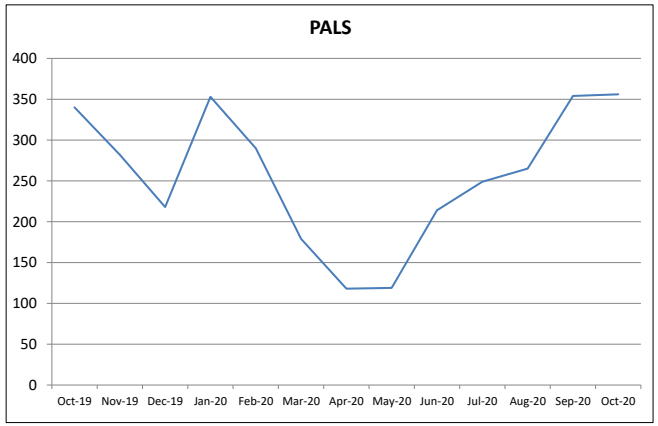
The Princess Alexandra Hospital NHS Trust

Having received 27 complaints in October we are again beginning to see a reduction in feedback entering the second wave. The top trending theme is medical care expectations complaints, this is consistent with this theme trending at around one third of cases (+/- 5) throughout the year. Additionally, the small numbers prevent attribution of significance. Where we can see significant changes in trends is in communication issues in PALS concerns, 101 in October 2020 vs 54 in October 2019.

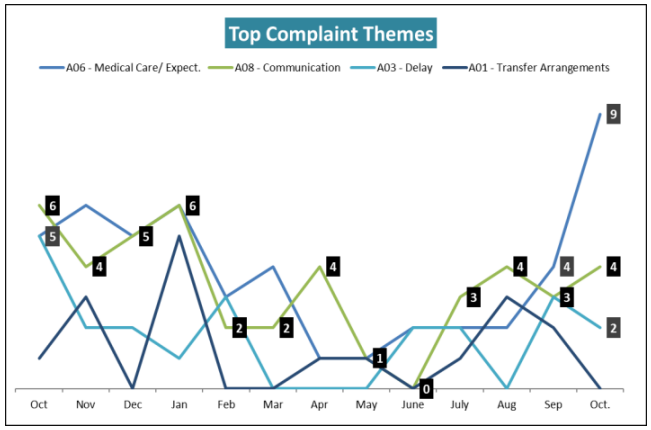
We are responding in a way which will support effective communication with families by scaling up virtual visiting, developing a new carers support project, introducing a COVID communication service; and continuing to support measures which were effective in the first wave based on our learning. These include proactively managing patient belongings, sharing messages and support for loved ones, as well as continuing to develop proactive measures to enable longer term improvements in the patient experience such as the Butterfly Hub, community partnerships with Rainbow Services, with the Dementia Action Alliance, championing the work of the patient panel and working with the ICS, CCG and Cancer Alliance on funding bids which have been approved by the Charitable Funds Committee worth around £254k to West Essex and PAH.

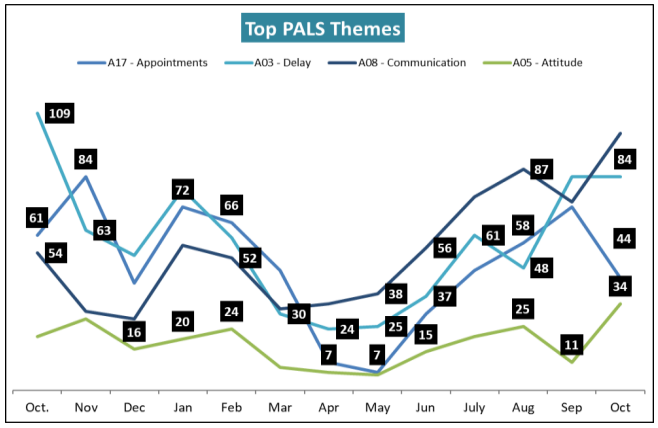
The oldest complaint case open remains a Medicine complaint opened on 10 April 2019 relating to Winter Ward. There are at present 294 PALS cases are open, 92 complaints open at month end.

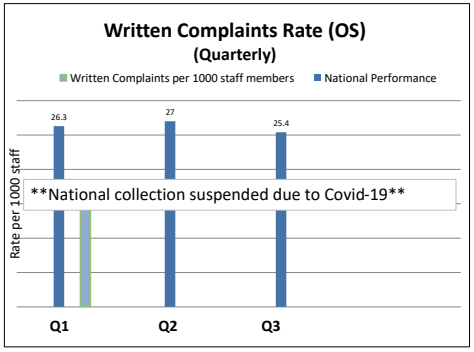




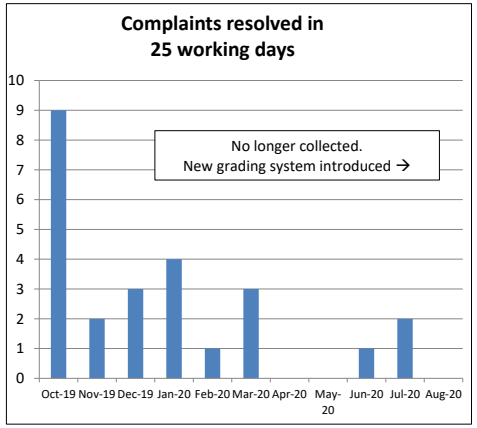
PALS converted to Complaints	
Oct-19	2
Nov-19	3
Dec-19	4
Jan-20	6
Feb-20	3
Mar-20	1
Apr-20	0
May-20	0
Jun-20	1
Jul-20	6
Aug-20	4
Sep-20	3
Oct-20	8

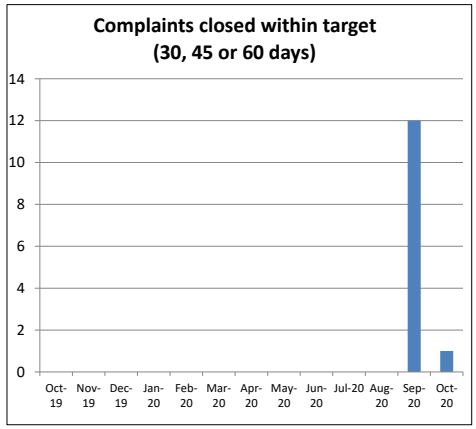


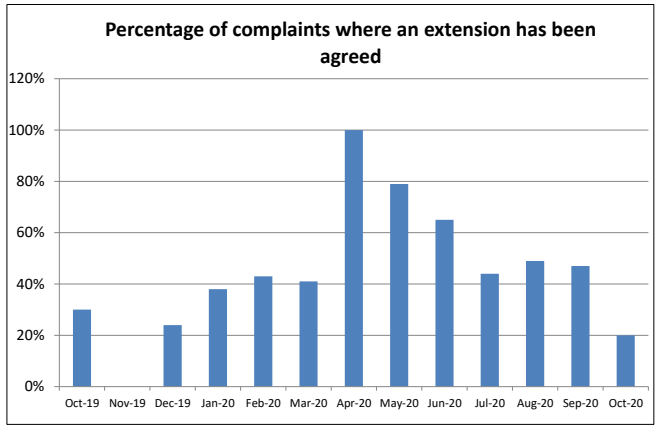


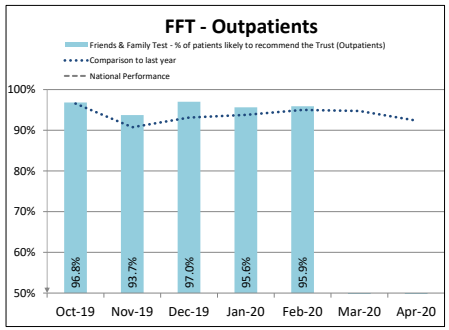


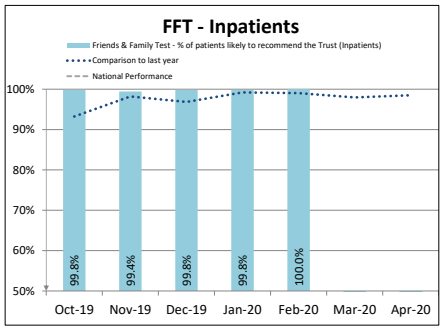
Patient Experience

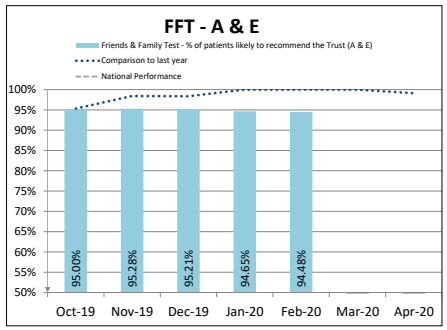


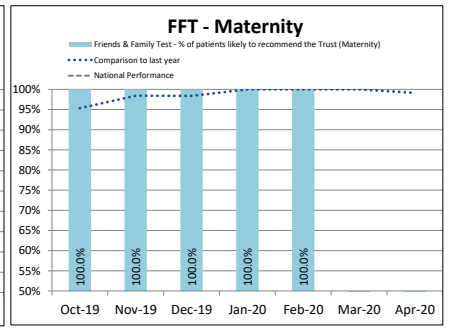












FFT national collection suspended due to Covid-19

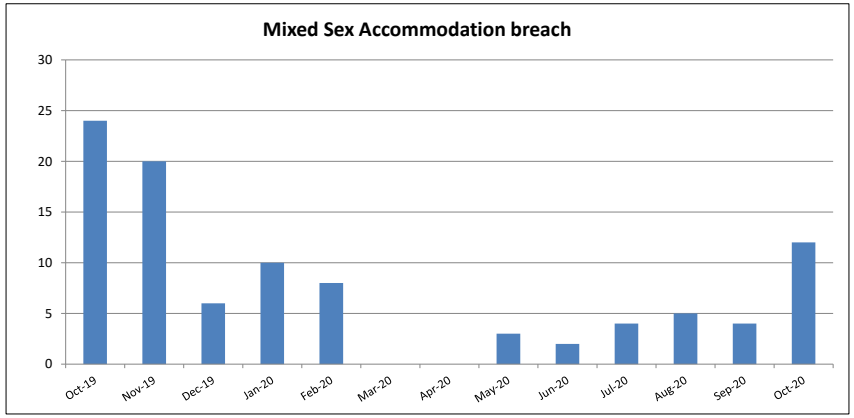
Patient Safety

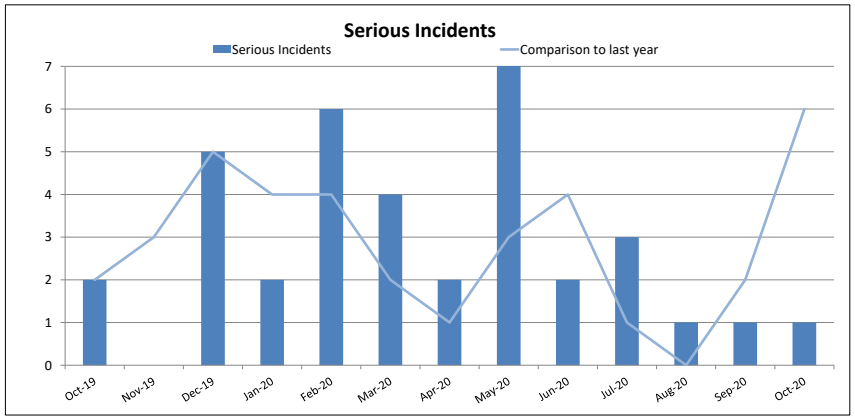
1 Our Patients Summary 1.3 Patient Safety

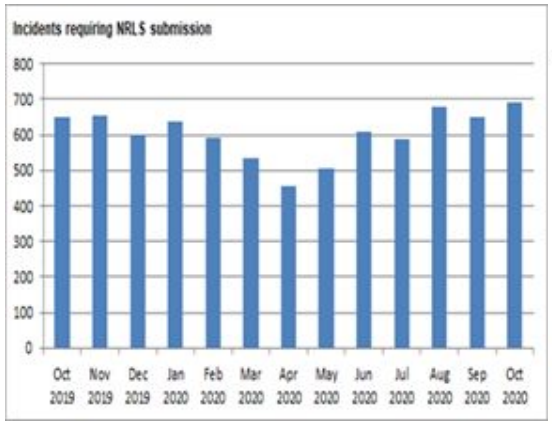
NHS The Princess Alexandra Hospital NHS Trust

1107 incidents were reported in October, 816 no harm (73.7%), 264 minor (23.8%), totaling 97.5%. 24 moderate (2.16%), 2 severe (0.25%) and 1 death graded harm (0.09%).

1 SI was reported in October (this mets the Never Event Criteria), a patient was inadvertently attached to air. Immediate remedial actions have taken place and an internal safety bulletin was circulated.
7 safety alerts were received in October, all 7 have been closed. The Trust currently has 5 open safety alerts.
One safety alert has breached its October 2020 deadline, EFA.2019.005 for removal of all floor Doorstops and Door Buffers.
Work needs to be completed in three areas of the Trust and will require an external contractor and Fire Alarm Company to complete.
Mixed sex accommodation breaches have increased in month and are all attributable to critical care.

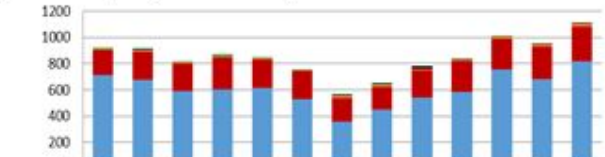




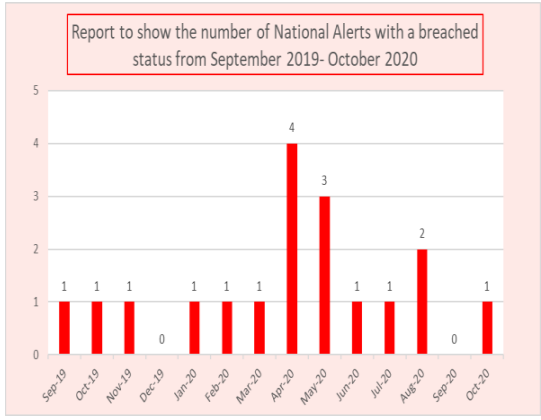


Severity of reported Incidents on Datix

Figure 1. Incident reporting numbers and severity Oct 2019 - Oct 2020



	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020
Death	0	2	0	0	0	0	3	2	22	1	0	1	1
Severe	1	1	2	7	2	2	7	4	2	2	3	3	2
Moderate	10	14	9	12	8	6	14	16	11	15	19	15	24
Minor	190	217	211	247	216	213	181	173	208	227	233	247	264
None	714	674	588	603	616	532	356	450	540	587	753	681	816

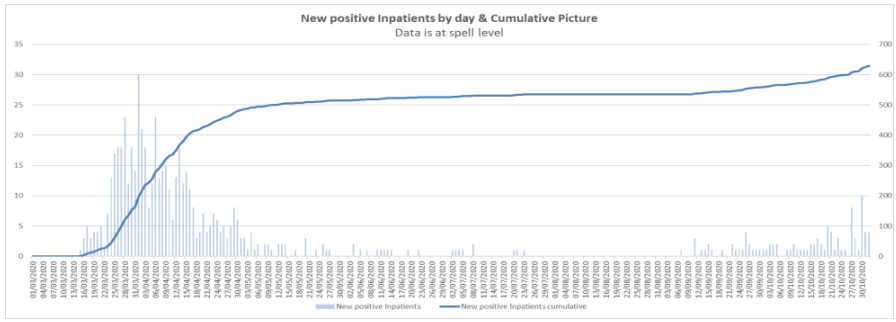


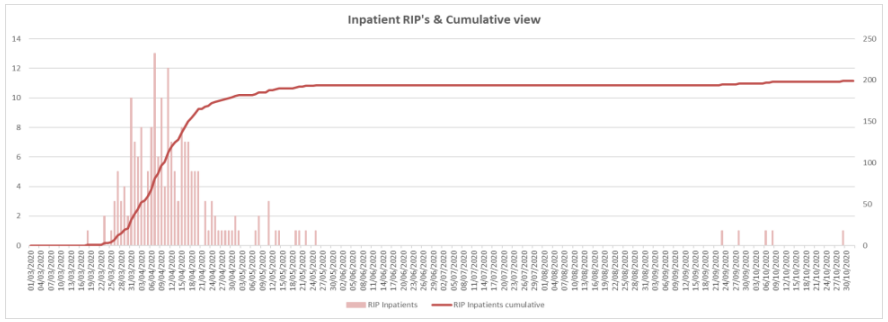
Infection Control

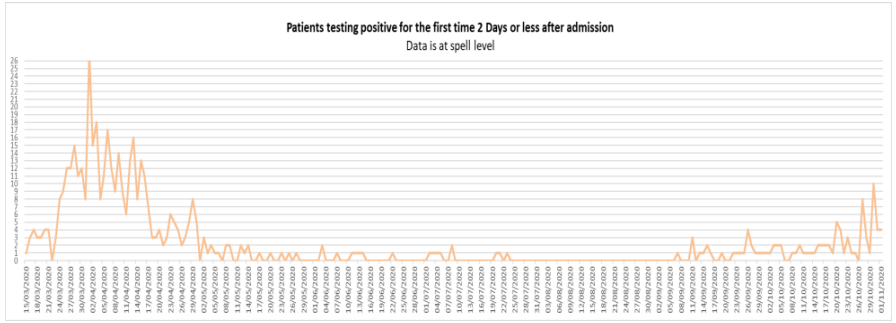
1 Our Patients Summary 1.4 Infection Control - Covid-19

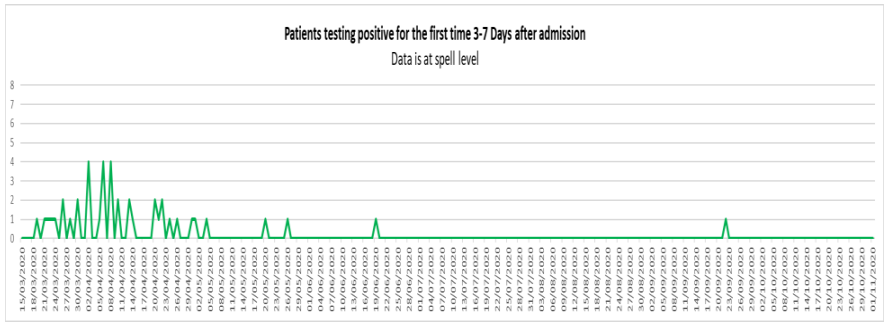
The Princess Alexandra Hospital NHS Trust

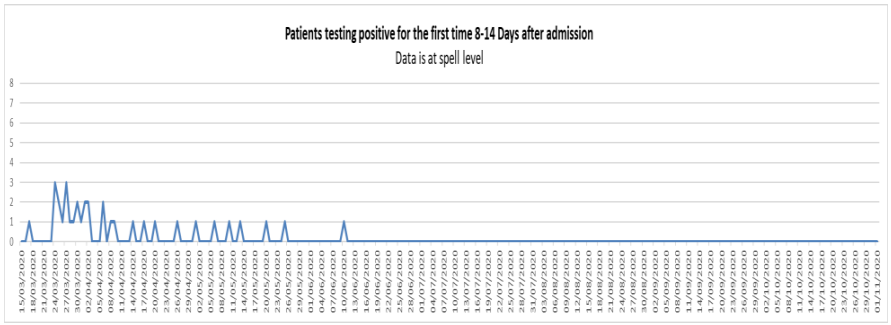
This page shows the latest position relating to Covid-19 within the organisation. Of note, the nosocomial infection graphs which demonstrates that the last probable hosptal acquired Covid infection was in June 20.

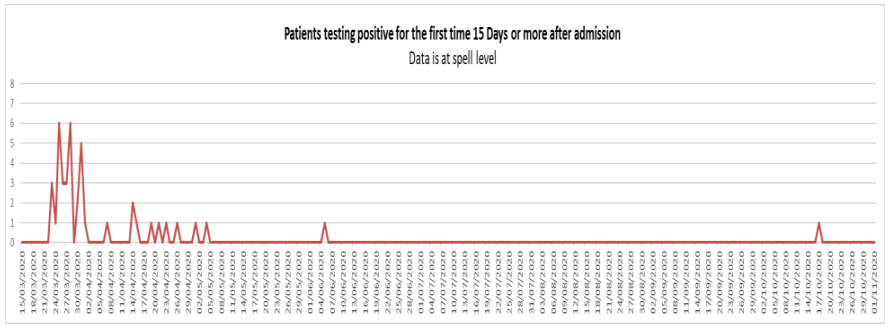




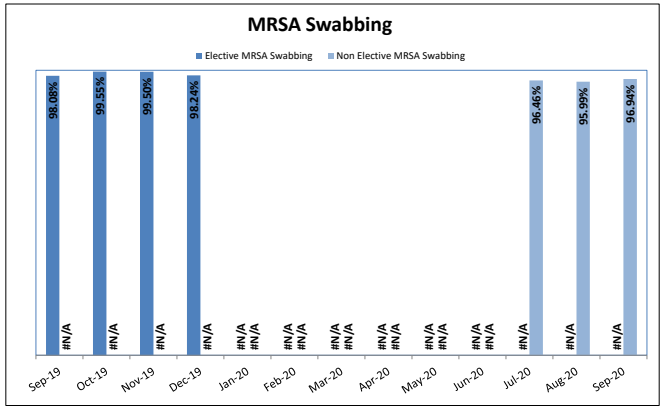








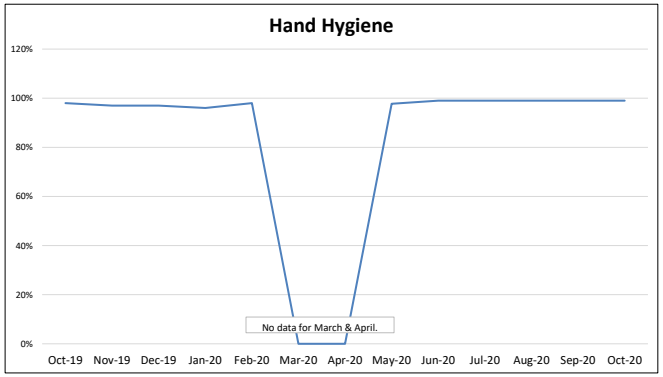
Infection Control



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

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



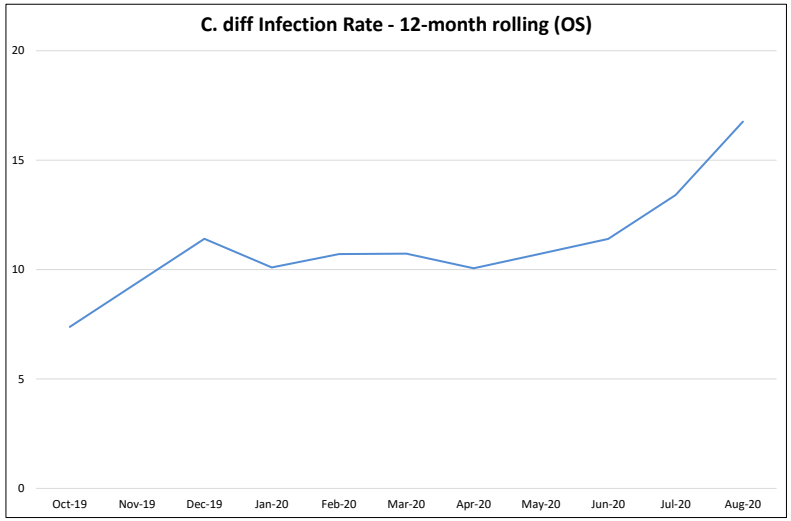
E Coli	
Oct-19	0
Nov-19	0
Dec-19	1
Jan-20	0
Feb-20	2
Mar-20	0
Apr-20	1
May-20	1
Jun-20	1
Jul-20	2
Aug-20	0
Sep-20	2
Oct-20	1

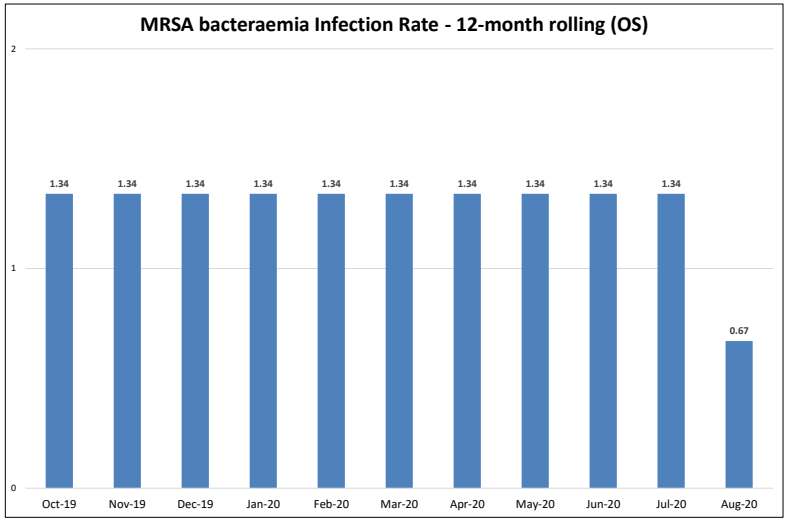
Klebsiella	
Oct-19	0
Nov-19	0
Dec-19	1
Jan-20	0
Feb-20	0
Mar-20	1
Apr-20	1
May-20	0
Jun-20	2
Jul-20	0
Aug-20	0
Sep-20	1
Oct-20	0

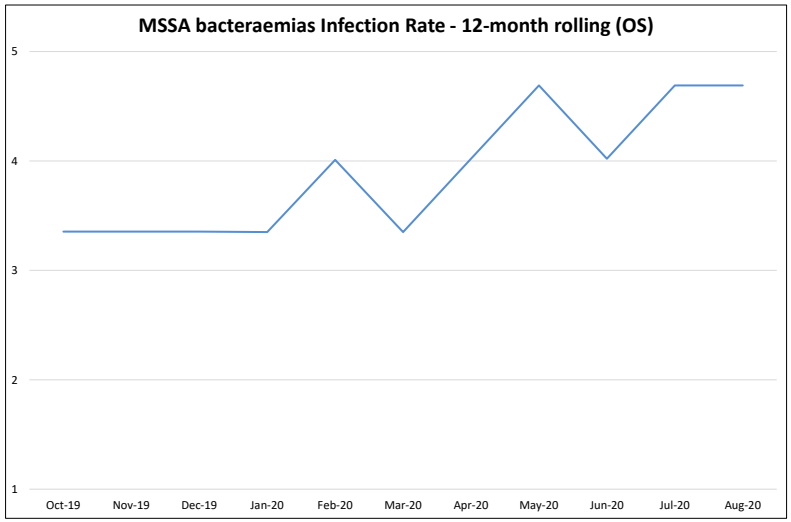
Pseudomonas	
Oct-19	2
Nov-19	0
Dec-19	0
Jan-20	0
Feb-20	0
Mar-20	0
Apr-20	0
May-20	1
Jun-20	0
Jul-20	0
Aug-20	0
Sep-20	1
Oct-20	0

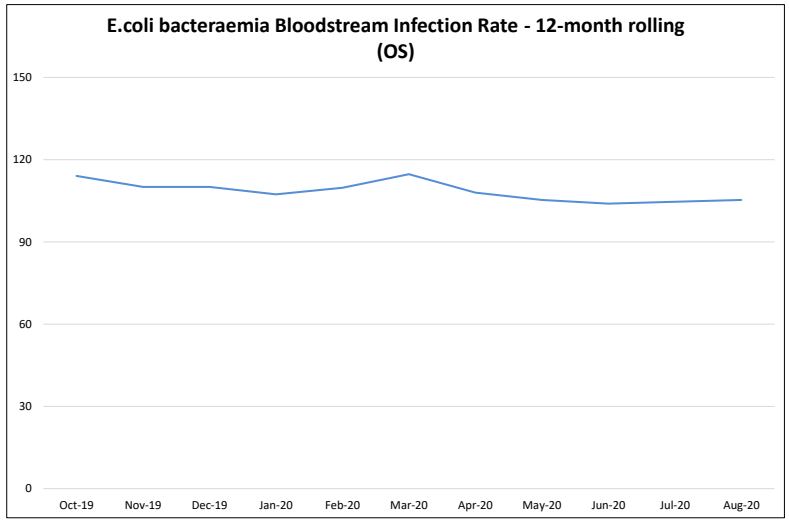
Infection Control

The following are the latest published data available.









