The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 5 October 2023 at 09.30 – 12.30
Venue: Kao Park Boardroom

	Item	Subject	Action	Lead	
01 Opening administration					
09.30	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	4
	1.4	Matters arising and action log	Review	All	6
09.35	**Patient Story: Disabilities and our Electronic Health Record**				
02 Chair and Chief Executive's reports					
10.00	2.1	Chair's report	Inform	Chair	8
10.05	2.2	CEO report	Inform	Chief executive	12
03 Risk					
10.20	3.1	Corporate risk register	Review	Medical Director	81
10.30	3.2	Board assurance framework 2023-24 *Diligent Resources: BAF 2023/24*	Review/ Approve	Head of corporate affairs	87
04 Patients					
10.35	4.1	Report from Quality and Safety Committee 29.09.23: • Part I • Part II – Maternity Oversight	Assure	Committee Chairs	91 99
10.45	4.2	Maternity: • SI report • Maternity Incentive Scheme	Assure	Chief nurse/ Director of midwifery	101 106
11.00	BREAK 11.00 -11.10				
11.10	4.3	Nursing, midwifery and care staff levels including nurse recruitment	Assure	Chief nurse	112
11.20	4.4	Learning from deaths (Mortality)	Assure	Medical Director	118
11.30	4.5	Electronic Health Record	Assure	Chief Information Officer	126
05 People					
11.35	5.1	Report from People Committee 25.09.23	Assure	Committee Chair	129
	5.2	Equality, Diversity and Inclusion Strategy	Approve	Director of People	132

	5.3	Workforce Race Equality Standards	Approve	Director of People	160
	5.4	Workforce Disability Equality Standards	Approve	Director of People	167
	5.5	Annual Medical Revalidation report and Statement of Compliance	Approve	Medical Director	176
	5.6	Fit and Proper Persons: revised framework 2023/24 *Diligent Resources: FPPT Framework Implementation*	Discuss	Director of People	205
06 Performance/pounds					
	6.1	Report from Performance and Finance Committee 28.09.23	Assure	Chair of Committee	219
	6.2	Finance update	Assure	Director of Finance	228
	6.3	Integrated performance report	Discuss	Chief Information Officer	238
	6.4	Self certification: Protecting & Expanding Elective Care Capacity	Approve	Chief Operating Officer	256
07 Strategy/Governance					
	7.1	Report from Strategic Transformation Committee 25.09.23	Assure	Chair of Committee	267
	7.2	Report from Audit Committee 11.09.23 and Terms of Reference	Assure/ Approve	Chair of Committee	272 274
	7.3	Report from Senior Management Team Meetings held in September 2023	Assure	Chair of Committee	281
	7.4	Corporate Trustee: Report from CFC.15.09.23	Assure	Chair of Committee	282
	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	Any unresolved issues			
	9.2	Review of Board Charter			
	9.3	Summary of actions and decisions	-	Chair/All	
	9.4	New risks and issues Identified	Discuss	All	
	9.5	Any other business	Review	All	
	9.6	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	
12.30		Close			

Date of next meeting: 7 December 2023

The Princess Alexandra Hospital NHS Trust

Purpose:
The purpose of the Trust Board is to govern the organisation effectively and in doing so to build public and stakeholder confidence that their health and healthcare is in safe hands and ensure that the Trust is providing safe, high quality, patient-centred care. It determines strategy and monitors performance of the Trust, ensuring it meets its statutory obligations and provides the best possible service to patients, within the resources available.
Quoracy:
One third of voting members, to include at least one Executive and one Non-Executive (excluding the Chair). Each member shall have one vote and in the event of votes being equal, the Chairman shall have the casting vote.

Board Membership and Attendance 2023/24			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chair	Hattie Llewelyn-Davies	Chief Executive	Lance McCarthy
Non-executive director (SID)	George Wood	Chief Nurse	Sharon McNally
Non-executive director	Colin McCready	Chief Operating Officer	Stephanie Lawton
Non-executive director	Helen Howe	Medical Director	Fay Gilder
Non-executive director	Darshana Bawa	Director of Finance	Tom Burton
No-executive director	Kim Handel		
Associate Non-executive director	Oge Austin-Chukwu	**Executive Members of the Board (non-voting)**	
Associate Non-executive director	Anne Wafula-Strike	Director of Strategy	Michael Meredith
Associate Non-executive director	Dr. Rob Gerlis	Director of People	Gech Emeadi
Associate Non-executive director	Elizabeth Baker	Director of Quality Improvement	Jim McLeish
		Chief Information Officer	Phil Holland
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public at Kao Park
Thursday 14 September 2023 from 09:30 to 09:40

Present:

Hattie Llewelyn-Davis	**Trust Chair (TC)**
Oge Austin-Chuku	Associate Non-Executive Director (ANED-OA)
Liz Baker (non-voting)	Associate Non-Executive Director (ANED-LB)
Darshana Bawa	Non-Executive Director (NED-DB)
Tom Burton	Director of Finance (DoF)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Rob Gerlis (non-voting)	Associate Non-Executive Director (ANED-RG)
Fay Gilder	Medical Director (MD)
Phil Holland	Chief Information Officer (CIO)
Helen Howe	Non-Executive Director (NED-HH)
Stephanie Lawton	Chief Operating Officer (COO)
Lance McCarthy	Chief Executive Officer (CEO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Chief Nurse (CN)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)

In attendance:
(not applicable)

Observing:
(not applicable)

Members of the Public
(not applicable)

Apologies:

Colin McCready	Non-Executive Director (NED-CM)
Heather Schultz	Head of Corporate Affairs (HoCA)

Secretariat:

Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The TC welcomed members, particularly new Associate Non-Executive Director Oge Austin-Chuku (ANED-OA), to the meeting.
1.1 Apologies	
1.2	These were noted as above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
02 Annual Report & Accounts	
2.1 Annual Report & Accounts	
2.1	This item was presented by the Director of Finance (DoF). He reminded colleagues that the draft accounts had been presented to the Audit Committee and Board on 20.06.23 but some remaining audit work had still required completion at that time (although it had been agreed that was unlikely to identify anything that would materially affect the accounts).

2.2	The report presented that day set out the final annual report and annual accounts for 2022/23 for formal Board approval. In addition to the annual report and accounts themselves, also included were: • The Letter of Representation from the Auditors (KPMG) • The ISA260 Report No material issues had been identified and the Trust's Annual Accounts remained unqualified.
2.3	The DoF continued that during the audit work a couple of areas had been identified for potential control weakness and for improvement going forward. The first was to do with the new financial accounting standard (IFRS 16) and how leases were accounted for
2.4	The TC thanked the DoF for his update and members noted the 'lesson learned' for the future.
2.5	The DoF highlighted the value for money (vfm) assessment. The auditors needed to ascertain whether the Trust had demonstrated vfm in the previous year – this was an NHS mandate. There were a number of subjective ways in which to look at this but the main one supporting the unfavourable opinion was the organisation's current deficit. There would now be a number of mitigations for that, for example, how the PQP programme was now operated (this had not been in place in the previous year). There were ongoing conversations therefore at system level about whether that ruling was entirely fair on the Trust, given the current contract arrangements.
2.6	In line with the recommendation the Board formally approved the Annual Report & Accounts and Letter of Representation and noted the ISA 260 report.
03 CLOSING ADMINISTRATION	
3.1 Any Unresolved Issues?	
3.1	There were no unresolved issues.
3.2 Review of Board Charter	
3.2	It was agreed behaviours had been in line with the Charter.
3.3 Summary of Actions and Decisions	
3.3	These are noted above.
3.4 New Issues/Risks	
3.4	No new issues or risks were noted.
3.5 Any Other Business (AOB)	
3.5	There were no items of AOB.
3.6 Reflections on Meeting	
3.6	Not undertaken.
	The meeting closed at 09:39

Signed as a correct record of the meeting:	
Date:	05.10.23
Signature:	
Name:	Hattie Llewelyn-Davies
Title:	Trust Chair

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In attendance:
(not applicable)

Observing:
(not applicable)

Members of the Public
(not applicable)

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Date:	05.10.23
Signature:	
Name:	Hattie Llewelyn-Davies
Title:	Trust Chair

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors – 5 October 2023

Agenda item:	2.1
Presented by:	Hattie Llewelyn-Davies
Prepared by:	Hattie Llewelyn-Davies
Date prepared:	27th September 2023
Subject / title:	Chair's Report

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

Key issues:	To inform the Board about my work; to increase knowledge of the role; to evidence accountability for what I do.
Recommendation:	The Board is asked to note the report.

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

Previously considered by:	Not applicable.
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	As the NED EDI Champion this continues to guide my work in all the areas noted below. Specific reference is made to disability in this report.
Appendices:	None

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patient at heart • everyday excellence • creative collaboration

1.0 Purpose/issue

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

2.0 Succession Planning and Board Development:

I am delighted to welcome Oge Austin-Chukwu to the board as our new associate Non-Executive Director. Oge brings a wealth of knowledge of the NHS, coaching and the voluntary sector to PAHT. She is also a GP working in the patch.

3.0 External Work:

I continue to work with the NHSE scheme mentoring new chairs and am now mentoring two chairs, one in our region, who chairs a very large teaching trust and one who chairs two trusts outside our region. I continue to find this work interesting and valuable and I hope the new chairs also find it helpful.

The Head of Corporate Affairs and I attended the NHS Providers Annual Governance conference together and I chaired one of the sessions on the development of good governance for Place based initiatives. As always it was good to learn from the experience of others and to know what issues we all find hard at the moment.

At an ICB level the chairs have agreed to meet each month to enable us to support the Exec teams more effectively in achieving the new ways of work together for the benefit of our local population. I am sitting on the panel to recruit a new board member for the ICB.

I have been chairing the Independent Remuneration Panel for Harlow Council over the last few months, which makes proposals for the allowances that Councillors receive for their work. It has been really interesting to work closely with Members and their officers on this.

Anne Wafula Strike and I are both members of the NHS Disabled Directors Network, which was set up to promote more people with disabilities to be appointed at board level but also to support them once appointed. I have developed a mentoring programme for new directors as part of this work, which has involved training ten new mentors to provide the service. I am currently developing a training programme for aspiring chairs with disabilities. The Group is very well supported by NHSE.

4.0 Internal Governance:

I was proud to attend our Annual General Meeting in July. It was great to see so many of our people come along, especially since we held it at Kao Park and it attracted a different audience than it would have done on the PAHT site.

I continue to attend the meetings of the Patient Panel at their invitation and was delighted to hear that Ann Nutt, the Panel chair, gave an inspirational presentation recently to the ICB.

4.0 Staff Welfare and Resilience:

The NEDs continue to do regular visits to our services, both as individuals and teams. Attached is the action list that has arisen from our regular visits.

5.0 Finally:

On behalf of the Board, I would like to thank all our colleagues for the way everyone has worked hard to ensure that our patients are kept safe during the Industrial Action. The Trust supports each one of our people and their individual decisions, but we also value the enormous efforts everyone takes to provide safe services.

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

Author: Hattie Llewelyn-Davies. Trust Chair.
Date: 30th March 2023

Chair's action matrix. version 3.5

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

Updated: September 23

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

Visit Date	Attendees	Venue	Feedback	Lead	Deadline	Action
07/09/2023	CM	Herts Essex	Environment good. Positive staff experience. Patient experience of OPD cancellations noted.	CSS	NA	No follow up required as actions in train.
05/07/2023	KM, DB	Aseptic Unit	TB not aware of trials run by Aseptic Unit team – refer comms.	CSS	NA	ADPE to refer to communications. Completed.
06/06/2023	HLD, AN, KH	Gibberd OPD	Blue Badge parking limited. External appearance.	CSS	NA	Parking issue escalated to EFM and picked up in scheduled works.
17/05/2023	HLD, HH, DB	Dementia environments	Identification of dementia friendly environments as an issue	Corporate	06/23	CAG to share actions from the visit following next PLACE visits.
04/04/2023	HH, DB	Sterile services	Joined staff morning huddle, positive staff and morale, space an issue. Innovation supported.	SCC	NA	No action identified. Positive feedback and data being shared by sterile services team.
27/03/2023	GW, HG	St Margaret's Hospital	OPD and Birchwood House staff met, positive staff engagement. Estates issues noted.	CSS	05/23	Aging NHS PropCo Estate noted and escalated to internal teams for review. Open.
08/02/2023	HLD, HG, AN, PP, FtSUG	OPAL Unit	Exemplary system working practice. Staff and patient voices heard and acknowledged.	Medicine	NA	No actions identified other than positive feedback which has been provided to the teams. Closed.

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Private) – 5 October 2023

Agenda item:	2.2							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	28 September 2023							
Subject / title:	CEO Update							
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	X
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report updates the Board on key issues since the last public meeting: - Lucy Letby trial verdict - Pay awards and industrial action - New Hospital Programme update - Alex Health Implementation - Other key headlines							
Recommendation:	The Trust Board is asked to note the CEO report generally and specifically to: – reflect on the Private Board discussion on 14 September in relation to the Lucy Letby trial verdict – acknowledge the correspondence from the national NHSE team – note the latest pay award and industrial action positions and the impact of industrial action on our colleagues, our patients and our finances – note progress with the development of the new hospital programme and PAHT 2030 priority and the recent visit by Lord Markham – note progress with the implementation of Alex Health and the digital health priority of PAHT 2030 – note the other key headlines							

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

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Risk / links with the BAF:	CEO report links with all the BAF risks
Legislation, regulatory, equality, diversity and dignity implications:	– Regulatory – Board requirement to assure itself of suitable practices and processes and approaches in place to make it easy to raise concerns – Regulatory – compliance with the latest FPPT Framework and PSIRF – Regulatory – Board requirement to assure itself of suitable practices and processes in place to minimise the risk to patient safety of IA ---------- – EDI – ensuring all colleagues, patients and visitors are aware of and feel equally able to raise concerns – EDI – impact of the previous and future rounds of industrial action of our doctors in training and consultant on our patients and the potential for a disproportionate impact on some of our patients – EDI – ongoing need to ensure that our recovery plans and our PQP plans are quality and equality impact assessed to prevent any unintended consequences or unequal impact on colleagues or patients – EDI – all the developments to our culture are underpinned by a proactive recognition of the need to ensure and to support EDI for all, in particular with this report in relation to access to and feeling able to openly complete the staff survey and access to COVID-19 and 'flu vaccinations
Appendices:	(1) Private Board paper (14 September) re: Lucy Letby verdict (2) Fit and Proper Person Test Framework for Board Members, 3 August 2023 (3) NHSE letter to providers in light of the Lucy Letby trial verdict, 18 August 2023

Chief Executive's Report
Trust Board: Part I – 5 October 2023

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

(1) Lucy Letby verdict / initial learning from the Countess of Cheshire Hospital case

On 21 August 2023, Lucy Letby was sentenced to life imprisonment with a whole life order at Manchester Crown Court for the very sad and shocking murder of 7 babies and attempted murder of 6 other babies in a neonatal unit at the Countess of Cheshire Hospital.

At our Private Board meeting on 14 September, we discussed a paper providing the Board with an overview of the verdict, the governance and risk management developments that have occurred nationally and locally since the deaths (June 2015 to June 2016), and the proposed approach to be taken considering the trial and verdict, in advance of the outcome of an independent inquiry. I have attached that paper as Appendix 1 for information.

As discussed, we continue to review all outstanding grievances and serious incidents to determine whether any warrant a change in direction to resolve them, through a different approach or speedier resolution, and through the next cycle of Performance Review Meetings from w/b 2 October, we will have open conversations about any worry areas or concerns that we collectively feel need to be addressed or reviewed differently in light of some of the context from the Letby trail (related to timely management and having the right difficult conversations at the right time).

As Board members we need to consider how we continue to use and enhance the Integrated Performance Report to triangulate data, to identify potential areas for concern or provide assurance of not being of concern. We should also continue to challenge ourselves and our behaviour to ensure we are creating the right environments for the right discussions and how we are enabling an organisational wide culture of openness.

The Board is asked to:

- ***reflect on the Private Board discussion on 14 September***
- ***acknowledge the correspondence from the national NHSE team***

(2) Pay Awards and Industrial Action

As Board members will be aware, all unions with healthcare workers as members, balloted their members at different times over the last 7 months over industrial action as part of their ongoing disputes with the government over remuneration and pay awards for NHS colleagues.

The government has accepted the recommendations of the different independent pay review bodies for all NHS colleagues:

- For Agenda for Change colleagues, agreements on 2022/23 backdated one-off payments (6% increase in salary) and 2023/24 pay rises (5% increase backdated to 1 April 2023) have been agreed between the government and unions. All colleagues have received their relevant pay increases.
- For Senior Managers, an announcement has been made by the SoS for DHSC of a 5% increase, backdated to 1 April 2023. We are still awaiting the formal letter confirming this before payments will be made.

- For medical colleagues, payments backdated to 1 April 2023 will be made in September salaries. First year doctors in training will receive a 10.3% increase; consultants will receive 6%; other doctors in training will receive different increases, dependent on their grade, between 6% and 10.3%.

The doctors' unions remain in dispute with the government about pay for doctors in training and for consultants. We have now had 7 sets of industrial action for doctors in training and 3 sets for consultants, covering 27 days between them, one of which was a combined day. By the time the Board meets we will also have managed a further 3 days of combined strike action on 2, 3 and 4 October.

Significant planning and preparation goes in to organising and coordinating every set of industrial action from many colleagues, reducing our operational effectiveness for days both before and after the actual strike days. During this time, we manage the hospital through an internal incident process with a formal cell structure in place; the incident management team cell looks at operational matters including appropriate staffing levels; the people cell has the remit to look at staff health and wellbeing support; the clinical cell oversees clinical decision making and patient safety and all report in to the strategic cell. All staff are reminded of the existing health and wellbeing support including the Here for you service, employee assistance programme, mental health first aiders and freedom to speak up guardians. During strike days executive team and senior managers visit areas to check on the welfare of colleagues; there is a daily communication to all colleagues thanking those who have covered services during the period and a reminder to look out for each other and take regular breaks. The message also highlights the additional operational and staff support in place. There is a dedicated industrial action workspace on our intranet (AlexNet) which covers everything related to industrial action.

We have not seen an increase in clinical incidents or patient safety concerns on strike days and have maintained and managed urgent and emergency care flow well over these dates. Thank you to all colleagues who have ensured that our patients have remained safe. We have cancelled large numbers of planned procedures and appointments over these dates, which is having an impact on the health and wellbeing of our patients, is preventing us from achieving our elective recovery plans, and putting our diagnostic, cancer and outpatient services under considerable strain. More information on our current performance against plan can be seen in our Integrated Performance Report.

We have seen a significant increase in anxiety, concern and frustration from our patients as a result of the industrial action with increasing number of complaints, PALS enquiries and reports from colleagues of poor behaviour towards them. I'd like to use this opportunity to thank all colleagues involved in the planning and coordination of strike action, or for undertaking different clinical roles to support rotas and maintain safe patient services, or for managing patient appointment changes and providing support and reassurance to patients who have felt the impact of industrial action.

The total additional cost to PAHT of industrial action up to the end of September, including the loss of income through reduced activity, is more than £3m.

The Board is asked to note the latest pay award and industrial action positions and the impact of industrial action on our colleagues, our patients and our finances.

(3) New Hospital Programme Update

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

Our Programme team are pushing ahead with our plans to purchase the land for the new hospital, continuing negotiations with the landowners and undertaking our detailed site surveys. We are awaiting

more specific detail on timeframes from the national NHP and are looking forward to working with them and key local stakeholders to implement 'hospital 2.0' (a vision for how hospital builds can be delivered with greater standardisation, efficiency and cost).

Lord Nick Markham CBE, Parliamentary Under Secretary of State at the DHSC and Minister for the Lords responsible for the NHP, visited us on 21 September. It was a good opportunity for us to further explain the problems and difficulties working in our current estate and the impact that the estate has on our colleagues' and our patients' experiences.

More information on NHP, 'hospital 2.0' and the next steps, can be found on our new hospital website, www.newpah.org with a summary article at From six to 40 by 2030 - The New Princess Alexandra Hospital (newpah.org).

The new hospital is a fundamental part of, and one of our 5 key priorities to deliver our strategy, PAHT 2030, and our vision of being Modern, Integrated and Outstanding. Together with the implementation of our Electronic Health Record, the digital and cultural transformations across the Trust and the improvements in care and quality improvement initiatives in place, we are making strong progress to achieving our vision.

The Board is asked to note progress with the development of the new hospital programme and PAHT 2030 priority and the recent visit by Lord Markham.

(4) Alex Health Implementation

We launched our Alex Health programme on 18 July. Working in partnership with Oracle Health colleagues our new electronic health record, Cerner Millenium, is due to go live in October 2024.

It is one the biggest transformation programmes that PAHT has ever seen and is core to the delivery of our digital strategy and the digital health priority that is part of PAHT 2030. We are currently in the design and build phase, due to be completed by January 2024.

More on the progress with the Alex Health implementation is later on the agenda.

The Board is asked to note progress with the implementation of Alex Health and the digital health priority of PAHT 2030.

(5) Other key headlines / developments for noting

Other key items of note for the Trust Board include:

Month 5 I&E position

More information on our financial income and expenditure position is provided later on the agenda. As a headline, at the end of month 5, we are adrift from our planned deficit plan by approximately £6m, due predominately to costs of industrial action, premium cover payments for medical staff, excess inflation costs not funded and lower levels of income than expected.

We continue to drive our Patient, Quality and Productivity (PQP) plans hard to support and underpin our drive towards PAHT 2030, the operating plan for 2023/24 and our financial efficiency requirements. Further PQP schemes are being developed with the clinical and corporate divisions to close this gap. These have been and will continue to be discussed in detail in the Performance and Finance Committee

Staff survey

The latest national staff survey opened to all colleagues on Monday 2 October. It is open for 8 weeks.

The People and OD team have developed a communications and engagement plan to encourage as many colleagues as possible to complete the survey and highlight what is working well for them as well as areas that could improve their experiences at work. Local teams will also be working with colleagues as part of the ongoing Feedback to Action work and local actions in response to last year's survey, recognising that the experiences of colleagues is variable, dependent on where in the organisation they work.

Vaccinations

Our annual 'flu vaccination programme started on 25 September for all colleagues. Vaccinations are available through regular walk-in clinics and roaming clinics.

The latest COVID vaccination programme is planned to start shortly. We are awaiting confirmation of the date of receipt of our COVID vaccinations, which we are expecting to be within the next two weeks. Planned joint COVID and 'flu vaccinations have been planned for the end of October and start of November.

The number of patients that we are caring for who are COVID-19 positive are increasing. Numbers have been increasing slowly over the last 3 months. We are currently caring for approximately 9-11 inpatients daily who are COVID-19 positive, rather than treating them for COVID-19.

Health and Care Partnership (HCP) Development

We have been working as a partnership of health and care and other organisations across West Essex for a number of years, focussed on improving the health and care provided to local residents.

As part of the creation of Integrated Care Systems (ICSs) and the subsequent formal creation of Integrated Care Boards (ICBs) as statutory organisations from 1 July 2022; there was a national expectation of the development of place-based partnerships within ICSs, focussing on the specific needs of the defined population. Within the Hertfordshire and West Essex ICS (HWE ICS) there has been a recent recognition of the benefits of working at place-based level for the benefit of the local population and a drive to support this effectively. This includes developing more formal place-based Health and Care Partnerships (HCPs) with devolved financial, quality, workforce, transformation and commissioning responsibilities from the ICB. There are a number of ongoing discussions planned to determine the scale of devolution to HCPs, aligned with the national requirement for all ICSs to reduce their running costs by 30% by April 2025.

The Board is asked to note these other key headlines.

Author: **Lance McCarthy, Chief Executive**
Date: **28 September 2023**

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Private) – 14 September 2023

Agenda item:	2.1							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	1 September 2023							
Subject / title:	Lucy Letby verdict and next steps							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	This report updates the Board on the recent Lucy Letby verdict and outlines the proposed approach to be taken at PAHT considering this and in advance of the outcome of the independent inquiry.							
Recommendation:	The Board is asked to acknowledge the governance and risk management developments over the last 5-6 years, to acknowledge the correspondence from the national NHSE team and to discuss the proposed approach to the Letby verdict and its comprehensiveness							

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:	n/a
Risk / links with the BAF:	This report links with all the BAF risks
Legislation, regulatory, equality, diversity and dignity implications:	– Regulatory – Board requirement to assure itself of suitable practices and processes and approaches in place to make it easy to raise concerns – Regulatory – compliance with the latest FPPT Framework and PSIRF – EDI – ensuring all colleagues, patients and visitors are aware of and feel equally able to raise concerns

Appendices:	(1) Fit and Proper Person Test Framework for Board Members, 3 August 2023 (2) NHSE letter to providers in light of the Lucy Letby trial verdict, 18 August 2023

Lucy Letby verdict and next steps
Trust Board: Part II – 14 September 2023

This report provides the Board with an overview of the recent Lucy Letby verdict, the governance and risk management developments that have occurred since the events, and the proposed approach to be taken considering the trial and verdict, in advance of the outcome of an independent inquiry.

1.1 Overview

On 21 August 2023, Lucy Letby was sentenced to life imprisonment with a whole life order at Manchester Crown Court for the very sad and shocking murder of 7 babies and attempted murder of 6 other babies in a neonatal unit at the Countess of Cheshire Hospital.

The deaths of the babies for which she was convicted occurred between June 2015 and June 2016.

It was recognised in June 2015., that there was a change in the pattern of deaths on the unit and an incident was raised. The deaths were initially classified as medication errors.

Following a departmental thematic review of 5 unexplained deaths in February 2016, Lucy Letby was found to have been on duty for each of the deaths. Concerns from colleagues were raised and escalated to the Trust Board. Lucy Letby was removed from working in the unit, the unit's services were reduced in terms of a reduction in the threshold for accepting babies and an external review through the Royal College of Paediatrics and Child Health (RCPCH) was initiated.

The RCPCH review reported in October 2016 and did not identify a definitive explanation for the increase in mortality, although highlighted there to be staff shortages across the unit. It recommended a detailed review of each death.

A specialist neonatologist undertook a summary case review and identified four cases that she felt would benefit from forensic review related to circumstances.

Following discussions with their regional neonatal lead, consultant colleagues from the unit asked for police involvement in March 2017 and the Cheshire Constabulary became involved in May 2017.

Lucy Letby was arrested in July 2018, charged with murder in November 2020 and sentenced on 21 August 2023 after a 9-month trial and a month of jury deliberations.

The government has announced that there will be an Independent Inquiry into events surrounding the case. Once this is published, we will ensure that this is discussed widely across the Trust and that any learning that we can take from this we absolutely implement; in the same way that we implemented the learning from the recent Ockenden and Kirkup reviews.

In the intervening period, whilst it's important to recognise that wilful harm of patients by NHS employees are rare events, in complex environments like a hospital harm can be caused, and patient safety put at risk unwittingly on a regular basis. We will therefore be reviewing all our current process for raising concerns and reporting incidents to ensure that they are all as tight as they can be and that all relevant learning is taken from these.

1.2 Enhancements nationally and locally since the Letby murders

The babies who were sadly killed or harmed by Lucy Letby, were between June 2015 and June 2016.

It's worth noting that a lot of developments and improvements to risk management, mortality reporting and reviews, Board reporting and speaking up have been implemented nationally and locally since this time. These have significantly increased oversight, triangulation of data and early identification of concerns at multiple levels through the Trust, including at the Trust Board itself. These include:

- Medical Examiners service, independently reviewing all deaths in the hospital
- Monthly mortality oversight group supporting enhanced mortality and morbidity meetings in all specialties
- Learning from Deaths oversight paper to every Quality and Safety Committee and every Trust Board meeting
- Enhancements in Dr Foster analysis of mortality
- Enhancements in mandatory neonatal mortality data returns, supported by a perinatal mortality review tool
- Regional neonatal operational delivery networks with regular meetings overseeing the provision of care across their neonatal and special care units including the oversight of mortality rates in all units
- Healthcare Safety Investigation Branch (HSIB) review of all neonatal deaths nationally with 7 days of death
- Enhanced oversight of nursing levels on all wards on a daily (or 3 x daily) basis, aligned with the real time case mix and acuity of the patients on each ward, reported formally every month through the Safer Staffing Report to Trust Board.
- Implementation of Maternity Safety Champions, both a NED and an Exec Director
- Introduction of the Guardian of Safer Working role to support doctors in training in raising concerns about anything and supporting them with their working hours, shift patterns and access to relevant learning
- Introduction of the Freedom to Speak up Guardian role and service. For information, we now have a lead guardian, 3 other guardians who are clinical and 11 Freedom to Speak up Ambassadors to support the raising of concerns across the organisation by all colleagues.
- Enhancement of the Fit and Proper Person Test for all Board members, first introduced in April 2015 and most recently updated with a new framework on 3 August 2023, due for implementation by 30 September 2023 (see appendix 1). The new framework requires there to an individual assessment, refreshed annually and recorded on ESR, enabling other NHS organisations to have access to the information as part of their recruitment processes.

1.3 Additional local improvements to risk, governance and incident reporting

As well as the developments and improvements highlighted above, we continuously look to enhance our local processes related to the management and understanding of risk and governance and openness in reporting and escalation. Further assurance to the Board can be provided through the following:

- In December 2018, colleagues identified an unusual cluster of stillbirths / perinatal deaths, deviating from our normally low perinatal death rate. External obstetric reviews were undertaken, and we asked NHSI to undertake a case review of all 8 deaths. A thematic review was also undertaken to highlight any systems or processes that were recurrently seen as issues in the provision of care. The review highlighted areas for the services to implement and it was recognised that there were no major issues identified that the services had not already identified and actioned. NHSI were happy that our governance processes were robust and that we had been open in our escalation to the regulators and the request for support from the regional quality team.

- Since June 2016, we have also continued to review, enhance, update and improve our systems of risk and incident reporting and management at PAHT. These include the series of recent Board Development discussions with NHS Providers and separately with our risk management team that have led to:
  - reshaping of our risk appetite understanding
  - changes to our risk categorisation
  - improvements to our risk reporting and oversight of risk
  - newly introduced corporate risk register

- We have improved and upgraded our DATIX system for the enhanced capture, reporting and management of incidents, improved our incident management reporting internally and externally and our lessons learned. We will shortly also have fully implemented the new national Patient Safety Incident Response Framework (PSIRF), replacing the current Serious Incident Framework, a cornerstone of last year's national patient safety strategy.

- To support assurance related to governance, how we as a Board lead the Trust and leadership within the Trust, we commissioned Deloitte to undertake a full well-led review in June 2021, aligned with the CQC well-led framework. With regular reporting of progress against recommendations, the Board has signed this off as fully actioned and embedded.

- Recent anonymous letters raising a range of concerns and allegations against Board members have been rapidly and openly discussed and investigated by Internal Audit fully with the report shared widely with external regional and national colleagues.

- Our recent improvements to the Integrated Performance Report, with the use of SPC charts, gives a better and easier to see indication of variation over time, supporting enhanced identification of potential areas of concern.

1.4 National guidance in the immediate pre and post-verdict period

1.4.1 NHSE National Leadership team letter

On 18 August 2023, we received the attached letter (appendix 2) from the NHSE national leadership team. In terms of immediate actions and assurances requested, they are focussed on ensuring colleagues feel safe to speak up. There are 5 specific requests, to ensure that:

1. All staff have easy access to information on how to speak up

2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme

3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well

5. Boards are regularly reporting, reviewing and acting upon available data

1.4.2 NHSE letter for neonatal units to share with current families

All Trusts across the country with a neonatal unit received a letter from NHSE colleagues to personalise and have available to share with current and near future families using neonatal facilities. We have personalised where appropriate for PAHT and the neonatal team have it available to share with families where suitable. Our neonatal colleagues are also spending time personally talking to families specifically about the how to raise concerns should they have any.

1.5 Next steps

There is always more that we can do to ensure all our processes are as tight as possible, our data is triangulated effectively and consistently and that all colleagues, patients and visitors feel confident to and know how to raise concerns.

We, as a Board, are responsible for ensuring we are assured that these processes and ways of working are as strong as they can be, and that through our actions, we create and encourage a suitable culture to support openness and escalation of concerns.

We will be reviewing all our current process for raising concerns and reporting incidents to ensure that they are all as tight as they can be and that all relevant learning is taken from these. We will make any changes to the processes as relevant to strengthen them and ensure they align with the national policies. The implementation of the PSIRF in the autumn will support assurance.

On 22 August, we discussed the Letby verdict in the weekly This is Us Briefing, including highlighting to colleagues how they can raise concerns, encouraging them to do so and asking colleagues to speak to the Patient Safety and Quality teams if they feel any patient safety concerns or incidents raised have not been fully addressed. This message was also communicated via email to all colleagues that afternoon. For information for the Board, the routes highlighted for colleagues to raise concerns included:

- To their line manager
- To their line manager's line manager
- To their people team business partner or the wider people team
- To their staffside representative
- Through the Freedom to Speak up Guardians (F2SUGs), of which we have a lead guardian, 3 guardians who are clinical and 11 F2SU ambassadors
- To the Guardian of Safe Working if they are a doctor in training
- Through DATIX

This information is all available and accessible on our Trust intranet AlexNet.

Our next Senior Management Team meeting is on 5 September and there is an item on this agenda to discuss our collective actions post the Letby enquiry. This will focus particularly on:

- how all our senior managers support colleagues in their divisions to have easy access to information on how to speak up and
- how we will all support ensure the right culture is in place so that line managers can ensure approaches are in place to support all colleagues to speak up, regardless of their band, role, cultural background or shift pattern.

This will require ongoing dialogue and review rather than just a one-off discussion.

All outstanding grievances and serious incidents will be reviewed by colleagues to determine whether any warrant a change in direction to resolve them, through a different approach or speedier resolution.

Through the next cycle of Performance Review Meetings with all the clinical and corporate divisions, we will have open conversations about any worry areas or concerns that we collectively feel need to be addressed or reviewed differently in light of some of the context from the Letby trail related to timely management and having the right difficult conversations at the right time.

As Board members we should consider how we continue to use and enhance the Integrated Performance Report to triangulate data to identify potential areas for concern or provide assurance of not being of concern. We should also continue to challenge ourselves and our behaviour to ensure we are creating the right environments for the right discussions and how we are enabling an organisational wide culture of openness.

