The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 4 August 2022 at 09.30 – 12.30
Venue: Virtual (via MS Teams)

	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	13
09.35	Patient Story: Anne's Story				
02 Chair and Chief Executive's reports					
10.00	2.1	Chair's report	Inform	Chair	14
10.05	2.2	CEO's report including: • COVID-19 update • ICS/ICB update	Inform	Chief executive	17
03 Risk					
10.15	3.1	Significant risk register	Review	Medical director	21
10.25	3.2	Board assurance framework 2022-23 *Diligent Resources: PAHT Board Assurance Framework 2022/23*	Review/ Approve	Head of corporate affairs	28
04 Patients					
10.30	4.1	Report from Quality and Safety Committee 29.07.22: • Part I • Part II – Maternity Oversight	Note	Committee Chairs	 32 36
10.40	4.2	Maternity Incentive Scheme: • PMRT • Maternity Quarterly Assurance (including Maternity SI report) • Preterm birth Deep Dive • Annual Maternity SI Thematic Review	Assure	Director of nursing and midwifery	 39 46 56 65
10.50	4.3	Nursing, midwifery and care staff levels including nurse recruitment	Assure	Director of nursing and midwifery	72
10.55	4.4	Interim mid-year nursing and maternity establishment review	Assure	Director of nursing and midwifery	92
11.05	4.5	Learning from deaths (Mortality)	Assure	Medical director	99
11.10	4.6	Deep dive: Improvement in Mortality indices	Assure	Medical director	106

		Diligent Resources: Telstra report for PAH			
		BREAK			
05 People					
11.30	5.1	Report from People Committee 25.07.22	Note	Committee Chair	108
11.35	5.2	Freedom to Speak Up Report	Note	DoP	111
11.45	5.3	Medical Revalidation Annual Report and Statement of Compliance	Approve	Medical Director	123
06 Performance/pounds					
11.55	6.1	Report from Performance and Finance Committee 28.07.22	Note	Chair of Committee	140
12.00	6.2	Integrated performance report	Discuss	Chief Information Officer	145
07 Strategy/Governance					
12.15	7.1	Report from Strategic Transformation Committee 25.07.22	Inform	Chair of Committee	203
12.20	7.2	Report from Senior Management Team Meetings	Inform	Chair of Committee	206
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	
12.30	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

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 2022/23			
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	Interim Director of Finance	Tom Burton
Chair of Charitable Funds Committee (CFC)	Dr. John Keddie	**Executive Members of the Board (non-voting)**	
Chair of Strategic Transformation Committee (STC)	Vacant	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
Associate NED	Dr. Rob Gerlis		
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public
Thursday 9 June 2022 from 09:30 to 11:30

Present:	
Hattie Llewelyn-Davis	**Trust Chair (TC)**
Liz Baker (non-voting)	Associate Non-Executive Director (ANED-LB)
Tom Burton	Interim Director of Finance (DoF)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Rob Gerlis (non-voting)	Associate Non-Executive Director (ANED-RG)
Fay Gilder	Medical Director (MD)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Helen Howe	Non-Executive Director (NED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Lance McCarthy	Chief Executive Officer (CEO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)
In attendance:	
Ann Nutt	Chair of Patient Panel (CoPP)
Laura Warren	Associate Director – Communications (AD-C)
Giuseppe Labriola	Director of Midwifery (DoM)
Staff Story:	
Ahmed Abdelaal (Staff Story)	(Dr-AA)
Members of the Public	
None	
Apologies:	
Phil Holland	Chief Information Officer (CIO)
Darshana Bawa (non-voting)	Associate Non-Executive Director (ANED-DB)
Colin McCready	Non-Executive Director (NED-CM)
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, particularly the new Interim Director of Finance, Tom Burton (I-DoF).
1.1 Apologies	
1.2	Apologies were noted as above.
1.2 Declarations of Interest	
1.3	It was noted that Associate Non-Executive Director Rob Gerlis (ANED-RG) would be Chair of Stellar Healthcare from 01.07.22.
1.3 Minutes of Previous Meeting	
1.4	These were agreed as a true and accurate reflection of the meeting held on 07.04.22 with the following amendments: Minute 4.7 'In response the MD confirmed there were ~~12~~ **11** criteria that would prompt a SJR …' Minute 4.17 Assurance had also been improved in terms of the Maternity Improvement Board/QSC Part II and there was also ~~now~~ a Maternity Safety Improvement Partner and links to the Regional Midwife.

	Minute 5.6 'Her reflection would be that the timing of the survey needed to be taken into consideration given it was soon after the publication of the CQC report and ~~had~~ **may have** influenced how staff had responded.'
1.4 Matters Arising and Action Log	
1.5	There were no matters arising and the action log was noted.
Staff Story: Certificate of Eligibility for Specialist Registration (CESR)	
1.6	The Director of People (DoP) welcomed Locum Consultant Anaesthetist Doctor Ahmed Abdelaal (Dr-AA) to the meeting and handed over to him to talk the Board through his story. Members were informed that CESR was for doctors who wished to join the GMC Specialist Register and whose specialist training, qualification or experience had been partly or completely acquired outside of an approved CCT (certificate of completion of training) programme in the UK. It was equivalent to a CCT and certified that the doctor had all of the competencies defined in the CCT curriculum known as specialist registration. The doctor would be required to compile a portfolio of evidence that demonstrated they had achieved the equivalent skills and experience reflective of a GMC approved training programme. The CESR process normally took around six months to complete.
1.7	Dr-AA continued that in response to his application for CESR, the GMC had accepted all the evidence submitted, apart from in Domain 1. Its recommendation had been that placements should be undertaken for higher level training in Neurosurgery, Cardiothoracic surgery and Paediatric surgery, in addition to high level ITU, general duties, intermediate level obstetrics and pain management. Those placements could be undertaken on a day release basis but should offer the experience equivalent to three months of training, as per GMC recommendations.
1.8	Dr-AA confirmed the above response had been received from the GMC after Christmas 2021 and he had been given 12 months in which to fulfil the criteria and be granted specialist registration.
1.9	Dr-AA continued that he tried to gain as much evidence from PAHT (where he had already been working for four years) but the challenge had been arranging placements for those specialities not provided at PAHT.
1.10	In order to complete the placements without compromising his commitment to PAHT, it had been agreed he could undertake eight weeks' work in four weeks and he had also used some of his annual leave to 'pay back' days owed to his department as well as undertaking extra lists not covered by an Anaesthetist.
1.11	In terms of the placements for specialties not covered at PAHT, Dr-AA informed members that the Neurosurgery placement was the easiest to find – that had been undertaken at Queen's Hospital, Romford in February 2022 and had been signed off. The placement for Cardiothoracic surgery was undertaken at Bart's in April 2022 and had also been signed off. The hardest to secure had been Paediatric surgery. In the intervening period he had focussed on Paediatric cases at PAHT (64 cases to date) and then finally at the third time of asking he had been able to secure an honorary placement at Birmingham Children's Hospital.
1.12	In terms of next steps Dr-AA confirmed his ambition would be to secure a substantive appointment at PAHT and also to establish a CESR programme in Anaesthesia and to become the Co-ordinator for that in the Trust.
1.13	In response to the above ANED-RG thanked Dr-AA for presenting his story. In his view there was a shortage of specialist staff across the ICS which needed to be addressed by some form of collaborative. He thanked Dr-AA for his dedication in terms of having to condense his working week in order to be able to undertake the CESR. In response Dr-AA stated that for other colleagues the process may be shorter in terms of securing placements.
1.14	In response to the above the CEO asked Dr-AA what else the organisation could have done to support him on the pathway. In response Dr-AA commented that better connections with other trusts in terms of the placements would have been helpful.

1.15	NED Helen Howe (NED-HH) commended Dr-AA for his work to date. She added it might be worthwhile in terms of the Co-ordinator role, to have a focus on culture/regulatory frameworks/ GMC rules which many colleagues from abroad may not be as familiar with as they embarked on their CESR journey. In response Dr-AA agreed and acknowledged the difficulties he himself had experienced coming over from Egypt.
1.16	In response to the above NED George Wood (NED-GW) commented that he found Dr-AA's enthusiasm to PAHT motivational. The Director of Nursing & Midwifery (DoN&M) added the tenacity shown to achieve the qualification was inspirational. She reflected however the experience in terms of nursing was the exact opposite, and if the organisation was smart in terms of its workforce strategy it could harness the experience presented that morning to understand what the organisation required moving forward in terms of specialist registration. A positive was that all specialties were covered in terms of the East of England (EoE) area. Dr-AA agreed and added that would also encourage other candidates. In terms of the EoE he had found that whilst the specialities were there, there was often insufficient capacity to support colleagues from other hospitals as well as their own.
1.17	In summary the TC thanked Dr-AA for presenting his story and for all his hard work to date. She acknowledged the ambition to create a substantive CESR Co-ordinator post and the elements that may need to be picked up in terms of the ICS moving forward to make the organisation more attractive to future recruits. She acknowledged the comments around culture and learning from existing structures, for example, nursing.
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	This report was presented by the TC and taken as read. Members had no comments.
2.2 CEO's Report	
2.2	This update was presented by the CEO. He informed members in terms of COVID, inpatient numbers were dropping slightly and progress in terms of recovery continued to be positive. He cautioned however that demand for Emergency Care continued to remain high and some of that was related to COVID. Changes continued to be made in terms of infection prevention and control guidance and some would be made imminently in terms of the use of face masks for patients/visitors to make that more in line with national guidance.
2.3	He drew members' attention to the fact there had been 320 monkeypox cases nationally, with two confirmed cases at the Trust, neither requiring admission. It was a rare but infectious disease so the IPC team had been working closely with ED colleagues to ensure full understanding of presenting symptoms and appropriate actions to undertake, including the use of the appropriate Personal Protective Equipment (PPE).
2.4	In terms of Maternity Services there had been good progress with the implementation of relevant actions aligned with the recent recommendations from the Ockenden review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. Since the last meeting there had also been confirmation from NHS Resolution that following a deep dive into evidence, the department had met all ten safety actions of the year 3 CNST Maternity Incentive Scheme (MIS). That demonstrated strong governance and oversight in the department and created a strong base for the year 4 MIS actions.
2.5	He reminded colleagues that on 01.07.22 Integrated Care Systems (ICS) would formally become Integrated Care Boards (ICB) following royal assent of the Health and Care Bill in April.
2.6	In terms of 'This is Us' there had been some good/ongoing embedding of new divisional structures and meetings to talk about what had gone well. He also reminded members that 'This is Us' week would run from 27.06.22 to 02.07.22 and he encouraged colleagues to take part in that, particularly the Annual People Awards.
2.7	As a final point the CEO confirmed that the government had published its review of health and social care leadership and management undertaken by Gordon Messenger. This had come up with seven recommendations around training and entry level, EDI and inclusion, appraisal, talent management, NED talent management and increased support for

	challenged trusts. It linked to the CQC Well-Led domain so colleagues would now go through those recommendations to see exactly what was required.
2.8	In response to a question from the Chair of the Patient Panel (CoPP) as to where appointments to the new ICBs had been advertised, it was confirmed that had been a campaign run under national guidance with the use of head-hunters.
2.9	In response to a second question from the CoPP, it was confirmed that actions were underway internally to address the issue of provision of food for patients waiting a long time in the ED.
2.10	At this point ANED-RG cautioned that the issue of long-COVID should not be forgotten in terms of both staff and patients.
2.11	NED Helen Glenister (NED-HG) flagged that the ICS was developing the Hertfordshire and West Essex Voluntary Social Enterprise Alliance focussed on the engagement of communities.
2.12	The CEO then reminded colleagues it was Pride month that month and there would be a number of activities and celebrations to support colleagues.
2.13	In response to the earlier conversation around monkeypox the TC commented it would be important to ensure people felt safe/welcomed and that staff were appropriately briefed.
2.14	ANED Anne Wafula-Strike (ANED-AWS) then asked whether there had been any specific messaging to the community on monkeypox. In response the CEO confirmed there had been messaging from Public Health England and Primary Care and messaging for patient staff/patients in the hospital, but nothing directly from the hospital to the community.
2.15	The TC thanked the CEO for his update.
03 RISK/STRATEGY	
3.1 Significant Risk Register	
3.1	This paper was presented by the Medical Director (MD). She drew members' attention to a new risk (with a score of 20) related to the requirement for the Maternity Unit to be refurbished. The CEO was able to update that work was underway to determine the work required for the maternity unit as part of a whole site development plan and from there an options appraisal would be shared with the Senior Management Team (SMT).
3.2	In response to a question from NED-GW around the sharing of medical records the MD provided assurance that My Shared Care Record was in use and Trust colleagues were also able to access Systm1. She acknowledged there were issues in terms of maternity records but the Director of Midwifery (DoM) was able to provide assurance there was a Task & Finish group looking at repatriating some of the work from the Lister hospital and for some midwives to be TUPED over. NED-GW provided an example of a case of a medical patient where a woman had been transferred over from the Lister but her medical records had been delayed which had delayed receipt of correct medication. The MD agreed to understand if medical record transfer from the Lister was a common problem for the clinicians
ACTION **TB1.09.06.22/07**	**Understand whether medical record transfer from the Lister was a common problem for clinicians.** **Lead: Medical Director**
3.3	In response to a question from ANED Liz Baker, it was confirmed the Maternity Unit was currently not fit for purpose in terms of estates elements and in terms of how patients were triaged. That was not however reflected in incidents, but was an issue in relation to compliance with the Ockenden requirements. The DoN&M noted that, for example, there were no ensuite bathroom facilities. It was emphasised however by the CEO that the department was not unsafe, but the current estate was far from ideal.
3.4	The TC summarised by stating that the SRR had been noted and that the site development plan would be reported to a future meeting of the Board. Potential gaps in sharing patient information between the Lister and PAHT were being addressed and the Medical Director would look into that further.
3.2 Board Assurance Framework (BAF) 2021/22	

3.5	This paper was presented by the Head of Corporate Affairs (HoCA). Following feedback received a revised BAF reporting format was being trialled that month and members were asked to provide feedback on that.
3.6	The risks had been updated with executive leads and reviewed at the relevant committees during May 2022. Following review at QSC in May 2022 it was proposed to reduce the risk score for BAF risk 1.0 COVID from 16 to 12. BAF risk 3.2 (Financial and Clinical Sustainability across health and social care system) was also included for consideration by the Board as the Board was responsible for reviewing that system risk. The remaining risk scores had not changed that month.
3.7	In response to the above NED-HG commented that she very much supported the changes in format. NED Helen Howe (NED-HH) also supported the revised format but requested that target scores remained within the summary document so the context was not lost. The HoCA agreed that could be actioned.
ACTION TB1.09.06.22/08	**Target scores to remain within the BAF summary document. Lead: Head of Corporate Affairs**
3.8	In line with the recommendation the Board approved the reduction in score for BAF risk 1.0 COVID from 16 to 12, noted the updates to the other risks discussed in committees and approved the revised reporting format.

04 PATIENTS	
4.1 Report from Quality & Safety Committee (QSC)	
4.1	The reports for both parts I and part II were presented by the TC and taken as read. Members had no comments and the TC confirmed that full assurance had been taken from both meetings.

4.2 Maternity Incentive Scheme (MIS) Year 4 Reports	
4.2	The DoN&M introduced this item. She informed colleagues that it was the fourth year that NHS Resolution had been operating the Clinical Negligence Scheme for Trusts (CNST) to support the delivery of safer maternity care. The submission date for the Board declaration of the evidence required for the current ten maternity safety actions was 15.01.23.
4.3	The papers summarising the evidence were reviewed in detail at the Quality and Safety Committee (QSC) and following the reverification process by NHS Resolution of Year 3's evidence, there was now a requirement that all papers for Year 4 be submitted to Trust Board.
4.4	The DoN&M continued that in relation to the current year, nine of the ten actions were well on track and the tenth would remain a focus. This action related to a data feed between national reporting and Trust systems, which the Information team were working hard to address.
4.5	NED-HH then asked whether there was any way that processes and the volume of reports could be streamlined (between QSC and Board) in terms of reducing the amount of paperwork. In response NED-HG stated that she had previously shared the same view, however in her current role as NED Maternity Safety Champion her view now was that the detail needed to be seen at both meetings.
4.6	In response to the above the DoN&M was able to advise that the DoM was currently working on a dataset which was less onerous and there were some areas where paperwork may be able to reduce in future. She would be cautious however that nothing should put achievement of the MIS at risk (in terms of the provision of evidence at the correct fora and to the required level of detail).
4.7	NED John Hogan (NED-JH) added his view would be there needed to be a step change in the provision of obstetric service and that should be embraced. He felt the amount of paperwork should start to reduce as the organisation started to meet requirements.
4.8	The DoP added that the thread throughout the paper was best practice and that, in her view, should be celebrated. The TC highlighted that the DoP had recently been appointed the executive Maternity Safety Champion lead. The DoQI commented that work was underway to understand how much of the evidence could be uploaded to the PM3 project management tool.

4.9	The TC summarised by recognising the volume of paperwork, but also the plans to use PM3 as much as possible. She thanked the DoM and his team for their achievement.
4.3 Maternity SI Report	
4.10	This paper was presented by the DoN&M and was taken as read. She drew members' attention to the fact that oversight of incidents was now provided by QSC (Part II). Members had no comments.
4.4 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
4.11	This paper was presented by the DoN&M and had also been to Workforce Committee (WFC). The key headline was that overall fill rates had stabilised now coming out of COVID and to acknowledge that the voice of nursing/midwifery had been heard in terms of the movement of that workforce around the organisation which was now being tracked following the Staff Survey.
4.12	She informed members that maternity staffing was now included as part of the report. It was also noted that the organisation was in the highest period of staff turnover it had seen in the previous 12 months which was in line with the ICS and nationally. She emphasised however there was still confidence around recruitment trajectories in the run up to winter.
4.13	In terms of midwifery staffing, ANED-RG asked whether there was any link in with community midwifery. In response the DoN&M confirmed the Continuity of Carer model brought ladies in for the whole pathway and supported the unit during period of high activity. Birthrate+ would review maternity staffing to understand the current position.
4.14	NED-GW flagged that the deprivation analysis was worthy of note and he asked how assurance was provided that babies were safe in terms of nutrition and care. In response it was confirmed that the Continuity of Carer model would prioritise those at higher risk (women from BAME backgrounds) and there was also an Enhanced Care Team to improve the interface between midwives and health visitors. There was also work underway in schools around safeguarding. ANED-RG highlighted it all linked to the levelling-up agenda and focussing on areas where support was required most.
4.15	The TC summarised by stating that the care staff levels had been noted and the Board recognised its role in terms of influencing the strategy in the ICS/place.
4.5 Learning from Deaths	
4.16	This update was presented by the MD and the paper was taken as read. She was able to inform colleagues that organisation had heard the previous week that mortality indices had all been 'as expected' now for ten consecutive months which was very reassuring.
4.17	She drew members' attention to the current work around fractured neck of femur and cardiac arrest and that there would be additional detail on the former at the Board's July meeting. She also flagged that Telestra had been requested to provide evidence that the improvement in mortality was not just about coding.
4.18	In response to a question from ANED-JK in terms of the difference between HSMR and SMR, the MD responded that HSMR was 56 diagnoses and SMR related to all diagnoses. The MD confirmed that neither marker had more credibility and the Trust should celebrate the reduction in both.
4.19	In response to a question from ANED-RG, the MD confirmed that the Trust compared very favourably with the ICS in terms of current mortality.
4.20	As a final point the MD informed colleagues that Telestra would be analysing the impact of COVID on HSMR.
05 PEOPLE	
5.1 Report from Workforce Committee (WFC)	
5.1	This paper was presented by NED-HH and key headlines were the Committee would be re-named to the People Committee with revised terms of reference (ToR) presented for Board approval. The outcomes of the Board workshop around the Staff Survey had been noted and

	would be discussed that day and that in terms of communications, a strategic review was planned which would be reported to WFC.
5.2	In line with the recommendation the Board approved the revised ToR.
5.3	In response to the above ANED-LB asked whether volunteers were recognised within the organisation given it had been Volunteers' week the previous week. In response it was confirmed an afternoon tea had been arranged by the Patient Panel the previous week and volunteers were an active part of the hospital. A Volunteers' Update was provided to WFC on a regular basis and they had been requested recently to also provide an update on their strategy.
5.4	NED-HG asked, in terms of volunteers, if the organisation was aware of where the gaps were. In response it was confirmed the strategy update would provide the response on that. The DoN&M added that COVID had added a delay to the recruitment of volunteers but that work had now started to gain some momentum. The DoP added that the CEO had recently recorded a video thanks to the organisation's volunteers.
5.5	The CEO then added there were currently four whole time equivalent paid posts supporting the volunteer workforce and he had recently had a discussion with the lead in terms of future recruitment and how quickly that could be undertaken. The organisation totally recognised the importance of investing in its volunteer workforce. NED-HH added it might be useful to speak to colleagues involved in the hospital charity about volunteers because there were many with specific skills that undertook more strategic work for the charity.
5.6	The TC summarised the requirement to recognise the need for a volunteer strategy and to understand the current position and what the gaps were.
5.2 Staff Survey Update	
5.7	This paper was presented by the DoP and highlighted the outcomes of a detailed Board workshop on the staff survey results and the response activities and improvement actions. Key issues would be understanding the results in the context of when staff were surveyed and longitudinal scores, understanding how the themes had been derived and any gaps to address those and what were the measures for improvement and the responsibilities and accountabilities for delivery of the plan.
5.8	In response to a question from the TC, the CEO confirmed it would now be down to time in terms of acting on the results and making a difference. For that reason he was cautious, but at the same time confident that targets would be met.
5.9	In response to a question from ANED-RG it was confirmed that interim Pulse surveys would be undertaken along with divisional engagement groups.
5.10	In line with the recommendation the Board noted the outcomes of the Board workshop to provide assurance of the plans to improve the experience of the organisation's people and also approved the four Trust-wide themes in terms of addressing the staff survey.
5.3 Gender Pay Gap	
5.11	This report was presented by the DoP and was taken as read. She reminded colleagues that the report provided details around the gap and was not an update on equal pay.
5.12	In line with the recommendation the Board noted the data and the ongoing actions to address the gender pay gap.
Break 1035-1050.	
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee	
6.1	This item was presented by the TC and the paper was noted. In line with the recommendation the Board approved the committee's revised Terms of Reference (ToR).
6.2 Integrated Performance Report	
6.2	This item was presented by the CEO and he highlighted that in terms of performance generally, all key metrics were still in some special cause variation as a result of the

	pandemic but the vast majority were moving in the right direction. The organisation still struggled in terms of the 4 hour ED standard and RTT.
6.3	The DoN&M flagged that Clostridium-difficile remained a concern albeit there was no particular increase in severity. There had also been an increase regionally/nationally, the reasons for which were unclear, but may relate to COVID.
6.4	In response to a point raised by NED-HG, it was agreed to discuss with the Chief Information Officer where data was lagging (Dec 21/Feb 22 for C-section/Mental Health) and whether some narrative could be provided around that.
ACTION TB1.09.06.22/09	**Consider whether some narrative can be provided in the IPR where data is lagging. Lead: Chief Information Officer**
6.5	In response to a concern raised by the TC around statutory/mandatory training the DoP was able to confirm a task and finish group had been established to address that for all staff groups.
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee	
7.1	This item was presented by NED-JH and members noted the transformation project showcase for the Safer Patient Flow Bundle and that the committee had been assured on the process and oversight of the PAHT2030 Dashboard and that the milestones for Digital Health and Culture were on track, but Transforming our Care was currently amber.
7.2 Report from Audit Committee	
7.2	This paper was presented by NED-GW and the committee had noted the progress being made in relation to the external audit. It was noted there were no issues or risks of significance to highlight and the Section 30 referral had been noted. In relation to Internal Audit, reasonable assurance had been received from the outgoing auditors and a request had been made of the incoming auditors around the benchmarking of legal services and any opportunities to reduce costs there.
7.3	The TC requested that thanks be provided to the Finance team for all their help over recent weeks.
7.3 Report from Senior Management Team	
7.4	This update was presented by the CEO and the paper was taken as read. Members had no comments.
7.4 NHS Provider Licence Self-Certification	
7.5	This update was presented by the HoCA who reminded members that the annual self-certification provided assurance that NHS providers were compliant with the conditions of their NHS provider licence. The licence required providers to self-certify as to whether they had: • Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6 (3)) - a declaration of 'confirmed' was proposed. • Complied with required corporate governance arrangements (Condition FT4) – a declaration of 'confirmed' was proposed for the six statements.
7.6	In line with the recommendation the Board approve a declaration of 'confirmed' in relation to both conditions G6 (3) and FT4.
08 QUESTIONS FROM THE PUBLIC	
8.1	There were no questions from the public.
09 CLOSING ADMINISTRATION	
9.1 Summary of Actions and Decisions	
9.1	These are noted in the shaded boxes above.

9.2 New Issues/Risks	
9.2	None.
9.3 Any Other Business (AOB)	
9.3	It was noted that a new 'thank you' card had been designed (in line with an action from the previous month) and it was agreed that one would be sent to Dr-AA after the meeting. The TC thanked the HoCA for her help with that.
ACTION **TB1.09.06.22/10**	**Thank you card to be sent to Dr-AA.** **Lead: Head of Corporate Affairs**
9.4	It was agreed some thought would be given to using microphones at the next meeting to help with the sound.
9.5	It was noted that the Quality Account would be published on 30.06.22 and QSC would be asked to grant delegated authority to the DoN&M and MD to sign off the final version before publication.
9.4 Reflection on Meeting	
9.6	It was agreed there had been some very useful discussion.

ACTION LOG: Trust Board (Public) 04.08.22

The Princess Alexandra Hospital NHS Trust

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~~ TB1.06.10.22	Second Board workshop took place on 07.07.22. Further review of strategy to Board planned for October for possible agreement/sign-off.	Open
TB1.09.06.22/07	Medical Records	Understand whether medical record transfer from the Lister was a common problem for clinicians.	MD	TB1.04.08.22	Verbal update to be provided.	Open
TB1.09.06.22/08	Board Assurance Framework	Target scores to remain within the BAF summary document.	HoCA	TB1.04.08.22	Actioned.	Closed
TB1.09.06.22/09	Integrated Performance Report	Consider whether some narrative can be provided in the IPR where data is lagging.	CIO	TB1.04.08.22	Actioned.	Closed
TB1.09.06.22/10	'Thank yous'	Thank you cards to be sent to Dr-AA.	HoCA	TB1.04.08.22	Actioned.	Closed

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors 4th August 2022.

Agenda item:	2.1
Presented by:	Hattie Llewelyn-Davies
Prepared by:	Hattie Llewelyn-Davies
Date prepared:	28.07.22
Subject / title:	Chair's Report

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	To inform the Board, other colleagues and members of the public about my role and to increase knowledge of the role and my 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:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	EDI has been taken into account in setting my annual objectives and as reported recently I am now the Board's EDI champion.
Appendices:	None

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1.0 Purpose/issue

This report outlines what is at the top of my agenda and what I have been doing since my last report to public Board on 6.6.22

2.0 Background

I was appointed at the new chair of PAHT following an external recruitment campaign and came into post in September 2021.

3.0 Issue

The Board has agreed my annual objectives and I will use this framework to guide these reports to the Board in future.

Objective	Update as at August 2022
Improve ratings from the CQC and other external assessments.	There is no specific update on this at present, although the board has worked on the self-assessment for this year's Well Led Review. The Trust is performing well in the region in terms of our elective recovery work. The Board has agreed work on the culture of PAH as a priority.
Ensure that PAH play a full and engaging role working with our partners across the ICS/ICB.	Lance, our CEO has been confirmed as the Acute sector member of the ICB. I continue to play an active part in all issues relating to Non-Execs. We have commissioned a development session for the board on our role in the ICS/B.
Using the Deloitte Well led review and the staff survey to further develop the board, Executive Team and the culture of our organisation.	We continue to have a very full development programme for the board. Heather, our Head of Corporate Affairs and I are working on succession planning for the board at present and will report back in October on this piece of work.

	We have begun establishing specific development support for our associate board members.
Develop role as the Board EDI Champion.	I continue to champion the issue at all times. We are preparing an EDI strategy at present. The video done by Anne and myself on self-disclosure on disability has gone down well and there is interest in using it throughout the ICS.

I have continued to maintain a presence at all staff events that I can get to, including attending all the staff awards during This Is Us Week and a number of staff induction events. (My thanks to everyone who organised the This is Us Week, it was great to be able to meet with lots of colleagues in this kind of informal setting.) Fay and I have met a group of consultants. NED Walkabouts are continuing to happen, my thanks to George who has led them when I have not been able to attend. I continue to maintain close contact with the Patient Panel and I hope support their work at all times.

Finally, I note with great sadness the resignation of John Hogan as a NED with the Trust. John has resigned for personal reasons and I and all my board colleagues will miss his wisdom, knowledge of the NHS and role as a highly experienced clinician greatly. I thank John for his commitment to and impact on the Trust during his time with us.

4.0 Recommendation

The Board is asked to discuss the report and give any feedback.

Author: Hattie Llewelyn-Davies. Trust chair.
Date: **28.07.22**

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 4 August 2022

Agenda item:	2.2
Presented by:	Lance McCarthy - CEO
Prepared by:	Lance McCarthy - CEO
Date prepared:	28 July 2022
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 meeting: - COVID-19, recovery and Urgent and Emergency Care - New hospital - Integrated Care System and Board developments - Director of Finance - This is Us *In Action*
Recommendation:	The Trust Board is asked to note the CEO report and the progress made on key items.

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:	COVID-19 item - regular clinical reviews of all patients waiting for elective care are undertaken to reprioritise if required and address any potential E&D impact caused by long waits.
Appendices:	None

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Chief Executive's Report
Trust Board: Part I – 4 August 2022

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

(1) COVID-19, recovery and Urgent and Emergency Care

1.1 COVID-19

As I have done at every public Board meeting for the last 2 years, 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 ongoing unprecedented demand for urgent and emergency care services.

As Board members will be aware, we have recently seen another spike in numbers of new COVID-19 infections in our local communities and as a result an increase in the number of COVID-19 positive inpatients in the hospital. At the time of writing the report we have 58 COVID-19 positive inpatients, up from 28 at the time of the last Board meeting, although down from 76 patients last week.

1.2 Recovery

We are continuing to work closely with place-based, system, IS and outsourcing 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 making strong progress in recovering all of our services with our planned activity now greater than pre-pandemic levels. More detail is available in the Integrated Performance Report.

1.3 Urgent and Emergency Care

We continue to see very high and sustained demand for our urgent and emergency care (UEC) services and the challenges we have as a system with accessing suitable community and social care capacity is putting considerable strain on our Emergency Department and our ability to have as effective and strong flow and access for ambulances as possible.

Our new electronic health record in ED (Nervecentre) was implemented on 27 July and continues to be embedded well by colleagues. It has supported timely triage based on the Manchester triage system, a key requirement within our CQC improvement notice, and has already enabled our patient records and information to be captured in a single system, supporting the improvements made by the ED teams for risk assessments and care planning.

(2) New hospital

There has been minimal progress with the development of the new hospital plans for Harlow since the last public Board meeting. We continue to work jointly with the national New Hospital Programme (NHP) but the pace of work to develop our Outline Business Case (OBC) has slowed, whilst we await the output of the NHP National Programme Business Case by DHSC and HMT colleagues and the associated prioritisation of the Cohort 3 schemes.

Subject to the outputs of these, any design changes required, and the capital allocation required to complete our OBC we will be in a position to complete and submit an OBC within a few months.

Our preferred option remains rebuilding the hospital on a greenfield site just to the north of the new junction (7a) of the M11, which officially opened on June 9th.

(3) Integrated Care System and Board developments

Hertfordshire and West Essex (HWE) Integrated Care System (ICS) became a formal entity on 1 July 2022 following royal assent of the Heath and Care bill in April. The inaugural Integrated Care Board of the ICS took place on 1 July, focussed predominately on the creation of it as an organisation with the associated governance arrangements.

HWE ICB members are:

Independent Chair	Rt Hon Paul Burstow
Non-Executive Director	Ruth Bailey
Non-Executive Director	Catherine Dugmore
Non-Executive Director	Professor Gurch Randhawa
Non-Executive Director	Thelma Stober

Statutory Executive Director posts:

Chief Executive	Dr Jane Halpin
Chief Financial Officer	Alan Pond
Medical Director	Dr Rachel Joyce
Chief Nursing Officer	Jane Kinniburgh

In addition, there are 8 partner members representing Hertfordshire and Essex County Councils, primary care from each of the 3 place-based health and care partnerships, community, mental health and acute services. I am the partner member for acute services.

System wide working groups are developing to align with the key priorities and ambitions of the system and clinical leads are being appointed to lead place-based and system-wide workstreams that are pathway focussed.

In addition there is an active acute provider group across the ICS undertaking a range of activities including:

- Elective provider collaborative discussions, including capital investment in additional capacity to support elective recovery across the system
- Maximisation of system wide Elective Recovery Fund (ERF) income
- Determination of sustainable solutions for the most fragile clinical specialties across the system
- Development of local Community Diagnostic Centre (CDC) business cases for capital and revenue investment

We continue to work closely with health, care and local authority colleagues locally to integrate care and address the health inequalities locally and support influencing the wider determinants of ill health and we are part of a national place-based development programme to influence this.

(4) Director of Finance

I'd like to formally congratulate and welcome Tom Burton to the substantive Director of Finance role following a competitive appointment process last week.

Tom has been with us as an interim since 30 May from his role as operational director of finance at the East of England Regional team for NHS England.

I am delighted that Tom is joining us on a permanent basis. Tom brings with him a wide range of experience that will support us in our ambitions as an organisation and continuing to improve our services for our patients and our people.

(5) This is Us *In Action*

Below is a selection of some of the improvements and achievements since we last met showing how we are really turning This is Us[1] *Into Action.*

- Sessions 2 and 3 of our 6-month PAHT 2030 Ready OD programme to support our senior leaders to work in a way that enables all of our colleagues to be the best that they can be and implement the transformational changes to underpin PAHT 2030
- Staff engagement and recognition week; 'This is Us week' (27 June to 2 July) with a series of events to celebrate, recognise and develop our people, including Our Amazing People awards aligned with our values and long-service awards for colleagues who have worked either 20 or 25 years at PAHT.
- Health and wellbeing and equality events as part of This is Us Week.
- Support for colleagues during the very warm weather, including free water, ice lollies and ice creams
- Ongoing mental health first aider support
- PAHT Night club, providing sleep advice for colleagues working night shifts
- Start of our weekly recognition and celebration of the diversity of our international colleagues through international food Wednesdays in the restaurant
- Ongoing development of apprenticeship opportunities for all colleagues with 10 new apprenticeships started including, chefs, administration, nursing and coaching. We now have 81 colleagues on apprenticeship schemes.

Author: **Lance McCarthy, Chief Executive**
Date: **28 July 2022**

[1] This is Us describes our values, our ways of working, our management practices and our leadership promises. It outlines the responsibilities for all of us who work at PAHT and supports us to deliver high quality care for our patients.

The Princess Alexandra Hospital NHS Trust

TRUST BOARD – 4 AUGUST 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:	26 July 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 and was taken from registers on 1 July 2022. This paper includes all items scoring 15 and above. The overall number of significant risks on the register has remained the same at 66 (table 1 and section 2). There is one new risk with an increased score up to 20 and one new risk scoring 16. The main themes for the 14 risks scoring 20 on the SRR are: • Seven are our performance risks, (unchanged): ○ three regarding referrals to treatment standards ○ two ED access standards ○ one for bed pressures on the emergency pathway ○ one for cancer-waiting times standard. • Three for our people - consultant cover in obstetrics and nursing cover in paediatric urgent care (FAWS), anaesthetic medical cover (surgery), this is unchanged. • Two for our patients: electronic storage of maternal CTG reports and system wide midwifery care with East Hertfordshire. • Two for our places regarding refurbishment of the maternity unit and a risk with score increased from 16 to 20, for the pharmacy aseptic unit (point 3.4.2) • Actions taken and mitigations in place for each of these risks are detailed in section three. One new risk scoring 16 regarding referral to treatment standard for paediatrics outpatients is in point 4.1. No new risks scoring 15 raised since 3 May 2022.							
Recommendation:	Trust Board is asked to review the contents of the significant risk register.							
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**			
	√	√	√	√	√			

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Previously considered by:	This paper has been reviewed at Risk Management Group meeting on 12 July 2022. Risk Management Group (RMG) reviews risks on a rotation; each service is monitored quarterly in line with the annual work plan. This paper discussed and approved at Senior Managers Group on 19 July 2022.
	Divisions and corporate teams review their risks at their local governance meetings. Teams escalate new risks and those that they require assistance with to RMG on a monthly basis.
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. This paper has been written with due consideration to equality, diversity and inclusion.
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 1 July 2022. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

Each areas risk register is reviewed on rotation at the Risk Management Group 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 66 significant risks on the risk register, the same number as in the paper discussed in July 2022 Trust Board. The breakdown by service is detailed is in table 1.

Table 1 – Significant Risks	Risk Score				
	15	16	20	25	Totals
Covid-19	1 (1)	1 (1)	1 (1)	0 (0)	**3 (3)**
Cancer & Clinical Support	2 (2)	10 (12)	1 (0)	0 (0)	**13 (14)**
Communications	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Estates & Facilities	2 (4)	3 (3)	0 (0)	0 (0)	**5 (7)**
Finance	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Health Safety and Resilience	1 (1)	0 (0)	0 (0)	0 (0)	**1 (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	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Learning from deaths	0 (0)	1 (0)	0(0)	0 (0)	**1 (0)**
Nursing	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Operational	2 (2)	1 (1)	4 (4)	0 (0)	**7 (7)**
Research, Development & Innovation	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Workforce - training	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
FAWs Child Health	2 (3)	2 (1)	1 (4)	0 (0)	**5 (8)**
FAWs Women's Health	3 (3)	4 (4)	4 (1)	0 (0)	**11 (8)**
Safeguarding Adults	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Medicine	0 (1)	0 (1)	0 (0)	0 (0)	**0 (2)**
Surgery	0 (0)	1 (1)	3 (3)	0 (0)	**4 (4)**
Urgent & Emergency Care	3 (1)	4 (2)	0 (0)	0 (0)	**7 (3)**
Totals	**19 (21)**	**33 (32)**	**14 (13)**	**0 (0)**	**66 (66)**

(The scores from paper presented at SMT in May and Trust Board in June 2022 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

Family and Women's

3.1.1 Electronic storage of Cardiotocography (CTG) for obstetrics - Phase 1

- The Trust needs electronic storage of CTG to cover antenatal and intrapartum care, (20202/06/01 raised in June 2020, score adjusted as software programme requires investment). Phase 2 requires electronic storage of CTG both antenatally and intrapartum.
  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. Presentation about centralised monitoring completed in February and awaiting decision of which to procure to provide CTG storage centrally.

3.1.2 System working for women living in East Hertfordshire

- Women that wish to deliver at PAHT and who live in East Herts will have their midwifery antenatal and post-natal care delivered by East Herts midwives. Both trusts do not undertake the same foetal growth monitoring and their records are kept separate. This reduces compliance with continuity of carer (2022/01/01 raised 21 January 2022).
  Action: PAHT midwifery staff are working with the team at East Hertfordshire community CCG. Risk discussed at Trust board and across the Local Midwifery Network Service. We continue to monitor any incidents that occur due to cross border working.

3.2 Our People

3.2.1 Family and Women's teams

Consultant cover in obstetrics

- Consultant cover improved and achieves 90 hours per week with extra ward rounds in place as recommended in the Ockenden report. Our unit delivers 3,800 babies per annum which means we should have 60 hours of cover, but we are aspiring to be better than the minimum.
  The national requirement of 98 hours consultant cover 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).
  Action: All consultant job plans have been reviewed and job descriptions amended. Recruitment is planned for further 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. 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 (4.8WTE including unit manager) and high numbers of staff on maternity leave. Paediatric ED attendance has increased by 10% in last 18 months 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 2021 with score increased in October 21 as result of increasing numbers of staff off the rota).
Action: Rolling band 5 adverts published and secondment opportunities available. Oversees nurses recruited and going through local training. Daily mitigation in place for joint children rotas across the service allowing staff to move across ward, ED to meet patient acuity and maintain skill mix. Additional staff sourced through NHSP & agency.

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. Staff are working flexibly and emergency and urgent elective workload is prioritised. Activity continues with no cancellations relating to lack of staff.

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, numbers & patterns of Attendance 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: Recovery action plan for each tumour site is monitored with robust tracking. 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.

3.3.3 Referral to treatment standards

Three risks associated with performance against the referral to treatment constitutional standard

- **Two** against 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.

- 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 to recommence 22 March 21. Monitored through daily PTL meetings and access RTT meetings and outsourcing continues.

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.

3.4 Our Places

3.4.1 Maternity Unit

- The maternity unit requires refurbishment which has been highlighted through external visits as part of the Ockenden assurance assessment, reviews within the maternity incentive scheme and from feedback received from service users (Reference: 2022/04/01).
  Action: Development plan is being created to share with the maternity leads and from there an options appraisal to be shared with SMT (no deadline at this time)

3.4.2 SCORE INCREASED: Pharmacy

- Aseptic unit to produce chemotherapy
  The Trust requires a new aseptic unit (reference Pharm/2014/06 on risk register since December 2014, score increased from 16 to 20 in July 2022) following discussion at the infection prevention & control committee due to growths on routine screening plates and lack of capacity to obtain chemotherapy from outside the trust.
  Action: Funding has been approved for the new unit at Senior Management Team, now planned for discussion at Performance & Finance Committee and then Trust Board. If approved would expect work to be completed by end of this financial year.

3.5 Our Pounds: Nil

4.0 One new risk with a score of 16 has been raised since 3 May 2022

4.1 **NEW:** Referral to treat standard for paediatric outpatients with mismatch in the numbers of referrals against the capacity of available clinic appointments in the children's service resulting in patient delays for initial review and treatment and then for ongoing treatment. There are currently 400 patients on the review list which is growing by approx. 20 patients each week (CH21/2022 raised June 2022

Action: Additional clinics being put into place including both weekdays and weekends. Regular locums have been sourced for weekend work. Triage of referrals takes place bi-weekly by consultants

4.2 No new risks with a score of 15 have been raised since 3 May 2022

5.0 Recommendation

Trust Board are asked to review the contents of the significant risk register.

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

The Princess Alexandra Hospital NHS Trust

Trust Board – 4 August 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 2022/23

Purpose:	**Approval**		**Decision**		**Information**		**Assurance**		
Key issues:	The Board Assurance Framework is presented for review and approval. The revised reporting format was endorsed by the Board at the meeting held in June and the summary dashboard is included in the papers as Appendix B with the detailed BAF available to Board members in the resources section of Diligent. The target risk score for each risk has been added to the dashboard as requested by the Board at the last meeting. The risks have been updated with executive leads and reviewed at the relevant committees during July 2022. The detailed risks were presented to committees. It is not proposed to change the risk scores for any of the risks this month. BAF risk 3.2 (Financial and Clinical Sustainability across health and social care system) is attached for consideration by the Board (the Board is responsible for reviewing this system risk).								
Recommendation:	The Board is asked to: • Note the updates to the risks and approve the BAF with no changes to the scores in month.								
Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**				
	x	x	x	x	x				

Previously considered by:	STC, QSC, PC and PAF in July 2022.
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance and risk management processes. The controls and mitigating actions outlined in the risks are designed to support delivery of the Trust's strategic objectives and promote an organisational culture that drives improvements in equality, diversity and inclusion.
Appendices:	Appendix B – BAF dashboard Appendix C – BAF risk 3.2

Board Assurance Framework Summary 2022.23

Risk Ref. Committee	Risk description	Year- end score (Apr 22)	June 22	August 22	Oct 22	Dec 22	Feb 23	Year-end score (Apr 23)	Trend	Target risk score	Executive lead
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population										
1.0 QSC	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	12					↔	8	CEO/ DoN&M
1.1 QSC	Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience.	16	16	16					↔	12	DoN&M/ MD
1.2 STC	EPR: The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	16	16	16					↔	12	DoIMT/ CIO
1.3 PAF	Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.	15* New risk	15	15					↔	10	COO
	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 WFC	Workforce: Inability to recruit, retain and engage our people	16	16	16					↔	8	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 PAF	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20					↔	8	DoS
3.2 Trust Board	Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	16	16	16					↔	12	DoS
3.5 STC	There is a risk that the new hospital will not be delivered to time and within the available capital funding.	16	16	16					↔	9	DoS
	Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators										
4.2 PAF	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	16	16	16					↔	12	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 PAF	Finance – revenue: Risk that the Trust will fail to meet the financial plan due to the following factors: An indicative annual budget for 22/23 has been established. A deficit plan has been submitted but national, allocations are not yet known and are linked to system envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement, with additional deficit expenditure to reflect	12	12	12					↔	8	DoF

Board Assurance Framework Summary 2022.23

	the current and forecast additional rising Inflation costs in 22/23.										
5.2 PAF	Finance - Capital: Risk that the Trust will fail to deliver the 2022/23 Capital programme within the Capital Resource Limit and ICS allocations.	12	12	12					↔	8	DoF

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2022-23**											
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) ICS workstreams with designated leads ii) System leaders Group iii) ICS governance structure iv) ICS priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) ICS Estates Strategy being developed. viii) ICS Clinical Strategy in place ix) ICS wide Strategy Group x) System agreement on governance and programme management	ICS CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) ICS Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and ICS updates (Board session on ICS governance Dec 21, June 2022)	**4 X 4= 16**	Lack of ICS demand and capacity modelling. **ACTIONS:** System leadership capacity to lead ICS -wide transformation		01/07/2022	**No changes to risk rating.**	**4x3=12** **~~March~~ September 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											

BOARD OF DIRECTORS:	**Trust Board 4 August 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 July 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
1.4 Action Log: Divisional reporting to QSC (quarterly)	Y	N	N	It was agreed that divisional quarterly performance reporting to QSC would be removed from the work-plan and the following were agreed: • To strengthen the formality of divisional reporting into Patient Safety Group (via an agreed template). • Effective governance through the quality framework and the accountability framework (through to the PRMs) would enable the highlighting of divisional achievements and risks to the committee. • Divisional and/or service representation would continue through deep dives agreed by the committee. This would also be key to continuing to enable and facilitate divisional exposure to Board sub-committees.
1.6 Quality PMO report re CQC Quality Improvement Compliance	Y	N	N	There was good overall progress. However, there were two additional amber ratings in July (over June): S5 (e-consent, consent on the day of surgery) and M37N (medicines – safety, prescribing, administering, recording). The impact on workforce and mechanism for monitoring the EDI impact in terms of the workforce will be included in future reports.
1.7 Quarterly Quality	Y	Y	N	The committee was provided with assurance that work was progressing and it agreed that the impact on the workforce

BOARD OF DIRECTORS:	**Trust Board 4 August 2022**			**AGENDA ITEM: 4.1**
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DATE OF COMMITTEE MEETING:	**29 July 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Improvement Update				would be considered further. EDI (equality, diversity and inclusion) would start to be addressed in future reporting.
2.1 Surgery & Critical Care Quarterly Performance Update	Y	Y	N	The committee was pleased to hear an update on complaints/complaints action plans which it had requested at a previous meeting. It also heard there had been no surgical site infections in the reporting period. QSC noted concern around the two stage consent process and asked for a further update at the next meeting.
2.2 Infection Control Update	Y	N	N	The committee received and noted the Infection Control Annual Report. It noted from the monthly report an increase in cases of *Clostridium Difficile* and was assured on the programme of work around antibiotic stewardship.
2.2 BAF Risk (1.0) COVID	Y	N	N	It was agreed the risk score should remain at 12.
2.3 Learning from Deaths Update	Y	N	N	HSMR continued to remain 'within expected range' and it was agreed that the full Learning from Deaths Update would now be presented bi-monthly, which would coincide with reporting to the Board. The committee welcomed the Telstra Deep Dive which contained a summary of their analysis of reasons for improvement in the Trust's mortality which noted the quality of record keeping, information and care.

