The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 1 February 2024 at 09.30 – 12.30
Venue: Kao Park Boardroom

	Item	Subject	Action	Lead	
01 Opening administration					
09.30	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	4
	1.4	Matters arising and action log	Review	All	16
09.35	**Patient story: The Patient View on Elective Pathways at PAHT**				
02 Chair and Chief Executive's reports					
10.00	2.1	Chair's report	Inform	Chair	18
10.05	2.2	CEO report	Inform	Chief executive	22
03 Risk					
10.20	3.1	Corporate risk register	Review	CEO	29
10.30	3.2	Board assurance framework 2023-24 *Diligent Resources: BAF 2023/24*	Review/ Approve	Head of corporate affairs	35
04 Patients					
10.35	4.1	Report from Quality and Safety Committee 26.01.24: • Part I • Part II – Maternity Oversight	Assure	Committee Chairs	38 44
10.45	4.2	Maternity: • SI report • Maternity Incentive Scheme • Maternity Safety Support Programme Exit and Sustainability Plan	Assure Ratify Ratify	Chief Nurse/ Director of midwifery	45 49 58
		Opportunity for members of the public to ask questions about the board discussions or have a question answered			
11.00	BREAK 11.00 -11.10				
11.10	4.3	Nursing, midwifery and care staff levels	Assure	Chief Nurse	86
11.15	4.4	Nursing Establishment Review	Assure	Chief Nurse	93
11.20	4.5	Learning from deaths (Mortality)	Assure	CEO	109

11.30	4.6	Electronic Health Record	Assure	Chief Information Officer	111
05 People					
11.35	5.1	Report from People Committee 22.01.24	Assure	Committee Chair	115
11.40	5.2	Gender Pay Gap	Approve	Director of People	118
06 Performance/pounds					
11.45	6.1	Report from Performance and Finance Committee 25.01.24	Assure	Chair of Committee	125
11.50	6.2	Finance update	Assure	Director of Finance	130
12.00	6.3	Integrated performance report (IPR)	Discuss	Chief Information Officer	141
12.10	6.4	Emergency Preparedness Annual Report and Core Standards Return	Approve	Chief Operating Officer	156
07 Strategy/Governance					
12.15	7.1	Report from Strategic Transformation Committee 22.01.24	Assure	Chair of Committee	183
12.20	7.2	Report from Senior Management Team Meetings held in January 2024	Assure	Chair of Committee	186
	8.1	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
09 Closing administration					
12.25	9.1	Any unresolved issues			
	9.2	Review of Board Charter			
	9.3	Summary of actions and decisions	-	Chair/All	
	9.4	New risks and issues identified	Discuss	All	
	9.5	Any other business	Review	All	
	9.6	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	
12.30		Close			

Date of next meeting: 4 April 2024

The Princess Alexandra Hospital NHS Trust

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.

Board Membership and Attendance 2023/24			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chair	Hattie Llewelyn-Davies	Chief Executive	Lance McCarthy
Non-executive director (SID)	George Wood	Chief Nurse	Sharon McNally
Non-executive director	Colin McCready	Chief Operating Officer	Stephanie Lawton
Non-executive director	Helen Howe	Medical Director	Fay Gilder
Non-executive director	Darshana Bawa	Director of Finance	Tom Burton
Non-executive director	Kim Handel		
Associate Non-executive director	Oge Austin-Chukwu	**Executive Members of the Board (non-voting)**	
Associate Non-executive director	Anne Wafula-Strike	Director of Strategy	Michael Meredith
Associate Non-executive director	Dr. Rob Gerlis	Director of People	Gech Emeadi
Associate Non-executive director	Elizabeth Baker	Director of Quality Improvement	Jim McLeish
		Chief Information Officer	Phil Holland
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public at Kao Park
Thursday 7 December 2023 from 09:30 to 12:30

Present:	
Hattie Llewelyn-Davis	**Trust Chair (TC)**
Oge Austin-Chukwu (non-voting)	Associate Non-Executive Director (ANED - OA)
Liz Baker (non-voting)	Associate Non-Executive Director (ANED-LB)
Darshana Bawa	Non-Executive Director (NED-DB)
Tom Burton	Director of Finance (DoF)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Rob Gerlis (non-voting)	Associate Non-Executive Director (ANED-RG)
Fay Gilder	Medical Director (MD)
Phil Holland	Chief Information Officer (CIO)
Helen Howe	Non-Executive Director (NED-HH)
Stephanie Lawton	Chief Operating Officer (COO)
Lance McCarthy	Chief Executive Officer (CEO)
Colin McCready	Non-Executive Director (NED-CM)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Chief Nurse (CN)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)
In attendance/Observing:	
Linda Machakaire (item 4.2)	Director of Midwifery (DoM)
Staff Story:	
Nneka Smith	Clinical Education Lead (non-medical) (CEL)
Members of the Public	
Zoe Tidman	HSJ
Charlotte Mogford	Graduate Management Trainee
Freya Cannon	Graduate Management Trainee
Sacha Mann	Graduate Management Trainee
Apologies:	
Kim Handel	Non-Executive Director (NED-KH)
Heather Schultz	Head of Corporate Affairs (HoCA)
Secretariat:	
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chair (TC) welcomed all to the meeting, particularly those members of the public who were in attendance.
1.1 Apologies	
1.2	Apologies were noted as set out above. It was with sadness that the Board noted the Head of Corporate Affairs (HoCA) absence, due to a family bereavement.
1.2 Declarations of Interest	
1.3	The Director of People (DoP) declared she was now a member of the National Council for terms and conditions for medical staff and agenda for change.
1.3 Minutes of Previous Meeting	

1.4	The minutes of the previous meeting were approved as an accurate record of the meeting held on 05.10.23.
1.4 Matters Arising and Action Log	
1.5	**Fab Change Quality Improvement (QI) Awards:** The Director of Quality Improvement (DoQI), at the request of the TC, informed members that the organisation had received six nominations for the finals of this event. Categories had covered a range of areas including Fab QI, QI Individual, Patient Co-design, Challenge category on feedback and actions. The Trust had won in the category of Co-production for its development of a Nutrition MDT Strategy and had received a 'highly commended' for its Cancer Frailty Pathway (driven by the MDT and Frailty Service). Congratulations went to all the teams for all their hard work in terms of quality improvement.
1.6	The action log was noted and members had no comments.
Staff Story: 'My journey as a LGBTQ+ staff member'	
2.1	The Clinical Education Lead (non-medical) (CEL) introduced herself to members and confirmed she was a member of the LGBTQ+ community and identified as queer and by the pronoun 'she/they'. Her story that day would explore her summary of lived experience including intersections and the barriers faced. She would also explore the training offered to non-medical educators and the impact of that and why inclusion was important to her in terms of being able to bring her whole authentic self to work.
2.2	The CEL informed colleagues that whilst positive steps had been taken in terms of LGBTQ+ inclusion, there had also been some backward steps. There were many people using services in the community and in the hospital's workforce who identified under the LGBTQ+ umbrella and colleagues needed to be aware how best to engage with and support those people. As an Educator herself she always facilitated training for those working with students and in education and she had teamed up with Mermaids who provided a good introduction to trans+ care and she had also undertaken a session for East of England Ambulance Service on Neurodiversity. There was a definite disparity across the non-medical umbrella in terms of training for educators.
2.3	The CEL continued that her training had had a positive impact on staff, learners and families. She cited one example where she had facilitated making changing rooms gender neutral in outpatients which had actually increased the ability of staff to x-ray more patients in one day. Her training had also supported staff in feeling more comfortable in approaching questions around pregnancy for transgender individuals.
2.4	Training had also had a positive impact on learners in terms of organising placements for external students. She had used her personal pronouns on her email signature which had immediately signalled she was someone who colleagues could speak to around their gender and how they identified. She added she also always wore her rainbow lanyard and associated 'pins' which was also a signal to others.
2.5	As a final point the CEL commented that LGBTQ+ training had an impact on organisations and directly on patient safety. She would be keen to explore additional avenues of training at the Trust going forward.
2.6	In response to the above the Medical Director (MD) stated she had been struck by the power of an email signature and she asked how the Trust's culture could be changed to recognise the impact a simple process such as that could have on colleagues. In response the Director of People (DoP) informed members there was some guidance on AlexNet which she would recirculate.
ACTION **TB1.07.12.23/15**	**Recirculate Trust guidance around email signatures.** **Lead: Director of People**
2.7	The Chief Operating Officer (COO) thanked the CEL for her story and added there was an opportunity there for her to spend some time with Service Managers on their Operational Development Programme in terms of shaping that programme to determine how inclusive the organisation actually was. This could support colleagues in terms of thinking differently around planning for the coming year and supporting service users.
ACTION	**Be part of the Operational Development Programme**

TB1.07.12.23/16	**Lead: Chief Operating Officer/Clinical Education Lead (non-medical)**
2.8	The Director of Strategy (DoS) asked the CEL whether she found PAHT an inclusive organisation. The CEL responded there were some positive elements, but there was much that could be done better and/or prioritised, which would signal how committed the organisation was to being inclusive. Her number one recommendation would be changes to the toilet facilities in the main corridor. The DoS agreed to look into this.
ACTION TB1.07.12.23/17	**Support changes to toilet facilities in the main corridor.** **Lead: Director of Strategy**
2.9	Non-Executive Director George Wood (NED-GW) asked whether consideration should be given to having a Freedom to Speak Up Guardian (FTSUG) dedicated to this area. The CEL responded it was a good idea but data had previously shown the uptake was minimal. It was more about working through why colleagues didn't feel safe to speak up and the associated actions to address that.
2.10	The DoP commented she would like to thank the CEL personally for sharing her story. There had been a number of colleagues who had a similar story to share but who had not felt confident in terms of sharing that story more widely with the Board/organisation. She also thanked the CEL for her other 'hats' around race and disability and asked what the organisation could do to also make those elements more comfortable for people to champion. The CEL responded that it was not just about talking and having meetings, it was about actions and the lower colleagues were between the Board and the 'ground' the less they saw, heard or experienced. So it was about breaking those barriers down and training would be key to that in terms of changing culture so that colleagues felt comfortable to push forwards.
2.11	The TC then flagged that she and Associate NED Anne Wafula-Strike (ANED-AWS) were both part of the DAWN Network and because that was a large group she did not feel she was overwhelming that group. LGBTQ+ was a small network so she asked how to move beyond that. The CEL responded this was about how those networks were advertised so that individuals felt able to come forward as allies. Once allies were part of those networks it was easier for members to feel their concerns were being heard by others.
2.12	In relation to allies, NED Helen Howe (NED-HH) asked whether there were sufficient for each group or whether there should also be an Allies Group. The CEL responded experience had shown there should not be a separate Allies Group because this created further divisions. The MD responded that Allyship was key and she herself had undertaken some online learning around that in the context of race after she had been challenged by a colleague. This had opened her thinking around this and why it was so important. The TC agreed and that her suggestion would be to undertake a Board Development session around Allyship – members agreed.
ACTION TB1.07.12.23/18	**Board to undertake a development session on Allyship.** **Lead: Trust Chair/Head of Corporate Affairs**
2.13	Associate NED Rob Gerlis (ANED-RG) then asked about coordinating with other partners for example the ambulance service, social care and schools. The CEL responded it was about networking and there were organisations who currently delivered session for the NHS for example in terms of mental health. She was linking in with them to see whether the scope of training could be widened and there was lots going on in primary and acute care too which was a good step forward. The DoP added that the ICS was also doing a lot in that space, albeit work was in its infancy.
2.14	The TC thanked the CEL for sharing her story which had been very powerful and had led to some actions (detailed above).
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	The TC introduced her update and the paper was taken as read. The paper majored on EDI and she thanked ANED-AWS for all that she was doing too in that space.
2.2	The TC informed members she had attended the Hertfordshire & West Essex ICB (HWEICB) Chairs' Network the previous evening where the work around the Urgent Treatment Centre

	(UTC) had been praised, for which she extended her thanks to the COO and to Associate NED Rob Gerlis (ANED-RG).
2.3	The TC then asked the Director of Strategy (DoS) for an update on disabled parking at Gibberd Ward. The DoS responded that signage was up and ready to go. All that remained was to paint the signs on the roadway. The TC thanked the DoS for his update and agreed to update the Chair of the Patient Panel on progress.
ACTION **TB1.07.12.23/19**	**Update the Chair of the Patient Panel on blue badge parking at Gibberd Ward. Lead: Trust Chair**
2.2 CEO's Report	
2.4	The CEO introduced his report and the paper was taken as read. He commented that the first point to note was the great progress on the UTC. The other element to highlight in the paper was the piece around pay awards and industrial action (IA) which had been accurate at the time of writing. However, as colleagues would be aware, there had been confirmation from the BMA earlier that week of junior doctor industrial action just before Christmas and also in early January 2024. Planning for that had started in earnest the previous day and learning would be taken from previous IA.
2.5	On a positive the government had announced £800m to support IA costs and through various allocations the Trust had received £2.98m of that via the ICB. In addition to that there had been a change to ERF levels of performance (which had now reduced) recognising the impact of IA on organisations' ability to meet performance commitments. This afforded the opportunity to mitigate some of the organisation's income loss as a result of the reduction in activity and it was also useful to note that whist £2.98m would be helpful, it would not cover the full costs of IA or the reduction in income.
2.6	The CEO continued (in relation to the £2.98m) that whilst the organisation had committed to performance targets on the ED 4 hour standard, cancer access and the 65 week standard it was clear that the newly announced periods of IA would have an impact on revised plans both financially, in terms of elective recovery and in terms of pressures on staff both clinical and non-clinical.
2.7	The DoS asked, in response to the above, whether there would be additional funding for any new periods of IA. The CEO responded he did not know. Consultant colleagues were also still being balloted on a potential deal, so it was impossible to know. In response then to a question from ANED-RG members noted that often pay deals were not 100% funded which then potentially became an organisational cost pressure.
2.8	In response to the above the DoQI commented that whilst the financial cost of IA was significant, the impact on the organisation's people was potentially greater in terms of planning. The TC added that the impact on patients could also not be forgotten.
2.9	The CEO continued that the remainder of his report related to 1) Progress towards delivery of PAHT2030 and 2) Ongoing work in relation to the new hospital including the land purchase and a link to the Public Accounts Committee Report in relation to the new hospital programme and associated actions.
2.10	The CEO then highlighted that section 4 of his paper detailed the progress on the implementation of the Trust's new electronic health record (EHR). Section 5 highlighted the strong response rate to the recent Staff Survey results. A new consultant development programme was up and running and there was a new finance/accounting system embedding. The CEO then flagged an error on p19 of his update where the forecast of £7.6m should read £9.4m (£7.6m was the system risk to break-even).
2.11	In terms of the Staff Survey, the Director of People (DoP) was able to confirm that the final response rate had been 49.5% against an internal target of 50% which was a big improvement on previous years.
2.12	In response then to a question from ANED-RG around the new hospital, the CEO confirmed a new hospital was required in both Harlow and Watford and there was currently ICB support for both, and both were part of the national New Hospital Programme (NHP). The expectation remained currently that both would be delivered by 2030. The ICB continued to support the whole system in terms of the operational changes needed to make that happen

	and to ensure the new hospitals were a success and patients were being managed in the right way. To support the delivery of healthcare outside the hospital setting, members were aware of the elective care hub to be developed at Watford and of the community diagnostic centre to be delivered on the St. Margaret's site in Epping. In summary the ICB was fully supportive and pushing in the same direction as the Trust.
2.13	In response to a question from NED Darshana Bawa (NED-DB), the MD responded that the consultant development programme supported the GMC monitoring work.
2.14	The TC summarised by stating there needed to be recognition of the impact of IA on patients, staff, the organisation's financial position and on its performance. The next two periods of IA which had been announced would be a huge challenge over the Christmas period.
03 RISK/STRATEGY	
3.1 Corporate Risk Register (CRR)	
3.1	This paper was presented by the MD. Key points to note were: • Risks scoring 15 and above continued to reduce in number (now at 43) which was a reflection of the sheer amount of work being undertaken by teams in terms of mitigation/resolution. • There was now a reduced risk score for Pharmacy Staffing down from 20 to 16. • There was a new risk scoring 15 related to fire safety.
3.2	In response to the above NED-GW commented there appeared currently to be a shortage of pharmacists, an area the organisation should keep an eye on. The MD responded that the pharmacy team works hard on culture to support both attraction and retention of staff and also of note, in two years' time, Pharmacists as part of their training would be prescribing Pharmacists, which would see a shift in their capabilities. NED Helen Howe (NED-HH) added that Pharmacy Assistants (as well as Technicians) would be key going forward and this would be reliant on the continuation of HEE funding so there were sufficient pre-registrations to recruit.
3.3	The DoQI added that the position was slightly different in the community where it was all about workload as well and how to engage community pharmacy in a different way and change the workforce plans across the system – and there was a good opportunity to do that currently.
3.4	The TC summarised by stating that the Board had recognised the strategic/cultural change models underway in Pharmacy which would impact both on the system and Trust wide. This would need to be raised at a system level to recognise the issues for PAHT despite positive recruitment.
3.2 Board Assurance Framework (BAF) 2023/24	
3.5	The BAF was presented by the CEO and was for review and approval. The risks had been updated with executive leads and reviewed at the relevant committees during November 2023. The risk scores had not changed that month and were summarised in Appendix B. The proposal was to add a new risk to the BAF - Risk 4.3 Industrial Action. The risk had been discussed at PAF and PAF had recommended that the Board approved the risk. The COO/MD and CN would be the executive leads and PAF would have oversight of the risk. The risk had been scored at 20.
3.6	In line with the recommendation, the Board approved the new risk relating to industrial action and the score of 20.
04 PATIENTS	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	<u>Report from QSC (Part I)</u> The Chief Nurse (CN) presented the report from QSCI and highlighted that the committee had received assurance on the following: • Adult Inpatient Survey Results (with associated action plan).

	• BAF risk 1.1 reviewed and score to remain at 16 with further review following new EHR implementation. • Compliance with Safeguarding training.
4.2	Report from QSC (Part II) ANED-RG confirmed the Committee had discussed the improvements in staffing with 16 WTE new starters. Pressures remained however in terms of skill mix and sickness absence. There had been a conversation around compliance with the Maternity Incentive Scheme (MIS) and the current risks in relation to safety actions 4 and 6. There had been two new serious incidents (SIs) in-month, neither of which required HSSIB investigation. The Committee had received an update on culture and a draft framework for exiting the Maternity Safety Support Programme.
4.2 Maternity Updates	
4.3	Maternity SI Report This item was introduced by the CN. She advised members the report had previously been presented to QSC (Part II) and that there had been two new SIs in October. The summary from those two cases had been included in section 3 of the paper and there were no new emerging themes, the learning from SIs through the associated improvement actions were included in the paper. Of note was the overarching work around culture in Maternity Services which the Committee had been updated on in terms of a refresh going into the next phase of the work.
4.4	In response to the above, NED Darshana Bawa (NED-DB) asked whether the two SIs referenced had been avoidable. The CN responded there was a huge amount of variability across all SIs and her understanding currently was that no direct cause/effect had been identified. The key however would be the learning coming from those.
4.5	At this point the TC flagged the cover sheet accompanying the paper did not reference maternity outcomes in relation to race/deprivation. The race element was also not referenced on the cover sheet to the MIS paper. The CN apologised and provided assurance that colleagues were now reviewing the demographics and EDI background for incidents and would address the cover sheets in terms of the following month's reporting.
ACTION **TB1.07.12.23/20**	**Cover sheets for maternity reports to be complete, particularly the EDI section.** **Lead: Director of Midwifery**
4.6	Maternity Incentive Scheme (MIS) The CN informed colleagues that in terms of the governance around the MIS, a Board declaration would be due for sign-off by 01.02.24. An update on progress would be provided for January's Board meeting so the Board was fully sighted on our compliance position at which point a request for delegated authority to QSC to inform our Board declaration would be requested for January's QSC given the Board meeting was scheduled for 01.02.24.
4.7	The Director of Midwifery (DoM) commented that the key for the Board was table 1 of the paper which provided the MIS position as of the middle of November. November QSCII had noted the moving picture and increased optimism the scheme would be achieved for year 5, however she recognised some risks remained. Evidence continued to be uploaded but she was able to provide assurance that safety action 7 would become compliant, safety action 8 which related to training required sign-off by the Governance Lead but compliance had been reached despite the revised target of 90% by 01.02.24. The safety action which remained at risk was safety action 6 which related to Saving Babies Lives. The requirements again on this action had changed but required 50% compliance achievement across all six elements.
4.8	In response to the above the CN commented the risk outlined above should be noted but the overall picture was becoming more optimistic. She cautioned the focus should not be on the financial aspects of the scheme but on the safety aspects.
4.9	In response to a question from ANED Oge Austin-Chukwu (ANED-OA) the CN confirmed that if one of the six elements of safety action 6 was not achieved then the safety action as a whole and the maternity incentive scheme would not be achieved.

4.10	In response then to an offer of support from the CEL, the DoM confirmed she would very much welcome support in terms of supervision obligations in terms of midwifery students and oversight of the current plans.
ACTION TB1.07.12.23/21	**Provide support with supervision obligations in terms of midwifery students and oversight of current plans. Lead: Clinical Education Lead (non-medical)**
4.11	NED-GW then asked whether planned IA would impact on the scheme's achievement that year. The CN responded that the picture would become clearer over the coming month. The DoM added that training compliance target dates were after the planned IA.
4.12	At this point the CN informed the DoM there had been a previous question in relation to avoidable harms relating to the two SIs declared in month and asked for the detail. The DoM agreed to update on this outside the meeting. The CN suggested the update be included in the next update to SI Update to QSCII.
ACTION TB1.07.12.23/22	**Two maternity SIs declared in October: Provide an update for December QSCII as to whether harms had been avoidable. Lead: Director of Midwifery**
4.13	The TC thanked the CN/DoM for their update. She noted the progress in terms of EDI reporting but that there was more work to be done around this. There was an action to update QSCII in December on avoidable harms in relation to the two SIs reported in-month. The Board noted the optimism in relation to achieving MIS year 5, albeit risk still remained and the offer of support from the CEL in relation to supervision obligations for midwifery students was noted.
4.14	At this point in the meeting there were no questions from members of the public.
Break 1038-1050	
4.3 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
4.15	The CN presented the update which had been discussed in detail at the People Committee. She immediately flagged that although the agenda referenced the paper covered 'Nurse Recruitment', that was not included within the report. .
ACTION TB1.07.12.23/23	**Board agenda to be revised ahead of February meeting. Lead: Board & Committee Secretary**
4.16	The CN continued she was pleased to report a very stable position for the wards and whilst the data presented related to September (due to the timing of report submission), a similar position was being seen for October.
4.17	She then drew members' attention to appendix I and highlighted one area (John Snow Ward) where fill was less than 72% in-month. This was because John Snow was the hospital's elective orthopaedic ward and demand when the rota had been compiled had not then been needed. She had no safety or quality concerns in terms of this area.
4.18	The TC thanked the CN for her update and noted achievements were remarkable and teams were to be commended. The current nursing position was unprecedented in the Trust's recent history and also in the ICB's.
4.4 Learning from Deaths (Mortality)	
4.19	This item was presented by the MD. She was pleased to report that HSMR had now moved to 'as expected' from July and the 'all diagnoses' SMR 12 month rolling position remained 'as expected'. SHMI (deaths in the 30 days after discharge) was also 'as expected'.
4.20	The MD continued that the above position was down to a huge amount of hard work over recent years in terms of reviewing care, notes, and the quality of coding and documentation.
4.21	In response to the above NED-HH stated she recognised the impact industrial action was having but was there a trajectory in terms of completing outstanding structured judgement reviews (SJRs). The MD responded colleagues were working closely with the divisions to support them in completing these but there was currently a huge amount of pressure on colleagues.

4.22	The DoQI then commended colleagues on the huge amount of work undertaken over a significant period of time to provide the organisation with assurance that the care it provided was of high quality. There was a large group of colleagues in the Trust who had brought this work to fruition under the current Medical Director's leadership and that group should be applauded.
4.23	The TC acknowledged the above and added some thought should now be given to how that work and the current position was communicated Trust-wide.
ACTION TB1.07.12.23/24	**Consider how the good work around mortality should be communicated Trust-wide. Lead: Communications Team**
4.24	The MD then continued and added that the in-month position for SMR for July was the second best the organisation had seen in the previous five years and was 'below expected'. This was a huge achievement given bouts of industrial action during that time.
4.25	In response to the above the Chief Information Officer (CIO) added that mortality data was produced and verified independently and he reiterated the previous points in terms of the assurance that provided that care was safe and of high quality.
4.26	In response then to a question from the TC, the MD confirmed that CUSUM breaches were an 'early warning' and as such there had been no new ones that month.
4.27	The TC thanked the MD for her update, which was a very good news story.
4.5 Electronic Health Record (EHR)	
4.28	This update was presented by the CIO. He updated that whilst the programme was running as planned, associated programme risks would need to continue to be managed, particularly in relation to the timeline. October 2024 go-live remained a critical focus point.
4.29	Resourcing remained a key risk albeit governance structures were in place to keep the work moving forwards. It was likely now that an external organisation would undertake the testing work – resourcing risks were likely to continue for the duration of the programme and the EHR Programme Board had continued oversight of all the programme risks.
4.30	The CIO continued that over the next three months data migration activity would commence. The first trial load would commence in January with results expected from March. This would be the first of three trial loads. In addition the test plan would be developed in terms of approach and producing local test scripts. The majority of detailed workflows would be completed using the Willow Road patient profiles to inform the validation of what the future state would look like at go-live in October. This would be a key component of the validate gateway review at the beginning of February 2024.
4.31	The CIO informed members there had been some excellent engagement from the Programme Board and organisation as a whole. The next critical gateway review would be at the end of January to confirm the future state.
4.32	In response to a request from NED Colin McCready (NED-CM) the CIO agreed to provide a high level programme timeline to show dependencies.
ACTION TB1.07.12.23/25	**Provide a high level EHR timeline. Lead: Chief Information Officer**
4.33	In response to a request for an update on external support from the CEO, the CIO informed members that the Trust had received consistent advice from both Oracle and NHS England that it would benefit from engaging with additional external support; to provide himself as SRO, and the Board with support and assurance and to give the best chance of a successful implementation. This work had recently commenced.
4.34	The TC thanked the CIO for his update.
4.6 Adult Inpatient Survey Results 2022	
4.35	This update was presented by the CN. She informed members these were the results from 2022 and the paper had previously been presented to November QSC. The results had been published by the CQC based on benchmarked data in September 2023 and although the results were not showing a significant deterioration from previous years, the Trust was still placed in the bottom third of trusts in quite a number of areas. Information in the appendices demonstrated 25 of 60 questions were rated worse in some way, covering a wide range of

	areas. Essentially the issues related to the organisation's admission process, noise at night, food, doctors/nurses, care and treatment and leaving hospital.
4.36	The CN continued that in terms of the action plan, the decision had been taken to focus on admission and discharge and a Task & Finish group had been established (including membership from the Patient Panel, discharge team, PMO, Quality First). This was an area colleagues believed needed some focus, acknowledging none of the results of the survey could be separated from the current operational challenges and was why admission/discharge issues were so visible in the data. The plan would not be delivered quickly and improvements would need to be aligned to the wider business of the organisation and would require the support of the Task & Finish group.
4.37	In response to the above NED-GW highlighted that the survey fieldwork had been completed in November 2022 which seemed a long time ago. The CN agreed but that there had been early indication of the results around September time. The data was based on responses from 441 patients which was a relatively small group but the results did triangulate with other Trust data in terms of complaints/PALS where themes were around access and effective communication.
4.38	ANED-OA asked whether more regular surveys were done around patient experience. The CN confirmed there was now a new platform for the Friends & Family test which would allow the organisation to drill down into data at a more local level.
4.39	The TC summarised by stating that the report had been noted, albeit the results were disappointing. There was more to do but colleagues had clear plans on how to take that work forward.
05 PEOPLE	
5.1 Report from People Committee (PC)	
5.1	NED-DB presented the report and highlighted the following: - Improvement in the vacancy rate to 9.4% but remaining above the target of 8%. - Consideration being given to undertaking exit interviews. - Work was underway to review areas of non-compliance with statutory and mandatory training compliance. The target was to achieve 90% compliance by 31.03.24. - Top themes from the People Pulse Q2 2023-24 results were discussed, some of which were disappointing, noting that the response rate was 0.6%.
5.2	NED-CM asked the organisation was using to undertake the exit interviews. The DoP agreed to find out.
ACTION **TB1.07.12.23/26**	**Provide the name of the party being used for exit interviews.** **Lead: Director of People**
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	NED-CM presented the report highlighting the challenging financial position and recent reforecast, PAF's desire to bring performance, finance and operations together, agreement around the new BAF risk for industrial action, approval of the elective hub full business case, extension of the waste contract and continuation of the work around the community diagnostic centre.
6.2 Finance Update	
6.2	This item was presented by the DoF who informed members there would be a significant change from the M7 to M8 position because of the changes that had come about from the recent national reforecasting exercise. The M7 position evidenced the continuing pressures in terms of temporary/agency staffing and under-delivery on ERF (in line with prior months). The immediate focus now would be on temporary staffing and income coding/capture.
6.3	He reminded members of the previous request to consider a temporary cash advance from the Department of Health and informed members the view was this would not now be required.
6.4	NED-DB flagged the good progress in relation to recurrent PQP savings.

6.5	In terms of capital the DoF highlighted that whilst a large amount was forecast for spend in the final quarter of the year, he was confident schemes would be delivered and the CRL achieved.
6.6	The TC summarised that the M7 position was noted, M8 would look different due to the reforecast, there was assurance around capital spend and there was no longer a need for a temporary cash advance.
6.3 M7 Integrated Performance Report (IPR)	
6.7	This update was introduced by the CIO and the highlights from the new format report were as follows: • **Cancer:** Performance was good with performance against the 2 week wait the best since May 2022. The 28 day faster diagnosis service was working well, with performance the best in the East of England. • **Urgent Care:** Ambulance handovers were now in common cause variation with 13% of handovers in less than 15 minutes. The opening of the new Urgent Treatment Centre (UTC) was having a positive impact with the 'time to be seen' now reduced, and the overall average ED wait time for the non-admitted pathway had come down by 30 minutes and was below four hours. • **Appraisals:** Reduced performance due to new learning/OD platform. • **RTT:** Decrease in patients waiting over 52 weeks linked to significant improvements in theatre productivity.
6.8	In response to a question from NED-GW in relation to KPIs for mental health/learning disabilities and where those were reported, the CIO responded that the full IPR was seen by relevant Board Sub-Committees. With reference to mental health/learning disabilities the full data set would be seen by QSC.
6.9	The MD asked whether it was straightforward to annotate the charts. This might be useful where performance for training/appraisal had dipped but where the reason for this was known (and due to the new learning platform). The CIO responded that could be addressed.
ACTION **TB1.07.12.23/27**	**Charts to be annotated where reasons for reduced performance are known.** **Lead: Chief Information Officer**
6.10	The Chief Operating Officer (COO) then informed members that a Winter Summit would be held on 12.12.23 and would bring together teams from across the organisation and system including from the ambulance service, virtual ward and community to work through plans to support patients through winter.
6.11	In response then to a request from NED-HH, it was agreed the full IPR would be included in Diligent Resources going forward.
ACTION **TB1.07.12.23/28**	**Full IPR to be included in Board Resources area going forward.** **Lead: Chief Information Officer/Board & Committee Secretary**
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee (STC)	
7.1	ANED-LB presented the report highlights included: • **PAHT2030**: 2022 milestones remained 'green' although incomplete. 2023 milestones were 'green' apart from Corporate Transformation which had moved to amber. New Hospital remained 'green' due to internal actions being 'green'. • **Massimo (Continuous Monitoring) Project:** The project had not yet delivered, albeit there had been huge amounts of learning from the work undertaken to date. From the outputs so far it was clear that this technology could keep patients safe and provide rapid treatment. It would be key in terms of moving to the new hospital, where the plan currently was for 100% single rooms. It was agreed it had been very useful to discuss a project where there had not yet been 100% success. • **Healthcare Partnership Development Programme**: There had been a very useful lead by the Place Director for HWEICB. Key to the discussion had been the ambition from 01.04.23 for the four HCPs across the system to have responsibility for financial

	performance and that this would require having key information available for the local population and flexibility in terms of how decisions were made and how finances were used collectively.
7.2 Report from Audit Committee (AC)	
7.2	This update was presented by NED-GW and was a verbal update. Key points to note were: • External Auditors had provided a timeline for the year which would require reconciliation of the new ledger. • The internal audit review of the aseptic unit was presented and closed off. • The number of waivers was down. • A Legal Services report evidenced that claims were down and thereby their associated value.
7.3	The DoP flagged that the audit report around statutory mandatory training, appraisal and recruitment was due to be presented to People Committee.
7.4	The TC thanked NED-GW for his update and also for allowing her to observe the Audit Committee meeting.
7.3 Report from Senior Management Team	
7.5	The report was noted.
08 QUESTIONS FROM THE PUBLIC	
8.1	There were no questions from the public.
09 CLOSING ADMINISTRATION	
9.1 Any Unresolved Issues?	
9.1	There were no unresolved issues.
9.2 Review of Board Charter	
9.2	It was agreed that Board members had adhered to the charter.
9.3 Summary of Actions and Decisions	
9.3	These are noted in the shaded boxes above.
9.4 New Issues/Risks	
9.4	Members noted the approval of the new BAF risk (4.3) relating to Industrial Action.
9.5	NED-GW asked what the proposed changes to immigration rules would mean in terms of the organisation's ability to recruit. The DoP responded this was a watching brief currently which would be overseen by the People Committee.
9.6	In response to the above the DoQI flagged the changes would impact significantly on the workforce in care homes. Integrated working with community colleagues would be key.
9.7	It was noted the above would be monitored by the Healthcare Partnership Board but should also remain a focus for the acute provider.
9.4 Any Other Business (AOB)	
9.8	In response to a question from ANED Anne Wafula-Strike (ANED-AWS), the DoP confirmed the contract for the current Trust website provider was about to expire so provision was likely to change soon.
9.5 Reflections on Meeting	
9.9	Members agreed that it had been a good meeting which had taken into account patients and quality of care.
9.10	The meeting closed at 11:50.

Signed as a correct record of the meeting:	
Date:	01.02.23

The Princess Alexandra Hospital NHS
NHS Trust

Signature:	
Name:	Hattie Llewelyn-Davies
Title:	Trust Chair

ACTION LOG: Trust Board (Public) 01.02.24

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.07.12.23/15	Email Signatures	Recirculate Trust guidance around email signatures.	DoP	TB1.01.02.24	To be actioned by Communications Team.	Proposed for closure
TB1.07.12.23/16	Operational Development Programme	Be part of the Operational Development Programme.	COO / Clinical Education Lead (non-medical)	TB1.01.02.24	Linking in Clinical Education Lead (non-medical) with Head of Performance & Planning who runs the programme.	Closed
TB1.07.12.23/17	Staff Story: Inclusivity	Consider changes to the toilet facilities in the main corridor.	DoS	TB1.01.02.24	Being progressed by the team.	Proposed for closure
TB1.07.12.23/18	Board Development	Board to undertake a development session on Allyship.	TC HoCA	TB1.01.02.24	Session being arranged.	Closed
TB1.07.12.23/19	Blue Badge Parking	Update the Chair of the Patient Panel on blue badge parking at Gibberd Ward.	TC	TB1.01.02.24	Actioned.	Closed
TB1.07.12.23/20	Reporting Cover Sheets	Cover sheets for maternity reports to be complete, particularly the EDI section.	DoM	TB1.01.02.24	Actioned.	Closed

ACTION LOG: Trust Board (Public) 01.02.24

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.07.12.23/21	Supervision Obligations	Provide support with supervision obligations in terms of midwifery students and oversight of current plans.	Clinical Education Lead (non-medical)	TB1.01.02.24	Verbal update to be provided by CN.	Open
TB1.07.12.23/22	Maternity SIs	Two maternity SIs declared in October: Provide an update for December QSCII as to whether harms had been avoidable.	DoM	TB1.01.02.24	No avoidable harms.	Closed
TB1.07.12.23/23	Public Board Agenda	Board agenda to be revised ahead of February meeting.	B&CS	TB1.01.02.24	Actioned.	Closed

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors – 1 February 2024

Agenda item:	2.1								
Presented by:	Hattie Llewelyn-Davies								
Prepared by:	Hattie Llewelyn-Davies								
Date prepared:	24th January 2024								
Subject / title:	Chair's Report								
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**		
Key issues:	To inform the Board about my work; to increase knowledge of the role; to evidence accountability for what I do								
Recommendation:	The Board is asked to note the report.								

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

Previously considered by:	Not applicable
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	As the NED EDI Champion this continues to guide my work in all the areas noted below.
Appendices:	NED Walkabout Matrix

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

1.0 Purpose/issue

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

2.0 Board Recruitment:

I am sad to report that Helen Howe's term as a Non Exec expires on 31 March 2024. We are going to miss Helen in so many ways, her professional skills and knowledge, her commitment to PAHT, her calm and determined way of offering challenge to the Board. Although she is not able to remain on the Board we very much hope that we will not lose touch with her.

We have gone out to advert to recruit a new Non-Executive Director and have had a good response so far. The final interviews will be the week commencing 19th February.

We will need to move some NEDs responsibilities around as a consequence of this change. We will make sure that we report the changes back to the next Board Meeting in Public.

3.0 External Work:

I am pleased to report that the work done by DNDN on training new board members and mentoring them for their first year is going really well. We are beginning to have an impact on the number of NEDs and Executive members with disabilities. We have also just approved our first formal Annual Work Plan. Moving us from being a very informal network to a more mature organisation.

At an ICB level the provider chairs continue to meet each month to enable us to support the Executive teams more effectively in achieving the new ways of work together for the benefit of our local population. The ICB moves to a new operating model over the next few months, which is very important for us in terms of delegations of decision making to local levels.

4.0 Staff Welfare and Resilience:

The NEDs continue to do regular visits to our services, both as individuals and teams. The most recent walkabout was to our kitchens to meet the staff who prepare food for our patients and our staff.

Attached is the action list that has arisen from our regular visits.

The Board is asked to discuss the report, and note it.

Author: Hattie Llewelyn-Davies. Trust Chair.
Date: 26th January 24.

Chair's action matrix. version 3.5

Team: PAHT Chair and non-executive directors service area visits

Updated: January 24

Non-Executive Directors initials:	OA: Oge Austin-Chukwu (Associate)	Others
HLD: Hattie Llewellyn-Davies (Chair) KH: Kim Handel GW: George Wood (senior independent) CM: Colin McCready	HH: Helen Howe DB: Darshana Bawa AWS: Anne Wafula-Strike (associate) LB: Liz Baker (Associate) RG: Rob Gerlis (Associate)	PP: Patient Panel FtSUG: Freedom to Speak Up Guardian

Visit Date	Attendees	Venue	Feedback	Lead	Deadline	Action
17/01/2024	HH & AWS	PAH – catering service	The kitchen facilities are well equipped, up to date, spacious and suitable for both Cook- Fresh and Cook-Chill services. The IT system is good (Symbiotics). Engagement with the EHR team is in place too for future The restaurant lacks appropriate facilities for customers with physical disabilities. This is being addressed in a significant re-	Corporate	Oct 2024	Investment is agreed in new freezers where existing ones in situ are now at the end of their life. There are plans for a significant refresh of the restaurant space (capital approved); and a move to a 7-day hot food offering to staff.

			design for which capital funding has been secured. Staff turnover is a challenge with managers and chefs moving on. A new catering manager and Head Chef have been appointed. Governance via Nutrition Steering Group to QSC			
7 November 2023	HLD	Dementia space	A planned spiritual garden, a dementia sensory garden and a staff garden area, part-funded by NHS Charities Together and part by the charitable funds committee.	Corporate	N/A	No actions were required to follow up.
		Carers support	The first part of the visit had also identified work by carer support charities and the carer experience lead. The development of a carer passport, lanyard, daily drop-in, and webpage were identified as positive progress in the hospital's work to support unpaid carers	Corporate	N/A	No actions were required to follow up.