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

1 Our Patients Summary 1.7 Patient Safety

NHS
The Princess Alexandra Hospital
NHS Trust

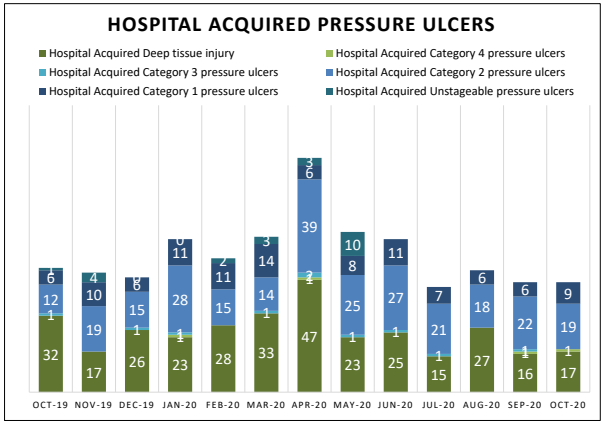
During October 2020 there were 103 reported falls (down from 113 in September) – this is the 3rd consecutive month with a small decrease in the total number of falls. 71 falls were classified as no harm and 30 as minor harm.

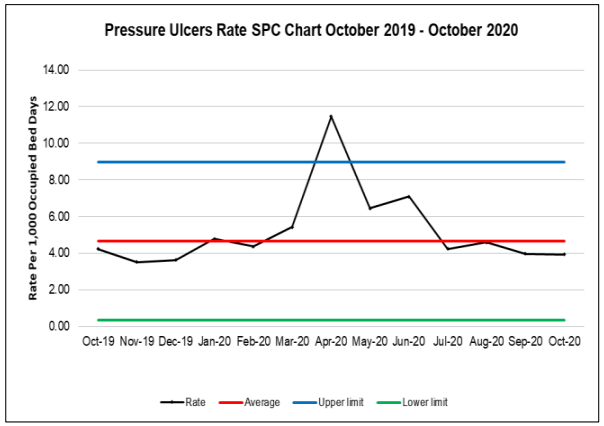
The 2 wards with the highest falls levels were Penn (15) and Winter (12).

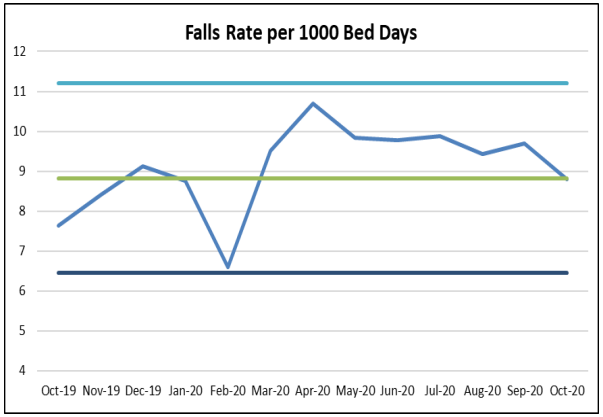
The falls rate per 100 patients showed a slight decrease to 6.85 compared with 7.33 in September (down for the 3rd consecutive month). There was a small increase in the rate per 100 patients (falls with harm) to 2.09 (from 1.95).

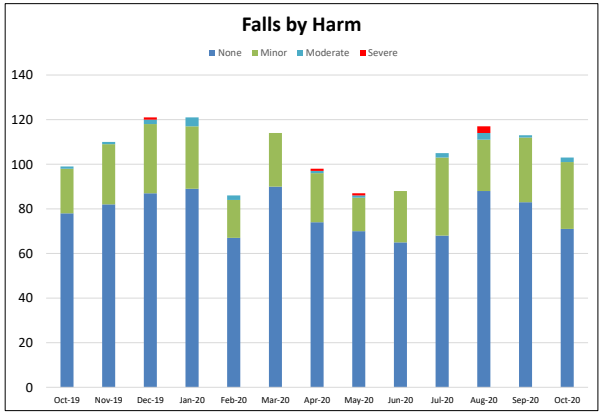
Falls per 1000 bed days showed a small decrease down from 9.70 in September to 8.80.

Occupied bed days remained stable compared with September.







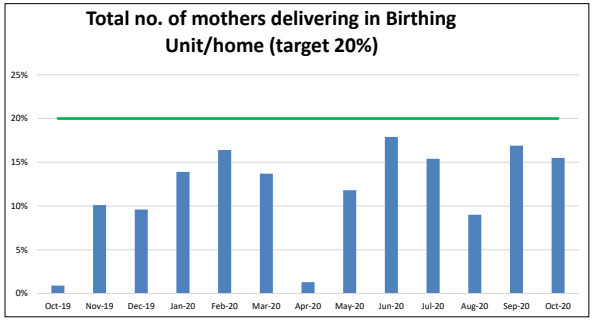


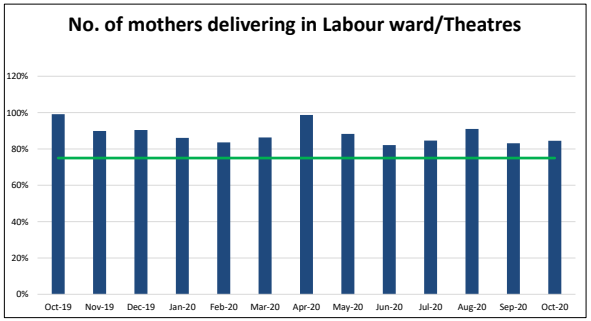
Family & Women's Service

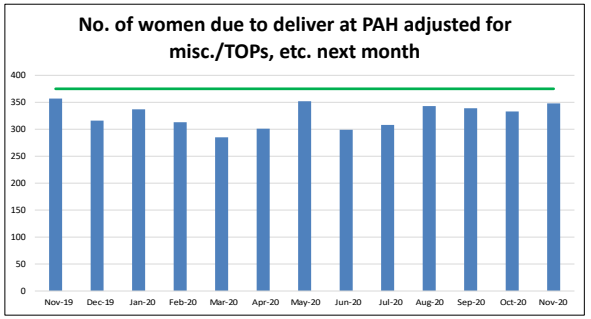
2 Our Patients Summary 1.8 Family & Women's Service

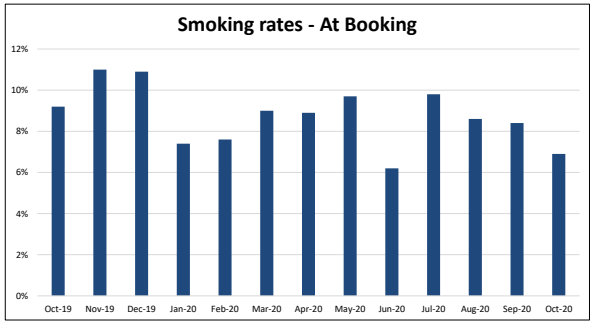
The Princess Alexandra Hospital NHS Trust

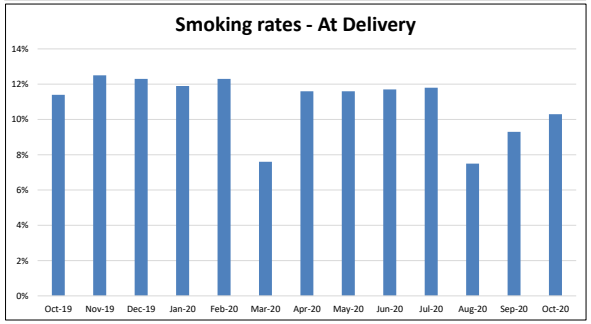
The Emergency C Section rate has followed an increasing monthly trend, since April 2020. The rate has gradually increased from 13.3% in March 2020 to 25.7% in November 2020.
The consultants & the wider multi-disciplinary team are aware of this unexpected & continuing, trend upwards. An Action Plan will be formulated by the newly appointed Lead Consultant for Labour Ward to look into this issue & to identify the root causes. Appropriate actions will then be formulated & put into place.
The rate of post-partum haemorrhage (PPH), over 1.5L, has decreased from 6.0% in September to 4.0% in October 2020. This rate is still higher than the National Average & work in conjunction with the Labour Ward Lead Anaesthetist, is ongoing including a review of the use of the routine prophylactic drugs given to protect women against PPH.
PAH has moved to a new 'Physiological' interpretation of CTG monitoring. Training compliance figures will be available from the November Dashboard onwards.

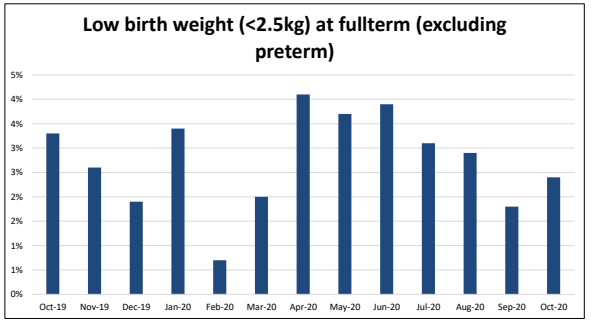


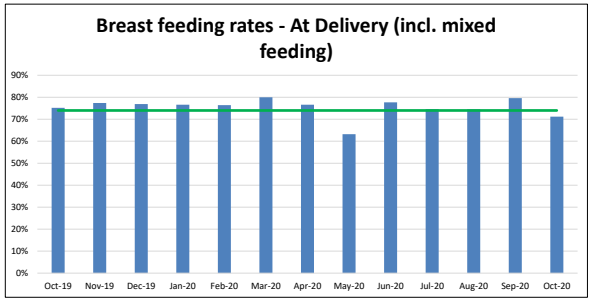


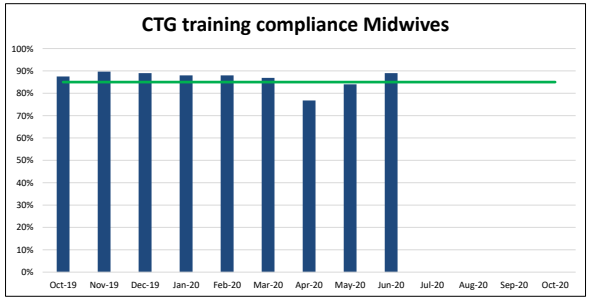


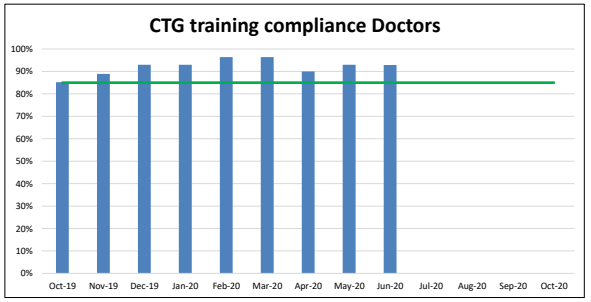






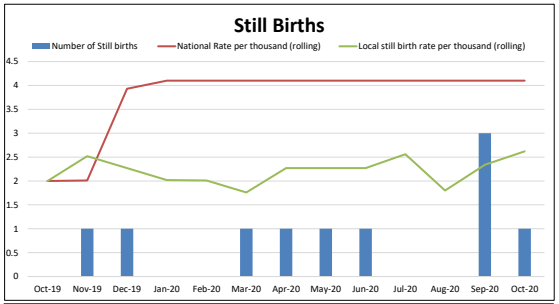


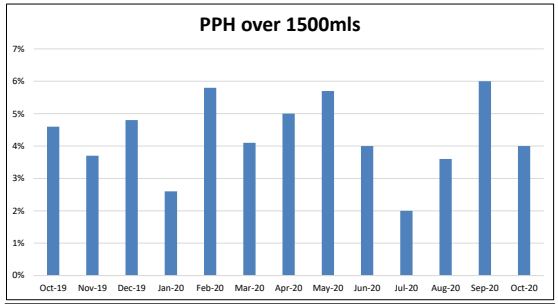


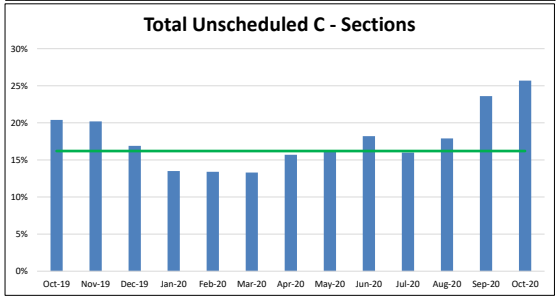


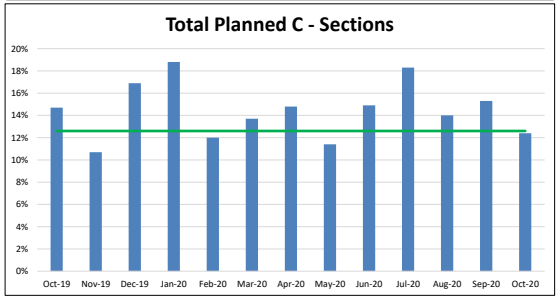
Family & Women's Service

The ONS releases new statistics for the National still birth rate once a year. New statistics will be released in the forthcoming months.







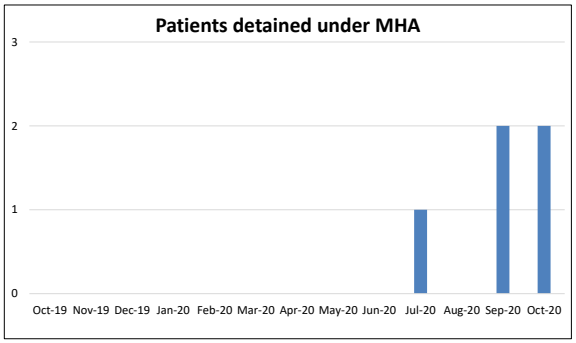


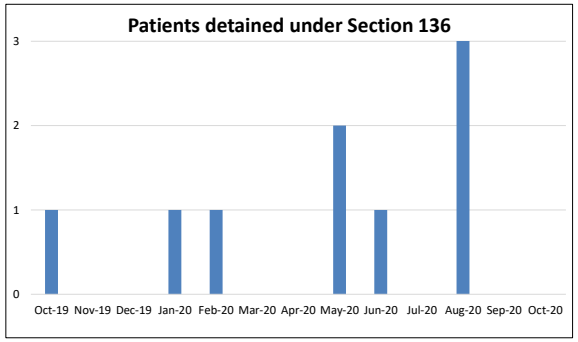
Mental Health

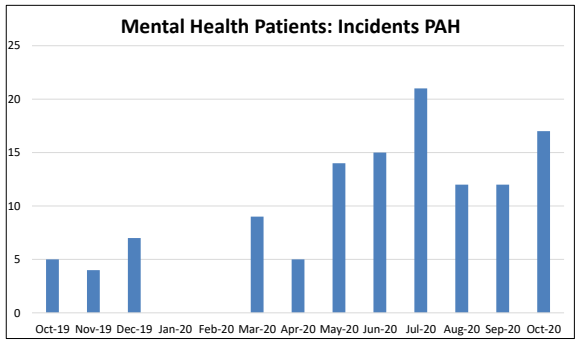
1 Our Patients Summary 1.10 Mental Health

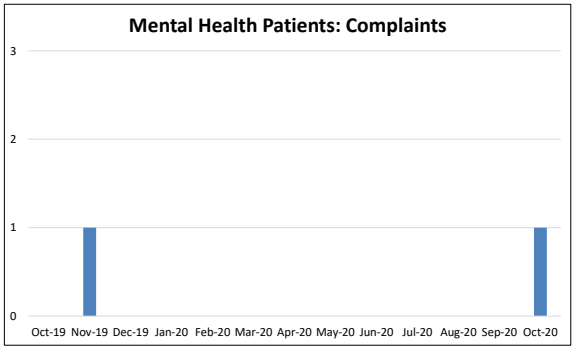
The Princess Alexandra Hospital NHS Trust

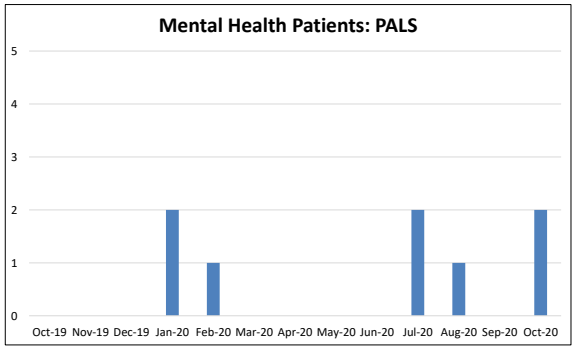
The Dementia Group are working to develop the patient safety indicators with the patient safety team so there is a view on the proportion if incidents suffered by patients with dementia compared to the Trust average. Training compliance has dropped below 90% for dementia training. This is predominantly within the medical staff group.

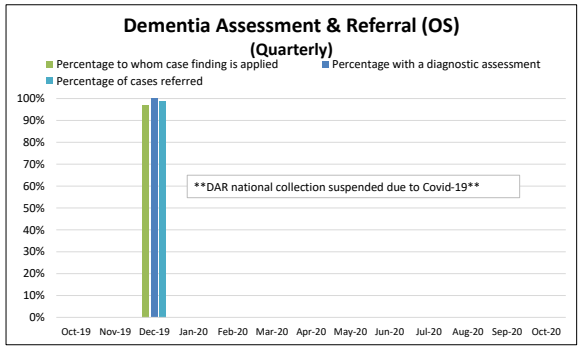


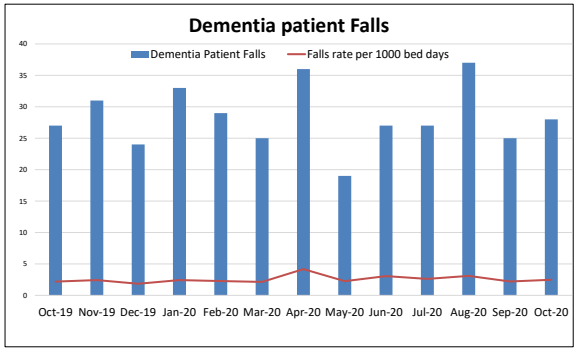


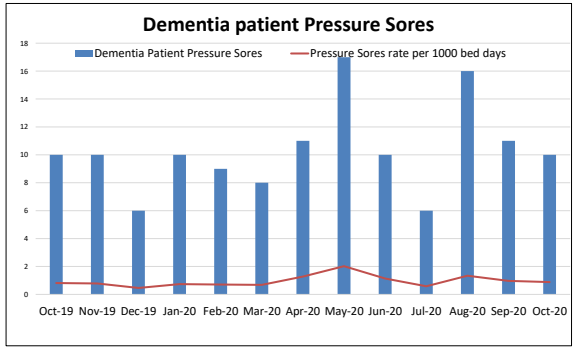


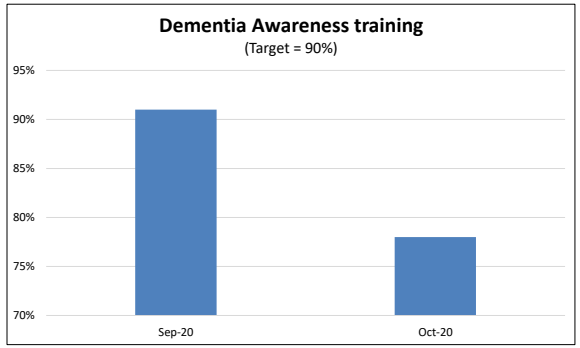










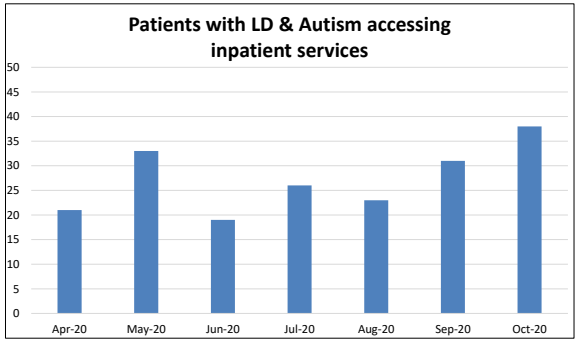


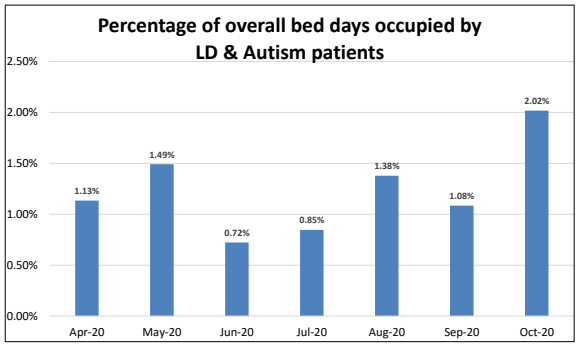
Learning Disabilities & Autism

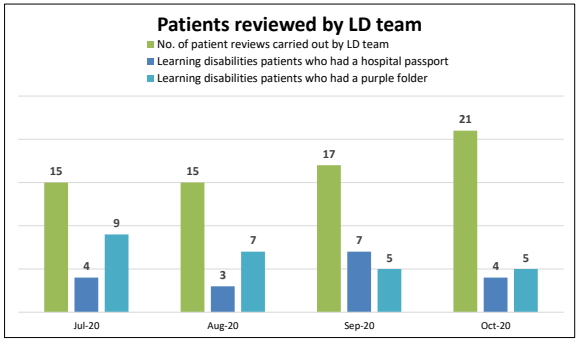
1 Our Patients Summary 1.11 Learning Disabilities & Autism

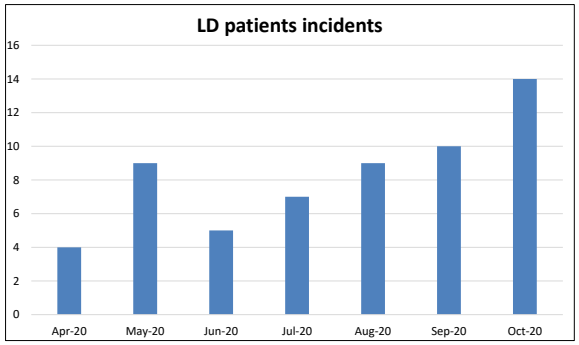
The Princess Alexandra Hospital NHS Trust

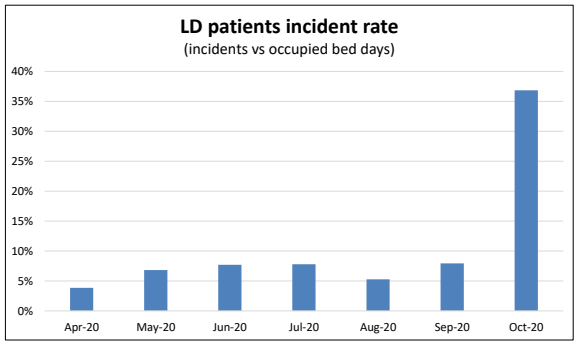
The Learning Disability Group are continuing to develop the KPIs for this patient group. Compliance with Level one training has dropped slightly in month. This is predominantly within the medical staff group. This has been escalated to the HCG leads. The proportion of patients with a hospital passport or This is Me book is a focus of the group.

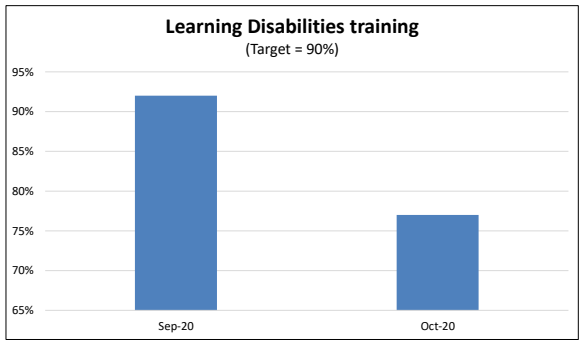












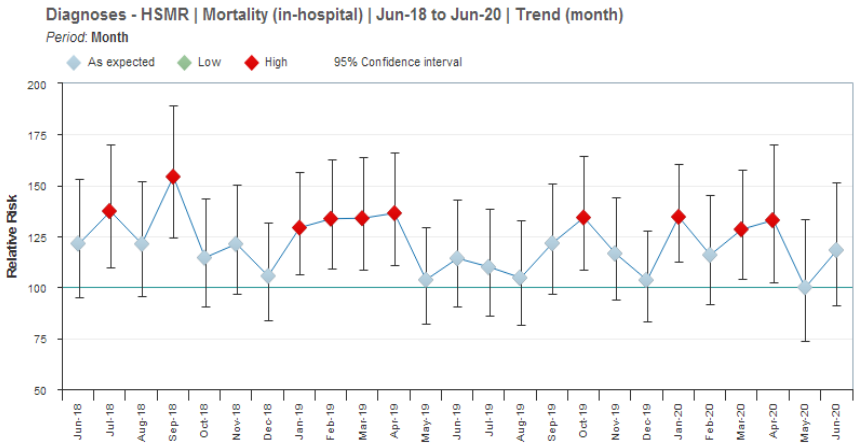
Mortality

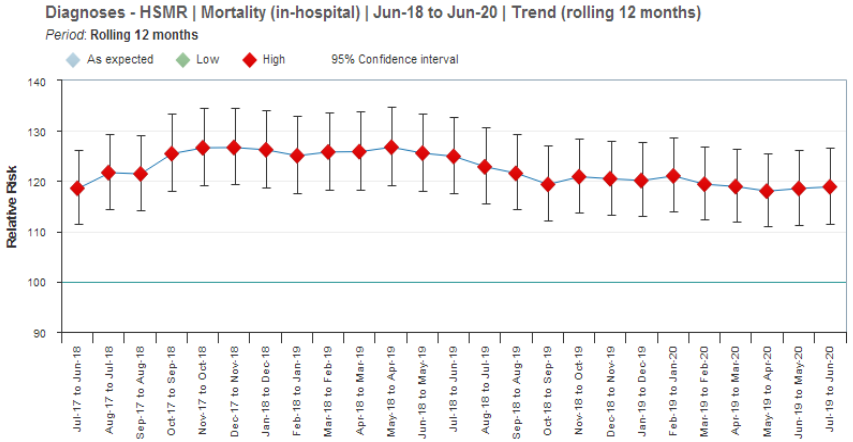
1 Our Patients Summary 1.12 Mortality

The Princess Alexandra Hospital NHS Trust

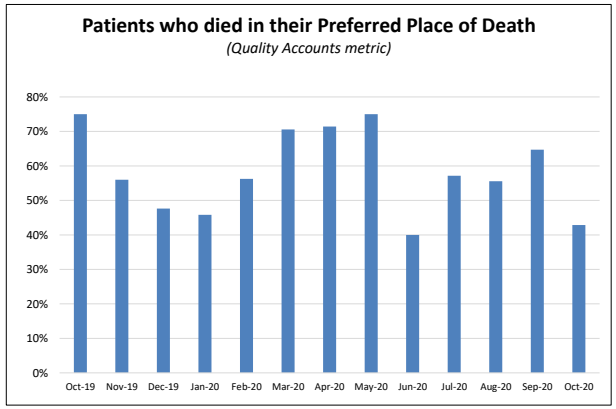
Quality Improvements are focused on improving our mortality rates through our learning from death process and Dr. Foster outlier alerts. These currently include our End of Life Quality Improvement Programme; improvements in recognition and treatment of AKI and Sepsis; the implementation of the Speciality Assessment Tool, Improved compliance with respiratory care bundles for COPD and pneumonia, implementation of non Invasive Ventilation out of critical care, timely transfer of patients with a fractured neck of femur to appropriate location, development of an automated mortality dashboard that allows the user to see the big picture as well as deep dive into the detail and the standardisation of mortality and morbidity meetings for all specialities to enhance learning.

The end of life quality improvement team are working to improve the overall compliance of the recording of preffered place of death which is regarded nationally as a better quality measure for recording an honest and open conversation with patients and their families. The measure below has many variances as to why the prefered place of death has not been met,which includes Patients choice, lack of hospice capacity and inability to fast track patients home due to complex discharge pathways.





Mortality Outlier Alerts (QA)	
Feb 18 - Jan 19	6
Mar 18 - Feb 19	7
Jul 18 - Jun 19	7
Aug 18 - Jul 19	6
Sep 18 - Aug 19	5
Oct 18 - Sep 19	5
Nov 18 - Oct 19	6
Feb 19 - Jan 20	6
Apr 19 - Mar 20	4
Jun 19 - May 20	8
Jul 19 - Jun 20	6



Executive Summary Our Performance

The Princess Alexandra Hospital NHS Trust

The RTT incomplete performance continues to track ahead of national performance however, due to the backlog recovery after the first wave of Covid-19 the Trust's performance is below national requirements. The Trust continues to book patients for admitted treatment in clinical priority order which is delaying the clearance of long waiting patients over 52 weeks. However this is the national approach & the Trust & ICS are fore-runners in finalising the clinical prioritisation of the admitted PTL. All admitted patients are being contacted to ensure that their current condition is accurately reflected in their clinical prioritisation & to establish if they are ready & willing to be booked for treatment. The Trust is continuing to work closely with the Independent Sector providers to utilise as much operating & diagnostic capacity as possible.