The Board is asked to:

- ***acknowledge the governance and risk management developments over the last 5-6 years***
- ***acknowledge the correspondence from the national NHSE team and***
- ***discuss the proposed approach to the Letby verdict and its comprehensiveness***

Author: **Lance McCarthy, Chief Executive**
Date: **29 August 2023**

Classification: Official

Publication reference: PRN00238_i

NHS England Fit and Proper Person Test Framework for board members

2 August 2023

NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

In the foreword to his review, Tom Kark KC stated that “The culture and management of each hospital Trust flows from the management team. Thus, the quality and culture of the management team is of the greatest significance to the ethos and success of the hospital, the effectiveness, and the working conditions (in the widest sense) of its staff, and ultimately the care, comfort, and safety of the patients to whom the Trust provides health services.”

The framework will introduce a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

This framework should be read in conjunction with associated guidance documents.

Contents

Section 1: Introduction

1.1 Background

The Kark Review (2019) was commissioned by the government in July 2018 to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT) as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This included looking at how effective the FPPT is:

> "… in preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors."

The review highlighted areas that needed improvement to strengthen the existing regime.

The specific recommendations from the Kark Review (2019) have been detailed in Appendix 1.

1.2 Purpose and benefits

This document supports the implementation of the recommendations from the Kark Review, and promotes the effectiveness of the underlying legal requirements by establishing a Fit and Proper Person Test Framework (also known as the 'Framework'). The purpose is to strengthen/reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

The Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

The Framework should be read in conjunction with the NHS Constitution, NHS People Plan, People Promise and forthcoming NHS Leadership Competency Framework for leaders at board level. This Framework supports transparency and should be the start of an ongoing dialogue between board members about probity and values. It should be seen as a core element of a broader programme of board development, effective

appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board.

The aim of strengthening the FPPT is to prioritise patient safety and good leadership in NHS organisations. The Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

The Framework will be fair and proportionate and has been developed with the intention to avoid unnecessary bureaucratic burden on NHS organisations.

Ensuring high standards of leadership in the NHS is crucial – well-led NHS organisations and better-led teams with both strong teamwork and strong governance translate into greater staff wellbeing and better clinical care. This requires accountable board members with both outstanding personal conduct and professional capabilities to effectively oversee NHS organisations that are often under significant financial restraint and operating in a highly regulated environment with public and political scrutiny.

As the FPPT assessment is on an individual basis, rather than in relation to the board as a whole, it is envisaged that aspirant board members who can demonstrate the characteristics described above should not be deterred from seeking to join the board of a more challenged NHS organisation. The FPPT assessment is one of general competence to act as a board member, and situational context should therefore be taken into account.

Ensuring that board members are demonstrating the right behaviours will help the NHS drive its cultural initiatives: namely, to foster a culture of compassion, respect and inclusion, and a feeling of belonging; as well as setting the tone at the top to encourage a listening and speaking up culture.

1.3 Applicability

The Framework applies to the board members of NHS organisations. Within this guidance, the term 'board member' is used to refer to:

- both executive directors and non-executive directors (NEDs), irrespective of voting rights
- interim (all contractual forms) as well as permanent appointments

- those individuals who are called ‘directors’ within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Those individuals who by virtue of their profession are members of other professional registers, such as the General Medical Council (GMC) or Nursing and Midwifery Council (NMC), should still be assessed against this Framework if they are a board member at an NHS organisation.

The Framework is designed to assess the appropriateness of an individual to effectively discharge their duties in the capacity of a board member.

It is recognised that some organisations may want to extend the FPPT assessment to other key roles, for example, to those individuals who may regularly attend board meetings or otherwise have significant influence on board decisions. The annual submission requirement is, however, limited to board members only.

Within this guidance, the term ‘NHS organisations’ refers to those institutions to which the Framework will apply; for the purposes of this Framework, this includes:

- NHS trusts
- NHS foundation trusts
- integrated care boards (ICBs)
- the following arm’s length bodies in the first instance:
  - Care Quality Commission (CQC)
  - NHS England.

ICB chairs will need to consider FPPT assessment on a member-by-member basis and take into account assurance received from other recruiting/appointing organisations, for example, in the case of partner members.

1.4 Personal data

Personal data relating to the FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR). The information contained in these records will not routinely be accessible beyond an individual’s own organisation. There will be no substantive change to the data controller arrangements from those already in place for ESR.

Although, as set out below, NHS England will not have day-to-day access to the system or its content, NHS England recognises that it may be considered a (joint) controller of the ESR fields because as the commissioner of the ESR module and author of the Framework, it has a role in determining the nature and purposes of processing.

The organisations that are uploading the content (and determining what is said about each board member), and the NHS Business Services Authority (as the main commissioner of ESR), will also each be a data controller. For the purposes of Article 26 UK GDPR, NHS England has put in place 'transparent arrangements' to set out its responsibilities in this respect.

NHS England has established that the most relevant lawful basis for processing the FPPT data contained in ESR is set out in Article 6(1)(e) UK GDPR. This is on the basis that the processing of personal data is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller (that is, the employer, or indeed NHS England in connection with any role it fulfils as a joint controller).

The aim of the maintaining a record of FPPT outcomes in ESR is to significantly improve the management of the NHS, and ultimately the experience and outcomes for patients, and is therefore in the public interest and done as part of the exercise of the functions of the organisation concerned.

As special category data would be processed as part of the maintenance of the ESR FPPT data fields, controllers will also rely on one of the lawful bases for processing set out in Article 9 UK GDPR: Articles 9(2)(b) – employment; 9(2)(g) – statutory/public functions; and 9(2)(h) (read with Schedule 1, paragraph 2 of the Data Protection Act 2018). This covers processing that is 'necessary for the management of the health service.'

NHS England recognises the requirements of Article 5(1) UK GDPR, and that personal data should be processed lawfully, fairly and transparently. In line with all other ESR data fields, fair processing information will be available to the users of the ESR system. Current ESR fair processing information can be found in the NHS Electronic Staff Record (ESR) privacy notice. The Framework and related guidance documents also help discharge transparency-related obligations.

Information that is the personal data of the applicant is exempt from the Freedom of Information Act under section 40(1) and any request should be processed under section

7 of the DPA. Regulation 5(3) of the EIR is the equivalent provision and has the same effect.

Arrangements for dispute resolution or request for review of content of data (in ESR and local records), or relating to the FPPT assessment outcome, are set out in the guidance document for chairs.

The launch of the Framework will involve NHS England and participating data controllers (NHS trusts, foundation trusts and integrated care boards) communicating to all board members in their organisation whose details will be included in ESR, in advance of the FPPT Framework (and standard reference tools) going live on 30 September 2023. By doing so directors will be afforded the opportunity to object if they have concerns regarding the proposed use of their data, and NHS England and participating data controllers will be able to consider these concerns and amend their approach if necessary. An example of a board member FPPT privacy template is attached at Appendix 6. Organisations should ensure that an appropriate policy document is in place in relation to special category data.

Section 2: Context

2.1 Current fit and proper persons regulations

In 2014, the government introduced a 'fit and proper person' requirement, via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 'Regulations').

This sets out the requirements for a FPPT which applies to directors and those performing the functions of, or functions equivalent or similar to the functions of, a director in all NHS organisations registered with the CQC, which includes all licence holders and other NHS organisations to which licence conditions apply. For the purposes of this guidance, we have referred to these individuals as 'board members'.

Regulation 5 recognises that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care. The regulation requirements are that:

a) the individual is of good character

b) the individual has the qualifications, competence, skills and experience that are necessary for the relevant office or position or the work for which they are employed

c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed

d) the individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity

e) none of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual.

The grounds of unfitness specified in Part 1 of Schedule 4 to the Regulated Activities Regulations are:

a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged

b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland

c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986

d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it

e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland

f) the person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

The good character requirements referred to above in Regulation 5 are specified in Part 2 of Schedule 4 to the Regulated Activities Regulations, and relate to:

a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence

b) whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

Integrated care boards (ICBs) are statutory bodies with the general function of arranging for the provision of services for the purposes of the health service in England and are NHS bodies for the purposes of the 2006 Act. The main powers and duties of ICBs are to commission certain health services as set out in sections 3 and 3A of the 2006 Act.

ICBs, together with the CQC and NHS England, are within scope of this Framework. One of the recommendations made by Tom Kark KC was to extend the scope of the FPPT into certain arm's length bodies (ALBs) to:

> "…bolster the strength and width of the test, as well as to put a stop to 'the revolving door,' the FPPT should be extended to commissioners as well as other arms-length bodies. It was described as 'incongruous' that it did not apply to commissioners."

2.2 Related principles and values

This section summarises relevant principles and values that underpin the Framework and provide additional context to understand its aims.

2.2.1 NHS Constitution

The NHS Constitution states:

> The NHS belongs to the people.
>
> It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives.
>
> It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need when care and compassion are what matter most.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

2.2.2 NHS guiding principles

The seven guiding principles that govern the way the NHS operates, and define how it seeks to achieve its purpose:

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. The patient will be at the heart of everything the NHS does.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities, and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair, and sustainable use of finite resources.
7. The NHS is accountable to the public, communities, and patients that it serves.

2.2.3 NHS values

These principles are underpinned by the core NHS values, which have been derived from extensive discussions with staff, patients and the public. The values are integral to creating a culture where patients come first in everything the NHS does.

These values are not intended to be limiting. Individual NHS organisations should use them as a basis on which to develop their own values, adapting them to local circumstances. The values should be taken into account when developing services with partner NHS organisations, patients, the public and staff.

The six core values are:

1. Working together for patients.
2. Respect and dignity.
3. Commitment to quality of care.

4. Compassion.
5. Improving lives.
6. Everyone counts.

2.2.4 The Nolan Principles of Standards in Public Life

NHS board members, in their capacity as public office holders, are expected to abide by the 'Nolan Principles' as defined by the Committee on Standards in Public Life:

1. Selflessness
   - Holders of public office should act solely in terms of the public interest.
2. Integrity
   - Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family or their friends. They must declare and resolve any interests and relationships.
3. Objectivity
   - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
4. Accountability
   - Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
5. Openness
   - Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
6. Honesty
   - Holders of public office should be truthful.
7. Leadership

– Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Section 3: FPPT Framework

The Framework sets out:

- When the full FPPT assessment is needed, which includes self-attestations (see sections 3.2 and 3.3).
- New appointment considerations (section 3.4).
- Additional considerations in specific situations such as joint appointments, shared roles and temporary absences (section 3.5).
- The role of the chair in overseeing the FPPT (section 3.6).
- The FPPT core elements to be considered in evaluating board members (section 3.7).
- The circumstances in which there will be breaches to the core elements of the FPPT (regulation 5) (section 3.8).
- The requirements for a board member reference check (section 3.9).
- The requirements for accurately maintaining FPPT information on each board member in the ESR record[1] (section 3.10).
- The record retention requirements (section 3.11).
- Dispute resolution (section 3.12).
- Quality assurance over the Framework (section 4).

Ultimate accountability for adhering to this framework will reside with the chair of an NHS organisation.

Throughout this document and the associated guidance, the term 'ESR' refers to the FPPT data fields in ESR. It is important to note that:

- Information held in ESR about board members is accessible by a limited number of senior individuals within their own organisation only.
- There is no access to FPPT information about board members in one organisation by another organisation or individual.

ESR provides a tool for individual organisations to record that testing has been carried out for the chair, who has overall accountability for the FPPT within their organisation. It

[1] For the purpose of the FPPT framework, 'ESR' refers to the FPPT data fields in ESR.

also records that testing is complete and enables reports to be run at local level as an audit trail of completed testing and sign off.

ESR is not a public register – there is no access to it by the public/externally. It provides a tool to help support chairs record some of their key FPPT requirements and provides a sign-off facility in one place. It is good practice for NHS organisations to report on the high-level outcome of the FPPT assessments in the annual report or elsewhere on their websites.

3.1 FPPT overview

The duty to take account of 'fit and proper person' requirements is pervasive, continuous and ongoing. However, for the purposes of the Framework, NHS England considers it appropriate for NHS organisations to be able to consistently demonstrate, on an annualised basis, that a formal assessment of fitness and properness for each board member has been undertaken. NHS organisations should consider carrying out the assessment alongside the annual appraisal.

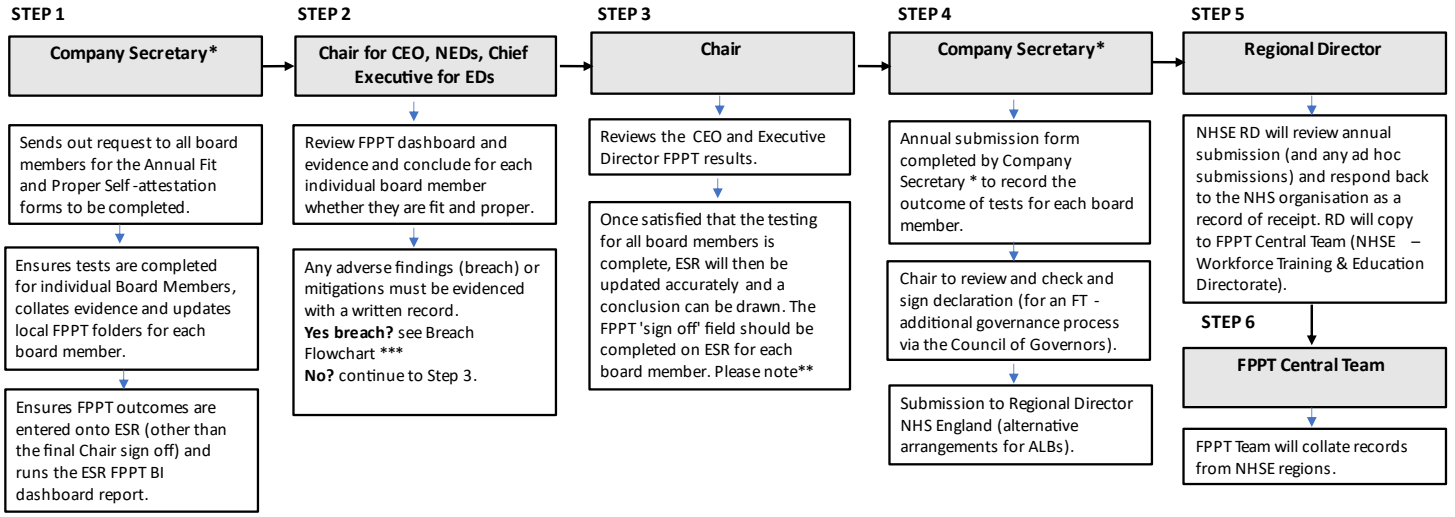
Chairs should ensure that their NHS organisation can show evidence that appropriate systems and processes are in place to ensure that all new and existing board members are, and continue to be, fit and proper (that is, the board members meet the requirement of Regulation 5), and that no appointments breach any of the criteria set out in Schedule 4 of the regulations.

Such systems and processes include (but are not limited to) recruitment, induction, training, development, performance appraisal, governance committees, disciplinary and dismissal processes.

As such, the chair in each NHS organisation will be responsible for ensuring that their organisation conducts and keeps under review a FPPT (in line with the list in section 3.2 below) to ensure board members are, and remain, suitable for their role.

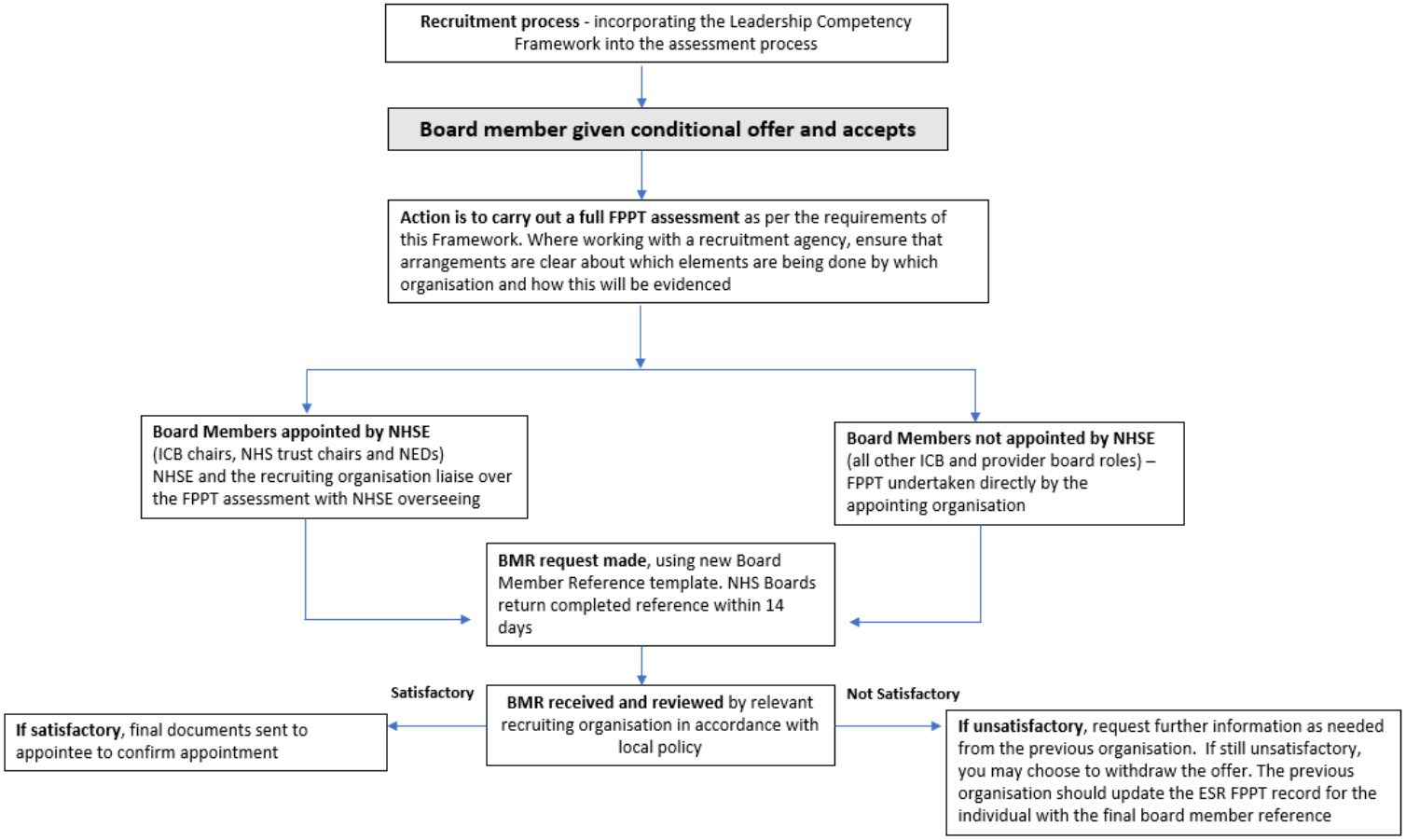
In evaluating a board member's fitness, a decision is expected to be reached on the fitness of the board member that is in the range of decisions that a reasonable person would make. NHS England recognises that chairs will need to make judgements about the suitability of board members and will support balanced judgements made in the spirit of the Framework.

The suggested approach to the assessment, including the Board Member Reference process, is set out in the three flow charts below and is also described in more detail in the supporting chairs' guidance document.

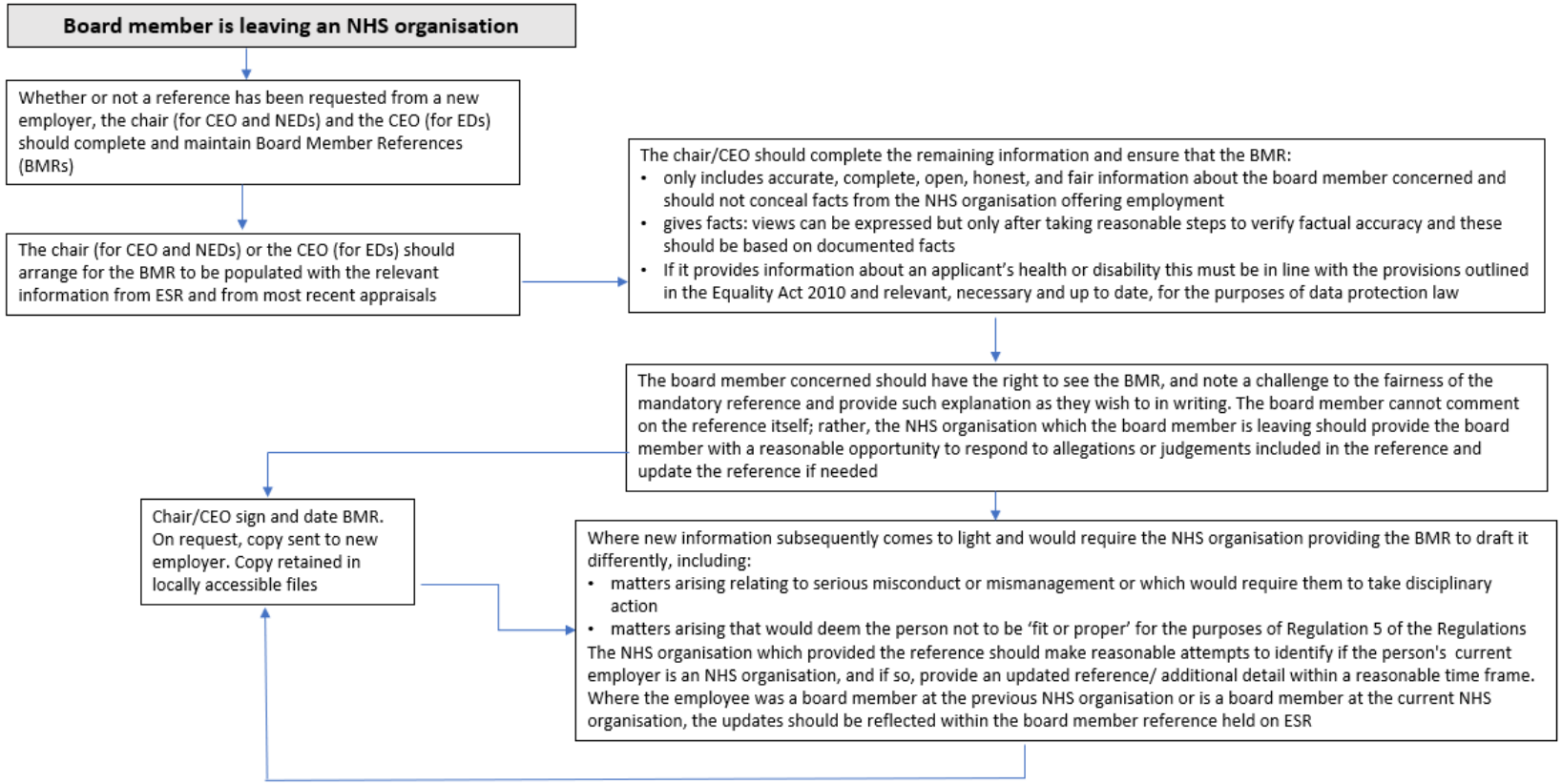


*Or senior member of staff nominated by and behalf of, the Chair, e.g., HRD
** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'
*** Please refer to the Chairs Guidance for the Breach Flowchart
SID = Senior Independent Director
ESR= Electronic Staff Record

Board Member Reference (BMR) – for appointments



Board Member Reference (BMR) – for leavers



3.2 Full FPPT assessment

A documented, full FPPT assessment – a complete assessment by the employing NHS organisation against the core elements (detailed in section 3.7) – will be needed in the following circumstances:

1. New appointments in board member roles, whether permanent or temporary, where greater than six weeks, this covers:
    a. new appointments that have been promoted within an NHS organisation
    b. temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis
    c. existing board members at one NHS organisation who move to another NHS organisation in the role of a board member
    d. individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.
2. When an individual board member changes role within their current NHS organisation (for instance, if an existing board member moves into a new board role that requires a different skillset, eg chief financial officer).
3. Annually; that is, within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months.

Note: for points 1a - 1d above (new appointments) the full FPPT will also include a board member reference check (see section 3.9).

For points 2 and 3 above, the board member reference check will not be needed.

The exact requirements for the initial FPPT assessment versus the annual FPPT assessment thereafter are detailed in section 3.10.1.

3.3 Self-attestation

Every board member will need to complete an annual self-attestation, to confirm that they are in adherence with the FPPT requirements. Self-attestations will be a necessary step that forms a part of the full FPPT assessment (see Appendix 3).

3.4 New appointments

NHS organisations should be able to demonstrate that appointments of new board members are made through a robust and thorough appointment process.

As such, no new appointments should be made to the post of board member unless the appointee concerned can demonstrate they have met the FPPT requirements as detailed in section 3.7 of this document.

As part of conducting the initial appointment process for a board member, an inter-authority transfer (IAT)[2] could be submitted to identify any of the applicant's previous or current NHS service/employment history. Alternatively, other arrangements could be made to collate the relevant information. This should also help identify any potential duplicate employment accounts for the appointee, eg when someone has more than one NHS role on ESR.

For the initial appointment of NHS trust chairs and ICB chairs only, once the NHS organisation has obtained board member references and completed the fit and proper person assessment, FPPT approval should be sought from the NHS England Appointments Team before they commence their role.

3.5 Additional considerations

There will be additional considerations when applying the FPPT for joint appointments across NHS organisations, shared roles within the same NHS organisation and periods of temporary absence. These additional considerations have been detailed below.

3.5.1 Joint appointments across different NHS organisations

Additional considerations are needed where there are joint appointments to support closer working between NHS organisations in the health and care system.

For instance, where joint appointments of a board member can help foster joint decision-making, enhance local leadership and improve the delivery of integrated care. Joint appointments may occur where:

- two or more NHS organisations want to create a combined role

[2] An IAT is an electronic way of gathering information from an employer for an applicant's previous or current NHS service using the ESR system. How to complete an Inter Authority Transfer (IAT) check in NHS Jobs user guide (nhsbsa.nhs.uk)

- two or more NHS organisations want to employ an individual to work across the different NHS organisations in the same role.

In the scenario of joint appointments, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the chair of the other contracting NHS organisation to ensure that the board member is fit and proper to perform both roles.

The host/employing NHS organisation will then provide a 'letter of confirmation' (Appendix 4) to the other contracting NHS organisation to confirm that the board member in question has met the requirements of the FPPT.

The chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the FPPT assessment of the board member.

Where there is a joint appointment, the host/employing NHS organisation responsible for the FPPT should also lead on conducting the joint appraisal and ensure adequate input from the other contracting NHS organisation.

Where the joint appointment results in a new board member (for the NHS organisation in question), it will constitute a new appointment and as such, the host/employing NHS organisation should provide a 'letter of confirmation' to the other NHS organisation(s).

For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a chair or NED) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the FPPT.

If the FPPT assessment at one organisation finds an individual not to be FPP, the chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not FPP at the other organisation.

3.5.2 Shared roles within the same NHS organisation

Where two individuals share responsibility for the same board member role (eg a job share) within the same NHS organisation, both individuals should be assessed against the FPPT requirements in line with sections 3.2 and 3.3.

3.5.3 Temporary absence

For the purpose of the FPPT process, a temporary absence is defined as leave for a period of six consecutive weeks or less (eg sick leave, compassionate leave or parental leave) and where the NHS organisation is leaving the role open for the same board member. As such there is no requirement to approve another permanent individual for the role of board member.

Where there is a temporary absence, it is expected that the HR director/company secretary will liaise with the chair and chief executive to ensure temporary cover is provided; and to ensure that local internal systems are adequately updated to record the start and projected end date of the temporary absence.

Where an individual is appointed as temporary/interim cover and is not already assessed as fit and proper, the NHS organisation should ensure appropriate supervision by an existing board member.

A full FPPT assessment should be undertaken for an individual in an interim cover role exceeding six weeks. Therefore, if the interim cover is expected to be in post for longer than six weeks, the NHS organisation should look to commence the FPPT assessment as soon as possible. Where the period of temporary absence is extended beyond six weeks, the FPPT assessment should commence as soon as the NHS organisation is aware of the extension. This FPPT assessment should be carried out in line with the requirements under section 3.2.

3.6 Role of the chair in overseeing FPPT

Chairs are accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of their NHS organisation is maintained to support an effective FPPT regime. As such, chairs' responsibilities are as below:

a) Ensure the NHS organisation has proper systems and processes in place so it can make the robust assessments required by the FPPT.

b) Ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained by the employing NHS organisation.

c) Ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.

d) Ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each board member.

e) Ensure an appropriate programme is in place to identify and monitor the development needs of board members.

f) On appointment of a new board member, consider the specific competence, skills and knowledge of board members to carry out their activities, and how this fits with the overall board.

g) Conclude whether the board member is fit and proper.

h) Chairs will also complete an annual self-attestation that they themselves are in continued adherence with the FPPT requirements. On an annual basis, chairs should confirm that all board members have completed their own FPPT self-attestation and that the FPPT is being effectively applied in their NHS organisation.

i) Ensure that for any board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) as to why there has been an issue about whether a board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual FPPT submission form (Appendix 5) to the relevant NHS England regional director.

Accountability for ensuring a new board member meets the FPPT assessment criteria will reside with the chair. In making such decisions the chair will be supported by existing processes and committees.

In considering their overall assessment of board members, chairs should confirm points d) and g) are adequately addressed, and where relevant for point i), appropriate action has been taken to address any concern.

It is good practice for the chair to present a report on completion of the annual FPPT in accordance with local policy, to the board in a public meeting and, where applicable, to the Council of Governors for Non-Executive Directors, for information.

3.6.1 Overseeing the role of the chair

Chairs will be subject to the same FPPT requirement, as per sections 3.2 and 3.3. In completing their own annual self-attestation, chairs will effectively be confirming that they have adequately addressed points a), b), c), e), f) and h) of section 3.6 above.

The accountability for ensuring that chairs in NHS trusts, foundation trusts and ICBs meet the FPPT assessment criteria will reside with NHS England regional directors, as is also the case for the chairs' annual appraisals.

For the chairs of NHS England and the CQC, this accountability will reside with the Department of Health and Social Care (DHSC).

Annually, the senior independent director (SID) or deputy chair will review and ensure that the chair is meeting the requirements of the FPPT.

If the SID and deputy chair are the same individual, another NED should be nominated to review the chair's FPPT on a rotational basis.

Once the NHS organisation has completed their annual FPPT assessment of the chair, they should sign this off within ESR. The annual FPPT submission, which summarises the results of the FPPT for all board members in the organisation, is then sent to the relevant NHS England regional director.

In relation to foundation trusts, there are no proposed changes to the Council of Governors' responsibilities in relation to the chair's FPPT assessment as it is not within the scope of the Framework to do so. However, as the chairs' annual appraisals are presented to the Council of Governors for information, the same should be the case for a summary of the outcome of the FPPT for non-executive board members.

This information can be retained by the Council of Governors as part of future considerations for any reappointments. Similarly, the Council of Governors should be informed of a satisfactory initial FPPT assessment for new chair and NED appointments.

3.7 FPPT assessment – core elements

This section of the Framework details the core elements that should be included in an FPPT assessment. The checks that underpin the core elements reflect the assessment criteria per Regulation 5 and Schedule 4 of the Regulations.

The full FPPT assessment will constitute an assessment against each of the core elements detailed below and should be conducted in accordance with section 3.2. Individual board members should complete self-attestations to confirm they are fulfilling the core elements of the FPPT assessment, as described below.

NHS organisations should assess board members against the following three core elements when considering whether they are a fit and proper person to perform a board role:

- Good character.
- Possessing the qualifications, competence, skills required and experience.
- Financial soundness.

Note: the FPPT checks relating to these core elements will be in addition to standard employment checks, as per the NHS organisation's recruitment and selection procedures and NHS Employers' pre-employment check standard. This can include CV checks, self-declarations, Google searches, proof of qualifications, proof of identity, right to work, etc.

The section below, which considers both Regulation 5 and Schedule 4 of the Regulations, explains matters that the NHS organisation should take account of in relation to the three core elements.

When an NHS organisation assesses a board member against these core elements in relation to being a fit and proper person, they should consider the nature, complexity and activities of their NHS organisation.

3.7.1 Good character

There is no statutory guidance as to how 'good character' in Regulation 5 of the 2014 Regulations should be interpreted. Chairs should be aware of the elements to consider when assessing good character (as detailed below).

To encourage openness and transparency, these should not be considered as a strict checklist for compliance, but rather as points for a conversation between the chair (or chief executive for executive board members) and a prospective board member during the appointment process. This will in turn emphasise the ongoing benefits of openness and transparency among board members.

When assessing whether a person is of good character, NHS organisations should follow robust processes to make sure that they gather appropriate information, and must have regard to the matters outlined in Part 1 and Part 2 of Schedule 4, namely:

- Convictions of any offence in the UK.
- Convictions of any offence abroad that constitutes an offence in the UK.
- Whether any regulator or professional body has made the decision to erase, remove or strike off the board member from its register, whether in the UK or abroad.

As such, NHS organisations should conduct:

- A search of the Companies House register to ensure that no board member is disqualified as a director.
- A search of the Charity Commission's register of removed trustees.
- A Disclosure and Barring Service (DBS) check in line with their local policy requirements:
  - each NHS organisation should outline within their local policy the relevant DBS check (basic, standard, enhanced or enhanced with barred lists) required for each individual board member role
  - in defining the required DBS level, NHS organisations should identify those board roles that fall within the definition of a 'regulated activity', as defined by the Safeguarding Vulnerable Groups Act 2006, as required barred list checks.
- A check with the relevant professional bodies where appropriate.

It is not possible to outline every character trait that a person should have, but it is expected that processes followed take account of a person's honesty, trustworthiness, reliability, integrity, openness (also referred to as transparency), respectfulness and ability to comply with the law.

Furthermore, in considering that a board member is of 'good character,' the relevant NHS organisation should also consider the following in relation to the individual in question:

- Compliance with the law and legal processes.
- Employment tribunal judgements relevant to the board member's history.

- Settlement agreements relating to dismissal or departure from any healthcare-related service or NHS organisation for any reason other than redundancy.
- A person in whom the NHS organisation, CQC, NHS England, people using services and the wider public can have confidence.
- Adherence to the Nolan Principles of Standards in Public Life.
- The extent to which the board member has been open and honest with the NHS organisation.
- Whether the person has been the subject of any adverse finding or any settlement in civil proceedings, particularly in connection with investment or other financial business, misconduct, fraud or the formation or management of a body corporate.
- Whether the person has been involved – as a director, partner or concerned in management – with a company, partnership or other organisation that has been refused registration, authorisation, membership or a licence to carry out a trade, business or profession.
- Whether the person has been a director, partner or concerned in the management of a business that has gone into insolvency, liquidation or administration while the person has been connected with that organisation or within one year of that connection.
- Whether the person involved as a director, partner or concerned with management of a company has been investigated, disciplined, censured, suspended, or criticised by a regulatory or professional body, a court or tribunal, whether publicly or privately.
- Any other information that may be relevant, such as an upheld/ongoing or discontinued (including where a board member has left the NHS organisation prior to an investigation being completed):
  - disciplinary finding
  - grievance finding against the board member
  - whistleblowing finding against the board member
  - finding pursuant to any trust policies or procedures concerning board member behaviour.