BOARD OF DIRECTORS:	**Trust Board 4 August 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 July 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				QSC agreed to reduce the frequency of reporting to bi-monthly going forward with bi-monthly reports to public Board continuing.
2.6 Patient Safety & Clinical Effectiveness Report	Y	N	N	The committee was assured, particularly around the programme of work underway in relation to documentation but noted further work is required around participation in national audits and the associated auditing of that.
2.7 Report from Vulnerable People Group	Y	Y	N	The report was noted. The group was taking a keen interest in compliance with Adult/Children Safeguarding training compliance and had requested a trajectory for compliance.
2.8 Sharing the Learning Update	Y	N	N	QSC was assured on the learning from incidents, complaints and claims and that the focus going forward should be around the implementation of that learning.
2.11 BAF Risk 1.1 (Clinical Outcomes)	Y	N	N	It was agreed the risk score should remain at 16.
3.1 Integrated Performance Report (IPR)	Y	N	N	The progress in falls management was recognised which had now moved to common cause variation.
4.2 Review List/ASI Update	Y	Y	Y (UEC Team)	The committee noted that good progress was being made. It was agreed a deep dive into ambulance handovers and the

BOARD OF DIRECTORS:	**Trust Board 4 August 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 July 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				quality and safety aspects for patients would be provided for the meeting in September.

BOARD OF DIRECTORS:	**Trust Board (Private) 4 August 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Hattie Llewelyn-Davies – Acting Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 July 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
1.5 Annual Work Plan	Y	Y	N	It was agreed a six monthly Committee Effectiveness Review would take place with findings reported back to the committee's September meeting.
2.1 Maternity Dashboard	Y	N	N	The committee was broadly assured in terms of the dashboard and welcomed the audit findings in relation to BBAs (born before arrival).
2.1 Midwifery Staffing	Y	N	N	The committee noted the excellent recent recruitment campaign and that 14 Band 4 Support Workers would join in August and 20 new midwives in September. It also noted that patient acuity was higher recently but the service was finding ways to protect the time of community midwives.
2.1 Maternity Incentive Scheme	Partial	Y	Y	IT concerns in terms of achieving safety action 2 were noted. There would be a meeting with the IT team in August after which the division would report back to the committee.

BOARD OF DIRECTORS:	**Trust Board (Private) 4 August 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Hattie Llewelyn-Davies – Acting Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 July 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Maternity Improvement Board	Y	N	N	Colleagues were thanked for their work particularly around triage and transitional care and the committee agreed there was assurance around the work of the Maternity Improvement Board.
2.2 Monthly SI Report/Quarterly Assurance Report	Y	N	N	The committee was pleased to note the positive feedback from the Regional Midwifery visit on 08.04.22 with the service being seen as responsive to change and having implemented the immediate/essential actions. Improvements in leadership and governance were also noted.
2.3 Perinatal Mortality Review Tool Quarterly Update	Y	Y	N	The service would provide a proposal on the future process/reporting for perinatal mortality.
2.4 Saving Babies Lives Quarterly Update	Y	N	N	It was noted that the service remained compliant and was meeting all the trajectories and recommendations. It was pleased to note that the Smoking Cessation Service was now running in-house.

BOARD OF DIRECTORS:	**Trust Board (Private) 4 August 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Hattie Llewelyn-Davies – Acting Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 July 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 Maternity Champions' Report	Y	Y	N	It was agreed that compliance with midwifery and obstetric statutory/mandatory training would be overseen by the committee and whilst a concern was noted regarding compliance it was acknowledged that a task and finish group had been established to review compliance across the organisation. The committee will receive an update in September.
2.6 Horizon Scanning	Y	N	N	It was agreed the Trust was making good progress and was clearly sighted on areas which required some additional focus.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 4 August 2022

4.2

Agenda item:	4.2
Presented by:	Sharon McNally, Executive Director of Nursing and Midwifery
Prepared by:	Kate Boxall, Bereavement Midwife
Date prepared:	27th July 2022
Subject:	Perinatal Mortality Review Tool (PRMT) Quarter 4 2021/2022

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

Key issues:	This is the fourth year that NHS Resolution are operating the Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care. The data provided in this report relates to the third year's scheme. Under the Clinical Negligence Scheme, Trusts are required to meet all ten maternity safety actions. Safety Action One relates to the use of the National Perinatal Mortality Review Tool to review perinatal deaths. This report provides information on all deaths of babies at The Princess Alexandra Hospital NHS Trust (PAHT) in Quarter 4 January / February /March 2021/2022 and the review process, findings and actions plans arising from the reviews. At PAHT we have a monthly PMRT meeting and all cases that meet the criteria are reviewed. Despite the limitations caused by the pandemic, the meetings continue on a monthly basis where able to do so. Currently the health group are on track to achieve the safety standard one for year four.
Recommendation:	To provide assurance to the Trust Board that maternity services are meeting the standards required from Safety Action One of the Maternity Incentive scheme.

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:	Divisional Board 27.7.22 Quality and Safety (Maternity Assurance) 29.7.22
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme – Year 4
Appendices:	

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

As part of the NHS Resolution Maternity Incentive Scheme: Safety Action One, the maternity service is required to provide a quarterly update to the board of all perinatal deaths in the preceding quarter, detailing the death review process to confirm they have been reviewed using the Perinatal Mortality Review Tool (PMRT) and any consequent action plans as a result of the review. This paper provides this information.

2.0 Background

The required standards for meeting Safety Action One have been updated 8th August 2021:

a) i. All perinatal deaths eligible to be notified to MBRRACE UK from 1 September 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death. This includes deaths after home births where care was provided by the Trust.

b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in the Trust, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

c) For at least 95% of all deaths of babies who died in the Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by Trust staff and the baby died either at home or in the Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

d) Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onward that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.

Table 1. The PMRT has been designed to support the review of the following perinatal deaths

Deaths eligible for notification from 1st January 2013 onwards are:
• Late fetal losses – the baby is delivered between 22+0 and 23+6 weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred. • Stillbirths – the baby is delivered from 24+0 weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life. • Early neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth. • Late neonatal deaths – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth. • Post-neonatal deaths – We are no longer collecting information for post-neonatal deaths because of the difficulty in ensuring complete data collection from the wide variety of places of death for these cases.

Table 2. Recommended composition of the local perinatal mortality review group

Core membership	Additional members
Roles within the group: • Chair and Vice-Chair • Scribe/Admin support • PMRT/Maternity Safety Champion Minimum of 2 of each of the following: • Obstetrician • Midwife • Neonatologist and Neonatal Nurse: (All cases where resuscitation was commenced / All neonatal deaths) • Bereavement team (1 acceptable) • Risk manager/governance team member (1 acceptable) • External panel member (1 acceptable) • Other members as appropriate to the organisation of care in the Trust/Health Board e.g. service manager	Named and invited to attend or contribute where applicable: • Pathologist • GP/Community healthcare staff • Anaesthetist • Sonographer/radiographer • Safeguarding team • Service manager • Any other relevant healthcare team members pertinent to case

3.0 Analysis

Since the commencement of the Maternity Incentive Scheme on 9th March 2018 there have been seventy one (71) cases reported (Stillbirths/Neonatal Deaths) that adhere to the PMRT criteria (see Table 1).

There were five deaths, notified to MBRRACE during January- March 2022 quarter 4.

Report ID	Review completed
79250	5/04/2022
79634	6/05/2022
80511	Under review
80385	Under review
80713	Under review

The PMRT meetings have a strong representation of obstetricians and midwives. There is one consultant neonatologist and one neonatal nurse who routinely attend all neonatal death reviews. All neonatal deaths are also reviewed at the Perinatal Morbidity and Mortality Meeting, which has a larger attendance. There have been recent improvement in having an external panel member –which is now achieved by the attendance of the Local Maternity Neonatal Systems (LMNS) Quality and Safety Governance Midwife, the LMNS Neonatal lead and representation from bereavement midwives in our LMNS.

Case one – 79250

A stillbirth at 34+6 gestation. Booked high risk due to obstetric history. Known smoker, referred for smoking pathway. Ultrasound Scan (USS) noted growth restriction with baby, had plan of twice weekly blood pressure and urine checks. Admitted for Induction of Labour (IOL) following confirmation of stillbirth. A post mortem did not determine a cause of death. Parents seen in Sensitive clinic with fetal medicine consultant and bereavement midwife

Grading	
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:	The review group identified care issues which they thought would have no difference to the outcome for the baby
Grading of care of the mother following confirmation of the death of her baby:	The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby.

Issues and Actions				
Issue:	Action	Implementation plan / comment	Responsible person	Target completion date
The mother was assessed as high risk and in need of Aspirin but Aspirin wasn't prescribed	Training Sharing the Learning	To ensure all women are assessed as per trust guidelines	Antenatal Clinic Midwife Community Matron	31/5/2022
It is not possible to tell from the notes as to whether the parents were offered the opportunity to take their baby home.	Training/document on checklist and notes	To implement once training recommences following Covid-19	Bereavement Midwife	31/5/2022
The care of this women and/or her baby was adversely affected by changes to the organisation of care and services to deal with the COVID-19 pandemic although these changes were the result of an organisational risk assessment	Practice was in line with Covid-19 guidance at the time.	Pathways for smoking cessation and monitoring have now returned to pre-pandemic pathways.	Not applicable	

Case two – 79634

A stillbirth at 27+1. Booked high risk due to history. Known smoker, referred for smoking pathway. Referred to Tertiary referral centre due to growth restriction with baby and other complications. Admitted for induction of labour following confirmation of stillbirth. Post mortem examination details cause of death as severely growth restricted baby. Has been seen in sensitive clinic with fetal medicine consultant and bereavement midwife

Grading	
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:	The review group identified care issues which they considered may have made a difference to the outcome for the baby
Grading of care of the mother following confirmation of the death of her baby:	The review group identified care issues which they considered would have made no difference to the outcome for the mother

Issues and Actions				
Issue:	Action	Implementation plan	Responsible person	Target completion date
It is not possible to tell from the notes if the parents were offered the opportunity to exercise their particular religious/spiritual/cultural wishes	To be discussed in bereavement study day for all staff	Training	Bereavement Midwife	31/5/2022
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	Practice was in line with Covid-19 guidance at the time.	No further action required		
The mother was assessed as high risk and in need of Aspirin but Aspirin wasn't prescribed	Training Sharing the Learning	To ensure all women are assessed as per trust guidelines	Antenatal Clinic Midwife Community Matron	31/5/2022

Case three – 80511

Booked high risk due to fertility investigations. Raised Body Mass Index. Covid-19 positive four days prior to admission. Admitted to labour ward at 26 weeks of pregnancy after previously declining to come in for monitoring with history of abdominal pain/period pain. Not suitable for transfer to another hospital as labour progressing, birth imminent shortly after admission. Paediatricians in attendance at birth. Male infant transferred to paediatric team for resuscitation. Consultant Paediatrician confirmed death after 52 minutes. Post mortem wasn't performed at parents request. Histology report confirmed Grade 1 Chorioamnionitis (an infection of the placenta and amniotic fluid around the baby). Cause of death extreme prematurity. Has been seen in sensitive clinic with fetal medicine consultant and bereavement midwife. Awaiting Serious Incident report prior to full completion of PMRT tool.

Case four – 80385

32 weeks pregnant, with history of learning disabilities. Booked at another Trust, transferred to PAHT as booked hospital on divert. Reduced baby movements at 27 weeks of pregnancy. Confirmed stillbirth on admission, induction of labour commenced. Birth of male infant, Post mortem concluded no obvious cause of death. Seen by fetal medicine consultant and bereavement midwife in sensitive clinic. Awaiting Serious Incident report prior to full completion of PMRT tool

Case five – 80713

Booked low risk. Ex-smoker, no medical history noted. Attended routine antenatal appointment, unable to auscultate baby's heart, confirmed stillbirth by ultrasound at 40 weeks of pregnancy. Elective Caesarean Section birth (Maternal choice) of baby. Post Mortem report concluded acute asphyxia. Cytogenetics (study of human chromosomes) – no significant abnormality detected. PMRT not completed in full as awaiting Post Mortem report, scheduled for next meeting. Appointment for Sensitive clinic with fetal medicine consultant and bereavement.

4.0 Recommendation

To provide assurance to the Trust Board that maternity services are meeting the standards required from Safety Action One of the Maternity Incentive scheme.

Author: Kate Boxall, Bereavement Midwife
Date: 27/7/2022

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 4 August 2022

4.2

Agenda item:	4.2							
Presented by:	Sharon McNally, Executive Director of Nursing and Midwifery							
Prepared by:	Erin Harrison – Lead Governance Midwife							
Date prepared:	27th July 2022							
Subject / title:	Maternity Assurance Report – Quarterly review Apr-Jul 2022 (Q1)							
Purpose:	**Approval**		**Decision**		**Information**	**x**	**Assurance**	**x**
Key issues:	The recent Maternity Incentive Scheme (MIS) Year 4, published in October 2021 has issued the requirement for quarterly reporting to Board including details on number of serious harm incidents, themes identified and actions being taken to address any issues, minimum staffing in maternity services and training compliance.							
Recommendation:	To provide assurance to the Trust Board that the maternity service are continually monitoring compliance and learning from complaints and incidents.							

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:	Divisional Board 27.07.22 Quality and Safety Committee (Maternity Assurance) 29.7.22
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme Year 4 Ockenden Report
Appendices:	N/A

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose/issue

This paper is to provide assurance to the Board

2.0 Background

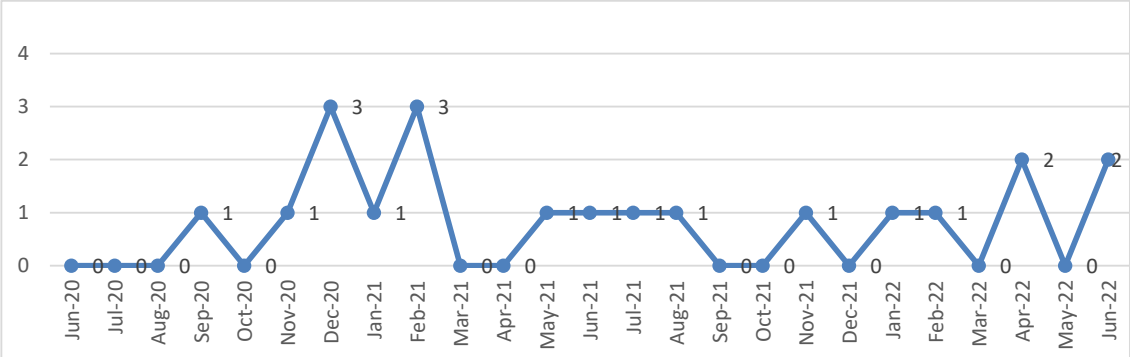
NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.
The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

3.0 Analysis

Serious Incidents

Maternity currently have 6 SI's under investigation, 1 of which is being investigated by HSIB, the detail can be found in Table 2. Table 1 details the trend of declared SI's within the last 24 months to June 2022.

Table 1. Comparison of SI's reported for Maternity in last 24 months (to June 2022)



There were 4 new serious incidents declared in Quarter 1 of 2022/23. The detail can be found in table 2.

Table 2. Serious Incidents declared and submitted for April- June 2022 (Q1)

Serious Investigations	
Number Declared for Q1 2022/23	**4**
Number Submitted for Q1 2022/23	**0**
Number Past CCG Deadline as of June 2022 (Not including HSIB/Approved Extensions)	**0**
Total Open SIs for Maternity to date (including HSIB)	**6**
New Serious Investigations declared	

Ref	Summary	Learning Points
Paweb 108641	Patient at 32+4 weeks pregnant was admitted for management of vomiting. Fetal heart rate concerns were noted on the monitor and therefore a decision for an emergency (category 1) caesarean section The baby was born in poor condition, intubated and admitted to the Neonatal Unit.	• Escalation was a concern from all parties involved. • Lack of appropriate documentation including use of CTG stickers
Paweb 113165	Woman attended another Trust with history of bleeding and infertility. Hysteroscopy undertaken which identified a man-made foreign object in the cervix and uterus. Unable to remove so booked for laparoscopy/laparotomy for removal.	• Round table held with Trust and notes/images received. • Awaiting further information relating to object in situ
Paweb 111144	Woman attended at 26+2 of pregnancy with abdominal pain and amniotic fluid leaking. The birth was imminent and the baby required extensive resuscitation at birth. After 52 minutes a decision was made to stop resuscitation.	• Room layout in rooms 7,8 & 9. In cases of premature birth resuscitaire needs to be used via piped gases. • Neonatal Consultant to be called at earliest opportunity
Paweb 115539	A woman in her fourth pregnancy attended the emergency department at 22+1 weeks of pregnancy. The mother collapsed whilst in the emergency department and was clinically unstable with a Hb of 30g/L. The baby was born with signs of life and passed to the midwife and neonatal consultant who was present for the birth. Neonatal resuscitation was not commenced for approximately 10 minutes. The baby responded well to resuscitation, was intubated and transferred to the neonatal intensive care unit (NICU). The baby died approximately 4 hours later.	• Case to be used for Perinatal Mortality and Morbidity Meeting • Review of gestation and pathways between the emergency department and Maternity • Communication between the emergency department and Labour Ward
All open serious incidents		
Paweb 108939 HSIB	Difficult delivery and breech extraction. 9 minutes from knife to uterus until baby delivered. Therapeutic cooling for 72 hours. No HIE noted on MRI.	• Lack of documentation of ‘infection’ on fetal monitoring stickers • Whole clinical picture not taken into consideration regarding

		chorioamnionitis and obstructed labour • Delayed obstetric review of 40 minutes due to handover
Paweb 107031 **Overdue – Extension agreed with CCG**	35 weeks with history of reduced fetal movements and Covid. On arrival intrauterine death diagnosed and disseminated intravascular coagulation. Post-mortem consistent with covid placentitis. Complex case which needs a multi-agency approach	• Cross border working with reviewing results • Communication barriers due to language barrier

Clinical Incidents

There is a daily Datix review meeting undertaken by the Senior Midwifery Team and the Governance Consultant to ensure that any incidents requiring escalation are identified immediately.

There has been an 8% increase in the amount of open incidents at the end of Q1, this is due to the specialist midwives, matrons and ward managers being required to support clinically. All moderate harm incidents have had a review and all relevant concerns have been escalated through the Trust Governance processes.

Table 3. Current Clinical incidents open and closed

Clinical Incidents (DATIX)	
Number of Incidents Submitted Last Quarter	296 (96% low or no harm)
Number of Incidents Moderate Harm or Above	13
DoCs Outstanding	None
Number of Open Incidents	126 (7 moderate harm or above)
Number of Incidents Submitted for last financial year April 2021 – March 2022	1262
Percentage of Open Incidents	43%

Table 4. Legal Cases Received over Q1 (Apr-June 2022)

Legal Cases			
	New	**Closed**	**NHSR (Early Notification Scheme)**
Apr 2022	0	1	1
May 2022	0	2	0
June 2022	1	1	0

Perinatal Mortality Review Tool Summary

PMRT was launched in January 2018 with the aim of standardising perinatal reviews across NHS maternity and neonatal units in England, Wales and Scotland. The tool is used to support a systematic, multidisciplinary, high quality review and to ensure that parents are involved in the process. This enables a structured process of review, learning, reporting and actions to improve future care and to come to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken which in turn involves a grading of the care provided. Reports will be published and shared with the family and placed in the medical notes.

PAHT perform a review of cases on a monthly basis which is undertaken as a multidisciplinary panel including midwives, obstetricians, neonatologists and external experts. Table 5 shows the current open cases for PAHT. All cases are within the reportable time frames for MIS Yr 4.

Table 5. Perinatal Mortality Review Tool Open Cases

Perinatal Mortality Review Tool Summary
10 open cases for PAHT 3 open with other Trusts All open cases for PAHT have dates booked for review, the oldest case dates back to 02/12/2021 and the final report is currently being written. This report is also linked with a serious incident within the Trust.

MBRRACE-UK Real Time Data Modelling for past 6 months

The MBRRACE-UK reporting system is in use across England, Scotland and Wales. The system is used to report all cases of maternal death, late fetal losses, stillbirths and neonatal deaths. PAHT is are compliant with all reporting requirements, Table 6 shows reported cases over the last 6 months.

Table 6. MBRRACE Reportable Cases

MBRRACE-UK Real Time Data Modelling for Past 6 Months

27 reported deaths to MBRRACE which included:

9 Antepartum stillbirths
0 Intrapartum stillbirth
2 Neonatal death
16 late miscarriage

Ethnicity:

White British	16
Any other white	3
Black or Black British African	3
Asian or Asian British Pakistani	1
Any other Ethnicity	2
Asian or Asian British Indian	1
Any other Asian Ethnicity	1

External Reviews and External Scrutiny

Table 7. External Reviews and Scrutiny

External Reviews and External Scrutiny
• *HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust* • *Coroner Reg 28 made directly to Trust*

PAHT currently have 1 case that is under investigation by HSIB as per Table 1.
Below shows the status of all reported cases to HSIB.

Cases to date	
Total referrals	15
Referrals/cases rejected	7
Total investigations to date	8
Total investigations completed	7
Current active cases	1
Exception reporting	0

On the 8th April the Regional Midwifery team undertook an assurance visit surrounding the Ockenden recommendations. There was positive feedback and the service was deemed as responsive to change and implementing the immediate and essential actions.

No inquests undertaken for maternity care

Staffing

Table 8. Current staffing across Maternity, Neonatal and Obstetric Workforce

Staffing

Staff feedback from frontline champions and walk-abouts:

Staff have escalated concerns surrounding the shortage of midwifery staffing.

This is not a concern unique to PAHT with maternity services across the country experiencing similar problems; and services identifying steps to address issues around staffing, leadership and resourcing.

The Directorate has also implemented a pay incentive for undertake Bank Shifts in order to reward staff who are undertaking extra shifts in addition to their contracted hours.

A recruitment day was also undertaken in Q1 with over 20 new midwives joining the workforce throughout September and October 2022.

There is ongoing recruitment internationally with 2 international midwives obtaining their NMC Pins and more joining over the summer period.

Consultant Obstetric Cover on the Labour Ward	87 hours cover (RCOG recommendation is 98 hours)			
Junior Doctor Rota Gaps	No rota gaps – Currently recruiting to implement a 2 tier rota (2 registrars per shift)			
Midwifery and Neonatal Staffing		**Apr**	**May**	**Jun**
	Vacancy Rate (<8%)	8.41%	6.98%	6.58%
	Overall Sickness (<3.7%)	4.05%	4.14%	4.73%

	Short Term Sick	1.14%	1.51%	2.38%
	Long Term Sick	2.91%	2.63%	2.35%
	Turnover (voluntary) (<12%)	18.2%	17.37%	17.98%

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	**Proportion of speciality trainees responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (Reported annually)**
Workshops have been booked with the Senior Leadership Team to discuss results and implement changes. Monthly feedback sessions in place via multiple sources	Awaiting Staff Survey

Training Compliance

With the ongoing pandemic a decision was made to suspend all training to support safe staffing. PROMPT, Neonatal Life Support and Fetal Monitoring study days have continued to be compliant with Maternity Incentive Scheme Year 4.

Table 9. Training Compliance

Training Compliance	
Child Safeguarding Level 3	**88%**
Resuscitation	**74%**
PROMPT	**90%**
Fetal Monitoring	**90%**

MIS Progress

The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. As in year three, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Year 4 was launched in August 2021 with the required minimal evidential standards updated and distributed in May 2022.

The 10 Safety Actions have not changed since last year's scheme however there has been inclusion of further evidence required.

Once all evidence has been collated the Board will be required to sign off the scheme which will be in December 2022.

Table 10. MIS Progress Year 4

MIS Progress Year 4			
SA 1	On Track	SA 6	On Track
SA 2	Concern	SA 7	On Track
SA 3	On Track	SA 8	Under review due to Obstetric Training Compliance
SA 4	On Track	SA 9	On Track
SA 5	On Track	SA 10	On Track

Ockenden

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11 December 2020, all Trusts providing maternity services were required to undertake an immediate response looking at 7 immediate and essential safety actions (IEA) and workforce planning (WF).

The IEA are:

1. Enhanced safety
2. Listening to women and their families
3. Staff training and working together
4. Managing complex pregnancies
5. Risk assessment throughout pregnancy
6. Monitoring fetal wellbeing
7. Informed consent

PAHT submitted their evidence in July 2021 and have received feedback regarding compliance. A meeting was held on 28.10.2021 across the Local Maternity and Neonatal System to review the grading and to submit queries relating to the feedback to the national team. PAHT have an action plan in place to ensure all immediate and essential safety actions are met. The service reviews the IEA's through the maternity improvement board and an update is provided as per Table 10.

The final report was released in March 2022, the service is currently in the process of reviewing the 15 new Immediate and Essential Safety Actions.

Table 11. Immediate and Essential Safety Actions outcomes

IEA Progress			
IEA 1	94%	IEA 5	93%
IEA 2	100%	IEA 6	77%
IEA 3	75%	IEA 7	57%
IEA 4	100%	WF	100%

Saving Babies Lives Care Bundle v2 (SBLCBV2)

'Saving Babies' Lives is a care bundle designed to support providers, commissioners and professionals take action to reduce stillbirths. The guidance was developed with clinicians, commissioners, charities and royal colleges and is based on the best available evidence. It supports the delivery of safer maternity care, as described by the National Maternity Review, in Better Births' 2016.

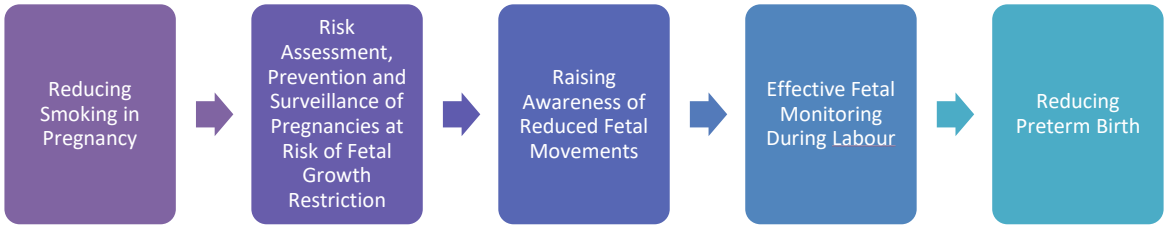


Table 12. Saving Babies Lives Score Card Summary

Saving Babies Lives Score Card Summary
Compliant with all elements. No areas of concern identified.

Complaints/PALS

Table 13. Current open complaints/PALs and Service User Feedback

Complaints	PALs	Compliments
April –2 (1 closed, 1 with PET) May – 4 (1 closed, 1 awaiting consent, 1 under investigation, 1 awaiting Divisional sign off) June – 3 (1 closed, 2 under investigation)	April – 6 (1 remains open) May – 13 (2 remain open) June – 6 (1 remains open)	April – 5 May – 4 June – 0
Themes		
All complaints received over Q1 related to direct care provided and communication. PALs themes were surrounding communication and delay.		
Service User Feedback		
"My wife & I would just like to make you aware of the exceptional experience & support we received during the labour, birth & post natal care of our son. We all felt the kindness, support & reassurance of everyone involved throughout our journey." "She was well looked after and had extremely good care from all staff during her stay. Special mention to Matelda (Tilly) who was an Angel & really helped my wife gain confidence and breastfeed with no issues, as well as, Holly and Molly for their support. We wish we could name the whole team who were on shift throughout those days, but didn't catch everyone's names. They do such a great job and deserve to have some recognition on the great work they do."		

4.0 Oversight

All highlighted concerns have been escalated at Divisional board. All incidents are discussed at the Divisional Patient Safety and Quality Group and Trust Incident Management Group and escalated where relevant for further investigation.
Staffing is assessed on a daily basis and the Directorate are currently out to advert for all vacancies.

The service are continuing to work towards the requirements of MIS Year 4, SBLCBv2 and the Ockenden IEA. Escalation will occur through board where non-compliance is anticipated or found to occur.

5.0 Recommendation

It is requested that the board accepts the report with the information provided and the ongoing work for assurance of compliance with local and national standards.

Author: Erin Harrison – Lead Governance Midwife
Date: 27.07.2022

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 4 August 2022

4.2

Agenda item:	4.2							
Presented by:	Sharon McNally, Executive Director of Nursing and Midwifery							
Prepared by:	Amber Dewick – Lead Midwife for Quality & Compliance							
Date prepared:	11th May 2022							
Subject / title:	Preterm Birth Deep Dive: April 2016 – March 2022							
Purpose:	Approval		Decision		Information	X	Assurance	X
Key issues:	Saving Babies Lives Care Bundle Version 2 (SBLV2), element 5 focuses on reducing the number of preterm births and optimising care when preterm birth cannot be prevented. The Princess Alexandra Hospital Trust's (PAHT) preterm birth rate is above the Regional Perinatal Quality Oversight Group (RPQOG) target of <6% and the NMPA target of <6.4%							
Recommendation:	To provide assurance to the Trust Board that the maternity service are continually monitoring compliance and learning from preterm birth in line with right place of birth guidance and SBLV2.							

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:	Divisional Board 22.6.22 Quality and Safety Committee (Maternity Assurance) 24.6.22
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with Year 4 of the Maternity Incentive Scheme which was updated in May 2022.
Appendices:	N/A

The Princess Alexandra Hospital NHS Trust

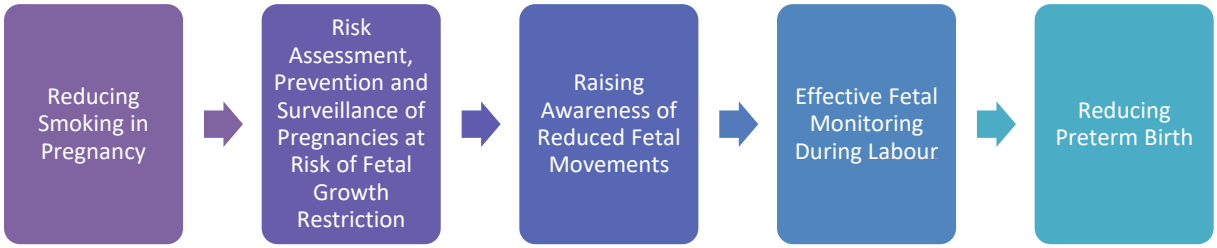
1.0 Purpose

This paper outlines the preterm birth rate (<27 weeks gestation) at PAHT, national data sets and steps taken to reduce the incidence.

2.0 Background

Saving Babies Lives Care Bundle v2 (SBLCBV2)

'Saving Babies' Lives is a care bundle designed to support providers, commissioners and professionals take action to reduce stillbirths. The guidance was developed with clinicians, commissioners, charities and royal colleges and is based on the best available evidence. It supports the delivery of safer maternity care, as described by the National Maternity Review, in Better Births' 2016.



Saving Babies Lives Care Bundle (SBLCB) incorporated element five 'Reducing Preterm Births' in response to The Department of Health's 'Safer Maternity Care' report. This element focuses on three intervention areas to improve neonatal outcomes which are, prediction and prevention of preterm birth and better preparation when preterm birth is unavoidable.

Preterm birth, defined as birth at less than 37+0 week's gestation, is a complication of pregnancy associated with high rates of early, late and post-neonatal mortality and morbidity. Preterm birth is estimated to cost the health services in England and Wales £3.4bn per year.

PReCePT – Preventing cerebral palsy in preterm babies

Magnesium sulphate given during preterm labour reduces the relative risk of cerebral palsy in very preterm infants by 30%.

The PReCePT programme, developed by the West of England AHSN with University Hospital Bristol and Weston, was the first ever perinatal quality improvement programme delivered on a national scale, bringing together midwives, obstetricians and neonatologists.

An estimated 48 cases of cerebral palsy were avoided as a result of PReCePT, saving around £38.4 million in lifetime health and social care costs.

3.0 Analysis

Preterm Birth

Maternity had a total of 3908 births between April 2021 and March 2022, 257 of which were born before 37+0 weeks' gestation.

Table 1 details the trend of preterm births during this time period.

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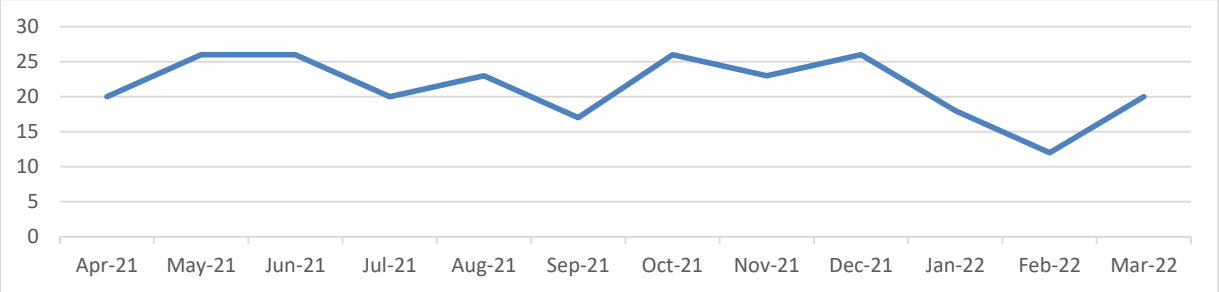
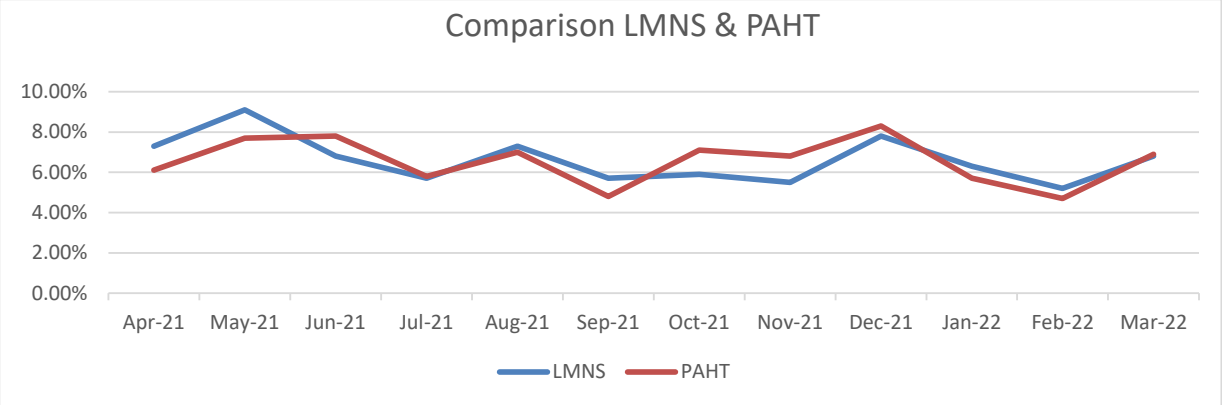
Table 1. Number of babies born before 37+0 weeks' gestation



There were 6 months where PAHT's rates were higher than the Local Maternal Neonatal Services (LMNS) average rates. This can be seen in Table 2.

Table 2. Comparison of the number of preterm births between the LMNS and PAHT.



The next tables show a breakdown of preterm births by gestation for PAH and the LMNS.

Table 3. Preterm Births at PAHT between 24 and 27 weeks gestation

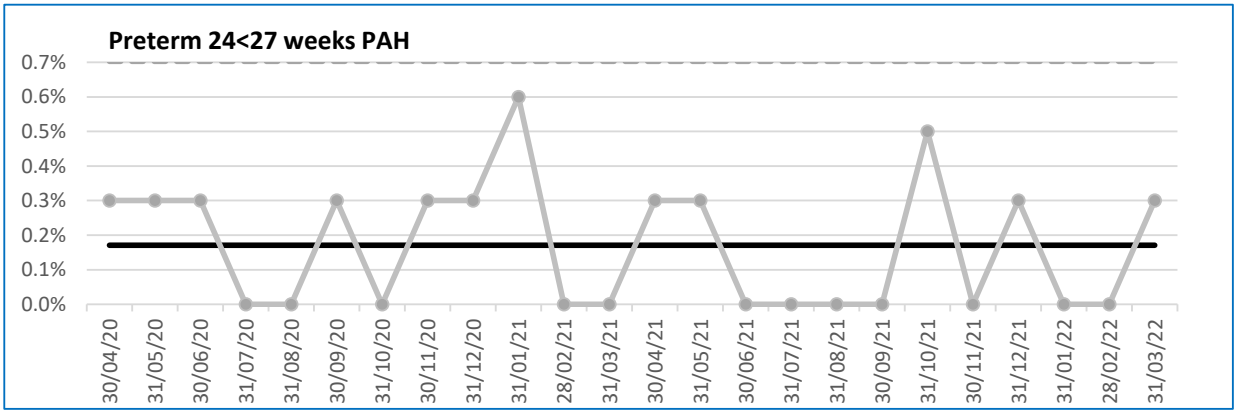


Table 4. Preterm Births across LMNS between 24 and 27 weeks gestation

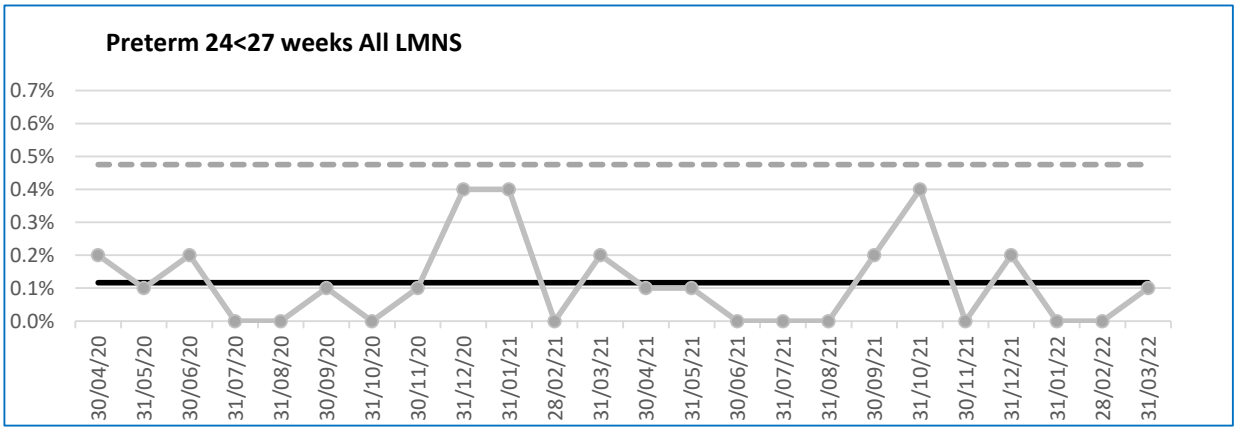


Table 5. Preterm Births at PAHT between 24 and 36+6 weeks gestation

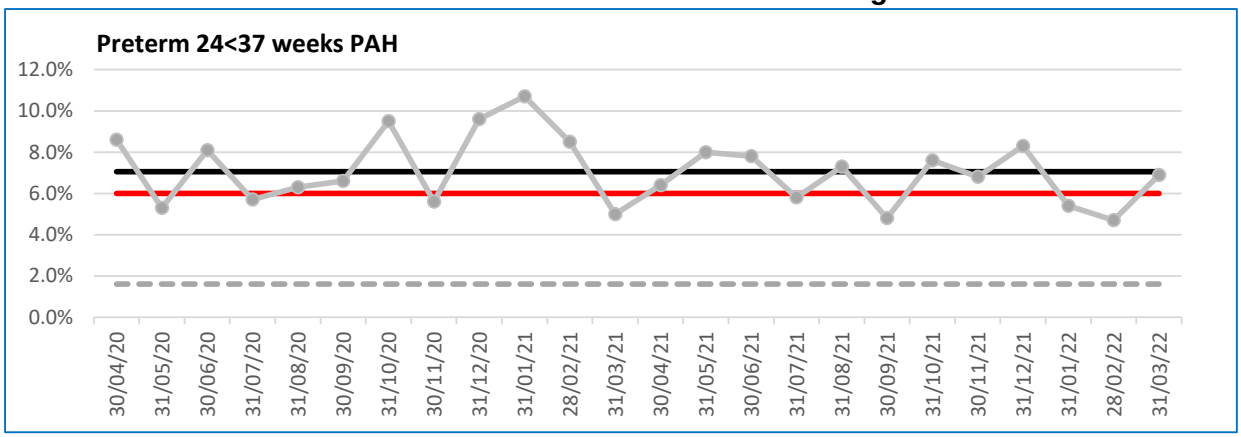
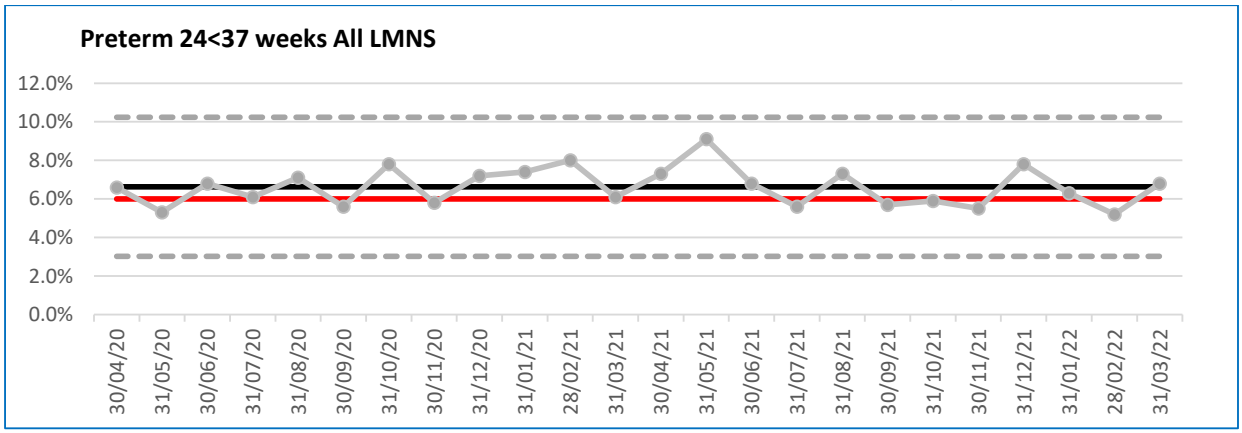


Table 6. Preterm Births across LMNS between 24 and 36+6 weeks gestation



The tables show no statistical variance that would cause concern and there were no reported months where the upper control limit was breached. With a local target set at 6% and PAHT mean 7% there is still some work to be done to reduce this rate further, across the LMNS the mean is 6.6%. This will be targeted by the Division to ensure improvement work is undertaken.

Right Place of Birth

PAHT is a level 2 local neonatal unit, that has the expertise to deliver care to singleton pregnancies from 27 week's gestation where an estimated fetal weight is >800 grams and from 28 week's gestation in multiple pregnancies where an estimated fetal weight is >800 grams.

Since the implementation of SBLCB version 2 (2016) a total of 13 babies were born at PAHT <27 week's gestation.

Table 7. Babies born <27 week's gestation per financial year.

Financial Year	Babies born <27 weeks
2016-2017	4
2017-2018	1
2018-2019	0
2019-2022	0
2020-2021	6
2021-2022	2

Of the 13 babies born at PAHT, 4 were born via Caesarean section and 9 were birthed vaginally. 3 of the 13 mothers (23%) received magnesium sulphate, administered for neuroprotection in the neonate. 4 of 13 mothers (31%) received a minimum of one corticosteroid steroids prior to birth, administered for acceleration of lung maturity in the neonate.

The main theme for non-administration of magnesium sulphate and corticosteroids was due to imminent birth, either due to spontaneous labour or expediated birth required under emergency circumstances.

Following a review of the 13 case, two cases had the potential to received steroids and magnesium sulphate and transfer arranged to a tertiary unit (See highlighted below)

Thematic Review (Break down per financial year)

Financial Year 2016 – 2017

There were 4 babies born at PAHT below 27 weeks gestation.