The number of ASIs is being kept under control although a recent increase in referrals & increased clinical absence has impacted the number of appointments waiting to be booked. The use of virtual clinics for clinicians self isolating due to track & trace will assist with maintaining clinical capacity.

Cancer 2 week wait target has continued to be below national performance due to continued pressure on Dermatology, Lower GI & Upper GI. Performance is improving in October & November with skin halving the number of 2ww breaches in the month. Breast symptomatic 2ww performance was 92.9% in September, close to achieveing the target.

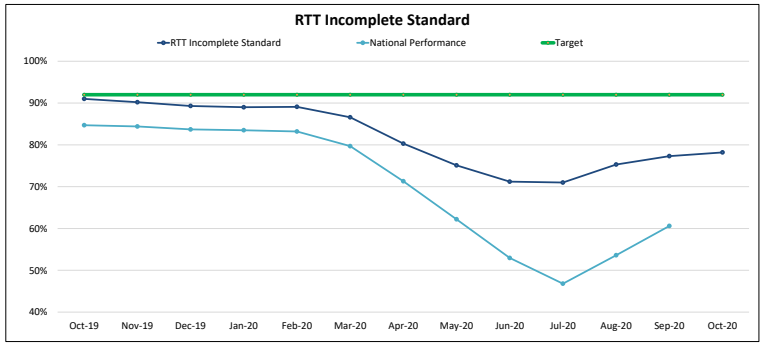
The 62 day performance of 66% against 75% national reflects the increased treatments of patients that have breached the 62 day target as we ensure that the longest waiting patients are diagnosed & treated as quickly as possible.

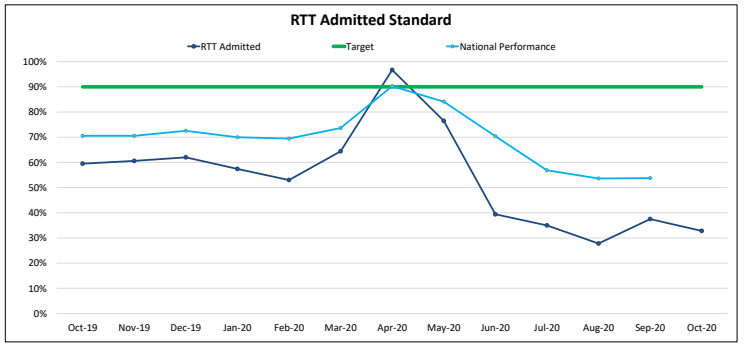
Cancer performance recovery is closely monitored through weekly PTL meetings and Access Board with a detailed action plan updated regularly.

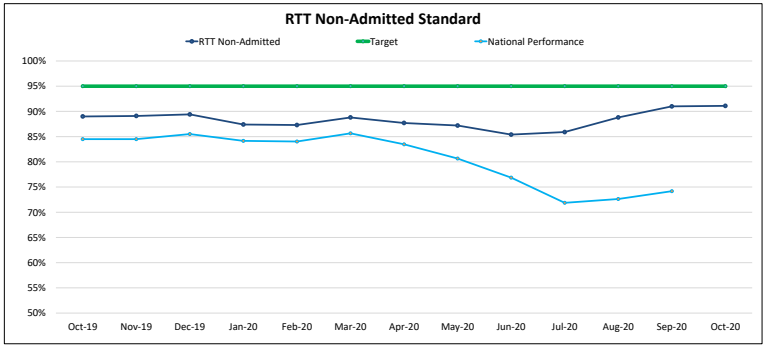
ED Performance has continued to be under pressure from both the acuity of patients attending, the admission rate & flow through the wards & discharge. The daily Patient Panels ensure that there is senior challenge to discharge planning & execution in addition to focussing on red to green days during a patient's stay. Further work on the professional standards is keeping a focus on ensuring patients receive timely investigation & decision making, tracked through the weekly Urgent Care Board. Bed occupancy reductions reflect the beds available on Covid wards but also increasing incidents of closed bays on non Covid wards due to patients becoming positive for Covid after a negative swab admission. The Adult Assessment Unit build is on track for opening in December which will increase emergency capacity & allow efficient flow of patients to be treated & discharged.

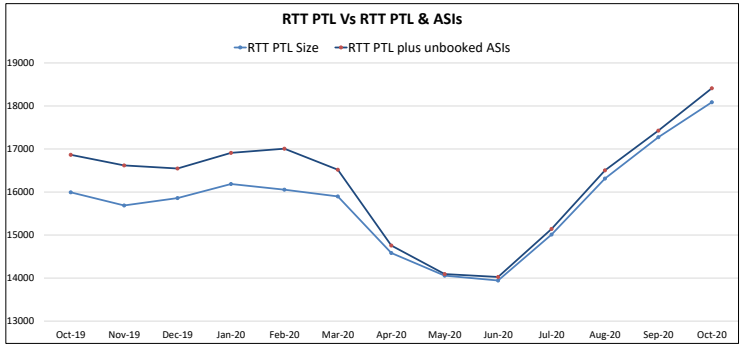
DM01 continues to track ahead of national performance but below the standard required as we work through the backlog of requests from the first phase of Covid. Additional demand from north London areas has increased the recovery period but commissioners are assisting to divert the demand.

RTT


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


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

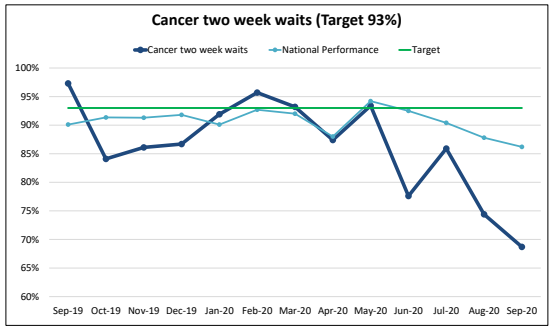

RTT Non-Admitted Standard
RTT Non-Admitted
Target
National Performance
100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20

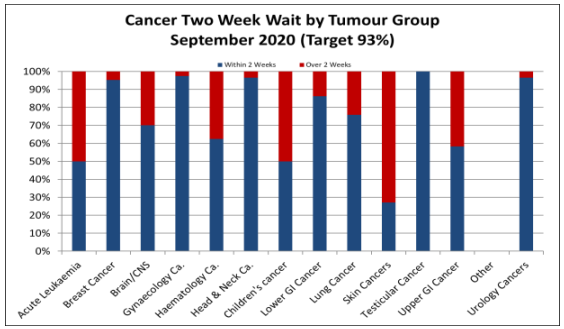

RTT PTL Vs RTT PTL & ASIs
RTT PTL Size
RTT PTL plus unbooked ASIs
19000
18000
17000
16000
15000
14000
13000
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20

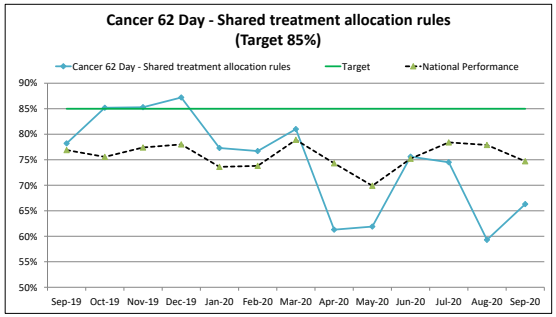
Cancer

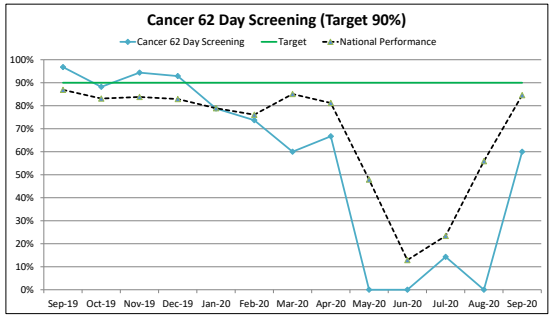
	Cancer 2 week waits - breast symptomatic	Cancer 31 Day First	Cancer 31 Day Subsequent Drug	Cancer 31 Day Subsequent Surgery
Sep-19	97.70%	97.40%	100.00%	100.00%
Oct-19	99.10%	100.00%	100.00%	100.00%
Nov-19	97.60%	100.00%	100.00%	100.00%
Dec-19	95.10%	97.90%	100.00%	100.00%
Jan-20	98.50%	94.40%	100.00%	100.00%
Feb-20	98.60%	96.90%	100.00%	100.00%
Mar-20	98.80%	97.10%	100.00%	100.00%
Apr-20	91.90%	95.10%	100.00%	90.00%
May-20	97.50%	90.70%	100.00%	100.00%
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%

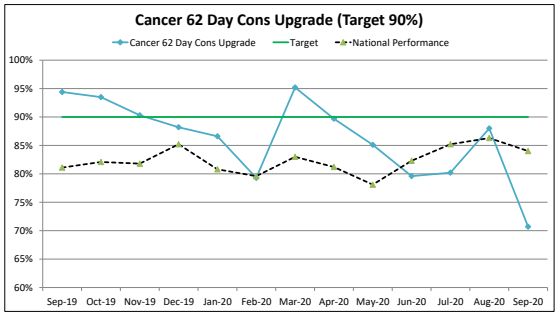
Note: Above heat map colour scale based on green = highest performance to red = lowest performance.

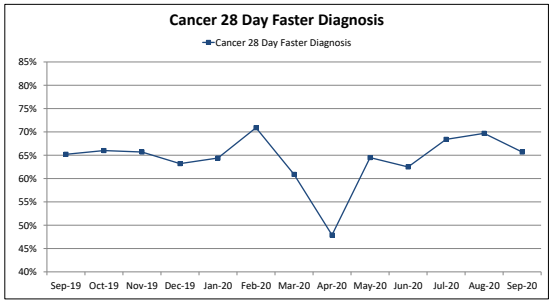




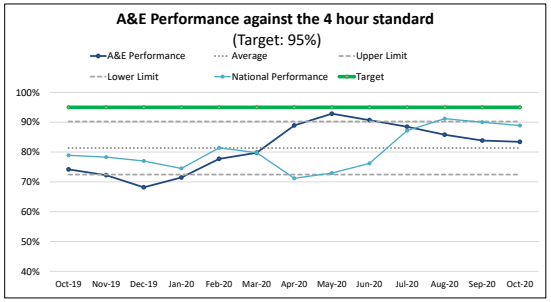


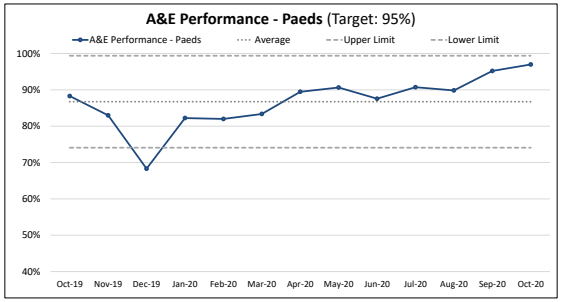


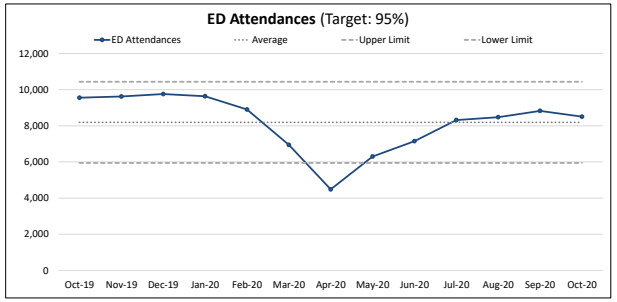


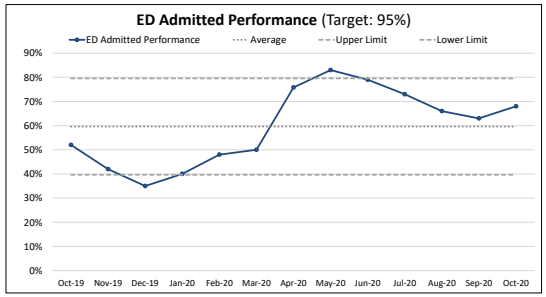


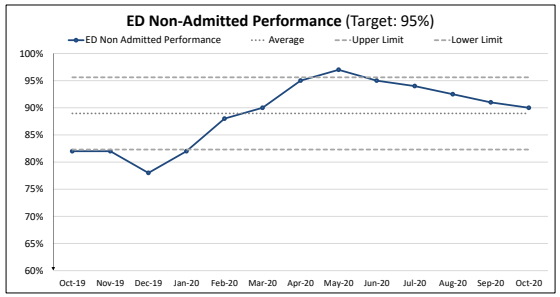
ED





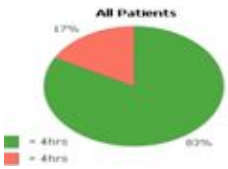






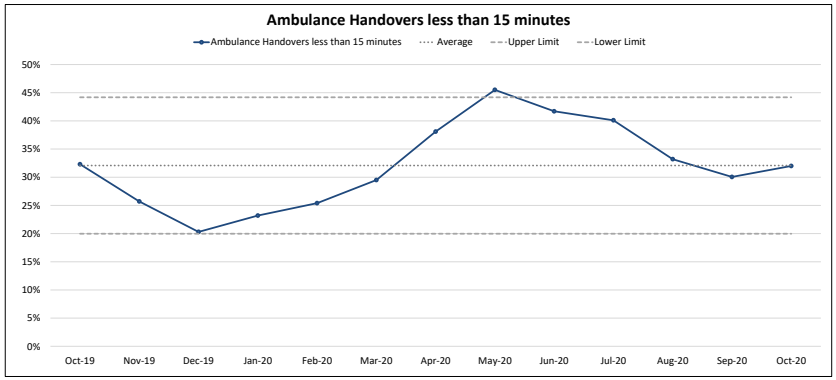
ED Internal Professional Standards

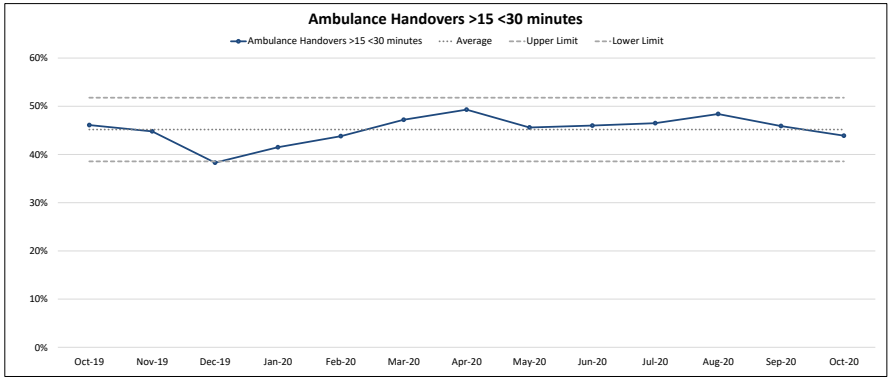
	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Target
Arrival to Triage - Average Wait (Minutes)	35	38.63	46	41	37	30	25	26	25	28	31	36	36	15
Triage to Exam - Average Wait (Minutes)	108	102	104	91	76	60	41	44	56	78	68	79	80	45
Exam to Referral to Specialty - Average Wait (Minutes)	88	96	99	103	97	97	88	82	84	96	94	86	96	90
Referral to Seen by Specialty - Average Wait (Minutes)	78	98	90	87	77	74	54	48	51	64	70	73	75	30
Seen by Specialty to DTA - Average Wait (Minutes)	87	96	105	99	87	91	66	67	69	70	85	94	99	30
DTA to Departure - Average Wait (Minutes)	116	217	249	169	134	157	110	55	74	134	111	132	100	30

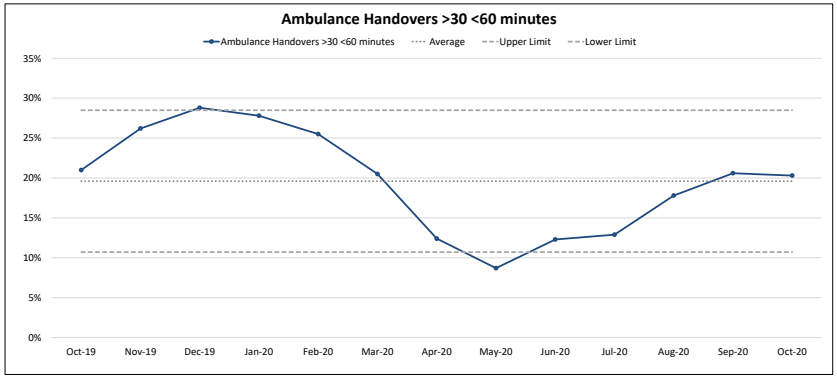


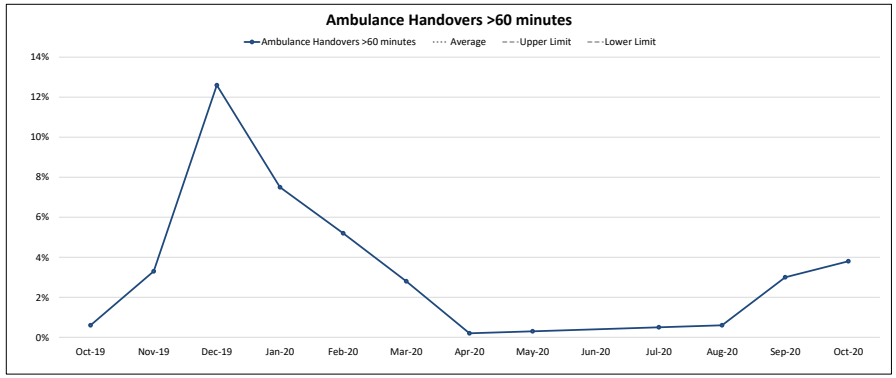
Measure	Standard	Average	Excess	Patients with Timestamp	Patients Who Breached	% Breached	Patients Who Breached Rank
Arrival to Triage	15	37	22	7,360	4,786	65%	
Triage to Exam	45	80	35	6,765	3,255	48%	
Exam to Referral to Specialty	90	96	6	2,417	577	24%	
Referral to Seen by Specialty	30	75	45	2,532	1,667	66%	
Seen by Specialty to DTA	30	99	69	1,626	726	45%	
DTA to Departure	30	100	70	2,516	965	38%	

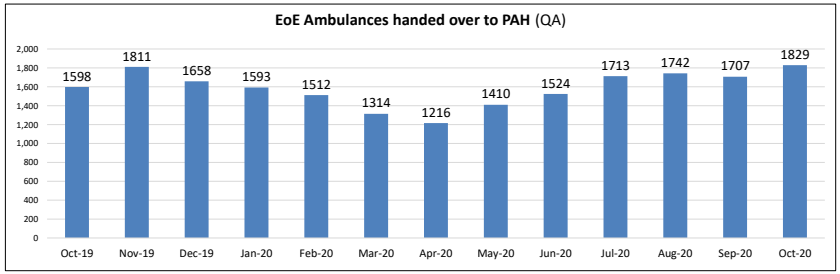
Ambulance


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

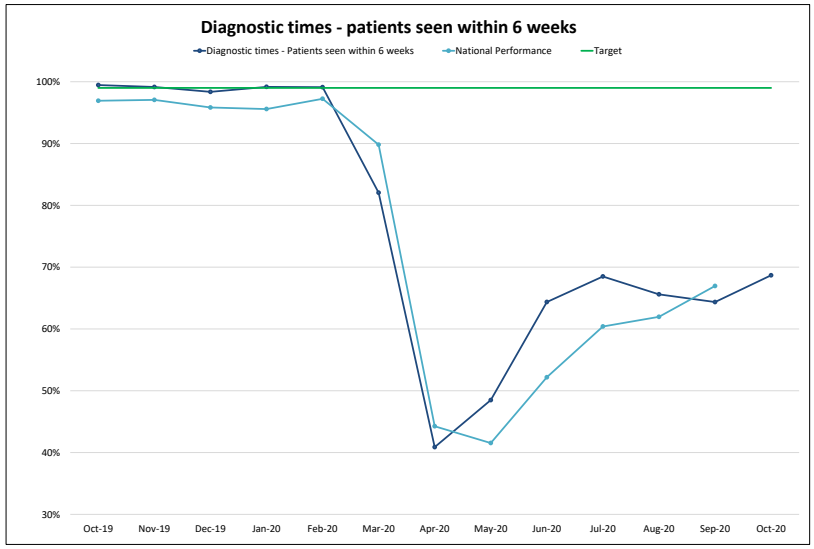

Ambulance Handovers >15 <30 minutes
Ambulance Handovers >15 <30 minutes
Average
Upper Limit
Lower Limit
60%
50%
40%
30%
20%
10%
0%
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20

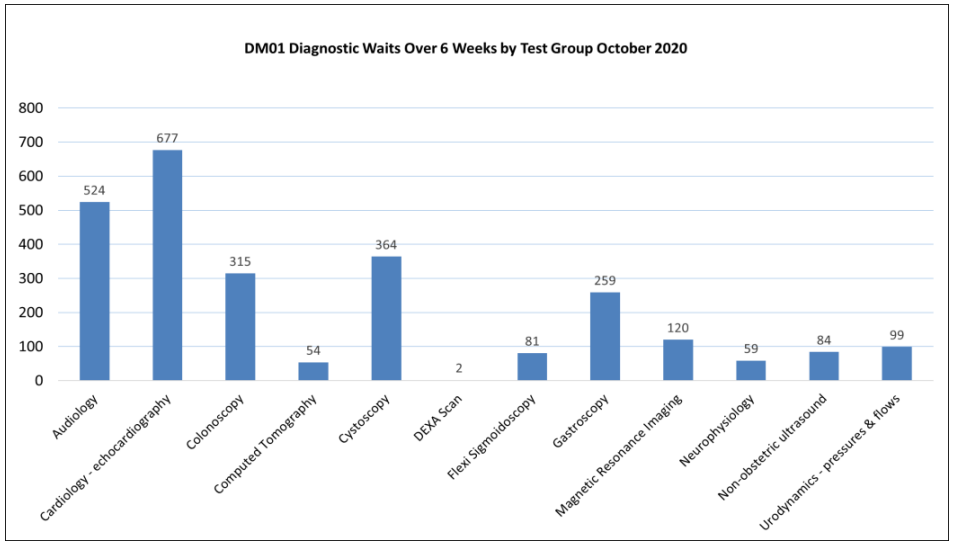

Ambulance Handovers >30 <60 minutes
Ambulance Handovers >30 <60 minutes
Average
Upper Limit
Lower Limit
35%
30%
25%
20%
15%
10%
5%
0%
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20


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


EoE Ambulances handed over to PAH (QA)
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
1598
1811
1658
1593
1512
1314
1216
1410
1524
1713
1742
1707
1829
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20

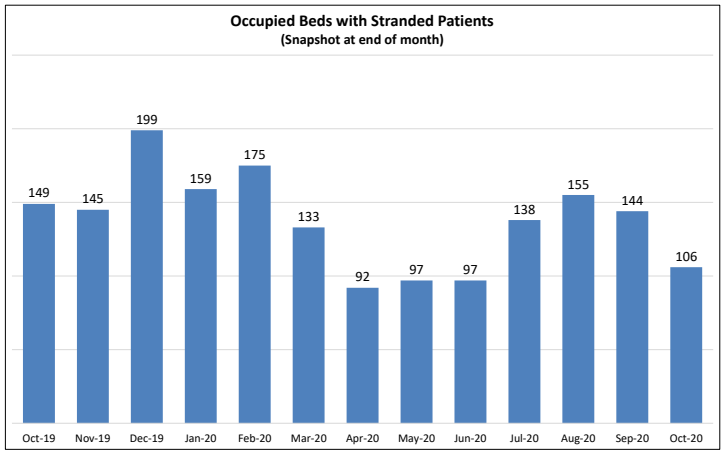
Diagnostics

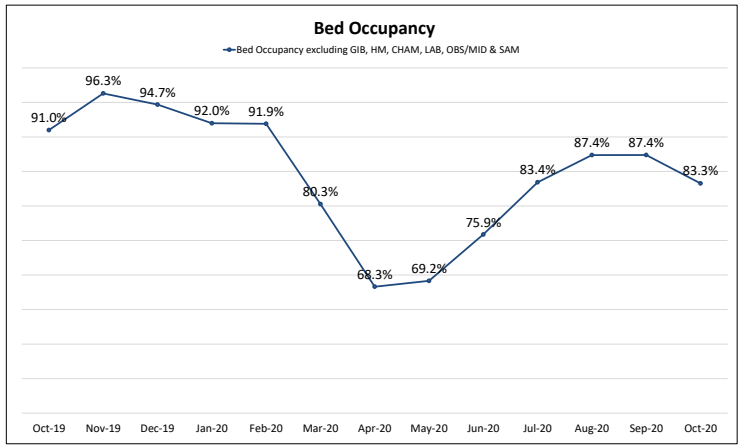




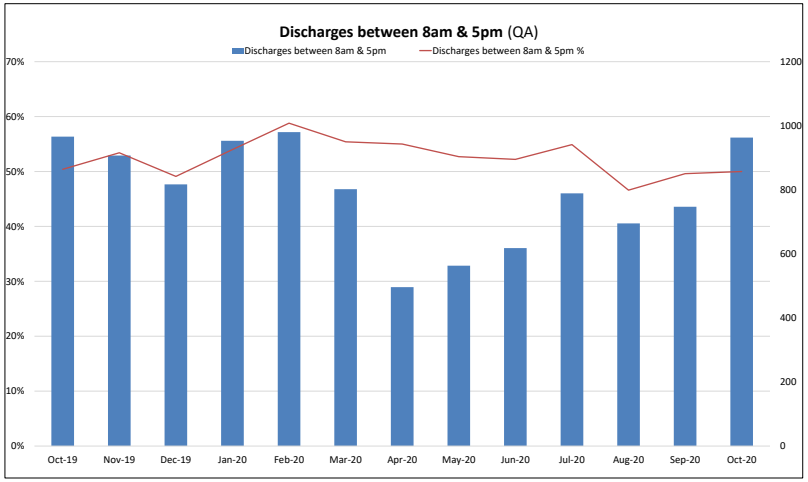
Test	% of Total Cohort - October 20	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Magnetic Resonance Imaging (MRI)	13%	99.86%	100%	100%	100%	100%	78%	34%	38.24%	58.63%	78.79%	79.10%	73.93%	89.31%
Computed Tomography (CT)	7%	100.00%	100%	100.00%	100.00%	99%	85%	59%	60.69%	77.37%	80.00%	79.26%	88.69%	90.24%
Non-Obstetric Ultrasound	31%	99.92%	99.92%	100.00%	100.00%	99.89%	83%	39%	65.86%	92.61%	96.79%	93.18%	95.77%	96.73%
DEXA	0%	100%	100.00%	100%	100%	100%	-	-	100.00%	77.55%	88.24%	84.93%	93.20%	92.86%
Audiology - Audiology Asessments	9%	100.00%	100%	99%	98%	100%	69%	23%	11.02%	11.11%	25.35%	23.67%	24.70%	29.85%
Cardiology - Echocardiography	18%	98%	100.00%	100.00%	99.87%	96%	74%	38%	40.29%	55.46%	53.62%	51.76%	52.13%	54.26%
Neurophysiology	1%	86%	93%	97%	94%	89.29%	49%	42%	5%	36%	32%	28%	30%	47.32%
Urodynamics	1%	89%	92.00%	88.57%	81.82%	80.56%	91%	30%	30.30%	24.39%	16.30%	3.26%	11.11%	5.71%
Colonoscopy	7%	98.68%	89.14%	74.72%	88.52%	97.94%	94%	63%	38.41%	42.69%	40.42%	34.46%	39.23%	46.34%
Flexi Sigmoidoscopy	2%	94%	95%	69.05%	94.64%	95.56%	87%	49%	53.52%	55.66%	43.85%	31.45%	38.89%	39.55%
Cystoscopy	7%	96.30%	92.00%	86%	81.82%	100%	94%	65%	48.57%	55.00%	41.03%	54.00%	25.55%	35.23%
Gastroscopy	5%	99.07%	89.57%	83.16%	89.09%	99.15%	92%	58%	40.15%	44.88%	40.05%	28.94%	29.92%	38.19%