3.7.1.1 Serious mismanagement or misconduct

To comply with Regulation 5, consideration of good character should also ensure, as far as possible, the individual has not been responsible for, contributed to or facilitated any

serious misconduct or mismanagement (whether unlawful or not) in the course of delivering CQC-regulated activity, in England or equivalent activities elsewhere.

In determining what amounts to 'serious misconduct or mismanagement,' beyond the decision by a court or professional regulators regarding individuals, context is paramount. Normally these would require to be findings of serious misconduct or mismanagement that are upheld after a disciplinary process.

NHS organisations should consider the mismanagement and misconduct behaviours in relation to the services they provide, the role of the board member/individual and the possible adverse impact on the NHS organisation or confidence in its ability to carry out its mandate and fulfil its duties in the public interest.

As part of reaching an assessment as to whether any actions or omissions of the board member amount to 'serious misconduct or mismanagement', NHS organisations should consider whether an individual board member played a central or peripheral role in any wider misconduct or mismanagement.

The NHS organisation should also consider whether there are any aggravating or mitigating factors; for instance (including but not limited to):

- The extent to which the conduct was deliberate and reckless.
- The extent to which the conduct was dishonest.
- Whether the issues are frequent or have continued over a long period of time.
- If lack of experience contributed to the issue that has been remediated through training.
- The extent to which the board member (or aspirant board member) demonstrates insight and self-reflection in relation to the conduct/issues identified.

Although NHS organisations have information on when convictions, bankruptcies or similar matters are to be considered 'spent', there is no time limit for considering serious misconduct or responsibility for failure in a previous role, for the purposes of Regulation 5.

Below are some examples of misconduct and mismanagement that NHS organisations would be expected to conclude as amounting to serious misconduct or

mismanagement, unless there are exceptional circumstances that make it unreasonable to determine that there is serious misconduct or mismanagement.

It is impossible to produce a definitive list of all matters that would constitute serious misconduct or mismanagement and, as such, the list below is not exhaustive.

This list sets the minimum expectations and should be read in conjunction with local policy expectations/requirements to determine whether or not a board member has been involved in serious misconduct or mismanagement:

- Fraud or theft.
- Any criminal offence other than minor motoring offences at work (although this and the issues set out in this section may be relevant to assessing whether an individual is of good character more generally).
- Assault.
- Sexual harassment of staff.
- Bullying or harassment.
- Discrimination as per the Equality Act 2010.
- Victimisation (which falls within the scope of the Equality Act 2010) of staff who raise legitimate concerns.
- Any conduct that can be characterised as dishonest, including:
  - deliberately transmitting information to a public authority or to any other person, which is known to be false
  - submitting or providing false references or inaccurate or misleading information on a CV.
- Disregard for appropriate standards of governance, including resistance to accountability and the undermining of due process.
- Failure to make full and timely reports to the board of significant issues or incidents, including clinical or financial issues.
- Repeated or ongoing tolerance of poor practice, or failure to promote good practice, leading to departure from recognised standards, policies or accepted practices.
- Continued failure to develop and manage business, financial or clinical plans.

In assessing whether misconduct or mismanagement was ‘serious’, regard should be had to all the circumstances. For instance, an NHS organisation could consider isolated

incidences of the following types of behaviour to amount to misconduct or mismanagement that does not reach the threshold of seriousness:

- Intermittent poor attendance.
- Failure to follow agreed policies or processes when undertaking management functions where the failures had limited repercussions or limited effects or were for a benevolent or justifiable purpose.

3.7.2 Qualifications, competence, skills required and experience

NHS organisations need to have appropriate processes for assessing and checking that the candidate holds the required qualifications and has the competence, skills and experience required.

For instance, where possible, checking the websites of the professional bodies to confirm that where required the board member holds the relevant and stated qualification.

Where NHS organisations consider that a board member role requires specific qualifications (for example, the chief financial officer being an accredited accountant, or the chief medical officer being a GMC-registered doctor), they should make this clear and should only appoint those candidates who meet the required specification, including any requirements to be registered with a professional body.

As such, job descriptions and person specifications should be clear in detailing required skills and relevant qualifications and/or memberships. These should be reviewed to ensure that they are appropriate and tailored for each board role.

In assessing competence, skills and experience for the purposes of the FPPT, the NHS organisation should look to use the outcome of their appraisal processes for board members, which will be based on the NHS Leadership Competency Framework (LCF) for board level leaders: a framework that will apply to all NHS organisations.

Given the appraisal process will feed into the full FPPT assessment, the appraisal process should be of an appropriate frequency and should give due consideration to assessing good character and conduct (that is, a behavioural assessment).

The NHS LCF provides guidance for the competence categories against which a board member should be appointed, developed and appraised. The LCF covers the following six competence categories:

- Setting strategy and delivering long term transformation.
- Leading for equality.
- Driving high quality, sustainable outcomes.
- Providing robust governance and assurance.
- Creating a compassionate and inclusive culture.
- Building trusted relationships with partners and communities.

In assessing whether a board member has the competence, skills and experience to be considered fit and proper, the FPPT assessment will:

- not just consider current abilities, but also have regard to the formal training and development the board member has undergone or is undergoing
- take account of the NHS organisation (its size and how it operates) and the activities the board member should perform
- consider whether the board member has adequate time to perform and meet the responsibilities associated with their role.

Regarding formal training:

- NHS organisations should ensure any necessary training is undertaken by board members where gaps in competency have been identified.
  - As such, a tailored learning development plan and training framework should support board members.
  - Both the development plan and training should be updated and delivered respectively with an appropriate frequency.

- Training constitutes continued development for board members.
  - Those consistently failing to undergo required training in a timely manner should be deemed to have missed an important obligation, and appropriate action should be taken in line with the NHS organisation's policies and procedures.
  - In turn, this may mean that a board member is not fit and proper.

3.7.2.1 Reasonable adjustments

In assessing if a board member can properly perform tasks to the requisite level of competence and skill for the office or position for which they are appointed,

consideration will be given to their physical and mental health in accordance with the demands of the role and good occupational health practice.

This means all reasonable steps must be made to make adjustments for people to enable them to carry out their role. As a minimum, these must be in line with requirements to make reasonable adjustments for employees under the Equality Act 2010; to prevent discrimination as defined by the Act.

Hence when appointing a person to a role, NHS organisations should have processes for considering their physical and mental health in line with the requirements of the role.

As such, NHS organisations should undertake occupational health assessments (OHA) for potential new board member appointments, in circumstances where the individual in question has indicated a physical or mental health condition as part of pre-employment checks (eg medical assessment questionnaire).

The results of the OHA should be evaluated, and relevant reasonable adjustments should be made in line with the requirements under the Equality Act 2010, so an individual can carry out their role.

While the OHA will not form part of the annual FPPT, it is an integral component of the recruitment process checks to ensure that the NHS organisation can demonstrate that they have taken account of and made any such reasonable adjustments for those in board member roles. This obligation is ongoing in relation to those with disabilities for the purposes of the Equality Act 2010.

The statutory duty to make reasonable adjustments must be considered on an ongoing basis and applies where a disabled person is put at a substantial disadvantage.

3.7.3 Financial soundness

NHS organisations must seek appropriate information to assure themselves that board members do not meet any of the elements of the unfit person test set out in Schedule 4 Part 1 of the regulations.

Robust processes should be in place to assess board members in relation to bankruptcy, sequestration, insolvency and arrangements with creditors. This, as a minimum, will include search of the insolvency and bankruptcy register and checks over county court judgement (CCJ) or high court judgement for debt.

3.8 Breaches to core elements of the FPPT (Regulation 5)

Regulation 5 will be breached if:

1. A board member is unfit on the grounds of character, such as:
   - an undischarged conviction
   - being erased, removed or struck-off a register of professionals maintained by a regulator of healthcare, social work professionals or other professional bodies across different industries
   - being prohibited from holding a relevant office or position (see section 3.7.1).
2. A board member is also unfit on the grounds of character if they have been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) in the course of carrying out a regulated activity.
3. A board member is unfit should they fail to meet the relevant qualifications or fail to have the relevant competence, skills and experience as deemed required for their role.
4. A board member is unfit on grounds of financial soundness, such as a relevant undischarged bankruptcy or being placed under a debt relief order.
5. An NHS organisation does not have a proper process in place to make the robust assessments required by the Regulations.
6. On receipt of information about a board member's fitness, a decision is reached on the board member that is not in the range of decisions a reasonable person would be expected to reach.

With regards to the above points, it is acknowledged that there could be circumstances where, for instance, board members are deemed competent but do not hold relevant qualifications.

In such circumstances there should be a documented explanation, approved by the chair, as to why the individual in question is deemed fit to be appointed as a board member, or fit to continue in role if they are an existing board member. This should be recorded in the annual return to the NHS England regional director (Appendix 5 part 2).

Furthermore, there may be a limited number of exceptional cases where a board member is deemed unfit (that is, they failed the FPPT) for a particular reason (other than qualifications) but the NHS organisation appoints them or allows them to continue their current employment as a board member.

In such circumstances there should be a documented explanation as to why the board member is unfit and the mitigations taken, which is approved by the chair. This should be submitted to the relevant NHS England regional director for review, either as part of the annual FPPT submission for the NHS organisation, or on an ad hoc basis as a case arises.

The NHS organisation shall determine breaches based on points 1 to 4, whereas any regulatory inspections, such as a CQC inspection will determine breaches of points 5 and 6.

3.9 Board member references

3.9.1 Content of the references

A standardised board member reference is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members within the NHS.

The aim of this is to help foster a culture of meritocracy, ensuring that only board members who are fit and proper are appointed to their role, and that there is no recycling of unfit individuals within the NHS.

The Leadership Competency Framework will help inform the ‘fitness’ assessment in FPPT. This is in line with the Kark Review’s (2019) recommendations on professional standards.

The Leadership Competency Framework references six competency domains which should be incorporated into all senior leader job descriptions and recruitment processes. It will also form the core of board appraisal frameworks, alongside appraisal of delivery against personal and corporate objectives.

The competency domains in the Leadership Competency Framework should be taken into account when the board member reference is written. It is recognised that no board director will be able to demonstrate how they meet all the competencies in the framework. What is sought as part of the board member reference is evidence of broad

competence across each of the six competency domains, and to ensure there are no areas of significant lack of competence which may not be remedied through a development plan.

Board level leaders will be asked to attest to whether they have the requisite experience and skills to fulfil minimum standards against the six competency domains. This attestation will be reviewed by the board director's line manager and overseen by the organisation's chair. The attestation record will be captured on ESR.

The annual attestation by board members is expected to be undertaken at the same time as the annual appraisal process and assessment of competence against the six competency domains will also be used to guide the board member's development plan for the coming year. The line manager will also capture stakeholder feedback as part of the appraisal process and summarise competence against each of the six competency domains. (A board member appraisal framework will be published ahead of the 2023/2024 appraisal process to support this process.) The annual appraisals of the past three years will then be used to guide the board member's reference.

NHS organisations will need to request board member references, and store information relating to these references (see section 3.10) so that it is available for future checks; and use it to support the full FPPT assessment on initial appointment.

NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally.

Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

a. New appointments that have been promoted within an NHS organisation.
b. Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.
c. Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.

d. Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

It is important that board member references checks are carried out in accordance with the data protection principles, as set out within data protection law. In particular, the process should be undertaken fairly, and the information generated should be accurate and up to date.

Requests for board member references should not ask for specific information on whether there is a settlement agreement/non-disclosure agreement in place.

The board member reference request instead asks for any further information and concerns about an applicant's fitness and propriety, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Information on settlement agreements should be retained locally (where applicable) and included in the overall consideration of the fit and proper status of the individual in question.

If there is a historical settlement agreement/non-disclosure agreement already in place which includes a confidentiality clause, NHS organisations should seek permission from all parties prior to including any such information in a board member reference.

Going forward, NHS organisations should consider inclusion of a term in any proposed settlement agreement to state that information about the settlement agreement can be included in ESR, and in doing so will not be a breach of confidence.

The existence of a settlement agreement does not, in and of itself determine that a person is not fit or proper to be a board member.

The board member reference is based on the standard NHS reference and includes additional requests for information as follows (relevant to the FPPT):

- Information regarding any discontinued, outstanding, or upheld complaint(s) tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the organisation's policies and procedures (for example, under the trust's equal opportunities policy).

- Confirmation of any discontinued, outstanding or upheld disciplinary actions under the trust's disciplinary procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct.

- Any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Discontinued investigations are included in the reference request to identify issues around serious misconduct and mismanagement and to deliberately separate them from issues around qualifications, competence, skills, and experience (which it is believed can be remedied) and health (which it is believed can improve), unless such competence and/or health issues could potentially lead to an individual not meeting the requirements of the FPPT.

Investigations (irrespective of reason for discontinuance) should be limited to those which are applicable and potentially relevant to the FPPT, and examples are as follows (this is not an exhaustive list and consideration will be needed on a case-by-case basis):

- Relating to serious misconduct, behaviour and not being of good character (as described in the FPPT Framework).
- Reckless mismanagement which endangers patients.
- Deliberate or reckless behaviour (rather than inadvertent behaviour).
- Dishonesty.
- Suppression of the ability of people to speak up about serious issues in the NHS, eg whether by allowing bullying or victimisation of those who speak up or blow the whistle, or any harassment of individuals.
- Any behaviour contrary to the professional Duty of Candour which applies to health and care professionals, eg falsification of records or relevant information.

The reason for discontinuing (including not commencing) an investigation should be recorded, including whether an investigation was not started or stopped because a compromise, confidentiality or settlement agreement was then put in place (recognising that such an agreement is not necessarily a conclusion that someone is not fit and proper for the purposes of the FPPT).

It will be necessary as a matter of fairness for the employee to have had an opportunity to comment on information that is likely to be disclosed as part of any reference request i.e., as part of any disciplinary procedures/action. NHS organisations should develop local policy about who provides references, when they are provided and what will/will not be included.

NHS organisations should take any advice that they deem necessary in an individual case where they have assessed that the employee or prospective employer is likely to bring a claim.

3.9.2 Obtaining references

At least one board member reference should be obtained when an NHS organisation is appointing a board member.

- For board members:
  - An NHS organisation should obtain a minimum of two board member references (using the board member reference template) where the individual is from outside the NHS, or from within the NHS but moving into the board role for the first time.
  - These two references should come from different employers, where possible.

- For an individual who moves from one NHS board role to another NHS board role, across NHS organisations:
  - Where possible one reference from a separate organisation in addition to the board member reference for the current board role will suffice.
  - This is because their board member reference template should be completed in line with the requirements of the framework so that NHS organisations can maintain accurate references when a board member departs.

- For a person joining from another NHS organisation:
  - The new employing/appointing NHS organisation should take reasonable steps to obtain the appropriate references from the person's current employer as well as previous employer(s) within the past six years.
  - These references should establish the primary facts as per the board member reference template.

- Where an employee is entering the NHS for the first time or coming from a post which was not at board member level:

- The new employing NHS organisation should make every practical effort to obtain such a reference which fulfils the board member reference requirements.
- In this scenario, the NHS organisation will determine their own reasonable steps to satisfy themselves they have pursued relevant avenues to obtain the information on potential incoming individuals through alternative means.
- For example, if a chief financial officer is joining from financial services, they can check the financial services register, or request for a mandatory reference under the financial services regulations.

It is acknowledged that where the previous employer is not an NHS organisation, there may be greater difficulty in obtaining a standardised NHS board member reference.

Nonetheless, for new appointments from outside of the NHS, employers should seek the necessary references to validate a period of six consecutive years of continuous employment (or provide an explanation for any gaps), or training immediately prior to the application being made.

In such cases where references from previous employers are unattainable for the previous six years, additional character or personal references should be sought. Character and personal references should be sought from personal acquaintances who are not related to the applicant, and who do not hold any financial arrangements with that individual.

References should never be used as the sole grounds for assessing an applicant's suitability for a post. Where negative issues are included in a reference, information should be carefully considered and weighed up against the wider range of evidence gathered as part of the recruitment process.

NHS organisations should aim to investigate negative information by sensitively raising it with the individual concerned, giving them the opportunity to explain the situation in more detail and/or, where appropriate, give them a chance to outline any learning from past mistakes or experiences to obtain the necessary assurances about their suitability for a role.

If a reference reveals something which is incompatible with the requirements of Regulation 5 of the Regulations, the individual should not be appointed to the role.

An NHS organisation should obtain references before the start of the board member's appointment. The NHS organisation requesting the reference should make it clear that this is being requested in relation to a person being appointed to the role of board member, or for other purposes linked to the board member's current employment.

The obligation to obtain a reference for a potential candidate for employment/ appointment in the role of board member applies irrespective of how the previous employment ended, for instance, resignation, redundancy, dismissal or fixed term work or temporary work coming to an end.

Where a potential candidate for employment/appointment in the role of board member has a gap between different employments, all reasonable efforts should be made to ensure that references covering those periods/gaps are obtained.

References should be obtained in writing (either via hardcopy or email) and NHS organisations will need to satisfy themselves that both the referee and the organisation are bona fide.

From time to time the information provided in a reference may contradict the information provided by board members.

There may be a reasonable explanation for apparent discrepancies and NHS organisations should proceed sensitively to seek the necessary assurances directly with the board member. In exceptional circumstances where there is serious misdirection, employers may feel it appropriate to report their concerns to the NHS Counter Fraud Authority.

Where an NHS organisation is unable to fully evidence that the incoming board member is fit and proper because of gaps in the board member reference, they may continue to hire the individual but should clearly document within ESR the gaps in relation to the board member reference and the reasons/mitigations for being comfortable with employing/appointing the board member.

In this scenario, the employing NHS organisation also should be able to demonstrate that they have exercised all reasonable attempts to obtain the missing information.

3.9.3 Providing references

An NHS organisation should aim to provide a reference to another NHS organisation within a 14-day period, which starts from the date that the reference request was

received. However, it should be acknowledged thar there are occasions of exceptional circumstances, and references may take more than 14 days to provide.

The references referred to above are for a request made in relation to the individual being appointed to the role of board member, or for other purposes linked to the board member's current employment.

Where a current board member moves between different NHS organisations, a board member reference form following a standard format (Appendix 2) should be completed by the employer and signed off by the chair of that NHS organisation.

The previous NHS organisation should provide information in relation to that which occurred:

- in the six years before the request for a reference
- between the date of the request for the reference and the date the reference is given
- in the case of disciplinary action, serious misconduct and/or mismanagement at any time (where known).

NHS organisations should also consider when providing the reference:

- That the process captures accurate, complete, open, honest and fair information about the board member concerned.
  - As such, references should not conceal facts from the NHS organisation offering employment.
- References should give established facts that are part of the history of the person.
  - It is unfair to give partial facts if those result in the offer being withdrawn, for example where this causes the recipient NHS organisation to assume the information is missing because it is negative, so the offer is withdrawn.
  - Views can be expressed but only after taking reasonable steps to verify factual accuracy and should be based on documented facts.
- The reference should be fair, such that the employee concerned should have the right to note a challenge to the fairness of the mandatory reference and provide such explanation as they wish to in writing.
  - This does not mean that the board member can comment on the reference itself; rather, that the NHS organisation (which the board member is leaving)

has provided those board members with a reasonable opportunity to respond to allegations or judgements upon which the reference is based.

  - Hence a board member's opinions are not required to be included within the reference, but should be appropriately considered when drafting them.
  - Where the NHS organisation providing the reference has not offered the employee the opportunity to previously (at the time the matter occurred) comment on the allegation, they ought to do so before including that allegation within the reference, rather than leaving the allegation out of the reference.
- Where the reference provides information about an applicant's health or disability this must be in line with the provisions outlined in the Equality Act 2010 and be relevant, necessary, and up to date, for the purposes of data protection law.

3.9.4 Revising references

If an NHS organisation has provided a reference to another NHS organisation about an employee or former employee, and has subsequently:

- become aware of matters or circumstances that would require them to draft the reference differently
- determined that there are matters arising relating to serious misconduct or mismanagement
- determined that there are matters arising which would require them to take disciplinary action
- concluded there are matters arising that would deem the person not to be 'fit or proper' for the purposes of Regulation 5 of the Regulations,

the NHS organisation that provided the reference should make reasonable attempts to identify if the person's[3] current employer is an NHS organisation and, if so, provide an updated reference/additional detail within a reasonable timeframe.

Where the employee was a board member at the previous NHS organisation or is a board member at the current NHS organisation, the updates should be reflected within the board member reference.

[3] For the avoidance of doubt, this refers to executive board members employed by an NHS organisation and non-executive board members who have been appointed.

Revised references between NHS organisations should cover a six-year period from the date the initial board member reference was provided, or the date the person ceased employment with the NHS organisation, whichever is later. The exception to this are matters that constitute serious misconduct or mismanagement: details of such events should be provided irrespective of time period.

3.9.5 Board member reference template

The board member reference template provided should be used by NHS organisations.

This Framework, along with the board member reference template, sets out the minimum requirements for a reference. An NHS organisation can provide information in relation to additional matters if it deems it necessary to do so.

If references are provided for the role of board member, or for other purposes linked to the board member's current employment, the NHS organisation providing the reference should look to complete all sections of the template even where the NHS organisation requesting the reference does not specifically ask for it.

As mentioned previously, NHS organisations should maintain board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer.

Therefore, the template should be completed, and retained locally in an accessible archive, for departing board members even where they have indicated they are moving onto a non-NHS role and/or performing a role that is not on the board, or where they have indicated they are to retire.

Often in these circumstances the individual may go on to act in the capacity of a board member at a future date, even if it is just on a temporary basis, for example to cover staff shortages.

3.10 Electronic Staff Record (ESR)

NHS Business Services Authority (NHSBSA) hosts ESR on behalf of the NHS, as commissioned by the Department for Health and Social Care.

New data fields in ESR will hold individual FPPT information for all board members operating in the NHS and will be used to support recruitment referencing and ongoing development of board members. The FPPT information within ESR is only accessible within the board member's own organisation and there is no public register.

ESR will hold information about each board member in line with the criteria detailed below in section 3.10.1.

NHS England will use its network of regional directors in a direct oversight role to ensure that individual NHS organisations (within the designated regions) are completing their FPPT, via annual submissions to the NHS England regional directors.

The CQC will continue in its regulatory role and as such may determine that reviews are required over the data integrity and controls that a particular NHS organisation has in relation to the records held in ESR.

There should be limited access to ESR in accordance with local policy and in compliance with data protection law. It is reasonably expected that the following individuals have access to the FPPT fields in ESR:

- chair
- chief executive officer (CEO)
- senior independent director (SID)
- deputy chair
- company secretary
- human resources director (HRD)/chief people officer (CPO).

Access will also be provided to relevant individuals within the CQC at a local level, where this information is necessary for their roles, noting the CQC's ability to require information to be provided to it under Regulation 5(5) of the Regulations.

The ESR FPPT data fields need to be maintained to ensure information about the serving board member is current. This will mean that ESR is specifically updated for:

- all board members within an NHS organisation
- new board members who have been appointed within an NHS organisation
- whenever there has been a relevant change to one of the fields of FPPT information held in ESR (as per section 3.10.1 below)
- updates for annual completion of the full FPPT
- annual completion of FPPT confirmed by chairs.

It will be the responsibility of each NHS organisation to ensure that ESR remains current and is updated for relevant changes in a timely manner. As a minimum it is expected

that each NHS organisation conducts an annual review to verify that ESR is appropriately maintained.

The chair will be accountable for ensuring that the information in ESR is up to date for their organisation.

NHS organisations will need to establish policies and procedures for collating the relevant information in an accurate, complete and timely manner for updating ESR.

NHS organisations will need to establish a process for individuals to access and exercise their rights in connection with the information held about them, in accordance with the requirements of data protection law.

3.10.1 Information held in ESR

The information that ESR will hold about board members is detailed below and also summarised in the FPPT checklist.

The supplementary guidance document provides specific step-by-step instructions for NHS organisations to update and maintain ESR.

The FPPT assessment on initial appointment of a board member will cover all points mentioned below:

- First name*
- Second name/surname*
- Organisation* (that is, current employer)
- Staff group*
- Job title* (that is, current job description)
- Occupation code*
- Position title*
- Employment history:*
  - This would include detail of all job titles, organisation departments, dates, and role descriptions.
  - Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, would not need to be explained.
- Training and development
- References:*

  - Available references from previous employers, board member references, including resignations or early retirement.
- Last appraisal and date
- Disciplinary findings
  - That is, any upheld finding pursuant to any trust policies or procedures concerning employee behaviour, such as misconduct or mismanagement, this includes grievance (upheld) against the board member, whistleblowing claims against the board member (upheld) and employee behaviour upheld finding.
- Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
- Type of DBS disclosed* †
- Date DBS received* †
- Disqualified directors register check
- Date of medical clearance* (including confirmation of OHA)
- Date of professional register check (eg membership of professional bodies)
- Insolvency check
- Self-attestation form signed
- Social media check
- Employment tribunal judgement check
- Disqualification from being a charity trustee check
- Board member reference*
- Sign-off by chair/CEO.

It should also be noted that the national insurance number is an additional check where there may have been a change of name highlighted in the initial or annual assessment.

The annual FPPT requires an NHS organisation to validate all fields above – except for:

* Fields marked with an asterisk (*) – these do not require validation as part of the annual FPPT unless a specific reason arises. However, these fields should still be updated in the event of a change to the information held.

† While not requiring annual validation, DBS checks will be done on a three-year cycle.

3.11 Record retention

The ESR FPPT data fields will retain records of completed tests to support the FPPT assessments. All supporting documents/records in relation to the FPPT will be held locally by each individual NHS organisation.

As such, an NHS organisation should establish, implement and maintain adequate policies and procedures to comply with GDPR and the NHS Records Management Code of Practice.

The NHS Records Management Code of Practice sets out expectations in relation to retaining actual staff documents/records for a period of six years.

However, NHS organisational case documents/records may be retained for longer than the standard six years, based on the facts of the case. This will be a local decision for each NHS organisation.

When determining how long to retain documents/records in relation to disciplinary and similar cases and where applicable, NHS organisations should make an assessment as to the severity of the misconduct and/or mismanagement and its impact to the FPPT. The more serious the issue the longer the retention period should be.

In relation to ESR, the information and accompanying references should be kept career long, which at a minimum should be until the 75th birthday of the board member.

3.12 Dispute resolution

1. Data and information

Where a board member identifies an issue with data held about them in relation to the FPPT, they should request a review which should be conducted in accordance with local policies in the first instance.

Where this does not lead to a satisfactory resolution for the board member, the following options are available:

- For NHS England-appointed board members (NHS trust chairs and NEDs and ICB Chairs) – the matter should be escalated to the NHS England Appointments Team.
- For chairs not appointed by NHS England – a further request for review can be made to the SID or deputy chair who would establish a process proportionate to

the matter being considered; for example, establishing a panel with at least one independent member.

- For all other board members (including NHS England-appointed board members, and chairs not appointed by NHS England where the above processes have not led to a satisfactory conclusion), the options could include:
  - referring the matter to the ICO
  - (For executive director roles only*) taking the matter to an employment tribunal (ET)
  - instigating civil proceedings.

2. Outcome of FPPT assessment

Where a board member disagrees with the outcome of the FPPT assessment and they have been deemed 'not fit and proper,' the following options are available:

- For NHS England-appointed board member roles – the matter should be escalated to the NHS England Appointments Team for investigation in accordance with extant policy and procedure.
  - Where this results in a board member being terminated from their appointed role, a BMR** must be completed and retained by the local organisation in accordance with the Framework.
- For non-NHS England-appointed roles (executive and non-executive) – local policy and constitution arrangements should be followed first.
  - NHS organisations may wish to take their own legal advice or seek advice from NHS England.

At any point, employees have the right to take the matter to an ET*.

* Chair and non-executive board members cannot take their organisation to ET unless in relation to discrimination, but they can instigate civil proceedings.

** Exit BMR to be drafted by local chair for non-executive directors [NEDs] (with support from the NHS England Appointments Team), and by the NHS England Appointments Team for chairs.

Section 4: Quality assurance and governance

To ensure that the FPPT is being adequately embedded within NHS organisations there will need to be quality assurance checks conducted by the CQC, NHS England and an external/independent review. The quality assurance checks over the various parts of the FPPT Framework have been detailed below.

4.1 CQC quality assurance

The CQC's role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations. As such, as part of the Well Led reviews, CQC will consider the:

- quality of processes and controls supporting the FPPT
- quality of individual FPPT assessments
- board member references, both in relation to the new employing NHS organisation but also in relation to the NHS organisation which wrote the reference
- collation and quality of data within the database and local FPPT records.

In doing so the CQC will have regard to the evidence that exists as to whether the board members meet the FPPT. For example, this includes, but is not limited to, checking the following forms of evidence:

- That the NHS organisation in question is aware of the various guidelines on recruiting board members and that they have implemented procedures in line with this best practice.
- Personnel files of recently appointed board members (including internal appointments of existing staff).
- Information or records relating to appraisals for board members.
- References and personal development plans.

The CQC may intervene where there is evidence that proper processes have not been followed or are not in place for FPPT. While the CQC does not investigate individual board members, it will pass on all information of concern that is received about the fitness of a board member to the relevant NHS organisation.

The CQC will notify NHS organisations of all concerns relating to their board member and ask them to assess the information received. The board member to whom the case refers will also be informed.

NHS organisations should then detail the steps they have taken to assure the fitness of the board member and provide the CQC with a full response within 10 days. The CQC will then carefully review and consider all information.

Where the CQC finds that the NHS organisation's processes are not robust, or an unreasonable decision has been made, they will either:

- contact the NHS organisation for further discussion
- schedule a focused inspection
- take regulatory action in line with their enforcement policy and decision tree if a clear breach of regulation is identified.

4.2 NHS England quality assurance

NHS England will have oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations.

4.3 Internal audit/external review

Every three years, NHS organisations should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The internal audit should include sample testing of FPPT assessment and associated documentation.

NHS organisations should consider inclusion of FPPT process and testing in the specification for any commissioned Well-Led/board effectiveness reviews.

4.4 Governance

For good governance, organisations should be clear about the reporting arrangements across the FPPT cycle. This is likely to include:

- an update to a meeting of the board in public to confirm that the requirements for FPPT assessment have been satisfied at least annually
- consideration by the Audit Committee, for example where there is a related internal or external audit review included in the audit programme

- relevant information to the Council of Governors (CoG) in an NHS foundation trust as described in section 4.5 below.

4.5 NHS foundation trusts – appointment and removal of the chair and non-executive directors

The document 'Your statutory duties- A reference guide for NHS foundation trust governors' refers to the role of the CoG in appointing and removing the chair and NEDs. The FPPT Framework should be considered alongside this document and the local trust constitution. The CoG in an NHS foundation trust:

- Should continue to make chair and NED appointments in accordance with their statutory duties and local constitution. These continue to be subject to satisfactory recruitment checks, and this will now include consideration of the initial FPPT assessment.
- Should continue to '…receive performance information for the chair and other non-executive directors as part of a rigorous performance appraisal process …' in accordance with their local constitution. Performance appraisals will now include application of the LCF in accordance with the Framework.
- Should be advised of any outcome from a non-executive board member (including the chair) FPPT assessment as 'not fit and proper.' Dependent on the circumstances and in accordance with the local constitution, the CoG would be involved as appropriate with any subsequent removal process, where applicable.

The CoG should receive support from the SID and/or the company secretary and use the governance arrangements already in place in their trusts, such as the nomination committee.

4.5 Integrated care boards

ICBs should apply the Framework alongside relevant statutory requirements and the existing requirements of their organisation's constitution.

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

Classification: Official

2.2

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
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18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

Publication reference: PRN00719

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

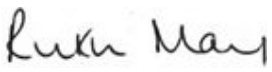
This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England



Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 October 2023

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:	4 October 2023							
Subject / title:	Corporate Risk Register							
Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper presents data for Trust risks scoring 15 and above for all our services. It is a snapshot of risks across the Trust and was taken from our Datix database on 5 September 2023. This paper had been reviewed at Risk Management Group in September. The overall number of risks scoring 15 and above is 50, a decrease of 8 from the paper presented to Risk Management and Senior Managers meetings in July. See section 2, tables 1 and 2. Section 3 provides detail on the 4 risks scoring 20. There is one new risk. • Three are risks in the category of Quality (Safety), for constitutional standards - two regarding the Emergency Department (ED) and one for referrals to treatment standard. These risks have been on our registers for several years. • The new risk is under statutory compliance for estates Actions and mitigations for each risk are detailed in section three. Two new risks scoring 16 have been raised since 4.7.2023, in section 4: • One for quality (patient experience): regarding PALs team staffing • One for people: staff shortages to deliver voluntary services A new risk scoring 15 raised since 4.7.2023, in section 5: • One risk under statutory compliance for estates							
Recommendation:	Trust board is asked to review and discuss the contents of the corporate 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**			
	√	√	√	√	√			

Previously considered by:	This paper has been reviewed at Risk Management Group Risks are reviewed regularly, therefore some changes are detailed in this paper comparted with that discussed at RMG

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

	Divisions and corporate teams review their risks at their local governance meetings. Teams escalate new risks and those that they require assistance with for discussion at Risk Management Group on a monthly basis.
Risk / links with the BAF:	There is a direct link between the risks detailed in this paper and on the BAF
Legislation, regulatory, equality, diversity and dignity 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

1.0 Introduction

This paper details risks scoring 15 and above with data extracted from the Datix system on 5 September 2023. This paper will continue to be updated during September as risk is managed as a dynamic process across services.

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

As we embed the new Risk Management Strategy and Policy we now assess and review risks against their categories, risk appetite and risk tolerance levels. The format of this paper therefore has been amended away from the 5Ps and moved to use of the risk categories.

Going forward this paper will cover risks that have been agreed for placement on the corporate risk register, this includes risks that:

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

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

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

The discussions at risk management group and senior management team meetings will evolve over the coming months and so the content of future papers may change as we adapt to the new approach. All feedback for the improvement of this paper is welcome

2.0 Context

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

There are 50 risks scoring 15 and above. RMG is progressing with the review of corporate and divisional risks escalated against the new criteria for inclusion onto the corporate register. A separate paper is completed and taken to Senior Management Team meeting monthly to ensure all leaders are sighted to these new risks and that the request for placement on the corporate register is discussed and agreed. The annual work plan has been changed mid-year to facilitate this.