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board – 1 February 2024

Agenda item:	2.2							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	25 January 2024							
Subject / title:	CEO Update							
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	X
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report updates the Board on key issues since the last public meeting: - Urgent Care pressures - Pay awards, pay reviews and industrial action (IA) - New Hospital Programme update / Community Diagnostic Centre consultation - Alex Health Implementation - Integrated Care Board / Health and Care Partnership							
Recommendation:	The Trust Board is asked to note the CEO report generally and specifically to note: – current urgent care pressures, our responses to them and, the reduction in ambulance handover delays, reducing clinical risk in the community – latest pay awards, pay reviews, ballots, referendums and industrial action positions, and the impact of the latest IA on the Trust's and the system's financial forecast outturns – progress with the development of the new hospital programme and the universally positive responses to our CDC public consultation – progress with the implementation of Alex Health and the key future milestones – key changes and developments across the HWE ICS							
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			

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patient at heart • everyday excellence • creative collaboration

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:	– Regulatory – Board requirement to assure itself of suitable practices and processes in place to minimise the risk to patient safety in relation to urgent care, particularly in light of IA and winter pressures – Regulatory – recognition of our inability this year to meet our regulatory requirement to breakeven financially ---------- – EDI – impact of the previous and future rounds of industrial action on our patients and the potential for a disproportionate impact on some of our patients, particularly those waiting for planned care – EDI – ongoing need to ensure that our recovery plans and our PQP plans are quality and equality impact assessed to prevent any unintended consequences or unequal impact on colleagues or patients – EDI – need to ensure that access to the enhanced diagnostics through the CDC developments and the ability to access the consultation for the proposals are fair and equitable for all – EDI – all the developments to our culture are underpinned by a proactive recognition of the need to ensure and to support EDI for all, in particular with this report in relation to access to and feeling able to openly complete the staff survey and ability to use digital and technological system enhancements (Alex Health for example)
Appendices:	None

Chief Executive's Report
Trust Board: Part I – 1 February 2024

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

(1) Urgent care pressures

Our urgent care performance and flow, as with many other acute providers, is under pressure and strain currently. The demand for our urgent care services, the acuity of attendees at ED and an increase in respiratory illnesses aligned with winter have all increased. In addition, since we last met as a Board we have had 2 further rounds of junior doctor industrial action (20 to 22 December 2023 and 3 to 9 January 2024) increasing the pressure on colleagues and services further.

We continue to work closely with all partner organisation in the West Essex and East and North Hertfordshire places and across the HWE ICS to support our patients safely and effectively; and we continue to see the patient experience and clinical outcome improvements and reduced ED pressures because of our new partnership-run Integrated Urgent Assessment and Treatment Centre (IUATC).

Our clinical colleagues have been working differently for the last 8 weeks to ensure the most effective use of Same Day Emergency Care (SDEC) and virtual ward and community bed capacity; and have changed how we use our discharge lounge, manage reverse boarding on some of our inpatient wards and utilise space within the ED differently to support the timelier handover of patients from the ambulance service. As a result, we have seen enabled a much-reduced wait for ambulance handovers, reducing the clinical risk in the community through the increased ability for ambulances to respond to calls in in a timelier manner. We have also managed the increase in demand and complexity for urgent care and the impact of IA without any additional serious incidents and maintaining our performance against the urgent and emergency care standards.

For the periods of IA, we provided very little planned care, including elective surgery, routine outpatient consultations and routine diagnostic activity. These decisions were made to ensure that we were able to maintain safe and effective care for our urgent and emergency care patients and to support our drive to improve the flow of patients into, through and out of the hospital and to reduce clinical risk in the community, This has put further pressure on the number of patients waiting for planned care and the length of time they are waiting.

The Board is asked to note the current urgent care pressures, our responses to them and, the reduction in ambulance handover delays, reducing clinical risk in the community.

(2) Pay Awards, pay reviews and Industrial Action (IA)

There are a number of ongoing ballots, referendums and pay reviews across the medical and nursing professions.

2.1 Consultants

For consultant medical colleagues, the government increased pay by 6% earlier this year and has reached an agreement with the doctors' unions over a pay award for consultant colleagues which includes an increase in average salary, a reduction in the spine points on the consultant grade and an increase in the value of local CEAs going directly into basic pay. The largest of the doctors' unions, the BMA, undertook a referendum on this offer between 14 December 2023 and 23 January. The results are not yet known and are expected to be reviewed by the BMA consultants committee shortly.

2.2 Specialty and Specialist Doctors

Specialty and Specialist (SAS) doctors have received a pay offer that would see their salaries increase by between 6.1% and 9.22% in addition to an agreement to a number of actions to support their career development, including an increase in the number of specialist roles. The BMA is undertaking a referendum of its members between 29 January and 28 February to accept or reject this.

2.3 Doctors in training / junior doctors

The doctors' unions remain in dispute with the government regarding pay for doctors in training (junior doctors). The current pay offer would see an increase in pay of between 8.1% and 10.3%, depending on where on the pay scales colleagues are. Since we last met as a Board, there have been two additional blocks of IA (20 to 22 December 2023 and 3 to 9 January 2024). There are currently no further planned dates for IA. The BMA are balloting their junior doctor members between 7 February and 20 March to extend their mandate for IA.

2.4 Nursing pay structure review

The Department for Health and Social Care (DHSC) is current reviewing the nursing pay structure to determine whether the Agenda for Change pay structure and scales create barriers to career progression and professional development for nursing colleagues. Views are being sought over a 12-week period, running through to early April. I have attached a link below to the government website for anyone interested in providing their views - Separate pay spine for nursing - GOV.UK (www.gov.uk).

2.5 Financial impact

In November 2023, £800m was transferred to organisations via Integrated Care Boards to help to cover the cost of industrial action to date in 2023/24. This was undertaken with the expectation that there would be no further periods of IA during the financial year. In addition, the proportion of elective activity needing to be undertaken relative to 19/20 levels to achieve additional funding through the Elective Recovery Fund (ERF) was reduced by a number of percentage points.

Our allocation did not cover the full cost of the IA and loss of income as a result, and we factored that in to our financial forecast outturn position. In addition, we committed, along with all other organisations across our system to achieve the 4-hour standard, 65 week waiting standard and cancer access standards for the end of 2023/24 aligned with receipt of the additional funding. The HWE ICS system at that point was projecting a breakeven financial position with significant risk of £7.6m. The additional costs and loss of income from the recent IA has increased the PAHT forecast deficit by £1.5m and the HWE ICS system deficit position by £10.9m.

The Board is asked to note the latest pay awards, pay reviews, ballots, referendums and industrial action positions, and the impact of the latest IA on the Trust's and the system's financial forecast outturns.

(3) New Hospital Programme Update / Community Diagnostic Centre (CDC) consultation

We continue to work closely with the national New Hospital Programme (NHP) and NHSE EoE Regional colleagues to progress our plans for building a new Princess Alexandra Hospital by 2030.

Our plans to purchase the land for the new hospital are ongoing with further negotiations with the landowners, meeting them and their land agents on 15 January. We have had sight of the NHP detailed demand and capacity planning model this week to determine expected activity levels and types of

activity over forthcoming years to help size and scale the new hospital appropriately. This provides with a great opportunity to embed it into our normal planning processes to better plan resource requirements. We are awaiting more specific detail from NHP relating to 'hospital 2.0' (a vision for how hospital builds can be delivered with greater standardisation, efficiency and cost) and a timeline delivery of a new hospital by 2030.

Whilst we continue to develop our plans for a new hospital, we also continue to invest in the infrastructure that we need now and, in the future, to support our population's and patients' needs. One of the currently most pressurised parts of acute care delivery is the demand for diagnostics to support timely clinical decision making. Diagnostic activity is expected to grow more than any other type of acute hospital activity over the next 10-20 years. Consequently, we have been developing plans to open a Community Diagnostic Centre (CDC) at St. Margaret's Hospital in Epping and enhance spoke facilities at Herts and Essex Hospital in Bishop's Stortford. More rapid diagnosis, closer to people's homes, will increase accessibility, improve outcomes, and save lives. We launched a public consultation on our plans with an event on the evening of 10 January at St Margaret's, attended by nearly 50 members of the local community, with universally positive feedback. We are currently expecting to open the CDC at St Margaret's in early 2025, including, CT, MRI, ultrasound, cardiology, respiratory and phlebotomy services. Extended cardiology, ultrasound and plain-film x-ray capacity will be available at Herts and Essex Hospital during 2024.

The new hospital and CDC developments are both fundamental parts of our strategy, PAHT 2030, and our vision of being Modern, Integrated and Outstanding. Together with the implementation of our Electronic Health Record, the digital and cultural transformations across the Trust and the improvements in care and quality improvement initiatives in place, we are making strong progress to achieving our vision.

The Board is asked to note progress with the development of the new hospital programme and the universally positive responses to our CDC public consultation.

(4) Alex Health Implementation

We continue to make strong progress with the implementation of our Alex Health programme, in partnership with Oracle Health colleagues.

Week beginning 29 January 2024, is an important week in the programme, with the expectation that we will hit our key milestone of signing off and approving the future state validation of all our processes. This is essential for us to work with Oracle Health colleagues to build the system we need.

We have several major milestones to achieve over future months including system build, data migration and training of colleagues, but remain on track to go live in October 2024.

The age and poor useability of our current system creates significant inefficiencies and risk for colleagues and doesn't help us manage patient care as effectively as many other organisations with more up to date and modern Electronic Health Record (EHR) solutions. We have been rated as the highest risk nationally in terms of EHR and are one of the least digitally mature acute hospitals in the country. The instance of the Oracle Millenium EHR solution that we are implementing (locally known as Alex Health) will be Healthcare and Information Management Systems Society (HIMMS) Level 6 compliant and will enable us to be one of the most digitally mature hospitals in the country. It will transform how our clinicians work, the information and speed of information available to them, to enable more timely and effective clinical decision making. Our patients will benefit from improved experiences, better clinical outcomes and improved safety as a result.

As I have described previously to Board members, the £30m capital investment in Alex Health is the biggest transformation programme that PAHT has ever seen. It is core to the delivery of vision of being Modern, Integrated and Outstanding and is a fundamental foundation of our digital strategy and the digital health priority that is part of PAHT 2030. A complex programme of change to clinical, non-clinical and technology processes is part of the Alex Health implementation, to support the maximisation of and delivery of full value and efficiency and benefits from the software solution.

The Board is asked to note progress with the implementation of Alex Health and the key future milestones.

(5) Integrated Care Board / Health and Care Partnership

5.1 Hertfordshire and West Essex Integrated Care Board (ICB)

HWE ICB has appointed an additional Non-Executive Director to the Board. Nick Moberly, CEO of the MS Society and formerly CEO at the Royal Surrey Hospital NHS Foundation Trust and King's College Hospital NHS Foundation Trust took up his role in December 2023 and will bring a wealth of NHS experience to the Board.

Much of the recent discussion and action across the ICB has been in relation to the national expected reduction in overheads and the changes to the ways of working and organisational structure as a result. In addition to this, the ICB is continued with the drive towards increased accountability for Health and Care Partnerships (3 geographical and 1 covering mental health, learning disability and autism) from 1 April 2024. A workshop to agree some of the key financial, performance and quality accountabilities as well as the appropriate teams to transfer to the HCPs is scheduled for 2 February.

5.2 West Essex Health and Care Partnership

The priority areas of focus for the West Essex HCP have been discussed and agreed through the professional leaders' group and the West Essex HCP Board. The strong focus of the HCP is ensuring care is provided for patients in the most appropriate setting, with a drive to ensure that the 'out of hospital' models of care are strengthened and developed to support this. The three agreed priorities for the HCP for 2024/25 are:

- Cardiovascular disease
- Frailty and end of life care
- Prevention and out of hospital care

Next steps for the HCP are to turn these priorities in to clear programmes of work for change and transformation and to align the governance and oversight of these with the changes to the governance and accountabilities from the ICB to the HCPs across HWE.

The Board is asked to note the key changes and developments across the HWE ICS.

Author: **Lance McCarthy, Chief Executive**
Date: **25 January 2024**

PAHT 2030 Roundel; outlining our vision. Priorities, objectives and values.

The Princess Alexandra Hospital NHS Trust

3.1

TRUST BOARD - 1 FEBRUARY 2024

Agenda item:	3.1							
Presented by:	Fay Gilder – Medical director							
Prepared by:	Lisa Flack – Compliance and clinical effectiveness manager Sheila O'Sullivan – Associate director of quality governance							
Date prepared:	17 January 2024							
Subject / title:	Corporate Risk Register							
Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper presents data for Trust risks scoring 15 and above for all our services. It is a snapshot of risks across the Trust and was taken from our Datix database 28.12.23. The overall number of risks scoring 15 and above is 44. See section 2, tables 1 and 2. Section 3 provides detail on the risks scoring 20, five risks are identified with one being new, the other with a score increased: The two risks cover - • Quality – clinical effectiveness: associated with the pharmacy automated dispensing system • Statutory / regulatory compliance: associated with the ability to provide hazardous materials decontamination Section 4 provides details of the new risk scoring 16: There is one new risks • Quality – safety: therapy treatment of stroke patients at PAHT There are no new risks identified							
Recommendation	Trust board is asked to • Review and discuss the contents of the corporate risk register							

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

Previously considered by:	Risk Management Group – January 2024 Senior Management Team – January 2024
	Divisions and corporate teams review their risks at their local governance meetings. Teams escalate new risks, closed risks and those that they require assistance with for discussion at Risk Management Group on a monthly basis.
Risk / links with the BAF:	There is a direct link between the risks detailed in this paper and on the BAF

Legislation, regulatory, equality, diversity and dignity	Management of risk is a legal and statutory obligation. This paper has been written with due consideration to equality, diversity and inclusion.
Appendices:	Nil

1.0 Introduction

This paper details risks scoring 15 and above with data extracted from the Datix system on 28.12.23. As risk is managed as a dynamic process across services, this paper will continue to be updated during January.

The Trust Risk Management Group (RMG) meets monthly and reviews risk by exception on rotation according to the annual work plan (AWP).

In accordance with the new Risk Management Strategy and Policy, risk is being assessed and reviewed against category, appetite and risk tolerance levels.

This paper covers risks that have been agreed for placement on the corporate risk register, as well as those operational risks that are completing the process for inclusion onto this register, this includes risks that:

a) have a current score of 15 or more
b) exceed the risk categories appetite tolerance level and cannot be managed locally

In addition to the corporate risk register there is an operational risk register that includes risks that are being managed locally within our corporate and divisional teams.

Both corporate and operational registers now also include trust wide risks. These are risks that have the potential to affect services / teams across the organisation. Their management is led by the relevant subject matter expert with input from affected services / teams.

The discussions at Risk Management Group and Senior Management Team meetings will continue to evolve over the coming months and so the content of future papers may change as we adapt to the new approach.

2.0 Context

The corporate risk register is a snapshot of risks across the Trust at a specific point in time and is made up of risks that have a current score of 15 as well as those risks that breach the risk tolerance levels and are not being managed at a local level.
Consideration is also given to patient safety risks with a consequence of 5.

There are 44 risks scoring 15 and above. RMG is progressing with the review of corporate and divisional risks escalated against the new criteria for inclusion onto the corporate register.

A separate paper is completed and taken to the Senior Management Team meeting monthly to ensure all leaders are sighted to these risks with the request that placement on the corporate register is discussed and agreed. The annual work plan will continue to be reviewed and updated to ensure that it reflects learning from this new way of working.

The breakdown by service for all risks scoring 15 and above is detailed is in table 1

Table 1 - Risks scoring 15 or more	Risk Score				
	15	16	20	25	Totals
Cancer & Clinical Support	3 (1)	4 (5)	1 (0)	0 (0)	**8 (6)**
Estates & Facilities	7 (7)	2 (2)	1 (1)	0 (0)	**10 (10)**
IM&T	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**

Corporate	0 (0)	1 (3)	1 (0)	0 (0)	**2 (3)**
FAWs Child Health	1 (1)	1 (1)	0 (0)	0 (0)	**2 (2)**
FAWs Women's Health	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Medicine	0 (1)	0 (0)	0 (0)	0 (0)	**0 (1)**
Surgery	2 (3)	3 (4)	0 (0)	0 (0)	**5 (7)**
Urgent & Emergency Care	1 (1)	5 (4)	0 (0)	0 (0)	**6 (5)**
Trust wide	2 (1)	6 (5)	2 (2)	0 (0)	**10 (8)**
Totals	**16 (15)**	**23 (25)**	**5 (3)**	**(0)**	**44 (43)**

(The scores from paper presented at RMG/ SMT in November and Trust board in December are detailed in brackets)

The breakdown of risks that exceed the risk category appetite tolerance is in table 2. Divisions and services consider those risks that breach appetite and score less than 15 and submit by exception to the RMG who will consider and where appropriate escalate with a recommendation that SMT give approval for inclusion onto the corporate risk register.

Table 2 – Number of risks by category that exceed appetite tolerance	**Risk Appetite tolerance level**	**Risk Score**					**Totals**
		10	**12**	**15**	**16**	**20**	
Quality – Safety	≥ 10	26 (24)	64 (65)	8 (7)	17 (16)	2 (2)	**117 (114)**
Quality – Patient Experience	≥ 12		11 (10)	3 (2)	0 (0)	0 (0)	**14 (12)**
Quality – Clinical Effectiveness	≥ 12		19 (19)	1 (0)	0 (1)	1 (0)	**21 (20)**
People	≥ 15			0 (1)	5 (6)	(0)	**5 (7)**
Statutory Compliance & Regulation	≥ 12		12 (11)	4 (4)	0 (0)	1(1)	**16 (16)**
Finance	≥ 12		5 (4)	0 (0)	0 (1)	0 (0)	**5 (5)**
Reputation	≥ 15			0 (1)	0 (0)	0 (0)	**0 (1)**
Infrastructure	≥ 15			0 (0)	1 (1)	0 (0)	**0 (1)**
Information and Data	≥ 10	0 (0)	12 (13)	0 (0)	0 (0)	0 (0)	**12 (13)**
Systems and Partnerships	≥ 15			0 (0)	0 (0)	0 (0)	**0 (0)**

2.1 Movement of risks from the Allocate system onto the Datix system

All open risks have been transferred onto the Datix risk register from the Allocate system.

3.0 Summary of risks scoring 20

There are 5 risks with a score of 20. A summary of these risks and actions / mitigations is below, information taken from divisional risks:

3.1 Quality – Safety:

3.1.1 Emergency care access standard

- There is a risk that patients may deteriorate as a result of failing to deliver the ED four-hour standard.
  Risk id 85: this is a Trust wide risk and is on the corporate risk register. This was initially raised 2016.
  Actions / mitigations: Use of the Manchester Triage tool and Nerve Centre to improve clinical information and prioritisation of patients. Improvement

trajectory agreed and oversight by the Urgent Care Board. Implementation and monitoring of CQC improvement plan.

3.1.2 Referral to treatment constitutional standards

- Risk that patients waiting over 52-week for treatment may deteriorate and come to clinical harm. The numbers of patients waiting over 52 weeks has increased significantly during Covid 19 pandemic and there is insufficient capacity to treat them all within the standard.
  Risk id 497: this is a Trust wide risk on the corporate risk register, raised February 2017, score increased since the pandemic.
  Actions / mitigations: Regular meetings to review patient target lists (PTL), with priority for long waits. Cancer PTL reviewed every 24-48hrs. Daily circulation of PTL for escalation and long wait plans. Trajectory to reduce number of patients waiting >52 weeks with oversight by the Elective Care Operational Group and System Access Board.

3.2 Statutory Compliance and regulation:

3.2.1 Estates infrastructure

- There is a risk that a critical infrastructure in the Trust's estate may fail due to understaffing of the department and the need to have a qualified individuals to complete regular testing and maintenance.
  Risk id 560: raised August 2023 this is on the corporate risk register since December 2023.
  Actions / mitigations: The Trust employs contractors to support internal gaps. Full review of current staffing levels taking place and business case in development.

3.2.2 NEW: HAZMAT decontamination capacity and capability

- There is a risk that should a hazardous materials incident occur PAHT will not be able to discharge their duties of decontamination for several people presenting themselves for dry or wet decontamination. That is caused by insufficient equipment, storage space (for equipment) and trained staff.
  Risk id 611: Risk raised in December 2023 and discussed at RMG, it is recommended for inclusion on the corporate risk register.
  Actions / mitigations: Purchase additional equipment for decontamination, undertake a baseline assessment to assess existing equipment, develop a training schedule and ensure this is accessible to staff. There is some equipment in place and staff who are trained to use it.

3.3 Clinical Effectiveness

3.3.1 SCORE INCREASED: Pharmacy automated dispensing system

- There is a risk that the automated dispensing system could be down by over 7 days if it breaks down. This is due to it being used past its estimated shelf life, some spare parts are no longer being manufactured in the UK so may require 7 days to source from Germany. This could lead to significant delays in medicines supply and dispensing.
  Risk id 127: originally raised in December 2013 and on the operational risk register, score was increased as a result of lack of availability for spares and delay arrival of these parts.
  Actions / mitigations: Trust has a system contract in place. Some refurbished parts are available but need to be imported from Germany. Business case completing due process for inclusion on capital plan.

4.0 New risk scoring 16 raised since 24 October 2023

4.1 Quality - Safety:

NEW: There is a risk that patients presenting to PAHT or those that are diagnosed with a stroke whilst an inpatient at PAHT may suffer harm (as the Trust is not a designated Stroke centre). This is due to the increased number of patients presenting to PAHT with strokes, a lack of a commissioned stroke pathway to support the required therapy provision and an insufficient number of specially trained therapists to deliver the appropriate care.

Risk id 566: Clinical support services risk initially approved in November 2023, added to corporate risk register in January 2024.

Actions / mitigations: Develop a neuro therapy list on NerveCentre to identify the stroke inpatients and improve communication between the different therapists involved, develop a neuro therapy MDT to be undertaken weekly. Further actions being assessed.

5.0 No NEW risk with a score of 15 raised since 24 October 2023

6.0 Recommendation

Trust Board are asked to review and discuss the contents of the corporate risk register

Authors: Lisa Flack – Compliance and clinical effectiveness manager
Sheila O'Sullivan – Associate director of quality governance

The Princess Alexandra Hospital NHS Trust

Trust Board – 1 February 2024

3.2

Agenda item:	3.2
Presented by:	Heather Schultz – Head of Corporate Affairs
Prepared by:	Heather Schultz – Head of Corporate Affairs
Subject / title:	Board Assurance Framework 2023/24

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

Key issues:	The Board Assurance Framework (BAF) is presented for review and approval. The risks have been updated with executive leads and reviewed at the relevant committees during January 2024. The risk scores have not changed this month and are summarised in Appendix B. The full BAF is available in the resources section of Diligent.
Recommendation:	The Board is asked to: - Note the BAF and approve the current risk scores.

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

Previously considered by:	STC, QSC, PC and PAF in January 2024.
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance in relation to risk management. The controls and mitigating actions outlined in the risks are designed to support delivery of the Trust's strategic objectives and promote an organisational culture that drives improvements in equality, diversity and inclusion.
Appendices:	Appendix B – BAF dashboard

Board Assurance Framework Summary 2023.24

Risk Ref. Committee	Risk description	Year- end score (Apr 23)	June 23	October 23	Dec 23	Feb 24	April 24		Trend	Target risk score	Executive lead
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide **our patients**, integrating care with our partners and reducing health inequities in our local population										
1.1 QSC	Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience.	16	16	16	16	16			↔	12	CN MD
1.2 STC	EPR: The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	16	16	16	16	16			↔	12	CIO
1.3 PAF	Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.	15	15	15	15	15			↔	10	COO
	Strategic Objective 2: Our People – we will support **our people** to deliver high quality care within a culture that supports engagement, recruitment and retention and results in further improvements in our staff survey results as we strive to be a model for equality, diversity and inclusion										
2.1 PC	GMC enhanced monitoring: There is a risk that the GMC/HEE will remove the Trust's doctors in training. This is caused by concerns regarding the quality of their experience, supervision and training. Removal of the doctors will result in the Trust being unable to deliver all of its services.	20	20	20	20	20			↔	10	MD
2.3 PC	Workforce: Inability to recruit, retain and engage our people	16	16	16	16	16			↔	8	DoP
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of **our places** and will work with our partners to develop an OBC for a new hospital, aligned with the development of our local Health and Care Partnership										
3.1 PAF	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20	20	20			↔	8	DoS
3.2 STC	System pressures: Capacity and capability to deliver long term financial and clinical sustainability at PAHT due to pressures in the wider health and social care system	16	16	16	16	16			↔	12	DoS
3.5 STC	New hospital: There is a risk that the new hospital will not be delivered to time and within the available capital funding.	20	20	20	20	20			↔	9	DoS
	Strategic Objective 4: Our Performance - we will meet and achieve **our performance** targets, covering national and local operational, quality and workforce indicators										
4.1 PAF	Seasonal pressures: Risk that the Trust will be unable to sustain and deliver safe, high quality care during seasonal periods due to the increased demand on its services.	12	12	12	12	12			↔	12	COO
4.2 PAF	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	20	20	20	20	20			↔	12	COO
4.3 PAF/	There is a risk that the ongoing Industrial Action creates deteriorated operational performance in both elective & urgent care. Industrial Action reduces the capacity of operational teams to deliver business as				20* NEW RISK	20			↔	8	COO/MD/CN

Board Assurance Framework Summary 2023.24

(QSC for patient harms)	usual and operational improvements in order to provide patients with effective & efficient services and deliver financial balance. This results in less operational performance improvement and deteriorating performance recovery.										
	Strategic Objective 5: Our Pounds – we will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way										
5.1 PAF	Finance - revenue : Risk that the Trust will fail to meet the financial plan due to the following factors: An annual plan has been set to deliver a deficit plan of £5.1m inclusive of a CIP requirement of c. £16.7m in 2023/24. The plan of £5.1m deficit was originally one of £12m deficit but was improved only following the agreement by the ICS to identify opportunities to improve the deficit through service reconfiguration and following £1.9m of non-recurrent funding allocated to the Trust in 2023/24. Inflation remains high, productivity remains a challenge and there is risk around income from the part move to a PbR basis. Cash will be a challenge in year with the potential deficit driving the Trust towards an adverse cash position.	12	12	16	16	16			↔	8	DoF

BOARD OF DIRECTORS:	**Trust Board (Public) – 1 February 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies**			
DATE OF COMMITTEE MEETING:	**26 January 2024**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Ophthalmology Deep Dive	Y	Y	N	The Committee felt assured that improvements to the service were being made. It was agreed there was more work to do in terms of further improving pathways to meet the service demand, communicating with patients and it was also agreed to provide an update in the two months' time on the SI cluster.
2.2 Infection Prevention & Control (IPCC) Update	Y	Y	N	The following key highlights were noted: • Clostridium difficile (C-diff) numbers had decreased over the last month. • COVID numbers nationally were going down but the Trust was still seeing a small number of outbreaks. • 'Flu numbers were also decreasing. The Trust had seen a few incidences but with minimal impact on the organisation/patients. • There had been a couple of significant outbreaks of norovirus in the Trust over recent weeks. • Measles was now a national concern and the focus was on staff vaccinations and FFP3 compliance with a particular focus on area of risk such paediatrics and the emergency department.
2.3 Care of the Dying Annual Report / Report from Strategic (22/23)	Y	Y	N	**Care of the Dying Annual Report:** QSC noted the many achievements but acknowledged the work still required in terms of the requirement for earlier referrals into the service.

BOARD OF DIRECTORS:	**Trust Board (Public) – 1 February 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies**			
DATE OF COMMITTEE MEETING:	**26 January 2024**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Learning from Deaths Group				ICB funding for the post of Discharge Facilitator had been very much welcomed and some work would now take place to understand access to the service from an EDI perspective. **Report from Strategic Learning from Deaths Group**: The key point to note was that Telstra had reported an error in the Trust's data submission to HES which had meant that they were unable to report on the mortality indices that month. The Information Team was working with Telstra to understand the cause and remedy the problem. As assurance Telstra had been able to analyse the data independently and could confirm the Trust's indices were as expected.
2.4 Report from Clinical Effectiveness Group	Y	Y	N	The key headline was that an update on audit and NICE had been discussed. Divisions had all confirmed they were working on updating the progress against all items and monitoring this robustly through local divisional patient safety and quality meetings. An action plan for 2024/5 would be developed by March 2024.
2.5 Report from Quality Compliance	Y	Y	N	There was no change that month in terms of the position in relation to red-rated items. The work would now broaden out in a move away from just the CQC must/should items to

BOARD OF DIRECTORS:	**Trust Board (Public) – 1 February 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies**			
DATE OF COMMITTEE MEETING:	**26 January 2024**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Improvement Group (QCIG)				include patient experience/regulator visits. An external peer review of items which had moved from green to blue would take place in the next couple of weeks.
2.6 Patient Safety & Quality Update	Y	Y	N	The key headlines in-month were noted and it was agreed, at a future point, to update QSC on the review underway regarding coronial processes.
2.7 Nutrition Strategy Quarterly Update	Y	Y	N	Progress was being made in terms of the revised structure to support the organisation's Nutrition Strategy in terms of the establishment of the three feeder groups. The committee noted that the kitchen had reverted back to cook chill for an interim period pending further recruitment to the catering team.
2.8 Report from Patient Safety Group	Y	Y	N	Key points to note were: **Patient Safety Strategic Priorities**: An update against the five priorities (falls prevention, VTE, diabetes, pressure ulcers and medicines optimisation) was noted, and that implementation plans were in place for each priority, setting out the actions to be completed, clear targets/performance indicators and an accountable owner. **Six Monthly Review of Work around Pressure Ulcers and Falls:** Overall pressure ulcer and falls rates per 1000

BOARD OF DIRECTORS:	**Trust Board (Public) – 1 February 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies**			
DATE OF COMMITTEE MEETING:	**26 January 2024**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				bed days had reduced in the reporting period. Alongside the ward accreditation process, pressure ulcers and falls prevention had clinical strategies in place which provided a framework to support driving improvements.
2.9 Report from Vulnerable People Group	Y	Y	N	The group had now agreed to include neurodiversity under its umbrella and the plan for Oliver McGowan training was progressing. Whilst QSC's concerns remained around compliance with safeguarding training, assurance was provided that this was being tracked via the People Committee.
2.10 PAHT2030 Change Strategy	Y	Y	N	The Strategy was endorsed for Board approval in April, after endorsement by the Strategic Transformation Committee in March.
2.11 BAF Risk 1.1 (Clinical Outcomes)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16. Following a previous request by QSC to consider the target risk score, June 2025 was proposed, six months post go-live of the new electronic health record. It was noted that a separate risk for EHR was being developed.

BOARD OF DIRECTORS:	**Trust Board (Public) – 1 February 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies**			
DATE OF COMMITTEE MEETING:	**26 January 2024**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.1 M9 Integrated Performance Report (IPR)	Y	Y	Y	Key points to note were issues in terms of the data capture around compliments due to vulnerabilities within that team, there would be a deep dive into MOH (massive obstetric haemorrhage at the Patient Safety Group and there was work to understand the rise in pressure ulcers over the last 2 months which may be linked to changes in process and how those were recorded.
3.2 Report Against Operating Plan	Y	Y	N	Key headlines were: • Industrial action in December had impacted the activity volumes for elective care and consequently elective backlogs rose at the end of the month. • Faster Diagnosis standard had been met for third month in a row and in mid-December the cancer backlog was at the March 2024 required standard. This had deteriorated at month end due to industrial action and holiday reduced capacity. • There had been improvements in ambulance handovers as a result of tight controls and improvements to increase bed capacity and flow. • Cancer harm review process was well established with three harms identified since April 2023. Long-waiting elective harm reviews were progressing with no harms identified to date.

BOARD OF DIRECTORS:	**Trust Board (Public) – 1 February 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies**			
DATE OF COMMITTEE MEETING:	**26 January 2024**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.1 Horizon Scanning Update	Y	Y	N	The paper updated on the impact of Junior Doctors' industrial action on quality and Phase 1 of the Fuller Enquiry.
4.2 Organ Donation Annual Report	Y	Y	N	It was noted that the organisation had missed no opportunities to ask for consent for organ donation and of seven opportunities, two cases had progressed to multi-organ donation.

BOARD OF DIRECTORS:	**Trust Board (Public)**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Rob Gerlis – Committee Chair**			
DATE OF COMMITTEE MEETING:	**26 January 2024**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Maternity Incentive Scheme (MIS)	Y	Y	N	Under delegated authority from the Board, the committee declared non-compliance against Safety Action 8 and therefore non-compliance against the MIS for Year 5. The maternity team is currently working towards improving compliance with Safety Action 8, but will not fully meet a 90% recovery plan as per requirements. The committee was assured that there were no safety concerns associated with not achieving Safety Action 8. The Board will receive an update on the financial impact of non-compliance.
2.2 Medical Workforce Review	Y	Y	N	The update was noted. Tools such as job planning, demand and capacity work, current clinical guidance and gap analysis will be used to inform medical establishment. The work will be included in the sustainability plan and updates presented to the committee.
2.3 Maternity Safety Support Programme Exit and Sustainability Plan	Y	Y	N	The Committee reviewed and endorsed the Sustainability Programme and readiness to exit the NHS England Maternity Safety Support Programme. The regional team will undertake a detailed review of the sustainability plan to review readiness. The paper will be presented to Board on 1 February 2024.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 February 2024

4.2

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery
Prepared by:	Erin Walters, Head of Maternity Governance and Assurance
Date prepared:	2 January 2024
Subject / title:	Overview of Serious Incidents within maternity services
Purpose:	
Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards. There have been 0 new maternity incidents declared since the last report for December 2023. There have been no maternity incidents closed since the last report (December 2023). Maternity services currently have 6 SI's under investigation (0 HSIB).
Recommendation:	To provide assurance to the Board that the maternity service are continually monitoring compliance and learning from Serious Incidents.

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

Previously considered by:	Patient Safety Group: Jan 24 – details of open incidents included in the PSG papers.
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the Ockenden Interim Report that was published in December 2020 with recommendations for maternity services. To also monitor outcomes of those in black and brown ethnicities (known to have poorer outcomes), and vulnerable groups. **Mothers and Babies: Reducing Risk through Audits and Confidential Enquires** MBRRACE Report (October 2023)
Appendices:	NA

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

This paper outlines the open and recently closed Serious Incidents within Maternity services with concerns, themes, areas of good practice and shared learning identified.

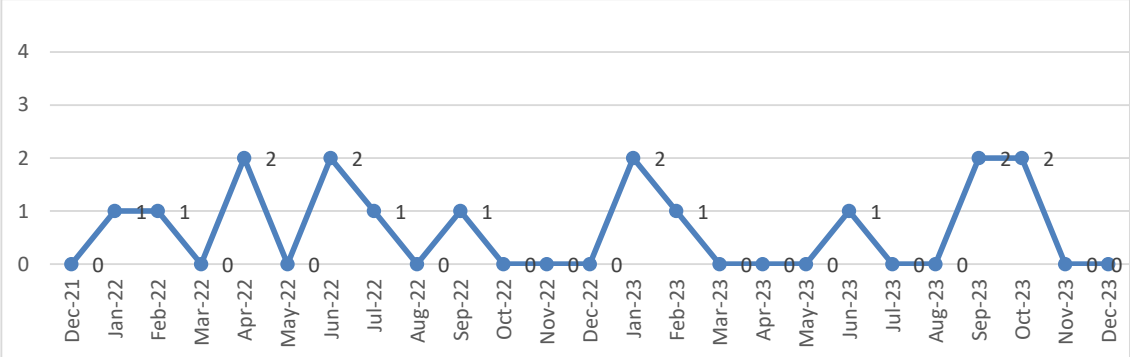
2.0 Background

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

3.0 Analysis

Maternity currently have 6 SI's under investigation, none of which are being investigated by Maternity and Neonatal Safety Investigations (MNSI) formally Healthcare Safety Investigation Branch (HSIB), the detail can be found in Appendix 1. Table 1 details the trend of declared SI's within the last 24 months to December 2023.

Table 1. Comparison of SI's reported for Maternity in last 24 months (to December 2023)



There were 0 new Maternity serious incident declared in December 2023

Table 2. Serious Incidents declared, submitted and closed for December 2023

4.0 Themes

Serious Investigations			
Number Declared for December 2023			0
Number Submitted for December 2023			0
Number Past CCG Deadline as of August 2023 (Not including HSIB/Approved Extensions)			1
New Serious Investigations declared in December 2023			
Ref	Ethnicity	Summary	Learning Points
Serious Investigations closed in December 2023			

Table 3 details the top themes identified in maternity SI's within the last 24 months to November 2023

Table 3. Top Themes

Total Number of SI's	Theme	Number
16	Neonatal death	5
	Hypoxic ischaemic encephalopathy	3
	Obstetric Haemorrhage	2
	Cross Border Working	2
	Delay in care	2
	Intrauterine death	2
	Cardiotocograph (CTG) interpretation	2
	Retained Object	2
	Escalation	2
	Medical Equipment	2
	Screening Incident	1
	Therapeutic Cooling	1

5.0 Oversight

All incidents are initially reviewed weekdays by an MDT of senior clinicians. Any that require further information/ investigation are escalated to the twice weekly Trust Incident Management Group (IMG) chaired by the Director of Clinical Quality Governance. This where management of the incident is decided i.e. SI declared. This is currently in a transition period with the implementation of the Patient Safety Incident Response Framework (PSIRF).

Further management and investigation is undertaken by the division. It is then approved and noted at Divisional Governance Board, then Patient Safety Group, then Quality and Safety Committee. Final oversight once complete is via Patient Safety Incident Assurance Panel, Trust Board, then the Local Maternity and Neonatal System.

Currently, the division is undertaking a review of the governance pathways and reporting structures to strengthen and develop the existing system so that it aligns further with local and national governance objectives.

Further assurance is achieved though triangulation of outcomes from investigations; this includes those from complaints and legal cases. The quality improvement agenda continues and is monitored via the Maternity Improvement Board and all the workstreams are tracked via the PM3 project management tool.

