The Princess Alexandra Hospital NHS Trust

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

Date and time: Thursday 3 February 2022 at 9.30 – 13.15
Venue: Microsoft Teams Meeting

	Item	Subject	Action	Lead	
01 Opening administration					
09.30	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	4
	1.4	Matters arising and action log	Review	All	16
09.35	Staff story: 'Midwifery and Registered Midwife Shortened Course'				
02 Chair and Chief Executive's reports					
10.00	2.1	Chair's report	Inform	Chair	17
10.10	2.2	CEO's report including: • COVID-19 update	Inform	Chief executive	20
03 Risk					
10.30	3.1	Significant risk register	Review	Medical director	27
10.40	3.2	Board assurance framework 2021-22	Review/ Approve	Head of corporate affairs	34
04 Patients					
10.45	4.1	Report from Quality and Safety Committee 28.01.22	Note	Committee Chair	47
10.55	4.2	Learning from deaths (Mortality)	Discuss	Medical director	49
11.05	4.3	Maternity SI report	Assure	Director of nursing and midwifery	52
11.15	4.4	Nursing, midwifery and care staff levels including nurse recruitment	Discuss	Director of nursing and midwifery	55
11.25	4.5	Maternity Establishment Review	Approve	Director of nursing and midwifery	70
		Break			
05 People					
11.50	5.1	Report from Workforce Committee 31.01.22	Note	Committee Chair	76
12.00	5.2	Vaccination as a condition of deployment (VCOD) for all healthcare workers	Inform	Director of People and OD	78
06 Performance/pounds					
12.10	6.1	Report from Performance and Finance Committee 27.01.22	Note	Chair of Committee	82

12.20	6.2	Integrated performance report	Discuss	Chief Information Officer	84
12.35	6.3	Trust's response to HSE	Note	Chief Operating Officer	163
12.45	6.4	Electronic Health Record update	Inform	Chief Information Officer / Director of Finance	168
07 Strategy/Governance					
13.00	7.1	Report from Strategic Transformation Committee 24.01.22	Inform	Chair of Committee	171
13.05	7.2	Report from Senior Management Team Meetings 4.01.22 and 18.01.22	Inform	Chair of Committee	173
08 Questions from the public					
	8.1	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
09 Closing administration					
	9.1	Summary of actions and decisions	-	Chair/All	
	9.2	New risks and issues Identified	Discuss	All	
	9.3	Any other business	Review	All	
13.15	9.4	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	

The Princess Alexandra Hospital NHS Trust

01.04.21	07.10.21
03.06.21	02.12.21
05.08.21	03.02.22

Purpose:

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

Quoracy:

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

Ground Rules for Meetings:

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

Board Membership and Attendance 2021/22

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

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Virtual Trust Board Meeting in Public
Thursday 2 December 2021 from 09:30 to 12:45

Present:	
Hattie Llewelyn-Davis	**Trust Chair (TC)**
Dr Amik Aneja	General Practitioner (GP-AA), Board Advisor
Helen Glenister	Non-Executive Director (NED-HG)
Darshana Bawa	NExT Non-Executive Director (NNED-DB)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Fay Gilder	Medical Director (MD)
John Hogan	Non-Executive Director (NED-JH)
Helen Howe	Non-Executive Director (NED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Lance McCarthy	Chief Executive Officer (CEO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Saba Sadiq	Director of Finance (DoF)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)
Pam Court	Non-Executive Director (NED-PC)
Phil Holland	Chief Information Officer (CIO)
In attendance:	
Chris Allen (patient story)	Emergency Planning & Resilience Manager
Kerry Riches (patient story)	Head of Patient Experience
Rachel Harding (patient story)	Matron - Nightingale Ward
Kay Cobbold (patient story)	Transfer of Care Matron
Sarah Webb	Deputy Director of Nursing & Midwifery
Finola Devaney (observing)	Director – Clinical Quality Governance
Members of the Public	
None present	
Apologies:	
None	
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chair (TC) welcomed all to the meeting.
1.1 Apologies	
1.2	There were no apologies.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of the Meeting held on 04.11.21	
1.4	These were agreed as a true and accurate record of that meeting with no amendments.
1.4 Matters Arising and Action Log	
1.5	The action log was noted.
Patient Story – 'Being on the other side'	
1.6	This item was introduced by the Director of Nursing & Midwifery (DoN&M). She welcomed Chris Allen, the organisation's Emergency Planning & Resilience Manager (CA) to the meeting. Nursing colleagues in attendance were welcomed and included the Deputy Director of Nursing & Midwifery (DDoN&M), Nightingale Ward Matron (M-NW) and Transfer of Care Matron (TC-M). She informed members that CA had been diagnosed with diabetes during

	the first wave of the pandemic and his story would detail his experience as an inpatient during that time. It was also a reflection on expectations of patients in terms of care delivery. The story would also touch on points of learning for the organisation to take forward. She handed over to CA.
1.7	CA introduced himself to members and started his story by commending the compassion and care shown to him by nursing and medical staff during his time as an inpatient. Staff had taken the time to sit with him and explain his diagnosis and what that would mean for him going forward, particularly in terms of daily injections.
1.8	CA then detailed some of the areas which had caused him some anxiety during his stay and those had been: **Food:** It had quickly become apparent to him the importance of food as not only nutrition but also as medicine. He had however found it challenging to always receive his 'five a day' and had even resorted to requesting it by hand on his menu request. He had also realised that in terms of breakfast particularly, the food offering was not optimal for a diabetic (keeping blood sugars down). **Environment:** He had been placed in a side-room with no windows/ventilation during summer and hydration had become an issue for him, particularly when drinks were served in small cups rather than mugs. The lack of windows had also felt slightly oppressive to him coupled with the fact he could not have visitors. A clock that ticked incessantly on the wall and an LED light and the noise of bins closing had disturbed him. **Discharge:** When he had received the green light to go home early one morning it had taken until 20:00 for discharge to happen due to a delay in TTAs (medication to take home).
1.9	The DoN&M thanked CA for the insight into his experience and handed over to the Deputy DoN&M (DDoN&M) who was also the chair of the Nutrition Steering Group (NSG) to reflect and respond to some of the issues raised.
1.10	The DDoN&M stated that the NSG was fully sighted on meal provision and its quality and was working with the Diabetic Lead and the kitchens to ensure appropriate meal provision. She acknowledged however there was more to be done. In terms of breakfast, catering staff were working to deliver a hot meal which was currently being piloted on two wards. Catering staff had been (and were always) fully engaged in patient meal provision but she acknowledged there was sometimes a disconnect with ward areas in terms of them knowing what was available for patients. To support improvements in this area a House-Keeper Task & Finish Group had been established to understand what might be available for patients in the kitchen and outside of the stated menu. The house-keeper role was integral to a personalised meal service and she acknowledged the organisation was struggling to recruit substantively to those posts. In terms of mugs being used instead of cups, the issue would be taken back to the group. She stated that CA's insight would be invaluable to NSG colleagues and also to the Task & Finish Group and he would be most welcome to join either/both groups.
1.11	The DoN&M then asked the Nightingale Ward Matron (NW-M) for her reflections. In response the NW-M reflected that some huge changes had been made to the environment of the ward the previous year. She acknowledged that one of the three side-rooms had a window and was being used as a staff room. That had now been changed however to a patient side-room. However that meant there was still a patient side-room that did not have a window. She continued that soft close bins were now on the ward and she would be checking all the clocks on the ward when she returned. In terms of the LED light she had done some investigation and had been surprised to learn it was for dementia patients to make the environment more friendly so could not be removed. However the team would continue to try to place more mobile patients into the side-rooms who could leave the area temporarily should they wish.
1.12	The DoN&M highlighted there had been a significant amount of learning and reactive actions taken in response to CA's story and those would be replicated across all other ward areas. She handed over to the Transfer of Care Matron (TC-M).
1.13	In response to the above the TC-M informed members the organisation had learned much the previous week from the multi-disciplinary agency discharge event (MADE). There had

	been recognition that TTAs were an issue and being ordered late in the day. In terms of improving discharge processes a review of complex discharges and 'pathway zeros' was underway. Some additional funding had been secured which would be used to recruit healthcare support workers to support discharges of 'pathway zeros' and 'pathway ones'. Some Band 6s would join on 09.12.21 from the community to support the team. She thanked CA for sharing his story and confirmed her commitment to addressing the timing issues of TTAs.
1.14	The DoN&M thanked CA for his story which had been helpful and powerful and would support the organisation's work to deliver outstanding care to its patients.
1.16	The TC thanked CA and the team for their presentation. She acknowledged the issues raised and that the learning needed to be wider than just the one ward. She had been pleased to hear the care provided by nursing and medical colleagues had been praised.
1.17	In response to the above the Director of Strategy (DoS) commented in terms of the potential number of other patients whose experiences had not been shared. He fully recognised the issues raised by CA and indeed on a recent visit to a refurbished ward had noticed a corridor light which could not be switched off. His suggestion therefore was the establishment of a 'Sleep Easy' group to support patients with rest. He flagged that the conversation was often around how hard it was to treat patients rather than, as had been heard that day, how hard it was to be a patient. The story that day had provided much food for thought in terms of the design of the new hospital and how important patient spaces were.
1.18	The Medical Director (MD) asked what was being done in terms of providing 'five a day' for patients. In response the DDoN&M confirmed a fruit bowl would soon be offered with the drinks trolley. She would however take back to catering staff the issues raised around serving vegetables with main meals as she suspected that this was an ordering issue.
1.19	At this point the Director of Quality Improvement (DoQI) asked CA a question around the support he received following discharge. At the same time NED Pam Court (NED-PC) commented that often 'beige' or bland food could be the food of choice for certain cohorts of patients and in terms of lighting, one size did not fit all. Her point therefore was around the importance of personalised care from the off which, she acknowledged was challenging in a large hospital.
1.21	NED Helen Glenister (NED-HG) raised a question in terms of hydration for patients who were not in inpatient areas. In response the DoN&M stated it was all about gleaning information from patients in terms of their experience which happened through the PALS contacts and the Patient Experience Team/Group. She acknowledged however the issues around the food and hydration offering in ambulatory care which would be addressed in the Nutrition & Hydration Strategy.
1.22	NED George Wood (NED-GW) commented there needed to be flexibility in the nutrition and hydration offering particularly for those patients who did not want to eat/drink at regular times. Associate NED Anne Wafula-Strike (ANED-AWS) stated her experience of hospital nutrition was different on each attendance. She asked CA whether he would have benefited from some form of entertainment whilst an inpatient. In response CA stated he had been able to pack a bag before his stay so had been able to bring books and an iPad with him. He acknowledged that would be different for someone brought in as an emergency. His view would be there was definitely some scope for an iPad trolley (as opposed to a book trolley) to provide some distraction for patients. In terms of the comment made by NED-PC around neuro-diversity he agreed that personalised care was critical for the future. He recognised it would be challenging but for longer term patients it would be essential. In response to the question raised earlier by the DoQI around support post discharge, he confirmed he had only had one outpatient appointment since his discharge which had been via telephone however his GP offered video calls and consultations with a Diabetic nurse so his care in the community had been good.
1.23	The TC thanked CA and colleagues for their presentation.
1.24	The TC summarised some of the learning points and highlights from the story and asked the DoN&M to report back on the key actions in two months' time: • A group to be established to address a good night's sleep for patients.

	• Support for mugs rather than cups. • Nutrition to be healthy and flexible. • Further work to be done around discharge entertainment for patients to be picked up by the Patient Experience Group. • An 'Outpatient Story' to be presented to a future Board meeting. • Consideration to be given to personalised care moving forward. It was agreed that amazing care had been delivered by staff despite the other challenges.
ACTION **TB1.02.12.21/10**	**Report back to Board on the actions taken to address issues identified during the Patient Story presented to Board on 02.12.21.** **Lead: Director of Nursing & Midwifery**
02 RISK/STRATEGY	
2.1 Chair's Report	
2.1	The TC introduced her paper and informed colleagues its purpose was to keep Board members and the public updated on her role and activities. Members had no questions and the report was noted.
2.2 CEO's Report	
2.2	The CEO introduced his report which, he explained, had been submitted prior to the identification of the new COVID variant, Omicron. Members would note from the paper that new community infections were increasing slightly but the numbers of inpatients had been fairly consistent over the previous five months with circa three new admissions per day on average. Latest forecasts were predicting the number of community infections to double over the coming ten weeks. The impact of Omicron on transmissibility and the efficacy of the vaccine were currently unknown and whether or not the hospital would start to see increased admissions. The organisation would work closely with regional and national colleagues to understand the potential impact and where necessary to introduce measures to address that.
2.3	The CEO continued that colleagues would have heard the Government was ramping up the pressure on the NHS in terms of the vaccination programme and for there now to be a reduced length of time between the second dose and the booster (six months to three months). Consideration was also being given for a second dose for those aged 12-16 and whether or not to vaccinate those aged 5-11.
2.4	In terms of hospital staff, he was pleased to report that just over 90% had received both vaccines with just under 80% also receiving the booster. The meeting would later touch on the requirement for some cohorts of NHS staff to be vaccinated by 01.04.22.
2.5	The CEO continued and acknowledged the huge pressure that staff had been under for the previous 21 months, and which was continuing. The pressure was not only in terms of managing the pandemic but also anxiety around the new strain, requirements in terms of recovery, and managing the increasing demand at the front door. The SHaW team were supporting staff as much as they could and in various ways.
2.6	The CEO informed colleagues that since the last Board meeting, where he had outlined the detail, initial feedback and Section 31 notice from the formal CQC inspection of the hospital's services between 6 July 2021 and 6 September, the final formal report had been received and had been published by CQC colleagues on 17.11.21. He drew members' attention to the black arrows in the table which showed how relevant ratings had changed by domain for each of the core services inspected. CQC colleagues had rated all eight areas that they inspected as the same as they had rated them in the last inspection for each of those areas. Consequently, the organisation had remained as 'Requires Improvement' overall and its core services of medicine and maternity had remained as 'Requires Improvement' and its Urgent and Emergency care (UEC) services had remained as 'Inadequate'.
2.7	The detailed report had recognised the pressure the organisation had been under during the pandemic, the impact it had on the organisation's people, the positive approach taken by colleagues within the organisation and how they worked together and their passion for patient care and desire to continue to learn. The report had included consistent themes of good practice and also five key themes for improvement across all areas. He highlighted the

	approval of business cases for NerveCentre and a new HER (electronic health record) to help address some of the organisation's issue and the continued hard work to develop actions locally to address the Section 31 notice and CQC concerns. The MADE event mentioned earlier would help support flow and also address some of the Section 31 concerns. He recognised the CQC report was not where it should be and there was more to do to improve services and provide outstanding care for patients and he believed that colleagues had the desire and passion to do that
2.8	In terms of consultant appointments four offers had been made in terms of the ED and in line with the recommendation the Board formally ratified those appointments.
2.9	In response to the above NED John Hogan (NED-JH) asked for any CQC feedback on the Trust's submissions in response to the Section 31 notice and how long those obligations would be in place. In response the DoN&M confirmed that feedback had been limited so far as there was some triangulation of data to be undertaken by them in terms of ED fill rate (which was quite healthy) against activity and ambulance handovers. In terms of a timeframe she suggested it was for the organisation itself to indicate when it felt ready for a review particularly in light of the current pressures on the department.
2.10	In response to a question from NED-GW in terms of the ramping up of the vaccination programme, the GP, West Essex CCG (GP-WECCG) stated that West Essex was seeing a 20% increase in demand for GP services and was therefore looking to some form of overflow service for patients to absorb some of the demand. COVID was currently rife in primary schools in the area so the doubling of infections mentioned earlier appeared accurate to him. Other areas being considered to address demand were visiting services, respiratory hubs and increasing UTC access. His view was that it would be challenging over coming months and system colleagues would need to work together to address the increasing demand on services.
2.11	NED Helen Howe (NED-HH) asked about plans for the staffing skill mix in the UTC. In response the Chief Operating Officer (COO) confirmed that colleagues were working on that with system and ICS partners. The expansion was on track to go live the following week with an additional six consulting rooms and operational from 0700-0200 seven days per week. There would be an increase in GPs and there would also be advanced care practitioners, HCAs and community staff so absolutely reflective of the mix of patients being seen and treated.
2.3 Significant Risk Register (SRR)	
2.12	This paper was presented by the MD and taken as read. She highlighted to colleagues that in August there had been 86 risks scoring 15 and above which had now reduced to 62. There were currently 11 risks scoring 20 and two new risks added in terms of staffing in Paediatrics/Urgent Care and in Anaesthetics. She asked members to note the huge amount of work being undertaken to mitigate those staffing risks.
2.13	In line with the recommendation, the Board noted the SRR.
2.4 Board Assurance Framework	
2.14	This paper was presented by the Head of Corporate Affairs (HoCA) and was taken as read. Colleagues noted the recommendation that month was to increase the risk score for the new hospital risk from 16 to 20. No changes were proposed to the other risk scores. She handed over to the DoS to brief the Board on the rationale for the increase in the risk score.
2.15	The DoS updated that the increased risk score would reflect the position of the new hospital programme in terms of current delays and the delay in feedback in relation to the outputs of the Design Convergence Review (DCR). In line with the recommendation the Board approved the increase in risk score from 16 to 20.
03 PATIENTS	
3.1 Learning from Deaths (Mortality)	
3.1	This paper was introduced by the MD and she drew members' attention to the fact that Dr. Foster was now known as Telestra. In terms of HSMR and the 12 month rolling average she

	was pleased to update that five data points were now showing as 'as expected' with the last data point being the end of June. She had spoken with Telestra that week and was hoping to receive the position for September/October later that month. SHMI remained 'as expected'.
3.2	The MD continued that the Strategic Learning from Deaths Group had not met that month due to a change to the meeting schedule to allow a written report to be submitted to QSC and then to Board. She informed colleagues that the group received a quarterly update on mortality improvements and she drew members' attention to the progress being made in terms of fractured neck of femur and End of Life. She was pleased to update that the Medical Examiner (ME) Service was going from strength to strength with the appointment of an additional ME and also a Bereavement Officer. This was in line with the requirement to scrutinise all community deaths from April 2022. As a final point she confirmed that all Medical PSQ posts had been appointed to.
3.2 Maternity SI Report	
3.3	This paper was presented by the DoN&M who informed members there had been no new SIs in-month. Data in terms of CTG (cardiotocography) training and in relation to PPH (post-partum haemorrhage) was also included within the Integrated Performance Report (IPR).
3.3 Nursing, Midwifery and Care Staff Levels	
3.4	This update was presented by the DoN&M, the highlight of which (for her) was the fill rate for overall RN/RM in month of 95.9%. In contrast however the risks were noted around staffing in Paediatric ED and also in Maternity. The workforce in Maternity was expected to improve as of that month and looked to be on track to do so.
3.5	In terms of the fill rate in ED, she informed colleagues some additional narrative would start to be added to that and also care hours per patient per day. She was also pleased to report that in terms of a previous area of challenge (healthcare support workers), 40 offers of employment had been made the previous weekend.
3.4 Nursing Establishment Review	
3.6	This paper was presented by the DoN&M and had previously been presented to both PAF and WFC. There was a requirement for Boards to receive a report outlining the assessment or resetting of the nursing establishment and skill mix by ward or service area at least annually. She confirmed the Board had not received a nursing establishment review for almost two years due to COVID and the paper that day would bring the organisation back in line with workforce intentions aligned to the National Quality Board (NQB). There would be a six monthly 'check-in' in Spring 2022.
3.7	Key highlights from the review were noted as follows: • A recommended change to the nursing workforce in terms of an uplift in qualified nurses of 25.63WTE and a reduction in unqualified care staff of 16.79 WTE. • Additional recommendation to substantiate a team of HCSW and RMNs who were able to provide enhanced care to patients who required 1:1 therapeutic care who were at potential risk to themselves or others (falls, dementia, mental health etc). The overall increase in budget from 2022/23 would be £1.27M however £550k was already included in the current run rate.
3.8	In response to the above NED-JH asked whether overall there would now be a shift to a higher skilled nursing establishment. In response the DoN&M stated there would be, aligning the organisation with the NQB, where it hadn't been previously.
3.9	In response to a comment made by NED-PC, it was agreed that once the establishment had been fully recruited to, the anticipated reduction in bank/agency spend would be tracked by the Executive and reported to PAF.
3.10	As a final point the CEO highlighted the ongoing work required in non-clinical services to ensure efficiencies and a redistribution of money to front-line clinical posts.
3.11	In line with the recommendation the Board supported the outcome and recommendations of the May 2021 nursing establishment review.

3.5 Quality & Patient Safety Strategy	
3.12	This paper was presented by the DoN&M who flagged that it was for approval (not noting). She informed colleagues the strategy had been developed after a significant amount of engagement with both clinical staff and patients across the organisation. It brought together the patient safety and experience priorities and provided a direction of travel. It was aligned to other organisational strategies, for example PAHT2030 with a digital and workforce agenda and also to clinical strategies. It had been presented to both QSC and WFC and aligned to the national patient safety priorities. She flagged that a couple of amendments had been flagged post-submission which related to the Mental Health strategy which would be corrected in the final version.
3.13	In response to the above the TC asked what work had been undertaken in terms of consulting with staff impacted by the strategy. In response the DoN&M confirmed engagement events had taken place and with patients too. Both had been supportive of the strategy.
3.14	In line with the recommendation the Board approved the Quality & Patient Safety strategy.
3.6 Nursing, Midwifery and AHP Strategy Update	
3.15	The DoN&M informed members that the Nursing, Midwifery and AHP strategy had been launched in the organisation in December 2020, bringing together the professions' priorities under a three year direction and focus. In 2020/21, despite the significant impact of the pandemic there were only five priorities that were not fully achieved. The paper described progress against those as well as progress against the new priorities that had been set for 2021/22. The paper also noted the risk to delivery against the three priorities in 2021/22. She confirmed the paper was for noting.
3.16	The DoN&M continued that the work had now caught up with the leadership and development programme for matrons and colleagues had previously noted the reduced nursing vacancy rate. She was pleased to update that communications would go live across the organisation around launching shared decision-making forums in line with a previous Board Staff Story on international nurses. Electronic dashboards were starting to be developed which would enable colleagues to drill down into their own data. There had also been some headway on the drive to ensure BAME staff were well represented in the organisation.
3.17	The work was focussed on specialist nurses and how they were used in terms of job planning to enable them to work at the top of their licence. Discussions were ongoing with Anglia Ruskin University (ARU) around a joint Professor of Nursing post. Scoping of consultant practitioner opportunities had identified key areas: Consultant practitioner in UEC and consultant practitioner in the care of the older person (Frailty). In addition Maternity services had identified a role for a midwifery consultant with the portfolio for midwifery-led care and public health.
3.18	Finally in terms of developing talent the organisation would be looking to launch a Chief Nursing Officer Fellowship across the organisation to talent spot and take staff forward.
3.19	Risks to the programme included COVID and HCSW vacancies albeit 40 offers had been made the previous weekend.
3.20	As a final point NED-HH commented that talent spotting and alignment to the BAME work would be key for the ten year People Strategy, in terms of picking up where there was opportunity for the under-represented at a senior level.
3.21	The TC thanked the DoN&M for all the hard work that had gone into the strategy.
04 PEOPLE	
4.1 Equality Delivery System 2 (EDS2)	
4.1	This update was presented by the Director of People (DoP) who informed members that EDS2 had been designed to help NHS organisations, in discussion with stakeholders, review and improve performance for patients, communities and staff in respect of all nine characteristics protected by the Equality Act 2010. The Trust had assessed its performance against 18 outcomes (within 7 thematic goals) and assigned an assessment grade of

	Undeveloped - Developing – Achieving – Excelling against each outcome. The report summarised the evidence collated to support the assessment ranking for each outcome: • **6** goals assessed as developing • **10** goals assessed as achieving • **2** goals assessed as excelling The EDS2 report would be approved annually.
4.2	NED-HH commented that the paper had been discussed at WFC however she would reflect that on occasion there were more than the nine protected characteristics to be taken into account. That would be something to reflect on as the Trust went forward with its health and wellbeing agenda. In response the DoP stated that she agreed and the Health & Wellbeing strategy tried to capture that very point so that people could be their 'authentic self' at work.
4.3	In line with the recommendation the Board approved the report.
4.2 Vaccination as Condition of Deployment	
4.4	This paper was presented by the DoP who informed Board members that the Department of Health and Social Care (DHSC) had formally announced that individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19 by no later than 01.04.22 to protect patients, regardless of their employer, including secondary and primary care. Organisations were now awaiting further guidance on the matter. The Trust would be taking a number of steps in preparation whilst it awaited further information but she was pleased to update that 86% of staff were fully vaccinated (both doses) and 77% had received the booster.
4.5	In response to the above NED-HH asked how many staff the above would currently apply to. In response the DoP stated she did not have the specific data to hand, especially with starters and leavers, and the organisation would be awaiting further guidance first.
4.6	ANED-AWS stated it would be useful to under people's reluctance to have the vaccine and try to address the root cause. In response the DoP cited historic issues in terms of vaccines being imposed on certain communities prior to efficacy approval as one reason, along with misconceptions. In response to a further question from the DoQI, the DoP confirmed that work was underway to identify the organisation's potential vulnerability in terms of that core group of nursing/medical frontline staff.
4.7	The TC thanked the DoF for her update and suggested the paper should be presented to the Board on a monthly basis going forward so that the potential risks could be clearly understood.
ACTION **TB1.02.12.21/11**	**Board to receive a monthly update going forward on the mandatory COVID vaccinations for some NHS staff.** **Lead: Director of People**
4.3 Flu Self-Assessment	
4.8	The DoP informed colleagues that in July 2021 national clinical and staff-side professional leaders had written to Chief Executives requesting that the best practice management checklist for healthcare worker vaccination was completed. It was a requirement that the self-assessment against those measures to be published in Trust Board papers for public assurance.
4.9	There DoP continued there had been a particular push for 'flu to come back onto the agenda given the current nationally low uptake of the 'flu vaccination compared to COVID. The organisation's current uptake was at 57% currently against an East of England average of 55% with the highest trust at 71% and the lowest at 38%. All trusts in the EoE were reporting 'flu vaccination rates lower than the previous two years.
4.10	The Board noted the organisation's 'flu self-assessment.
05 PERFORMANCE/POUNDS	
5.1 Integrated Performance Report	
5.1	This update was presented by the Chief Information Officer (CIO) and the following key highlights were noted:

	Patients: There was a significant level of mental health activity both in ED and across ward areas and close working with partners to ensure the right level of care was delivered. There had been an MRSA bacteraemia that month which was under investigation. **People:** Appraisal and statutory/mandatory training compliance had plateaued in terms of performance and there had been a slight increase in sickness. The new training facility was about to open on site which would support face to face training sessions. **Pounds:** M7 had achieved a breakeven position by using the M6 surplus and recovery funding. There had been a conversation at PAF in terms of assurance around the CIP programme and capital expenditure was at £13.5m against a £15.5m plan. There was confidence however that the capital resource limit would be achieved. **Places:** The organisation's Green Plan would be presented at the Private session and some sustainability KPIs would be added to the IPR in future iterations. Food waste had dropped below target in-month and there was potentially some learning to be taken from the Patient Story earlier in terms of the organisation's food offering and reducing waste. <u>Performance</u> **RTT:** Remained in special cause variation (SCV) and recovery actions continued with patients being seen in clinical priority. **Cancer 2WW:** In SCV with a large reduction largely caused by a significant increase in skin/breast referral due to increased media coverage. **4 hour standard:** Had returned to SCV for under-performance with a number of indicators still flagging. Attendances for October had exceeded the higher volumes experienced since May and were the highest for over six years. **52 WW:** Still in SCV and volume was increasing. Continued focus on clinical priority patients and no 104 week waiting patients. **Diagnostics:** Still in SCV with performance plateauing. Focus on the booking of the longest waiting patients. Trajectories and plans were in place across all modalities to increase capacity and return to the standard by mid-2022. **Cancer 62 day pathway:** Remained in common cause variation (CCV) with a second consecutive month of improved performance and back to near the mean. **Super-stranded patients:** Remained in CCV and performing well compared to peers across the midlands and east region.
5.2	As a final point the CIO added there would be a focus from the following month on staffing, patient safety, elective recovery and the urgent care pathway with a focus on KPIs for all and delivery against targets and compared to peer organisations.
5.2 Elective Recovery Plan	
5.3	This update was presented by the COO who informed colleagues that the plan had also been discussed at PAF the previous week. The paper set out the organisation's approach to recovery with a clear focus on support for workforce recovery as well as for services. In terms of the backlog of patients there were clear actions in place to clinically prioritise those who were waiting and to support treatment for those who had waited longer than 104 weeks by 31.12.21. There was good oversight from clinical teams to review patients and undertake harm reviews where appropriate and all cancer pathways were being coordinated and fed through the Cancer Board. With the support of the Patient Panel all long-waiters had received a written communication informing them of the current position and providing assurance they had not been forgotten. Actions were in place to focus on rebuilding capacity across the organisation. There was ongoing work in terms of activity levels and starting to plan for the coming year, taking into account the backlog and next year's activity to ensure the right workforce was in place at the right time.
5.4	In response to the above NED-HG asked how frequently patients were reviewed/reprioritised. In response the COO confirmed there was a patient tracking list which was reviewed on a regular basis with the clinical team and the operational managers. This occurred at least every month when clinical teams would meet with operational managers to review and

	prioritise patients on their lists. Any communication direct from GPs would then generate a further review.
5.5	In terms of workforce recovery NED-HH highlighted that one initiative currently underway was to document in staff appraisal where a conversation had taken place around health and wellbeing.
5.6	At this point NED-GW raised a point in relation to theatre productivity which he stated would be helpful to bring into the IPR, both for the organisation but also in terms of the ICS and how trusts were performing. The COO agreed that would be useful and also that a paper would be coming to January PAF around theatre optimisation and efficiency.
ACTION TB1.02.12.21/12	**Data on theatre productivity to be added to the Integrated Performance Report (IPR). Lead: Chief Operating Officer/Chief Information Officer**
5.3 Response to NHSE/I letter regarding Ambulance Handover	
5.7	This item was presented by the COO who reminded colleagues that a letter from NHSE/I had been received by all trusts in terms of required improvements for ambulance handovers. The paper presented that day was a summary of the Trust's actions and its response to NHSE/I.
5.8	In response to a question from NED-JH the COO confirmed that some slight improvements had been seen over the previous two weeks but the position was challenging particularly in terms of space in the ED. However that week had seen the go live of 'intelligent conveyancing' across the region to share out pressures amongst all acute Trusts.
5.9	The CIO suggested the data around ambulance handovers could be added to the IPR to evidence the trajectory and improvements.
ACTION TB1.02.12.21/13	**Ambulance handover data to be added to the Integrated Performance Report (IPR). Lead: Chief Information Officer**
5.4 H2 Financial Plan	
5.10	The paper was noted.
06 GOVERNANCE	
6.1 Reports from Committees	
6.1	<u>Performance & Finance Committee – 25.11.21</u> NED-PC highlighted the discussion had included capital, the Health & Safety action plan and M7 performance. <u>Quality & Safety Committee – 26.11.21</u> Members had no comments/questions on the paper and NED-HG confirmed there was nothing to add. <u>Workforce Committee – 29.11.21</u> NED-HH highlighted the new ten year strategy for HR in the NHS which had been issued on 22.11.21. There would be a Board Development session around that in due course. <u>Senior Management Team – 09.11.21/16.11.21</u> Members had no questions/comments.
6.2 Corporate Trustee	
6.2	<u>Charitable Funds Committee – 19.11.21</u> Associate NED John Keddie (ANED-JK) updated colleagues that the annual report and accounts for the charity had been reviewed and were recommended to the Corporate Trustee for approval (that included the letter of representation). Final submission to the Charity Commission was required by 31.01.22. In addition the Committee had discussed its annual effectiveness review and noted areas for improvement including quality and timeliness of papers. The composition of the Committee would be reviewed again June 2022. The Committee had reviewed its terms of reference (ToR) and changes had been made to the Committee's membership. Those were also presented that day for approval.

6.3	ANED-JK continued that the Committee had approved funding for two future events (Royal Berkshire Shoot/Snowball) and had also approved funding in the sum of £35k from the Just Giving for COVID charitable fund to fit out the Alex Lounge for staff.
6.4	The DoF informed colleagues that the annual report and accounts had received a 'make-over' that year and now included a CFC Chair's Report, and an expanded section on donations which nowincluded stories of the good work the charity had been involved in. She continued that they had been independently examined by Ernst & Young (EY) and their findings were included on pages 226-7. EY had identified one minor amendment in terms of the independent examination fee which had been corrected. The request that day was for the Corporate Trustee to also approve the letter of representation (including the annual return to the Charity Commission), both of which had been reviewed and endorsed by CFC.
6.5	In line with the recommendation the Corporate Trustee approved: • The 2020/21 Charitable Fund Annual Report and Accounts. • The Letter of Representation. • The revised ToR for the CFC.
6.6	NED-GW congratulated the team on all their hard work and for also achieving a year-end surplus. He suggested the CFC membership also included either the Associate Director of Patient Experience or the Volunteer Services Manager (to link in with patient experience) and also for consideration to be given to external trustees to support with promotion of the charity.
6.7	In response to the above the DoF agreed both were helpful suggestions but her view would be to await the arrival of the new Head of Fundraising in January 2022.
6.8	As a final point ANED-JK extended his thanks to NED-HG for a 'bucket collection' at the recent Saffron Walden Symphony Orchestra which had raised over £700.
07 QUESTIONS FROM THE PUBLIC	
7.1	There were no questions from the public.
08 CLOSING ADMINISTRATION	
8.1 Summary of Actions and Decisions	
8.1	These are presented in the shaded boxes above.
8.2 New Issues/Risks	
8.2	Colleagues agreed to note a new risk around the likelihood of mandatory COVID vaccination for some cohorts of NHS staff.
8.3 Any Other Business (AOB)	
8.3	There were no items of AOB.
8.4 Reflection on Meeting	
8.4	The MD questioned whether sufficient time had been spent in discussion of certain items, including for example the Quality & Patient Strategy. She acknowledged that the strategy had been discussed in detail at QSC.
8.5	NED-HH reflected that many of the papers presented that day had already been to Board Committees which, in her view, meant fewer questions were asked at Board.
8.6	In response to the above the TC stated that she and the HoCA would discuss outside the meeting: • The reporting from Committees to Board. • How the above points were reflected in the Board agenda and also in accompanying cover sheets (which could include key points raised at Board Committees).
ACTION **TB1.02.12.21/14**	**Discuss the reporting from Committees to Board and the content of cover sheets where papers have already been presented to a Board Committee.** **Lead: Trust Chair/Head of Corporate Affairs**

Signed as a correct record of the meeting:	
Date:	03.02.22

The Princess Alexandra Hospital NHS
NHS Trust

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

Trust Board Meeting in Public
Action Log 03.02.22

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.07.10.21/07	Risk Management Approach/Appetite	Provide an update to Trust Board (for Q1) on progress with revising the risk management approach and risk appetite.	DoN&M MD	Q1 2022/23	Item not yet due.	Open
TB1.07.10.21/08	IPR	Review trajectories for each KPI in the IPR to understand what might be achievable.	Exec Team	~~TB1.02.12.21~~ TB1.03.02.22	Actioned - Urgent Care is the first addition for January 2022.	Closed
TB1.02.12.21/10	Patient Story	Report back to Board on the actions taken to address issues identified during the Patient Story presented to Board on 02.12.21.	DoN&M	TB1.03.02.22	These are being picked up by the relevant groups and will feed into QSC: . Restful night time and discharge – on the agenda for next Patient Experience Group. . Hydration and nutrition – actions to be taken by the Nutrition and Hydration Group.	Proposed for closure
TB1.02.12.21/11	Mandatory COVID Vaccination for NHS Staff	Board to receive a monthly update going forward on the mandatory COVID vaccinations for some NHS staff.	DoP	TB1.03.02.22	To be addressed at item 5.2 @ TB1.03.02.22.	Proposed for closure
TB1.02.12.21/12	IPR	Data on theatre productivity to be added to the Integrated Performance Report (IPR).	CIO COO	~~TB2.13.01.22~~ TB2.03.03.22	Not yet included, defer to March.	Open
TB1.02.12.21/13	IPR	Ambulance handover data to be added to the Integrated Performance Report (IPR).	CIO COO	TB2.13.01.22	Actioned.	Closed
TB1.02.12.21/14	Board Reporting Template	Discuss the reporting from Committees to Board and the content of cover sheets where papers have already been presented to a Board Committee.	TC HoCA	TB1.03.02.22	Actioned.	Closed

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors 3rd February 2022.

Agenda item:	2.1								
Presented by:	Hattie Llewelyn-Davies								
Prepared by:	Hattie Llewelyn-Davies								
Date prepared:	27th January 2022								
Subject / title:	Chair's Report								
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**		
Key issues: please don't expand this cell; additional information should be included in the main body of the report	To inform the Board and other colleagues about my work; to increase knowledge of the role; to evidence accountability for what I do								
Recommendation:	The Board is asked to discuss the report, give feedback for future content and note it.								
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**				

Previously considered by:	Not applicable
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	The work on Non Executive appointments were guided by the Trusts commitment to EDI and its recruitment policies. Board development sessions have covered legislation, regulation and EDI.
Appendices:	None

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 two 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 NED Recruitment:

I am delighted to welcome to the Board Colin McCready as a NED, along with Liz Baker and Darshana Bawa as Associate NEDs. All three of them bring great skills and experience to us and will add strength and depth to the Board. Colin and Darshana strengthen our financial and accounting skills, Liz brings skills in capital projects. Darshana was originally with us as a NEXT Director, but has developed her knowledge and skills and the Board has agreed to appoint her as an associate.
Colin will take over as chair of the Performance and Finance committee once he has settled in.

3.0 Board Development and Training:

As part of the Well Led Review that the Board commissioned last year, the Board agreed to set up a Strategic Transformation Committee to oversee the implementation of the big pieces of work the Trust is undertaking. The Committee has now had its first meeting and the report of its work is on the agenda.

As part of the outcomes from the review, the Board has committed to a programme of board development and to strengthen the way it works. In the last two months we have undertaken training on regulation, equalities, development training for managers, sustainability, Trust finances and green issues.
The Committee Chairs have met together to agree a new process to ensure the board is assured of the work done by the committees. The new layout of the Board Agenda today reflects this.

We are seeking a venue where it will be possible to meet face to face, with appropriate pandemic protections in place, but where any members of the public who want to, will be able to join us.

4.0 My Priorities:

I reported to the last Board meeting that my priorities for my first six months would be as follows:

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

I have reported on b) and c) above.
On a) I have continued to learn more about the patch and the issues the wider system faces, including a number of meetings with the Integrated Care System. I have had the pleasure of attending a meeting of the Patient's Panel. Sadly, due to the restrictions put in place for the Omicron Surge it has not been possible to begin our planned programme of walkabouts, but this will happen as soon as possible.

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

Author: Hattie Llewelyn-Davies. Trust Chair.
Date: 27th January 2022

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 3 February 2022

Agenda item:	2.2							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	27.01.22							
Subject / title:	CEO Update							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report updates the Board on key issues since the last public Board meeting: - Current pressures - Vaccination as a Condition of Deployment - New hospital - Electronic Health Record - Planning Guidance - National and regional appointments and changes - Consultant appointments - Recent achievement / significant improvements for our patients							
Recommendation:	The Trust Board is asked to note the CEO report; note the progress made on key items and to ratify the offer of 2 consultant appointments, made through delegated authority to an AAC panel.							

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

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

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Chief Executive's Report
Trust Board: Part I – 3 February 2022

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

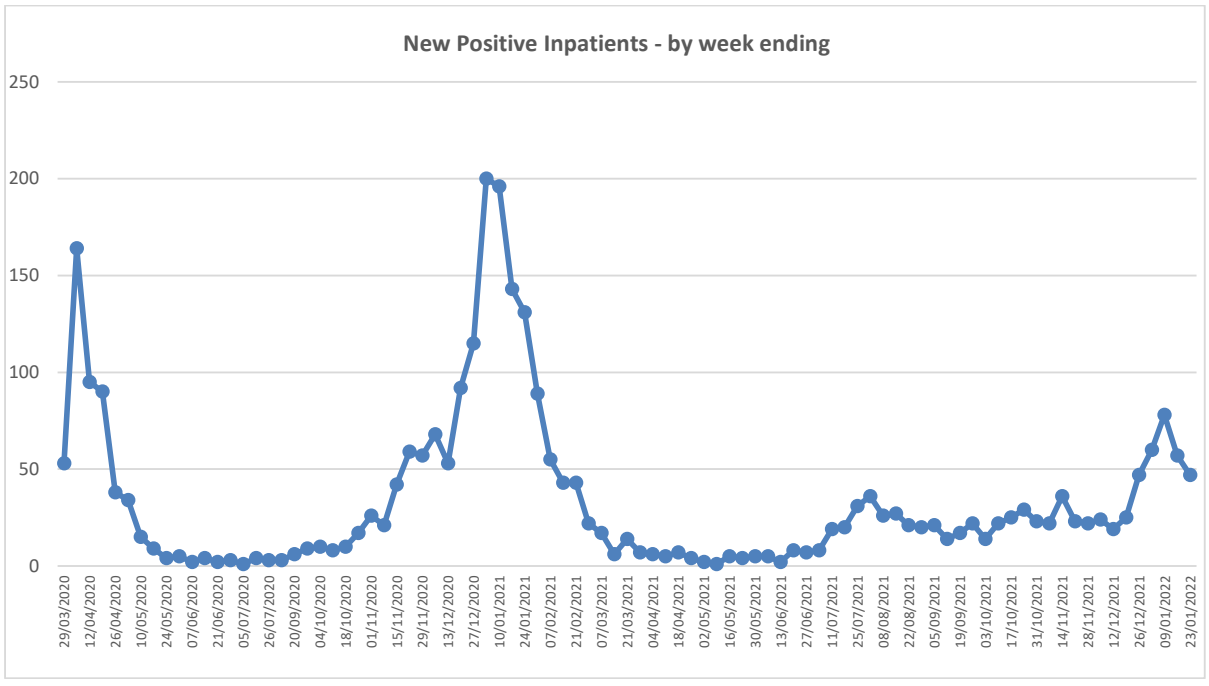
(1) Current pressures

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

Despite most parts of the economy opening up and many aspects of life returning to pre-pandemic norms, we are still in the pandemic.

The number of new COVID positive inpatients at PAHT, as a result of the Omicron variant, started to rise materially in w/b 20 December 2021. This smaller 3rd peak continued for 3 weeks, since when we have seen a weekly reduction; down to 47 in week ending 23 January.

The number of hospital IPs and the proportion of these requiring critical care support have both been significantly lower in this wave compared to previous waves, despite the number of new infections in the local community being significantly higher than in previous waves, as a result of the impact of the vaccination programme and less severe illness from the current variant. In late December and early January, Harlow had the highest number of new infections of any local authority in the East of England, averaging in excess of 1,800 new infections per 100,000 population at one point. This put considerable strain on our staffing levels for a few weeks at the start of January, with sickness absence increasing to as high as 10% with colleagues absent due to testing positive for COVID-19 or contact isolating whilst waiting for confirmation of their status. We have now returned to near normal levels of sickness absence for this time of year.



At the time of writing the report we have 52 covid positive inpatients in the hospital, 1 of whom is receiving critical care support.

All our teams are continuing to work hard at recovering our non-covid services. We are continuing to work closely with ICS colleagues, local cancer alliance and our local independent sector colleagues to maximise every opportunity for our longest waiting and most urgent patients to receive the interventions they require in a timely manner. We are on track to ensure there are no patients waiting for more than 104 weeks by the end of this financial year and most of our diagnostic activity and our outpatient activity is now greater than pre-pandemic levels, however, our ability to restore our elective activity to pre-pandemic levels has been impacted on by the covid admissions and the ongoing increase in demand for our urgent and emergency care services.

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

As discussed at previous Board meetings, the impact of the pandemic and the pressures and anxieties experienced by colleagues over the last 2 years cannot be underestimated, exacerbated by the increased rate of sickness absence and reduction in fill rates for shifts experienced over recent weeks, compounding the pressures on colleagues. We continue to enhance our health and wellbeing support for all colleagues who continue to remain under considerable strain and pressures.

(2) Vaccination as a Condition of Deployment (VCOD)

On 6 January 2022, the government made new legislation, approved by parliament, that amended the Health and Social Care Act and made COVID-19 vaccination a condition of deployment for all healthcare workers undertaking CQC regulated activity. All 'in scope' colleagues must be fully vaccinated by 1 April 2022 to protect our patients. This requires unvaccinated colleagues to have their first dose of COVID-19 vaccination by today (3 February) in order to be able to have their second dose by 1 April 2022.

Our people and SHaW teams have been working closely with all individuals who are not yet vaccinated to support them on an individual basis and have also been working closely with union representatives and staff networks.

At the time of writing this paper, 96% of PAHT colleagues were fully vaccinated and 92% had received their first dose. These numbers are increasing on a daily basis.

Further detail on the VCOD process is provided in a specific paper later on the agenda.

(3) New hospital

We continue to work at pace with the development of the new Princess Alexandra Hospital in conjunction with the national New Hospital Programme (NHP). Our Outline Business Case is continuing to be developed and we are expecting to be able to submit this in the spring 2022, subject to approval to proceed from the NHP and any design changes required as a result of the output of the NHP Design Convergence Review.

(4) Electronic Health Record

Our Outline Business Case (OBC) for an Electronic Health Record (EHR) for the Trust was approved by the national Joint Investment Sub-Committee on 17 January 2022.

Subject to formal approval by the Trust Board this afternoon, the procurement of this is planned to start next week.

A whole organisation EHR will be transformational to the way that we capture patient information and share and access it in a timely manner by all clinicians across the Trust and with relevant clinicians outside of the Trust. It will enable us to use our data much more effectively and bring us efficiency benefits as well as clinical benefits for our patients. It is the foundation of our exciting digital strategy as we strive to become the most digitally advanced hospital in the country at the time of opening our new hospital.

Thanks to the IT and finance teams who have developed the comprehensive OBC and procurement paperwork over recent months. Further detail is provided later on the agenda.

(5) Planning Guidance

The NHS Operational Planning Guidance for 2022/23 was issued on 24 December 2021. Within the guidance are 10 priorities for focus during the year:

- Investing in the workforce and strengthening compassionate and inclusive culture
- Response to COVID-19
- Elective care, backlogs and waiting times standards
- Improving the responsiveness of urgent and emergency care and community care
- Improving timely access to primary care
- Improving mental health services and services for people with LD
- Developing an approach to population health management and the reduction in health inequalities
- Exploiting the potential of digital technologies
- The effective use of resources
- Establishing Integrated Care Boards and enabling collaborative system working

Within the detail there are a number of specific areas of focus for PAHT as an acute provider, key ones outlined below:

- Eliminating 104 week waits by 31 March 2022 and maintaining this
- Reducing waits in excess of 78 weeks
- Reducing follow up outpatient attendances by 25%
- Recover cancer access targets
- Increase diagnostic activity to 120%+ of pre=pandemic levels
- Increase elective surgical activity to 104%+ of pre-pandemic levels
- Develop plans for investment in community diagnostic hubs
- Fully implement the Ockenden maternity recommendations
- Expand Urgent Treatment Centre activity
- Ongoing improvement against the UEC standards
- Drive towards the increased use of virtual wards
- Minimise delayed discharges
- Ongoing development of ICS and place-based partnerships to support local populations and reduce health inequalities

Colleagues are working through detailed plans to meet the requirements articulated in the planning guidance, with a detailed draft plan being worked up for mid-March. This plan will be discussed through the various Board committees with the final plan signed off at the end of April.

(6) National and Regional appointments and changes

Since we last met there have been a number of changes to key national, regional and local roles.

National NHSEI changes:

- Richard Meddings CBE has been appointed as the new chair of NHSEI and starts in March
- Mark Cubbon has been appointed as the chief delivery officer for NHSEI, focussing on the merger of NHSE, I , Digital and X, refreshing the NHS LTP and supporting ICS development
- Jim Mackey has been appointed as the SRO and national director for elective recovery, in addition to his CEO role at Northumbria Healthcare NHS FT
- Prof Sir Keith Willett, national director for emergency planning and incident management, is leaving this role in March to Chair South Central Ambulance Service FT
- Hugh McCaughey, national improvement director is retiring in the spring
- Ian Dodge - national director of primary care, community services and strategy is retiring in July

EoE Regional Office

- The recruitment process for the Regional Director role at NHSEI EoE is underway with the final panel interviews scheduled for today (3 February)

HWE ICS

- Karen Taylor started as the CEO at Hertfordshire Partnership University NHS FT on 1 December
- Adam Sewell-Jones started as the CEO at East and North Hertfordshire NHS Trust on 3 January
- Christine Allen, CEO at West Hertfordshire Hospitals NHS Trust, has announced her retirement, leaving the role in June
- The senior ICS roles supporting Rt Hon Paul Burstow and Dr Jane Halpin as the Chair Designate and CEO Designate respectively for HWE ICS are in the process of being scoped and recruited to

(7) Consultant appointments

Following an AAC panel on 27 January, 2 offers of appointment as a consultant at PAHT have been made to colleagues to work in our diabetes and endocrinology department:

- Dr Eleftheria Panteliou
- Dr Anneke Graf

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

(8) Recent achievements / significant improvement for our patients

Our amazing colleagues at PAHT continue to make significant improvement for our patients' experience and outcomes on a regular basis and continue to be recognised widely for their achievements. Below are a selection of some of the improvements and achievements since we last met, including a summary of our recently introduced proudest moments of the week:

- Kirstie Savege (Midwifery Matron) was awarded a prestigious Cavell Nurses Star award for her contribution to midwifery practice

- We have been reassessed by the UNICEF Baby Friendly Initiative and re-accredited as a Baby Friendly Hospital. The assessors commended us on achieving this during the pandemic, maintaining our training; and they found that a high percentage of mothers were happy with the care at PAHT– valuing the kindness from our staff

- UTC expansion to 18 hours per day and enabling c. 60% of all UEC attendances to be seen through it, reducing the pressure on the ED and enabling a reduction in ambulance handover delays and reducing crowding in the ED

- Patient Initiated Follow Ups have been implemented in 8 specialities, leading to reduction in follow ups, improved patient experience and increased clinician capacity. 280 patients have been discharged to PIFU to date with the number increasing every week.