It is anticipated that ideally there should be two full cycles of corporate and divisional teams discussing their risks at RMG for this to be achieved. The first cycle was completed by the end of July and the second cycle will be completed by end of October 2023.

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

Table 1 - Risks scoring 15 or more	Risk Score				
	15	16	20	25	Totals
Cancer & Clinical Support	0 (1)	6 (5)	0 (1)	0 (0)	**6 (7)**
Estates & Facilities	7 (4)	2 (3)	1 (1)	0 (0)	**10 (8)**
IM&T	0 (0)	1 (2)	0 (0)	0 (0)	**1 (2)**
Operational	0 (0)	0 (3)	0 (0)	0 (0)	**0 (3)**
Corporate	0 (0)	4 (0)	0 (0)	0 (0)	**4**
FAWs Child Health	1 (1)	1 (1)	0 (0)	0 (0)	**2 (2)**
FAWs Women's Health	1 (4)	0 (4)	0 (0)	0 (0)	**1 (8)**
Medicine	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Surgery	4 (3)	3 (3)	0 (0)	0 (0)	**7 (6)**
Urgent & Emergency Care	1 (2)	7 (6)	1 (1)	0 (0)	**9 (9)**
Trust wide	2 (4)	4 (6)	2 (2)	0 (0)	**8 (12)**
Totals	**17 (20)**	**29 (33)**	**4 (5)**	**0 (0)**	**50 (58)**

(The scores from paper presented at RMG/ SMT in July are detailed in brackets)

The breakdown of risks that exceed the risk category appetite tolerance is in table 2. Risks scoring less that 15 will be considered by the divisions / corporate teams for inclusion onto the Corporate risk register through reporting as an exception to the RMG who will consider and where appropriate escalate with a recommendation that SMT give approval.

Table 2 – Number of risks by category that exceed appetite tolerance	Risk Appetite tolerance level	Risk Score					Totals
		10	12	15	16	20	
Quality – Safety	≥ 10	21 (21)	67 (63)	7 (9)	19 (25)	3 (5)	**117 (123)**
Quality – Patient Experience	≥ 12		9 (10)	2 (4)	1 (0)	0 (0)	**12 (14)**
Quality – Clinical Effectiveness	≥ 12		15 (14)	0 (0)	1 (1)	1 (1)	**17 (16)**
People	≥ 15			2 (2)	6 (3)	0 (0)	**8 (5)**
Statutory Compliance & Regulation	≥ 12		12 (11)	5 (2)	0 (1)	1 (0)	**18 (14)**
Finance	≥ 12		4 (4)	0 (0)	1 (1)	0 (0)	**5 (5)**
Reputation	≥ 15			1 (1)	0 (0)	0 (0)	**1 (1)**
Infrastructure	≥ 15			1 (1)	1 (1)	0	**1 (2)**
Information and Data	≥ 10	0 (1)	12 (9)	0 (0)	0 (0)	0 (0)	**12 (10)**
Systems and Partnerships	≥ 15			0 (0)	0 (0)	0 (0)	**0 (0)**

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

It should be noted that while the vast majority of risks have been transferred onto the Datix risk register from the Allocate system, there continues to be a few teams that have yet to complete this task. Therefore 18 risks are still stored on the Allocate system.
Support has been offered to those who are yet to complete this work.

3.0 Summary of risks scoring 20

There are 4 risks with a score of 20, one is new. A summary of these risks and mitigations is below, information taken from divisional risk registers:

3.1 Quality – (Safety):

3.1.1 Emergency care access standard – Two risks on the register

- There is a risk that patients may deteriorate as a result of failing to deliver the ED four-hour standard. (Risk reference: 85, on Trust wide risk register, also on the corporate risk register. This was initially raised 2016).
- There is a risk that the Trust is not meeting the national ED four-hour standard which is caused by lack of capacity, non-compliance with internal professional standards, staffing capacity and patient demand within the department. This may result in a risk to patient safety and experience and potential to cause harm. (Risk reference: 310, on emergency department operational risk register, initially raised 2016 on ED register).
  Actions: Expand the skill base of nursing staff through our training programme, expand consultant presence until 22.00 hours, use of rapid assessment, triage and adult assessment unit. Now using the Manchester Triage tool and Nerve Centre to improve clinical information and prioritisation of patients. Breach validation for all patients exceeding 4 hours, safety huddles 3 hourly with regular board rounds with ED Bronze, agreed escalations in place. Improvement trajectory agreed and oversight using the Urgent Care board.

3.1.2 Referral to treatment constitutional standards

- Risk that patients waiting over 52-week for treatment may deteriorate and come to clinical harm. The numbers of patients waiting over 52 weeks has increased significantly during Covid 19 pandemic and there is insufficient capacity to treat them all within a year. (Risk reference: 497, on Trust wide risk register, also on corporate risk register, raised February 2017, score increased since the pandemic).
  Action: Meetings to review patient target lists (PTL) and individual patients completed with outpatient bookers, to escalate relevant cases to divisional teams. Patients booked in order of clinical priority, monitoring of PTL continues weekly, with priority for long waits. Cancer PTL reviewed daily. Daily circulation of PTL for escalation and long wait plans. Trajectory to reduce number of patients waiting >52 weeks with oversight by the Elective Care Operational Group and System Access Board.

3.2 Statutory Compliance and regulation:

3.2.1 NEW: Estates infrastructure

- The is a risk that a critical infrastructure in Trust estate may fail due to understaffing of the department and the need to have a qualified individual to complete regular testing and maintenance (Risk reference: 560, raised August 2023 on Estates & Facilities operational risk register)
- **Action**: Trust employs contractors to complete all necessary checks, completed work schedule is in place.

4.0 Two NEW risks with a score of 16 have been raised since 4/7/2023

- **4.1 Quality (Patient Experience): NEW: Loss of PALs team functionality due to a fragile staffing model**
  There is a risk that the PALs service will not be able to answer calls live or respond to families face to face in a timely way to resolve concerns due to due to unplanned leave and leavers (Risk reference: 541, this is a corporate risk and currently on an operational risk register, raised August 2023)
  Action: Process mapping and streamlining functionalities by reviewing job roles taking place. Task delegation to divisional subject matter leads, with Assistant service managers and Service managers supporting. Temporary contracts in use to cover band 3 role and a band 2 administration assistant in place.

People:

4.2 NEW: Staff shortages to deliver voluntary services strategy

- There is a risk we will be unable to recruit new volunteers and continue to maintain the service offered as a result of substantive staff vacancies (Risk reference: 537, on corporate services operational risk register, raised August 2023)
  Action: Voluntary service manager is working additional hours on NHSP, voluntary services strategy and policy are in place. Compliments and thanks to the team are recorded for sharing within the service.

5.0 One NEW risk with a score of 15 raised since 4/7/2023

5.1 NEW: Fire safety

- There is a risk that the Trust is non-compliant with managing healthcare fire safety as we need to have a rehearsed fire emergency plan, an arson policy and a fire strategy for each of our buildings (Risk reference: 554, on Estates & Facilities operational risk register, raised August 2023)
  Action: Contractors used to complete checks. Fire policy in place. Fire dampers serviced and maintained and certificated using a contractor.

6.0 Recommendation

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

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

The Princess Alexandra Hospital NHS Trust

Trust Board – 5 October 2023

3.2

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

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

Key issues:	The Board Assurance Framework (BAF) is presented for review and approval. The risks have been updated with executive leads and reviewed at the relevant committees during September 2023. The risk scores have not changed this month and are summarised in Appendix B. It is proposed to increase the risk score for BAF Risk 5.1 (Finance – revenue) from 12 to 16. The risk was discussed at PAF and PAF supported the increase in score. The risk is attached as Appendix C. The full BAF is available in the resources section of Diligent.
Recommendation:	The Board is asked to: - Approve the increase in score for BAF risk 5.1 and note the updates to the risks.

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

Previously considered by:	STC, QSC, PC and PAF in September 2023.
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance in relation to risk management. The controls and mitigating actions outlined in the risks are designed to support delivery of the Trust's strategic objectives and promote an organisational culture that drives improvements in equality, diversity and inclusion.
Appendices:	Appendix B – BAF dashboard Appendix C – BAF risk 5.1 Finance

Board Assurance Framework Summary 2023.24

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

Board Assurance Framework Summary 2023.24

	Risk that the Trust will fail to meet the financial plan due to the following factors: An annual plan has been set to deliver a deficit plan of £5.1m inclusive of a CIP requirement of c. £16.7m in 2023/24. The plan of £5.1m deficit was originally one of £12m deficit but was improved only following the agreement by the ICS to identify opportunities to improve the deficit through service reconfiguration and following £1.9m of non-recurrent funding allocated to the Trust in 2023/24. Inflation remains high, productivity remains a challenge and there is risk around income from the part move to a PbR basis. Cash will be a challenge in year with the potential deficit driving the Trust towards an adverse cash position.										

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2023-24**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.													
BAF 5.1		**Finance - revenue :** Risk that the Trust will fail to meet the financial plan due to the following factors: An annual plan has been set to deliver a deficit plan of £5.1m inclusive of a CIP requirement of c. £16.7m in 2023/24. The plan of £5.1m deficit was originally one of £12m deficit but was improved only following the agreement by the ICS to identify opportunities to improve the deficit through service reconfiguration and following £1.9m of non recurrent funding allocated to the Trust in 2023/24. Inflation remains high, productivity remains a challenge and there is risk around income from the part move to a PbR basis. Cash will be a challenge in year with the potential deficit driving the Trust towards an adverse cash position.	**Causes:** The main causes of risk are : (i) The current financial regime operates under 'block contract' arrangements in the main (c. 70% of activity). There is limited capacity for Commissioner contracts to be varied and we do not feel the current allocation recognises the full cost of delivering services e.g. Provision of Urgent Treatment Centre, or some of the ancillary costs arising from community provision etc. Non recurrent funding experienced in recent years e.g. Covid is reducing. (ii) Productivity remains a challenge for the Trust having seen a decrease in Covid. We have not factored PbR Under delivery into our position but will remain a risk as we struggle to compare to the 'new normal'. Elective Recovery Funding activity levels have been set for 23/24. The system may not achieve the required activity levels. Consequently, this may put the reimbursement of ERF in jeopardy (though all ERF funding has been paid regardless of performance within the system). (iii) Financial plans include a requirement to deliver CIPs which have now been branded as Patient Quality and Productivity schemes (PQP). PQP programme is identified but delivery will be challenging; there the plans have been modelled against GIRFT opportunity and there remains a plan for delivering the full amount but it will be challenging to deliver savings at this level. iv) The final movement from £12.0m to £5.1m includes £5.1m of funding due from the ICS formally in M12 and we also require services to be reviewed and decommissioned accordingly by the system. We assume such opportunities will arise in year in line with the agreed Memorandum of Understanding signed by stem partners to deliver financial wellbeing at a system level. v) Productivity and cost challenges arising from the industrial action which is impacting our ability to live within our means.	4 X 4= 16	**Exec leads:** DoF **Committee** : Performance and Finance Committee	Key Controls include : (i) Oversight of Directorates and their PQP programmes; the financial position is much better understood by all. (ii) Divisional / Corporate performance review meetings are in place where performance is being monitored and has been recently reinvigorated; anticipated to take the approach more into the engine room approach modelled within PQP, led by the DoF. (iii) Vacancy control groups are in place but will attract more scrutiny and oversight; linked to the concept of 'earned autonomy' that will be delivered through the PQP and PRM programme. (iv) Oversight of the Trust's financial performance by the EMT, SMT, PAF, People and Audit Committee. (v) Monthly monitoring of financial performance by HWE and NHSE through the submission of financial returns; [potential to move to a more challenging environment e.g. SOF4. (vi) Strengthening of financial control and governance including an improved governance process for business case investmentusiness case approval process. (vii) Development of bilateral working groups at Place / System level to improve commissioning / spend decisions across the ICS. viii) Better system oversight and a collective response to the wider challenges within the ICS.	(i) Performance review meetings - monitoring against plan and forecast, including reinvigorated Performance Review Meetings (PRM's). (ii) Internal audit reports / Head of Internal Audit Opinion (iii) External audit opinion (iv) Cash management monitoring and adequate cash balances (v) PQP tracking including 'deep dives' by lead NED. (vi) Reductions in run rate evidenced alongside transformation initiatives.	Positive Assurances : (i) Delivery against YTD and forecasted plans. (ii) CIP delivery and forecast to plan. (iii) Substantial assurance rating on internal audit reports. iv) Monthly reports to PAF and IPR reporting v) A bottom up exercise is being undertaken to better understand the cost pressures driving the underlying position within the Trust. vi) The Trust is now more cognisant of the risks around financial delivery and actions are being taken to reduce run rates across all areas. vii) The position is being discussed with commissioners and regulators alike. viii) The system is now moving to a monthly cycle of meetings with NHSE chairing to oversee financial delivery within the Trust. ix) A CEO led forum has been developed within the ICS to look at the long term financial viability of the system and to look at system opportunities.	~~4x3=12~~ 4 X 4= 16	**Gaps in Control** : (i) Instances of non-compliance across the organisation in relation to SFIs i.e. non compliant waivers (ii) Activity and demand and capacity planning not fully triangulated with finances. (iii) PQP delivery plans established but being refined. (iv) Embedding management of temporary staffing costs and impact on the ground in light of clinical need. (v) Existence of manual processes across the Trust and over reliance on 'work around'. (vi) Deliverability of the recovery plan within the system.	**Gaps in Assurance :** (i) Proposed financial regime for oversight to be confirmed (both system level and regional) (ii) Fully triangulated business and operational planning including demand and capacity plans. (iii) Business case benefits development and realisation process. (iv) Focus and prioritisation of finance across the wider gamut of challenges across the Trust. (v) Pace of change of delivery given other cultural challenges.	21/09/2023	**Residual risk score increased to 16**	**4 x 2 = 8 (Q4 2023/24)**
			Effects: (I) Challenges to meet financial control targets, including delivery of our CIP (ii) Delivery of revenue position may impact on future capital availability. iii) May require additional external support in addition to prescribed system financed initiatives (above).							**ACTIONS:** (i) Transformational and modernisation work plans. (ii) Demand and capacity planning and modelling to be regularised. (iii) Introduction of a PMO. (iv) Review of Governance Manual/SFI's				

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Kim Handel (Chair)**			
DATE OF COMMITTEE MEETING:	**29 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Infection Prevention & Control (IPCC) Update	Y	Y	N	The DIPC reported there had been a couple of cases of STEC (shiga toxin-producing Escherichia coli) which was rare, but patients had done well. There was work underway to improve the Staphylococcus aureus bacteraemia rate and additional work was also underway around Gram-negative bacteraemias even though performance in terms of pseudomonas was good. There had been a slight increase in cases of Clostridium-difficile over the summer but comparatively, the Trust performance was good. It was noted that the reason training compliance, with regards to IPC, had recently dipped was due to the implementation of a new learning platform along with a review of the staff profile, which had resulted in an additional number of staff now requiring training.
2.2 Report from Learning from Deaths Group and Learning from Deaths Update	Y	Y	N	Mortality indicators are improving (reference LFD report for Board). Despite a backlog in outstanding structured judgement reviews (SJRs) due to added recent pressures on consultants, the Committee noted the number of other areas, for example divisional M&Ms and review of all deaths by the Medical Examiners, where learning and opportunities to improve were being captured.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Kim Handel (Chair)**			
DATE OF COMMITTEE MEETING:	**29 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 Report from Clinical Effectiveness Group (CEG)	Y	Y	N	• The group had approved the Clinical Audit Strategy up to 2027. • In terms of a Trust-wide effectiveness update on audit and NICE, divisions had been asked to confirm participation in national quality account audits. • A paper had been discussed on compliance against Local Safety Standards for Invasive Procedures (LocSSIPs) and National Safety Standards for Invasive Procedures (NatSSIPs) and a task and finish group is progressing that work.
2.4 Report form Clinical Compliance Group	Y	Y	N	• **Annual Cervical Screening Report:** This has demonstrated a high level of accuracy and consistency in information submitted. A risk has been identified for the administration team in Colposcopy regarding staffing levels. The group had requested that the division review the risk score and updates with progress to address the risk were being made to external stakeholders including West Essex Programme Board. • **Procedural documents:** Trust compliance was slowly improving and was now 84%. The group had been pleased to note this had increased by 6% since February 2023 with the aim now for a compliance rate of 90%.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Kim Handel (Chair)**			
DATE OF COMMITTEE MEETING:	**29 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 Medicines Optimisation Annual Report	Y	Y	N	The team was commended on a very comprehensive and positive report, despite current workforce issues. The Committee noted the huge amount of work underway to ensure patient safety in terms of medicines management and an offer of support was made to pull current projects into the Trust's PM3 software tool so those could be properly monitored and tracked going forward.
2.6 BAF Risk 1.1 (Clinical Outcomes)	Y	Y	N	In line with a previous request the risk score had been reviewed but the recommendation was that this should remain at 16 and QSC was happy to endorse this recommendation.
2.7 Quality Programme Management Office (QPMO) Update	Y	Y	N	The focus remained on addressing reds and progressing ambers. The two red-rated items remained: • S2 (ED 4 Hr standard) sustained lower quartile performance • S3/N (Safeguarding Training) where it is considered there is currently insufficient assurance and grip, remains a cause of concern. There were three red milestones which related to compliance trajectories not being met rather than actions

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Kim Handel (Chair)**			
DATE OF COMMITTEE MEETING:	**29 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				undelivered. External peer review panels continued to be held successfully, providing a good level of challenge and oversight and additional BAU forms were being prepared.
2.8 Quality Improvement & Transformation Update including draft QI Strategy	Y	Y	N	The paper outlined the scope and focus for the emerging PAHT2030 Change Strategy. QSC reviewed the proposed scope and focus of the Strategy and endorsed the proposed trajectory and next steps.
2.9 Reports from Patient Safety Group	Y	Y	N	The key focus of the group's August meeting had been the new Patient Safety Incident Response Framework (PSIRF) and the new ways of working this would require. Key highlights from the September meeting had been the notable increase in acts of violence and aggression against staff. Additionally, the key recommendation from the Serious Hazards of Transfusion (SHOT) Annual Report which had been had been to ensure that policies and training were in place to avoid delays in transfusion that the formal pre-transfusion risk assessment for Transfusion Associate Transfusion Overload (TACO) should be undertaken wherever possible for all patients receiving a blood transfusion (in line with national learning).

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Kim Handel (Chair)**			
DATE OF COMMITTEE MEETING:	**29 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.10 Volunteer Strategy	Y	Y	N	The Strategy was presented for information only as it had already been endorsed by the Senior Management Team and also the People Committee. The work of the Trust's volunteers was highly commended.
2.11 Patient Safety & Quality Update	Y	Y	N	Key headlines for July/August were: • 1130 incidents reported in July and 1111 in August. • 616 incidents open >30days: 206 (of 616) with formal investigation and 410 for reviews within divisions. • 17 open serious incidents (SIs) – two new incidents raised in July/August. • Benchmark data outlined. • 9 new claims in July and 5 in August – 7 closed over the 2 months at a cost of 229k. • 12 new inquests notified, 4 closed and no care concerns. • 727 procedural documents 84%. • Clinical Audit Strategy 2023-26 approved. NICE guidance: 189 under review and 17 yet to be assessed – increasing position. It was noted that new functionality would be added to Datix to provide an alert to colleagues that incidents remained open.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Kim Handel (Chair)**			
DATE OF COMMITTEE MEETING:	**29 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.12 Lucy Letby Verdict and Learning	Y	Y	N	The report provided an update on the recent Lucy Letby verdict and outlined the proposed approach to be taken at PAHT and in advance of the outcome of the independent inquiry. QSC noted the detail in the report and considered the role of the Committee in understanding, reviewing and acting upon available data and intelligence to read any signals.
2.13 Sharing the Learning 4 Monthly Update	Y	Y	N	The report was presented for information and identified the learning from eight cases, a mixture of both complaints and incidents. The Committee was assured that learning was taking place and processes were being reviewed where appropriate.
2.14 Nursing Midwifery & AHP Update	Y	Y	N	This was provided for information as it had already been presented to the People Committee. The paper provided an update to the four-year strategy for Nursing, Midwifery & AHPs, highlighting key achievements and risks to the programme. Delivery of the strategy had made good progress, with oversight and progress monitored through the Nursing, Midwifery & AHP senior leadership team. Work had commenced to develop the next iteration of the strategic priorities for 2024–27. Following feedback from

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DATE OF COMMITTEE MEETING:	**29 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				the People Committee, the update to strategic priorities impacting on quality were noted.
3.1 M5 Integrated Performance Report	Y	Y	N	The Committee was assured that patient safety and quality metrics were reasonably positive and stable.
3.2 Review List/ASI Update	Y	Y	Y	Operational and clinical teams were working hard to reduce the backlog of patients waiting for appointments. The Trust had plans in place with recovery trajectories to monitor progress on the actions in place. Increased demand for appointments to support patients on suspected cancer pathways was increasing. Industrial action was contributing to additional pressure on backlog clearance. The Trust was collaborating in a national requirement to see all March '24 65+week patients in clinic by 31.10.23. The impact of the industrial action on both out-patients and theatre scheduling was shown in the report. The competing pressures on out-patient capacity of open pathways (both new and follow-up), ASIs, cancer and urgent referrals, along with preparation for and recovery from industrial action were impacting the long waits of all patients.
4.1 Horizon Scanning Update	Y	Y	N	• **Industrial action:** The Trust's governance structure remained in place to support strike action and after-

BOARD OF DIRECTORS:	Trust Board (Public) – 5 October 2023			AGENDA ITEM: 4.1
REPORT TO THE BOARD FROM:	Quality and Safety Committee (QSC)			
REPORT FROM:	Kim Handel (Chair)			
DATE OF COMMITTEE MEETING:	29 September 2023			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				action reviews were being held following each event. All patient safety and patient experience incidents were being captured and the longer term impact the industrial action would have on both quality of care and treatment was fully recognised. • **Healthcare Safety Investigation Branch (HSIB):** HSIB had published their annual report plus three new reports: 1) Harm caused by delays in transferring patients to the right place of care 2) The selection and insertion of vascular grafts in haemodialysis patients and 3) Variations in the delivery of palliative care services to adults. • **Herts and West Essex ICB Quality Strategy:** A whole system workshop was held on 06.09.23 to finalise the Quality Strategy which would be launched in coming months. The Chair of the ICB Quality Committee had undertaken all site visits including PAHT.

BOARD OF DIRECTORS:	**Trust Board (Public)**			**AGENDA ITEM:**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Rob Gerlis - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Maternity Report (dashboard)	Y	Y	N	QSC II noted a small reduction in month in relation to PPH, slight increases in both complaints and the pre-term birth rate An update on actions being taken in relation to the increase in pre-term birth rates will be presented to the next meeting. The impact of industrial action on mandatory training rates for medical staff was highlighted. Going forward, the dashboard would highlight the neonatal sections which are aligned to learning from the Letby case. Staffing red flags have reduced. Compliance with the requirements of Year 5 of the Maternity Incentive Scheme was discussed and the risks around achieving 6 of the 10 safety actions highlighted. A full risk assessment is underway and will be reported back to the next meeting. The Board will receive a detailed update on compliance with the scheme in the public session.
2.3 Maternity SI Report	Y	N	N	No new maternity incidents have been declared since the last report for August 2023. Maternity services currently have 2 SI's under investigation (0 HSIB).

BOARD OF DIRECTORS:	**Trust Board (Public)**			**AGENDA ITEM:**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Rob Gerlis - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 Deep Dive Birth Reflections Service	Y	N	N	The paper provided an overview of the themes and actions from the Birth Reflections Clinic. Areas of improvement and challenge for both Maternity and neonatal services were noted.
2.6 Maternity and Neonatal Safety Champions' Report	Y	N	N	The maternity safety champion completed a walk round. The group discussed two reports; 'Black Child Clean Air' report and 'Review of Neonatal Care for Black, Asian and Ethnic Minorities'. The service is reviewing the recommendation and actions will be implemented as needed.
2.8 Maternity Safety and Support Programme Report	Y	N	N	Work is underway in relation to the service exiting the programme – a refresh of the medical culture is underway and ICB oversight after the exit is being reviewed.

The Princess Alexandra Hospital NHS Trust

Public Trust Board: 5 October 2023

4.2

Agenda item:	4.2							
Presented by:	Linda Machakaire, Director of Midwifery, Gynaecology & Assistant Chief Nurse							
Prepared by:	Erin Walters, Head of Maternity Governance and Assurance							
Date prepared:	04th September 2023							
Subject / title:	Overview of Serious Incidents within maternity services							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards. There have been no new maternity incidents declared since the last report for August 2023 There have been no maternity incidents closed since the last report (July 2023) Maternity services currently have 2 SI's under investigation (0 HSIB).							
Recommendation:	To provide assurance to the Quality and Safety Committee that the maternity service are continually monitoring compliance and learning from Serious Incidents.							

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

Previously considered by:	Quality Safety Committee Part 2
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the Ockenden interim report that was published in December 2020 with recommendations for maternity services.
Appendices:	1. Open Serious Incidents under investigation

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

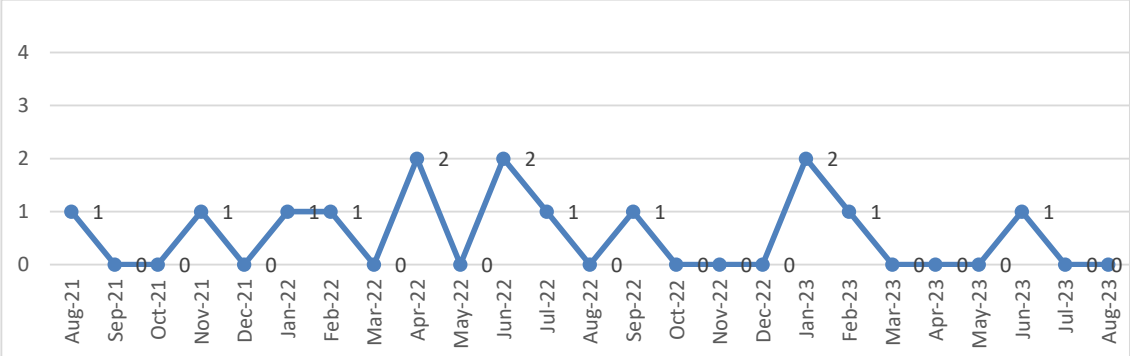
2.0 Background

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

3.0 Analysis

Maternity currently have 2 SI's under investigation, neither of which are being investigated by Healthcare Safety Investigation Branch (HSIB), the detail can be found in Appendix 1. Table 1 details the trend of declared SI's within the last 24 months to August 2023.

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



There were no new Maternity serious incident declared in August 2023

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

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

4.0 Themes

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

Table 3. Top Themes

Total Number of SI's	Theme	Number
14	Neonatal death	4
	Cardiotocograph (CTG) interpretation	2
	Obstetric Haemorrhage	2
	Cross Border Working	2
	Delay in care	2
	Intrauterine death	2
	Hypoxic ischaemic encephalopathy	2
	Retained Object	2
	Escalation	1
	Medical Equipment	1
	Screening Incident	1
	Therapeutic Cooling	1

5.0 Oversight

All highlighted concerns have been escalated at Divisional level. All incidents are discussed at the Women's Weekly Assurance Meeting, the monthly Divisional Governance Meeting and the twice weekly Trust Incident Management Group with escalation, where relevant, for further investigation. A Maternity Assurance Committee has been established (February 2022) to provide assurance for quality and safety of the maternity service.

The Maternity Improvement board (MIB; launched 12th August 2021) continues to drive change within the service.

Current work streams for the MIB include:

- Maternity Triage and Telephone Helpline
- Induction of Labour
- Transitional Care
- Fetal Growth
- Diabetes
- Caesarean Booking Process
- Culture
- Antenatal Care – Booking Pathway
- Antenatal Care – Antenatal Clinic Demand and Capacity
- Pre-Term Birth

Each work stream has an identified lead and progress is reported back to the Maternity Improvement Board, and digitally tracked through the PM3 project management tool. MIB reports into the monthly executive Maternity Assurance Committee.

There are three work streams that are subject to closure following extensive work and evidence of improvement:

- Massive Obstetric Haemorrhage/Post-Partum Haemorrhage
- Huddles, Handover and Ward Rounds
- Fundamentals of Care

All evidence will be bought through the Maternity Improvement Board and closed by the Multidisciplinary Team.

6.0 Recommendation

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

Author: Erin Walters, Head of Maternity Governance and Assurance
Date: 04th September 2023

The Princess Alexandra Hospital NHS Trust

Open SI's under Investigation (excluding in month new declaration)

Ongoing Serious Investigations				
Ref	**Date Reported on STEIS and STEIS Code**	**Ethnicity**	**Summary**	**Learning Points**
Paweb 127181	**21/02/2023** 2023/3821	White British	The patient was readmitted unwell and found to have a retained vaginal swab was identified.	• Ensure the WHO checklist is completed for every patient undergoing a surgical procedure in theatre • LOCSSIPS forms are in place for procedures outside of theatre • "Pause for Gauze" - when counts are taking place noise and distractions must be kept to a minimum to enable the scrub and circulating practitioner to complete the surgical counts. • All swabs should be recorded in multiples of five on the count board. Additional swabs require an individual count and are added to the count board in five's e.g. 5+5+5 • Perineal checks should be offered at every postnatal opportunity, and documented .
PAweb 131328	**15/06/2023** 2023/11702	White British	A full-term baby was transferred to a tertiary neonatal unit for advanced care. Diagnostic investigations were performed to assess long term well-being.	• Case referred to HSIB but rejected • Following initial review of the incident no care issues were identified which may have changed the outcome • Communication between the MDT in view of baby's diagnosis

Trust Board Public Meeting - 5 October 2023

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery, Gynaecology and Assistant Chief Nurse
Prepared by:	Elita Mazzocchi – Maternity Transformation Programme Manager
Date prepared:	27/09/2023
Subject / title:	Maternity Incentive Scheme Year 5 – Update 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	This is the fifth year that NHS Resolutions are operating the Clinical Negligence Scheme for Trusts (CNST) to support the delivery of safer maternity care. The Trust must demonstrate achievement of all the ten safety actions to recover the element of the CNST maternity incentive fund contribution. This paper outlines the trajectory required to achieve the NHS Resolution Maternity Incentive Scheme (MIS) payment for 2023/ 24 and provides assurance that plans are in place to aid achievement of compliance with the ten safety actions.								
Recommendation:	To provide assurance to the Trust Board that the maternity services are continually monitoring compliance with MIS year 5.								
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:	Risk that not achieving compliance with MIS Year 5 has safety implications, and will also mean the Trust is unable to recover the financial contribution that it can re-invest to improve safety.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Resolution publication, Care Quality Commission, Regulatory implications with non-compliance of CNST 10 safety actions, Ockenden recommendations.
Appendices:	N/A

1.0 Purpose

This paper outlines the trajectory required to achieve the NHS Resolution Maternity Incentive Scheme payment for 2023/24 and provides an update on the current compliance position and plans in place to aid compliance with the ten safety actions.

The Scheme requires the Trust's Chief Executive Officer (CEO) to confirm that:

- The Trust Board is satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required sub-requirements, as set out in the safety actions and technical guidance document included in this report.
- There are no reports for the years 2022/ 23 or 2023/ 24 related to maternity services that may subsequently provide conflicting information to your declaration (e.g., Care Quality Commission (CQC) inspection reports, Healthcare Safety Investigation Branch (HSIB) investigation reports, etc.). All such reports should be brought to the attention of the MIS team before the submission deadline.

In addition, the Integrated Care System (ICB) Accountable Officer (AO) will need to be apprised of the MIS safety actions' evidence and, jointly with the CEO, the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

2.0 Background

NHS Resolution is currently in year five of the Clinical Negligence Scheme for Trusts (CNST*)* *Maternity Incentive Scheme* (MIS), which aims to support the delivery of safer maternity care.
The MIS applies to all acute Trusts that provide 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.

MIS year 5 was launched at the end of May 2023. In July 2023, the guidance was further updated, including new publication with updated timescales and standards.

Trusts are required to report compliance with MIS year 5 by **1 February 2024, at 12 noon** to NHS Resolution. However, the majority of the standards have an interim deadline of **8 December 2023.**

Once all evidence has been collected, the Trust Board, Chief Executive Offer (CEO), and Integrated Care Board (ICB) Accountable Officer (AO) will need to sign off on the Scheme's submission, ensuring that the evidence provided demonstrates achievement of the ten maternity safety actions, meeting the required sub-requirements as outlined in the safety actions and technical guidance document included in this report.

Trusts that can demonstrate they have achieved all ten safety actions will recover the portion of their contribution related to the CNST maternity incentive fund and will also receive a share of any unallocated funds. For the Princess Alexandra Hospital NHS Trust (PAHT), this equates to a minimum of ≥£1.2m.

The ten safety actions have remained unchanged from previous years; however, the standards and additional evidence requirements have been updated. This includes recommendations from recently published reports such as *Saving Babies' Lives V3* (NHS England, May 2023) and the new *Core Competency Framework v2* (NHS England, May 2023).
The ten safety actions are framed as questions, as follows:

Safety action	Standard
Safety action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Safety action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Safety action 3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?
Safety action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?
Safety action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?
Safety action 6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?
Safety action 7	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?
Safety action 8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?
Safety action 9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?
Safety action 10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

Each safety action has a required standard and minimal evidential requirements to demonstrate compliance. The MIS year 5 guidance provides details of the assurance framework, along with timescales and responsible personnel for each of the evidential requirements before final sign-off by the Trust Board.

3.0 MIS year 5 progress update and trajectory

PAHT maternity services have been working toward achieving the MIS year 5 safety actions and meeting the evidence submission requirements to qualify for the rebate. The Child Health and Women's Service (CHAWS) Division holds bi-weekly meetings to review progress and collect evidence, which is then shared monthly at the Trust's Quality and Safety Committee (QSC) and Trust Board, to provide oversight on the delivery program.

Outlined in the table below is a summary of the trajectory of compliance with MIS year five, as of September 2023.
Safety action 3, 4, 5, ,6 ,7 ,8 and 9 are currently at risk.
Safety action 2 has been met.
Safety action 1 and 10 are on track.

MIS year 5 – Trajectory

Met
On Track
At risk

Safety action no.	Sept-23	Oct-23	Nov-23	Dec-23	Jan 24
1					
2					
3					
4					
5					
6					

7					
8					
9					
10					

3.1 Safety Action 1
The Perinatal Mortality Review processes have been significantly strengthened and are now fully embedded within the maternity service. We are pleased to report that the trajectory for this safety action has been set as compliant by the submission date.
A robust monthly review of progress with each of the eligible cases is conducted using the MBRRACE-UK portal. A monthly report, which includes details of the deaths reviewed, any emerging themes, and consequent action plans, along with overall compliance with the Scheme's requirements, is provided to the Quality and Safety Committee (QSC) and Trust Board.