Case 1: Female infant born via emergency Caesarean section, under General Anaesthetic (GA) due footling breech presentation at full dilation at 24+3 weeks gestation, weighing 560 grams. The mother received one dose of steroids and Magnesium sulphate commenced one hour prior to birth.

Case 2: Male infant born via spontaneous vaginal birth at 25+4 weeks, weighing 818 grams. The mother received one dose of steroids. Magnesium sulphate was not commenced due to imminent birth.

Case 3: Female infant born via spontaneous vaginal birth at 24+0 weeks gestation, weighing 662 grams. The mother attended with a history of vaginal bleeding and tightening spontaneously. One dose of steroid was administered. Magnesium sulphate was not administered.

Case 4: Male infant born via emergency Caesarean section, under GA due to antepartum haemorrhage and suspected placental abruption at 26+3 weeks, weighing 920 grams. Full course of steroids administered. Magnesium sulphate not commenced due to imminent birth.

Financial Year 2017 – 2018

There was one baby born below 27 weeks gestation

Case 1: Female infant born via spontaneous vaginal birth at 26+5 weeks gestation, weighing 932 grams. The mother arrived to the unit fully dilated and birth imminent therefore Magnesium sulphate was not commenced. One dose of steroids was administered.

Financial Year 2018 – 2019

There were no babies born at PAHT below 27 weeks gestation.

Financial Year 2019 – 2020

There were no babies born at PAHT below 27 weeks gestation.

Financial Year 2020 – 2021

There were 6 babies born at PAHT below 27 weeks gestation.

Case 1: Female infant born via emergency Caesarean section, under GA due to transverse presentation at 25+1 weeks gestation, weighing 695 grams. The mother arrived to the maternal fetal assessment until in established labour with a history of vaginal bleeding and contracting for 2 days. Magnesium sulphate and the first dose of steroids were administered prior to birth.

Case 2: Female infant born via spontaneous vaginal breech birth at 23+3 weeks gestation, weighing 500 grams. The mother attended the unit via ambulance with a history of vaginal bleeding and contracting. She was admitted to the antenatal ward and opioids administered following speculum examination findings of cervical os closed. The woman was admitted to PAHT for 6 hours prior to birth. Steroids and magnesium sulphate were not administered. It is unclear why she was not transferred to a tertiary centre.

Case 3: Female infant born via spontaneous vaginal birth at 26+2 weeks gestation, weighing 895 grams. Steroids and magnesium sulphate were prepared but not administered as birth imminent (<2 hours from arrival to the birth).

Case 4: Female infant born via spontaneous vaginal birth at 25+4 weeks gestation, weighing 685 grams. First dose of steroids was administered. Magnesium sulphate was not administered, unclear of rationale as other preterm protocol had been commenced.

Case 5: Female infant born via spontaneous vaginal birth at 26+0 weeks gestation, weighing 892 grams. The mother had received no antenatal care as was unaware of pregnancy. Steroids and magnesium sulphate were not administered due to alternative diagnosis of urinary tract infection.

Case 6: Female infant born via spontaneous vaginal breech birth at 26+6 weeks gestation, weighing 1120 grams. The mother had received no antenatal care as concealed pregnancy. Magnesium sulphate was administered and steroids were administered.

Financial Year 2021 – 2022

There were 2 babies born at PAHT below 27 weeks gestation.

Case 1: Male infant born via spontaneous vaginal birth at 25+4 weeks gestation, weighing 870 grams. The mother arrived to the unit with a history of contracting. Steroids and magnesium sulphate were not administered due to imminent birth (<1 hour from arrival to birth)

Case 2: Male infant born via emergency Caesarean section under GA due to fetal heart concerns at 25+1 weeks, weighing 900 grams. Unclear why steroids and magnesium sulphate were not administered as mother was admitted >7 hours prior to birth.

Common Themes

From 2016, the most common themes arising for non-administration of magnesium sulphate and/or steroids in the 10 cases was imminent birth in 6 cases (60%), alternative diagnosis in 1 case (10%) and lack of awareness surrounding preterm birth protocol in 1 case (10%).

In 2 of the cases it is unclear why the mother was not transferred to a tertiary centre and magnesium sulphate and steroids administered, learning will be shared following this report and targeted teaching surrounding the importance of the preterm birth programme will be implemented.

Barriers

The information inputted onto Badger Net is not consistent with the maternity notes. Several cases have reported where no magnesium sulphate or steroids were administered despite evidence of administration on the JAC electronic prescription system and Cosmic. A preterm proforma is under development to address this issue.

4.0 Actions Undertaken (See Appendix 1 for full details)

- A guideline is in place for management of preterm birth which is under review and being updated in accordance with the RCOG guidance regarding antenatal steroids. A pathway is also in place for referral to a tertiary centre (Level 3 unit).
- Monitoring compliance with SBLV2 and Maternity Incentive Scheme Year 4.
- Exception reporting through the Local Maternity Neonatal Services and Integrated Care System.
- Patient notes include risk assessment for those at an increased risk of preterm birth.
- Preterm Birth Clinic being developed.
- Expression of interest to be disseminated for PreCept champions.
- PreCept education event to take place

The Princess Alexandra Hospital NHS Trust

5.0 Oversight

All highlighted concerns have been escalated at Divisional level. All incidents have a review of care undertaken to determine any care or service delivery issues. This is also discussed at the Divisional Governance Meeting and Trust Incident Management Group and escalated where relevant for further investigation.

6.0 Recommendation

It is requested that the board accepts the report with the information provided and the ongoing work with preterm birth and the actions undertaken to reduce the instance of preterm birth.

Author: Amber Dewick – Lead Midwife for Quality & Compliance
Date: 11th May 2022

Action	Responsible	Expected completion date
Develop clear guidance in caring for preterm birth including referral pathway	Lead Midwife for Quality & Compliance	Sept 2022
Monitoring compliance with SBLV2	Lead for Governance	Ongoing
Monitoring compliance with Maternity Incentive Scheme Year 4.	Lead for Governance	Ongoing
Exemption reporting through the Local Maternity Neonatal Services and Integrated Care System.	Lead for Governance	Ongoing
Patient notes include risk assessment for those at an increased risk of preterm birth.	Healthy Lifestyle Midwife	Completed
Preterm Birth Clinic being developed.	Divisional Director/Fetal Medicine Consultant	Mar 2023
Expression of interest to be disseminated for PReCePT champions.	Lead Midwife for Quality & Compliance	Sept 2022
PReCePT education event to take place	Lead Midwife for Quality & Compliance	Sept 2022

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 4 August 2022

4.2

Agenda item:	4.2							
Presented by:	Sharon McNally, Executive Director of Nursing and Midwifery							
Prepared by:	Erin Harrison, Lead Governance Midwife							
Date prepared:	13th June 2022							
Subject / title:	Maternity Serious Incidents: Thematic Review							
Purpose:	Approval		Decision		Information	x	Assurance	x
Key issues:	This paper outlines the Serious incidents that have occurred for Maternity Services in the last financial year (2021/22). The report will look at reporting standards, thematic analysis, identify areas of good practice and shared learning that has been identified.							
Recommendation:	It is requested that the board accept the report with the information provided and the ongoing work with the investigation process.							

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:	Divisional Board 22.6.22 Quality and Safety Committee (Maternity Assurance) 24.6.22
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme Year 4 Ockenden Report
Appendices:	1. SI detailed breakdown by case

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

This paper outlines the Serious Incidents that have occurred for Maternity Services in the last financial year (April 2021 – March 2022). The report will look at reporting standards and thematic analysis; alongside identifying areas of good practice and shared learning.

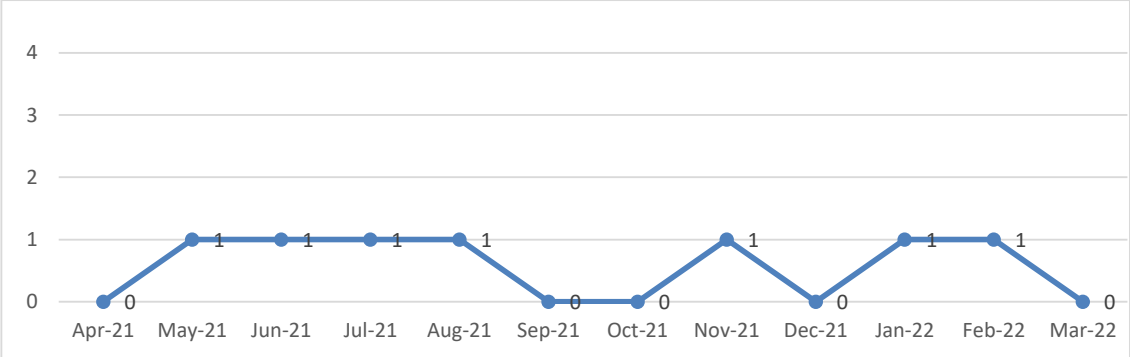
2.0 Background

As part of the national Ockenden requirements, the maternity service provides a summary of serious incidents monthly to this committee and Trust board. This paper has been prepared at the request of the committee to provide a deep dive into maternity services serious incident investigations with a thematic oversight.

3.0 Analysis

During the time period of April 2021 – March 2022, the maternity service declared 7 serious incidents. Table 1 details the trend of declared serious incidents within the 2021/22 reporting period.

Table 1. Total Number of serious incidents reported for Maternity in 2021/22 financial year



There have been no areas of statistical variation in reporting that would cause concern. There are clear lines of communication from the Division to the Board surrounding cases that meet the serious incident declaration threshold.

Table 2 details the top themes identified in maternity serious incidents within the financial year 2021/22.

Table 2. Top Themes by category

Total Number of SI's	Theme	Number
7	Emergency Caesarean	3
	Fetal Monitoring	3
	Neonatal Therapeutic Cooling	2
	Intrauterine Death	2
	Cross Border Working	1
	Fetal Laceration	1
	Massive Obstetric Haemorrhage	1
	Neonatal Death	1

The main theme from the serious incidents reported in this period consisted of emergency caesarean sections where there were concerns over fetal monitoring and poor neonatal outcomes. All cases that met the criteria for investigation by the Healthcare Safety Investigation Branch (HSIB)[1] were reported as required with consent from the families involved.

Table 3 demonstrates a thematic deep dive into each case. Appendix 1 details individual case by case data.

Table 3: Thematic Deep Dive

Age	29% of women were in their 20's, 71% were in their 30's	Pregnancy for women who are either teenage or over 40 years old are statistically more at risk of having adverse outcomes. This was not reflected in the Serious Incidents declared for 2021/22.
Ethnicity	86% of women were White British Ethnicity 14% were of any other White Background	The most recent MBRRACE report which demonstrated that women who were Black or of Minority Ethnicity were at higher risk of morbidity and mortality. This was not demonstrated within the case reviews at PAHT.
Medical history	57% of women had a pre-existing medical condition at booking or throughout pregnancy. 43% of women had no health concerns at booking or throughout pregnancy.	Of the 7 cases 4 women had pre-existing medical conditions. Following a review of each case this had no impact on the outcome of the case. Women who have medical conditions are at higher risk of complications throughout their pregnancy.
Raised BMI (>30)	29% of women had a BMI of >30. 71% of women had a BMI of 18-30.	Raised BMI can cause a variety of issues during pregnancy, labour and birth. Of the 2 cases where a raised BMI was noted this did not impact on the outcome.
Primigravida	86% of women were in their first viable pregnancy.	6 women were in their first viable pregnancy. All were on the appropriate care pathways.
VBAC	0% of women had had a previous caesarean section.	Caesarean sections are known to have higher mortality and morbidity rates compared to vaginal births.

[1] HSIB are an independent organisation that is part of a national action plan to make maternity care safer. They have a reporting criteria in which they will undertake independent reviews of maternity care following family consent.

		This was not an issue for any case in this reporting period.
Smoker	86% of the women were non-smokers. 14% (1 woman) was a known smoker	Smoking in pregnancy is a serious health matter and can affect both the mother and fetus. This was not a recognised theme in the cases reported.
Substantive Midwife	86% of women were cared for by a substantive midwife	One case involved an agency midwife. There is a local process for agency induction and it was not felt that this impacted on the case.
Substantive Obstetrician	86% of women were cared for by a substantive obstetrician	One case involved a locum registrar and this was escalated via the appropriate channels. The service has a Locum induction pack to ensure competencies are assessed by a Consultant.
Growth Normal (On ultrasound scan and birthweight)	100% of the babies involved were between the expected birth centiles.	All babies were born within normal weight ranges. Babies that are too large or too small carry higher risks and increases the chance of morbidity and mortality significantly. This was not a theme for the babies in this reporting period.
≥Term (≥37 weeks gestation)	86% of cases were at term. 14% (1 case) was preterm.	The majority of babies are born at term and therefore there is a higher likelihood that incidents will involve a term pregnancy.
Labour Ward	100% of cases occurred on the Labour Ward	All cases occurred on the labour ward compared to previous years where there were incidents on the Birth Centre.
Out of Hours	86% of cases occurred within normal working hours. 1 case was overnight.	It is recognised that there are less specialist and senior staff available out of hours for both midwifery and obstetric staffing models. The service has an escalation policy in place and on call senior midwifery and obstetric support. Only 1 case occurred out of hours and this did not impact on the level of care provided.
Induction of Labour	43% of women had their labour expedited by induction of labour.	NMPA details that 30% of women are induced in the UK. When it is considered better for mother or baby that the baby is born soon rather than to continue the pregnancy, induction of labour may be offered. Induction aims to start off labour by giving medication, breaking the waters, or both. This can be for many different reasons, for example when a baby is not growing well, if a woman has an existing condition like diabetes or if she develops a complication like pre-eclampsia. Induction is also offered to women without complications between 41 and 42 weeks to prevent prolonged pregnancy, and increasingly before 40 weeks to women aged over 40.
CTG Classification Concerns	43% of cases had concerns with the fetal monitoring	CTG is a method of recording the fetal heart rate throughout labour. CTG classification has been found to be a theme in this thematic review. All staff involved completed the fetal monitoring study day and associated competency.
Escalation Concerns	100% of cases were escalated within the expected timeframes and to the right staff member.	It is a positive that all cases were referred to appropriately and to the right staff member.
Vaginal Delivery	43% of women had a vaginal birth	3 women had vaginal births
Caesarean Section	57% of women required a caesarean section for their birth	4 women had caesarean births
Poor Apgar's (<less than 7 at 5 minutes)	43% of babies had poor apgar scores at birth	Babies born with low apgar scores are more likely to require resuscitation and require neonatal support or transfer to a local NICU or Tertiary centre.
Poor Cord Gases (venous PH <7.23)	43% of babies had blood gases outside the normal range at birth	Babies born with low blood gases are at higher risk of hypoxia and therefore require further neonatal support.
HIE (grade 2 or higher)	29% of the cases involved a diagnosis of HIE	Hypoxic Ischaemic Encephalopathy is a neonatal complication that can have lifelong effects on the baby

		physically. 2 babies were referred due to HIE however are doing well in their recovery.
Neonatal Death	14% (1 case) was a neonatal death 29% were not applicable as stillborn 57% were born alive	There was a reduction in neonatal death as a theme over this reporting period with one case. All staff and the family were supported following the incident.
Weekend	86% of cases occurred on a weekday.	It is recognised that there are less specialist and senior staff available out of hours for both midwifery and obstetric staffing models. The service has an escalation policy in place and on call senior midwifery and obstetric support. Only 1 case occurred during the weekend and this did not impact on the level of care provided.
Handover Time (between 07:30-08:00hrs and 20:00-20:30hrs)	86% of cases did not occur during the handover period.	One case occurred during the handover period and this was found to be a contributing factor within the report.

Of the themes identified 43% evidenced concerns with fetal heart rate monitoring. Since these cases all staff within the service have undertaken a CTG training day which encompasses a competency assessment. All staff are invited to weekly teaching and this is undertaken across the LMNS. Individuals involved in the cases were supported by both the Fetal Monitoring Lead Midwife and Consultant; and 1:1 sessions were provided where requested. The compliance is also part of the Maternity Incentive Scheme and Saving Babies Lives Care Bundle which is monitored by the Division with Board Level Oversight.

43% of women had a labour that was induced out of the 7 cases. The national average is 30% across all births. Induction of labour increases the risk of intervention and therefore increasing the need of obstetric led care. Induction of labour is currently a work stream as part of the maternity improvement board to review the current processes and guidance as well as involving birthing people to ensure that the service meets the required needs. This includes a review of information that is provided to families.

Term pregnancies remains a theme as per previous years but this is expected as the majority of births fall within the term gestation limits. This is not a concerning feature.

There have been improvements from both 2019 and 2020 reporting where the following were identified as themes:

- Escalation – in previous years this was raised as an area of concern. No cases in this reporting period had a lack of escalation involved in the care. There was targeted teaching undertaken and feedback provided at each study day and during handovers to spread the importance of timely escalation. The service also implemented escalation stickers to evidence escalation. It is positive to see that this was no longer a factor in this period.

- Smoking – in previous years reports this was noted to be a theme. With the work undertaken as per Saving Babies Lives Care Bundle and the successful employment of a Healthy Lifestyles Midwife it is positive to see that only 1 case out of the 7 involved a current smoker. There has been an update to the Maternal notes to include conversations surrounding smoking behaviour and the service now has links within Herts and Essex that provide smoking cessation services and prescriptions.
- Birth centre – no cases in this reporting period occurred on the Birth centre. All cases presented to the Labour ward and this was appropriate due to clinical backgrounds. It is not uncommon to have a higher instance of adverse outcomes on the Labour Ward due to the requirement for obstetric led care and interventions.
- Growth – whilst it is noted that there is still work to be undertaken surrounding plotting of fundal heights it was encouraging to see that all babies involved in these cases were of normal weight. This is due to the ongoing work with the Saving Babies Lives Care Bundles and the requirements to provide pathways for babies at risk of growth restriction. The service has also employed a Fetal Medicine Midwife who has a background in growth surveillance.

4.0 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. All Serious Incidents are discussed as part of the Local Maternity and Neonatal System Serious Incident Review meeting on a monthly basis as per the Ockenden recommendations.

5.0 Recommendation

It is requested that the Board accepts the report with the information provided and the ongoing work with the investigation process.

Author: Erin Harrison, Governance Lead Midwife
Date: 13th June 2022

Appendix 1 – Individual data analysis of each case

	Paweb 98457	Paweb 99016	Paweb 102303	Paweb 101460	Paweb 106256	Paweb 108939	Paweb 107031
Age	29	29	31	36	33	38	35
Ethnicity	White - British	White - British	White - British	White - British	White - British	White - British	Any other white
Medical history	No	Yes	Yes	No	No	Yes	Yes
Raised BMI (>30)	No	No	No	No	Yes	Yes	No
Primigravida	Yes	No	Yes	Yes	Yes	Yes	Yes
VBAC	No	No	No	No	No	No	No
Smoker	No	No	No	Yes	No	No	No
Substantive Midwife	Yes	Yes	Yes	No	Yes	Yes	Yes
Substantive Obstetrician	No	Yes	Yes	Yes	Yes	Yes	Yes
Growth Normal (On ultrasound scan and birthweight)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
≥Term (≥37 weeks gestation)	Yes	Yes	Yes	Yes	Yes	Yes	No
Labour Ward	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Out of Hours	No	No	Yes	No	No	No	No
Induction of Labour	Yes	Yes	No	No	No	Yes	No
CTG Classification Concerns	No	No	Yes	Yes	N/A*	Yes	N/A*
Escalation Concerns	No	No	No	No	No	No	No
Vaginal Delivery	No	Yes	No	Yes	Yes	No	No
Caesarean Section	Yes	No	Yes	No	No	Yes	Yes
Poor Apgar's (< 7 at 5 minutes)	No	No	Yes	Yes	N/A*	Yes	N/A*
Poor Cord Gases (venous PH <7.23)	No	No	Yes	Yes	N/A*	Yes	N/A*
HIE (grade 2 or higher)	No	No	Yes	No	N/A*	Yes	N/A*
Neonatal Death	No	No	Yes	No	N/A*	No	N/A*
Weekend	No	Yes	No	No	No	No	No
Handover Time (between 07:30-08:00hrs and 20:00-20:30hrs)	No	No	No	No	No	Yes	No

*N/A is due to the infant being still born

Trust Board (Public) – 04.08.22

Agenda item:	4.3
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery, Giuseppe Labriola, Director of Midwifery
Date prepared:	20.7.2023
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels for June 2023 and an update to Nursing and Midwifery Workforce Position – Hard Truths Report

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	Part A: Overall staffing risk rating in month: Green with an increased overall RN/M fill rate (↑1.5 %) to 94.8%. The fill rate of HCSW has increased by 0.3%% to 109.7 %. Part B: Maternity staffing - Amber Part C: Vacancy rates are increasing for Band 5's due to leavers predominantly due to cost of living but active recruitment pipeline is in place for international nurses Vacancy is 7.2% and Band 5 is 12.3%. HCSW vacancy is 10%. Recruitment work is ongoing utilising NHSE &ICS best practise with healthy pipelines of both.
Recommendation:	The Board is asked to note the information within this report.

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

Previously considered by:	Workforce Committee (WFC) – 26.7.22
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Divisions have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18

Appendices:	**Appendix 1:** Registered fill rates by month against adjusted standard planned template. RAG rated. **Appendix 2a:** Ward staffing exception reports. **Appendix 2b:** Red Flags (NICE) **Appendix 2c:** Red Flag data **Appendix 2d:** Staffing Incidents trend data **Appendix 2e:** Staffing Incidents by ward **Appendix 3a:** Care Hours Per Patient Day (CHPPD) Model Hospital Data **Appendix 3b:** Ward Level CHPPD **Appendix 4:** Temporary staffing demand and fill rate data

To update and inform the Board on actions taken to provide safe, sustainable and productive staffing levels for nursing, midwifery and care staff in June 2022. To provide an update on plans to reduce the nursing and HCSW vacancy rate over 2022/23.

1.0 BACKGROUND

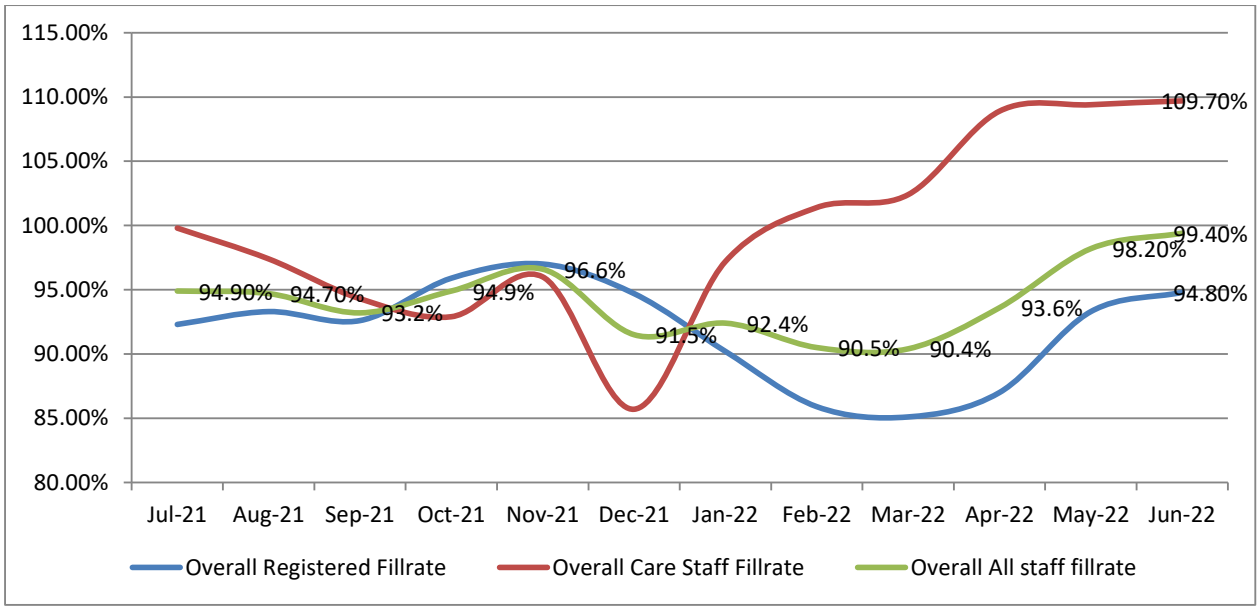
The report is collated in line with The National Quality Board recommendations (June 2016).

2.0 ANALYSIS

2.1 Fill rates for areas submitted to UNIFY:

There was an increase of fill in June compared to May by 1.2%%. Overall care staff fill rates increased by 0.3% to 109.7% with RN fill rate increasing by 1.5% to 94.8%.

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 May 2022	90.8%	107.4%	96.5%	111.9%	93.3%	109.4%	98.2%
In Patient Ward average June 2022	93.3%	107.8%	96.7%	112.1%	94.8%	109.7%	99.4%
Variance May 2022 – June 2022	↑2.5%	↑0.4%	↑0.2%	↑0.2%	↑1.5%	↑0.3%	↑1.2%

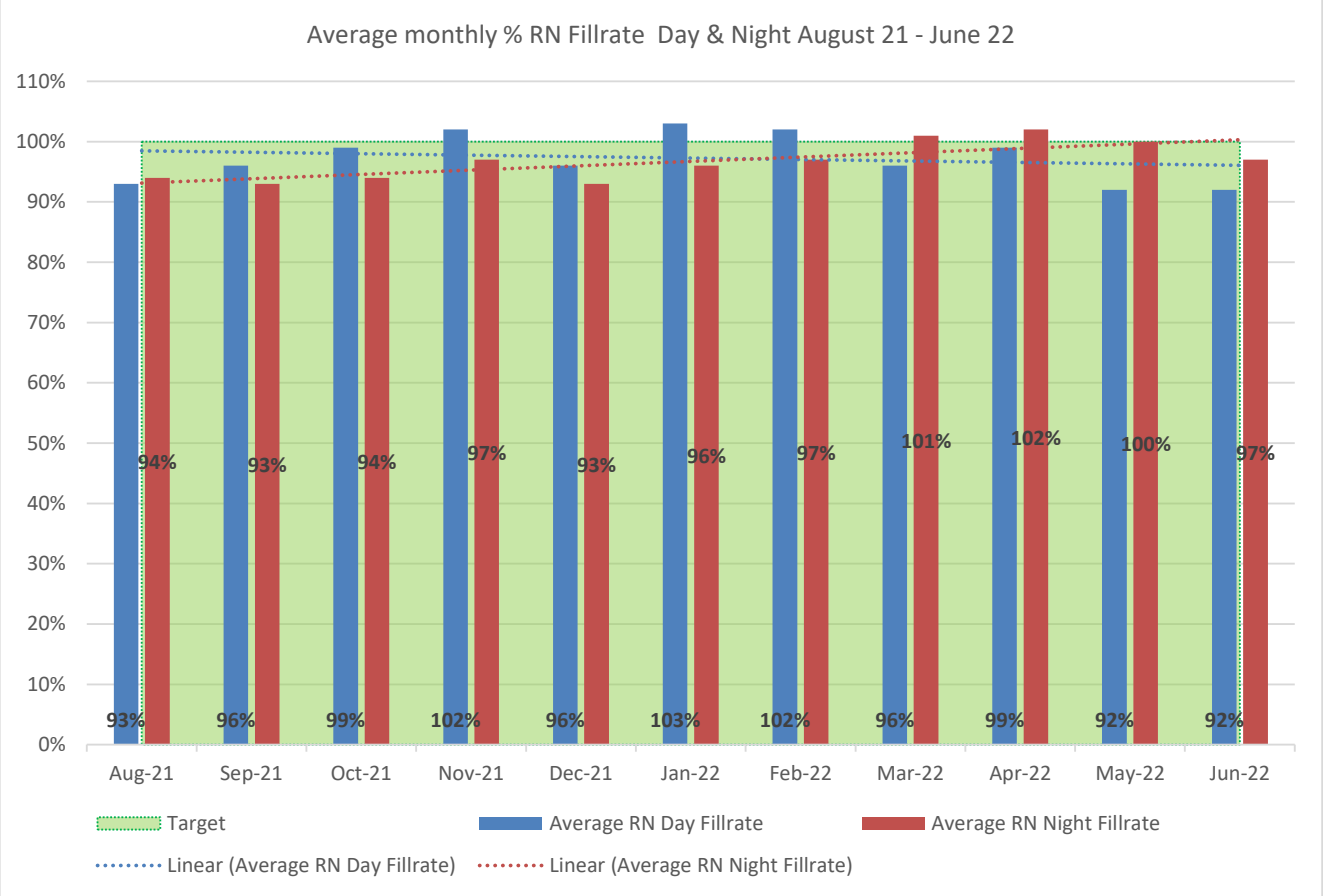


2.2 Fill rates for areas not covered by UNIFY:

	Day		Night	
A&E Nursing	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
April 2022	99.3%	88%	102.4%	84.1%
May 2022	91.8%	84.6%	99.7%	84.9%
June 2023	91.5%	80.9%	97.4%	86.3%

Staffing within ED remains subject to a CQC Section 31 notice. There is weekly executive oversight of the nursing (and medical) retrospective and prospective fill rates prior to submission of the data to the

CQC. The following graph shows the trend in fill rate since August 2021 when the improvement notice was served.



2.3 Fill rates by ward:

John Snow reported average fill rates below 75% for HCA against the standard planned template during June. While the overall fill rate was 74.7%, the RN fill was 104% with the HCA 36.3%. As with previous months this is because as JS ward is operating as an elective orthopaedic ward there is a fluctuating acuity and volume of patients for which the staffing is adjusted daily according to safecare however the set demand template is not adjusted.
Appendix 1. Shows the fill rates by ward against the standard but revised planned templates

Date	Ward name	% RN overall fill	% overall ward fill
Mar-22	Dolphin	69.4%	73.1%
	John Snow		72.4%
	Tye Green	71.8%	
Apr-22	John Snow		71.2%
May-22	No Wards		
Jun-22	John Snow		74.7%

Appendix 2a: Ward staffing exception reports provides additional detail on the impact on care where the fill is < 75% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes.

2.4.1 Red Flag Data*: (Appendix 2b: NICE Red Flag Events)*

(Appendix 2c) The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards (excluding Maternity) decreased to 68 (↓37) against May which reflects reduced Covid absence and increased recruitment and bank and agency fill. If a nursing red flag event occurs for number of staff on duty to meet the care needs of patients, staff escalate the situation and if appropriate complete a Datix.

2.4.2 Datix reports: (*Trend data Appendix 2d)*

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 28 (↑7), Ray, Tye Green and Winter all raised 3 Datix reports in relation to staffing levels. ***(Appendix 2e).*** The majority of the datix incident reports were raising concerns with a lack of available staff to provide 1:1 enhanced care.

2.5 Care Hours per Patient Day* (CHPPD):

The Trust overall CHPPD has remained static for the last three month (7.6 CHPPD). The Trust total CHPPD compared to the latest Model hospital national median data, shows the Trust having 7.6 and the national median being 8.0 (April 2022 data) **Appendix 3a** shows the Trust comparative CHHPD data via the Model Hospital portal based on April 2022 data

Appendix 3b shows the CHPPD for each ward and the Trust total for June 2022

2.6 Bank and Agency fill rates *(Appendix 4 data tables)*

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 table below shows a summary of secondary staffing demand.

June 2022									
	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts	Change in fill from previous month
RN	3327	2274	68.3%	487	14.6%	83%	566	17%	↑3.9%
HCA	1751	1496	85.4%	0	0%	85.4%	255	14.6%	↑3.8%
RMN	291	32	11.0%	223	76.6%	87.6%	36	12.4%	↓1.9%

In June, there was an increase in registered nursing demand ↑273 shifts compared to May; there was a reduction in fill rate from 86.9% in May to 83% in June.

To support patients requiring enhanced care there has been increased demand for RMNs. These shifts are created by Matron or above level to add a level of assurance regarding the need. The Trust has appointed a RMN lead nurse who will work in conjunction with the Lead Nurse for Falls & Enhanced Care and the Interim Safe Staffing Lead to ensure that the requirement is validated and the patients' needs can only be meet by a RMN.
In June there was a reduction in RMN demand ↓45 shifts requested in June compared to May; there was an increase in fill rate from 87.6% in June compared to 85.7% in May ***(RMN shift data Appendix 4)***

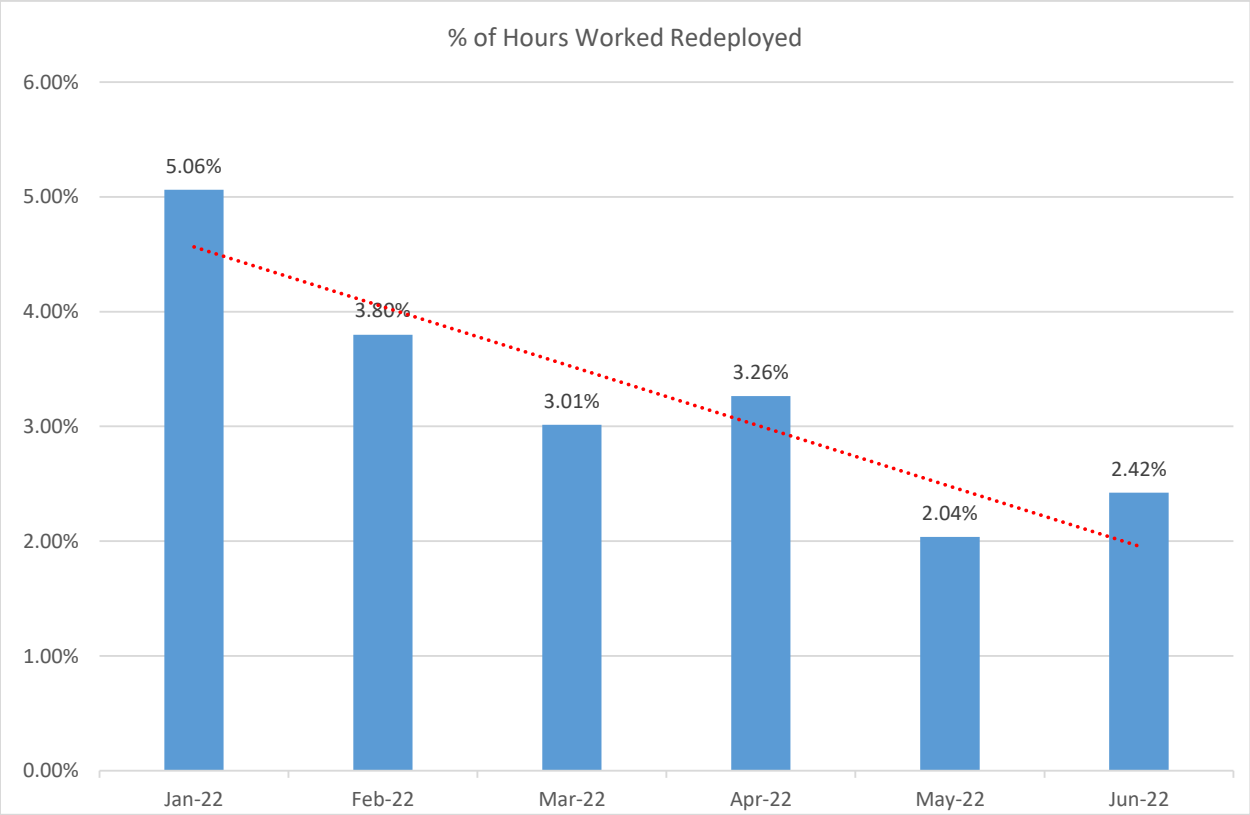
2.7 Redeployment of staff:

The table below shows how the Trust is supporting safe staffing through redeployment of staff to meet acuity and dependency. The data does not capture the moves of bank or agency staff; (including multi post holders). Also excluded are the Maternity Wards and the Enhanced Care Team.

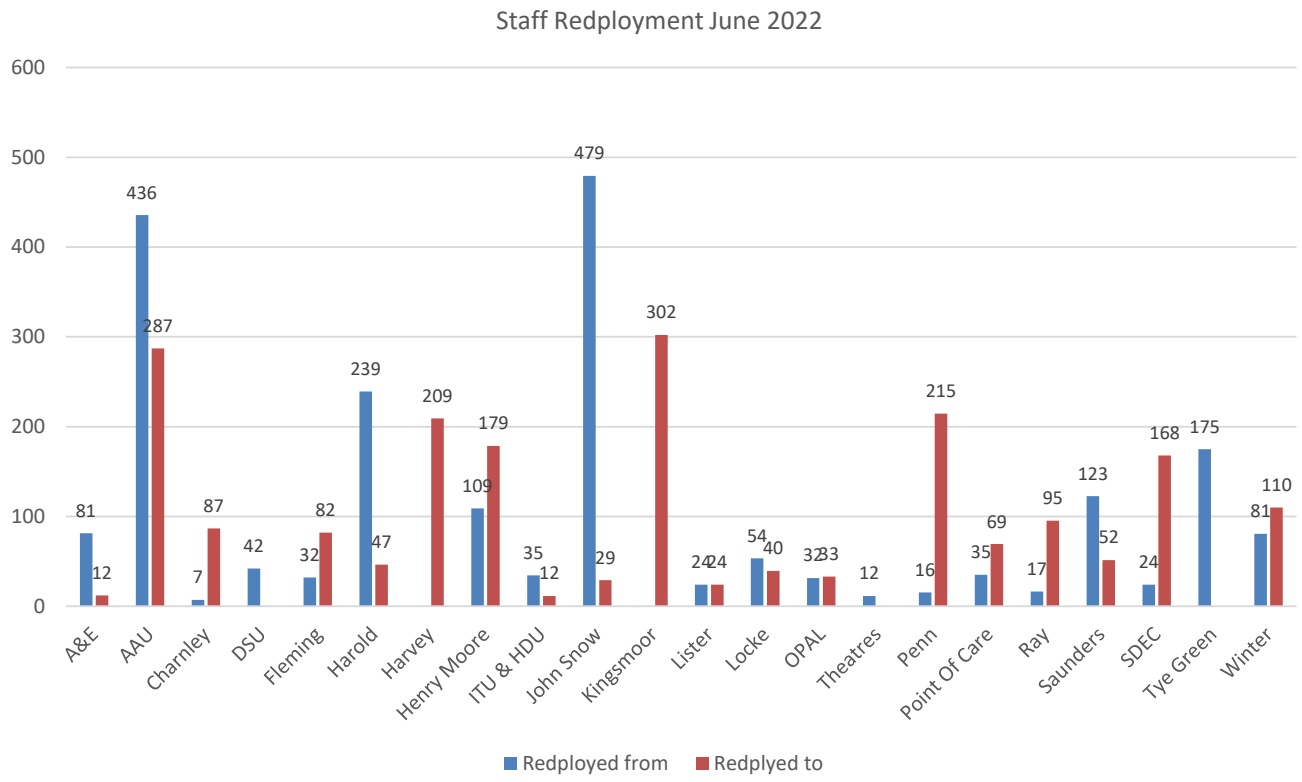
The accuracy of these reports continues to be dependent on the wards and site team redeploying staff, capturing and recording these moves in real-time in the e-Roster or SafeCare systems. While essential to ensure the safe staffing across the Trust moving substantive staff can impact with poor staff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

The senior nursing leadership teamwork closely with ward managers and teams to ensure there is understanding of the rationale for moves and to ensure there are positive conversations.
The data shows the number of hours of staff worked, the hours redeployed and the percentage of hours worked redeployed to support safe staffing.
The graph shows the trend over the past 6 months, which shows an overall reduction though there was a small increase in June up 0.38% to 2.42%. following a high of 5% in January when Covid absence was at its highest.

Date	Total Hours Worked	Total Hours Worked Bank / Agency	Total Hours Worked Excluding Bank & Agency	Total Hours Redeployed	Total Hours Not Redeployed	% of Hours Worked Redeployed
Jan-22	115052.8	34953.0	80099.8	4053.8	76046.0	5.06%
Feb-22	100224.4	23181.4	77043.0	2927.3	74115.8	3.80%
Mar-22	111821.2	25239.2	86582.0	2609.6	83972.4	3.01%
Apr-22	117185.3	30586	86599.3	2827	83772.3	3.26%
May-22	136878	35846	101032.0	2057	98975.0	2.04%
Jun-22	119226.1	34626	84600.1	2049	82551.1	2.42%



The following graph shows the hours moved from ward to ward during June 2022. The highest exporter of staff was John Snow which reflects the fluctuating demand. Staff are redeployed within the surgical division in the first instance to support skills retainment.



Part B Midwifery Staffing

The National Institute for Health and Care Excellence (NICE) published the report: Safe midwifery staffing for maternity settings in 2015, updated in 2019. This guideline aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if there are not enough midwives to meet the needs of women and babies in the service. The guidance was produced in response to previous reports such as the Francis report (2013).

The activity within maternity services is dynamic and can change rapidly. It is therefore essential that there is adequate staffing in all areas to provide safe high-quality care by staff who have the requisite skills and knowledge. Regular and ongoing monitoring of the activity and staffing is vital to identify trends and causes for concern, which must be supported by a robust policy for escalation in times of high demand or low staffing numbers.

The addition of midwifery to the safe staffing report this month includes a detailed overview of systems and processes in place to maintain safe staffing. The detail will be pulled in the appendices for information in following months.

Each month the planned versus actual staffing levels are submit to the national database using the information provided from the Allocate rostering system.

Table 1. Fill rates for the Labour Ward and Birth Centre

	Fill Rates LW Registered Midwife (RM)		Fill rates LW Maternity Care Assistants (MCA)		Fill Rates Birth Centre RM		Fill rates Birth Centre MCA	
	Day	Night	Day	Night	Day	Night	Day	Night
June								

Table 2. Fill rates for the antenatal ward and postnatal ward

	Fill Rates AN ward RM		Fill rates AN ward MCA		Fill Rates PN ward RM		Fill rates PN ward MCA	
	Day	Night	Day	Night	Day	Night	Day	Night
June								

Intrapartum acuity:

The maternity service implemented the use of the Birthrate Plus intrapartum acuity tool in 2021. The data is inputted into the system every 4 hours by the Labour Ward Co-ordinator and measures the acuity and the number of midwives on shift to determine an acuity score. Birthrate Plus defines acuity as "the volume of need for midwifery care at any one time based upon the number of women in labour and their degree of dependency" A positive acuity scores means that the midwifery staffing is adequate for the level of acuity of the women being cared for on Labour Ward at that time. A negative acuity score means that there may not be an adequate number of midwives to provide safe care to all women on the Labour Ward at the time. In addition, the tool collects data such as red flags which are defined as a "warning sign that something may be wrong with midwifery staffing" (NICE 2015). PAHT has adopted the red flags detailed in the NICE report.

There should be a compliance with data recording of at least 85% in order to have confidence in the results.

During the reporting period of June the Labour Ward did not achieve a 85% confidence factor in the month – 60% of recordings were made where staffing met acuity. 72% compliance of the tool was achieved. The majority of negative acuity is amber with up to 2 midwives short with a much smaller percentage of occasions being red which equates to 2 or more midwives short.

The Birth Centre has not been included in the analysis due to staffing challenges. Midwives were redeployed to the Labour Ward and inpatient wards resulting in closure of the birth centre. When the birth centre is closed and on divert to Labour Ward, the acuity tool would not be completed in this area.

Table 3. Intrapartum Acuity

Red flags:

In total there were 10 red flags recorded during this reporting period. The majority of these related to delays in the induction of labour process (n=1, 8%), the co-ordinator not able to maintain supernumerary status (n=8, 62%), delay in presentation and triage, (n=2, 15%) . All delays for induction of labour and the inability for the co-ordinator to be supernumerary will be incident reported via the DATIX system and thoroughly reviewed

Action: There is a working group in progress reviewing the process of Induction of Labour. This includes improving the flow of activity through the unit and to minimise delays in transfer.

1:1 care in established labour:

1:1 care is defined as “care provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same midwife for the whole of labour” (NICE 2015). During this reporting period there were 0 occasions when 1:1 care was recorded as not being provided.

Supernumerary status of the coordinator :

Supernumerary status of the coordinator is defined as the coordinator not having a caseload. The acuity tool has time built in for the coordinator to be supernumerary when it is recorded. The data identifies that the coordinator was not supernumerary on 8 occasions (62%) during the reporting period.

Action: As part of the investigations into the loss of supernumerary status by the co-Ordinator, the individual senior midwives have been supported to understand the recognition and actions required to address the red flag. This is in addition to the training arranged in September. For example, 4 of the occasions were by one midwife over a period of days with high activity and all actions taken were appropriate and enabled the co-ordinator to maintain supernumerary status or for an additional senior midwife or manager to do so for a short period of time, maintaining oversight and the safety of the unit.

Specialist Midwives:

The maternity service has a wide range of specialist midwifery posts to support. These staff members are redeployed and assist in times of increased activity and acuity. This is alongside the midwifery management team, community midwives and continuity of carer midwives

During this reporting period there were 113 management actions taken. The majority of these related to redeploying staff internally (n=82, 28%), additional staff sourced from bank/agency (n=66, 23%), staff unable to take breaks (n = 15, 5%) and escalation to the manager on call (n=19, 7%). On (n=35, 12%) occasions the on call continuity of carer midwives were in the maternity unit to support and the birth centre closed (n=53, 18%).

Action: Work has been commenced to strengthen the escalation model in the service to include an additional band 6 midwife on a voluntary basis to the oncall rota. Several stakeholder meetings have been held and a draft pilot standard operating procedure has been developed. The aim of the rota is to enhance the current escalation model with core midwives, to reduce the red flags. The pilot is in its infancy however the aim is to go live the beginning of August for three months.

As part of June’s midwifery recruitment drive several of the newly qualified midwives (14) agreed to work as Band 4’s throughout the summer and the recruitment team has begun the required training for them to start asap. Plans to commission a maternity specific training day may be required to avoid any delays with start dates. Three new starters ‘keep in touch events’ are taking place to support the transition to the team. These new additions to the team will also support a reduction in red flags.