- For week ending 21 January:

- For week ending 14 January:

Author: **Lance McCarthy, Chief Executive**
Date: **27 January 2022**

The Princess Alexandra Hospital NHS Trust

TRUST BOARD – 3 February 2022

3.1

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:	21 January 2022							
Subject / title:	Significant Risk Register							
Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper presents the Significant Risk Register (SRR) for all our services. The Significant Risk Register (SRR) is a snapshot of risks across the Trust at a specific point and includes all items scoring 15 and above. The overall number of significant risks on the register is the same as December 21 at 68 (table 1 and section 2). The main themes for 14 risks scoring 20 on the SRR are: • Nine are operational pressures: two ED access standard, three referral to treatment standard, one cancer-waiting times, one existing and one new bed pressures, and new is use of PACU for inpatient care. • Three for our people: two for FAWs covering consultant cover in obstetrics and nursing in paediatric urgent care. One for Surgery regarding doctor rotas for anaesthesia. • Two for our patients covering: electronic storage of maternal CTG reports and delays for medical review in same day admissions unit. Actions taken and mitigations in place for each detailed in section 3 Three new risks scoring 16 raised since 27 October 2021 in section 4							
Recommendation:	Trust Board are asked to review the contents of the Significant Risk Register and to approve all new risks added and those with amended scores.							

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

Previously considered by:	Senior Management Team on 18/1/22 Risk Management Group reviews risks on a rotation; each service is monitored quarterly as per annual work plan.

	Divisions and corporate teams review their risks at their local governance meetings
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and on the BAF
Legislation, regulatory, equality, diversity and dignity implications:	Management of risk is a legal and statutory obligation
Appendices:	Nil

The Princess Alexandra Hospital NHS Trust

3.1

1.0 Introduction

This paper details the Significant Risk Register (SRR) across the Trust; the registers were taken from the web-based Risk Assure system on 30 December 2021. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

Each areas risk register is reviewed on rotation according to the annual work plan (AWP).

2.0 Context

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

There are 68 significant risks on the risk register, as in the paper discussed in December Trust Board. The breakdown by service is detailed in the table below.

Table 1	Risk Score				
	15	16	20	25	Totals
Covid-19	1 (1)	0 (0)	1 (1)	0 (0)	**2 (2)**
Cancer & Clinical Support	2 (2)	13 (8)	0 (0)	0 (0)	**15 (10)**
Communications	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Estates & Facilities	0 (0)	4 (4)	0 (0)	0 (0)	**4 (4)**
Finance	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Health Safety and Resilience **(formerly Non-Clinical Health & Safety)**	1 (0)	1 (1)	0 (0)	0 (0)	**2 (1)**
Information Data Quality and Business Intelligence	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
IM&T	1 (1)	2 (2)	0 (0)	0 (0)	**3 (3)**
Integrated Hospital Discharge Team	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Learning from deaths	0 (0)	1 (1)	0 (1)	0 (0)	**1 (1)**
Nursing	0 (1)	0 (0)	0 (0)	0 (0)	**0 (1)**
Operational	2 (2)	1 (1)	4 (4)	(0)	**7 (7)**
Research, Development & Innovation	0 (0)	0 (1)	0 (0)	0 (0)	**0 (1)**
Workforce	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
FAWs Child Health	2 (2)	0 (0)	1 (2)	0 (0)	**3 (4)**
FAWs Women's Health	4 (5)	4 (3)	2 (2)	0 (0)	**10 (10)**
Safeguarding Adults	2 (1)	(0)	0 (0)	0 (0)	**2 (1)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Medicine	1 (2)	0 (0)	0 (1)	0 (0)	**1 (3)**
Surgery	0 (1)	3 (3)	5 (5)	0 (0)	**8 (9)**
Urgent & Emergency Care	1 (1)	3 (3)	1 (1)	0 (0)	**5 (5)**
Totals	**19 (21)**	**36 (31)**	**14 (16)**	**0 (0)**	**68 (68)**

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

3.0 Summary of risks scoring 20 and above

There are 14 risks with a score of 20. A summary of these risks and mitigations is below:

3.1 Our Patients

3.1.1 Electronic storage of Cardiotocography (CTG) for obstetrics

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

3.1.2 Delays to assessment in Same Day Emergency Care unit (SDEC)

- Patients are having lengthy delays waiting for a medical review in SDEC. There are two doctors to review 40 to 45 patients (SDEC-120721, raised in April 21 with score increased in August due to increasing waiting times of 4-5 hours)
  Action: Unit kept open past its planned opening hours with staff taking time back in lieu. Where possible additional doctors are allocated to the unit. Division is completing a mapping and benchmarking against other trusts. Improvements made with planning to booked scans and since GP navigator roles in place both having a positive impact. Going through local governance arrangements to downgrade this risk currently and it will be removed from the significant risk register.

3.1 Our People –

3.2.1 Family and Women's team

Consultant cover in obstetrics

- Consultant cover achieves 87 hours per week including the extra four hours at the weekend associated with extra ward rounds as recommended in the Ockenden report, against the national requirement of 98 hours a week for units with 4,000-5,000 deliveries per annum. There is a high potential for obstetric consultants needing to be called into the trust (2020/10/01 December 2020). Our unit delivers approx. 3,800 per annum, which means we should have 60 hours of cover, but we are aspiring to be better than the minimum.
  Action: All consultant job plans were reviewed. Recruitment is planned for two new WTE substantive roles, as staff are due to come off the on-call rota for health reasons. We are unlikely to be at 98 hours in the short term. Once the new Clinical Director is in post, the intention is to complete a workforce review as part of the work on the Maternity Strategy. A hot week consultant role is in place, to ensure there are twice daily ward rounds on labour ward as per Ockenden recommendations.

Nursing cover for paediatric emergency and urgent care unit

- Paediatric ED nursing workforce has vacancies (5.8WTE) and high numbers of staff on maternity leave (8WTE), with further staff to go off over coming months (4WTE). Paediatric ED attendance has increased by 10% in last year with a reduction in the numbers of patients being admitted. Ward acuity can support the sharing of the nursing team across both areas and not compromise safety, (PED03/03/2021 raised in March with score increased in October as result of increasing numbers of staff off the rota).

Action: Additional staff sourced through NHSP & agency, rolling band 5 posts out to advert. Staff moved from Dolphin ward to cover ED so qualified workforce in both areas adjusted to meet the patient acuity and skill mix dependency.

3.2.2 Surgery Team

Medical cover for the anaesthetic service

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

3.3 Our Performance

3.3.1 ED performance

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

- Compliance with the statutory standard for the Emergency department (ED) (001/2017 on operations team register since April 2014)
- Achieving the standard of patients being in ED for less than 12 hours (002/2016 raised July 2016 on operational team register)
  Actions: Daily monitoring of previous days breaches, number/patterns of attendance reviewed to facilitate changes to ED pathway and improve performance. ED board rounds daily and daily huddle to review treatment plans and pathways (7 days per week). Internal professional performance standards agreed and implemented. Electronic tracking process in place to ensure escalation to consultant and nurse in charge if patient is not meeting internal professional standards. East of England escalation process in place to reduce ambulance offload delays.

3.3.2 Cancer access standard

- Not achieving 85% of all patients referred by GP to receive treatment within the cancer 62 day standard (005/2016 on register since July 2016)
  Actions: Revised patient target list (PTL) has granular information for oversight of individual patients on cancer pathway to ensure action detailed weekly by patient on the pathway. Recovery action plan in place and trajectory monitored at tumour level.

3.3.3 Referral to treatment standard

Three risks associated with performance against the national standard

- Risk of 52-week breaches because of the pandemic, pauses to OPD clinics and elective surgical activity. The numbers of patients waiting between 40 to 52 weeks is monitored and tracked by operational teams (Operational register 006/2017 and S&CC004/2020B)
  Action: Working with STP partners to manage paediatric urology, patients booked in order of clinical priority, monitoring of PTL continues weekly, with cancer PTL reviewed daily. Plan to address longer term service provision

underway with Addenbrooke's and E&N Herts. Demand and capacity modelling to be completed in January 2022.

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

3.3.4 Bed pressures for Emergency care

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

3.3.5. NEW: Bed pressures for elective care

Risk that at times of extreme pressure for non-elective beds has an impact on bed availability for elective care as these beds may be reassigned for emergency medical capacity, including outliers. This will reduce elective admissions and operating capacity, (S&CC002/2021 raised November 2021)
Action: Bronze and silver bed escalation in place, multiple daily meetings to discuss patient flow and escalation, outsourcing to increase elective capacity.

3.3.6 NEW: Patients receiving ward care on the Post Anaesthetic Care Unit (PACU - Recovery)

- Due to lack of in-patient beds patients are remaining on PACU rather than being placed on a ward, leading to delays in sending for patients as PACU is full, resulting in cancellations and breaching of he mixed sex accommodation guidance (PACU001/2018 with score increasing due increased frequency of occurrences).
  Action: Daily safety huddles to review bed status and capacity, with review of overnight stays, segregating patients who are overnight stay from the recovery patients. Cancellation of elective patients the day before their operation.

3.4 Our Places: Nil

3.5 Our Pounds: Nil

4.0 New risks with a score of 15 and 16 raised since 27 October 2021

4.1 Radiology risks each with a score of 16

- Risk that radiology equipment for plain x-rays will not be replaced in a timely way leading to delays to backlog recovery programme for both OPD and GP referrals (RAD 2021.05 on the register since early November 2021).
  Action: Platinum service contract in place to expediate engineer cover for repairs, completion of quality assurance tests undertaken regularly, short term lease renal is available

- Risk that radiology equipment for CT colon examinations (2 insufflators), will not be replaced in a timely way leading to delays for patients on the cancer waiting list (RAD 2021/06 on register since early November 2021.
  Action: Both units covered by service contract in place to expediate engineer cover for repairs, short term lease renal is available.

- Risk that radiology equipment for ultrasound (3 units), will not be replaced in a timely way leading to delays for patients as part of delivery and recovery activity (RAD 2021/07 on register since early November 2021).
  Action: Short term lease renal is available and units are serviced regularly and quality checked by sonographers daily.

5.0 Recommendation

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

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

Date: 24 January 2022

The Princess Alexandra Hospital NHS Trust

Trust Board – 3 February 2022

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 2021/22

Purpose:	**Approval**		**Decision**		**Information**		**Assurance**		
Key issues:	The Board Assurance Framework is presented for review and approval. The risks have been updated with executive leads and reviewed at the relevant committees during January 2022. The risk scores have not changed this month and are summarised in Appendix B. The full BAF is attached as Appendix C.								
Recommendation:	Note the update.								
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:	STC, QSC, WFC and PAF in January 2022.
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance.
Appendices:	Appendix B – BAF dashboard Appendix C – BAF January 2022

Board Assurance Framework Summary 2021.22

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

The Princess Alexandra Hospital NHS
NHS Trust

The Princess Alexandra Hospital Board Assurance Framework

2021-22

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objectives 1-5													
BAF 1.0		**COVID-19:** Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on staffing levels, staff health and wellbeing, operational performance and patient outcomes.	Causes: i) Highly infectious disease with emerging new variants ii)Human Factors: Failure of public to adhere to Public Health messages and increasing Covid demand iii) Sustainability of supply chains during peak covid periods iv) Limitation and configuration of PAHT estate v) Vacancy and absence rates vi) Public perceptions around accessing services as normal	**5 X 5= 25**	Chief Executive /Deputy Chief Executive supported by Executive team QSC	i) Level 4 national incident declared by NHS England reduced to level 3 March 21st 2021,increased to level 4 on December 12 2021 ii) PAHT incident co-ordination centre and incident management team established iii) COVID-19 incident management governance structure in place iv) Compliance with national directives v) Ongoing engagement with ICS and Local Resilience Forum, Local Delivery Board re-instated vi) COVID-19 patient pathways instigated vii) Staff being redeployed to provide additional support ix) Daily executive oversight of incident management x) Recovery and restoration planning (PAHT/ICP and ICS) xi) Separation of hospital into Covid and Covid free areas xii) Use of independant sector for elective patients xiii) Staff vaccination programme xiv) Engagement with critical care network xv) Back to Better Campaign launched xvi) Staff health and wellbeing initiatives introduced xvii) Nosocomial death review process in place	i) Incident Management Team Meeting ii) Strategic Incident Management Cell iii) IPC Cell and Infection Control Committee iv) Site Management Cell v) Communications Cell vi) People Cell viii) Clinical Cell ix) Incident management group	i) Incident management action and decision logs ii) QSC updates monthly from March 2020 to date iii) Trust Board updates (March 20 to date) iv) Recovery Plans and submissions (Recovery paper to Board August 21 and paper being presented to PAF Nov, Trust Board Dec '21) v) Covid risk register	**4x4=16**	i) Adaptability and configuration opportunity of clinical areas	None.	Jan-22	**Score to remain at 16.**	**3x3=9 September-February 2022**
			Effects: i) Increased numbers of patients and acuity levels ii) Shortages of staff, staff shielding and increased sickness; **staff fatigue and reduced resilience** iii) Shortages of equipment, medicines and other supplies iv) Lack of system capacity v) Staff concerns regarding safety and well-being vi) Changing national messaging vii) Potential for patient harm due to cancellation of elective surgery and nosocomial infection due to transmissibility							Actions: i) Critical network support ii) Surge planning: iii) Second Covid ward being prepared iv) Maximising elective daycases				

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population													
BAF 1.1		Variation in outcomes resulting in poor clinical quality, safety and patient experience.	Causes: i) Unwarranted variation in care ii) System wide flow iii) Workforce gaps	4 X 5 = 20	Director of Nursing/ Medical Director **Quality and Safety Committee**	i) Quality and safety governance structures in place ii) Robust Appraisal/ medical and nursing iii) End of Life and deteriorating patient simulation programme for all staff, across ICP and ICS iv) Education & training in communication skills such as breaking bad news training. v) Sharing the Learning Programme vi) Commissioner reviews and engagement in quality and safety processes vii) Risk Management Training Programme and refresh of the risk management strategy 2021/22 viii) FTSUG's and 5 clinical FTSUG's appointed ix) Electronic handovers, Hospital at Night and E-Obs and observation compliance reports x) Schwartz Rounds xi) NHSI/NHSE Oversight xii) Patient Experience Strategy xiii) NED lead appointed for Mortality xiv) Mortality Strategy including dashboard in development , tracker, updates on work streams and learning from deaths. SMART software database implemented in July 21 xv) '15 steps' walkabouts (on hold over Covid and starting August 2021)- appreciate enquiry to commence August 21 xvi) Nursing Establishment review (bi-annually) and successful nursing recruitment campaign xvii) Safer Staffing policy and use of SafeCare to inform daily staffing xviii) Real time patient feedback implemented across all wards xix) Robust management of variations in neonatal outcomes xx) Engagement in external reviews MBRRACE,HSIB and LeDeR and Healthcare Safety Investigation Branch (maternity) xxi) Medical examiners (MEs) and Lead ME appointed and Strategic Learning from Deaths=established xxii) Complaints workshops held and development of PE strategy as part of Quality strategy (Sept 21) xxiii) Joint GIRFT and Model Hospital quality improvement programme xxiv) Appointment of divisional medical PS&Q leads December 2021 xxv) Quality peer review process in place xxvi) Covid-19 governance structure/meetings in place xxvii) Divisional restructure xxviii) Appointment of DMD (quality) tba xxix) Board approval of PAHT quality strategy November 2021, organisational launch Feb 2022	i) National Surveys and audits, national quality audits ii) Cancer Survey iii) CEO Assurance Panels iv) Incident Management Group meetings, SIAP meetings v) QSC, PAF, Risk Management Group and Board meetings vi) Patient Safety and Quality meetings, PRMs and Patient Experience meetings vii) Infection Control Committee viii) Integrated Safeguarding meetings ix) Patient Panel meetings/ Vulnerable Patient Group x) PLACE Inspections xi) Medicines Optimisation Group xii) End of Life xiii) AKI & Sepsis Group xiv) Urgent Care Board xv) Deteriorating Patient Group xvi) Cardiac arrest review panels xvii) Twice weekly Long Length of Stay meetings xviii) Quality Compliance Improvement Group, Clinical Compliance Group xxix) ICS Oversight Meeting Monthly - section 31 notice) xxx) Dr Foster (Telstra) monthly mortality reports	i) CEO Assurance Panels (as required) ii) Reports to QSC on Patient Experience (bi-monthly), monthly Serious Incidents, monthly Safer Staffing, Patient Panel (bi-monthly) , Safeguarding, monthly Infection Control and Covid-19 updates Quality and safety data in the Integrated Performance Report iii) Monthly Mortality Improvement report to QSC including updates on ME reviews and monthly IPR report iv) CQC inspection reports (ED, Medicine, Maternity, Well-led inspection report November 21, Section 31 notice issued and IRMER May 21 (November 21 - notice lifted) and GIRFT reports) v) Dr Foster reports and engagement vi) Quarterly Coding reports to PAF vii) Freedom to Speak Up Guardians quarterly reports to WFC viii) Patient stories and learning from deaths reports to Public Board meetings (bi-monthly) ix) Internal Audit reports tiaa 2019: Safeguarding (substantial assurance) and Complaints (reasonable assurance) x) TARN review (March 21) xi) Current HSMR ~~104.27 99.7~~ 'as expected, and TARN mortality 'better than expected' xii) Nervecentre business case for ED approved (November 21)	4x4=16	Lack of modernisation in some reporting processes including: i) Clinical audit plan developed and to be implemented - improved tracking of local audits and drive to improve collation and input of data for national audits ii) Disparity in local patient experience surveys versus inpatient survey iii) Staffing, site footprint and bed constraints iv) NICE oversight and management of compliance with guidance v) Frequency and consistency of approach to M & M meetings vi) Clinical documentation not supported by existing infrastructure **ACTIONS:** i) Inpatient Survey action plan in place and Staff Survey 2020/21 action plan in place (Sept 2021) iii) Ongoing work with Dr Foster in relation to mortality iv) EPR development and OBC to PAF/Board September 2021 - approved v) Medical records Committee leading programme of work to improve documentation vi) Review of Mortality Strategy vii) Review of departmental clinical governance meetings agenda, attendance and frequency viii) Q&S metrics to be included in PRMs ix) Raising awareness of 5 patient safety priorities HCG (governance structures and IPR reporting x) Quality first workstream 'back to better' UEC to improve safety and quality for patients	i) Demonstrating an embedded learning programme from Board to ward. ii) Inconsistent re-audit iii) Lack of data to support information on progress with some patient safety metrics.	01/01/2022	**Risk rating to remain at 16.**	**4x3=12 March 2022**
			Effects: i) Higher than expected Mortality rates ii) Increase in complaints/ claims or litigation iii) Persistent poor results in National Surveys iv) Poor reputation and low staff morale v) Patient harm vi) Loss of confidence by external stakeholders											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population **Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way**													
BAF 1.2		**EPR** The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	Causes: i) Poor clinical engagement with the system, due to lack of usability and limited functionality. ii) Timely system fixes/enhancements iii) Static functionality	**5 X 4= 20**	Chief Information Officer/Chief Operating Officer **Strategic Transformation Committee**	i) Fortnightly DQ meetings held at ADO level ii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iii) Performance Mgt Framework in place. iv) User Training programme. v) Super users in place to deliver focused support. vi) Access Policy vii) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management) viii) Development of capacity planning tools/information ix) Weekly ICT/COSMIC meetings ongoing x) New EPR Board established – chaired by CEO xi) EPR replacement programme established xii) EPR SOC developed and benefits realisation with link to HIMSS xiii) EPR OBC developed and to be presented to Board September 21 xiv) OBC reviewed and approved by Trust Board, submitted for regional and national approval. Anticipated Jan 22 xv) OBC verbally approved by JISC 17 January 2022	i) Access Board ii) EPR Programme Board (to be chaired by CIO) iii) Board and PAF meetings iv) Weekly meetings with Cambio vi Weekly DQ meetings vi) Monthly performance reviews	i) Weekly Data Quality reports to Access Board and daily DQ reports to organisation ii) Quarterly E-Health reports to PAF iii) Reports to EPR Programme Board iv) EPR SOC approved by SMT, PAF and Board (March to April 21 and May 21 Trust Board). Regional team approval received to proceed straight to OBC. v) EPR OBC approved by SMT (02/09), considered by PAF and approved by Board September 21 vi) OBC verbally approved by JISC on 17 January 2022	**4 X 4= 16**	i) Continue to develop 'usability' of EPR application to aid users ii) Resource availability iii) Capacity within operational teams to ensure completeness of data quality iv) Elements of system remain onerous (completion of discharge summaries) v) External system support vi) Compliance with refresher training vii) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training. Supplier requests to remove contractual requirement to comply with national standards e.g. ISNs - 2 risks associated 1) exposes PAH to technical compliance issue as supplier not compelled to comply and 2) financial risk – assurance PAH have declined supplier request on advice from NHSD.	Jan-22	**Risk rating unchanged**	**4x3=12** **end of 2022**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** OBC developed to procure new EPR solution. Ongoing user training programme underway.				

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

The Princess Alexandra Hospital Board
Assurance Framework 2021-22

Risk No		PRINCIPAL RISKS				KEY CONTROLS	ASSURANCES ON CONTROLS	BOARD REPORTS						
		Principal Risks		RAG Rating (CXL)	Executive Lead and Committee	Key Controls	Sources of Assurance	Positive/negative assurances on the effectiveness of controls	Residual RAG Rating (CXL)	Gaps in Control and Actions	Gaps in Assurance	Review Date	Changes to the risk rating since the last review	Target RAG Rating (CXL)
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 2: Our People – we will support our people to deliver high quality care within a within a compassionate and inclusive culture that improves engagement, recruitment and retention and results in further improvements in our staff survey results **Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators**													
2.3		**Workforce:** Inability to recruit, retain and engage our people	**Causes:** i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels viii) Covid -19 ix) Vaccination as a condition of deployment **Effects**: Low staff morale, high temporary staffing costs, poor patient experience and outcomes/ increased mortality and impact on Trust's reputation. Covid-19 effects - delays in workforceplanning, recruitment programmes and additional health and wellbeing pressures on teams Staff vacancies in key clinical areas.	**5 X 4 =20**	Director of People, OD & Communications **Workforce Committee**	i) People strategy 'joy to work at PAHT' ii) Behaviour charter and vision and values iii) People management policies, systems, processes & training iv) Management of organisational change policies & procedures v) Freedom To Speak Up Guardian roles vi) Equality and inclusion champions vii) Event in a Tent held annually viii) Staff recognition awards held locally and trust wide annually ix) Enhanced controls around temporary staffing x) Line Manager development programme underway xi) Behaviour workshops held xii) New consultant development programme launched xiii) Staff engagement groups and Staff Council xiv) International recruitment programme for nurses and ED doctors xv) Medical staffing review underway (Medical Safer Staffing) xvi) Additional recruitment ('Bring back staff') during Covid xvii) Provision of Health and Well-being support during Covid-19 including psychological support and absence line.Back to Better campaign launched March 21 xviii) Communications Strategy approved June 2020 xix) NHS People Plan and ICS People Plan xx) Webinars during Covid (BAME, Vaccination)	i) WFC, QSC, SC, PAF, SMT, EMT. ii) People board iii) JSCC, JLNC iv) PRMs and health care group boards v) People Cell established (Covid-19)	i) Workforce KPIs reported to WFC bi-monthly and inluded in IPR (monthly) ii) People strategy deliverables iii) Staff survey results 2020 (reported March 2021) iv) GMC survey (July 21) v) WRES and WDES reports 2021 (WFC and Board) vi) OD Framework approved (WFC June 2020) vii) Medical workforce plan update to WFC November 2020 and June 2021 viii) Dignity at Work report January 2021 ix) Culture and values refresh (EIAT, September 2021) x) Compassionate and inclusive leadership session (Board development session March 21) xi)Here to hear listening event and survey xii Deloitte well-led review survey xiii) NHSE/I pulse survey xiv) NHSE/I FTSU assessment xv) Anti-racism Board session xvi) Board session on leadership development opportunities December '21	**4 x4 = 16**	Pulse surveys targeted for all staff Medical engagement Effective intranet/extranet for staff to access anywhere 24/7 Roll out of e-rostering to all areas Safer Medical Staffing plan in development CV19 staff vaccination implementation plan Actions i) ~~P~~lans for medical staff Jan '22 ii) Extranet for staff - completed iii) Staff survey action plan underway iv) Review of raising concerns (increase in FTSUGs - completed, lead FTSUG Q3, senior inclusion lead Q3) vi CV19 staff booster implementation plan - Q3 vi) NHSE/I Health and wellbeing framework assessment - Q4 vii) Allocate rostering system review assessment and plans - completed vii) Review of management and leadership development provision - completed viii) Deloitte well-led review actions - Q3 to 2022/23 Q2 VCOD implementation plan - Q4	None identified.	11/01/2022	**Risk score to remain at 16**	**4 x2 = 8** **March 2023**

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.1		**Estates & Infrastructure** Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	**Causes:** i) Limited NHS financial resources (Revenue and Capital) ii) Lack of capital investment, iii) Current financial situation, iv) Inherited aged estate in poor state of disrepair v) No formal assessment of update requirements, vi) Failure to comply with estates refurbishment/ repair programme historically, vii) Inability to undertake planned preventative maintenance viii) Lack of decant facility to allow for adequate repair/maintenance particularly in ward areas.	**5 X 5= 25**	Director of Strategy **Performance and Finance Committee**	i) Schedule of repairs ii) Six-facet survey/ report received (£105m) iii) Potential new build/location of new hospital iv) Capital programme - aligned to red rated risks. v) STP Estate Strategy developed and approved. vi) Modernisation Programme for Estates and Facilities underway vii) Robust water safety testing processes viii) Annual asbestos survey –completed and red risks resolved. ix) Trust's Estate strategy being developed x) Annual fire risk assessment completed and final report received, compliance action plan being developed. xi) New estates and facilities leadership team in place with authorised persons in posts x) Sustainability Manager in post xi) Emergency Capital funding £4.3m xii) Compliance Manager appointed xiii) Significant capital programme for year c.£40m xiv) Green Plan approved for onward submission to ICS (January 2022)	i) PAF and Board meetings ii) SMT Meetings iii) Health and Safety Meetings iv) Capital Working Group v) External reviews by NHSI and Environmental Agency vi) Water Safety Group vii) Weekly Estates and Facilities meetings viii) Monthy Estates Board meeting	i) Reports to SMT (as required) ii) Signed Fire Certificate iii) H&S reports quarterly to PAF. iv) Ventilation assurance report v) Annual and quarterly report to PAF: Estates and Facilities quarterly report) vi) IPR monthly ix) Annual Sustainability report to PAF (May 2021 and update to PAF Sept 21) x) Capital projects report (PAF monthly, Trust Board Nov 2021 and weekly updates at EMT, reports to SMT, 5 year Capital Plan to Private Board in February 2022)	**5x4=20**	i) Planned Preventative Maintenance Programme (time delay) ii) Sewage leaks and drainage iii) Electrical Safety/Rewiring - ongoing iv) Maintaining oversight of the volume of action plans associated with compliance. **ACTIONS:** i) EBME review underway ~~ii) Green Plan in development (PAF in November 21 and Trust Board in December 21)~~	i) Estates Strategy /Place Strategy developing within ICS ii) Compliance with data collection and reporting iii) PPM data not as robust as required	21/01/2022	**Residual risk rating unchanged.**	**4 x 2 =8 (Rating which Trust aspires to achieve but will depend on relocating to new hospital site)**
			Effects: i) Backlog maintenance increasing due to aged infrastructure ii) Poor patient perception and experience of care due to aging facilities. iii) Reputation impact iv) Impact on staff morale v) Poor infrastructure, vi) Deteriorating building fabric and engineering plant, much of which was in need of urgent replacement or upgrade, vii) Poor patient experience, viii) Single sex accommodation issues in specific areas, ix) Out dated bathrooms, flooring, lighting – potential breach of IPC requirements, x) Ergonomics not suitable for new models of care. xi) Failure to deliver transformation project and service changes required for performance enhancement xii) Potential slips/trips/fall to patients, staff or visitors from physical defects in floors and buildings xiii) Potential non compliance with relevant regulatory agency standards such as CQC, HSE, HTC, Environmental Health.											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iii) The resources required for delivery at a programme and workstream level have not been defined or secured iv) The current governance structure is under development given the shift in focus from planning to delivery. v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS Trust Board	i) STP workstreams with designated leads ii) System leaders Group iii) New STP governance structure iv) STP priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) STP Estates Strategy being developed. viii) STP Clinical Strategy in place ix) STP wide Strategy Group implemented x) Independant STP Chair and independant STP Director of Strategy appointed. xi) System agreement on governance and programme management xii) New ICS governance and structure meetings set up with PAH attending task-finish groups	STP CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) STP Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and STP updates (Board session on ICS governance Dec 21)	**4 X 4= 16**	Lack of ICS demand and capacity modelling. ~~Implications of white paper and statutory changes.~~ **ACTIONS:** System leadership capacity to lead ICS -wide transformation		21/01/2022	**No changes to risk rating.**	**4x3=12 March 2022**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership													
BAF 3.5		**New Hospital:** There is a risk that funding for the new hospital will not be sufficient to deliver the preferred way forward and that the new development can not be delivered to the timescale needed to meet increasing demand.	Causes: ii) Funding is not made available for the preferred way forward ii) enabling works are delayed iv) new design guidance from NHP results in a substantial redesign v) the required SoA can not be delivered within the agreed affordability envelope vi) the land purchase is not completed successfully and in a timely manner vii) Development of new standards and programme approach by NHP has delayed ~~may delay~~ OBC viii) Advisors stood down due to lack of funding Effects i) Hospital remains on existing site and continued investment in existing site will be required ii) Unable to deliver all of the service transformation iii) Unable to manage system demand due to lack of transformation iv) Digital transformation not complete v) Poor staff retention due to failing infrastructure vi) Unable to reach outstanding service provision due to failing infrastructure vii) New hospital~~, if delayed,~~ will be undersized because demand management is delayed viii) Loss of clinical engagement ix) loss of public confidence	**5 X 4= 20**	Director of Strategy Strategic Transformation Committee from January 2022	i) Detailed programme of work ii) New national team appointed to provide transaction support and bi-weekly meetings with lead for scheme iii) continual monitoring-of proposed solution to ensure it is deliverable within the available funding envelope iv) National Programme design convergence review initiated v) Regular meetings with stakeholders, MPs, Council leaders vi) Regular meetings with landowners	i) New Hospital Programme Board ii) Strategic Transformation Committee iii) Trust Board iv) External advisory meetings as required v) Reviews undertaken by NHP	i) Monthly reports to Trust Board and Strategic Transformation Committee. ii) Letters of support received from JIC. iii) confirmation received that programme management structure is appropriate. ~~iv) Expert advice received on procurement strategy.~~ v) Landowners have accepted offer in principle vi) Positive technical review feedback vii) Positive meeting between MP's and Secretary of State	**4 x 5 = 20**	Extended delay to the DCR which is outside of the control of the Trust New lead for national programme appointed resulting in delay on issue of guidance Actions i) Support national team in areas such as Design Convergence Review and commercial strategy ii) Agree Heads of Terms for land transaction iii) Paper on land to NHP and JIC	None.	Jan-22	**Risk score unchanged.**	**3x3=9** **March 2022**

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
BAF 4.2		**4 hour Emergency Department Constitutional Standard** Failure to achieve ED standard resulting in increased risk to patient safety and poor patient experience.	**Causes:** i) Access to community and OOH services. ii) Change in Health Demography with increase in long term conditions. iii) Changes to working practice and modernisation of systems and processes iv) Delays in decision making, patient discharges and impacting on flow v) Lack of assesment and short stay capacity, lack of CDU space vi) Increase in volume of patients presenting to ED vii) Volume of ambulance patients and delays offloading patients	**4 X 5 = 20**	Chief Operating Officer Performance and Finance Committee	i) UEC improvement plans in place and monitored through the UCPB and workstreams ii) Regular monitoring and weekly external reports iii) Daily oversight and escalation iv) Robust programme and system management v) Developing plans to expand the footprint and space of the Urgent Treatment Centre. vii) Local Delivery Board in place with system partners. UEC ICS Board in place with COO representation ix) ED action plan reported to PAF/Board x) Co-location of ENP's, GP's, Out of hours GP'S to support minor injuries increasing opportunities for re direction and more bookable appointments xi) Weekly Urgent Care operational meetings and Urgent Care Board in place xii) Focus on length of stay in ED for all patients xii) Think 111 First plans to be expanded, working with the national team xiii) Training and education centre in use as a temporary extension to the ED: all walk-ins redirected there first, with risk assessments for patients.	i) Operational meetings ii) Board, PAF and SMT meetings iii) Monthly Operational Assurance Meetings iv) Monthly Local Delivery Board meetings v) Weekly System review meetings vi) System Operational Group vii Urgent Care Board	i) Daily ED reports to NHSI ii) Monthly PRM reports from HCGS - development of Divisional IPR iii) Monthly IPR reported to PAF/QSC and Board reflecting ED performance (PAF, QSC Jan 22) iv) UEC deep dive presentation QSC Sept 21	**4x5=20**	i) Staffing (Trust wide) and site capacity ii) System capacity and demand pressures iii) Leadership changes being embeded and strengthened ahead of winter Actions: 1. All trust consultant escalations and awareness of current pressures 2. Review of capacity in UTC and SDEC to support attendance and walk in patients through ED 3. Review of weekly medical and nursing staffing 4. Capacity through inpatient wards and and application of red to green oversight in place 5. Daily review and panel of pathway zero patients and simple discharges 6. Executive oversight daily 7. Attendance from senior clinicans at the ED safety huddles and real time escalation of all specialty delays	None noted.	21.01.22	**Risk score to remain at 20.**	**4x3 =12 March 2022**
			Effects: i) Reputation impact and loss of goodwill. ii) Financial penalties. iii) Unsatisfactory patient experience. iv) Potential for poor patient outcomes v) Jeopardises future strategy. vi) Increased performance management vii) Increase in staff turnover and sickness absence levels											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.													
BAF 5.1		**Finance - revenue :** The Trust has established an indicative annual breakeven budget for 21/22. For the first half of the financial year (H1) income allocations are know and are linked to System envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement. For the second half of the year (H2) the national finance regime is under development and therefore allocations available to the Trust are uncertain.	**Causes:** The main causes of risk are : (i) The current financial regime operates under 'block contract' arrangements. There is limited capacity for Commissioner contracts to be varied. (ii) There is uncertainty of the financial regime to be operated in H2. (iii) Financial plans include a requirement to deliver CIPs with a step change in delivery required in H2 - the ability to control costs and the deliverability of CIPs will be influenced by COVID, restore and recover. (iv) The Trust has a number of cost pressures that will require mitigation. (v) Although the Trust has improved its vacancy rates it remains over reliant on temporary staffing which attracts premium costs - continued improvements in substantive recruitment is required. (vi)The CIP ask in H2 is being increased. This increases the potential for non-delivery of the CIP (vii) Elective Recovery Funding activity levels have been increased from M4. Therefore the system may not achieve the required activity levels. Consequently, this may put the reimbursement of ERF in jeopardy.	**4 X 4= 16**	**Exec leads:** DoF **Committee** : Performance and Finance Committee	**Key Controls include :** (i) Agreed H1 financial envelopes including continued levels of COVID funding. (ii) Health Care Group / Corporate performance review meetings are in place where performance is being monitored. (iii) Exec led vacancy control group. (iv) Oversight of the Trust's financial performance by the EMT, SMT, PAF, Workforce and Audit Committee. (v) Monthly monitoring of financial performance by NHSE/I through the submission of financial returns. (vi) Strengthening of financial control and governance including an improved governance process for business case investmentusiness case approval process. (vii) Development of CIP workshops and plans. (vii) Temporary staffing audit underway and focus on reduction in temporary staffing.	**Sources of Assurance :** (i) Performance review meetings - monitoring against plan and forecast (ii) Internal audit reports / Head of Internal Audit Opinion (iii) External audit opinion (iv) Cash management monitoring and adequate cash balances (v) CIP tracking (vi) Reduction in run rate spend on temporary staffing	**Positive Assurances :** (i) Delivery against YTD and forecasted plans. (ii) CIP delivery and forecast to plan. (iii) Substantial rating on internal audit reports. (iv) Unqualified value for money opinion	**4x3=12**	**Gaps in Control** : (i) Instances of non-compliance across the organisation in relation to SFIs i.e. non compliant waivers (ii) Activity and demand and capacity planning. (iii) CIP delivery (iv) Embedding management of temporary staffing costs (v) Existence of manual processes across the Trust	**Gaps in Assurance :** (i) National H2 Financial regime is under development and therefore uncertainty over allocations in H2. (ii) Fully integrated business and operational planning including demand and capacity plans. (iii) Business case benefits realisation process	21.01.22	**Residual risk score not changed.**	**4 x 2 = 8 (Q4 2021/22)**
			Effects: (i) Challenges to meet financial control targets, including delivery of our CIP (ii) Delivery of revenue position may impact on future capital availability.							**ACTIONS:** (i) Transformational and modernisation work plans. (ii) Demand and capacity planning and modelling to be regularised. (iii) ~~Consideration being given to the~~ Introduction of a PMO. (iv) Review of Governance Manual/SFI's				

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way													
BAF 5.2		Finance : In year delivery of the Trust's Capital programme within the Capital Resource Limit and ICS allocations.	**Causes:** The main causes of risk to delivery are (i) An over-subscribed capital programme. (ii) Operational pressures that may constrain the delivery of a capital scheme. (iii) Confirmation of external funding sources within a timeframe to allow projects to be completed including adequate planning and procurement preparation. (iv) Incomplete and/or untimely production of business cases that do not facilitate required approvals. (v) Single year funding settlements that do not support development of longer term / 5 year plans and management of a plan over financial years. (vi) As the ICS takes on increasing responsibilities for capital planning the Trust will be competing for capital resource across the ICS. (vii) The development of the New Hospital will continue to be a significant programme of work. (viii) Costs for building projects are increasing therefore adding pressure to the capital programme. (ix) The capital programme has an overplanning margin wich increases the risk of breaching the CRL if all projects deliver.	**4 X4 = 16**	**Exec leads:** DoF **Groups:** Capital Working Group, SMT, EMT and Performance and Finance Committee, New Hospital Committee	**Key Controls:** (i) The Trust has developed a 'Risk based' prioritised capital programme which is agreed through the capital working group, SMT, PAF and the Board. The CWG meets monthly to monitor progress on pre agreed schemes. (ii) The Risk Management Committee detail all risk that require capital investment. (iii) The Trust undertakes a six facet survey which informs of all backlog maintenance risks and how this element of capital is spent. (iv) Business cases are required for all capital investment. (v) All capital projects have a senior responsible officer and project lead and report into HCG/Corporate areas. (vi) Application of external funding for additional, ad hoc capital. (vii) Discussion with system partners to ensure that the Trust does not breach its CRL as capital allocations can be moved across the system.	**Sources of Assurance :** (i) Frontloaded capital trajectories that monitor expected performance against plans, including cashflow forecasts. (ii) YTD and forecast reports detailing progress. (including New Hospital) (iii) Internal audit reports. (iv) A prioritised capital programme that allows for flexibility and longer term planning. (vi) Business case review process verifies investments are strategic/operational and meet the Trust's requirements to achieve its objectives.	**Positive Assurances :** (i) Delivery against YTD and forecasted plans. (ii) Business cases approved timely. (iii) Substantial internal audit reports. (iv) Reduction in non-compliant waivers. (v) Approval of external funding and receipt of PDC/MoU	**4x3=12**	**Gaps in Control**: (i) Compliance to business case and approval process as this is a new process and is currently being embedded within the organisation.	**Gaps in Assurance:** (i) Improvements in forecasting trajectories and development of longer term capital programme.	21.01.22	**Residual risk score not changed.**	**4 x 2 =8 (Q4 2021/22)**
			Effects: (i) Risk to under/overshoot of CRL.							**ACTIONS:** (i) Business Development Group is being initiated in line with the revised Capital and Revenue investment guidance				

BOARD OF DIRECTORS: Trust Board (Public) 3 February 2022 **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: Quality and Safety Committee

REPORT FROM: Helen Glenister – Committee Chair

DATE OF COMMITTEE MEETING: 28 January 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
1.6 CQC Update including QPMO update	Yes	Yes	CEO scrutiny panel end March 2022	QSC was assured on the work underway and progress made in in relation to the CQC Must and Shoulds and the Section 31 notice. A table top review of business as usual elements will take place on 4 February 2022 with a report back to QSC at a future meeting on the ongoing monitoring of recommendations that are considered 'business as usual'.
2.1 IPC update (including COVID-19, learning from nosocomial infections and patient compliance with precautions)	Yes	Yes	QSC and Board to consider next steps in relation to non-compliance by patients	QSC was assured that robust infection control practices and processes are in place. An update on alert organisms was received and cases of C.difficile have reduced when compared to numbers earlier in the year, and last year. Learning from the review of Nosocomial C-19 Deaths at PAHT (Second Wave) was noted and commended. QSC was assured that there had been processes in place and also noted the learning from a recent incident where a patient had not been compliant with precautions in place to prevent spread of COVID-19.
2.1 BAF risk 1.0 Covid-19	Yes	N		Risk score to remain unchanged at 16.
2.2 Mortality	Yes	N		QSC was content with the practices in place and the learning from deaths. This item will be discussed at Board.
2.3 BAF Risk 1.1 Clinical Outcomes	Yes	N		Risk score to remain unchanged at 16.

BOARD OF DIRECTORS:	**Trust Board (Public) 3 February 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee**			
REPORT FROM:	**Helen Glenister – Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 January 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.4 Maternity: - SI Report - Quarterly Maternity Assurance Report, - Plan for Default Midwifery Continuity of Carer	Yes	N		QSC received the monthly SI report and quarterly report with details on serious harm incidents, themes identified and actions being taken to address any issues, minimum staffing in maternity services and training compliance. QSC noted the action plan outlining plans for implementation of Midwifery Continuity of Carer by 2023.
2.6 Patient Safety & Clinical Effectiveness Report	Yes	N		Never event reported in month and will be taken through Trust internal process and QSC to receive an update on this at next meeting.
3.2 Review List/ASI Update	Partially	N		Ongoing performance monitoring to continue via operational forums and PAF. QSC assured that processes are in place to monitor patient safety and quality elements.
3.3 Quarterly Quality Improvement Update	Yes	N		Content with progress made to date.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) - 3 February 2022

Agenda item:	4.2							
Presented by:	Dr Fay Gilder, Medical Director							
Prepared by:	Dr Fay Gilder, Medical Director							
Date prepared:	27 January 2022							
Subject / title:	Learning from deaths update							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues: please don't expand this cell; additional information should be included in the main body of the report	Telstra Data Quality HSMR and SHMI position as expected #NOF SMR and update ME update SJR update							
Recommendation:	For noting and debate							

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

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

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

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

2.0 Context

BAF 1.1 'Variation in outcomes in resulting in poor clinical quality, safety and patient experience'

3.0 Key Points

3.1 Dr Foster (now known as Telestra) data quality update

The latest report is using what is known as 'flex' data. This is a dataset that is incomplete. There is another dataset using 'freeze' data. This data is complete and accurate. We have discussed with Telstra which dataset we wish to use going forward. In summary the freeze data is significantly more accurate. The impact of this is that there is a delay for freeze data so we will have data that is a month older to work from (ie end of September data is analysed for January – a 4 month lag).

3.2 HSMR, SHMI and SMR diagnostic outliers

Verbal update from Telstra at time of writing is that the accurate 12 month rolling HSMR remains as expected (101.1) and the September in month HSMR is as expected (104). SHMI remains as expected at 0.9749

SMR diagnostic outlier - # neck of femur

3.3 Mortality Improvement Programmes (cyclical 3 monthly updates)

The mortality improvement programme leads provide updates quarterly to the Strategic Learning from Death group. Highlights from specific programmes are below.

Plans are in place for specific tasks for each of the mortality improvement programmes which now have identified measures. The informatics team will be supporting provision of the data to monitor progress on a monthly basis.

Non-invasive ventilation (NIV) continues to be successfully delivered on Locke ward. Reviews of each case are being undertaken by the respiratory team to ensure continuous learning.

The SMART system continues to be used successfully by the Medical Examiners and those undertaking Structured Judgement Review to support the learning from death process.

To support the AKI improvements the team met with the renal from the Lister Hospital to process map the current pathway for renal referrals. The team are to meet again to develop ideas for the "to be" process in an aim to improve information sharing and patient experience.

Notes review continue to take place with coding on sepsis patients. The team are also working with the paediatrics team.

#NOF update - the team are working hard to make improvements in the pathway. The analysis reported on 18 January 2022 (email Dr Snook) is that crowding in ED, lack of beds

on Tye Green, covid positive #NOF and full trauma lists are all causing significant delays to the treatment of these patients.

3.3 Medical Examiner Service

In December 93.9% of our MCCDs have been completed (national target 95%).
Timely medical examiner scrutiny (7 deaths) was prevented by lack of availability of the ward doctors and Christmas Bank Holidays (a 4 day weekend).

3.4 Structured Judgement Reviews

There were 104 deaths in December 2021. 33 cases were referred for SJR's. The national expectation is that SJRs are performed on 25% of deaths.

There has been good progress made on the backlog of SJRs (65 in December 2021, 37 January 2022). Divisions have been made aware of their outstanding SJRs and have described their plans to address this.

4.0 Next steps

SMART mortality software has now been in use for 6 months. The dashboard has been reviewed by the medical director with a view to ensure clarity of use both in this report and by the divisions. In particular the dashboard will be used to inform the discussion of the findings and learnings of SJRs within each division and where appropriate at a Trust wide level. That work is ongoing and will be described in more detail in the April paper.

5.0 Recommendation

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

Author: Dr Fay Gilder, Medical Director
Date: 27 January 2021

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 3 February 2022

4.3

Agenda item:	4.3							
Presented by:	Giuseppe Labriola, Director of Midwifery							
Prepared by:	Erin Harrison, Lead Governance Midwife							
Date prepared:	07th January 2022							
Subject / title:	Overview of Serious Incidents within maternity services							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards. There was 0 new maternity incident declared since the last report There were 0 maternity incidents closed since the last report Maternity services currently have 5 SI's under investigation.							
Recommendation:	To provide assurance to the Quality and Safety Committee that the maternity service are continually monitoring compliance and learning from Serious Incidents.							

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

Previously considered by:	PSG.11.01.21 (meeting cancelled but some papers circulated to members as assurance).
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the Ockenden report that was published in December 2020 with recommendations for maternity services.
Appendices:	N/A

The Princess Alexandra Hospital NHS Trust

1.0 Purpose

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

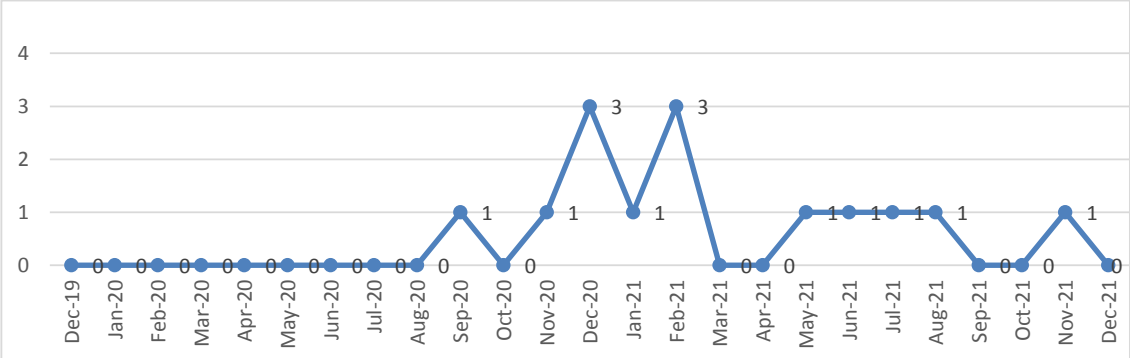
2.0 Background

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

3.0 Analysis

Maternity currently have 5 SI's under investigation, 3 of which are being investigated by HSIB. Table 1 details the trend of declared SI's within the last 24 months to December 2021

Table 1. Comparison of SI's reported for Maternity in last 24 months (to December 2021)



There were 0 new serious incidents declared in December 2021. The detail can be found in Table 2.

Table 2. Serious Incidents declared and submitted for December 2021

Serious Investigations	
Number Declared for December 2021	**0**
Number Submitted for December 2021	**0**
Number Past CCG Deadline as of December 2021 (Not including HSIB/Approved Extensions)	**2**

4.0 Thematic Review

Table 3 details the top themes identified in maternity SI's within the last 24 months to December 2021

Table 3. Top Themes

Total Number of SI's	Theme	Number
14	Obstetric Haemorrhage	6
	CTG interpretation	5
	Compliance with guidance	3
	Hypertension	3
	Intrauterine death	3
	Escalation	2
	Neonatal death	2
	Delay in Care	2
	Hypoxic ischaemic encephalopathy	2
	Laceration at caesarean	1
	Fetal growth	1

5.0 Oversight

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

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

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

Each work stream has an identified lead and progress is reported back to the Maternity Improvement Board. This will feed into the Executive Maternity Board once it has been established.

6.0 Recommendation

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

Author: Erin Harrison – Lead Governance Midwife
Date: 07.01.2022

Trust Board – 3 February 2022

4.4

Agenda item:	4.4
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery
Date prepared:	17.1.2022
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels and an update to Nursing and Midwifery Workforce Position – Hard Truths Report

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:	Overall staffing risk rating in month: Amber ED, Paediatric and maternity staffing: Red The fill rate for overall RN/RM in month 94.7%. The fill rate of HCSW has dropped from 96.6% in November to 85.7% in December. This is due to a combination of continued vacancies, staff unavailability due to apprenticeship study days and increase in demand of patients identified as requiring enhanced care. Data should be viewed in context of changing landscape of Covid admissions over the month with associated moving of wards and staff absence in the final 10 days of the month. This adds difficulty in analysing at ward level data and in reflecting changing safest staffing picture over the course of the month. Overall vacancy rate for RN was 0% and Band 5 -9.4%. HCSW vacancy was 15.5%. HCSW Recruitment pipeline of RN and HCSW remains green.
Recommendation:	The committee is asked to note the information within this report

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

Previously considered by:	WFC.31.01.22
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	Appendix 1: Registered fill rates by month against adjusted standard planned template. RAG rated. Appendix 2: Ward staffing exception reports. Appendix 3 : Ward Level CHPPD

1.0 PURPOSE

To update and inform the Committee on actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff in December 2021. To provide an update on plans to reduce the nursing and HCSW vacancy rate over 2020/21.