3.2 Safety action 2
This action has been successfully met and externally verified by NHS Digital.

3.3 Safety Action 3
To address safety action 3, we have established fortnightly meetings to ensure consistent progress with the transitional care (TC) initiative. We have also achieved improved engagement from our multidisciplinary team (MDT).
The current TC guideline is currently under review and is planned to be ratified in October 2023. A draft TC action plan has been developed and is undergoing peer review by the neonatal and maternity teams.
The trajectory for this action has been set as not on target due to challenges in gaining engagement from medical staffing. This issue has been escalated to the Divisional Director and Director of Midwifery for additional support.

3.4 Safety Action 4
All required actions regarding the Anaesthetic workforce have been successfully undertaken and are on track.
However, due to non-compliance with the neonatal workforce and neonatal nursing workforce, an action plan outlining how to meet the British Association of Perinatal Medicine (BAPM) standards will need to be developed and shared with the Board and East of England Operation Delivery Network (ODN).
The trajectory for safety action 4 has been set as not on target due to the aforementioned challenges in gaining engagement from medical staffing, which is actively being addressed.

3.5 Safety Action 5
Work continues diligently to monitor compliance surrounding the midwifery workforce. This includes the use of the Birthrate+ tool and ensuring that staffing papers are presented to the Trust Board in line with required standards.
The submission trajectory for safety action 5 has been set as non-compliant for December 2023. This allowance allows for all the relevant reports and action plans to be thoroughly submitted.

3.6 Safety Action 6
Efforts are ongoing to ensure that all appropriate audits are carried out and reported in line with standards. Quarterly national reporting has recommenced, and there will be differing trajectories in place for each element of Saving Babies Lives (SBL) Care Bundle v3. However, the current trajectory has been set as non-compliant due to the complexity of the multiple requirements associated with the new version of SBL. There is also a current non-compliance issue with the diabetes pathway for preconception care, which has been raised to the Quadrumvirate and via the Maternity Risk Register.

3.7 Safety Action 7

A collaborative approach continues to be maintained for this safety action, and all efforts are being made to ensure the standards will be met. Ongoing discussions between the current Maternity Voices Partnership (MVP) Chair and ICB regarding renumeration are ongoing. Until an agreement is reached, the trajectory for this action will be set as non-compliant for February 2024.

3.8 Safety Action 8

Despite the challenges posed by the COVID-19 pandemic, all relevant training has continued. The Division is on target to reach a compliance rate of over 90%.
However, the trajectory has been set as non-compliant for December 2023 due to the impact of industrial actions on training compliance for medical staff, which is currently lagging behind target. The Divisional Director, Operations, and Clinical lead are actively working on allocating medical staff to additional ad hoc training sessions, which have been scheduled to support this. A draft action plan to achieve the core competency framework has also been drafted and is undergoing peer review.

3.9 Safety Action 9

Monthly safety champions meetings and walkarounds continue to be conducted. However, the trajectory for this action has been set as non-compliant due to the temporary absence of the Non-Executive Safety Champion, resulting in some of the requirements being paused until their return.

3.10 Safety Action 10

All reportable cases are consistently submitted where relevant and following liaison with the Trust Legal Team. Duty of Candour compliance is reported to the Trust Board via the quarterly assurance paper.
The trajectory for safety action 10 has been set as compliant by February 2023, aligning with the reporting dates and requirements to submit data up until the submission date.

4.0 Summary and next steps

In light of the above, it is unlikely that the PAHT maternity services will meet the MIS year 5 requirements. This is primarily due to the impact of industrial action which has affected the availability and capacity to contribute and engage with the scheme. This affects the service's ability to achieve the necessary requirements within the limited timeframe set by NHS Resolution, particularly impacting safety action 4, 6, and 8.

Progress and all highlighted concerns have been escalated at CHAWS Divisional Board, Governance Board and have been noted at QSC. A progress update is also provided at these groups on a monthly basis.

Furthermore, a comprehensive risk assessment is currently being undertaken to formalise the risk and impact on services regarding the MIS non-compliance.

Monitoring and regular meetings continue to take through the governance framework to review progress with actions.

5.0 Recommendation

It is requested that the Trust Board accepts the report with the information provided and the ongoing work for assurance of compliance with local and national standards. We remain committed to achieving the highest standards of maternity care and safety.

Author: Elita Mazzocchi
Date: 27/09/2023

Trust Board (Public) – 5 October 2023

Agenda item:	4.3
Presented by:	Giuseppe Labriola – Deputy Chief Nurse
Prepared by:	David Dellow – Safe Staffing Lead and Giuseppe Labriola – Deputy Chief Nurse
Date prepared:	9th July 2023
Subject / title:	Report on Nursing and Care Staff Levels for July 2023.

Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The overall fill rate for July was 99.39%. Registered Nurse (RN) fill increased to 93.6% with care staff fill rates decreasing by 1.3% to 111.3%. No wards reported average fill rates below 75% for RN against the standard planned template during July, this is the forth consecutive month.							
Recommendation:	The committee is asked to note the information within this report.							

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

Previously considered by:	PC.25.09.23
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Divisions have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	**Appendix 1:** Registered fill rates by month against adjusted standard planned template. RAG rated. **Appendix 2**: ITU / HDU compliance with Guidelines for the provision of Intensive Care Services

There was an upward trend in Registered and the overall average fill rates in July; with the overall fill rate increasing to 99.3%. RN fill rate increased by 1.2% to 93.6% with care staff fill rates decreasing by 1.3% to 111.3%. Nightingale ward closed 28th June.

We continue to utilise NHS Professionals (NHSP) and agency to mitigate vacant shifts and enhancements for NHSP shifts continue to promote improved fill rates.

Emergency Department (ED) fill decreased in July, with RN nights being the exception. RN Day fill was 92.4%, (↓0.7%) with RN Night increasing 0.2% to 98.3%. There was also a reduction in fill rates for care staff in July with days, (↓2.3%) and nights decreasing by 9.8%% to 86.8%

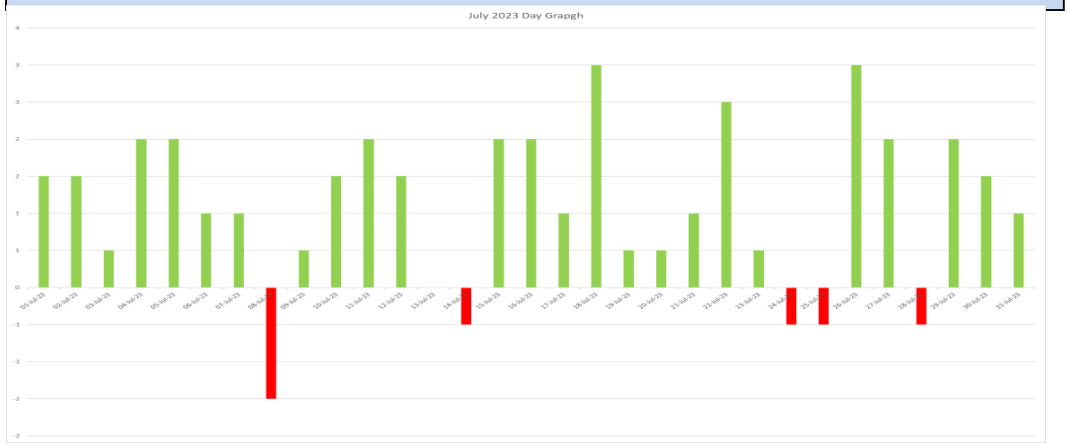
Critical care fill rates in July - the unit had more than the required numbers of staff for acuity of patients on 25 occasions during the day (green bars) and 30 occasions at night. The numbers on the left of the graph and strength of the bars denotes by how many staff. There were 5 occasions in the month when staffing fell below the required staffing levels across day and night. On one occasion this was by 2 or more staff. On these occasions, the Intensive Therapy Unit (ITU) team were supported by the Critical Care Matron, Practice development nurse and the supervisory nurse in charge working in the clinical numbers to support delivery of safe patient care. Regular reporting and comparison month on month will help to provide a benchmark for this variation. See Appendix 2 for background on how safe staffing is calculated for critical care areas.

Inpatient Fill rate including maternity wards

ED Fill rate

	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 (%)
May 2023	91.8%	89.1%	94.6%	92.7%
June 2023	93.1%	91.7%	98.1%	96.6%
July 2023	92.4%	89.4%	98.3%	86.8%

Critical Care Fill rate



The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards increased to 162(↑5) against June. This report now includes Maternity (41). (December 22 had 383 occasions). 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.

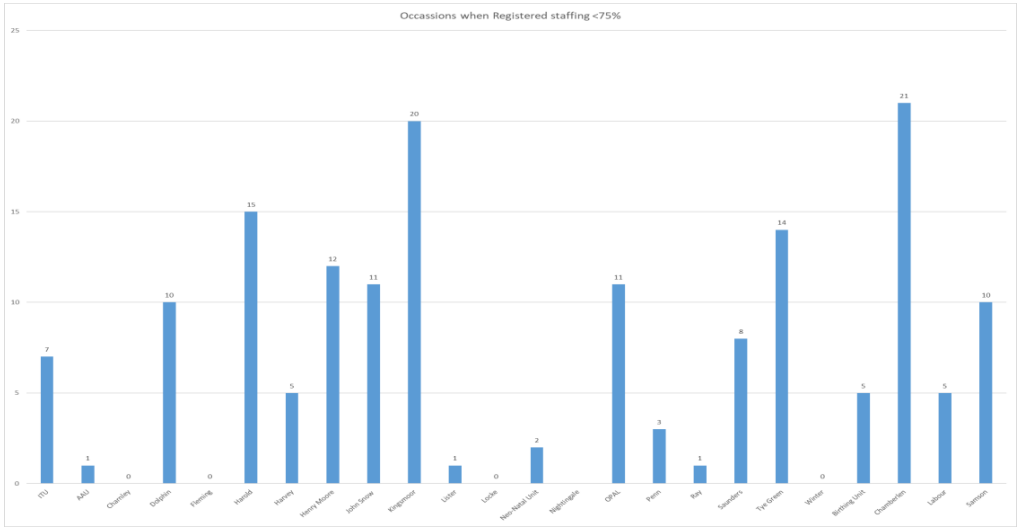
Datix reports in relation to staffing levels decreased to 26 (↓10) against June. Tye Green raised 10 with Birthing Unit and OPAL raising 3 each.

No wards reported average fill rates below 75% for RN against the standard planned template during July. This is the forth month in a row. Details on the impact on care can be found below.

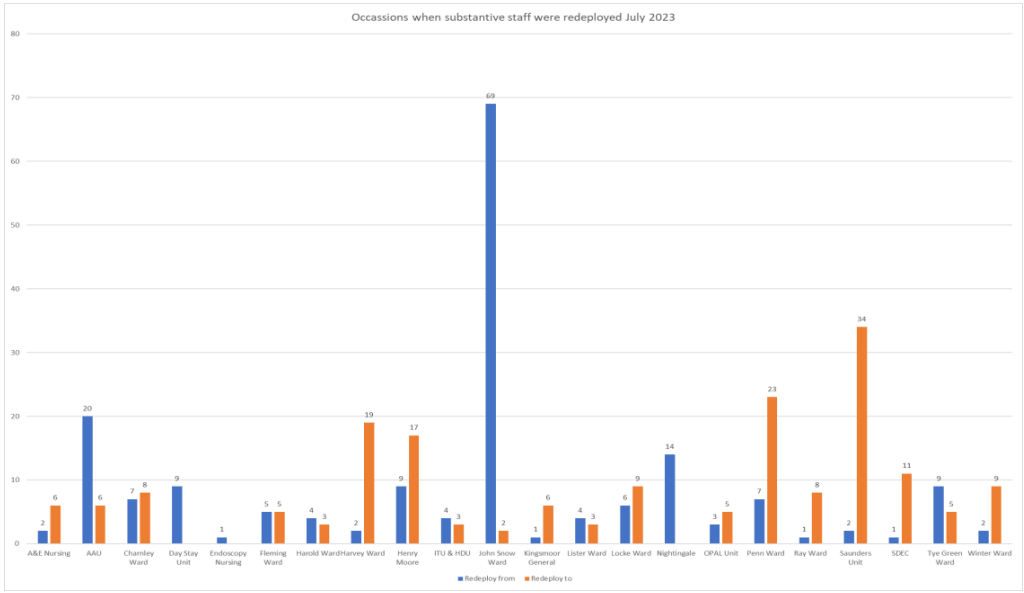
Redeployment of staff continues to be undertaken to support SafeCare as part of the daily huddles. In July, AAU and John Snow were the wards who redeployed the highest number of substantive staff. Highest net receivers of staff was Saunders, Penn and Harvey Wards. The deputy chief nurse and safer staffing lead are formalising a new process for the daily staffing huddles and the use of SafeCare which will commence from September 2023.

Following the ward managers awayday a small working group are developing a buddy ward redeployment SOP, this has been presented to the nursing teams and is currently undergoing the ratification process.

Occasion when RN staffing <75%

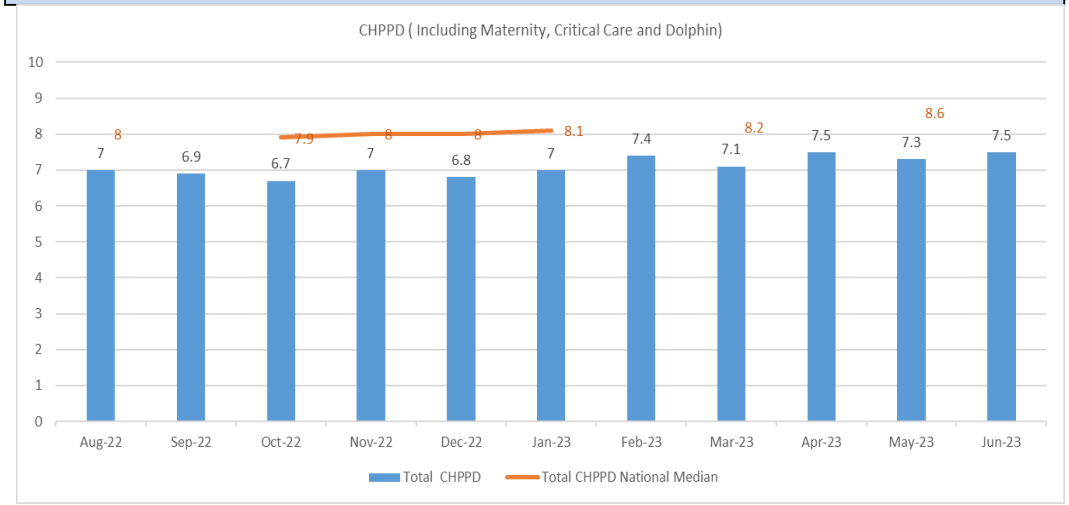


Redeployment



Overall Care Hours Per Patient Day (CHPPD) was 7.6 for July 2023. The Model Hospital data for May 2023 shows the Trust with a CHPPD of 7.3 against the national median of 8.6.

CHPPD



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

	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
ITU & HDU	82.7%	76.4%	88.9%	71.0%	85.8%	73.7%	84.7%
Saunders Unit	81.0%	125.5%	120.3%	160.9%	95.7%	138.9%	112.0%
Penn Ward	87.6%	110.4%	99.8%	159.7%	92.8%	129.1%	105.8%
Henry Moore Ward	87.2%	73.0%	119.8%	81.9%	100.2%	77.2%	90.3%
Harvey Ward	81.8%	116.9%	101.3%	124.7%	89.8%	120.6%	100.9%
John Snow Ward	90.2%	35.6%	84.2%	52.2%	87.3%	40.8%	67.2%
Charnley Ward	93.9%	132.2%	103.2%	115.7%	98.4%	124.3%	105.8%
AAU	90.6%	141.2%	109.0%	122.4%	98.8%	132.2%	105.8%
Harold Ward	77.4%	92.3%	97.5%	104.1%	86.2%	97.9%	89.9%
Kingsmoor General	73.1%	105.8%	102.6%	133.7%	84.3%	119.2%	97.3%
Lister Ward	89.5%	109.7%	107.9%	138.9%	97.3%	123.7%	107.8%
Locke Ward	101.5%	106.8%	118.5%	125.2%	108.7%	115.6%	111.5%
Ray Ward	93.3%	120.5%	113.0%	181.6%	101.6%	143.7%	116.7%
Tye Green Ward	77.5%	100.4%	88.5%	135.8%	82.2%	114.8%	94.9%
Nightingale Ward	100.0%	114.9%	90.4%	120.2%	95.4%	117.4%	104.2%
Opal Unit	94.8%	120.2%	117.1%	141.2%	104.2%	130.2%	114.6%
Winter Ward	85.8%	101.6%	100.0%	103.1%	91.8%	102.3%	95.0%
Fleming Ward	99.5%	100.0%	97.7%	90.3%	98.6%	95.2%	98.0%
Neo-Natal Unit	81.0%	64.4%	93.1%	75.9%	86.3%	68.3%	81.8%
Dolphin Ward	82.7%	76.4%	88.9%	71.0%	85.8%	73.7%	84.7%
Birthing Unit	93.5%	100.8%	97.5%	104.3%	95.4%	102.4%	97.0%
Chamberlin Ward	109.5%	99.1%	97.5%	96.8%	103.8%	98.0%	101.8%
Labour Ward	93.3%	108.2%	95.0%	91.3%	94.1%	100.1%	97.1%
Samson Ward	85.6%	95.3%	90.8%	88.6%	88.1%	92.1%	89.1%
Total	87.9%	104.5%	100.7%	119.8%	93.6%	111.3%	99.3%

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

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

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

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

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

All shifts include a supervisory nurse.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) - 5 October 2023

4.4

Agenda item:	4.4							
Presented by:	Fay Gilder | Medical Director							
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Information Team Fay Gilder | Medical Director							
Date prepared:	5 October 2023							
Subject / title:	Learning from deaths and Mortality Paper							
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:	Learning from Deaths Update

The Princess Alexandra Hospital NHS Trust

4.4

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 update on mortality indices for Princess Alexandra Hospital (PAHT)

3.1 Background

Fully coded data has been submitted to HES for the month of October 2022 onwards. Previous papers have explained the impact of incompletely coded date being submitted for the months of May-August 2022.

3.2 Analysis

REPORT HEADLINES

Data Period: May 2022 - Apr 2023

Metric	Result
HSMR	111.4 (higher-than-expected) (104.2 – 118.8)
HSMR position vs. peers	Regional bespoke peer group = 17 acute trusts: • 6 higher-than-expected • 5 within expected • 6 lower-than-expected Region as a whole = 102.0 (higher-than-expected) (100.8 – 103.3) **Trust are statistically significantly higher than current peer group*
All Diagnosis SMR	109.1 (higher-than-expected)
Significant Diagnosis Groups	• Diabetes mellitus with complications (204 superspells; 14 deaths) • Fluid and electrolyte disorders (299 superspells; 22 deaths) • Respiratory failure, insufficiency, arrest (adult) (64 superspells; 29 deaths)
CUSUM breaches	• Cardiac dysrhythmias (13 deaths) (Feb-23) • Disease of mouth, excluding dental (1 death) (Nov-22) • Essential hypertension (1 death) (May-22) • Fluid and electrolyte disorders (22 deaths) (Jan-23) • **Immunity disorders (1 death) (Jul-22)** • Other liver diseases (15 deaths) (Mar-23) • Respiratory failure, insufficiency, arrest (adult) (29 deaths) (Dec-22)

	• **Transient cerebral ischaemia (1 death) (Jan-23)**
SHMI position	(Apr-22 to Mar-23) 107.60 (as expected) *N.B. DQ issues have been noted as part of the publicly available SHMI release, reflecting the reduction in volumes*

Figure 1 – HSMR Monthly Trend

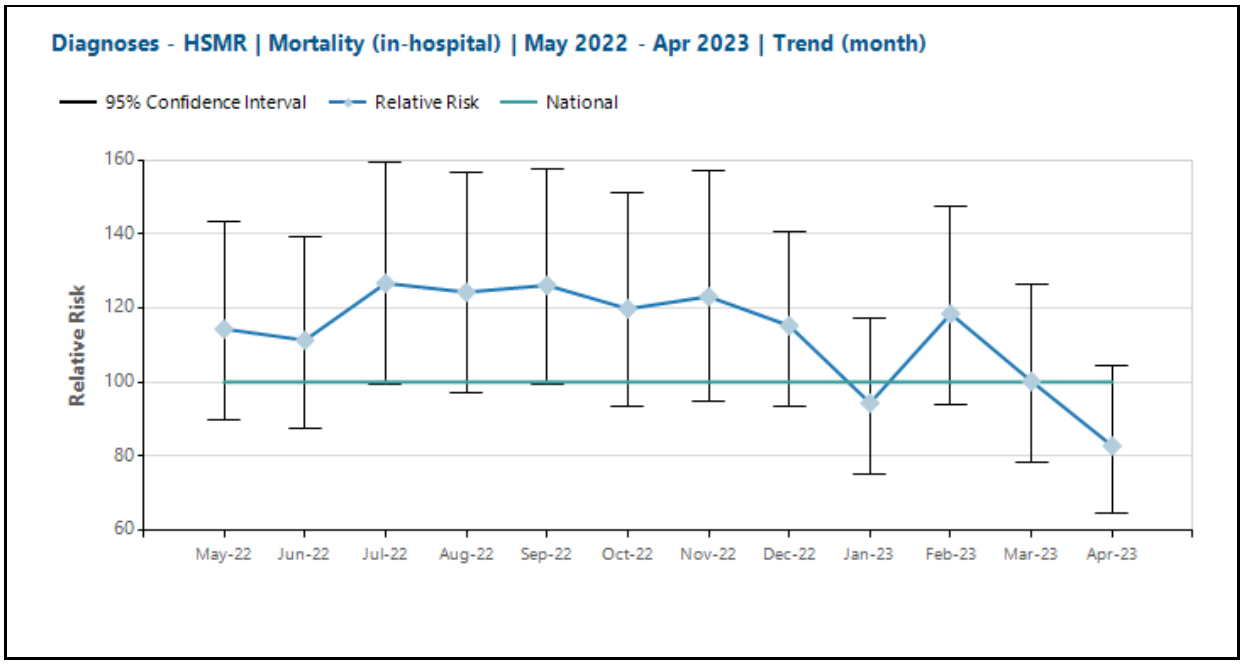
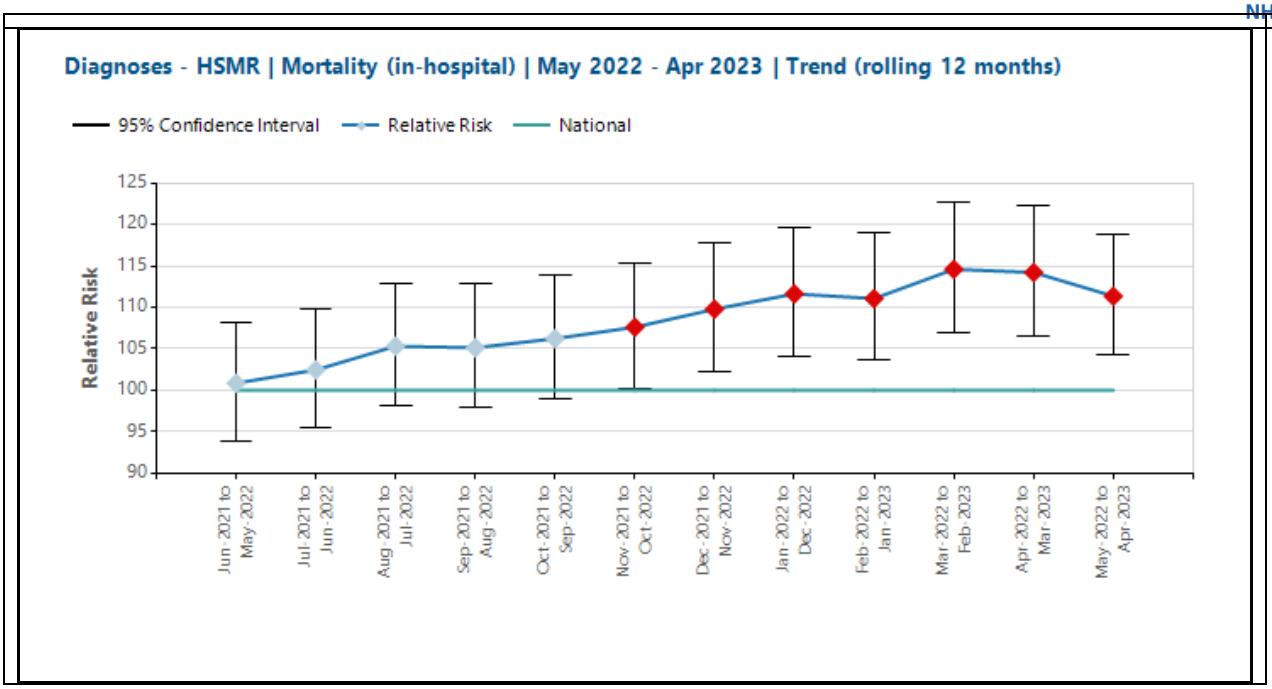


Figure 2 – HSMR 12 Month Rolling Trend



STANDARDISED MORTALITY RATIO OVERVIEW

Key points

SMR for Apr-23 is 78.9 and “lower-than-expected”, based on 4943 superspells and 82 deaths (crude rate 1.7%).

SMR for the period May-22 to Apr-23 is 109.1 and “higher-than-expected”, based on 66,972 superspells and 1134 deaths (crude rate 1.7%).

Each SMR metric has improved this month, and the single-month value is the third lowest the Trust have reported in the last five years (60 periods).

There are three diagnosis group outliers, however none of these are new.

Figure 3 – SMR Monthly Trend

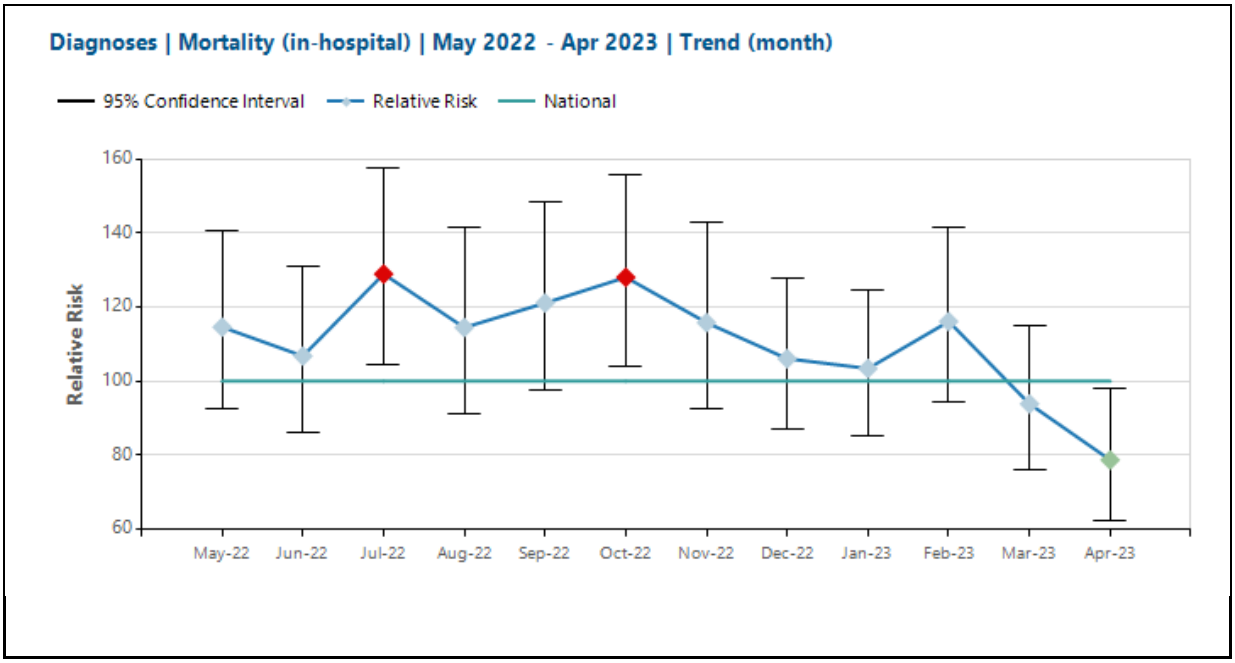
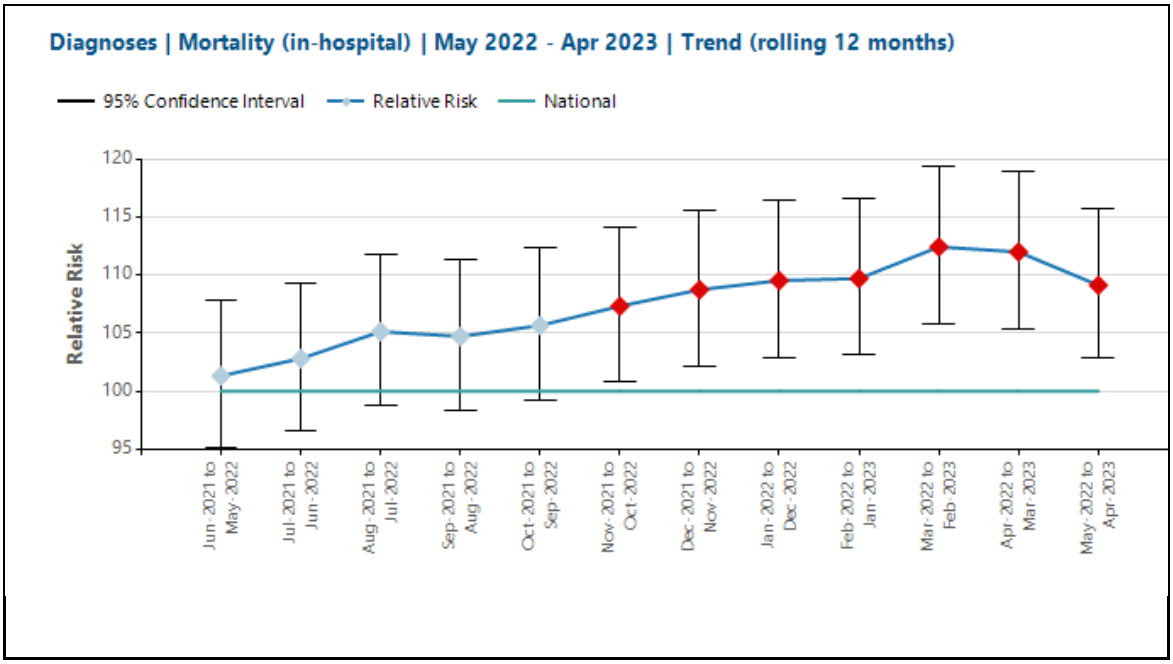


Figure 4 – SMR All Diagnoses Rolling Trend



SMR Statistically Significant Diagnosis Groups

Diagnosis group	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		564	100.0 %	570	65	11.5 %	34.6	6.1 %	30.4	**187.9**	145.0	239.5
Fluid and electrolyte disorders	55	298	52.8 %	302	22	7.4 %	12.1	4.1 %	9.9	**181.4**	113.7	274.7
Diabetes mellitus with complications	50	204	36.2 %	204	14	6.9 %	6.4	3.2 %	7.6	**217.7**	118.9	365.3
Respiratory failure, insufficiency, arrest (adult)	131	62	11.0 %	64	29	46.8 %	16.0	25.9 %	13.0	**180.9**	121.1	259.8

3.3 Summary

Mortality indices are improving. Analysis of the causes for the 'above expected indices' has been described in previous papers. Further work has identified that the coding team had not been informed that Nervecentre ED was in use so this was not used as a source of data. This was rectified in earlier this year.

4.0 Mortality Programme Updates

Strategic Learning from Deaths Group was not held in September due to the number of apologies received so there is no update

5.0 Learning from deaths process update

5.1 Mortality Narrative

There were 65 deaths in August 2023.
9 cases referred for SJR's

There are 141 outstanding SJRs (over 6 weeks of the patients' death.) The Divisional Directors for Medicine and Surgery have devised a plan to work on the backlog, although this has not started as yet particularly due to the time pressures created by industrial action.

There were no cases presented to the second review panel.

5.2 Work Initiated from SJRs and Mortality Improvement Concepts

- Specialist Palliative Care Team coding support – there are positive indications that this work is having an impact as most recent Telstra report has shown an improvement in the level of palliative care coding.

- Level 2 Mortality Reviews to be completed on SMART. This continues to be rolled out across UEC and Medicine.
- Junior doctors to be involved in all M&M meetings and actively take part in M&M reviews (level 2). On-going roll out.
- Updated Learning from Deaths Policy now on AlexNet.
- Alcohol detox audit undertaken and new policy was discussed at Grand Round September 2023
- Re-launch of M&M in oncology. Form is live on SMART and has been shared with Chemotherapy Lead Consultant and Nurse.

6.0 Medical Examiner (ME) Headlines

100% of deaths scrutinised between 9 Medical Examiners.

15 cases were referred to the Coroner:
Of these, 3 Form A's were issued (COD agreed with coroner).
9 post-mortems were requested
1 death certificates were issued by the GP.

Ongoing Developments:

The community death pilot with St Claire Hospice continues to run smoothly.
GP death scrutiny has now been expanded to almost all GP practices with the PAH catchment area. Work will continue to engage with the final few.

Site Team training has now been booked and once complete, a new system will be implemented in the A&E department for patients who die within hours of their admission. The aim is to reduce the number or breaches associated with delays obtaining a certifying

A formal process for the scrutiny of perinatal deaths is being constructed using an MDT approach.

7.0 Risks

No changes identified for the Learning from Deaths risk register. The Learning from Deaths risk register has been moved from Health Assure Allocate to Datix.

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

Public Trust Board Thursday 5 October 2023

4.5

Agenda item:	4.5
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	18 September 2023
Subject / title:	Alex Health Programme Update

Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	Update provided on progress to: • Current state and future state reviews • Progress through gateways • Risk and issue management							
Recommendation:	The Board is asked to note the contents of this paper.							

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

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

Introduction

The Trust Board will be aware that the Alex Health programme is a key element of our digital strategy, and the main delivery item through 2023 to 2025. This paper articulates progress to date of the programme

Alex Health Programme Update

The programme continues at pace to ensure we meet our gateway deadlines, to enable our October 2024 go live. We have recently undertaken our current and future state reviews for our processes and have now commenced the data collection activities to support and test our future state. The reviews have had significant engagement throughout the organisation and been led by our workstream leads.