6.0 Recommendation

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

The Princess Alexandra Hospital NHS Trust

Author: Erin Walters, Head of Maternity Governance and Assurance
Date: 02nd January 2024

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 February 2024

Agenda item:	4.2								
Presented by:	Linda Machakaire – Director of Midwifery								
Prepared by:	Elita Mazzocchi – Maternity Transformation Programme Manager Linda Machakaire – Director of Midwifery								
Date prepared:	19th January 2024								
Subject / title:	Maternity Incentive Scheme year 5 progress update								
Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**	**X**	
Key issues:	The Quality and Safety Committee and the Trust Board have been appraised of the progress the Maternity Incentive Scheme Year 5 regarding the ten Safety Actions. A process to review all available evidence to declare compliance was performed on 8 January 2024 with the Chief Executive Officer for the Princess Alexandra Hospital NHS Trust (PAHT) present, as was the Chief Nurse, Director for Quality, the Integrated Care Board including the Chief Nurse, and Local Maternity and Neonatal System colleagues. This paper gives the final position of compliance to the safety actions. Compliance is declared on nine safety actions with the exception being Safety Action 8, where non-compliance is declared. Not all the staffing groups will meet 90% compliance by the 12 weeks post monitoring period. The outstanding group is the trainees where the rotating group of GP Trainees non-compliance has affected the overall compliance in that group, and is not recoverable.								
Recommendation:	The Quality and Safety Committee declared non-compliance against Safety Action 8 and therefore non-compliance against the maternity incentive Year 5 on behalf of the Board.								
Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**				
	X	X	X	X	X				

Previously considered by:	Divisional Board, December 2023 Quality and Safety Committee 26.01.24
Risk / links with the BAF:	Strategic Objectives: our Patients, Performance, Pounds

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme Year 5
Appendices:	1. Appendix 1-Summary of open actions

1.0 Purpose

This paper outlines the current compliance of PAHT maternity service with MIS year 5, and provides an overview of the actions that requires to be undertaken in order to achieve full compliance with the Scheme.

The full MIS guidance is available here: https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

2.0 Background

NHS Resolution is operating the fifth year of MIS, to continue promoting safer maternity care. The MIS applies to all acute trusts providing maternity services and belonging to the CNST. As in previous years, members contribute an additional 10% of the CNST maternity premium to the scheme, forming the CNST maternity incentive fund. The scheme encourages adherence to ten maternity safety actions as outlined in previous iterations.

Trusts demonstrating fulfilment of all ten safety actions will recover the portion of their contribution related to the CNST maternity incentive fund and may receive a share of unallocated funds. Trusts failing to meet the ten-out-of-ten threshold will not recover their contribution but could be eligible for a smaller discretionary payment from the scheme to aid progress on unmet actions.

To qualify for payment under the scheme, Trusts must submit their completed Board declaration by 1st February 2024, and adhere to several conditions, including achieving all ten maternity safety actions, including Trust Board and ICB evidence sign off.

3.0 Progress update

A review of the evidence for the 10 safety actions has been carried out in January 2024. The review team included the Trust's CEO, LMNS Programme Managers, Director of Midwifery, Divisional Director, Associate Director of Ops, ICB Accountable Officers, Trust's Governance Lead and local maternity team members.

Upon review of the evidence, the group signed off as compliant 9 of the 10 safety actions – please see table below.

Table 1. Current progress with safety actions

Safety action	Current position, Nov 2023	Lead responsible
1. PMRT	Compliant	Director of Midwifery (DOM)
2. MSDS	Compliant	Maternity Digital lead midwife
3.Transitional Care & ATAIN	Compliant	DOM Head of Nursing (HON)
4. Medical Workforce	Compliant	Divisional Director (DD)
5. Midwifery staffing	Compliant	DOM
6. SBL	Compliant	Divisional Director, DOM, Clinical Director
7. MVP	Compliant	Integrated Care Board DOM
8. Training	Non-Compliant* (see below)	Divisional Director, Clinical Director, Associate Director of Operations
9. Safety Champions	Compliant	Deputy DOM
10. MNSI/ HSIB/ EN	Compliant	Head of Maternity Governance and Assurance

*Non-Compliance with Safety Action 8, training

As of 19 January 2024, all staffing groups meet compliance with training required at 90% except:

- Obstetric Consultants – 80%
- Obstetric trainees – 73%
- Anaesthetic Consultants – 84%

Compliance of 90% can be reached to for the outstanding consultant groups by the end of the February 2024 (extended period), but not for the trainees. This is because the rotational doctors (mainly GP trainees) have left maternity and cannot be recalled. Going forward, there is a commitment and collaborative working between the operational and education teams to prevent this situation from recurring. As the GP trainees are included in the obstetric rota, it is mandatory that they attend the training.

Action plan

The maternity team are currently working towards compliance with Safety Action 8, as outlined above, but will not fully meet a 90% recovery plan as per requirements.

The Princess Alexandra Hospital NHS Trust

4.0 Recommendation

On behalf of the board, the committee is recommended to declare non-compliance against Safety Action 8 and therefore non-compliance against the maternity incentive year 5

Authors:
Elita Mazzocchi, Maternity Transformation Programme Manager;
Linda Machakaire Director of Midwifery
Date: 19/01/2024

The Princess Alexandra Hospital NHS Trust

Appendix 1-Summary of open actions

Actions	RAG	Lead	Completion date	Update
Safety action 3				
1. TC guideline in line with MIS requirements, to include babies 34+0 weeks and above is ratified and published on the intranet		Head of Nursing/ Divisional Director /Director of Midwifery	31/10/2023	Completed Jan 2024
2. TC action plan to be ratified and sign off by the Trust Board, LMNS and ICB		Head of Nursing/ Divisional Director /Director of Midwifery	31/10/2023	Complete
3. Progress with action plan shared with Trust Board, LMNS and ICB		Head of Nursing/ Divisional Director /Director of Midwifery	30/11/2023	Complete
Safety action 4				
4. Undertake a 6 months audit that demonstrate compliance with criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023		GM, Service Manager	31/10/2023	Complete
5. Implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance or develop an action to this effect		Clinical Director	31/10/2023	Completed
6. Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance or an action plan to be written and signed off by Board		Associate Director of Operations / Divisional Director	31/10/2023	Complete

7. Compensatory SOP to be developed		Divisional Director	30/11/2023	Complete
8. Action plan to be shared with the Trust Board, Trust Board level safety champions and LMNS meetings		Divisional Director	31/10/2023	Complete
9. Undertake an audit to review compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person		Clinical Director	31/10/2023	Complete
10. The episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance		Clinical Director	If required	N/A
11. Trust position with points 4,5,6,7, 8 to be shared with Trust Board, Board level safety champions and LMNS		Divisional Director	31/10/2023 and monthly	Complete
12. Demonstrate compliance with the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes or develop an action plan to address deficiencies		Divisional Director	31/10/2023	Complete
13. The neonatal medical workforce action plan to be shared with ODN and LMNS		Divisional Director	30/11/2023	Complete
14. Neonatal nursing action plan to be updated and shared with ODN and LMNS		Divisional Director	30/11/2023	Shared with ODN and LMNS
Safety action 5				
15. Evidence midwifery staffing budget reflects establishment to include ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide		Director of Midwifery	07/10/2023	Complete and included in staffing paper

evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.				
16. Submit staffing report to the Board every 6 months		Director of Midwifery	07/10/2023	Complete
17. Continue to monitor compliance with red flags		DOM/ HOM	Monthly	Ongoing
Safety action 6				
18. Quarterly quality improvement discussions to be held with the ICB, using the new national implementation tool		Head of Governance and Assurance	31/10/2023 and monthly	Complete
19. Audit to be undertaken to assess compliance with all elements		Head of Governance and Assurance/ Divisional Director	31/10/2023	Complete

20. Ability to implement diabetes elements, including access to a maternity dietician		Divisional Director	31/10/2023	50% compliance achieved
Safety action 7				
21. ICB to provide evidence that evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support		Director of Midwifery	31/10/2023	Complete
22. ICB to provide evidence that MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way		Director of Midwifery	31/10/2023	Complete
Safety action 8				
23. Doctors to attend training to enable 90% with NLS, SBL, fetal monitoring PROMPT and obstetric emergencies		Divisional Director / Obstetric anaesthetic lead	30/01/2024 and monthly	
24. Weekly monitoring of compliance with training		CL/LM/ Divisional Director	31/10/2023 and monthly	Complete
Safety action 9				
25. NED role to be reallocated and activities to be re established		Chief Nurse	01/10/2023	
26. Score card to be resubmitted to board		Head of Governance and Assurance	31/10/2023	Complete and submitted in Nov 23
27. X2 quarterly meetings to be set up with QUAD and safety champions		Head of Midwifery	30/11/2023	Complete
28. Evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented		Head of Midwifery	31/10/2023	As above
29. Safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework to be reflected in the minutes of LMNS/ICS/Local & Regional Learning System meetings?		Head of Midwifery	31/10/2023	Complete

End.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 February 2024

4.2

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery & Gynaecology
Prepared by:	Linda Machakaire – Director of Midwifery & Gynaecology Erin Walters – Head of Maternity Governance and Assurance
Date prepared:	14 December 2023 v1; 15 January 2024 v2; 19 January 2024 v3
Subject / title:	Maternity Safety Support Programme Exit and Sustainability Plan

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

Key issues:	The Princess Alexandra Hospital NHS Trust (PAHT) entered the NHS England Maternity Safety Support Programme (MSSP) in 2020 following the Care Quality Commission (CQC) inspection of PAHT maternity services in 2019 and 2021. The key thematic areas raised were maternity staffing, medical culture, maternity triage and governance. This report provides a review of improvements made, our sustainability of improvement, and our readiness to exit the programme. The Sustainability Plan will be monitored via the Quality and Safety Committee (QSC) with progress and assurance provided to the Trust board via exception reporting. QSC considered this paper and endorsed the recommendation to exit the programme pending confirmation from the Regional Maternity Team of the detailed evidence base within the action plan. QSC will confirm its endorsement at their next meeting in February, for consideration by the Board in March 24.
Recommendation:	The Board are asked to note the improvements to the service, our sustainability plan and the plan to request endorsement to support request to exit the MSSP.

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

Previously considered by:	QSC Part 2 – November 2023 (draft outline) QSC Part 2 – January 2024 – MSSP exit and sustainability plan.
Risk / links with the BAF:	Strategic Objectives: our Patients, People, Performance, Pounds

Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme Year 5, NHS Resolution 2023 Saving Babies Lives Care Bundle v3, NHS England 2023 Maternity Self-Assessment Tool, NHS England 2022 60 Supportive Steps to Safety, NHS Regional 2022 Equity and Equality: Guidance for Local Maternity Systems NHS England 2021
Appendices:	1. Appendix 1: Background to MSSP. 2. Appendices 2a and 1b: CQC Key issues RAG and progress 3. Appendix 3: Maternity Structure December 2023 4. Appendix 4: QSC Minutes December 2023 5. Appendix 5: 'This and That' Communication

1.0 Executive summary.

This paper seeks endorsement from committee to support the application of our maternity service to exit the Maternity Safety Support Programme (MSSP). PAHT entered the MSSP in 2020 in line with the programme entry criteria of a drop from Outstanding CQC rating to Requires Improvement (background to MSSP criteria can be found in **Appendix.1**), As a member of the MSSP, a Maternity Improvement Advisor (MIA), allocated by NHSE, has been working with the service.

The key thematic areas identified for improvement on entry to the programme were:

- Maternity Triage (section 2.2)
- Maternity Workforce (section 2.3)
- Medical Culture (section 2.4)
- Governance (section 2.5)

Additionally, the service has focused on ensuring a solid foundation for improvement through strengthening the leadership structure to drive improvement across all the domains with an additional focus on the safe, effective, and well led domains.

The request to endorse exit from the programme has been delayed following a change in the senior leadership post holders over the last year and the opportunity to consolidate and consider our improvement with fresh eyes. This is included in further detail under section 2.1.

Additionally, broader service improvement and sustainability is included in further detailed under sections 2.6 and 2.7.

The CQC inspections in 2019 and 2021 also identified ‘must dos’ and ‘should dos’ progress against which is outlined in **Appendix 2a & 2b.**

Oversight of progress of the improvement programme has been though:

- Local governance within the service including the maternity improvement board, service presence of the board maternity safety champions and discussion at divisional board.
- Establishment of maternity QSC, with reporting and membership of the MIA.

Criteria for exit from MSSP has changed since joining the programme. Changes in 2022 meant the introduction of exit criteria identified via a diagnostic phase with the Trust, the MIA, the Integrated Care Board (ICB), the Local Maternity and Neonatal System (LMNS), and East of England Chief Midwife and regional team. External recognition from the bodies, groups, individuals listed above regarding the significant improvements attained enables the Trust to seek exit from the programme. The sustainability plan proposed will need the approval of the Trust Board (initiated via the Quality and Safety Committee), the LMNS, ICB, and regional team.

This document outlines the progress against the MSSP improvement priorities for consideration of the committee for endorsement to request exit from the programme.

2.0 Assessment of key improvement priorities.

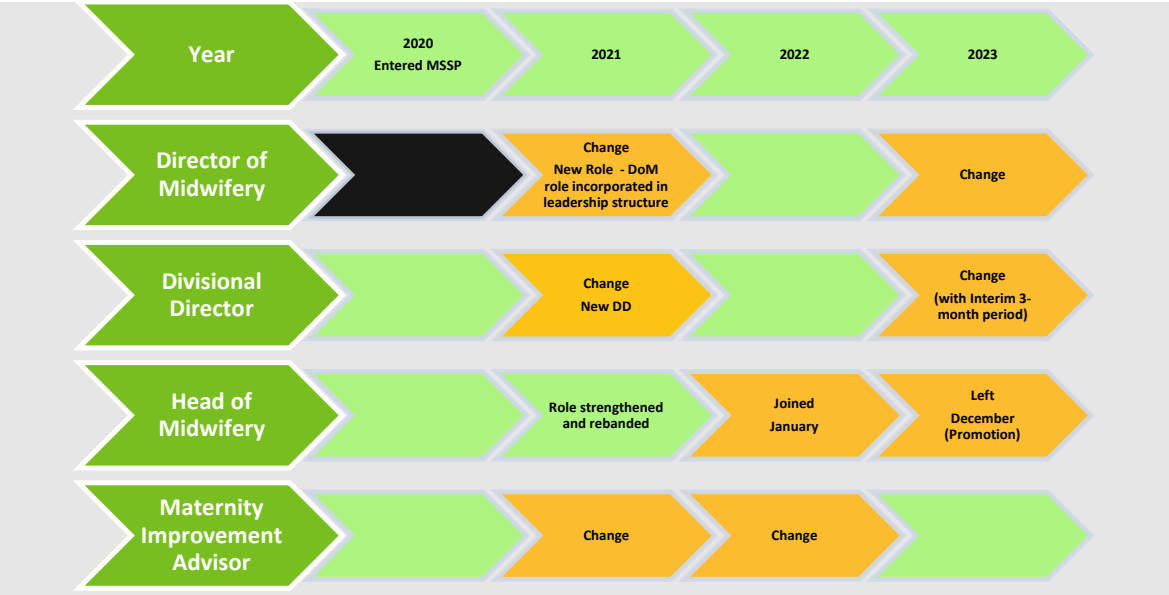
This section will provide a detailed update to the improvement domains:

2.1 Strengthening Leadership and governance.

Since entering the MSSP, the maternity service of the Princess Alexandra Hospital has sought to strengthen the leadership of the service and additionally has undergone significant leadership changes that are summarised below on **Figure 1**.

In 2021, a director of midwifery role was introduced into the leadership structure and the head of midwifery role was strengthened. Additionally, the last three years have seen changes to post holders within the senior leadership which offers continuity risks and challenge alongside opportunities that refreshed leadership offers.

Figure 1: Leadership changes at PAHT



The significance of the above is that whilst progress plans have actions and can be assessed to denote improvements, embedding and sustaining these is reliant on leadership that is consistent so as to follow through on its vision, mission and strategy. This can be difficult to achieve if there are significant changes in personnel/ post-holders, as seen over 2022 onwards. Additionally, all the middle-senior management are new in post over the last 18 months; all four Band 8As (matrons) and hospital-based Band 7s (Ward Leads), **Appendix 3.**

Therefore, when the initial proposal and plan to exit the MSSP was due to be presented to the QSC in July 2023, it was decided collectively by the regional East Of England Chief Midwife, MIA, and new senior leadership at PAHT to postpone it so as to allow the new Divisional Director (DD) and Director of Midwifery (DOM) to appreciate the state of progress and be part of formulating a sustainability plan.

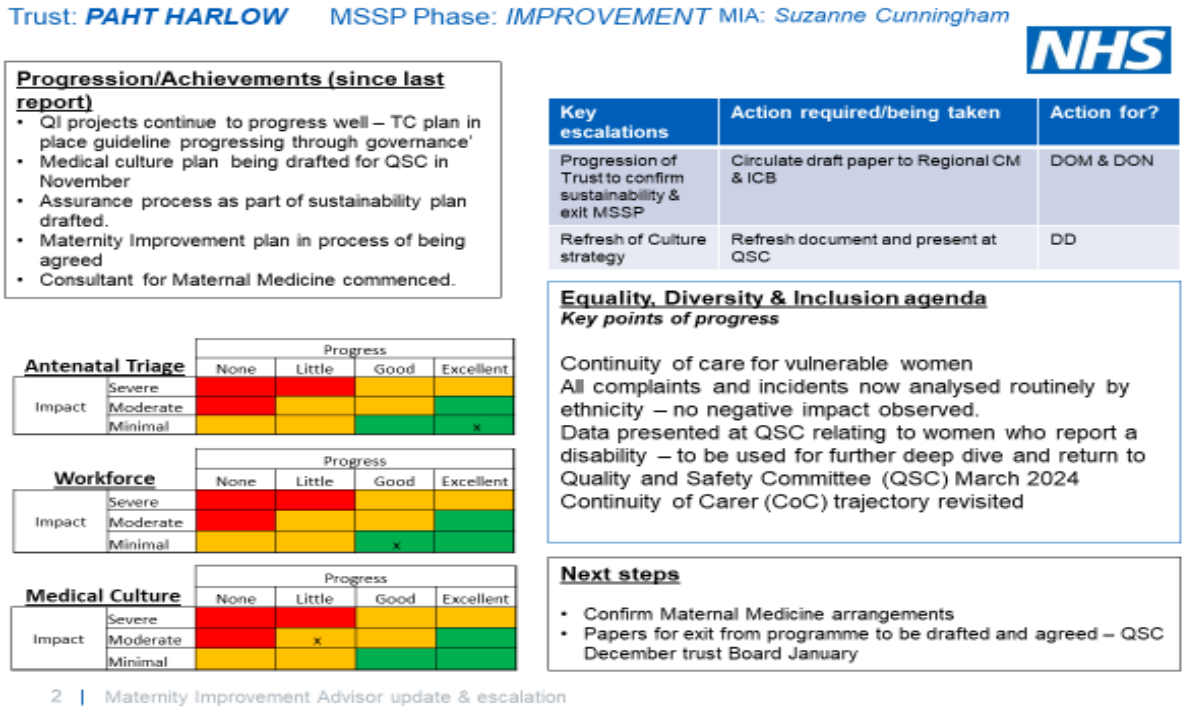
Progress of the CQC action plan, the Maternity and Neonatal three-year delivery plan, and all projects within it is monitored and reported monthly through the PAHT Quality and Safety Committee (QSC). QSC is a Board sub-committee and is chaired by a non-executive director on behalf of the Board. It has membership that comprises of internal and external stakeholders and includes:

- The Maternity Improvement Advisor (MIA)
- Senior Leadership in maternity, DD, DOM, Head of Midwifery (HOM), Maternity Transformation Programme Manager (MT-PM), Associate Director of Operations

- Trust Board representation including executive and non - executive directors. The executive members include the chief nurse, medical director, chief operating officer, and the director of quality improvement.
- Maternity and Neonatal Safety Champions – which includes the executive director of people
- The Director of Clinical Quality Governance
- The Maternity Voices Partnership Chair
- Regional Team including Chief Midwifery Officer and Deputy, and Maternity Quality Lead
- Key partners from the ICB

QSC provides a monthly highlight report to the Trust Boarding Meeting held after each QSC. The MIA provides a monthly report demonstrating progress of the three main issues and an example is given in **Figure 2**:

Figure 2: PAHT Improvement



Trust: PAHT HARLOW MSSP Phase: IMPROVEMENT MIA: Suzanne Cunningham

NHS

Progression/Achievements (since last report)

- QI projects continue to progress well – TC plan in place guideline progressing through governance'
- Medical culture plan being drafted for QSC in November
- Assurance process as part of sustainability plan drafted.
- Maternity Improvement plan in process of being agreed
- Consultant for Maternal Medicine commenced.

Key escalations	Action required/being taken	Action for?
Progression of Trust to confirm sustainability & exit MSSP	Circulate draft paper to Regional CM & ICB	DOM & DON
Refresh of Culture strategy	Refresh document and present at QSC	DD

Antenatal Triage

Impact	Progress: None	Little	Good	Excellent
Severe				
Moderate				
Minimal				x

Workforce

Impact	Progress: None	Little	Good	Excellent
Severe				
Moderate				
Minimal			x	

Medical Culture

Impact	Progress: None	Little	Good	Excellent
Severe				
Moderate		x		
Minimal				

Equality, Diversity & Inclusion agenda

Key points of progress

Continuity of care for vulnerable women
All complaints and incidents now analysed routinely by ethnicity – no negative impact observed.
Data presented at QSC relating to women who report a disability – to be used for further deep dive and return to Quality and Safety Committee (QSC) March 2024
Continuity of Carer (CoC) trajectory revisited

Next steps

- Confirm Maternal Medicine arrangements
- Papers for exit from programme to be drafted and agreed – QSC December trust Board January

2 | Maternity Improvement Advisor update & escalation

2.2 Maternity Triage

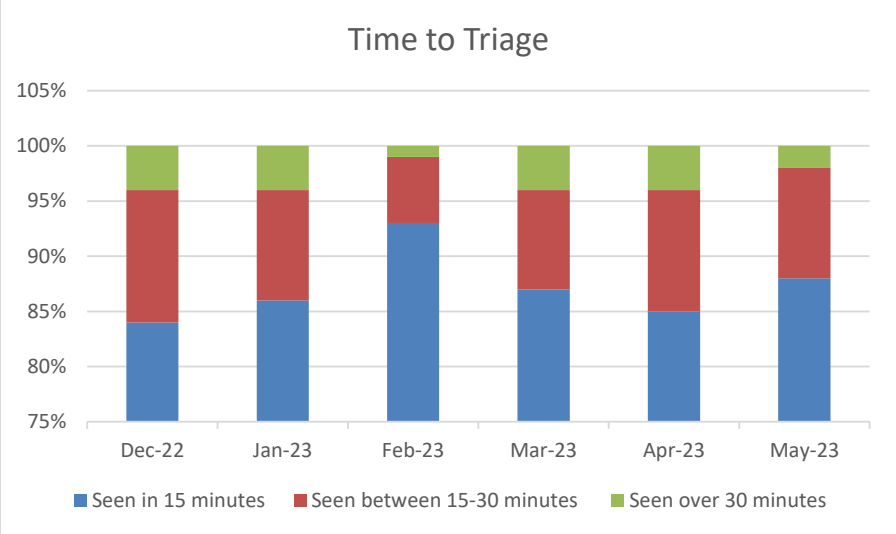
The Maternity Triage celebrated its one-year anniversary on 22 November 2023, having implemented the Birmingham Symptom Specific Obstetric Triage System (BSOTS) the year before. Service users from 22 weeks of pregnancy and up to 14 days postnatal are seen within Maternity Triage by experienced midwives and obstetricians who are led by an equally experienced Team Leader in the new location aligned to the maternity unit. Evaluation of the first year has been highly positive as demonstrated by the MIA report.

Midwifery staffing shortages in this area are mitigated by redeploying experienced midwives from other areas as autonomy and experience are very important in this busy part of maternity. Learning from incidents and complaints is communicated directly back to the team via the Matron and to the rest of the unit via safety messages, newsletters, and email. The service

compliance with BSOTS standards are monitored through monthly audits and as part of the annual audit programme. This is reported to Divisional Governance and Divisional Board.

An audit in June 2023 assessed compliance in some BSOTS key performance indicators KPIs. Time taken to triage shown below in **Figure 3**.

Figure 3: Triage times over 6 months



Recommendations from this audit included:

- Changing the processes for checking results and reviewing post change regularly
- Getting patient feedback and enlisting help of Maternity Voices Partnership to do so
- Quality Improvement project for Telephone Triaging

The performance in Maternity Triage will be monitored via Labour Ward Forum and Divisional Governance.

2.3 Midwifery and Support Staff

The funded establishment for maternity for both midwives and support workers was determined on completion of a Birth Rate Plus (BR+) review in November 2021 with a subsequent workforce review paper taken to the Trust Board by the DOM in February 2022, to which the Board agreed to the proposals made. The posts, with an initial pay value of £1,049,180 that the business case sought, are shown below in **Tables 2 and 3**.

Table 2: Additional roles to meet midwife: birth ratio of 1:23

Band 5 Registered Nurses	**0.19 WTE**
Band 6 Registered Midwives	5.90 WTE recurrent until FY 2024/2025
Band 4 Nursery Nurses	1.78 WTE (in training until FY 2024/25)

Band 3 Maternity Support Workers	3.99 WTE (in training until FY 2024/25)

Table 3: Additional managerial and specialist roles sought

Band 8c Consultant Midwife	**1.00 WTE**
Band 8a Intrapartum and Complex Care Matron	1.00 WTE
Band 7 Preceptor Support Midwife	1.00 WTE (Funded until December 2022)
Band 7 Diabetic Midwife	0.60 WTE
Band 7 Fetal Medicine Midwife	1.00 WTE (Funded until September 2022)
Band 7 Perinatal Mental Health Midwife	1.00 WTE (Funded until May 2022)
Band 4 Governance and Education Administrator	1.00 WTE
Band 2 Maternity Care Assistants	4.28 WTE

It has taken some time to reach the funded establishment agreed in 2022. As of end of December 2023, there are 7.70wte (4.8% of funded establishment) midwifery vacancies overall, but 15.36WTE amongst the support workers (23.7% of funded establishment). The recruitment and retention plan for the latter group include a collaborative effort with nursing counterparts, a programme to support transition from Band 2 to 3, facilitating volunteers within maternity (as some then wish to work there), and rolling adverts.

For midwifery, recruitment is from the following avenues:

- 3-year midwifery course
- Shortened (24 months) for post registration staff
- International educated midwives
- Retire and return; legacy roles
- Return-to-practice

Also, under consideration are midwifery apprenticeships for existing support staff.

PAHT ensure there is a safe staffing ratio in place to support women in a variety of ways. As already mentioned, the funded established in based on the last BR+ review, with another due in November 2024. There is robust rota management led by the two staffing co-ordinators in close collaboration with the ward leads and matrons, with ultimate responsibility and accountability with the Director of Midwifery and Deputy/ Head of Midwifery to ensure they fulfil the required staffing numbers and include a safe skill-mix to ensure staff are well supported, and the safety of our women. Rosters are released 8 weeks in advance so that there is forward-planning for identified staffing shortages. Subsequently, the maternity service conducts a regular review and planning of staffing a few weeks ahead. This is supported by the escalation policy which is aligned to the Operational Pressures Escalations Levels (OPEL). Framework. Gaps are addressed via our temporary staffing team, and senior management (out of hours) with redeployment of staff where possible. Daily, staffing is monitored and any potential red flags highlighted in advance.

Safety huddles are held to discuss any potential challenges in maternity and neonatal services. Monthly staffing reports are reported via the maternity Quality Safety Committee (QSC). These include a discussion on red flags and mitigation around these, vacancies, Bank and Agency usage, staff in the pipeline, and recruitment plans. Supernumerary status of the co-ordinator

is noted on these reports, as is 1:1 care in labour. The compliance on these is usually 100% and has met the requirements for the Maternity Incentive Scheme in Years 1 through to 5. As mentioned previously, the membership of QSC includes a significant proportion of the Trust Board, executive and non-executive members. Minutes from the December 2023 QSC meeting are embedded below. These are yet to be agreed. An exception report then goes to the Trust Board meeting.

QSCMinutesDEC2023docx Appendix 4

The Trust has recruited a lead Professional Midwifery Advocate who has a focus on retention and wellbeing with several initiatives in place including multidisciplinary recruitment to support a richness of experience and skill sets. The midwifery PMA service recently drew up "contracts" (that were imported from the nursing PNA service) for line-managers to roster 7.5 hours per month for the PMAs in their wards/ areas so that they have protected time to carry out their PMA role.

There are currently 13 PMAs giving a ration of 1:19. There are 2 more midwives who have training places. In addition, a recent call-out from NHS England notified maternity units that there are 49 PMA training places still available nationally and some midwives from PAHT have submitted an expression of interest (EOI).

2.4 Medical Culture

The Divisional Director (DD) presented a culture paper to QSC in November 2023 outlining the progress made in this area since the previous submission a year ago. As mentioned previously, the sustainability of some workstreams is highly dependent on having consistent leadership to initiate change and improvements, embed them, and then maintain these. The workstream on culture was commenced and presented in December 2022 by the then Divisional Director who subsequently left in April 2023, with the new DD starting in June 2023. The interim period was covered by the Associate Medical Director. Thus, the new leadership is presented with an opportunity to review the current position, understand progress and slippage, ensure SMART actions and accountability are defined and fed through the Divisional Board and QSC. The resulting all encompassing (i.e. *whole* workforce) Culture Strategy will be monitored via the (MSSP) Sustainability Plan and QSC.

2.4.1 Unit Culture

To ensure that culture work in inclusive of all the maternity workforce as it, the role of Freedom to Speak Up Guardians (FTSUG) and Ambassadors had been highlighted to staff as have efforts to create psychologically safe spaces to speak up and raise concerns. Additionally, the Professional Midwife Advocacy role (inclusive of student midwives and medical staff who wish to use the service) has been raised via the departments, division and Trust. This is reinforced in various forums and when opportunities present themselves e.g. the Lucy Letby verdict. Communication was sent by the Chief Executive Officer (CEO) about various ways to speak up, and the DOM sent the embedded message to staff:

TNT for Week beginning 28 AUG 23 Appendix 5

FTSUG Workshops facilitated by the Lead FTSUG for the Trust, were held with staff face-to-face, and via an anonymous survey for those who missed the in-person sessions. The themes, and suggestions from staff on how to overcome some issues raised, will form the basis for workstreams that staff can participate in to be a part of creating a safer and happier work environment. Feedback from the sessions is due to staff imminently. A quadrumvirate comprising of the Director of Midwifery, Divisional Director, Associate Director of Operations and Neonatal Matron is due to receive the MatNeo Collaborative culture survey results (SCORE Survey) in January 2024 and the improvement work from that will be included in the Culture Strategy.

2.5 Governance

Governance was identified as a must do area of improvement for maternity services following the 2019/ 2021 CQC reports.

Figure 4: Governance Structure 2019-2021

A formal review of governance processes and structure was undertaken following admission to the MSSP. This involved a review of the current workforce within the division/ service and to align with the rest of the Trust.

The review involved the creation of a new post (Governance Lead Band 8a) to oversee governance for the division, this went out to advert in December 2020 and was appointed to in January 2021.

This role allowed for better oversight and as an escalation point for the service level leads (Band 7s). The role also involved a closer working relationship with the other Divisional Leads and the Director of Clinical Quality and Governance for information sharing and learning.

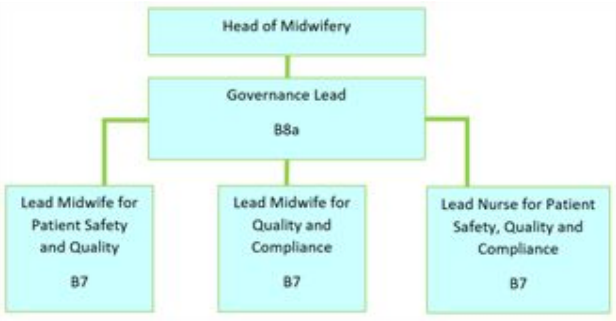


Figure 5: Governance Structure (Jan 2021)

Following the appointment of a Director of Midwifery in 2021 a further review was undertaken looking at the meeting structures and with the information obtained from the CQC, the Ockenden Interim Report, and Maternity Self-Assessment Tool.

To strengthen the governance processes more so, a further restructure was undertaken to include training as part of this, including fetal monitoring. This was to ensure that learning from incidents and patient safety events could be bought directly into training. This also allowed for reviews of the current training programme to ensure it met the needs of national requirements such as Maternity Incentive Scheme, Saving Babies Lives Care Bundle and the Core Competency Framework. A new role was created for preceptor support to encourage retention and well-being of Newly Qualified Midwives but to also ensure their transition was smooth and provided additional clinical support as an adjunctive for improving safety within the unit.

Reporting structures were also reviewed to ensure that all meetings within the service had Terms of Reference and Minutes that reported into the Divisional Governance Group or Divisional board for oversight and assurance. This also ensured that there were no blurred boundaries in terms of the escalation process. This also led to the development and introduction of the Maternity Improvement Board where key workstreams were driven and reported/escalated as appropriate.

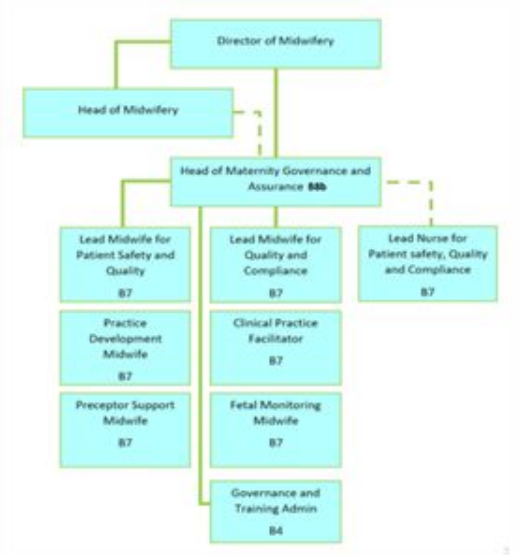


Figure 6: Current Governance Structure

All the asks of the CQC were completed with regards to Governance following the 2019/2021 reviews. With the changes in appointments to the roles of Director of Midwifery and Divisional Director, the Triumvirate and Head of Maternity Governance and Assurance have been reviewing the current system to identify where there could be strengthening and building of reporting structures/roles to evolve this further. A current review is underway to refresh current pathways and ensure that reporting mechanisms are fit for purpose with the ever-changing national picture in terms of maternity and neonatal working. This will be bought through the Quality and Safety Committee once complete.

2.6 Other Service Improvements

2.6.1 Maternity Transformation

A senior maternity transformation role was added to the maternity structure in September 2022. This role has been pivotal in assuring compliance in national and regional targets and local with supporting the Maternity Improvement Board and the workstreams within that. Other services improvements since 2020 that have been implemented include the following:

- Physiology based guidelines for intrapartum fetal monitoring
- Computerised antenatal CTG
- Centralised CTG monitoring on Labour Ward
- MDT study day for fetal monitoring with a competency assessment for all staff
- Daily MDT safety huddles on labour ward with representation from wards, Birth Centre
- Minimum twice per day consultant led ward round using structured proformas for the ward round documentation
- Local Safety Standards for Invasive Procedures (LocSSIPs) on Labour Ward
- Obstetric Anal Sphincter Injury (OASI) care bundle
- e-consent for maternity
- Electronic request /electronic diary for Caesarean section bookings

Maternity Improvement Board

The MIB was formulated in 2022 and included in its terms of reference were 2 parts; Part 1 for workstreams, and Part 2 for compliance. The nine workstreams included Maternity Triage and Telephone Helpline, Induction of Labour were formulated. The workstreams are led by staff with different skills and roles which adds some diversity of thinking and contribution. Current improvement work is reported and tracked on the project management portal PM3.This is monitored via the QSC, the MVP meetings, and via Trust Board on monthly basis. Current workstreams include diabetes in pregnancy, antenatal clinic capacity, caesarean section booking pathway, culture, and pre-term birth.

The completed workstreams are monitored and audited as part of the annual audit programme and governance oversight. This includes maternity triage, the safety huddle, and centralised fetal monitoring. Quality improvement methodology training has been incorporated in the annual maternity mandatory training for multi-disciplinary staff.

2.6.2 Maternal Medicine Network

A Maternal Medicine Obstetric Consultant has been appointed and will be working towards implementation of approved and formal pathways that will ensure that women with comorbidities receive the right care in the right place (be it their local unit, tertiary unit, or between the two) from the right person, at the right time. The Maternal Medicine Obstetric Consultant has commenced by ensuring maternity staff know about their appointment, role, and the clinics have been started, that staff are aware of how to refer to his clinic and whom to refer, and that an awareness and profile of MMNs is raised. As part of their introduction, a webinar was held for staff by the MMN consultant and DOM where the latest Mothers and

Babies: Reducing Risk through Audits and Confidential Enquires MBRRACE Report (October 2023) key findings were also discussed and disseminated to staff. The negative impact of inequalities in healthcare and access were also discussed, the role of the regional Maternal Medicine Centres, our local one being Cambridge, and how to strengthen local pathways e.g. diabetes in pregnancy. This action remains open with a trajectory of completion of 2024/25. The Maternal Medicine Consultant is reviewing the current guidance and updating it.

2.6.3 Complaints, user involvement, and feedback

The local Maternity Voices Partnership (MVP) is West Essex and there is a very active and passionate chair in post who is a former service user of maternity services at PAHT. The MVP has its own website and a continually active social media presence. This ensures equality and to hear voices of those least heard from, 'listening events' are held to support the gathering of feedback from black and brown women and people, and those from the most economically deprived communities.

The MVP chair attends the monthly Divisional Governance meeting and QSC, and offers input into PAHT training content. Users offer their invaluable support in recruitment events and they walk the patch and give the maternity service direct feedback.

To ensure feedback is captured in a timely manner, the service has a QR code available for all service users to share their experience in all areas. Some changes have been as a result of user feedback for example, 24/7 presence for one support person, and family time (14.00 - 17.00) on the maternity wards. Also, the service is looking at introduce an objective pain-scale to assess pain on the maternity unit as a result of feedback from a service user.

PAHT holds a weekday Patient Advice and Liaison Service (PALS), incidents, and complaints meeting daily to address immediate learning and take prompt actions from feedback. The Senior Midwifery Team also attend Trust facilitated complaints training. Following the CQC Maternity Survey and subsequent action plan, the Trust has achieved and overall improvement in responses.

Maternity involves service users in various aspects of the maternity service. Examples are below:

- Parents are encouraged to direct questions to an investigation team as a way of ensuring participation in investigation for incidents and Perinatal Mortality Reviews for example, and to seek their input and experience.
- 15 Steps led by the MVP chair is often with some recent service users speaking to pregnant women/ people and mothers on the ward, asking of their experiences and feedback
- Co-production with information; a lot of content on the padlet (e.g. the tour of the maternity unit is collaborative work between service users and maternity staff

Quality Improvement Initiatives are also undertaken with our service users, based on their feedback. Some examples have been given above. The recent improvements to the décor and provisions of the bereavement Star Room are another example. There is ongoing collaborative work between the Emergency Department (ED) and gynaecology to improve the experience of women/ people in early pregnancy who attend the ED.

The service will assess current compliance and implement needed changes to align with the recently publicised Maternity and neonatal voices partnership MNVP Guidance (November, 2023).

2.6.5 Equity and Equality Agenda

The Herts and West Essex Local Maternity and Neonatal System has 3 provider Trusts one of which is PAHT. The Equity and Equality baseline assessments conducted in 2021/ 22 led to an action plan whose key priorities included:

- Implementing the COVID-19 four actions (to better increase access to care for black and brown women)
- Personalised care
- Better ethnicity data collection
- Co-production; Actions for perinatal illness and loss; support for neonatal and maternity staff
- Leadership and accountability

This collaborative work with the region is ongoing. Locally, PAHT'S Consultant Midwife has commenced work on implementing the Nursing and Midwifery Council (NMC) Anti-Racism resource framework. The Consultant Midwife has engagement from staff across maternity and also the Trust Equality Diversity and Inclusion (EDI) Lead. The maternity is also looking to implement the Fivexmore 6-steps to empower black women, and the 5-steps to ensure staff enable staff to actively listen and remove communication barriers.