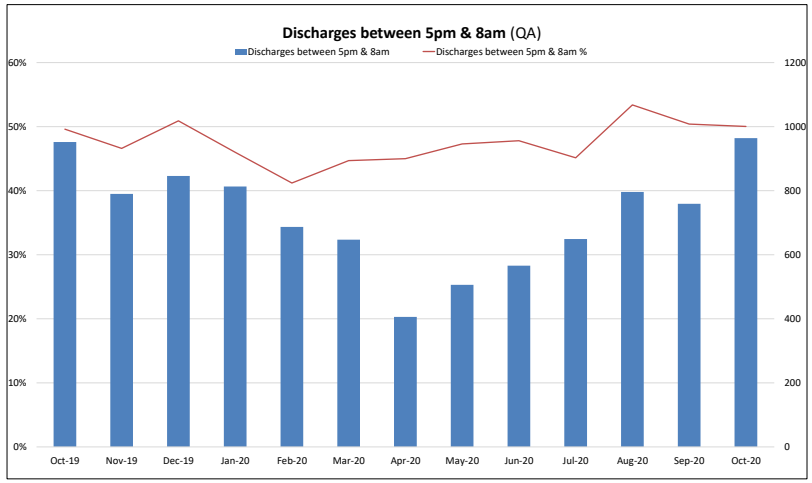
Stranded Patients

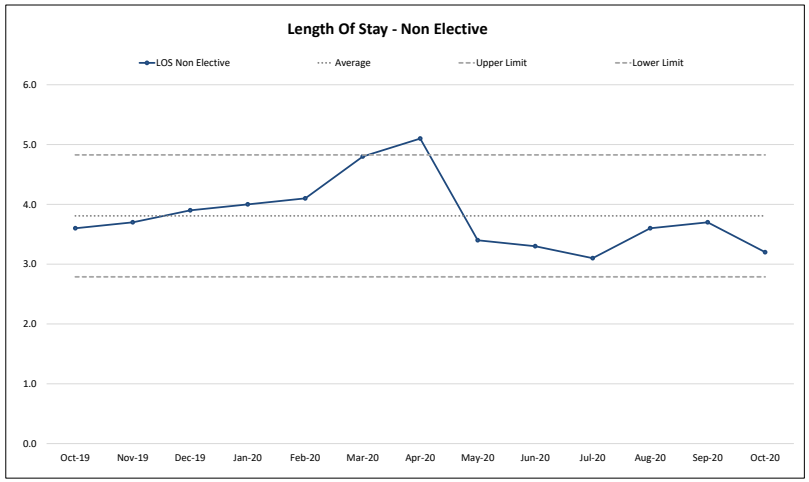


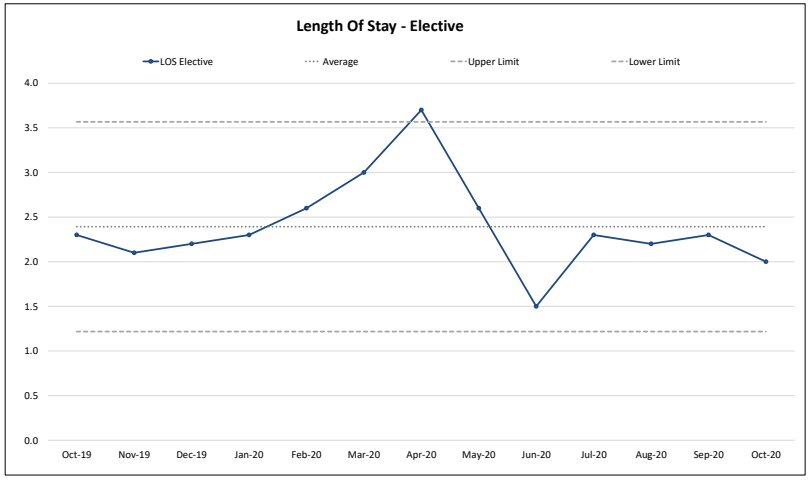


Discharges & LOS

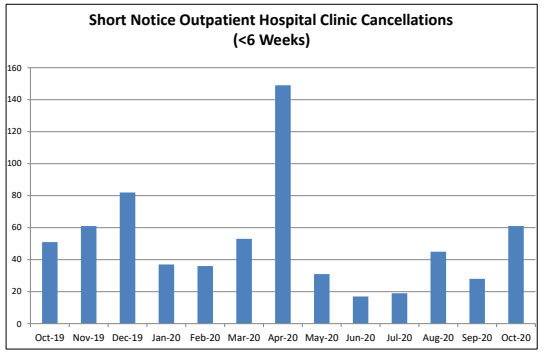


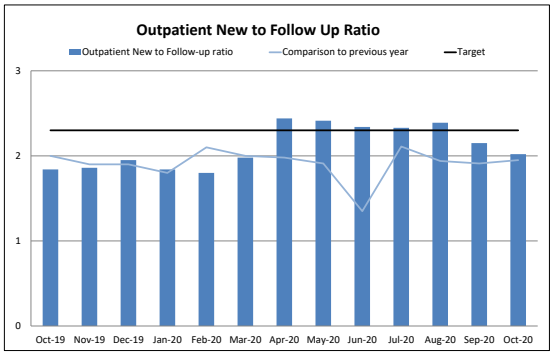


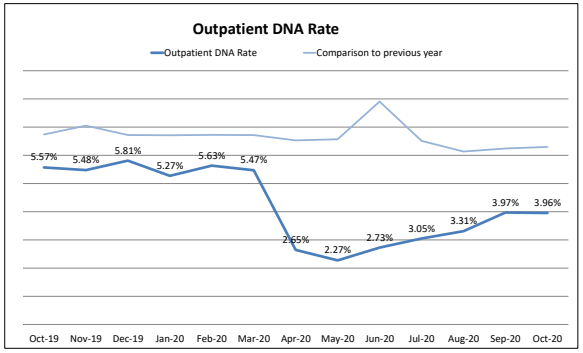


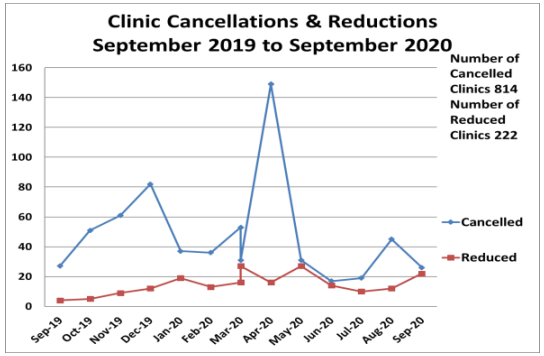


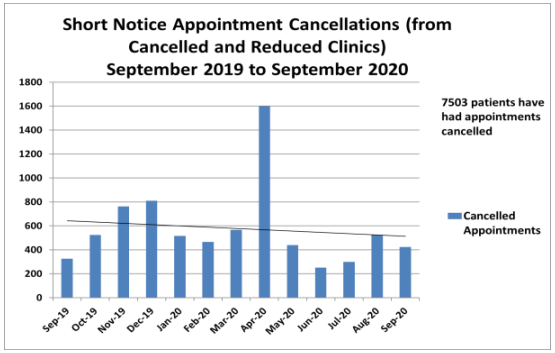
Outpatients & Cancelled Operations

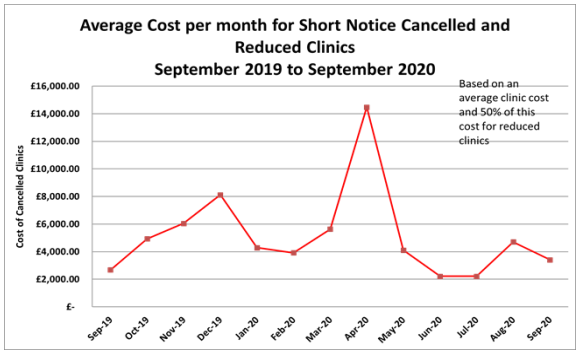








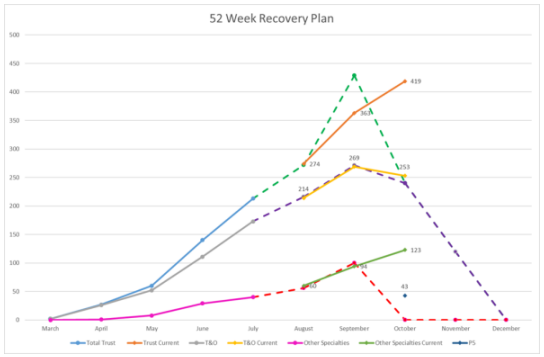


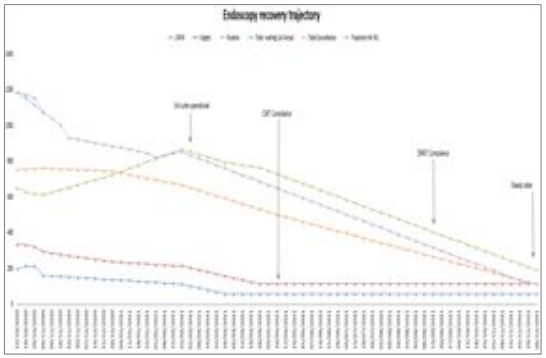


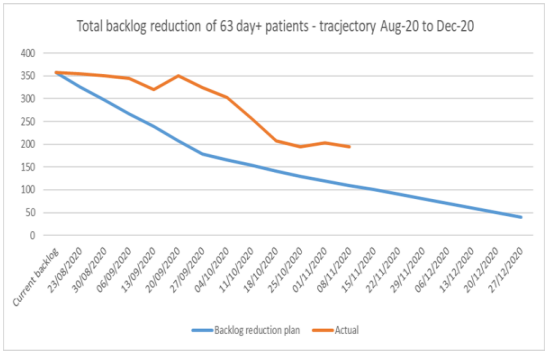
DNA Rate for Follow Up Appointments per Specialty for October

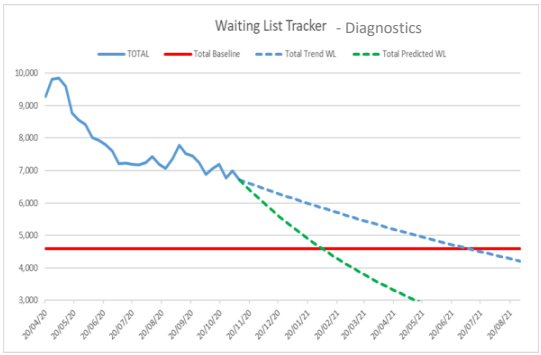
Anaesthetics	Anticoagulant Service	Breast Surgery	Cardiology	Chemical Pathology	Clinical Haematology	Clinical Oncology	Colorectal Surgery	Community Midwifery	Dermatology	Diabetic Medicine	Dietetics	Endocrinology	ENT	Gastroenterology	General Medicine	General Surgery	Geriatric Medicine	Gynaecology	Medical Oncology	Neonatology	Neurology	Obstetrics	Ophthalmology	Optometry	Oral Surgery	Orthoptics	Paediatric Diabetic Medicine	Paediatrics	Physiotherapy	Respiratory Medicine	Rheumatology	Trauma & Orthopaedics	Urology	Vascular Surgery	Well Babies	Total
0.0%	0.0%	12.5%	5.1%	1.2%	0.5%	0.0%	0.0%	4.4%	4.0%	2.9%	9.9%	0.6%	5.6%	3.5%	0.2%	2.0%	0.0%	0.8%	0.6%	0.0%	1.8%	1.9%	6.7%	15.7%	4.7%	10.4%	12.0%	8.1%	5.7%	2.0%	3.5%	8.0%	4.2%	0.0%	1.9%	4.1%

Recovery Trajectories









	Metric	Oct-19 Actuals	Oct-20 Actuals	Oct-19 vs Oct-20
Outpatients	First appointments	11,891	10,950	92.1%
	Follow up appointments	21,120	22,170	105.0%
	procedures	TBC	TBC	TBC
	Face to face	TBC	TBC	TBC
	Virtual	TBC	TBC	TBC
Inpatients	Day cases	2,199	1,708	77.7%
	Elective	390	345	88.5%
	Non-elective	3,315	3,497	105.5%
ED	A&E attendances	9,560	8,506	89.0%

Executive Summary Our People

The Princess Alexandra Hospital NHS Trust

People measures

The overall trust vacancy rate is 8.4% just above the trust KPI of 8%. Overall recruitment continues against plan with some administrative posts placed on hold for potential redeployments following consultation.

Weekly establishment meeting continue to take place to review bank & agency usage against vacancy & activity. Additional temporary staff are being used to support the trust activity recovery plan & temporary & substantive recruitment has commenced for the new adult assessment unit.

Staff turnover is currently sitting at 10% under the trust KPI of 12%. The HR business partnering team are working with the HCGs to ensure exit questionnaires are completed for leavers.

The majority of sickness absence reasons for the month relate to musculoskeletal (MSK) & stress & anxiety. Support around good manual handling is promoted in key areas where this is a high absence reason such as estates & facilities. The increase in stress & anxiety cases has been attributed to COVID & return to work. Staff health & wellbeing & the business partnering team are advising managers with support to these cases.

Overall KPI for statutory & mandatory training has reduced to 86%. The trust introduced an electronic training booklet for staff to complete offline with the expectation that we will see improvement in trust compliance over the next month.

Time to hire days have also decreased over the last 2 quarters & links to establishment meetings where bottle necks can be identified & addressed.

Health and Wellbeing

Work continues to promote psychological & physical health amongst our employees & the trust are working with our ICS colleagues to develop a system wide health & wellbeing offer.

Trauma & risk (TRiM) training took place in June for PAHT staff with 15 staff across all staff groups trained. This cohort of people completed their assessments & will be working alongside staff health & wellbeing & our mental health first aiders. Staff access this offer through our staff health & wellbeing department.

The trust have been working with EPUT to provide clinical reflection sessions to our critical care staff & we will be looking to extend this offer for the next 6 months.

Workforce Indicators Summary

Agency Spend 4.00%
Bank Spend 10.95%

Target: 15%

Staff In Post
3753.01
WTE

Training
83%

Target: 90%

Sickness
4.14%

Target: 3.7%

9.51%

Target: 8%

Turnover
9.82%

Target: 12%

Medical Suspended
Non-Medical 76%

Target: 90%

Scorecard

NHS The Princess Alexandra Hospital NHS Trust

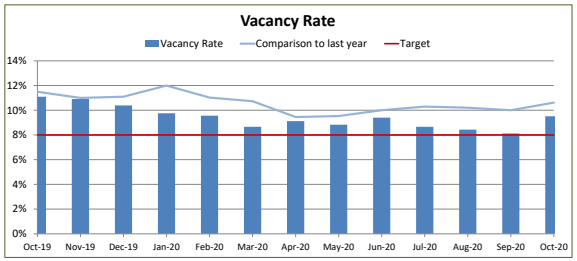
People Measures as at 31 October 2020	Trust Target	Trust	CCCS	FAWS	Medicine HCG	Surgery HCG	Estates & Facilities	Corporate	People	Finance
Funded Establishment- WTE		3753.01	903.77	483.84	945.35	779.22	278.29	140.32	57.68	164.54
Vacancy Rate	8.0%	9.51%	6.87%	10.40%	12.62%	11.61%	12.14%	0.00%	3.92%	13.27%
Agency % of paybill	7.0%	4.0%	2.1%	1.1%	4.1%	7.3%	0.0%	4.0%	0.0%	6.9%
Bank Usage - wte	n/a	292.21	42.78	48.65	110.33	47.05	17.28	9.23	1.82	15.07
Agency Usage -wte	n/a	60.21	12.45	3.96	13.09	20.87	0.00	5.74	0.00	4.10
October 2020 Sickness Absence	3.7%	4.14%	3.77%	3.65%	4.11%	4.01%	**7.84%**	3.37%	**6.92%**	2.11%
Short Term Sickness	1.85%	2.16%	1.72%	1.46%	2.79%	2.48%	2.32%	2.28%	3.31%	1.04%
Long Term Sickness	1.85%	1.98%	2.05%	2.19%	1.32%	1.53%	5.52%	1.09%	3.61%	1.08%
Rolling Turnover (voluntary)	12%	9.82%	10.60%	9.28%	11.36%	8.01%	7.85%	9.05%	11.85%	10.46%
Statutory & Mandatory Training	90%	83%	88%	83%	81%	**76%**	80%	84%	85%	87%
Appraisal	90%	**76%**	84%	**74%**	**71%**	**68%**	87%	**65%**	**74%**	**75%**
FFT (care of treatment) Q2	67%	78%	76%	84%	83%	78%	61%	75%	68%	82%
FFT (place to work) Q2	61%	65%	56%	72%	69%	62%	45%	75%	60%	67%
Starters (wte)		64.31	7.40	9.78	13.94	11.80	7.00	12.00	0.40	2.00
Leavers (wte)		31.51	9.50	3.06	7.80	7.61	1.60	0.53	1.40	0.00
Time to hire (Advert to formal offer made)	31Days									

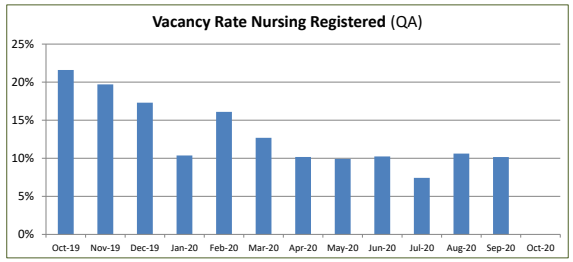
Workforce Indicators

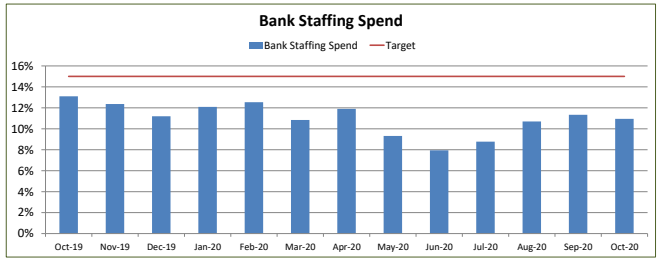
3 Our People Summary

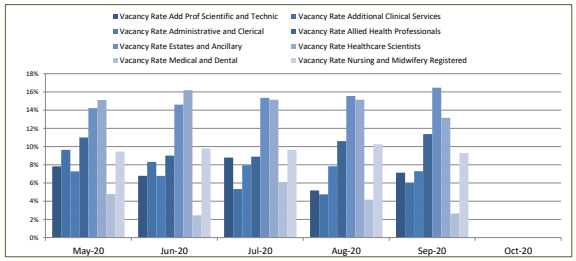
3.3 Well Led

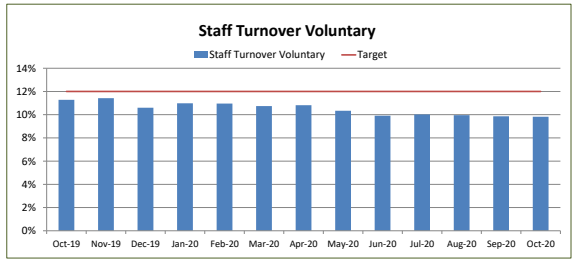
NHS The Princess Alexandra Hospital NHS Trust

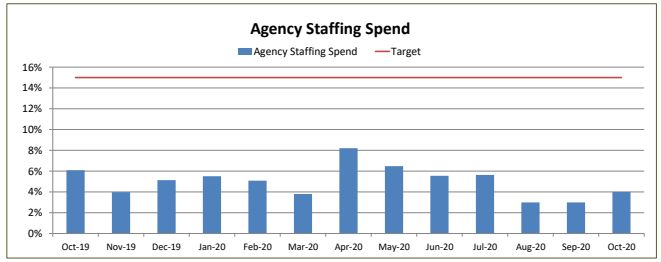


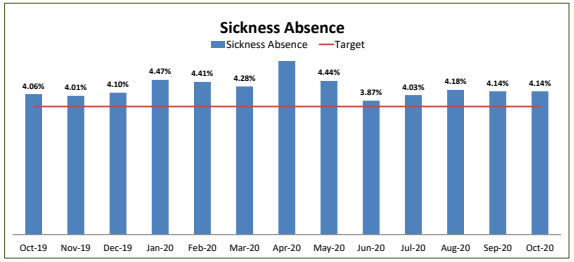


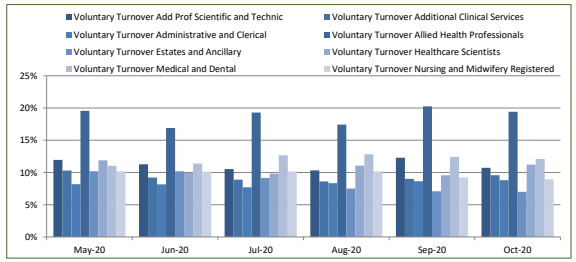


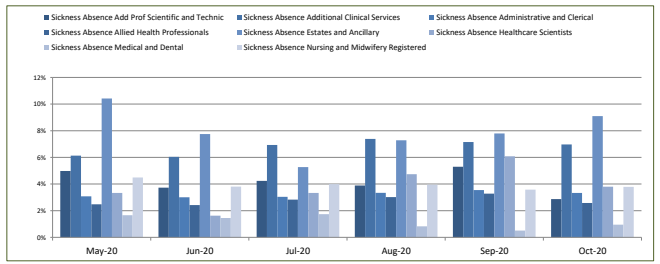


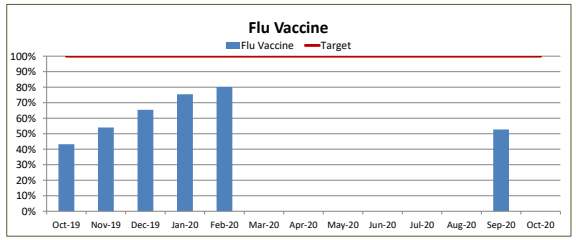




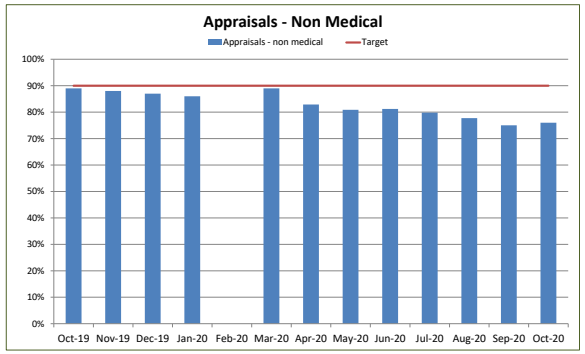


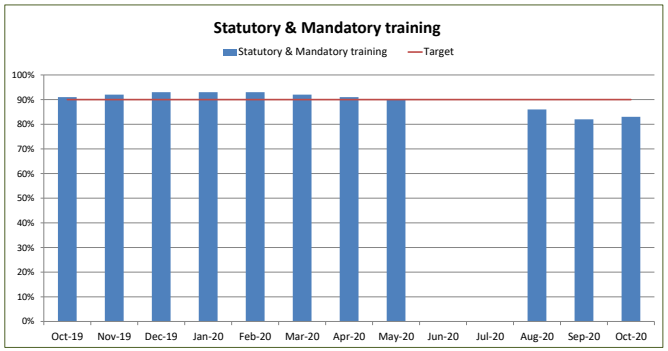


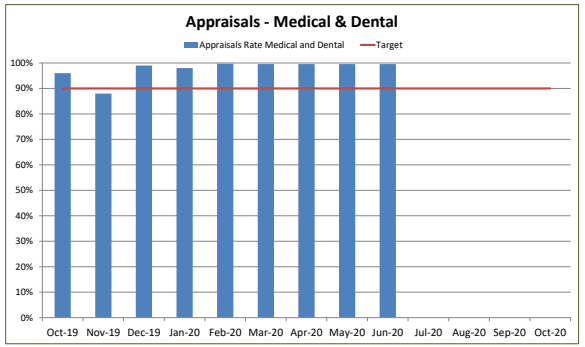


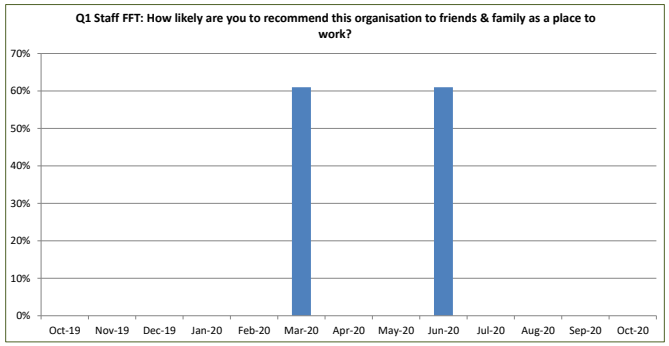


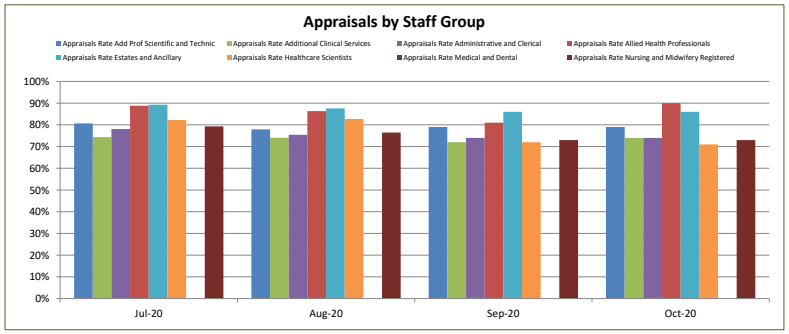
Workforce Indicators

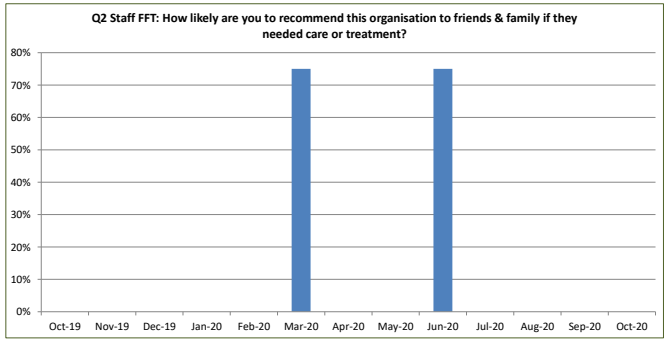












Workforce Indicators

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

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

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

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

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

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

Executive Summary Our Places

The Princess Alexandra Hospital NHS Trust

2019-2020 Emergency backlog maintenance schemes: All projects are now completed.

Estates capital programme 2020-21 summary overview: All project managers continue to push hard to progress all schemes within the programme. A comprehensive review and challenge of all project timescales has been undertaken, and where appropriate a number of the schemes have now been successfully accelerated. Development projects currently in works phase onsite is the Adult Assessment Unit (AAU), Multi-faith Facility and Dolphin Ward refurb.

The major risk to the bigger schemes continues to be access to work-areas due to decant dependencies. Juggling between decanting space while minimising impact on service delivery is a challenge. All project sponsors / stakeholders have been given decant dates. For those schemes where the decant solution is proving challenging, the risk will be added to their health care groups risk register. The below 3 schemes are currently running at higher risk for this reason.

- Frailty Assessment Area in Emergency Department
- Williams Day Unit
- Colposcopy Refurbishment

A review of the scheme decant plans is the key agenda item at the next Space Utilisation Group (SUG) Meeting scheduled for Tuesday 17th November. All health care groups must demonstrate flexibility in sharing the limited space available onsite to enable the successful completion of the 2020/21 programme.

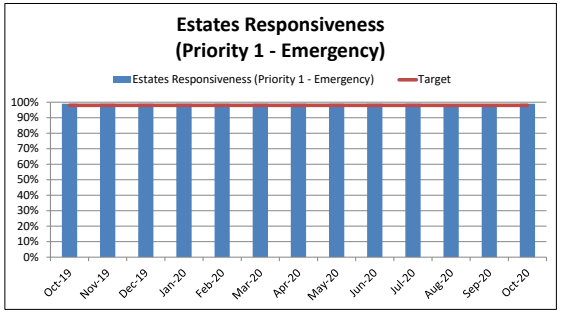
Completed projects (during reporting period)
Relocated Electro-Biomedical Engineering (EBME) Facility
Completed at the end of September this new venue provides a fully HTM compliant environment, which is a significant improvement on the existing workshop and infrastructure. Now fully equipped with a new ventilation system, medical gas storage, ventilated workstations and EBME Library, this purpose built workshop is now in the right location to provide improved service response times to all clinical areas.
The Alex Study
This project evolved from the staff initiative 'you said, we did'. Led and championed by Kapila Gunasekera and Dev Dutta, the redesigned space provides a high-end office environment for our Doctors to work and study.