Table 4 – Intrapartum acuity, red flag data and management actions taken

June	Red flags	1:1 care not met (number)	Supernumerary not met (number)	Management actions (number)	Acuity % Positive	Red %	Amber %	Assessment periods	Confidence Factor %
Labour Ward	10	0	8	113	60%	6%	34%	129/180	72%

Maternity inpatient wards:

The maternity service implemented the use of the Birthrate Plus ward based acuity tool in 2021. The data is inputted into the system every 12 hours by the Midwife in Charge and is a prospective assessment of expected activity. The data collection covers all women on the ward, classified accordingly to their clinical and social needs. Antenatal women are classified according to their clinical indicators. Further data is collected to record women or babies who may have extra needs. For each category an agreed amount of staff time is allocated.

Table 5 – maternity inpatient wards, red flag data and management actions taken

June	Red flags	Extra Care breakdown	Management actions (number)	Acuity % Positive	Red %	Amber %	Assessment periods	Confidence Factor %
Antenatal Ward	20	69% exceptional care needs 31% safeguarding	5	52%	0%	41%	61/90	67.78%
Postnatal Ward	0	79% extra care babies, 9% exceptional care needs 7% Sepsis	2	44%	3%	33%	73/90	81.11%

Antenatal Ward - During this reporting period there were 5 management actions taken. The majority of these related to redeploying staff internally (n=1, 20%) and specialists/managers working (n=2, 40%). On (n=2, 40%) occasions the on call continuity of carer midwives were in the maternity unit to support. In total there were 20 red flags recorded during this reporting period. The majority of these related to delays in the induction of labour process (n=18, 90%), inability to provide 1:1 care in labour (n=1, 5%) and delay in admission and beginning of induction process (n=1, 5%).

Postnatal Ward – During this reporting period there were 2 management actions taken. Redeploy staff internally (n=1, 50%) and escalate to manager on call (n=1, 50%). In total there was 1 red flag reported. This related to delay in providing pain relief (n=1, 100%)

Action: The Induction of labour workstream for the maternity improvement board continues to progress various elements as previously shared: daily review of those waiting for transfer to labour ward, digital booking, alignment with the Local Maternity and Neonatal System Induction of Labour (IOL) pathways and review of assessment for IOL using a Bishop Score system. Where red flags are raised with delays these are highlighted at the Safety Huddle, which occurs daily. Additionally, in response, risks to ensure that women and their babies are safe and the necessary actions are taken by the team, to address issues where needed. All antenatal women are seen on the daily ward round and by the senior leadership team to address concerns with delays should women and partners be concerned. The IOL workstream

moving forward will have the addition of either the Maternity Transformation lead or the Head of Midwifery.

B: Workforce:

4.0 Nursing Recruitment Pipeline:

Registered Nurse pipeline for 2022/23.

The following table includes uplift of nursing posts agreed in last establishment review and additional funding agreed for Kingsmoor and the enhanced care pool. Current vacancy rate is 12.3% for Band 5 and 7.2% overall. Recruitment for international nurses is ongoing and the Trust is working with new agencies to expand pool. It is anticipated that we will require 150 international nurses in year to reduce the vacancy rate to less than 3% considering turnover and projected local recruitment. NHSI funding is available to support recruitment costs.

There are currently 29 Registered Degree Nurse Apprentices at varying stages of their training.

NB the table below excludes midwives and includes posts with external funding which are not included in budgets

Nursing Establishment v Staff in post												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Funded Establishment WTE	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.3
Staff in Post WTE	958.49	946.49	947.49	950.49	958.49	974.49	989.49	999.49	1009.49	1011.49	1016.49	1018.49
Vacancy WTE	62.79	74.79	73.79	70.79	62.79	46.79	31.79	21.79	11.79	9.79	4.79	2.79
Actual RN Vacancy Rate	6.1%	7.3%	7.2%	6.9%	6.1%	4.6%	3.1%	2.1%	1.2%	1.0%	0.5%	0.3%
Forcast Vacancy Rate in Business Plan												

Band 5 Establisment V Staff in Post												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Funded Band 5 Establisment WTE	569	569	569	569	569	569	569	569	569	569	569	569
Band 5 Staff in Post WTE	515	506	499	492	503	514	533	551	562	573	574	578
Band 5 Starters	7	1	9	20	20	28	27	20	20	10	13	10
Vacancy Band 5 WTE	54	63	70	77	66	55	36	18	7	-4	-5	-9
Actual Vacancy Rate	9.5%	11.1%	12.3%	13.5%	11.6%	9.7%	6.3%	3.2%	1.2%	-0.7%	-0.9%	-1.6%
Forcast Vacancy Rate in Business Plan												

Actual/Projected Starters Pipeline												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
RNs (not Band 5)	1	3	3	4	4	4	4	6	6	8	8	8
Band 5 Newly Qualified + Local	1	1	3			8	7				3	
Band 5 International Recruitment	6	0	6	20	20	20	20	20	20	10	10	10
Band 5 Starters	**7**	**1**	**9**	**20**	**20**	**28**	**27**	**20**	**20**	**10**	**13**	**10**
Total Starters	8	4	12	24	24	32	31	26	26	18	21	18

Projected Leavers WTE												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
RNs (not Band 5) Leavers	9	3	5	7	7	7	7	7	7	7	7	7
Band 5 Leavers	7	8	16	9	9	9	9	9	9	9	9	9
Total Leavers	**16**	**11**	**21**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**	**16**
N&M Turnover %	14.97%	14.14%	15.69%									

Turnover:

Turnover has increased again to 15.69% in month. This is the highest rate for over 12 months. Feedback from managers and recruitment and retention lead is there is a significant shift in international nurses looking for cheaper areas to live due to rise cost of living. Actions in response are being undertaken by the people team at local and ICS level and there is support from the national team on nurse retention that the team are engaging with.

Healthcare Support Worker pipeline

HCSW vacancy rate in June was 10%. Recruitment activity continues to be successful with a healthy pipeline and steady recruitment however turnover remains higher than hoped. It is unlikely that we will reach vacancy of less than 1.5% until October.

Establishment V Staff in Post												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-22	Feb-22	Mar-22
Funded Establishment WTE	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64
Staff in Post WTE	373.00	376.00	381.00	391.00	401.00	411.00	421.00	421.00	421.00	421.00	421.00	421.00
Vacancy WTE	50.64	47.64	42.64	32.64	22.64	12.64	2.64	2.64	2.64	2.64	2.64	2.64
Actual B2/B3 Vacancy Rate	12.0%	11.2%	10.1%	7.7%	5.3%	3.0%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%

Actual/Projected Starters Pipeline												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total Starters	1	8	11	15	15	15	15	5	5	5	5	5

Projected Leavers WTE												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total Band 2/3 Leavers	**10**	**5**	**6**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
HCSW Turnover %	17.42%	22.41%	23.75%									

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 **19.7.2022**

Appendix 1

Ward level data: fill rates June 2022. *(Adjusted Standard Planned Ward Demand)*

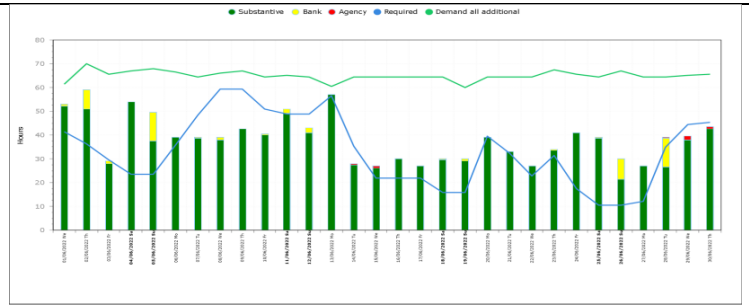
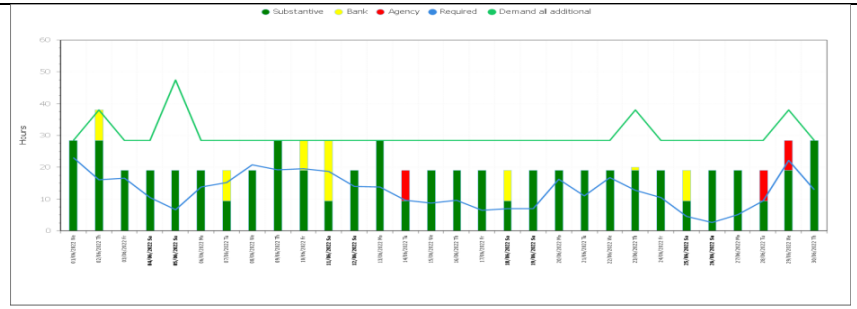
Appendix 1 has captured the fill rate at ward level, the accuracy of this data is dependent on all ward / staff moves and redeployment being captured and recorded accurately in Health Roster. Maternity Wards have been removed from this appendix. Total is different to total in table 3.2 due to this appendix excluding Maternity Wards

	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	96.6%	136.4%	99.1%	80.0%	97.8%	108.2%	98.6%
Saunders Unit	89.3%	113.1%	93.2%	114.8%	91.0%	113.8%	99.1%
Penn Ward	89.0%	112.4%	90.9%	155.0%	89.8%	128.5%	103.7%
Henry Moore Ward	109.2%	110.3%	101.7%	107.0%	105.7%	108.8%	106.7%
Harvey Ward	77.5%	135.3%	96.7%	133.3%	85.3%	134.3%	103.1%
John Snow Ward	107.6%	39.0%	100.0%	30.5%	104.0%	36.3%	74.7%
Charnley Ward	93.3%	127.0%	92.0%	132.4%	92.7%	129.6%	103.2%
AAU	124.4%	128.0%	113.8%	147.7%	119.1%	137.4%	123.8%
Harold Ward	136.5%	91.5%	124.4%	92.7%	130.7%	92.0%	111.4%
Kingsmoor General	85.7%	83.4%	94.2%	105.1%	89.3%	92.2%	90.6%
Lister Ward	94.7%	115.4%	96.7%	127.7%	95.5%	121.3%	105.1%
Locke Ward	90.1%	125.2%	98.4%	116.8%	93.7%	121.2%	101.0%
Ray Ward	88.7%	135.8%	101.3%	158.3%	94.0%	146.6%	110.2%
Tye Green Ward	78.6%	97.7%	84.8%	103.3%	81.3%	100.0%	88.6%
OPAL	104.9%	175.6%	118.4%	107.1%	110.0%	131.3%	117.9%
Winter Ward	84.7%	110.5%	100.0%	114.7%	90.5%	112.5%	98.7%
Fleming Ward	80.9%	103.7%	104.0%	103.2%	90.1%	103.5%	94.2%
Neo-Natal Unit	96.6%	105.1%	96.8%	86.7%	96.7%	95.9%	96.6%
Dolphin Ward	85.8%	69.3%	100.9%	91.2%	92.5%	76.6%	88.5%
Total	80.9%	107.2%	99.5%	114.7%	88.5%	110.6%	95%

Appendix 2a: 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 (June data)

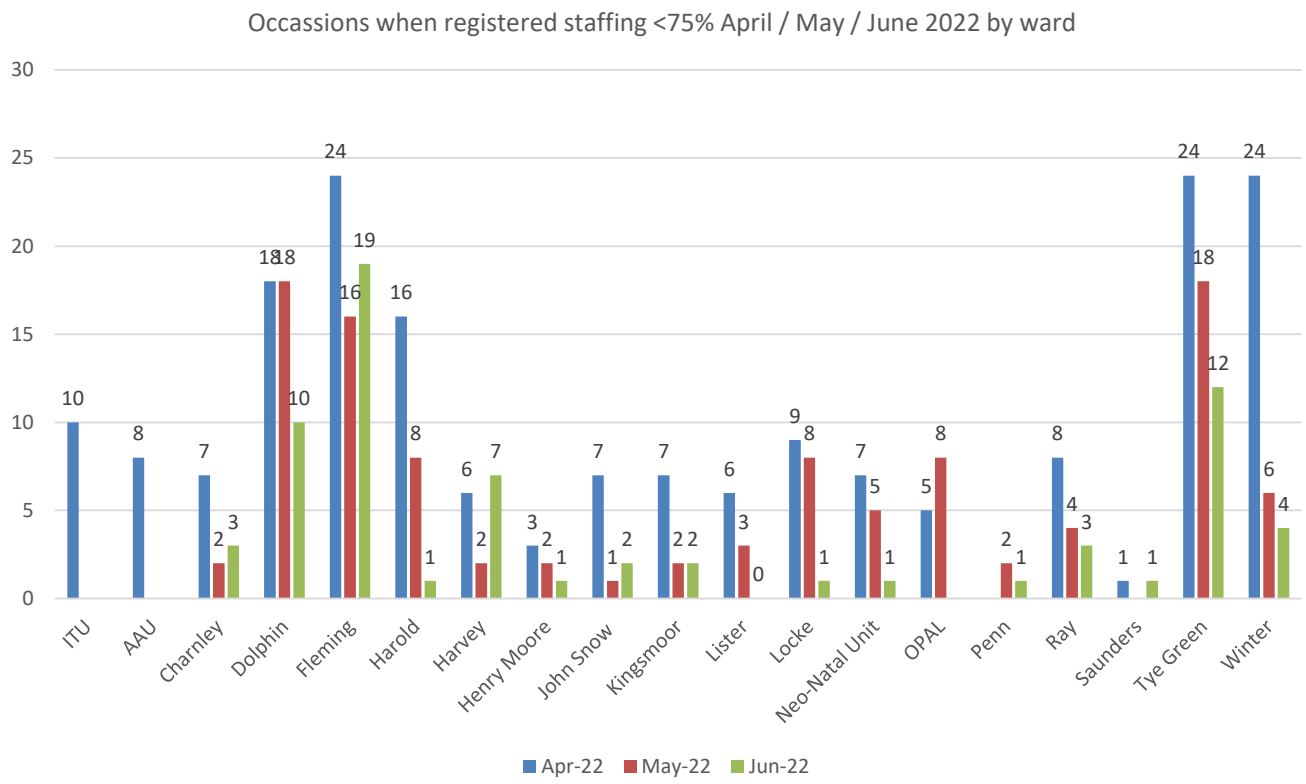
Report from the Associate Director of Nursing for the HCG							
Ward	Analysis of gaps			Impact on Quality / outcomes			Actions in place
John Snow	The acuity and dependency of the ward has meant that the requirement for care support workers has been reduced. The actual template for staffing reflects this demand.			No impact on patient quality or outcomes			Forward look reviews of planned patient acuity and dependencies in place to ensure staffing template meewebbts patient and ward need.
Quality Metric	PU	Falls	Staffing Datix	SIs	Drug Errors	Complaints	PALS
Number in month	0	0	0	0	0	0	0

Required vs Actual Day	Required vs Actual Day
	

Appendix 2b: 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 over the past three months.



Appendix 2c: Nursing Red Flags (NICE)

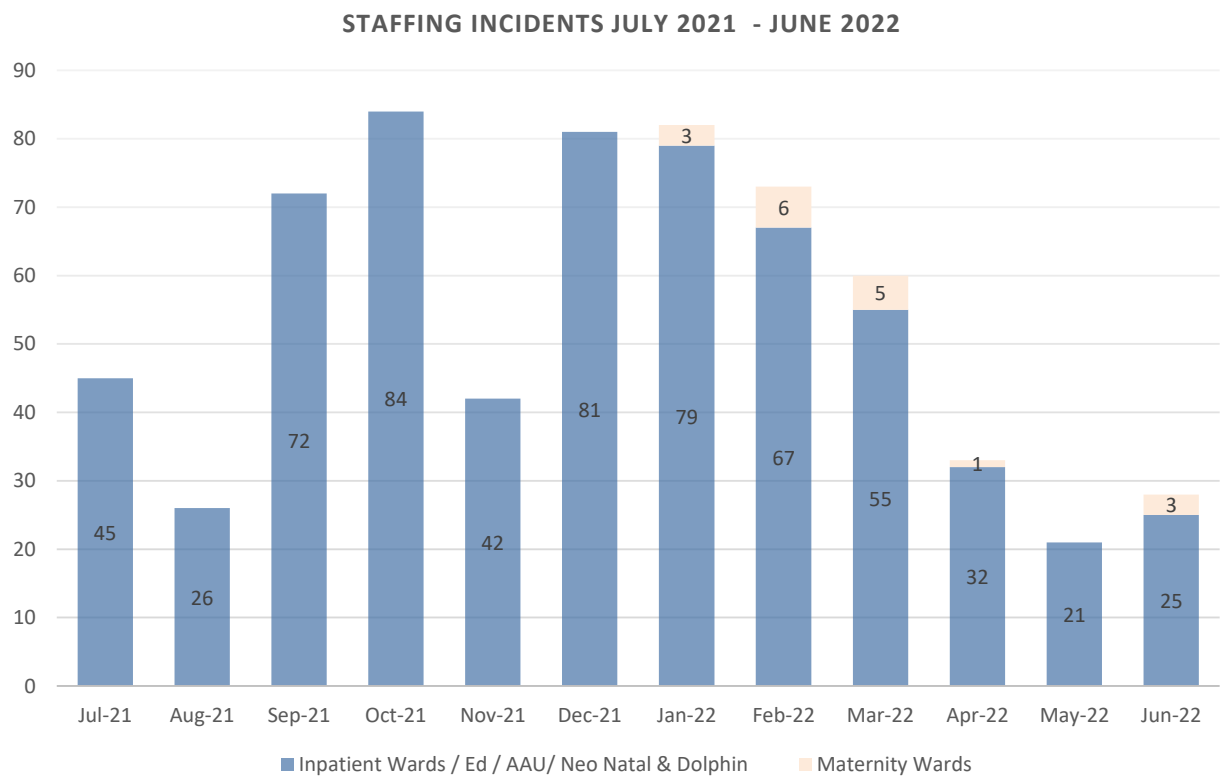
The National Institute for Health and Care Excellence (NICE) guideline Safe staffing for nursing in adult inpatient wards in acute hospitals (2014)1 recommends red flags relating to adult inpatient wards.
Recommendations for the registered nurses on wards who are in charge of shifts are:

- Monitor the occurrence of the nursing red flag events (as detailed below) throughout each 24-hour period. Monitoring of other events may be agreed locally.
- If a nursing red flag event occurs, it should prompt an immediate escalation response from the registered nurse in charge. An appropriate response may be to allocate additional nursing staff to the ward or areas in the ward.
- Keep records of the on-the-day assessments of actual nursing staff requirements and reported red flag events to inform future planning of ward nursing staff establishments or other appropriate action.

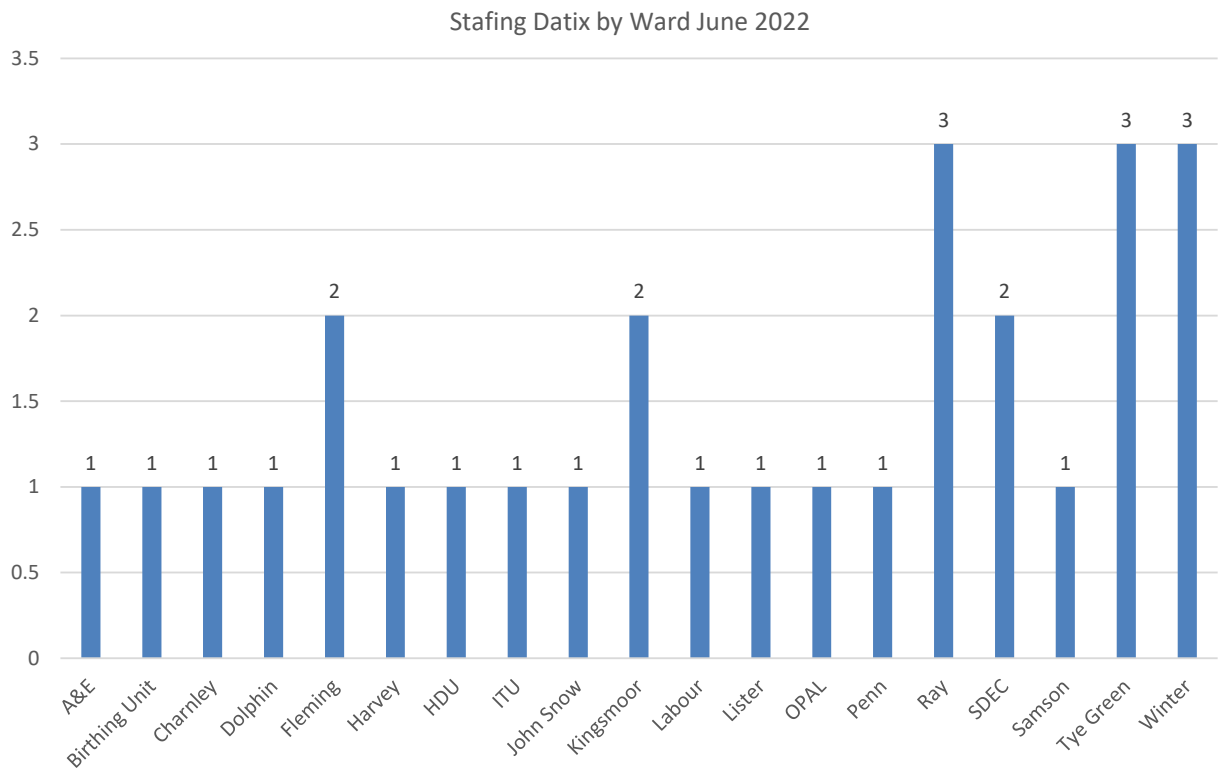
Nursing red flags

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
    - pain: asking patients to describe their level of pain level using the local pain assessment tool
    - personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration
    - placement: making sure that the items a patient needs are within easy reach
    - positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised. 1 www.nice.org.uk/guidance/SG1 7
- A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (that is, the loss of more than 25% of the required registered nurse time).
- Fewer than two registered nurses present on a ward during any shift.
- Note: other red flag events may be agreed locally.

Appendix 2d: Staffing Incidents Trend Data



Appendix 2e: Staffing Incidents by ward June 2022



Appendix 3 Care Hours per Patient Day (CHPPD):

CHPPD has been confirmed as the national principle measure of nursing, midwifery and healthcare support worked deployment on inpatient wards (NHSI, 2018).

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.

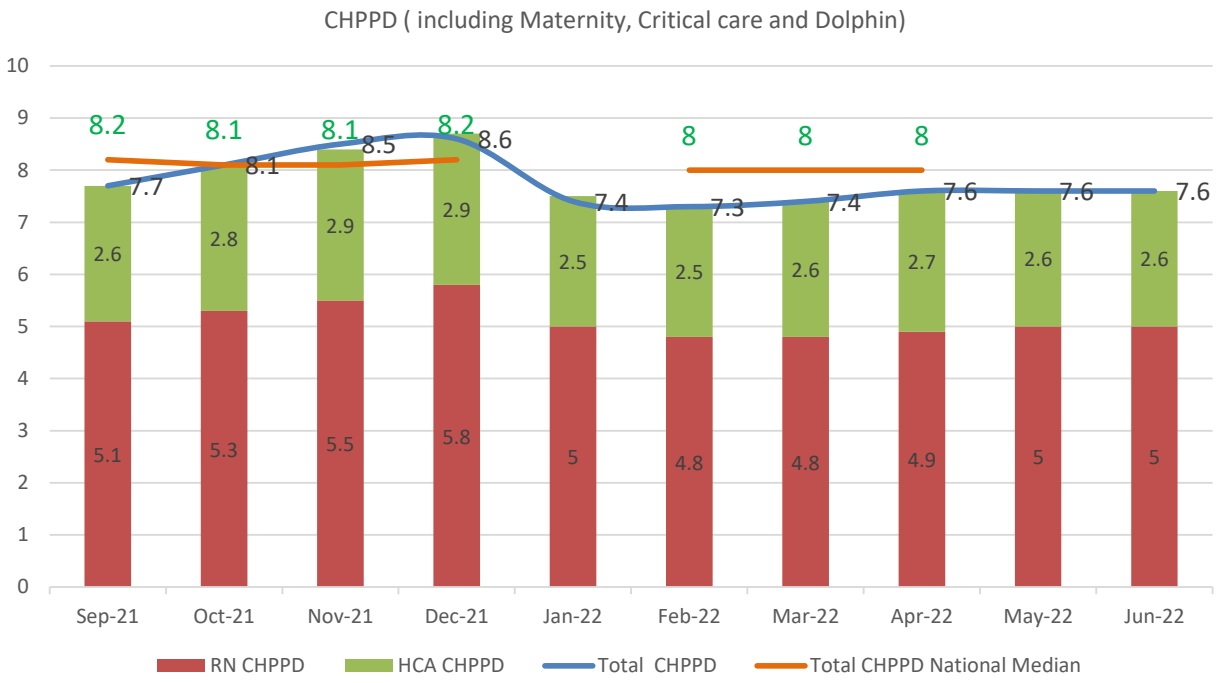
Care Hours per Patient Day* (CHPPD) is calculated every month by adding together the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants.

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.

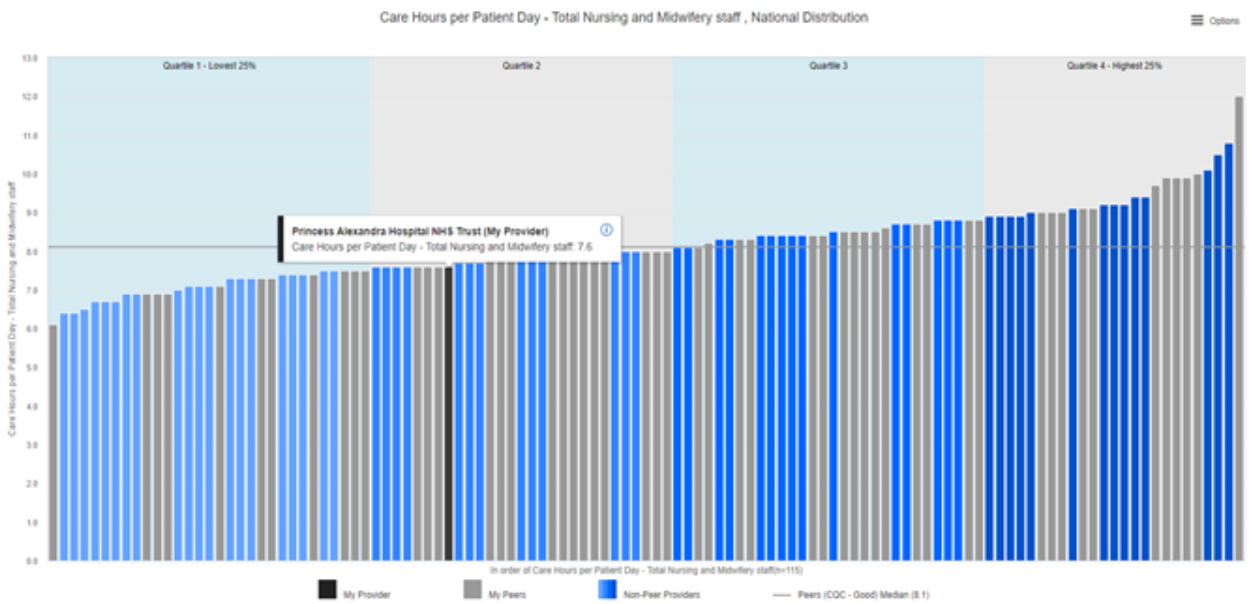
The accuracy of this report is dependant of the rosters being up to date and accurate bed occupancy numbers.

Appendix 3a: Shows Trust total , Registered and Unregistered CHPPD against National Median.
(National Median from Model Hospital) *(No National Median Data for Jan 2022)*



Trust comparative data via the Model Hospital portal is presented below based on April 2022 data

	April 2022 data	National Median (April 2022)	Variance against national median
CHPPD Total	7.6	8.0	-0.4
CHPPD RN	4.9	4.8	+0.1
CHPPD HCSW	2.7	3.1	-0.4



Appendix 3b

The table below shows the CHPPD for each ward and the Trust total for June 2022, based on the Trusts Unify submission for June 2022 Maternity Wards recorded separately

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total (including Maternity)	**5.0**	**2.6**	**7.6**

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Ward Total	**4.9**	**2.6**	**7.4**
ITU & HDU	28.6	2.6	31.3
Saunders Unit	3.5	2.4	5.9
Penn Ward	3.4	2.7	6.1
Henry Moore Ward	4.7	2.5	7.2
Harvey Ward	3.5	3.2	6.7
John Snow Ward	5.8	1.5	7.3
Charnley Ward	4.0	2.3	6.3
AAU	6.4	2.6	9.0
Harold Ward	4.0	2.8	6.9
Kingsmoor General	3.2	2.6	5.8
Lister Ward	4.2	3.2	7.4
Locke Ward	4.4	2.1	6.5
Ray Ward	3.6	2.5	6.1
Tye Green Ward	3.5	2.7	6.2
OPAL	5.0	3.5	8.5
Winter Ward	3.8	2.8	6.6
Fleming Ward	3.7	1.9	5.6
Neo-Natal Unit	9.4	1.9	11.2
Dolphin Ward	8.4	2.3	10.7

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Maternity Ward Total	**6.0**	**2.9**	**8.9**
Labour Ward	10.2	3.1	13.3
Birthing Unit	17.2	8.6	25.9
Samson Ward	2.5	2.7	5.2
Chamberlen Ward	6.2	1.9	8.1

Appendix 4: Temporary Staffing Demand & Fill Rate

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.

RN temporary staffing demand and fill rates: ***(April 2022 data supplied by NHSP 5.7.2022)***

Last YTD month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
January 2022	3775	2346	62.1%	535	14.2%	76.3%	535	23.7%
February 2022	3424	2188	63.9%	519	15.2%	79.1%	717	20.9%
March 2022	3842	2519	65.6%	534	13.9%	79.5%	789	20.5%
April 2022	2815	1950	69.3%	176	6.3%	75.5%	689	24.5%
May 2022	3054	2168	71%	486	15.9%	86.9%	400	13.1%
June 2022	**3327**	**2274**	**68.3%**	**487**	**14.6%**	**83%**	**566**	**17%**
June 2021	2688	1761	65.5%	400	14.9%	80.4%	527	19.6%

HCA temporary staffing demand and fill rates: ***(April 2022 data supplied by NHSP 5.7.2022)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
January 2022	2116	1540	72.8%	0	0%	72.8%	576	27.2%
February 2022	1715	1384	80.7%	0	0%	80.7%	331	19.3%
March 2022	1893	1520	80.3%	0	0%	80.3%	373	19.7%
April 2022	1776	1442	81.2%	0	0%	81.2%	334	18.8%
May 2022	1648	1470	89.2%	0	0%	89.2%	178	10.8%
June 2022	**1751**	**1496**	**85.4%**	**0**	**0%**	**85.4%**	**255**	**14.6%**
June 2021	1334	1143	85.7%	0	0%	84.55	215	15.55

RMN temporary staffing demand and fill rates: ***(April 2022 data supplied by NHSP 5.7.2022)***

Last YTD month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
January 2022	508	44	8.7%	297	58.5%	67.1%	167	32.9%
February 2022	465	26	5.6%	315	67.7%	73.3%	124	26.7%
March 2022	428	20	4.7%	337	78.7%	83.4%	71	16.6%
April 2022	478	45	9.4%	276	57.7%	67.2%	157	32.8%
May 2022	336	48	9.8%	255	75.9%	85.7%	48	14.3
June 2022	**291**	**32**	**11.0%**	**223**	**76.6%**	**87.6%**	**36**	**12.4%**
June 2021	217	21	9.7%	120	55.3%	65.0%	76	35.0%

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board (Public) – 04.08.22

Agenda item:	4.4
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Sarah Webb – Deputy Director of Nursing and Giuseppe Labriola, Director of Midwifery
Date prepared:	29/6/2022
Subject / title:	Interim mid-year nursing and maternity establishment review

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	An interim establishment review was undertaken in March 2022 in line with national recommendations. There are no changes recommended from this interim review. The next full establishment review is due to report to be undertaken in September and reporting to Board in December 22.
Recommendation:	The Board is asked to note the information within this report.

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

Previously considered by:	Workforce Committee 26.7.2022
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Divisions have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18 There are no ED&I implications identified from this report
Appendices:	Appendix 1 Regulatory requirements and best practice guidance Appendix 2 Acuity Accuracy Audit Results Appendix 3 Full SCNT results compared to May 2021 full review Appendix 4: Average daily number of enhanced care patients May 2021 / March 2022

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

This report details the results of the mid-year review, which was undertaken in March 2022 in line with regulatory requirements and provides assurance that the changes / assumptions made following the full review undertaken in May 2021 were correct.

1.0 BACKGROUND AND NATIONAL CONTEXT

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

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

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

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

2.0 Process and methodology

The last full establishment review was conducted in May 2021, gaining Board approval in January 2022.

The data collection for this interim nursing establishment review was undertaken during a period of two weeks between the 28.2.2022 and 13.3.2022 for the following areas utilising approved acuity and dependency tools.

Adult Inpatient Wards	Safer Nursing Care Tool Adult Inpatient Areas
AAU	Safer Nursing Care Tool Adult Inpatient Areas and Assessment Areas
Dolphin	Safer Nursing Care Tool Children's Inpatient Areas
ED Inc Children's ED	Baseline Emergency Staffing Tool

Due to the ongoing Covid pandemic, there were still a number of ward closures and moves following the review in May 2021. All care was taken to ensure that these moves were taken into account when comparing the data.

The Safer Nursing Care Tool (SNCT) multipliers are incorporated into the SafeCare module of Allocate Health roster; the nurse in charge completes this twice a day for each area. The Shelford group do not recommend data collection is undertaken from SafeCare audits but recommend a separate daily acuity data collection undertaken and validated by a core group of senior staff who have completed SNCT training. Due to the Covid pandemic it was agreed that the data collections for 2021 census and the interim establishment review could be completed using SafeCare census. The Trust will return to the recommended Shelford process for the next full review in September 2022.

During the census period, the acuity data entered onto Safecare should be validated on a daily basis by a Matron.

The (Baseline Emergency Staffing Tool) BEST data collection was completed on an hourly basis, 24 hours per day for a week as stipulated in the audit process for ED and Children's ED.

The SNCT calculation is based upon a funded headroom allowance of 22% (leave allowance including annual, study, sickness etc.), our trust allowance is currently 20%, it should be noted that the Royal College of Nursing (RCN) recommends 25%. The Ward Manager role is fully supervisory.

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

3.0 Data quality

On analysis of the BEST data for ED and Children's ED it became apparent that there was an error with the national formulas that calculate staffing requirements within the BEST toolkit. This has been escalated to the RCN (owners of the tool); l to date the issues have not resolved the issues. This means that the ED data collected can't be used to inform any changes to the establishment. The ED SNCT tool is being released to the Trust and this will be used to inform the full establishment review which will be undertaken in September 2022.

To ensure accuracy of the acuity data the matrons were required to complete a daily audit. If there is a discrepancy found Safecare should be corrected. To ensure accuracy of Safecare a total of 14 audits per ward should have been undertaken over the 2 week census period. No ward managed to achieve 14 audits with the highest number being 7 (1 ward) with 6 (3 wards) In addition to low compliance there was a higher than expected discrepancy rate in those audits undertaken with an average acuity accuracy of 87.9% across the trust. Full results are found in **Appendix 2**

Although data was collected for Fleming, John Snow, Henry Moore and OPAL unit the they have been excluded from the analysis for the reasons stated:

Fleming: the ward was closed part way during the census period due to a Covid outbreak.
OPAL Unit: the unit was not included in the May 2021 census

John Snow & Henry Moore: as elective surgery wards the recovery programme was commencing during the census period and therefore patient numbers would not reflect the norm for the wards.

4.0 Findings

The results of the interim establishment review need to be considered in context of the low compliance with accuracy audits and high discrepancy rate.

The following wards SNCT results were within 1 WTE of that calculated in the May 2021 review.

Medicine	Surgery	UEC	FAWS
Kingsmoor Lister Locke Winter Ray	Penn Saunders	Charnley	

There were 5 areas where the SNCT results differed by more than 1 WTE from the May 2022 establishment review. These were:

Ward	Division	SNCT May 2021 WT	SNCT March 2022 WTE	Difference WTE	Audit confidence
Kingsmoor	Medicine	41.4	39.3	2.1	4 audits 83% accurate
Harold	Medicine	46.6	38.1	8.5	5 audits 73% accurate
Tye Green	Medicine	46.6	42.7	3.9	5 audits 85% accurate
Harvey	Surgery	28.4	25.6	2.8	0 audits undertaken
AAU	UEC	49.1	43.9	5.2	6 audits 93% accurate

All areas SNCT data indicated that they needed less WTE than reported in March 2021. All areas have low compliance with completion of accuracy audits and high discrepancy rates for those that were undertaken.

All wards staffing requirements are reviewed using Safecare as part of the daily safe staffing assurance process and staff resources are allocated to ensure patient safety and efficiency according to professional judgement and acuity data completed on Safecare.

Full table of results can be found in **Appendix 3.**

Enhanced Care:

Following the last skill mix review it was identified there was a requirement for an enhanced care team, consisting of 12.43WTE Band 2 and 4.14WTE RMN.

Recruitment is underway with 4.55 WTE (Head Count 6 staff) appointments.
The Trust has also appointed a RMN lead, who will be working with the Enhanced Care Lead regarding the level of support the wards require.

There has been an increasing number of requests for RMNs, with nearly 900% increase between March 2021 and 2022 ***(Appendix 4).*** The Enhanced Care Lead undertakes spot audits to validate the assessments and requests to ensure they cannot be met by other staff groups. The Lead RMN post commences in August and will provide oversight on criteria for patients who require and RMN and will lead on recruitment to the RMN enhanced care posts.

5.0 Going forward

A full establishment review will be undertaken in September 2022. The staffing establishment review will fully align with the Safer Nursing Care Tool (SNCT) model, 20 days of data at 15:00pm looking back at the past 24hrs, Monday to Friday for 4 weeks, overlaid

with nurse sensitive indicators and will be led by the HoN for Surgery who has completed the Safe Staffing Fellowship training.

Further training will be undertaken with matrons and ward managers to support understanding of the tool and consistency of data collection.

The Trust has recently acquired the licence for SNCT for the Emergency Department (covers both adult and paediatric ED) and training with NHE/I will be undertaken in July and the tool will be rolled out in August. 6.0 Midwifery Staffing

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

In addition, a full workforce review was also review completed by the director of midwifery. The methodology of this review involved reviewing each cost centre to determine funded posts, alongside establishing what was recommended by Birthrate Plus for midwifery staffing, and using professional judgement to determine the staffing levels needed for all midwifery areas. The Birthrate Plus report and the workforce review identified that 22.74 WTE posts (midwives, support workers, specialist and managerial posts) were needed for the maternity service. This was approved and funded by the Trust board in February 2022.

The baseline of the workforce review previously presented is still current and describes a three year plan for the midwifery workforce

Reviewing the birth rate for 2021/2022, has demonstrated an increase in births (maternities) to 3,869 from 3,788 in 2020/2021.

With the birth rate of 3,869 the midwife to birth ratio meets the Birthrate Plus ratio of 1:23. Reviewing the last six months of births and forecasting with predicted births over the next six months, the midwife to birth ratio meets the Birthrate Plus ratio of 1:23.

In conclusion, the maternity service has the required establishment for the level of acuity and activity within the service. However, in line with the Ockenden report, there is a requirement to review the specialist midwifery staffing alongside the immediate essential actions. This may mean that additional investment, utilising the maternity incentive scheme funding, is used to fund additional specialist roles. The director of midwifery will complete this review during August 2022 and provide an update on PAHT's position via the Quality and Safety Committee (Maternity Assurance).

A further workforce review for the maternity service will be complete in December 2022

7.0 Recommendations:

Following the interim review, no changes to the current establishments are recommended. Work will continue to validate the BEST tool for review of the ED workforces however if this is not available before the end of July the SCNT data collection tool will be utilised and any recommendations will be noted in the Hard Truths paper and Divisional reports to Workforce.

APPENDICES

Appendix 1: Regulatory requirements and best practice guidance

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

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

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

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

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

Appendix 2: Acuity Accuracy Audit Results

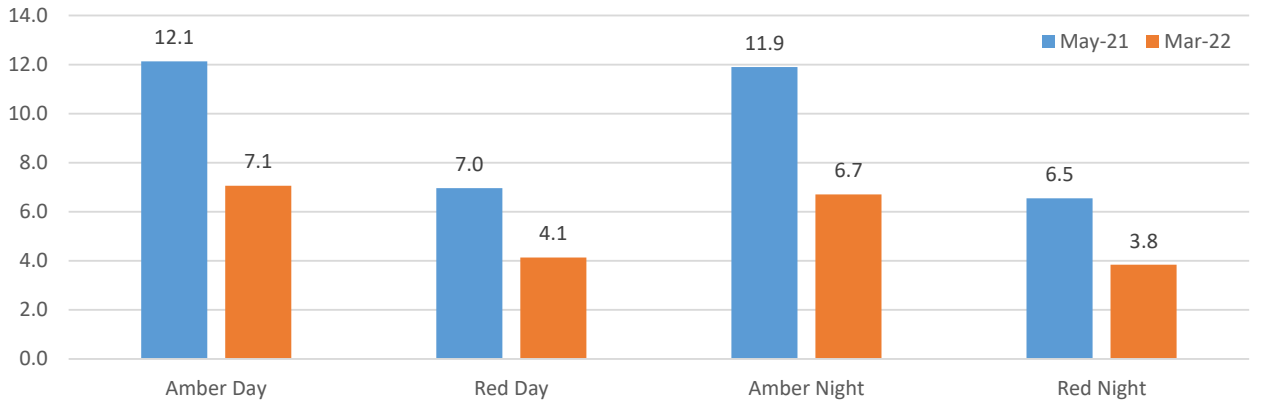
Ward	28-Feb-22	01-Mar-22	02-Mar-22	03-Mar-22	04-Mar-22	05-Mar-22	06-Mar-22	07-Mar-22	08-Mar-22	09-Mar-22	10-Mar-22	11-Mar-22	12-Mar-22	13-Mar-22	Ward Average	count
Charnley	69.00%	92.50%	92.50%			85.00%		82.00%	96.00%	96.00%					87.57%	7
AAU	78.00%	96.40%	96.20%					100.00%	100.00%	88.00%					93.10%	6
Dolphin		90.00%	90.90%	100.00%	100.00%				100.00%	72.70%					92.27%	6
Flemming		58.00%	100.00%	100.00%							69.20%	100.00%			85.44%	4
Harold			80.00%		100.00%				34.60%	72.00%		78.20%			72.96%	5
Harvey																0
Henry Moore												100.00%			100.00%	1
John Snow																0
Kingsmoor General			71.80%	87.00%	86.00%						88.40%				83.30%	4
Lister			96.00%		92.00%			91.00%		96.10%	88.40%	85.10%			91.43%	6
Locke		85.00%	100.00%		92.80%						92.50%				92.58%	4
OPAL	69.00%							58.00%		75.00%		75.00%			69.25%	4
Penn					96.20%										96.20%	1
Ray		96.40%	100.00%		92.00%			69.00%				81.40%			87.76%	5
Saunders					100.00%						100.00%				100.00%	3
Tye Green			80.00%		79.00%			87.50%		84.00%	82.60%	100.00%			85.52%	6
Winter	92.80%				92.00%			82.00%		78.60%	78.60%	66.60%			81.77%	6
Trust Average	77.20%	86.38%	90.74%	95.67%	93.00%	85.00%	#DIV/0!	81.36%	82.65%	82.80%	85.67%	85.79%	#DIV/0!	#DIV/0!	87.94%	

Appendix 3: Full SCNT results compared to May 2021 full review

The Princess Alexandra Hospital NHS
NHS Trust

Ward Name - establishment review	HCG	May 2021 review					Interim March 2022 review			
		Currrent template		Template WTE	Skill Mix		SNCT Review RN	SNCT Review HCSW	SNCT WTE	Degree of confidence
		Day	Night		Day RN%	Night RN%				
Kingsmoor	Medicine	5+4	4+3	41.4	55.6%	57.1%	27.5	11.8	39.3↓	4 audits 83% accurate
Lister	Medicine	6+3	4+3	41.4	66.7%	57.1%	27.5	11.8	39.3	5 audits 91% accurate
Locke	Medicine	6+2	5+2	38.8	75.0%	71.4%	26.8	11.5	38.3	3 audits 90% accurate
Ray	Medicine	5+2	4+2	33.6	71.4%	66.7%	26.3	11.3	37.6	0 audits undertaken
Winter	Medicine	5+3	5+3	41.4	66.7%	57.1%	28.2	12.1	40.2	6 audits 81% accurate
Fleming	Medicine	6+2	4+2	36.3	75.0%	66.7%	16.2	6.9	23.1	4 audits 81% accurate
Harold	Medicine	6+4	5+3	46.6	60.0%	62.5%	26.7	11.4	38.1↓	5 audits 73% accurate
Tye Green	Medicine	6+4	5+3	46.6	60.0%	62.5%	29.9	12.8	42.7↓	5 audits 85% accurate
Penn	Surgery	5+3	3+2	33.8	55.6%	57.1%	23.8	10.2	34	1 audit 96% accurate
Saunders	Surgery	5+3	4+2	36.3	62.5%	66.7%	27.7	11.9	39.5	3 audits 100% accurate
Harvey	Surgery	4+2	3+2	28.4	66.7%	60.0%	17.9	7.7	25.6↓	0 audits undertaken
Henry Moore	Surgery	4+2	3+2	28.4	66.7%	60.0%	8.3	3.6	11.9	1 audit 100% accurate
John Snow	Surgery	3+2	2+1	20.8	60.0%	66.7%	24.4	10.5	34.9	0 audits undertaken
Charnley	UEC	5+2	5+2	36.1	71.4%	71.4%	25.1	10.8	35.9	7 audits 87% accurate
AAU	UEC	8+2	7+2	49.1	80.0%	77.0%	30.7	13.2	43.9↓	6 audits 93% accurate

Appendix 4: Average daily number of enhanced care patients May 2021 / March 2022



WTE required for Red only May 2021	29.03
WTE required for Red only March 2022	16.99

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 4 August 2022

4.5

Agenda item:	4.5
Presented by:	Fay Gilder | Medical Director
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Quality First Team Information Team
Date prepared:	July 2022
Subject / title:	Learning from deaths and Mortality Paper – June 2022 data

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

Key issues:	This paper provides assurance on the learning from death process and highlights key pieces of learning and updates on the current programme of work to improve clinical practice and patient outcomes.
Recommendation:	To note the progress being made on the learning from death process and the improvement work to address this.