2.7 Sustainability Plan and monitoring

This overarching plan and monitoring spreadsheet have been developed by the Midwife Governance Lead for Maternity and Gynaecology. It brings together the national and local initiatives, drivers, and improvement plans and will enable tracking of PAHT's progress against all of these, including the maternity and neonatal 3-year delivery plan and will include any subsequent reports. It also importantly tracks progress of local initiatives and workstreams. Detailed monitoring will be via the Divisional Board, assurance via the Quality and Safety Committee, with a summary sent to the Trust Board. External scrutiny will be provided LMNS, ICB, and the regional maternity team. The cover page (with contents) is captured in **Figure 3.**

Figure 3. Sustainability Plan Cover Page

Child Health and Women's Services — 22 January 2024

ACTION PLAN	ASSIGNED TO	DATE REVIEWED	STATUS	% COMPLETE	NOTES	STATUS
Maternity Self Assessment	HoM/G	06.12.2023	In Progress	98%	Update strategy, learning culture, second safety huddle,	Not Started
Ockenden Pt 2	DoM/DD	06.12.2023	In Progress	85%	outstanding acitons include; maternal medicine, staffing uplift, HDU provision, IOL delays.	In Progress
3 year plan	DoM/DD	12.12.2023	In Progress	72%	related to PCCP, workforce, guidelines,	Complete
East Kent	DoM/DD	12.12.2023	In Progress	68%	Dashboards and data, listening to women and teams and PSIRF	Embedded
CQC Must and Shoulds 2019	HoM/G	06.12.2023	In Progress	95%	BLS MT trajectory	On Hold
MIS 5	DoM/DD	12.12.2023	In Progress	90%	reported separately to QSC	N/A
SBLCB v3	DoM/DD	12.12.2023	In Progress	80%	reported separately to QSC	
60 steps	DoM/DD	06.12.2022	In Progress	61%	MIS, RCOG workforce, digital maturity, MDAU service, maternal medicine, HDU service, TC, PN ward rounds, community bases.	
CQC maternity survey	DoM/DD	12.12.2023	In Progress	44%	action plan in place with MVP, improvements made.	
GMC 2022	DD	TBC	In Progress	TBC		
MBRRACE Maternal Deaths 2022	DoM/DD	22.01.2024	In Progress	60%		
MBRRACE Perinatal Deaths 2022	DoM/DD	06.12.2023	In Progress	82%		
Staff Survey 2023	DoM/DD	TBC	In Progress	TBC	Awaiting data release	
Core Competency Framework	HoM/G	22.01.2024	In Progress	78%	Action plan approved by QSC Nov 2023	
Equity and Equality Guidance for LMNS	DoM/DD	22.01.2024	In Progress	13%	All other actions on track for completion within timeframes	

Summary:

This paper provides a detailed overview of the progress and transformation that has been made with our maternity services at PAHT since entering the MSSP, providing detailed information on improvements and on-going workstreams which demonstrate readiness to exit the programme. It concludes with the sustainability plan and the governance arrangements regarding this.

5.0 Recommendation

It is requested that the committee accepts the information provided, and endorse the Princess Alexandra's NHS Hospital Trust maternity's exit from the Maternity Safety Support Programme.

Appendix 1: Background to MSSP.

Background

The Secretary of State for Health and Social Care commissioned the MSSP in 2018. The CQC's inspection of PAHT maternity services between March and April 2019 rated the service as 'Requires Improvement', and the service entered the MSSP on 16 June 2020. Following a further CQC unannounced inspection in July 2021 (where the Caring and Responsive domains were not inspected) and after all additional evidence was reviewed, the CQC did not revise its findings on publication of the report in November 2021, **Table 1**.

Table 1. CQC ratings for PAHT

Year	Safe	Effective	Caring	Responsive	Well-Led	Overall
2019	RI	RI	G	G	RI	RI
2021	RI	RI	G (2019)	G (2019)	RI	RI

Key

Inadequate (I)	Requires Improvement (RI)	Good (G)	Outstanding (O)

The NHS England Maternity Safety Support Programme (MSSP)

The overall objective of the MSSP is to deliver targeted support to maternity units that have been rated Inadequate by the CQC or have dropped a rating to Requires Improvement and is a safety support initiative led by NHS England (NHSE). The CQC supports this through the provision of intelligence to identify priorities for improvement and assurance that required changes have been made. NHSE then provide a programme of support that is designed to be flexible and adaptive to meet the individual needs of the Trust's improvement journey.

Criteria for entry to the MSSP are maternity services which have:

- An overall rating of inadequate
- An overall rating of requires improvement with an inadequate rating for either Safe and Well-Led or a third domain
- Been issued with a CQC warning notice
- Dropped their rating from a previously outstanding or good rating to requires improvement in the Safety or Well Led domains

- Department of Health and Social Care (DHSC) or NHSE request for a review of services or inquiry

- Been identified to CQC with concerns by the Maternity and Newborn Safety Investigation (MNSI) programme (previously Healthcare Safety Investigation Branch, HSIB).

A Maternity Improvement Advisor (MIA) was allocated to PAHT to work with the executive and divisional leaders to support the delivery outcomes identified in the CQC report.

Historically, the criteria for leaving the programme is a CQC reassessment and improvement in the rating by at least one in the safe and well-led domains. Changes in 2022 meant the introduction of exit criteria identified via a diagnostic phase with the Trust, the MIA, the Integrated Care Board (ICB), the Local Maternity and Neonatal System (LMNS), and East of England Chief Midwife and regional team. External recognition from the bodies, groups, individuals listed above regarding the significant improvements attained enables the Trust to seek exit from the programme. The sustainability plan proposed will need the approval of the Trust (initiated via the Quality and Safety Committee), the LMNS, ICB, and regional team.

The Princess Alexandra Hospital NHS Trust

Appendix 2a: Musts and Shoulds - 2019

M14	The service **must** ensure staff accurately complete women's care records with all necessary assessments required to safely monitor mothers and their babies.	Embedded
		Embedded
M15	The service **must** ensure staff complete fetal growth charts at each appointment.	Embedded
M16	The service **must** ensure staff complete and annotate cardiotocograph traces in line with national guidance	Embedded
M17	The service **must** ensure policy and guidance documents are reviewed in a timely way and reflect current working practices to enable staff to be able to give women the most up to date information	Embedded
M18	The service **must** ensure staff are compliant with basic life support training meets the trust's compliance target of 90%.	In progress
M19	The service **must** ensure medicines and hazardous substances are stored securely.	Embedded
M20	The service **must** ensure all incidents are reviewed in a timely way to promote learning and service improvement	Embedded
M21	The service **must** ensure risk registers accurate reflect the risks identified, are updated in a timely way and risks are closed appropriately once all actions are completed	Embedded
M22	The service **must** ensure that staff complete mandatory training to meet the trust's compliance target	Embedded
S6	The service **should** ensure there is an arrangement in place for a dirty utility in the antenatal clinic.	On Hold
S7	The trust **should** ensure staff circulating in theatres wear personal protective equipment in line with national guidance to prevent health care associated infections.	On Hold
S8	The trust **should** ensure reusable equipment is cleaned appropriately after its use.	Complete
S9	The trust **should** ensure that electrical equipment is up-to-date with safety testing.	Complete
S10	The trust **should** ensure senior midwives and consultants participate in skill simulation training.	Embedded
S11	The trust **should** ensure maternity services have access to designated maternity physiotherapy practitioners	Embedded
S12	The trust **should** ensure improved sustainability and transformation partnership working in maternity services	Embedded
S13	The trust **should** ensure managers use effective change management processes to facilitate required improvements in a timely way.	Embedded
S14	The trust **should** ensure detailed minutes of meetings are recorded to accurately reflect discussions, actions and responsibilities.	Embedded

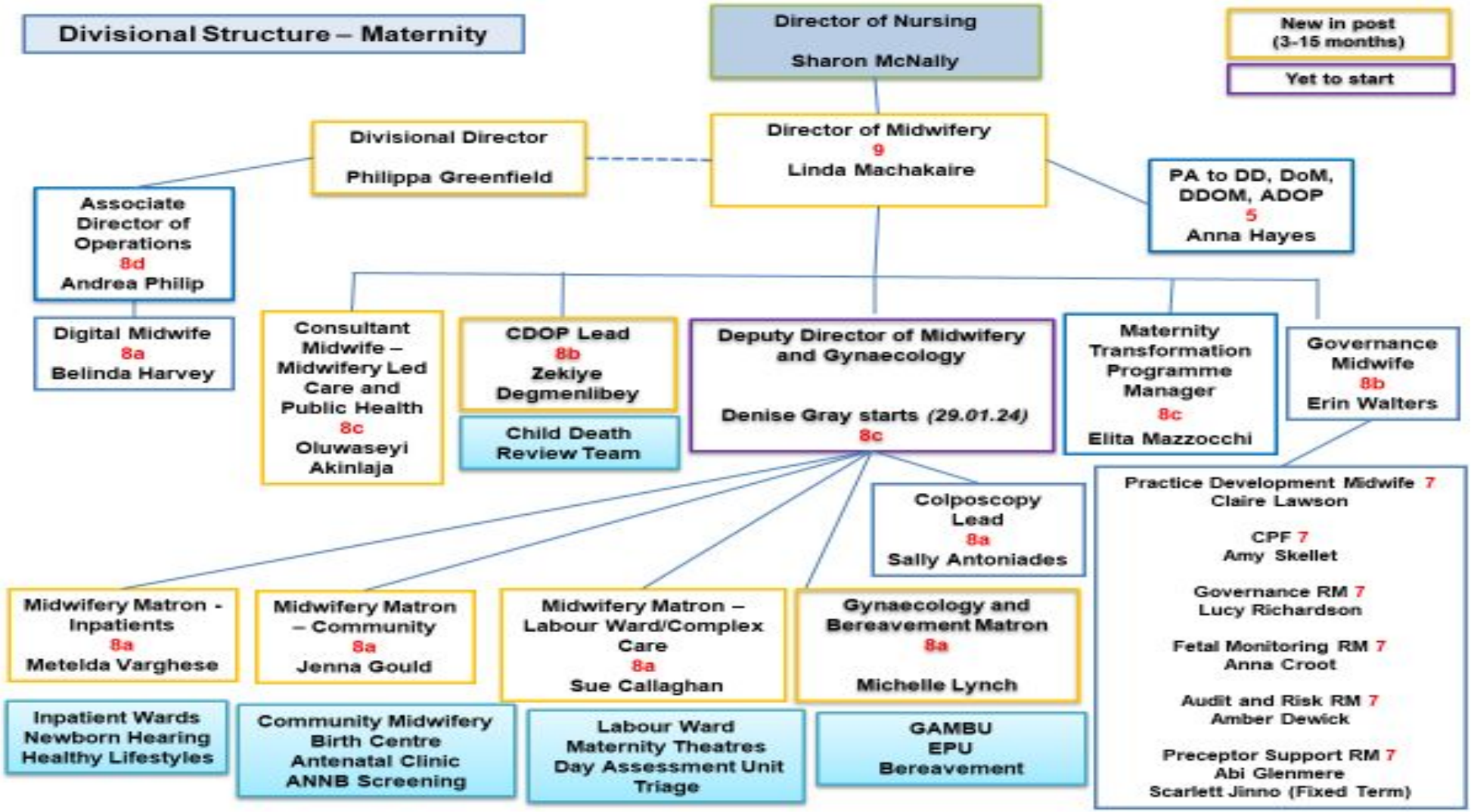
The 2019 report was published on 31 July 2019. An immediate review was undertaken for all must and should dos. There is currently 1 action outstanding with two actions on hold.
Basic Life Support (BLS) training has been included as part of the mandatory midwifery training week since March 2023. The progress was delayed with this action due to the Covid-19 pandemic and the suspension of face to face training and assessments. Compliance has been transferred to a new system which at this moment has limited access therefore to continue with monitoring the action has been kept open.

Both the Antenatal Clinic and Theatre action were assessed and put **on hold**. Antenatal Clinic use single use equipment and due to the current infrastructure, there was no vicinity in which a dirty utility could be placed. Due to the usage of single use equipment, clinical waste bins in all rooms, and following discussions with Infection Prevention and Control a decision was made that a sluice room was not necessary.

Appendix 2b: Must and Shoulds 2021

Action No	Recommendations / Action	Progress
S29N	The service should ensure that safety champion roles and responsibilities are clear to maternity staff and they are involved in the process.	Embedded
S30N	The service should ensure they are infection prevention control compliant.	Complete
S31N	The service should ensure staff have access to the right equipment at the right time at important points in a woman's treatment.	Complete
S32N	The service should consider internal security access between labour and post natal wards	Embedded
M22N	The service must ensure that medical staff complete mandatory and safeguarding training and ensure compliance with the trust target.	Complete
M38N	The service must implement an effective governance system and ensure systems to manage risk and quality performance are effective.	Complete
M39N	The service must ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit.	Complete
M40N	The service must ensure a robust, embedded and audited maternity triage system with appropriate guidance and training to help keep women and babies safe.	Embedded

Appendix 3: Maternity Structure



The Princess Alexandra Hospital NHS Trust

4.2

THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST

Minutes of the Virtual Meeting of Quality & Safety Committee Part II
Held on Friday 22 December 2023 @ 12:00-13:00

Present:

Members

Hattie Llewelyn-Davies	**Acting Committee Chair/Trust Chair (ACC)**
Helen Howe	Non-Executive Director (NED-HH)
Kim Handel	Non-Executive Director (NED-KH)
Oge Austin-Chukwu	Associate Non-Executive Director (ANED-OA)
Sharon McNally	Chief Nurse (CN)
Stephanie Lawton	Chief Operating Officer (COO)
Ogechi Emeadi	Director of People/Maternity Safety Champion (DoP)
Fay Gilder	Medical Director (MD)
Jim McLeish	Director of Quality Improvement (DoQI)
Finola Devaney	Director of Clinical Quality Governance (D-CQG)
Giuseppe Labriola	Deputy Chief Nurse (DCN)
Andrea Philip	Associate Director – Operations – CHaWS (ADO-CHaWS)
Linda Machakaire	Director of Midwifery (DoM)
Elita Mazzocchi	Maternity Transformation Programme Manager (MT-PM)
Oluwaseyi Akinlaja	Consultant Midwife (CM)
Erin Walters	Head of Maternity Governance and Assurance (HoMGA)
Philippa Greenfield	Divisional Director CHaWS (DD-CHaWS)

External attendees

Suzanne Cunningham	Maternity Improvement Advisor – NHSE/I (MIA)
Matt Fry	NHSE (NHSE-MF)
Chloe Ribeiro	Maternity Voices Partnership Chair (MVP-C)

Apologies

Anne Wafula-Strike	Associate Non-Executive Director (ANED-AWS)
Kirsty Cater	Deputy Regional Chief Midwife (DRCM)
Lance McCarthy	CEO (CEO)
Wendy Matthews	Regional Chief Midwife (RCM)
Martine Pringle	Regional Maternity Quality Lead (RMQL)
Rob Gerlis	Committee Chair/Associate Non-Executive Director (CC)
Clodagh Hewins	Clinical Quality Assurance Lead – Children, Young People & Maternity Services – WECCG (CQAL)
Rosalind French	Head of Children & Maternity Commissioning – WECCG (HoCMC)

Secretariat

Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

1.0 OPENING ADMINISTRATION	
1.1	The Acting Committee Chair (ACC) welcomed everyone to the meeting.
1.1 Apologies for Absence	
1.2	As above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.

1.3 Minutes of Previous Meeting	
1.4	These were agreed as a true and accurate record of the meeting held on 24.11.23 with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising. It was noted that items on the action log were either proposed for closure or not yet due. Members were content that all items proposed for closure could be closed.
1.5 Annual Work Plan 2023/24	
1.6	This was presented for information and it was noted it would be refreshed for 2024/25.
02 ITEMS FOR DISCUSSION	
2.1 Monthly Maternity Report	
2.1	This update was presented by the Director of Midwifery (DoM). The first item of note was a reminder that the service currently had gold accreditation for breast-feeding and would be going through reaccreditation at the end of the year. A lot of work had been done around this and the key concern was having the correct workforce in place but it was currently a focus in terms of the initiation rate/collaborative working.
2.2	At this point the Chief Nurse (CN) flagged that the Performance & Finance Committee (PAF) that week had raised a question in relation to the October data for post-partum haemorrhage (PPH) (in relation to the integrated performance report (IPR)) where there had been a rise in October but subsequent reduction in November. She asked the DoM whether there was any detail she could provide on the increase in rate to 6% in October. The DoM responded that she believed this had been discussed at QSCII in November but reminded members there needed to be an understanding of the morbidities around PPHs but she could bring back some further detail around this.
2.3	The ACC responded that the question could possibly be rephrased in terms of had there been a reason for the spike in October from around 3% to 6%. The DoM responded there was no reason she could understand at the current time. The ACC suggested the DoM circulate an email briefing members on the reasons for the increase.
ACTION QSC2.22.12.23/23	**Circulate an email to Committee members with an explanation for the spike in PPH in October and subsequent reduction in November. Lead: Director of Midwifery**
2.4	The DoM then drew members' attention to p20 of the pack and the reference to the 'Brazil Effect' and apologised if colleagues were not familiar with the meaning of that. By explanation she reminded colleagues that Caesarean section (C-section) rates had been a focus for a while in terms of their actual rate. In 2016 in the RCOG Congress, a paper had been presented on the position in Brazil where women in their 40s/50s were now having health issues associated with previous C-sections. This was a group that was now growing (in the UK) but there were still some underlying issues related to public health and work that still needed to be done in terms of not always using the mantra 'once a C-section, always a C-section', but in effect balancing that with choice.
2.5	
2.6	The DoM then continued that in relation to incidents, there had been one closure of the unit in October. There fact there had been no closures before this linked to the fact that to close the unit required a receiving hospital to be named. Given current pressures across the country, other organisations had been unable to accept admissions from other units. Otherwise, closing the unit is an event the service tries to avoid.
2.7	In terms of training, the ambition by the end of January was to achieve the threshold of 90%. The current midwife to birth ratio was 1:23 with the funded establishment. The service was nearly at its funded establishment (only three whole time equivalents (WTEs) short in November).

2.8	The DoM continued that in relation to the Neonatal Dashboard the Committee had spoken previously about 'right place of birth'. There is ongoing work to ensure that as a Level 2 unit, babies under a certain gestation are able to make it to another more appropriate unit or, that if they were born at PAHT, they are first stabilised before being transferred out. The DoM flagged that 'antenatal steroids' had been rated as red for most of the year but she cautioned that the criteria around this had changed slightly so in many neonatal dashboards, this particular figure had dropped. Colleagues were aware of this change and there was ongoing work to ensure the data was collected as well as it could be.
2.9	In terms of staffing she highlighted that the establishment was much improved however many newly qualified midwives were being supported. 21% of the workforce was currently Band 5 and requiring support and this was a challenge in terms of the skill mix. There were various work-streams as part of the Improvement Board (e.g. induction of labour) and colleagues were trying to look at the capacity around C-sections. This was a significant challenge in that there were insufficient slots and people were labouring before their date or in order to facilitate what would be an urgent C-section, those were being booked as a category 3 C-section and sometimes performed out of hours (weekends) albeit not all cases were appropriate for that. A team was currently working to try to improve the capacity.
2.10	The DoM then drew members' attention to p27 and the red flags. This was data that came from Birthrate+ and was reviewed daily. Birthrate+ undertook the workforce review which identified the number of midwives required for the community but there wasn't that day to day scrutiny as the toll does not allow for that.
2.11	At this point Associate NED Oge Austin-Chukwu (ANED-OA) highlighted the report stated there had been delays in induction of labour for 23 women (31% of inductions) and she asked whether it was known if this had then led to a C-section.
Divisional Director Child Health & Women's Services joined the meeting.	
2.12	The DoM responded there was a newly established Maternity SitRep reported every two weeks, and the service had made its third submission that week. The service had been asked to collect data around delays of over 24 hours in induction of labour and elective C-section and those were reported to NHSE. Colleagues had been asked to Datix any delays although this was not being done as regularly as it should be. Delays and the reasons for them are reported, and the service would be able to pull themes. Once there was sufficient data (in three months or so) she would be able to provide more clarity around the causes of delays.
2.13	ANED-OA then clarified that her question was whether the causes of delays then led to adverse circumstances. The DoM responded she could not provide those figures either but gave an example that if there was a woman at risk of infection, and she was delayed for induction, then there would be a risk that delay/ infection could lead to a baby requiring special care. She proposed therefore she reported back in a few months' time once the data was available. The ACC agreed and that the report should provide the detail around delays in C-section and impact of those. It was agreed this would be in February 2024.
ACTION **QSC2.22.12.23/24**	**Provide a report for February's meeting on the detail around delays in C-section and the subsequent impact of that.** **Lead: Director of Midwifery**
2.14	At this point the Deputy CN (DCN) commented it was good to see the positive impact of recruitment but it would also be good to look at the trajectory/ retention and the turnover each month as nationally nurses leaving the register had crept up. The DoM agreed and that there was something around 'stay' interviews which linked to culture. This was reflected in the workshops with the lead freedom to speak up guardian with people expressing the importance of feeling valued and belonging in a team.
2.15	The DoM then continued that in terms of the community establishment, although it was being reported there were only three WTEs across the service, this was because there were midwives who were still supernumerary /B5 and rotating within the hospital, without as many experienced midwives going out into the community who are Band 6. In the community the

	vacancy there was 8.72 so over the next couple of months the trajectory would be to have more experienced midwives going out into the community so that the benefit of only have 3 WTEs vacancy was felt across the board/ service. Vacancies of 8.72 equated to circa one whole team in the community.
2.16	The slide on p28 evidenced how vacancies had dropped. There is however still a significant amount of vacancies in the support worker structure. Agency/ bank had not yet come down - there is currently double-running with the supernumerary staff but the expectation was that the use of bank/ agency should reduce over the next three months.
2.17	At this point NED Helen Howe (NED-HH) flagged that when the Birthrate+ analysis had previously been undertaken for the staffing required, there had been a different profile for a year or so while the organisation had tried to develop that maternity assistant category. She asked whether that reconciliation was still within new colleagues' minds and whether the service was on plan. The DoM responded that most units worked on a ratio of 90% to 10% (midwives to support workers) and to have clear pathways where those women without complications had maternity support workers able to provide care (the 10%). However, she was aware some upskilling was required as many maternity support workers were Band 2 and it was about that transition to be able to fully carry out that role and care for women in that low risk pathway that would help even out that position.
2.18	The DCN then reminded members that when there had been the investment in Maternity there had been a three-year workforce plan which looked to upskill support workers. Currently the interim establishment review for nursing and midwifery was underway which would provide an opportunity to touch base on the progress with that upskilling and that would come to the Committee for review/ approval.
2.19	In response to the above, the ACC asked whether broadly the plan was still on target against the original strategy. The DoM confirmed it was, broadly. A fresh Birthrate+ assessment due by November 2024 so that would be a good opportunity at which to pull everything together.
2.20	As a final point the DoM highlighted a project called 'Create Space' which the previous Deputy DoM had taken forward. From staff feedback this had been received well particularly on Samson Ward (postnatal) with staff reporting they would be using the breathing techniques they had been taught for other occasions/ intances, and not just at the beginning of the shift.
2.21	The ACC thanked the DoM for her update. She summarised by stating that the key issue had been the referral from PAF in relation to the spike in PPH in October. The delays in care for C-sections were noted and there would be an update on this in February, the importance of staff retention was noted, and colleagues would report back on the skill mix point raised by NED-HH based on the original strategy and whether this was still on target.
2.2 Maternity Incentive Scheme (MIS) Update	
2.22	This update was presented by the DoM who reminded colleagues the Trust required to report its compliance with MIS by 01.02.24. She drew members' attention to p33 of pack and flagged the position in terms of progress was continually moving.
2.23	Currently the prediction was that by the deadline date, the Trust would not be compliant with safety action 8 (SA8) related to training. Colleagues had pulled together the numbers of staff required to complete that training by 31.01.24 and had flagged where appropriate, where staff needed to be released to undertake that. Colleagues were therefore aware of the numbers but members were reminded that industrial action was also a factor.
2.24	In response to the above the Director of Quality Improvement (DoQI) asked how many staff were required to undertake the training and what support did the division need to achieve this. The Maternity Transformation Programme Manager (MT-PM) responded it equated to 16 doctors for emergency training and 7 for foetal monitoring, adding on an additional 10 to 15 trainee GPs. The DoQI responded numbers were not huge therefore but asked again what support the team required with this to be compliant. The Medical Director (MD) then suggested the new GP trainees could undertake the training as part of their induction. The

	MT-PM responded that was being considered, however the training needed to be delivered in a multi-disciplinary way so could not therefore be delivered to only that cohort of colleagues because other colleagues would be required at the same time for example, anaesthetists, midwives and support workers. However, this was being considered along with factoring in another training session – the key however would be around releasing staff for the time the training required.
2.25	In response to the above the Director of People (DoP) highlighted that as Safety Champion, she was now part of the quadrumvirate meeting and she would be happy to take this as an action and speak with senior colleagues in terms of how this safety action could be achieved.
ACTION QSC2.22.12.23/25	**Discuss with the CHaWS Quadrumvirate what support was required to achieve MIS Safety Action 8. Lead: Director of People**
2.26	The ACC summarised by stating that there were circa 35 doctors still to train, there was a very tight timescale in which to do this and as stated earlier in the meeting, it would be shame to miss out on achievement of MIS by failure to complete training. She would therefore encourage colleagues to ask for whatever was needed to support achievement of the scheme and colleagues completing their training.
2.3 Maternity Serious Incidents Update	
2.27	This update was presented by the Head of Maternity Governance & Assurance (HoMGA). She informed members there were currently six open SIs, and no new incidents reported for November. A number of incidents were about to go through the final part of the governance process. The first (never event: retained swab) had been submitted to the integrated Care Board (ICB) and had come back with comments so now needed to be finalised. Three others were about to be sent to the ICB once they had gone through the Trust process. The two outstanding cases had been reported the previous month and were currently in the early stages of the governance process. There were no changes to top incident themes.
2.4 Deep Dive Medical Workforce	
2.28	The ACC opened this item and commented it was disappointing the paper had not been received. The Divisional Director (DD) apologised to the Committee stating there had been extenuating circumstances which meant she had not delivered this work. These were primarily around workforce, job-planning and motivating the consultant team to engage with that.
2.29	In response to the above, the ACC asked what would be a realistic timescale in which to present the report. The DD responded it would depend on what the Committee wanted to know. But until such time as she had been able to job plan the consultant body and been able to understand the issues around sick leave, she would not be able to articulate the gaps in the workforce and what that needed to look like to remedy the position. She could offer an update for the next meeting and commit to trying to make a start to things over the next two months.
2.30	The ACC commented it would be helpful to the DD if her brief was clearer. The Chief Operating Officer (COO) then responded that she had been working closely with the DD on divisional issues and her view would be a high-level report could be presented to the next meeting with the full detail then in March.
ACTION QSC2.22.12.23/26	**Deep Dive Medical Workforce: Highlight report to be presented in January with the full detail in March. Lead: Divisional Director CHaWS**
2.31	The ACC responded that would be very helpful and the first line of that high level update should clearly include the question the Committee sought a response to.
ACTION QSC2.22.12.23/27	**Deep Dive Medical Workforce: Provide clarity around the request from the Committee on this. Lead: Board & Committee Secretary**

2.32	The ACC summarised that the Committee noted the absence of a report and the reasons for that. The COO would now work closely with the DD to provide an interim report at the end of January which would clearly define the original ask/question, and that a full report would be provided in March, recognising the link to the MSSP.
2.5 Maternity and Neonatal Safety Champions' Report	
2.33	This item was presented by the DoP in her role as Maternity & Neonatal Safety Champion. She apologised that the update was a verbal one but this was due to the timing of the most recent meeting and the transition of leadership within the team.
2.34	The DoP informed members that the last meeting had been well attended and had focussed on some of the papers that had already been discussed earlier in the meeting. Items for escalation were: • The good work around training in reaching 80% with the focus now on what was required to achieve 90% and which colleagues were outstanding. • Walkabouts continued but the DoP and NED Kim Handel as the safety champions would now take specific safety themes in terms of those elements that should have been embedded in practice and there would be reports back on those. • Both champions continued to go on the 'Futures' website and an additional role for the DoP going forward would be to attend the quadrumvirate meetings. The key highlights from the two attended to date were the focus on staffing and culture. • Consideration to be given to a second daily safety huddle in light of IA. • Thanks to Jo Keable and all she had done to support the team in her time at the Trust.
2.6 Horizon Scanning Update	
2.35	No update provided due to apologies.
2.7 Maternity Safety and Support Programme (MSSP) Exit Plan	
2.36	This update was provided by the Maternity Improvement Advisor (MIA) who advised that reports were now bi-monthly and the one within the pack related to October/November. The main focus of work currently was the team's focus in relation to coming off the programme and the process that entailed. The PAHT team had put together a paper which had now been circulated to regional partners and returned with comments. The final piece in her view was just to tie up what the assurance would look like from the Trust, ICB and from region. Her final comment would be to include some elements of celebration. There had been lots of improvements to celebrate and those were key as to why the service was ready to come off the programme. Other than that, the only other outstanding elements were troublesome areas, for example, training, particularly medical training which had become more obvious in recent months. Most would be complete by April but the team would need to be more organised in that area in terms of moving forward. She acknowledged IA had not helped that year.
2.37	In response to the above Matt Fry, NHSE (NHSE-MF) emphasised the important point above in terms of governance and making sure the exit plan was airtight in terms of follow-up actions and where support was required. He was aware regional colleagues had already commented on the plan so he asked as to the timeline for the plan to be finalised and next steps. The DoM responded she was working through the comments received after which the draft report should be ready for recirculation. She needed to add an appendix and make the governance structure clearer in terms of how the sustainability plan would be monitored and having agreement on the principles around that. Some of the comments had suggested the plans for monitoring should be more mature.
2.38	The MIA responded that her view would be QSCII had the correct membership to undertake the monitoring required and this element, in her view, did not need to be over-complicated.

2.39	The DoM then commented that the final version of the plan should be ready for January's QSCII.
ACTION QSC2.22.12.23/28	**Final iteration of MSSP exit plan to be presented to January's meeting. Lead: Director of Midwifery**
2.40	In response to the above the CN flagged that consideration would need to be given to the timings of January's QSCII bearing in mind the final MIS position would also need to be discussed (including Board declaration). The ACC responded she was sure that January's QSCII could be extended slightly if that was required.
2.41	The MIA then flagged that the MSSP sustainability plan could easily be presented to February's QSCII because the process thereafter was relatively quick in terms of final submission to NHSE. Having final MIS sign-off would only strengthen exit from the MSSP. The CN responded that the Board had already been alerted to the request for delegated authority to QSCII for MIS sign-off at its January meeting as the Board would not meet until 01.02.24.
2.42	The ACC thanked colleagues for their update and reiterated the Committee's offer of support in terms of MIS and also with the final version of the MSSP plan.
03 CLOSING ADMINISTRATION	
3.1 Any Unresolved Issues?	
3.1	There were no unresolved issues.
3.2 Review of Board Charter	
3.2	It was agreed behaviours had adhered to the Charter.
3.3 ITEMS FOR CHAIRMAN'S REPORT TO BOARD	
3.3	To be agreed outside the meeting.
3.4 New Risks and Issues Identified	
3.4	It was agreed the risk around training remained.
3.5 Items for Deep Dive	
3.5	It was noted that the Medical Workforce report would be presented in January/March.
3.6 Any Other Business (AOB)	
3.6	There were no items of AOB. Members reflected there had been some good discussion.
3.7	The meeting ended at 12:55.
	Date of next meeting: 26 January 2024 @ 12:00

Agreed as a true and accurate record of the meeting	
Date:	26.01.24
Signature:	
Name:	Rob Gerlis
Title:	Committee Chair and Non-Executive Director

28 August 23 - 3 September 23

tnt Weekly This 'n That

Letby verdict 5 key messages to Trusts

1. Speaking UP

Do you know how to, and who to contact, to raise concerns within your ward? Within your department, division, or at Trust level? Do you know where to get information about 'speaking up'. Discuss with colleagues and friends and direct them here

2. Accessing the National Speaking Up Support Scheme

Have you heard of this national scheme?
Ask your People Team Business Partner or the Freedom to Speak up Guardian

Even the quietest or least heard voices are audible

Speaking up is not your thing. You'd rather tell your friend about a problem at work and ask them not to tell anyone because you don't like to make a fuss.
What would enable you to turn this moan or gripe to a loved one into speaking to someone who can do something about it? Tell us.
Can someone else speak on your behalf? PMA? PNA? Union Rep?

How will the Board know you have a voice?

Do you not know how to raise a concern? The Board wants to know.
Can you speak up with confidence? The Board wants to know.
Have you spoken up and then got treated differently? The Board wants to know.
Have you spoken up and not received feedback? The Board wants to know.
Let the Board know!

Board reporting

The Trust Board receives reports from the Freedom to Speak Up Guardian; an example is here: (page 13) information from the incidents we report on Datix, and listen to what we say on the Staff Survey and then build it into plans and actions to make our working environments better.

Trust Board (Public) – 1 February 2024

Agenda item:	4.3
Presented by:	Giuseppe Labriola – Deputy Chief Nurse
Prepared by:	David Dellow – Safe Staffing Lead and Giuseppe Labriola – Deputy Chief Nurse
Date prepared:	16.1 2024
Subject / title:	Report on Nursing and Care Staff Levels for December 2023.

Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The overall fill rate for December has remained stable for Registered Nurses and Healthcare support workers No ward reported average fill rates below 75% for RN against the standard planned template during December.							
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

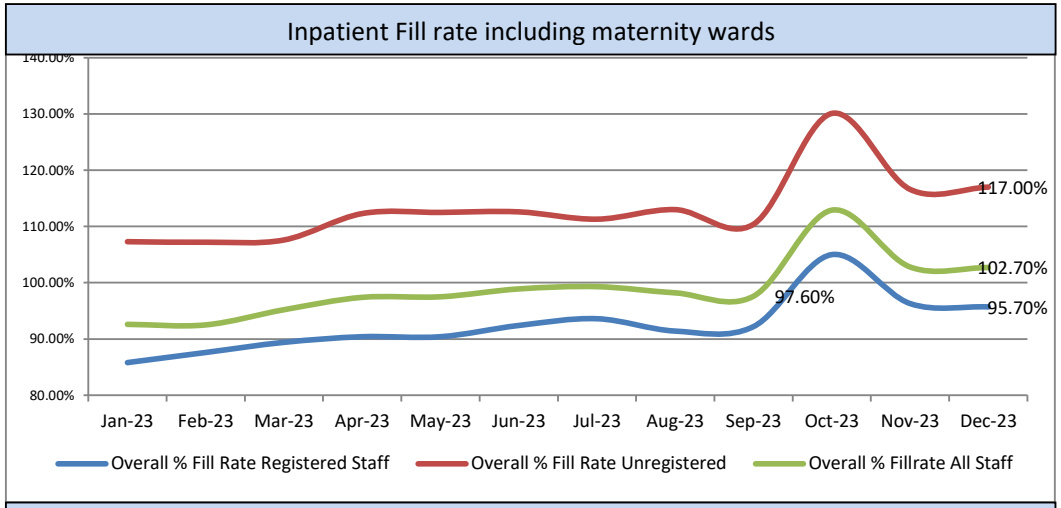
Previously considered by:	People Committee: 22.01.24.
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Divisions have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	**Appendix 1:** Registered fill rates by month against adjusted standard planned template. RAG rated. **Appendix 2**: ITU / HDU compliance with Guidelines for the provision of Intensive Care Services **Appendix 3:** Nightingale Ward SafeCare AM Census data (required vs actual hours)

There was a decrease in the Registered Nurse and the overall average fill rates in December; with the overall fill rate decreasing to 102.7% (↓0.1%). Registered fill rate fell by 0.6% to 95.7% with care staff fill rates increasing by 0.4% to 117%.

We continue to utilise NHS Professionals (NHSP) and agency to mitigate vacant shifts. In addition, our senior nurses and midwives are also supporting individual areas. There are planned recruitment events throughout January for healthcare support workers to recruit into vacant posts.

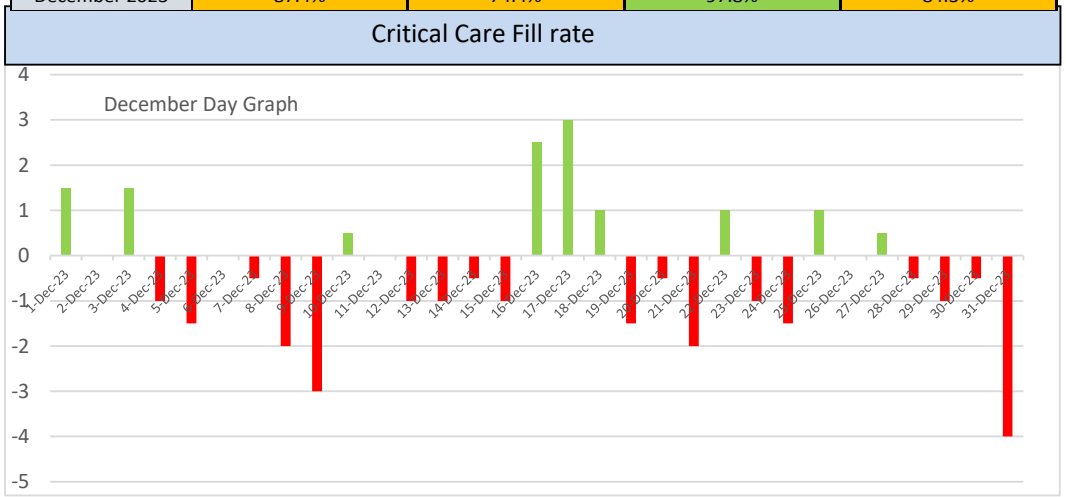
Emergency Department (ED) Registered fill decreased for RN Day, fill was 87.4%, (↓1.8%) with RN Night increasing to 97.8%. (↑2.5%) There was a fall in fill rates for care staff in December Days (↓3.7%) to 74.1% and nights decreasing by 9.6% to 84.3%. There has been an increase in unavailability during December (sickness and annual leave) which the deputy chief nurse is monitoring through divisional roster governance meetings. Matrons and the practice development nurse supported the department during this period.

Critical care fill rates in December - the unit had more than the required numbers of staff for acuity of patients on 9 occasions during the day (green bars) and 8 occasions at night. The numbers on the left of the graph and strength of the bars denotes by how many staff. There were 37 occasions in the month when staffing fell below the required staffing levels across day and night. There were 11 occasions when this was by 2 or more staff with 2 occasions when this was 4. On occasions when staffing fell below the required levels, the Intensive Therapy Unit (ITU) team were supported by the Critical Care Matron, Practice development nurse and the supervisory nurse in charge working in the clinical numbers to support delivery of safe patient care. This was due to increased capacity within the department. See Appendix 2 for background on how safe staffing is calculated for critical care areas.