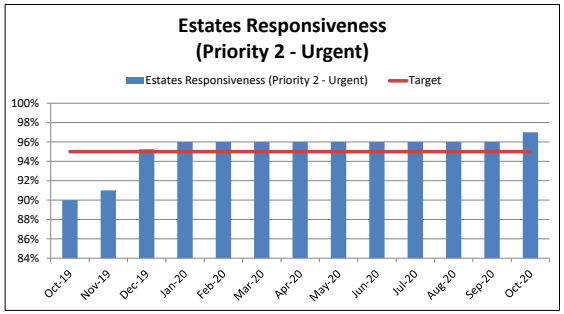
FACILITIES
Catering: the number of meals served have remained low due less patients being in the hospital due to the ongoing impact of Covid-19 pandemic. Food waste is up due issues with the food service on the wards this is being addressed with the domestic team, weekend wastage is higher due to order of additional meals 'just in case'! The introduction of the new menu on the wards has raised a few concerns which in conjunction with the Nutritional Steering group will be addressed and the menu change accordingly. General feedback from the patients is that the food is very tasty but choices are limited especially for patient who are in hospital for over a week. From the beginning of November 2020 patient satisfaction surveys for catering will be reintroduced.
Domestics: the Domestic modernisation programme is reaching its end with the go live date of 4th January 2021. The consultations for the domestic staff and the ward assistants have now been concluded with the new schedule of cleaning and working patterns now being compiled. The new equipment is due for delivery by 30th November with training for the staff to be provided through December. All vacancies going onto TRAC.
Portering: the proposed portering electronic solution is currently being trialled by a small number of portering staff. Compiling a profiling of the portering department to share with the HCG to ensure buy in and agreement for the service provision.

ESTATES
Black building test is scheduled for 15th November 2020. Maintaining a safe and stable oxygen supply to all ward areas ensuring patient safety. 71% recovery on backlog – refrigeration, air-conditioning and ventilation assets servicing and maintenance and remedial works completed where required. Fire safety management contract out to market (4 bidders). New water safety management contract awarded to clear water. New grounds & garden contract awarded (snow clearance & gritting)

The Estates and Facilities team are currently top of the trust for their appraisal compliance at 86.7% and second in the Trust for their core training at 86% however managers are still working hard to get the figures back up to above the 90% trust target.

Places


Estates Responsiveness (Priority 1 - Emergency)
Estates Responsiveness (Priority 1 - Emergency)
Target
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20


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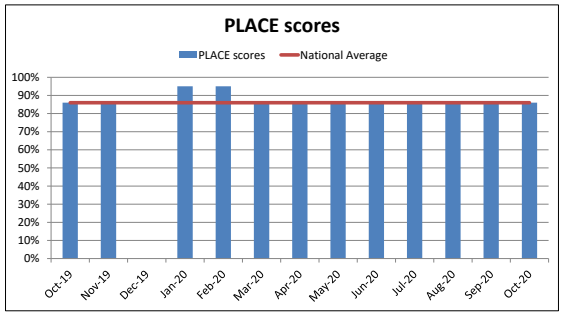
Jul-20
Aug-20
Sep-20
Oct-20


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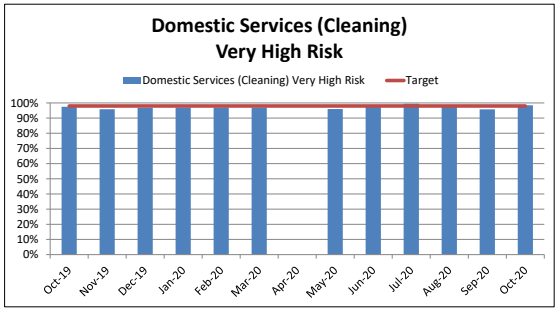
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20


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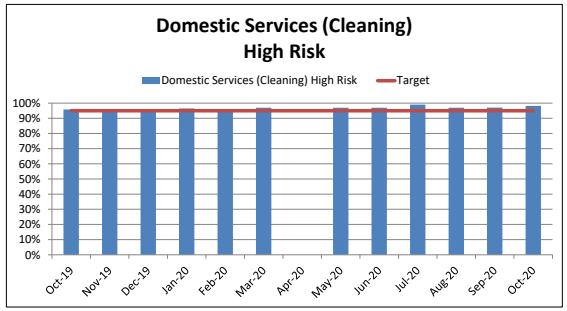
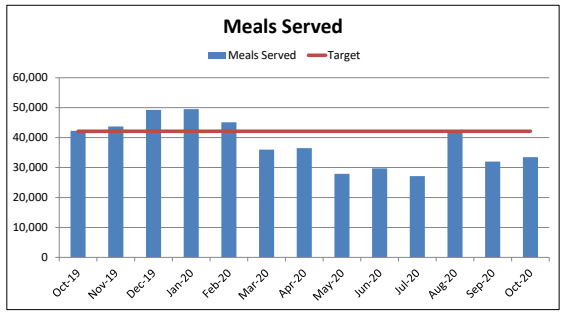
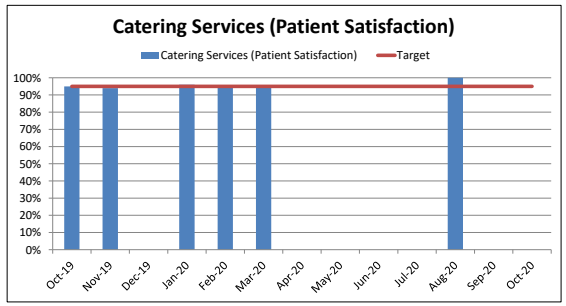
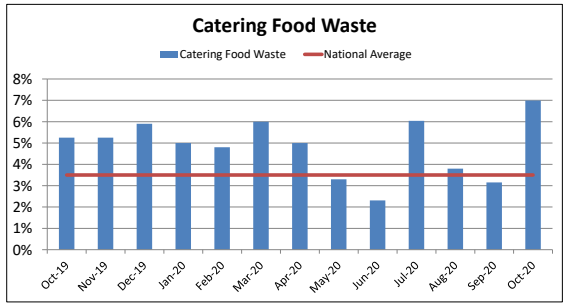
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20


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


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


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


Catering Food Waste
Catering Food Waste
National Average
8%
7%
6%
5%
4%
3%
2%
1%
0%
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20

Executive Summary Our Pounds

The Princess Alexandra Hospital NHS Trust

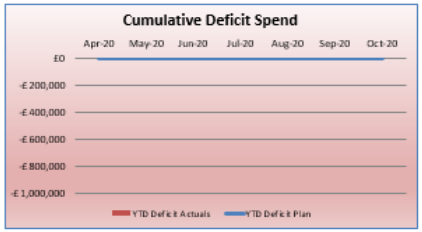
The Trust has now submitted a revised Operating plan submission for m7-12 which will now form the basis of reporting. This plan is for a £0.5m deficit. Against this plan the Trust is recording at £0.1m favourable variance. Capital expenditure has increased by £4.0m to £13.2m although remains behind expected plans. Sufficient cash resources are in place to ensure creditors are paid in a timely manner upon approval.

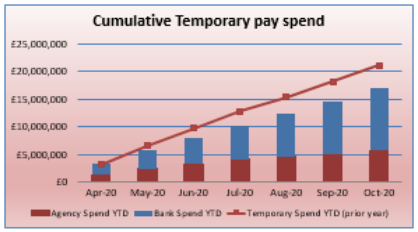
Pounds

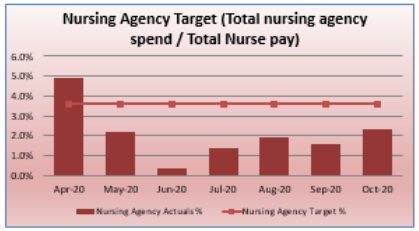
5 Our Pounds Summary — 5.1 Overall financial position

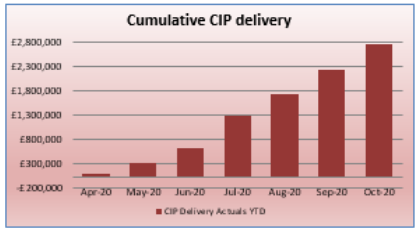
NHS The Princess Alexandra Hospital NHS Trust

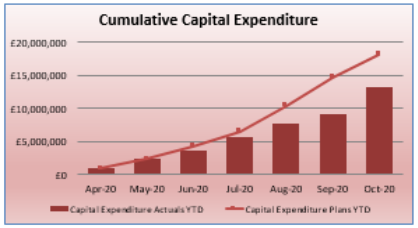
OUR POUNDS		
Metric	Annual Plan	Latest month
Deficit	£0	£0
Agency Spend £s	-£10,292,000	-£5,717,409
Bank Spend £s	TBC	-£11,269,582
Nursing Agency Target (Total nursing agency spend / Total Nurse pay)	3.6%	2.3%
Capital Expenditure	-£43,089,000	-£13,201,000
BPPC Volume	95%	90%
BPPC - £s	95%	88%
Cash Balance	£1,000,000	£54,853,000

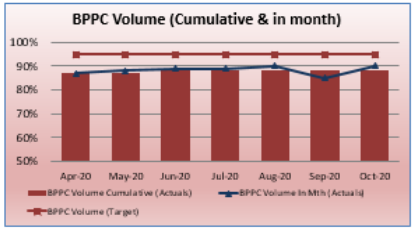


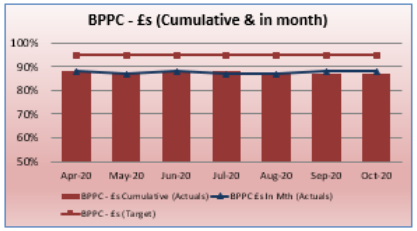


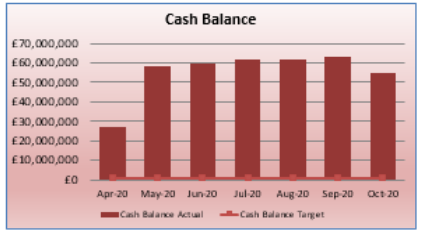












respectful | caring | responsible | committed

CQC Rating

NHS
The Princess Alexandra Hospital
NHS Trust

CQC

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

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

CQC Inpatient Survey (OS)

20 June 2019

This survey looked at the experience of 76,668 people who were discharged from an NHS acute hospital in July 2018. Between August 2018 & January 2019, a questionnaire was sent to 1,250 recent patients at each trust. Responses were received from 422 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

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The Princess Alexandra Hospital NHS Trust

Trust Board – 03.12.20

5.2

Agenda item:	5.2
Presented by:	Ogechi Emeadi, director of people, OD and communications
Prepared by:	Padraig Brady, Lead Strategic HR Business Partner Alex Anyanwu and Shahid Sardar, BAME Staff Network Amanda McEvoy, people team, HWE, ICS
Date prepared:	24 November 2020
Subject / title:	Workforce Race Equality Standard (WRES) April 2019 – March 2020

Purpose:	Approval	x	Decision	x	Information	x	Assurance	

Key issues:	The WRES is mandated through the NHS Standard Contract to report and monitor on its compliance with the national Race Equality indicators. The Trust reports annually on its progress. The Trust has implemented a number of supportive initiatives, working with the Trust BAME staff network to promote awareness and initiatives to support progress in the indicators. Key findings are summarised in the report. The trust also works with ICS system partners on the inclusion agenda. Further plans are detailed in the presentation in Appendix 2.
Recommendation:	To present the Trust Board with key findings of the Trust's Workforce Race Equality Standard (WRES) report for approval and note the additional work undertaken with the ICS to improve the experience of our people.

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:	Equality, Diversity and Inclusion Steering Group and WFC.30.11.20
Risk / links with the BAF:	There is increased risk of turnover and internal/external challenges from staff and patients if the Trust does not effectively meet and manage its obligations under the Workforce Race Equality Standard. This could also lead to reputational risk. (BAF 2.1, 2.3)
Legislation, regulatory, equality, diversity and dignity implications:	The Trust has a number of statutory duties arising from the Equality Act 2010.
Appendices:	Appendix 1 – WRES Data Appendix 2 – ICS WRES data and actions.

The Princess Alexandra Hospital NHS Trust

5.2

Purpose

To provide oversight of the Trust Workforce Race Equality Standard report (WRES) for Trust wide publication.

This paper presents the revised recommendation for 2020/21, which builds on from action and key objectives of the Black & Minority Ethnicity Staff Network

The data covers the period from Apr18 - Mar19 and Apr19 - Mar 20, respectively.

Context

The Workforce Race Equality Standard (WRES) was introduced in 2015 as part of the NHS standard contract to enable employees from black, asian and minority ethnic (BAME) backgrounds to have equal access to career opportunities and receive fair treatment in the workplace.

This is a legal duty under the Equality Act 2010 and the evidence shows that a motivated, inclusive and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisation.

The WRES forms part of the Trust's statutory duties under the broader equality and inclusion landscape – Equality Act 2010.

WRES is self-assessed against 9 indicators, four of which relate specifically to workforce data, four are based on data from the national NHS staff Survey questions and the final one considers BAME representation on the Trust board.

Analysis of the data enables the Trust to adopt a 'learning organisation' approach and produce an action plan contributing to a culture of continuous improvement. This will be essential in helping to bring about a workplace that is free from discrimination.

Positive progress taken in this reporting period

1.0 PAHT BAME Staff Network

There is a well established BAME Network which is positively supported by the Trust. The Network meets regularly and has supported the Trust in its WRES, as well as providing balanced support and challenge throughout the last three years.

Most recently the BAME Network has run several events on the subject of the BAME experience at work, particularly in the NHS during Black History Month with leading voices in the field including:

- John Brouder, former CEO, NELFT
- Marcel Vige, mental health equalities lead with national Mind
- with Rob Neil CBE and Cherron Inko-Tariah MBE benchmarking PAH against internationally recognised standards for staff networks
- Professor Elizabeth Anionwu on dealing with emotional impacts of racism in her leadership journey

We have delivered these sessions and offered them to colleagues at EPUT, who we are partnering with as a peer trust and we know that hundreds of colleagues at PAH have benefited.

The remainder of the report details several other areas where the BAME network has been active in supporting the Trust.

2.0 Reverse Mentoring

Within PAHT, the BAME network (as part of the wider Equality Diversity and Inclusion Steering Group) has been working with the Executive team to launch a reverse mentoring scheme for all staff, which commenced September 2020. The reverse mentoring scheme is an opportunity for those in non-managerial/junior roles to regularly meet with an executive director to discuss their experiences. Details of how the scheme will operate has been promoted to all staff and there is an application process for interested staff to outline how the scheme will benefit them.

3.1 ICS BAME Telephone Helpline

Originally developed as a support response due to Covid-19, the helpline remit is expanded to become an initial point of reference/support for any BAME staff to use within the ICS patch. The helpline is staffed by BAME members of staff representing all of the Trusts within the ICS working on a rota that allows the helpline to run 7 days per week from 2pm – 8pm. The helpline was launched on a phased approach with the launch for PAHT staff occurring on 22nd June. There was an expected upturn in calls as each organisation's launch took place and since restrictions such as shielding has been paused, the level of calls received has decreased. Feedback from BAME staff in organisations across the ICS show that they value having an independent support resource in addition to any site-specific mechanisms that exist within each employing organisation.

3.2 ICS BAME Webinar

The chair of the PAHT BAME network was part of the ICS working group to develop an ICS BAME webinar inviting BAME and non-BAME staff to join from across the system. The webinar programme invited keynote speakers to participate in sessions including emotional resilience, cultural intelligence and supporting BAME colleagues more widely within the NHS.

The Princess Alexandra Hospital NHS Trust

4.0 COVid-19 Support to BAME colleagues

As part of the overall Trust response to the Covid-19 pandemic, the Trust has implemented a number of measures specifically to support our BAME colleagues. Specific advice has been made available to staff and managers of BAME staff to undertake comprehensive risk assessments, as BAME staff have been nationally recognised as an identified vulnerable staff group.

A number of webinars have been regularly undertaken within PAHT to support BAME colleagues. Attendance at the webinars has been high and the webinars included representation from the BAME Network, Executive Team, Director of IPC, Occupational Health and HR.

Results against the WRES Staff Indictors

Indicator 1: Percentage of staff in each of the AFC pay bands 1-9 or Medical and Dental Subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce

The overall percentage of BAME staff compared to White staff employed by the Trust in 19/20 increase to 30% (27% in 18/19). This has seen an increase of BAME staff across all bandings and grades excluding senior roles such as Band 8D and 9 were the total number of BAME staff remains the same from 18/19 when compared to the increase in these senior roles for White staff in 19/20.

There has been a significant increase of BAME staff in band 5 from the ongoing international recruitment campaign for Registered Nurses which has positively contributed to the significant decrease in the nurse vacancy to below 10% Development plans will progressed during the next 12 months for Band 5 nurses to access nurse leadership training.

The Trust Medical & Dental workforce represents 59% of BAME Staff, a slight increase from 58% in 18/19.

Indicator 2: Relative likelihood of white staff being appointed from Shortlisting compared to BAME staff

This metric continues to improve year on year in the number of BAME staff shortlisted and the number of BAME appointed from shortlisting. The relatively likelihood of White staff being appointed compared to BAME staff is currently 1.23 compared to 1.30 in 18/19. (Any score less than 1.00 is seen as a positive).

The recruitment team are currently reviewing the Recruitment Policy and refreshing recruitment processes which will have impact on this metric in the next reporting period. In addition, the Trust's ongoing international recruitment is not yet reflected in this data.

Indicator 3: Relative likelihood of BAME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation compared to white staff (two years rolling average)

The likelihood of BAME staff entering the formal disciplinary process two years rolling average is now 1.94 times compared to 0.40 times the previous two rolling years.

Whilst this is a concern for the BAME network, the data breakdown in Appendix 1, (Page 8) shows that the overall numbers of PAHT staff entering into a formal disciplinary process over the course of the last 24 months is 41 in total which is very low for a Trust of our size.

Positive steps are taking place to overall the Trust Disciplinary Policy, working in partnership with the BAME network with the aim of introducing a moderating decision tool, including BAME representatives. This will underpin the importance of transparency and consistency.

Indicator 4: Relative likelihood of white staff accessing non-mandatory training and CPD compared to BAME staff

The number of BAME staff access CPD continuous professional development (CPD) is 32% (41% in 18/19) compare to White staff 63% (55% in 18/19). The likelihood of White staff when compared to BAME is 0.94 (*Any score less than 1.00 is seen as a positive)*

It is likely that the onset of Covid-19 at the latter end of this reporting period will have had an impact on this data, as training providers had started to reduce the number of training activities being offered.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

BAME staff experiencing bulling, harassment and abuse from patients decreased to 28.1% (31.1% in 2018) compared to 26.8% for White staff in both years. The national average is 29.9% for BAME staff (staff survey results).

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

BAME staff experiencing harassment, bulling and abuse from staff or colleagues increased slightly to 31.1% (29.6% in 2018) when compared to an increase of 29.2% for White staff (26.8% in 2018). BAME national average is 28.8% (staff survey results).

Prior to the onset of Covid-19, the People team had worked on a staff awareness issue “In My Shoes”, an exercise teams can use to promote respect for each other – one of the core Trust values. The people team will consider how this tool can be utilised by staff which is compliant with Covid-19 safety guidance.

Indicator 7: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

BAME staff believing that the Trust provides equal opportunities and career progression remains stable at 72.2% when compared to 71.7% in 2018 compared to 86.1% for White staff (86.8% in 2018). BAME national average is 74.4% (staff survey results).

Indicator 8: Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months

The number of BAME staff reported feeling discriminated at work from managers or colleagues has decreased slightly from 16.3% in 2017 to 14.1% in 2019. The BAME national average is 13.8% (staff survey results).

The Princess Alexandra Hospital NHS Trust

Indicator 9: Percentage difference between PAH Board voting membership and its overall workforce

This Year the Trust has a voting board member who identifies from a BAME background. This indicates an increase of 8.3% compared to 0% in 18/19

Recommendations

Indicators	Actions	Lead	Timescale
1	To review the current disciplinary policy and process to include a best-practice panel-led approach to decision-making providing a consistency to what allegations of misconduct require progression to a formal disciplinary process.	**Strategic HR Business Lead**	**By March 2021**
2	To review the current recruitment process within the Trust to ensure recruitment panels are promoting Equality, Diversity and Inclusion representation. The review should include providing recruitment and selection training for managers and guidance on panel composition including EDI representation and/or People reps	**Head of Recruitment**	**By Jan 2021**
3	To review the process for accessing CPD funded courses to ensure it is accessible to all staff; ensuring the process for distribution and allocation of funded CPD courses is managed consistently and by a diverse decision-making panel	**AD – Training & Development Lead**	**By Jan 2021**
4	The Trust is committed to recruiting 2 clinical FSUG and will work with the BAME network to encourage applications from BAME Staff	**CEO/Trust Board**	**By Jan 2021**
5	The Trust is committed to appointing a senior role with responsibility for progressing with Inclusion initiatives for staff and patients.	**CEO/People Director**	**By Jan 2021**
6	The Trust will support developing and training dignity at work/ anti-bullying and harassment champions to provide awareness and support regarding dignity at work and work with managers and the People Team to identify and resolve issues of bullying and harassment.	**CEO/People Director**	**By Jan 2021**
7	To develop regular recruitment monitoring data reports (e.g. numbers of candidates applying, shortlisted, interviewed, offered, withdrawn) by protected characteristic, which is reviewed on a regular basis, to identify any potential inclusion obstacles within our recruitment processes.	**People Systems/Head of Recruitment**	**By Dec 2020**

The Princess Alexandra Hospital NHS Trust

[APPENDIX 1] Analysis of WRES standard Metric data

Indicator 1 – Staff Profile

WRES Indicator No.	WRES Report March 2019	WRES Report March 2020
Percentage of BAME Staff employed within the Trust	**27%**	**30%**
Proportion of staff who have self-reported their ethnicity	**94%**	**94%**

1.Headcount and Percentage of non-clinical staff in each Pay band AFC Band 1-9 & VSM

	2019				2020			
	White		BAME		White		BAME	
Band 1	43	83%	9	17%	31	76%	6	15%
Band 2	328	88%	36	10%	329	82%	40	10%
Band 3	117	73%	6	4%	116	84%	13	9%
Band 4	159	92%	8	5%	172	94%	5	3%
Band 5	55	82%	6	9%	63	84%	7	9%
Band 6	55	81%	9	13%	49	79%	11	18%
Band 7	29	73%	9	23%	48	77%	12	19%
Band 8a	27	90%	3	10%	27	79%	5	15%
Band 8b	15	75%	4	20%	24	89%	3	11%
Band 8c	7	88%	1	13%	9	69%	3	23%
Band 8d	10	100%	0	0%	12	100%	0	0%
Band 9	4	100%	0	0%	5	100%	0	0%
VSM	9	90%	1	10%	8	89%	1	11%

Headcount and Percentage of clinical staff in each Pay band AFC Band 1-9 & VSM

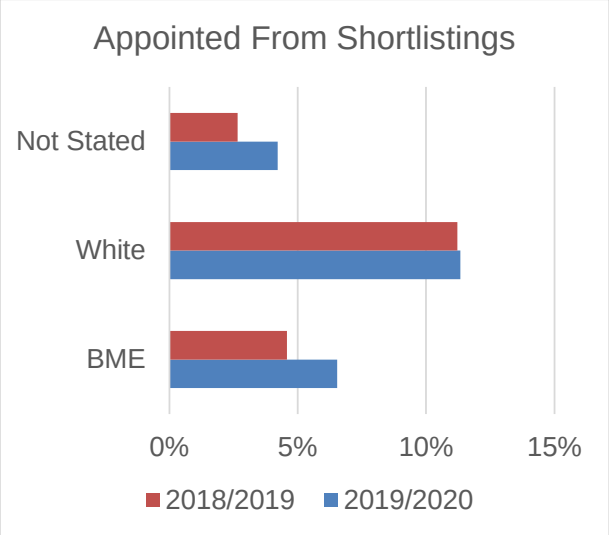
	2019				2020			
	White		BAME		White		BAME	
Band 1	0	0%	0	0%	0	0%	0	0%
Band 2	330	81%	77	19%	328	82%	71	18%
Band 3	158	79%	23	12%	147	80%	22	12%
Band 4	73	70%	24	23%	75	61%	42	34%
Band 5	207	50%	204	49%	196	36%	339	63%
Band 6	305	67%	134	29%	302	63%	147	31%
Band 7	184	64%	84	29%	188	66%	81	28%

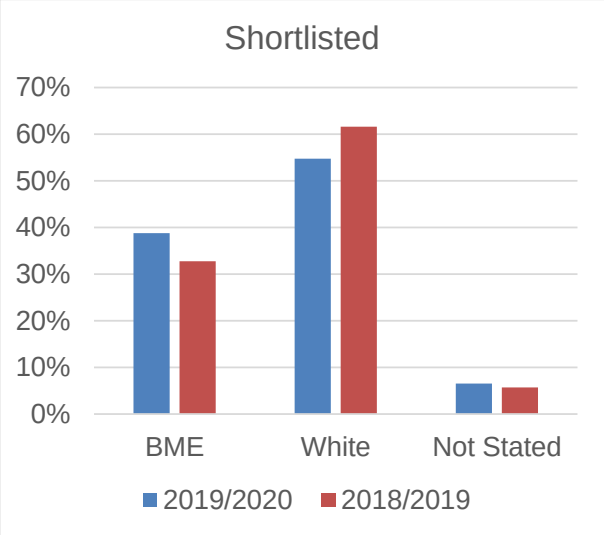
Band 8a	64	69%	15	16%	62	65%	21	22%
Band 8b	21	81%	1	4%	22	71%	3	10%
Band 8c	7	70%	1	10%	7	70%	1	10%
Band 8d	7	88%	1	13%	7	88%	1	13%
Band 9	0	0%	0	0%	0	0%	0	0%
VSM	0	0%	0	0%	0	0%	0	0%

Percentage of Medical & Dental Staff

Medical & Dental	142	33%	252	58%	145	30%	282	59%

Indicator 2 – Recruitment shortlisting and appointed from shortlisting data by ethnicity



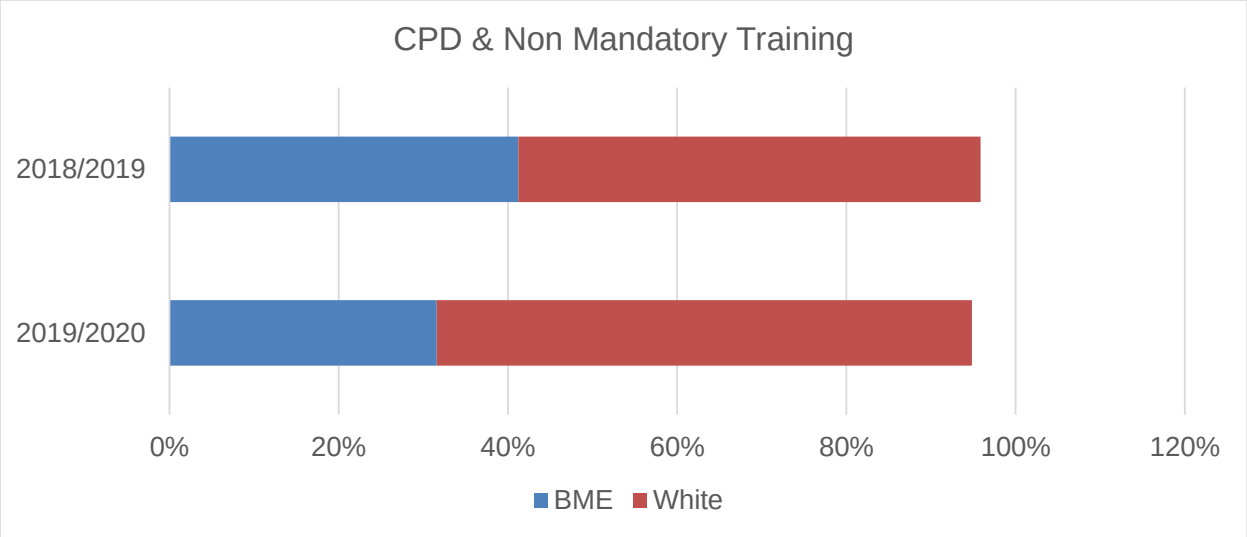


Indicator 3 - Relative likelihood of BAME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation compared to white staff (two years rolling average)

	BAME	White	Not Stated
2019/2020	10	11	3
2018/2019	2	13	2

The Princess Alexandra Hospital NHS Trust

Indicator 4 - Percentage of staff that access CPD & non mandatory training by ethnicity



	BAME	White	Not Stated
2019/2020	31.61%	63.22%	5.18%
2018/2019	41.24%	54.64%	4.12%

Indicator 5 – 8 Data from the NHS Staff Survey

		2017	2018	2019
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	29.6%	26.8%	26.8%
	BAME	28.5%	35.1%	28.1%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	24.9%	26.8%	29.2%
	BAME	28.5%	29.6%	31.1%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	84.8%	86.8%	86.1%
	BAME	70.7%	71.7%	72.2%
Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	White	7.0%	6.5%	6.5%
	BAME	16.3%	12.5%	14.1%

Indicator 9 Voting members of the Board by Ethnicity

	BAME	White	Not Stated
2019/2020	8.3%	83.3%	8.3%
2018/2019	0%	100%	0%

Equality, Diversity & Inclusion Work Stream Update

25th November 2020

'One workforce across Hertfordshire and West Essex; delivering high quality, seamless, and person centred care'

Right Care	Right Time	Right Way	Right Place	Right Person	Right Skills	Right Values

HWE ICS People Plan

Supporting Vulnerable Groups - Already Done

- Establishment of a BAME staff support line
- Agreed consistent risk assessment and outcomes for all vulnerable groups
- Research methods being explored to understand BAME staffing needs and views on Covid-19 response
- Creation of system-wide ED&I network and BAME chairs network for ongoing transformation

2.SUPPORTING OUR STAFF
Supporting our workforce, through a consistent set of interventions, ensuring Herts and West Essex is recognised as the 'best place to work'.