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

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

The Princess Alexandra Hospital NHS Trust

4.5

1.0 Purpose/issue

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

2.0 Background

PAHT has a learning from death process that meets the national requirements.
The risks associated with this are captured on the learning from death risk register.

3.0 Current Telstra/ NHS Data Headlines

Data Period: Mar 2021 - Feb 2022

Metric	Result
HSMR	96.0 "within expected"
HSMR position vs. peers	Regional acute peer group (17 trusts): • 4 "higher-than-expected" • 6 "within expected" • 7 "lower-than-expected" Region as a whole = 97.7 "lower-than-expected" (96.5 – 99.0)
All Diagnosis SMR	95.4 "within expected"
Significant Diagnosis Groups	• **Alcohol-related mental disorders (231 superspells; 4 deaths)**
CUSUM breaches	**There are no new CUSUM alerts this month** • Lymphadenitis (Nov-21) • Fracture of neck of femur (hip) (Mar-21) (Sep-21) • Sprains and strains (Jun-21) • Lung disease due to external agents (May-21)
SHMI position	(Feb-21 to Jan-22) 95.48 "within expected"

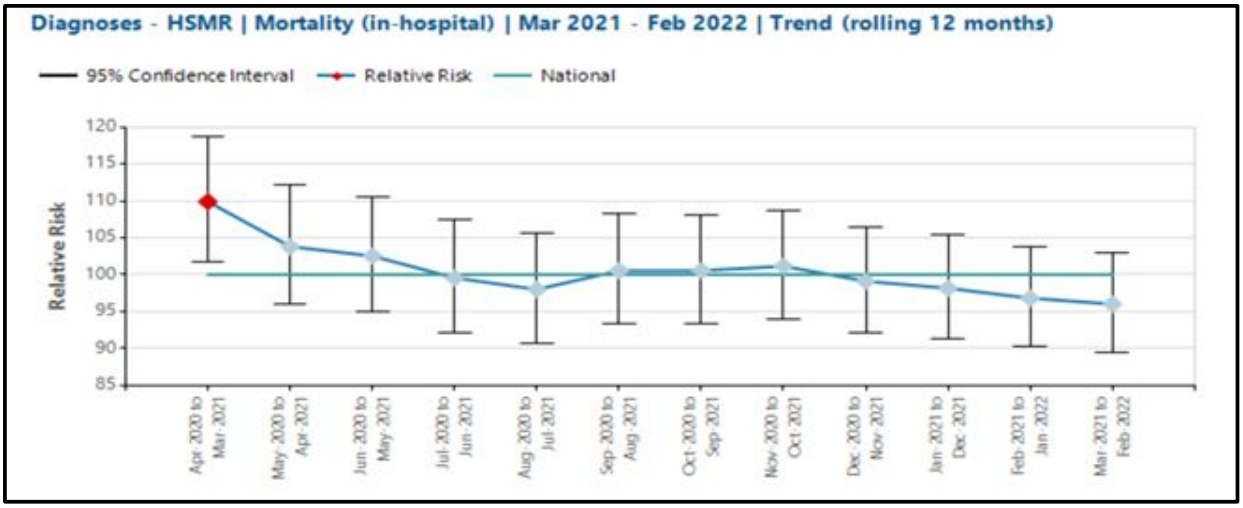
3.1 Hospital Standard Mortality Rate (HSMR) - Rolling 12 Months

modern • integrated • outstanding

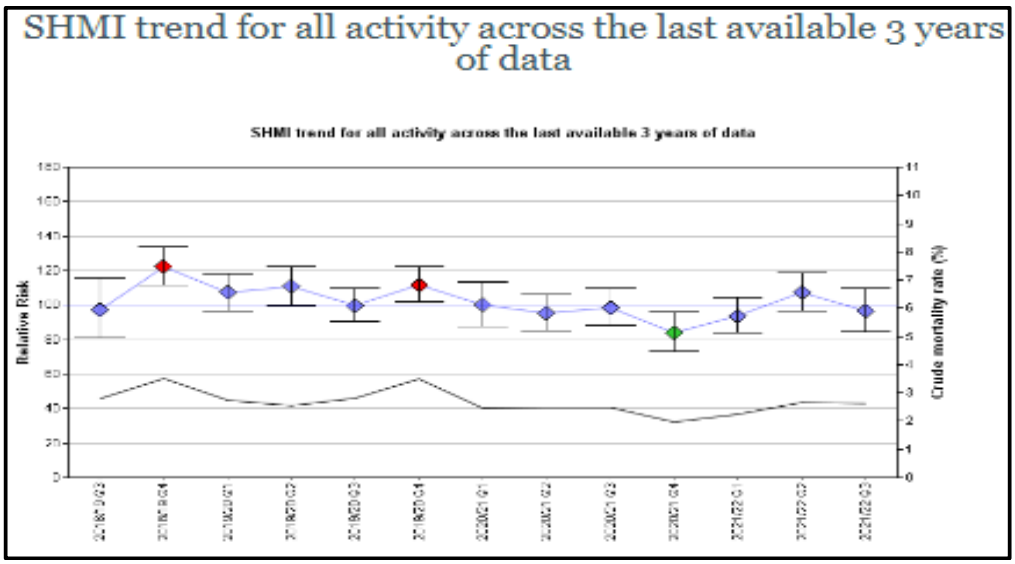
patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

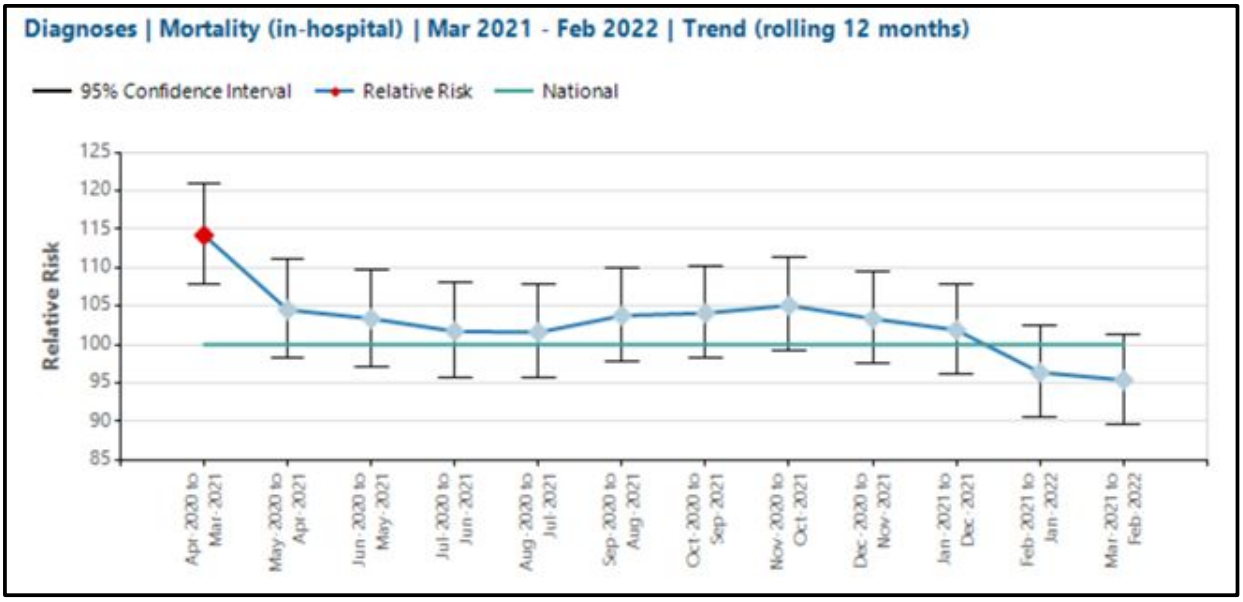
3.2 Hospital Standard Mortality Rate (HSMR) – Monthly



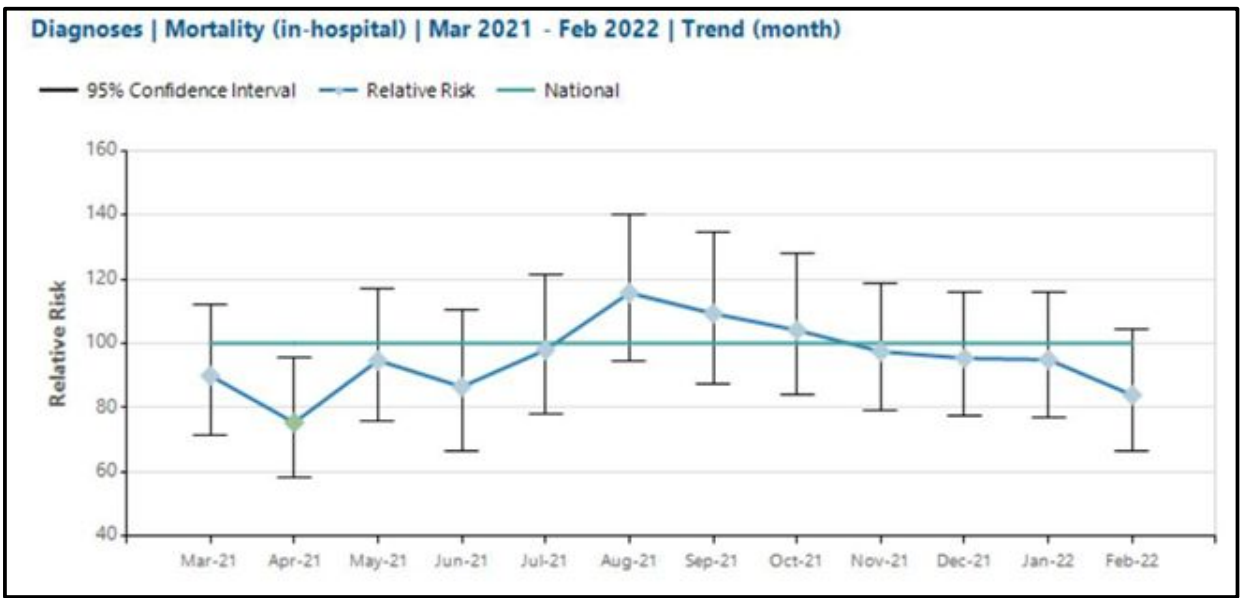
3.3 Summary Hospital-level Mortality Indicator (SHMI)



3.4 Standardised Mortality Ratio (SMR) – all diagnoses rolling trend



3.5 Standardised Mortality Ratio (SMR)



3.6 Standardised Mortality Ratio (SMR) outlying groups

There is one new outlying group:

- Alcohol-related mental disorders. (The notes for these patients will be pulled for a clinical coding audit).

4.0 Mortality Programme Updates

The mortality improvement programme leads provide updates quarterly to the Strategic Learning from Death group (SLfD). The following were explored at the July 2022 group.

4.1 End of Life Care

A verbal update was provided by the clinical lead for end of life:

- The team has been depleted by a Lead Nurse (Band 8b) and an Administration post which has caused issues and delays with work within the team, including a lack of contemporaneous figures and delays in starting the NACEL audit. The lead nurse role has been advertised with a view to shortlisting in August 2022 and an administration assistant has been appointed with a start date.
- The team are working to strengthen the working relationship with St Clares Hospice.

4.2 Fractured Neck of Femur

The lead clinician proved a verbal update on the on-going issues with this pathway, which includes:

- Long waits to get to ward from ED
- Receiving multiple admissions at once
- Bed closures due to COVID
- Delays in getting patients back out to the community, including community hospitals due to COVID
- Reduced service for physiotherapy due to staffing issues – there is a recruitment plan in place for this

5.0 Learning from deaths process update

5.1 Mortality Narrative

- There were 93 deaths in June 2022
- 34 cases referred for SJR's:
- There are 53 outstanding SJRs (over 6 weeks of the patients' death.) ***The majority of these are included in the rolling audit for deaths after 30 days of readmission and the team are working through the backlog of these. There were also issues with notes being sent to SMH for storage when they had not been finished with causing delays. There is a dedicated consultant working through the backlog of the Medicine SJRs. It is anticipated that the backlog of SJR's over 6 weeks will be cleared by September/October 2022.***

5.2 Key Learning to be addressed

5.2.1 Learning themes from SJR's:

- End of Life pathway (preferred place of death, PEACE document) – work on-going
- Incorrect attribution of covid on the death certificate
- Inadequate discharge planning
- Avoidable re-admissions – end of life patients in particular

- Good care and treatment provided
- Nil issues noted from many reviews
- Unexpected readmissions for acutely unwell issues which were appropriately treated

5.2.2 Monthly M&M meetings

- There is evidence of cross speciality learning via the M&M meetings and process
- All learning is discussed with the MDT for sharing

5.3 Second Review Panel Cases

There are no second panel referrals or panel hearings in June 2022.

6.0 Medical Examiner (ME) Headlines

Statistics:

During June 2022 there were 93 deaths - **100% scrutinised between 10 Medical Examiners.**

19 cases were referred to the **Coroner**:

Developments:

IT:
Electronic ME system SMART continues to be used daily for Trust deaths.
Community deaths are now recorded on the National ME system.

Community Deaths:
The community death pilot with St Claire Hospice is ongoing and GP death scrutiny is in the process of being expanded.

Work with Dr Alexander Field is being undertaken to comply with the national requirement to include perinatal death scrutiny.

6.1 National Medical Certificate of Cause of Death (MCCDs)

National MCCDs issued within 72 hours: (National Target)

64 of the remaining 74 were issued in time (The 19 coroners referrals are exempt from the Trust Statistics)

The result is a rate for **June 2022 of 86.5%**, which is below **the National target** of 95%.

An improvement project is being commenced to improve this.

7.0 Risks

The Trust has a Corporate Mortality Risk Register and each individual project has its own risks and issues log. This is reviewed as part of the Strategic Learning from Death Group. The risk register was not due to be reviewed at last month's meeting and there were no new or changed risks that required discussion.

8.0 Recommendation

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

The Princess Alexandra Hospital NHS Trust

Trust Board 4 August 2022

4.6

Agenda item:								
Presented by:	Dr Fay Gilder							
Prepared by:	Dr Fay Gilder							
Date prepared:	19 July 2022							
Subject / title:	Telstra Deep Dive into causes for sustained improvement found in the Princess Alexandra Hospital mortality indices							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This paper contains a summary of and the Telstra analysis of reasons for improvement in: HSMR (Hospital standardised mortality ratio) SMR (Standardised mortality ratio) SHMI (Summary hospital-level mortality indicator) For the Princess Alexandra Hospital Trust (PAH)							
Recommendation:	Mortality reporting to QSC reduces to bimonthly aligned with public Board							

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

Previously considered by:	QSC 29 July 2022
Risk / links with the BAF:	BAF 1.1 Variation in outcomes resulting in poor clinical quality, safety and patient experience.
Legislation, regulatory, equality, diversity and dignity implications:	*'Learning from Deaths'* - National Quality Board, March 2017 *This paper has been written with due consideration to equality, diversity*
Appendices:	1. Telstra report for PAH in Resources (Diligent)

The Princess Alexandra Hospital NHS Trust

4.6

1.0 Purpose

This paper provides a high level summary of the Telstra deep dive in to reasons for the improvement of the mortality indices for Princess Alexandra Hospital (PAH)

2.0 Background

There has been a sustained improvement in all of the mortality indices for PAH. Telstra (aka Dr Foster) was asked to provide a deep dive into the reasons for improvement. This paper provides a high level summary with the original report attached.

3.0 Analysis

From the end of 2020 onwards, mortality indices for PAH have made a marked improvement.

3.1 Documentation

Particularly in the current financial year, there are clear improvements in both SMR and SHMI models (pg 7-10 of report). Increased expected rates within the SHMI model are noted, as opposed to crude rates, and as such this points to an improvement in quality of documentation. Using HES-based data, it is possible to note that there has been a long-term trend of improved secondary diagnoses and comorbidity capturing that certainly provides evidence of this (pg 32-33 of the report). Crude rates in the SMR model have returned to pre-pandemic levels, while expected rates are higher than ever before, indicating that there has been a step up in terms of quality of documentation. In the last financial year, within the SHMI model, crude and expected rates are lower than before. It should also be noted that across both models, crude rates and expected rates have never been so similar.

3.2 Quality of care (pg 26-30 of the report)

There is a demonstrably clear improvement in quality of care as evidenced by:
-a decline in the proportion of spells with a complication of care flag and patient safety indicator flag.
- the proportion of deaths from ‘high risk’ patients has increased whilst the proportion of deaths in medium risk patients has decreased
-noted improvements in mortality for patients following along length of stay post-operatively
-reduced number of SMR outlier alerts

4.0 Recommendation

The report sets out a clear explanation for both improved documentation and quality of care as contributing to the sustained improvement in the mortality indices for PAH. Board is asked to consider a recommendation of bimonthly mortality reporting to QSC in line with Public Board. The meeting report from the strategic learning from deaths group would continue to be submitted monthly to QSC.

Author: Dr Fay Gilder, Medical Director
Date: 19 July 2022

BOARD OF DIRECTORS: Trust Board (Public) 4 August 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 25 July 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 People Report	Yes	N	N	PC received assurance on the progress being made to improve workforce metrics/KPIs. The following was highlighted; recent successful recruitment open days, increased rolling turnover and concerns around temporary staffing costs (agency- cost pressure impact; bank- normal rates).
2.2 GMC Survey	Yes	Y	N	PC received assurance in regards to the plans in place to improve the outlying areas identified in the GMC survey. It was noted the 2022 survey results would be published shortly and a more detailed update would presented to the Committee November.
2.3 Freedom to Speak Up Report	Yes	N	N	PC were assured in regards to the work of the Freedom to Speak Up Guardians. Current trends in reporting included; poor behaviours and bullying and harassment. PC supported the draft Freedom to Speak Up Vision and Strategy. The paper is on the Board agenda.
2.4 Staff Survey Update	Yes	Y	N	PC received an update on the quarter one Pulse staff survey results. It was noted response rate had increased by 605 and 7 out of the 9 core engagement questions had improved scores.
2.5 UEC Staffing Deep Dive (Section 31)	Yes	N	N	PC received assurance on the key risks, achievements and forward view for the nursing and medical staffing in the Emergency Department in response to the CQC Section 31 notice. The positive feedback received from the CQC was

BOARD OF DIRECTORS: Trust Board (Public) 4 August 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 25 July 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				noted and staffing data would be reported to the CQC monthly from September.
2.6 Nursing, Midwifery & AHP Strategy	Yes	N	N	PC received the refreshed Nursing, Midwifery and AHP strategy, which had been extended to four years with an accompanying work plan for 2023/24.
2.7 Safer Nurse Staffing Report	Yes	N	N	PC were assured in regards to the provision of safe nursing and midwifery staffing and that processes are in place for managing and monitoring staffing levels.
2.8 Nursing and Midwifery Establishment Position	Yes	Y	N	PC noted the interim establishment review undertaken in March. No changes to the establishment were recommended. The next full establishment review is to be undertaken in September and reporting to Committee in December.
2.9 Workforce planning	For Information	N	N	An overview of the process and principles of developing a workforce plan was received for information.
2.10 Workforce Equality Strategic Framework	Yes	N	N	PC received assurance on the Workforce equality strategic framework to drive forward the equality and diversity agenda. A detailed plan and report would be shared with the Committee in the Autumn.
2.11 BAF Risk 2.3 (Workforce)	Yes	N	N	Risk score to remain unchanged at 16. The controls had been updated and the cost of living crisis was included.
3.1 Communications Update	For Information	N	N	PC noted the success of Lance's digital diary. The new recruitment pages to be added to the website were noted.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS: Trust Board (Public) 4 August 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 25 July 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
4.1 Learning and OD Update	Yes	Y	N	PC were assured on the learning and organisational development activities including; a 9% increase in compliance for Information Governance Training. It was noted Statutory and Mandatory training compliance was at 86% and the Statutory and Mandatory Governance Group was reviewing the 3 modules which had the biggest impact on compliance.
4.2 Guardian of Safer Working Hours Report	Yes	N	N	PC received assurance in regards to the actions taken to resolve any issues affecting safe working hours raised through exception reports. Current themes continued to be staff shortage and a lack of senior support.
4.3 Annual Report on Medical Revalidation and Compliance Statement	Yes	N	N	PC received assurance in regards to the compliance rate for Doctors appraisals. 351 out of 355 doctors had appraisals completed. PC recommended the report to Trust Board for approval.
4.4 Horizon scanning - Labour market trends 2022	For Information	N	N	PC received information on current trends in the labour market identified from various national reports. In response to the trends identified, processes had been identified to combat these. PC noted the planned release of the Health and Social Care Select Committee Workforce Report which planned to identify the shortage of staffing were a clinical risk to patient safety. The recent Pay award was noted along with concerns around the impact of the cost of living crisis on staff.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 4 August 2022

5.2

Agenda item:	5.2							
Presented by:	Lindsay Hanmore							
Prepared by:	Lindsay Hanmore – Lead Freedom to Speak Up Guardian							
Date prepared:	6 July 2022							
Subject / title:	Freedom to Speak up Culture							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The purpose of this paper is to update and provide analysis on the Trust's freedom to speak up data. It will highlight themes of concerns raised, attempt to identify any gaps in groups not speaking up, what actions are being taken to address concerns and triangulate information from other feedback mechanisms. Themes include: ➢ No referrals over last 2 years ➢ Breakdown of referrals ➢ Themes ➢ Next steps ➢ Draft FTSU strategy							
Recommendation:	For the committee/group to agree the Freedom To Speak Up Vision and Strategy and to confirm supportive of the mechanisms being put in place to improve our speaking up culture.							

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:	Staff Health and Well Being Group July 2022/WFC.25.07.22
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	Freedom to speak up principles are contained with the NHS Contract Positively promoting employment legislation and good practice
Appendices:	1. Draft – Freedom to Speak Up Vision and strategy

The Princess Alexandra Hospital NHS Trust

5.2

1.0 Purpose/issue

The purpose of this paper is to update and provide analysis on the Trust's freedom to speak up data. It will highlight themes of concerns raised, attempt to identify any gaps in groups not speaking up, what actions are being taken to address concerns and triangulate information from other feedback mechanisms.

2.0 Background

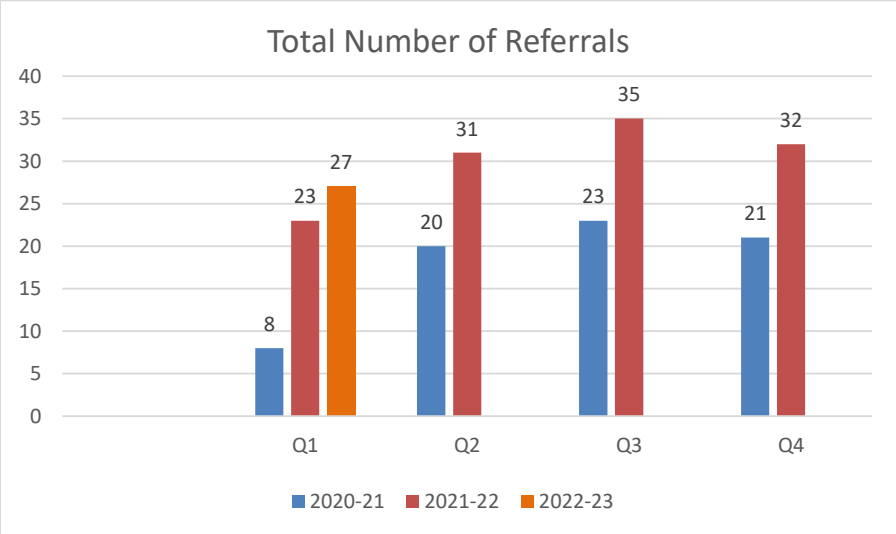
2.1 Freedom to speak up principles are contained with the NHS Contract. Good "speak up" cultures are linked with improved patient safety and quality, higher staff well being and retention with lower levels of dissatisfaction.

2.2 In total the Trust now has six guardians, four of whom are clinical. It has recently appointed a lead freedom to speak up guardian in an aim:

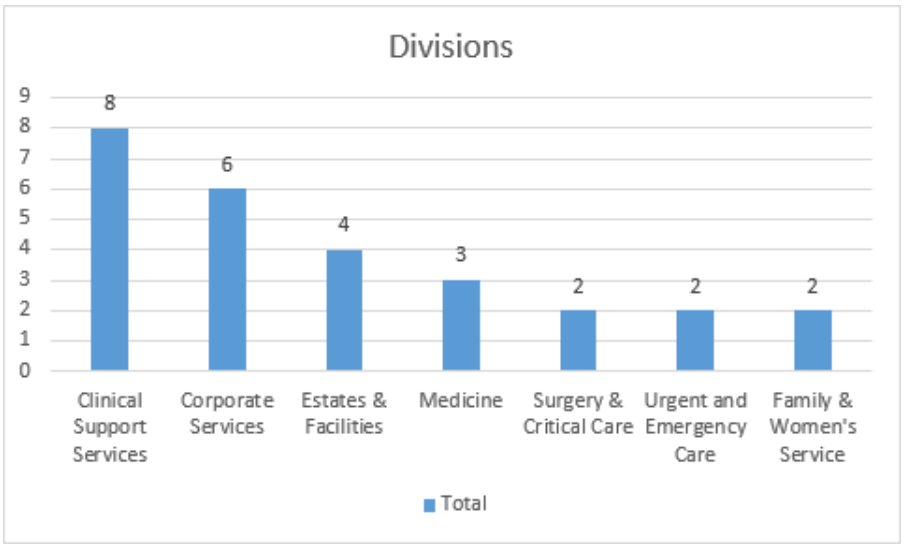
- To raise the profile of speaking up and listening up across the organisation
- To explore, understand and address the barriers to staff speaking up
- To increase accessibility for staff to be able to speak up
- To support managers to listen up and executives and senior leaders to follow up
- To report nationally on local referrals and themes
- To keep the leadership teams appraised of themes, learning and required actions triangulating with other feedback ie whistleblowing, exit interviews and staff surveys
- To ensure there is action and learning from themes and to share the learning from changes made through people speaking up

3.0 Data and analysis

3.1 Number of referrals



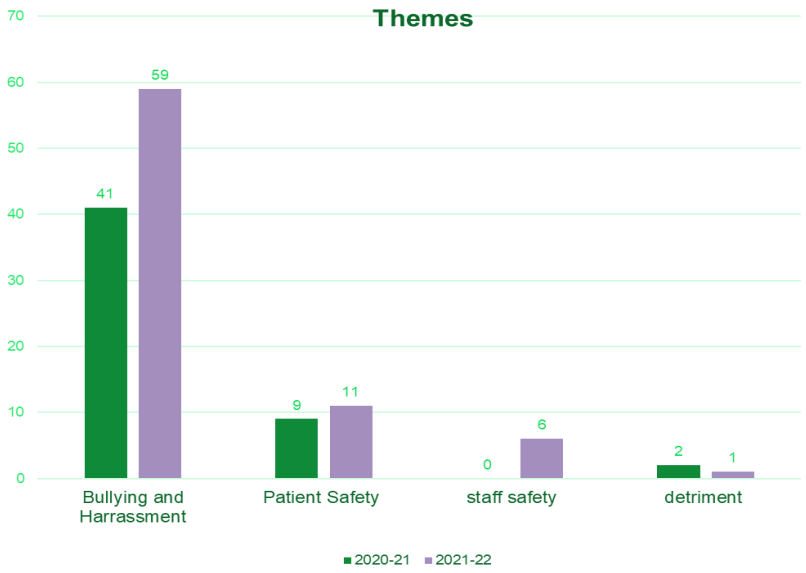
3.1.2 Breakdown of referrals for Quarter 1 2022-23



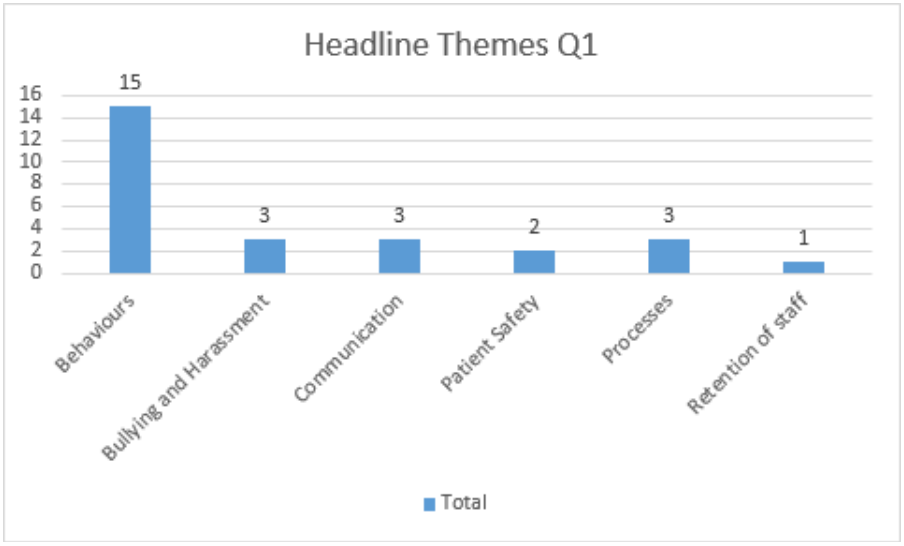
The number of referrals in quarter 1 was 27. We will continue to encourage staff to speak up internally through a number of mechanisms. External and anonymous whistleblowing cases should decrease when staff have confidence that actions will be taken to address their concerns raised internally.

Although local actions are taken to support staff who raise concerns it remains a challenge to demonstrate any Trust wide improvements that can be shared with staff anonymously to improve their confidence that speaking up makes a difference.

3.2 Themes from previous two years



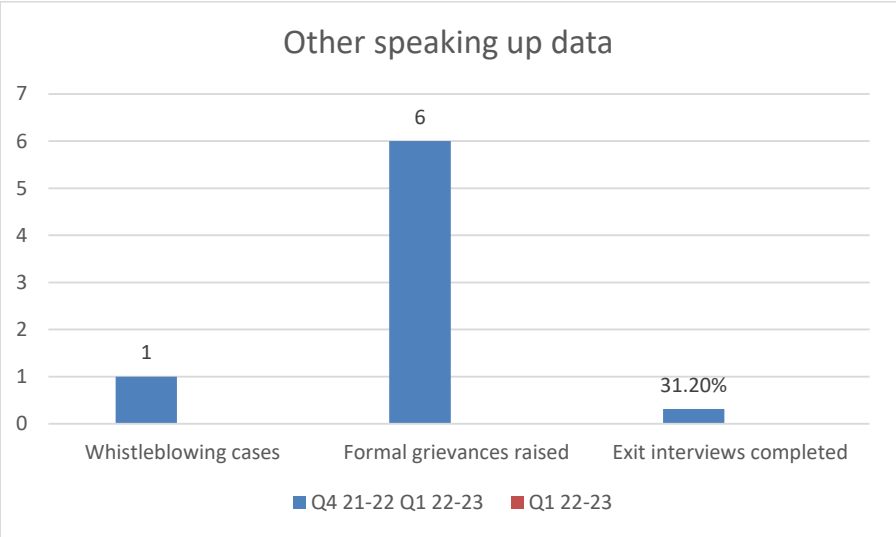
3.2.2 Themes from Quarter 1 2022-23



Themes remain consistent with bullying and harassment and poor behaviours remaining the most common, and slightly above the national average in 2020-21 with 48% of our themes being this and 36% from the NGO national data base. The newly developed database from this quarter has broken the feedback down into more specific themes including behaviours, rather than free text capture.

Staff who do speak up are listened to, supported in their decision making about next steps and signposted for other mechanisms of support ie staff health and well-being and human resources. Interestingly the themes from exit interviews do not demonstrate staff leaving for bullying and harassment reasons but this will continue to be monitored and triangulated with data from the staff survey, retention and sickness rates and number of whistleblowing cases.

3.3



3.4

On deeper analysis of referrals, it appears that it is often the way managers speak to staff that is the biggest concern and the fact that they do not feel listened to. The lead guardian is raising the profile of listening up skills by meeting with leadership teams across the organisation to address this and has facilitated a number of listening events with staff groups to understand the barriers to them speaking up.

The new data base now captures more details about referrers to help us identify gaps in staff groups not speaking up so we can work with these groups to overcome barriers. It does appear that individuals from more vulnerable groups are not speaking up.

We are working closely with the Head of Equality Diversity and Inclusion and more recently the ICS lead for overseas nurses to explore these barriers and to ensure everyone has a voice.

4.0 Risks

The main risk to developing a safe speaking up culture in the Trust appears to be either the fear of repercussions or the fact that nothing appears to happen. In an aim to address this a wide range of communication tools will be utilised to provide assurance to those speaking up that they will be supported through the whole process and to share examples of changes put in place to address feedback.

5.0 Next Steps

5.1 A freedom to speak up vision and strategy has been drafted and reviewed by key stakeholders and will be presented at the Workforce committee for ratification and publication. It aligns with the Quality and Patient Safety Strategy 2020-2030. See Appendix 1

5.2 An e-form has been developed for the guardians to capture data more accurately so that thematic analysis can be undertaken. This will be developed into a speaking up dashboard with support of the Business Intelligence and Informatics Team.

5.3 An e-form to capture feedback from staff who have spoken up has been launched to ensure continuous improvements are put into place.

5.4 We need to encourage staff to view the speaking up module on the National Guardian Office (NGO) website to increase confidence and for them to see the benefits of speaking up.

5.5 We need to ensure managers view the listening up module to support their development to support staff who wish to raise concerns.

5.6 A follow up module has just been launched for executives and senior leaders and the lead guardian will be working with those teams to ensure they view the module.

5.7. The role of Freedom to Speak up Ambassadors is being introduced to increase accessibility for staff and to reach a wide range of staff groups and those who may find it harder to speak up. This was launched during the Trust's This is Us week at the end of June 2022.

6.0 The impact will be monitored by:

- Annual staff survey results – in particular with the key questions focused on staff reporting concerns and feeling they are treated fairly.
- Numbers of FTSU referrals and themes
- Feedback from those who have spoken up
- Grievances – numbers and themes
- Exit interviews – numbers and themes
- Staff retention rates
- Patient and staff safety incidents
- Number of issues raised externally ie directly to CQC or NHSE/I
- National benchmarking data from National Guardian's office

7.0 Recommendation

For the Board to agree the Freedom To Speak Up Vision and Strategy and to confirm supportive of the mechanisms being put in place to improve our speaking up culture.

Author: Lindsay Hanmore
Date: 6th July 2022

The Princess Alexandra Hospital NHS Trust

5.2

Freedom to Speak Up vision and strategy

2022-2025

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

5.2

Background

Following the Mid-Staffordshire Inquiry, Sir Robert Francis published a report in 2015 that highlighted the importance of cultures that embrace transparency and support raising concerns to improve patient safety.

The report provided recommendations for NHS trusts, supported by the National Guardian's Office, and is now included in the NHS contract that is monitored by the Care quality Commission (CQC).

Compliance with this contract is assessed by the CQC under the key lines of enquiry and as part of the well-led questions.

When things go wrong, we need to make sure lessons are learnt, and things are improved.

It is important that we speak up if we think that something might go wrong and to learn from things that do go wrong; this helps to improve our ways of working and to prevent them from happening again in the future.

Even when things are good, but could be even better, we should feel able to speak up and be confident that our suggestion will be used as an opportunity for improvement.

The freedom to speak up initiative empowers and assures our people that their voice matters, concerns will be listened to and positive actions will be introduced to benefit our patients and people.

Context

This strategy will be aligned with the Quality and Patient Safety Strategy 2020-2030 priorities to address the 2020 Staff Survey results. The key priorities are:

Priority one: Improving the physical and mental health and wellbeing of our people. Our people's mental health and wellbeing is a key factor of our mental health strategy.

Priority two: Improving our learning and safety culture, encouraging people to openly raise concerns and ensure they are acted upon (improving psychological safety).

Priority three: Improving the effectiveness of line managers. By focusing on creating a culture of wellbeing and psychological safety for our people, and by improving the effectiveness of our managers, we will provide better quality and safer care to all our patients at PAHT.

The Princess Alexandra Hospital NHS Trust

Our speaking up vision

We are striving to ensure that our people feel enabled to speak up in order to support and improve patient safety and quality, the health and wellbeing of our people, and staff experiences.

We are working hard to drive and support a positive culture at PAHT by removing barriers to speaking up and to continuously learn from feedback.

Our values

Our strategy and vision support the overarching trust strategy and is underpinned by our trust values:

- **Patient at heart:** Speaking up protects patient safety and improves the lives of our people.
- **Everyday excellence:** When things go or might go wrong we need to make sure lessons are leant and things are improved.
- **Creative collaboration:** We continually use views and suggestions from our people in order to make better decisions together.

Our speaking up strategy

We will deliver our vision by prioritising the following actions:

1. Reaching out to a wide range of our people and divisions to raise profile of speaking up and to explore barriers to speaking up
2. Utilise protected characteristic data to explore where there are gaps in feedback and identify kind ways of addressing this
3. Listen to the experiences of our people in regards to speaking up and their ideas for potential solutions to address barriers
4. Develop the role of freedom to speak up ambassadors across the organisation
5. Implement the role, deliver training and support ambassadors to be another mechanism for staff to speak up to
6. Provide support and supervision to guardians and ambassadors
7. Share staff stories of speaking up and what has changed because of this, to encourage openness, transparency and confidence in the process
8. Develop a speaking up dashboard so that the data can be analysed and triangulated with a range of feedback mechanisms
9. Analysis of all data to understand and address themes and to monitor impact of strategy
10. Use a range of communication tools to raise profile of guardian role and speaking up strategy
11. Support staff and managers across the organisation to listen up to staff and ensure there is continuous learning from feedback
12. Benchmark speaking up information from other organisations and reach out to learn from those that have made and seen improvements

Freedom to speak up roles and responsibilities at PAHT

Everyone has a role to support the freedom to speak up culture and the following people have specific responsibilities:

Chief executive and chair

To engender an open culture which invites and encourages both positive and negative feedback from all who use and work within our services. They are crucial in setting the cultural expectations of how these conversations should take place within the organisation. They need to model the ability to take open feedback and to be challenged.

Non-executive director for Freedom to Speak up

To support the Freedom to Speak Up Guardians with any challenges that they may face. They should facilitate the trust board members to focus discussions and to ensure triangulation of information so that trends and emerging issues are highlighted.

Director of people, organisational development and communications

To promote the Freedom to Speak Up vision and strategy and facilitate mechanisms to ensure everyone has the access to the resources required to speak up and listen.

Lead Freedom to Speak Up Guardian

- To raise the profile of speaking up and listening up across the organisation
- To explore, understand and address the barriers to staff speaking up and target specific areas identified with barriers.
- To increase accessibility for staff to be able to speak up
- To support managers to listen up
- To report nationally to National Guardian Office on local referrals and themes
- To keep the leadership teams appraised of themes, learning and required actions
- To share the learning from changes made through people speaking up
- To provide supervision and support for other guardians

Freedom to Speak Up Guardians

- To provide an independent channel for our people to speak up to.
- To offer support, advice and help to escalate matters and signpost to other support mechanisms
- To be grateful for all feedback
- To escalate, maintaining confidentiality as appropriate
- To provide feedback to the individuals raising concerns on how the issue is being handled and what learning has taken place
- Seek feedback from referrers on how they felt the situation was dealt with to enhance learning
- To facilitate the collation of themes from feedback and maintain accurate and confidential records.
- Provide supervision and support to ambassadors

Freedom to Speak Up Ambassadors (currently under development)

- Be another point of contact for staff and to listen to their concerns
- Provide immediate support and signposting for staff members raising concerns
- Feedback concerns to speak up guardians
- Liaise with staff health and well being champions and mental health first aiders to keep up to date on their roles

How we will monitor and measure the impact of this strategy

- Annual Staff Survey results – in particular with the key questions focused on staff reporting concerns and feeling they are treated fairly
- Numbers of Freedom To Speak Up referrals and themes
- Feedback from those who have spoken up
- Grievances – numbers and themes
- Exit interviews
- Staff retention rates
- Patient and staff safety incidents
- Number of issues raised externally, for example, directly to CQC or NHSE/I
- National benchmarking data from National Guardian's office

Reporting

The lead guardian will facilitate quarterly reports to the trust board that includes qualitative and quantitative information related to all speaking up mechanisms. The report will aim to provide assurance to the trust board that issues are being identified, reported and acted upon.

The information will include the number of referrals and analysis of the themes reported directly to the guardians and will be triangulated with other feedback mechanisms. It will clarify the number of anonymous referrals and analysis of feedback received if any detriment is suffered because of speaking up.

It will provide information on actions taken to address themes and the improvements required

All reports will be reviewed by the workforce board prior to submission to the trust board.

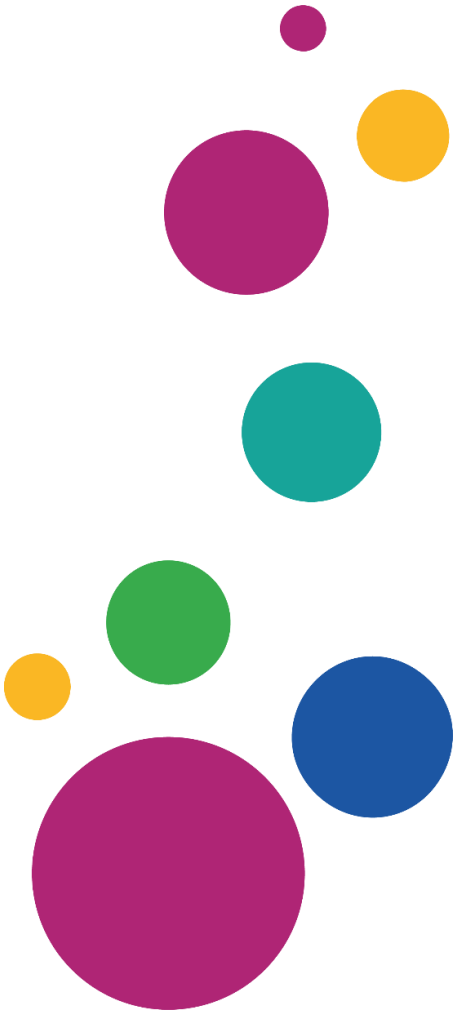
Information on our speaking up cases and data is required to be updated onto the National Guardian's Office portal.

As a trust, we will monitor trends and benchmarking data to inform progress and will have a trajectory of improvement to measure success by 2025.

What will success look like?

- Improved Staff Survey results and staff retention rates
- Increased numbers of referrals from a diverse range of staff
- Positive feedback from those who have spoken up
- Reduction in gravity of themes from feedback
- Evidence of shared learning from staff stories

- Reduction in patient harm incidents and complaints due to proactive intervention prompted by staff speaking up



The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 4 August 2022

5.3

Agenda item:	5.3							
Presented by:	Fay Gilder – Medical Director							
Prepared by:	Jane Bryan - Medical Resourcing Manager							
Date prepared:	September 2021							
Subject / title:	Annual Board report and statement of compliance							
Purpose:	**Approval**	**x**	**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 report gives a summary of Appraisal & Revalidation and relates to the completed round of appraisals for 2021/22 for the permanent medical staff of The Princess Alexandra Hospital NHS Trust (PAHT). The paper sets out a summary of the process for the annual appraisal, compliance data and how this is monitored and assessed to ensure it is quality assured.							
Recommendation:	For information and sign-off of statement of compliance							

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:	WFC.25.07.22
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation
Appendices:	Annual Board Report and Statement of Compliance

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated last year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template were as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2021 – 31 March 2022 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Princess Alexandra Hospital NHS Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes Action from last year: Dr Fiona Hikmet to be appointed to Responsible Officer later this year, R.O training is complete, this action has been rolled over to this year Comments: Dr Fay Gilder, Responsible Officer (R.O) /Dr Jeff Phillips Deputy Responsible Officer Action for next year: Fiona Hikmet to take up role of Responsible Officer

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: None Comments: None Action for next year: None

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes Action from last year: None Comments: None Action for next year: None

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes -Action from last year: Appraisal and Revalidation Policy/Responding to concerns policy were to be reviewed in June

Comments: Actioned/responding to concerns has been reviewed/Medical Appraisal and Revalidation policy currently under review as of July 2022 Action for next year: Medical Appraisal policy to be shared with JLNC for comment/ published

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Yes- the last) peer review was carried out by Mid Essex Hospital Services NHS Trust in 2016. A Higher Level Responsible Officer visit was also carried out in 2018

Actions from last year: None

Comments: The report following the Higher Level Responsible Officer visit confirmed satisfaction that the actions and recommendations from the previous visit had been carried out and that PAHT continued to deliver good practice in relation to professional standards work

Action for next year: None

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Yes – the guidance from the 2022 Medical Appraisal guide has been shared with our appraisers and appraisees, a new template has been incorporated into our Appraisal software systems. The new model received positive feedback, the incorporation of a stronger focus relating to health and wellbeing and less onerous requirement for documentation was welcomed

Action from last year: to increase completion rate to previous level (following the suspension of appraisals during 2019/2020 there had been some challenges with some doctors re-engaging with the process for timely appraisals, resulting in a decrease in the compliance rate compared to previous years). The compliance rate has now increased significantly in line with previous levels

Comments:

Action for next year: to maintain the high compliance rate

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A

Comments: N/A

Action for next year: N/A

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

Action from last year: To review the Medical Appraisal and Revalidation policy mid 2022

Comments: This policy is currently under review as of July 2022 and will be circulated to the JLNC for comment.