ED Fill rate

A&E Nursing	Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
October 2023	93.3%	79.5%	96.0%	87.0%
November 2023	89.2%	78.1%	95.3%	93.9%
December 2023	87.4%	74.4%	97.8%	84.3%



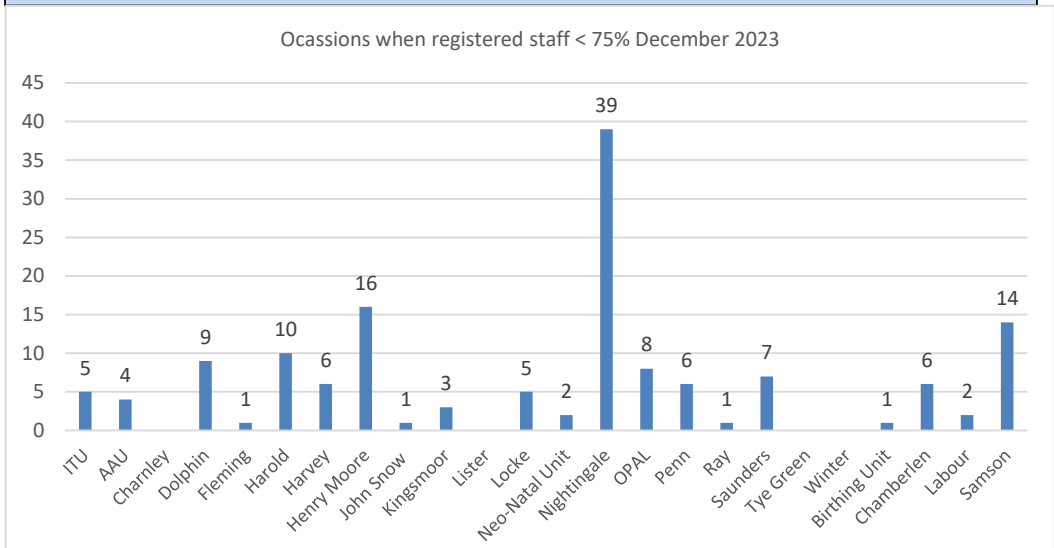
The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards increased by 2 occasions in December, though Nightingale Ward alone had 39 shifts at <75%. If Nightingale Ward was excluded then the number would have increased by 13 to 107. This report now includes Maternity (23). If a nursing red flag event occurs for the number of staff on duty unable to meet the care needs of patients, staff escalate the situation and if appropriate complete a Datix.

Datix reports in relation to staffing levels decreased to 49 (↓6) against November. Tye Green Ward raised 8 with Penn Ward and Tye Green Ward 6 each.

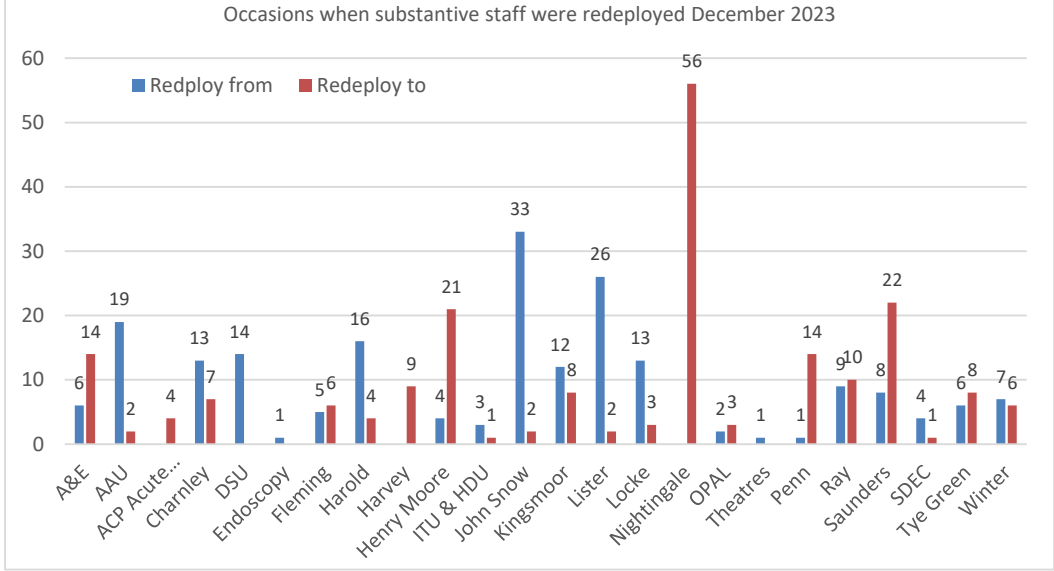
No wards reported average fill rates below 75% for RN against the standard planned template during December. Nightingale Ward Registered Nurse Day staffing was 71.3% on average, SafeCare data from the morning census shows that on 50% of occasions even though the staffing did not meet the standard templated demand, the staffing was sufficient to meet the required patient hours. **(Appendix 3)** Staffing is reviewed a minimum of 3 times a day and Registered Nurse staffing is always at a minimum of 2 RNS against the template of 3. Depending on the patient acuity and dependency staffing levels are reviewed and adjusted. There has been no significant change in patient outcomes. Staff redeployment demonstrates Nightingale to be the highest receiver of staff.

Redeployment of staff continues to be undertaken to support SafeCare as part of the daily staffing huddles. In December, John Snow Ward remained the ward who redeployed the highest number of substantive staff. This is an elective orthopaedic ward and had reduced inpatients due to Industrial Action. The highest net receiver of staff were Nightingale Ward, with Saunders Ward and Henry Moore Ward being the next highest. During Industrial Action, outpatient department staff

Occasion when RN staffing <75%

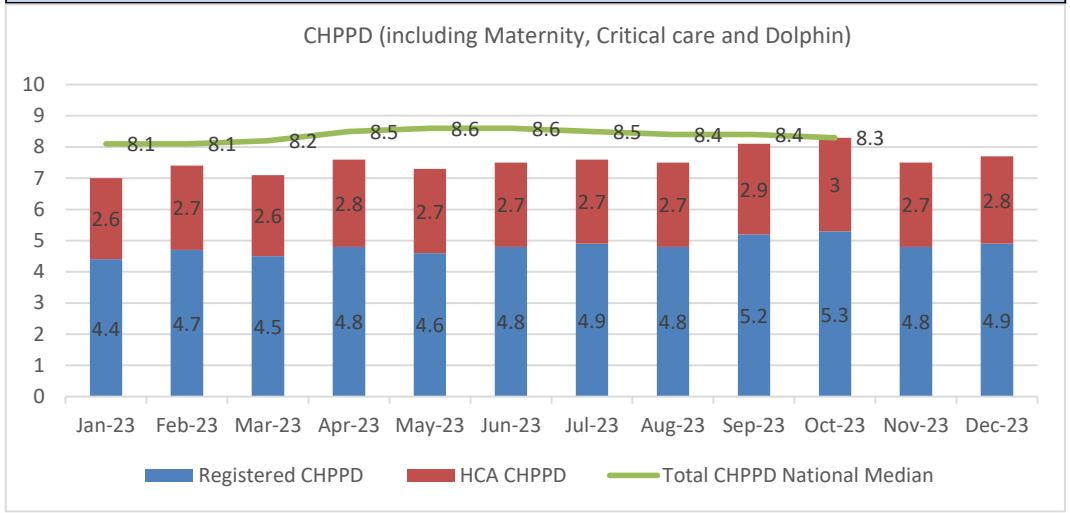


Redeployment



Overall Care Hours Per Patient Day (CHPPD) was 7.7 for November 2023. The Model Hospital data for October 2023 shows the Trust with a CHPPD of 8.3 against the national median of 8.3.

CHPPD



Appendix.1. Ward level data: fill rates December 2023. *(Adjusted Standard Planned Ward Demand)*

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
ITU & HDU	93.0%	72.8%	92.3%	105.7%	92.6%	89.2%	92.3%
Saunders Unit	82.0%	121.4%	120.3%	178.0%	96.3%	142.9%	113.9%
Penn Ward	85.2%	124.0%	101.5%	170.3%	92.1%	141.6%	109.8%
Henry Moore Ward	79.9%	104.8%	123.8%	107.8%	97.4%	106.2%	101.2%
Harvey Ward	82.1%	143.5%	116.8%	134.0%	96.2%	139.0%	111.7%
John Snow Ward	91.0%	42.8%	83.8%	47.3%	87.6%	44.2%	68.8%
Charnley Ward	96.9%	122.9%	97.3%	127.5%	97.1%	125.1%	105.1%
AAU	90.2%	106.5%	101.0%	118.4%	95.0%	112.2%	98.6%
Harold Ward	83.5%	107.5%	98.0%	117.2%	89.9%	112.1%	96.9%
Kingsmoor General	90.9%	136.3%	129.5%	114.0%	105.5%	125.6%	113.0%
Lister Ward	89.8%	112.9%	104.1%	132.8%	95.8%	122.4%	106.4%
Locke Ward	92.5%	127.1%	100.9%	149.2%	96.0%	137.7%	112.6%
Ray Ward	88.3%	100.8%	105.4%	158.9%	95.6%	122.9%	105.3%
Tye Green Ward	92.9%	110.8%	108.6%	133.6%	99.7%	120.1%	107.6%
Nightingale	71.3%	76.5%	83.4%	101.1%	77.1%	88.2%	81.6%
Opal Unit	99.6%	112.6%	92.3%	115.0%	96.1%	113.8%	103.2%
Winter Ward	86.0%	126.0%	102.2%	136.7%	92.8%	131.1%	108.1%
Fleming Ward	86.1%	114.5%	100.0%	108.2%	92.0%	111.5%	98.0%
Neo-Natal Unit	103.1%	50.1%	98.2%	93.3%	100.7%	71.7%	95.9%
Dolphin Ward	87.6%	75.2%	85.9%	88.0%	86.8%	79.5%	85.0%
Labour Ward	113.2%	110.1%	98.8%	108.1%	106.3%	109.2%	107.0%
Birthing Unit	134.8%	102.2%	120.3%	96.7%	127.9%	99.6%	118.4%
Samson Ward	92.7%	173.6%	95.7%	120.0%	94.1%	148.0%	115.7%
Chamberlen Ward	99.5%	86.7%	97.8%	96.7%	98.7%	91.4%	96.9%
Total	91.7%	111.0%	101.2%	124.3%	95.9%	117.0%	102.7%

Appendix 2: ITU / HDU compliance with Guidelines for the provision of Intensive Care Services (Version 2.1 July 2022)

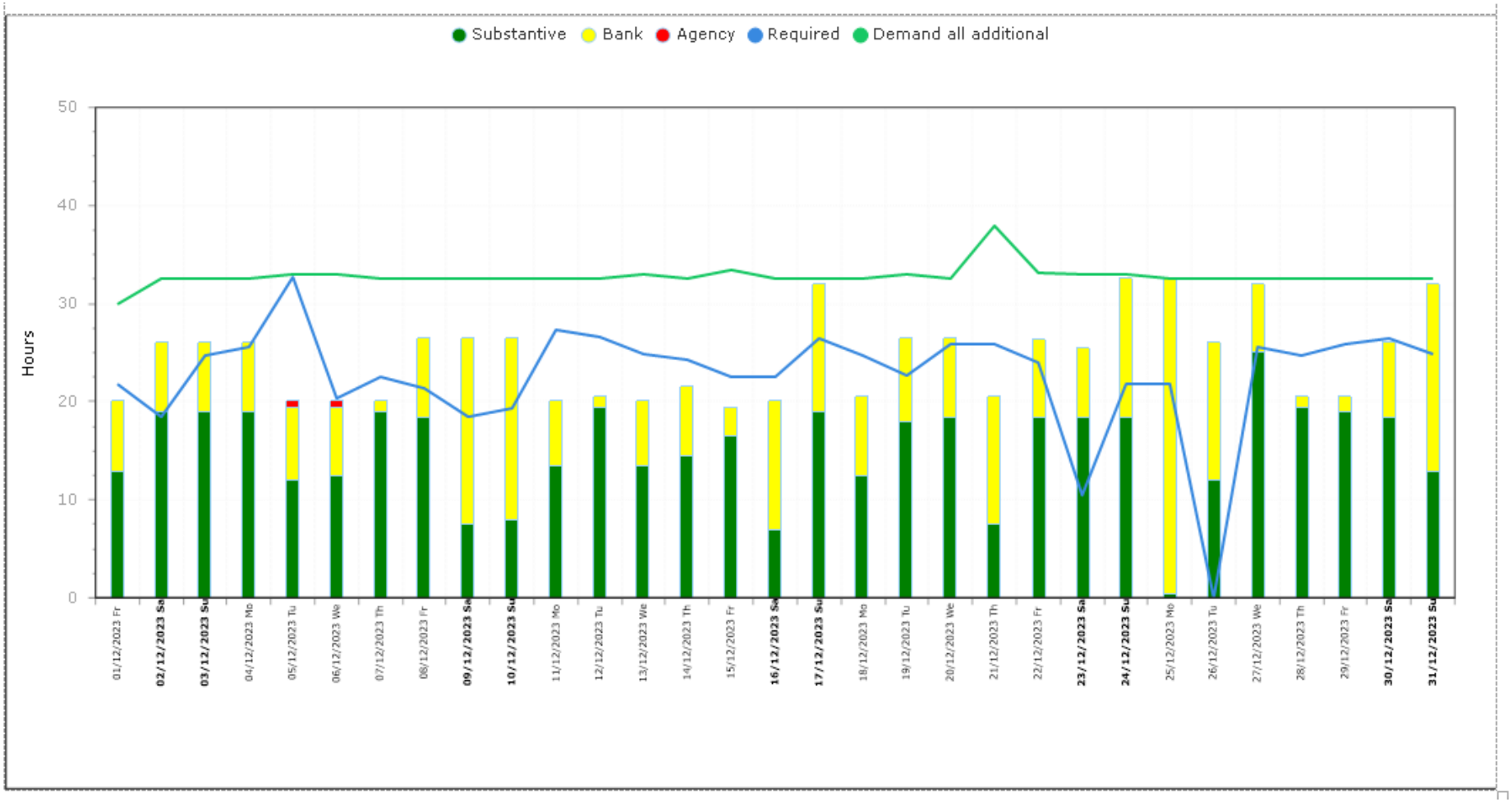
To ensure that the Board is given an overview of departments other than the inpatient wards and ED and to strengthen our compliance with the NQB 2013 and NQB 2016, this report will be looking at other metrics going forward.

Registered nurse staffing standards published within the Core Standards for Intensive Care Units, state

- Level 3 patients must have a registered nurse/patient ratio of a minimum 1:1 to deliver direct care
- Level 2 patients must have a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care

The graph shows the actual staffing levels against the required number for the patients within the department each day shift. Red bars indicate when shifts had less than the recommended staffing numbers. The strength of the bar indicates how many shift short it was. The green bars indicate when there were more staff than the patient numbers required.
All shifts include a supervisory nurse.

Appendix.3. Nightingale SafeCare AM Census data (required vs actual: Hours)



NHS
The Princess Alexandra Hospital
NHS Trust

4.4

Trust Board (Public) – 1 February 2024

Agenda item:	4.4
Presented by:	Giuseppe Labriola, Deputy Chief Nurse
Prepared by:	Giuseppe Labriola, Deputy Chief Nurse
Date prepared:	8th January 2024
Subject / title:	Full year nursing and midwifery establishment review

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

Key issues:	A full establishment review was undertaken in September 2023 in line with national recommendations. The recommended changes are included within section 4, additionally it is recommended that the clinical practice educators' team is increased due to the support our workforce need in clinical practice. These changes can be funded from within the current budgeted establishment envelope and no additional funding is sought for the recommendations. A new Head of Nursing for Children's services joins the organisation in January 2024 and part of their remit will be to complete a full review of paediatric nursing staffing across the service. The next interim establishment review is due to be completed in March 2024 and reporting to Board in June 2024 using the refreshed SNCT methodology
Recommendation:	The Board is asked to note the information within this report and support the outcome and recommendations.

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

Previously considered by:	EMT 10.01.24 SMT 16.01.24 People Committee: 22.01.24: methodology and recommendations supported.
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Divisions 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 There are no ED&I implications identified from this report
Appendices:	Appendix 1 Regulatory requirements and best practice guidance Appendix 2: Nurse sensitive indicators March 2023 Appendix 3: Full SCNT results compared to September 2022 full review Appendix 4: Current ward establishment versus proposed Appendix 5: Average daily number of Level 4 enhanced care patients March 2022 / March 2023 Appendix 6: Refreshed SNCT levels and descriptors

1.0 Background and National Context

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

This report details the results of the full year review, which was undertaken in September 2023 in line with regulatory requirements and provides assurance that the review was undertaken in line with regulatory requirements.

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

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

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

Further information and references are in **Appendix 1.**

2.0 Process and methodology

The last full establishment review was conducted in September 2022, gaining Board approval in January 2023. An interim establishment review was undertaken in March 2023

The data collection for this full establishment review was undertaken during a period of 20 days between the 4th September 2023 and 3th October 2023 for the Adult inpatient wards, Adult Assessment Unit, Opal and Dolphin Ward utilising approved acuity and dependency tools. Data for the emergency departments were collected over 12 days, with Paediatric ED collecting data between 11th September and 22nd September 2023, with Adult ED collecting data between the 6th and 17th November.

Adult Inpatient Wards	Safer Nursing Care Tool Adult Inpatient Wards in Acute Hospitals and Adult Acute Assessment Units
Adult Assessment Unit (AAU) and Older Person's Assessment and Liaison Service (OPAL)	Safer Nursing Care Tool Adult Inpatient Wards in Acute Hospitals and Adult Acute Assessment Units
Dolphin Ward	Safer Nursing Care Tool Children's & Young People's Inpatient Wards

Emergency Department – Adults and Paediatrics	Emergency Department Safer Nursing Care Tool

The data collection for the inpatient wards, consisted of collecting patient dependency/acuity data at 15:00hrs (scoring the patient at the predominant level they have been in the past 24 hours) for 20 days to determine each ward's average acuity and dependency mix. Data is collected by senior nursing staff who have undertaken and passed the Trust's SNCT training and assessment.

The Emergency Department Safer Nursing Care Tool data collection is twice per day over 12 days at intervals of 12 hours, that allows capture of 24 hours over the 12 days (scoring the patients at their current level of acuity). Patients who were in the department for more than 12 hours were counted at only one data point

The SNCT calculation is based upon a funded headroom allowance of 22% (leave allowance including annual, study, sickness), it should be noted that the Royal College of Nursing (RCN) recommends 25%. The Ward Manager role is fully supervisory.

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

A full breakdown of the nurse sensitive indicators that were reviewed when considering the SNCT results are available in **Appendix 2.**

3.0 Data quality

To ensure accuracy of the acuity data the matrons should complete a twice weekly audit. If there is a discrepancy found SNCT should be corrected. To ensure accuracy of SNCT a total of 8 audits per ward should have been undertaken over the 20-day census period. Only 3 wards managed to achieve 8 or more audits, with 3 not having any audits undertaken. This was a significant increase in compliance with only 3 audits undertaken overall in total in March 2023. There is an on-going training programme which will increase the number of ward-based assessors to facilitate the matrons to undertake a more reliable external validation for the mid-year establishment review due in March 2024.

For this review we are confident that the SNCT data collected is accurate as all of the staff that gathered the data have been trained, assessed and passed their PAHT interrater reliability assessment for SNCT. To strengthen this for the next establishment review the Trust is on track to have a minimum of 3 trained staff on each ward, which removes the reliance on matrons inputting patient acuity and allows them the time to independently validate the data which will strengthen our confidence. This is in line with the SNCT recommendations.

4.0 Findings

No changes to an establishment should take place until there are two consecutive reviews demonstrating an increasing or decreasing trend in nursing and midwifery staffing. In addition, this should be triangulated with patient and staff outcomes and professional judgment of the senior nursing and midwifery team.

The results of the establishment review need to be considered in context of the low compliance with accuracy audits. However, the results were broadly in line with previous audit periods thus whilst the validation cycle requirements were not met, there is a level of confidence in the data submitted locally.

Division	Ward	SNCT Change	Final Recommendation
Urgent and Emergency Care	AAU	No change	No change
	SDEC	No change	No change
	Charnley	No change	No change
	ED	No change	No change
Surgery	Henry Moore	Increase by 5.4 WTE RN* *no increase in funding required as within divisional envelope*	Current rota reflects the additional increase. No additional investment required.
	John Snow Unit	No change	No Change
	Penn	Increase by 0.7 WTE RN	Increase by 0.7 WTE RN, funded from overall nursing establishment envelope: no additional investment required.
	Saunders	No change	No Change
	Harvey	No change	No Change
	Critical Care	No change	No Change
Medicine	Fleming	No change	No change
	Tye Green	No change	No change
	Harold	No change	No change

	Winter	No change	No change
	Lister	Increase by 2.5 WTE RN	** see narrative under workforce intentions. No change to establishment recommended. Evaluate at next SNCT review.
	Locke	No change	No change
	Ray	No change	No change
	Kingsmoor	No change	No change
	Opal	Increase by 3 WTE RN* *no increase in funding required as within divisional envelope*	Current rota reflects the additional increase. No additional investment required.
CSS	Outpatients	There is not a nationally recognised tool to support calculating nursing workforce demand in outpatients. However, the CSS nursing leadership team will be reviewing capacity and demand modelling for outpatients staffing within the next 6 months and this will be reported in the next establishment review paper.	
	William's Day Unit (Chemotherapy unit	There is not a nationally recognised tool to support calculating nursing workforce demand for chemotherapy units. However, the CSS nursing leadership team led by the Head of Nursing for Cancer will be reviewing capacity and demand modelling for chemotherapy nursing within the next 6 months and this will be reported in the next establishment review paper.	
CHAWs	Paediatric ED	SNCT data showed that the staffing for the core paediatric ED footprint was covered by the current budget. This excluded Paediatric Ambulatory Care unit (PACU) and the triage model. The financial impact of the staffing model for triage and PACU will be brought as a separate business case when the final paediatric UTC model has been agreed. A new Head of Nursing for Children's services joins the organisation in January 2024 and part of their	

		remit will be to complete a full review of paediatric nursing staffing across the service.	
	Dolphin	No change	No change
Escalation Ward - Medicine	Nightingale	Open as a part funded medical escalation area and not included in the September SNCT review. Anticipate this ward will be open till the end of June 2024.	

*For Henry Moore and OPAL Wards, no additional funding is requested. From reviewing divisional rosters, templates have been aligned to support changes to the establishment. Penn Ward requires an increase in their establishment of 0.7 WTE RN which will be provided from the surgical divisional budget.

A full breakdown of the findings from the establishment review can be found in **Appendix 3.** Current compared to proposed ward establishments setting are provided in **Appendix 4.**

Workforce intentions

There has been significant progress in reducing the vacancy rate for Registered Nurses and there has been a focussed programme of work recruiting international Registered Nurses to the workforce. Newly qualified and more experienced international Registered Nurses have enabled a crucial role in diversifying our workforce, addressing staffing challenges and enhancing cultural competence in patient care. However, there are challenges which include adapting to a new healthcare system, overcoming language barriers, cultural adjustments and variations in training standards. Adequate support and orientations programmes are essential to address these issues and ensure their successful integration into the workforce. As an organisation we have employed a substantial number of international Registered Nurses with limited or no post registration experience which provides challenges for these Registered Nurses in practice.

In 2019, the board approved the established of 5 WTE Clinical Practice Educators and 1 WTE Practice Development Nurse to support the development of skills and capability of the circa 1,400 WTE nursing and midwifery workforce.

**This establishment review has highlighted that a Registered Nurse increase is required in Lister Ward of 2.5 WTE. Lister Ward are trialling an externally funded initiative aiming to reduce the need for post care admission with a team providing re-conditioning support to patients on the ward. The divisional and senior nursing teams have reviewed the nurse sensitive indicators which do not demonstrate that Lister Ward is an outlier for quality outcomes and based upon professional nursing judgement should not have an increase in establishment at this current time, rather to review alongside subsequent establishment reviews.

Part of the establishment review is meeting with the divisional and ward-based nursing teams to discuss professional nursing judgment before a change in establishment is recommended. During these discussions, across all divisions, it was identified that more preceptor support nurses and clinical practice educators would be required to support our

junior workforce, and internationally educated workforce. This will expand the clinical practice educators to provide more practice development education in clinical areas and working alongside our Registered Nurses in preceptor support roles. This is a similar model that has been used successfully in our maternity service. No additional funding is requested as the moves will take place within existing surgical budgets.

Further consideration will take place throughout 2024 with the medicine division around substantive recruitment for Nightingale Ward to minimise temporary staffing spend and to provide a stable and experienced workforce. Nightingale ward is funded as a winter escalation ward and utilised for part of the year.

Enhanced Care

Following the establishment review in September 2021 it was identified there was a requirement for an enhanced care team, based on average daily number of Level 4 enhanced care patients. **Appendix 5** details the change in demand for the enhanced care team based upon September 2022 compared to September 2023, demonstrating the increased acuity and complexity of these cohort of patients presenting within the organisation.

Recruitment continues with 7.92 WTE in post and budget of 12.43 WTE.

The Trust has appointed a Registered Mental Health Nurse lead who will commence in post January 2024. This postholder will be working with the Enhanced Care Lead regarding the level of support the wards require for registered mental health nurses.

In line with recruitment in to the Enhanced Care Pool, the demand for RMN support has reduced by 30% between March 2022 – March 2023, which equates to a significant reduction in the use of agency staff and a significant cost saving. This is in part due to the Enhanced Care Pool where we have introduced a specialist mental health care support worker booked through NHS professionals, there has been a steady demand for this cohort of staff since December 2022.

5.0 Going forward

A mid-year interim establishment review will be undertaken in March 2024. The staffing establishment review will fully align with the new Safer Nursing Care Tool (SNCT) model which was released in October 2023, which increases the level of data collection from 20 days to 30 days of data. The data collection will continue at 15:00 hours looking back at the past 24 hours, seven days a week for 30 days of data as a minimum, overlaid with nurse sensitive indicators and will be led by the Associate directors of nursing and Deputy Chief Nurse.

Within the new refreshed SNCT tool the levels of care for patient classification, detailing staffing required for the level of care required by the patients has been adjusted. Enhanced care and ward layout are now taken into consideration and two additional levels of care are now within the tool. The new multiplier values reflect the WTE nurse staffing required to provide care for patients assessed at the appropriate SNCT levels. The refreshed tools takes into account the ageing population's impact on inpatient acuity and dependency, single room

ward design, Care hours per patient day (CHPPD) and proportion across days and nights; and supporting inpatients with increasing care requirements due to risk of falls, confusion and mental health needs (enhanced care). The detail is provided in **Appendix 6**.

Further training will be undertaken with matrons and ward managers to support understanding of the updated tool and consistency of data collection. There is a plan for ongoing training to ensure that the Trust is compliant with the new SNCT guidance. The guidance states, that a minimum of 3 senior ward nurses (Band 6 or above) have undertaken and passed the Trust's SNCT training and assessment.

Inclusion of other areas not included within this paper, including the methodology applied, will be included in the establishment reviews moving forward in 2024. The areas which have not been formally reviewed and reported since Covid 19, include theatres, cardiac catheter laboratories, outpatients and chemotherapy day unit in line with safe practice and demand and capacity for services.

All reviews will align to the agreed methodology within the recently approved PAHT Policy *the Nursing Establishment Setting Policy*.

The SNCT calculation is based upon a funded headroom allowance of 22% and this has been incorporated within the reviews. This headroom allowance is insufficient, particularly for specialist areas such as critical care, the emergency department and maternity services, which have greater training requirements for staff which will inflate the headroom required. A piece of work will take place this year to identify what headroom should be recommended for nursing and midwifery staff, including headroom requirements for our specialist areas.

6.0 Maternity services

Midwifery staffing is evidenced by application of the Birthrate Plus methodology, with a recommended cycle of a full review using this methodology every 3 years. The maternity service undertook a workforce review in the autumn of 2021 using Birthrate Plus casemix methodology (Midwifery workforce tool recommended by NICE). Casemix is categorised into five categories (1-V) 1 being a woman with a low risk pregnancy and straightforward birth with V being a woman with a complex pregnancy +/or birth. The acuity within the population denotes the WTE required to safely run a maternity service as it takes into consideration activity and acuity, as well as specialist midwifery services and managerial responsibilities. Birthrate Plus recommends that the maternity service should be funded to a midwife to birth ratio of 1:23.

Midwifery and Support Staff

The funded establishment for maternity for both midwives and support workers was determined on completion of a Birth Rate Plus (BR+) review in November 2021 with a subsequent workforce review paper taken to the Trust Board by the Director of Midwifery (DoM) in February 2022, to which the Board agreed with the recommendations.

It has taken time to reach the funded establishment agreed in 2022. As of end of November 2023, there are 3.10 WTE midwifery vacancies overall (funded establishment is 161.91 WTE

for Bands 5 - 7 including specialists), but 10.81 WTE amongst the support workers (16.71%). The recruitment and retention plan for support workers include a collaborative trust wide recruitment, a programme to support transition from Band 2 to 3, facilitating volunteers within maternity (as some then wish to work there), and rolling adverts.

For midwifery, recruitment is from the following avenues:

- 3-year midwifery course
- Shortened (24 months) for post registration staff
- International educated midwives
- Retire and return; legacy roles
- Return-to-practice

Also, under consideration are midwifery apprenticeships for existing support staff.

The maternity service ensures there is a safe staffing ratio in place to support women in a variety of ways. As previously mentioned, the funded established in based on the last BR+ review, with a further due in November 2024. There is robust rota management led by the two staffing co-ordinators in close collaboration with the ward leads and matrons, with ultimate responsibility and accountability with the DoM and Deputy DOM/ Head of Midwifery to ensure they fulfil the required staffing numbers and include a safe skill-mix to ensure staff are well supported, and the safety of our women. Rosters are released 8 weeks in advance so that there is forward-planning for identified staffing shortages. Subsequently, the maternity service conducts a regular review and planning of staffing a few weeks ahead. This is supported by the escalation policy which is aligned to the Operational Pressures Escalations Levels (OPEL) Framework. Gaps are addressed via our temporary staffing team, and senior management (out of hours) with redeployment of staff where possible.

Daily, staffing is monitored and any potential red flags highlighted in advance.
Safety huddles are held to discuss any potential challenges in maternity and neonatal services. There is a monthly report that is reviewed at the board which is details the current vacancies and recruitment plans.

The Trust has recruited a lead Professional Midwifery Advocate (PMA) who has a focus on retention and wellbeing with several initiatives in place including multidisciplinary recruitment to support a richness of experience and skill sets. The PMA head count in November 2023 was 13, giving a ratio with midwives of 1:19 (recommended is less than or equal to 1:20). In addition to individual clinical supervision, their focus is to have career conversations and restorative supervision sessions. There is consideration of “stay interviews/ discussions” which will enable the maternity leadership to understand what motivates colleagues to remain in their roles and at PAHT.

The establishment review has detailed that the maternity service has the required funded establishment for the level of acuity and activity within the service, and that no additional

funding is requested. The service meets the Birthrate Plus recommendation of midwife to birth ratio of 1:23.

7.0 Recommendations

The Board is asked to note the context and recommendations of this report; the recommended changes to ward establishments as included in section 4 and the recommendation to increase the clinical practice educators' team. No additional funding is requested to facilitate these recommendations, as divisional budgets and rosters have been reviewed to enable flexibility of funding across the workforce to meet the demand.

Appendix 1: Regulatory requirements and best practice guidance

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

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

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

Lord Carter’s report, ‘Operational Productivity and Performance in English Acute Hospitals: Unwarranted variations’ (revised February 2016), identified efficiency opportunities and the requirement for organisations to meet the challenges of maintaining and improving quality, operational performance, finance and efficiency. The latest CQC Consultation document outlines how effectively a provider uses its resources is one of the factors that determines the quality and responsiveness of its care.

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

Appendix 2: Nurse sensitive indicators September 2023

	PALS (Inc bereavement, GP queries)	PALS queries referred to complaints	New Complaints	Compliments	Pressure ulcers	Falls	SI	Staffing levels	Medication errors
ED	21	1	0	0	0	6	0	9	9
AAU	1	0	0	0	3	3	0	4	9
Charnley	1	0	1	0	2	7	0	0	1
Dolphin	3	0	0	0	0	0	0	0	2
Fleming	2	0	0	0	1	2	0	1	1
Harold	3	0	1	0	8	10	0	0	0
Harvey	2	0	0	0	2	4	0	0	7
Henry Moore	2	0	0	0	0	1	0	1	0
John Snow	3	0	0	0	1	1	0	0	0
Kingsmoor	8	0	1	0	3	8	0	3	1
Lister	3	0	0	0	2	12	0	2	1
Locke	6	0	0	0	8	8	0	1	2
OPAL	2	0	0	0	1	9	0	0	1
Paeds ED	2	0	0	0	0	0	0	4	2
Penn	1	0	0	0	2	0	0	6	1
Ray	5	0	0	0	5	4	0	1	2
Saunders	7	0	0	0	2	3	0	1	1
Tye Green	7	0	0	0	5	7	0	6	0
Winter	4	0	1	0	2	5	0	0	1

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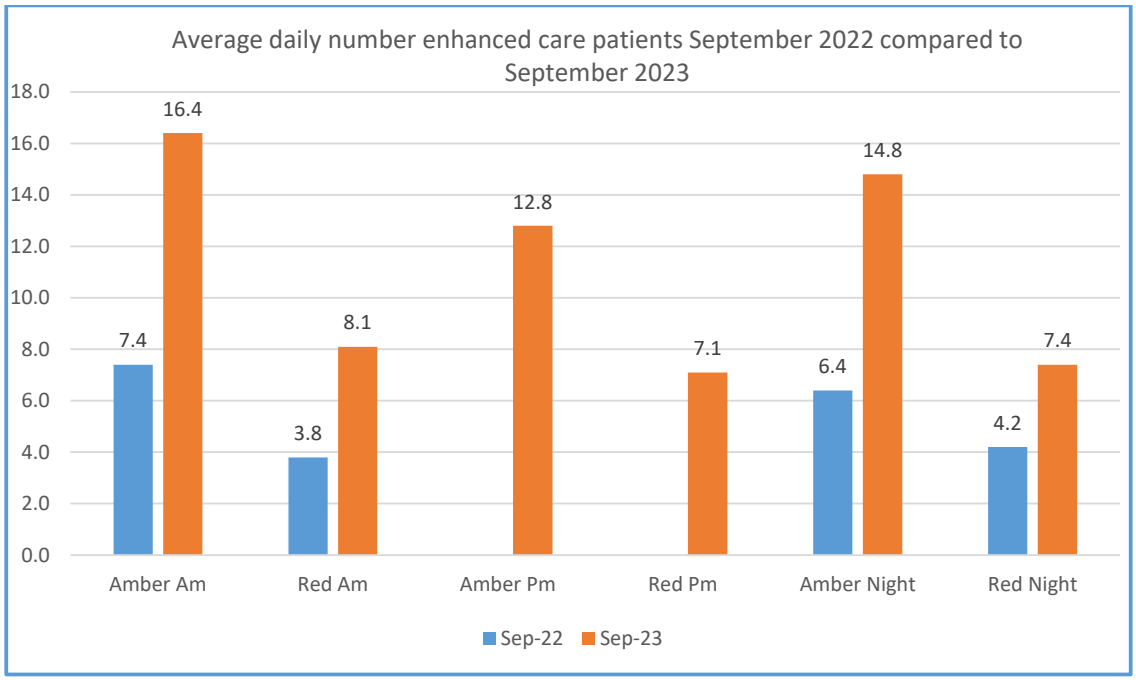
Appendix 3: Full SCNT results compared to September 2022 full review and March 2023 interim review

Ward	Sep-22				Mar-23				Current template			Sep-23				Variance WTE March 23 vs September 2023	Variance WTE September 22 vs September 2023
	SNCT Data WTE	% RN	RN required WTE	HCA required WTE	SNCT Data WTE	% RN	RN required WTE	HCA required WTE	LD	Night	WTE	SNCT Data WTE	% RN	RN required WTE	HCA required WTE		
AAU	45.5	80	36.4	9.1	47.2	80	37.8	9.4	8+2	7+2	49.1	45.3	80	36.2	9.1	-1.9	-0.2
Charnley	35.2	70	24.6	10.6	35.6	70	24.9	10.7	5+2	5+2	36.1	35.6	70	24.9	10.7	0	0.4
Dolphin	23.2	60	13.9	9.3	32.5	60	19.5	13.0	5+2	4+1	31.1	29.1	60	17.5	11.6	-3.4	5.9
Fleming	31	70	21.7	9.3	31.1	70	21.8	9.3	5+2	4+2	33.6	32	70	22.4	9.6	0.9	1
Harold	43.1	75	32.3	10.8	42.6	75	32.0	10.7	7+3	6+3	49.1	46.4	75	34.8	11.6	3.8	3.3
Harvey	24.2	60	14.5	9.7	24.9	60	14.9	10.0	4+2	3+2	28.4	26.7	60	16.0	10.7	1.8	2.5
Henry Moore	12.6	60	7.6	5.0	15.9	60	9.5	6.4	3+2	3+2	25.8	18	60	10.8	7.2	2.1	5.4
John Snow	11.7	60	7.0	4.7	11.3	60	6.8	4.5	2+2	2+1	18.1	10.8	60	6.5	4.3	-0.5	-0.9
Kingsmoor	39.2	60	23.5	15.7	39.9	60	23.9	16.0	6+3	4+3	41.4	38.6	60	23.2	15.4	-1.3	-0.6
Lister	38.9	60	23.3	15.6	40.9	60	24.5	16.4	5+3	4+3	38.8	41.4	60	24.8	16.6	0.5	2.5
Locke	39.2	60	23.5	15.7	34.5	60	20.7	13.8	5+4	4+3	38.8	42.6	60	25.6	17.0	8.1	3.4
Nightingale		60	0.0	0.0	19.9	60	11.9	8.0	3+3	3+2	25.8		60	0.0	0.0		0
OPAL Beds only	12.6	65	8.2	4.4	15.7	60	9.4	6.3	3+2	3+2	25.8	15.6	60	9.4	6.2	-0.1	3
Penn	37.3	60	22.4	14.9	38.3	60	23.0	15.3	5+3	4+2	36.3	38	60	22.8	15.2	-0.3	0.7
Ray	37.3	60	22.4	14.9	37.7	60	22.6	15.1	5+3	4+2	36.3	35.2	60	21.1	14.1	-2.5	-2.1
Saunders	35.3	60	21.2	14.1	33.1	60	19.9	13.2	5+3	4+2	36.3	33.5	60	20.1	13.4	0.4	-1.8
Tye Green	46.2	60	27.7	18.5	45.4	60	27.2	18.2	6+4	5+3	46.6	46.8	60	28.1	18.7	1.4	0.6
Winter	39.3	60	23.6	15.7	38.4	60	23.0	15.4	5+3	4+3	38.8	39.5	60	23.7	15.8	1.1	0.2

Appendix 4: Current ward establishment compared to proposed ward establishment

Ward	Current template			Proposed template		
	LD	Night	WTE	LD	Night	WTE
AAU	8+2	7+2	49.1	8+2	7+2	49.1
Charnley	5+2	5+2	36.1	5+2	5+2	36.1
Dolphin	5+2	4+1	31.1	5+2	4+1	31.1
Fleming	5+2	4+2	33.6	5+2	4+2	33.6
Harold	7+3	6+3	49.1	7+3	6+3	49.1
Harvey	4+2	3+2	28.4	4+2	3+2	28.4
Henry Moore	3+2	3+2	25.8	3+2	3+2	25.8
John Snow	2+2	2+1	18.1	2+2	2+1	18.1
Kingsmoor	6+3	4+3	41.4	6+3	4+3	41.4
Lister	5+3	4+3	38.8	5+3	4+3	38.8
Locke	5+4	4+3	38.8	5+4	4+3	38.8
Nightingale	3+3	3+2	25.8	3+3	3+2	25.8
OPAL Beds only	3+2	3+2	25.8	3+2	3+2	25.8
Penn	5+3	4+2	36.3	5+3	4+2	37
Ray	5+3	4+2	36.3	5+3	4+2	36.3
Saunders	5+3	4+2	36.3	5+3	4+2	36.3
Tye Green	6+4	5+3	46.6	6+4	5+3	46.6
Winter	5+3	4+3	38.8	5+3	4+3	38.8

Appendix 5: Average daily number of Level 4 enhanced care patients September 2022 / September 2023



WTE required for Red only September 2022	21.7
WTE required for Red only September 2023	40.2

This data provides a summary on the average number of patients per day that require either Amber (within eyesight) or level 4 Red (constant observation). Reviewing the average number of patients per month that required enhanced care that required constant observation demonstrated that 40.2 WTE staff would be required to provide this level of care. The Trust has appointed a Registered Mental Health Nurse lead who will commence in post January 2024. This postholder will be working with the Enhanced Care Lead regarding the level of support the wards require for registered mental health nurses and enhanced care.