3. BRINGING IN THE BEST
Use of the Health and Care Academy to enable implementation of attraction, recruitment and retention initiatives, and new education and training pathways consistently across the system.

4. LEADING THROUGH COMPASSION
Compassionate leadership and management delivered at all levels of the system.

5. CONNECTED COMMUNITIES
Maximising the contribution of volunteers and voluntary sector across the system, building on the success of the sector's response and interest generated during the Covid response.

6. A PRODUCTIVE WORKFORCE
Enabling our workforce to make best use of new technology, develop new ways of working and build a capability and infrastructure to understand and plan future workforce requirements.

7.DEVELOPING OUR STAFF
System-wide career pathways, new apprenticeship models and professional development to supply the skills and roles required for our system.

8. EQUALITY & INCLUSION FOR ALL
Build on support for BAME staff, enable system-wide understanding and responses to ensure support and opportunity for all staff.

1. SERVICE RECOVERY
Ensuring we restore services, gain an understanding of workforce constraints and requirements and prepare for future challenges.

Themes and Work Streams for Health & Social Care

Themes In Support Of The People Plan	Work Streams Developed Within E,D&I Agenda
• System and processes	• Creation of a system wide dashboard and Recruiting and promoting a diverse workforce
• Experience	• ICS wide online webinars and Voices of influence sessions
• Leadership & Development	• BAME Talent pool, development & pipeline
• Cultural Intelligence	• Unconscious bias & Cultural Competency / Intelligence programme roll out
• Mentoring & Coaching	• Reverse mentoring programmes and coaching for BAME talent development

3

National / Regional Average Comparison: 2019 WRES

National Average: 2019 WRES

- 1.46 likelihood of white colleagues being appointed from **shortlisting** compared to BAME staff
- 1.22 likelihood of BAME staff entering formal **disciplinary** process compared to white staff
- Staff experiencing **bullying and harassment from patients** and the public: 27.9% white staff and 30.3% BAME staff
- Staff experiencing **bullying and harassment from colleagues:** 23.6% white staff and 28.4% BAME staff

Bedfordshire, Luton and Milton Keynes

Shortlisting likelihood	0.9	
Disciplinary likelihood	1.34	
% bullying/harassment by patients	BAME	White
	29.57	31.33
% bullying/harassment by colleagues	BAME	White
	25.10	25.07

Cambridgeshire and Peterborough

Shortlisting likelihood	1.1	
Disciplinary likelihood	0.67	
% bullying/harassment by patients	BAME	White
	26.42	23.42
% bullying/harassment by colleagues	BAME	White
	26.78	23.46

Hertfordshire and West Essex

Shortlisting likelihood	1.6	
Disciplinary likelihood	2.41	
% bullying/harassment by patients	BAME	White
	28.98	26.62
% bullying/harassment by colleagues	BAME	White
	27.44	23.06

East of England Ambulance

Shortlisting likelihood	1.6	
Disciplinary likelihood	2.39	
% bullying/harassment by patients	BAME	White
	48.60	49.30
% bullying/harassment by colleagues	BAME	White
	29.70	32.00

Mid and South Essex

Shortlisting likelihood	1.3	
Disciplinary likelihood	0.9	
% bullying/harassment by patients	BAME	White
	33.90	31.05
% bullying/harassment by colleagues	BAME	White
	28.28	25.73

Norfolk and Waveney Health and Care Partnership

Shortlisting likelihood	1.4	
Disciplinary likelihood	1.35	
% bullying/harassment by patients	BAME	White
	37.46	31.16
% bullying/harassment by colleagues	BAME	White
	34.20	26.40

Suffolk and North East Essex

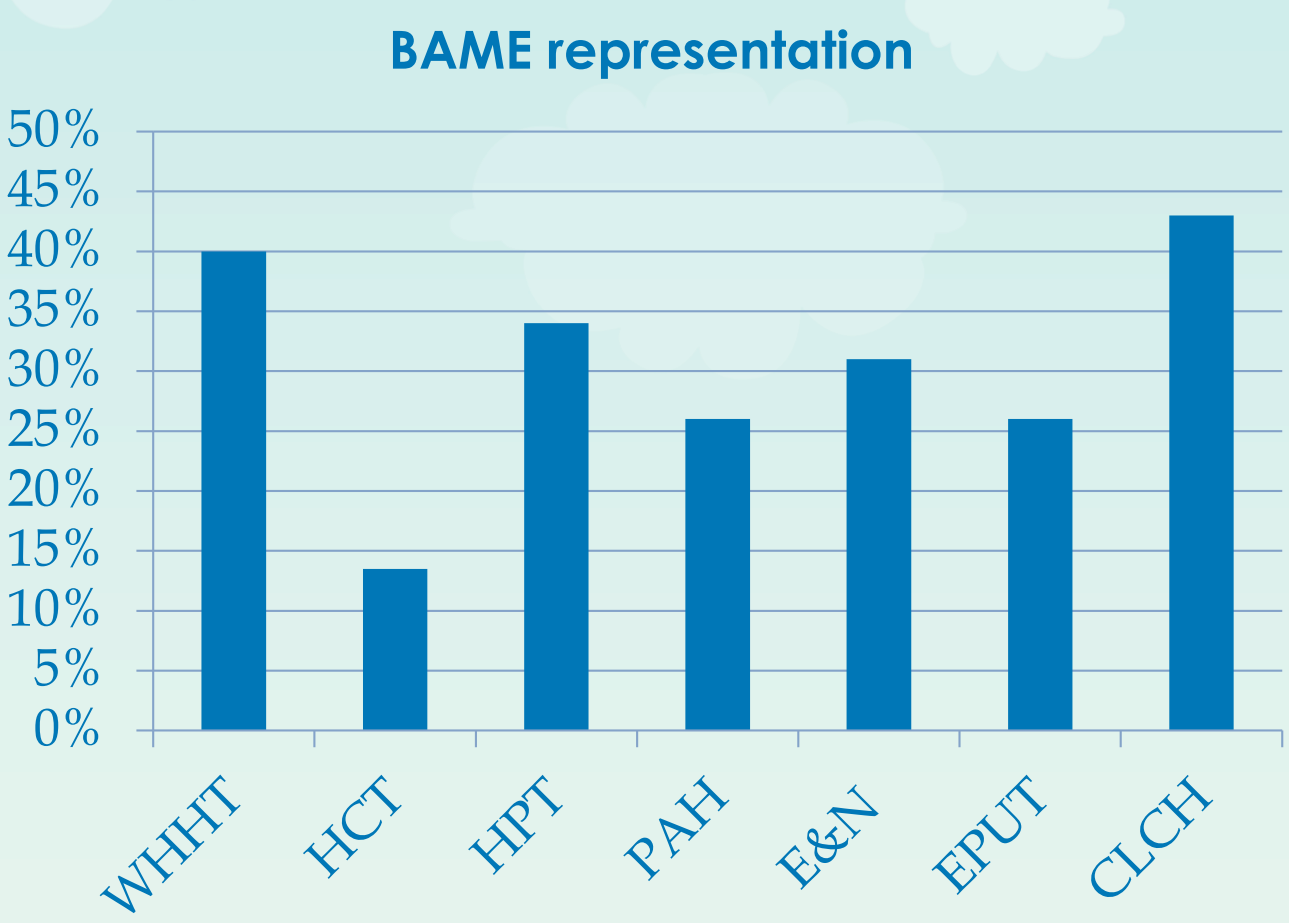
Shortlisting likelihood	1.3	
Disciplinary likelihood	0.6	
% bullying/harassment by patients	BAME	White
	30.85	26.95
% bullying/harassment by colleagues	BAME	White
	27.80	24.50

WRES Diversity Dashboard

The local population across the ICS varies significantly, for example from 9% in Hemel Hempstead to 19% in Watford.

20% of staff in East of England identify as BAME according to ESR, which is very close to the national average of 20%.

In London 45% of staff identify as BAME according to ESR.



Creation of a system wide dashboard

- We aim to make health and social care in HWE a supportive and inclusive environment to work in.
- **OUTCOMES:**
- Eradication of workplace discrimination monitored through WRES, WDES and other data sources.
- Collaborative working on specific metrics
- Just culture in relation to sharing areas of improvement to foster collaboration/learning
- Annually reviewing progress

ACTIVITY COMPLETED
All relevant organisations input latest data, e.g.: WRES, WDES and gender pay gap data

DATE	ACTIVITY IN PROGRESS
NOV 20	Data shared in Excel format to ICS meetings
DEC 20	Data shared in Excel format across all ICS organisations
JAN 21	Development of a visual dashboard to represent the data collated
FEB 21	Dashboard circulated on a monthly basis across the ICS and taken to Exec boards for monitoring
MAR 21	Evaluation of progress and reviewing / updating data to create meaningful action plans

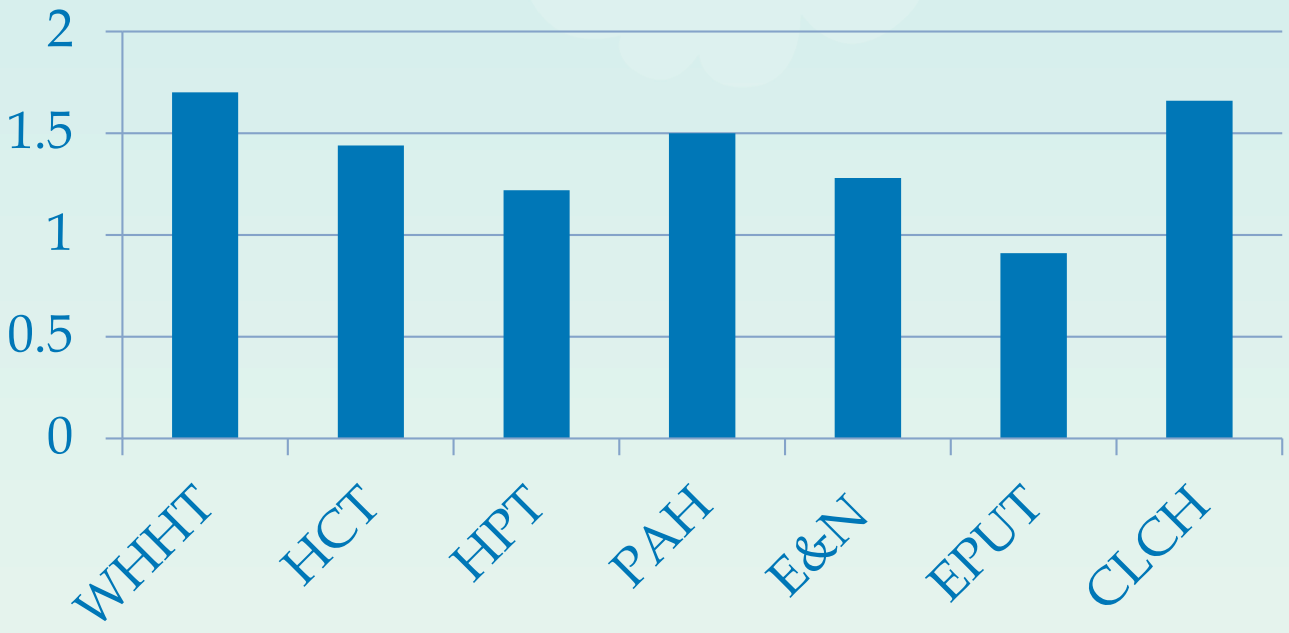
WRES Diversity Dashboard

- The average across the East of England is 1.39.

London has the highest relative likelihood (1.60) of white applicants being appointed from shortlisting compared to BME applicants

It should also be noted most Trusts calculated their figure via the recruitment software TRAC, which excludes overseas nurses and Doctors.

Relative likelihood of White applicants being appointed from shortlisting compared to BAME applicants



Recruiting and promoting a diverse workforce

As a system we will seek to recruit and promote a diverse workforce at all levels and have our senior leadership teams representative of the whole workforce

OUTCOMES:

- Fair and transparent recruitment practices.
- Increase of staff from diverse backgrounds being recruited and promoted into more senior roles

ACTIVITY COMPLETED
Agreement on the role of the Inclusion Ambassadors / Champions in each organisation
Work stream linked in with ICS recruitment group for consistency

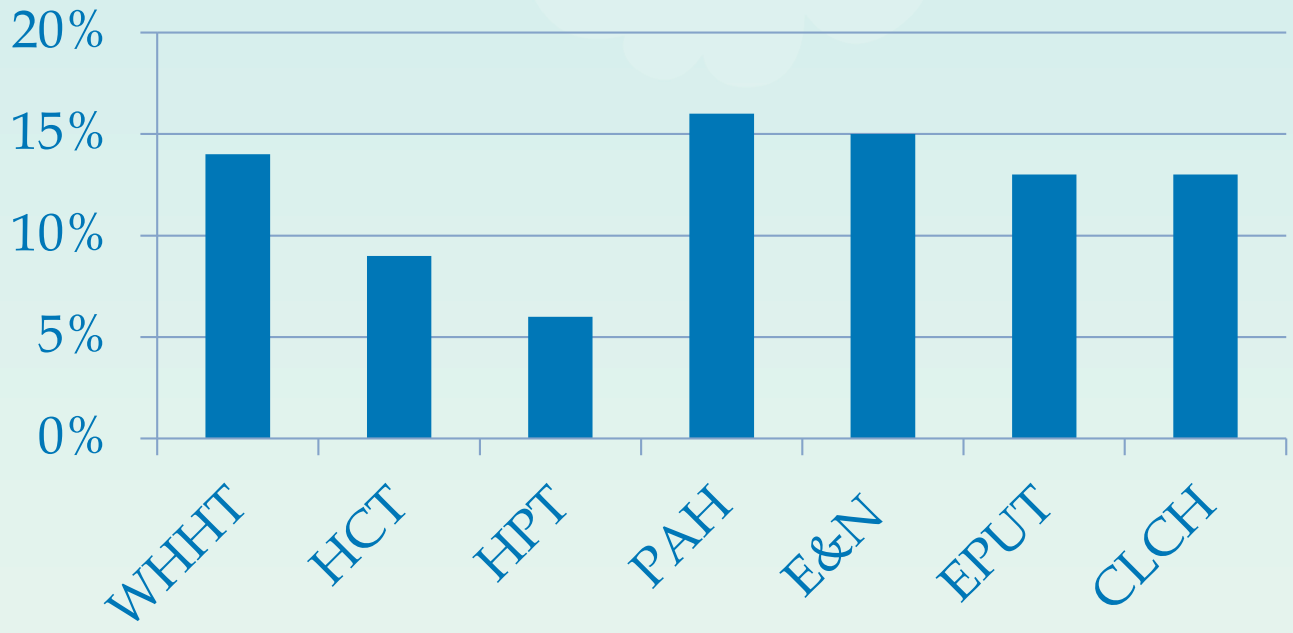
DATE	ACTIVITY IN PROGRESS
NOV 20	Development of framework to measure JDs against for consistency
DEC 20	Recruitment of Inclusion Ambassadors / Champions where they are not already in place
JAN 21	Review of shortlisting practices across the ICS to ensure equity
JAN 21	Creation of process to ensure Inclusion Ambassadors / Champions are on all interview panels for roles 8a and above
MAR 21	Review and evaluate data to measure the impact of the interventions

WRES Diversity Dashboard

East of England's average is 15% and White colleages 7%.

This closely mirrors the national average picture.

BAME staff who have personally experienced discrimination at work from colleagues. (NHS Staff Survey)



ICS Wide Online Webinars:

We want to ensure that the Herts and West Essex health and social care workforce is inclusive and diverse and a place where discrimination, violence and bullying do not occur.

OUTCOMES:

- Wider understanding of issues across the workforce and knowledge of where to access support

ACTIVITY COMPLETED
Establishment of system-wide EDI and BAME networks – enabling joint working and delivery of comprehensive plans to ensure staff inclusivity at all levels.
Delivery of a BAME webinar across the system – aiming to create an inclusive culture to talk about addressing racism in the workplace, using positive leadership to create an environment that supports black and ethnic minority employees to challenge systemic racism
Voices of Influence online event, where staff from BAME backgrounds shared lived experiences of working in the NHS

DATE	ACTIVITY IN PROGRESS
OCT 20	Joint monthly meetings diarised for E,D&I Leads and BAME network leads – other network chairs to be invited according to agenda
NOV 20	Create clear communication and engagement plan for this and future webinars
JAN 21	.Planning topics and speakers for next webinar scheduled for 12th January 2021
JAN 21	Develop a mechanism to capture feedback and to evaluate the impact / effectiveness of the webinars
MAR 21	Refine and review webinar format / topics based on feedback received

WRES Diversity Dashboard

Board representation

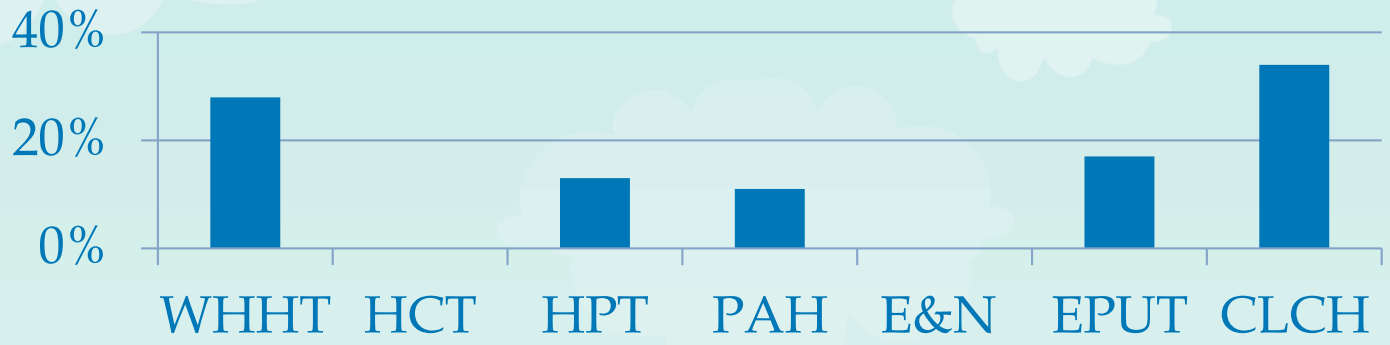
HCT's & E&N's 0% disparity us due to the fact BAME Board representation overall is 0%

The national average for BAME representation at Board level is 8%;, East of England's is 6%, London's average is 17%

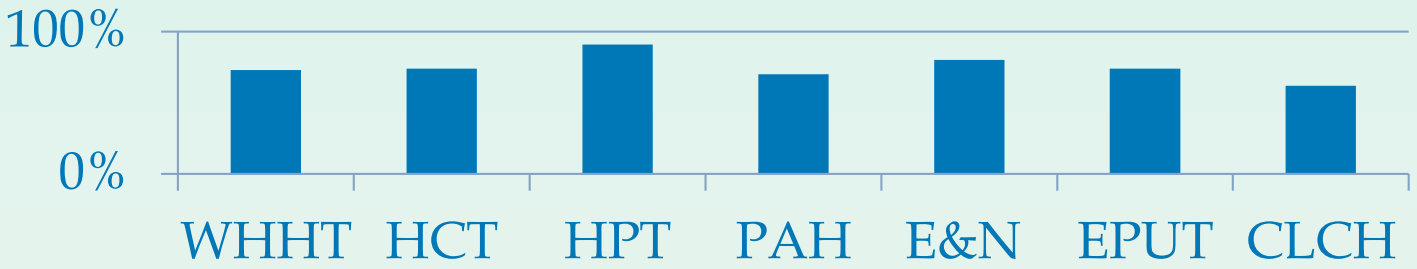
Equal opportunities

The East of England average for BAME colleagues is 72% and White colleagues 85%

Percentage difference between the organisations' board voting membership and its overall workforce



BAME staff believing that organisation provides equal opportunities for career progression or promotion. (NHS Staff Survey)



BAME Talent Development / Pipeline

Enriching the learning experience for BAME staff by learning from lived experiences, alongside a coach from the senior team with a BAME background

OUTCOMES:

- **Enabling BAME staff to succeed when putting themselves forward for promotion**

Proposal for BAME Staff Development & Pipeline

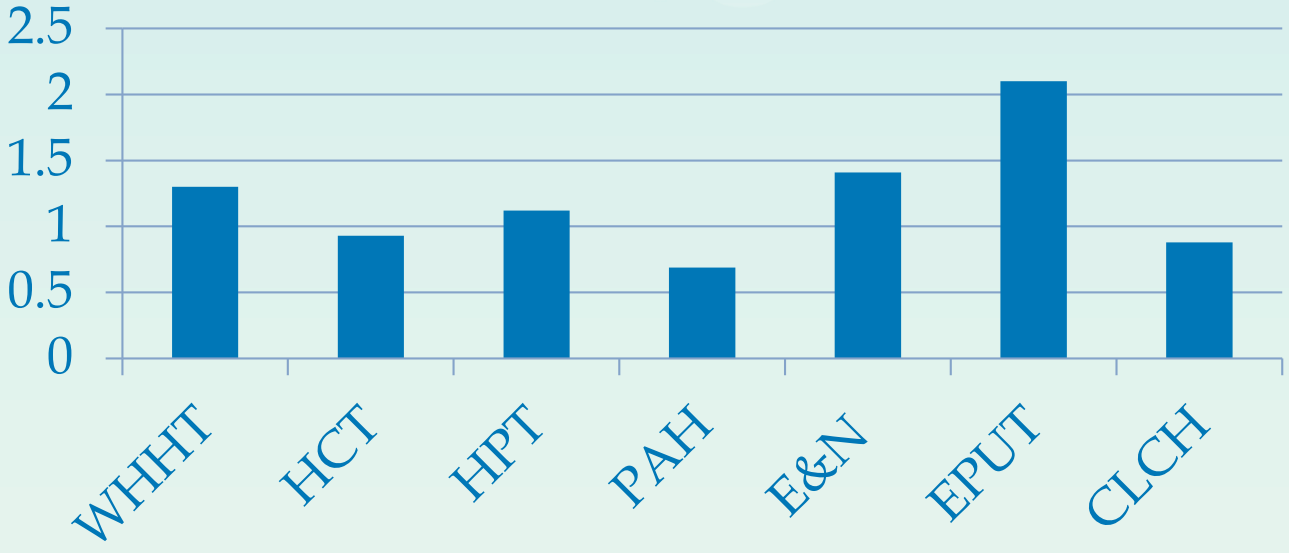
DATE	ACTIVITY IN PROGRESS
DEC 20	Existing coaches and those interested in coaching BAME staff who are band 8a and above approached for coaching training, in order to support BAME staff in their development
JAN 21	Coaching begins for identified staff Stretch opportunities identified for delegates
JAN 21	Procure 2x cohort of 25 people of "Stepping Up" programme. 3 months programme 1x for band 5/6 and 1x band 7
JAN 21	Identify 2x 25 BAME staff to attend "Stepping Up" programme through open readiness process
JAN 21	Developing Band 7s who recruit with shortlisting & interview panel skills, alongside unconscious bias / cultural competence training
JAN 21	Look at tool / system for tracking delegates career progression as well as a database for storing "ready now", "ready soon" delegates – visible for all organisations within the systems
FEB 21	Allocate coach to each delegate from pool of identified coaches
MAR 21	Stretch opportunities and additional skills sessions put in place for delegates
JUN 21	Evaluate learning from programme and track career progress over next 12-24 months (coaching to continue to support individuals)

WRES Diversity Dashboard

- East of England's average is 0.92 and therefore performs better than the national average of 1.2.

Non-mandatory training – refers to any learning, education, training or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement (e.g. fire safety training) or mandated by the organisation (e.g. clinical records system training).

Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BAME staff



Unconscious bias & Cultural Competency / Intelligence programme roll out

We want staff to be educated about unconscious bias and challenge them to recruit and promote a diverse workforce

OUTCOMES:

- **More open challenge of staffs unconscious bias at every level**

ACTIVITY COMPLETED
Benchmarking of unconscious bias training across the system, with development of an enhanced and consistent programme for the whole system
Agreement to combine both programmes and deliver as one complete and rounded programme

DATE	ACTIVITY IN PROGRESS
DEC 20	Trainers identified and Train The Trainer sessions booked
DEC 20	Development and delivery of a shared approach to cultural competency training as part of system-wide CPD requirements.
JAN 21	Combined Sessions commence across the system for all staff
MAR 21	Evaluate programme rollout and create metrics to measure change in behaviour and culture

NEXT STEPS

- To create a truly rich and diverse workforce, working together for common goals in a supportive environment

- Providing identified resource where needed to support the work going forward
- Widening work to cover Primary Care and Social Care in all work streams
- Creating clear metrics to measure the effectiveness of each of the work streams
- Having a standing item on each organisations Executive Board agenda for the dashboard to be reviewed
- Communicating top down and bottom up about the work being done in order to fully engage all staff
- Rollout of reverse mentoring at senior level in all organisations
- Duplicate process undertaken with WRES for WDES and Gender Pay Gap and wider inequalities
- Tracking improvement through Staff Survey results and ongoing WRES / WDES figures

The Princess Alexandra Hospital NHS Trust

Trust Board – 03.12.20

5.3

Agenda Item:	5.3
Presented by:	Jim Mcleish Director of Quality Improvement
Prepared by:	Ellie Manlove – People Transformation Lead
Date prepared:	26 November 2020
Subject	Healthcare worker flu vaccination best practice management checklist

Purpose:	Approval	x	Decision		Information		Assurance	

Executive Summary:	In October 2020 national clinical and staff side professional leaders wrote to Chief Executives requesting that the best practice management checklist for healthcare worker vaccination was completed. It is a requirement that the self-assessment against these measures is published in Trust Board papers for public assurance. The attached self-assessment demonstrates the Trust is compliant with each of the measures and supporting narrative is included.
Recommendation:	For Trust Board to note the self-assessment and approve for publication in the Trust board papers.

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

Previously considered by:	Infection Prevention and Control Committee IPC Cell
Risk / links with the BAF:	1.0 Covid 1.1 variation in clinical outcomes
Legislation, regulatory, equality, diversity and dignity implications:	National regulatory directive to deliver vaccination programme as outlined by regional infection control policy and linked to national winter planning. Annual flu programme - GOV.UK (www.gov.uk)
Appendices:	n/a

Healthcare worker flu vaccination best practice management checklist

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	All staff members are now required to complete a consent form, if they wish to opt out; the need to mark why and tick to say they understand the risk of flu and take full responsibility if they then get the flu.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	This has been ordered and delivered into the Trust w/c 21 September 2020.
A4	Agree on a board champion for flu campaign (3,6)	Director Of Quality Improvement
A5	Agree how data on uptake and opt-out will be collected and reported.	This information is being collated by the SHAW team and reported via the people information team.
A6	All board members receive flu vaccination and publicise this (4,6)	Board members had to have flu jabs and photos as part of the Virtual Event Not in a Tent
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives. (3,6)	Flu champions have all been trained, these are mainly nursing staff. Additional bank nurses have also been recruited and deployed.
A8	Flu team to meet regularly from August 2020 (4)	Monthly meetings in place and planning meetings from Summer 2020 with weekly meetings from September 2020.
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions. (3,6)	Posters, regarding why you should get the flu vaccination posted around the hospital, screen savers, weekly updates to all senior staff at Exec Brief.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on	All published on Alex and widely communicated across all healthcare groups and via the IPC & People Cell.

	social media and on paper. (4)	
B3	Board and senior managers having their vaccinations to be publicised. (4)	As per A6.
B4	Flu vaccination programme and access to vaccination on induction programmes. (4)	All new staff are given immunisation as part of pre-employment checks.
B5	Programme to be publicised on screensavers, posters and social media. (3, 5,6)	Flu plan agreed with communications to include screensavers, posters, social media and internal communications.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups. (3,6)	Flu report in use, Weekly flu uptake to be publicised via Comms/ Alex page/ Staff briefing and SHaW newsletter. Uptake is discussed at EMT on a weekly basis.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered. (3,6)	Flu champions trained this year. Emphasis is for the HCG to take ownership for uptake plus additional bank support.
C2	Schedule for easy access drop in clinics agreed. (3)	Roaming clinic times to be advertised. All drop ins welcome during SHaW working hours.
C3	Schedule for 24 hour mobile vaccinations to be agreed. (3,6)	Night and weekend clinics, outpatient nurse at Herts and Essex and St Margaret's trained as flu champions and have agreed to take responsibility of vaccinating all staff based there.
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this. (3,6)	Incentives for Flu Champions.
D2	Success to be celebrated weekly. (3,6)	Via InTouch, weekly briefing.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 03.12.20 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: New Hospital Committee (NHC)
REPORT FROM: Lance McCarthy (Committee Chair)
DATE OF COMMITTEE MEETING: 23.11.20 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

OBC Timeline: The Committee discussed that we are still on track to deliver an OBC by March 2021. Increased work on the benefits of Modern Methods of Construction (MMC) to the buildability and the cost of the scheme is ongoing and these are being linked into the revised national team and the wider HIP programme of 40 hospitals across the country. Any benefit or changes to our scheme as a result of this will be discussed at the PAH Board in December.