2.0 BACKGROUND

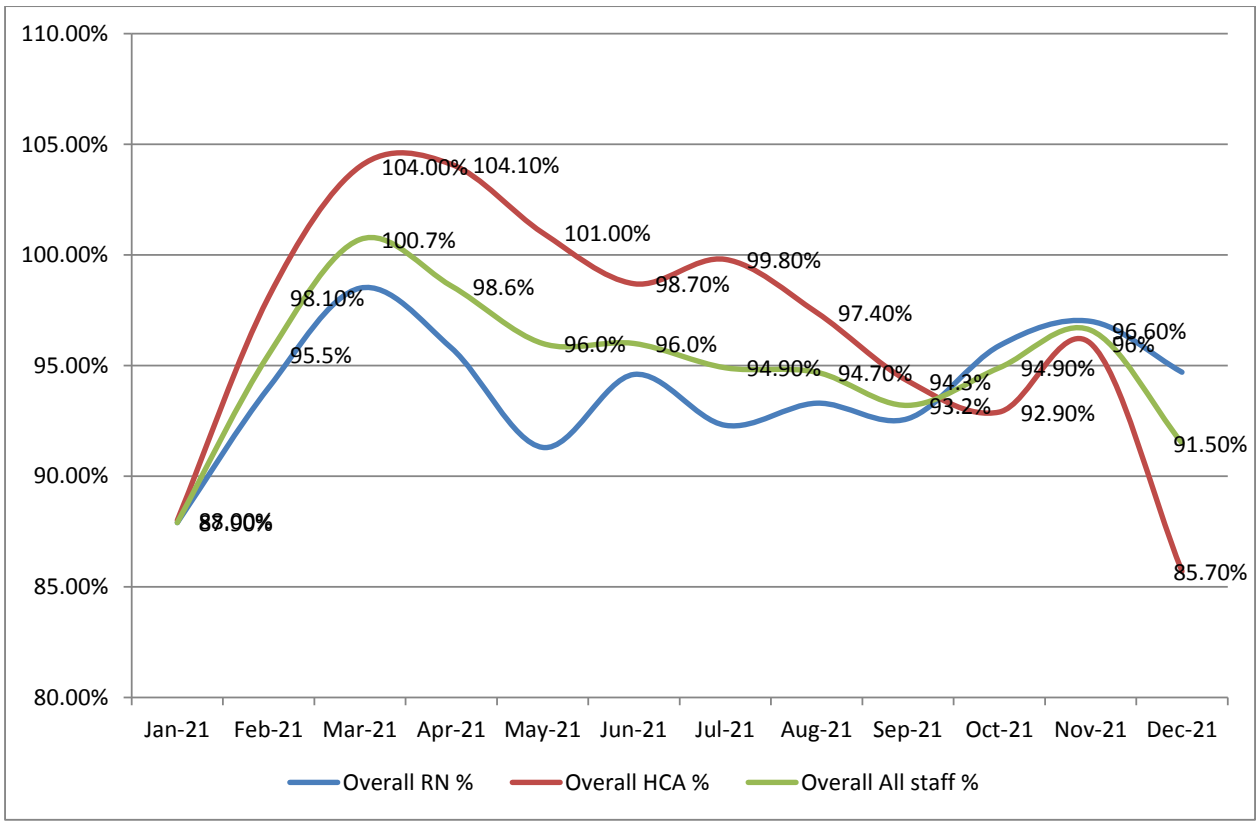
The report is collated in line with The National Quality Board recommendations (June 2016).

3.0 ANALYSIS

3.1 The Trust Safer Staffing Fill rates for December 2021 against the standard templates for overall RN/RM in month has decreased to 94.7%, which is a decrease of 2.3% against November 2021. NB Templates were not adjusted in month following approval of the establishment review paper. This will be reflected in next months templates.

3.2 Ward level breakdown of fill rate data is included in Appendix 1; the accuracy of this continues to be dependent on all staff moves being captured on Health Roster

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
In Patient Ward average December 21	91.4%	80.9%	98.8%	92.3%	94.7%	85.7%	91.5
In Patient Ward average November 21	95%	91%	99.2%	103%	97%	96%	96.6%
Variance December 21 - November 21	↓3.6%	↓10.1	↓0.4%	↓10.7%	↓2.3%	↓10.3%	↓5.1%



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

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

Red <75%	Amber 75 – 95%	Green >95%

	Day		Night	
A&E Nursing	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
October 2021	99%	71%	106%	78.3%
November 2021	101.7%	81.1%	109%	78.5%
December 2021	96.4%	72.2%	104.3%	78.2%

ED fill rates are currently reported to the CQC as part of the requirements of the Regulation 31 notice. There is weekly Exec oversight of the information and mitigation worked through. Staffing huddles are focussed on prioritising ED to maintain numbers. Fill rates for HCSW remain low in month however ED have appointed 4 HCSW's in December and January and are a priority for allocation of newly appointed HCSW's who are in the pipeline.

3.5 Fill rates by ward

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

3.6 Areas of concern

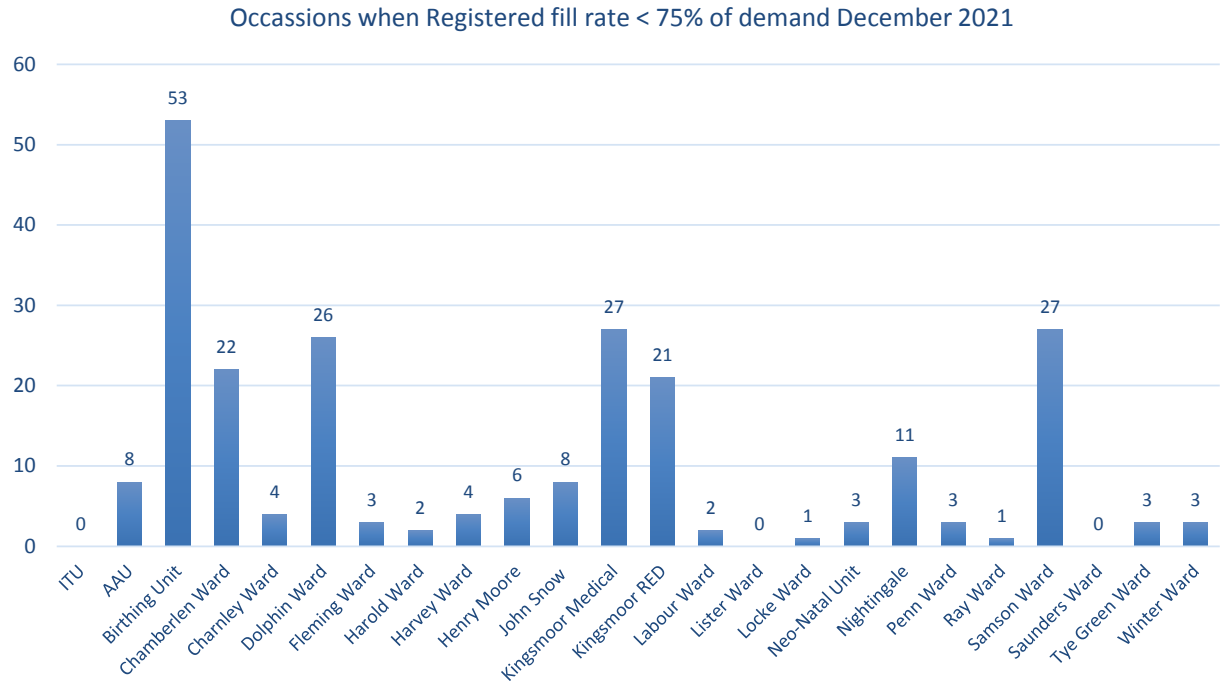
Paediatric ED and Dolphin Ward
There are ongoing high rates of maternity leave and vacancies within the service which is impacting on service delivery. In December this was compounded by period of high sickness absence due to Covid, Al business continuity and actions to ensure safe staffing and safe care continue including twice daily acuity and staffing huddles with an agreed capacity cap. Weekly reporting of Paediatric ED staffing levels are sent to the CQC for assurance.

All alternatives including redeployment from ICS partners, international recruitment, redeployment of non-paediatric nurses to support workforce and enhanced NHSP rates to increase temporary staff fill are being considered and pursued.

3.7 Red flag data:

A red flag event occurs when registered nurse fill rate drops below 75% of the planned demand.

The graph below demonstrates the number of occasions/shifts where the reported fill rate has fallen below 75% by ward. Appendix 2 Ward staffing exception reports where the fill is < 75% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes. NB due to changes of ward function and associated staff templates over the month in response to the Omicron wave the ward level data there is a low level of assurance that the data is correct.



3.8 Care Hours per Patient Day* (CHPPD): has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018).

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

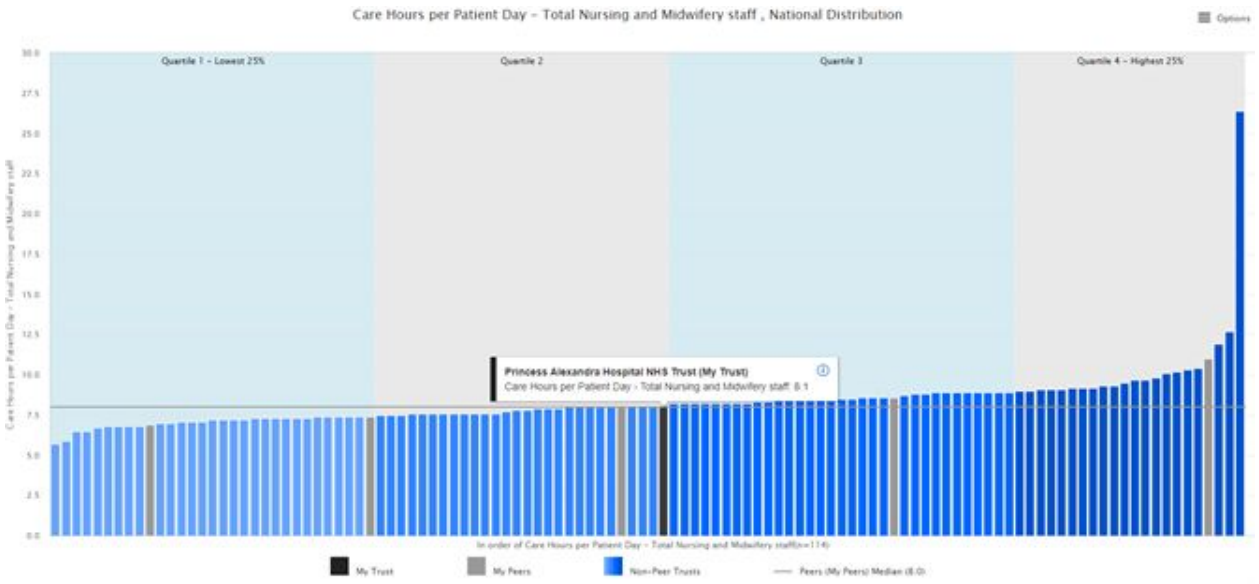
CHPPD covers both temporary and permanent care staff but excludes student nurses and midwives. CHPPD relates only to hospital wards where patients stay overnight.

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

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

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

	October 2021 data	National Median (October 2021)	Variance against national median
CHPPD Total	8.1	8.1	-
CHPPD RN	5.3	4.7	+0.6
CHPPD HCSW	2.8	3.2	-0.4



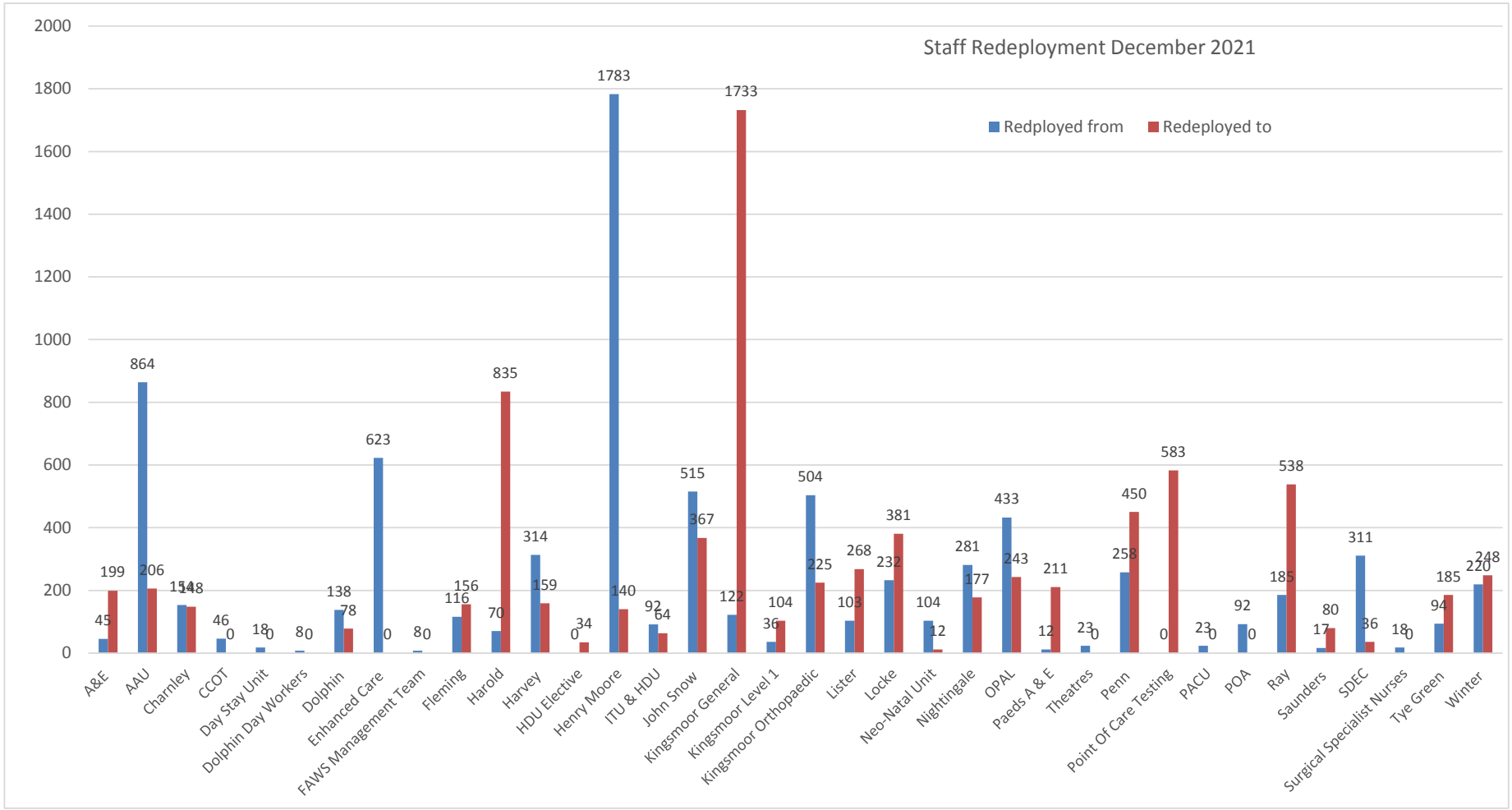
3.9 Redeployment of staff:

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

The accuracy of these reports continues to be dependent on the wards and site team redeploying staff, capturing and recording these moves in real-time in the e-Roster or SafeCare systems.
While essential to ensure the safe staffing across the Trust moving substantive staff can impact on staff satisfaction and retention rates and therefore is monitored closely to minimise the impact on staff.

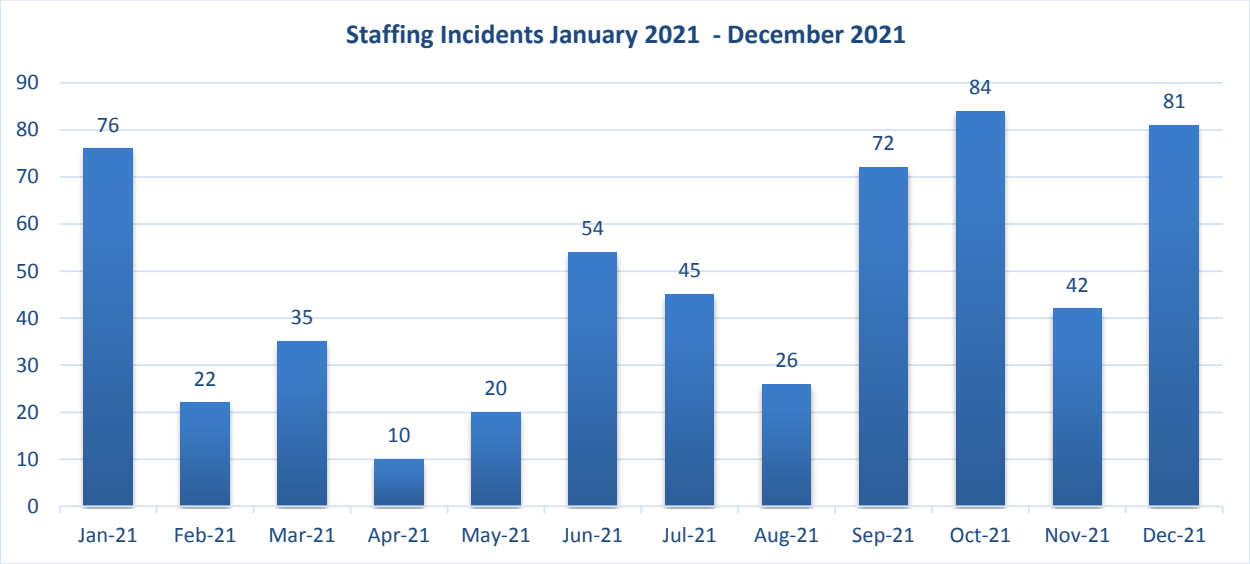
The large numbers for both Henry Moore and Kingsmoor General reflect the ward reconfiguration that took place in month from elective surgery to Covid capacity.

Redeployment of staff to ensure safe care is a key function of safe staffing however staff satisfaction is poor when staff are frequently moved. The senior nursing leadership team work closely with ward managers and teams to ensue there is understanding of the rationale for moves and to ensure there are positive conversations.


Staff Redeployment December 2021
Redployed from
Redeployed to
2000
1800
1600
1400
1200
1000
800
600
400
200
0
A&E 45 199
AAU 864 206
Charnley 154 148
CCOT 46 0
Day Stay Unit 18 0
Dolphin Day Workers 8 0
Dolphin 138 78
Enhanced Care 623 0
FAWS Management Team 8 0
Fleming 116 156
Harold 70 835
Harvey 314 159
HDU Elective 0 34
Henry Moore 1783 140
ITU & HDU 92 64
John Snow 515 367
Kingsmoor General 1733 122
Kingsmoor Level 1 36 104
Kingsmoor Orthopaedic 504 225
Lister 103 268
Locke 232 381
Neo-Natal Unit 104 12
Nightingale 281 177
OPAL 433 243
Paeds A & E 12 211
Theatres 23 0
Penn 258 450
Point Of Care Testing 0 583
PACU 23 0
POA 92 0
Ray 185 538
Saunders 17 80
SDEC 311 86
Surgical Specialist Nurses 18 0
Tye Green 94 185
Winter 220 248

3.10 Datix reports:

The trend in reports completed in relation to nursing and midwifery staffing is included below and shows that the number of incidents recorded had increased in month to 81 (↑39). ED, Locke and Tye Green are the areas raising the most Datix reports in relation to staffing levels ED 6 (7.4%), Locke 10 (12.3%) with Tye Green raising 14 (17.2%).



Triangulation with patient safety incidents raised has not identified any patient safety issues as a direct result of the staffing concerns however the impact on staff with stress and anxiety is noted as well as delays in providing care or transfer of care. Falls and Pressure ulcer harm rates and incidents per 1000 bed days has remained stable over the previous quarter.

3.11 Bank and Agency fill rates

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

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

In December there was a reduction in registered requirements, the main areas utilising agency staff continued to be A&E Nursing and critical care where specialist skills are required, along with an increased demand for RMNs. Despite the decrease in registered demand (↓594 shifts) in December compared to November there was a decrease in fill rates. As winter incentive scheme was approved to incentivise substantive staff to increase the number of shifts they undertook which based on the data available was not successful possibly due to the high sickness absence rates due to Omicron over December.

RN temporary staffing demand and fill rates*: (December 2021 data supplied by NHSP 11.1.21)*

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
July 2021	2792	1809	64.8%	498	17.4%	82.2%	498	17.8%
August 2021	2585	1880	72.7%	424	16.8%	89.5%	271	10.5%
September 2021	2538	1767	69.6%	452	17.8%	87.4%	319	12.5%

October 2021	2982	1862	62.4%	456	15.3%	77.7%	664	22.3%
November 2021	3067	2401	68.7%	508	16.6%	85.3%	452	14.7%
December 2021	**2772**	**1807**	**65.2%**	**474**	**17.1%**	**82.3%**	**491**	**17.7%**
December 2020	3485	1820	52.2%	430	12.3%	64.6%	1235	35.4

The HCSW demand shows an increase in unregistered demand (↑176 shifts), there was a reduction in fill rate from 82.1% in November to 77.4% in December. There were 2 agency HCA filled shifts booked for Paediatric ED in December. Fill rates of HCSW temp staffing is variable across the week and in line with when apprentices have study days. All new HCSW starters are invited to join the bank.

HCA temporary staffing demand and fill rates: ***(December 2021 data supplied by NHSP 11.1.21)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
July 2021	1588	1353	85.3%	0	0	85.2%	235	14.8%
August 2021	1642	1456	88.7%	0	0	88.7%	186	11.3%
September 2021	1773	1271	71.6%	0	0%	71.6%	502	28.3%
October 2021	1804	1359	75.3%	0	0%	75.9%	434	24.1%
November 2021	1652	1352	81.8%	4	0.2%	82.1%	292	17.9%
December 2021	**1828**	**1413**	**77.3%**	**2**	**0.1%**	**77.4%**	**413**	**22.6%**
December 2020	1923	1035	53.8%	38	2.0%	55.8%	850	44.2%

B: Workforce:

4.0 Nursing Recruitment Pipeline

The overall clinical nursing vacancy rate in December was 0.0%. The vacancy rate for Band 5 RN's was -9.4%). The table below includes projections of starter including international nurses who are in the pipeline, nursing apprenticeships due to qualify and student nurses who have accepted offers of employment with the Trust. The vacancy rate is against funded establishment for clinical nursing posts and does not include additional posts required for support service or midwifery or those required to support Covid additional demand

Nursing Establishment v Staff in post												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Funded Establishment WTE	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25	966.25
Staff in Post WTE	915.00	920.00	922.00	937.00	936.00	936.00	961.58	967.58	966.58	973.58	979.58	986.58
Vacancy WTE	51.25	46.25	44.25	29.25	30.25	30.25	4.67	-1.33	-0.33	-7.33	-13.33	-20.33
Actual RN Vacancy Rate	5.3%	4.8%	4.6%	3.0%	3.1%	3.1%	0.5%	-0.1%	0.0%	-0.8%	-1.4%	-2.1%
Forcast Vacancy Rate in Business Plan												

Band 5 Establisment V Staff in Post												
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Funded Band 5 Establisment WTE	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2	522.2
Band 5 Staff in Post WTE	498	502	516	520	523	548	558	558	571	577	584	592
Band 5 Starters	12	16	16	8	11	30	17	9	18	13	14	15
Vacancy Band 5 WTE	24.2	20.2	6.2	2.2	-0.8	-25.98	-35.98	-35.98	-48.98	-54.98	-61.98	-69.98
Actual Vacancy Rate	4.6%	3.9%	1.2%	0.4%	-0.2%	-5.0%	-6.9%	-6.9%	-9.4%	-10.5%	-11.9%	-13.4%
Forcast Vacancy Rate in Business Plan												

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

The Trust receive support for recruitment of healthcare support workers from NHSE/I. The table below provides the pipeline and recruitment trajectory for HCSW. The vacancy rate has remained high since April despite the recruitment team working closely with the practice development team, department leads in supporting the recruitment and on boarding of this group of staff. Sustained increase in posts is proving problematic due to high turnover but it should be noted that some of the turnover is driven by HCSW commencing apprenticeship pathways to foundation degree and nursing degrees as part of a pathway to becoming a registered nurse. The nurse recruitment lead and recruitment team have held a number of open days and recruitment events and there are 50 offer holders in the pipeline who should commence by the end of March 2021. NHSE/I have extended the financial offer to support HCSW recruitment into 2022.

Establishment V Staff in Post												
	Apr-21	May-21	Jun-21	Jul-21	Aug-20	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Funded Establishment WTE	419	419	419	419	419	419	419	419	419	419	419	419
Staff in Post WTE	366.00	375.00	376.00	368.00	365.00	370.00	358.00	356.00	354.00	366.00	381.00	386.00
Vacancy WTE	53	44	43	51	54	49	61	63	65	53	38	33
Actual B2/B3 Vacancy Rate	12.6%	10.5%	10.3%	12.2%	12.9%	11.7%	14.6%	15.0%	15.5%	12.6%	9.1%	7.9%
Forcast Vacancy Rate in Business Plan												

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

Projected Leavers WTE												
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total Band 2/3 Leavers	**0**	**10**	**8**	**11**	**12**	**6**	**14**	**12**	**13**	**8**	**5**	**5**
HCSW Turnover %	11.59%	12.23%	12.45%	16.86%	15.98%	16.96%	18.73%	19.34%	20.07%			

4.1 Apprenticeships

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

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

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

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

5 RECOMMENDATION

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

Author: Sarah Webb, Deputy Director of Nursing and Midwifery

Date 12.01. 2022

Appendix 1

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

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

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
ITU & HDU	103.8%	79.5%	99.3%	38.7%	101.6%	59.1%	95.5%
John Snow Ward + Henry Moore Escalation	127%	108%	107%	127%	117.8%	116.3%	117.2%
Harvey Ward	80.6%	71.0%	103.2%	81.6%	89.8%	76.1%	83.5%
Lister Ward	95.5%	93.6%	112.2%	104.2%	102.6%	97.9%	100.5%
Locke Ward	106.1%	87.1%	104.4%	114.3%	105.3%	97.4%	102.6%
Ray Ward	104.3%	72.1%	121.2%	134.5%	110.6%	91.7%	102.6%
Saunders Ward	116.9%	62.0%	91.0%	133.3%	105.9%	89.1%	99.9%
Nightingale Ward	79.0%	48.9%	105.2%	88.4%	89.6%	63.9%	78.9%
Tye Green Ward	86.5%	93.6%	98.0%	94.3%	91.4%	93.9%	92.6%
Winter Ward	92.0%	80.4%	103.4%	104.8%	96.8%	90.4%	94.0%
Charnley Ward	82.0%	80.7%	97.6%	93.4%	88.6%	85.9%	87.4%
AAU	98.0%	74.7%	90.8%	94.0%	94.5%	83.9%	91.0%
Kingsmoor Surgery	114.3%	103.0%	159%	70.9%	132.1%	87.4%	115.7%
Penn	107.8%	95.6%	116.5%	77.4%	111.3%	87.8%	101.6%
Fleming Ward	86.6%	76.8%	97.7%	109.2%	91.3%	89.1%	90.5%
Harold Ward	92.3%	80.5%	116.3%	100.6%	102.5%	88.7%	96.4%
Neo-Natal Unit	90.7%	112.9%	91.6%	135.8%	91.2%	124.3%	96.7%
Dolphin Ward	68.8%	91.4%	86.4%	85.6%	76.6%	89.5%	79.8%
Maternity	92.0%	90.8%	91.8%	66.2%	91.9%	79.0%	88.0%
Total	91.4%	80.9%	98.8%	92.3%	94.7%	85.7%	91.6%

Appendix 2

Ward staffing exception reports
Reported where the fill is < 75% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes. Please note, further review of data sets will enable a more robust and detailed analysis going forward (Janay data)

	Report from the Associate Director of Nursing for the HCG		
Ward	Analysis of gaps	Impact on Quality / outcomes	Actions in place
ITU	**HCSW fill on nights 38.7%. Overall HCSW fill 59.1%**	Unable to identify from data set at ward level outcome level data, but acknowledged shortages likely to delay timeliness and responsiveness of care	Template not adjusted to reflect acuity of patients or additional support provided by theatre staff when required
Harvey	**HCSW fill nights 71.0%**	Unable to identify from data set at ward level, , but acknowledged shortages likely to delay timeliness and responsiveness of care	acuity and dependency monitored at huddles and staffing in line with safe care requirements.
Ray	72.1% HCSW fill days	Unable to identify from data set at ward level, but acknowledged shortages likely to delay timeliness and responsiveness of care	– additional non rostered staff available to support
Saunders	62.0% HCSW fill days	Unable to identify from data set at ward level, , but acknowledged shortages likely to delay timeliness and responsiveness of care	– additional non rostered staff available to support
Kingsmoor Surgery	70.9% HCSW fill nights	Unable to identify from data set at ward level, but acknowledged shortages likely to delay timeliness and responsiveness of care	– over 100% RN fill
Nightingale	48.9% HCSW fill days	Unable to identify from data set at ward level, , but acknowledged shortages likely	– additional non rostered staff available to support

		to delay timeliness and responsiveness of care	
Dolphin	68.8% RN fill days	Unable to identify from data set at ward level, , but acknowledged shortages likely to delay timeliness and responsiveness of care	Template not adjusted to reflect actions taken and beds closed as a result of daily staffing reviews.
AAU	**74.7% HCSW fill days**	Unable to identify from data set at ward level, , but acknowledged shortages likely to delay timeliness and responsiveness of care	– additional non rostered staff available to support
Maternity	66.2% HCSW fill days	Unable to identify from data set at ward level, , but acknowledged shortages likely to delay timeliness and responsiveness of care	– additional non rostered staff available to support

Appendix 3

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

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Total	**5.8**	**2.9**	**8.6**
ITU & HDU	30.7	3.0	33.7
John Snow Ward	6.1	4.1	10.3
Harvey Ward	4.5	3.2	7.7
Lister Ward	4.1	3.1	7.2
Locke Ward	4.6	2.1	6.8
Penn Ward	4.2	3.0	7.2
Ray Ward	4.7	2.9	7.6
Saunders Unit	12.8	6.0	18.7
Nightingale Ward	6.1	3.1	9.2
Tye Green Ward	3.3	3.0	6.4
Winter Ward	4.5	3.2	7.7
Charnley Ward	3.8	2.9	6.7
AAU	8.4	3.7	12.2
Kingsmoor Red	3.7	1.0	4.8
Kingsmoor Medical	9.3	4.3	13.6
Fleming Ward	4.5	2.4	6.9
Harold Ward	3.7	2.5	6.3
Neo-Natal Unit	9.5	2.6	12.1
Dolphin Ward	43.9	17.1	61.0
Labour Ward	9.5	2.5	12.0
Birthing Unit	15.0	4.9	20.0
Samson Ward	2.3	1.9	4.1
Chamberlen Ward	5.9	1.2	7.0

The Princess Alexandra Hospital NHS Trust

Trust Board – 3 February 2022

4.5

Agenda item:	4.5
Presented by:	Giuseppe Labriola, Director of Midwifery
Prepared by:	Giuseppe Labriola, Director of Midwifery
Date prepared:	6th January 2022
Subject / title:	Midwifery Workforce Review

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

Key issues:	Birthrate Plus® (BR+) were commissioned to review the workforce at The Princess Alexandra Hospital NHS Trust (PAHT) and make recommendations on the midwife: birth ratio, based upon the acuity and activity of the service. A midwifery workforce review was also undertaken by the director of midwifery to ascertain staffing needed in clinical areas. Both reviews have determined that there is a deficit of clinical midwives, maternity support workers and specialist/managerial midwifery posts. Phased over the remainder of the year and 2022/23, it is recommended that £1,049,180 is invested within maternity to maintain safe staffing with external funding received (Ockenden) or expected (MIS) of £1,055,822 against the investment cost.
Recommendation:	To note the recommendation of an uplift to the midwifery establishment to maintain safe staffing and achieve midwife to birth ratios.

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

Previously considered by:	Divisional Triumvirate Divisional Board **EMT** 14.01.2022 **SMT** 18.01.2022
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Appendices:	1 (Midwifery Workforce review incorporating birthrate plus review) (In Diligent Resources/available on request)

1.0 Purpose

BR+ is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units for a significant number of years.

PAHT had a formal midwifery workforce review completed by BR+ in May 2019 detailing an uplift of midwifery staffing was required, which was funded.

A further review was funded by the Local Maternity and Neonatal System and this was completed in November 2021 supporting the need for further investment in the midwifery workforce.

2.0 Context

BR+ is based upon an understanding of the total midwifery time required to care for women/people and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE (2015) safe staffing guideline for midwives in maternity settings, and have been endorsed by the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists.

An individual service will produce a casemix based on clinical indicators of the wellbeing of the mother/person and infant throughout labour and delivery. Each of the indicators has a weighted score designed to reflect the different processes of labour and delivery and the degree to which these deviate from obstetric normality. Five different categories are created - the lower the score the more normal are the processes of labour and delivery. Other categories classify women/people that are admitted to the delivery suite for other reasons than for labour and delivery.

Together with the casemix, the number of midwife hours per patient/client category is based upon the well-established standard of one midwife to one woman/person throughout labour, plus extra midwife time needed for complicated Categories III, IV & V, calculates the clinical staffing for the annual number of women delivered.

In addition, BR+ determines the staffing required for antenatal inpatient and outpatient services, postnatal care of women/people and babies in hospital and community care of the local population birthing in either the local hospital or neighbouring ones.

The method works out the clinical establishment based on agreed standards of care and specialist needs and then includes the non-clinical midwifery roles to manage maternity services. Skill mix adjustment of the clinical staffing between midwives and competent & qualified support staff can also be applied.

3.0 Analysis

The casemix at PAHT indicates that 72.4% of women are in the 2 higher categories IV and V which is noticeable higher than the average for England of

58%. Comparisons were made between the previous casemix review in 2019 and an increase of 10.7% was noted in the Generic casemix, in the highest risk categories IV and V.

The casemix is unique to each maternity service as it reflects the clinical and social needs of women/people, local demographics, clinical decision making and adherence to national guidelines.

Table 1. PAHT Casemix

PAHT Casemix	% Cat I	% Cat II	% Cat III	% Cat IV	% Cat V
% Generic Casemix 2021 (MLU and DS)	3.4	9.1	15.2	27.3	45.1
		27.7%		72.4%	
% Generic Casemix 2019 (MLU & DS)	*4.7*	*17.9*	*15.7*	*26.8*	*34.9*
		38.3%		*61.7%*	

4.0 Midwifery workforce at PAHT

At present whilst supportive of implementing a 90:10 (midwife: appropriately trained support worker) skill mix ratio within the service, the current support staff do not have the required qualification, knowledge, skill and experience to replace elements of a midwifery role. The recommendation is to grow this skill within the workforce model.

The service is committed to implementing the 90:10 skill mix ratio following the appropriate training with the timeframe for completion 2024/25 (financial year). Replacing elements of a midwifery role with a support worker needs to be managed appropriately to ensure that the service remains safe and of a high quality.

A local workforce review has been completed (Appendix 1) resetting the cost centres across the service and detailing what is needed to run the service. In essence, the workforce review understands the complexities of the local service and staffing ward areas based on their locality and geography, which BR+ is unable to analyse.

The local workforce review ensures that the midwifery staffing meets NICE recommendations and the National Quality Board Safe, sustainable and productive staffing (January 18) for the midwifery workforce. Ongoing calculations of acuity, activity and the collection of maternity red flags may be aided in the future by the BR+ application which has been developed and has received excellent feedback from maternity services where it is used. The maternity service at PAHT are currently in the early phases of the intrapartum application and the ward acuity application.

The local workforce review describes a three-year plan with our workforce:

Phase 1 (FY 2021-2022): realigning the cost centres and ensuring our staff are in the correct places. This will involve consultations with staff who may be affected. Conducting a training needs analysis for our maternity support workers. Funding released to enable the recruitment process to commence for the following posts: 1 WTE Consultant Midwife, 0.60 WTE Diabetic Midwife, 1 WTE Matron, 0.19 WTE Registered Nurses, 1 WTE Perinatal Mental Health Midwife, 5.90 WTE Registered Midwives, 5.77 WTE Maternity Support Workers, 4.28 WTE Maternity Care Assistants, 1 WTE Governance Administrator = **£934, 726.** The recruitment timelines for these posts are likely to have minimal impact on the 2021/2022 budgets, with temporary staffing costs only being incurred for the Registered Midwives and Maternity Care Assistants roles **- £34, 244**.

Phase 2 (FY 2022- 2023): starting a comprehensive training package for our maternity support workers and re-defining their roles and responsibilities. During this time, it is not appropriate or safe to skill mix the midwives on the unit. Releasing funding for the following posts: 1 WTE Preceptor Support Midwife, 1 WTE Fetal Medicine Midwife = **£114, 454**

Phase 3 (FY 2024 - 2025) : would be applying a 90:10 split in appropriate areas with suitably trained staff with a further workforce review of the service looking at the midwifery establishment.

The service should be funded for a midwife:birth Ratio of 1:23. With the birth rate of 3,839 the midwife:birth ratio was 1:24 including a proportion of nursery nurse roles within the calculation. Including the additional midwifery posts requested (5.90 WTE until 2024 and specialist/managerial roles) brings the midwife:birth ratio to 1:23

The calculation only meets the midwife:birth ratio with the additional roles as requested:

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)

In addition, further managerial and specialist roles are needed as detailed in the BR+ report. A gap analysis has been completed with the RCM strengthening midwifery leadership manifesto which enables a review of services to include more specialist roles necessary for a modern maternity service.

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

4.0 Resources required

£1,049,180 is required to provide the additional roles requested to maintain safe staffing. The service has received Ockenden funding for 3.9 WTE Band 6 Midwives. Considering this funding of £205, 822, and the additional funding of £850,000 received, as the service met year three of the Maternity Incentive Scheme, **£1,055.822** has been received in total to contribute towards the costs of this workforce review.

The request for funding to be released is detailed in the following financial year quarters:

Phase 1: Quarter 4 2021/22	Funding released to **enable recruitment** process to commence for posts = £642, 320. The recruitment timelines for the posts are likely to have minimal impact on the 2021/2022 budgets, with temporary staffing costs only being incurred for the Registered Midwives and Maternity Care Assistants roles - £34, 244.
Phase 1: Quarter 1 2022/23	Release of funding for Perinatal Mental Health Midwife postholder = £57, 227
Phase 1: Quarter 2 2022/23	Release of funding for Consultant Midwife, Diabetic Midwife, Matron and Governance administrator postholders= £235, 179
Phase 2: Quarter 3 (2022/23)	Release of funding for Preceptor Support Midwife and Fetal Medicine Midwife = £114, 454
Total	**£1, 049.180**

5.0 Recommendation

£1, 049.180 is required to provide the additional roles requested to maintain safe staffing. The service has received Ockenden funding for 3.9 WTE Band 6 Midwives. Considering this funding of £205, 822, and the additional funding of £850,000 received as the service met year three of the Maternity Incentive Scheme, £1,055.822 has been received in total to contribute towards the costs of this workforce review. There is a phased approach to the workforce review. For 2011/22 Quarter 4, funding released to **enable recruitment** process to commence for posts = £642, 320. The recruitment timelines for the posts are likely to have minimal impact on the 2021/2022 budgets, with temporary staffing costs only being incurred for the Registered Midwives and Maternity Care Assistants roles (£34, 244). Furthermore, £57, 227 to be released in 2022/23 Quarter 1, £235, 179 in 2022/23 Quarter 2 and £114, 454 in 2022/23 Quarter 3.

Author: Giuseppe Labriola, Director of Midwifery
Date: 6th January 2022

BOARD OF DIRECTORS: Trust Board (Public) 3 February 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: Workforce Committee (WFC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 31 January 2022

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Guardian of Safer Working Hours	Partial	Y	N	WFC recognised the issues behind the exception reports were not solved but were confident there were actions in place to address the issues, particularly staffing levels and senior clinical support.
2.2 Voluntary Service Update	Yes	Y	N	WFC was assured in terms of the activity of the voluntary services team. Further assurance was required in regards to the progress against the patient experience strategy.
2.3 Workforce Report	Yes	Y	N	It was agreed subsequent reviews/reports on the following topics would be brought back to the WFC; exit interviews, outcome of review of finance vacancy rates, reasons for direct agency bookings and the support framework for redeployment. The Board will be updated on the latest information on VCOD.
2.4 Safer Nurse Staffing Report & 2.5 Winter Preparedness (nursing and midwifery staffing)	Yes	N	QSC	WFC were assured in regard to the provision of safe nursing and midwifery staffing (in line with the recommended actions detailed by NHSE/I) and recognised that the Quality and Safety Committee would monitor the patient safety elements of the staffing. WFC acknowledged that the data set underpinning the report in 2.4 in relation to patient safety is under review.
2.6 Midwifery Establishment Review	Yes	N	N	WFC approved the uplift in the midwifery establishment to maintain safe staffing and achieve midwife to birth ratios. The

BOARD OF DIRECTORS: Trust Board (Public) 3 February 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: Workforce Committee (WFC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 31 January 2022

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				paper was recommended to Board for approval and it was noted PAF had supported the recommendation.
2.7 BAF Risk 2.3 (Workforce)	Yes	N	N	Risk score to remain unchanged at 16.
2.9 Health and Wellbeing Report	Yes	N	N	WFC received assurance in regards to the further promotion of the PhysioMed service to all PAHT people and the recruitment of a back care post. The opening of the Alex lounge in February 2022 was noted.
3.1 Communications Update	Yes	N	N	WFC noted the successful launch of Alexnet and the positive feedback received.
4.1 Learning and OD Update	Yes	Y	N	WFC were assured on the learning and organisational development activities including; creation of a statutory and mandatory governance group, final 2021 response rate for annual staff survey was 47.3% and a review of mandatory training. It was agreed to bring back a report on the development on new roles at PAHT
4.2 Medical staffing workforce planning	Partial	Y	N	WFC received assurance on the medical recruitment strategy and local processes to manage the medical establishment within the Trust. Further updates would be received on the job planning process and the overall operating plan would be received at Performance and Finance Committee.

The Princess Alexandra Hospital NHS Trust

Trust Board – 3 February 2022

5.2

Agenda item:	5.2
Presented by:	Ogechi Emeadi – Director of People, OD and Communications
Prepared by:	Ogechi Emeadi – Director of People, OD and Communications
Date prepared:	27 January 2022
Subject:	Vaccination as a condition of deployment (VCOD)

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	• The Department of Health and Social Care (DHSC) formally announced (9 November) that individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19 by no later than 1 April 2022 to protect patients, regardless of their employer, including secondary and primary care. • This means that unvaccinated individuals will need to have had their first dose by 3 February 2022, in order to have received their second dose by the 1 April 2022 deadline. • Phase 2 guidance has been received with regards to a redeployment framework, and advice regarding formal steps for staff who remain unvaccinated on 1 April 2022 including dismissal • At the time of writing 147 members of staff remain unvaccinated or the trust does not have their vaccination status. This number includes temporary
Recommendation:	Trust Board are asked to note the report

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

Previously considered by:	Cell structure - People cell, strategic cell Executive Management Team Senior Management Team
Risk / links with the BAF:	NHS People plan BAF Risk 2.1 Workforce Capacity 3.2 Ability to recruit, retain and engage KLOE 4 – Good governance
Legislation, regulatory, equality, diversity and dignity implications:	Equality Act 2010 CQC well led *Pending VCOD regulation
Appendices:	Appendix 2 – Vaccination as a Condition of Deployment (VCOD) for Healthcare Workers Phase 2: VCOD Implementation

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

1.0 Introduction

This paper provides an update to the Board on the actions it is taking to ensure that the Trust meets its obligation to comply with the vaccination of a condition of deployment for healthcare workers regulations.

2.0 Background

The Department of Health and Social Care (DHSC) has formally announced that individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19 no later than 1 April 2022 to protect patients, regardless of their employer, including secondary and primary care. This means that unvaccinated individuals will need to have had their first dose by 3 February 2022, in order to have received their second dose by the 1 April 2022 deadline.

Making COVID-19 vaccination a condition of deployment in health and adult social care settings (domiciliary care and other CQC-regulated settings) is intended to:

- Protect all those who use health and care services, a large number of whom are vulnerable, as well as the wider community.
- Protect workers themselves by increasing vaccination rates.
- Help reduce COVID-19 related sickness absences.

NHS guidance states that roles in scope include workers who have face-to-face contact with patients and/or service users and who are deployed as part of CQC regulated activity. This include individuals working in non-clinical ancillary roles who enter areas which are utilised for the provision of a CQC-regulated activity as part of their role and who may have social contact with patients, but not directly involved in patient care (e.g. receptionists, ward clerks, porters, and cleaners), regardless of contracted hours or working arrangements. All honorary, voluntary, locum, bank and agency workers, independent contractors, students/trainees over 18, and any other temporary workers are also in scope.

3.0 Current vaccination status by staff group

The trust has previously reported to the Board in January 2022, the rationale and process for deciding those staff who are in and out of scope of the regulations. Whist the trust continues to encourage all staff to be fully vaccinated, this report focuses on the status of staff who are deemed to be in scope for the purposes of the regulations.

The table below includes those staff who are unvaccinated, do not know the vaccination status and those who are temporarily exempt eg pregnancy, etc. The data is correct at the time of writing.

Staff Group	Headcount	Covid-19 Vaccination 1 Given	Covid-19 Vaccination 1 Given %	Covid-19 Vaccination 1 Not Given	Covid-19 Vaccination 1 Not Given %	Covid-19 Vaccination 2 Given	Covid-19 Vaccination 2 Given %	Covid-19 Vaccination 2 Not Given	Covid-19 Vaccination 2 Not Given %
Add Prof Scientific and Technic	92	88	95.7%	4	4.3	85	92.4%	7	7.6
Additional Clinical Services	641	607	94.7%	34	5.3	581	90.6%	60	9.4
Administrative and Clerical	794	760	95.7%	34	4.3	744	93.7%	50	6.3
Allied Health Professionals	169	161	95.3%	8	4.7	159	94.1%	10	5.9
Estates and Ancillary	319	304	95.3%	15	4.7	293	91.8%	26	8.2
Healthcare Scientists	103	98	95.1%	5	4.9	93	90.3%	10	9.7
Medical and Dental	526	519	98.7%	7	1.3	509	96.8%	17	3.2
Nursing and Midwifery Registered	1191	1155	97.0%	36	3.0	1116	93.7%	75	6.3
Grand Total	**3840**	**3693**	**96.2%**	147	3.8	**3581**	**93.3%**	259	6.7

4.0 Action taken to date

The SHaW (staff health and wellbeing) nursing team, director of infection, prevention and control and the chief pharmacist have undertaken individual conversations with those staff who have not had their first vaccination in an effort to promote education of the vaccine and discus any concerns, and encourage staff to book their vaccination.

Discussions have also taken place with those staff who have received their 1st dose vaccination to ensure that they are supported to have their second dose vaccination

New staff joining the trust are advised of the VCOD requirement as part of their advert and application process and data indicates that applicants are or will be compliant with their vaccination status by 1st April 2022

We are holding more walk-in vaccination clinics at the trust. These walk-in clinics will give all our people the chance to receive the first or second dose of the COVID-19 vaccine, booster dose or flu vaccine.

The director of people has written to those staff where we do not have a record of vaccination status requesting their intentions.

Managers (supported by the people team) are meeting with those individuals where we do not hold a record of their vaccination status but who are in scope of the regulations. The purpose of these meetings is to discuss vaccination intentions/exemptions, the decision around being in scope, and if remaining unvaccinated – potential redeployment and adjustments options where possible.

Support has also been provided by staff networks, equality champions and faith leaders.

5.0 Next steps

Phase 2: VCOD Implementation guidance has now been published. The guidance includes a redeployment framework and advice regarding formal steps for staff who remain unvaccinated on 1 April 2022 including dismissal

Following 3 February – (the last date in which the first dose vaccination can be given in order to be compliant with the regulations from 1 April 2022) staff who remain unvaccinated and are not exempt, will be invited to a formal meeting with a manager to discuss any further options. Where alternative options have not been possible, the outcome of this meeting may be dismissal. In this instance, the contractual notice period will apply and suitable alternative options will continue to be reviewed until 31 March 2022

6.0 Recommendation

Trust Board are asked to note the report for information. Updates will be continued to be reported to Trust board on a monthly basis.

Authors: Ogechi Emeadi, director of people

Date: 27 January 2022

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) 3 February 2022**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**George Wood – Acting Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 January 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1. Financial Results including I&E position and CIP	Partial	Yes	N	Month 9 financial performance (break even achieved) was noted. Concerns were expressed in relation to 2022/23 financial performance around income uncertainty, delivery of elective activity and associated funding, access to capital and, finally, the need for a robust CIP programme to be established.
2.6 Maternity Establishment Review	Yes	No	N	PAF approved the uplift in the midwifery establishment to maintain safe staffing and achieve midwife to birth ratios. The paper was recommended to Board for approval.
3.1 Integrated Performance Report – 104 week waits	Partially	N	N	Whilst there was confidence in the work underway, complete assurance could not be provided in terms of clearance of the over 104 week wait list; patient choice could also have an impact on achieving this aim.
3.4 Surgery Deep Dive	Partial	Yes	To be raised at WFC.31.01.22.	The deep dive into theatre utilisation provided a level of assurance on planning for 2022/23 however, anaesthetic staffing capacity was noted as a concern and the PAHT pay/benefits offering compared to London hospitals and the risk that posed to elective recovery in particular.
4.1 Report from the Health & Safety Committee	Yes	No	N	PAF was assured in terms of the HSE submission requirement of 31.01.22. Board approval required 03.02.22
2.5 BAF Risk 5.1 (Finance)	Yes	N	N	Risk score to remain unchanged at 12.
2.5 BAF Risk 5.2 (Capital)	Yes	N	N	Risk score to remain unchanged at 12.