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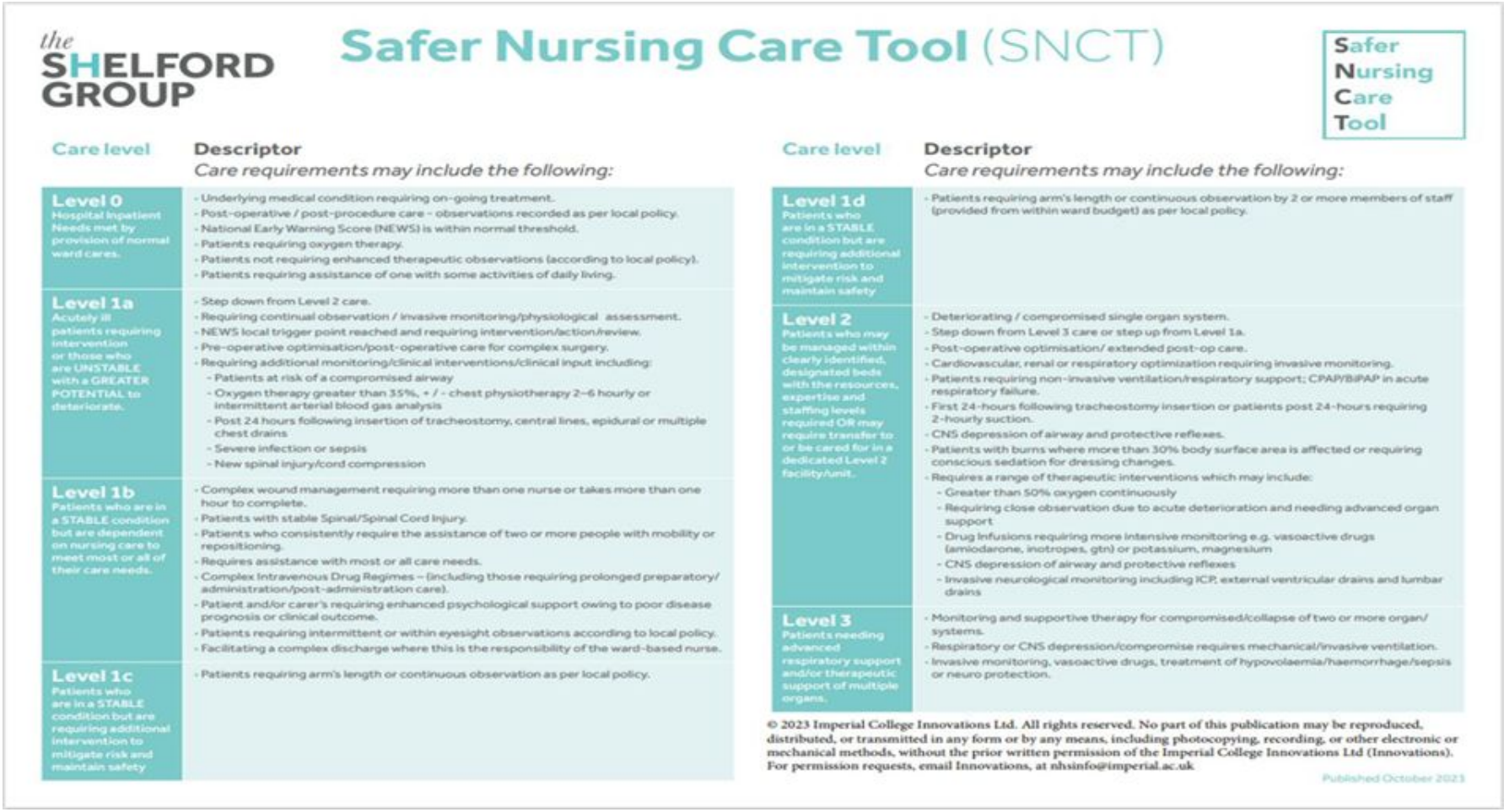
Appendix 6: Refreshed SNCT Care Levels and descriptors



the SHELFORD GROUP

Safer Nursing Care Tool (SNCT)

Safer Nursing Care Tool

Care level	Descriptor *Care requirements may include the following:*
Level 0 Hospital Inpatient Needs met by provision of normal ward cares.	- Underlying medical condition requiring on-going treatment. - Post-operative / post-procedure care – observations recorded as per local policy. - National Early Warning Score (NEWS) is within normal threshold. - Patients requiring oxygen therapy. - Patients not requiring enhanced therapeutic observations (according to local policy). - Patients requiring assistance of one with some activities of daily living.

Level 1a
Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.
	- Step down from Level 2 care.
	- Requiring continual observation / invasive monitoring/physiological assessment.
	- NEWS local trigger point reached and requiring intervention/action/review.
	- Pre-operative optimisation/post-operative care for complex surgery.
	- Requiring additional monitoring/clinical interventions/clinical input including:
	  - Patients at risk of a compromised airway
	  - Oxygen therapy greater than 35%, + / - chest physiotherapy 2–6 hourly or intermittent arterial blood gas analysis
	  - Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest drains
	  - Severe infection or sepsis
	  - New spinal injury/cord compression

Level 1b Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.	- Complex wound management requiring more than one nurse or takes more than one hour to complete. - Patients with stable Spinal/Spinal Cord Injury. - Patients who consistently require the assistance of two or more people with mobility or repositioning. - Requires assistance with most or all care needs. - Complex Intravenous Drug Regimes – (including those requiring prolonged preparatory/ administration/post-administration care). - Patient and/or carer's requiring enhanced psychological support owing to poor disease prognosis or clinical outcome. - Patients requiring intermittent or within eyesight observations according to local policy. - Facilitating a complex discharge where this is the responsibility of the ward-based nurse.
Level 1c Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	- Patients requiring arm's length or continuous observation as per local policy.

Care level	Descriptor *Care requirements may include the following:*
Level 1d Patients who are in a STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	- Patients requiring arm's length or continuous observation by 2 or more members of staff (provided from within ward budget) as per local policy.

Level 2
Patients who may be managed within clearly identified, designated beds with the resources, expertise and staffing levels required OR may require transfer to or be cared for in a dedicated Level 2 facility/unit.
	- Deteriorating / compromised single organ system.
	- Step down from Level 3 care or step up from Level 1a.
	- Post-operative optimisation/ extended post-op care.
	- Cardiovascular, renal or respiratory optimization requiring invasive monitoring.
	- Patients requiring non-invasive ventilation/respiratory support; CPAP/BiPAP in acute respiratory failure.
	- First 24-hours following tracheostomy insertion or patients post 24-hours requiring 2-hourly suction.
	- CNS depression of airway and protective reflexes.
	- Patients with burns where more than 30% body surface area is affected or requiring conscious sedation for dressing changes.
	- Requires a range of therapeutic interventions which may include:
	  - Greater than 50% oxygen continuously
	  - Requiring close observation due to acute deterioration and needing advanced organ support
	  - Drug Infusions requiring more intensive monitoring e.g. vasoactive drugs (amiodarone, inotropes, gtn) or potassium, magnesium
	  - CNS depression of airway and protective reflexes
	  - Invasive neurological monitoring including ICP, external ventricular drains and lumbar drains

Level 3 Patients needing advanced respiratory support and/or therapeutic support of multiple organs.	- Monitoring and supportive therapy for compromised/collapse of two or more organ/ systems. - Respiratory or CNS depression/compromise requires mechanical/invasive ventilation. - Invasive monitoring, vasoactive drugs, treatment of hypovolaemia/haemorrhage/sepsis or neuro protection.

Published October 2023

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 2 February 2024

4.5

Agenda item:	4.5							
Presented by:	Lance McCarthy | Chief executive Officer							
Prepared by:	Fay Gilder | Medical Director							
Date prepared:	24 January 2024							
Subject / title:	Learning from Deaths update							
Purpose:	**Approval**		**Decision**		**Information**	**x**	**Assurance**	x
Key issues:	This paper provides an update on data submission for mortality indices interpretation and programme of work to support structured judgement review (SJR) completion.							
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**
	✓	✓	✓		

Previously considered by:	n/a
Risk / links with the BAF:	BAF 1.1 Variation in outcomes resulting in poor clinical quality, safety and patient experience.
Legislation, regulatory, equality, diversity and dignity implications:	*'Learning from Deaths'* - National Quality Board, March 2017 *This paper has been written with due consideration to equality, diversity and inclusion in respect of our patients, people and potential providers.*
Appendices:	

The Princess Alexandra Hospital NHS Trust

4.5

1.0 Purpose/issue

The purpose of this paper is to update Board on the mortality indices and SJR completion progress.

2.0 Background

Princess Alexandra Hospital Trust (PAH) has a learning from death process that meets the national requirements.
The risks associated with this are captured on the learning from death risk register.

3.0 Current Telstra update on mortality indices for Princess Alexandra Hospital (PAH)

It has not been possible to present the mortality indices to Board this month. This is due to issues with the way data is processed as it is submitted to Hospital Episodes Statistics (HES).

As well as submission to HES we also independently submit our data to Telstra. Telstra will be working with us to provide us with mortality indices in the interim and this will be presented to public board in April.

Local intelligence suggests that we remain 'within expected' for the 12 month rolling HSMR and SMR.

2.0 Structured Judgement Reviews

Considerable work is occurring to support the timely completion of SJRs. The Associate Medical Director (Mortality) has been educating medical colleagues in all relevant clinical specialties regarding the importance and the undertaking of SJRs.

An improvement is expected within 3 months and this will be tracked through the Divisional Review Meetings.

3.0 Risks

No changes identified for the Learning from Deaths risk register.

4.0 SLFD Group

SLFD group meeting summary is presented and discussed at QSC on a monthly basis with key points highlighted in the QSC summary presented to Board. A NED attends the SLFD group.

5.0 Recommendation

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

The Princess Alexandra Hospital NHS Trust

Public Board 1 February 2024

Agenda item:	4.6
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	25 January 2024
Subject / title:	Alex Health Programme Update

Purpose:	**Approval**		**Decision**		**Information**	**X**	**Assurance**	**X**
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The Alex Health programme is still on course to implement in October, with our key milestones being hit to date. This paper will outline progress over the last 8 weeks, plans for the next period, current risks we are managing and mitigating, emerging concerns, and review of our critical path.							
Recommendation:	The Board is asked to note the contents of this paper.							

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:	Alex Health Programme Board
Risk / links with the BAF:	1.2 Data Quality
Legislation, regulatory, equality, diversity and dignity implications:	The Alex Health Programme in ensuring it support the organisation on complying with our regularly and legal obligations such as access to records and data protection act. It will also support increasing access to information for our diverse population through being able to access the information in different means and protecting their information appropriately.
Appendices:	

Introduction

The Alex Health programme is still on course to implement in October, with our key milestones being hit to date. This paper will outline progress over the last 8 weeks, plans for the next period, current risks we are managing and mitigating, emerging concerns, and review of our critical path.

Programme Progress

The programme has continued to deliver against critical path milestones. The key deliverables have been:

- Completion of primary and secondary circuits to enable resilient connection to the Oracle environment and our version of Millenium.
- Completion and sign off of all data collection workbooks required for future state validation
- Completion of a minimum of 70% of workflows for future state validation

The above is being managed through weekly meetings of the programme including Clinical Design Advisory Group, Configuration Board, Change Advisory Board, and Operational Readiness Group which all report into a weekly Implementation Board chaired by the Programme Director.

In addition, we are now being supported by an external partner, who have significant experience in EHR deployments. They will be supporting key members of the programme in their leadership and decision making, as well as providing external assurance to the SRO and CEO on effectiveness of the programme.

Plans for the next period

The key milestone that we will be achieving shortly is Future State Validation which will happen week commencing 29 January. This is one of the key activities in the programme whereby we validate the work we have completed through data collection workbooks and workflow design to ensure that system will support our processes and pathways. This work is being led by our Deputy Director of Quality Improvement, closely supported by our clinical digital team, workstream leads and subject matter experts.

The following key activities will also be completed over the next 4 – 6 weeks:

- Completion and approval of the Training Plan at implementation board
- Commencement of post future state validation of our internal and external engagement programme. Further detail on this can be seen in appendix one
- Commencement of our data migration trial load one
- Approval of the validate gateway

Current Risks and Issues

While the programme is currently rated at amber, there are inevitably some significant risks that we continue to manage and mitigate. The key risks (currently scored over 15) are summarised below:

- Lack of flex in our timeline.
- Resourcing gaps
- Training plan development
- Comms and Engagement

Key risks and issues continued to be managed through the Implementation Board with detailed mitigation plans

Emerging Concerns

Whilst we actively and robustly manage our risks, we also are alert to emerging concerns to ensure we have early sight of them. These are gathered through our formal governance route, but also a number of informal channels to triangulate this information. Key emerging concerns are as follows:

- Development of our Android environment for mobile nursing access
- Post Implementation structures and support

Critical path timeline review

As described in the 'plans for next period' section, we continue to track to our critical path and on course to meet our next key milestone of future state validation by the end of 2nd February 2024, enabling the commenced of the approval of the validate gateway. The following dates are our next key critical path deliverables:

- W/C 29 January commencement of data migration trial load 1 (completing week commencing 18 March)
- W/C 19 February commencement of system testing (completing week commencing 18 March)
- W/C 25 March testing checkpoint
- W/C 12 February commence of lesson plan creation (completing on week commencing 8 April)

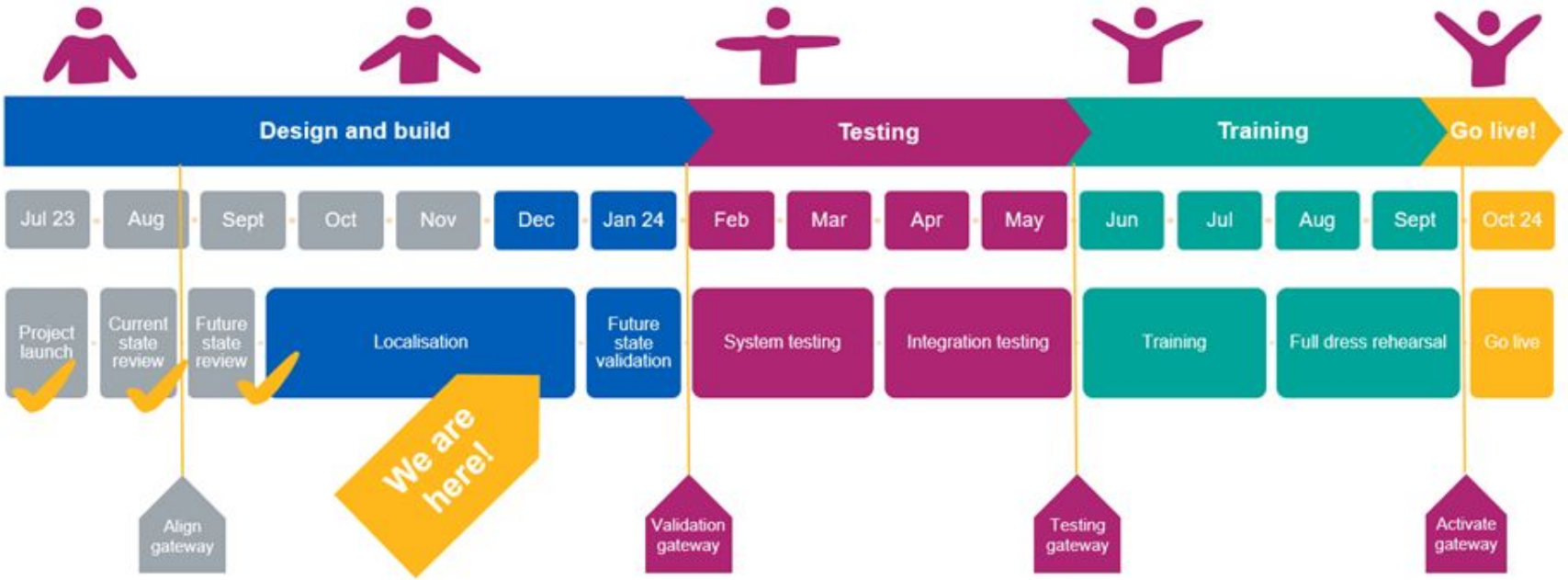
Conclusion

The Trust Board is asked to review and consider the contents of this report

Phil Holland

Chief Information Officer and Alex Health SRO

Our roadmap to go-live



BOARD OF DIRECTORS: Trust Board (Public) - 1 February 2024 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Darshana Bawa – Committee Chair

DATE OF COMMITTEE MEETING: 22 January 2024

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 Staff survey results	Y	Y	N	The 2023 Staff Survey results from the 62 Trusts using Picker were discussed. The results are currently under embargo pending publication of the national results. The committee will receive a full update when the results are published in March 2024.
2.2 Communications update	Y	N	N	An update on the activity of the Communications team was noted including the success of the public engagement event for the Community Diagnostic Centre
2.3 Communications review	Y	Y	N	The outcome of the external review was noted along with areas of good practice and recommendations for the strategic direction of the communications portfolio. A further update will be presented in July.
2.4 Learning &OD update	Y	Y	N	Appraisals and statutory and mandatory training compliance were discussed along with a programme of work to optimise the functionality of TiMS. The improvement in compliance rates for both appraisals and statutory and mandatory training was noted albeit still below target.
2.5 Guardian of Safer Working	Y	Y (ongoing)	N	There were 65 exception reports during October to December 2023, the majority due to working over hours. Five immediate patient safety reports were submitted. None were about a particular patient or incident but described minimal staffing where safety may have been compromised. These occurred in EAU, Respiratory Medicine and T&O. Actions have been agreed with each specialty.

2.6 Freedom to Speak up	Y	N	N	There continues to be an increasing number of referrals each quarter, Perceived poor behaviours between colleagues continues to be the largest theme and have been addressed through recommendations for improved conversations.
2.7 People Report (KPI's) including: Recruitment Deep Dive	Y	Y (deep dive)	N	The vacancy rate increased to 8.93% and sickness has increased to 5.03%. Time to hire is 62 days and work is underway to reduce this. Temporary staffing costs are being monitored; the total spend for December 2023 was £4.04m, which was a reduction of 60k on November 2023. A recruitment deep dive will be presented to a future meeting and content is to be discussed offline.
2.8 Safer Nurse Staffing Report	Y	N	N	The overall fill rate for December has remained stable for Registered Nurses (RN's) and Healthcare support workers. No wards reported average fill rates below 75% for RN's against the standard planned template during December 2023.
2.9 Nursing Establishment Review	Y	N	Y (to Board for approval)	A full establishment review was undertaken in September 2023 in line with national recommendations. The recommended changes were noted and it was recommended that the clinical practice educators' team is increased. No additional funding is required to implement these recommendations. The next interim establishment review is due to be completed in March 2024 and reporting to Board in June 2024 using the refreshed SNCT methodology. **The committee recommended the paper to Board.**
2.10 PAHT 2030 Culture Milestones	Y	N	N	The 2022/23 milestones remain green overall with one milestone currently delayed (amber). Our Culture 2023/24 also remains green overall, with two milestones currently delayed (amber).
2.11 Annual Equality Delivery System Review.	Y	N	Y	The outcomes of the annual Equality Delivery System review were discussed and the organisation's grading as 'Developing' was noted. Following review by the ICS the paper will be presented to the Board.
2.12 Gender Pay Gap	Y	N	Y (Board)	The paper was recommended to Board for approval.
2.13 GMC Enhanced Monitoring	Y	N	N	Positive progress was noted.

2.14 BAF Risk 2.1: (GMC enhanced monitoring)	Y	N	N	The risk score remains unchanged at 20.
2.15 Medical Workforce review	Y	N	N	The committee was pleased to receive the report on the external review of 8 medical specialties which was undertaken to understand the workforce required to deliver both high quality medical education and patient care. Key recommendations and actions were discussed.
2.16 Horizon scanning including Long Term Change Management	Y	N	N	The department of health is looking for evidence from different perspectives across the health and care system that will inform the government's consideration of separating nurses pay from other staff under Agenda for Change.
2.17 BAF Risk 2.3 Workforce: Inability to recruit, retain and engage our people	Y	N	N	The risk score remains unchanged at 16 pending receipt of the national staff survey results.
2.18 Voluntary Services	Y	N	N	An update was discussed; there are currently 101 active volunteers and work is underway to recruit additional Compassionate Care Namaste volunteers from 90 expressions of interest.
2.19 Report from People Meeting	Y	N	N	The report was noted.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 February 2024

5.2

Agenda item:	5.2
Presented by:	Ogechi Emeadi – Director of People
Prepared by:	Denise Amoss, Associate Director of Organisational Development & Learning (Interim) Nathaniel Williams, People Information and Systems Lead; Monika Kalyan, Head of Equality, Diversity & Inclusion
Date prepared:	20 December 2023
Subject:	Gender Pay Gap Reporting 2023

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	Under the Equality Act 2010, the Princess Alexandra Hospital NHS Trust, is required to publish gender pay gap information by 30th March each year. The gender pay gap is about the difference between men and women's average pay within an organisation. • The gender pay gap as at 31 March 2023 reports men have higher mean and median average pay than women • The difference between mean pay of men and women is 24% and that of median average pay is 13% • Whilst medical and dental staff are separated from Agenda for Change staff and very senior managers, the mean gap is that women earn 1% less than men and the median gap is in favour for women earning 7% more than men • The medical and dental mean and median pay gap is 18% and 20% in favour for men.
Recommendation:	For approval.

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:	People Committee.22.01.24
Risk / links with the BAF:	2.1 Workforce capacity 2.3 Internal engagement 2.4 Workforce capabilities
Legislation, regulatory, equality, diversity and dignity implications:	The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 requires the Trust to publish its gender pay gap report every year. If we do not report on time or if we provide inaccurate information, we could face legal action from the Equality and Human Rights Commission.
Appendices:	

The Princess Alexandra Hospital NHS Trust

5.2

1. Introduction

The gender pay reporting legislation requires all organisations employing more than 250 people to measure and publish their gender pay information based on earnings. As at 31 March 2023, our gender profile is 77% women and 23% men.

2. Background & context

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

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

2.3 The NHS has a national pay structure, job evaluation system and contractual terms and conditions for medical and non-medical staff, which has been developed in partnership with trade unions. This national framework provides a robust set of arrangements for pay determination.

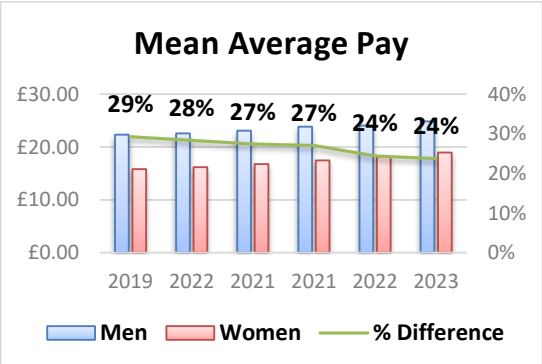
2.4 The gender pay reporting requirements were introduced to highlight the differences in pay between men and women giving more transparency across all industry sectors. This assists employers to consider the reasons for any differences and to take any corresponding action.

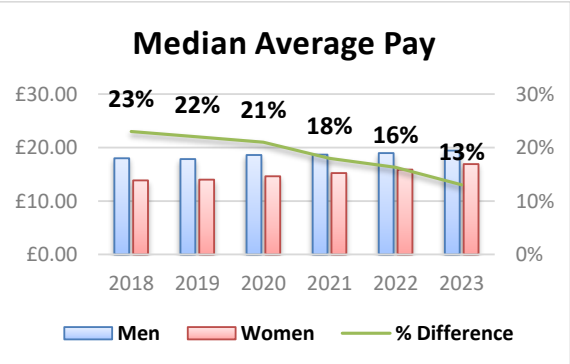
3. Requirements

Information taken as at 31 March 2023 for the following:

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

4. Mean and median ordinary pay





modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The trust mean gender pay gap indicates that women earn 24% less than men for the reporting period compared to 29% in 2018. The median pay gap indicates that women earn 13% less than men, an improvement from the previous reporting periods. The high pay difference is partly due to medical & dental staff being the highest paid staff group.

The tables below give a clear separation of medical and dental staff group when compared to Agenda for Change (AfC) pay bands (including very senior managers - VSM) for this reporting period only.

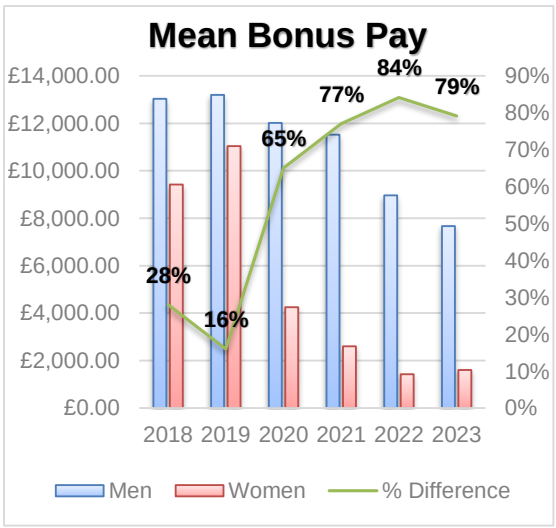
AfC &VSM	Mean Hourly Rate	Median Hourly Rate
Men	£17.99	£15.20
Women	£17.74	£16.29

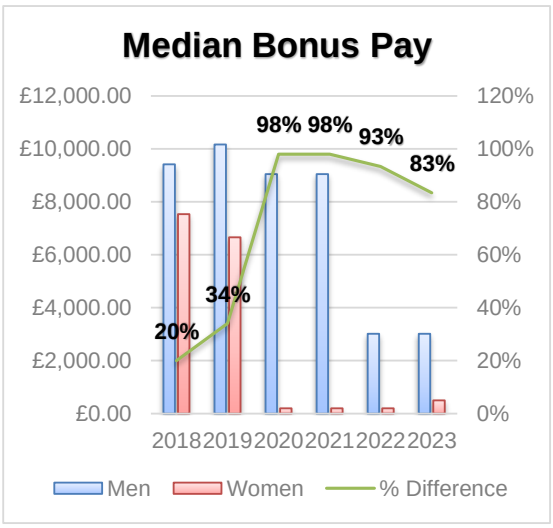
M&D only	Mean Hourly Rate	Median Hourly Rate
Men	£39.99	£37.14
Women	£32.92	£29.88

The mean pay gap for Agenda for Change pay band including VSM, show the mean hourly rate women earn is 1% less than men and the median pay shows that women earn 7% more than men. Within medical and dental staff, the mean and median pay gap indicates that women earn 18% and 20% less respectively than men.

5. Mean and median bonus pay gap

The Consultant staff group were the only staff group prior to this reporting period in receipt of bonuses (in line with NHS national terms and conditions for medical staff). This reporting period includes a welcome bonus payment for our international nurses. For the purposes of this report, bonuses are exclusively made up of local and national consultant clinical excellence awards, discretionary points and welcome bonus.





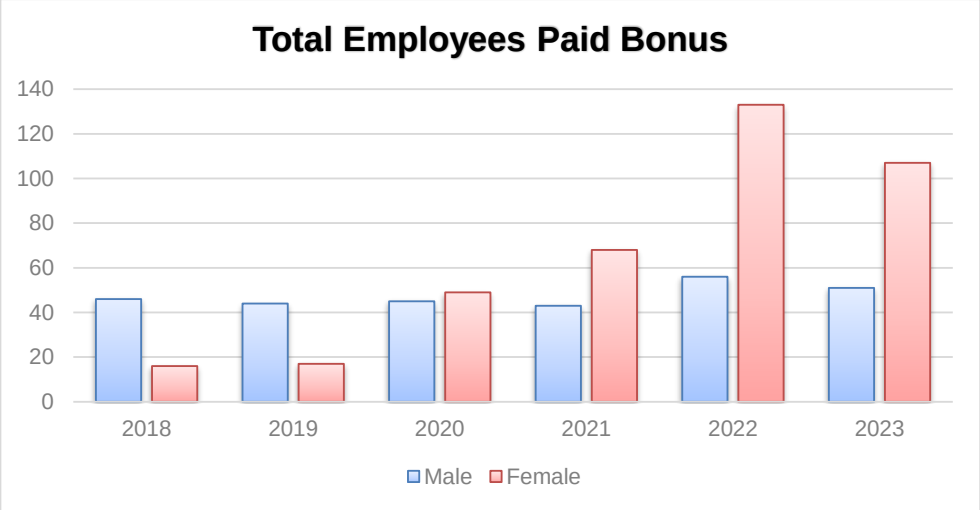
The tables below give a clear separation of the bonus paid to consultants and the welcome bonus paid to our international nurses for this reporting period.

M&D only	Mean Bonus Payment	Median Bonus Payment
Men	£11,271.88	£9,550.65
Women	£10,174.27	£7,076.26

International Nurses	Mean Bonus Payment	Median Bonus Payment
Men	£458.82	£500.00
Women	£419.15	£500.00

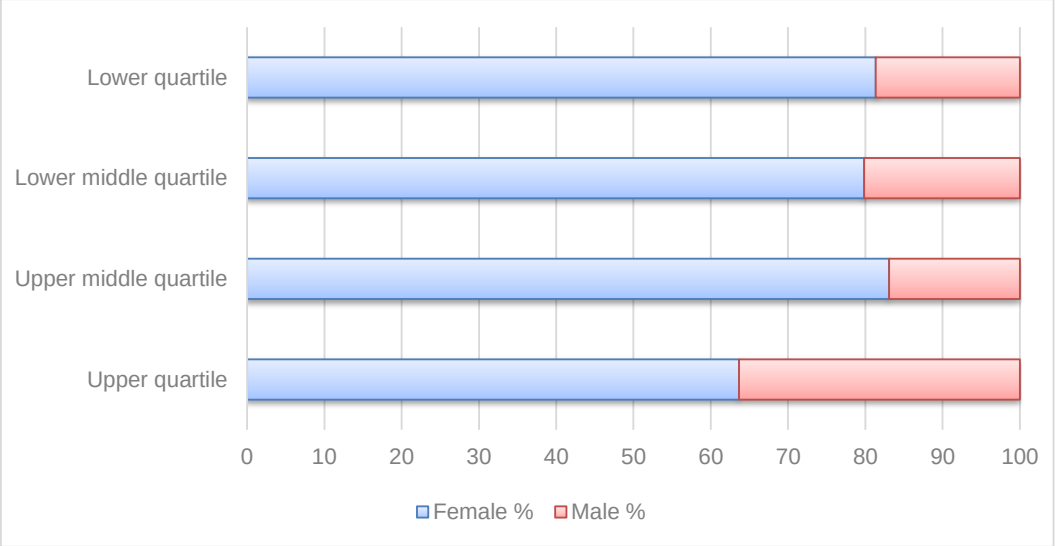
6. Total Employees paid bonus

The chart shows more women received the bonus payment in this reporting period than men. This is due to the ninety-four international staff who were women that received between £200 - £500 welcome bonus compared to only seventeen men who received between £200 - £500 welcome bonus.



7. Pay distribution by gender

The chart shows the proportion of men and women employees in each quartile. Employees are allocated into each quartile based on their hourly rate of pay. Lower quartile is our lowest pay quartile and upper quartile is our highest pay quartile.



8. Progress

The Trust has already carried out a number of actions that form part of our commitment to address the gender pay gap. These actions are outlined below. 2022-2023 actions:

Action 1: Continue to promote and encourage flexible working arrangements where practicable across all areas

Health and wellbeing integrated into our new appraisal framework launched in 2023 encouraging line managers to have regular conversations about wellbeing with their direct reports. Specific prompts in the appraisal template regarding working patterns and adjustments and health and wellbeing resources available and how to access them.

PAHT has signed up to the Essex Family-Friendly Employers Charter. The Charter is a set of minimum principles that employers in Essex should meet to be deemed family-friendly. The charter sets out how employers can help parents and carers manage their work and caring commitments.

PAHT has a clear Flexible Working Policy & Procedure with different working options outlined on both AlexNet and our Recruitment site https://www.pah.nhs.uk/agile-working.

Other key activity:

- SHAW plan designed with staff, launched in 2023
- Staff health and wellbeing newsletter produced monthly with signposting to national support i.e. national obesity support programme for NHS staff.
- Self-referrals promoted to support long term conditions and to support and develop management plans.
- Health and wellbeing champions
- Health and wellbeing Guardian – Non-Exec Director
- Health lifestyles are encouraged with discounted gym memberships and access to fitness apps/ online classes.
- Physiotherapy services are in place to support with MSK.

- Psychological support services - Here for you
- Employee Assistance programme 24/7
- Occupational health services
- Mental health first aiders (MHFA)

PAHT's other certification / accreditation badges

- NHS Pastoral Care Quality Award
- Apprenticeships
- Menopause Friendly
- Disability confident scheme level 2
- NHS Rainbow badge
- Stonewall Diversity Champions
- Happy to Talk Flexible Working
- Armed Forces Covenant

Action 2: Raising awareness on shared parental leave
Shared Parental Leave policy launched in 2022.

Action 3: Promote guidance to help support any staff members experiencing menopausal symptoms, encourage open conversations and create a better working environment
We are proud to be an independently accredited menopause friendly employer. We have a Menopause Policy for our people as well as training for all staff, supervisors and managers. We also have Menopause Advocates within the trust. There is also Line Manager Guide.

Menopause awareness training sessions. Our staff health and wellbeing (SHaW) team have arranged menopause awareness training sessions to open up the conversation, to help people understand what the menopause is and why we need to talk about it. The training covers the signs and symptoms and how to support people going through the menopause. There are sessions specifically for those that manage people and general sessions open to all staff.

Training delivered so far:
Menopause awareness – managers' sessions
6 September, 1pm to 2pm
1 November, 1pm to 2pm
Menopause awareness - all staff sessions
4 October, 1pm to 2pm
6 December, 1pm to 2pm

Action 4: Establish a women's network
Invitation to participate in a new network for women included in internal communication channels (October and December 2023) meeting dates to be set for 2024.

9. Next steps and actions for 2024

PAHT will continue to build on previous actions (outlined in section 8) and work with staff to develop more specific focus. This will enable tailored actions to be put in place for 2024/25 to deliver change and a reduction in the gender pay gap.

Action	Lead	Timescale	Outcome/impact
Implement the Mend the Gap review recommendations for medical staff and	Medical workforce leads	March 2024	Improvement in specific areas

develop a plan to apply those recommendations to senior non-medical workforce	EDI lead for non-medical workforce		Monitoring key indicators on a regular basis
Further advertise flexible working options on PAHT's recruitment campaigns	People team	March 2024	Improve awareness of flexible working
Compare PAHT gender pay gap metrics against other appropriate NHS Trusts	People information	November 2024	Introducing greater levels of transparency around gender pay gap
Establish women's staff network and development of a detailed gender pay action plan in liaison with the network	EDI lead	March 2024	Enabling the development of a robust and detailed gender pay gap action plan
Review shared parental policy with staff network for any underlying impact on the gender pay gap	People team with EDI lead	October 2024	Understanding the impact of the current shared parental policy will enable the policy to be improved to eliminate any negative impact

Our success metric is year-on-year reduction in the gender pay gap.

Note: this report will be presented to the EDI steering group 23 February 2024.

10. Recommendations

The Board is asked to note the gender pay gap data including the publication date of this data and continue to support ongoing actions to address the gender pay gap

BOARD OF DIRECTORS:	**Trust Board (Public) 1 February 2024**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**25.01.24**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 M9 Integrated Finance Report including Deep Dive into Trauma & Orthopaedics	Y	Y	N	The Trust reported a deficit of £2.5m in M9 against a deficit plan of £2.0m and a £14.1m deficit YTD against a £5.6m YTD deficit plan. This was based on the original submitted plan in April 2023, i.e. a £5.1m deficit for the full year. In November 2023 a revised forecast position for the year-end was provided. The Trust's M9 position was favourable to this forecast in-month and YTD by £0.5m, predominantly due to a favourable non-pay position and non-recurrent support from technical measures. **T&O Deep Dive** PAF had previously requested a deep dive into a speciality where expenditure could be linked to performance and quality. This had therefore been done for Trauma & Orthopaedics where it could be seen that since the previous summer and following a visit from the GiRFT team, the speciality was now making improvements in terms of touch-time, productivity, theatre utilisation and recovery.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) 1 February 2024**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**25.01.24**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.2 Capital Update	Y	Y	N	As at M9, YTD capital spend totalled £8.1m, and this included the external funding spend. This would require the Trust to spend £23.1m within the last quarter of the year to achieve 2023/24 CRL, inclusive of additional PDC funding but there were a number of moving parts to the programme described within the report.
2.3 Contracts Update	Y	Y	N	The up-to-date contract schedule as at January 2024 was presented and there were no contracts of any concern that were expiring or not addressed via the work plan.

BOARD OF DIRECTORS:	**Trust Board (Public) 1 February 2024**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**25.01.24**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.4 PQP Update	Y	Y	N	Year to date (YTD) at M9, PQP has over-delivered against divisional trajectories by £2.26m and over-delivered against the Trust target by £443k. In-month, PQP had over-delivered by £1.58m against trajectory, and over-delivered by £1.06m against target. In total, £2.88m was delivered in-month and £11.16m YTD. Delivery of the non-recurrent central support (£4.1m) had commenced in M9 (£975k). The Trust had delivered 55% YTD and 25% in M9 recurrently, behind the target (80%). Divisional PQP plans totalled £16.7m, including £4.1m central support. Concern was noted that the level of recurrent PQP delivery remained below target. Key areas of focus include; delivery of the £16.5m PQP target; increasing income capture, coding of activity; reducing temporary pay costs; planning and preparation of the 2024/35 PQP programme.
2.5 BAF Risk 5.1 (Finance – Revenue)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
2.6 Finance Modernisation Update	Y	Y	N	Rollout remained a positive story and colleagues had been nominated by the provider (SBS) for an award.