As a reminder, below is a table of the functionality we will be implementing in the Millennium product:

Core Oracle Cerner scope below to meet and exceed the core PAHT requirements:

- PAS (Registration, Scheduling)
- Order Comms
- EPMA
- Clinical Documentation
- Emergency Department
- Clinical Documentation (Nursing and Physician)
- Theatres and Anaesthesia
- Perioperative Supply Chain
- Critical Care (incl. Infusion Management)
- AKI, Sepsis
- Maternity, Fetalink and NICU (Maternity)
- Patient Flow and Patient Tracking (excludes required hardware e.g. RFID tags)
- Clinical Trials (Powertrials)
- Infection Control
- Cerner Patient Portal (Healthelife / Zesty)
- Bridge (Breast Milk, Transfusion and Specimen collections)
- Command Centre
- Mobility (Dr's, Nurses, Porters): Powerchart Touch and Camera capture (200), Medanets (1500), CareAware Connect shared device (500)
- BMDI – 39 Beds (ICU, Anaesthesia, HDU, Theatres, Recovery Rooms)
- Vitals Link – 280 Beds (excludes devices) –
- Services included for Cerner to implement 10 devices for (2) unique device types at (1) facility and provide knowledge transfer to the Trust
- Iaccess – Instant Access
- 7/24 Downtime Viewer
- Reporting – PI Explorer (Includes Business Objects)
- Ignite Millennium API
- Care Pathways – Bundle, post go-live phase (Initial 6)
- Single Document Capture
- Interfaces
- Code Upgrade Services (1x)
- 0.5 FTE Health Integration Partner

Excluded: Kiosks, 3M Medicode, QAS, Devices for BMDI and Vitalslink, CareAwareTracking Hardware (RFID tags etc).

We approved our first gateway recently to enable progress through to the current state review. Gateway reviews are contractual mechanisms to ensure we have formal checkpoints through the programme.

We have a further gateway review to approve in October. There are a small number of items to be resolved which we have plans in place to deliver prior to the gateway date.

Risk and Issue Management

As we would expect with a programme of this complexity, there are a number of issues that we need to focus our attention. The majority of these relate to resourcing both from our perspective and Oracle Health. We expect resourcing to remain on the risk register for the duration of the programme and it is a subject we will continue to have a high degree of focus on. The main areas where gaps exist are:

- PAS inpatient and capacity management
- Technical design
- Transformation

The other areas that we have highlighted increased risk to the Programme Board concern decision to be made on the scope of order comms and the patient portal.

All of these have been highlighted to the Programme Board with mitigation plans in place.

Conclusion

The Committee is requested to consider and note the contents of this report

Phil Holland
Chief Information Officer

BOARD OF DIRECTORS: Trust Board (Public) 5 October 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Darshana Bawa – Committee Chair

DATE OF COMMITTEE MEETING: 25 September 2023

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	Y	N	The following metrics were noted: • Vacancy rate in August 23: 11% - a decrease on previous months. • Bank and Agency - Direct engagement continues to improve, currently at 92.48% / £22,360 missed savings for August. • Sickness absence rate is 4% • Rolling turnover is reducing slowly, currently 14% – leaving reasons linked to work life balance/ cost of living development and retirement • Time to hire – reduced by 3 days to 61 days in August.
2.2 Safer Nurse Staffing Report	Yes	N	N	The Committee were assured in regards to the provision of safer nurse and midwifery staffing and that processes are in place for managing and monitoring staffing levels. The paper will be discussed at Board
2.3 BAF Risk 2.3 Workforce: (Inability to recruit, retain and engage our people)	Yes	Y	N	The risk score remains unchanged at 16. It was noted that the target risk score/date will be reviewed before the next meeting.
2.4 PAHT2030 Culture Milestones	Yes	N	N	The update was noted; the majority of the milestones are rated 'green' with some further work required. One red milestone was

BOARD OF DIRECTORS: Trust Board (Public) 5 October 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Darshana Bawa – Committee Chair

DATE OF COMMITTEE MEETING: 25 September 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				noted, this is related to the new hospital workforce which has not progressed due to national timescales.
2.5 BAF Risk 2.1: (GMC enhanced monitoring)	Yes	Y	N	The score remains unchanged at 20.
2.6 EDI Strategy	Yes	Y	N	The committee endorsed the strategy for Board approval subject to clarity on some of the language and feedback from the Trust Chair as EDI lead. Progress reports will be presented to PC in line with the annual workplan.
2.7 WRES & WDES Annual Reports	Yes	Y	N	The committee recommended the reports to Board for approval and will be included in the public Board papers.
2.8 Horizon Scanning	For noting	Y	N	- Updated Good Medical Practice standards published - focus on behaviours and values which support good team work, make everyone feel safe to speak up, and empower doctors to provide quality care. - New sexual safety charter - ten pledges for organisations to follow to safeguard staff - The NHS Staff Council, on behalf of NHS trade unions and employers, have agreed to incorporate a home and agile/hybrid working framework into the NHS Terms and Conditions of Service (NHS TCS) Handbook (Section 35).
2.9 Guardian of Safer Working Hours Report	Yes	Y	N	The report for the period April to June 2023 was noted; 59 exception reports were received with 6 immediate safety concerns raised in this quarter, however none related to a specific patient incident. They all describe generally unsafe

BOARD OF DIRECTORS: Trust Board (Public) 5 October 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Darshana Bawa – Committee Chair

DATE OF COMMITTEE MEETING: 25 September 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				working environments and an unexpected absence of a senior member of the team.
2.10 Fit and Proper Persons: Revised Framework	Yes	N	N	An update on the revised framework was noted. The Board will receive a paper on the revised requirements.
3.1 Communications Update	Yes	N	N	PC noted the recent communications activities. An update was provided on the external communications review and the executive programme: 'A day in the life'.
4.1 Learning and OD update	Yes	N	N	The update was noted. Appraisal rates were discussed following the roll out of TiMS.
4.2 Feedback to action	Yes	N	N	The committee commended the approach taken to address the previous staff survey results and received a briefing on the initiatives being considered in relation to encouraging staff to complete the next survey.

The Princess Alexandra Hospital NHS Trust

Trust Board - 5 October 2023

5.2

Agenda item:	5.2							
Presented by:	Denise Amoss, Associate Director of Organisational Development & Learning (Interim)							
Prepared by:	Monika Kalyan, Head of Equality, Diversity & Inclusion							
Date prepared:	September 2023							
Subject / title:	Equality, Diversity & Inclusion Strategy 2020-2030							
Purpose:	**Approval**	**X**	**Decision**	**X**	**Information**		**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report sets out The Princess Alexandra Hospital NHS Trust's (PAHT) equality, diversity and inclusion strategy; our vision, principles, goals and focus areas, as well as our journey to this point. The strategy is underpinned by the Trust values and strategic outcomes. It provides a blueprint for creating an inclusive environment for all our people, and also provides a framework to ensure that we deliver an appropriate and inclusive service to our patients, service users, their families, and carers. We ask that members of the Board adopt and embrace this strategy within their individual roles.							
Recommendation:	The Board is asked to approve the Equality, Diversity & Inclusion Strategy 2023 – 2030.							

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:	Equality, Diversity & Inclusion Steering Group; People meeting; JSCC SMT & People Committee
Risk / links with the BAF:	2.3 inability to recruit, retain and engage our people
Legislation, regulatory, equality, diversity and dignity implications:	Trust's statutory duties to promote equality amongst all groups of people.
Appendices:	Appendix 1 Overview Appendix 2 Equality, Diversity & Inclusion Strategy – summary Appendix 3 Full Equality, Diversity & Inclusion Strategy

Equality, Diversity and Inclusion Strategy

The Princess Alexandra Hospital NHS Trust

Trust Board

Denise Amoss
Associate Director of Organisational Development & Learning (Interim)

5 October 2023

Prepared by Monika Kalyan

Why we need a strategy

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NHS Trust

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

What is EDI?

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NHS Trust

- **Equality** is about fair treatment, and we believe that employment and our services should be accessible to all. Everyone has individual needs and the right to have those needs respected.

- **Diversity** is about respecting difference and can include individuals and groups with varying backgrounds, experiences, perceptions, values and beliefs. It is important that we understand, value and respect those differences.

- **Inclusion** is about recognising and valuing the differences we each bring and creating an environment where everyone can be their true selves and has equal access to services, opportunities, resources and can contribute to the organisation's success

The voices of our people

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NHS Trust

- Staff and patients' voices at the heart of the design of this strategy
- The experience of our colleagues is prioritised alongside that of our patients and service users
- Our goal is that everyone will feel that their voice and their views matter. This process confirmed to us that dialogue at the grassroots is just as important, if not more so.
- Two crucial themes emerged and are reflected in our strategy, ensuring that our work has a recent and reliable evidence base:
  - staff experiences are closely linked with better outcomes for employees and patients; and we know from the conversations, that EDI can no longer be an add on – inclusivity must be central to everything we do in the healthcare system.

Our vision

The Princess Alexandra Hospital NHS Trust

- All the insights shared with us led to the following vision.

To have a naturally inclusive organisation where everyone feels valued and is treated with fairness and respect

To achieve this, we aim to:

- Ensuring the voice of our people, patients and communities we serve are heard
- Promoting equality of opportunity and dignity and respect for all patients, service users, families, carers and our people
- Valuing and harnessing people's difference

Our goals

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NHS Trust

Our people

1. To put equality, diversity and inclusion at the heart of our organisation
2. Recruit, retain, develop and support a diverse workforce.

Our patients

3. Improve patient experience and outcomes for people with protected characteristics and other communities who experience marginalisation

Our community

4. Engage our diverse communities across our services and pathways.

Triangulated approach

The Princess Alexandra Hospital NHS Trust

National, regional and local context

- Levelling Up White Paper, 2023
- Messenger Review– Leadership for a collaborative and inclusive future (July 2022)
- NHS equality, diversity, and inclusion improvement plan
- NHS People Plan (2020) with specific actions for promoting civility and respect and improving sense of ‘belonging’.
- NHS Constitution. NHS values of Everyone Counts, Compassion, Dignity, and Respect.
- Restorative Just Culture Community of Practic
- Ockenden Report, 2022t
- East of England Anti-Racism strategy 2021

*The vast majority of feedback focuses upon the areas recommended.

For divisions & departments

- Cascade of briefing throughout each level of management/supervision until all teams have received a team brief
- Define objectives
- Determine outcomes
- List actions that are needed

Delivery of this strategy requires actions at multiple levels – individual, team, trust and system

Accountability

The Princess Alexandra Hospital NHS Trust

- The delivery of EDI is overseen by the Equality Diversity and Inclusion Steering Group (EDISG) chaired by the director of people, organisational development and communications.

- Workstreams will be monitored through Workforce Race Equality Standard, Workforce Disability Equality Standard, EDI reporting, Equality Delivery System, staff survey analysis and evidence from staff networks, patient groups.

Next steps

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NHS Trust

Action	Date
Finalise communication plan	06/10/23
Trust Board approve strategy	05/10/23
Launch strategy	10/23

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The Princess Alexandra Hospital NHS Trust

Equality, diversity and inclusion strategy 2023-2026

Making The Princess Alexandra Hospital NHS Trust (PAHT) a truly inclusive employer and health service provider for our diverse people, patients and local community

Introduction

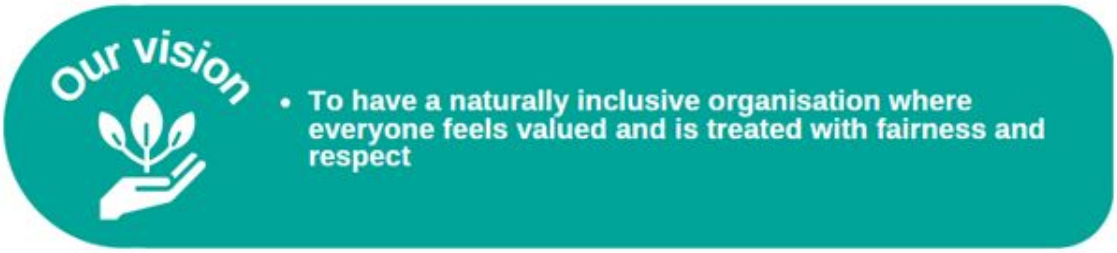
This is a summary of our equality, diversity and inclusion (EDI) strategy, which sets out PAHT's aim, vision, goals and areas of focus for the next three years.

EDI is at the core of our organisation and we fully recognise our responsibility to engage our whole community that includes: our people, partner organisations, community groups, our patients and their carers and families.

We want to build a reputation of being a values-based organisation, focused on delivering care to our patients with a person-centred approach and we are committed to ensuring EDI is at the heart of our business.

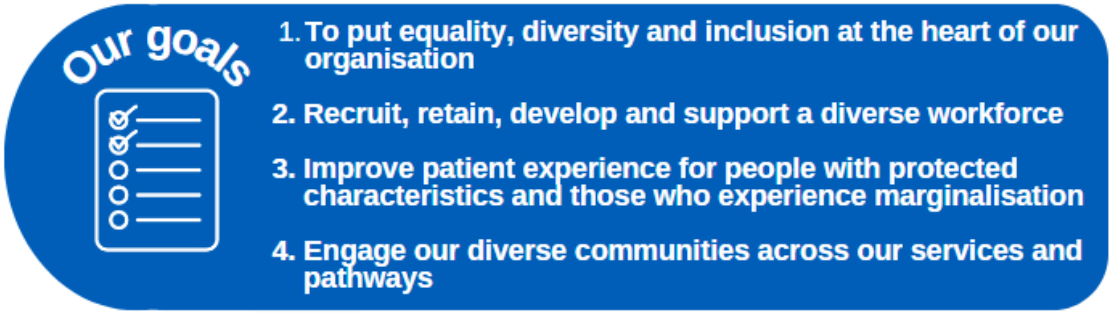
Our policy is to respect the diversity of all, treat each person fairly and equally based on their needs, regardless of characteristics[1].

We are also committed to creating an inclusive environment where everyone feels valued and respected because of their differences. This is a place where all of our people can be the whole and best version of themselves and reach their full potential.



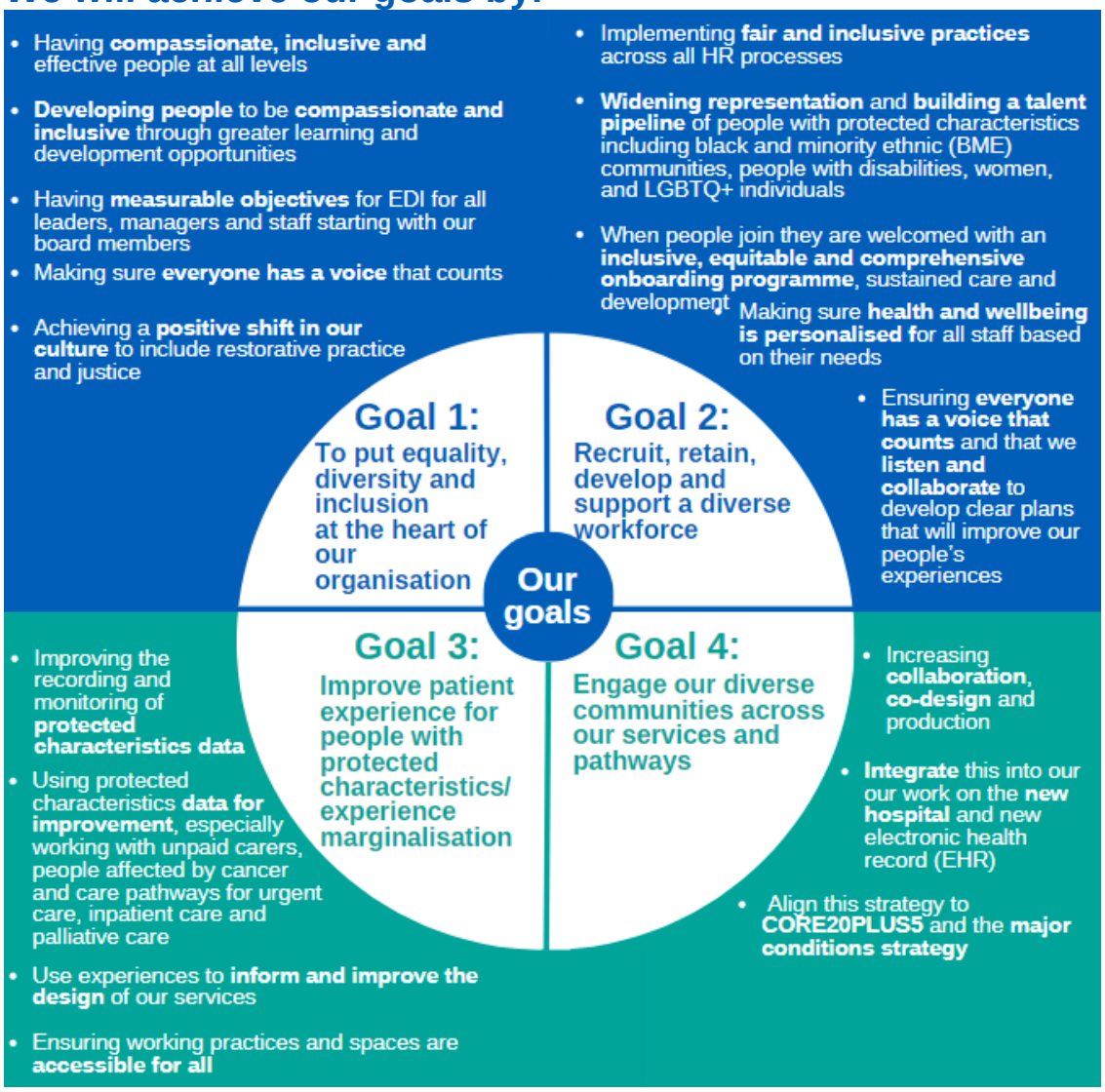
[1] whether those defined and protected by UK law in the 2010 Equality Act or other characteristics.

The Princess Alexandra Hospital NHS Trust



We are working to achieve an inclusive and diverse organisational culture, to be recognised for our forward-thinking approach, ensuring everyone we engage with feels valued and respected and to contribute to EDI best practice on a regional level.

We will achieve our goals by:



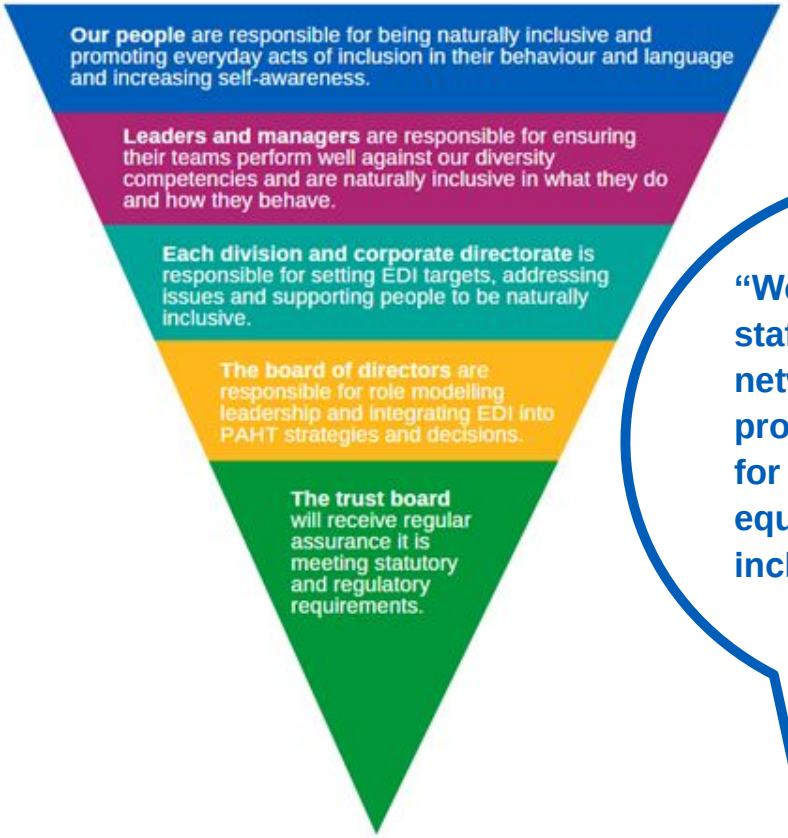
The Princess Alexandra Hospital NHS Trust

Accountability

The delivery of EDI will be overseen by the Equality Diversity and Inclusion Steering Group (EDISG) chaired by the director of people, organisational development and communications.

The EDISG is responsible for setting the strategic direction for our EDI objectives, monitoring their delivery and championing inclusive behaviour across the Trust. The group will also ensure that resources are targeted to support key priority areas.

Progress against our EDI objectives and action plans will be reviewed quarterly.



"We have a range of staff equality networks which provide a safe space for staff to discuss equality, diversity and inclusion."

The learning and organisational development team are responsible for monitoring this strategy and supporting a cultural shift through effective development programmes and learning opportunities.

We ask that all our people adopt and embrace this strategy within their individual roles and workplaces.

For the **Disability and Wellbeing Network** and **LGBTQ+ Staff Network** email: **paht.equalityandinclusion@nhs.net**

For the **Race Equality and Cultural Heritage (REACH) Staff Network** email: **paht.race.equality@nhs.net**

The Princess Alexandra Hospital NHS Trust

Equality, diversity and inclusion strategy 2023-2030

Making The Princess Alexandra Hospital NHS Trust (PAHT) a truly inclusive employer and health service provider for our diverse people, patients and local community

5.2

The Princess Alexandra Hospital NHS Trust

5.2

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The Princess Alexandra Hospital NHS Trust

Introduction

This document sets out The Princess Alexandra Hospital NHS Trust's (PAHT) equality, diversity and inclusion strategy; our vision, principles, goals and focus areas for the next three years, as well as our journey to this point. Equality, diversity and inclusion are at the core of who we are as an organisation. As the largest employer in Harlow, with almost 4,000 staff, with over a quarter from an ethnic minority background, PAHT recognises that we have a responsibility to engage our whole community.

Our starting point is that everyone has the right to be treated fairly and equitability. This is true whether they are members of PAHT staff, those from partner organisations that we work with, community groups we seek to engage, or the patients, carers and families who our work is ultimately for.

We aim to maintain and promote a zero-tolerance approach to discrimination in any form, and we are committed to planned and consistent action to reduce and eliminate all practices that allow the continuation of discriminatory behaviours, policies or practices.

We value both visible and non-visible difference as a key part of a healthy organisation. We will strive to harness peoples' differences to create an environment in which people feel valued, staff talents are fully utilised, and we deliver against our strategy.

We know that celebrating individual difference and bringing diverse teams together with disparate styles and talent will foster innovation and continuous improvement for patients, service users, their families, carers and our staff.

We recognise that equality and diversity are most effective and sustainable if we are inclusive, and all staff are welcome, valued and able to contribute.
We want to build a reputation of being a values-based organisation that focuses on ensuring that all care delivered to patients by our staff has a truly person-centred focus.

We are in no doubt that equality, diversity and inclusion is a collective responsibility, and the Trust Board has a duty to ensure this work is at the heart of our business.

We are asking all staff to adopt and embrace this strategy within their individual roles and workplaces. This strategy is for 2023–2030.

Setting the context

National, regional and local context

COVID-19 shone the spotlight on the health inequalities faced by many of our communities. We recognise now, more than ever, it is essential to focus on addressing these inequalities and to value the diversity of our staff by developing and sustaining an inclusive and compassionate workplace.

Our strategy is supported by a wide range of academic papers, government reports, rich source of information on staff experience derived from the annual staff survey and lived experience data to inform our direction of travel.

NHS Constitution: NHS values of Everyone Counts, Compassion, Dignity, and Respect.

The NHS People Plan and People Promise (2020): specific actions for promoting civility and respect and improving sense of 'belonging'.

The NHS equality, diversity, and inclusion improvement plan (June 2023: builds on the People Promise, using the latest data and evidence to identify six high impact actions organisations across the NHS can take to considerably improve equality, diversity and inclusion.

The Messenger Review– Leadership for a collaborative and inclusive future (July 2022): reaffirmed the need for action on equality, diversity and inclusion (EDI).

Creating and maintaining a restorative 'Just and learning' culture. The approach is centred around creating a culture where staff feel supported and empowered to learn when things do not go as expected, rather than allocating blame.

Ockenden Report (2022): it recognised within the Ockenden report that women from black and ethnic minority backgrounds, and women living in areas with higher rates of social deprivation are at increased risk of maternal and neonatal morbidity and mortality.

Levelling Up White Paper (2023): recognising that discrimination undermines social justice.

East of England Anti-Racism strategy (2021): sets outs actions required to challenge, confront & remove racism.

PAHT 2030 strategy.

Legal requirements and standards

The Trust is required to provide assurance of delivery against a number of national standards and compliance frameworks for EDI.

These include:

The Equality Act 2010 - outlaws discrimination based on access to goods and services as well as employment, on the basis of nine protected characteristics.

Health and Social Care Act 2012 - introduced the first legal duties about health inequalities and specified duties for health bodies to have due regard to reducing health inequalities between the people of England.

Human Rights Act 1998 - sets out the fundamental rights and freedoms that everyone in the UK is entitled to and requires all public bodies carrying out public functions to respect and protect human rights. The aim is that all people are treated with dignity, respect, equality, fairness and autonomy.

Accessible Information Standard - sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

Gender Pay Gap - became mandatory for all public sector employers with more than 250 employees to measure and publish their gender pay gap.

Equality Delivery System- is a framework for NHS organisations to continuously improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS.

The Workforce Race Equality Standard (WRES) - requires NHS organisations to report on nine indicators of race equality and to agree actions to ensure employees from black and minority ethnic backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

The Medical Workforce Race Equality Standard (MWRES) focuses on doctors and dental staff measured against eleven indicators. MWRES enables organisations to understand the challenges that exist in the medical workforce, with the aim of encouraging improvement by learning and sharing good practice.

The Model Employer sets out an ambition to increase Black and minority ethnic (BME) representation at all levels of workforce by 2028. This ambition has been expedited by the NHS People Plan 2020 to increase senior leader representation by 2025 to equate to either the organisational or community percentage, whichever is highest.

The Workforce Disability Equality Standard (WDES) requires NHS organisations to report on indicators of disability and to agree actions to ensure disabled employees have equal access to career opportunities and receive fair treatment in the workplace.

Sexual Orientation Monitoring Information Standard - provides a consistent mechanism for recording the sexual orientation of all patients/service users aged 16 years across all health services in England.

The NHS Standard Contract Section 13 Equity of Access, Equality and Non-Discrimination outlines standards and requirements that must be adhered to ensure NHS services promote equality and address health inequalities.

Health and Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role.

What led us to this point

Over the past year, PAHT has been on a journey of learning and internal discussion, to inform the development of this EDI strategy. This feedback has informed the focus, prioritisation and direction of our work on EDI.

Our established EDI steering group has provided strategic oversight for the planning and delivery of our EDI development.

The steering group meets quarterly, and includes members of staff from across PAHT.

Staff survey and workforce data reflecting the lived experience of our staff demonstrates that we have more to do before we can say inclusive workplace environments are the norm across our organisations. For example, women make up 78% of our workforce but experience a pay gap. Just under 40% of the workforce is from a BME background but face disadvantage across some aspects of their working lives. The 2022 Workforce Race Equality Standard (WRES) data showed that 29.3% of BME staff experienced bullying, harassment or abuse from other staff in the preceding year; the NHS Staff Survey along with the Workforce Disability Equality Standard (WDES) shows that disabled staff are under-represented when compared to the general population. The NHS staff survey data shows that 31.4% of disabled staff have experienced bullying from their colleagues, compared to 18.9% of non-disabled staff.

We are committed to ensuring that this strategy is not seen as being separate, but is clearly linked with existing strategies and through our ways of working, so that it can successfully act as a lever for change and service improvement. The expectation being that all leaders and managers will be familiar with this strategy and ensure that equality considerations are an integral part of our daily business including: service delivery, staff recruitment and retention, professional development and staff training, service redesign and development, and procurement and commissioning of any goods and services.

Protected groups include those for age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and

sexual orientation but if we are to think holistically about our responsibilities other groups to take into account in order to address health inequalities would include armed Forces families, Gypsies, Roma, Travellers, showmen and liveaboard boaters, people experiencing homelessness, people experiencing alcohol and/or drug dependence, sex workers, migrants and refugees, young carers, victims of modern slavery and people in contact with the criminal justice system.

This strategy focuses on the long-term vision for equality, diversity and inclusion, while also highlighting our focus areas.

We held a number of meetings with staff networks where we invited staff to talk about what mattered to them. In addition to this we have also used the rich source of information on staff experience derived from the annual staff survey to inform our direction of travel.

We have agreed a set of core principles that underpin the development and delivery of our ambitions and priority areas. These will help guide our work and refresh our approach to equality, diversity and inclusion. We want to achieve deeper cultural change moving beyond compliance and 'tick boxing' to a truly inclusive way of working. These principles will raise our level of aspiration and quicken the pace of change.

Overarching principles and approach

We will optimise our efforts by linking our EDI goals to the Trust's five strategic objectives. EDI will be clearly defined as an integral part of our hospital vision, firmly embedded and fundamental to its success. A standalone or silo approach to EDI will not be enough to create change or visible progress.

The goals within our Equality, Diversity and Inclusion Strategy 2023-30 link closely to those described in the NHS People Plan, the Trust's people strategy, patient safety experience and quality strategy, the quality improvement strategy and the patient engagement and coproduction strategy and the Care Quality Commission's (CQC) domains of safe, effective, caring, responsive, and well led.

Diversity and inclusion is 'everybody's business' and everyone in the Trust is therefore expected to take an active part. To foster a diverse and inclusive workplace we need to create the right levels of EDI awareness and education, focusing on challenging unconscious bias, privilege and micro aggressions and promoting allies. Our staff networks also play an important role in creating education opportunities for their members and allies. This will be a central component to engage the hearts and minds of all our staff, inspire team actions and accountability for change.

Leaders set the tone and culture of their NHS organisation. Leaders who demonstrate compassion and inclusion, and focus on improvements, are key to creating cultures that value and sustain a diverse workforce. Staff will in turn feel more empowered to deliver great care and patient experience.

As highlighted in the Messenger Review, July 2022 principles of EDI should be embedded as the personal responsibility of every leader and every member of staff. It is in this context our chief executive, chair and board members will have distinct objectives on improving inclusion in our organisation. Our board of directors and senior leadership team will be visible and accessible with Team PAHT building a reputation as a truly inclusive employer and service provider for our staff, patients, local health and social care community.

A data-driven approach will enable us to establish a baseline (where are we now?) and track progress. We will align our data to create a new benchmark and monitor what good looks like to ensure our interventions have an impact and report regularly to the Trust Board.

We will work collaboratively with staff and act on their feedback. Staff will feel fulfilled, free to speak up and believe they are being treated fairly. Their involvement will be encouraged and celebrated at the earliest opportunity to shape the services we provide for patients, carers and their families.

To support these core principles, we will ensure we maintain a balance between planning (what should be happening) and space for emergence and dialogue (what is actually happening). This requires our diversity and inclusion approach to be deeply collaborative - listening to lived experiences, listening to understand, listening to make change.

Our strategy

Our vision

- *To have a naturally inclusive organisation where everyone feels valued and is treated with fairness and respect.*

Our mission is to eliminate discrimination, reduce health inequalities, promote equality of opportunity and dignity and respect for all our patients, service users, their families, carers and our staff.

Our policy is to respect the diversity of all, treating each person fairly and equally, based on their needs and regardless of characteristics whether those defined and protected by UK law in the 2010 Equality Act or other characteristics.

We are committed to creating an inclusive environment where everyone feels valued and respected; a place where every member of staff can be the whole and best version of themselves, so they can reach their own potential and help us to achieve our goals.

Our aims

- *Ensuring the voice of our people, patients and communities we serve are heard*
- *Promoting equality of opportunity and dignity and respect for all patients, service users, families, carers and our people*
- *Valuing and harnessing people's difference*

Our goals and objectives

The aims of this strategy are driven by our commitment to EDI. We want everyone who comes into contact with us to feel valued and respected, and for our programmes, activities and day-to-day ways of working to demonstrate our stated commitment to EDI.

We also want to use our increasing knowledge and experience to make a leading contribution to promoting EDI on a regional stage. We want to engage with organisations who share this ambition, and to encourage those that we work with, including partners, to demonstrate a similar commitment to EDI.

Our strategy has four goals:

Goal 1: To put equality, diversity and inclusion at the heart of our organisation

We will achieve this by:

- Having compassionate, inclusive and effective people at all levels
- Developing people to be compassionate and inclusive through greater learning and development opportunities
- Having measurable objectives for EDI for all leaders and managers
- Making sure everyone has a voice that counts.
- Achieving a positive shift in our culture to include restorative practice and justice.

Goal 2: Recruit, retain, develop and support a diverse workforce.

We will achieve this by:

- Implementing fair and inclusive practices across all HR processes
- Widening representation and building a talent pipeline of people with protected characteristics including BME communities, people with disabilities, women, and LGBTQ+ individuals.
- Ensuring that, wherever in the world our people join us from, they are welcomed with an inclusive, equitable and comprehensive onboarding programme, sustained care and development.
- Ensuring health and well-being is personalised for all staff based on their needs.
- Ensuring everyone has a voice that counts and that we listen and collaborate to develop clear plans that will improve our people's experiences.

Goal 3: Improve patient experience and outcomes for people with protected characteristics and other communities who experience marginalisation

We will achieve this by:

- Improving the recording and monitoring of protected characteristic data
- Using protected characteristics data for improvement, especially working with unpaid carers, people affected by cancer and care pathways for urgent care, inpatient care and palliative care
- Using experiences to inform and improve the design of our services
- Ensuring working practices and spaces are accessible for all

Goal 4: Engage our diverse communities across our services and pathways

We will achieve this by:

- Increasing collaboration and co-design and production with protected groups, particularly in our work on the new hospital and new electronic health record aligned to CORE20PLUS5 and the major conditions.

Accountability

The delivery of EDI is overseen by the Equality, Diversity and Inclusion Steering Group (EDISG) chaired by the director of people, organisational development and communications.

The EDISG is responsible for setting the strategic direction for our EDI objectives, monitoring their delivery and championing inclusive behaviour across the Trust.

Workstreams will be monitored through Workforce Race Equality Standard, Workforce Disability Equality Standard, EDI reporting, Equality Delivery System, staff survey analysis and evidence from staff networks, patient groups.