BOARD OF DIRECTORS:	**Trust Board (Public) 3 February 2022**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**George Wood – Acting Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 January 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.3 BAF Risk 4.2 (4 Hour Emergency Department Standard)	Yes	N	N	Risk score to remain unchanged at 20.
4.4 BAF Risk 3.1 (Estate and Infrastructure)	Yes	N	N	Risk score to remain unchanged at 20.

The Princess Alexandra Hospital NHS Trust

Trust Board – 3 February 2022

Agenda item:	6.2
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	21 January 2022
Subject / title:	M9 2021/22 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	

6.2

Key issues:

Patients		
Patients	MRSA	We have reported 3 bacteraemias in the last rolling 12 month period. RCA for December case is underway. Expected focus to be on management and documentation of intravenous devices
	C Section (planned)	Our planned C section rate has bveen above the mean for the last seven months and in special cause variation. Work to improve the elective c-section pathway is underway & includes the plan to appoint a midwife consultant with a public health & midwifery led care.
People		
People	Appraisals	In common cause variation. Performance had been constant up to October, however there has been a regression in performance since November. This is likely attributable to Omicron in terms of demand as well as staff sickness
	Statutory and Mandatory Training	Whle in common cause variation, performance has remained at 87%, and below the target of 90%. Face to face training is continuing to be delivered at St Margarets prior to the new learning and education facility being available.
	Sickness Absence	In common cause variation and continues to perform at or near the target. We saw a small reduction in December compared to the previous two months.
Performance		
Performance	RTT	Performance remains in special cause variation, but recovery actions are in place, with patients being treated in clinical priority
	Cancer 2 week wait	Following the dip in performance in September, we have returned to above the lower control limit and at a similar level of performance between April and Sept 2021. Performance remains in special cause variation
	Cancer 62 day pathway	Performance remains in common cause variation however is near the lower control limit. The recovery trajoectory is being reviewed in light of the impact of the current Omicron wave
	Four hour standard	Remains in special cause variation, however, performance has improved to near the lower control limit and similar to performance seen in August. Changes in service delivery have seen improvements in other metrics such as ambulance handovers, bed allocation and triage time
	Diagnostics	Still in special cause variation with performance generally consistent for the previous six months. Focus is being placed on the booking of the longest waiting patients
	52 week waits	Still is special cause variation, with a continued focus on clinical priority patients. The volume is expected to increase while we respond to the Omicron wave
	Bed Occupancy	Bed occupancy remains at a high level, and has been in special cause variation for the previous ten months.
Pounds		
Pounds	Surplus	The Trust has achieved YTD break-even as at December (month 9), which is in line with plan. The Trust has used COVID funding to balance the position in month. This is due principally to the under achievement of the CIP delivery and ERF insourcing. Actions to support divisions to reduce their run rates are being taken.
	CIP	The Trust has only delivered £1.921m of savings against a year to date plan of £4.650m. Currently the Trust is forecasting to only deliver CIPs of £2.040m of a total target of £7.052m for the full year. Only £0.614m of these savings are expected to be recurrent.
	Capital Spend	Year-to-date capital spend is £16.671m against a revised capital plan of £16.779m. This under-performance of £0.108m reflects timing differences and the Trust anticipates achieving its Capital Resource Limit
	Cash	The Trust continues to have a healthy cash balance of £49.400m. The focus on reducing payables continues along with improving the Trust's performance against the Better Payment Practice Code.
Places		
Places	Catering Food Waste	Remains below the national target

The Princess Alexandra Hospital NHS Trust

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

Previously considered by:	PAF.27.01.22 and QSC.28.01.22
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	

6.2

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report for December 2021

modern • integrated • outstanding

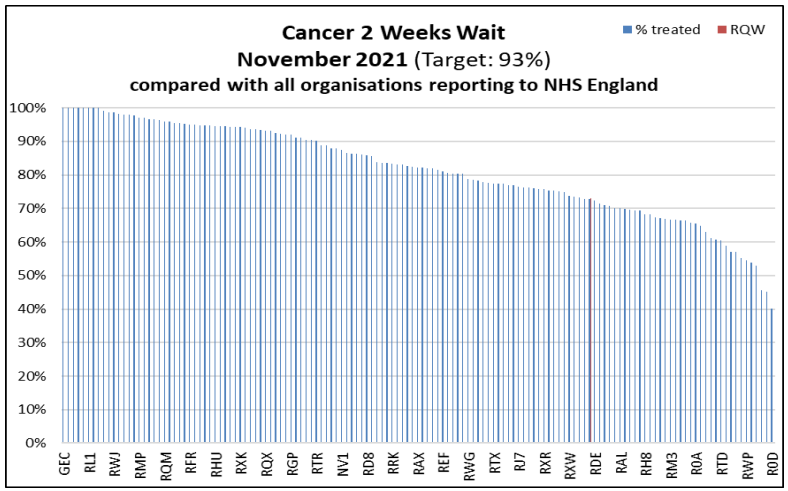
patient at heart • everyday excellence • creative collaboration

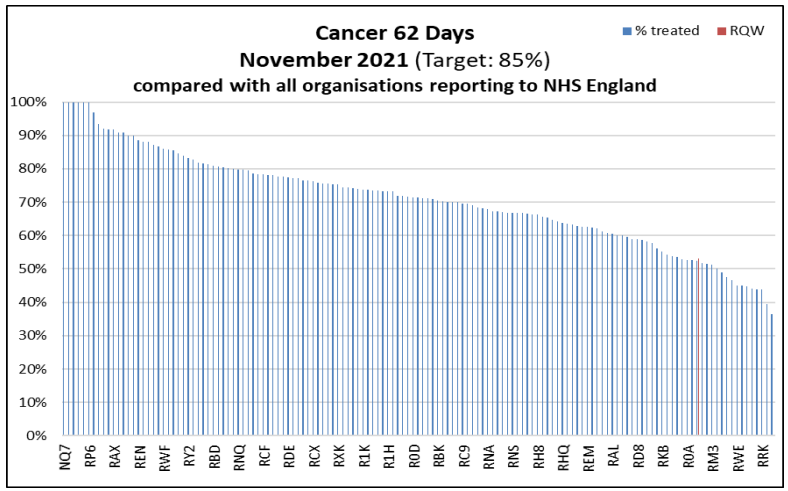
Performance Summary

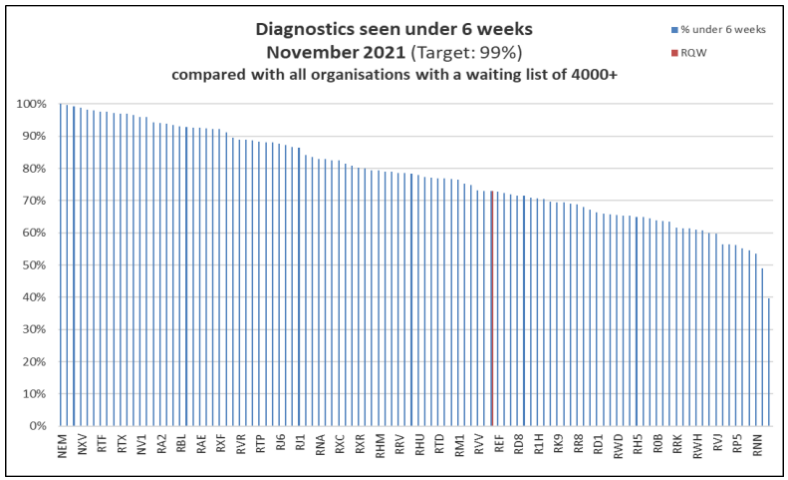
Patients		
Patients	**MRSA**	We have reported 3 bacteraemias in the last rolling 12 month period. RCA for December case is underway. Expected focus to be on management and documentation of intravenous devices
Patients	**C Section (planned)**	Our planned C section rate has bveen above the mean for the last seven months and in special cause variation. Work to improve the elective c-section pathway is underway & includes the plan to appoint a midwife consultant with a public health & midwifery led care.
Pounds		
Pounds	Surplus	The Trust has achieved YTD break-even as at December (month 9), which is in line with plan. The Trust has used COVID funding to balance the position in month. This is due principally to the under achievement of the CIP delivery and ERF insourcing. Actions to support divisions to reduce their run rates are being taken.
Pounds	CIP	The Trust has only delivered £1.921m of savings against a year to date plan of £4.650m. Currently the Trust is forecasting to only deliver CIPs of £2.040m of a total target of £7.052m for the full year. Only £0.614m of these savings are expected to be recurrent.
Pounds	Capital Spend	Year-to-date capital spend is £16.671m against a revised capital plan of £16.779m. This under-performance of £0.108m reflects timing differences and the Trust anticipates achieving its Capital Resource Limit
Pounds	Cash	The Trust continues to have a healthy cash balance of £49.400m. The focus on reducing payables continues along with improving the Trust's performance against the Better Payment Practice Code.
Places		
Places	Catering Food Waste	Remains below the national target
People		
People	**Appraisals**	In common cause variation. Performance had been constant up to October, however there has been a regression in performance since November. This is likely attributable to Omicron in terms of demand as well as staff sickness
People	**Statutory and Mandatory Training**	Whle in common cause variation, performance has remained at 87%, and below the target of 90%. Face to face training is continuing to be delivered at St Margarets prior to the new learning and education facility being available.
People	**Sickness Absence**	In common cause variation and continues to perform at or near the target. We saw a small reduction in December compared to the previous two months.
Performance		
Performance	**RTT**	Performance remains in special cause variation, but recovery actions are in place, with patients being treated in clinical priority
Performance	**Cancer 2 week wait**	Following the dip in performance in September, we have returned to above the lower control limit and at a similar level of performance between April and Sept 2021. Performance remains in special cause variation
Performance	**Cancer 62 day pathway**	Performance remains in common cause variation however is near the lower control limit. The recovery trajoectory is being reviewed in light of the impact of the current Omicron wave
Performance	**Four hour standard**	Remains in special cause variation, however, performance has improved to near the lower control limit and similar to performance seen in August. Changes in service delivery have seen improvements in other metrics such as ambulance handovers, bed allocation and triage time
Performance	**Diagnostics**	Still in special cause variation with performance generally consistent for the previous six months. Focus is being placed on the booking of the longest waiting patients
Performance	**52 week waits**	Still is special cause variation, with a continued focus on clinical priority patients. The volume is expected to increase while we respond to the Omicron wave
Performance	**Bed Occupancy**	Bed occupancy remains at a high level, and has been in special cause variation for the previous ten months.

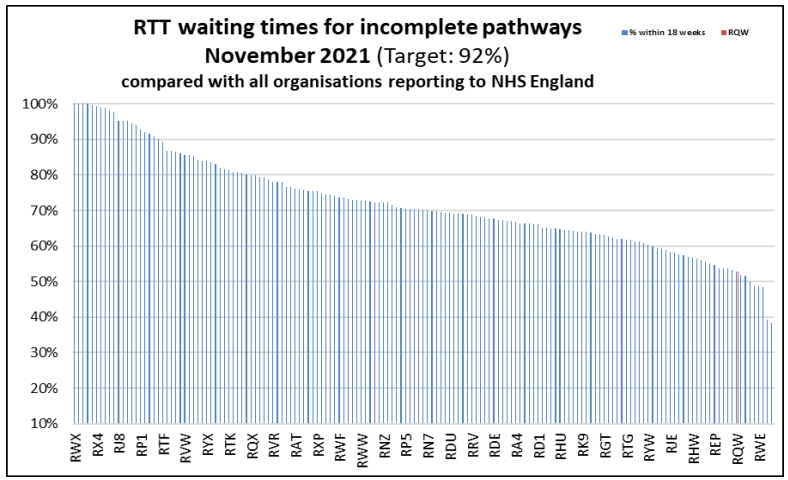
Summary

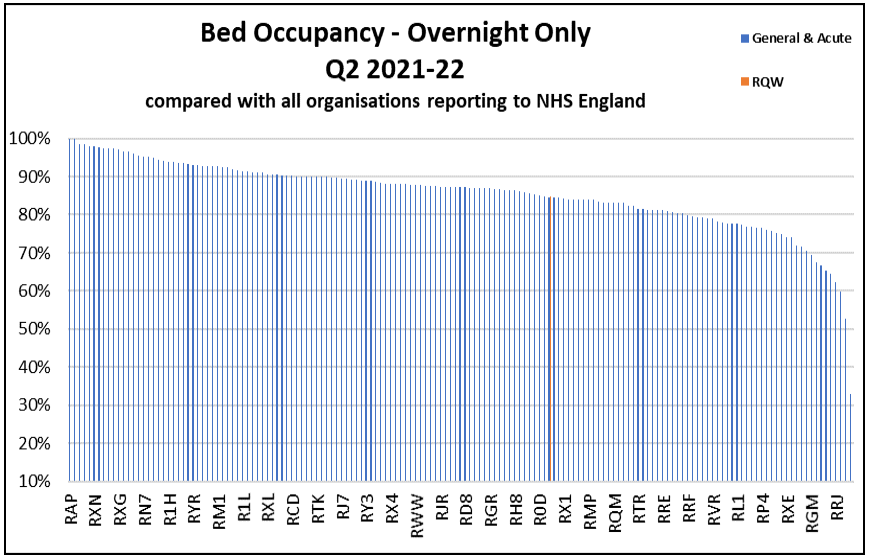
National Benchmarking

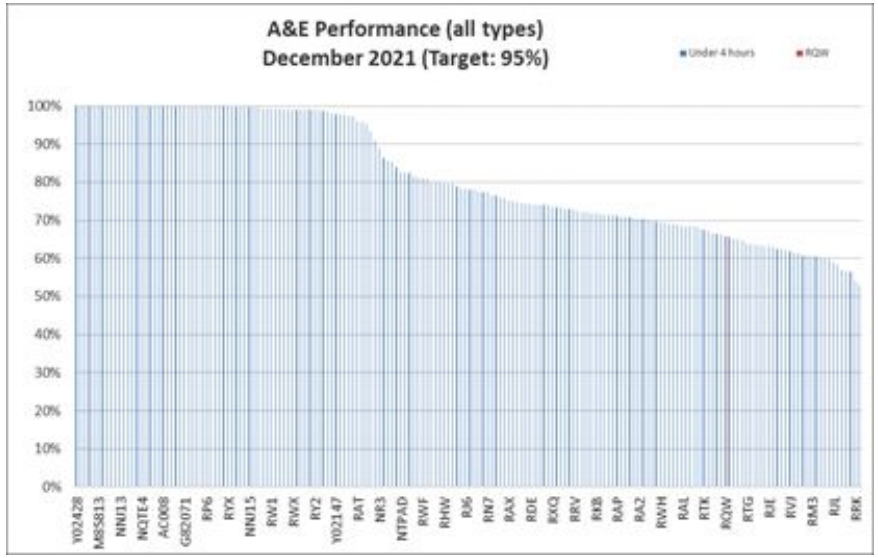


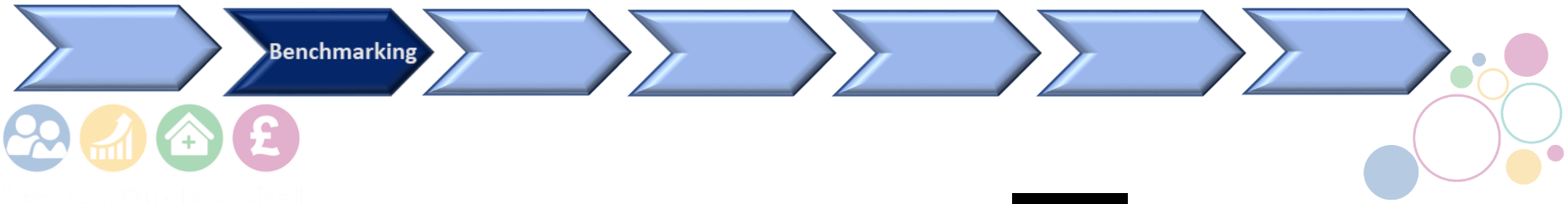


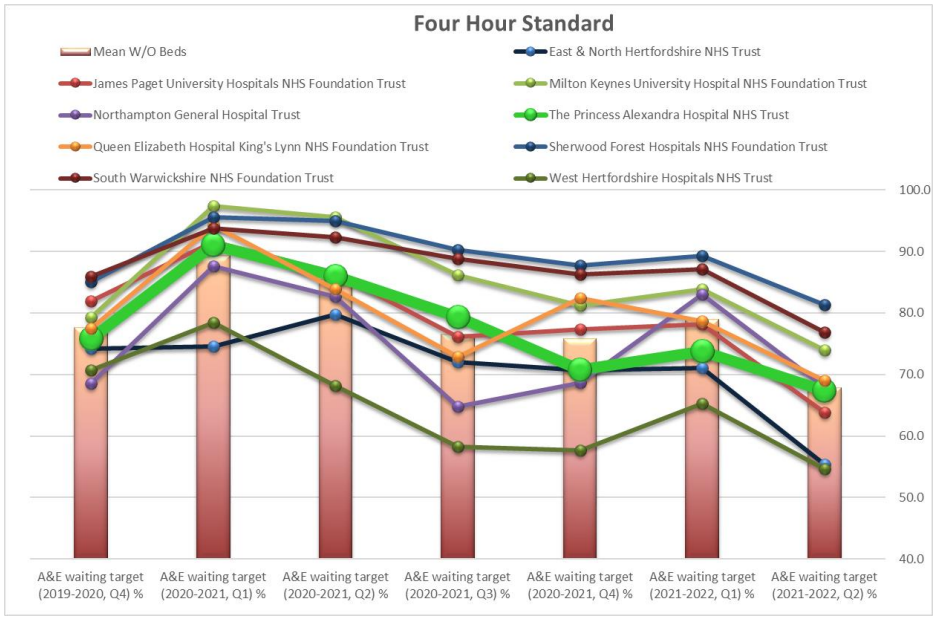


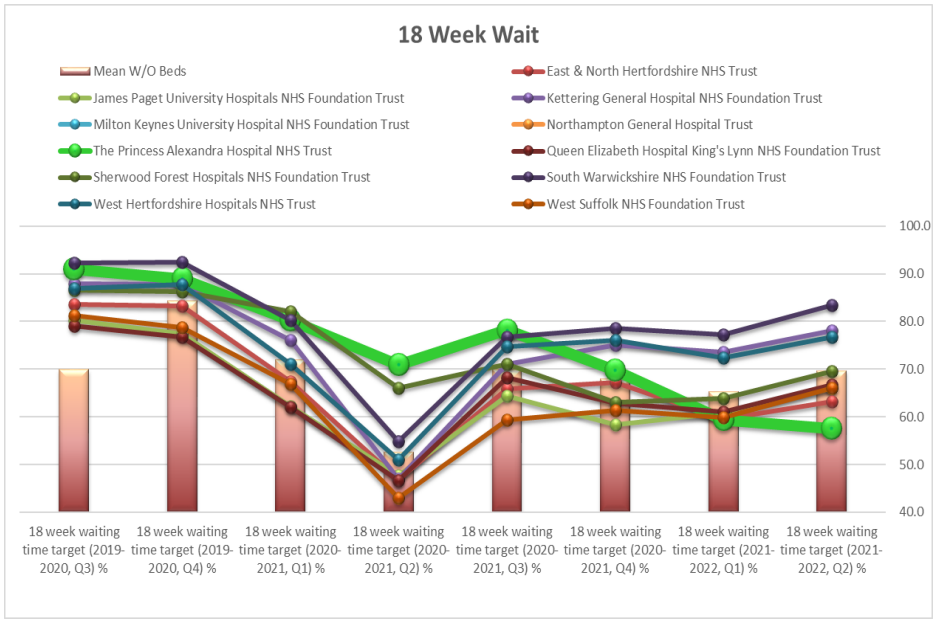


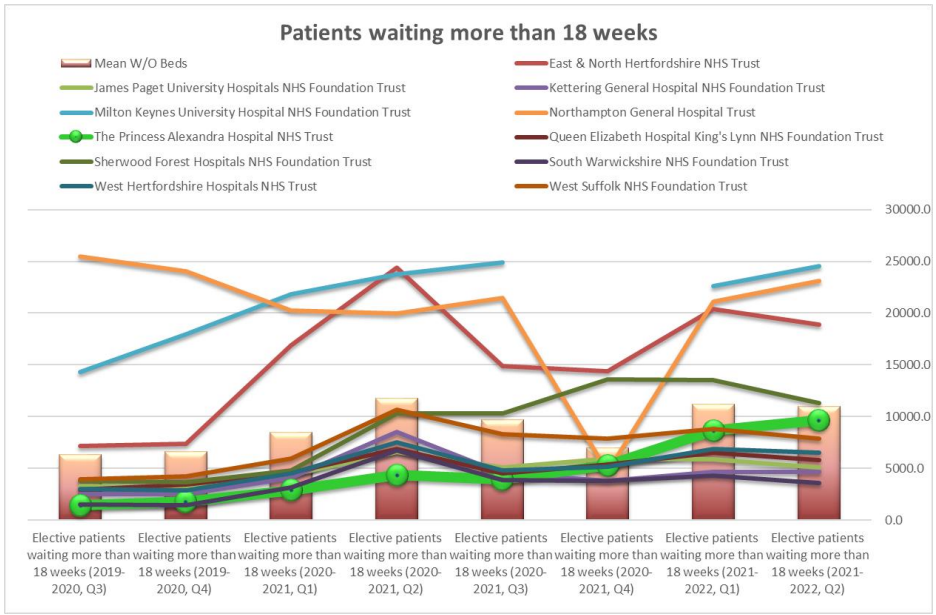

Bed Occupancy - Overnight Only
Q2 2021-22
compared with all organisations reporting to NHS England
General & Acute
RQW
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
RAP RXN RXG RN7 R1H RYR RM1 R1L RXL RCD RTK RJ7 RY3 RX4 RWW RJR RD8 RGR RH8 R0D RX1 RMP RQM RTR RRE RRF RVR RL1 RP4 RXE RGM RRJ

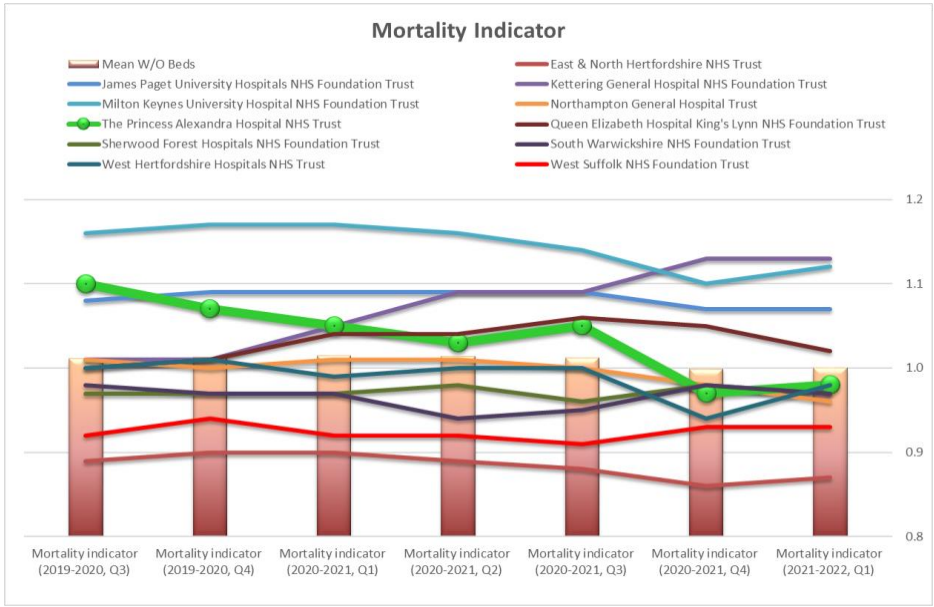

A&E Performance (all types)
December 2021 (Target: 95%)
Under 4 hours
RQW
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%


Benchmarking

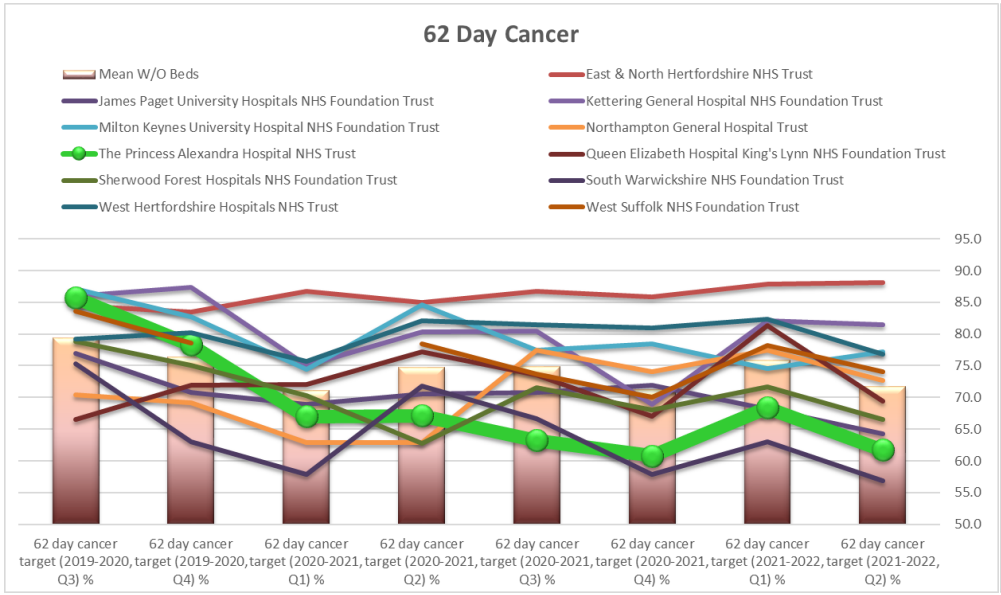

Four Hour Standard
Mean W/O Beds
East & North Hertfordshire NHS Trust
James Paget University Hospitals NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northampton General Hospital Trust
The Princess Alexandra Hospital NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
South Warwickshire NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
100.0
90.0
80.0
70.0
60.0
50.0
40.0
A&E waiting target (2019-2020, Q4) %
A&E waiting target (2020-2021, Q1) %
A&E waiting target (2020-2021, Q2) %
A&E waiting target (2020-2021, Q3) %
A&E waiting target (2020-2021, Q4) %
A&E waiting target (2021-2022, Q1) %
A&E waiting target (2021-2022, Q2) %

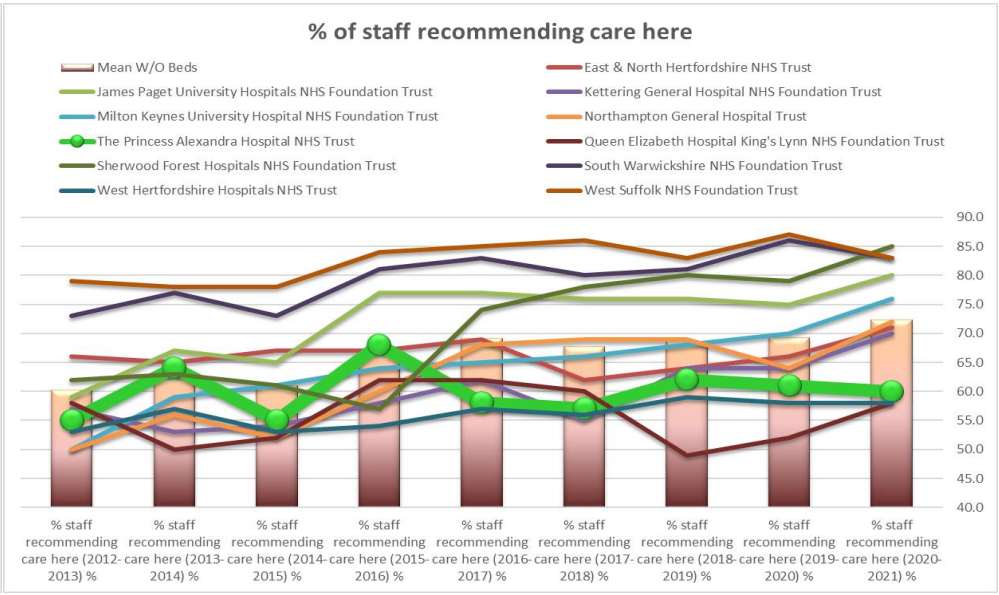

18 Week Wait
Mean W/O Beds
East & North Hertfordshire NHS Trust
James Paget University Hospitals NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northampton General Hospital Trust
The Princess Alexandra Hospital NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
South Warwickshire NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West Suffolk NHS Foundation Trust
100.0
90.0
80.0
70.0
60.0
50.0
40.0
18 week waiting time target (2019-2020, Q3) %
18 week waiting time target (2019-2020, Q4) %
18 week waiting time target (2020-2021, Q1) %
18 week waiting time target (2020-2021, Q2) %
18 week waiting time target (2020-2021, Q3) %
18 week waiting time target (2020-2021, Q4) %
18 week waiting time target (2021-2022, Q1) %
18 week waiting time target (2021-2022, Q2) %

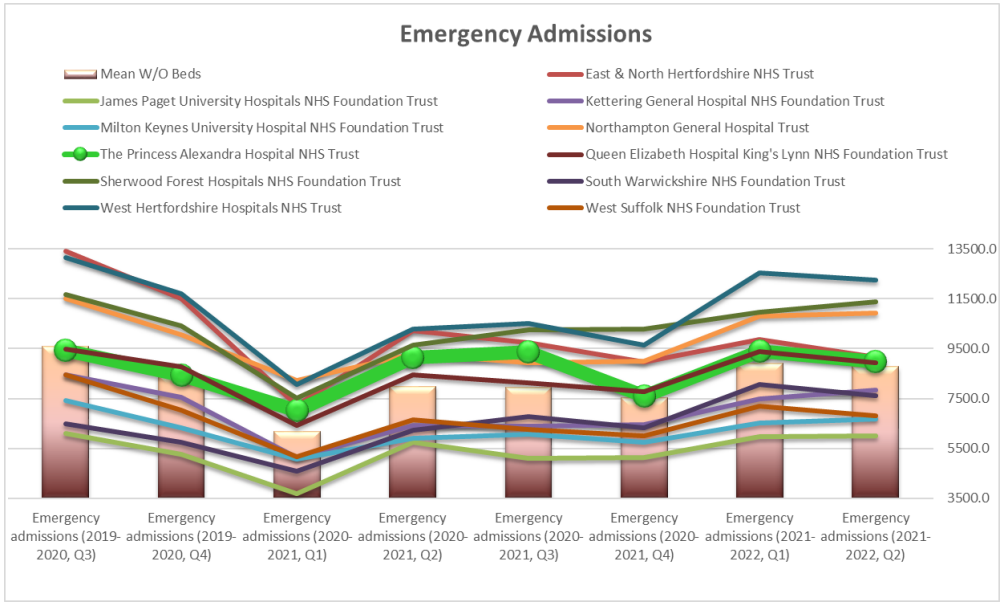

Patients waiting more than 18 weeks
Mean W/O Beds
East & North Hertfordshire NHS Trust
James Paget University Hospitals NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northampton General Hospital Trust
The Princess Alexandra Hospital NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
South Warwickshire NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West Suffolk NHS Foundation Trust
30000.0
25000.0
20000.0
15000.0
10000.0
5000.0
0.0
Elective patients waiting more than 18 weeks (2019-2020, Q3)
Elective patients waiting more than 18 weeks (2019-2020, Q4)
Elective patients waiting more than 18 weeks (2020-2021, Q1)
Elective patients waiting more than 18 weeks (2020-2021, Q2)
Elective patients waiting more than 18 weeks (2020-2021, Q3)
Elective patients waiting more than 18 weeks (2020-2021, Q4)
Elective patients waiting more than 18 weeks (2021-2022, Q1)
Elective patients waiting more than 18 weeks (2021-2022, Q2)


Mortality Indicator
Mean W/O Beds
East & North Hertfordshire NHS Trust
James Paget University Hospitals NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northampton General Hospital Trust
The Princess Alexandra Hospital NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
South Warwickshire NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West Suffolk NHS Foundation Trust
1.2
1.1
1.0
0.9
0.8
Mortality indicator (2019-2020, Q3)
Mortality indicator (2019-2020, Q4)
Mortality indicator (2020-2021, Q1)
Mortality indicator (2020-2021, Q2)
Mortality indicator (2020-2021, Q3)
Mortality indicator (2020-2021, Q4)
Mortality indicator (2021-2022, Q1)

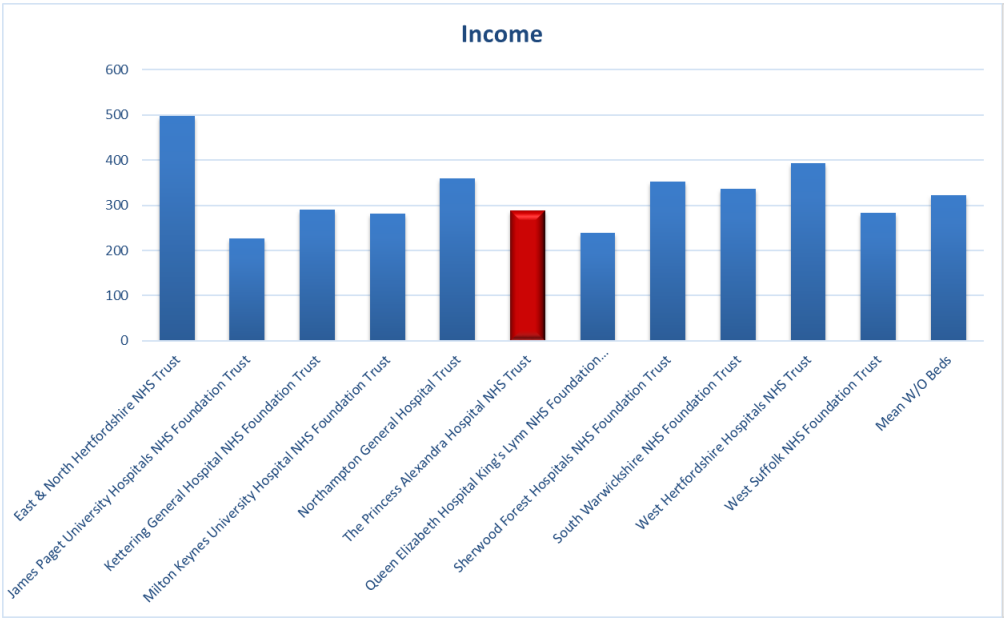

Benchmarking

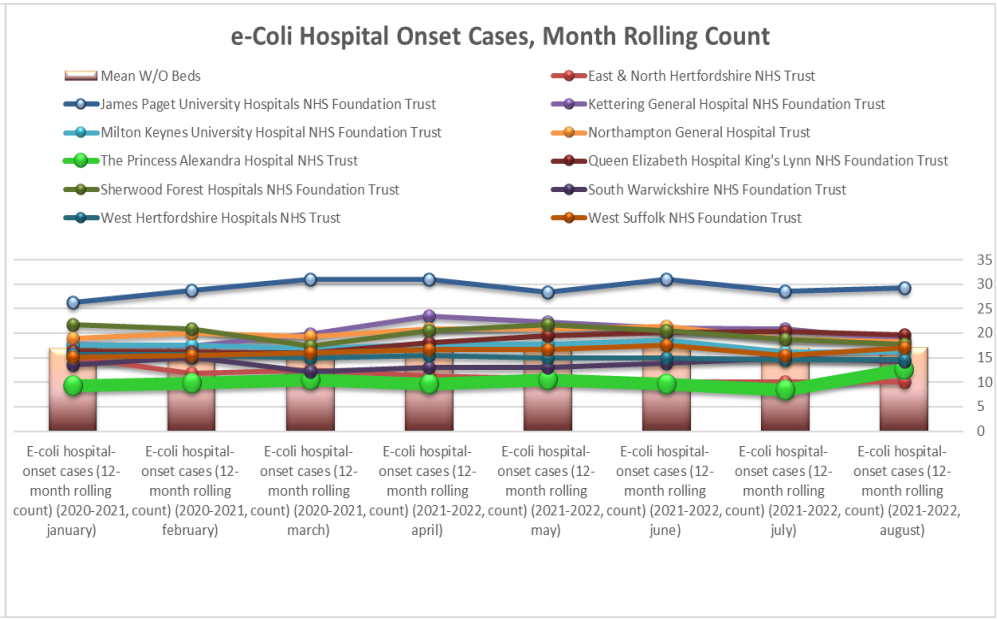

62 Day Cancer
Mean W/O Beds
East & North Hertfordshire NHS Trust
James Paget University Hospitals NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northampton General Hospital Trust
The Princess Alexandra Hospital NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
South Warwickshire NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West Suffolk NHS Foundation Trust
95.0
90.0
85.0
80.0
75.0
70.0
65.0
60.0
55.0
50.0
62 day cancer target (2019-2020, Q3) %
62 day cancer target (2019-2020, Q4) %
62 day cancer target (2020-2021, Q1) %
62 day cancer target (2020-2021, Q2) %
62 day cancer target (2020-2021, Q3) %
62 day cancer target (2020-2021, Q4) %
62 day cancer target (2021-2022, Q1) %
62 day cancer target (2021-2022, Q2) %

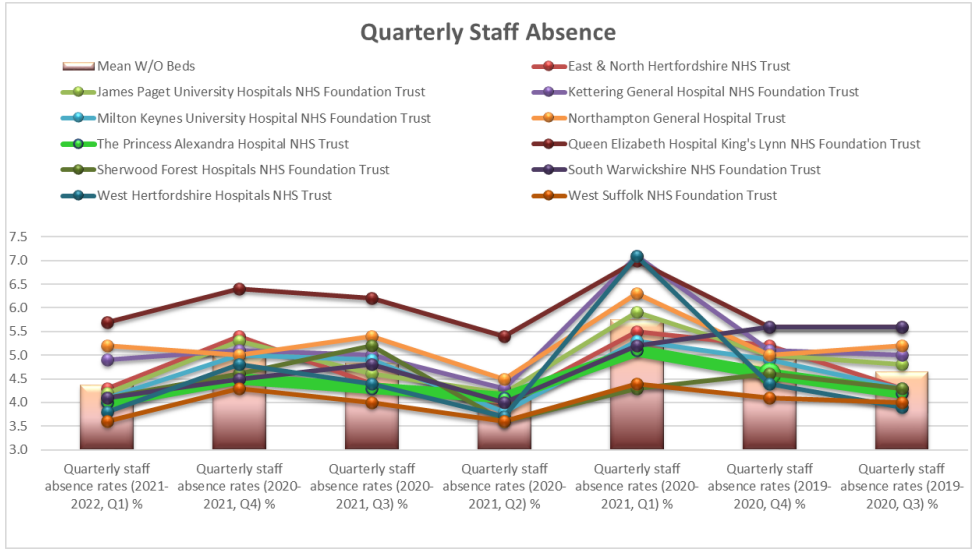

% of staff recommending care here
Mean W/O Beds
East & North Hertfordshire NHS Trust
James Paget University Hospitals NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northampton General Hospital Trust
The Princess Alexandra Hospital NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
South Warwickshire NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West Suffolk NHS Foundation Trust
90.0
85.0
80.0
75.0
70.0
65.0
60.0
55.0
50.0
45.0
40.0
% staff recommending care here (2012-2013) %
% staff recommending care here (2013-2014) %
% staff recommending care here (2014-2015) %
% staff recommending care here (2015-2016) %
% staff recommending care here (2016-2017) %
% staff recommending care here (2017-2018) %
% staff recommending care here (2018-2019) %
% staff recommending care here (2019-2020) %
% staff recommending care here (2020-2021) %


Emergency Admissions
Mean W/O Beds
East & North Hertfordshire NHS Trust
James Paget University Hospitals NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northampton General Hospital Trust
The Princess Alexandra Hospital NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
South Warwickshire NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West Suffolk NHS Foundation Trust
13500.0
11500.0
9500.0
7500.0
5500.0
3500.0
Emergency admissions (2019-2020, Q3)
Emergency admissions (2019-2020, Q4)
Emergency admissions (2020-2021, Q1)
Emergency admissions (2020-2021, Q2)
Emergency admissions (2020-2021, Q3)
Emergency admissions (2020-2021, Q4)
Emergency admissions (2021-2022, Q1)
Emergency admissions (2021-2022, Q2)


Benchmarking


Income
600
500
400
300
200
100
0
East & North Hertfordshire NHS Trust
James Paget University Hospitals NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northampton General Hospital Trust
The Princess Alexandra Hospital NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation...
Sherwood Forest Hospitals NHS Foundation Trust
South Warwickshire NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West Suffolk NHS Foundation Trust
Mean W/O Beds


e-Coli Hospital Onset Cases, Month Rolling Count
Mean W/O Beds
East & North Hertfordshire NHS Trust
James Paget University Hospitals NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northampton General Hospital Trust
The Princess Alexandra Hospital NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
South Warwickshire NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West Suffolk NHS Foundation Trust
35
30
25
20
15
10
5
0
E-coli hospital-onset cases (12-month rolling count) (2020-2021, count) (2020-2021, january)
E-coli hospital-onset cases (12-month rolling count) (2020-2021, count) (2020-2021, february)
E-coli hospital-onset cases (12-month rolling count) (2020-2021, count) (2020-2021, march)
E-coli hospital-onset cases (12-month rolling count) (2021-2022, count) (2021-2022, april)
E-coli hospital-onset cases (12-month rolling count) (2021-2022, count) (2021-2022, may)
E-coli hospital-onset cases (12-month rolling count) (2021-2022, count) (2021-2022, june)
E-coli hospital-onset cases (12-month rolling count) (2021-2022, count) (2021-2022, july)
E-coli hospital-onset cases (12-month rolling count) (2021-2022, count) (2021-2022, august)


Quarterly Staff Absence
Mean W/O Beds
East & North Hertfordshire NHS Trust
James Paget University Hospitals NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Milton Keynes University Hospital NHS Foundation Trust
Northampton General Hospital Trust
The Princess Alexandra Hospital NHS Trust
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust
South Warwickshire NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West Suffolk NHS Foundation Trust
7.5
7.0
6.5
6.0
5.5
5.0
4.5
4.0
3.5
3.0
Quarterly staff absence rates (2021-2022, Q1) %
Quarterly staff absence rates (2020-2021, Q4) %
Quarterly staff absence rates (2020-2021, Q3) %
Quarterly staff absence rates (2020-2021, Q2) %
Quarterly staff absence rates (2020-2021, Q1) %
Quarterly staff absence rates (2019-2020, Q4) %
Quarterly staff absence rates (2019-2020, Q3) %


Benchmarking

Patients

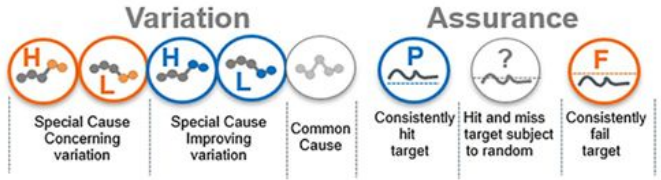
*We will continue to improve the quality of care, outcomes & experiences that we provide **our patients**, integrating care with our partners & reducing health inequity in our local population*

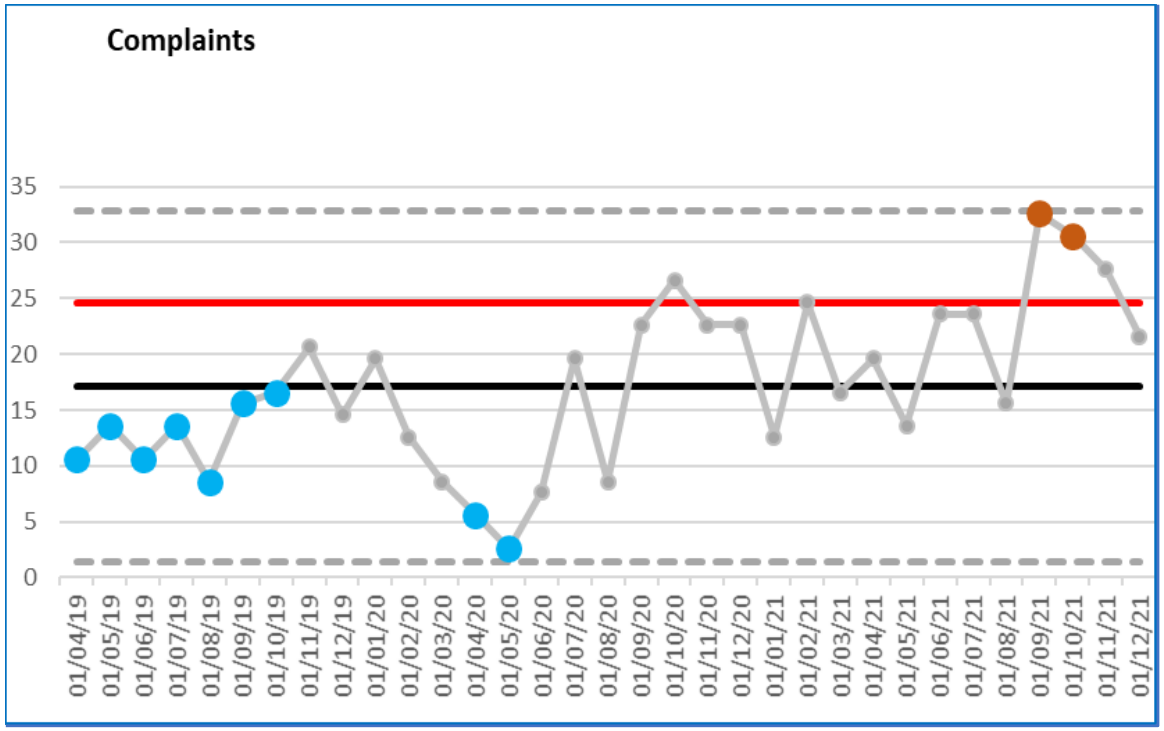
Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Complaints	Following an increase in complaints over the last 4 months, the latest month continues to show a downward trend. The focus is on ensuring timely response & learning, Communication remains the significant trend in the complaints received & remains a priority improvement in the delivery of our Quality strategy.	For information	NA
MRSA	Bacteraemia reported in December, rolling 12 months we have reported 3 bacteraemias. The RCA & learning from the December case is underway, there is a focus on management & documentation of intravenous devices.	For information	NA
Delivering at home or the birthing unit	7.1% of women delivered in the birth unit & 1% had a home birth against a target of 20%. Staffing pressures have impacted on pathways & periods of closure of the birthing unit.	For information	Staffing modelling demonstrates an expected improved staffing trajectory from Q4 (covid permitting)
Breast feeding rates	PAH successfully passed the Baby Friendly Initiative (BFI) re-assessment, which took place in November '21.	For recognition	NA
C-section (Planned)	Our planned c-section rate has shown a sustained level of increase over the last 6 months. Work to improve the elective c-section pathway is underway & includes the plan to appoint a midwife consultant with a public health & midwifery led care.	For information	NA

KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
Complaints	Dec 21	22	25			18	2	33
Compliments	Dec 21	15	50			132	-109	373
PALS	Dec 21	208	none			281	146	416
Complaints closed within target	Dec 21	7	none			5	-4	14
% of complaints where an extension has been agreed	Dec 21	39%	none			41%	4%	78%
Mixed Sex Accommodation Breach	Dec 21	2	0			7	-4	18
Serious Incidents	Dec 21	1	none			5	-4	14
MSSA	Dec 21	1	none			1	-1	3
CDIFF	Dec 21	1	none			5	-2	12
Hand Hygiene	Dec 21	98%	none			92%	74%	110%
eColi	Dec 21	2	none			1	-2	4
Klebsiella	Dec 21	0	none			1	-1	3
Pseudomonas	Dec 21	0	none			0	-1	1
Falls per 1000 bed days	Dec 21	6	9			9	6	11
Falls total minor, moderate & severe	Dec 21	23	13			25	12	38
Pressure Ulcers per 1000 bed days	Dec 21	5	3			4	1	8
Pressure Ulcers: grade 3, 4 & unstageable	Dec 21	3	3			4	-3	10
Total number of mothers delivering in birthing unit/home	Dec 21	8%	20%			11%	0%	22%
Number of mothers delivering in Labour Ward/Theatres	Dec 21	91%	75%			88%	76%	101%
Number of women due to deliver at PAH adjusted for misc/TOP	Dec 21	325	375			334	278	389
Smoking rates at booking	Dec 21	11%	none			9%	4%	14%
Smoking rates at delivery	Dec 21	9%	6%			10%	5%	15%
Breast feeding rates at delivery	Dec 21	73%	74%			75%	66%	85%
Total Planned C-Sections	Dec 21	20%	none			15%	8%	23%
Total Unscheduled C-Sections	Dec 21	21%	none			18%	13%	24%

Patients

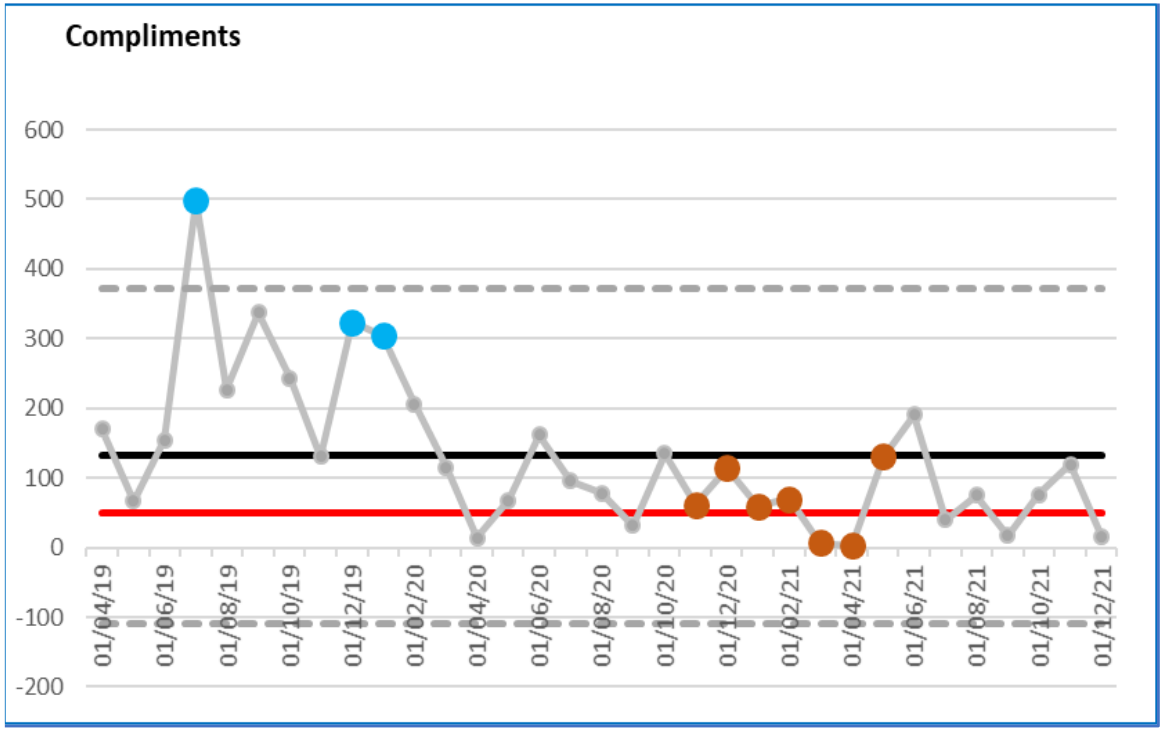
KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
PPH over 1500mls	Dec 21	3%	none			4%	1%	7%
CTG training compliance midwives	Dec 21	70%	85%			67%	46%	87%
CTG training compliance doctors	Dec 21	73%	85%			73%	47%	99%
Still births	Dec 21	1	none			1	-1	3
Patients detained under MHA	Dec 21	0	none			0	-1	2
Patients detained under section 136	Dec 21	1	none			1	-2	3
Mental health patient incidents	Dec 21	7	none			11	-1	23
Mental health patient complaints	Dec 21	1	none			0	-1	1
Mental health patient PALS	Dec 21	4	none			1	-1	4
Patients with LD and Autism accessing inpatient services	Dec 21	29	none			25	0	49
Patients who died in their preferred place of death	Dec 21	60%	none			57%	21%	92%
C-DIFF Hospital onset healthcare associated	Dec 21	0	none			2	-3	7
C-DIFF Community onset healthcare associated (Acute Admissio	Dec 21	0	none			1	-1	3
C-DIFF Community onset indeterminate association (Acute Adm	Dec 21	0	none			1	-1	3
C-DIFF Community onset community associated (No acute conta	Dec 21	1	none			1	-3	5
Covid-19 new positive inpatients	Dec 21	169	0			128	-134	391
MRSA	Dec 21	1	0			0	0	1





Dec-21
22
Variance Type
Common cause variation
Target
25
Target Achievement
Hit & miss target subject to random variation

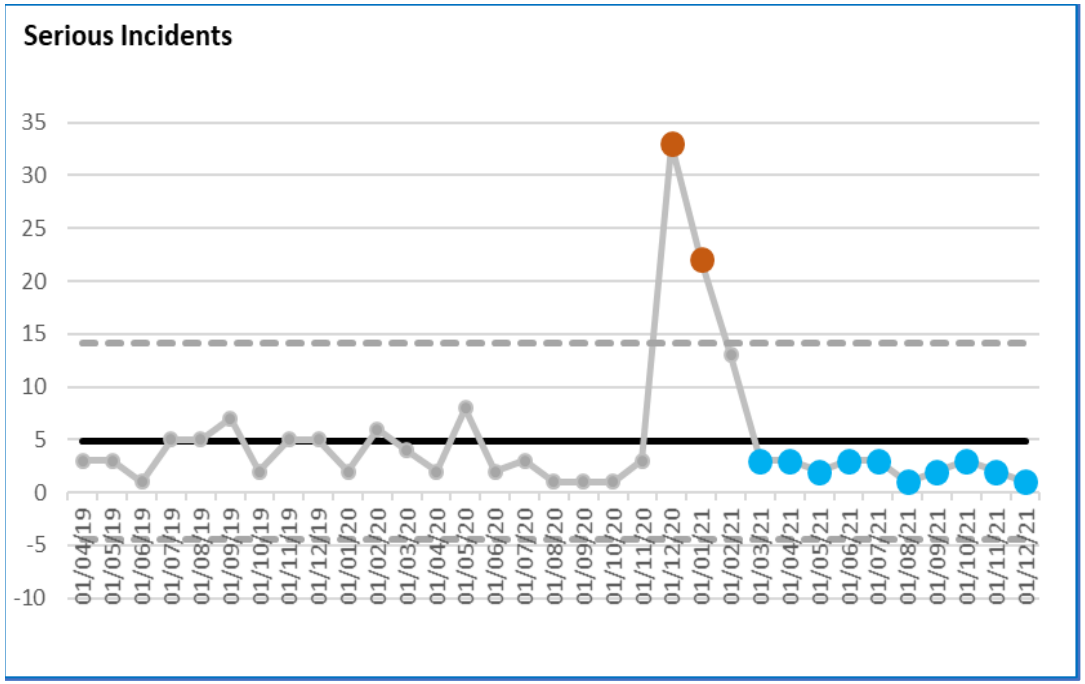
Background	What the chart tells us	Issues	Actions	Mitigation
Complaints	Common cause variation in alignment with other evidence we are receiving of a surge in feeedback.	Complaints increase reflects operational issues.	Following a increase in complaints over the last 4 months, the latest month continues to show a downward trend. The focus is on ensuring timely response & learning, this is supported by the patient experience team & divisional leadership teams. Communication remains the significant trend in the complaints received & remains a priority improvement in the delivery of our Quality strategy.	No further action required.