BOARD OF DIRECTORS:	**Trust Board (Public) 1 February 2024**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**25.01.24**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
3.1 M9 Integrated Performance Report	Y	Y	N	Key M9 headlines were noted and the IPR will be discussed at Trust Board.
3.2 Report Against Operating Plan	Y	Y	N	Key headlines were: • Activity levels maintained despite industrial action in the week before Christmas. • Faster Diagnosis Standard met for third month in a row although cancer backlog numbers increased due to holiday and industrial action reductions in capacity, although in mid-December the cancer backlog was at the March 2024 required standard. • Routine elective backlogs also increased due to Christmas and industrial action. • Urgent Care improvements in ambulance handovers • Theatre utilisation/activity levels impacted by industrial action and holiday period. Improved utilisation across the ICS and at PAH with 80% touch-time.
3.3 BAF Risk 4.1: Seasonal Pressures	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 12.
3.4 BAF Risk 1.3: Recovery Programme	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 15.
3.5 BAF Risk 4.2: 4 Hour Emergency Department Constitutional Standard	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.

BOARD OF DIRECTORS:	**Trust Board (Public) 1 February 2024**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**25.01.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.6 BAF Risk 4.3: Industrial Action	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.
4.3 BAF Risk 3.1 - Estate and Infrastructure	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.
				Other agenda items were: • New Hospital Update • Health & Safety Update

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 February 2024

Agenda item:	6.2							
Presented by:	Tom Burton, DoF							
Prepared by:	Beth Potton, DDoF							
Date prepared:	24 January 2024							
Subject / title:	Month 9 Financial Performance							
Purpose:	**Approval**		**Decision**		**Information**		**Assurance**	**X**
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The Trust reported a deficit of £2.5m in month 9 against a deficit plan of £2.0m and a £14.1m deficit YTD against a £5.6m YTD deficit plan. This means the Trust is adverse to the in month plan by £0.5m and adverse to the YTD plan by £8.5m. This is based on our original submitted plan in April 2023, i.e. a £5.1m deficit for the full year. In November 2023 we provided a revised forecast position for the year end. The Trusts M9 position is favourable to this forecast in month and YTD by £0.5m, predominantly due to a favourable non-pay position and non-recurrent support from technical measures. Capital spend YTD is £8.1m with an annual plan of £31.2m including externally funded schemes (e.g., EHR, NHP and CDC).							
Recommendation:	The Board is asked to note the month 9 financial results.							
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:	Paper at EMT, Paper to SMT, Paper to PAF
Risk / links with the BAF:	BAF risks 5.1 and 5.2
Legislation, regulatory, equality, diversity and dignity implications:	No impact on EDI identified.
Appendices:	See finance report attached

The Princess Alexandra Hospital NHS Trust

Summary finance notes

- The Trust declared a deficit of £2.5m in month 9 and a £14.1m deficit YTD. This means that the Trust is adverse to the month 9 plan by £0.5m and adverse to the YTD plan by £8.5m. This is based on our original submitted plan in April 2023, i.e. a £5.1m deficit for the full year.

- At the end of November 2023, all ICS's were required to undertake a revised forecast exercise. This was undertaken, along with additional funding being received for industrial action to November 2023 and a reduction in the ERF baseline. As a system we had a revised year end forecast position of break-even with PAH submitting a revised forecast of £14.5m deficit.

- The expectation was that there were no further industrial actions planned and therefore no further industrial action costs or income loss should be forecast.

- Industrial action was announced for December 2023 and January 2024. The national team have now asked for a revised year end forecast to include these two industrial action periods which has moved the PAH forecast from £14.5m deficit to £15.9m deficit.

- The table below details the current month 9 reported position against the original plan submitted in April 2023, the revised forecast excluding industrial action and the revised forecast including industrial action.

- If we consider the position against the revised forecast, it can be seen that the Trust is slightly ahead (£0.5m) of the revised forecast including industrial action.

Table 1: Month 9 and YTD Position Compared to Original Plan and Revised Forecasts

	FY Budget £'m	Dec-23 Budget £'m	Dec-23 Actual £'m	Dec-23 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Original Plan Submitted in April 2023	(5.4)	(2.0)	(2.5)	(0.5)	(5.6)	(14.0)	(8.5)
Revised Forecast Variance excl Ind Action	(14.8)	(2.5)	(2.5)	(0.0)	(14.1)	(14.0)	0.00
Revised Forecast Variance incl Ind Action	(16.2)	(3.0)	(2.5)	0.5	(14.5)	(14.0)	0.5

Note: These numbers exclude the adjustment for capital donations/grants/peppercorn leases which are £0.3m for the year.

	FY Budget £'m	Dec-23 Budget £'m	Dec-23 Actual £'m	Dec-23 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Original Plan Submitted in April 2023	(5.1)	(2.0)	(2.5)	(0.5)	(5.4)	(13.8)	(8.4)
Revised Forecast Variance excl Ind Action	(14.5)	(2.5)	(2.5)	(0.0)	(13.8)	(13.8)	0.0
Revised Forecast Variance incl Ind Action	(15.9)	(3.0)	(2.5)	0.5	(14.3)	(13.8)	0.5

Note: These numbers include the adjustment for capital donations/grants/peppercorn leases which are £0.3m for the year.

- The Trust has an ambitious efficiency programme of £16.7m for 2023/24. Through the PQP exercise, the Trust and operational colleagues have identified opportunities and put in place sustainable efficiency schemes that will begin to address the current underlying deficit. PQP delivery YTD at M9 is £11.2m against a plan of £1.1m. This favourable position is predominantly due to a YTD adjustment for the recognition of pay savings delivered within CSS and £1m central support released in month.

- Cash balance is £17m as at the end of month 9. The Trust is still able to meet its short-term cash obligations but with an increasing deficit, additional oversight is being provided of the cash balance currently. Following the confirmation of additional funding both nationally and within the system, we anticipate much of the risk around cash will be ameliorated within the current year. There is, as yet, no confirmation as to whether the Trust will receive any cash support relating to Industrial Action in December and January.

- Capital spend YTD at M9 is £8.1m with a total capital programme for the year of £31.2m which includes externally funded schemes (New Hospital, EHR and CDC). The spend profile to the end of March 2024 is significant if the capital programme is to be achieved but assurance has been received that these will be fully utilised in year and where slippage has been identified review is underway to pull schemes forward from 24/25 capital programme.

The Princess Alexandra Hospital
NHS Trust

December - Month 9

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS Trust

Note: the various changes that have been made to funding allocations and budgets in 2023/24 make comparison against original targets challenging. We have endeavoured to clarify performance against the original plan and revised forecast throughout.

- The Trust declared a deficit of £2.5m in month 9, with a reported deficit of £14.0m YTD. This means that the Trust is adverse to the YTD plan by £8.5m. Against the revised forecast completed in November and adjusted for the industrial action in December the Trust is £0.5m better than the expected forecast position both in month and year to date.

- In month 9 , the Trust has reported the second consecutive income surplus plus additional non recurrent support to the position driven by:
  - Depreciation support of £0.3m. The full year value will be £1.2m;
  - £0.7m balance sheet release from prior year;
  - £0.4m of ERF over-performance.

- The YTD position includes activity underperformance of £0.6m contributing to the current YTD deficit position.

- Temporary staffing continues to be a key driver of the deficit with costs exceeding vacancies by £14.8m YTD. This includes £1.6m of costs relating directly to industrial action YTD. Finance are continuing to review with Divisions and Corporate Services the increase in temporary staffing and to identify opportunities to reduce costs in the remaining months.

Summary financial results

NHS
The Princess Alexandra Hospital
NHS Trust

	FY Budget £'m	Dec-23 Budget £'m	Dec-23 Actual £'m	Dec-23 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Income							
NHS & non-NHS Income	351.0	27.6	29.1	1.5	262.2	269.8	7.6
Income Total	**351.0**	**27.6**	**29.1**	**1.5**	**262.2**	**269.8**	**7.6**
Pay							
Substantive	(221.3)	(18.4)	(17.4)	1.0	(166.2)	(153.1)	13.1
Bank	(4.3)	(0.4)	(2.5)	(2.1)	(3.3)	(22.4)	(19.0)
Agency	(6.1)	(0.4)	(1.5)	(1.1)	(4.8)	(13.7)	(8.9)
Pay Total	**(231.7)**	**(19.2)**	**(21.4)**	**(2.3)**	**(174.4)**	**(189.2)**	**(14.8)**
Non-Pay							
Drugs & Medical Gases	(30.1)	(2.4)	(2.2)	0.2	(22.8)	(21.2)	1.6
Supplies & Services - Clinical	(20.5)	(1.6)	(1.6)	0.1	(15.5)	(16.1)	(0.6)
Supplies & Services - General	(4.2)	(0.3)	(0.6)	(0.3)	(3.2)	(4.9)	(1.7)
All other non pay costs	(51.3)	(4.5)	(4.3)	0.2	(37.6)	(38.8)	(1.2)
Non-Pay Total	**(106.1)**	**(8.8)**	**(8.7)**	**0.2**	**(79.1)**	**(81.0)**	**(1.9)**
Financing & Depn							
Depreciation	(14.7)	(1.3)	(1.3)	0.0	(11.4)	(11.3)	0.1
PDC & Interest	(3.9)	(0.3)	(0.3)	0.0	(2.9)	(2.4)	0.6
Financing & Depn Total	**(18.6)**	**(1.6)**	**(1.5)**	**0.0**	**(14.3)**	**(13.7)**	**0.6**
Grand Total	**(5.4)**	**(2.0)**	**(2.5)**	**(0.5)**	**(5.6)**	**(14.0)**	**(8.5)**

Forecast Performance

The Princess Alexandra Hospital NHS

	FY Budget £'m	Dec-23 Budget £'m	Dec-23 Actual £'m	Dec-23 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Original Plan Submitted in April 2023	(5.4)	(2.0)	(2.5)	(0.5)	(5.6)	(14.0)	(8.5)
Revised Forecast Variance excl Ind Action	(14.8)	(2.5)	(2.5)	(0.0)	(14.1)	(14.0)	0.00
Revised Forecast Variance incl Ind Action	(16.2)	(3.0)	(2.5)	0.5	(14.5)	(14.0)	0.5

Note: These numbers exclude the adjustment for capital donations/grants/peppercorn leases which are £0.3m for the year.

	FY Budget £'m	Dec-23 Budget £'m	Dec-23 Actual £'m	Dec-23 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Original Plan Submitted in April 2023	(5.1)	(2.0)	(2.5)	(0.5)	(5.4)	(13.8)	(8.4)
Revised Forecast Variance excl Ind Action	(14.5)	(2.5)	(2.5)	(0.0)	(13.8)	(13.8)	0.0
Revised Forecast Variance incl Ind Action	(15.9)	(3.0)	(2.5)	0.5	(14.3)	(13.8)	0.5

Note: These numbers include the adjustment for capital donations/grants/peppercorn leases which are £0.3m for the year.

The table details the current month 9 reported position against the original plan submitted in April 2023, the revised forecast excluding industrial action and the revised forecast including industrial action.

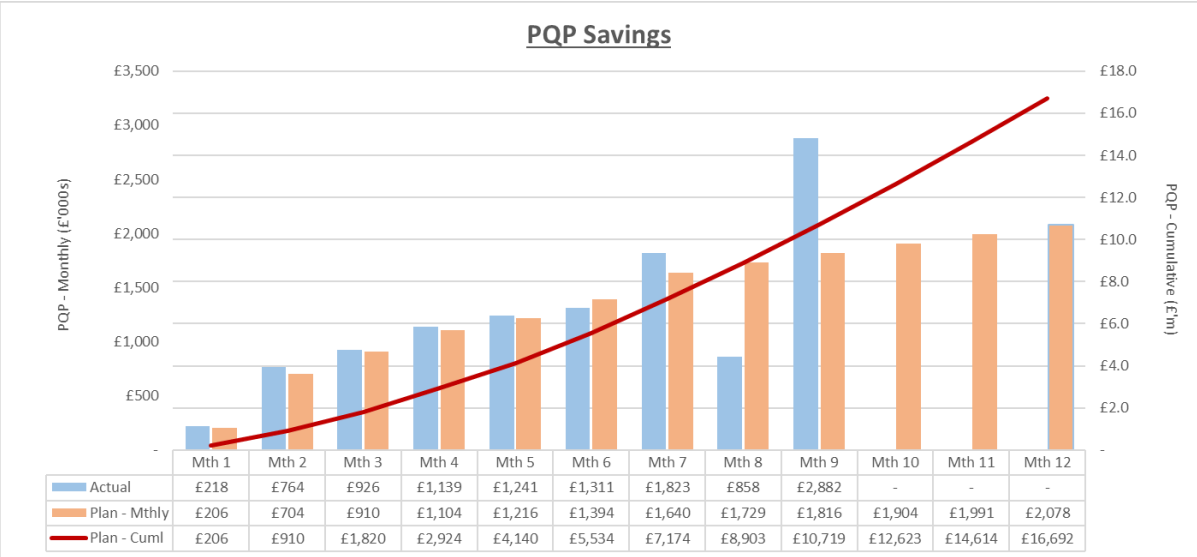
If we consider the position against the revised forecast, it can be seen that the Trust is slightly ahead (£0.5m) of the revised forecast including industrial action. This is largely due to some income recovery achievement ahead of forecast in Q4.

PQP

The Princess Alexandra Hospital NHS Trust

PQP Delivery at month 9 is ahead of plan. The YTD delivery is £11.2m against a YTD plan of £10.7m. In M9 delivery was ahead of plan by £1.1m.

There are further income opportunities that have been identified but given the changes to the elective income regime and for prudence, we have excluded income capture from this analysis.



	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Mth 10	Mth 11	Mth 12
Actual	£218	£764	£926	£1,139	£1,241	£1,311	£1,823	£858	£2,882	-	-	-
Plan - Mthly	£206	£704	£910	£1,104	£1,216	£1,394	£1,640	£1,729	£1,816	£1,904	£1,991	£2,078
Plan - Cuml	£206	£910	£1,820	£2,924	£4,140	£5,534	£7,174	£8,903	£10,719	£12,623	£14,614	£16,692

The figures presented above do not necessarily reconcile to PM3 reported figures by month due to timing of reporting and prior month changes.

The in month favourable position on the PQP programme is predominantly due to a YTD adjustment for the recognition of pay savings delivered within CSS as well as the beginning of the release of some of the £4m of central support to the PQP programme.

There remains a gap on schemes including:

- Outpatient and theatre utilisation
- Contract changes in estates
- Non pay reductions in CSS
- Private patient income
- Workforce reductions in OPAL and job planning.

- A significantly higher proportion of the PQP programme than planned is being delivered non recurrently. If more schemes cannot be converted or identified recurrently, then there will be a negative financial impact in 24/25.

Statement of Financial Position

The Princess Alexandra Hospital NHS Trust

Statement of Financial Position

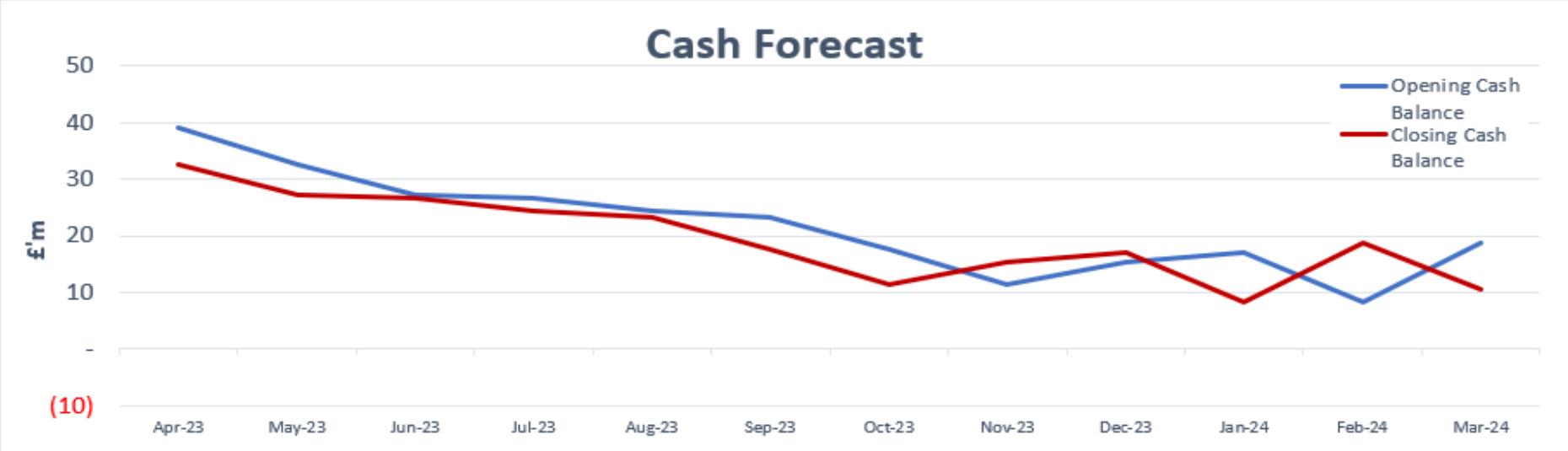
Statement of Financial Position	Mar-23	Nov-23	Dec-23	Movement In Month	Movement YTD
	£'m	£'m	£'m	£'m	£'m
Non-current assets					
Property, plant & equipment	164.9	162.0	163.3	1.4	(1.6)
Right of use assets	66.0	30.5	29.1	(1.4)	(36.9)
Intangible assets	15.5	16.6	16.7	0.1	1.1
Trade & other receivables	1.2	0.6	0.6	0.0	(0.6)
Non-current assets	**247.6**	**209.6**	**209.6**	**0.0**	**(38.0)**
Current assets					
Inventories	5.1	5.3	5.3	0.0	0.1
Trade & other receivables	14.4	21.6	16.5	(5.1)	2.1
Cash & cash equivalents	39.2	15.3	17.0	1.7	(22.2)
Current assets	**58.7**	**42.1**	**38.7**	**(3.4)**	**(20.0)**
Total assets	**306.4**	**251.7**	**248.4**	**(3.4)**	**(58.0)**
Current liabilities					
Trade & other payables	(52.8)	(44.0)	(44.6)	(0.7)	8.2
Provisions	(0.8)	(1.2)	(1.2)	0.0	(0.4)
Borrowings	0.0	(1.9)	(1.9)	0.0	(1.9)
Current liabilities	**(53.6)**	**(47.0)**	**(47.7)**	**(0.7)**	**5.9**
Net current assets/ (liabilities)	**5.1**	**(4.9)**	**(9.0)**	**(4.1)**	**(14.1)**
Total assets less current liabilities	**252.8**	**204.7**	**200.7**	**(4.1)**	**(52.1)**
Non-current liabilities					
Trade & other payables	0.0	0.0	0.0	0.0	0.0
Provisions	(1.3)	(0.9)	(0.9)	0.0	0.4
Borrowings	(66.0)	(24.8)	(24.6)	0.2	41.3
Total non-current liabilities	**(67.3)**	**(25.7)**	**(25.5)**	**0.2**	**41.8**
Total assets employed	**185.5**	**179.0**	**175.1**	**(3.9)**	**(10.3)**
Financed by:					
Public dividend capital	347.9	340.9	340.9	0.0	(7.0)
Income and expenditure reserve	(162.4)	(168.9)	(172.8)	(3.9)	(10.4)
Revaluation reserve	0.0	7.0	7.0	0.0	7.0
Total taxpayers' equity	**185.5**	**179.0**	**175.1**	**(3.9)**	**(10.4)**

- **Non Current Assets** PPE increased of £1.4m is due to fixed assets additions and decrease of £1.4m in Right of Use Assets represents year to date leases depreciation.
- **Trade and Other Receivables** has decrease by £5.1m from last month and this is mainly due to reversal of previous month deferred Income for NHS Herts & West Essex ICB on High Cost Drugs.
- **Cash balances** has increased by £1.7m from previous month and it is as a result of additional support received from NHS Herts & West Essex ICB of £2.9m National Settlement Funding 2023 & £2.5m for risk Share MOU 2023, which net off with a payment of £3.2m to the NHS Professionals for outstanding invoices.
- **Trade and Other Payables** The increase of £0.7m is due to more invoices raised to Essex Partnership Univ. NHS FT of £176K and other customers.
- **Borrowings** decrease representing payment of liability falling due & post audit adjustment in ROU assets, following revaluation of St Margaret's Hospital.

Cashflow

The Princess Alexandra Hospital NHS Trust

	<----------YTD---------->									<----------Forecast---------->		
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Opening Cash Balance	39,196	32,503	27,345	26,748	24,462	23,316	17,659	11,384	15,285	16,978	8,393	18,858
Closing Cash Balance	32,503	27,345	26,748	24,462	23,316	17,659	11,384	15,285	16,978	8,393	18,858	10,683



This cashflow is based on the assumption that the 2023/24 planned deficit of £15.9m is achieved, which deteriorate the cashflow position to £10m and we have not been notified of any additional funding from the regional team on the last two industrial actions.

Also this assumes that all 2023/24 capital PDCs will be received in February 2024

Capital Analysis 23/24

The Princess Alexandra Hospital NHS Trust

	Month 9			YTD			Forecast		
	In-Month Forecast £'m	In-month Actual £'m	Variance £'m	Forecast £'m	Actual £'m	Variance £'m	Plan & profile £'m	FY Forecast	Variance £'m
Internally Funded Schemes									
Estates									
Ward refurbs and remedial works	200	-	200	400	1	399	1,000	1,000	-
New car park option	50	-	50	50	24	26	200	200	-
New UPS/IPS to critical areas - Phase 1 Main theatres/ED/ITU/HDU	120	(1)	121	120	10	110	634	634	-
Other Estate Schemes	720	6	714	1,657	670	987	3,629	3,797	(168)
Estates BLM									
Estates BLM Schemes	499	(15)	514	1,301	1,304	(3)	3,114	3,114	-
ICT & Information									
ICT & Information Schemes	138	23	114	804	790	14	1,230	1,425	(195)
EHR	-	-	-	328	-	328	821	891	(70)
Corporate									
Finance Modernisation	46	205	(159)	407	424	(17)	545	545	-
Medical Equipment									
Medical Equipment (Surgery)	116	-	116	497	313	183	501	501	-
Medical Equipment (CSS)	25	(4)	29	467	453	14	1,815	1,815	-
Other Equipment (People)	26	-	26	54	28	26	64	64	-
Medical Equipment (Medicine)	-	-	-	-	-	-	-	-	-
Medical Equipment (CHAWS)	-	-	-	109	-	109	145	145	-
Contingency	-	-	-	-	-	-	1,027	594	433
CRL to be allocated to plan									
YTD spend on Internal Schemes	1,939	215	1,725	6,194	4,017	2,177	14,725	14,725	-
Externally Funded Schemes									
New Hospital	111	53	58	729	512	217	1,060	729	331
New Hospital CPO	249	(90)	339	995	163	832	1,700	995	705
New Hospital - Enabling works	100	-	100	275	-	275	508	-	508
CDC	580	152	428	2,123	968	1,155	5,225	1,250	3,975
EHR	888	478	410	5,328	2,410	2,918	8,000	8,000	-
YTD spend on External Schemes	1,928	593	1,335	9,450	4,053	5,397	16,493	10,974	5,519
Total - Internal and External	3,867	808	3,060	15,644	8,070	7,574	31,218	25,699	5,519

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 February 2024

Agenda item:	6.3
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Antoinette Woodhouse – Head of Information
Date prepared:	25th January 2024
Subject / title:	Integrated Performance Report

Purpose:	Approval		Decision		Information	X	Assurance	

6.3

Key issues: please don't expand this cell; additional information should be included in the main body of the report

Patients		
Patients	Tissue viability	The rate of pressure ulcers per 1000 bed days is outside of the upper tolerance level for the month of December. The causes are multifactorial and being reviewed by the TVN and the senior leadership team.
People		
People	Appraisals	Appraisals is still in special cause variation but is improving. Approximately 1,100 appraisals need to be recorded before end of March to reach 90% target
	Statutory and Mandatory Training	Steady increase on compliance with all divisions on the upwards with the exception of Estates & Facilities that went from 69% to 67.8%. None of the main divisions are hitting the target.
	Sickness Absence	Is within common cause variation but is seeing a slight increase in staff sickness absence during the winter months away from the target
Performance		
Performance	Referral to Treatment	Performance is in common cause variation but is significantly below the target. The impact of the December industrial action and holiday annual leave has reduced capacity.
	Cancer 2 week wait	In common cause variation. Head & Neck and Urology tumour sites now achieving the 2week wait standard. Upper GI is very close to achieving the standard. Breast, Head & Neck & Urology have high referral numbers and contributes to the gap.
	Cancer 62 day pathway	In common cause variation and is in the 4th month of a decent away from the target which is impacted by high breast, head & neck and urology referral numbers.
	Four hour standard	Remains in special cause variation. A number of indicators are in special cause variation highlighting the continued pressure on the service
	Diagnostics	Remains in common cause variation, second month of improvement back towards the mean
	78 week waits	The impact of the December industrial action and holiday annual leave has reduced capacity.
	Stranded Patients	Performance is in common cause variation following a 7-month drop in occupancy.
	Ambulance handovers	1 in 5 ambulance handovers were in less than 15 minutes and and 1 in 3 were handed over between 15 & 30 minutes.
Pounds		
Pounds	Surplus	In special cause variation. The Trust reported a deficit of £2.5m in December
	CIP	In common cause variation. December is ahead of the plan
	Capital Spend	In common cause variation and inconsistently passing and falling short of the target. As at Month 9 the year to date capital spend is £7.6m behind plan.
Places		
Places	Housekeeping	The new Synbiotix system has now been rolled out for the food ordering service on the wards. Feedback to date on the system is good.
	Catering	Meal numbers are increasing due to the increase in patient numbers across the trust.
	Places Summary	ED CQC - fabric works. Plan to be agreed with end users for least imapct on service for all users but complete in a timely manner ahead of CQC visit
		Medical Gas infrastructure - final phase of AVSU renewal programme

Recommendation:	PAF is asked to note and discuss the contents of 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	X

Previously considered by:	PAF.25.01.24 and QSC.26.01.24
Risk / links with the BAF:	Links to all BAF Risks
Legislation, regulatory, equality, diversity and	No regulatory issues/requirements identified, the IPR demonstrates a full view of service delivery to ensure we take into account equality, diversity and dignity
Appendices:	M9 IPR

Integrated Performance Report:

December 2023

As at 26/01/2024

Executive Summary

NHS
The Princess Alexandra Hospital
NHS Trust

Patients		
Patients	**Tissue viability**	The rate of pressure ulcers per 1000 bed days is outside of the upper tolerance level for the month of December. The causes are multifactorial and being reviewed by the TVN and the senior
Patients	**PPH over 1500mls**	Has moved out of special cause into common cause variation with a contnued downward trend towards target levels.
Pounds		
Pounds	**Income/Activity**	Has moved into special cause improving variation. the Trust's elective and day case activity are below plan presenting a challenge to income plan.
Pounds	**Capital Spend**	In common cause variation and inconsistently passing and falling short of the target. As at Month 9 the year to date capital spend is £7.6m behind plan.
Pounds	**Surplus \ Deficit**	Special cause variation & inconsistently passing and failling short of the target. The Trust reported a deficit of £2.5m in December
Pounds	**Cost Improvement Plan**	Common cause variation and inconsistently passing and falling short of the target. December is ahead of the plan, year to date recognition of a pay benefits in CSS and central support beggining to be recognised from M9 is the reason for the favourable in-month variance
Places		
Places	**Housekeeping**	The new Synbiotix system has now been rolled out for the food ordering service on the wards. Feedback to date on the system is good.
Places	**Catering**	Meal number are increasing due to the increase in patient numbers across the trust.
Places	**Places Summary**	ED CQC - fabric works. Plan to be agreed with end users for least imapct on service for all users but complete in a timely manner ahead of CQC visit
		Fleming Ward - agreement to proceed with a full upgrade option working with newly appointed P23 contractor on CDC at SMH with completion before xmas 2023
		Medical Gas infrastructure - final phase of AVSU renewal programme

People		
People	**Appraisals**	Appraisals is still in special cause variation but is improving. Approximately 1,100 appraisals need to be recorded before end of March to reach 90% target
People	**Statutory and Mandatory Training**	Steady increase on compliance with all divisions on the upwards with the exception of Estates & Facilities that went from 69% to 67.8%. None of the main divisions are hitting the target.
People	**Sickness Absence**	Is within common cause variation but is seeing a slight increase in staff sickness absence during the winter months away from the target
Performance		
Performance	**Referral to Treatment**	Performance is in common cause variation but is significantly below the target. The impact of the December industrial action and holiday annual leave has reduced capacity and the number of long waiting patients over 78+ weeks has increased however the number of 65+ week patients at 31/3/24 remains ahead of trajectory.
Performance	**Cancer 2 week wait**	In common cause variation. Head & Neck and Urology tumour sites now achieving the 2week wait standard of 93%. Upper GI is very close to achieving the standard. Breast, Head & Neck & Urology have high referral numbers and contributes to the gap in achieving the 93% target
Performance	**Cancer 62 day pathway**	In common cause variation and is in the 4th month of a decent away from the target which is impacted by high breast, head & neck and urology referral numbers.
Performance	**Four hour standard**	Remains in special cause variation. A number of indicators are in special cause variation highlighting the continued pressure on the service
Performance	**Diagnostics**	Performance remains in common cause variation, we have seen the second month of improvement back towards the mean
Performance	**78 week waits**	Has been in special cause variation for the last 10 months. The impact of the December industrial action and holiday annual leave has reduced capacity, the 78+ week waits have increased and the reduction in long waiting patients over 52+ weeks has slowed but the number of 65+ week patients at 31/3/24 remains ahead of trajectory.
Performance	**Stranded Patients**	Performance is in common cause variation following a 7-month drop in occupancy. The last 3 months has seen an increase closer to the mean.
Performance	**Ambulance handovers**	Both between 15 & 30 minutes and less than 15 minutes handovers are in common cause variation and saw a decrease in handover times. 1 in 5 ambulance handovers were in less than 15 minutes and and 1 in 3 were handed over between 15 & 30 minutes.

Section summaries

The Princess Alexandra Hospital NHS Trust

Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Tissue viability	The rate of pressure ulcers per 1000 bed days is outside of the upper tolerance level for the month of December. The causes are multifactorial and being reviewed by the TVN and the senior leadership team.	For information	NA

Places Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
D.30	Estates new MICAD resporting system is sheduled to be trailled within the next couple of weeks. Once working accurate figures and reportes can be produced	For information	
D.31	FR1(very high risk) overall cleaning score for December was 98.17%, broken down into areas: Domestic :98.39% Estates: 97.22% Nursing: 95.69%	For information	
D.32	FR2 (high risk) Scores for cleaning december 96.57% , broken down into areas: Domestic :96.75% Estates: 96.87% Nursing:94.939%	For information	
D.33	Currently using cook chill for patient feeding with no figures available	For information	
D.34	Currently no figures available for food waste		

Section summaries

People Summary	Board Sub Committee: Worforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Vacancies	Overall monthly vacancies is 8.9% a reduction from 9.4% in Oct23. CSS, Medicine, Surgery, E&F and Finance divisions are all carrying vacancies over the target rate of 8.0% whilst CHAWs and UEC have vacancies of 3.2% & 7.2% respectively.		
Statutory & Mandatory training	Steady increase on complaiance with all divisions on the upwards with the exception of Estates & Facilities that went from 69% to 67.8%. Nonoe of the main divisions are hitting the target.		
Sickness Absence	Sickness rate has increased to 5.4%, which was an increase of 0.6% from November 23. Sickness continues to remain above the Trust target of 3.7%. Divisions are supported to actively review all attendance cases when triggered to ensure that staff have the appropriate health and wellbeing support in place to help to improve attendance including referrals to Staff Health and Wellbeing. Covid sickness absence and influenza symptoms has increased over the past two months in line with an population increase of covid and flu. Covid sickness is included as part sickness reporting for this winter therefore it is expected that we continue to see an increase. The most common cause recorded for absence in December is cold / flu followed by Anxiety/stress/depression		
Appraisals	Compliance increased steadily from 24% at end September (B5 and below expired after 30 September) Approximately 1100 appraisals need to be recorded before end of March to reach 90% target		

Section summaries

The Princess Alexandra Hospital NHS Trust

Performance	Board Sub Committee: Worforce Committee		
Focus Area	Description and action	Reason for Inclusion	Target Date for Resolution if applicable
Diagnostics	Diagnostic appointments waiting over 6 weeks are steady at 73%, however it should be noted that the improved audiology performance is not included in this standard as the new software reporting is in development.	For information	28/02/2024
RTT	Elective long waits have improved at the November month end as there was no industrial action and a full month of elective activity which was significantly increased on previous months. The RTT standard remains low as the backlog is being cleared in clinical & chronolgical order.	For recognition	31/03/2024
Urgent Care	Ongoing pressure in urgent care with the 4 hour standard remaining low over the Christmas and early part of January. Particular focus from all areas of the Trust on reducing the ambulance handover times has created reduced delays, the best improvement in the region.	For information	
Cancer	Continued achievement of the 28 day Faster Diagnosis Standard which is a key clinical safety measure. Continued focus on treating the patients that have waited longer than 62 days is impacting the performnace but appropriate clinical care. Anticipated tumour site level 62 day performance from Fenruary onwards.	For recognition	31/03/2024

Introduction

About this pack

The Trust produces this Integrated Performance Report (IPR) on a monthly basis to inform our Board, Executive team, Divisions and other stakeholders of the performance across core domains.

This particular report provides a summary of all metrics for the 'our patients' pillar and is structured as follows:

Indicators Summary	Overview of metric performance
Metrics Reports	SPC charts detailing trajectory and variation of metric performance
User Guide & Supporting Information	Outline of document interpretation, report content and SPC calculation logic

For further information about this IPR please contact paht.information@nhs.net

Contents

Key Performance Indicators In Special Cause Variation

NHS
The Princess Alexandra Hospital
NHS Trust

5P Section	KPI	SPC Status	Performance	BAF Risk Reference	Current Risk Score	Target Risk Score
Patients	Tissue viability per 1000 bed days		5	1.1	16	12
	Serious Incidents		1	1.1	16	12
People	Statutory & Mandatory training		80.0%	2.3	16	8
	Vacancy Rate		8.9%	2.3	16	8
	Voluntary Turnover		12.5%	2.3	16	8
	Appraisals - non-medical		52.0%	2.3	16	8
Performance	78 week waits		104	1.3	16	12
	4 hour standard		50.8%	4.2	20	12
	Cancer two week wait		78.9%	1.3	15	10
	Ambulance handovers between 15 & 30 minutes		29.6%	4.2	16	12
	Patients over 12 hours in ED from arrrival		112.25	4.2	16	12
	Patients over 7 days length of stay		174	4.2	16	12