Action for next year: None

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes

Action from last year: None

Comments: None

Action for next year: None

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal

network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Yes Appraisers attend a monthly appraiser's forum to be briefed on changes, raise queries and able to have discussion. They also participate in annual refresher training. In addition there is an appraisers What's app group where queries may be discussed/raised. There is a quality assurance process in place. The Deputy RO quality assures the last five appraisals of all doctors undergoing revalidation each year (approximately 20%) of the appraisees. Any themes are raised with appraisers at meetings. The Clarity system ensures that the minimum standard of quality assurance is met as the appraisals cannot be 'completed' otherwise. This is not the same for some of the non-electronic systems used in other organisations. Anonymous feedback forms are completed by Appraisees as part of the trust process for individual appraisers and the process carried out, this is discussed at the Appraisers forum and reviewed where necessary Action from last year: None Comments: The forums were temporarily suspended during suspension of appraisals in 2019/2020 but then resumed in September 2020 and have continued since. Action for next year: None

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Comments: The Quality Assurance forms are sent to the Medical Director/RO

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Princess Alexandra Hospital NHS Trust	
Total number of doctors with a prescribed connection as at 31 March 2022	355
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	351
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	4
Total number of agreed exceptions	1

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes Action from last year: None Comments: None Action for next year: None

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes Action from last year: None Comments: None Action for next year: None

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Yes Action from last year: None Comments: None Action for next year: None

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes Action from last year: None Comments: None Action for next year: None

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes -

Action from last year: None, the policy had been agreed last year

Comments: None

Action for next year: None

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: None

Comments: The Workforce Committee is provided with data relating to any formal cases, which includes doctors. The Board is provided with statistical analysis annually including formal cases with analysis including protected characteristics.

Action for next year: None

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Yes

Action from last year: None

Comments: Includes all information requested and received via the Medical Practitioner Information transfer forms

Action for next year: None

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes Action from last year: None Comments: None Action for next year: None

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes Action from last year: None Comments: None Action for next year: None

Section 6 – Summary of comments, and overall conclusion

Since the last Board report, the impact of Covid and temporary suspension of Appraisals resulted in the overall completion rate reducing to 78% as at 31st March 2021. The appraisal completion rate as at 31st March 2022 has now increased to **98%.**

- **New Actions:**
- New Responsible Officer, Dr Fiona Hikmet will be appointed to the role later this year
- The Medical Appraisal and Revalidation policy is currently under review as of
- July 2022

This report was prepared by- Jane Bryan, Medical Professional Standards Manager

Section 7 – Statement of Compliance:

The Board of Princess Alexandra Hospital NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive

Official name of designated body: Princess Alexandra Hospital NHS Trust

Name: Lance McCarthy Signed: _

Role: Chief Executive

Date:

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

BOARD OF DIRECTORS:	**Trust Board (Private) 4 August 2022**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 July 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 M3 Financial Results	Partial	Y	N	The Trust reported a deficit of £2.1m against breakeven in month (£6.2m YTD) due to on-going expenditure relating to COVID and winter pressures that was not funded. Due to the phasing of the plan, which was updated between M2 and M3, the overall deficit for the Trust was £6.5m YTD against plan. PAF was assured there was control in terms of finances but acknowledged the current financial position was not where the Trust wanted to be.
2.2 CIP Update	Partial	Y	N	The organisation was behind on delivery against the CIP plan in-year but had taken measures since the last meeting to include a review by the region of the current position. The requirement to control run-rate had been emphasised at the last CIP meeting in July 2022.

BOARD OF DIRECTORS:	**Trust Board (Private) 4 August 2022**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**28 July 2022**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.3 Capital Update	Y	Y	N	The capital programme was significantly over-subscribed and remained so but to a far smaller level and further work was expected to take that down to the proposed allocation. Funding assumptions remained prudent and no further capital made available from national sources had been factored into the plan. The Capital Working Group (CWG) had been tasked to draft by the end of July, a capital plan within the £14.1m funding available. Re-prioritisation by deferring schemes likely increased the Trust's risk exposure (operational and financial), and it was recommended all additional risks be reported at both Trust and ICS level.
2.4 ERF and Elective Income	Y	Y	N	The paper provided a brief on Elective Recovery Fund and a general look at income position from 21/22 to 22/23. As with other areas of the recovery agenda, Operations/Finance colleagues would work closely to monitor achievement of prescribed activity targets relative to the available funding.
2.5 Community Diagnostic Centre Business Case	Partial (for Board approval)	Y	N	PAF endorsed the case for Integrated Care Board (ICB) approval with the caveat that further work be done around the delivery model to quantify the financial risk the organisation might be exposed to.

BOARD OF DIRECTORS:	**Trust Board (Private) 4 August 2022**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 July 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.6 Aseptic Unit Business Case	Partial (for Board approval)	Y	N	PAF endorsed the case for Board approval with the caveat that further work done (and included in the case) to explain the gap in costings from the original case.
2.7 BAF Risks 5.1 (Revenue) and 5.2 (Capital)	Y	N	N	PAF agreed that the score for risk 5.1 (revenue) should remain at 12. PAF agreed that the score for the risk 5.2 (capital) should remain at 12.
3.1 M3 Integrated Performance Report	Y	N	N	The improvements in Cancer 2 Week Wait and Ambulance Handover performance were noted.
3.2 BAF Risk 1.3 (Recovery Programme)	Y	N	N	PAF agreed that the risk score should remain at 15.
3.3 BAF Risk 4.2 (ED 4 Hour Standard)	Y	N	N	PAF agreed that the risk score should remain at 20.
3.4 Winter Planning Update	Y	N	N	The first event had been held the previous week and had been very well attended by system colleagues. The national

BOARD OF DIRECTORS:	**Trust Board (Private) 4 August 2022**			**AGENDA ITEM: 6.1**
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DATE OF COMMITTEE MEETING:	**28 July 2022**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				priorities for Urgent & Emergency Care would be issued shortly and would include occupancy, length of stay, discharge planning and ambulance handover. The first local system meeting would take place the following day where ICS and local acute plans would be pulled together. A further event was planned for September and winter planning would also be the subject of a Board discussion too that month.
3.5 Quarterly e-Health Update	Y	N	N	PAF was informed of current gaps in the Coding and Information teams but plans were in place in terms of 'growing our own'.
4.1 New Hospital Update	Y	N	N	An update on the latest information received from the New Hospital Programme was noted and that a Communications & Engagement strategy was being developed which would launch over the summer.
4.2 BAF Risk 3.1 (Estate and Infrastructure)	Y	N	N	PAF agreed that the risk score should remain at 20.
4.3 Health & Safety Bi-Monthly Update	Y	N	N	The summary of activity was noted.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 4 August 2022

Agenda item:	6.2
Presented by:	Phil Holland – Chief Information Officer (CIO)
Prepared by:	Phil Holland – Chief Information Officer (CIO)
Date prepared:	25 July 2022
Subject / title:	M3 2022/23 Integrated Performance Report (IPR)

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

6.2

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

Patients		
Patients	**Falls**	After two months of positive special cause variation, performance has returned to common cause variation
	PPH	Whilst still in common cause variation, two months increasing will be monitored by the Division (see SPC commentary)
People		
People	**Appraisals**	Still in special cause variation, with performance consistently at or near 80%
	Statutory and Mandatory Training	In specal cause variation, and showing a statistically consistent trend. Performance has reduced to 86%, and below the target of 90%.
	Sickness Absence	In common cause variation and continues to perform at or near the target. We have continued to see an overall downward trend since October
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	Reutrned to common cause variation after 12 months in negative special cause variation, following a fourth month of performance improvement
	Cancer 62 day pathway	Performance remains in negative special cause variation. Focus is being placed on the long wait patients, which is having an impact on the overall performance
	Four hour standard	Remains in special cause variation. However, we have seen an improvement in performance for all ambulance handovers over 30 minutes. We also continue to see improvement in a number of other indicators including specialty review to decision to admit, arrival to triage, and ED examination to referral to specialty
	Diagnostics	Performance remains in common cause variation for the fifth consecutive month
	52 week waits	Still is special cause variation, with a continued focus on clinical priority patients. We are continuing to see an overall downward trajectory of patients waiting
	Bed Occupancy	Bed occupancy remains at a high level, and has been in special cause variation for the previous eleven months.
Pounds		
Pounds	Surplus	The Trust reported a deficit of £2.1m in June (month 03) and a year to date deficit of £6.2m against planned surplus of £0.2m in month and £0.4m year to date. This was due to some prior year expenditures paid in month 01 and the effect of prior period contracts still in position. We are reviewing the Trust underlying position to identify major drivers of deficit and will be working with divisional leads to review our spend profile and identify any non-recurrent expenditure still in position.
	CIP	The Trust CIP target for the year is £11.7m and planned delivery for month 03 is £1.0m (£2.9m year to date). Identified CIP are being assessed and delivery will be reported in month 4
	Capital Spend	The Trust total revised CRL for 2022/23 is £15.2m. This includes element of the new hospital PDC of £1.1m. As at M3, year to date capital spend totals £2.6m which is £1.7m overspend against plan.
	Cash	The Trust continues to have a healthy cash balance of £39.5m. There is a continued push to reduce aged payables & maintain the current Trust's performance against the Better Payment Practice Code.
Places		
Places	Catering Food Waste	Remains at or 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.28.07.22 and QSC.29.07.22
Risk / links with the BAF:	Links to all BAF risks.
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified, the IPR demonstrates a full view of service delivery to ensure we take into account equality, diversity and dignity
Appendices:	M3 IPR

6.2

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report for June 2022

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Performance Summary

Patients		
Patients	**Falls**	After two months of positive special cause variation, performance has returned to common cause variation
Patients	**PPH**	Whilst still in common cause variation, two months increasing will be monitored by the Division (see SPC commentary)
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Places		
Places	Catering Food Waste	Remains at or below the national target

People		
People	**Appraisals**	Still in special cause variation, with performance consistently at or near 80%
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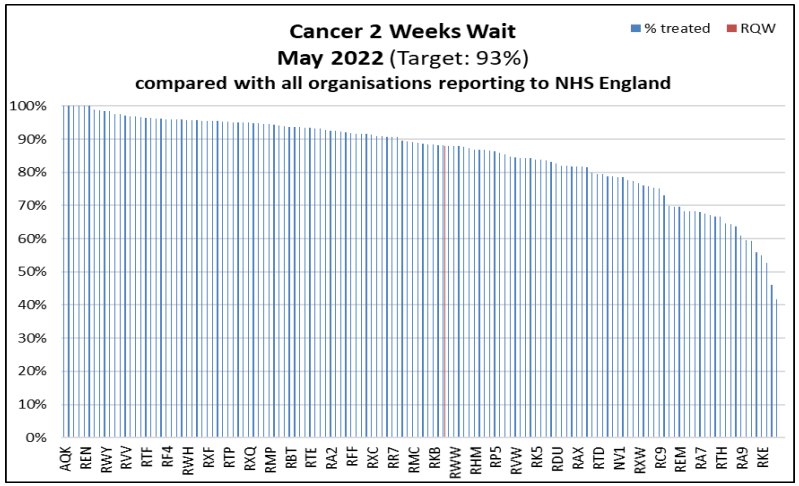
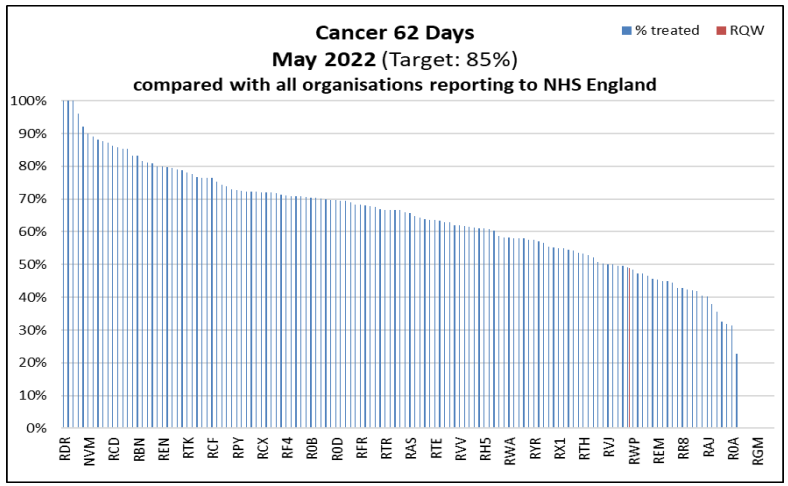
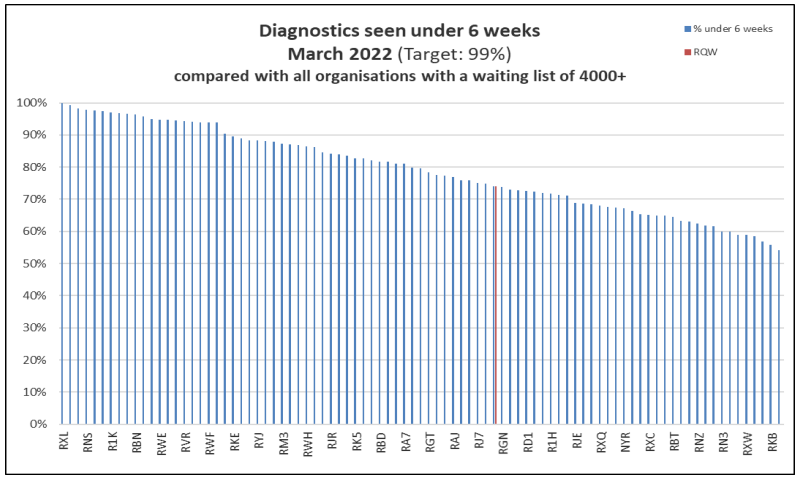
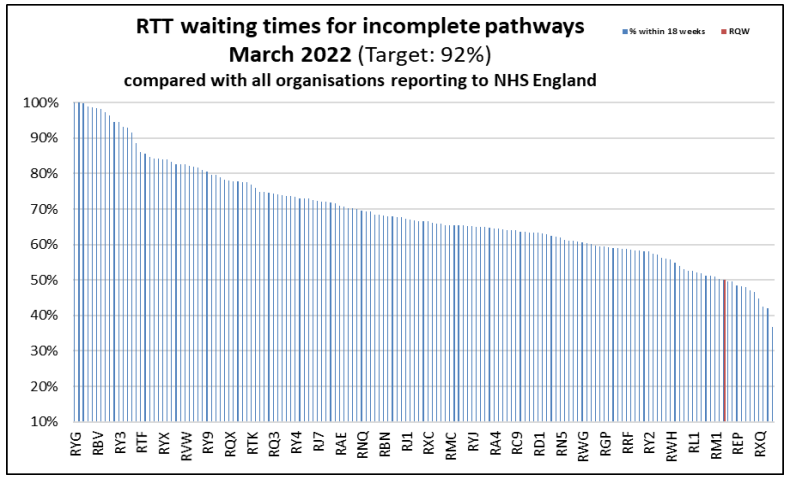
Performance	**Diagnostics**	Performance remains in common cause variation for the fifth consecutive month
Performance	**52 week waits**	Still is special cause variation, with a continued focus on clinical priority patients. We are continuing to see an overall downward trajectory of patients waiting
Performance	**Bed Occupancy**	Bed occupancy remains at a high level, and has been in special cause variation for the previous eleven months.

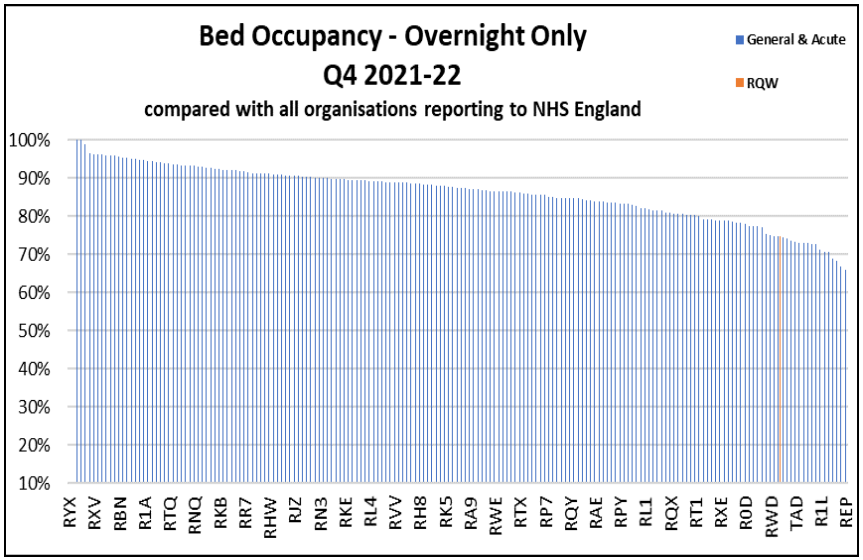
National Benchmarking

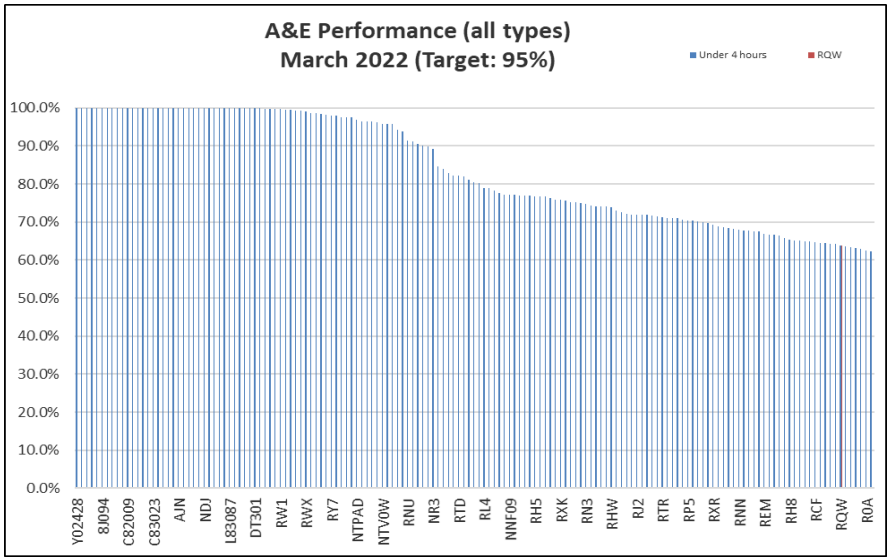









Bed Occupancy - Overnight Only
Q4 2021-22
compared with all organisations reporting to NHS England
General & Acute
RQW
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
RYX RXV RBN R1A RTQ RNQ RKB RR7 RHW RJZ RN3 RKE RL4 RVV RH8 RK5 RA9 RWE RTX RP7 RQY RAE RPY RL1 RQX RT1 RXE R0D RWD TAD R1L REP


A&E Performance (all types)
March 2022 (Target: 95%)
Under 4 hours
RQW
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Y02428 8J094 C82009 C83023 AJN NDJ L83087 DT301 RW1 RWX RY7 NTPAD NTV0W RNU NR3 RTD RL4 NNF09 RH5 RXK RN3 RHW RJ2 RTR RP5 RXR RNN REM RH8 RCF RQW R0A


Benchmarking

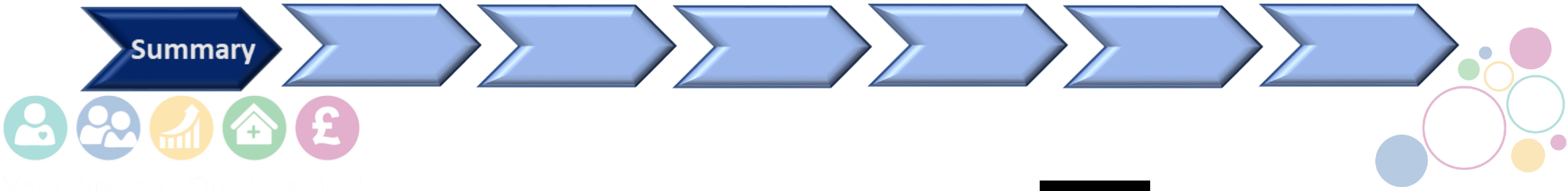
The difference between common and special cause variation

Common Cause Variation

- Is inherent in the design of the process
- Is due to regular, natural or ordinary causes
- Shows that a process is stable and overall predictable
- Also known as random or unassignable variation
- Shown as grey line with grey markers on our SPC charts

Special Cause Variation

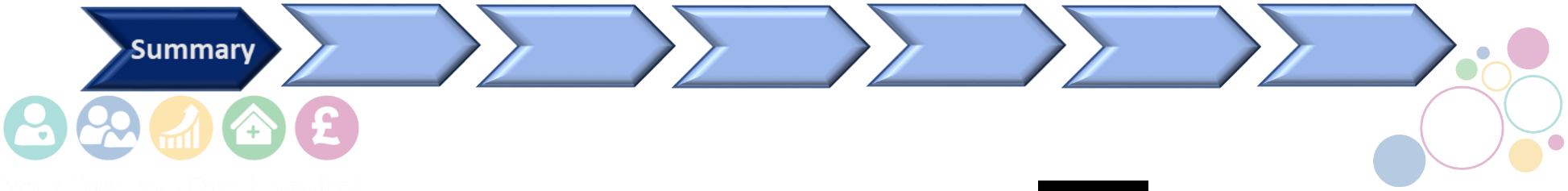
- Is due to irregular causes that are not inherent in the design of the process
- Results in an unstable process that is not predictable
- Also known as non-random or assignable variation
- Shown as blue or orange markers on our SPC charts



How is special cause variation defined and identified

It can be positive and improving (identified by blue markers), or negative and deteriorating (orange markers). The following factors identify special cause variation in our SPC charts

- A single point outside of the upper or lower control limits
- A run of points above or below the average (mean) line.
- Six consecutive points increasing or decreasing
- Two consecutive points near the upper or lower process control limits



Patients

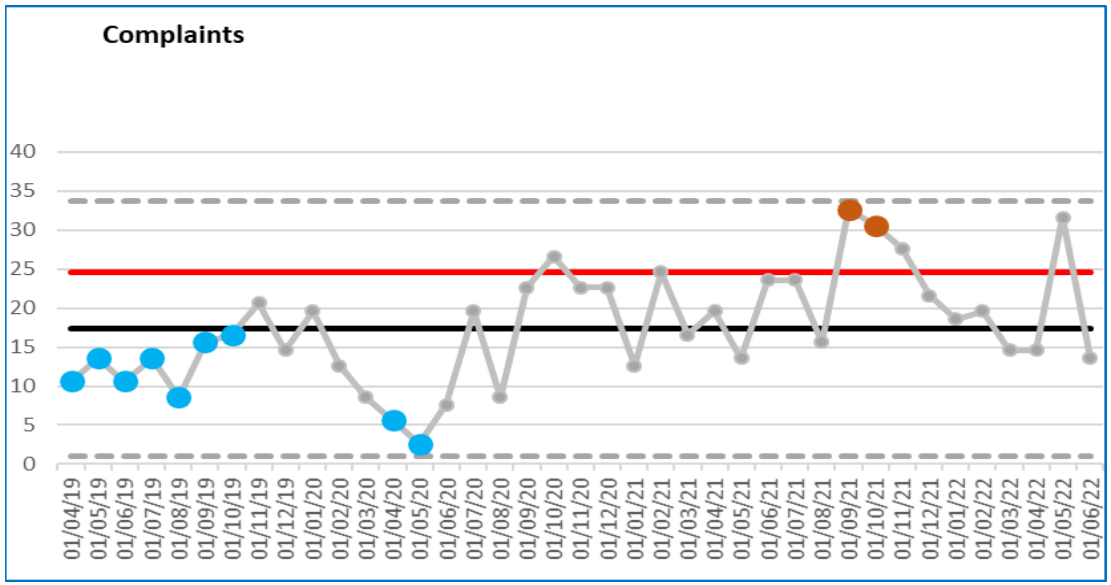
*We will continue to improve the quality of care, outcomes & experiences that we provide **our patients**, integrating care with our partners & reducing health inequity in our local population*

Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Pressure Ulcers	There has been an increase in month in the number of reported grade 3,4 and unstageable tissue injuries. The rate per 1000 bed days remains stable. The PU strategy is centred to drive down avoidable patient harm, some details of which are included within the PU page.	For information	Strategic aim is a zero tolerance for avoidable harm
C. Difficile	There has been an increase in our prevalence of C. Difficile. Significant focus both locally and regionally due to increased rates across healthcare. Please see page narrative work oversight and work underway.	For increased visibility and awareness	NA
PPH	There has been an increase in month. Please see page for narrative which includes latest national benchmarking data.	For information	NA

KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
Complaints	Jun 22	14	25			18	1	34
Compliments	Jun 22	89	50			118	-102	339
PALS	Jun 22	275	none			281	148	414
Complaints closed within target	Jun 22	8	none			6	-3	14
% of complaints where an extension has been agreed	Jun 22	48%	none			43%	9%	77%
Mixed Sex Accommodation Breach	Jun 22	14	0			7	-4	18
Serious Incidents	Jun 22	3	none			4	-4	13
MSSA	Jun 22	1	none			1	-1	3
CDIFF	Jun 22	8	none			5	-3	13
Hand Hygiene	Jan 22	97%	none			92%	75%	109%
eColi	Jun 22	1	none			1	-2	4
Klebsiella	Jun 22	0	none			1	-1	3
Pseudomonas	Jun 22	1	none			0	-1	1
Falls per 1000 bed days	Jun 22	9	9			8	6	11
Falls total minor, moderate & severe	Jun 22	23	13			25	10	39
Pressure Ulcers per 1000 bed days	Jun 22	3	3			4	1	7
Pressure Ulcers: grade 3, 4 & unstageable	Jun 22	13	3			4	-3	11
Total number of mothers delivering in birthing unit/home	Jun 22	7%	20%			11%	-1%	22%
Number of mothers delivering in Labour Ward/Theatres	Jun 22	92%	75%			89%	76%	101%
Number of women due to deliver at PAH adjusted for misc/TOPs	Jun 22	325	375			330	273	386
Smoking rates at booking	Jun 22	7%	none			9%	3%	14%
Smoking rates at delivery	Jun 22	8%	6%			10%	5%	15%
Breast feeding rates at delivery	Jun 22	77%	74%			76%	66%	85%
Total Planned C-Sections	Dec 21	20%	none			15%	8%	23%
Total Unscheduled C-Sections	Dec 21	21%	none			18%	13%	24%

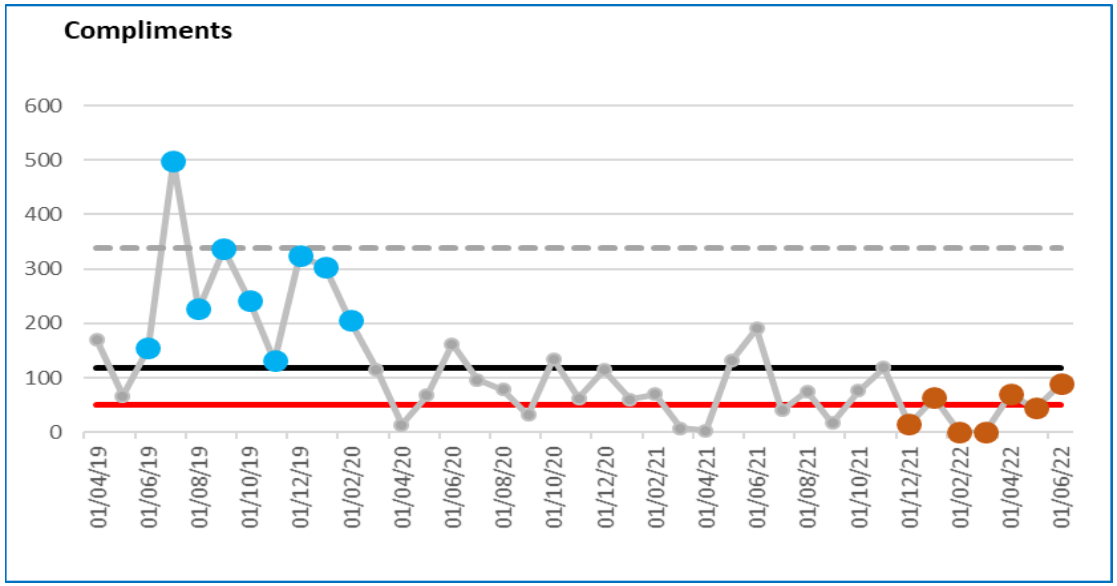
Patients

KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
PPH over 1500mls	Jun 22	6%	none			4%	1%	7%
CTG training compliance midwives	Jun 22	91%	85%			71%	51%	90%
CTG training compliance doctors	Jun 22	90%	85%			75%	51%	100%
Still births	Jun 22	2	none			1	-2	3
Patients detained under MHA	Jun 22	0	none			0	-1	2
Patients detained under section 136	Jun 22	0	none			1	-2	3
Mental health patient incidents	Jun 22	16	none			12	0	23
Mental health patient complaints	Jun 22	1	none			0	-1	1
Mental health patient PALS	Jun 22	3	none			2	-1	5
Patients with LD and Autism accessing inpatient services	Jun 22	31	none			25	4	46
Patients who died in their preferred place of death	Jan 22	54%	none			57%	21%	92%
C-DIFF Hospital onset healthcare associated	Jun 22	5	none			2	-3	7
C-DIFF Community onset healthcare associated (Acute Admissio	Jun 22	2	none			1	-1	3
C-DIFF Community onset indeterminate association (Acute Adm	Jun 22	0	none			1	-1	3
C-DIFF Community onset community associated (No acute conta	Jun 22	1	none			1	-3	5
Covid-19 new positive inpatients	Jun 22	133	none			137	-111	384
MRSA	Jun 22	0	0			0	0	1
Births	Jun 22	315	none			315	315	315
Instrumental births	Jun 22	32	none			32	32	32
Pre- term births	Jun 22	28	none			28	28	28
Continuity of carer	Jun 22	23%	none			23%	23%	23%
Women booked in month			none					



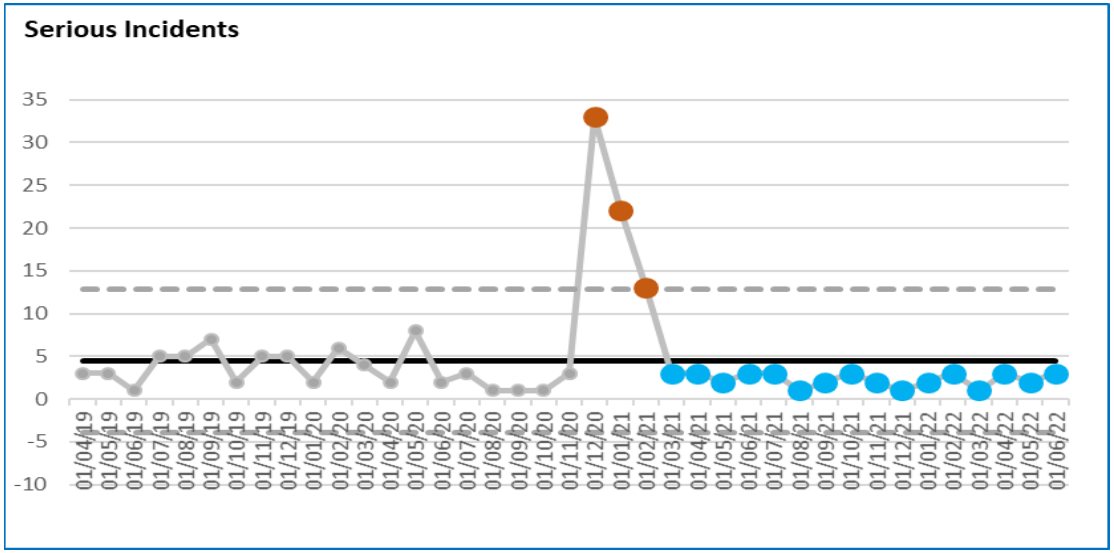
Jun-22
14
Variance Type
Common cause variation
Target
25
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Complaints	Common cause variation	Pandemic complaints and issues continue to proliferate, but gradually subsiding. Pre-pandemic patterns beginning to resurface. Since October 2021 (137 open cases) we have seen a downward trend & we are now focused on eliminating the pandemic backlog.	Reductions ongoing - now 98 cases live with an additional 22 either without consent or at final sign off.	Elimination of backlog of open cases is on track. To be at 60 open cases by December 2022.



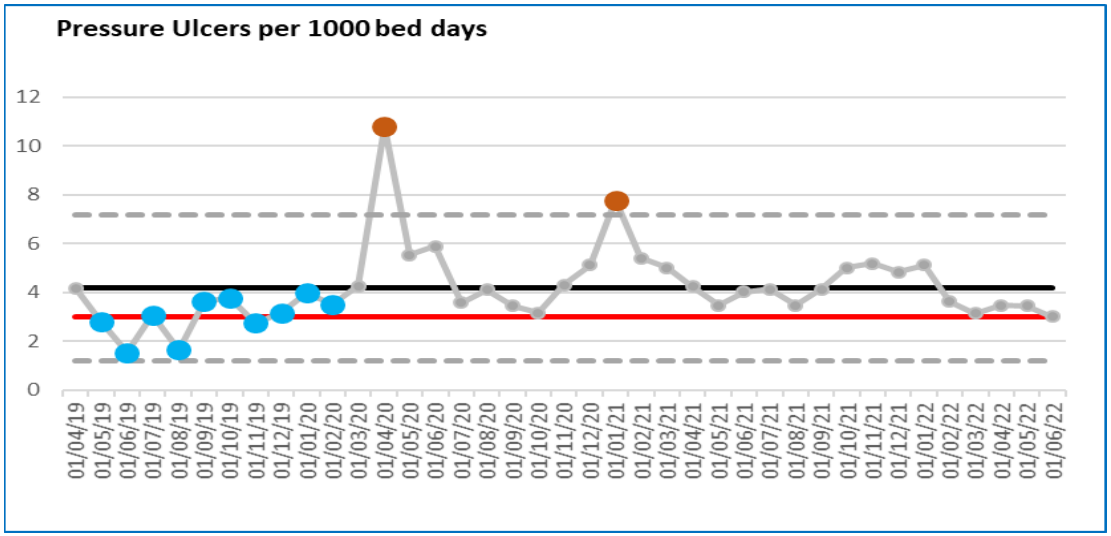
89
Variance Type
Special cause variation
Target
50
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Compliments	Special cause concerning variation while hit & missing the target	During the last 12 months compliments have seen a decline due to staffing pressures.	Will return to recording this data when staffing issues resolved. Keeping staffing gap under regular review.	Continuing to receive and hold feedback and data in preparation for return to normal staffing and encourage staff to return compliments despite the data delay.



Jun-22
3
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

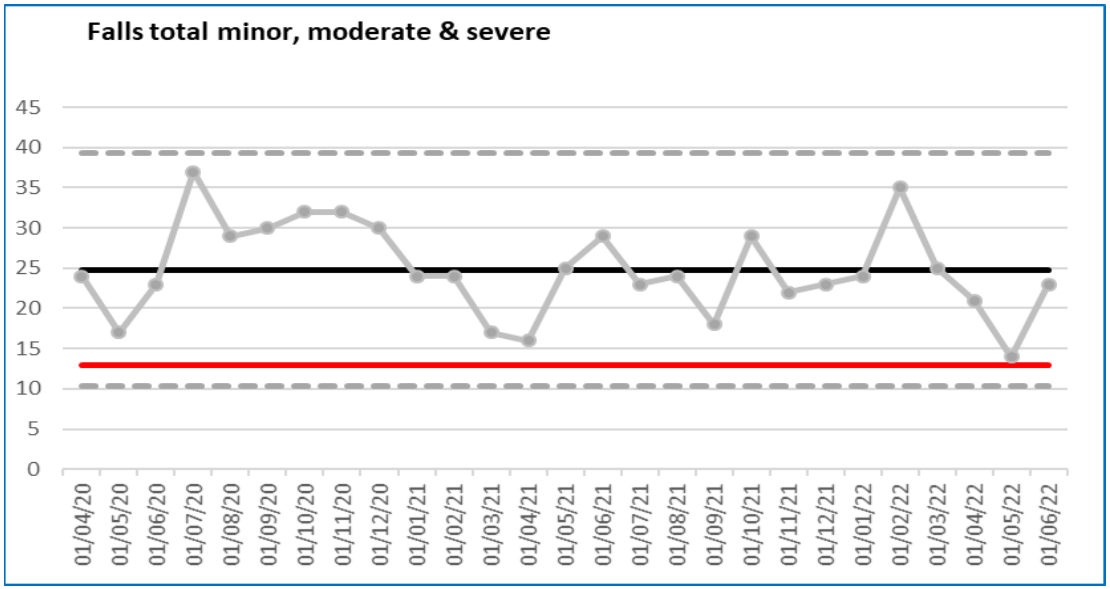
Background	What the chart tells us	Issues	Actions	Mitigation
Serious Incidents (SIs)	Trust reporting numbers for serious incidents raised each month is consistent & month on month	The significant spike seen during the winter 20/21 was associated with nosocomial Covid-19 hospital infections during wave 2 of the pandemic. We do not expect to see this replicated in future months. Where an incident meets the national reporting criteria to be raised externally as a serious incident (SI) it will be raised. There is no internally set target	Incident management group meets twice a week to review new incidents & those with completed investigations. During June 2022, the trust raised three SI. In month no SIs were closed. The trust has 17 investigations of serious incidents open at this time	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.



Jun-22
3.02
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

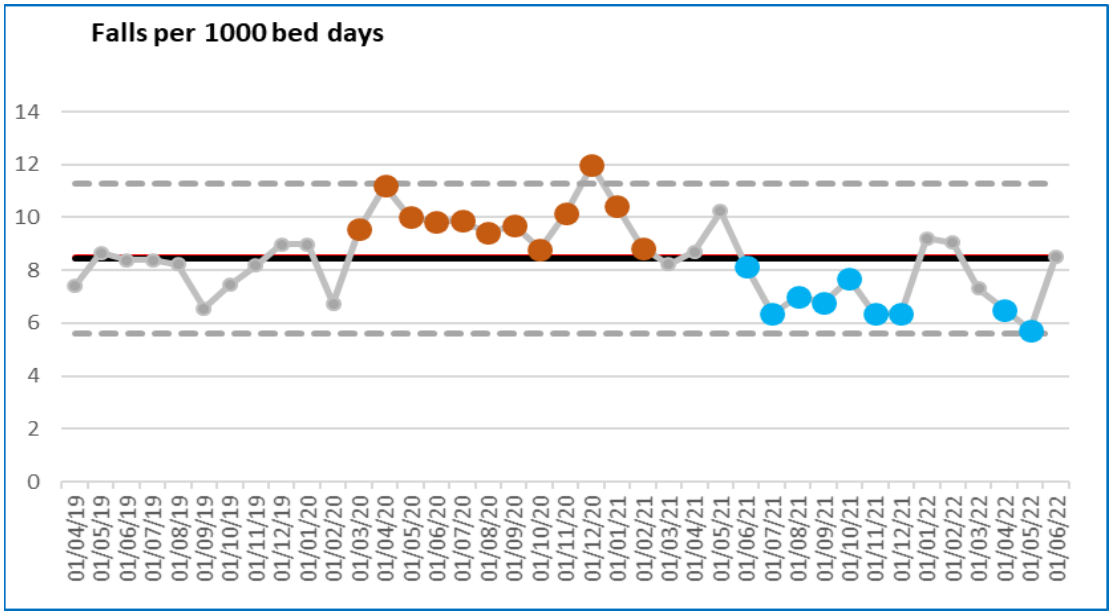
Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers per 1000 bed days	Common cause variation while hit & missing the target			

Patients



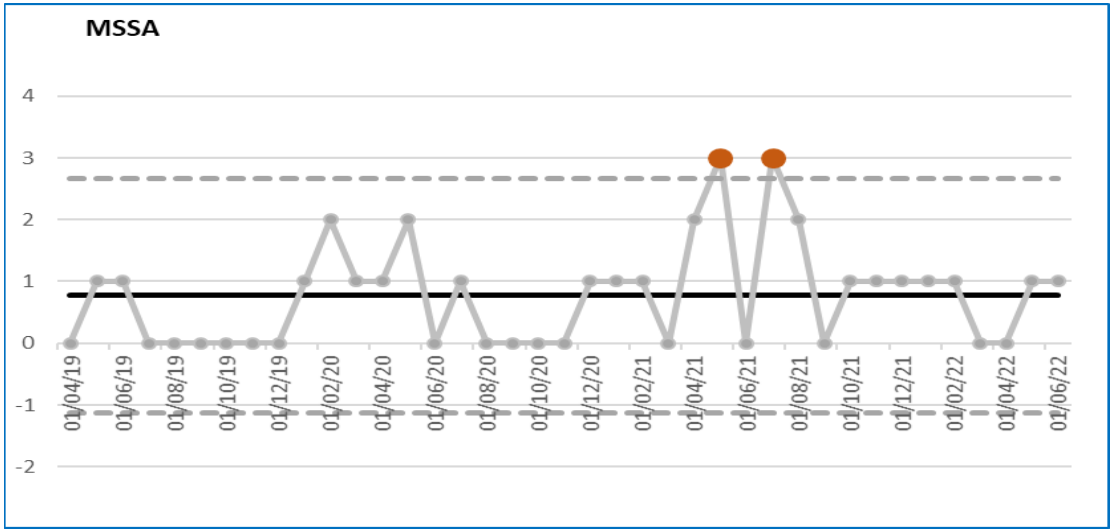
Jun-22
23
Variance Type
Common cause variation
Target
13
Target Achievement
Hit & miss target subject to random variation

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	A new falls prevention strategy has been developed for the financial year 2022/23. The Trust remains committed to reducing falls with harm by 50% by the end of 2022/23	New falls strategy in place for 2022/23.New method for validating falls with harm is in place	Nil at this point



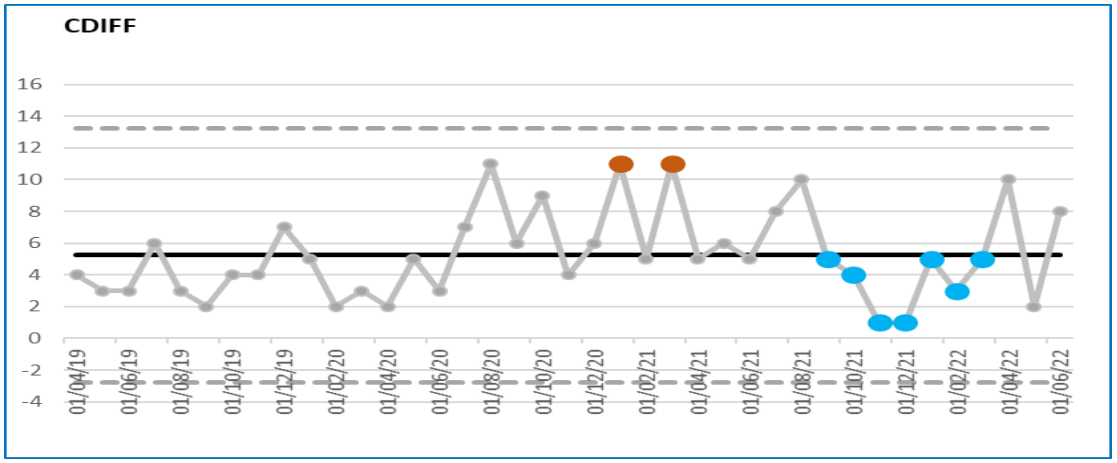
Jun-22
8.5
Variance Type
Common cause variation
Target
8.5
Target Achievement
Hit & miss target subject to random variation

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



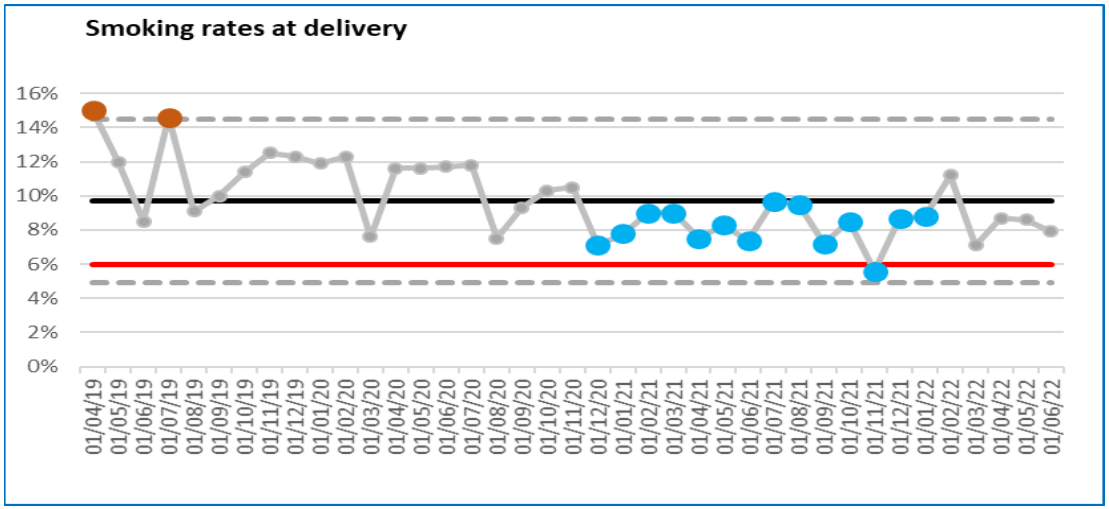
Jun-22
1
Variance Type
Common cause variation
Target
None
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
MSSA	Common cause variation	During 2021-2022 there has been a significant increase of cases of MSSA bacteraemia. In 2020-2021, there were a total of seven cases for the year, compared with 18 cases to date between April - January 2022.	RCA meetings have taken place to identify sources of infection. A significant proportion of cases appear to be linked to IV devices - therefore an action plan has been developed 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, introduction 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