Dec-21
15
Variance Type
Common cause variation
Target
50
Target Achievement
Hit & miss target subject to random variation

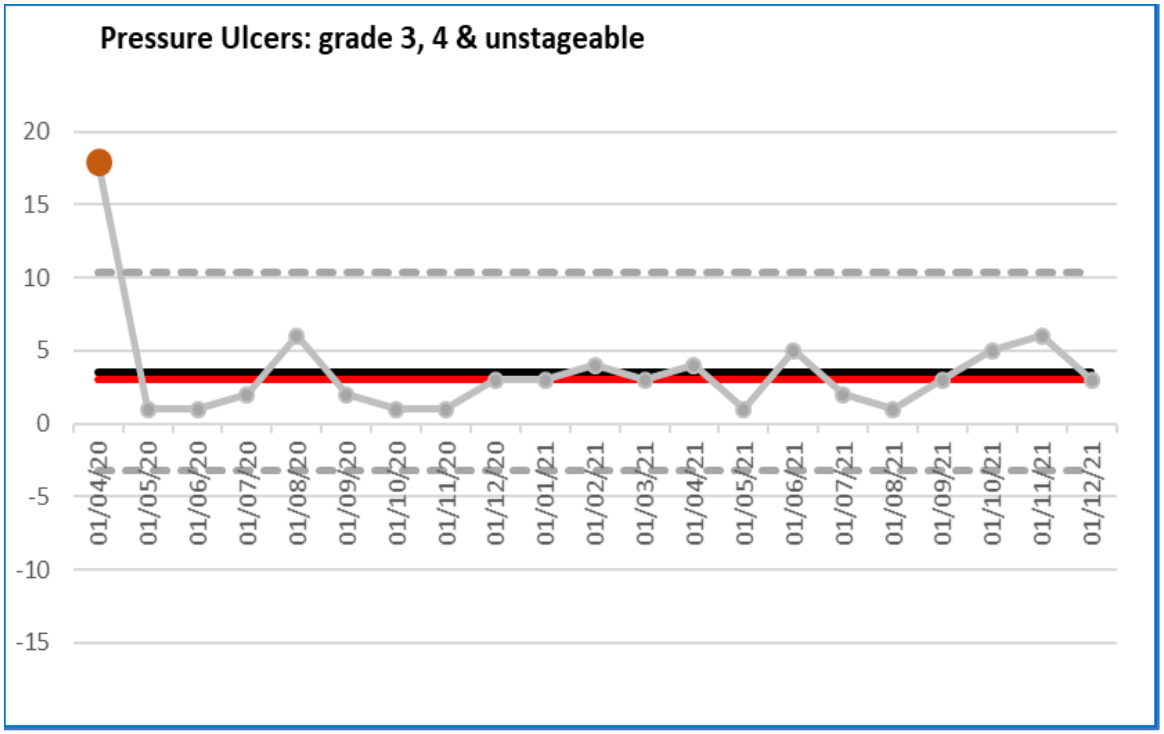
Background	What the chart tells us	Issues	Actions	Mitigation
Compliments	Common cause variation while hit & missing the target	During the last 12 month compliments have seen a decline, now stabilised.	None needed	None needed at present.

Patients



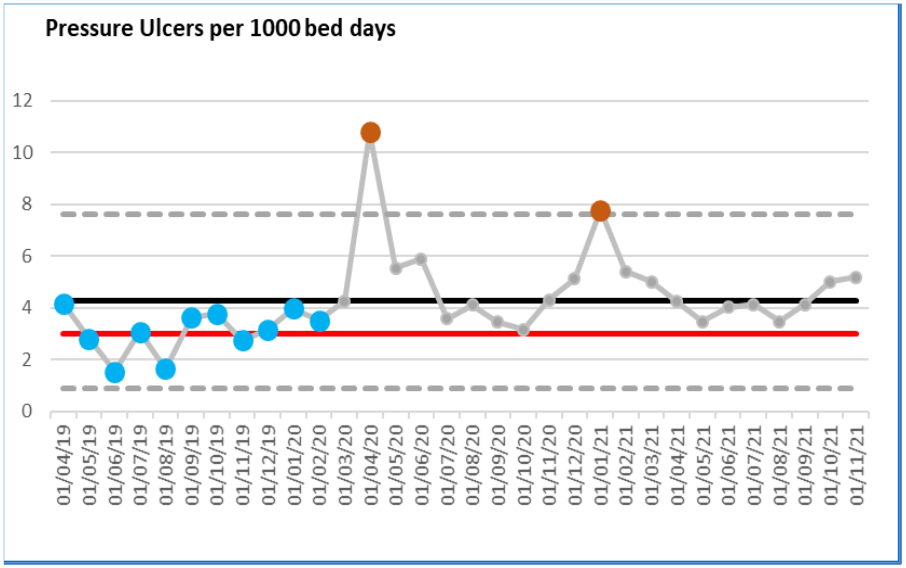
Dec-21
1
Variance Type
Special cause improving variation
Target
The trust does not have a target submission no. for SIs each month
Target Achievement
Our level of serious incidents reported per month is consistent & within our tolerance range

Background	What the chart tells us	Issues	Actions	Mitigation
Serious Incidents (SIs)	Trust reporting numbers for serious incidents raised each month is consistent & within the internally set tolerance range	The significant spike seen during the winter months 20/21 was associated with nosocomial Covid-19 hospital infections during wave 2 of the pandemic. We do not expect to see this replicated in future months.	Incident management group meets twice a week to review new incidents & those with completed investigations. Where an incident meets the national reporting criteria to be raised externally as a serious incident it will be raised. During December 2021 the trust raised one SI that will be completed with system partners. In December six SIs were closed. The trust has 18 investigations for serious incidents open.	Daily local review of incidents by each divisional team is completed with appropriate second stage review at the incidents management group. IMG submits a monthly report on both incident themes & serious incidents onto the Patient Safety Group.



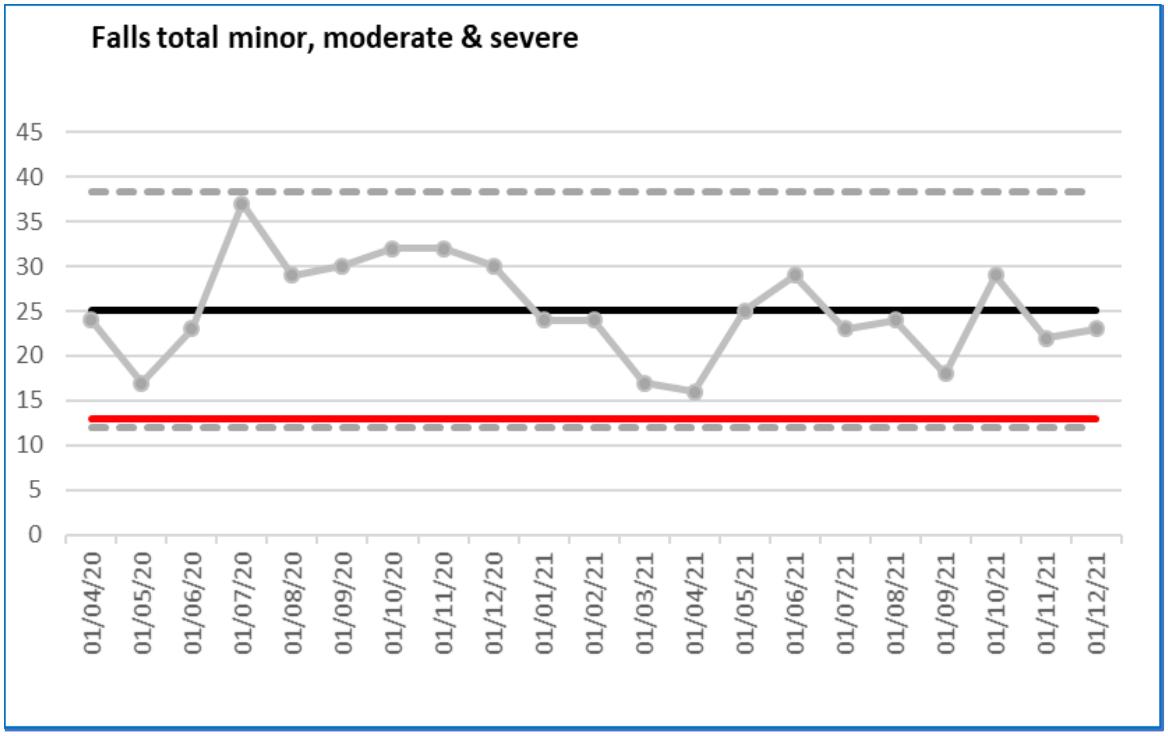
Dec-21
3
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers: grade 3, 4 & Unstageable	Common cause variation while hit & missing the target	Three moderate harms	Three moderate harms with ongoing investigation & all remaining were minor harms. Eleven pressure ulcers were medical device related, attributable to O2 devices, ET tube, nasogastric tube, saO2 probe & stockings. TVNs will conduct an SSKIN audit & feedback will be provided to the ward managers & matrons/ADDON for action planning.	The Trust has now 42 tissue viability link practitioners who are developing projects in their area around pressure ulcer prevention.



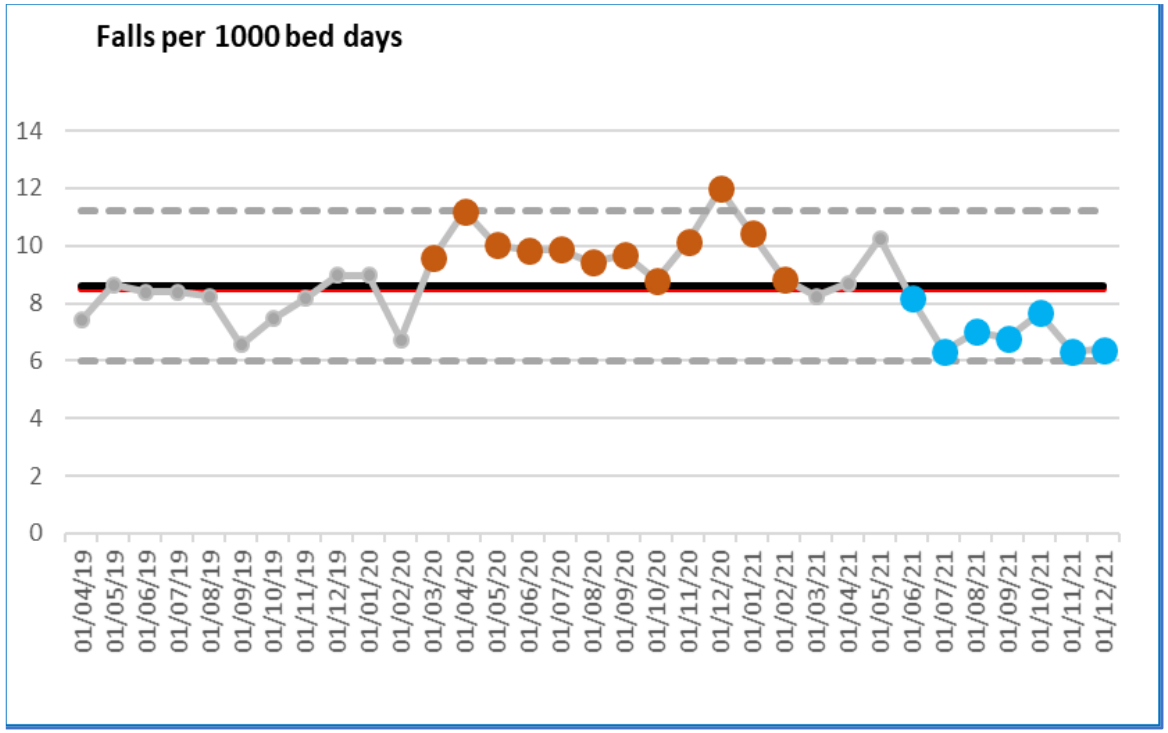
Nov-21
5.19
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers per 1000 bed days	Common cause variation while hit & missing the target	There were a total of 61 pressure ulcers in December, 4 less than November. Of those 61 PUs, there were a total of 46 patients injured, meaning 12 patients sustained more than one pressure ulcer during admission, the higher being one patient with 6 pressure ulcers (COVID pneumonitis patient in ITU due to prolonged hours of proning, sadly passed away). Three moderate harms with ongoing investigation & all remaining were minor harms. Eleven pressure ulcers were medical device related, attributable to O2 devices, ET tube, nasogastric tube, saO2 probe & stockings.	The highest number of hospital acquired pressure ulcers were from ITU/ Henry Moore (COVID) with a total of 19 pressure ulcers. These were mainly sustained to face, chest & knees due to prolonged hours of proning. Intensive care unit is still in the process to trial proning patients directly on dolphin mattress as opposed to face cushions to attempt & reduce the number of PUs. Tye Green ward followed with 12 pressure ulcers in total. TVNs will conduct an SSKIN audit and feedback will be provided to the ward managers & matrons/ADDON for action planning. TVNs are aware of the shortage of staff during December; this could possibly have impacted in the number of hospital acquired pressure ulcers.	The Trust has now 42 tissue viability link practitioners who are developing projects in their area around pressure ulcer prevention. All pressure ulcer prevention resources are available via Alexnet, Youtube, ward folders & X drive.



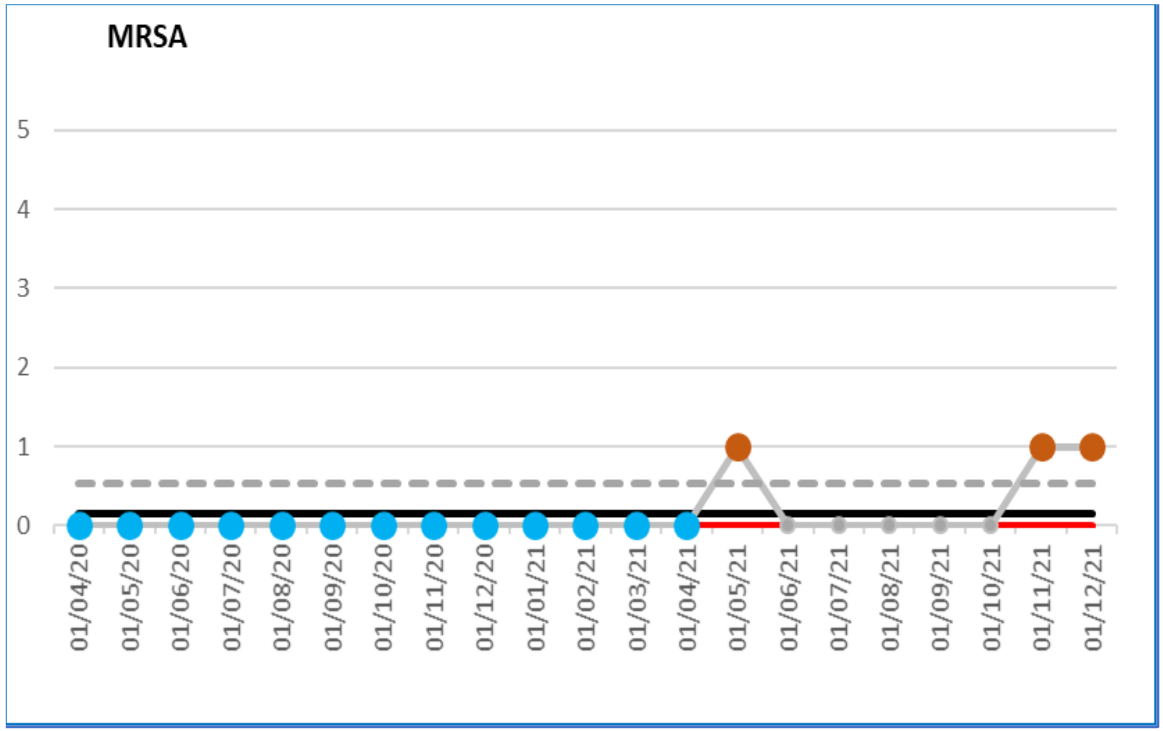
Dec-21
23
Variance Type
Common cause variation
Target
13
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Falls total minor, moderate & severe	Common cause variation & hit and miss target subject to random variation	The Trust's falls action plan aim is to reduce falls with harm by 50% by the end of March 2022	1. Strategic falls action plan is in place 2. The Enhanced Care programme is being embedded across the Trust 3. Falls awareness training is mandatory for all nursing, care & AHP staff & current compliance is 90% 4. The STOPIT initiative is being rolled out across the Trust (initiative to de-prescribe culprit medications)	No mitigating factors at this time



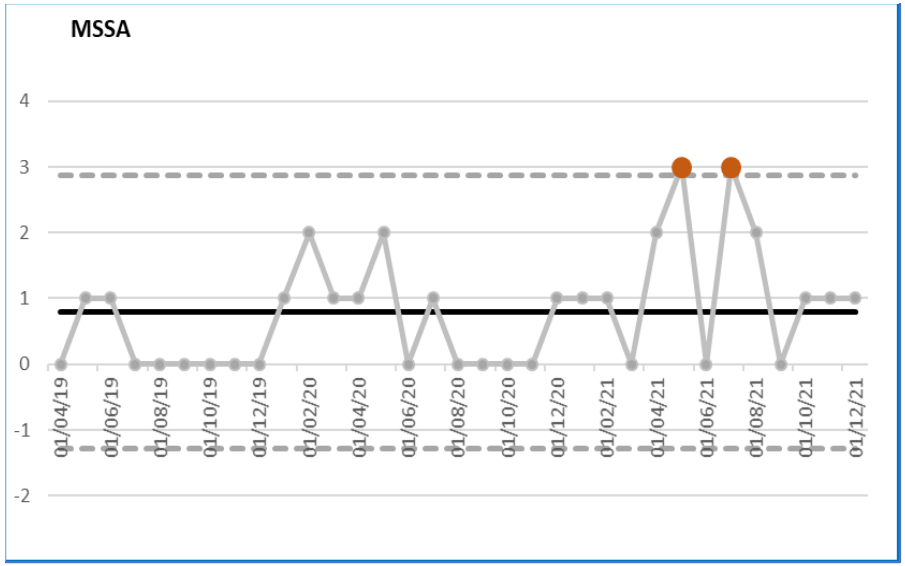
Dec-21
6.37
Variance Type
Special cause variation
Target
8.5
Target Achievement
Hit & miss target subject to random variation

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



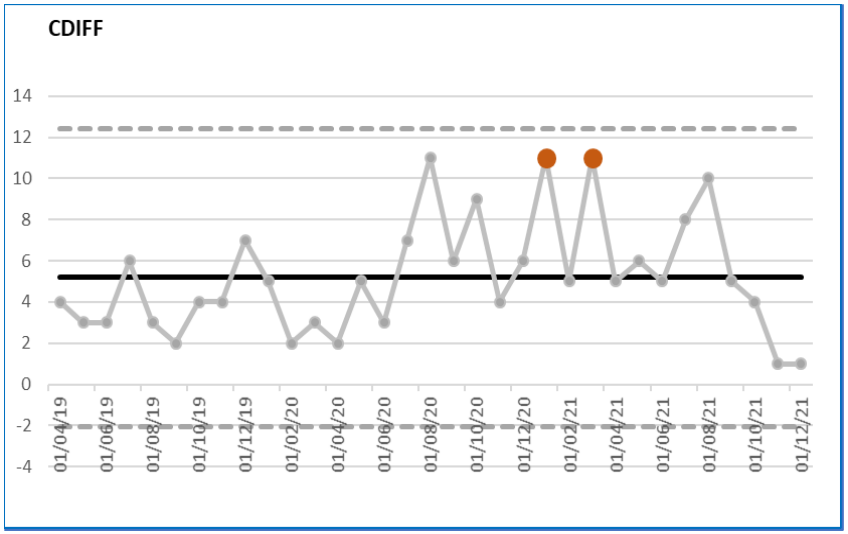
Dec-21
1
Variance Type
Special cause variation
Target
0
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
MRSA	Special cause concerning variation		1. RCA and learning from December MRSA bacteraemia underway 2. Focus on management ad documentation of intravenous devices (see MSSA information) 3. Actions and learning overseen by the Infection Prevention and Control Committee.	



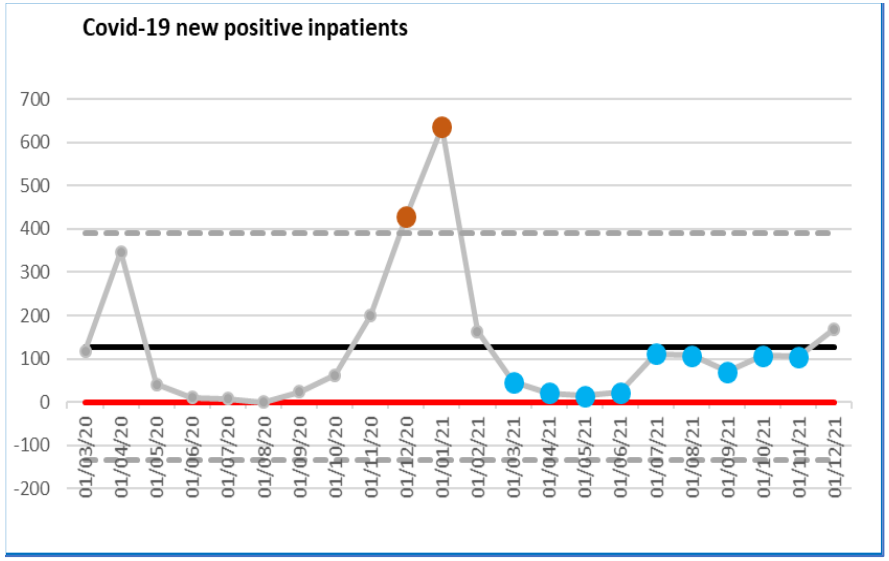
Dec-21
1
Variance Type
Common cause variation
Target
None
Target Achievement
N/A

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



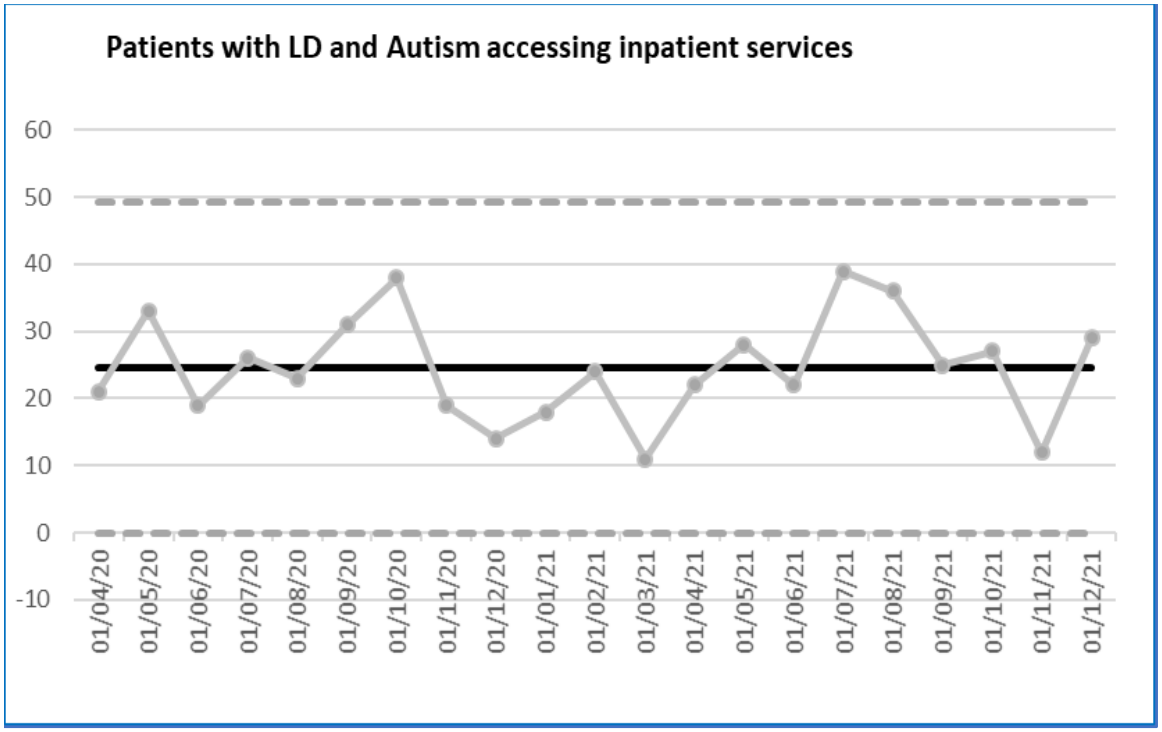
Dec-21
1
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

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



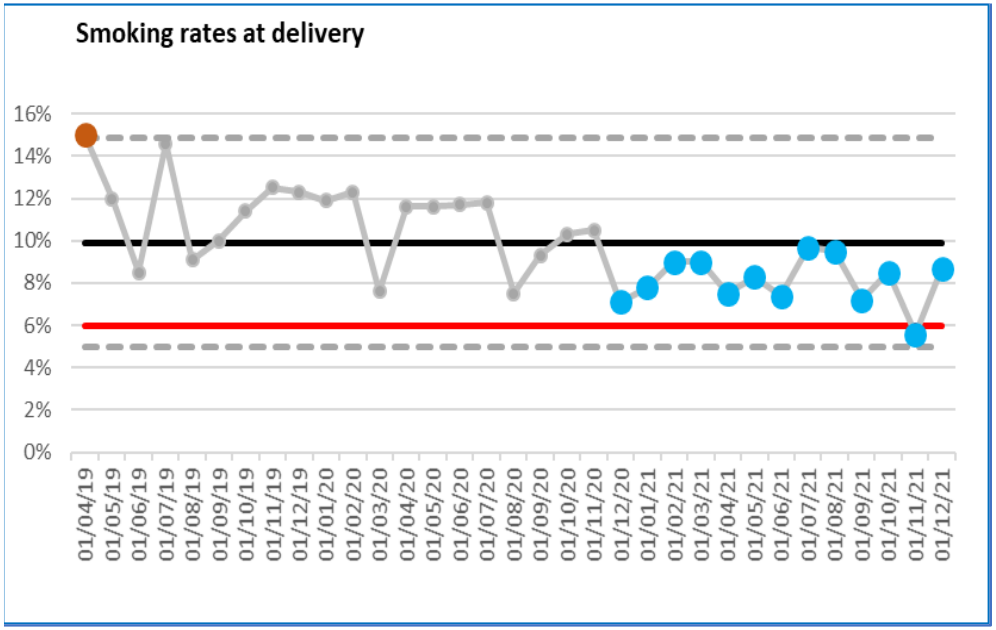
Dec-21
169
Variance Type
Common cause variation
Target
0
Target Achievement
Hit & miss target subject to random variation

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



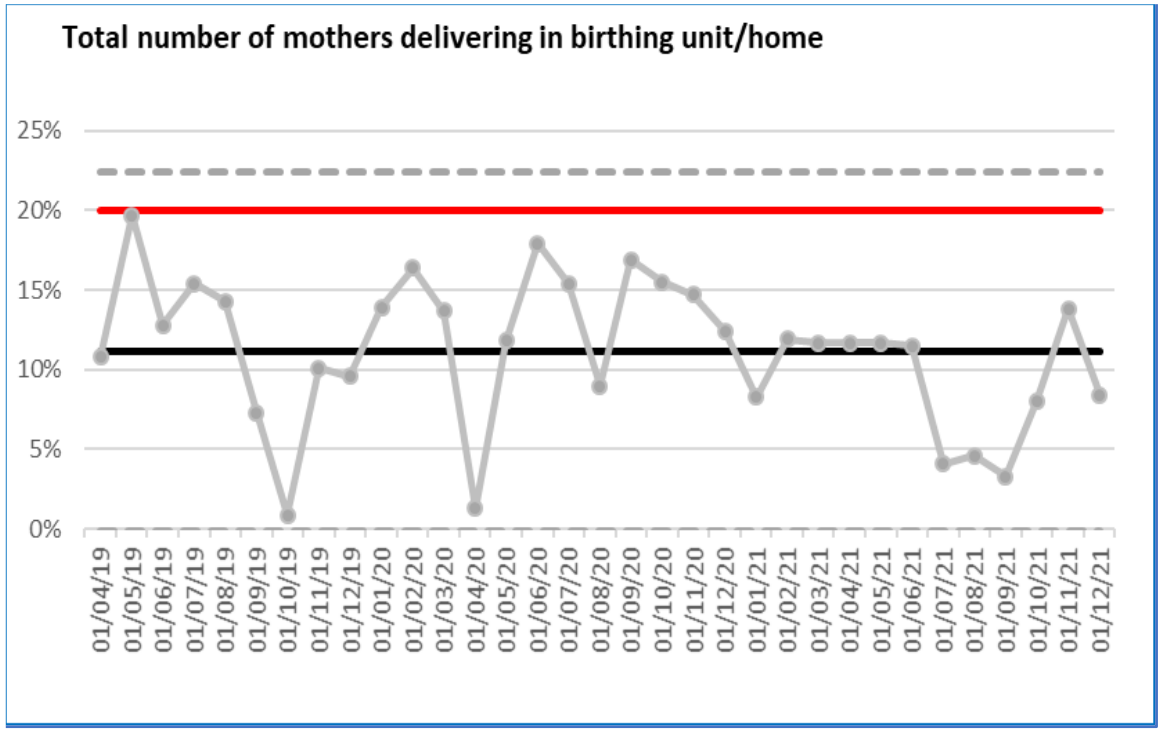
Dec-21
29
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
Patients with learning disabilities & autism accessing inpatient services	Common cause variation	The number of patients with LD will continue to fluctuate especially as the recovery programme continues. Work continues to ensure LD patients are able to access services & provide feedback on their experience.	LD steering plan in place supporting the work of the Learning Disability Nurse. LD nurse supporting with upskilling of enhanced care team	Nil required



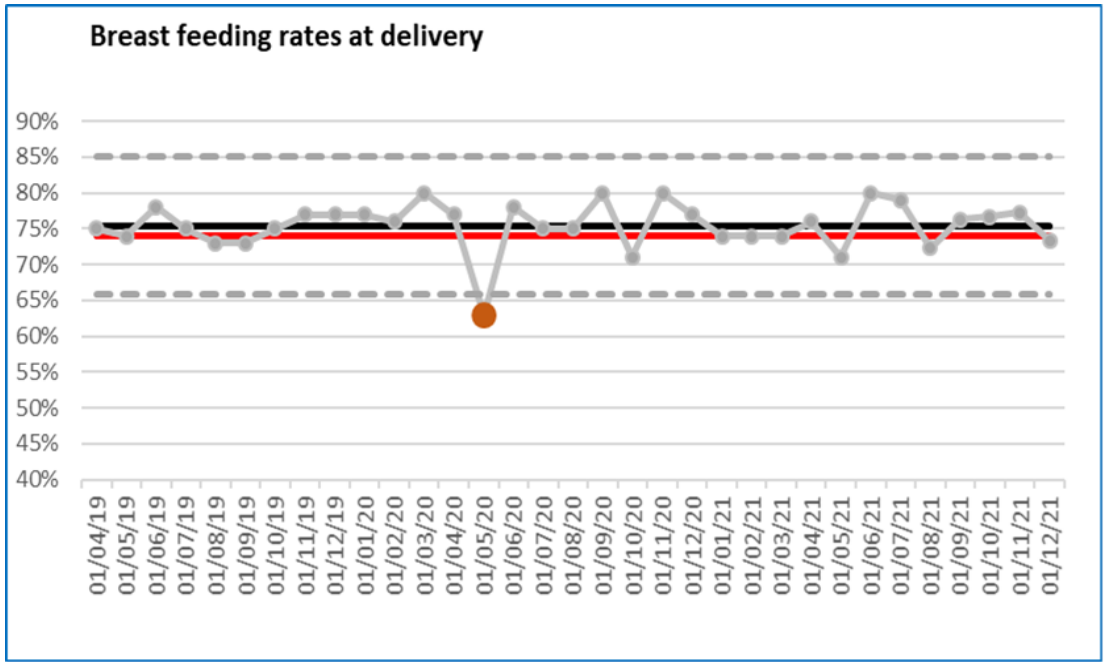
Dec-21
8.4%
Variance Type
Special cause variation
Target
6%
Target Achievement
Hit and miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Smoking rates at delivery	Special cause variation and inconsistently hit & missing target	Smoking rates at delivery	The smoking at delivery rate for December '21 was 8.7%, compared to the target of <6%.set by the LMNS.	A Healthy Lifestyles midwife is in post, with the remit of improving services & pathways for smoking in pregnancy. PAH have recently received 12 months of funding to provide an in house stop smoking service rather than to refer all women externally to PROVIDE. A Memorandum of Understanding between the West Essex & Hertfordshire CCGs is in place, to ensure each organisations role & responsibilities are set out.



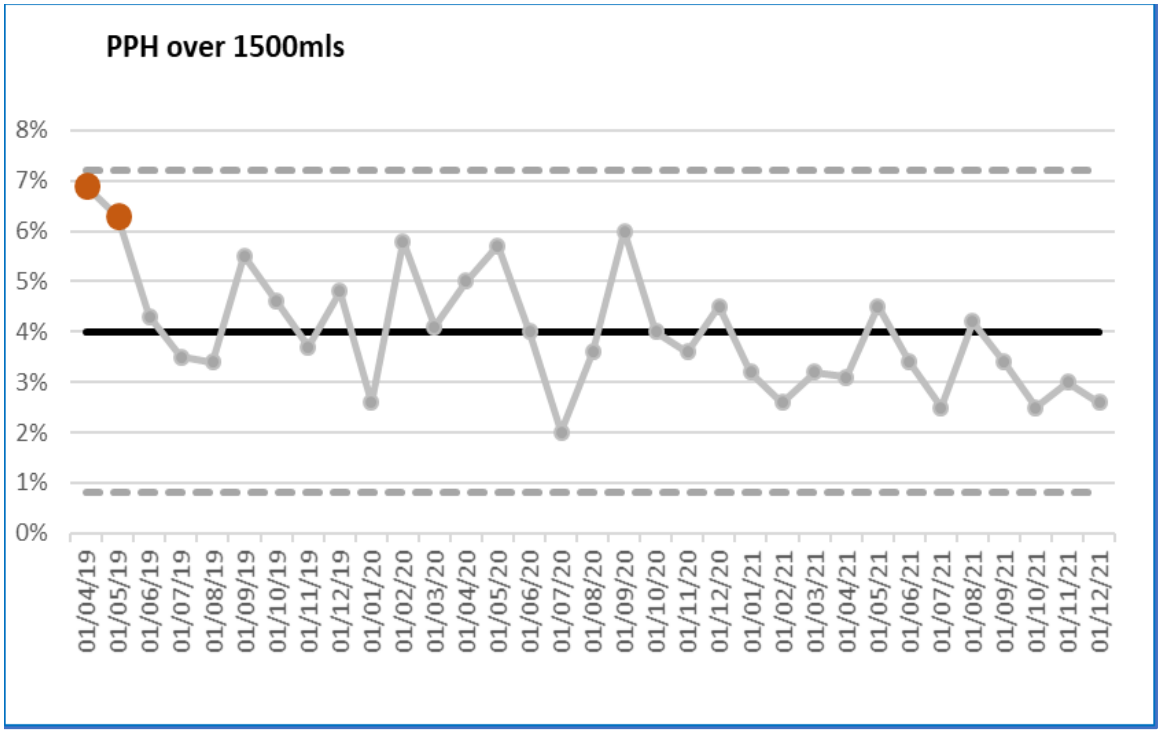
Dec-21
8.4%
Variance Type
Common cause variation
Target
20%
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Total no. of mothers delivering in birthing unit/home	Common cause variation & hit & missing target	Mothers delivering in birthing unit/home	7.1% of women delivered in the birth unit & 1% had a home birth. Periodic closure of the birth centre to maintain safe staffing.	Midwives are being re-deployed to the most appropriate area in terms of maintaining safe staffing levels.



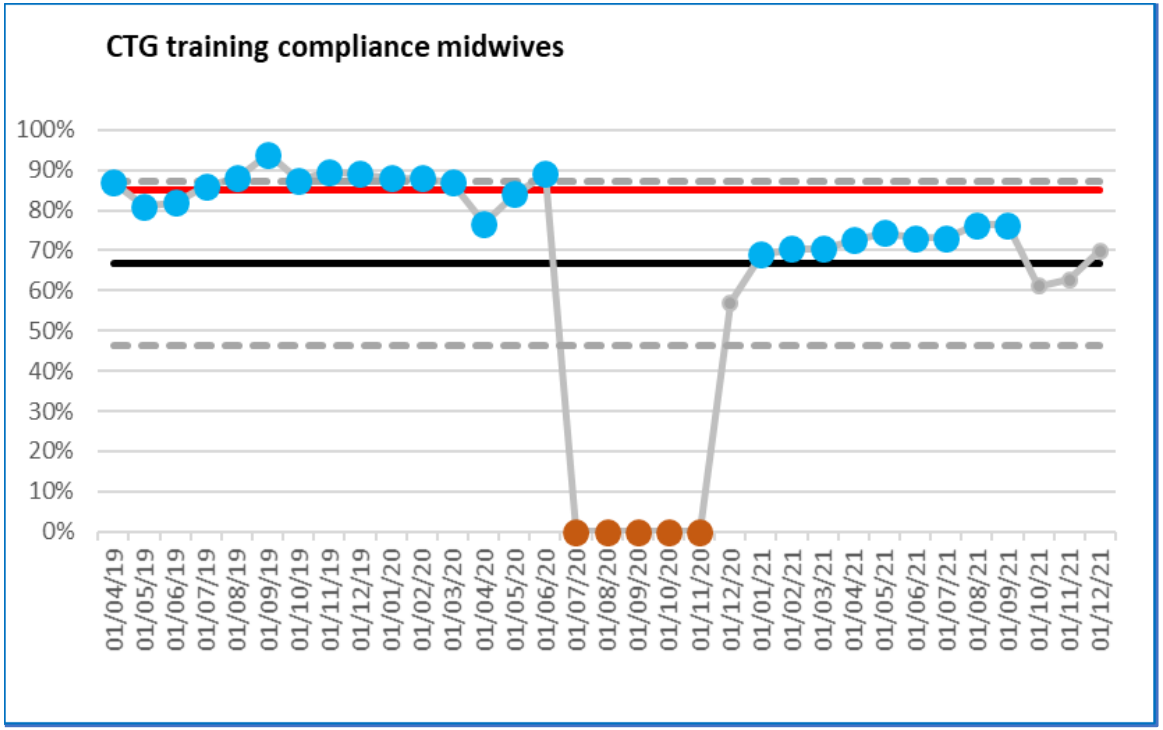
Dec-21
73.4%
Variance Type
Common cause variation
Target
74%
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Breast feeding rates at delivery	Common cause variation & inconsistently hit & missing target	Breast feeding rates at delivery	73.4% of PAH delivered women breast feeding at delivery in December '21, compared to the latest National Average rate of 73.6% (NMPA Audit 2019). PAH successfully passed the Baby Friendly Initiative (BFI) re-assessment, which took place in November '21. The Assessment Report has made recommendations for improvement including; assisting Mums with a baby in NICU to effectively express their breastmilk, enabling mums to be able to discuss what responsive breast feeding is & knowing about caring & loving relationships.	We currently have BFI Level 3 accreditation & the assessment was a reaccreditation to maintain our Level 3 status. An action plan is being developed focusing on 3 areas of improvement.



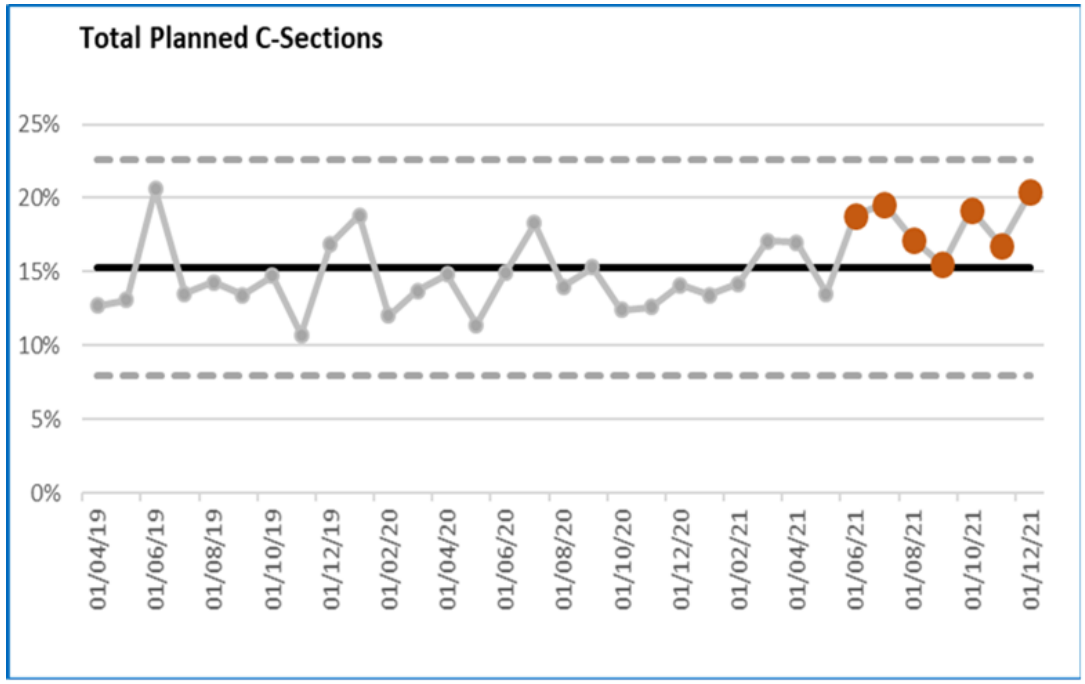
Dec-21
2.60%
Variance Type
Common cause variation
Target
Not set
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
PPH over 1500mls	Common cause variation	PPH over 1500mls	The massive PPH rate for December was 2.6%, compared to 3.0% in November. This is below the latest reported National Average 2.9%.	A 'massive obstetric haemorrhage action plan', developed in partnership with Watford & Lister Hospitals, is in place % the rate is continuously monitored. A new work stream group has been commenced to look at any further actions that may be applied.



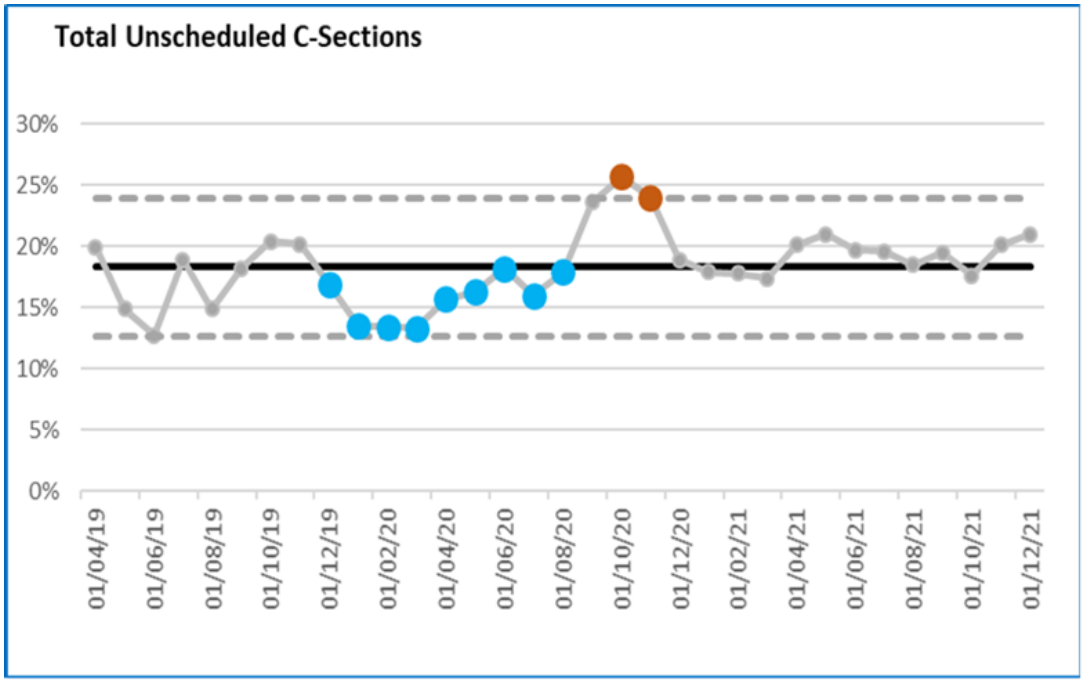
Dec-21
69.9%
Variance Type
Common cause variation
Target
85%
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
CTG training compliance midwives	Common cause variation & inconsistently hit & missing target	Compliance with CTG training for midwives below trajectory	The Midwives CTG Training compliance rate has increased by 7.1% to 69.9% for December (123/176 midwives). 44 additional Midwives have attended their Fetal Monitoring Study Day but have not yet passed the competency & another 9 midwives are booked to attend.	The CTG Specialist Midwife has a plan in place, including trajectory targets, to achieve full compliance by the end of March 2022. All outstanding RMs & obstetricians have been given a deadline of 14 Jan '22 to complete their assessment.