Figures included are for December 2023

Patients section measures in special cause variation

NHS
The Princess Alexandra Hospital
NHS Trust

SPC for C.13 - Serious Incidents

Previous month ...
November-2023

0

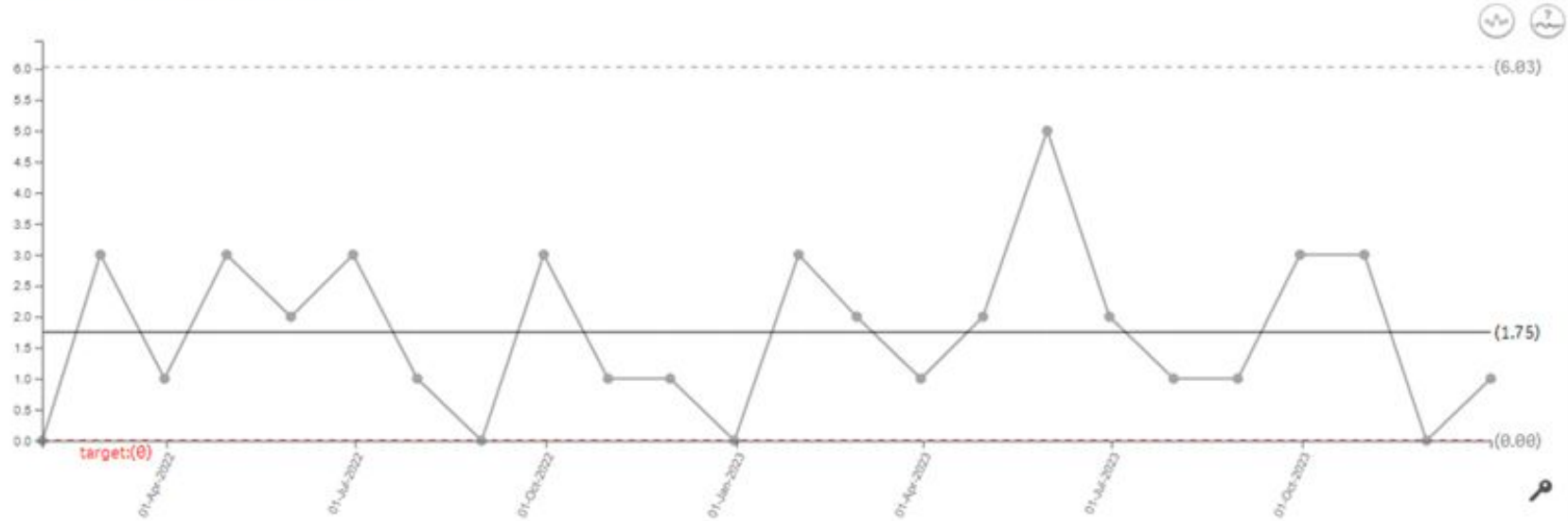
Month to date v...
December-2023

1

Target
December-2023

0.0

Target is at Trust-wide level



SPC for C.14 – Tissue Viability per 1000 bed days

Previous month ...
November-2023

5

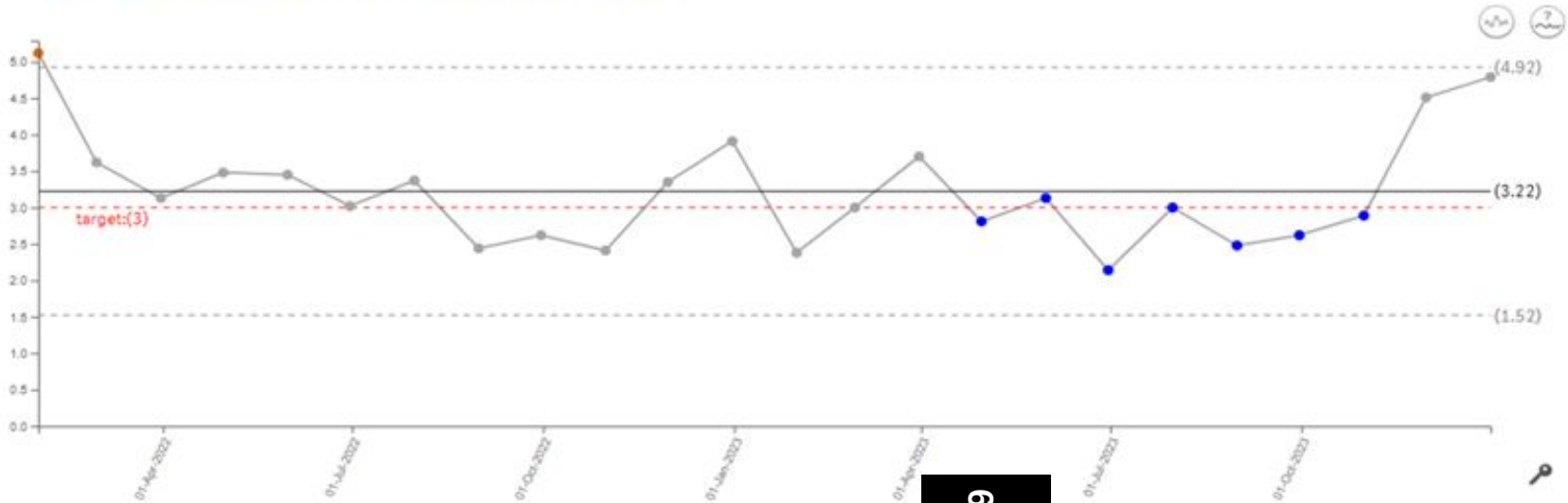
Month to date v...
December-2023

5

Target
December-2023

3.0

Target is at Trust-wide level



People section measures in special cause variation

NHS
The Princess Alexandra Hospital
NHS Trust

SPC for D.29 - Statutory & Mandatory training

Previous month ...
November-2023

78.0%

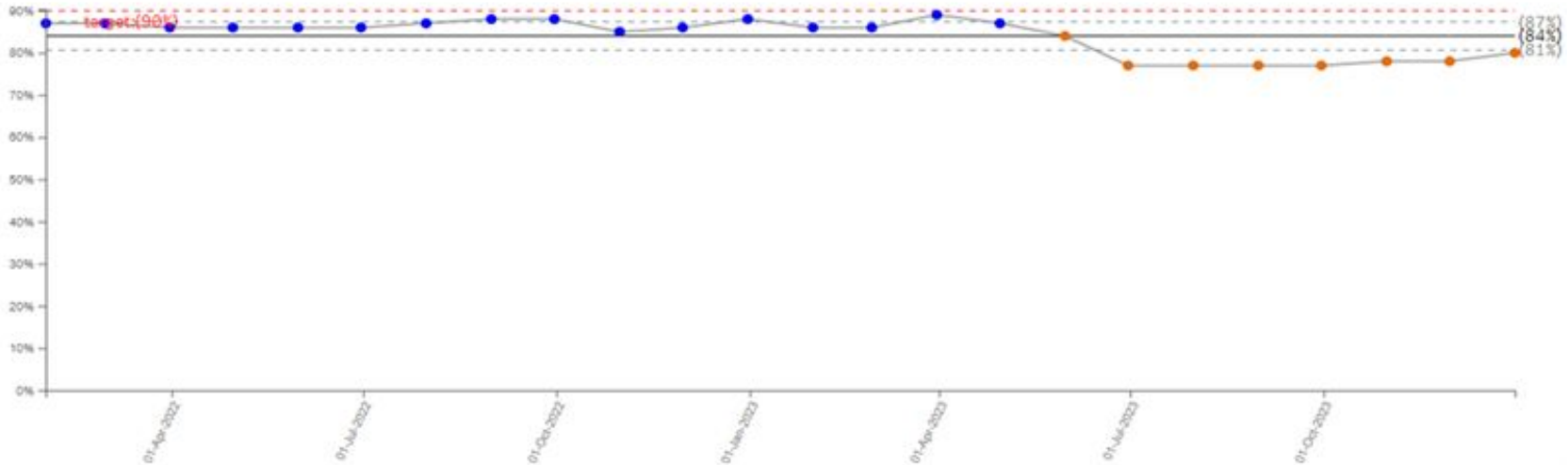
Month to date v...
December-2023

80.0%

Target
December-2023

90.0%

Target is at Trust-wide level



SPC for D.27 - Vacancy Rate

Previous month ...
November-2023

8.8%

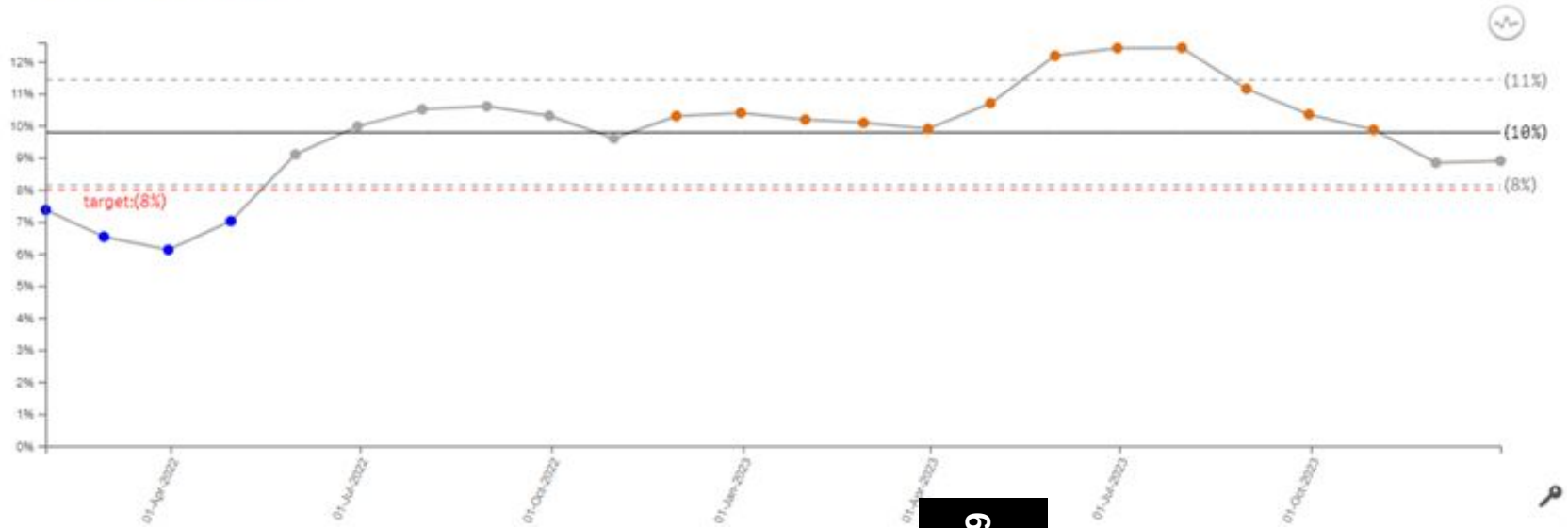
Month to date v...
December-2023

8.9%

Target
December-2023

8.0%

Target is at Trust-wide level



6.3

People section measures in special cause variation

The Princess Alexandra Hospital NHS Trust

SPC for D.24 - Staff Turnover Voluntary

Previous month ...
November-2023

12.5%

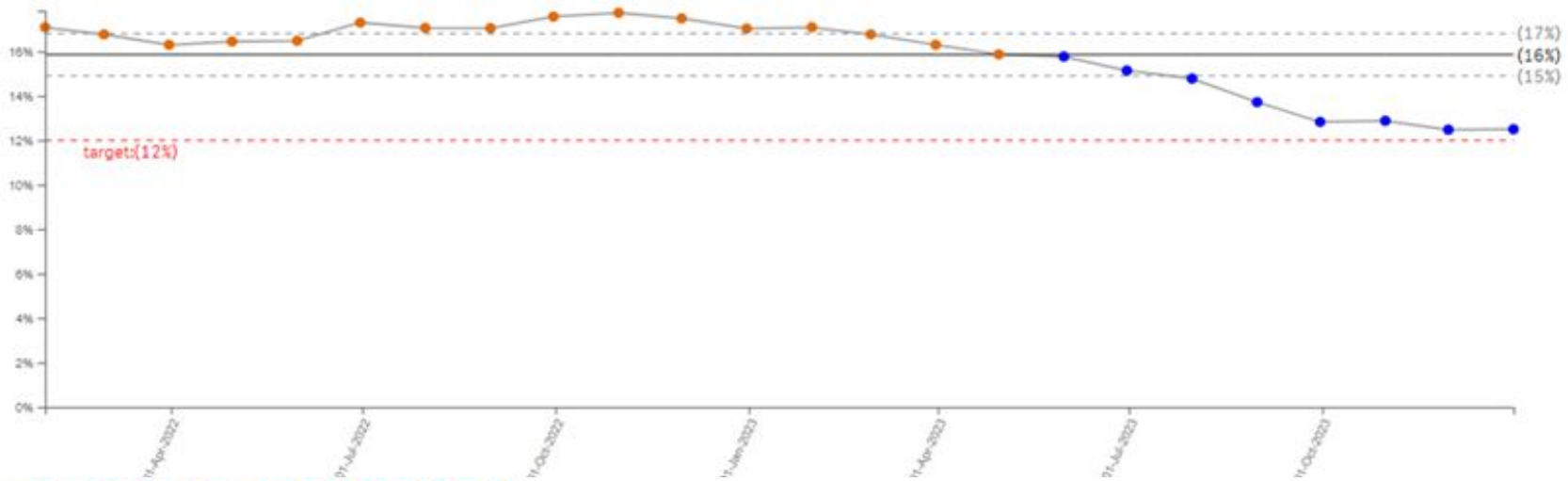
Month to date v...
December-2023

12.5%

Target
December-2023

12.0%

Target is at Trust-wide level



SPC for D.28 - Appraisals – non-medical

Previous month ...
November-2023

34.0%

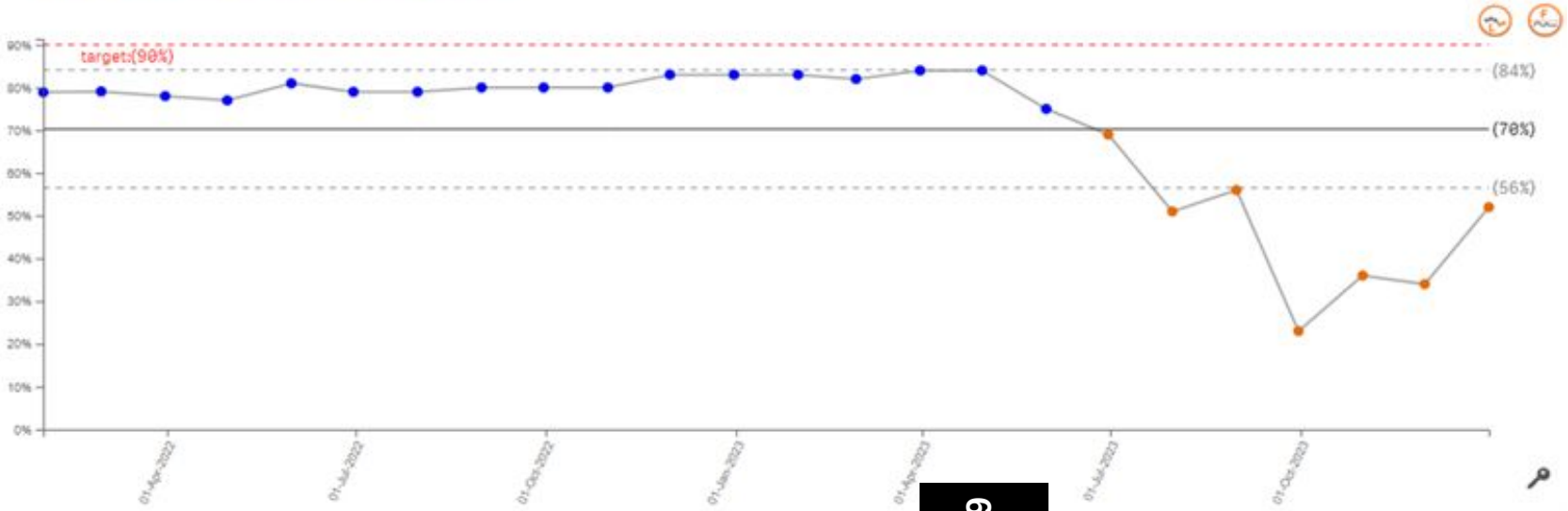
Month to date v...
December-2023

52.0%

Target
December-2023

90.0%

Target is at Trust-wide level



6.3

Performance section measures in special cause variation

SPC for A.4 - Proportion of Patient treated within 4 hours in ED

Previous month ...
December-2023

50.8%

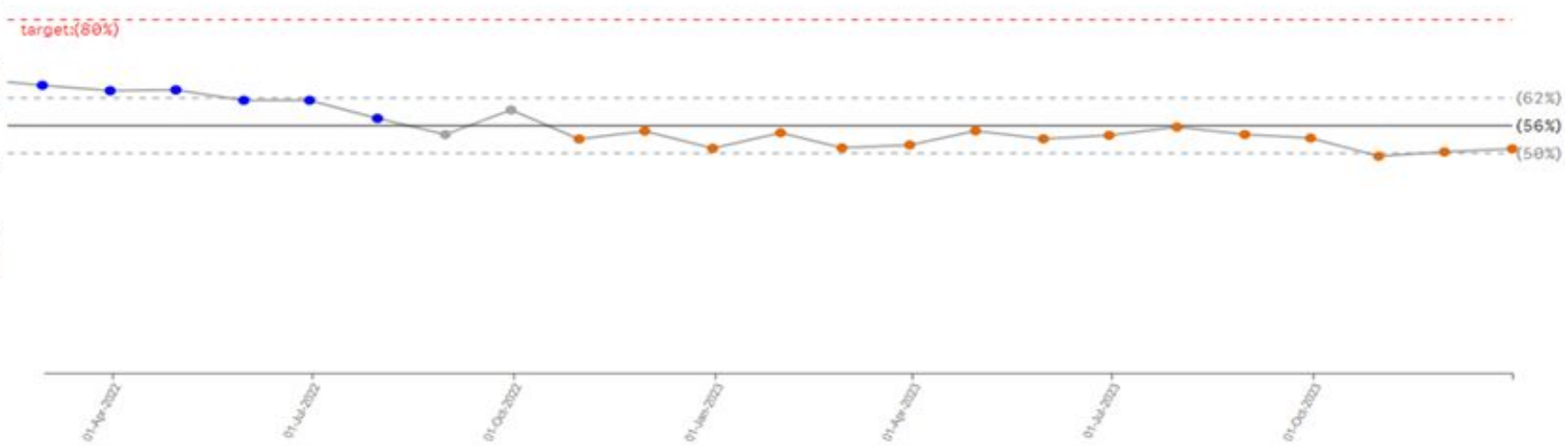
Month to date v...
January-2024

55.3%

Target
December-2023

80.0%

Target is at Trust-wide level



SPC for C.20 - Cancer two week waits

Previous month ...
October-2023

83.3%

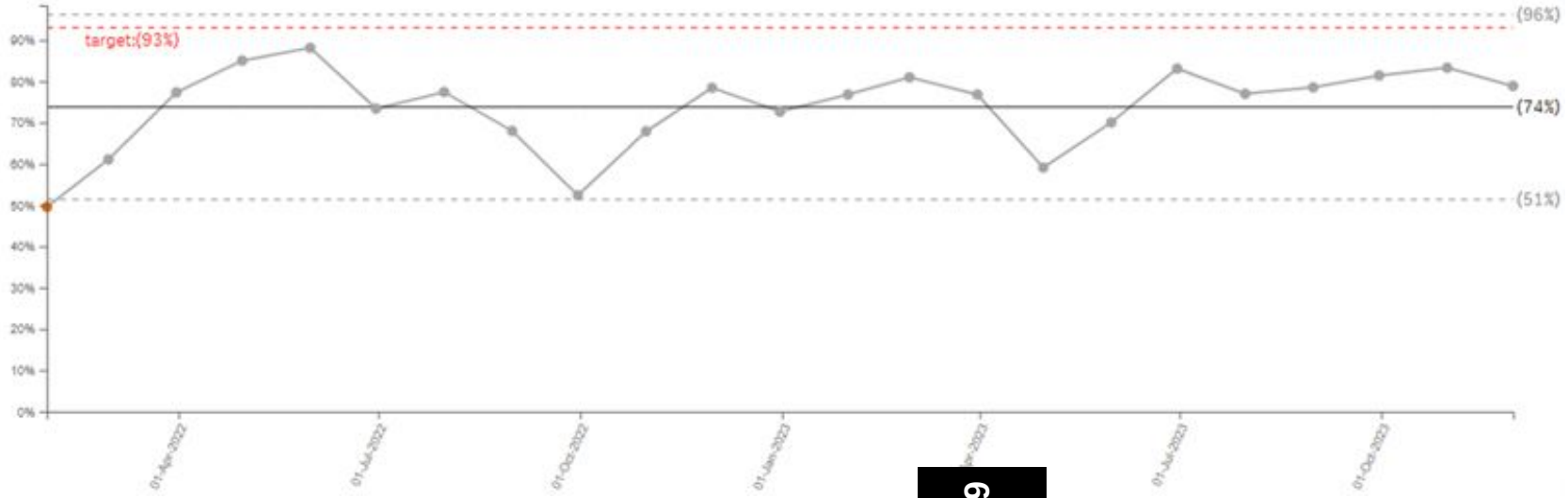
Month to date v...
November-2023

78.9%

Target
November-2023

93.0%

Target is at Trust-wide level



6.3

Performance section measures in special cause variation

NHS The Princess Alexandra Hospital NHS Trust

SPC for A.19 - Proportion of Ambulance Handovers Between 30 & 60 minutes

Previous month ...
December-2023

26.3%

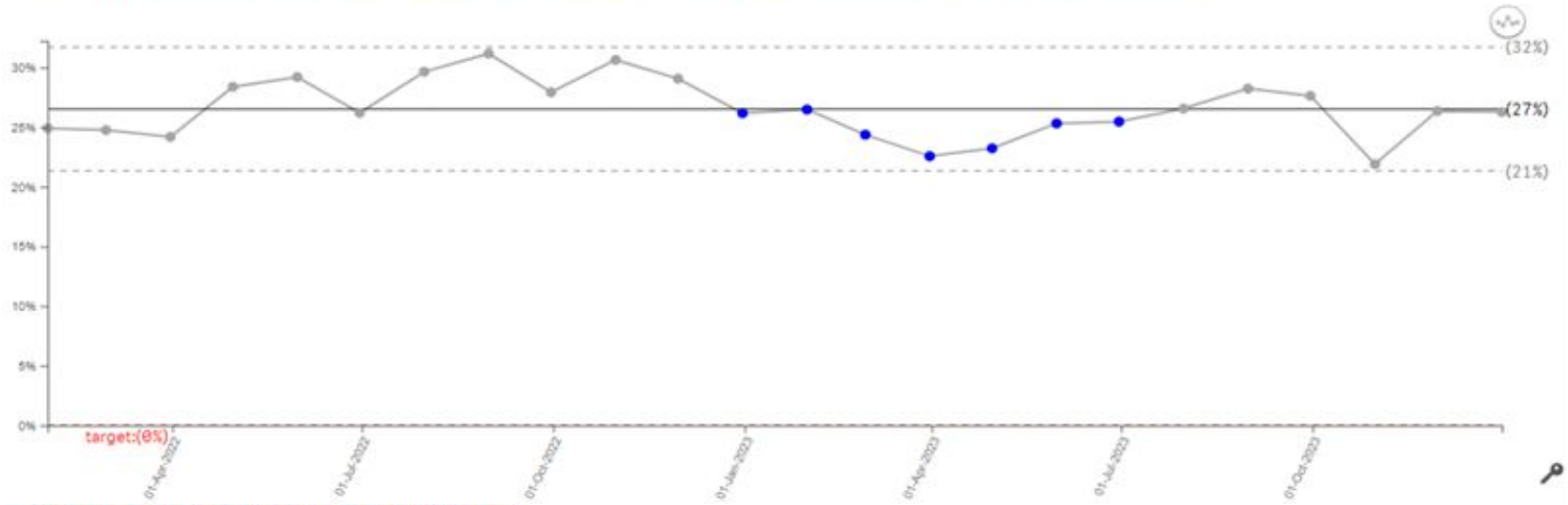
Month to date v...
January-2024

27.9%

Target
December-2023

0.0%

Target is at Trust-wide level



SPC for D.37 - RTT over 78-week waiters

Previous month ...
October-2023

118

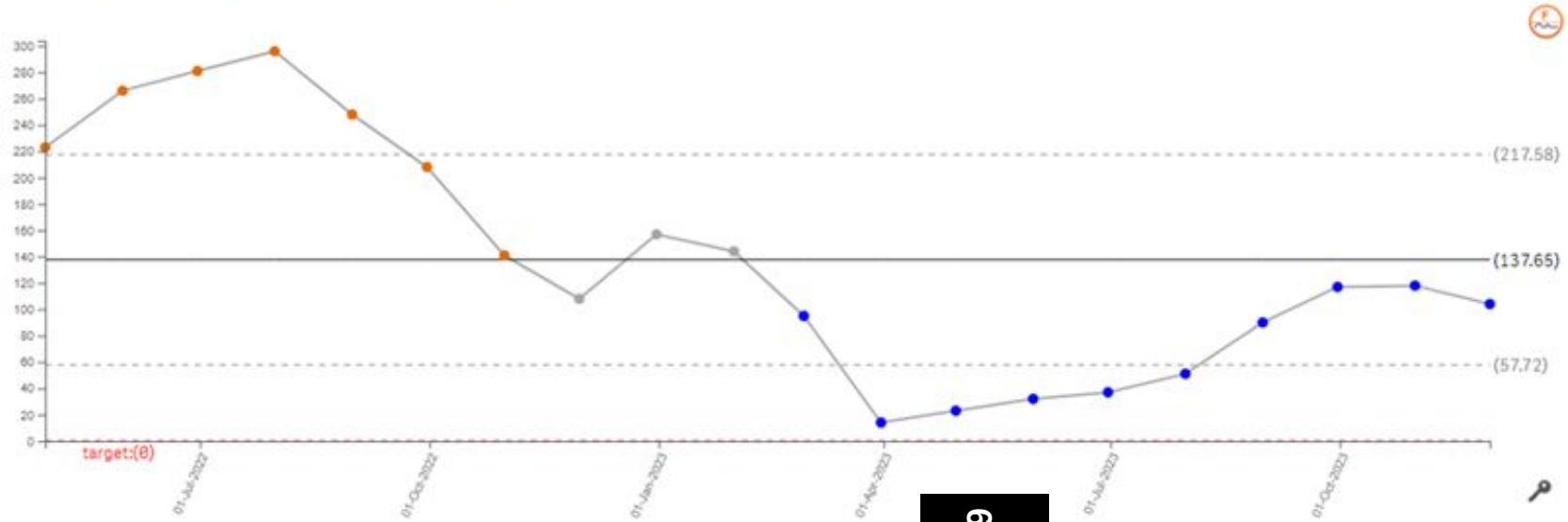
Month to date v...
November-2023

104

Target
November-2023

0.0

Target is at Trust-wide level



6.3

Performance section measures in special cause variation

SPC for D.42 - Occupied Beds with Stranded Patients (Over 7 days)

Previous month ...
November-2023

173

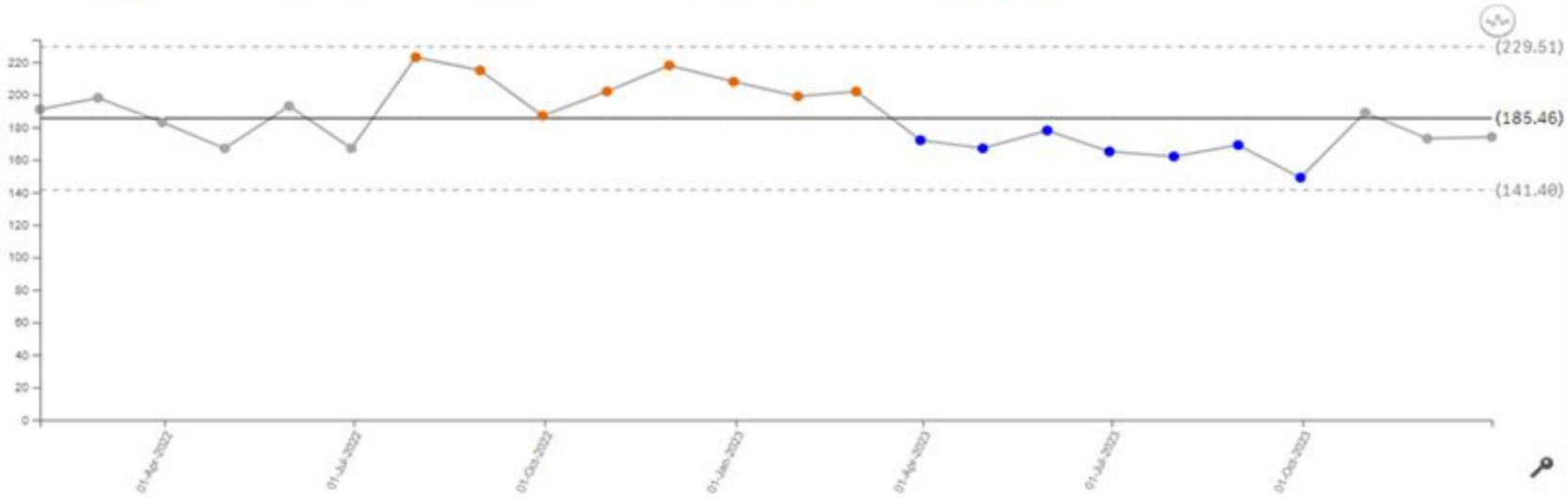
Month to date v...
December-2023

174

Target
December-2023

No Target Set

Target is at Trust-wide level



SPC for A.10 - Seen by Specialty to DTA - Average Wait (mins)

Previous month ...
December-2023

112.25

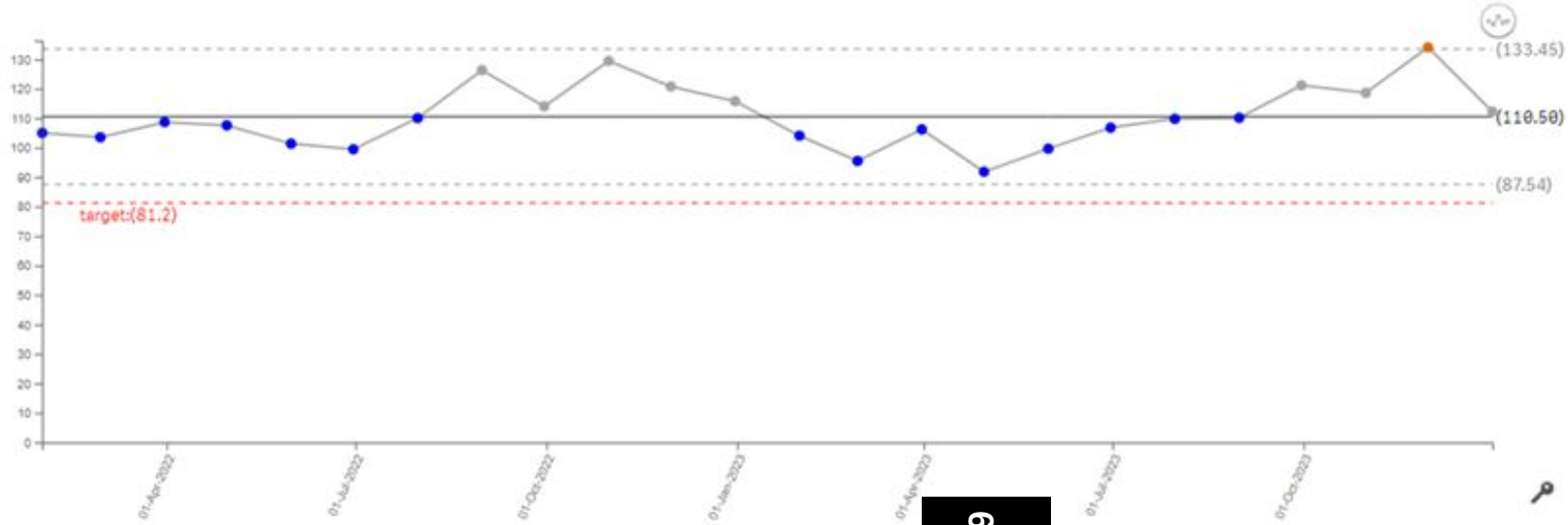
Month to date v...
January-2024

123.07

Target
December-2023

81.2

Target is at Trust-wide level



The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 1 February 2024

6.4

Agenda item:	6.4
Presented by:	Steph Lawton Chief Operating Officer
Prepared by:	Claire Aubrey Robson Emergency Preparedness Resilience Response and Business Continuity (EPRR/BC)
Date prepared:	11/12/2023
Subject / title:	Annual Report of Emergency Preparedness and Business Continuity and Forward Plan
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	2023 EPRR Assurance Process for which the trust was assessed as partially compliant Business Continuity Programme and Business Continuity Management System Major Incident preparedness.
Recommendation:	The board considers the approval of the core standards submission. Be assured that the Business Continuity Programme/ BCMS is now a work in progress and the executives give their full support to the BCMS Major Incident Preparedness including testing, training and equipment.

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

Previously considered by:	Approved Health and Safety Committee 13th December 2023 PAF.21.12.23
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	Civil Contingency Act 2004 Health and Social Care Act 2022 NHS England EPRR Core standards NHS England EPRR Framework July, 2022 NHS Core Standard Contract
Appendices:	Core Standards Report 2023

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

1.0 Purpose/issue

This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (CCA) 2004 and the NHS England Emergency Preparedness Framework 2022 and on its annual core standards assurance return to NHS England. It covers the 4 main areas:

1. Emergency Preparedness and measurement of that through the Core Standards Report;
2. Business Continuity, the BC cycle that is developed through the BC Programme;
3. Testing and exercising;
4. Major Incident preparation of staff, equipment and preparedness.

2.0 Background

The Civil Contingencies Act 2004 outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. PAHT is a category 1 responder and as such has a legal duty to ensure its preparedness and ability to respond during a civil emergency or event, and during that event it will be able to continue its responsibilities as an acute hospital.

To ensure compliance of provider and commissioner organisations, NHS England and Improvement undertake a yearly Core Standards Assurance process.

3.0 Content

1. Emergency Preparedness and measurement of that through the Core Standards Report

As an organisation the Trust scored partially compliant for 2023 NHS England and Improvement Core Standards Assurance. The core standards had been changed from previous years and required evidence of the self-assessment with documentation which was the first time for this level of scrutiny and will be the methodology for the core standards for next year. The theme for the 'deep dive' was the Trust capacity and capability to achieve training compliance for PAHT strategic, operational command response as outlined by the National Occupational Standards. This forms part of the preparedness for a business continuity, major or critical incident.

The Emergency Preparedness Resilience and Response Manager attended a virtual assurance confirm and challenge meeting with our Commissioners, which confirmed the Trust self-assessment of partially compliant. The core standards report highlighted the several areas of improvement for its business continuity and major incident preparedness. The breakdown of the partial compliance areas of business, 3 were with regards to business continuity (BC), and 0 within EPRR, 4 for Hazardous materials, chemical biological, radioactive, nuclear de-contamination (Hazmat/CBRN) preparedness. See Appendix 1.

The scoring is based on the following criteria.

Organisational rating	Criteria
Fully compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

	Fully Compliant	Partial Compliance	Non-Compliant
EPRR Core Standards	40	0	0
Business Continuity	7	3	0
Hazmat/CBRN	8	4	0
Deep Dive	8	2	0

2. Business Continuity

Review in is progress for the business continuity programme. All divisions and departments have provided their business impact analysis and business continuity plans. Work is ongoing for the updating and complete review of the business continuity policy and guidance. This includes the web pages on the Alex Net, full engagement with key stakeholders is underway and progress and actions are recorded in the emergency preparedness and business continuity meetings. The Trust wide business continuity plans require a complete review which is planned for 2024.

3. Testing and exercising

- PAHT EPRR manager took part in 'Exercise Fox' has been on going throughout 2022 and 2023 This was a regional exercise for EPRR Leads with a Tactical commander.
- Continued testing of the evacuation and impacts of a catastrophic RAAC plank failure within the Eastern Region Hospitals as there are four whole hospital sites within the region constructed with RAAC planks. These are James Paget Hospital, Hinchinbrook Hospital, The Queen Elizabeth Hospital King's Lynn and West Suffolk NHS Foundation Trust. The learning and development from this ongoing planning is also being implemented into PAHT evacuation and mass casualty plans.
- The Trust had command team in place for the receipt of the virtual patients including the EPRR and Site manager.
- Table top exercises are including in the embedding of learning within the Hazmat/CBRN training, the learning from those exercises has been included into the action cards in the major incident plan.
- Partnership/ICB testing and exercising, Mighty Oak for power outage and Cyber incident where PAHT has a key role as a category 1 responder and an acute trust.
- Testing and exercising has been ongoing with the ICB and the LRF/ERF for national power outages which includes PAHT as a category 1 responder under the CCA 2004
- Other internal testing and exercising with other internal partners has been through, child abduction and security lockdown.

4. Major Incident preparation of staff, equipment and preparedness.

- Major Incident Policy as a result of the outcomes of the testing and exercising is being reviewed and updated, there have been some significant changes with those updates.
- There were not been any declarations of major incidents in the last period. There have, however, been business continuity incidents dues to excess demand within the Trust declaring business due to the high 'Opel 4' declaration, due to pressures on capacity within the organisation. Business continuity due to staff shortages has been due to the industrial action (IA). Significant preparedness had been made ensuring, provision of our core services, patient and staff safety. After action reviews conducted and the organisational learning from that implemented into the continued development of the trust during IA, and good practices adopted throughout the trust too.
- Considerable work had been done to highlight the shortage of staff within the EPRR team in order to ensure that the trust is fully compliant with its legal requirements both under CCA 2004, Health and Care Act 2022 and mandated by NHSE.

Training

- Loggist training has commenced with the IBC and will continued in early 2023 and due to recommence in early 2024, 1 loggist has already been trained and 6 awaits training from PAHT.
- Hazmat training has commenced in February 2023 and continuing
- Major incident strategic and tactical commander training recommenced 2023, all the on call strategic and tactical commanders and those who perform Director on call and senior manager on cal. This training will continue for those who require a refresher and new to the roles.
- Business continuity training for the practitioners commenced in 2023 and is on-going. This assists the practitioners/plan owners in writing or reviewing their BCPs.

Major Incident and Hazardous Materials Equipment

The major Incident store and the equipment was tested in the summer of 2023 and the equipment locally audited. The result of that highlighted key equipment and additional training is necessary to ensure PAHT is compliant with our ability to respond patients presenting themselves to the PAH from a CBRN or Hazmat incident. This is being addressed, actioned and progress is being presented at the relevant meetings. A risk assessment has been completed and going through due process.

5.0 Recommendation

The board approves or amends the Core Standards Return with formal sign off at the public board and is assured that the ongoing programme of work will be undertaken to mitigate any risks to the organisation.

Author: Claire Aubrey Robson (EPRR)
Date: 12th December 2023

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
Domain 1 - Governance					
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations
Domain 2 - Duty to risk assess					
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain Plans					
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
Domain 4 - Command and control					
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.
Domain 5 - Training and exercising					
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board
Domain 6 - Response					

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies
Domain 7 - Warning and informing					
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response
Domain 8 - Cooperation					

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency
42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004
Domain 9 - Business Continuity					

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning
Domain 10 - CBRN					

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Y	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Y	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Y	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
67	CBRN Support to acute Trusts	Capability	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response. The support provided by NHS Ambulance Services must include, as a minimum, a biennial (once every two years) CBRN/HazMat capability review of the hospitals including decontamination capability and the provision of training support in accordance with the provisions set out in these core standards.		Evidence predominantly gained through assessment and verification of training syllabus (lesson plans, exercise programme), ensuring all key elements in "detail"" column are expressed in documentation. This will help determine: -If IOR training is being received and is based on self-presenters to ED. -Whether PRPS training is being delivered. -Training re: decontamination and clinical care of casualties. Specific plans, technical drawings, risk assessments, etc. that outline: -The acute Trusts' CDU capability and how it operates. -Its provision of clinical radiation monitoring. -How scientific advice is obtained (this could also be an interview question to relevant staff groups, e.g., ""what radiation monitoring equipment do you have, and where is it?" Any documentation provided as evidence must be in-date, and published (i.e., not draft) for it to be credible. Documented evidence of minimum completion of biannual reviews (e.g., via a collated list).
68	CBRN Support to acute Trusts	Capability Review	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.		Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. -Evidence of progress/close-out of actions.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**1 February 2024**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**	
REPORT FROM:	**Liz Baker - Chair**	
DATE OF COMMITTEE MEETING:	**22 January 2024**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 PAHT2030 Update / Corporate Transformation: Medical Administration	Y	Y	N	**PAHT2030**: STC agreed with the recommendation to close 2022/23 milestones for 'Transforming Our Care' and 'New Hospital'. Although 2022/23 milestones remained incomplete for the other priorities, those were on track with revised timelines, were progressing well and were rated green. 'Digital' was likely to be 'blue' the following month. 2023/24 milestones were green, except for 'Corporate Transformation' which remained 'amber'. 'New Hospital' remained green due in terms of internal actions. 2024/25 milestones were in development and included in the pack as drafts in terms of assurance around ongoing planning. **Medical Administration:** This project had stalled over recent months but had now been re-energised with some new leadership and support from EHR colleagues. The move now to a clinical dictation system would be a key enabler of the new electronic health record (EHR) at go-live in October 2024.
2.2 New Hospital Update	Y	Y	N	An update on the land purchase was noted and that recruitment was underway for a new Programme Team.

The Princess Alexandra Hospital NHS Trust

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REPORT FROM:	**Liz Baker - Chair**			
DATE OF COMMITTEE MEETING:	**22 January 2024**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 BAF Risk 3.5 (New Hospital)	Y	Y	N	It was agreed that the risk score would remain at 20.
2.4 Digital Transformation Update	Y	Y	Y	The electronic health record programme remained on track. 'Future State Validation' would take place during the last week of January and this was a key milestone for the programme following a significant amount of work. Internal communications would now be a key focus and go-live was still on track for October 2024.
2.6 BAF Risk 1.2 (EHR)	Y	Y	N	It was agreed that the risk score would remain at 16 and consideration would be given to the requirement for a standalone BAF risk related solely to EHR.
3.4 BAF Risk 3.2 System Pressures	Y	Y	N	The risk score remained unchanged at 16.
Items noted: - Strategic/System Update including reports from the West Essex and East & North Hertfordshire Healthcare Partnership Boards - Stakeholder Update				
4.1 Discussion Topic: Healthcare Partnership Development				

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:		**1 February 2024**		**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:		**Strategic Transformation Committee (STC)**		
REPORT FROM:		**Liz Baker - Chair**		
DATE OF COMMITTEE MEETING:		**22 January 2024**		
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**

Collaboration through Health & Care Partnerships (HCP) is the preferred way of working to deliver the scale of change that needs to be seen across the local health economy. As part of this an HCP network has been established to help shape and inform how these services and this partnership will be delivered. A series of minimum requirements has been established to start the process of formalising HCPs from April 2024 under three themes: leadership, finance, and governance.

The discussion topics at STC will continue to run on a regular basis with the aim of supporting the HCPs to gain greater autonomy, functions, and responsibilities incrementally over time, as the system adapts, changes and matures.

Key features of the operating model for HCPs includes:

- Accountable Officers for each partnership.
- Senior Leadership Teams for each partnership, supported by ICB place teams.
- Devolved budgets to HCPs to enable local investment and/or reallocation.
- Streamlined ICB governance to simplify lines of accountability.
- Committees in Common to be the initial model of governance for all HCPs.

Discussion topics will be focused on these key elements at each of the Sub-Committees to aid and inform the development of our West Essex Partnership.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 1 February 2024 **Item No: 7.2**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy
DATE OF MEETINGS: **16 January 2024**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at the SMT meeting on 16 January November 2024:

- SMT – way forward (new SMT meeting structure agreed from Q1 of 2024/25)
- Quality Update
- Corporate Risk Register Update
- Nursing Establishment Review (bi-annual update)
- Guardian of Safer Working report
- Freedom to Speak Up
- Medical Workforce review
- Recovery Dashboard
- IPR
- Review Lists
- Finance update M9 and Capital

7.2