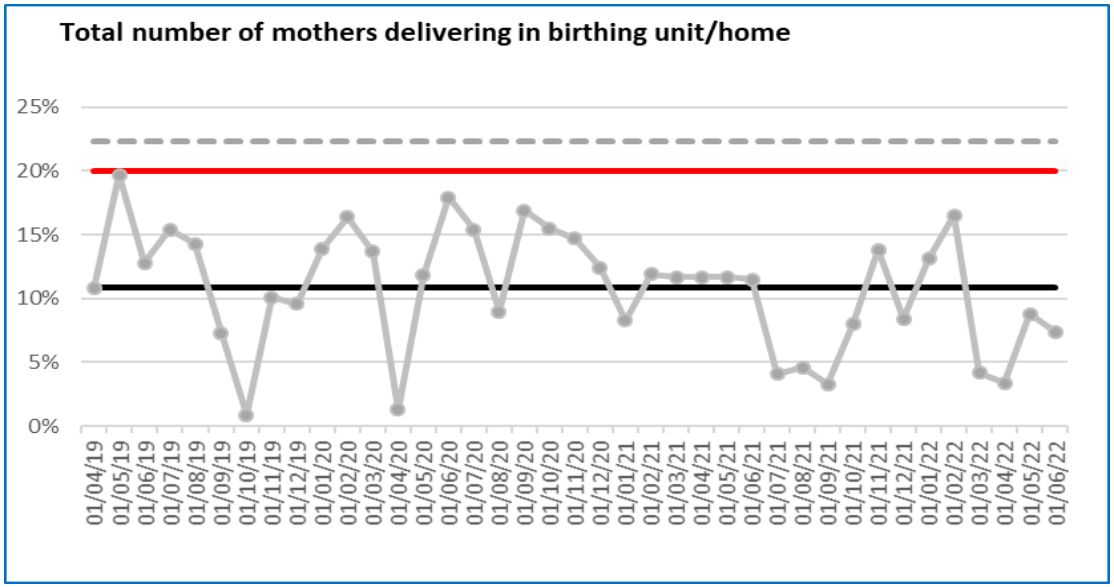
Jun-22
8
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

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. Over the last few months the Trust has 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 30 cases.	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 10. There is a requirment for a focus on the COHA cases to understand at what point patients are acquiring C.difficile; this is a joint approach between the acute and CCG teams.	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 increased, severity of infection did not; there have not been any deaths where C.difficile has been the cause of death



Jun-22
7.9%
Variance Type
Special cause variation
Target
6%
Target Achievement
Hit and miss target subject to random variation

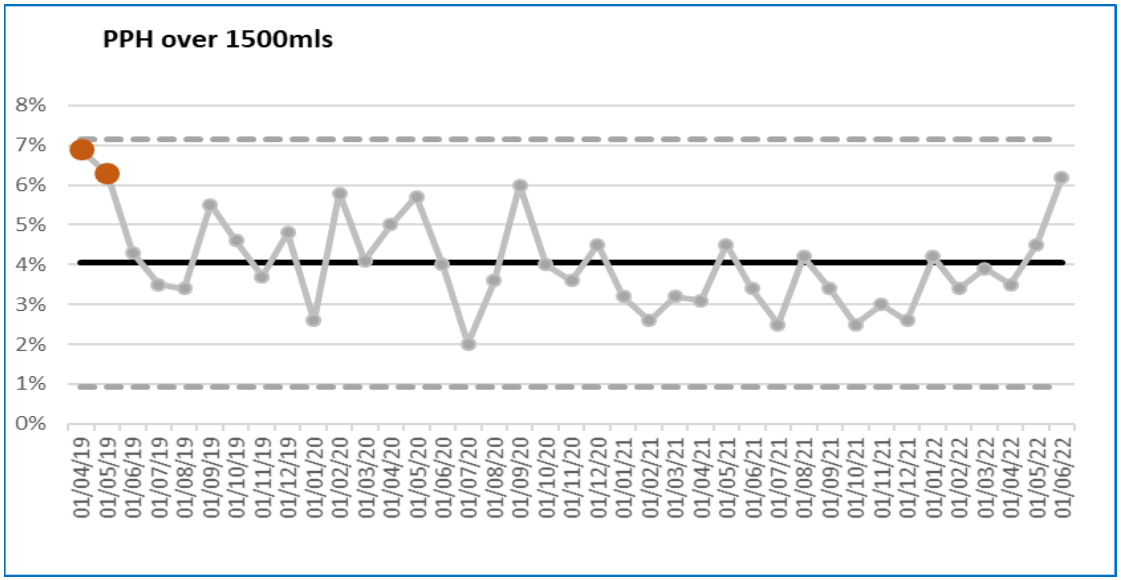
Background	What the chart tells us	Issues	Actions	Mitigation
Smoking rates at delivery	Special cause variation and inconsistently hit & missing target	Smoking rates at delivery	The smoking at delivery rate for June 22 was 7.9%, compared to the target of <6% as set by the LMNS	We have added new fields to COSMIC to collect women's smoking status at around 36 weeks gestation. This will give us an additional opportunity with targeting women who need additional support prior to delivery A new in house Maternity Stop Smoking Advisor has commenced and will be offering appointments to women to assist them to stop smoking Data on the stop smoking progress of these women will be collected on COSMIC to report on the stop smoking clinic KPI's



Jun-22
7.4%
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		Midwives are being re-deployed to the most appropriate area in terms of maintaining safe staffing levels – resulting in periodic closure of the Birth Unit to maintain safe staffing

Patients



Jun-22
6.20%
Variance Type
Common cause variation
Target
Not set
Target Achievement

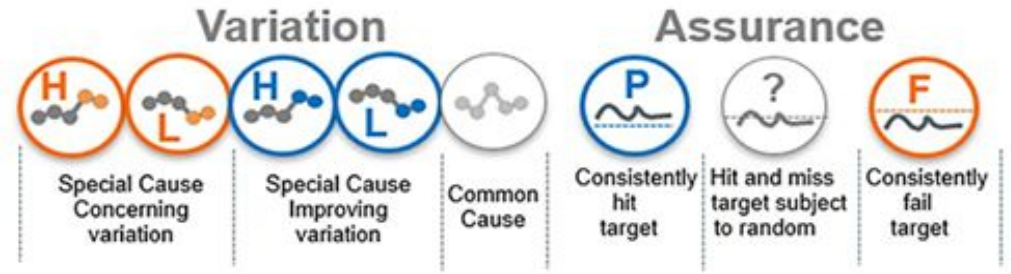
Background	What the chart tells us	Issues	Actions	Mitigation
PPH over 1500mls	Common cause variation	PPH over 1500mls		Haemorrhage (MOH) was undertaken by the maternity service and presented to Quality and Safety in May 2022. This review compared local and national data over a 24 month period. The review found a decline in MOH rates from May 2020 and noted that the national mean has now risen to 3.7%. The mean rate at PAHT is 3.6% and MOH is a workstrem as part of the maternity improvement board. The service continues to review all MOH and has transitioned to the use of a new drug to treat MOH at Caeserean Section births

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**
Staffing	vacancey rate reduced to 14.36% actively recruiting into vacant posts, weekly establishment update meetings held, in month 1 x catering manager, 2 x domestics, 2 x porters, 4x kitchen assistants and 17x housekeepers going through recruitment process	For information	
Catering	Electronic meal ordering service phased roll out July 2022 on Penn ward. Recruitment of chefs difficult due to the national shortage use of band and agency to fill the gaps where possible.	For increased visibility and awareness	
Leases	Florence nightingale surrendered and STM laundry to be surrendered by end of June 2022	For information	
Estates	Two main circuit board upgrades completed. Whole site medical gas risk assessment complete report due early July 2022 Significant gaps in the knowledge and competency within the engineering team. This is due to a national shortage of engineers working in the NHS, geographical location and high risk/complex systems within healthcare buildings	For increased visibility and awareness	
Capital	Parndon Hall - mothballing works on site completed and asset empty of users Aseptic Suite development – Temporary planning approval granted until 1st July 2030	For information	
Sustainablility	Low Carbon Skill Fund (Salix Funding) Application put in value of funding if successful £78K Electric vehicle trial a success moving forward with lease for EFM oiof 6 vehicles to replace current fleet.	For information	

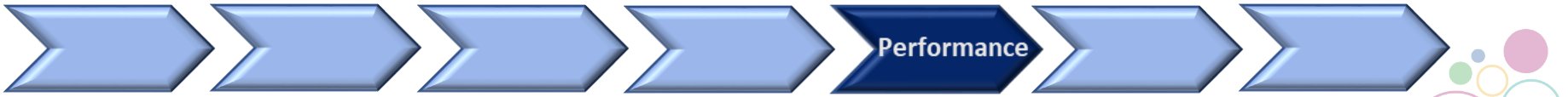
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Estates Responsiveness (Priority 2 - Urgent)	Jun 22	96%	95%			95%	91%	99%
Meals Served	Jun 22	44575	42120			37559	26049	49068
Catering Food Waste	Jun 22	2%	4%	L		5%	-1%	10%
Domestic Services (Cleaning) Very High Risk	Jun 22	98.2%	98.0%	H		97.7%	94.6%	100.9%
Domestic Services (Cleaning) High Risk	Jun 22	98.2%	95.0%			96.8%	93.6%	100.0%



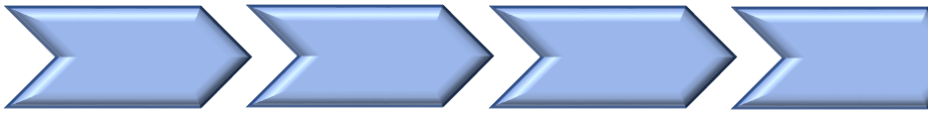
Performance

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

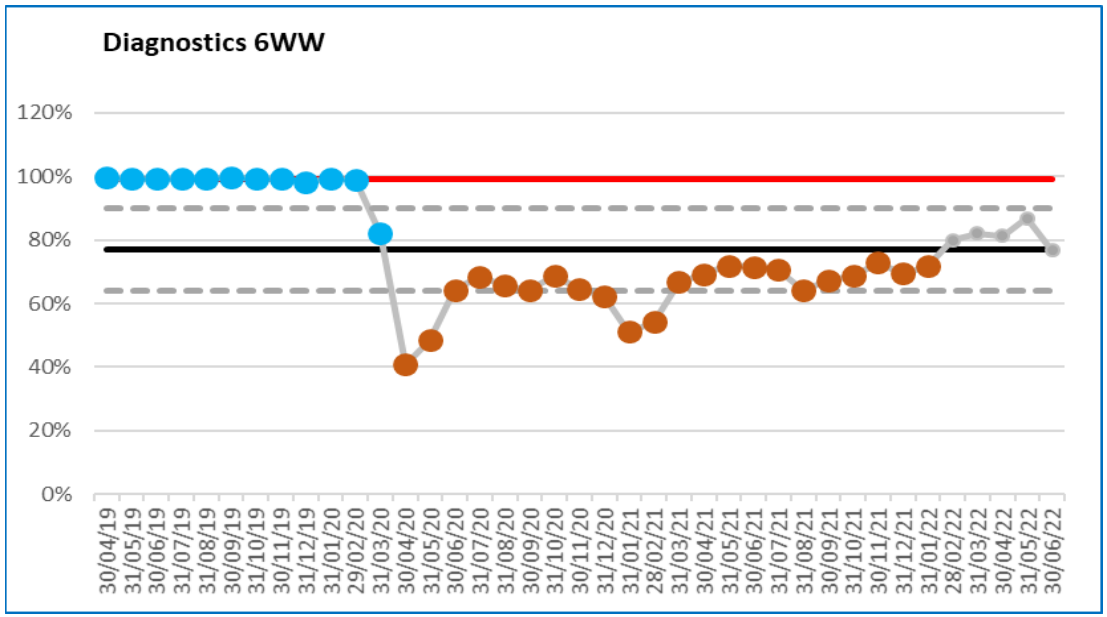
Performance	Board Sub Committee: Worforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Urgent Care	The Urgent care departments continue to see increased demand with 50% of the demand being minor attendances. There are continued improvement plans in progress along with te national 100 day challenge. Executive oversight through Urgent Care Board and the CQC Quality Project workstream.	For increased visibility and awareness	
Cancer	All cancer metrics continue to improve and have ongoing imprvement plans. Further Faster Diagnosis Standard work on developing the pathways should create sustainability in performance over the next year. PAH recovery performance against plan is best in the ICS.	For recognition	
Referral to Treatment	Continued clinical prioritisation of booking to mitigate potential deterioration of patients' conditions and close monitoring of long waiting patients and their appointment requirements. Theatre demand & capacity modelling complete and two further elective theatres due to open over July and August. Overall numbers of patients on waiting list increased this month but in line with increased referrals both currently and a year ago.	For increased visibility and awareness	
Diagnostics	Diagnostics performance has deteriorated this month due to sigbificant staffing shortages and lost scanning time from electrical testing, chiller relocation and the Ride London event access restrictions. Further MRI vans have been secured for July & August to help recover	For increased visibility and awareness	



KPI	Latest month	Measure	Target	Performance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 1 metrics								
RTT incomplete	Jun 22	51%	92%			71%	66%	75%
RTT admitted	Jun 22	45%	90%			52%	27%	77%
RTT Non admitted	Jun 22	78%	95%			86%	83%	89%
RTT PTL vs RTT PTL & ASIs	Jun 22	80%	none			93%	90%	96%
Cancer 31 days First	May 22	82%	96%			93%	84%	102%
Cancer 31 days Subsequent Drugs	May 22	100%	98%			99%	90%	107%
Cancer 31 days subsequent surgery	May 22	100%	94%			92%	55%	129%
Cancer 2WW	May 22	88%	93%			81%	63%	100%
Cancer 62 day shared treatment	May 22	49%	85%			67%	47%	88%
Cancer 62 day screening	May 22	33%	90%			65%	13%	117%
Cancer 62 Day Consultant Upgrade	May 22	59%	90%			83%	64%	103%
Cancer 28 day faster diagnosis	May 22	66%	none			66%	50%	82%
4 Hour standard	Jun 22	62%	95%			74%	66%	81%
ED attendances	Jun 22	10923	none			9148	7076	11221
ED Admitted performance	Jun 22	19%	95%			46%	30%	61%
ED non admitted performance	Jun 22	68%	95%			81%	74%	89%
ED Arrival to Triage	Jun 22	43	15			47	30	64
ED Triage to examination	Jun 22	134	60			99	76	123
ED Examination to referral to specialty average wait	Jun 22	121	45			103	91	116
ED referral to be seen average wait	Jun 22	84	30			79	57	101
Seen by specialty to DTA	Jun 22	86	60			96	75	118
DTA to departure	Jun 22	193	30			219	94	344
Ambulance handovers less than 15 minutes	Jun 22	17%	100%			26%	14%	37%
Ambulance handovers between 15 and 30 mins	Jun 22	37%	0%			41%	33%	49%
Ambulance handovers between 30 and 60 mins	Jun 22	20%	0%			22%	12%	32%

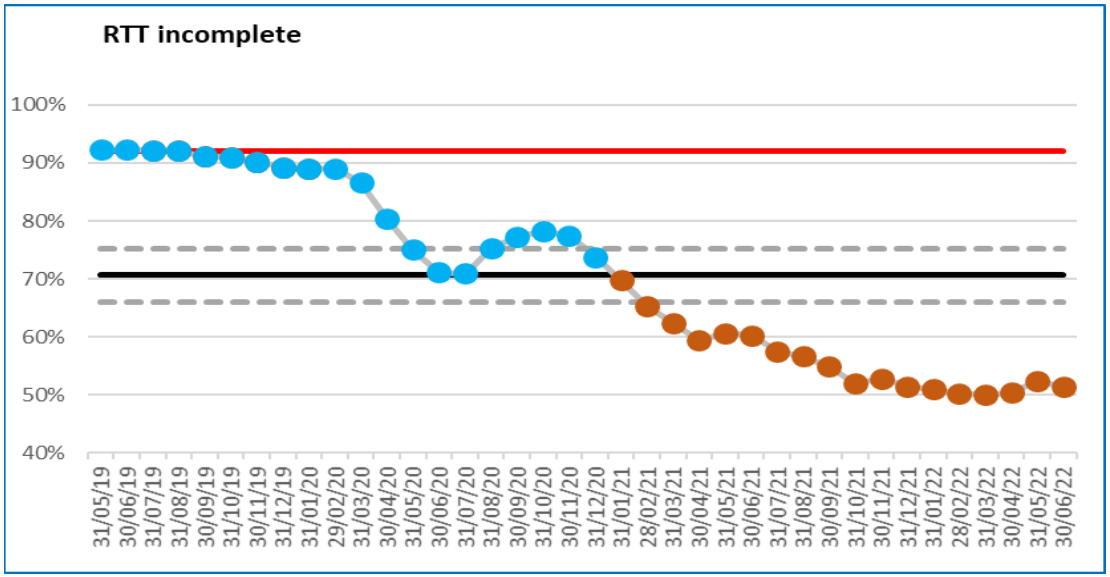


KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 2 metrics								
Ambulance handovers > 60 mins	Jun 22	18%	0%			11%	2%	21%
Diagnostics 6WW	Jun 22	77%	99%			77%	64%	90%
Patients with a Length of Stay more than 7 days	Jun 22	167	80			151	101	202
Bed occupancy	Jun 22	92%	85%			89%	81%	96%
Discharges between 8am and 5pm	Jun 22	692	none			718	481	955
Discharges between 5pm and 8am	Jun 22	716	none			701	442	959
LOS non elective	Jun 22	5.1	5.1			4.0	3.1	4.8
LOS elective	Jun 22	2.8	4.2			2.3	0.7	4.0
Short Notice clinical cancellations	May 22	4	none			42	-31	116
OP new to follow up ratio	Jun 22	2.0	2.3			2.1	1.8	2.5
OP DNA Rate	Jun 22	5.8%	8.0%			4.9%	3.7%	6.0%
52 Week waits	Jun 22	1785	0			839	546	1131
Proportion of Majors Patient treated within 4 hours in ED Paeds	Jun 22	52%	95%			78%	63%	94%
Patients with a Length of Stay more than 21 days	Jun 22	57	25			45	19	71
12 Hour waits in ED from Arrival	Jun 22	922	0			538	228	849
12 Hour Trolley waits in ED from DTA	Jun 22	99	0			77	-10	165



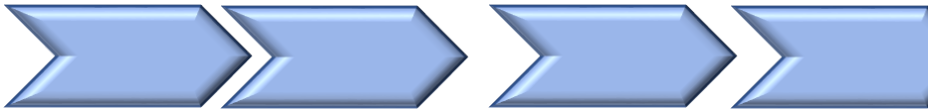
Jun-22
76.70%
Variance Type
Special cause variation
Target
99.00%
Target Achievement
Consistently failing target

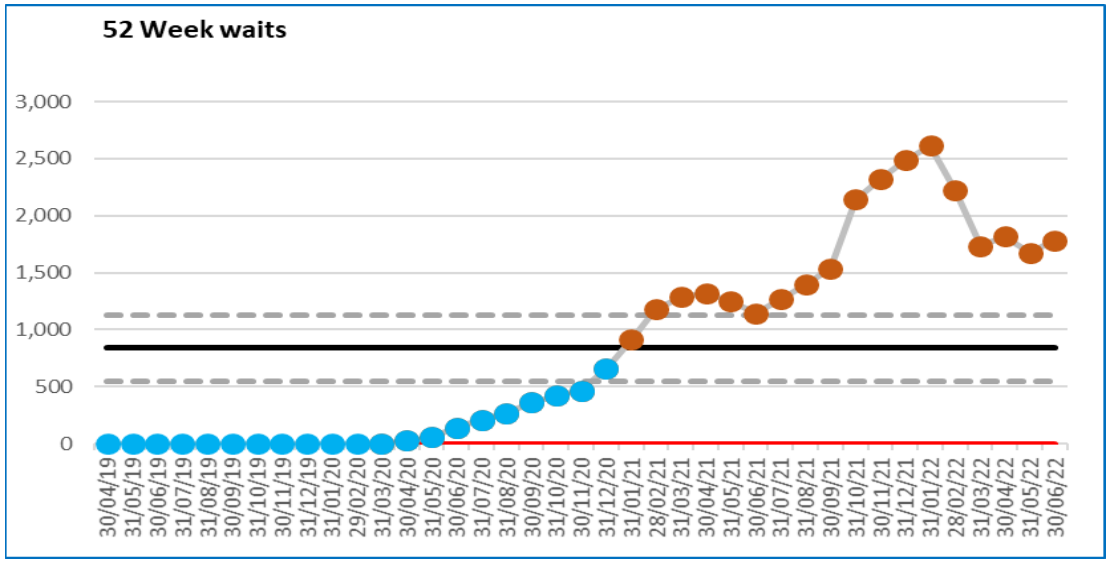
Background	What the chart tells us	Issues	Actions	Mitigation
Diagnostics 6 week wait	Special cause concerning variation and consistently failing target	Increased referral levels (+20%) continuing. Ongoing staffing challenges	Additional capacity is being delivered as extra sessions & use of independent 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. Demand & Capacity model developed to aid planning



Jun-22
51.4%
Variance Type
Special cause variation
Target
92%
Target Achievement
Consistently failing target

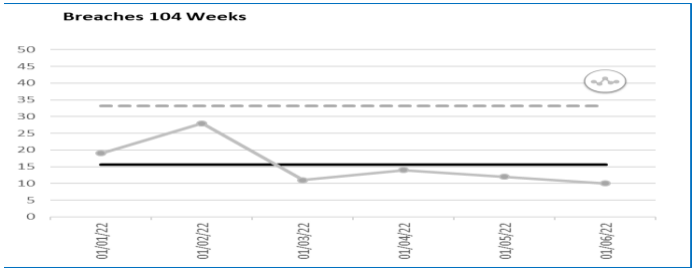
Background	What the chart tells us	Issues	Actions	Mitigation
RTT Incomplete	Special cause concerning variation and consistently failing target	The performance against the RTT standard has been below the target and statistical mean for 12 months as a result of covid activity pressure pausing elective 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 bed capacity has increased with the opening of an Orthopaedic ward. Insourcing operating in Urology & General Surgery has commenced. 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.

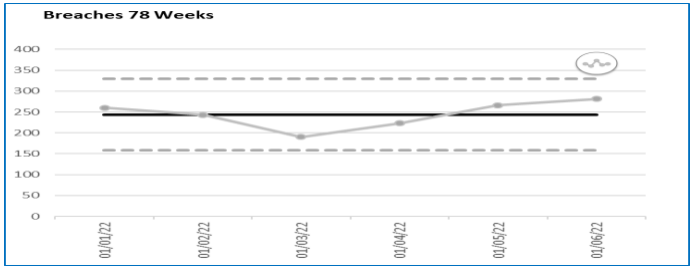


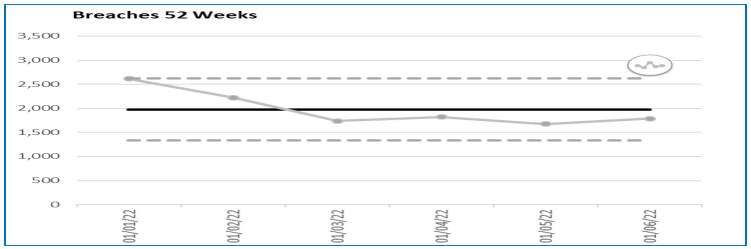


Jun-22
1785
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

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. Balance between emergency & elective capacity is an ongoing challenge. Challenge of anaesthetic workforce availability restricting the number of elective lists.	Daily review of 104 week breach patient next steps. Weekly meeting to track & expedite long waiting patient appointments. Clinical Harm Questionnaires being texted to patients to identify deteriorated patients that require faster appointments and patients that can be discharged. Investment in additional RTT validation staff to improve data quality of the waiting lists. Trust wide improvement trajectory being collated.	Clinical review of long waiting patients being implemented with interim & treatment harm review process to monitor for potential harm. Patients over 104 weeks all have appointments/treatment plans.

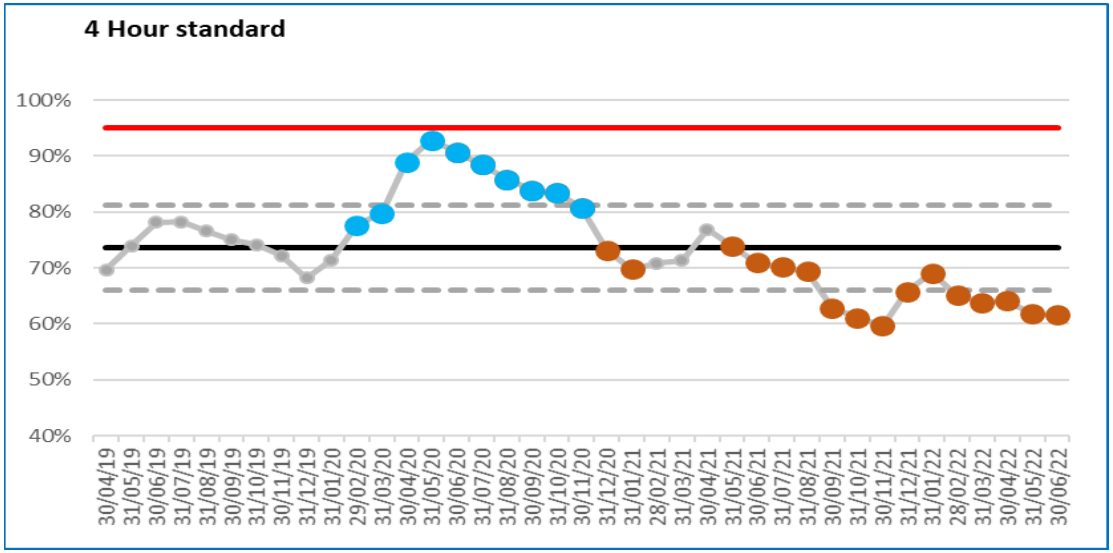






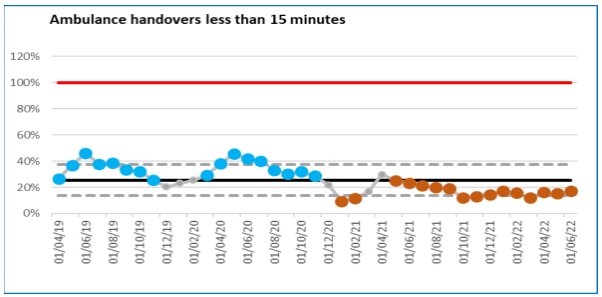
Jun-22
H
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target
F

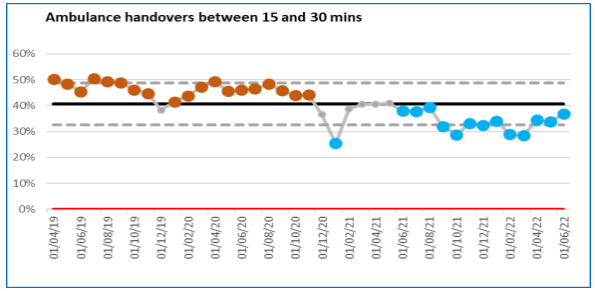
Background	What the chart tells us	Issues	Actions	Mitigation
Breaches	Special cause concerning variation and consistently failing target	Booking in clinical priority order instead of chronological order has led to increasing numbers of long waiting lower priority patients. Balance between emergency & elective capacity is an ongoing challenge. Challenge of anaesthetic workforce availability restricting the number of elective lists.	Daily review of 104 week breach patient next steps. Weekly meeting to track & expedite long waiting patient appointments. Clinical Harm Questionnaires being texted to patients to identify deteriorated patients that require faster appointments and patients that can be discharged. Investment in additional RTT validation staff to improve data quality of the waiting lists. Trust wide improvement trajectory being collated.	Clinical review of long waiting patients being implemented with interim & treatment harm review process to monitor for potential harm. Patients over 104 weeks all have appointments/treatment plans.

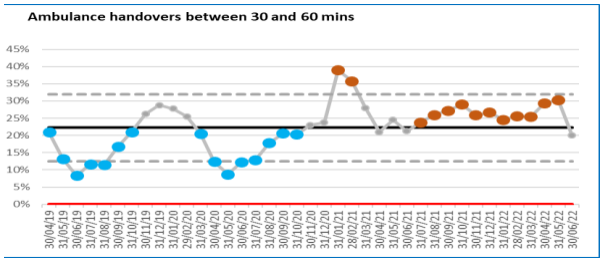


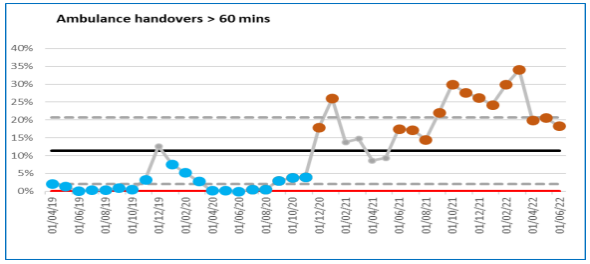
Jun-22
61.59%
Variance Type
Special cause variation
Target
95%
Target Achievement
Consistently failing target

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 divisional oversight continues through the Urgent Care Board & CQC Quality Project workstream. Internal, Regional and national discharge projects in place. Response to the national "100 day challenge" being prepared to improve flow and ED performance.	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. Weekly regional discussion on pressure points. Evening ICS system call to support emergency areas out of hours.



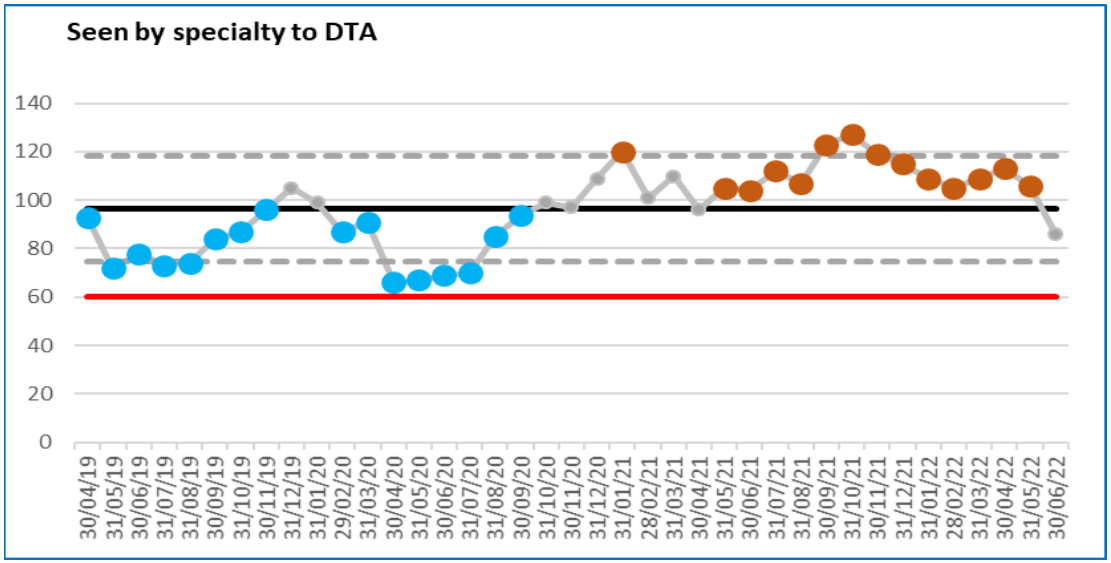






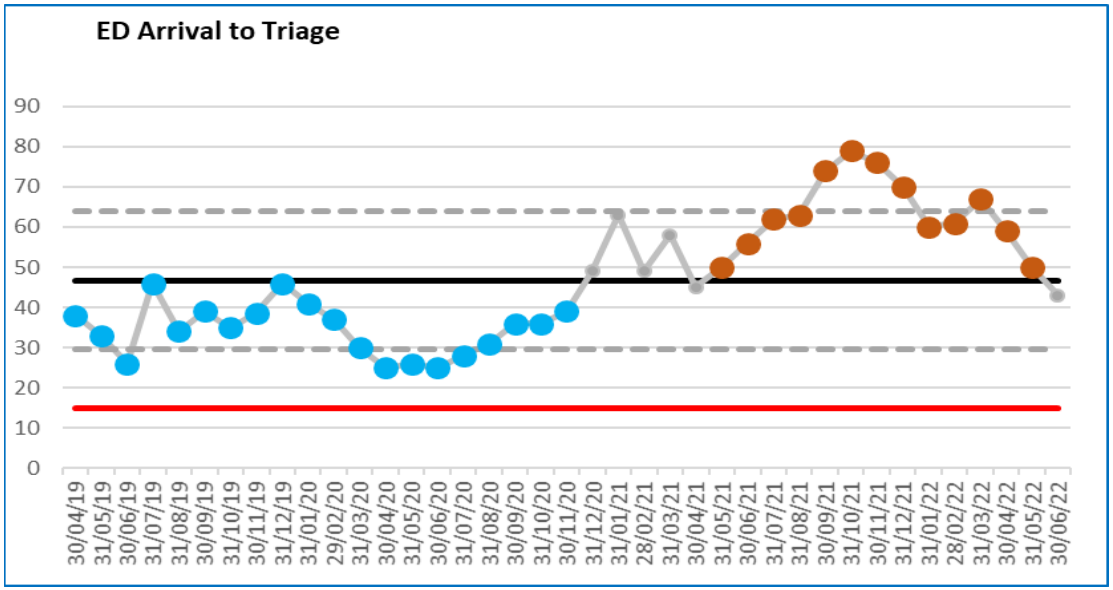
Jun-22
20.0% 30-60 min
Variance Type
Special cause variation
Target
0%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Ambulances handovers between 30 and 60 minutes	Special cause concerning variation and consistently failing target	The % of ambulance conveyances over 30 minutes has increased above the statistical average. Increased ambulance activity, increased attendances and delays in bed availability for admissions from the emergency department.	Ongoing improvement programme monitored through Urgent Care Board. Daily system call with EEAST to enact load levelling and manage volume across the acute Trusts. Drop & Go service maintained despite extreme pressure. Improved staffing enabling the 4th Rapid Assessment & Triage team to assess faster	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



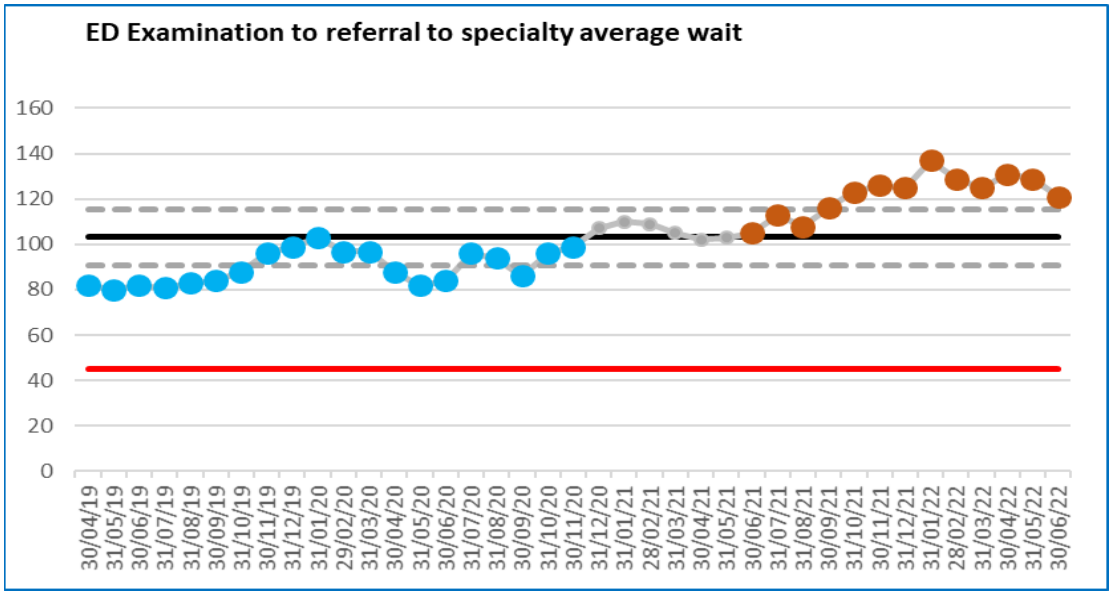
Jun-22
86 minutes
Variance Type
Special cause variation
Target
60 minutes
Target Achievement
Consistently failing target

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



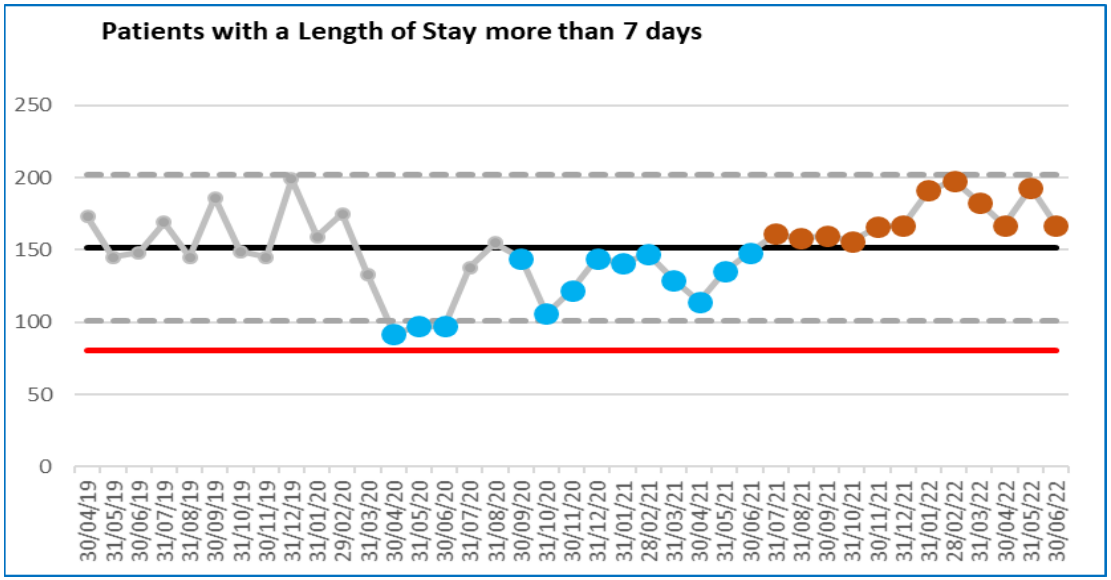
Jun-22
43 minutes
Variance Type
Special cause variation
Target
15 minutes
Target Achievement
Consistently failing target

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. Expansion to 4 RAT teams as staff vacancy has decreased and skill mix is improving	Close review through breach analysis at Urgent Care Board



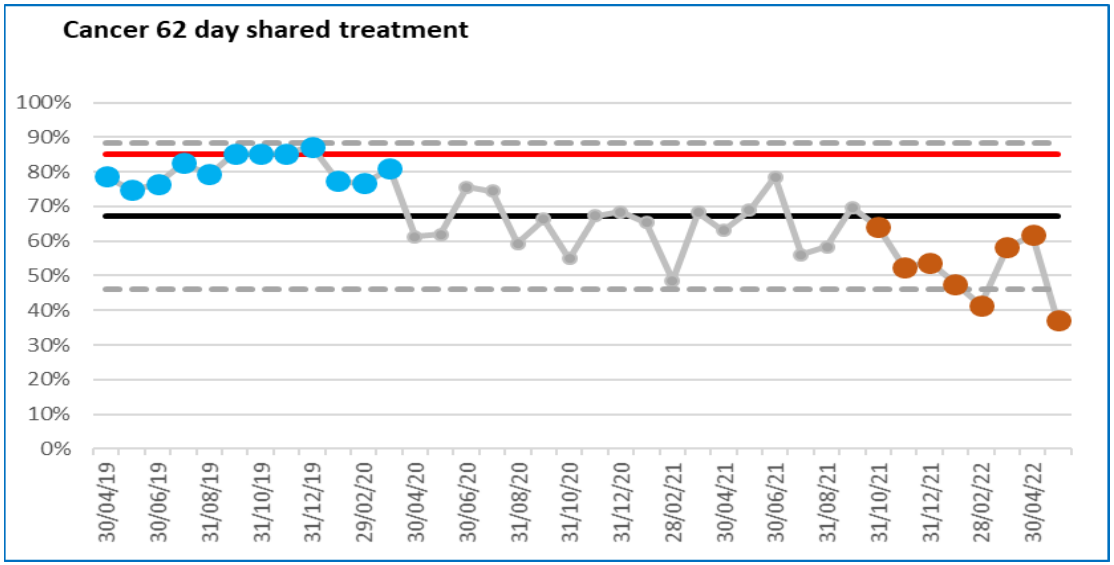
Jun-22
121 minutes
Variance Type
Special cause variation
Target
45 minutes
Target Achievement
Consistently failing target

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



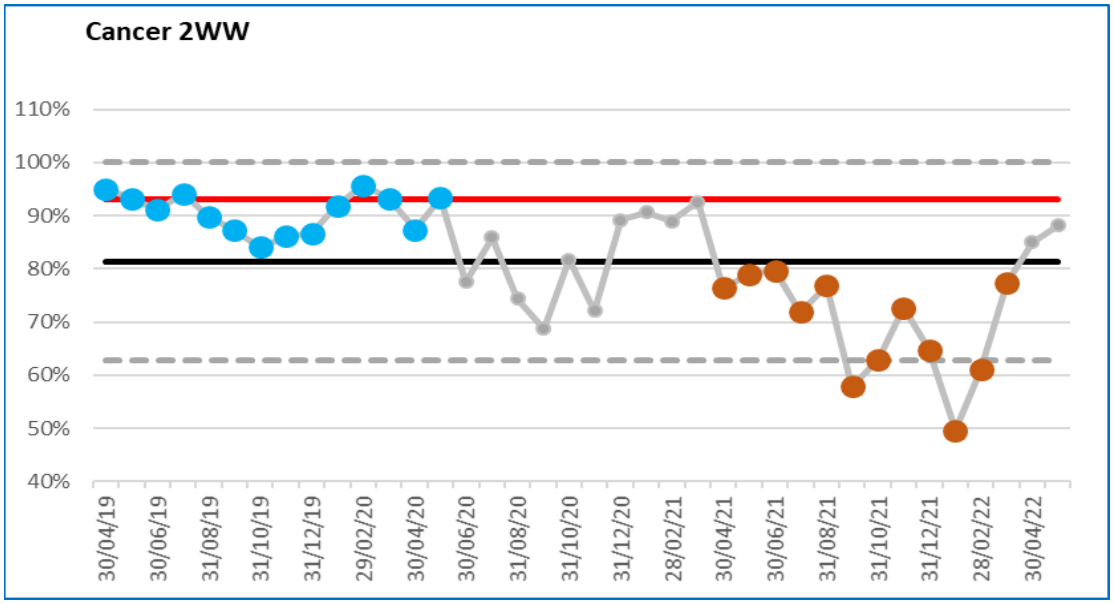
Jun-22
167
Variance Type
Special cause concerning variation
Target
80
Target Achievement
Consistently failing target

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	Daily patient panel review to understand discharge constraints. HIT Team review of patients appropriate for discharge extended across weekends. Close working with community bed providers & commissioners ensuring effective bed usage. National improvement programme continues and development of the "100 day challenge"	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.



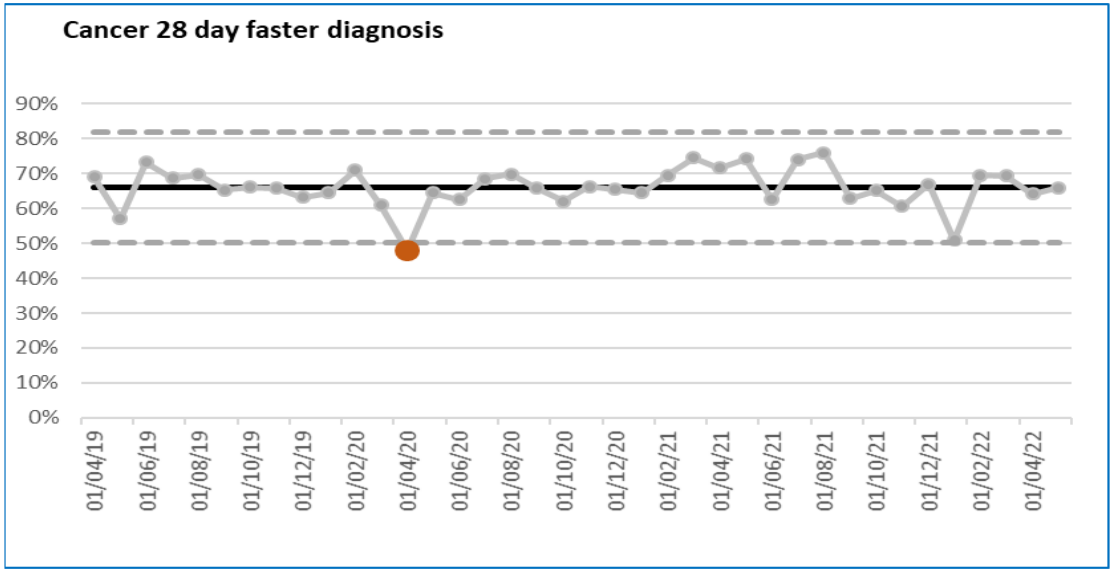
May-22
37.14%
Variance Type
Common cause variation
Target
85%
Target Achievement
Consistently failing target

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. The backlog of patients over 62 days continues to decrease and is close to the submitted trakectorry. Theatre capacity is due to ncrease in July & August which will enable more diagnostics and treatment capacity.	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.