Dec-21
20%
Variance Type
Special cause variation
Target
None
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
Total Planned C-Sections	Special cause variation	There has been an increase in elective caesarean sections in month	A workforce review has been completed with a new role of Consultant Midwife planned to lead on public health & midwifery led care. The remit will include a weekly dedicated birth choices & vaginal birth after caesarean clinic (VBAC), with the aim to improve elective caesarean section pathways.	Birth choices & VBAC clinics are provided by a midwifery matron within their substantive role, as when is required. The birth choices clinic is supported by a consultant obsetrician.



Dec-21
21%
Variance Type
Common cause variation
Target
None
Target Achievement

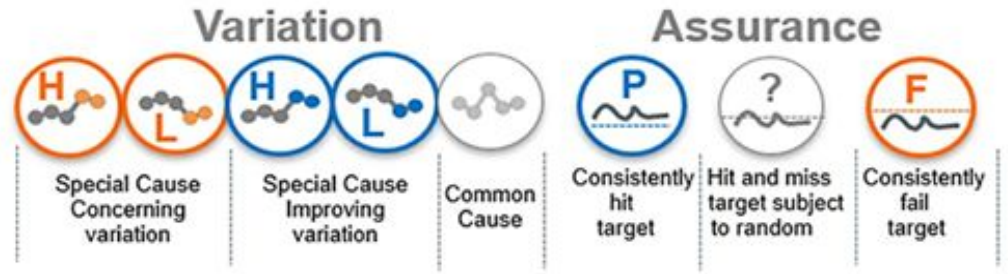
Background	What the chart tells us	Issues	Actions	Mitigation
Unplanned C-Sections	Common cause variation	Increase in emergency caeserean section rate	A job request was submitted to Cambio EPR (Electronic Patient Record) provider for the implementation of the use of the Robson Criteria within the maternity EPR system. The Robson criteria is a global standard for assessing, monitoring and comparing caesarean section rates locally and across organisations.	The Division are implementing a multi disciplinary team working group to review caesarean section rates which will report directly into the maternity improvement board for oversight and assurance.

Places

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

Places Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Domestic	The NSC scores have reached the national standards compliance. Transformation Domestic programme for model hostpital data we have now reduced our cleaning costs as shown in model hospital date on average of nearly 10% per sqm	For information	ongoing
Housekeepers	Ongoing recruitment for housekeepers & training in situ weekly meetings for the task & finish group for housekeepers,Bsse number is 51.72wte - currnetly in post 27.7wte, currently going through the recuritment process is 11.4wte, number of housekeepers vacancies 12.62wte still to recurit. The electronic meal ordering system is now being carried forward & dates for trials will be shared in the coming weeks.	For increased visibility and awareness	Jun-22
Catering	Catering manager will be leaving the trust on the 28th January 2022, interviews for Chef production manager 27th January 2022 & the Catering manager role to be reviewed to fit with the needs of the business	For increased visibility and awareness	ongoing
Porters	The recruitment of a 5th portering supervisor has been appointed & now waiting for offical start date. Review of the complete servcies is now underway & an update in the next meeting to move forward.	For increased visibility and awareness	ongoing
Communication for patients	There is atrust wide project to work with all HCGs to streamline methods of communication with patients & more departments to use Synertec & Dr. Doctor to reduce the cost of Royal mail & reduce paper costs reduction in carbon footprint & sustainability.	For recognition	Sep-22
Property servcies	Working with finance to complete the lease information IFRS 16 submission for costs associated	For increased visibility and awareness	TBC
Estates and Capital risks	Nurse call system upgrade due completion by Mar-22	For information	Mar-22
	Medical gas AVSU/Flow meters installation works are further impacted due to Covid/ Winter pressures & a revised programme due early Feb-22 (equipment purchase completed)	For information	Feb-22
	Revised reduced scope for Butterfly unit agreed, orders raised & awaiting programme of works to complete by end of March	For information	Mar-22
	Feasibility works for Maternity wards refurbishment are currently progressing & awaiting outline costings by end of Jan – outline scope led by project development team including lead architect & mechanical, electrical & plumbing engineers to support HCG to develop full business case with decant solution	For information	Jan-22

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Estates Responsiveness (Priority 2 - Urgent)	Dec 21	96%	95%			95%	91%	99%
Meals Served	Dec 21	41680	42120			37190	27415	46965
Catering Food Waste	Dec 21	3%	4%	L		5%	-1%	11%
Domestic Services (Cleaning) Very High Risk	Dec 21	98.4%	98.0%			97.6%	94.0%	101.3%
Domestic Services (Cleaning) High Risk	Dec 21	99.0%	95.0%			96.6%	93.2%	100.1%

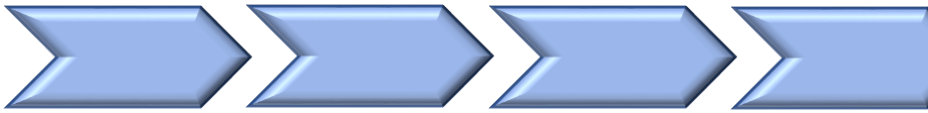


Performance

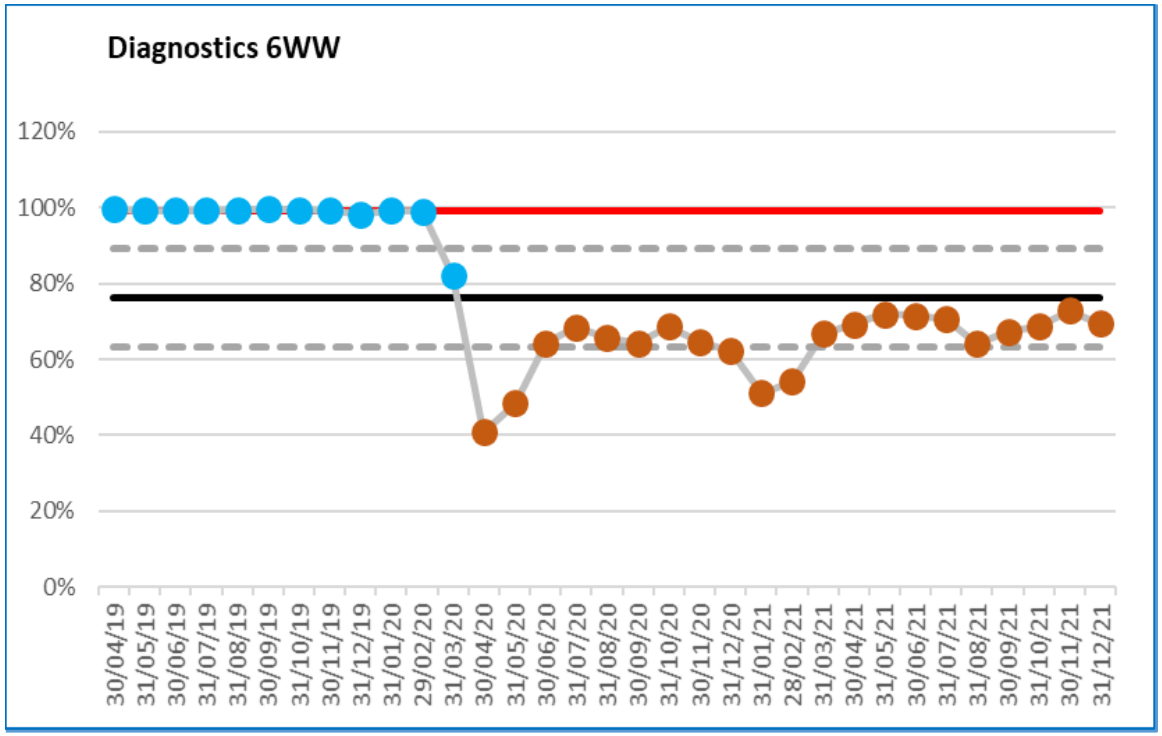
*We will meet & achieve **our performance** targets, covering national & local operational, quality & workforce indicators.*

Performance	Board Sub Committee: Performance & Finance Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
2 week wait referral & 28 day diagnosis standard	The November 2ww performance shows a continued improvement from September & October. Breast has seen significant increase in referrals due to national media interest & additional capacity is in place & average 2ww booking time is better than other local Trusts. Upper & Lower GI 2ww performance is static but significant increases in 28 day diagnosis standard have been made (~20%). Skin first appointment & diagnosis standard are poor due to increased referrals & reduced capacity. Routine capacity converted to cancer & new referral triage process will improve performance. Clinical risk is mitigated as skin has achieved the 62 day treatment standard all year & was very close in November. Urology 28 day performance is of concern due to significant increase in numbers of patients & increasing complexity of patients requiring diagnostics in theatres rather than as out-patients. Additional capacity is being sourced wherever possible & clinicians agreed to work at weekends.	For information	28/02/2022
62 day performance & patients waiting longer than 62 days (backlog)	62 day performance is poor due to the focus on treating the longest waiting patients first, 19 of 40 patients treated with cancer had waited longer than 62 days. This is reflected in the decrease in the number of patients waiting longer than 62 days, from 277 at the end of October to 199 at the end of November. Further cancer information staff & a pathway project manager will ensure that sustainable improvements are put into place in early 2022. Elective operating for treatments & diagnostics are being maintained but are limited by the availability of only 6 in-patient beds & no elective critical care capacity. Alternative providers are being sourced where possible, e.g. The Wellington which have critical care facilities. The recovery trajectories are being revised to take into account the impact of the current Covid-19 wave.	For information	31/03/2022
Urgent Care Standards	Significant changes to support both winter urgent care & the Omicron Covid wave have been implemented during December. The aims were to increase emergency in-patient capacity both acute & community, increase discharge of medically fit patients (without criteria to reside) & improve flow through urgent treatment facilities. The Trust has converted the new Training & Education facility into an Urgent Treatment Centre streaming service for both Covid & non Covid attendances which has ensured maximum number of patients streamed to GP & UTC services away from the emergency department. Staffing vacancy during the latter half of December has been high & impacted the timeliness of services but the UTC streaming has mitigated the impact of staffing vacancy. Small improvements in a most urgent care standards can be seen including in the 4 hour standard and ambulance handovers.	For information	N/A
104 week breaches	The ICS set an aim to have no routine patients waiting longer than 104 weeks by 31st December (national aim 31/3/22). The preparations for Omicron & the staffing vacancy levels impacted the Trust's achievement of this aim, however we did reduce patients waiting longer than 104 weeks from 48 to 21. The 21 have close tracking & have appointments or procedures booked. The Trust is also monitoring future 104 week breaches to ensure they have expedited treatment & do not reach 104 weeks.	For information	31/03/2022
DM01	MRI performance has improved by 10% on November. Some routine referrals have been cancelled due to staffing absence from Covid. CT performance has deteriorated from 98% in Nov again due to staffing absence. Using Independent Sector & insourcing capacity whenever available. Also have high levels of unplanned & emergency demand. Non Obstetric Ultrasound static at 98%, staffing absence due to Covid will prevent the further improvement to 99% in January. Overall DM01 recovery – still hoped to be April, but will be Covid dependent & need to continue to improve service level diagnostics including Echos which we have limited insourcing capacity. Theatre capacity for the more complex service diagnostics is impacting recovery.	For information	30/04/2022

KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 1 metrics								
RTT incomplete	Dec 21	52%	92%			74%	69%	79%
RTT admitted	Dec 21	56%	90%			54%	26%	81%
RTT Non admitted	Dec 21	80%	95%			88%	85%	91%
RTT PTL vs RTT PTL & ASIs	Dec 21	84%	none			95%	92%	97%
Cancer 31 days First	Nov 21	96%	96%			94%	87%	101%
Cancer 31 days Subsequent Drugs	Nov 21	100%	98%			99%	93%	105%
Cancer 31 days subsequent surgery	Nov 21	100%	94%			93%	66%	120%
Cancer 2WW	Nov 21	73%	93%			83%	67%	100%
Cancer 62 day shared treatment	Nov 21	53%	85%			70%	50%	90%
Cancer 62 day screening	Nov 21	64%	90%			67%	15%	119%
Cancer 62 Day Consultant Upgrade	Nov 21	88%	90%			86%	66%	105%
Cancer 28 day faster diagnosis	Nov 21	61%	none			66%	51%	81%
4 Hour standard	Dec 21	66%	95%			75%	67%	83%
ED attendances	Dec 21	9592	none			8774	6883	10665
ED Admitted performance	Dec 21	32%	95%			50%	33%	67%
ED non admitted performance	Dec 21	74%	95%			83%	75%	91%
ED Arrival to Triage	Dec 21	70	15			45	28	62
ED Triage to examination	Dec 21	110	60			92	70	113
ED Examination to referral to specialty average wait	Dec 21	125	45			98	87	110
ED referral to be seen average wait	Dec 21	87	30			79	56	102
Seen by specialty to DTA	Dec 21	115	60			95	73	117
DTA to departure	Dec 21	369	30			186	82	291
Ambulance handovers less than 15 minutes	Dec 21	15%	100%			27%	15%	40%
Ambulance handovers between 15 and 30 mins	Dec 21	33%	0%			42%	34%	50%
Ambulance handovers between 30 and 60 mins	Dec 21	27%	0%			22%	12%	32%

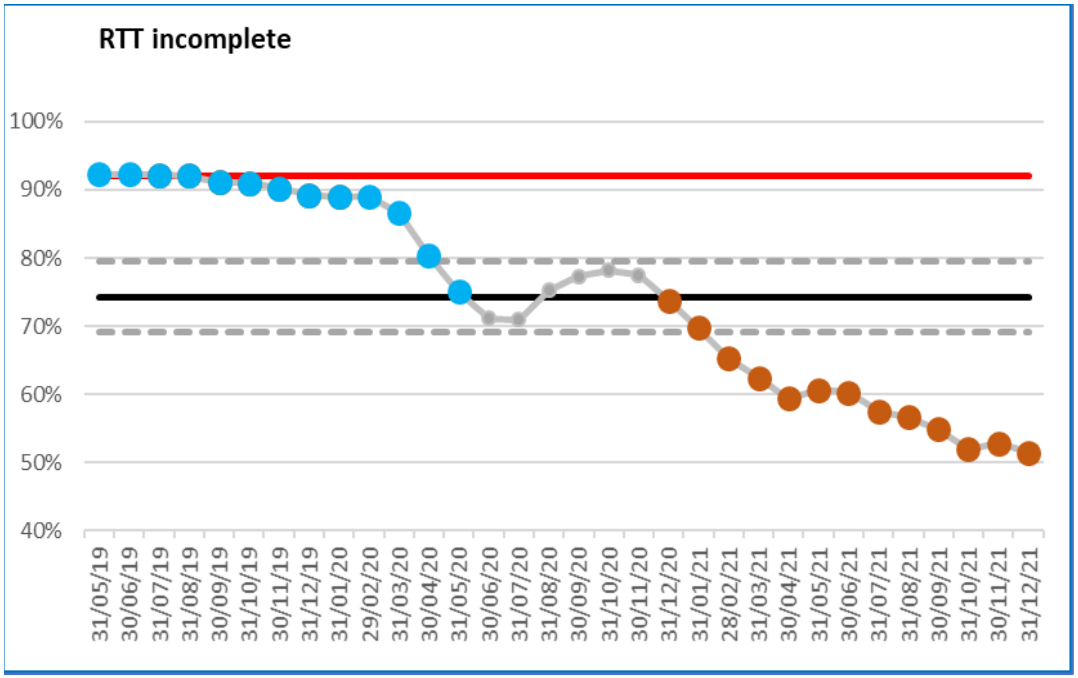


KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 2 metrics								
Ambulance handovers > 60 mins	Dec 21	26%	0%			9%	0%	18%
Diagnostics 6WW	Dec 21	69%	99%			76%	63%	89%
Occupied beds with stranded patients	Dec 21	167	80			146	95	196
Bed occupancy	Dec 21	92%	85%			88%	80%	97%
Discharges between 8am and 5pm	Dec 21	661	none			725	476	974
Discharges between 5pm and 8am	Dec 21	674	none			700	438	961
LOS non elective	Dec 21	4.2	5.1			3.8	2.8	4.7
LOS elective	Dec 21	2.9	4.2			2.3	0.5	4.0
Short Notice clinical cancellations	Dec 21	67	none			45	-29	119
OP new to follow up ratio	Dec 21	2.1	2.3			2.1	1.8	2.5
OP DNA Rate	Dec 21	5.6%	8.0%			4.8%	3.6%	6.0%
52 Week waits	Dec 21	2486	0			632	396	868
Proportion of Majors Patient treated within 4 hours in ED Paeds	Dec 21	59%	95%			81%	66%	97%
Super stranded patients	Dec 21	58	25			41	16	66
12 Hour waits in ED from Arrival	Dec 21	965	0			438	135	740
12 Hour Trolley waits in ED from DTA	Dec 21	197	0			44	-27	115



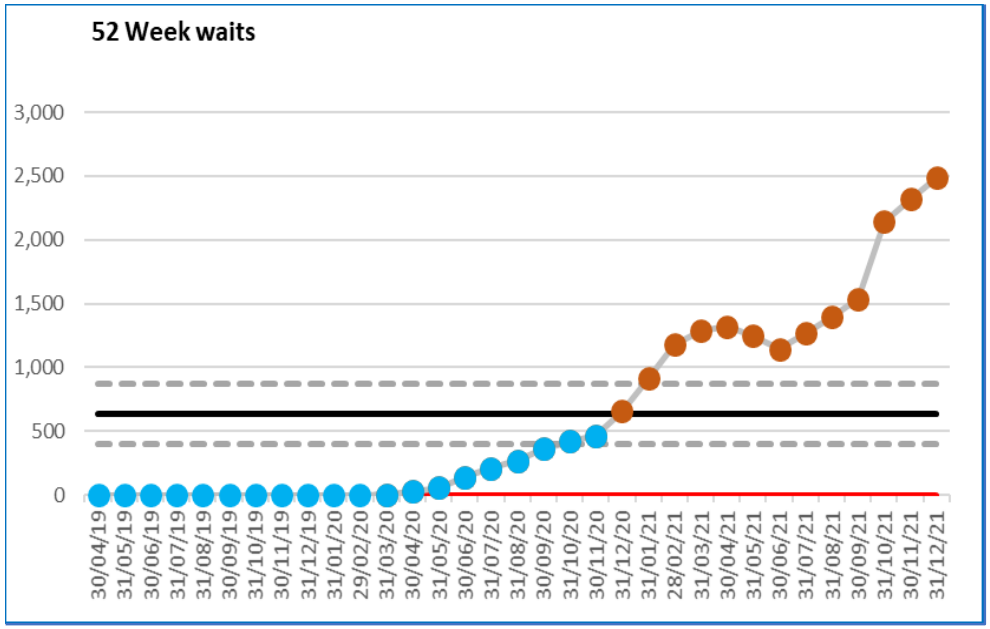
Dec-21
69.41%
Variance Type
Special cause variation
Target
99.00%
Target Achievement
Consistently failing target

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



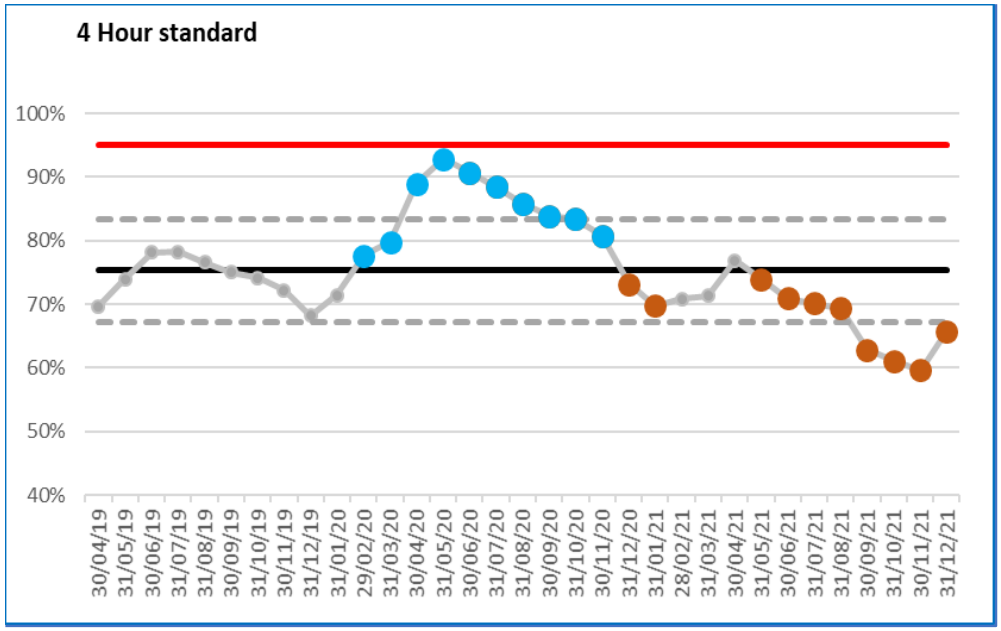
Dec-21
51.5%
Variance Type
Special cause variation
Target
92%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
RTT Incomplete	Special cause concerning variation and consistently failing target	The performance against the RTT standard has been below the target and statistical mean for 12 months as a result of covid activity pressure pausing elective activity which created a backlog of patients waiting longer than 18 weeks for first definitive treatment. The balance of emergency, elective and recovery remains an ongoing challenge	Admitted backlog being booked & treated in clinical order not chronological. Elective operating capacity significantly reduced in December due to bed & anaesthetist capacity however operating has continued. Virtual & face to face clinics & additional sessions being put on where possible including insourcing at PAH. Weekly oversight from healthcare groups. All specialties remain under constant review	Admitted backlog clinically prioritised. Non admitted - clinical priority booking at sub specialty level. Clinical Reviews of long waiting patients & harm reviews being put into place. Extensive outsourcing to Independent Sector of suitable patients.



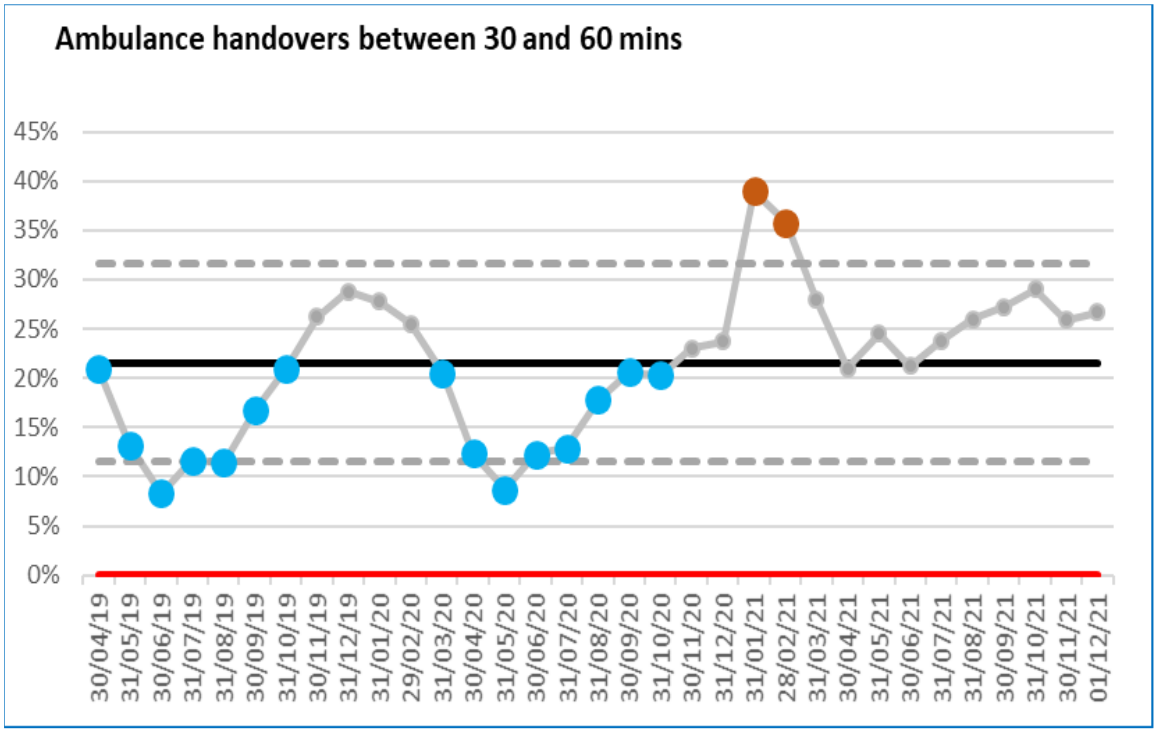
Dec-21
2486
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
52 week waits	Special cause concerning variation and consistently failing target	Booking in clinical priority order instead of chronological order has led to increasing numbers of long waiting lower priority patients. Modelling indicates number of 52 week patients will increase until March 2022. Balance between emergency & elective capacity is an ongoing challenge. Challenge of inpatient capacity & space, anaesthetic workforce availability & ongoing covid pressures will & has impacted on the speed of recovery	All patients over 78 weeks increased in priority to P3 & patients that will be over 104 weeks by 31/3/22 being prioritised along with urgent & cancer patients. Ongoing outsourcing of lower clinical priority patients to Independent sector. Working with ICS colleagues to develop a sustainable solution to support elective surgery through periods of emergency pressure by bidding for 22/23 elective recovery capital. Elective ward capacity reduced to 6 beds which are mainly used for cancer & 104 week patients. Commissioned theatre, elective critical care & beds capacity & demand project to inform recovery trajectory & actions.	Clinical review of long waiting patients being implemented with interim & treatment harm review process to monitor for potential harm.



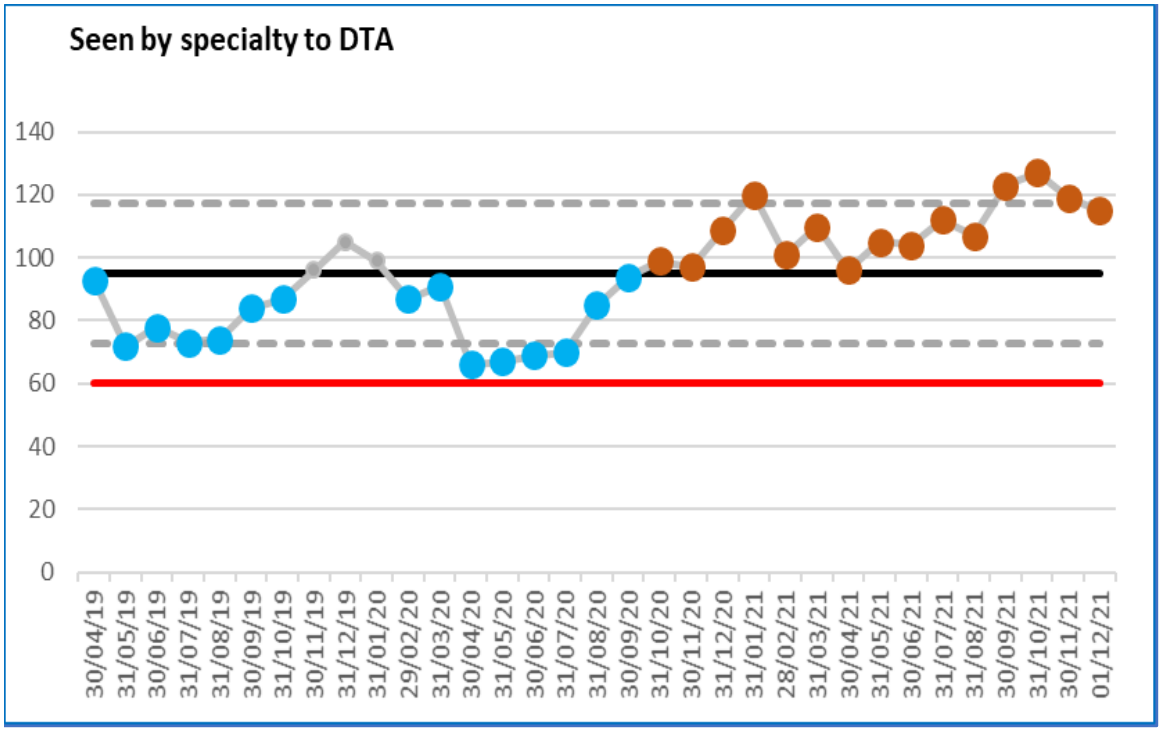
Dec-21
65.74%
Variance Type
Special cause variation
Target
95%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Four hour standard	Special cause concerning variation and consistently failing target	The performance against the four hour standard has been consistently below the statistical mean for four months & close to the lower control limit. Significant increases in attendances has exacerbated the pressure on the emergency pathways.	Executive and Healthcare group oversight continues through the Urgent Care Board & CQC Quality Project workstream. Internal, ICS, Regional and national discussions taking place to support the increase in patients. The Urgent Treatment Centre was moved to an alternative location to stream all walk-in attendances to appropriate services reducing pressure in the Emergency Department (29/12). The volume of patients has decreased over the end of the year into January. Implementing processes to meet national requirement of 50% decrease in the number of patients without criteria to reside to improve flow.	Safety huddle in ED 3 times a day to review safety and pressure in the department and to escalate where additional support is required. Additional UTC hours & services. SDEC unit developed OPEL status and reviewing demand and capacity to support urgent care. Weekly regional discussion on pressure points. Evening ICS system call to support emergency areas out of hours.



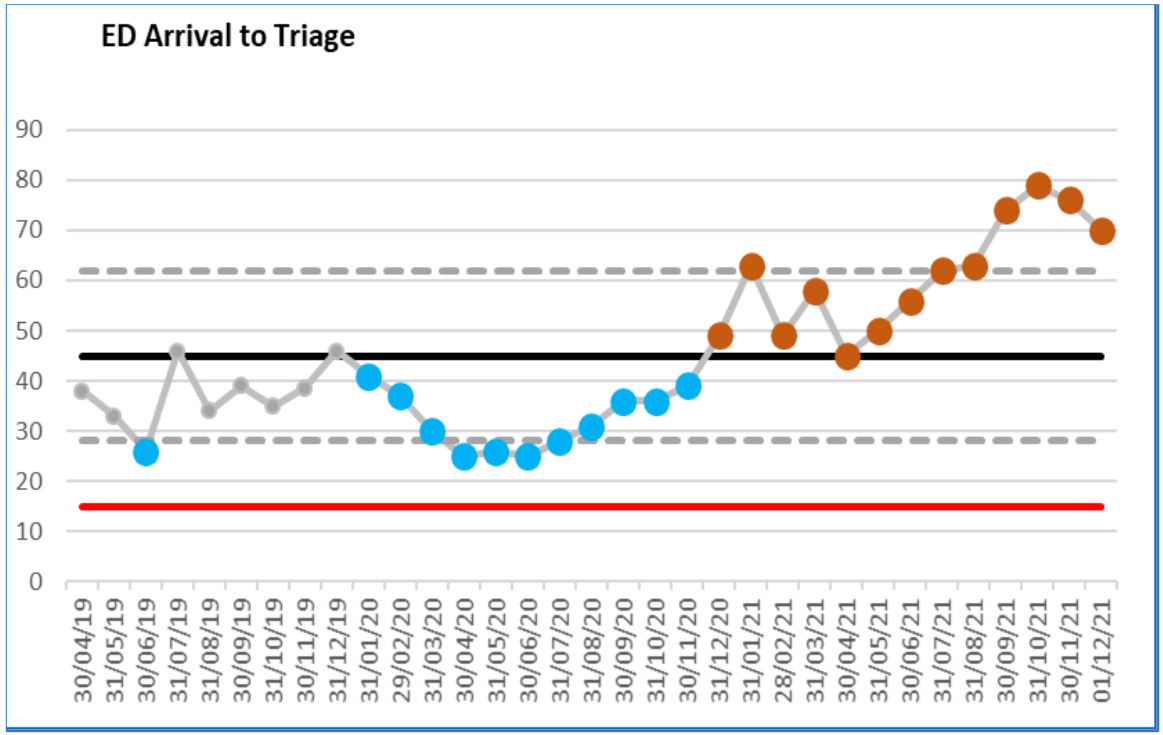
Dec-21
26.70%
Variance Type
Common cause variation
Target
0%
Target Achievement
Consistently failing target

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



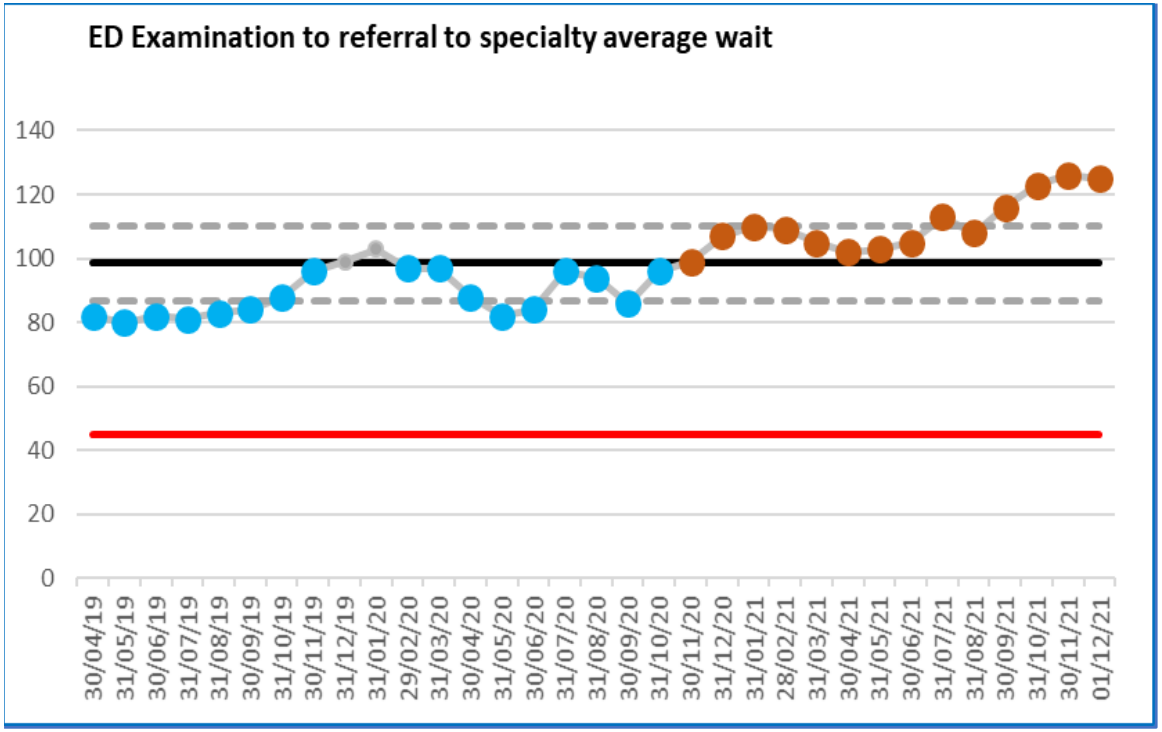
Dec-21
115 minutes
Variance Type
Special cause variation
Target
60 minutes
Target Achievement
Consistently failing target

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



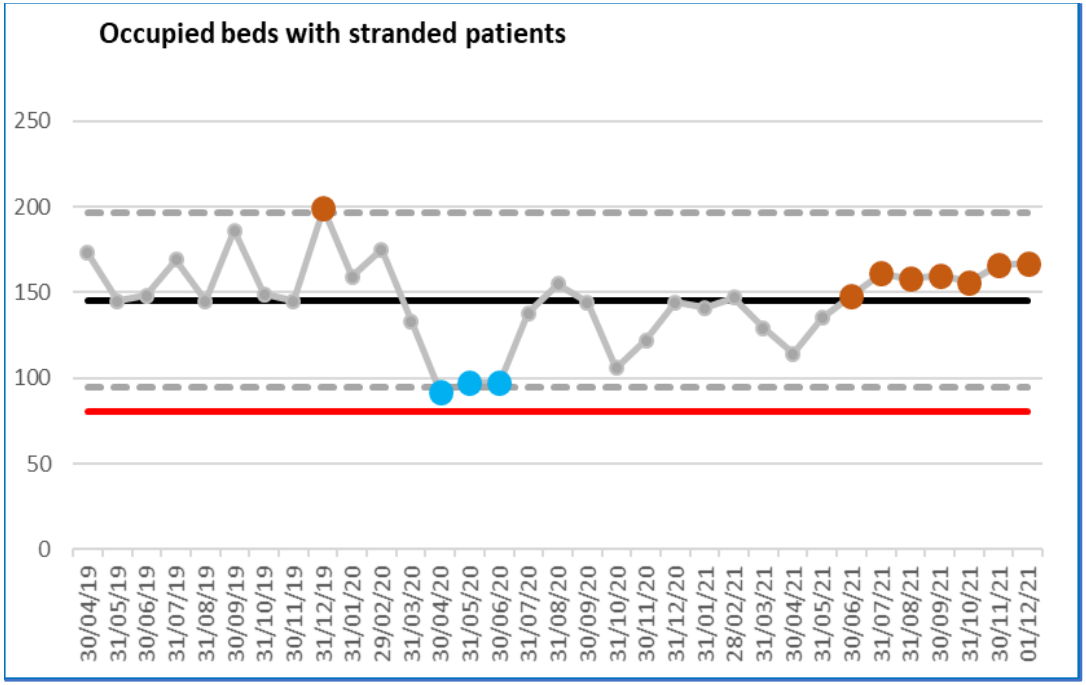
Dec-21
70 minutes
Variance Type
Special cause variation
Target
15 minutes
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Seen by specialty to DTA	Special cause concerning variation and consistently failing target	The average time from being seen by specialty to decision to admit has been consistently increased over the statistical average for 8 months	IPPS measurements of time to streaming & triage through Urgent Care Board. UTC expansion and location change to take all walk-in attendances and stream to appropriate service from the end of December.	Close review through breach analysis at Urgent Care Board



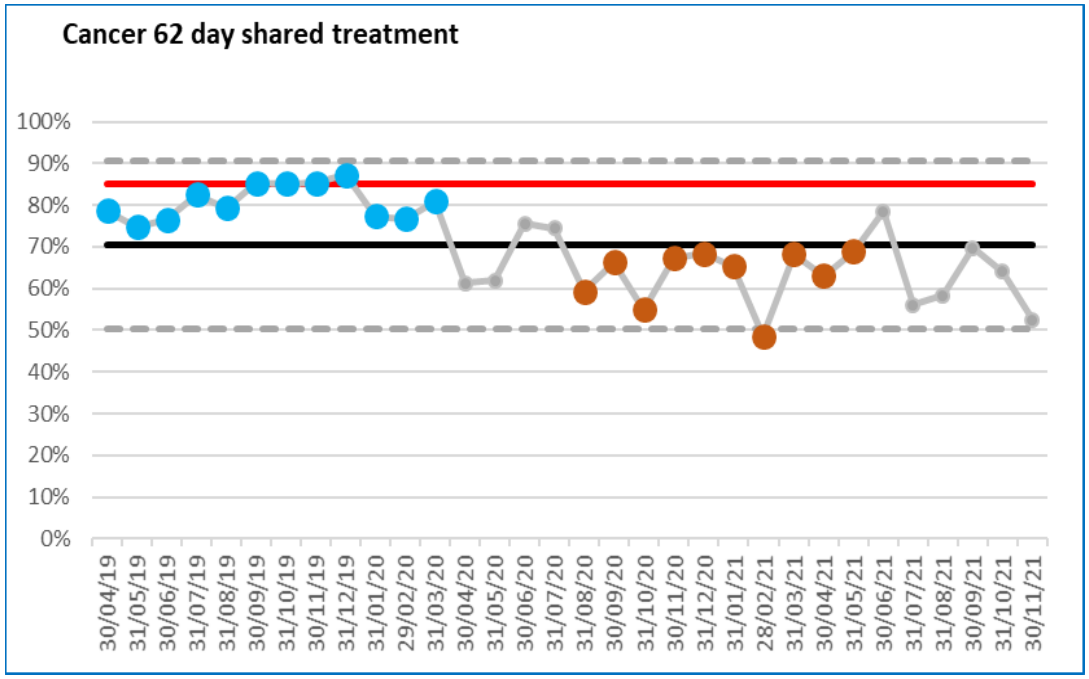
Dec-21
125 minutes
Variance Type
Special cause variation
Target
45 minutes
Target Achievement
Consistently failing target

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



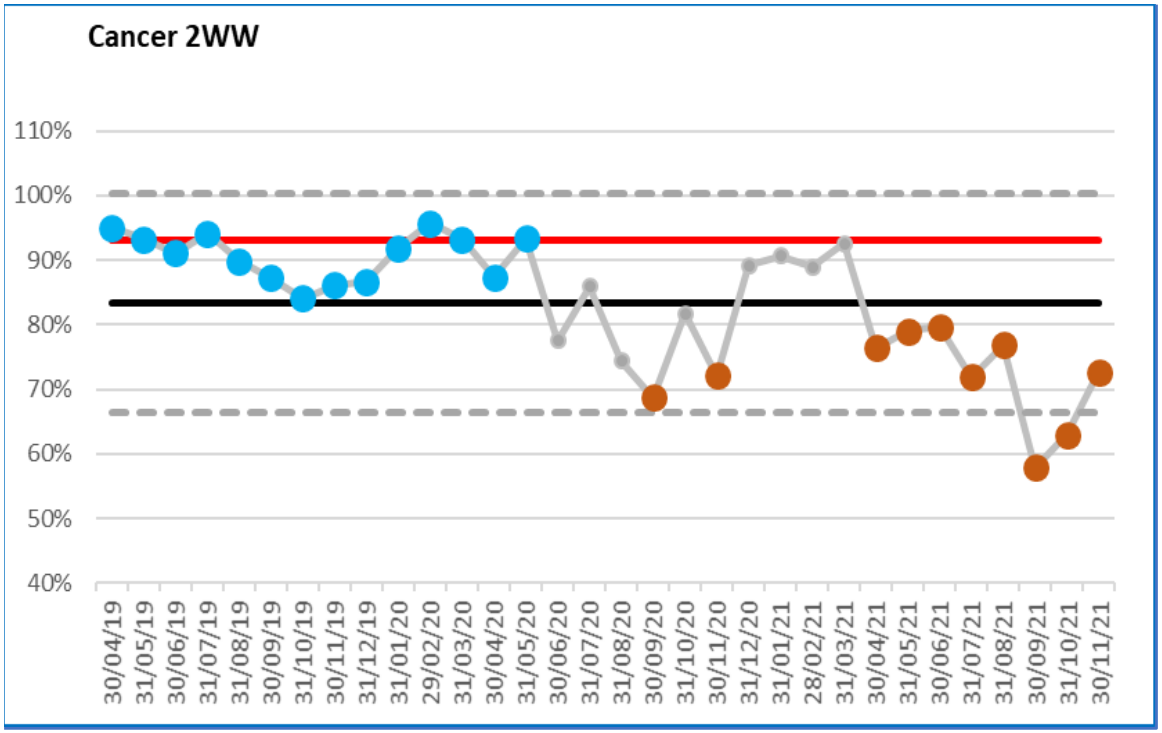
Dec-21
167
Variance Type
Special cause concerning variation
Target
80
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Occupied beds with stranded patients	Special cause concerning variation & consistently failing target	The performance against the target for stranded patients has failed consistently, however, we have shown common cause variation for the last 12 months	Safer & Red 2 Green refresh underway to support robust discharge planning. Daily patient panel review to understand discharge constraints. HIT Team review of patients appropriate for discharge extended across weekends. Additional community capacity is in place from end of December with Gibberd ward as community capacity and additional Covid community capacity opened. External senior national consultant support secured to work alongside consultant & nursing teams on the inpatient wards.	Review via daily bed meetings, daily system meetings & weekly capacity planning meetings. EDD review underway. Use of nerve centre to track patient EDDs & support for discharge in place.



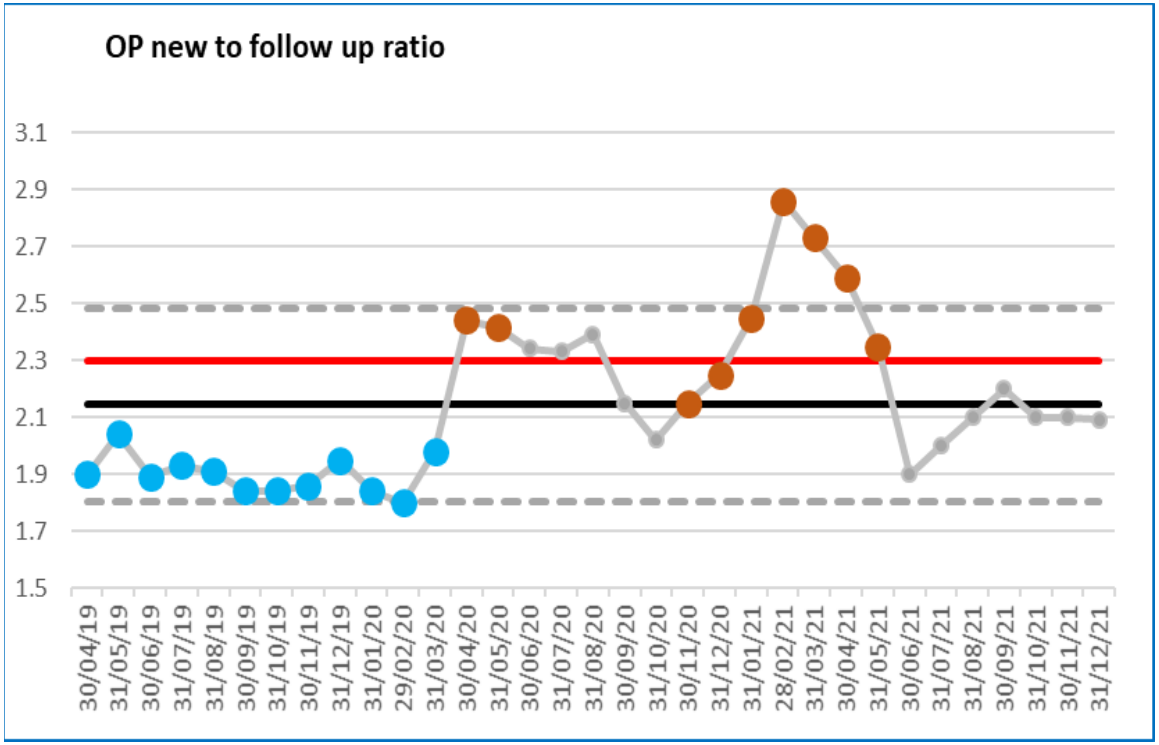
Nov-21
52.50%
Variance Type
Common cause variation
Target
85%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 62 day shared treatment	Common cause variation and hitting and missing target radomly	The performance against the target has failed for over 12 months.	The Trust has continued to focus on diagnosing & treating the backlog of patients that developed over the Covid period & the 62 day performance reflects the increased numbers of patients treated after 62 days in their pathway. Maintained daycase and limited in-patient operating capacity to support cancer & urgent elective patients. The Trust has a recovery trajectory that aims to return to national performance in February 2022 however this may require revision due to the impact of Omicron Covid on elective activity.	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting. Prioritisation of cancer patients in booking diagnostics & treatments. Clinician discussions at Cancer Board to escalate concerns and review cancer conversion rates which remain steady.



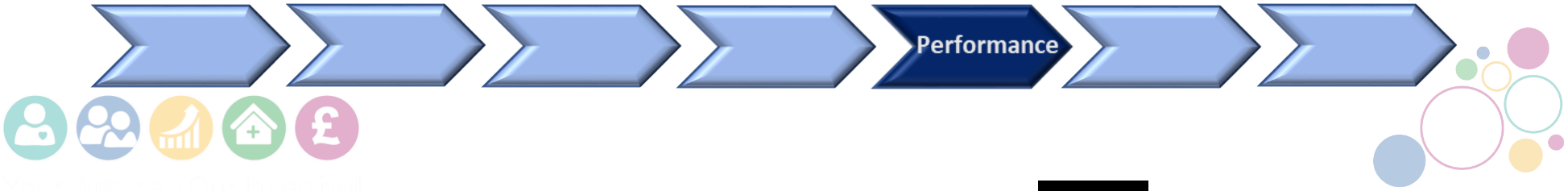
Nov-21
72.70%
Variance Type
Special cause concerning variation
Target
93%
Target Achievement
Inconsistently passing and falling short of target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 2 week wait	Special cause concerning variation & inconsistently passing and falling short of the target	Ongoing increased referrals and capacity issues due to staff absence in conjunction with clinic booking issues. Dermatology has seen significant increases in 2ww referrals and has staffing issues	Clinic booking processes being refined, additional clinic capacity implemented wherever possible, including using insourcing for routine appointments. Dermatology photograph triage process implemented and all routine slots utilised for 2ww capacity. Colorectal pathway improvements in place. Breast referral numbers significantly higher that usual and additional capacity in place.	Close review of 28 day diagnosis standard for each tumour site failing 2ww. Dermatology achieving 62 day performance. Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to Cancer Board & executive reporting.