Progress against our EDI objectives and action plans will be reviewed quarterly.

The learning and organisational development team are responsible for monitoring this strategy and supporting a cultural shift through effective development programmes and learning opportunities.

We ask that all our people adopt and embrace this strategy within their individual roles and workplace.

Appendix 1 High impact focus areas

Our people	Our patients	Our community
Ensure our recruitment and selection processes are free from bias so we make the fairest and best selection decisions and positively attract and retain diverse individuals within the workforce Widen recruitment opportunities within local communities to include the creation of career Embed EDI in onboarding Implement inclusive talent management processes. Support career progression of staff with protected characteristics and improve development opportunities, taking positive action to promote equality from initial recruitment and beyond. Sponsorship, mentoring and coaching and promoting positive action programmes e.g. Ready Now, stepping up, reverse mentoring programme Encourage access to CPD across protected characteristics Develop and implement an improvement plan to eliminate pay gaps Implement the Mend the Gap review recommendations for medical staff and develop a plan Implement an effective flexible working policy including advertising flexible working options on recruitment campaigns.	Ensure positive attitudes towards welcoming the diversity of patients, carers and service users and endeavour to meet their diverse needs, particularly in urgent and emergency care, older people's inpatient care and palliative care services. Improve the quality of the protected characteristic data by establishing service equality monitoring and driving DQ (data quality) initiatives through a newly established digital communication steering group to standardise and rationalise patient communications. Enable the Trust to use experiences to inform and improve the design of our services through our patient experience strategy on harnessing the lived experience using a new FFT and experience gathering tool (IQVIA). Improve the monitoring of patient data to shape the Trust's approach to understanding, achieving and measuring equitable access and outcomes for patients working with Safety and Quality teams to review incident data, patient experience teams to review complaints data. EDI issues imbedded in frontline staff forums, safety huddles and other forms of reflective practice. Understand the potential impacts of the decisions we make on patients, their families, carers and service users, by protected characteristics and identify ways to mitigate these through our engagement and	Actively involve people in changes to policies, procedures and service improvements that affect them Champion and recognise inclusive behaviours to share good practice across the Trust Celebrate and share good practice of both individuals and teams across our three hospital sites throughout the year Improve our presence at EDI community events, such as local Pride and encourage staff to take the lead in campaigns Ensure multiple options are available for staff requiring individual support and advice relating to EDI issues in addition to their managerial team Health Equity Partnership Programme Prevention Programme LTP commitments on tobacco, alcohol, obesity and TB Identify and understand our local community, what their specific needs are and how these can be considered when planning the delivery of care through staff networks, WRES, WDES, gender pay gap and clinical audit Work collaboratively with local partners to address health inequalities and improve health outcomes

Develop and implement an improvement plan to address health inequalities within the workforce. Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety. Review data by protected characteristic on bullying, harassment, discrimination and violence and plans implemented to improve staff experience year-on-year. Ensure that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Review disciplinary and employee relations processes. Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence. Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Focus on effectively addressing bullying and harassment, abuse, violence and discrimination at work Supportive methods in place for staff who report/ experience discrimination and how this support links to	coproduction strategy working in particular on nutrition and hydration issues and supporting unpaid carers. Close the gap on the personal data we collect on patients to identify whether equality trends through cross cutting programmes such as the EHR implementation and protected characteristics data quality initiative. As part of the new Safety Framework develop a compensation process for Patient Safety Partners. Increase patient collaboration and co-production to ensure their views and perspectives inform our D&I work programme as part of the engagement and coproduction strategy and to support the 6 Major conditions strategy. Use data and story-telling to identify outcome focused interventions for EDI	

FTSU adopt the NHS Resolution 'Just and Learning Culture Charter'. Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence Education resources and activities to support cultural awareness Support for staff networks to thrive and be part governance processes. Embed Menopause Friendly Accreditation standards Ensure the Trust board demonstrate how lived experience is being used to improve culture Trust board to review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework		

The Princess Alexandra Hospital NHS Trust

Report to the Trust Board: 5 October 2023

5.3

Agenda item:	5.3
Presented by:	Denise Amoss, Associate Director of Organisational Development & Learning (Interim)
Prepared by:	Nathaniel Williams, People Information & Systems Lead Monika Kalyan, Head of Equality, Diversity & Inclusion
Date prepared:	September 2023
Subject:	Annual Workforce Race Equality Standard (WRES) report for 2023

Purpose:	**Approval**	x	**Decision**		**Information**		**Assurance**		
Key issues: please don't expand this cell; additional information should be included in the main body of the report	The paper provides the Trust's 2023 Workforce Race Equality Standard (WRES) data set and a summary of action taken for protecting, supporting, and engaging with our Black and minority ethnic colleagues. A refreshed WRES action plan to address systemic racism, aligned to the East of England Regional anti-racism strategy. Note that the WRES position set out in this paper sits alongside the Trust's overarching commitment to workforce inclusion across a range of protected characteristics.								
Recommendation:	To approve the WRES progress report and action plan.								

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:	Equality, Diversity & Inclusion Steering Group; People meeting; JSCC SMT & People Committee
Risk / links with the BAF:	2.3 inability to recruit, retain and engage our people
Legislation, regulatory, equality, diversity and dignity implications:	The WRES was introduced in April 2019 and it is mandated through the NHS Standard Contract.
Appendices:	Appendix 1 WRES data Appendix 2 Areas of action for 2023-2024

1.0 Context

This paper provides the Committee with the 2023 WRES data set for PAHT that has been submitted to NHS England in August 2023, together with a summary of action taken in the past year and proposed refreshed WRES action plan. The data in this report covers the period from April 2022 to March 2023.

The WRES was introduced in April 2015 as the NHS England WRES briefing for boards states that NHS workforce race equality delivers better care, outcomes and performance. Research and evidence such as that from Professor Michael West and Professor Jeremy Dawson has found that less favourable treatment of Black, and minority ethnic (BME) staff in the NHS, through poorer experience or opportunities, has significant impact on the efficient and effective running of the NHS and adversely impacts the quality of care received by patients. West and Dawson assert “The greater the proportion of staff from a Black or minority ethnic background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction. The experience of BME staff is a very good barometer of the climate of respect and care for all within NHS Trusts”

The Committee is reminded that, in its simplest form, the WRES offers NHS organisations the framework to understand their workforce race equality performance, including the degree of BME staff representation at senior management and board level. The WRES indicators highlight differences between the experience and treatment of white staff and BME staff in their organisations. The WRES is intended to help all NHS organisations to focus on where they are right now on this agenda, where they need to be, and how they can get there.

The PAHT WRES plan is informed by a number of publications and wider actions:

- In May 2021 NHS England WRES team published the WRES report analysing all national data submitted across the NHS, and wrote to all Trusts advising them for the first time of their Race Disparity Ratio and benchmarked their relative likelihood of BME and white staff progressing to lower, middle and upper tiers of Agenda for Change bandings based on 2020 data.
- The National WRES team has also set out Model Employer leadership targets for the NHS; an ambition for all posts across the NHS to increase black and minority ethnic representation at all levels of workforce by 2028 including at senior leadership and Board level by to equate to either the organisational or community percentage, whichever is highest.
- East of England Anti-racism strategy, PAHT has put in place various initiatives which are referenced in this report.
- In 2022 the Trust committed to the UNISON Eastern Antiracism Charter. This outlines various pledges under the themes of Leadership, Process and Audit.
- The NHS equality, diversity, and inclusion improvement plan published in June 2023 builds on the People Promise, using the latest data and evidence to identify six high impact actions organisations should take to considerably improve equality, diversity and inclusion.

2.0 WRES key findings

The Trust’s WRES data was submitted to NHS England in August 2023. The results for each indicator are set out below.

In summary the Trust has, improved in 5 of the 9 indicators in the last year:

- **Metric 1: Percentage of staff in each of the AFC pay bands 1-9, medical & dental and VSM compared to overall workforce:** Percentage of BME Staff employed within the

Trust has increased from 37% to 39% when compared to last year. BME staff at VSM is one compared to two headcounts from last year

- **Metric 3: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff**. The likelihood of BME staff entering the formal disciplinary process is now 0.30 times more likely than White groups as compared to 0.60 in 2022. Any score less than 1 is seen as a positive outcome for BME groups. The numbers of BME staff that entered the formal disciplinary process is 0.26% (0.42% in 2022)
- **Metric 4: Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:** The likelihood of White staff accessing non-mandatory training and CPD when compared to BME staff is 0.99 as compared to 1.27 in 2022 an improvement

Underperformed in 4 indicators in the last year:

- **Metric 2: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME:** The % of BME staff appointed was 23% (24% in 2022) compared to 34% white (30% in 2022). The relative likelihood of White staff being appointed compared to BME staff is currently 1.44, an increase from 2022. Any score less than 1 is seen as a positive outcome for BME groups. Please note that most international recruitment is not included in the number as they do not go through the recruitment system.
- **Metric 5: BME board membership – Executive and Non-Executive Directors**: BME representation at board level is 16% when compared to 21% last year.

Table 1:

National Staff Survey question	BME 2022	White	BME 2021	White
Metric 6: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	34.0%	30.8%	33.3%	29.1%
Metric 7: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	29.3%	26.4%	30.6%	28.3%
Metric 8: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	40.6%	53.2%	41.0%	50.8%
Metric 9: Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months.	17.5%	6.9%	18.4%	7.7%

3.0 Key activity in the past 12 months

Actions in 2022/23

- Inclusion of Inclusion Champions when interviewing for roles of band 8a and above.
- Roll out of inclusive recruitment training for hiring managers
- Workshops to support REACH network members

- REACH rebranded and relaunched with bespoke leadership development support for its leaders
- Collaboration with the ICS to implement new career development programme for BME staff
- Signed up to UNISON Eastern Antiracism Charter
- Commenced roll out of Anti-racism work programme for AHP
- Increase in the pool FTSU ambassadors
- The FTSU Guardian has attended the BME staff network to recruit from the BME community

The EDI steering group, including the REACH staff network has met at a minimum of every quarter to ensure the WRES action plan has traction and engagement. Activities include: REACH chairs meeting with EDI lead every 4-6 weeks to bring ideas together to inform the wider EDI strategy; promoting staff to become inclusion champions; proactively encouraging network members to apply for band 8a and above positions; and informally mentoring BME staff.

4.0 Moving forward

The success of our WRES action plan set out in Appendix 2 and our participation in the implementation of the regional anti-racism strategy will require all colleagues to be supportive and inclusive in their behaviour. We require all leaders to be accountable and responsible for creating an inclusive culture where racism and discrimination is not tolerated and action is taken to address racial harassment, micro-aggressions and incivility. Measures to meet our Model Employer goals and with what are described as 'accountability nudges' by Roger Kline will be incorporated in our anti-racism plan. We will continue to inform educate and support colleagues and leaders to be accountable. Our aim is to shift the current culture and improve the experience of work and opportunity for Black, Asian, minority, ethnic staff.

5.0 Next steps

Once approved by the Board, this report and accompanying action plan will be published on the Trust's website.

6.0 Recommendations

The Committee is asked to note that:

- Discuss and approve the latest WRES dataset and proposed WRES actions.
- Note the employer commitment to implementing the East of England Ant-racism strategy, tackling racism and discrimination to be an anti-racist organisation.
- Ensure your personal information on ESR is updated, including on ethnicity.
- Consider personal actions and commitment to progress race equality and inclusion at PAHT as part of the broader inclusion agenda.

The Princess Alexandra Hospital NHS Trust

5.3

APPENDIX 1 WRES DATA

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

Non-Clinical	Apr21-Mar22		Apr22-Mar23	
	White	BME	White	BME
Band 1	71%	14%	69%	13%
Band 2	80%	14%	80%	15%
Band 3	87%	7%	86%	9%
Band 4	90%	7%	91%	7%
Band 5	78%	17%	82%	13%
Band 6	80%	14%	70%	26%
Band 7	84%	12%	86%	13%
Band 8a	82%	15%	88%	10%
Band 8b	70%	26%	71%	25%
Band 8c	64%	36%	64%	36%
Band 8d	91%	9%	73%	27%
Band 9	100%	0%	100%	0%
VSM	78%	22%	89%	11%
NEDS	70%	20%	70%	20%

Percentage of **clinical** staff in each Pay band AFC Band 1-9 & Medical & Dental

Clinical	Apr21-Mar22		Apr22-Mar23	
	White	BME	White	BME
Band 2	67%	30%	64%	33%
Band 3	84%	14%	80%	18%
Band 4	61%	32%	56%	42%
Band 5	24%	71%	24%	72%
Band 6	60%	37%	55%	42%
Band 7	63%	32%	64%	32%
Band 8a	68%	27%	61%	33%
Band 8b	68%	24%	70%	22%
Band 8c	90%	10%	64%	29%
Band 8d	88%	13%	78%	22%
Band 9	100%	0%	100%	0%
Medical & Dental	30%	70%	27%	68%

<table>
<tr><th>Indicator</th><th>2021</th><th>2022</th><th>2023</th></tr>
<tr><td>Relative likelihood of white staff being appointed from Shortlisting compared to BME staff across all posts</td><td>1.37</td><td>1.28</td><td>1.44</td></tr>
<tr><td></td><td colspan="3">
<table>
<tr><td></td><td colspan="2">2021</td><td colspan="2">2022</td><td colspan="2">2023</td></tr>
<tr><td></td><td>White</td><td>BME</td><td>White</td><td>BME</td><td>White</td><td>BME</td></tr>
<tr><td>Relative likelihood of appointment from shortlisting</td><td>33%</td><td>24%</td><td>30%</td><td>24%</td><td>34%</td><td>23%</td></tr>
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</td></tr>
<tr><td>Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation compared to white staff (two years rolling average)</td><td>1.15</td><td>0.60</td><td>0.30</td></tr>
<tr><td></td><td colspan="3">
<table>
<tr><td></td><td colspan="2">2021</td><td colspan="2">2022</td><td colspan="2">2023</td></tr>
<tr><td></td><td>White</td><td>BME</td><td>White</td><td>BME</td><td>White</td><td>BME</td></tr>
<tr><td>Likelihood of staff entering formal disciplinary process</td><td>0.21%</td><td>0.24%</td><td>0.70%</td><td>0.42%</td><td>0.85%</td><td>0.26%</td></tr>
</table>
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<tr><td>Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff</td><td>1.15</td><td>1.28</td><td>0.99</td></tr>
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<table>
<tr><td></td><td colspan="2">2021</td><td colspan="2">2022</td><td colspan="2">2023</td></tr>
<tr><td></td><td>White</td><td>BME</td><td>White</td><td>BME</td><td>White</td><td>BME</td></tr>
<tr><td>Likelihood of staff accessing non-mandatory training & CPD</td><td>9.33%</td><td>8.09%</td><td>14.08%</td><td>10.96%</td><td>23.8%</td><td>24.0%</td></tr>
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<tr><td>Total Board Members % by ethnicity</td><td colspan="3">
<table>
<tr><td></td><td colspan="2">2021</td><td colspan="2">2022</td><td colspan="2">2023</td></tr>
<tr><td></td><td>White</td><td>BME</td><td>White</td><td>BME</td><td>White</td><td>BME</td></tr>
<tr><td>Total Board members - % by ethnicity</td><td>71%</td><td>17%</td><td>74%</td><td>21%</td><td>79%</td><td>16%</td></tr>
</table>
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</table>

APPENDIX 2 AREAS OF ACTION FOR 2023 - 2024

WRES Metric	Actions	Lead
1	Undertake an ethnicity pay gap audit in order to inform actions to further address inequality. Agree approach for advertising of stretch assignments and secondment opportunities Promote a range of anti-racism resources, videos, e-learning and webinars across our departments and divisions.	People - information team L&OD
2	Review and implement recommendations given in De-biasing Recruitment toolkit that has been developed for the region by Research fellow and diversity expert Roger Kline Increase pool of existing inclusion champions.	People – resourcing and retention
3	Provide managers and leaders with development and support to improve cultural intelligence, knowledge and understanding when leading diverse teams to help Review people management processes with just and learning culture lens	L&OD People - Business Partners
4	Sponsorship, mentoring and coaching and promoting positive action programmes e.g. Ready Now, reverse mentoring Career development seminars for BME staff Promote access to CPD	L&OD
5 – 8	Review how best to embed in the organisation the NHSI Civility and Respect Toolkit Implementation of actions in EoE Anti-racism strategy including review of key policies and procedures for reporting racism and other categories Promote quarterly attendance of the FTSUG at the REACH network meetings to update on trends of complaints/reports	People - Business Partners L&OD
9	Work with skilled and experienced recruitment agencies to source potential candidates from diverse backgrounds when senior and VSM vacancies arise Adopt inclusive approach to talent management and succession planning. BME staff network leads to be invited to attend Board meetings	People – resourcing and retention L&OD

The Princess Alexandra Hospital NHS Trust

Report to the Trust Board: 5 October 2023

5.4

Agenda item:	5.4
Presented by:	Denise Amoss, Associate Director of Organisational Development & Learning (Interim)
Prepared by:	Nathaniel Williams, People Information & Systems Lead Monika Kalyan, Head of Equality, Diversity & Inclusion
Date prepared:	September 2023
Subject:	Annual Workforce Disability Equality Standard 2023

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	This paper sets out the latest annual Workforce Disability Equality Standard (WDES) metrics and report for PAHT. In summary, the Trust has improved on six of the ten WDES metrics since 2022 (metrics 1, 4, 5 ,6, 7 and 8). There has been a worsening in the position for metrics 2,4 and 9a. **Metric 4 comprises four component parts, two of which have improved.* The report provides an update on each of the areas of the WDES action plan, and sets out action in a number of areas to progress disability equality and inclusion at PAHT.
Recommendation:	To approve the WDES report and action plan.

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:	Equality, Diversity and Inclusion Steering Group JSCC SMT People Committee
Risk / links with the BAF:	2.3 inability to recruit, retain and engage our people
Legislation, regulatory, equality, diversity and dignity implications:	The WDES was introduced in April 2019 and it is mandated through the NHS Standard Contract.
Appendices:	**Appendix 1** WDES DATA **Appendix 2** Actions for 2023-2024

1.0 Purpose

1.1 The WDES forms part of the Trust's duties mandated in the NHS contract and considered by the CQC. This paper sets out the latest annual Workforce Disability Equality Standard (WDES) metrics and report for PAHT, now in its fifth year. WDES is assessed against 10 evidence-based metrics three of which relate specifically to workforce data, six are based on data from the National NHS staff survey questions (and the final one considers disabled and non-disabled representation on the Trust board. The report covers April 2022 – March 2023. While progress has been made in some areas, the results highlight the continued disparity of experience for our staff with disabilities, health conditions and neuro differences compared to those without.

1.2 The WDES is a key part of the PAHT workforce commitment to inclusion: we will strive to drive out inequality, recognising we are stronger as an organisation which values difference and inclusion.

1.3 A note on language: the term 'disabled staff' is used throughout this report to refer to anyone with a disability, long term health condition or neurodifference that is protected under the Equality Act 2010. This is in line with the language used throughout WDES, and based on self-reporting through ESR or the National Staff Survey. It should be noted that many of these staff will not consider themselves 'disabled' and caution should be used in applying this term to individuals. 'Non-disabled' is used throughout the report to refer to anyone who does not have a disability, long term health condition or neurodifference, according to their ESR or National Staff Survey response.

2.0 WDES Metrics for 2022/23

2.1 There are ten metrics within the WDES that highlight and examine the inequalities between disabled and non-disabled staff. **Appendix 1** gives a breakdown of PAHT data against WDES indicators for 2022/2023.

2.2 3% of our total workforce have identified as disabled. This is an increase on the previous reporting period.

2.3 In summary, there is an improvement in the position against the following metrics:
Metric 1: Percentage of disabled staff compared with overall workforce
Metric 4: Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.
Metric 4: Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. **Metric 4 comprises four component parts.*
Metric 5: Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion
Metric 6: Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
Metric 8: Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to
carry out their work

2.4 There has been a worsening in the position for 4 of the ten metrics:
Metric 2: Relative likelihood of being appointed from shortlisting. Non-disabled and disabled applicants are equally as likely to be appointed after shortlisting
Metric 4: Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months.
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months. **Metric 4 comprises four component parts.*
Metric 9a: Staff engagement score for Disabled staff, compared to non-disabled staff.

2.5 There is no change in the position for 2 of the ten metrics:
Metric 3: relative likelihood of entering the formal capability process.
Metric 10: difference between the Board voting membership and its overall workforce.

2.6 **Metric 9b**: Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

2.6.1 The Trust has and continues to act to ensure the voices of disabled staff are heard and acted upon in the organisation. The PAHT Disability and Wellbeing Network (DAWN) has been active since March 2022. The DAWN is for staff with any visible or invisible disability, physical or mental health condition or neurodifference, as well as anyone with an interest in equality and inclusion in this area.

2.6.2 The Network continues to provide a safe space for disabled staff and to act as a mechanism to ensure disabled staff voices are heard and acted upon across PAHT. Members of the DAWN have been directly involved in shaping and influencing many of the work streams mentioned in this report.

2.6.3 Key members of the network are invited to attend the Equality, Diversity and Inclusion Steering Group. The original WDES action plan was co-produced with members of the network, and the network continues to shape priorities and work streams.

2.6.4 The network is often used as a consultative mechanism, with members asked to share their views on a number of significant areas.

3.0 WDES action plan progress

3.1 Key actions taken in 2022/2023:

- Short film and messages shared through communication channels for staff to update their disability status on ESR
- A number of staff stories from disabled staff continue to be developed and shared, helping to create a culture where disability and difference is celebrated and is openly discussed
- Progressed to Level 2 of the Disability Confident scheme
- Work is underway with Project Search to support employment opportunities for young adults with a learning disability or autism spectrum conditions, or both. 11 interns to commence in October 2023.

- Disability training delivered by Mills & Reeve LLP commenced for staff in the People department covering legal principles from case law, statutory guidance and ways to promote disability inclusion. To be extended to other managers.
- Information about EDI including staff networks included on the careers microsite.
- Discussions have taken place with the DAWN and with individuals who were invited to share their experiences, with their feedback having prompted changes to processes.
- Where staff raise concerns via the DAWN or directly to the EDI team, they are supported and action taken to address those concerns. This is often undertaken in collaboration with the wider People team, Freedom to Speak Up guardian and Staff Health and Wellbeing (SHAW) team.
- The SHAW plan reviewed by the DAWN; the network agreed it is useful tool to support an open conversation to create a shared understanding about any health conditions, disabilities or neurodifferences and the support an individual requires to enable them to perform well.

3.2 **Appendix 2** shows actions for 2023 – 2024

4.0 Recommendations

The Committee is asked to:

- Note and discuss the WDES metrics, changes from 2022 and the engagement of staff with disabilities, health conditions and neuro-differences.
- Note that the WDES position set out in this paper sits alongside the Trust's overarching commitment to workforce inclusion across a range of protected characteristics.
- Agree the updated action plan and this report
- Ensure their personal information on ESR is updated, including disability status.
- Consider personal actions and commitment to progress disability equality and inclusion at PAHT as part of the broader inclusion agenda.

The Princess Alexandra Hospital NHS Trust

APPENDIX 1 WRES DATA

Metric 1

Percentage of staff in AfC (agenda for change) pay bands or medical and dental subgroups and very senior managers (VSM) (including executive board members) compared with the percentage of staff in the overall workforce.

Table 1 shows headcount and percentage of disabled and non-disabled **non-clinical** staff by bands

Non- clinical staff	Bands 1-4		Bands 5-7		Bands 8a-8b		Bands 8c-9 &VSM		Non-Executives	
Disabled	27	3%	5	2%	2	3%	2	5%	2	20%
Non-Disabled	473	59%	130	59%	44	63%	30	73%	7	70%
Unknown	305	38%	86	39%	24	34%	9	22%	1	10%

Table 2 shows headcount and percentage of disabled and non-disabled **clinical** staff by bands & grade

Clinical staff	Bands 1-4		Bands 5-7		Bands 8a-8b		Bands 8c-9 &VSM	
Disabled	13	2%	33	2%	5	4%	1	4%
Non-Disabled	462	71%	901	64%	76	53%	19	79%
Unknown	180	28%	470	34%	63	44%	4	17%

Table 3 identified the headcount and percentage of medical staff who are disabled and non-disabled

Medical staff	M&D consultants		M&D career grade		M&D trainee grade	
Disabled	0	0%	0	0%	5	3%
Non-Disabled	97	48%	102	74%	171	86%
Unknown	106	52%	36	26%	24	12%

Metric 2

Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts. This refers to both external and internal posts.

Relative likelihood is 1.23 compared to last year (1.14). A figure below 1.00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting.

Metric 3

Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

Disabled staff are 0.00 times more likely to enter a formal capability process compared to non-disabled staff. The indicator has remained constant as compared to last year (0.00). A figure above 1.00 indicates that disabled staff are more likely than non-disabled staff to enter the formal capability process.

Table 5 National Staff Survey indicators

	Staff with a LTC or illness: 2022	**Staff without a LTC or illness:**	**Staff with a LTC or illness: 2021**	**Staff without a LTC or illness:**
Metric 4				
Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months.	40.7%	29.2%	32.2%	29.2%
Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.	19.0%	11.6%	19.3%	13.6%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.	31.4%	18.9%	27.4%	20.8%
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	56.4%	51.8%	52.8%	44.8%
Metric 5				
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	43.4%	50.1%	42.6%	49.1%
Metric 6				
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	35.7%	26.3%	41.1%	31.5%
Metric 7				
Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	30.9%	40.4%	24.6%	37.4%
Metric 8				
Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustment(s) to enable them to carry out their work	30.9%	40.4%	24.6%	37.4%
Metric 9a				

staff engagement score (0–10) for Disabled staff, compared to non-disabled staff.	5.9	6.6	6.1	6.7

* Metric 4 comprises four component parts, two of which have improved

Metric 9b
Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard (Yes or No)?

Metric 10

Headcount and percentage of the organisations board voting membership and executive board members.

Table 4

	By Voting membership of the Board		By Executive membership of the Board	
Disabled	1	9%	0	0%
Non-Disabled	9	82%	6	67%
Unknown	1	9%	3	33%

APPENDIX 2 Identified areas to action for 2023/2024

	Actions	Responsibility	Timescale
1	Further promote benefits of sharing disability status on ESR	People - information team with EDI team	December 2023
2	De-biasing the recruitment process, particularly through a disability and neurodiversity lens	People – resourcing and retention	February 2024
2 & 3	Implement commitments made under the Disability Confident level 2 scheme.	People – resourcing and retention & EDI team	Ongoing
4 – 9a	Share staff stories, talk openly about and increase understanding of disability, health conditions and neurodifferences to develop a culture where staff feel comfortable and confident to share their personal experiences, including recording this on ESR.	EDI team	February 2024
4 – 9a	Develop resources and staff stories focused on neurodiversity, improving the organisational understanding of neurodiversity and the strengths and talents that neurodivergent people bring to their teams.	EDI team People - Business Partners	February 2024
4 – 9a	Promote and embed the new SHAW plan and ensure this is well communicated, including Access to work, awareness of duty to make reasonable adjustments, with regular review points to learn and improve.	SHAW manager	January 2024
4 – 9a	Promoting Violence Reduction & Prevention Standards Policy	Local Security Management	December 2023
4 – 9a	Review data relating to violent incidents across the organisation to include as many protected characteristics as possible, to allow for more targeted consideration and identification of incidents linked to characteristics (i.e. disability, ethnicity, sexual orientation, etc.)	Patient Safety	January 2024
4 – 9a	Accessibility of training: improve accessibility and adjustments for training and development opportunities and provide access to hearing loops and other relevant equipment	L&OD	December 2023
4 – 9a	Roll out disability champion training. Training will be targeted at areas that would benefit most.	L&OD	September 2023 – March 2024
4 – 9a	Encourage disabled staff to become Inclusion champions	EDI team	December 2023
4 – 9a	Review sickness management process including implementation of NHS Employers guidance on Disability leave, in collaboration with the DAWN	People - Business Partners	February 2024

4 – 9a	Signpost and provide support to disabled staff with Blue Badge	SHAW team	October 2023
4 – 9a	Mark and celebrate International Day for Disabilities – 3rd December	EDI team	December 2023
9b	Agree time off arrangements for network chairs	People – business partners	October 2023
10	Board members to update their disability status and other equality information on ESR to role model this to the organisation.	Board of directors	December 2023

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 October 2023

5.5

Agenda item:	5.5							
Presented by:	Fay Gilder – Medical Director							
Prepared by:	Jane Bryan - Medical Professional Standards Manager							
Date prepared:	September 2023							
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 data and relates to the completed round of appraisals for 2022/23. This includes all medical staff (excluding doctors in training) directly employed by The Princess Alexandra Hospital NHS Trust (PAHT). The paper sets out a summary of the processes for the annual appraisal, compliance data, and revalidation processes, and how these are monitored and assessed for quality assurance purposes, as requested by NHS England.							
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:	n/a
Risk / links with the BAF:	BAF Risk 1.1 Clinical Outcomes
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

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.2 Feb 2023

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.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

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 in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide 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,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

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

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

Action from last year: Deputy Medical Director to undertake training to be appointed to R.O role Comments: Training is complete- however the current R.O (the Medical Director) remains Action for next year: None

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

Action from last year: None Comments: Sufficient funds are in place to carry out this role Action for next year: N/A

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

Action from last year: None Comments: We continue to maintain accurate records of all doctors with a prescribed connection as part of our appraisal and revalidation process. Action for next year: None

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

Action from last year: Review of medical appraisal policy to take place Comments: Policy is in place- currently under review Action for next year: To complete review, finalise, and incorporate *new medical good practice guidance* into document

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

Comments:

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. The report was very positive.

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.

Action from last year: None

Comments: Processes are in place to provide support to all locums and fixed term doctors

Action for next year: None

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole scope of 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.[1]

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal

Action from last year: None

Comments: All doctors have annual appraisal covering whole scope of practice

Action for next year: to incorporate new good medical practice requirements into templates and associate appraisal documents, policies and processes

7. 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

8. 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).

There is a current policy in place but this requires review to update with 2024 guidance

Action from last year: To revise the medical appraisal policy

Comments: There are some final amendments to be completed/new good medical practice requirements to be added

Action for next year: To complete and sign off revised policy at JLNC

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

Action from last year: None

Comments: We continue to ensure we retain the necessary numbers of trained appraisers

Action for next year: None

meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

10. 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).

Action from last year: None Comments: Appraisers attend a bi monthly appraiser's forum where they are briefed on changes to guidance, may raise queries and are able to discuss any issues. They also participate in annual refresher training, as well as attend update sessions. In addition, there is an appraisers what's app group for updates/queries 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 processes carried out. This is discussed at the Appraisers forum and reviewed where necessary

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

11. 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.

Action from last year: None Comments: The Quality Assurance forms are sent to the Medical Director/RO Action for next year: None

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: The Princess Alexandra Hospital HNS Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	314
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	295
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	14
Total number of agreed exceptions	5

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.

Action from last year: None Comments: We have a robust process in place, and continue to make timely recommendations to the GMC 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.

Action from last year: None

Comments: we ensure that we confirm the reasons for recommendations to all doctors as part of our process ahead of submission.

Action for next year: None

Section 4 – Medical governance

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

Action from last year: None

Comments: Robust clinical governance processes in place

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.

Action from last year: None

Comments: Effective systems regarding conduct and performance are in place in line with national guidance and policies

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.

Action from last year: none

Comments: Responding to concerns policy and processes are in place, in line with the national framework guidelines - NHS England

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]

Action from last year: None

Comments: We have a robust process in place which includes sharing concerns and information effectively between Responsible Officers and timely completion of MPIT forms.

[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

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

Action from last year: None

Comments: Safeguards are in place, processes for responding to concerns are carried out in line with the NHS England framework

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.

Action from last year: None

Comments: A system is in place for appropriate employment checks with our recruitment team

Action for next year: none

Section 6 – Summary of comments, and overall conclusion

-General review of actions since last Board report

- *The Medical appraisal policy is in the process of being finalised*
-
- *A decision has been made that the current R.O/Medical Director will remain in post,- previous action closed*
-
- ***Actions still outstanding***
- *Finalisation and agreement of revised medical appraisal policy*
- ***New Actions:***

- *To incorporate the new "good 'medical practice guide into processes and related documents*

Current issues:

- *None to report*

Overall conclusion:

- *The overall medical appraisal annual completion rate at 31st March 2023 was 94%*
-
- *The number of non-completion of appraisals was largely due to doctors appointed on fixed term contracts who had left the organisation prior to completion*
-
- *All relevant policies, processes and templates will be reviewed to reflect the new good medical practice guidance.*

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

Section 7 – Statement of Compliance:

The Board of Princess Alexandra NHS Hospital 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 NHS Hospital Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS England
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London
SE1 6LH

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

Publication reference: PR1844

Classification: Official

Publication reference: PR1844

NHS England

5.5

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.2 Feb 2023

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.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

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 in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide 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,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

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

Action from last year: Dr Fiona Hikmet to take up role of Responsible Officer Comments: Dr Fiona Hikmet is now Responsible Officer for St Clare Hospice Action for next year: To continue with Dr Fiona Hikmet as RO

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. Medical appraisal policy and procedure are approved by St Clare Hospice Clinical Governance Working Group and committee Action from last year: None Comments: None Action for next year: None

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

Yes – We are part of Princess Alexandra Hospitals NHS trust process and their R.O is responsible for St Clare Hospice, PAHT's Appraisal and revalidation process was peer reviewed in 2016 , the report was very positive. A Higher Level Responsible Officer visit was also carried out in 2018ns from last year

Comments: None

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.

Action from last year: None

Comments: Had no locum doctors in post at hospice

Action for next year: Remain vigilant to follow the process if needed

Section 2a – Effective Appraisal

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.[1]

Yes. All appraises aware of 2022 Medical Appraisal guide

Action from last year: Maintained compliance

Comments: None

Action for next year: To continue with compliance

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), 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 moved to the revised model may want to describe their plans in this respect.

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

N/A Action from last year: Comments: Action for next year:

8. 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).

Policy in place Action from last year: None . Comments: None Action for next year: None

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

Yes. Work in partnership with Princess Alexandra Hospital Trust which has adequate number of appraisers Action from last year: None Comments: None Action for next year: None

10. 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 refresher training, forums, appraisers meeting and Appraisals carried out are quality assured as part of process. Action from last year: None Comments: None

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

Action for next year: None

11. 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.