CPO Approval: The Trust's case would be presented to the Joint Investment Committee on 01.12.20 and to the PAH Board on 03.12.20.

Enabling Works: The Committee supported the requirement for enabling costs and recognised a level of investment may be required to keep the programme on schedule. The Committee agreed that prior to incurring enabling costs the item should be discussed and agreed at JIC meeting on 01.12.20.

Budget: The Committee recognised the total costs of the new scheme continue to reduce as increased specificity is determined, but that they still remain c. 10% - 15% higher than targeted. This will reduce further as we continue to develop the scheme and focus on MMC.

BAF Risk: The New Hospital BAF risk was discussed in line with the recommendation that the score remained at 16. Members agreed to continue the discussion outside the meeting to agree whether or not there were other risks from the risk register that should be included on the BAF.

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

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

- General programme update (verbal)
- Update on land acquisition and way ahead
- Comms & Engagement Strategy
- Advisor procurements for FBC
- Update on programme affordability and running costs
- Standing Items:
  - Decisions/Risks and Issues/(Changes)/Programme

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

A work plan is being developed.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 03.12.20 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: Performance and Finance Committee (PAF)
REPORT FROM: Pam Court - PAF Chairman
DATE OF COMMITTEE MEETING: 26.11.20 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- Capital programme: The programme is currently £5.0m behind plan with £32m to be spent in the remaining 5 months of the financial year. PAF was assured that a five year Capital plan has been developed and spend is being monitored weekly including at EMT meetings. Planned spend will be accelerated in the last months of the financial year, but is dependent in part on confirmation of funding and then procurement and delivery lead times.
- CIPs: A deep dive into the CIP programme was received and PAF noted the significant work underway and the focus on transformational CIPs going forward.
- PAF received an update on activity in the hospital and the impact on elective procedures.
- New Hospital (affordability update): PAF received an update on the current status of the assessment of the revenue and capital affordability of the Trust's preferred option for the new hospital and noted the ongoing work to finalise the affordability work ahead of the draft OBC in January 2021.
- Pathology: PAF discussed the current position in relation to the procurement of a supplier to provide Pathology Services to 6 ICS partners. This item is included on the Board agenda.

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

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

- M7 Integrated Performance Report
- Annual Report of Emergency Preparedness and Business Continuity and Forward Plan
- Service Line Reporting
- M7 Financial results
- BAF risks: Finance, ED, Estate and EPR were discussed and PAF supported the recommendation that the risk scores remain unchanged.

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

The Committee continues to make progress against its work plan.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 03.12.20 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: Quality & Safety Committee (QSC)
REPORT FROM: Helen Glenister – QSC Chair
DATE OF COMMITTEE MEETING: 27.11.20 (Virtual Meeting)

SECTION 1 – MATTERS FOR THE BOARD'S ATTENTION

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

- **COVID-19:** The Committee was provided with a detailed update on the current position within the Trust particularly in relation to rising numbers of inpatients and the impact on the elective and cancer pathways. Actions from some national learning relating to covid management and nosocomial learning had been circulated the previous week (ten recommendations) and a gap analysis against those would now be undertaken and fed back to the Infection Control Committee and QSC.
- **Learning from Deaths:** HSMR and SHMI were both now 'as expected' but the improvement work would very much continue with a particular focus on depth of coding and the End of Life pathway across the system.
- **Maternity Deep Dive:** External feedback was still awaited on the incident cluster and should arrive by mid-December. There had been positive feedback and huge support from regional colleagues in relation to the Maternity Safety Programme and some excellent work undertaken around Continuity of Care.
- **Incidents:** The Committee noted an increase in incidents in October (97% of which were either low or no harm) with the numbers of moderate harm incidents at the higher end of the tolerance range, comprising 2.16% of total incidents. There has also been one never event.
- **Review Lists:** Assurance was provided that progress was being made and numbers of patients were slowly reducing.
- **Quality Account:** Following approval for delegated authority at September's meeting (to the Director of Nursing and Medical Director) the Quality Account had been finalised and would be published in line with the deadline of 30.11.20.

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

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

- COVID-19 Update
  - Report from Infection Prevention & Control Committee
  - Infection Control: Monthly Update
- Report from Strategic Learning from Deaths Group
- Learning from Deaths Update
- Report from Patient Safety Group
- Monthly Patient, Safety, Quality & Effectiveness Report
- CCCS Healthcare Group Quarterly Performance Update
- Report from Clinical Effectiveness Group
- Pain Management Project Update
- Annual Report on Safeguarding Children & Adults (available in Board Resources area)
- Maternity Annual Report
- M7 Integrated Performance Report
- BAF Risks 1.0 (COVID-19) and 1.1 (Clinical Outcomes) – both scores to remain at 16.
- Patient Experience Update
- Update from Patient Panel
- Position Statement: Patient First Programme in ED
- Clinical Ethics Annual Report

The Princess Alexandra Hospital NHS
NHS Trust

SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
• The Committee continues to make good progress against its work plan.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 03.12.20 **AGENDA ITEM NO: 6.1**

REPORT TO THE BOARD FROM: Senior Management Team
CHAIR: Lance McCarthy - Chairman
DATE OF MEETINGS (Monthly going forward): 10 November 2020

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE
The following items were discussed at the SMT meeting held on 10 November 2020: - Capital programme update and expenditure forward view - PATHWEB – Overarching plan - Frailty Update - Nursing, Midwifery and Allied Health Professionals Strategy - Audit results - Staff Wellbeing - Self Service Business Case – Revised. - Upper GI Bleed Business Case - Financial Update: Month 6 & 7 highlights including Operating Plan for Months 07 – 12 - Temporary Staffing – Medical Rotas - Cancer Update - Integrated Care Pathway for Adult & Paediatrics Presenting to ED with Abdominal Pain implementation Update

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS

MEETING DATE: 03.12.20 **AGENDA ITEM NO: 6.2**

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

REPORT FROM: John Keddie – Chairman

DATE OF COMMITTEE MEETING: 18.11.20

SECTION 1 – MATTERS FOR THE CORPORATE TRUSTEE/TRUST BOARD'S ATTENTION
The following items are escalated for noting: • The Committee's Effectiveness Review 2019/20 was discussed and the revised Terms of Reference were approved and recommended to Board for approval **(Appendix 1)**. Minor amendments to the membership were agreed. • The financial position was noted; total fund balances at M6 were £686k, an increase from 1 April of £44k and £36k ahead of forecasted levels. During the period the charity received income totalling £253k and incurred expenditure of £209k. • A bid for funds to provide support for carers, including a Resource Centre was considered. Members supported the bid to NHS Charities Together, acknowledging that the location of the required Resource Centre required further discussion. • The Charity's Annual Report and Accounts were reviewed and recommended to the Corporate Trustee for approval at the meeting on 03.12.20. • Fundraising Update received and CFC welcomed the new Head of Fundraising to the Trust.
SECTION 3 – PROGRESS AGAINST THE COMMITTEE'S ANNUAL WORK PLAN
The CFC is making good progress against its annual work plan.

6.2

Your future | Our hospital

The

CHARITABLE FUNDS COMMITTEE
2020/21

TERMS OF REFERENCE

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

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

SCOPE AND DUTIES:

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

ACCOUNTABLE TO: Corporate Trustee/Board of Directors

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

CHAIRMAN: Non-Executive Director.

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

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

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

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

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

DATE APPROVED: By Charitable Funds Committee: 18.11.20
By Trust Board:

NEXT REVIEW DATE: July 2021

Membership and Those in Attendance	
Members	
Chairman - Non-Executive Director	John Keddie
Non-Executive Director	Helen Glenister
Director of People, OD and Communications	Ogechi Emeadi
Director of Strategy	Michael Meredith
Deputy Chief Finance Officer	Simon Covill
Head of Financial Services	Colin Forsyth
Associate Director of Communications	Laura Warren
In Attendance/Invited as Required	
Head of Fundraising	Mari-Louise White
Charitable Funds & Income Assistant	TBC
Fund Raisers/Managers within the Trust	As identified
Representative of Breast Fund (Associate Specialist Surgeon)	Ashraf Patel
Secretariat	
Head of Corporate Affairs	Heather Schultz
Committee Secretary	Lynne Marriott/member of secretariat

The Princess Alexandra Hospital NHS Trust

Trust Board (Corporate Trustee)
3 December 2020

Agenda Item:	6.2
Presented by:	Simon Covill – Acting Chief Finance Officer
Prepared by:	Colin Forsyth – Head of Financial Services
Date prepared:	25 November 2020
Subject / Title:	PAH Charity Annual Report and Accounts 2019/20

Purpose:	Approval	✓	Decision	✓	Information		Assurance	

Key issues:	The Charitable Funds Committee has reviewed The Princess Alexandra Hospital Charitable Fund's 2019/20 accounts and report, and these are presented to the Trust Board (as Corporate Trustee) for approval.
Recommendation:	The Trust Board (as Corporate Trustee) for The Princess Alexandra Hospital NHS Trust Charitable Fund is asked to approve: • The Annual Report and Accounts 2019/20; • The Letter of Representation, authorising the Chair of the Charitable Funds Committee and Acting Chief Finance Officer sign the Letter; and • Authorise that the Chair of the Charitable Fund Committee and the Acting Chief Finance Officer sign the accounts certificates.

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

Previously considered by:	Charitable Funds Committee 18 November 2020
Risk / links with the BAF:	Failure to comply with Charity Commission requirements, insufficient funds to meet liabilities, reputational damage from lack of financial control over charitable funds.
Legislation, regulatory, equality, diversity and dignity implications:	As a condition of its registration, the Charity is required to comply with Charity Commission guidance and reporting requirements.
Appendices:	Appendix 1 – Annual Report and Accounts 2019/20 Appendix 2 – Letter of Representation

The Princess Alexandra Hospital NHS Trust

1.0 PURPOSE

The purpose of this report is to present, and request approval of the Charitable Fund Annual Report and Accounts 2019/20 and associated assurance statements.

2.0 CONTEXT

The Annual Report and Accounts were reviewed and agreed by the Charitable Funds Committee on the 18 November 2020.

The Charity is not required to submit a full set of Charity Accounts to NHS England and Improvement. However, a submission of an annual report and accounts does need to be made to the Charity Commission on an annual basis (by 31 January 2021 for 2019/20 accounts).

The Annual Report and Accounts for 2019/20 (Appendix 1) are presented for approval by the Corporate Trustee prior to submission to the Charity Commission.

The Accounts do not require a full audit. Charity Commission guidance (CC31, Independent examination of charity accounts: trustees, June 2015) is that:

> For financial years ending on or after 31 March 2015, trustees may opt for an independent examination instead of an audit provided their charity's gross income is not more than £1m, or where gross income exceeds £250,000, its gross assets are not more than £3.26 million

The 2019/20 Annual Accounts have now been reviewed by the appointed independent examiner Ernst & Young LLP. The report of the independent examiner is included within the Annual Report and Accounts (Pages 13/14).

3.0 KEY POINTS TO NOTE ON THE BASIS OF THE PREPARATION OF THE ACCOUNTS

In producing the 2019/20 Accounts, the following key points should be noted:

- The Trust submitted its draft accounts and working papers for review to the independent examiner as per the agreed local timetable.

- There have been no independent examiner initiated changes to the Annual Report and Accounts that impact on the overall financial position reported in the draft Accounts. No changes have been made to the accounts as a result of the Independent examination.

- The financial statements have been prepared under the historic cost convention and in accordance with the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland (FRS102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

- The accounts have been prepared on a going concern basis. Fund balances are stable, with growth predicted for the future year. There are no material uncertainties about The Princess Alexandra Hospital NHS Trust Charitable Fund and its ability to continue as a going concern. There are no material uncertainties affecting the current year accounts.

The Annual Report and Accounts 2019/20 can be found at Appendix 1.

The Princess Alexandra Hospital NHS Trust

4.0 KEY FINANCIAL HEADLINES

The summary financial position for the charity is:

	2019-20 Total Funds £000	2018-19 Total Funds £000
Income and endowments from:		
Donations and Legacies	**198**	326
Other income	**484**	515
Investments	**4**	3
Total	**686**	**844**
Expenditure on:		
Raising funds	**(227)**	(244)
Charitable activities		
- Contributions to the Trust	**(174)**	(202)
- Medical Research	**(130)**	(90)
- Patient welfare and amenities	**(154)**	(108)
- Staff welfare and amenities	**(15)**	(13)
Total	**(700)**	**(657)**
Net (expenditure) / income	**(14)**	187
Transfers between funds	**0**	0
Net movement in funds	**(14)**	187
Reconciliation of funds:		
Total funds brought forward	**656**	469
Total funds carried forward	**642**	**656**

The overall level of funds has remained stable across the two years, although there has been a fall in income; in 2018/19 the Trust received significant legacies for both the Eye Unit and the Neurology Department.

6.0 LETTER OF REPRESENTATION TO EXTERNAL INDEPENDENT EXAMINER

As part of the review process the Corporate Trustees are required to formally present a Letter of Representation to the independent reviewer confirming the basis upon which the accounts have been prepared. The draft letter of Representation (Appendix 2), once approved, requires signing by both the Chair of the Charitable Funds Committee and the Interim Chief Finance Officer.

The letter of representation provides assurance to the Trust's independent examiners on matters within the Annual Report and Accounts 2019/20 presented to them for the review. The draft letter is included at Appendix 2. This letter is required by the independent examiner prior to them signing the Independent Examiner's report.

The Princess Alexandra Hospital NHS Trust

7.0 RECOMMENDATION

It is recommended that the Trust Board (as Corporate Trustee) for The Princess Alexandra Hospital NHS Trust Charitable Fund approve:

- The Annual Report and Accounts 2019/20;
- The Letter of Representation, authorising the Chair of the Charitable Funds Committee and the Acting Chief Financial Officer to sign the letter; and
- Authorise that the Chair of the Charitable Fund Committee and the Acting Chief Finance Officer sign the accounts certificates.

Author: Colin Forsyth, Head of Financial Services
25 November 2020

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

The Princess Alexandra Hospital's Charity

6.2

Annual Report and Accounts 2019-20

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

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The Princess Alexandra Hospital NHS Trust Charitable Fund
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OUR BACKGROUND

The Princess Alexandra Hospital NHS Trust Charitable Fund (the "Charity"), was formed under a trust deed dated 21 March 1996, and is registered with the Charity Commission, registration number 1054745.

The Princess Alexandra Hospital NHS Trust Charitable Fund is registered as an Umbrella Fund, which encompasses three unrestricted special funds; The Princess Alexandra Hospital General Fund, The St Margaret's Hospital General Fund and The Herts and Essex Hospital General Fund.

The Trustee of the Charity is The Princess Alexandra Hospital NHS Trust ("the Trust"), a Body Corporate. This responsibility is managed by the Board members, with voting rights, of the Trust.

Charitable Funds received by the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service and Community Care Act 1990, and these funds are held on trust by the Corporate Body.

The beneficiaries of the Charity are the patients, staff and visitors of The Princess Alexandra Hospital NHS Trust.

OUR OBJECTIVES

Through fundraising activities, events and appeals, we will further improve the provision of high quality patient care at the cutting edge of technology throughout the Trust, focusing on areas not covered or fully supported by central NHS funds.

The Trust Board confirm that they have referred to the guidance contained in the Charity Commission's general guidance on public benefit when reviewing the Charity's activities and objectives and in planning future activities.

The Trust Board shall hold the Charitable Fund, and use the income where applicable, and at their discretion the capital, for any charitable purpose or purposes relating to the National Health Service. Within the single registered charity there are a number of funds, each managed by a fund manager. There is specific criteria documented and funds should only be spent in line with the purposes of the fund. This criteria is for internal guidance only, and has no legal standing. However, expenditure from funds given by the general public must be seen as being appropriate and in line with their wishes. The receipt given for donations is in line with Charity Commission guidelines and states that the funds will be used "*for the general puposes of (the) Charity, and I desire they use such sum to....*". This means that the Charity will try to spend the cash in accordance with the donor's wishes, but retains the right to use discretion. Unless raised for a specific object, charitable funds should be spent within a three year time period, and should not be built up for future years.

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

OUR ACTIVITIES, ACHIEVEMENTS AND PERFORMANCE

During the year, the funds continued to support a wide range of charitable and health related activities benefiting both patients and staff. In general, they are used to purchase the very varied additional goods and services that the NHS is unable to provide. Charitable funds were used to purchase much needed equipment across the Trust, the case studies below provide furtther details on how charitable funds have been used within the Trust, and the signifcant difference this has made to the quality of care and the services provided.

Neurology

The neurology unit team are very thankful for the charitable donations they have received, including an extremely generous legacy of £116,899.53 to help improve the care of patients who have experienced symptoms of a stroke.

This gift will fund specialist training for clinicians to enhance their knowledge regarding the diagnosis and treatment of patients affected by symptoms of stroke and stroke-like presentations.

Additionally, the neurology botox service is soon to develop ultrasound techniques for more targeted treatment of dystonia (a movement disorder in which a person's muscles contract uncontrollably) and focal spasticity (a condition in which muscles stiffen or tighten, commonly seen following stroke) thanks to this generous legacy. Enabling the purchase of specialist equipment and staff training will make a real difference to the care and treatment available for our neurology patients.

Ophthalmology: The Optos system for hydroxychloroquine screening

With the kind donations to the Eye Unit, totalling £64,500, we have purchased specialist diagnostic equipment to help prevent sight loss.

The Optos system enables enhanced screening of our ophthalmology patients who are taking the medication hydroxychloroquine to detect any changes to their sight and enable early intervention.

Hydroxychloroquine is a medication used to treat several conditions including rheumatoid arthritis, systemic lupus erythematosus, some skin conditions (especially photosensitive ones) and others that involve inflammation. Patients at PAHT are prescribed hydroxychloroquine to help manage these conditions. It is a very safe and effective drug but, like all medicines, it can cause side effects.

It is known that some patients who take hydroxychloroquine for more than five years and/or in high doses are at increased risk of damage to their retina, the light sensitive layer of cells at the back of the eye. This is known as retinal toxicity or retinopathy. Severe retinopathy, especially in the central area called the macula, causes significant, irreversible sight loss.

With the Optos system, we are now able to offer patients taking hydroxychloroquine regular eye health checks to screen them for signs of retinopathy. The Optos system does not prevent retinopathy (disease of the retina which results in impairment or loss of vision), but helps to detect the earliest definitive signs of it before a patient notices any symptoms. At the screening appointment, patients will have three tests:

- **A visual field test:** In this test, one eye is tested at a time while the other is temporarily covered with a patch. A computer randomly flashes points of light and when you see a light, you press a button.

OUR ACTIVITIES, ACHIEVEMENTS AND PERFORMANCE (continued)

- **Fundus photography:** The fundus photograph is a photograph of the surface of your retina. The patient has a special photograph taken that detects abnormal levels of a substance called lipofuscin in the retina, which may be an early sign of disease. This test is called fundus autofluorescence (FAF) imaging.

- **An Optical Coherence Tomography (OCT) scan of the back of your eye:** This is a scan that provides a cross-sectional image of the various layers of your retina.

Currently there are approximately 20 patients being screened daily at the Eye Unit, using the Optus system. Monitoring our patients' eyes in this way has helped to detect very early signs of damage to the retina and ensures that we can offer the best care possible.

The outpatients' department: Bariatric couches

With thanks to the Right Honourable Robert Halfon MP, we received a donation of £2,617.50 for the outpatients' service, which we used to fund two bariatric couches.

The bariatric couches enhance the quality of care we can provide to our patients by offering more support for patients with a higher body mass index. This ensures that our bariatric patients can be examined by a clinician whilst maintaining safety and comfort.

These couches can be used by all patients, but do offer an increased level of support for patients who are above average weight and build.

The Neonatal Intensive Care Unit (NICU): Transport incubator

We were very pleased to be able to use £33,721.70 of our charitable funds to purchase a new transport incubator for our Neonatal Intensive Care Unit (NICU).

The transport incubator is the main piece of equipment used to collect and safely transfer babies from the maternity department to NICU. This piece of equipment is also essential for us to transfer babies to other hospitals for specialist clinical appointments. It is fully equipped with a ventilator, suction, monitors, oxygen supply and thermoregulatory (temperature control) for all babies and is the safest and recommended mode of transport of babies to and from different areas within and outside of PAHT.

With this equipment, we can ensure:

- Safe transfer of pre-term and term neonates (newborns) requiring admission to NICU. Neonates cannot be safely transferred in any other way

- Safe transfer of pre-term and term neonates in an ambulance to other hospitals for specialist diagnostic appointments

- Safe provision of care for pre-term and term neonates in an emergency situation with all of the required equipment

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

OUR ACTIVITIES, ACHIEVEMENTS AND PERFORMANCE (continued)

The Neonatal Intensive Care Unit (NICU): Jaundice monitor (bilimeter)

With donations totalling £15,533.68, we have purchased four jaundice monitors (bilimeters).

Recommendations from The National Institute for Health and Care Excellence (NICE) guidelines show that these monitors are important to reduce the requirement for blood samples to be taken from babies when measuring jaundice levels.

Blood testing requires a baby to have a heel prick, which is a painful stimuli and can have a long-term impact on babies' neurological development. The jaundice bilimeter measures the reading through the skin and does not require the need for painful stimuli. This has helped us to provide a better quality of care and experience for our babies.

Thank you to our community for generously donating to our Neonatal Intensive Care Unit.

The Breast Unit: charity fundraising event

The Breast Unit Charity held a spectacular Great Chef's Banquet at the Royal Garden Hotel, London, on 14 March 2020, raising a fantastic £30,000 to enhance patient care.

Ashraf Patel, breast surgeon, and the charity team were truly humbled that so many supporters attended the event with their families and friends. They enjoyed a four course meal cooked by celebrity chefs led by Anton Edelmann (former head chef at The Savoy), Steve Munkley (executive chef of The Royal Garden), and Giorgio Locatelli (chef, Locanda Locatelli). Also cooking up a storm at the banquet were Claire Clarke MBE, MOGB, and Sarah Crouchman, directors of luxury London patisserie Pretty Sweet, and Nigel Haworth (chef ambassador, Northcote and Obsession Festival). Entertainment for the evening was provided by professional rock and pop band Rollacoaster.

During the evening a former patient gave an emotive speech about her breast cancer experience at St Margaret's Hospital and the significant impact that the three charity funded bespoke programmes available made to her recovery.

The money raised will help the team to continue their breast cancer clinical trials in addition to their support events: Fabulous and Beautiful, Moving On and exercise programmes. The Breast Unit team are extremely thankful to all for their generous donations.

OUR ACTIVITIES, ACHIEVEMENTS AND PERFORMANCE (continued)

The Breast Unit: research

Over many years, the charity has raised over £4.5 million for the Breast Unit at St Margaret's Hospital, Epping. The money is used to fund research nurses for clinical trials and the provision of Fabulous and Beautiful, Moving On and exercise programmes to support patients during their breast cancer treatment and recovery. Access to charitable funds have enabled the Breast Unit to carry out 44 breast cancer research trials, enhancing the care available to patients at The Princess Alexandra Hospital NHS Trust (PAHT).

COVID

Community support our charity in the fight against coronavirus (COVID-19)

Our community kindly rallied to support us in the fight against coronavirus (COVID-19).

While our dedicated coronavirus (COVID-19) charity appeal launched in April, by September 2020 we had £165,000 of donations (including £113,000 very kindly provided through grants from the NHS Together charity, www.nhscharitiestogether.co.uk), which we will explore in further detail in our 2020/21 charitable annual report.

Our teams are extremely grateful and delighted by this hugely generous outpouring of support for our amazing people who work so hard to deliver outstanding care and to keep people safe.

During these unprecedented times in the fight against COVID-19, the help and support of patients, visitors, family and friends has been crucial. We received many gifts to share with our people, which have been really appreciated. We were also asked by many if they could make a donation to our hospital.

In response to these requests, we created a JustGiving page, as a simple and fast way to donate. Our community are encouraged to please continue to support us via this page.

From autumn/winter 2020, we will be opening a new staff area with bright, modern space and facilities. We have funded this project in response to staff feedback about how important a new staff area is to support their health and wellbeing. Contributions have also been made partly via the coronavirus (COVID-19) charity appeal, in recognition of the hard work and dedication of our people.

John Keddie, non-executive director at PAHT, chairs The Princess Alexandra Hospitals' Charity. He said:

> "It was overwhelming to see such a significant sum raised in a short time. It is testament to the level of support our amazing people have in the local community.
>
> "All donations to the PAHT charity are used to directly enhance the experience and wellbeing of our patients and staff, and all funds raised go directly to the hospital.
>
> "We are so thankful to everyone who has donated."

Ogechi Emeadi, director of people, organisational development and communications, said:

> "It was astonishing to see the donations rise sharply every week and we are truly grateful to everyone for thinking about our teams at this difficult time.
>
> "Please also continue to share your kind words with our teams, as this means so much to us all."

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

OUR ACTIVITIES, ACHIEVEMENTS AND PERFORMANCE (continued)

LEGACIES

During the year, the Charity received notification of legacies bequeathed totalling £31,000.

A legacy bequeathed to the Neurology Department in 2018-19 reached completion, and an additional £7,000 was received by the charity in addition to the £110,000 already received.

The intention for this legacy is to use these monies to optimise clinicians current knowledge base, and the services they provide in improving the care of those patients presenting with a stroke.

A legacy notified to the Charity in 2018-19 reached completion during 2019-20 and £24,000 was received for use in the General Purpose Fund. Possible uses for these monies are being considered by the Charitable Funds Committee members.

FUTURE PLANS

Mindful of the many changes in the NHS, the future direction of the Charity will be shaped by those changes. The reconfiguration of services and the plans for redesigning patient care to meet the needs of the future will influence the priorities for spending charitable funds. However, the Charity will continue to meet its objectives in the future.

FINANCIAL REVIEW

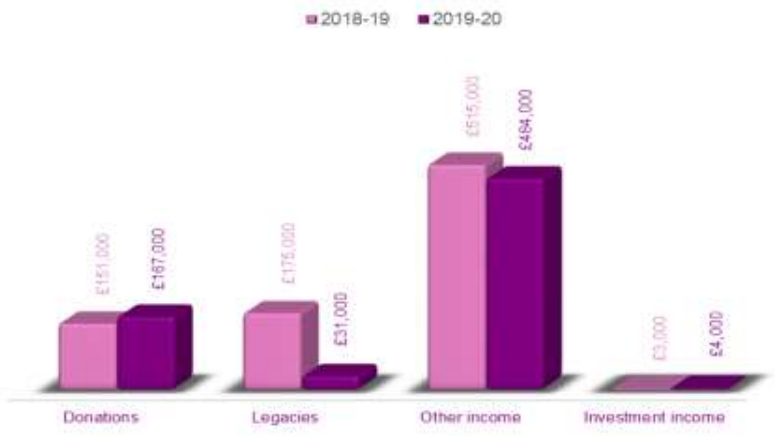
These financial statements have been prepared under the historic cost convention and in accordance with the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland (FRS102), the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015. The detailed statements can be found on pages 15 to 25 of this report.

The charity is constituted of 100 individual funds as at 31 March 2020 (99 in 2018-19).