Dec-21
2.09
Variance Type
Common cause variation
Target
2.3
Target Achievement
Inconsistently passing and falling short of target

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

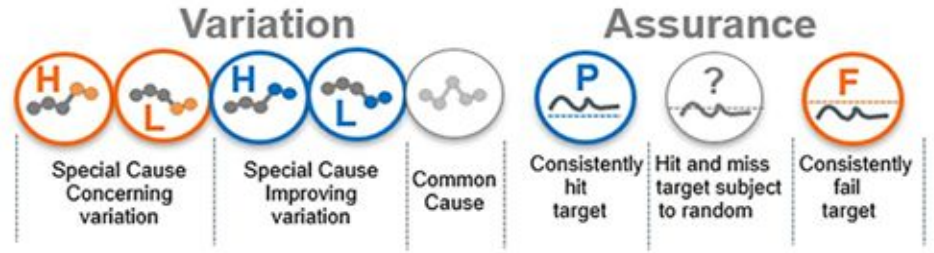


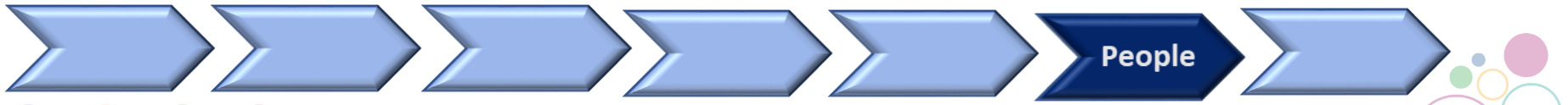
People

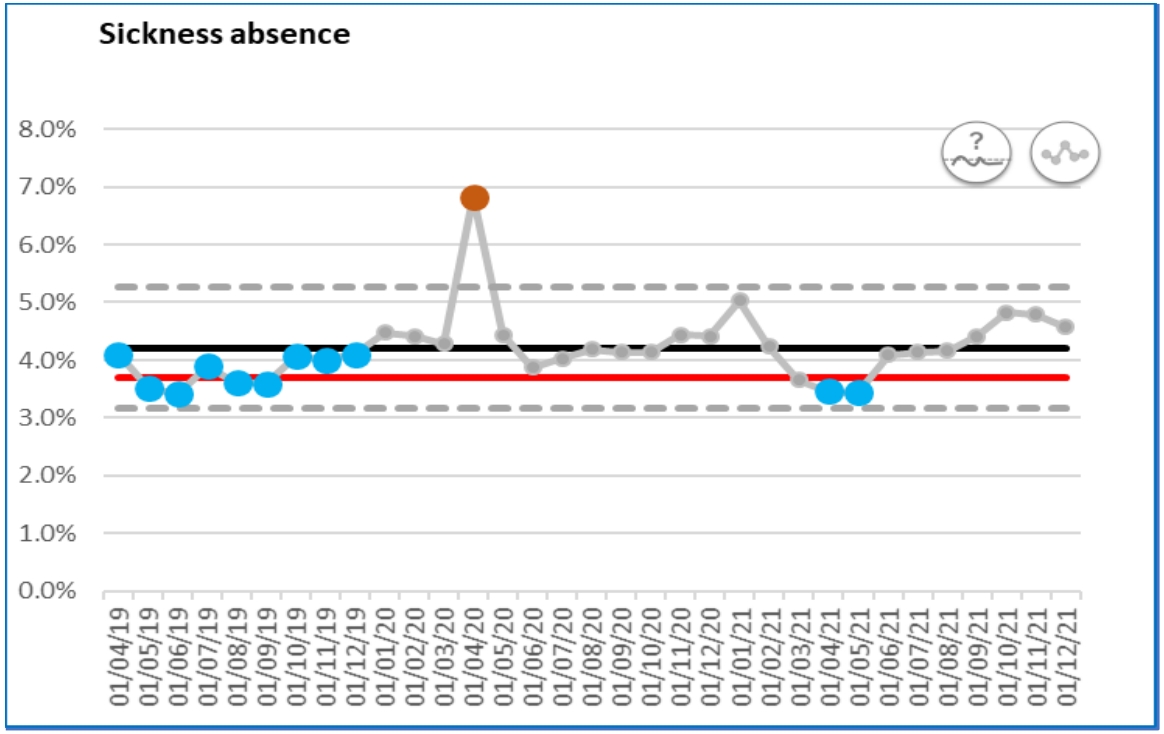
*We will support **our people** to deliver high quality care within a culture that continues to improve how we attract, recruit & retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.*

People Summary	Board Sub Committee: Worforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Appraisals	Divisional feedback indicated that staff workplace moves over the last year have compounded appraisals being completed by the appropriate manager & this has continued into Q3/4 due to demands in services in response to the Omicron varient. Staff sickness absence has also impacted completion of appraisals.	For information	Q4/1
Sickness	Absence due to COVID has been the predominant reason for absence. In Dcember, this accounted for 2/3s of absence. Mental health and MSK and cold and flu were the non-COVID reasons. Health & wellbeing initiatives in place to actively signpost to the trust psychological support service "Here for you" and physiomed, the physiotherapy support service.	For information	Q4/1
Statutory and Mandatory training	Statutory & mandatory training has continued to be provided throughout December, however some face to face sessions were cancelled due to service requirement. There has also been a delay to the learning & education facility opening therefore some face to face sessions continue to be delivered at St Margarets. LOD & HRBP teams continue to support divisions with action plans to support the release of staff to undergo training. Staff sign posted to the training booklet to complete some core training. There will be training facilities on the main hospital site in the autumn.	For information	Q4/1
Vacancy	Recruitment has continued throughotr December with successful recruitments to housekeeper roles & consultant posts. International nurse recruitment continues with approx 29 international nurses due to join the trust within Q4/1.	For information	Q3/4
Rolling turnover	There has been an increase in turnover within all divisions. PAHT are not an outlier in this when comparing EoE data. Exit questionnaires are being encouraged with thematic reviews taking place in key areas with the highest turnover.	For information	Q4/ Q1

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Appraisals - non medical	Dec 21	78.2%	90.0%		F	82.0%	76.7%	87.3%
Agency staffing spend	Dec 21	7.3%	15.0%		P	5.0%	2.3%	7.8%
Bank staffing spend	Dec 21	13.5%	15.0%		P	11.6%	9.0%	14.2%
Vacancy Rate	Dec 21	8.4%	8.0%	L	F	9.6%	8.3%	10.9%
Staff turnover - voluntary	Dec 21	14.5%	12.0%	H	?	11.3%	10.4%	12.2%
Sickness absence	Dec 21	4.6%	3.7%		?	4.2%	3.2%	5.3%
Statutory and Mandatory training	Dec 21	87.0%	90.0%	L	?	88.7%	85.8%	91.6%

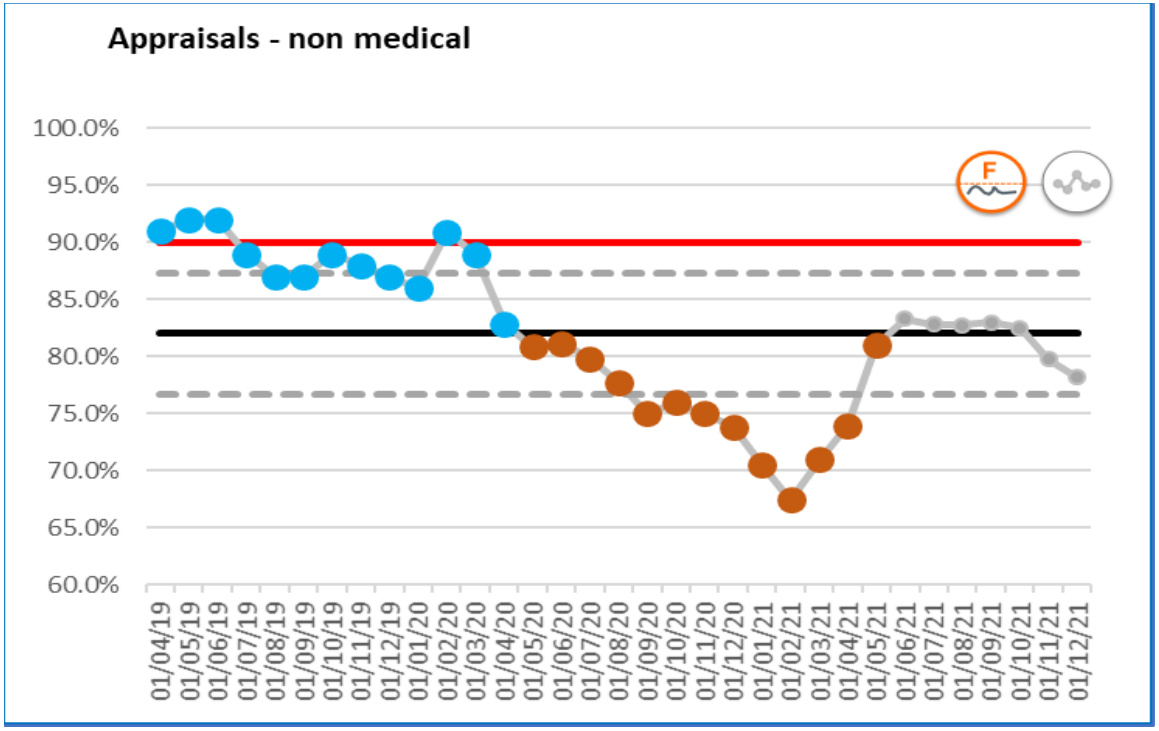






Dec-21
4.57%
Variance Type
Common cause variation
Target
4%
Target Achievement
Inconisistently passing & falling short of the target

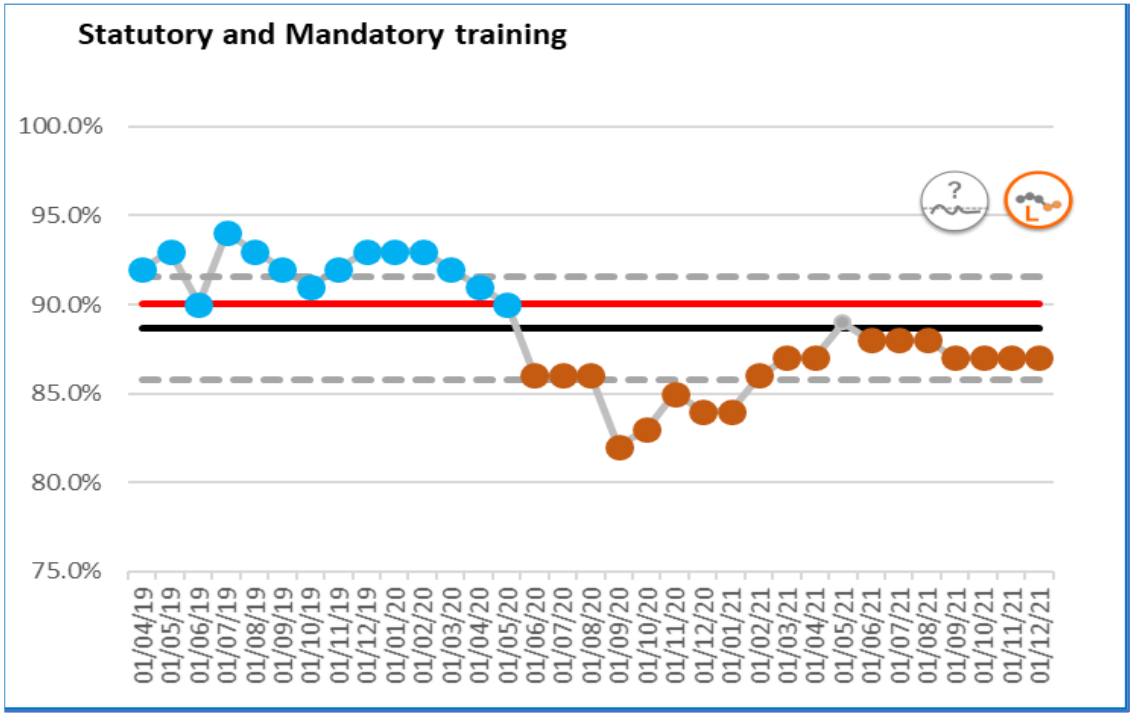
Background	What the chart tells us	Issues	Actions	Mitigation
Sickness absence	Variation indicates inconsistently passing & falling short of the target	Cases of COVID amongst staff has led to an increase in absence in Dec. This trend is reflected across the system and nationally	Staff can return to work at day 8 if they have a recorded negative lateral flow test and both day 6 and day 7	The SHaW and people team reinstated the absence management line, recording absences contemporaneously & providing advice & guidance to managers on COVID & testing guidelines



Dec-21
78.20%
Variance Type
Common cause variation
Target
90%
Target Achievement
Consistently failing target

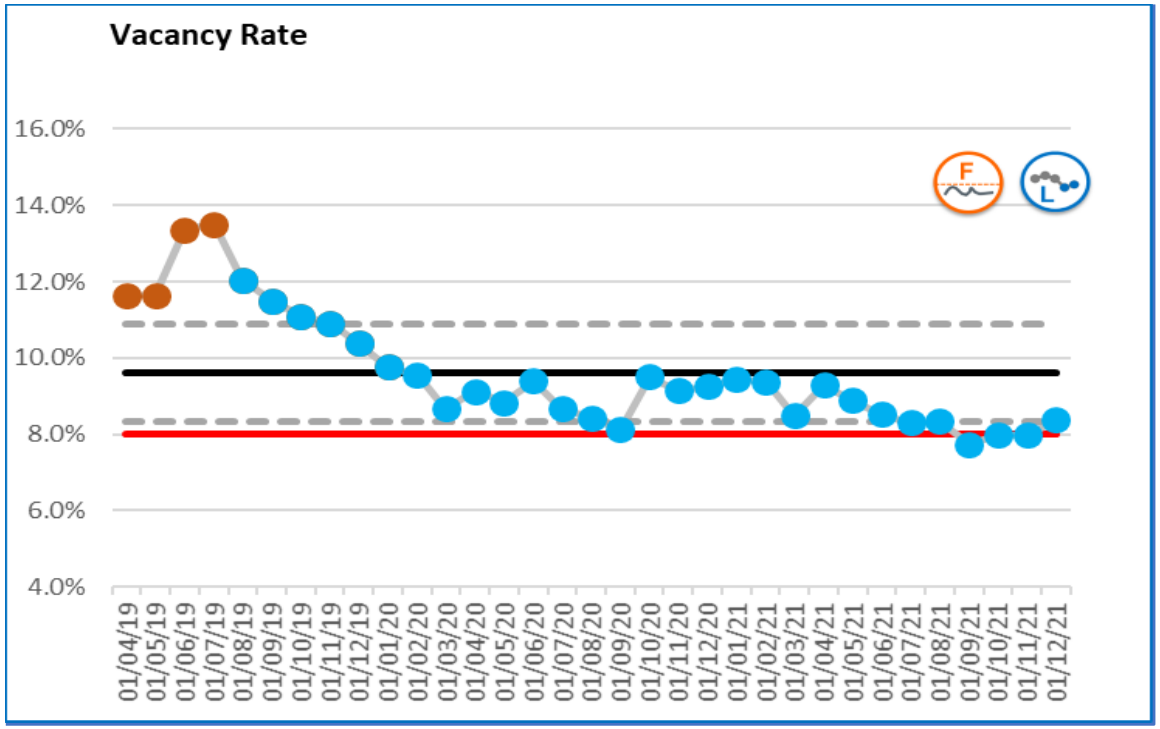
Background	What the chart tells us	Issues	Actions	Mitigation
Appraisal non medical	Common cause concerning variation & consistently falling short of target	Appraisal rates have been impacted by absence rates and pressures on services	Staff and managers have been encouraged to complete appraisals where possible. Monthly reporting of compliance rates are provided to divisions & presented through PRM packs	Compliance rates discussed at monthly HCG board meetings & performance review meetings with actions agreed

People



Dec-21
87%
Variance Type
Special cause variation
Target
90%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Statutory and Mandatory Training	Special cause concerning variation & consistently failing target	Absence rates also impacting on training, particularly face to face training. Reported challenges of protected time to complete training is compounded by the delay in the opening of the learning & education centre which is providing an additional clinical environment at this current time	Staff sign posted to training booklet to support completion for some core training. Face to face training continues to be delivered both on site & at St Margarets, Epping	Training data discussed at divisional board meetings on a monthly basis. New training venue based on site planned for autumn



Dec-21
8.38%
Variance Type
Special cause variation
Target
8.00%
Target Achievement
Consistently failing

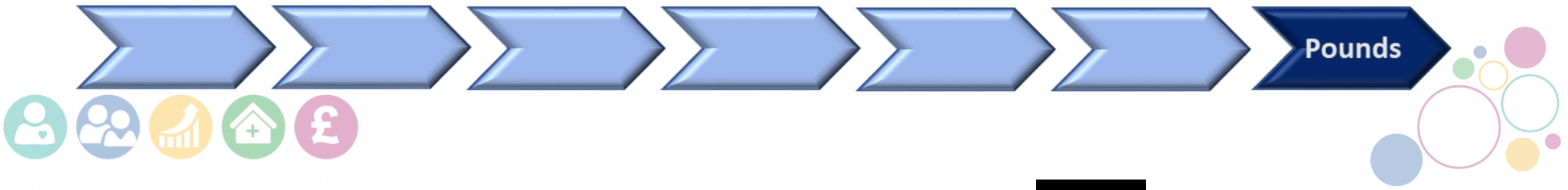
Background	What the chart tells us	Issues	Actions	Mitigation
Vacancy Rate	Special cause improving variation & consistently failing target	Focus on vacancy rates remain within housekeeping and AHPs	Recruitment has continued across the divisions with successful recruitmnt programmes delivered to support the decrease in vacancy rates in housekeeping, HCSW, Consultants. The international nurse recruitment pipeline continues per plan	Recruitment plans for divisions reviewed at divisional board meetings & at monthly performance review meetings.

People

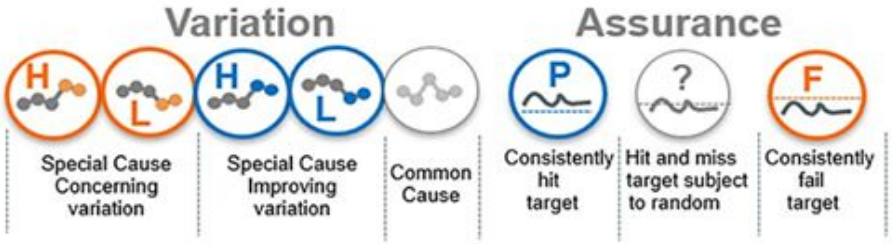
Pounds

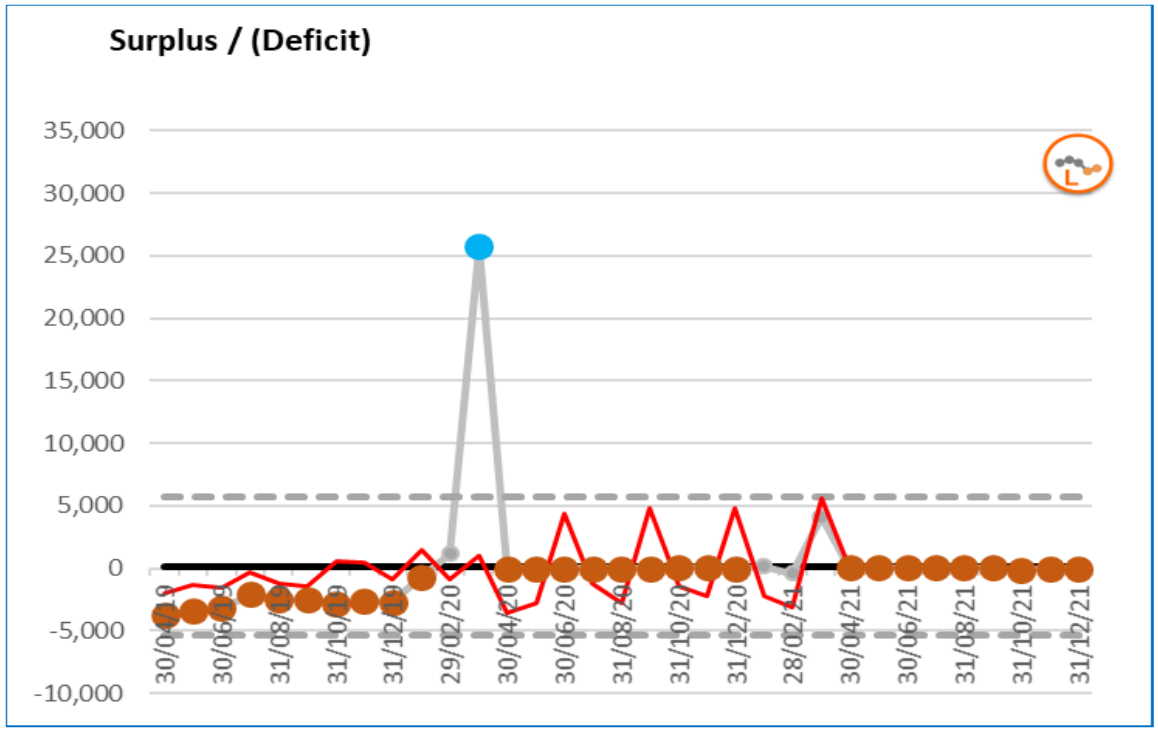
*We will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way*

Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Surplus	The Trust has achieved YTD break-even as at December (month 9), which is in line with plan. The Trust has used COVID funding to balance the position in month. This is due principally to the under achievement of the CIP delivery & ERF insourcing. Actions to support divisions to reduce their run rates are being taken.	For information	
CIP	The Trust has only delivered £1.921m of savings against a year to date plan of £4.650m. Currently the Trust is forecasting to only deliver CIPs of £2.040m of a total target of £7.052m for the full year. Only £0.614m of these savings are expected to be recurrent.	For information	
Capital Spend	Year-to-date capital spend is £16.671m against a revised capital plan of £16.779m. This under-performance of £0.108m reflects timing differences & the Trust anticipates achieving its Capital Resource Limit.	For information	
Cash	The Trust continues to have a healthy cash balance of £49.400m. The focus on reducing payables continues along with improving the Trust's performance against the Better Payment Practice Code.	For information	



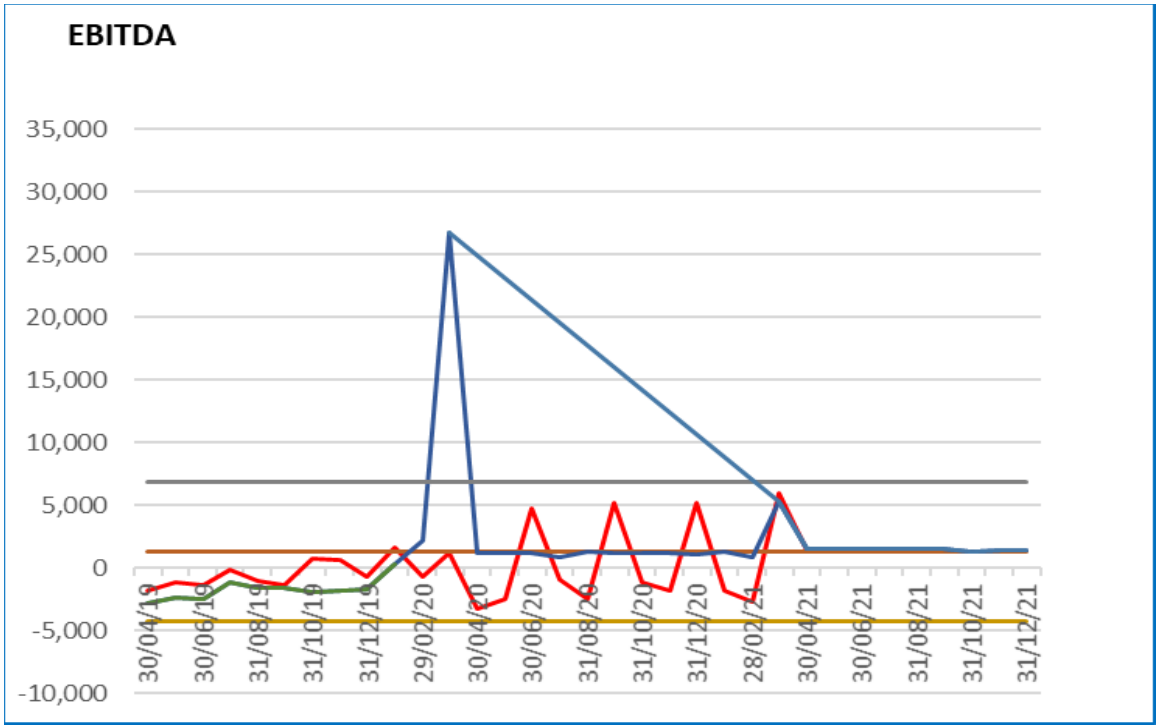
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Surplus / (Deficit)	Dec 21	0	0			135	-5413	5684
EBITDA	Dec 21	1448	0			1289	-4320	6899
CIP	Dec 21	44	0			547	-276	1370
Income	Dec 21	29406	0			25863	14893	36832
Operating Expenditure	Dec 21	29431	0			25421	19624	31218
Bank Spend	Dec 21	2461	0			1945	1351	2539
Agency Spend	Dec 21	1331	0			839	414	1264
Capital Spend	Dec 21	2122	0			2536	-3287	8360





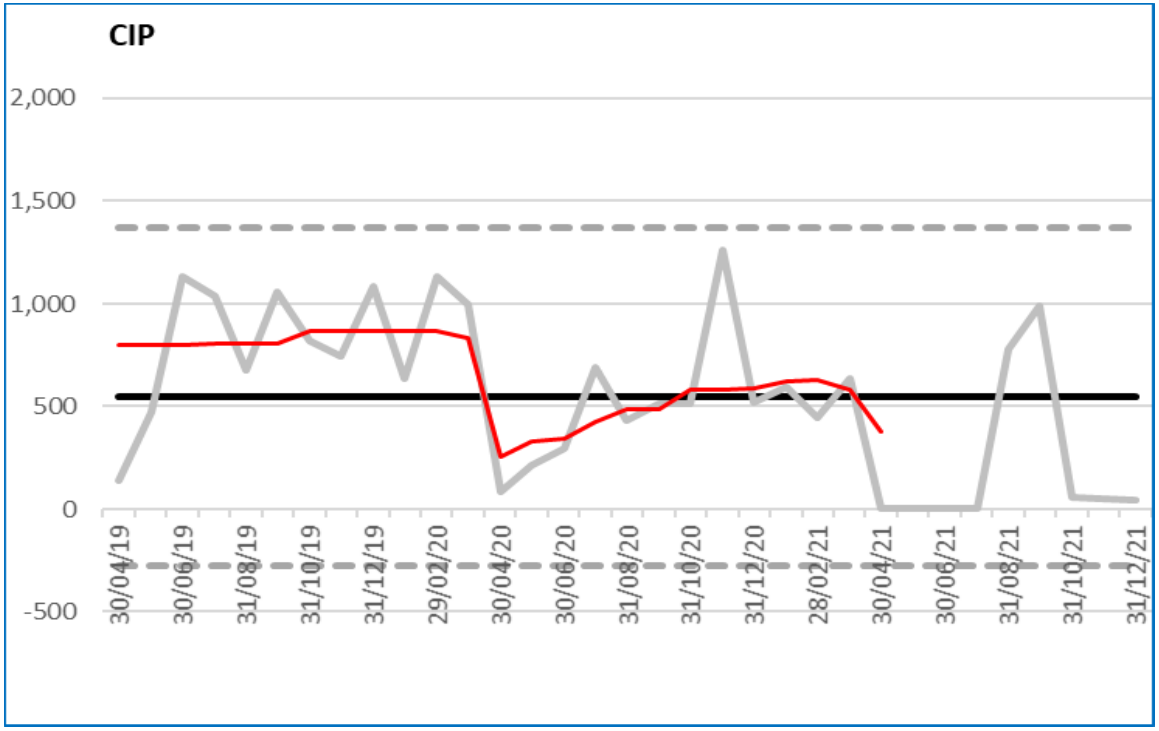
Dec-21
0
Variance Type
Special cause concerning variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Surplus/Deficit	Special cause concerning variation & inconsistently passing and falling short of the target	The Trust has achieved a breakeven finanical performance at M9 by using winter funding and COVID-19 funding to cover the under delivery of CIP	Divisions are working to reduce their run rate supported by the Finance Department.	N/A



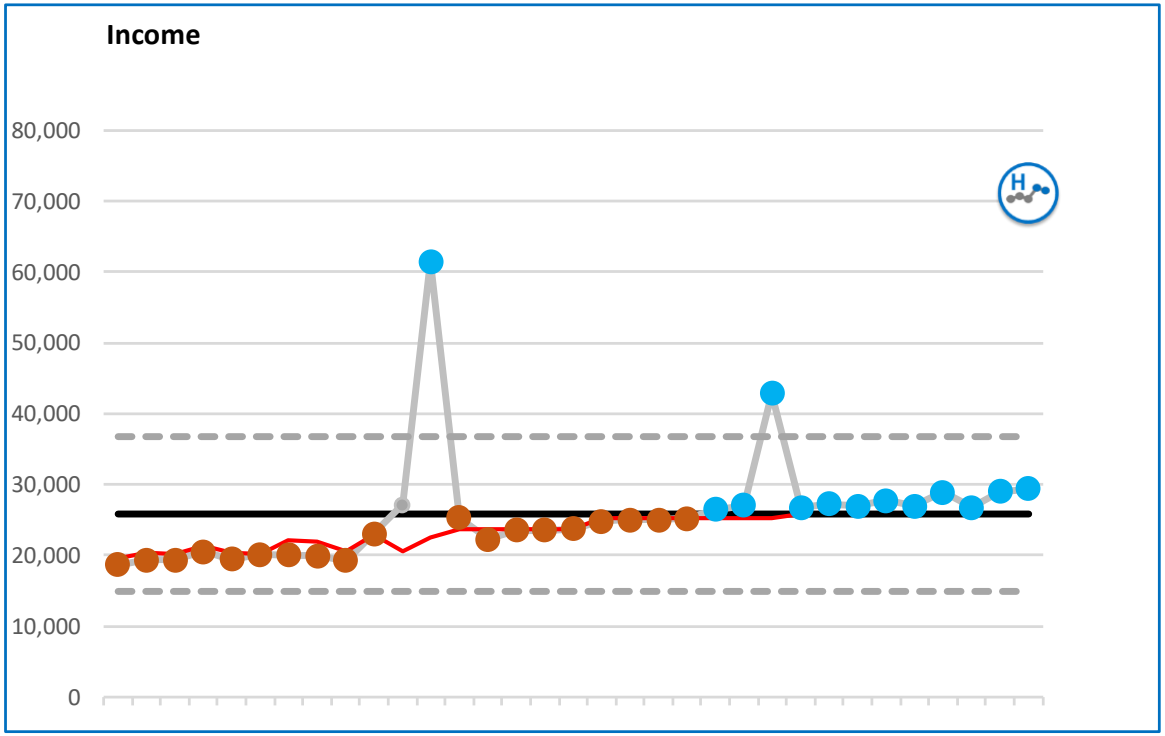
Dec-21
1448
Variance Type
Special cause concerning variation
Target
362
Target Achievement
Inconsistently passing and falling short of the target

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



Dec-21
44
Variance Type
Common cause variation
Target
375
Target Achievement
Inconsistently passing and falling short of the target

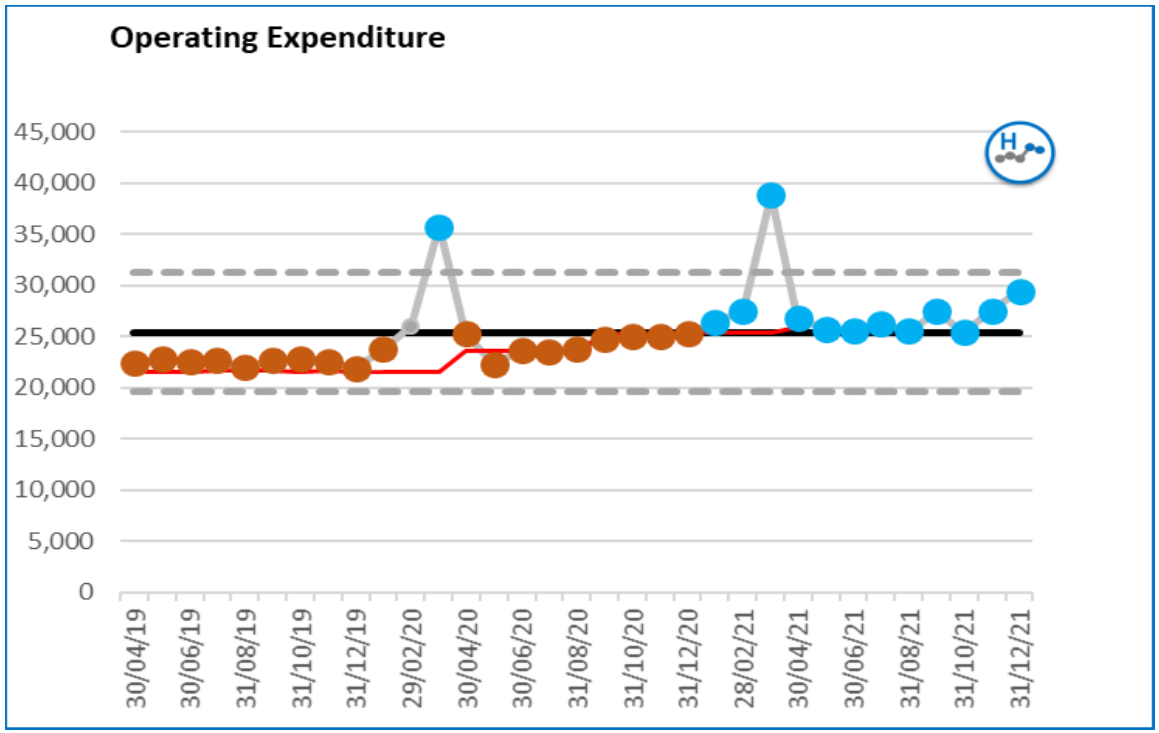
Background	What the chart tells us	Issues	Actions	Mitigation
CIP	Common cause variation and inconsistently passing and falling short of the target	CIP delivery is behind plan as at M9 (£2.729m).	Divisions are being supported to develop and deliver their cost improvement plans.	N/A



Dec-21
29406
Variance Type
Special cause improving variation
Target
26097
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
Income	Special cause improving variation	More elective activity was performed YTD than planned for M1-6. Income for H2 is in line with baseline plan with increases reflecting winter funding	N/A	N/A

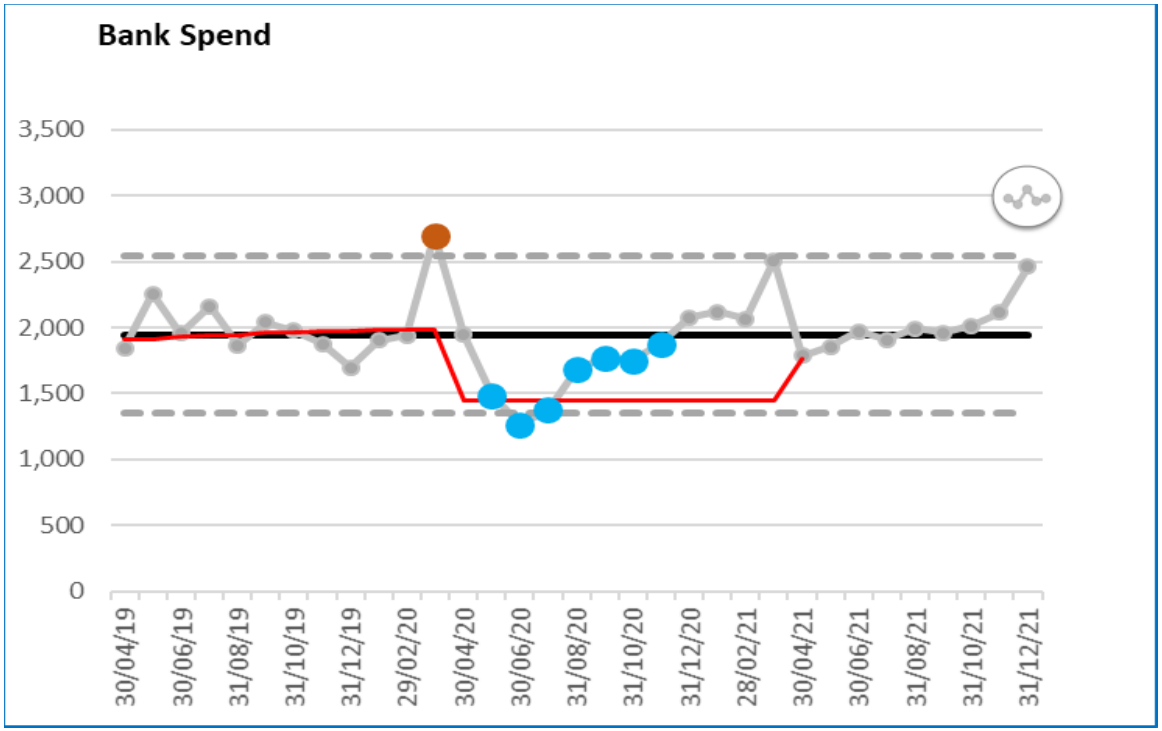
Pounds



Dec-21
29431
Variance Type
Special cause improving variation
Target
26710
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
Operating Expenditure	Special cause improving variation	Expenditure is above plan due to CIP under achievement.	Divisions are working to reduce their run rate supported by the Finance Department.	N/A

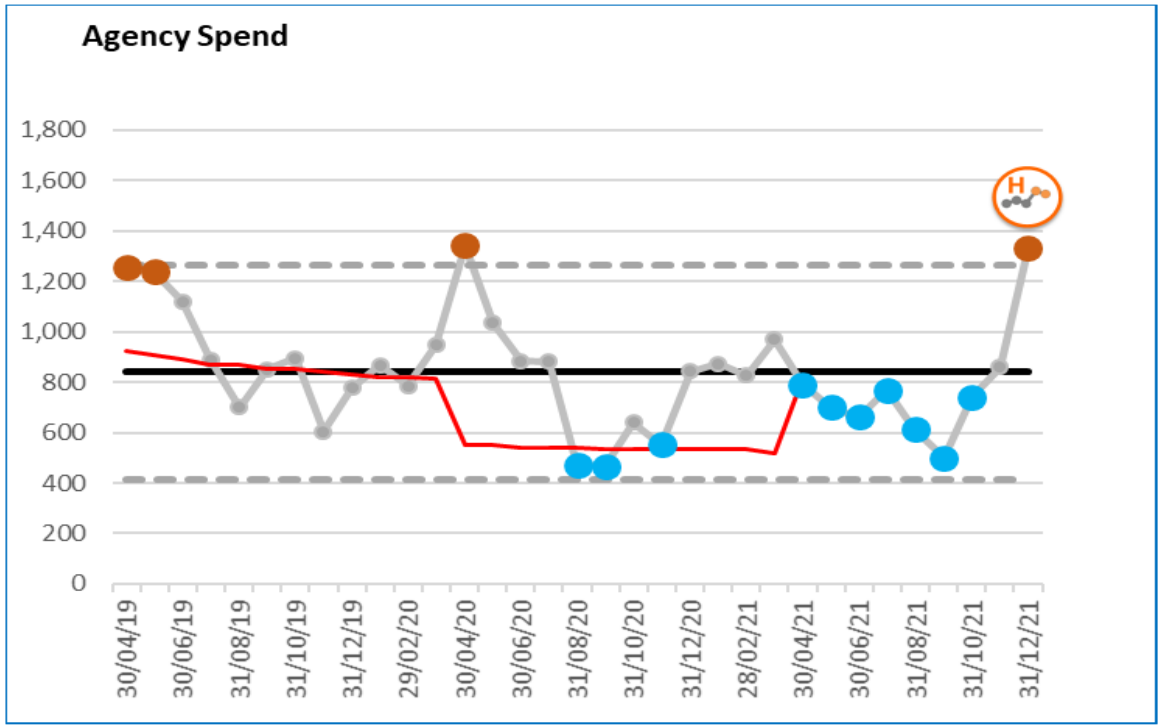
Pounds



Dec-21
2461
Variance Type
Common cause variation
Target
1863
Target Achievement
Inconsistently passing and falling short of the target

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

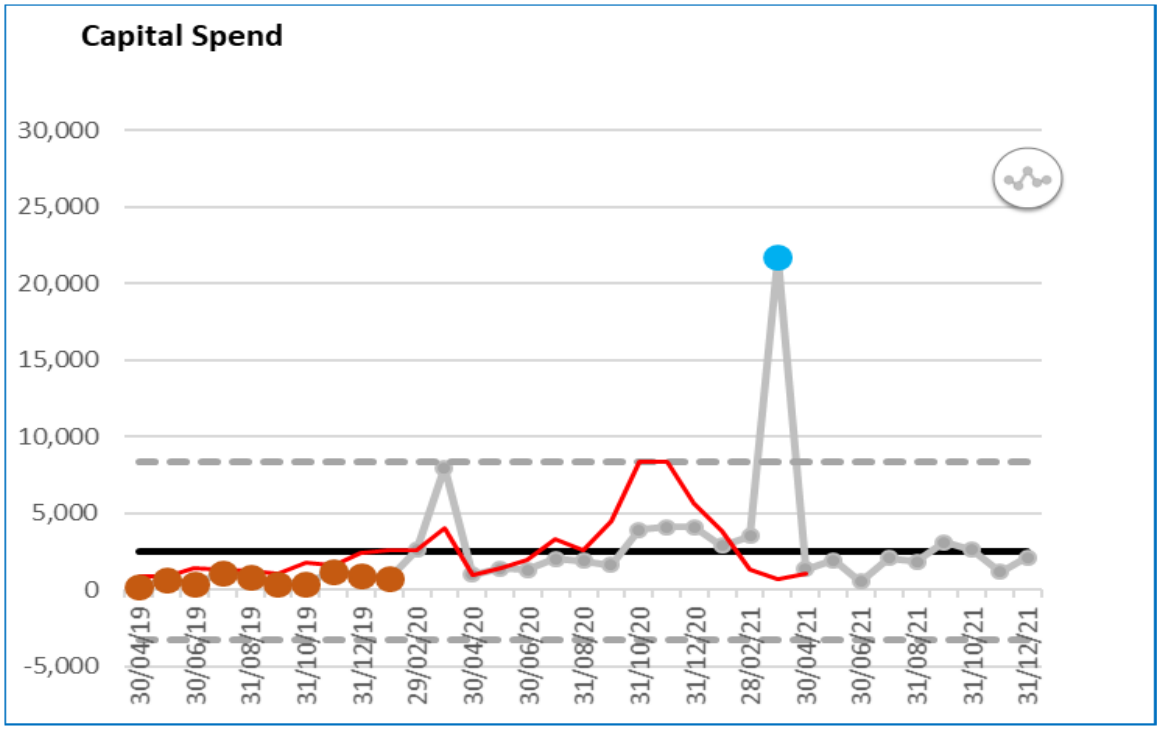
Pounds



Dec-21
1331
Variance Type
Special cause variation
Target
886
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Agency Spend	Special cause concerning variation & inconsistently passing and falling short of the target	Agency spend is below plan for M9 as more bank staff have been utilised	The bank and agency review meeting is supporting Divisions to reduce this spend. Recruitment plans are being developed to support longer term sustainability of clinical services.	N/A

Pounds

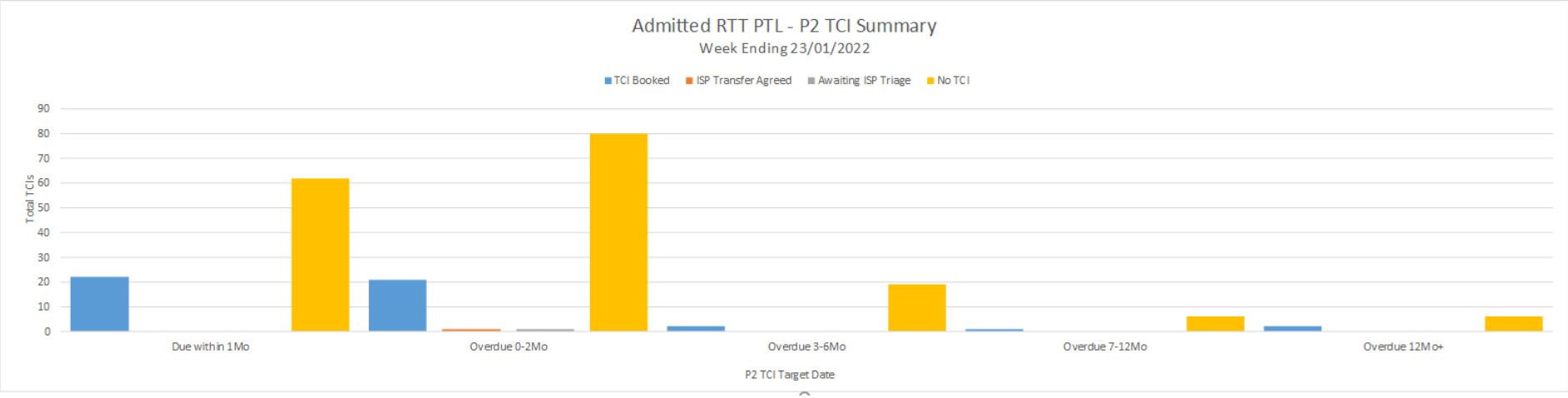


Dec-21
2122
Variance Type
Common cause variation
Target
3693
Target Achievement
Inconsistently passing and falling short of the target

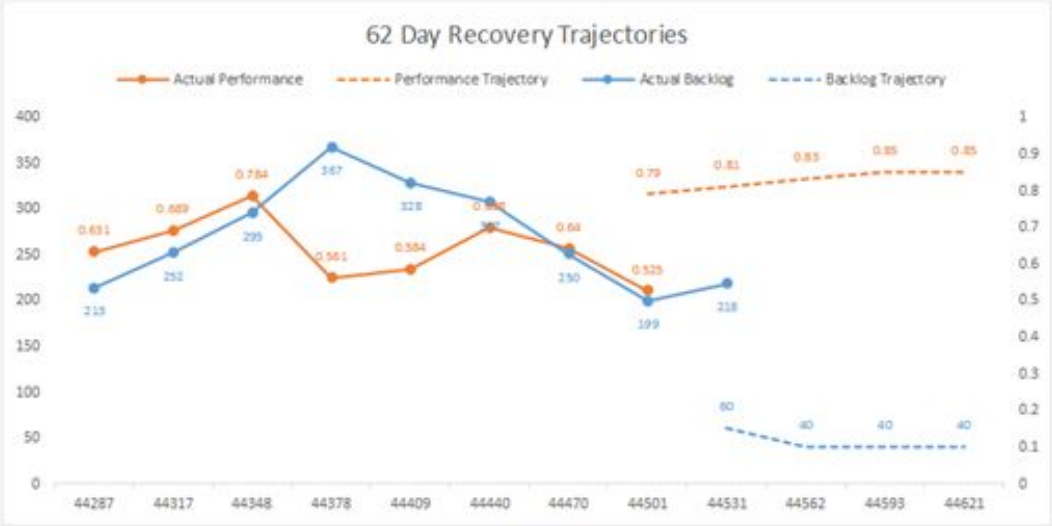
Background	What the chart tells us	Issues	Actions	Mitigation
Capital Spend	Common cause variation and inconsistently passing and falling short of the target	Spend is marginally behind plan. This is a timing issue. The capital programme includes an over planning margin. The Trust is forecasting achievement of its CRL.	The CWG monitors the capital programme and is bringing the programme back into balance.	N/A

Appendix A – Recovery Dashboard

Clinical Prioritisation

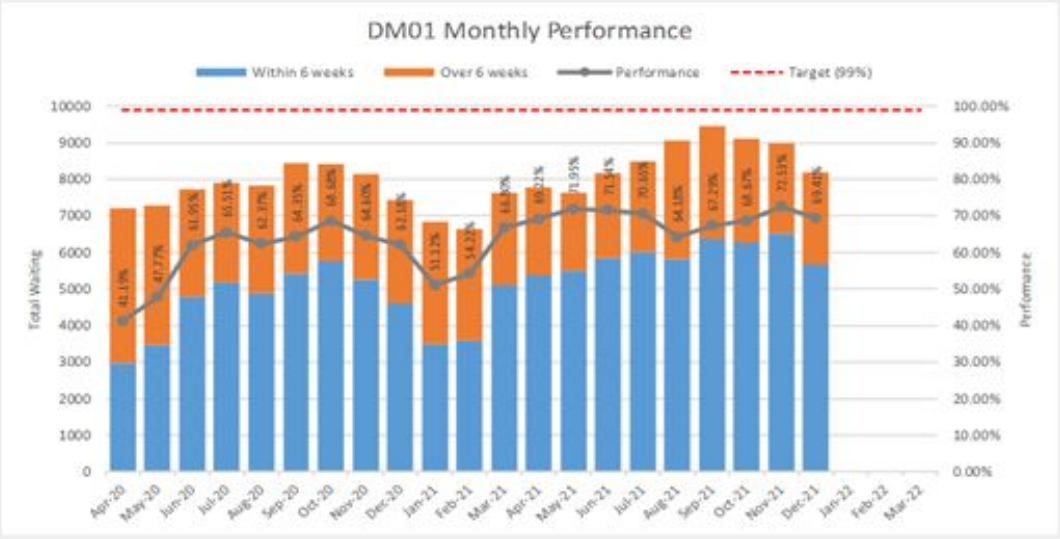


Cancer

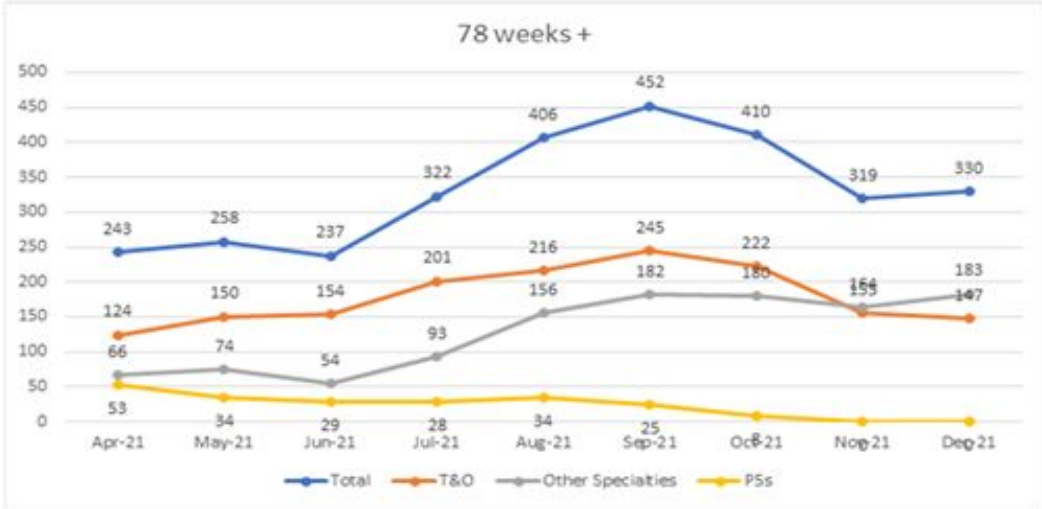


Month	Cancer Performance			
	2WW Performance	28 Faster Diagnosis Performance	31 Day Performance	62 Day Performance
Apr-21	76.4%	71.5%	93.5%	63.1%
May-21	79.0%	74.1%	100.0%	68.9%
Jun-21	79.7%	62.5%	96.2%	78.4%
Jul-21	71.9%	77.1%	92.6%	56.1%
Aug-21	76.9%	75.9%	88.4%	58.4%
Sep-21	57.9%	62.8%	86.9%	69.8%
Oct-21	62.3%	65.1%	96.1%	64.1%
Nov-21	72.7%	60.6%	96.3%	52.5%