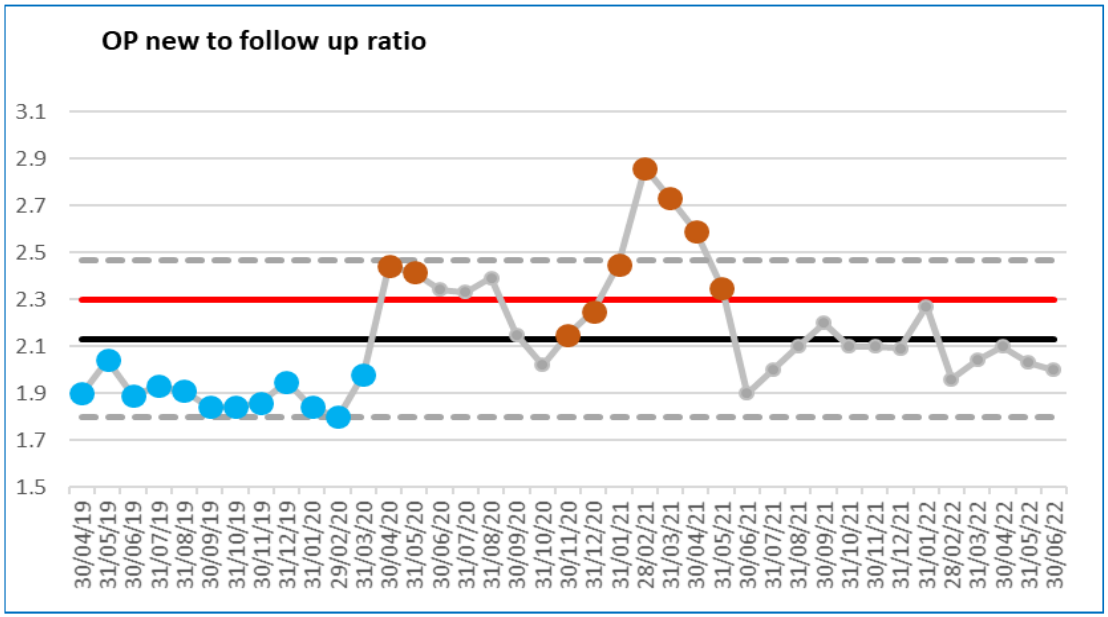
May-22
88.13%
Variance Type
Special cause concerning variation
Target
93%
Target Achievement
Inconsistently passing and falling short of target

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 restrictions due to staff absence and vacancies	5 of the 10 tumour sites achieved the national standard including breast & dermatology. Close review of capacity versus demand, escalation to services if mismatched. Straight to test in lower GI endoscopy booking improvements continuing. CQUIN actions for Lung and Urology will create improvements.	Close review of 28 day diagnosis standard for each tumour site failing 2ww. Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to Cancer Board & executive reporting.



May-22
65.94%
Variance Type
Common cause variation
Target
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 28 day faster diagnosis	Common cause variation and hitting and missing target radomly	The performance against the target has failed for over 12 months.	28 day Faster Diagnosis Improvement Manager delivering Frailty pathway, success with Lower GI triage process and improved data recording following clarification of CWT Guidance. Development of Lung, Upper GI and Prostate faster diagnosis pathways with the CQUIN work commencing.	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.



Jun-22
2.01
Variance Type
Common cause variation
Target
2.3
Target Achievement
Inconsistently passing and falling short of target

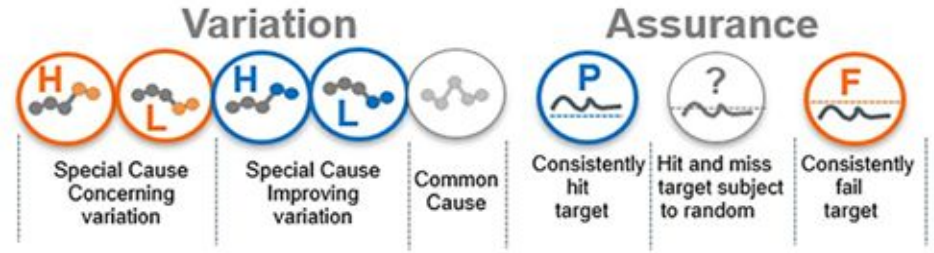
Background	What the chart tells us	Issues	Actions	Mitigation
OP new to follow up ratio	Common cause variation and inconsisrtently passing and falling short of the target	Additional insourcing to clear the overdue follow-up appointments is impacting the ratio.	Ongoing monitoring & increased volumes of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

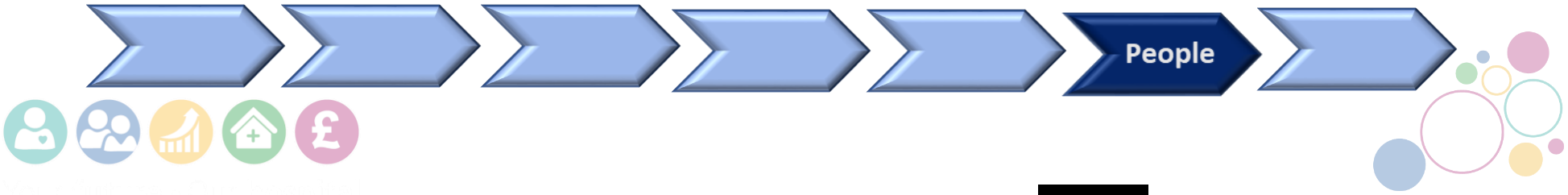
People

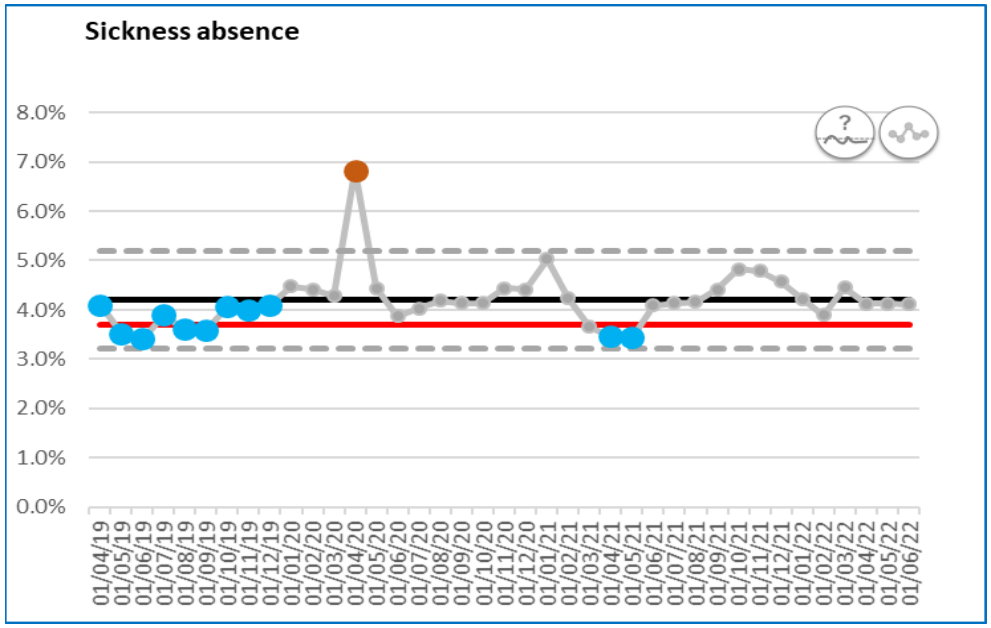
*We will support **our people** to deliver high quality care within a culture that continues to improve how we attract, recruit & retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.*

People Summary		Board Sub Committee: Worforce Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Sickness	Sickness absence rates across the trust remain static. There have been an increase in COVID related absences, other reasons continue to be linked to mental health and MSK. Advice and guidance around testing and isolation perods provided by O/H. Individual long term cases and actions discussed at management level	For information	Q2
Appraisal	Appraisal rates have fallen again this month. Work pressures have been cited as reasosns for this. Individualised reports sent to triumvirate and managers. Managers asked to book outstanding appraisals within the next month Compliance rates are addressed at PRMs	For information	Q2
Stat and Mand Training	Compliance remains static, challenges of protected time to complete training cited. There is a blended approach to training, delivered both via teams and face to face in the learning and education facility.	For information	Q2
Vacancy	Increase in vacancy rate is reflected by the overall establishment increase. Midwifery, Nursing and A&C hold the highest vacancy rates. Recruitment open days have been successful in recruiting HCSW, housekeepers and Midwives. 26 midwives were recruited in June and there is a recruitment pipeline for housekeepers and HCSW. The recruitment team have submitted a bid to	For information	Q3
Turnover	The trust voluntary turnover has been ibcreasing over the last 12 months. This is reflected across both EoE and the ICS. Leaving reasons are linked to health and wellbeing/ fatique, promorion and moving area for a better cost of living. There are a number of initialtives in place to address these. Continued promotion of the trusts health and wellbeing offer including sessions on burnout and sleep hygiene. The recruitment and L&OD team are organising an in house recruitment and development fair for August. PAHT are part of the retention pathfinder programme within the ICS	For information	Q3

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Appraisals - non medical	Jun 22	79.0%	90.0%	L	F	81.5%	76.5%	86.6%
Agency staffing spend	Jun 22	7.2%	15.0%	H	P	5.2%	2.4%	8.0%
Bank staffing spend	Jun 22	11.7%	15.0%		P	11.8%	9.4%	14.2%
Vacancy Rate	Jun 22	9.9%	8.0%		?	9.3%	7.8%	10.8%
Staff turnover - voluntary	Jun 22	17.3%	12.0%	H	?	12.0%	11.1%	12.9%
Sickness absence	Jun 22	4.1%	3.7%		?	4.2%	3.2%	5.2%
Statutory and Mandatory training	Jun 22	86.0%	90.0%	L	?	88.3%	85.8%	90.8%

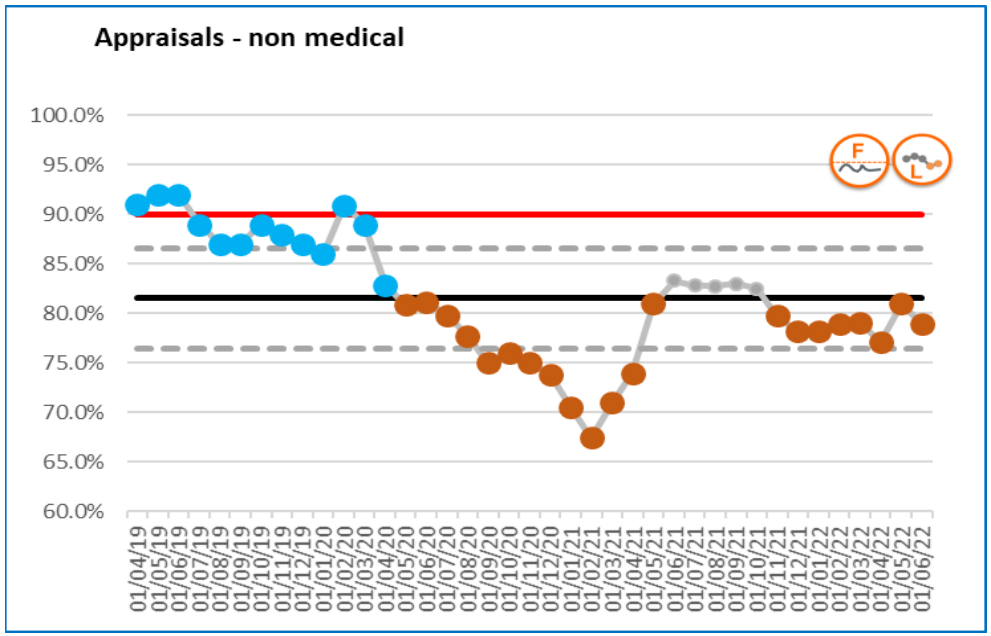






Jun-22
4.11%
Variance Type
Common cause variation
Target
4%
Target Achievement
Inconisistently passing & falling short of the target

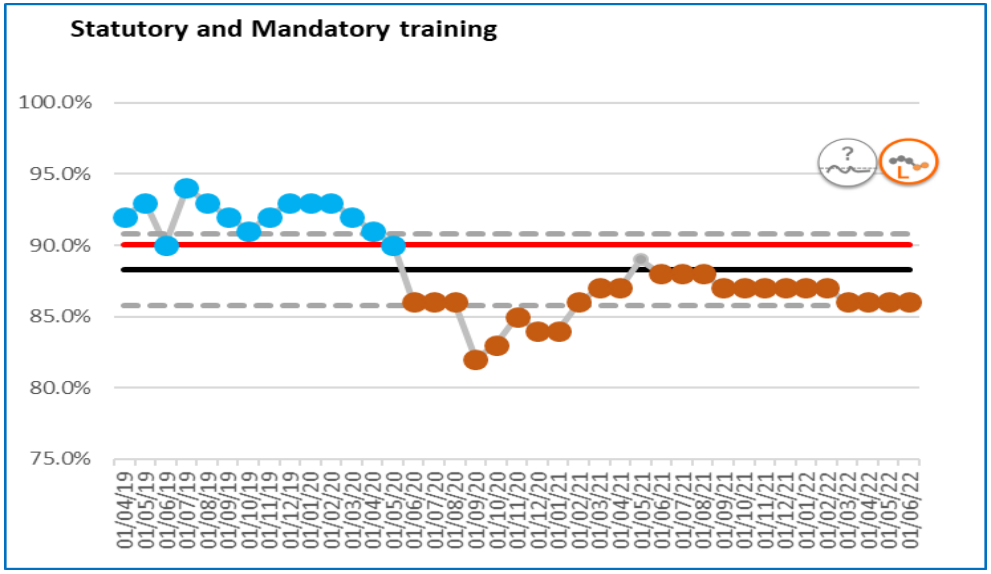
Background	What the chart tells us	Issues	Actions	Mitigation
Sickness absence	Variation indicates inconsistently passing & falling short of the target	Sickness absence rates across the trust remain static. There have been an increase in COVID related absences, other reasons continue to be linked to mental health and MSK	Advice and guidance around testing and isolation perods provided by O/H. Individual long term cases and actions discussed at management level	Absences reports submitted via the HRBP to managers for support and action



Jun-22
79.00%
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 fallen again this month. Work pressures have been cited as reasosns for this	Individualised reports sent to triumvirate and managers. Managers asked to book outstanding appraisals within the next month Compliance rates are addressed at PRMs PRMs	Compliance rates discussed at monthly divisional board meetings & performance review meetings with actions agreed. People information team able to support any challenges with MyESR

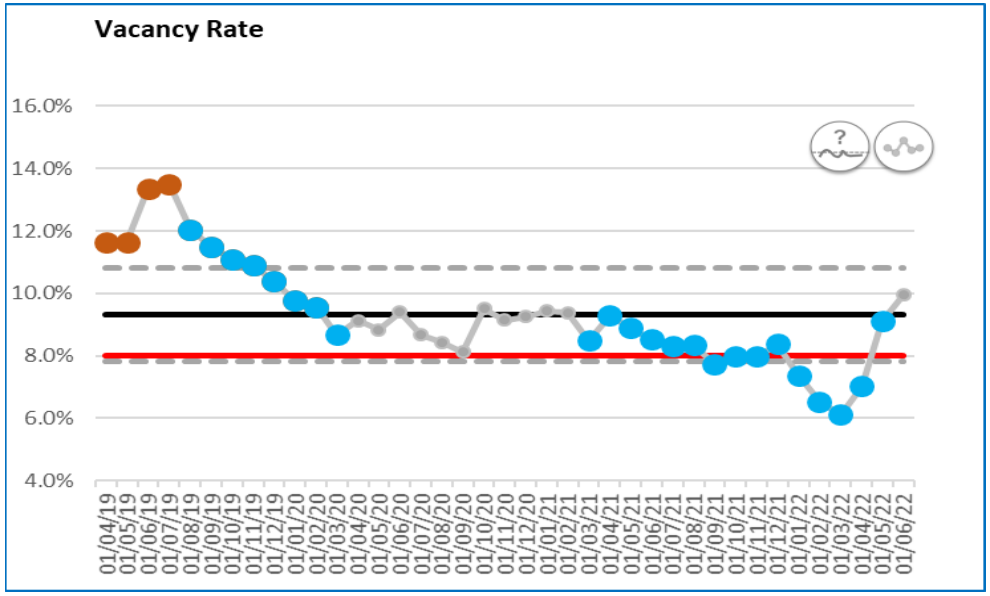
People



Jun-22
86%
Variance Type
Special cause variation
Target
90%
Target Achievement
Consistently failing target

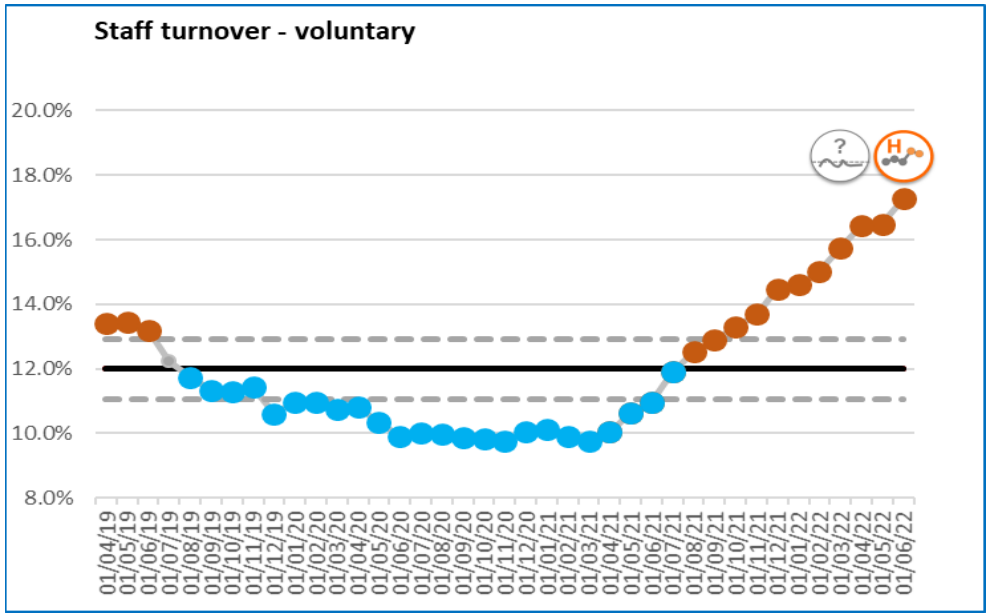
Background	What the chart tells us	Issues	Actions	Mitigation
Statutory and Mandatory Training	Special cause concerning variation & consistently failing target	Compliance remains static, challenges of protected time to complete training cited.	There is a blended approach to training, delivered both via teams and face to face in the learning and education facility.	Compliance rates are addressed at PRMs

People



May-22
9.94%
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	Increase in vacancy rate is reflected by the overall establishment increase. Midwifery, Nursing and A&C hold the highest vacancy rates	Recruitment open days have been successful in recruiting HCSW, housekeepers and Midwives. 26 midwives were recruited in June and there is a recruitment pipeline for housekeepers and HCSW. The recruitment team have submitted a bid to recruit internationally to radiographers and OTs	Vacancy rates are discused in monthly divisional meetings and PRMs



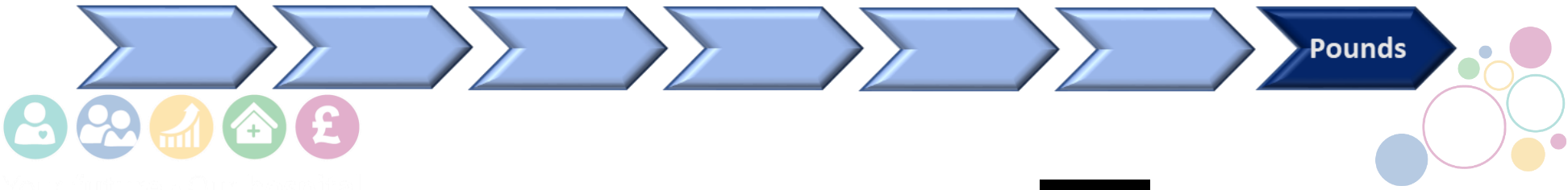
Jun-22
9.94%
L
Variance Type
Special cause variation
Target
12.00%
Target Achievement
Consistently failing
F

Background	What the chart tells us	Issues	Actions	Mitigation
Turnover Rate	Special cause Concerning variation & consistently failing target	The trust voluntary turnover has been ibcreasing over the last 12 months. This is reflected across both EoE and the ICS. Leaving reasons are linked to health and wellbeing/ fatique, promorion and moving area for a better cost of living	There are a number of initialtives in place to address these. Continued promotion of the trusts health and wellbeing offer including sessions on burnout and sleep hygiene. The recruitment and L&OD team are organising an in house recruitment and development fair for August. PAHT are part of the retention pathfinder programme within the ICS	Retention initiatives are discussed at recruitment and retention steering groups. Staff survey action plans in place for divisions

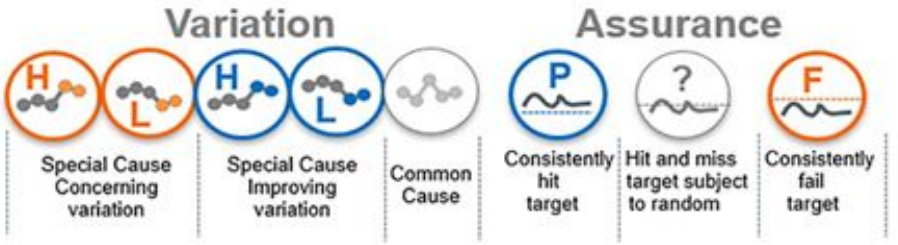
Pounds

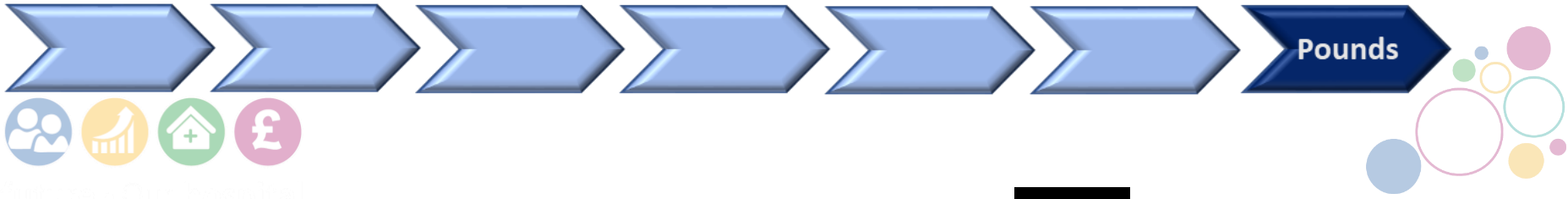
*We will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way*

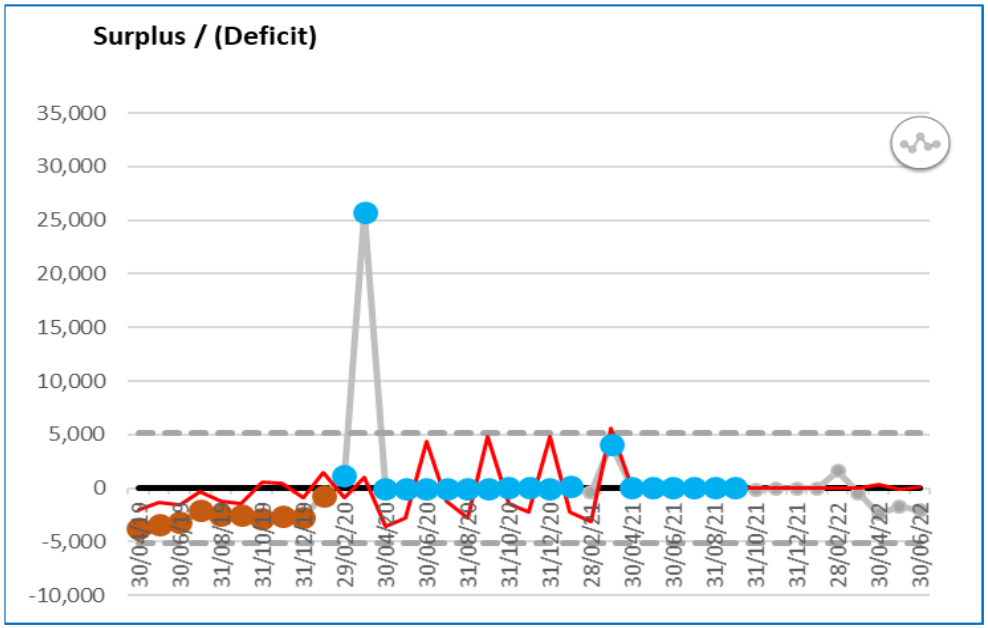
Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Surplus	The Trust reported a deficit of £2.1m in June (month 03) and a year to date deficit of £6.2m against planned surplus of £0.2m in month and £0.4m year to date. This was due to some prior year expenditures paid in month 01 and the effect of prior period contracts still in position. We are reviewing the Trust underlying position to identify major drivers of deficit and will be working with divisional leads to review our spend profile and identify any non-recurrent expenditure still in position.	For information	
CIP	The Trust CIP target for the year is £11.7m and planned delivery for month 03 is £1.0m (£2.9m year to date). Identified CIP are being assessed and delivery will be reported in month 4	For information	
Capital Spend	The Trust total revised CRL for 2022/23 is £15.2m. This includes element of the new hospital PDC of £1.1m. As at M3, year to date capital spend totals £2.6m which is £1.7m overspend against plan.	For information	
Cash	The Trust continues to have a healthy cash balance of £39.5m. There is a continued push to reduce aged payables & maintain the current 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)	Jun 22	-2116	0			-17	-5164	5131
EBITDA	Jun 22	-665	0			1157	-3972	6286
CIP	Jun 22	0	0			546	-512	1603
Income	Jun 22	27584	0			26477	16144	36811
Operating Expenditure	Jun 22	28249	0			26269	20030	32508
Bank Spend	Jun 22	2150	0			2055	1279	2830
Agency Spend	Jun 22	1325	0			908	336	1479
Capital Spend	Jun 22	-230	0			2451	-3674	8576



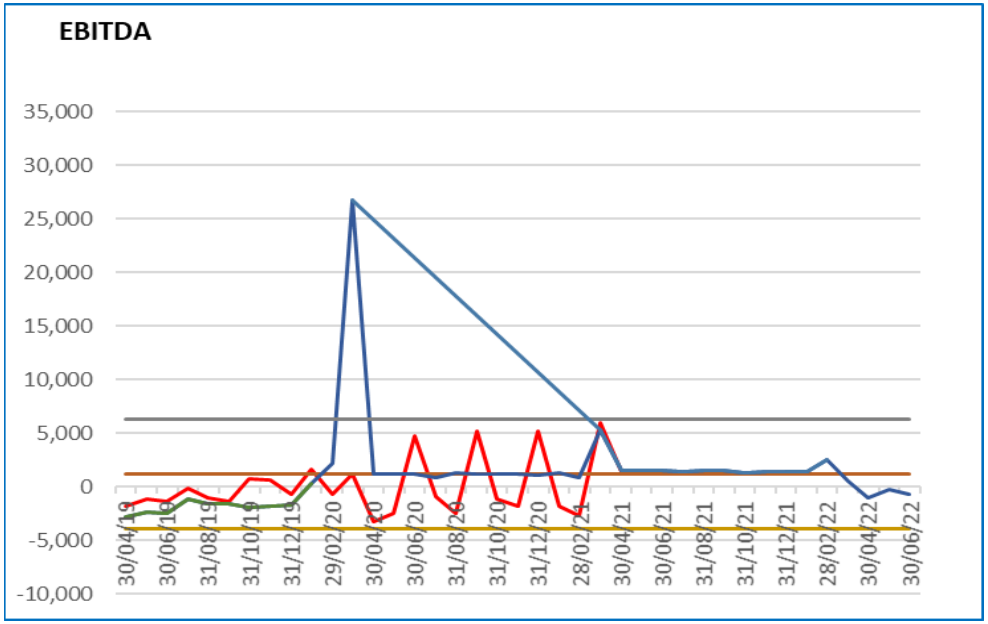




Jun-22
-2116
Variance Type
Special cause concerning variation
Target
0
Target Achievement
Consistently failing target

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

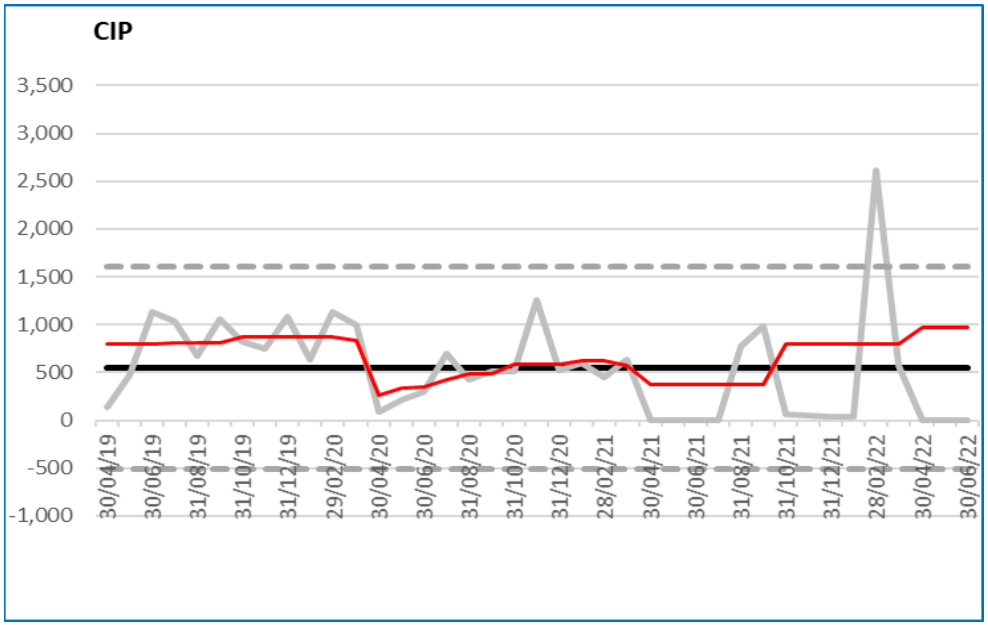
Pounds



Jun-22
-665
Variance Type
Special cause concerning variation
Target
1450
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			

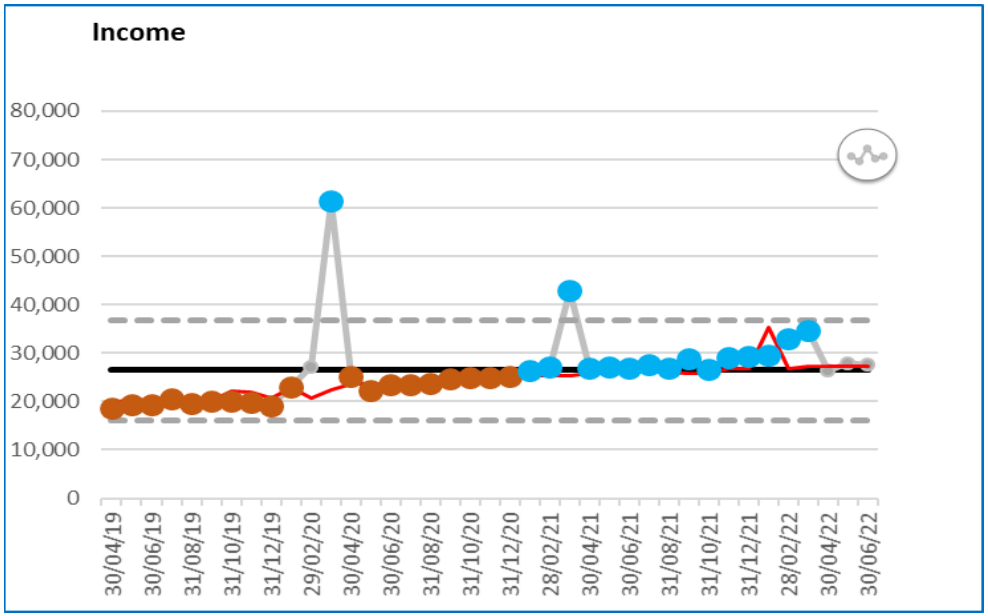
Pounds



Jun-22
0
Variance Type
Common cause variation
Target
801
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			

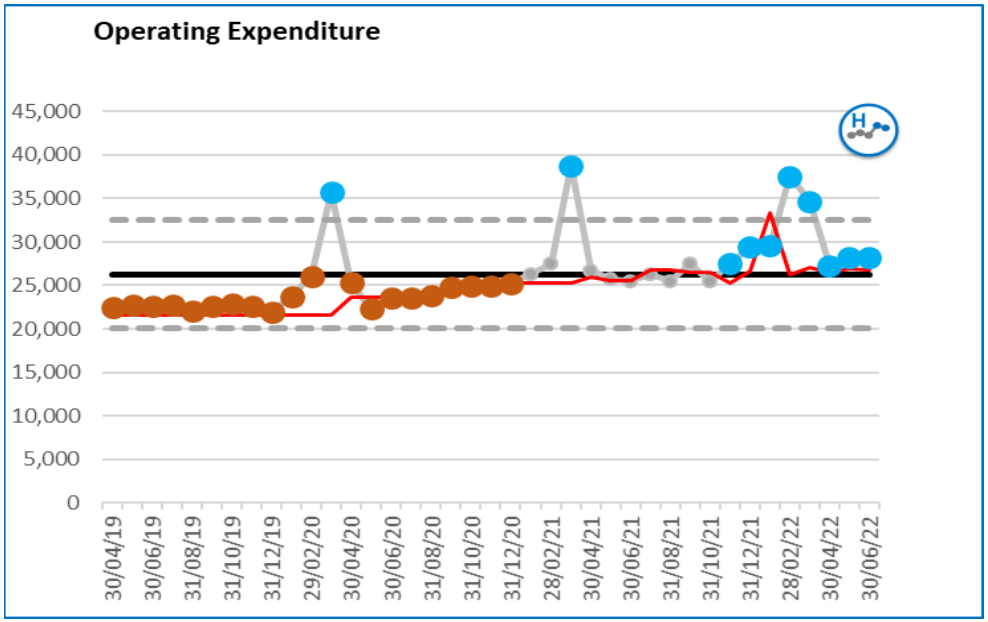
Pounds



Jun-22
27584
Variance Type
Special cause improving variation
Target
26684
Target Achievement

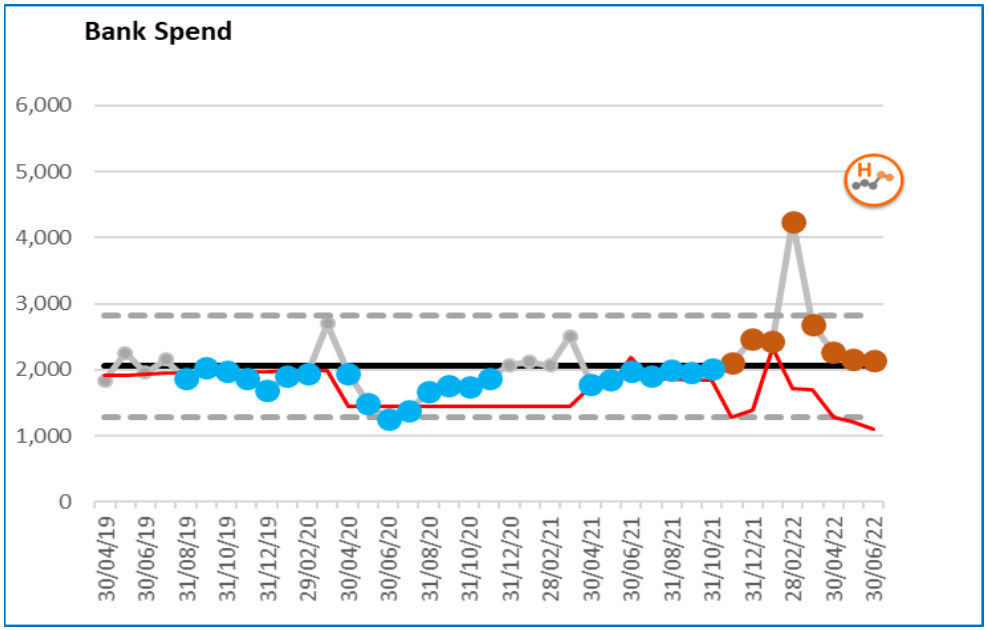
Background	What the chart tells us	Issues	Actions	Mitigation
Income	Special cause improving variation			

Pounds



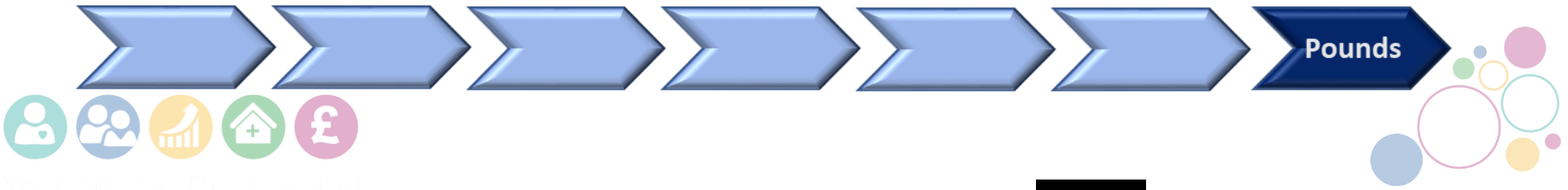
Jun-22
28249
Variance Type
Common cause variation
Target
26709
Target Achievement

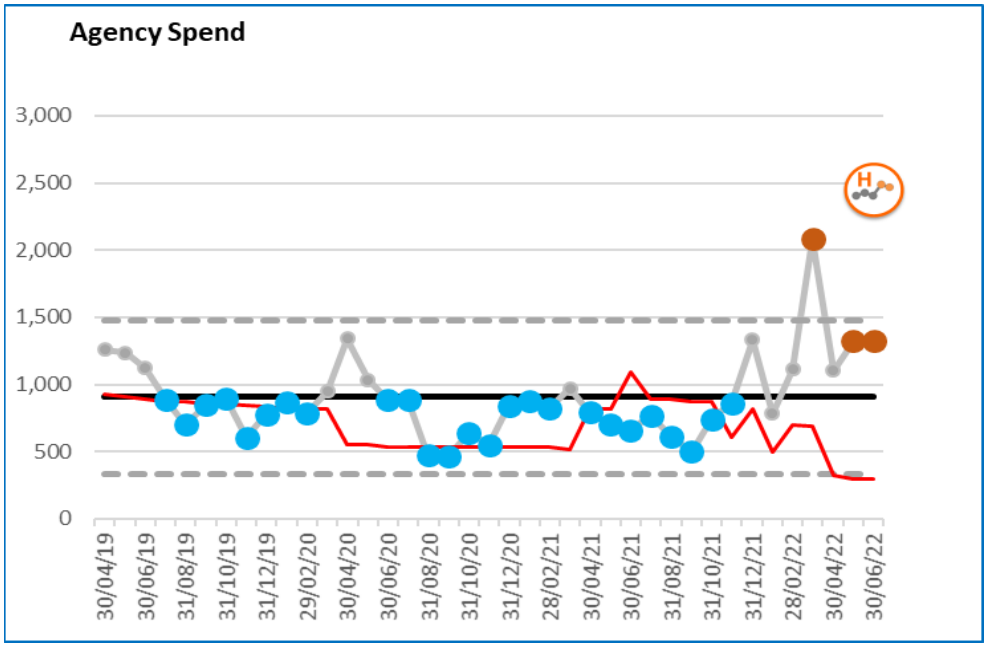
Background	What the chart tells us	Issues	Actions	Mitigation
Operating Expenditure	Common cause variation			



Jun-22
2150
Variance Type
Special cause variation
Target
1110
Target Achievement
Inconsistently passing and falling short of the target

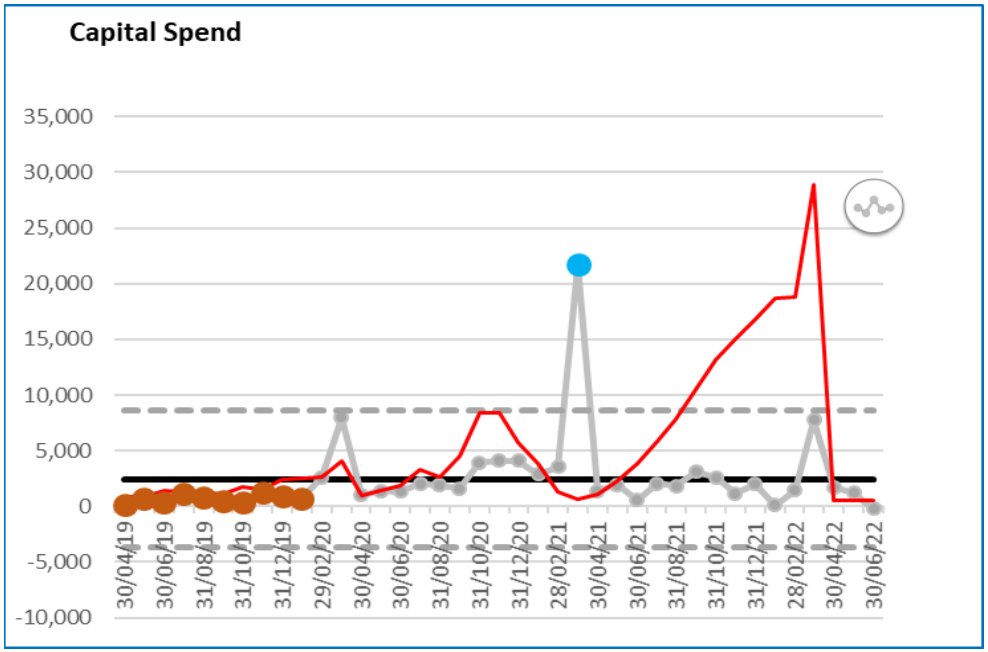
Background	What the chart tells us	Issues	Actions	Mitigation
Bank Spend	Common cause variation & inconsistently passing and falling short of the target			





Jun-22
1325
Variance Type
Common cause variation
Target
1107
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Agency Spend	Common cause variation & inconsistently passing and falling short of the target			



Jun-22
-230
Variance Type
Common cause variation
Target
18682
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			

Pounds

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**4 August 2022**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**	
REPORT FROM:	**Liz Baker – Acting Committee Chair**	
DATE OF COMMITTEE MEETING:	**25 July 2022**	

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 PAHT2030 Update	Y	Y	N	*Culture* and *Digital Health* continued to meet delivery targets. *Corporate Transformation* was being exception reported but was making some progress particularly in terms of GHX deployment. In terms of *Transforming our Care*, 90% of the clinical outcomes framework had been agreed.
2.2 System Transformation Update	Y	Y	N	The virtual hospital business case was on schedule and had been developed in conjunction with colleagues in the ICS. It was hoped it would be finalised by the end of July with mobilisation due around September. There was recognition of the workforce impact and that national reporting updates would be required.
2.3 Transformation Project Showcase: *Alertive*	Y	N	N	The rollout of this had been very successful and has removed the requirement for the use of social media platforms for communicating with colleagues. There were nearly 2500 registered users of the system and 481 of 537 bleeps have been retired. Rollout was already impacting positively in terms of time savings and also financially.
2.4 Clinical Transformation	Y	Y	N	28 clinical strategies are in development, 15 would be delivered this year and the rest by February 2023. The *Transforming our*

The Princess Alexandra Hospital NHS Trust

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Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				Care strategy primarily related to PAHT users but there is engagement across the broader Essex/Hertfordshire area and the Committee recognised the need for engagement outside the Trust. It was agreed the internal governance around the strategies would be considered further and the need for change was recognised internally and externally.
2.5 New Hospital Update	Y	Y	N	An update on the latest information received from the New Hospital Programme was noted and that a Communications & Engagement strategy is being developed which will launch over the Summer.
2.6 BAF Risk 3.5 (New Hospital)	Y	N	N	It was agreed the risk score would remain at 20.
2.7 EHR Update	Y	Y	N	Work was progressing well and the Board had agreed to the recommendation of the preferred provider. Contract negotiations would now start in earnest.
2.8 BAF Risk 1.2 (EHR)	Y	N	N	It was agreed the risk score would remain at 16.

The Princess Alexandra Hospital NHS Trust

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DATE OF COMMITTEE MEETING:	**25 July 2022**	

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.1 Strategic/System Update	Y	Y	N	The Committee noted that the ICB had gone live on 01.07.22 with some good initial stakeholder conversations. It had recognised the need to identify those areas of highest risk in terms of health inequalities, deprivation and those living with long-term health conditions which requires the development of a long-term plan with clear mitigating actions.
3.2 Report from West Essex Health Care Partnership	Y	Y	N	This provided an update/assurance that the local Healthcare Partnership is continuing to work together to build relationships and drill down into the data to identify next steps.
4.1 Community Diagnostic Centre (CDC) Business Case	Partial	Y	N	The need for the CDC was fully recognised and the business case had been developed in conjunction with the outgoing CCG – this is a good example of collaborative working with the ICS. The proposed phased approach was noted along with the key risks of affordability, workforce, cost control and future funding. The case would now go to PAF/Trust Board for sign-off.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 4th August 2022 **Item No: 7.2**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy – Chairman
DATE OF MEETINGS: **05.07.22 and 19.07.22**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at SMT meetings in May

5 July 2022:

- UEC Performance
- This is Us Week Update
- Recovery Dashboard
- Information Governance Update
- Theatre efficiency progress - Four Eyes
- Car Parking Changes

19 July 2022:

- Community Diagnostic Centre Business Case
- Aseptic Unit Business Case
- Nutritional strategy update
- UEC Performance
- Operational model for virtual hospital
- Quality Briefing
- Quality PMO report
- Nursing Midwifery & AHP Strategy
- ED NerveCentre Readiness
- Staff Survey Update
- Recovery Snapshot
- Significant Risk Register
- M3 2022/23 Financial Position

7.2