Income

The Charity received income for the year totalling £686,000, a decrease of £158,000 compared to 2018-19.

This income is comprised of donations, legacies, other income (from fundraising activities) and dividends and interest. A comparision of 2019-20 and 2018-19 income is shown below.



The majority of the donations were made by patients and visitors (in excess of 1,000 separate donations).

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

Income (continued)

Legacy income for 2019-20 comprised of a bequest of £24,000 for the General Purpose Fund, to benefit the hospital as a whole, and £7,000, the residual amount of a larger legacy (£110,000 of which was received in 2018-19) for the Neurology Department.

Investment income of £4,000 was received in 2019-20 (£3,000 in 2018-19)

Income from activities for generating funds totalled £484,000. Of this income, £442,000 was raised for the purposes of research, £22,000 for the Long Live Liver Appeal, £9,000 for the Gibberd Garden Fund, £9,000 for the Improving Cancer Services Appeal and £2,000 for the My Life Memory Software Appeal.

Investments

The investments realised an increased level of income in 2019-20 to those received in 2018-19, due to higher balances being held in the interest bearing bank accounts.

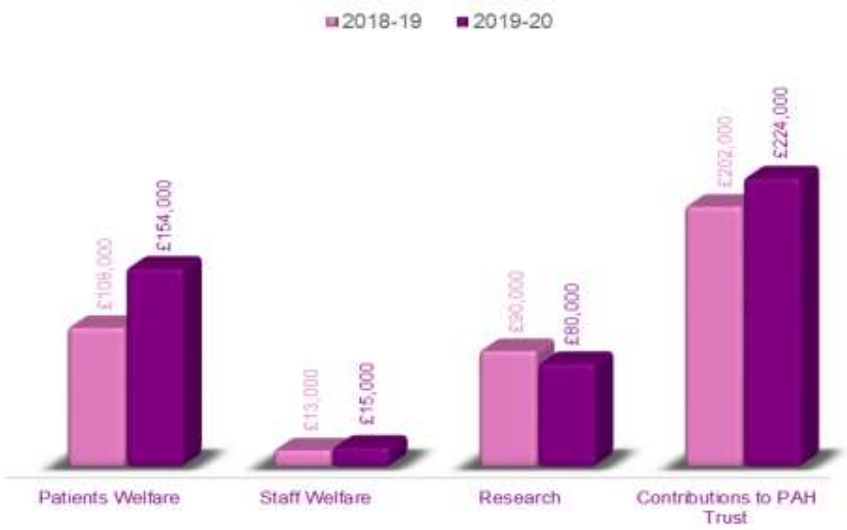
6.2

Expenditure

During the year the Charity provided support to users of The Princess Alexandra Hospital NHS Trust in many forms, including education and training for staff and the supply of medical equipment for patient treatment. In total, resources expended were £455,000 which is an increase of £56,000 compared to 2018-19.

The majority of the contributions to The Princess Alexandra Hospital NHS Trust were comprised of purchases of medical equipment, computer software and hardware and furniture for wards.

A comparison of 2019-20 expenditure and 2018-19 expenditure is shown below.



The Charitable Fund aims to maintain fund balances to allow for a minimum of 6 months of operating costs (administrative and fundraising) and does not hold designated reserves. The Trust Board confirms that the Charity's assets are available and adequate to fulfil the obligations of the Charity.

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

STRUCTURE, GOVERNANCE AND MANAGEMENT

The Princess Alexandra Hospital NHS Trust Charitable Fund was formed under a trust deed dated 21 March 1996, The Charity is registered with the Charity Commission under registration number 1054745.

The responsibility for the identification, implementation and monitoring of the strategic direction of the Charity is performed by the Trust Board of Directors, along with the day to day running of the Charity.

The Trust Board consists of a Chairperson, eight Executive Directors (three non-voting) including the Chief Executive, five Non-Executive Directors and two Associate Non-Executive Directors. The Non-Executive Directors are appointed for their specialist expertise and/or local knowledge.

Appointments to Executive Director posts, including that of the Chief Executive, follow a common process. Posts are normally advertised nationally and short-listed candidates meet with senior Trust and local health economy staff prior to formal interview. The final decision on appointments is made by an interview panel, chaired by the Trust Chair, which includes executive level staff from NHS Improvement and local Clinical Commissioning Groups (CCG's), other Trust Non-Executive Directors and an external assessor.

There are no formal training procedures in place for members of the Trust Board relating specifically to the Charity. However, the Non-Executive Directors, who are members of the Charitable Funds Committee, regularly attend sessions provided by the Association of NHS Charities which include a variety of relevant topics. Briefings from the Association are included in the papers for each meeting of the Charitable Funds Committee.

The Trust Board have adopted policies which achieve the objects stated in the trust deed by ensuring funds are used for the purpose for which the donor intended and are not accumulated unless part of a greater project or fund raising scheme.

Risk Management

The Trust Board have the overall responsibility for ensuring that the Charity has an appropriate system of controls, financial and otherwise. The systems of financial control are designed to provide reasonable, but not absolute, assurance against material mismanagement or loss. They include:

- regular consideration by the Charitable Funds Committee of financial results;
- delegation of authority and segregation of duties; and
- identification and management of risks.

There is a formal risk management process in place, detailed in the Trusts' Risk Management Strategy. The Trust Board will identify the primary risks in each category and develop or amend formal policies and action plans to mitigate the risks identified.

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

REFERENCE AND ADMINISTRATIVE DETAILS

The Princess Alexandra Hospital NHS Trust Charitable Fund is registered with the Charity Commission under registration number 1054745. It's working name is The Princess Alexandra Hospitals Charity.

The Princess Alexandra Hospital NHS Charitable Fund is registered as an Umbrella Fund, which encompasses three unrestricted special funds whose names and objects are as follows:

The Princess Alexandra Hospital General Fund
For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by The Princess Alexandra Hospital.

The St. Margaret's Hospital General Fund
For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the St. Margaret's Hospital.

The Herts & Essex Hospital General Fund
For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the Herts & Essex Hospital.

The purposes of the unrestricted funds are to support any charitable purpose relating to the NHS. There are 99 designated funds and 1 unrestricted fund (100 in 2018-19).

The Charity's assets consist of cash investments, which are available and adequate to fulfil the obligations of all of the above funds.

The Charity has no paid or unpaid volunteers, and no paid employees, but it is supported in its activities by The Princess Alexandra Hospital NHS Trust. The administrative function is performed by the Finance Department of The Princess Alexandra Hospital NHS Trust, the services of which are re-imbursed by the Charity.

For day to day operations, the Charity adheres to the Standing Orders and Standing Financial Instructions of the Corporate Body (The Princess Alexandra Hospital NHS Trust).

Our Principal Office

The Princess Alexandra Hospital NHS Trust Charitable Fund
Hamstel Road
Harlow
Essex
CM20 1QX
Telephone: 01279 444455

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

REFERENCE AND ADMINISTRATIVE DETAILS (continued)

Trustees

The Trustee of the Charity is The Princess Alexandra Hospital NHS Trust, governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011. This responsibility is managed by the Board members (with voting rights) of the Trust.

Board members for the period 1 April 2019 to 31 March 2020 are listed below:

Chairman

Steve Clarke

Executive Directors

Lance McCarthy - *Chief Executive Officer*
Trevor Smith - *Chief Financial Officer*
Dr Andy Morris - *Chief Medical Officer (to 27 March 2020)*
Marcelle Michail - *Chief Medical Officer (from 30 March 2020)*
Stephanie Lawton - *Chief Operating Officer*
Sharon McNally - *Director of Nursing & Midwifery*
James McLeish - *Director of Quality Improvement (non-voting)*
Ogechi Emeadi - *Director of People (non-voting)*
Michael Meredith - *Director of Strategy and Estates (non-voting)*

Non-Executive Directors

The following non-executive directors were in post during the period 2019-20:

John Hogan
Andrew Holden
Pam Court
Helen Glenister
George Wood *(from 1 July 2019)*
John Keddie *(from 1 July 2019) - Associate Non-Executive Director*
Helen Howe - *Associate Non-Executive Director*

The Trustees are assisted in the their work by a number of professional advisors, as detailed below:

Independent Examiners

Ernst & Young LLP
400 Capability Green
Luton
LU1 3LU

Bankers

Barclays Bank PLC
Water Gardens
Harlow
Essex
CM20 1AN

RBS
280 Bishopsgate
London
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PARTNERSHIP WORKING AND NETWORKS

The Princess Alexandra Hospital NHS Charitable Fund is one of 129 NHS linked charities in England and Wales who are eligible to join NHS Charities Together. As a member charity, we have the opportunity to discuss matters of common concern, exchange information and experiences, and to participate in conferences and seminars which offer support and education for our Trustees.

We remain indebted to the work of the WRVS, who support us at St Margaret's Hospital, and the Anne Robson Trust, who work in partnership with the Trust to set up and embed teams of Butterfly Volunteers. These volunteers give their time to patients who are in the last days and hours of their life.

There are many ways in which the staff and public can help to raise funds for the Charity. These include:

- making a donation. Donations can be made by cash or cheque, and these donations can be received by the ward or department concerned, the Cashier's office within The Princess Alexandra Hospital or by post to the Finance Department. Donations can also be made online through the Justgiving page for the Charity (www.justgiving.com/pahnhs)
- holding or taking part in a fundraising event
- setting up a regular donation
- leaving a gift to the Charity in your will.

Please contact the Fundraising Team (paht.fundraising@nhs.net) for more ideas on how you could help.

THANK YOU

On behalf of the staff, patients and visitors who have benefitted from improved services due to donations and legacies, the Corporate Trustee would like to thank all patients, relatives and staff who have made charitable donations.

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

TRUSTEE STATEMENTS

Statement of Trust Board's Responsibilities in respect of the financial statements.

Under charity law, the Trust Board are responsible for preparing the Trustee's Annual Report and Accounts for each financial year which show a true and fair view of the state of affairs of the Charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice requires that the Board of Directors:

- Select suitable accounting policies and apply them consistently
- Make judgements and estimates that are reasonable and prudent
- State whether the recommendations of SORP have been followed, subject to any material departures disclosed and explained in the financial statements
- State whether the financial statements comply with the Trust Deed, subject to any material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to assume that the Charity will continue its activities.

The Trust Board are required to act in accordance with the Trust Deed and the rules of the Charity within the framework of Trust law. The Trust Board are responsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the Charity at that time, and to enable the Trust Board to ensure that, where any statements of accounts are prepared by the Trust Board under section 132(1) of the Charities Act 2011, those Directors have general responsibility for taking such steps as are reasonably open to the Trust Board to safeguard the assets of the Charity and detect fraud and other irregularities.

The Trust Board confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 15 to 25 attached have been compiled from, and are in accordance with the financial records maintained by the Trust Board.

By order of the Trust Board

Chair of Charitable Funds Committee (Non-Executive Director) _____ **Date** _____

Chief Financial Officer _____ **Date** _____

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

Independent examiner's report to the trustee of The Princess Alexandra Hospital NHS Trust Charitable Fund

I report on the accounts of the Trust for the year ended 31 March 2020 **,** which are set out on pages 15 to 25.

Respective responsibilities of trustees and independent examiner
The charity's trustees are responsible for the preparation of the accounts. The trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.
It is my responsibility to:

► examine the accounts under section 145 of the Charities Act;
► to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act; and
► to state whether particular matters have come to my attention.

Basis of independent examiner's report
My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the accounts present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement
In connection with my examination, no material matters have come to my attention which gives me cause to believe that in, any material respect:

► the accounting records were not kept in accordance with section 130 of the Charities Act; or
► the accounts did not accord with the accounting records; or
► the accounts did not comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give 'true and fair' view which is not a matter considered as part of an independent examination.

I have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Independent examiner's report to the trustee of The Princess Alexandra Hospital NHS Trust Charitable Fund (continued)

Use of our report

This report is made solely to the trustees, as a body, in accordance with our engagement letter dated 16 April 2018. The examination has been undertaken so that we might state to the trustees those matters that are required to be stated in an examiner's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the trustees as a body, for this examination, for this report, or for the statements made.

Name: Debbie Hanson
For and on behalf of Ernst & Young LLP
Relevant professional qualification or body: CIPFA
Address: 400 Capability Green, Luton, LU1 3LU
Date:

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDING 31 MARCH 2020

		2019-20			2018-19
	Note	Unrestricted Funds £000	Designated Funds £000	Total Funds £000	Total Funds £000
Income and endowments from:					
Donations and Legacies	3	39	159	**198**	326
Other income	4	0	484	**484**	515
Investments	5	0	4	**4**	3
Total		**39**	**647**	**686**	**844**
Expenditure on:					
Raising funds	1g/6	0	(227)	**(227)**	(244)
Charitable activities					
- Contributions to the Trust	7	(5)	(169)	**(174)**	(202)
- Medical Research	7	0	(130)	**(130)**	(90)
- Patient welfare and amenities	7	0	(154)	**(154)**	(108)
- Staff welfare and amenities	7	0	(15)	**(15)**	(13)
Total		**(5)**	**(695)**	**(700)**	**(657)**
Net (expenditure) / income		34	(48)	**(14)**	187
Transfers between funds		0	0	**0**	0
Net movement in funds		34	(48)	**(14)**	187
Reconciliation of funds:					
Total funds brought forward	18	7	649	**656**	469
Total funds carried forward		**41**	**601**	**642**	**656**

6.2

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

BALANCE SHEET AS AT 31 MARCH 2020

	Note	2019-20 £000	2018-19 £000
Current assets:			
Debtors	13	82	175
Cash and cash equivalents	14	742	512
Total current assets		**824**	**687**
Liabilities:			
Creditors: Amounts falling due within one year	15	(182)	(31)
Net current assets		**642**	**656**
Total net assets		**642**	**656**
The funds of the Charity:			
Unrestricted funds	18	41	7
Unrestricted (designated)	18	601	649
Total charity funds		**642**	**656**

6.2

These financial statements were approved by the Trust Board on 3 December 2020 and signed on their behalf.

Chair of Charitable Funds Committee (Non-Executive Director) **Date**

Chief Financial Officer **Date**

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

STATEMENT OF CASHFLOWS AS AT 31 MARCH 2020

	Note	2019-20 Total Funds £000	2018-19 Total Funds £000
Cash flows from operating activities:			
Net cash provided by operating activities	16	226	51
Cash flows from investing activities:			
Dividends, interest and rents from investments	5	4	3
Net cash provided by investing activities		**4**	**3**
Increase in cash and cash equivalents		**230**	**54**
Cash and cash equivalents as at 1 April	14	512	458
Cash and cash equivalents as at 31 March	14	**742**	**512**

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

NOTES TO THE ACCOUNTS

1. Accounting Policies

(a) Basis of Preparation

These financial statements have been prepared under the historic cost convention and in accordance with the Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland (FRS102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2015.

Going concern:
The Trust Board consider that the Charity is a going concern. Fund balances are stable, with growth predicted for the future year. The Trust Board consider that there are no material uncertainties about The Princess Alexandra Hospital NHS Charitable Fund and its ability to continue as a going concern. There are no material uncertainties affecting the current year accounts.

(b) Funds structure

The Princess Alexandra Hospital NHS Trust Charitable Fund is registered as an Umbrella Fund, encompassing three unrestricted special funds whose names and objects are:

The Princess Alexandra Hospital General Fund
For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by The Princess Alexandra Hospital.

The St Margaret's Hospital General Fund
For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the St Margaret's Hospital.

The Herts & Essex Hospital General Fund
For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the Herts and Essex Hospital.

The purposes of the unrestricted funds are to support any charitable purpose relating to the NHS; 99 unrestricted designated funds and 1 unrestricted general fund have been established to reflect the non-binding wishes of donors (99 in 2018-19).

(c) Incoming Resources

Cash donations, gifts, legacies, investment income and income from fund raising events are included in the full statement of financial activities as soon as the conditions for receipt have been met and there is reasonable assurance of receipt.

The Charity received no gifts in kind.

The Princess Alexandra Hospital NHS Trust Charitable Fund
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NOTES TO THE ACCOUNTS (continued)

1. Accounting Policies (continued)

(d) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is virtually certain; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

(e) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- there is a present legal or constructive obligation resulting from a past event
- it is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- the amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

(f) Allocation of overhead and support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration and internal and external examination/audit costs. Support costs have been apportioned between fundraising costs and charitable activities on the basis of fund balances.

(g) Charitable activities

Costs of charitable activities comprise all costs in the pursuit of the charitable objects of the Charity. These costs, where not wholly attributable, are apportioned between the categories of expense in addition to the direct costs. The total costs of each category of expense include an apportionment of support costs as shown in note 9.

(h) Debtors

Debtors are amounts owed to the Charity. They are measured on the basis of their recoverable amount.

(i) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the Charity as they fall due. Cash equivalents are short term, highly liquid investments in interest bearing savings accounts.

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

NOTES TO THE ACCOUNTS (continued)

1. Accounting Policies (continued)

(j) Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to pay to settle the debt.

(k) Realised gains and losses

There are no realised gains or losses in 2019-20 (nil in 2018-19).

(l) Events after the end of the reporting period

No events (either adjusting or non-adjusting) occurred after the end of the reporting period for 2019-20 (nil in 2018-19).

2. Related Party Transactions

The Princess Alexandra Hospital NHS Trust Charitable Fund is managed by The Princess Alexandra Hospital NHS Trust, a corporate body established by order of the Secretary of State for Health. As such, the Trust is the ultimate controlling party and the Trust Board of the Charity are the Directors of the Trust, as detailed in page 10 of this Annual Report and Accounts.

Details of The Princess Alexandra Hospital NHS Trust are:

	2019-20		2018-19	
	Turnover	**Adjusted Financial Performance**	Turnover	Adjusted Financial Performance
	£000	**£000**	£000	£000
Nature of business				
Provision of healthcare	288,491	50	236,700	(16,542)

The Trust's auditors (Ernst & Young LLP) confirmed that the Trust's accounts gave a True and Fair view of the financial position and were prepared in accordance with the National Health Service Act 2006 and associated Accounts Directions. However, as a result of COVID, auditors were unable to verify stocks through attendance at sufficient stocktakes and as such issued a qualified opinion on the 2019-20 Trust accounts due to this limitation of scope (unqualified accounts issued for 2018-19).

The Trust Board received no remuneration or re-imbursement of expenses from the Charitable Fund during 2019-20 (nil in 2018-19).

NOTES TO THE ACCOUNTS (continued)

2. Related Party Transactions (continued)

The main beneficiaries of the Charity are the patients, staff and visitors of The Princess Alexandra Hospital NHS Trust. The Charity has provided grant funding for items purchased on behalf of these beneficiaries totalling £455,000 as detailed in notes 7 and 8 of these accounts.

Expenditure of the Charity is considered to be a grant to The Princess Alexandra Hospital NHS Trust, as the staff, patients and visitors of the Trust are the ultimate beneficiaries.

3. Income from donations and legacies

	Unrestricted Funds £000	Designated Funds £000	Total 2019-20 £000	Total 2018-19 £000
Donations	15	152	167	151
Legacies	24	7	31	175
Total	**39**	**159**	**198**	**326**

4. Income from other trading activities

Income relates to funds received from fundraising events (and where VAT is not chargeable). The Charity receives no income from "trading" (i.e. from the sale of merchandise), nil trading income in 2018-19.

	Designated Funds £000	Total 2019-20 £000	Total 2018-19 £000
Long Live Liver Appeal	22	22	1
Gibberd Ward Garden Appeal	9	9	0
My Life Memory Software Appeal	2	2	1
Improving Cancer Services	9	9	6
CT Equipment Appeal	0	0	1
Maternity Equipment Appeal	0	0	41
Breast Unit Fundraising Team events	442	442	465
Total	**484**	**484**	**515**

5. Investment income

	Designated Funds £000	Total 2019-20 £000	Total 2018-19 £000
Interest from cash and cash equivalents	4	4	3
	4	**4**	**3**

The Princess Alexandra Hospital NHS Trust Charitable Fund
Annual Report and Accounts 2019-20

NOTES TO THE ACCOUNTS (continued)

6. Expenditure on raising funds

	Designated Funds £000	Total 2019-20 £000	Total 2018-19 £000
PAH Fundraising	0	0	2
Improving Cancer Services	0	0	1
Long Live Liver Appeal	1	1	0
Breast Unit Fundraising Team events	223	223	237
Support costs	3	3	4
	227	**227**	**244**

7. Charitable expenditure

The Charity pursued its charitable activities by making grants. Support costs have been apportioned across the categories of charitable expenditure on the basis of fund balances as at the 31 March 2020. 2018-19 totals include support costs.

	Grant funded activity £000	Support Costs £000	Total 2019-20 £000	Total 2018-19 £000
Contributions to the Trust	159	15	174	202
Medical Research	130	0	130	90
Patient welfare and amenities	154	0	154	108
Staff welfare and amenities	15	0	15	13
Total	**458**	**15**	**473**	**413**

8. Analysis of grants

There were no grants made payable to individuals during 2019-20 (nil in 2018-19). All grants are made to The Princess Alexandra Hospital NHS Trust to provide for the care of NHS patients, and the welfare of it's staff and visitors. The total cost of making grants, including support costs, is disclosed on the Statement of Financial Activities and the actual funds spent on each category of charitable activity is disclosed in note 7.

Institution receiving grant support	Number of Grants paid	Total 2019-20 £000	Total 2018-19 £000
Princess Alexandra Hospital NHS Trust	1	455	413
Total	**1**	**455**	**413**

NOTES TO THE ACCOUNTS (continued)

9. Allocation of support costs and overheads

The financial administration costs have been allocated between governance and charitable activity on the basis of staff time. External audit costs were wholly allocated to governance. The basis of apportionment of support costs is disclosed in note 1f. Net incoming resources for the year are stated after charging:

	Raising funds £000	Charitable Activities £000	Total 2019-20 £000	Total 2018-19 £000
Charitable activity				
Administration - staff costs	3	11	14	14
Other - bank charges	0	1	1	1
Governance				
External examination	1	2	3	3
Fundraising Regulator levy charge	0	1	1	1
Total	**4**	**15**	**19**	**18**

10. Trustees' remuneration, benefits and expenses

The Trust Board give their time freely and receive no remuneration for the work that they undertake as Trustees.

11. Analysis of staff costs

The Charity does not employ any staff.

12. Independent Examiners remuneration

The independent examiners remuneration of £3,000 (£3,280 in 2018-19) related solely to the independent examination carried out in 2019-20, with no additional work undertaken.

13. Analysis of current debtors

	Total 2019-20 £000	Total 2018-19 £000
Debtors under 1 year		
Debtors (host Trust)	20	32
Accrued income	12	110
Prepayments	50	33
Total	**82**	**175**

NOTES TO THE ACCOUNTS (continued)

14. Analysis of cash and cash equivalents

	Total 2019-20 £000	Total 2018-19 £000
Cash held as short term investments and deposits	700	503
Cash at bank and in hand	42	9
Total	**742**	**512**

15. Analysis of liabilities

Creditors due within 1 year	Total 2019-20 £000	Total 2018-19 £000
Trade creditors	72	11
Creditors (host Trust)	110	20
	182	**31**

16. Reconciliation of net (expenditure) / income to net cash flow from operating activities

	Total 2019-20 £000	Total 2018-19 £000
Net (expenditure) / income (as per the statement of financial activities)	(14)	187
Adjustments for:		
Dividends, interest and rents from investments	(4)	(3)
Decrease/(increase) in debtors	93	(85)
Increase/(decrease) in creditors	151	(48)
Net cash used by operating activities	**226**	**51**

17. Transfers between funds

There were no transfers between accounts in 2019-20 (nil in 2018-19).

NOTES TO THE ACCOUNTS (continued)

18. Analysis of unrestricted and designated fund movements

	Balance 1 April 2019 £000	Income £000	Expenditure £000	Balance 31 March 2020 £000
Unrestricted Funds				
Herts & Essex Hospital	0	0	0	0
Princess Alexandra Hospital	(7)	(39)	5	(41)
St Margaret's Hospital	0	0	0	0
Total	**(7)**	**(39)**	**5**	**(41)**
Designated Funds				
Herts & Essex Hospital	(1)	0	0	(1)
Princess Alexandra Hospital	(491)	(132)	182	(441)
St Margaret's Hospital	(157)	(515)	513	(159)
Total	**(649)**	**(647)**	**695**	**(601)**
Total Funds	**(656)**	**(686)**	**700**	**(642)**

The Charity does not hold any restricted or endowment funds.

The Princess Alexandra Hospital NHS
NHS Trust

Hamstel Road
Harlow
Essex
CM20 1QX

Ernst & Young LLP
400 Capability Green
Luton
LU1 3LU

7 December 2020

Dear Sirs

This representation letter is provided in connection with your examination of the financial statements of The Princess Alexandra Hospital NHS Trust Charitable Fund ("the Charity") for the year ended 31 March 2020. We recognise that obtaining representations from us concerning the information contained in this letter is a significant procedure in enabling you to complete your examination as to whether there are matters to which attention should be drawn to enable a proper understanding of the financial statements to be reached.

We understand that the purpose of your examination of our financial statements is to report whether any matter has come to your attention which gives you reasonable cause to believe that in any material respect the requirements have not been complied with:

- to keep accounting records in accordance with section 130 of the 2011 Act;
- to prepare accounts which accord with the accounting records; and
- to prepare accounts which comply with the accounting requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008.

We understand that this examination is substantially less than an audit and involves an examination of the accounting records and related data to the extent you considered necessary in the circumstances, and is not designed to identify - nor necessarily be expected to disclose – all fraud, shortages, errors and other irregularities, should any exist.

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

A. Financial Statements and Financial Records

1. The Trustees consider that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

2. We have fulfilled our responsibilities, as set out in the engagement letter, for the preparation of the financial statements in accordance with the Charities SORP and UK Generally Accepted Accounting Practice.

3. We acknowledge, as trustees of the Charity, our responsibility for the fair presentation of the financial statements. We believe the financial statements referred to above give a true and fair

view of the financial position and financial performance of the Charity in accordance with UK GAAP, and are free of material misstatements, including omissions. We have approved the financial statements.

4. The significant accounting policies adopted in the preparation of the financial statements are appropriately described in the financial statements. We have disclosed to you any significant changes in our processes, controls, policies and procedures that we have made to address the effects of the COVID-19 pandemic on our system of internal controls.

B. Fraud

1. We acknowledge that we are responsible for the design, implementation and maintenance of internal controls to prevent and detect fraud.

2. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

3. We have no knowledge of any fraud or suspected fraud involving management or other employees who have a significant role in the Charity's internal controls over financial reporting. In addition, we have no knowledge of any fraud or suspected fraud involving other employees in which the fraud could have a material effect on the financial statements. We have no knowledge of any allegations of financial improprieties, including fraud or suspected fraud, (regardless of the source or form and including without limitation, any allegations by "whistleblowers") which could result in a misstatement of the financial statements or otherwise affect the financial reporting of the Charity.

C. Compliance with Laws and Regulations

1. We have disclosed to you all known actual or suspected noncompliance with laws and regulations whose effects should be considered when preparing the financial statements.

D. Information Provided and Completeness of Information and Transactions

1. We have provided you with:

   - Access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters.

   - Additional information that you have requested from us for the purpose of the examination and

   - Unrestricted access to persons within the entity from whom you determined it necessary to obtain evidence.

2. All material transactions have been recorded in the accounting records and are reflected in the financial statements, including those related to the COVID-19 pandemic.

3. We have made available to you all minutes of the meetings of trustees or subcommittees of trustees (or summaries of actions of recent meetings for which minutes have not yet been prepared) held through the period to the most recent meeting on the following date: 18 November 2020.

4. We confirm the completeness of information provided regarding the identification of related parties. We have disclosed to you the identity of the Charity's related parties and all related party relationships and transactions of which we are aware, including sales, purchases, loans, transfers of assets, liabilities and services, leasing arrangements, guarantees, non-monetary transactions and transactions for no consideration for the period ended, as well as related

balances due to or from such parties at the year end. These transactions have been appropriately accounted for and disclosed in the financial statements.

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

E. Liabilities and Contingencies

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

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

3. We have recorded and/or disclosed, as appropriate, all liabilities related litigation and claims, both actual and contingent, and have not given any guarantees to third parties.

F. Subsequent Events

1. There have been no events subsequent to period end which require adjustment of or disclosure in the financial statements or notes thereto.

G. Other information

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

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

H. Reporting to regulators

1. We confirm that we have reviewed all correspondence with regulators, in England and Wales, which has also been made available to you, and the serious incident report guidelines issued by the Charity Commission (updated in 2017). We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the signing of the balance sheet.

Yours faithfully

John Keddie
Chair of the Charitable Funds Committee

Simon Covill
Acting Chief Finance Officer