DM01


DM01 Monthly Performance
Within 6 weeks
Over 6 weeks
Performance
Target (99%)
Total Waiting
Performance
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22

RTT


78 weeks +
500
450
400
350
300
250
200
150
100
50
0
243
258
237
322
406
452
410
319
330
124
150
154
201
216
245
222
155
183
66
74
54
93
156
182
180
147
53
34
29
28
34
25
8
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Total
T&O
Other Specialties
P5s

Appendix B
Quality Improvement Plan

QIP Project Reference	Quality Programme	QIP Action	Project Owner	PMO Evidence Required	QPMO Update
Urgent and Emergency Services					
M1	Urgent Care	The trust must ensure detailed up to date records are kept in relation to provision of care and treatment and it is reflective of reflective of each patient's full clinical pathway	Chief Nurse	Audit of 10 random records per week	On track for delivery against the set timescales
M2/N	Urgent Care	The service must ensure that medical staff training meets the compliance target of 90%.	Medical Director	Workforce training compliance report	Behind delivery date but plan in place to progress
M3/N	Urgent Care	The service must ensure it has enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Skill gap	Chief Nurse	Ratio of skilled versus unskilled Evidence of documentation Escalation and actions if not in place	On track for delivery against the set timescales
M23	Urgent Care	The trust must ensure all appropriate risk assessments for patients attending the department are completed in a timely way to ensure appropriate mitigating actions can be taken	Chief Nurse	In review	On track for delivery against the set timescales
m24	Urgent Care	The trust must ensure all risk assessments for patients presenting with a mental health crisis are completed in a timely way in order to identify and mitigate any risks to patient and staff safety.	Chief Nurse	In review	On track for delivery against the set timescales
m25	Urgent Care	The trust must ensure all staff comply with all trust infection prevention and control (IPC) guidance in order to minimise the risk of the spread of infection.	Chief Nurse	In review	On track for delivery against the set timescales
m26	Urgent Care	The trust must ensure that staffing resources are used efficiently throughout the ED to reduce delays to patient	Chief Nurse		On track for delivery against the set timescales
m27/N	Urgent Care	The trust must ensure that there is robust oversight of the clinical decisions unit (CDU) including that patients cared for there meet the inclusion criteria. / The trust must ensure that there is a clear record and oversight of patients being admitted to clinical decisions unit. (Regulation 17 (1)(2)(a)).	Chief Nurse	In review	On track for delivery against the set timescales. Unit not operaional at this current time.
m28	Urgent Care	The trust must ensure the triage process is robust and accurately identifies those patients who are the most sick.	Chief Operating Officer	In review	On track for delivery against the set timescales
m29	Urgent Care	The trust must ensure the monitoring of the time to specialist review and total time spent in the department is accurate.	Chief Nurse	In review	On track for delivery against the set timescales
M30/N	Urgent Care	The Registered Provider must operate an effective system which will ensure that every patient attending the Emergency Department has an initial assessment of their condition to enable staff to identify the most clinically urgent patients	Chief Operating Officer	In review	On track for delivery against the set timescales
M31/N	Urgent Care	The Registered Provider must devise a process and undertake a review of current and future patients clinical risk assessments, care planning and physiological observations, and ensure that the level of patients' needs are individualised, recorded and acted upon. This must include, but not limited to skin integrity, falls, and mental health assessments.	Chief Nurse	In review	On track for delivery against the set timescales
M32	Urgent Care	The registered provider must ensure that it implements an effective system with the aim of ensuring all patients who present to the emergency department at the Princess Alexandra Hospital patient observations are completed within 15 minutes of arrival and as appropriately thereafter in line with trust policy.	Chief Nurse	In review	On track for delivery against the set timescales
M33.N	Urgent Care	The trust should ensure all appropriate staff are familiar with the doffing procedures for personal protective equipment in the aerosol generating procedures room. (Regulation 12)	Chief Nurse		On track for delivery against the set timescales
M35.N	Urgent Care	The trust must ensure that there are safe toilet facilities for adult patients presenting with mental ill health. (Regulation 13 (1))	Chief Operating Officer		On track for delivery against the set timescales
T4	Urgent Care	The trust must ensure the out of hours endoscopy process is embedded and understood by all appropriate staff in the department.	Medical Director	Staff meetings minutes	On track for delivery against the set timescales
S25.N	Urgent Care	The trust should ensure they continue to improve safeguarding training compliance for nursing and medical staff. (Regulation 13)	Medical Director		On track for delivery against the set timescales
S2/N	Urgent Care	The trust should ensure that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.	Chief Nurse	Monitored through the Urgent Care Board	On track for delivery against the set timescales
S22	Urgent Care	The trust should continue to recruit registered nursing and health care staff in order to meet establishment guidelines	Chief Nurse	Under review	On track for delivery against the set timescales
S24	Urgent Care	The trust should ensure the minutes of the Urgent and Emergency Care meetings are detailed.	Director of Quality improvement	Under review	On track for delivery against the set timescales

Paediatric Urgent and Emergency Services					
M34.N	Paediatric Urgent and Emergency Services	The trust must ensure that the paediatric mental health room is fit for purpose and meets the standards set out in Facing the Future, Standards for Children in Emergency Care Settings. (Regulation 13 (1))	Chief Nurse		On track for delivery against the set timescales
S25.aN	Paediatric Urgent and Emergency Services	The trust should ensure they continue to improve safeguarding training compliance for nursing and medical staff. (Regulation 13)	Chief Nurse		On track for delivery against the set timescales
Medical Care (including older people's care)					
M4/N	Medical care (including older people's care)	The service must ensure it has enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment	Chief Nurse	Ratio of skilled versus unskilled Evidence of documentation on training Escalation and actions if not in place	On track for delivery against the set timescales
M5/N	Medical care (including older people's care)	The service must ensure that systems and processes to identify risk at ward level are embedded.	Chief Nurse	Evidence of discussion on wards Increase in risks (good sign) as means open reporting culture Responses and actions to risk Check escalation upwards	On track for delivery against the set timescales
M6/N Falls	Medical care (including older people's care)	The service must ensure that staff keep detailed records in relation to risk assessments and care plans for patient falls	Chief Nurse	Evidence of discussion on wards Increase in risks (good sign) as means open reporting culture Responses and actions to risk Learning from events Check escalation upwards	On track for delivery against the set timescales
M6/N Ulcers	Medical care (including older people's care)	The service must ensure that staff keep detailed records in relation to risk assessments and care plans for patient pressure ulcers.	Associate Director of Nursing	Evidence of discussion on wards Increase in risks (good sign) as means open reporting culture Responses and actions to risk Learning from events Check escalation upwards	On track for delivery against the set timescales
M8	Medical care (including older people's care)	The service must ensure that medical staff training meets the trust compliance target of 90%.	Associate Medical Director	Workforce training compliance report	On track for delivery against the set timescales
M9	Medical care (including older people's care)	The service must ensure that hazardous chemicals are kept in a locked cupboard.	Director of Strategy and Estates	Identify which areas have hazardous chemicals Audit areas	On track for delivery against the set timescales
M36.N	Medical care (including older people's care)	The trust must ensure that records of patients' care and treatment are completed with appropriate detail and contemporaneously. (Regulation 17 (1)(2)(a)).	Chief Nurse		On track for delivery against the set timescales
M37.N	Medical care (including older people's care)	The trust must ensure staff follow systems and processes to safely prescribe, administer, record and store medicines. (Regulation 12 (1)(2)(a))	Chief Nurse		On track for delivery against the set timescales
M37b.N		The trust must ensure staff follow systems and processes to safely prescribe, administer, record and store medicines. (Regulation 12 (1)(2)(a))	Medical Director		On track for delivery against the set timescales
S3/N	Medical care (including older people's care)	The service should ensure all staff complete safeguarding training in line with national guidance.	Chief Nurse	Report with % trained and process for monitoring going forward	On track for delivery against the set timescales
S27.N	Medical care (including older people's care)	The trust should ensure that all ward areas are free from clutter and relative rooms are fit for purpose at all times. (Regulation 15).	Chief Nurse		On track for delivery against the set timescales
S28.N	Medical care (including older people's care)	The trust should ensure that all ward areas display information on how to make complaints, performance data and information relevant to patients and families on health promotion. (Regulation 17).	Chief Nurse		On track for delivery against the set timescales
Surgery					
M10	Surgery	The service must ensure that actions to protect patient safety are put in place in a timely manner.	Chief Nurse	Staff training on patients safety in surgical areas	Evidence of implementation and embedding
M11	Surgery	The service must continue to monitor and actively recruit to ensure staffing with the appropriate skill mix is in line with national guidance	Chief Nurse	Ratio of skilled versus unskilled Evidence of documentation Escalation and actions if not in place	Evidence of implementation and embedding
M12	Surgery	The service must ensure that assessments are updated in patient records and that there is oversight of NEWS2 observation timeliness for deteriorating patients.	Chief Nurse	Audit of 10 random records per week	Evidence of implementation and embedding
M13	Surgery	The service must ensure that policies are reviewed in a timely manner and that they are shared with staff	Medical Director	Audit of 10 random records per week	Evidence of implementation and embedding
S5	Surgery	The service should consider revising the consenting of patients on the day of surgery in line with best practice. ***(Looking at eConsent)***	Medical Director	Check progress of e consent Check current progress Audit 10 patients records per week	Behind delivery date but plan in place to progress

Family and Women's Services					
M14	Maternity	The service must ensure staff accurately complete women's care records with all necessary assessments required to safely monitor mothers and their babies.	Chief Nurse	Audit of 10 random records per week	On track for delivery against the set timescales
M15	Maternity	The service must ensure staff complete fetal growth charts at each appointment.	Chief Nurse	Audit of 10 random records per week	On track for delivery against the set timescales
M16	Maternity	The service must ensure staff complete and annotate cardiotocograph traces in line with national guidance	Chief Nurse	Audit of 10 random records per week	On track for delivery against the set timescales
M18	Maternity	The service must ensure staff compliance with basic life support training meets the trust's compliance target of 90%.	Director Of People Organisational Development & Communications	Staff training identify gaps who is not trained and why not	On track for delivery against the set timescales
M19	Maternity	The service must ensure medicines and hazardous substances are stored securely.	Chief Nurse	Identify which areas have hazardous chemicals Audit areas	On track for delivery against the set timescales
M22/N	Maternity	The service must ensure that staff complete mandatory training to meet the trust's compliance target.	Director Of People Organisational Development & Communications	Workforce training compliance report	Evidence of implementation and embedding
M38.N	Maternity	The service must implement an effective governance system and ensure systems to manage risk and quality performance are effective. Regulation 17 (1)(2)(a)	Medical Director		On track for delivery against the set timescales
M39.N	Maternity	The service must ensure all steps are taken to appropriately manage and maintain safe staffing in the maternity unit. Regulation 18 (1)	Chief Nurse		On track for delivery against the set timescales
M40.N	Maternity	The service must ensure a robust, embedded and audited maternity triage system with appropriate guidance and training to help keep women and babies safe. Regulation 17 (1)(2)(a)	Chief Nurse		On track for delivery against the set timescales
S6	Maternity	The service should ensure there is an arrangement in place for a dirty utility in the antenatal clinic.	Chief Nurse	Check for assurance and sustainability	Evidence of implementation and embedding
S8	Maternity	The trust should ensure reusable equipment is cleaned appropriately after its use.	Chief Nurse	Check for assurance and sustainability	On track for delivery against the set timescales
S14	Maternity	The trust should ensure detailed minutes of meetings are recorded to accurately reflect discussions, actions and responsibilities.	Chief Nurse	List of all meetings/Tor/Mins	Evidence of implementation and embedding
S19	Services for children and young people	The service should improve access to allied health professionals, specifically in the Neonatal Intensive Care Unit.	Chief Nurse	Check recruitment and process for access	On track for delivery against the set timescales
S29.N	Maternity	The service should ensure that safety champion roles and responsibilities are clear to maternity staff and they are involved in the process. (Regulation 17)	Chief Nurse		Evidence of implementation and embedding
S30.N	Maternity	The service should ensure they are infection prevention control compliant. (Regulation 12)	Chief Nurse		On track for delivery against the set timescales
S31.N	Maternity	The service should ensure staff have access to the right equipment at the right time at important points in a woman's treatment. (Regulation 12)	Chief Nurse		On track for delivery against the set timescales
S32.N	Maternity	The service should consider internal security access between labour and post natal wards	Director of Strategy and Estates		On track for delivery against the set timescales
Trust					
S4	Trust	The service should monitor national audits and use the results to improve outcomes for patients	Medical Director	Set up process to monitor against	Behind delivery date but plan in place to progress
Services for Children and Young people					
S15	Services for children and young people	The service should continue to ensure staff complete safeguarding training, in line with national guidance	Chief Nurse	Check for assurance and sustainability	On track for delivery against the set timescales
S16	Services for children and young people	The service should ensure there is a nurse trained in advanced paediatric life support (APLS) or European paediatric advanced life support (EPALS) on every shift, in line with guidelines from the Royal College of Nursing.	Chief Nurse	Check recruited and in place	On track for delivery against the set timescales
S18	Services for children and young people	The service should continue to improve transitional arrangements for young people moving to adult services – QI team supporting update project	Chief Operating Officer	Check with Robbie Ayers	Behind delivery date but plan in place to progress
End of Life Care					
S20	End of life Care	Continue to work towards a 7 day service to support patients at end of life	Medical Director	Present back at next Compliance	Evidence of implementation and embedding

Appendix C
Urgent Care Pathway Deep Dive

Current Position

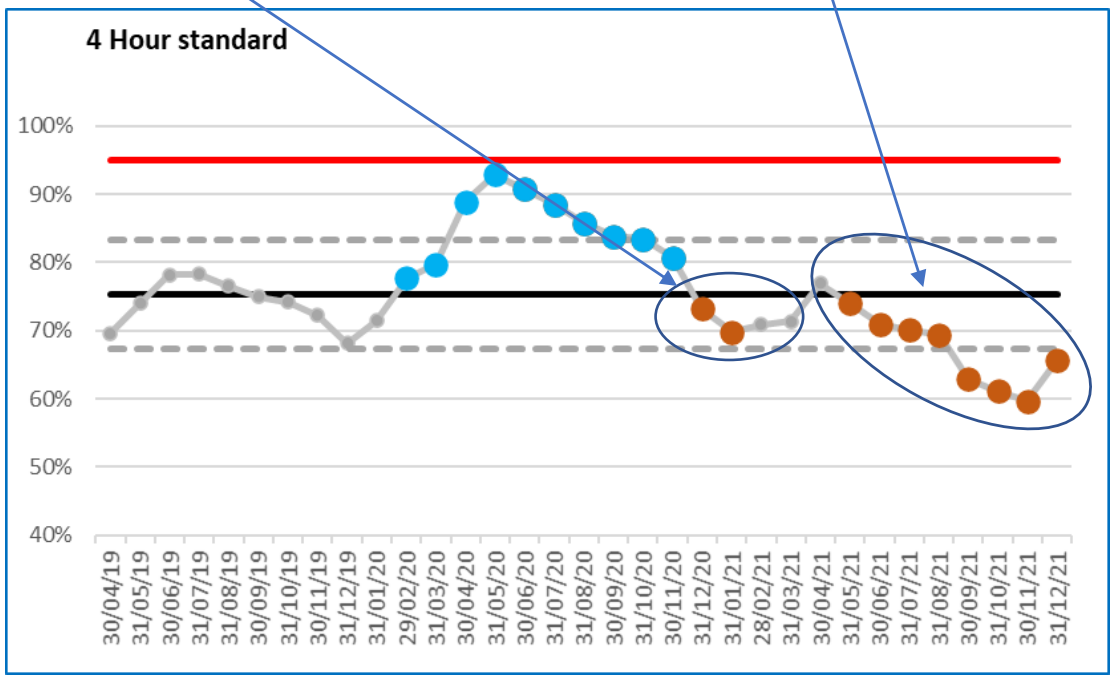
We have not been able to meet the four hour standard for a significant period of time, and since May 2021 there has been a gradual reduction in performance against the standard.

This is driven by a number of factors:
Delays in ambulance offloads
Increased delays in time to triage
Increased delays in wait for specialty review from time of referral
More than doubling of patients waiting more than 12 hours from arrival over last six months

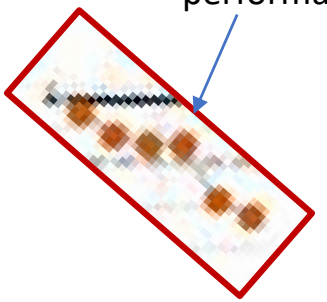
What is the current baseline

The end of 'lockdown' precipitated a significant increase in attendances higher than at any time over the last five years, impacting our performance against the standard

Covid Wave 2

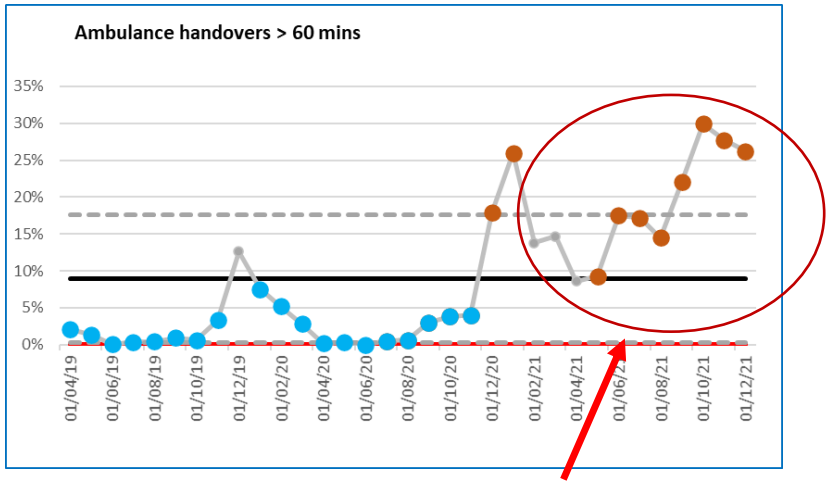


Similar correlation to overall performance against the four hour standard is mirrored in non admitted performance

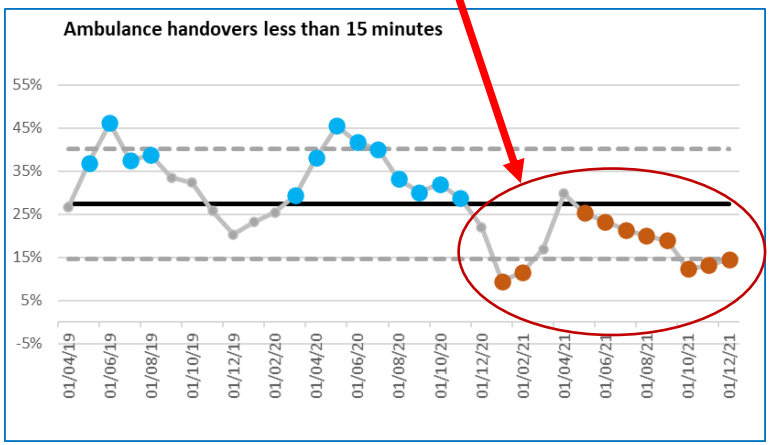


The time series above is for June to November 2021

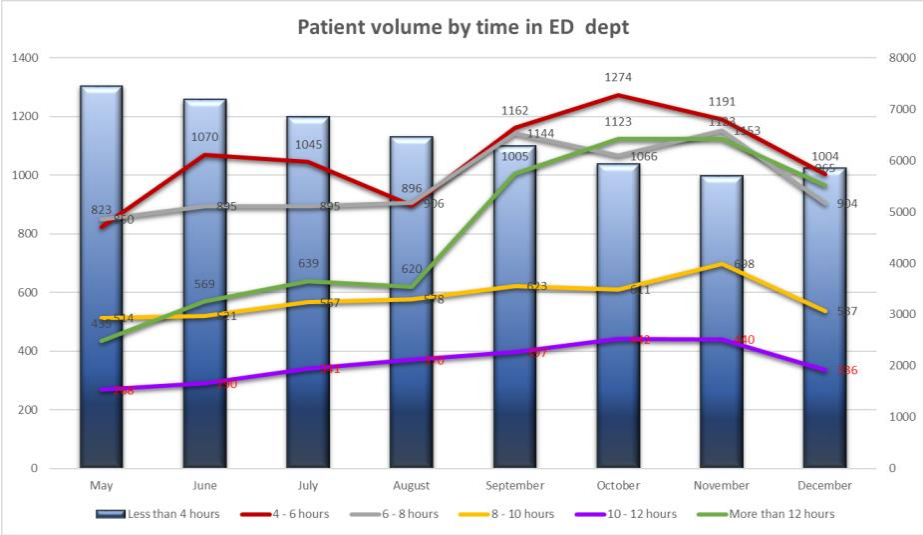
Patient Delays, Ambulance and Emergency Department



Unsurprisingly, as we have seen the proportion of patients offloaded withing 15 minutes, reduce, we have seen a mirror in the proportion of patients waiting over an hour to be offloaded.

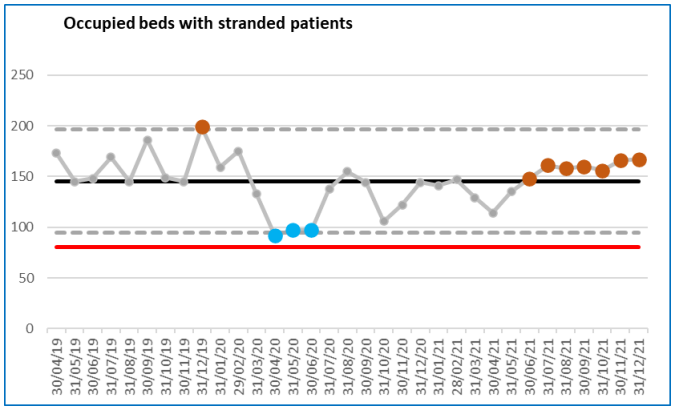


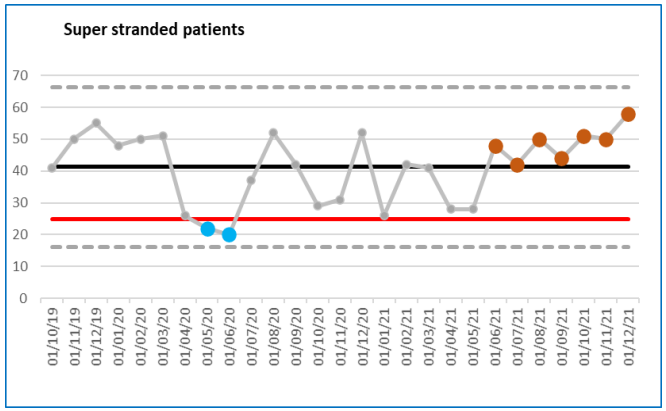
Below shows the breakdown of patients by time period. The gradual reduction of patients in the dept less than four hours is understandably consistent. However, the below shows the significant increase in patients waiting over 12 hours in the dept (nearly double in four months), and those waiting between four and six hours)

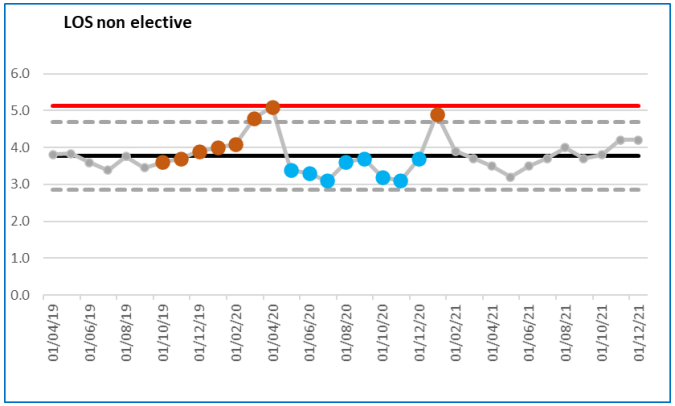


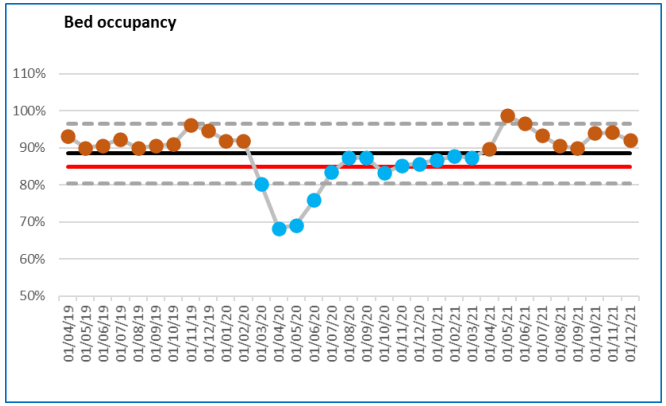
Bed Occupancy

There has been a gradual increase in length of stay, stranded and super stranded patients. However, none of these increases have been significant, and none are in special cause variation. Whilst overall occupancy is in special cause variation, it is consistent with occupancies levels that we generally experienced prior to the first Covid wave in March 2020. If bed occupancy was a key driver to deliver of the four hour standard, we would expect to see more of a direct correlation, ie the consistent downward trend of four hour standard performance set against a consistent upward trend of bed occupancy. This correlation is not evidenced

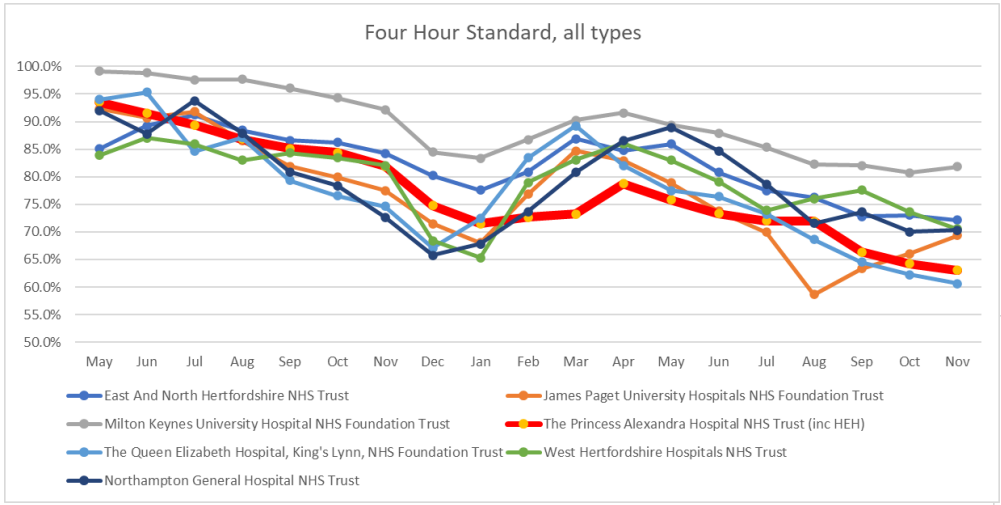


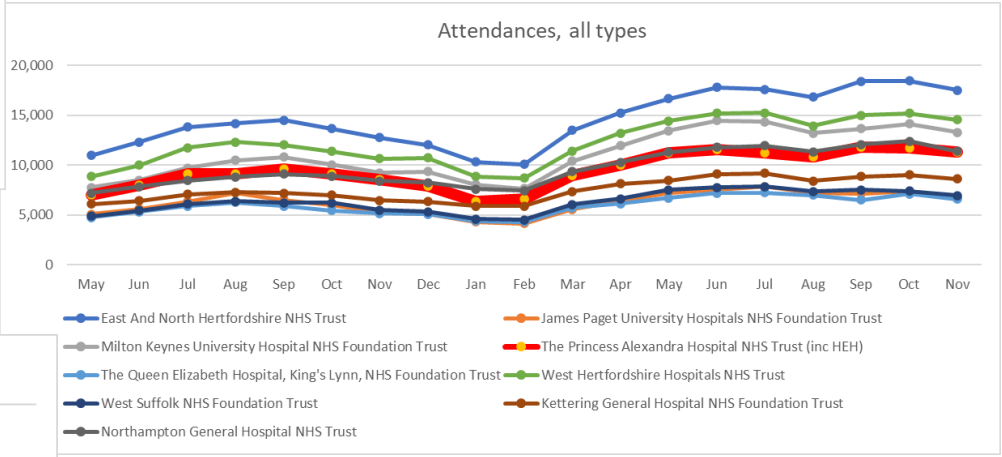


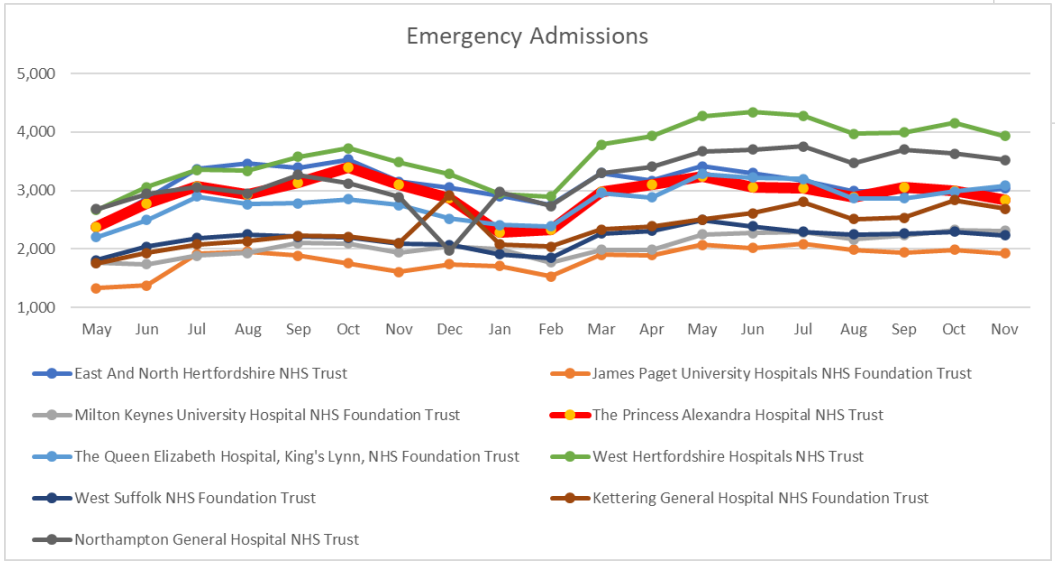




Benchmarking with peers

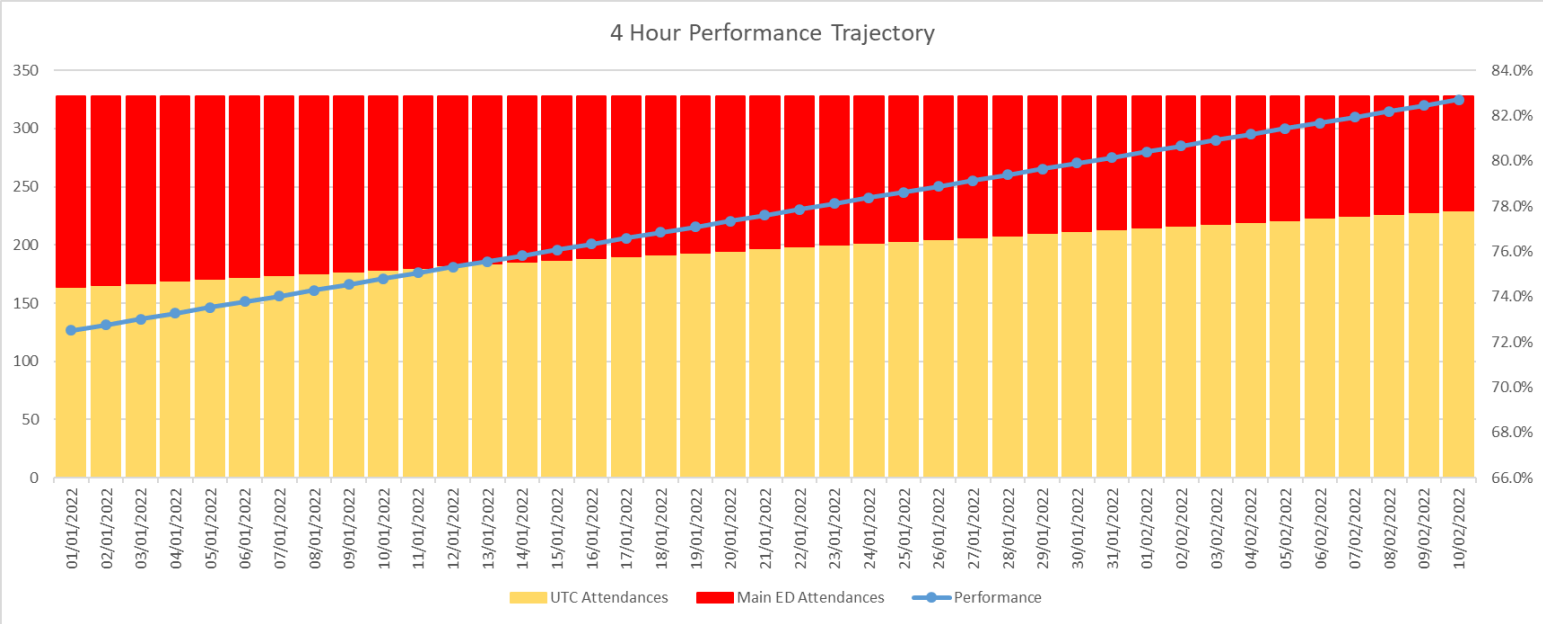






Attendances and admissions have followed a consistent trend with peers over the last 18 months. However, performance against the four hour standard has not been as consistent

Trajectory



Based on the average daily attendances we have seen between 01/11/2021 – 31/12/2021. If we continue on trajectory for UTC to see 70% of patients by mid February & performance for UTC remains the same (which we have seen so far) and ED 4 hour performance remains as is. We should see a positive impact on overall 4 hour performance – reaching almost 83% by mid February.

Trust Board (Public) – 3 February 2022

Agenda item:	6.3									
Presented by:	Stephanie Lawton, Chief Operating Officer									
Prepared by:	Stephanie Lawton, Chief Operating Officer									
Date prepared:	28 January 2022									
Subject / title:	Trust response to the Health and Safety Executive									
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**			
Recommendation:	The Trust Board is asked to note the formal response from the Chief Executive to the Health and Safety Executive following their formal inspection in October 2021.									

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:	
Risk / links with the BAF:	Health and Safety
Legislation, regulatory, equality, diversity and dignity implications:	Health and Safety Act 1974
Appendices:	1 – Letter to the HSE 2 - Evidence to the HSE

NHS
The Princess Alexandra Hospital
NHS Trust

Princess Alexandra Hospital
Hamstel Road
Harlow
Essex
CM20 1QX

28 January 2022

Dear Jessica

Re: HSE Reference Number: 4692007

I am writing in response to your HSE inspection and subsequent letter dated 2 November 2021. I attach our response to the inspection with the supporting evidence as detailed in your letter. I understand that Stephanie Lawton Chief Operating Officer discussed the progress made across the organisation following your visit in October and appraised you of the context our teams have been working in since December to date.

I am pleased to advise you that the Trust Board and senior management teams across the divisions have been fully sighted and informed of the progress made and the small areas of work that remain ongoing.

Detailed below as requested is the Trust response with examples of the specific areas you requested.

1. **Control of risk to Lone Workers including training**

   The Trust policy and procedure to support Lone Working has been reviewed and updated with the Local Security Management Specialist. The LSMS has reviewed the number of devices in operation across the Trust and has now instigated a monthly report from the service provider that details when and where a device has been activated. This report will be shared with divisional safety and risk teams and presented at the health and safety committee. The majority of lone worker devices are allocated to staff within the Family and Women's Division. The devices in operation contain a timer which is activated when the user is in a position of lone working. If the timer button is not activated, this triggers an automatic alarm signal to the service provider who raises an alarm in the control centre, the service operator can speak to the lone worker through the device and if no response or not satisfied with the response can raise this immediately with the police. A code word has been agreed with the team and all staff are aware of the application and use of code word going forward.

   A monthly report from the Maternity Services team will be presented at the FAWs Divisional Board meeting. An audit timetable and programme with regular training for staff on the application of devices is in place and will commence at the start of the new financial year 2022/23.

   The white board in the Maternity Unit with details of midwives supporting home births has been updated to ensure midwife details are updated once support has

concluded. A "buddy system" for community midwives is in place and will be supported by the new electronic device system once this is launched. However the FAWs Division is confident that the pathway which included linkage to safeguarding, GP services, HCPs etc. was working well in terms of highlighting potentially volatile environments.

The overarching Trust policy is being presented at the Trust Policy Group in February 2022. Following ratification, a copy will be shared with you for information. Due to severe operational pressures in the Maternity Service over the last 6 weeks, there was a slight delay in finalising the policy. I understand Stephanie appraised you of this during her call with you on the 27th January 2022.

A copy of the risk assessment for lone working in Maternity is attached below. The detailed outlined above addresses the recommendations in points 1&3 in your letter.

2. Ward specific risk assessments and training for violence and aggression

The process of ward risk assessment has been reviewed by the heads of nursing and medical patient and safety teams. Nightingale Ward at the time of your visit was a medical ward. This ward is predominantly used for winter escalation capacity. The ward following your visit has been used as both medical and surgical capacity. There have also been periods over the last 8 weeks where the ward has been closed down. In terms of specific ward risk assessment, I have attached a copy of the generic ward risk assessment the team have completed for Nightingale ready for its re occupation and also a copy of the main medical ward.

Training needs analysis in relation to violence and aggression is part of a wider trust review of all statutory and mandatory training. This work is well underway led by the Trust Director of People with the aim to have clear training requirements in place from the start of the year April 2022. All ward risk assessments have been reviewed and now incorporate violence and aggression. An example of this is attached.

3. Completion of debrief forms following V&A incidents

The Trust policy pertaining to management of violence and aggression has been reviewed and in accordance with your suggestion we have now incorporated debrief into the policy. This is due to be ratified 1st February 2022.

The Violence Prevention Reduction Standard Policy has been reviewed with a gap analysis completed. A detailed action plan is in place with compliance dates monitored through the estates and facilities departmental governance forum with regular reports into the health and safety committee. The Director of Strategy and Estates has full executive oversight of all actions. All workplace incidents will be reviewed by the estates and facilities team through the datix report which will determine whether a debrief form and discussion is sufficient, a round table review or requires further investigation and action.

4. Core Security Cover

A full review of the security service has been completed with our current service provider, estates and operational teams. As an interim and immediate measure additional security presence onsite has been increased with 3 additional guards 24/7. A detailed business case is currently being developed and will be addressed through the annual business planning

cycle. The security service is currently an externally commissioned service. It is anticipated that the revised security resource and service will be in place at the start of April 2022.

5. **Manual Handling**

We recognise the importance of having a competent person for this role and can confirm that the advert has been published, with interviews scheduled for February, as Stephanie informed during her call. The development of this post will be influential to further improvements being made.

In addition to the above the Trust's Electrical Bio Medical Engineering (EBME) department centrally manage the procurement, servicing and maintenance provision of all medical equipment including beds and hoists. The team are also responsive for ensuring training on all new equipment.

The Trust's portering team are undertaking clinical manual handling training relevant to their specific roles and responsibilities across the organisation. This training has been designed in conjunction with the portering team.

As part of the risk and governance oversight within the facilities department, the portering team review all datix incidents relating to manual handling and equipment and have developed a range of standard operating procedures specific to the equipment used.

6. **Control of risk from COVID-19**

I am pleased to confirm that immediate and ongoing action was taken in relation to the doctor's mess. All junior doctors have been reminded of Covid-19 compliance requirements. The junior doctor's mess president has been pro-active in her approach in supporting the Trust with providing clear and ongoing instructions to all users of the facility. There are regular spot checks on the use and standard of the room. The estates and facilities team together with the health and safety manager are frequent attenders to ensure compliance is evident. A number of the chairs were removed to provide social distancing, additional stickers have been placed appropriately with ventilation improved. Our Health & Safety Manager has also diarised quarterly spot checks to ensure that this is maintained.

Your letter also details a number of additional recommendations. I am pleased to provide a further update in relation to the actions taken.

1. **Sharing risk assessments**
   Risk assessments are shared within the Divisions, where applicable they are also lodged onto the Divisional risk registers and reviewed regularly at the risk management group. Exception reports give information on progress of actions which will be tracked through the performance review meetings. In addition, divisions all frequent safety huddles where incidents and events are discussed, and immediate steps taken to prevent further occurrence. Learning from these huddles are shared across divisional teams.

2. **ED V&A Risk Assessment**
   The emergency department have reviewed their risk assessment which now incorporates all areas within emergency care including the mental health room within ED majors. The team are continuing to work with mental health colleagues to enhance facilities and support for patients presenting at PAH. The Trust Mental Health Quality Forum which has system representation is monitoring all incidents and pathways. This detail is shared at the Board's Quality and Safety Committee.

The Princess Alexandra Hospital NHS Trust

3. **Review of Policies**
   - Manual Handling Policy
   - Security Policy
   - Management of violence and Aggression policy
   - Lone worker policy

   All policies are being presented on the 1st February 2022 at the Trust Policy Group for formal ratification. Thereafter, detailed implementation and training will follow and be rolled out across the Trust.

4. **Contact Numbers for Security team**
   Contact details for the security have been restated. The Trust has published details of all contact numbers on the newly launched intranet page. In addition to the main hospital numbers, the emergency department have access to mobile radios with immediate contact through to the security team.

5. **Completion datix reports**
   Datix incidents where applicable are discussed at Incident Management Group. Service areas are monitored for trend analysis and the data is shared with the health and safety committee. Staff are all encouraged to complete incident reports in a timely manner.

6. **V&A alerts on patient records**
   IT software and system updates and modifications and improvements are a constant focus for the IT team and elements are being explored to support this. The software application is just being reviewed. The go live date had to be postponed following testing where an issue remains unresolved. The IT team are working on a go live date within the next few weeks.

I would like to add that we have an additional group within the Trust chaired by our SHaW team (Staff Health and Wellbeing). This group actively monitors staff incidents and where required support staff via a referral system. In addition, all staff are able to make direct contact with the team if they should need to. We also have health and wellbeing champions across the Trust who provide support and advice at local level.

Thank you for your ongoing support with these improvements.

Yours sincerely,

Lance McCarthy
CEO
Princess Alexandra Hospital NHS Trust

The Princess Alexandra Hospital NHS Trust

Public Board Meeting
3 February 2022

Agenda item:	6.4
Presented by:	Phil Holland CIO and Saba Sadiq Director of Finance
Prepared by:	EHR Programme Team
Date prepared:	27th January 2022
Subject / title:	EHR Programme Update

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	The Trust Board are requested to note: 1. Approval, with conditions to be factored into the development of the Full Business Case, of the EHR Outline Business case at the Joint Investment Sub Committee meeting on 17th January 2022 2. EHR as an enabler to deliver new ways of working and as underpinning infrastructure in our New Hospital 3. The benefits to our patients, people and partners 4. The expected timescale for the development of the Full Business Case
Recommendation:	The Board are requested 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:	
Risk / links with the BAF:	1.2 EPR
Legislation, regulatory, equality, diversity and dignity implications:	N/A
Appendices:	N/A

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

1.0 Purpose

Provide an update to the Trust Board on the progress of the Electronic Health Record (EHR) programme and the approval of the EHR Outline Business Case (OBC) by NHS England and NHS Improvement's (NHSE/I) Joint Investment Sub Committee (JISC).

2.0 Background

Following a programme of work started in early 2020, in May 2021 the Trust Board approved a Strategic Outline Case (SOC) that set out the rationale for a significant investment in an integrated Electronic Health Record (EHR) system to replace the Cambio Cosmic solution and a range of other clinical systems that have been deployed over recent years within the Trust. This investment represents the biggest investment the Trust will have made until the New Hospital is approved and is key enabling infrastructure of the delivery plan for the Trust's 2030 strategy.

In May 2021 NHSE/I approved the Trust's SOC and agreed to the development of an OBC on the basis of the SOC.

The OBC was developed to provide the necessary information to make the case for change underpinned by new ways of working, determine 'the preferred way forward' and its financial implications and any related risks. This OBC was approved by the Trust Board in September 2021 and submitted to NHSE/I for approval on 15 September 2021.

3.0 Why a new EHR is needed

A new EHR will be a major step forward in the transformation of our care. We are limited by the Trust's existing EHR solution which is not able to meet all of our current or future requirements. Over the last few years, the Care Quality Commission has consistently raised concerns with our record keeping mechanisms despite the best efforts of our people to work around the limitations of current systems. This has led to a risk on the Trust's significant risk register and the Board Assurance Framework.

As well as addressing the existing risk the Trust is looking to the future. The Trust has been identified as the recipient of New Hospital Programme funding for the building of a new hospital. The intention is that, upon opening, our New Hospital will already be enabled with an embedded digitally mature EHR to support delivery of new clinical pathway benefits for our patients and people. A new EHR that is capable of supporting the Trust's plans and future digital strategy is therefore needed.

4.0 What benefits will a new EHR deliver

A new EHR will bring significant benefits to our patients, our people and our health system partners:

- **Better care**: improving and delivering patient-centre care, including safety, effectiveness, communication, education, timeliness, efficiency, and equity.

- **Better health**: encouraging healthier lifestyles across our population, including increased physical activity, better nutrition, avoidance of behavioural risks, and wider use of preventative care.
- **Better use of resources**: promoting preventative medicine and improved coordination of health care services, and reducing waste and redundant tests.
- **Better decision making**: integrating patient information from multiple sources including GP practices and health and social care providers across the One Health and Care Partnership.

The right care at the right time, by the right people in the right place.

5.0 What has happened since OBC submission

Following the submission of the OBC the Trust has been engaging with representatives of NHSEI, NHS X, NHS Digital and Department for Health and Social Care to respond to their queries and enable them to complete their review processes. This process concluded in January 2022 with NHSEI/ making a recommendation to the JISC, supported by NHS X that the OBC be approved, and the Trust proceed to develop a Full Business Case (FBC) for the implementation of a new integrated EHR for the Trust. On Monday 17 January 2022 the Joint Investment Sub Committee supported this recommendation subject to a small number of conditions on how the FBC will be developed.

6.0 Next steps

The Trust is now in a position to assess potential suppliers and decide on the best solution for the Trust considering capability, usability and value for money. A FBC will be prepared reflecting the outcome of the assessment and recommend the preferred option. This will be used to apply for funding and gain approval to invest in this essential digital technology that will enable the Trust to start to deliver its 2030 strategy.

It is intended that the FBC will be submitted for approval by the end of 2022 and implementation of the new EHR will commence in 2023/24, and be fully operational in 2024/25.

7.0 Recommendation

The Trust Board is asked to note the achievement of this milestone in the EHR programme and the next steps, including FBC timeline.

BOARD OF DIRECTORS: **Trust Board (Public) 3 February 2022** **AGENDA ITEM: 7.1**

REPORT TO THE BOARD FROM: **Strategic Transformation Committee**

REPORT FROM: **John Hogan – Committee Chair**

DATE OF COMMITTEE MEETING: **24 January 2022**

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
1.3 Work Plan	Partial	Yes	Exec	PAH 2030 progress to be reported to each meeting. Executive to review workstream reporting and what is being reported to other committees.
1.4 ToRs	Yes	Yes	HoCA	Recognition that this is developing as the committee develops. HoCA to check with Executive colleagues and revise as necessary with a full review in six months' time.
2.1 PAHT 2030	Partial	Yes	Executive	STC requested delivery plan ASAP to enable proper monitoring.
2.2 New Hospital	Partial	Yes	DoS	MM to review level of independent challenge to programme.
2.3 BAF New Hospital Risk 3.5	Yes			Risk score to remain unchanged.
2.4 System Transformation	Yes	Yes	Executive	Executive to ensure alignments with ICS/P/B as their role becomes clearer.
2.5 PMO	Partial	Yes	DD - PMO	STC needs to understand role and purpose of PMO as well as monitor progress of actual tasks.
2.6 Clinical Strategy	Partial	Yes	MD/HoCA	Programme of work on consultant culture change and engagement needed. Committee to decide whether to invite Rob Gerlis to meetings on next agenda. To add presentations of projects on the agenda for future meetings to enable scrutiny.
2.7 Virtual Hospital	Partial	Yes	DMD	Proposals needed to develop remote monitoring/digital input to ensure effective service.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) 3 February 2022**			**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee**			
REPORT FROM:	**John Hogan – Committee Chair**			
DATE OF COMMITTEE MEETING:	**24 January 2022**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.8 EPR/EHR	Assured	Yes		Timetable to be provided to next meeting to enable monitoring.
2.9 EPR/EHR BAF Risk	Yes	No		Risk score to remain unchanged.
3.4 Review of meeting	Yes			Made a good start. Recognised that culture change/programme key to most items. Committee needs actual projects and timelines to be assured.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 3rd February 2022 **Item No: 7.2**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy – Chairman
DATE OF MEETINGS: **04.01.22 and 18.01.22**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

- The following items were discussed at SMT meetings in January

4 January 2022:

Due to operational pressures this meeting focussed on the Covid position and operational pressures. Members were given an opportunity to raise any concerns they had in regards to Covid/operational pressures.

18 January 2022:

- Significant Risk Register
- Quality Briefing
- Quality PMO report
- Recovery Snapshot – Weekly
- Deloitte Well Led Action Plan
- Midwifery Establishment Review
- 8x8 Outage and lessons learned
- Vaccination as a condition of deployment
- Update on actions taken to ensure nursing and midwifery safe staffing during winter 21/22
- 2022/23 Operational Planning Guidance

7.2