Yes. Quality assurance system in place in liaison with Princess Alexandra Hospital Trust. Action from last year: None Comments: None Action for next year: None

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:	St Clare Hospice
Total number of doctors with a prescribed connection as at 31 March 2023	6
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	5
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	1
Total number of agreed exceptions	1 (appraisal at last working place for a new starter)

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. A Clinical Governance Working Group meets quarterly, chaired by Medical Director where appraisals are a standing item.
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 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]

Yes Action from last year: None Comments: None 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

[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

Comments: None
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 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. Through Human Resources Team
Action from last year: None
Comments: None
Action for next year: None

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

The current appraisal completion rate as at 31st March 2023 was 100%. There was a new consultant appointed who had her appraisal within this period at previous workplace. She is now registered with hospice as DB.

- **General review of actions since last Board report: RO is in place.**
- **Actions still outstanding: None**
- **Current Issues: None to report**
- **New Actions: Continue with compliance and support.**

Overall conclusion: St Clare Hospice is a Designated Body working in close relationship with Princess Alexandra Hospital Trust and is compliant of all required actions.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] 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: St Clare Hospice

Name: Mrs Sarah Thompson

Signed: _ 

Role: Chief Executive Officer

Date: 13.09.2023

NHS England
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London
SE1 6LH

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

Publication reference: PR1844

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 October 2023

5.6

Agenda item:	5.6
Presented by:	Ogechi Emeadi, director of people, OD and communications
Prepared by:	NHS Employers Ogechi Emeadi, director of people, OD and communications
Date prepared:	19 September 2023
Subject / title:	Fit and Proper Persons Framework

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	The FPP framework is effective from 30 September 2023 and NHS organisations are expected to use it for all new board level appointments or promotions and for annual assessments for all board members going forward from that date. It should be read alongside the NHS Constitution, NHS People Plan, People Promise and forthcoming NHS Leadership Competency Framework. The Framework will introduce a requirement for and means of retaining certain information relating to testing the requirements of the FPPT for board members, a set of core elements for the FPPT assessment of all board members, and a new way of completing references.
Recommendation:	The Board is asked to: i. Note the requirements under the FPPT framework. ii. Support the proposal that the framework only applies to Trust board membe iii. Support the proposal of those who should have access to ESR

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

Previously considered by:	PC.25.09.23
Risk / links with the BAF:	2.3 In ability to recruit, retain and engage our people
Legislation, regulatory, equality, diversity and dignity implications:	CQC Well led The Nolan Principles The Kark Review The annual assessment should be consider against the protected characteristics to ensure fairness of application of the framework.

Appendices:	Appendix 1: PRN00238-i-Kark-implementation-fit-and-proper-person-test-framework.pdf (england.nhs.uk) Appendix 2: The board member reference template Appendix 3: New starter/annual NHS FPPT self-attestation

The Princess Alexandra Hospital NHS Trust

The Fit and Proper Persons Framework

1. Introduction

NHS England published a revised Fit and Proper Person Test (FPPT) Framework in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. The review highlighted areas that needed improvement to strengthen the existing regime. This paper set out the key changes and how the trust is preparing for the new requirements.

The chair of the Trust is responsible for ensuring that their organisation is adhering to the Framework.

2. Purpose of the Framework

The new Framework sets to strengthen individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS.

It is a core element of a broader programme of board development, effective appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board.

The Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

3. Applicability

The Framework applies to executive and non-executive directors of the trust integrated care boards (ICBs), NHS trusts and foundation trusts, NHS England and the CQC, interim as well as permanent appointments where greater than six weeks. Whilst there is scope within the framework to extend cover to other senior managerial positions, it is proposed for PAHT that it only applies to Trust Board members.

4. The key changes

4.1. Updates in the NHS Electronic Staff Record (ESR) to record the testing of relevant information about board members' qualifications and career history.

New data fields in ESR will hold individual FPPT information for all board members operating in the NHS and will be used to support recruitment referencing and ongoing development of board members. The FPPT information within ESR is only accessible within the board member's own organisation and there is no public register.

The chair will be accountable for ensuring that the information in ESR is up to date for their organisation. As a minimum, it is expected that each NHS organisation conducts an annual review to verify that ESR is appropriately maintained.

There should be limited access to the FPPT fields of ESR. It is proposed that the following will have access:

- chair
- chief executive officer
- senior independent director (for the chair)
- director of people
- trust secretary

4.2. Board member reference – A new standard board member reference template for references for all new appointments.

For board members who leave their position, organisations must complete and retain locally the new board member reference, whether or not a reference has been requested by a prospective employer. Appendix 2

4.3. An NHS Leadership Competency Framework will provide guidance for the competence categories against which a board member should be appointed, developed and appraised.

4.4. The annual assessment needs to be in line with the FPPT checklist which is set out at appendix 7 of the framework. The trust will need to ensure that all board members are familiar with this document. Appendix 3

4.5. The duty to store information relevant to the annual assessment (as set out in the checklist) will apply to existing directors (as they will have to comply with the assessment each year) and not only new appointees/promotions.

5. Quality assurance and governance

Every three years, organisations should undertake an internal audit to assess the processes, controls and compliance supporting the FPPT assessments.

External quality assurance checks will be conducted by the CQC, NHS England and an external/independent review. The Care Quality Commission's (CQC's) role is to ensure NHS organisations have robust processes in place to adequately perform the FPPT assessments, and to adhere to the requirements of Regulation 5 of the Regulations. NHS England has oversight through receipt and review of the annual FPPT submissions to the relevant NHS England regional director from NHS organisations.

6. Next steps

6.1. The trust will update its local policies, contracts and settlement agreements templates in line with the supporting information, guidance and templates published on NHS England's website.

6.2. Working with the chair, continue to ensure board directors know about the new FPPT requirements and data points being added to ESR to record the testing of relevant information about board members' qualifications and career history.

6.3. From **30 September 2023**, use the new board member reference template for references for all new board appointments and complete and retain locally the new board member reference for any board member who leaves their position.

6.4. NHS England is finalising the new NHS Leadership Competency Framework for board level roles, due **by September 2023** so that you can implement this alongside the FPPT Framework.

6.5. A new board appraisal framework will also be published, incorporating the Leadership Competency Framework, **by March 2024**. NHS England will ask you to use this for all future annual appraisals of board directors from this point.

7. Recommendation

The Board is asked to:

i. Note the requirements under the FPPT framework.
ii. Support the proposal that the framework only applies to Trust board members
iii. Support the proposal of those who should have access to ESR

The Princess Alexandra Hospital NHS Trust

Authors: Ogechi Emeadi, director of people, OD and communications
NHS Employers

Date: 20 September 2023

Appendix 2: The board member reference template

Board Member Reference

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

External/NHS organisation receiving request

Recruitment officer

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants:

To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role

A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)

B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A):

(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		

9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □

Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS**	Yes □	No □

• **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12) **Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**		

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix 3: New starter/annual NHS FPPT self-attestation

Every board member should complete the template (over the page) annually and this attestation should be submitted to [complete as applicable, eg the company secretary] on behalf of the chair.

Fit and Proper Person Test annual/new starter* self-attestation

[NAME OF NHS ORGANISATION]

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

*Delete as appropriate

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**28 September 2023**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 M5 Financial Results	Y	Y	Y	In M5 the Trust reported a deficit of £9.3m YTD, a £3.4m YTD deficit in August was assumed in the final planning submission leaving an overall YTD deficit of £6.0m against plan. Up to and including M4, the national guidance for reporting had been to report elective income in line with plan. This had now been updated from M5 to report actual performance for elective income following an adjustment to the baseline for Industrial Action in April 2023. The month 5 position included non-recurrent funding from the ICB of £2.1m. Given the moving elements within elective income, a detailed analysis of the Q2 position with baseline and tariff changes would be presented to PAF in October. It was agreed to provide some additional detail for the next meeting around debtors/debt collection specifically from other NHS organisations.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.2 Forecast Update	Y	Y	N	The report set out the approach to forecasting within the Trust, highlighting the approaches that the organisation was being asked to model in line with Regional and National Requests, and how to align with those requirements. An assessment of the indicative 3 year Mid Term Financial Plan for the ICS based on current estimates was also included. Overall, the Trust was flagging the risk that it may not achieve financial balance in the current financial year and faced a challenging financial environment in future years as a consequence of that. The forecast remained an iterative process as changes to the elective recovery fund were awaited.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 PQP Update	Y	Y	N	At M5, including income**, there was an over-delivery against divisional** trajectories of £1.4M and an over-delivery against the Trust target of 1.2M with £5.36M delivered YTD. In month, including income there was an over-delivery of £941k against trajectory and an over-delivery of £1.09M against target. In total £2.3M was delivered. At M5, **excluding income**, there was an over-delivery of £383k against trajectories and an over-delivery against the Trust Target of £148k with £4.29M delivered YTD. In month, excluding income, there was an under-delivery of £128k against trajectories but an over-delivery against the Trust Target of £25k. In total £1.24M was delivered. In terms of recurrent savings, the Trust had delivered 71.6% YTD (target 80%) and 72% in M5. Divisional PQP plans totalled £15.94M in year, with additional pipeline schemes in Estates & Facilities being calculated and support being provided to Medicine.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.4 Finance Modernisation Update	Y	Y	N	The report provided an update on the Financial Modernisation Project, in particular the migration to SBS (Shared Business Services) with an anticipated go-live date of 01.11.23. The project was currently progressing well with good engagement and collaborative working across several departments. The project had been categorised as red due to two work-streams with identified risks for go-live. Those were being actively managed, and the project was expected to revert to green very quickly.
2.5 BAF Risk 5.1 (Finance – Revenue)	Y	N	N	In line with the recommendation it was agreed that the risk score would increase from 12 to 16 given the current financial positions/forecast positions of both the Trust and the system.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 September 2023**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.6 Quarterly Procurement Update	Y	Y	N	Key points to note were: • The service remained on budget for FY23/24. • On target to over-deliver baseline savings target for FY23/24. • Forecasting In-Year savings of £1.6m for FY23/24. • Overall good operational performance – improvement from last quarter. • Workload continued to outstrip capacity – nonclinical Procurement. • Progressing Inventory Management opportunity for PAHT with NHS SC. • Outline Business Case being developed for Contract Management - to release further savings. PAF was pleased to receive a list of the major PAHT contracts expiring in the next year.
2.7 Business Case Process Update	Y	Y	N	The report provided an update on the re-introduction of a Business Case Development Group. The initial meeting had taken place on 25.09.23 with clear objectives to ensure appropriate membership, frequency of meetings and documentation/templates. Terms of reference and associated membership were being worked through.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.1 M5 Integrated Performance Report	Y	Y	N	Key headlines were: **ED 4 Hour Standard:** Remained in special cause variation highlighting the continued pressures on the service. **Diagnostics:** Whilst performance remained in special cause variation, there had been a second month of improvement back towards the mean. **Ambulance Handovers:** Now in common cause variation with 18% in less than 30 minutes. **Stranded Patients:** Length of stay over seven days had reduced to near the mean for the first time since June 2022, however the indicator remained in special cause variation. **Cancer 62 Day:** Return to special cause variation due to the last data point being below the lower control limit. Focus was being placed on long wait patients which was having an impact on the overall performance.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 September 2023**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.2 Report Against Operating Plan	Y	Y	N	The performance dashboard showed the key trajectories and August performance with narrative explanations. Industrial action continued to have an impact on elective activity and PAF noted the operational challenges; the cancer backlog had increased and 78 week waits were expected to increase from the end of September 2023. Actions being taken to address performance against the ED standard were noted.
3.3 Protecting Expanding Elective Care Capacity – Assurance Framework	Y	Y	N	NHSE had written to trusts in early August to seek assurance against a set of activities that would drive outpatient recovery at pace. It had suggested that Boards discussed and challenged that work appropriately and undertook a board self-certification process to be signed-off by trust chairs and chief executives by 30.09.23. The Trust was assured for 11 requirements, had limited assurance for 2 areas but plans were in place to address those actions.
3.4 BAF Risk 4.1 (Seasonal Pressures)	Y	N	N	In line with the recommendation it was agreed that the risk score would remain at 12.
3.5 BAF Risk 1.3 (Recovery Programme)	Y	N	N	In line with the recommendation it was agreed that the risk score would remain at 15.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.6 BAF Risk 4.2 (4 Hour ED Emergency Department Constitutional Standard)	Y	N	N	In line with the recommendation it was agreed that the risk score would remain at 20.
4.1 Health & Safety Bi-Monthly Update	Y	N	N	Key headlines were: • Part 2 of the external audit by Essex County Fire & Rescue Service was now complete with remedial actions underway and reported to the Health & Safety Committee. • Estates and Health & Safety team continued to work through the compliance requirements for building projects to ensure legislation was followed. • Safety sub-groups for water, ventilation, medical gases, electricity and fire were in place and working well. Additional risks in relation to all had now been recorded on the risk register for each discipline and would be overseen via the Health & Safety Committee.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 October 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28 September 2023**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.2 Elective Hub Update	Y	Y	Y	The paper articulated the revised timeline and a requirement to spend a further £1.4m of the system capital allocation for the scheme ahead of GMP and FBC approval. The FBC, with final costings, would be presented to each Acute Trust and ICB Board in December. This would take the total commitment to £1.9m, ahead of receipt of the Guaranteed Maximum Price and approval of the FBC. The paper would be discussed in the Board private session on 05.10.23.
4.3 BAF Risk 3.1 (Estate & Infrastructure)	Y	N	N	In line with the recommendation it was agreed that the risk score would remain at 20.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 October 2023

6.2

Agenda item:	6.2
Presented by:	Tom Burton, DoF
Prepared by:	Beth Potton, DDoF
Date prepared:	26 September 2023
Subject / title:	Month 5 Financial Performance

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report provides an update on the Trust's financial performance for August 2023 (Month 5). The Trust reported a deficit of £0.3m in month 5 against a plan of £0.4m deficit and a £9.3m deficit YTD against a £3.4m plan. The Trust has a year-to-date financial position which is £6.0m adverse to plan. The system position continues to remain challenge and we are being asked as a system to identify means of mitigating the pressures.
Recommendation:	The Committee is asked to note the month 5 financial results.

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

Previously considered by:	Verbal update at EMT, Paper to SMT
Risk / links with the BAF:	BAF risks 5.1 and 5.2
Legislation, regulatory, equality, diversity and dignity implications:	No impact on EDI identified.
Appendices:	See finance report attached

The Princess Alexandra Hospital NHS Trust

Summary finance notes

- The Trust declared a deficit of £0.3m in month 5 and £9.3m YTD. This means that the Trust is adverse to the YTD plan by £6.0m.

- There have been two key reporting changes requested through guidance issued by NHSE for month 5:

    - Inclusion of the medical staff pay award including backpay to April 2023. The expenditure and income have been accrued in the month 5 position along with budget adjustments to align. The current funding received for medical pay awards does not cover the full cost and further discussions are ongoing via the regional NHSE team to establish further funding. No deficit derived from the medical pay awards is included in the current month 5 position.

    - Up to and including month 4, the national guidance for reporting has been to report elective income in line with plan. This has now been updated from month 5 to report actual performance for elective income following an adjustment to the baseline for Industrial Action in April 2023. Slide 8 provides further information. Activity underperformance is contributing £0.6m to the current deficit position YTD.

- The month 5 position includes non-recurrent funding from the ICB in line with planning of £2.1m. This is shown all within the month which has allowed the in month position to remain slightly ahead of plan.

- The Trust has an ambitious efficiency programme of £16.7m for 2023/24. Through the PQP exercise, the Trust and operational colleagues have identified opportunities and put in place sustainable efficiency schemes that will begin to address the current underlying deficit. PQP delivery YTD at M5 is £4.2m against a plan of £4.1m.

- Cash balance is £23.3m as at month 5. Overall, the Trust is still in a position to meet its short-term cash obligations but with an increasing deficit, additional oversight is being provided of the cash balance in this time.

Month 5 Finance

NHS
The Princess Alexandra Hospital
NHS Trust

August - Month 5

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS Trust

Monthly Summary

- The Trust declared a deficit of £0.3m in month 5 and £9.3m YTD. This means that the Trust is adverse to the YTD plan by £6.0m. There have been two key reporting changes requested through guidance issued by NHSE for month 5:
    - Inclusion of the medical staff pay award including backpay to April 2023. The expenditure and income have been accrued in the month 5 position along with budget adjustments to align. The current funding received for medical pay awards does not cover the full cost and further discussions are ongoing via the regional NHSE team to establish further funding. No deficit derived from the medical pay awards is included in the current month 5 position.
    - Up to and including month 4, the national guidance for reporting has been to report elective income in line with plan. This has now been updated from month 5 to report actual performance for elective income following an adjustment to the baseline for Industrial Action in April 2023.
    - Further adjustments have been made to the recording of income in line with national guidance.
- The month 5 position includes non-recurrent funding from the ICB in line with planning of £2.1m. This is shown all within the month which has allowed the in month position to remain slightly ahead of plan. Further analysis outlining the impact on the month 5 position with and without this income is shown on slide 4.

Summary financial results

The Princess Alexandra Hospital NHS

	FY Budget £'m	Aug-23 Budget £'m	Aug-23 Actual £'m	Aug-23 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Income							
NHS & non-NHS Income	351.0	30.0	31.8	1.8	144.5	146.9	2.3
Income Total	**351.0**	**30.0**	**31.8**	**1.8**	**144.5**	**146.9**	**2.3**
Pay							
Substantive	(221.2)	(19.3)	(17.8)	1.5	(92.1)	(83.5)	8.6
Bank	(4.3)	(0.4)	(2.7)	(2.4)	(1.9)	(12.7)	(10.8)
Agency	(6.2)	(0.6)	(1.6)	(1.1)	(3.1)	(7.6)	(4.4)
Pay Total	**(231.7)**	**(20.2)**	**(22.1)**	**(1.9)**	**(97.1)**	**(103.7)**	**(6.6)**
Non-Pay							
Drugs & Medical Gases	(30.0)	(2.5)	(2.5)	0.0	(12.5)	(11.5)	1.0
Supplies & Services - Clinical	(20.6)	(1.7)	(1.3)	0.4	(8.5)	(9.0)	(0.5)
Supplies & Services - General	(4.2)	(0.4)	(0.4)	(0.1)	(1.8)	(2.5)	(0.7)
All other non pay costs	(51.3)	(4.0)	(4.3)	(0.3)	(20.1)	(21.9)	(1.8)
Non-Pay Total	**(106.1)**	**(8.6)**	**(8.5)**	**0.1**	**(42.8)**	**(44.9)**	**(2.1)**
Financing & Depn							
Depreciation	(14.7)	(1.3)	(1.2)	0.0	(6.4)	(6.4)	0.0
PDC & Interest	(3.9)	(0.3)	(0.3)	0.1	(1.6)	(1.2)	0.4
Financing & Depn Total	**(18.6)**	**(1.6)**	**(1.5)**	**0.1**	**(8.0)**	**(7.6)**	**0.4**
Grand Total	**(5.4)**	**(0.4)**	**(0.3)**	**0.1**	**(3.4)**	**(9.3)**	**(6.0)**

Summary financial results

The Princess Alexandra Hospital NHS Trust

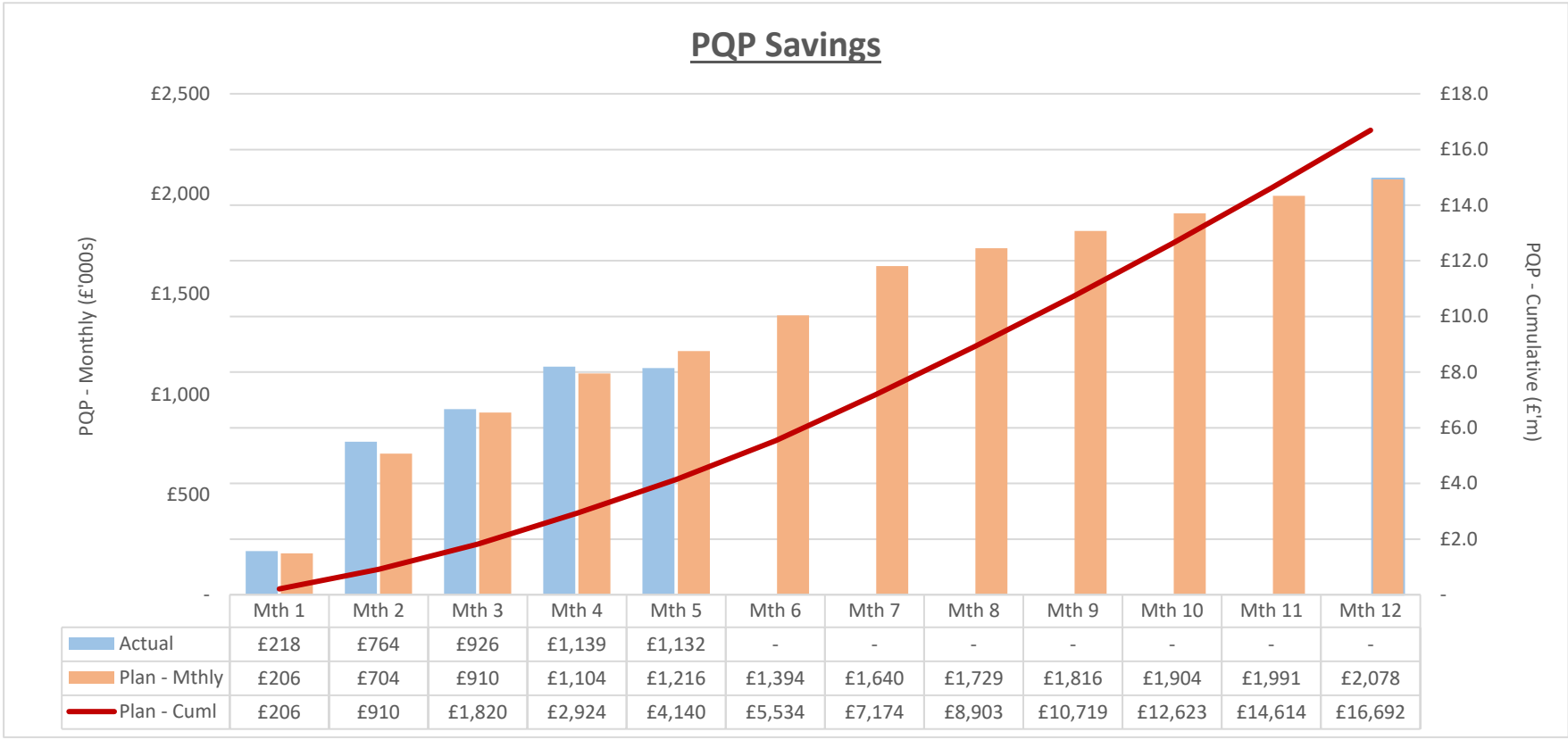
Month 5 position adjusted for non-recurrent income from ICB

	FY Budget £'m	Aug-23 Budget £'m	Aug-23 Actual £'m	Aug-23 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Income							
NHS & non-NHS Income	351.0	30.0	29.7	(0.3)	144.5	144.8	0.2
Income Total	**351.0**	**30.0**	**29.7**	**(0.3)**	**144.5**	**144.8**	**0.2**
Pay							
Substantive	(221.2)	(19.3)	(17.8)	1.5	(92.1)	(83.5)	8.6
Bank	(4.3)	(0.4)	(2.7)	(2.4)	(1.9)	(12.7)	(10.8)
Agency	(6.2)	(0.6)	(1.6)	(1.1)	(3.1)	(7.6)	(4.4)
Pay Total	**(231.7)**	**(20.2)**	**(22.1)**	**(1.9)**	**(97.1)**	**(103.7)**	**(6.6)**
Non-Pay							
Drugs & Medical Gases	(30.0)	(2.5)	(2.5)	0.0	(12.5)	(11.5)	1.0
Supplies & Services - Clinical	(20.6)	(1.7)	(1.3)	0.4	(8.5)	(9.0)	(0.5)
Supplies & Services - General	(4.2)	(0.4)	(0.4)	(0.1)	(1.8)	(2.5)	(0.7)
All other non pay costs	(51.3)	(4.0)	(4.3)	(0.3)	(20.1)	(21.9)	(1.8)
Non-Pay Total	**(106.1)**	**(8.6)**	**(8.5)**	**0.1**	**(42.8)**	**(44.9)**	**(2.1)**
Financing & Depn							
Depreciation	(14.7)	(1.3)	(1.2)	0.0	(6.4)	(6.4)	0.0
PDC & Interest	(3.9)	(0.3)	(0.3)	0.1	(1.6)	(1.2)	0.4
Financing & Depn Total	**(18.6)**	**(1.6)**	**(1.5)**	**0.1**	**(8.0)**	**(7.6)**	**0.4**
Grand Total	**(5.4)**	**(0.4)**	**(2.4)**	**(2.0)**	**(3.4)**	**(11.4)**	**(8.1)**

PQP

The Princess Alexandra Hospital NHS Trust

PQP Delivery at month 5 remains on track YTD. There are further income opportunities that have been identified in month 5 but given the changes to the elective income regime, our overall income position is under review by the finance team and for prudence, we have excluded income capture from this analysis.



	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Mth 10	Mth 11	Mth 12
Actual	£218	£764	£926	£1,139	£1,132	-	-	-	-	-	-	-
Plan - Mthly	£206	£704	£910	£1,104	£1,216	£1,394	£1,640	£1,729	£1,816	£1,904	£1,991	£2,078
Plan - Cuml	£206	£910	£1,820	£2,924	£4,140	£5,534	£7,174	£8,903	£10,719	£12,623	£14,614	£16,692

Statement of Financial Position

The Princess Alexandra Hospital NHS Trust

Statement of Financial Position

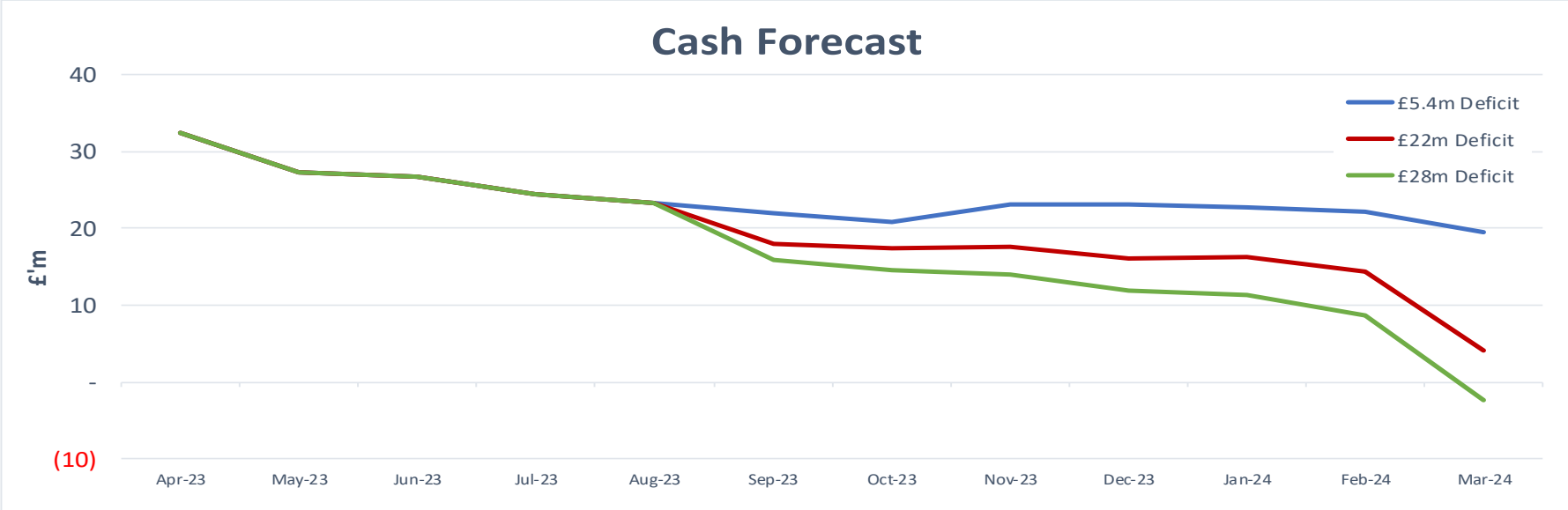
Statement of Financial Position	Mar-23 £'m	Jul-23 £'m	Aug-23 £'m	Movement In Month £'m	Movement YTD £'m
Non-current assets					
Property, plant & equipment	164.9	164.6	164.2	(0.4)	(0.7)
Right of use assets	66.0	30.9	30.8	(0.1)	(35.2)
Intangible assets	15.5	15.4	15.7	0.4	0.2
Trade & other receivables	1.2	0.6	0.6	0.0	(0.6)
Non-current assets	**247.6**	**211.5**	**211.4**	**(0.1)**	**(36.3)**
Current assets					
Inventories	5.1	5.3	5.3	0.0	0.1
Trade & other receivables	14.4	11.2	13.5	2.2	(0.9)
Cash & cash equivalents	39.2	24.5	23.3	(1.2)	(15.9)
Current assets	**58.7**	**41.0**	**42.0**	**1.1**	**(16.7)**
Total assets	**306.4**	**252.4**	**253.4**	**0.9**	**(53.0)**
Current liabilities					
Trade & other payables	(52.8)	(42.8)	(44.3)	(1.5)	8.5
Provisions	(0.8)	(1.2)	(1.2)	0.0	(0.4)
Borrowings	0.0	(1.9)	(1.9)	0.0	(1.9)
Current liabilities	**(53.6)**	**(45.9)**	**(47.3)**	**(1.5)**	**6.3**
Net current assets/ (liabilities)	**5.1**	**(4.9)**	**(5.3)**	**(0.4)**	**(10.4)**
Total assets less current liabilities	**252.8**	**206.6**	**206.0**	**(0.5)**	**(46.7)**
Non-current liabilities					
Trade & other payables	0.0	0.0	0.0	0.0	0.0
Provisions	(1.3)	(0.9)	(0.9)	0.0	0.4
Borrowings	(66.0)	(25.4)	(25.3)	0.2	40.7
Total non-current liabilities	**(67.3)**	**(26.4)**	**(26.2)**	**0.2**	**41.1**
Total assets employed	**185.5**	**180.2**	**179.8**	**(0.3)**	**(5.6)**

- **Non Current Assets** have decreased slightly from last month. The decrease of £34.5m in ROU assets represents post audit adjustment, following revaluation of St Margaret's Hospital. Depreciation charges are (£0.9m) and amortisation (£0.2m).
- **Trade and Other Receivables** increase from last month is mainly due to income accrual of £2.1m non recurrent funding from ICB in line with planning assumptions.
- **Cash balances** has decreased by £1.2m from last month and is mainly due to payment of NHS Professional Ltd older invoices.
- **Trade and Other Payables** The increase of £1.5m is largely due to unpaid NHS Professional Ltd invoices received this month.
- **Borrowings** decrease representing payment of liability falling due & post audit adjustment in ROU assets, following revaluation of St Margaret's Hospital.

Cashflow

The Princess Alexandra Hospital NHS Trust

	YTD					<-Forecast						
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
£5.4m Deficit	32,503	27,345	26,748	24,467	23,316	22,064	20,944	23,103	23,176	22,724	22,201	19,515
£22m Deficit	32,503	27,345	26,748	24,467	23,316	17,972	17,382	17,555	16,157	16,292	14,299	4,051
£28m Deficit	32,503	27,345	26,748	24,467	23,316	15,960	14,638	14,079	11,950	11,354	8,629	(2,299)



We are modelling further cashflow forecasts based on alternative deficit scenarios, these are still being refined but indicate we may require additional revenue support towards the end of the financial year if we deliver a deficit above the planned £5.4m.

Capital Analysis 23/24

The Princess Alexandra Hospital NHS Trust

	Plan		M0 5			YTD		
	Original Plan	Revised Plan	YTD Forecast £'m	Actual £'m	Variance £'m	Plan and profile £'m	Actual £'m	Variance £'m
Internally Funded Schemes								
Estates								
2023-24 Ward Refurbishment	5,824	1,000	-	-	-	1,000	-	1,000
New car park option	1,000	200	-	165	- 165	200	165	35
New UPS/IPS to critical areas - Phase 1 Main theatres/ED/ITU/HDU	764	764	276	-	276	764	8	756
Other Estate Schemes	4,762	3,365	838	-	838	3,365	528	2,837
Estates BLM								
Estates BLM Schemes	3,554	3,554	1,269	288	981	3,554	642	2,912
ICT								
ICT Schemes	3,974	1,864	618	304	314	1,864	726	1,138
EHR	1,911	1,911	-	-	-	1,911	-	1,911
Corporate							-	
Finance Modernisation	545	545	225	-	225	545	47	498
Medical Equipment								
Medical Equipment (Surgery)	3,080	293	284	-	284	293	143	150
Medical Equipment (CSS)	652	552	367	-	367	552	381	171
Other Equipment (People)	64	33	22	-	22	33	-	33
Medical Equipment (Medicine)	125	-	-	-	-	-	-	-
Medical Equipment (CHAWS)	189	109	49	-	49	109	-	109
Contingency	289	535	-	-	-	535	-	535
YTD spend on Internal Schemes	**26,733**	**14,725**	**3,948**	**757**	**3,191**	**14,725**	**2,640**	**12,085**
Externally Funded Schemes								
New Hospital	1,060	1,060	440	62	378	1,060	201	859
New Hospital CPO	1,700	1,700	378	-	378	1,700	112	1,588
CDC	5,225	5,225	1,162	29	1,133	5,225	280	4,945
EHR	8,000	8,000	1,776	292	1,484	8,000	781	7,219
YTD spend on External Schemes	**15,985**	**15,985**	**3,756**	**383**	**3,373**	**15,985**	**1,374**	**14,611**
Total - Internal and External	**42,718**	**30,710**	**7,704**	**1,140**	**6,564**	**30,710**	**4,014**	**26,696**

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 October 2023

Agenda item:	6.3
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Zoe Collis – Associate Director of Business Intelligence.
Date prepared:	21st September 2023
Subject / title:	Integrated Performance Report

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

6.3

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

Patients		
Patients	**MSSA**	An increase in MSSA bacterium in month. RCA meetings have taken place to identify causes of concern. A proportion are due to IV devices and an action plan has been developed with divisions which will include enhanced monitoring, audit and additional training.
Patients	**Falls by harm and Falls per 1000 bed days**	Number in month has fallen and demonstrates a gradual downwards trajectory. Falls strategy in place and plans being developed for implemention of 23-24 strategy
People		
People	**Appraisals**	Remains in common cause variation for the fourth consecutive month and the lowest we have seen on the chart. **No data since April 2023**
People	**Statutory and Mandatory**	Consistantly failing the target and has seen a fall against the standard again in June. **No more recent data provided**
People	**Sickness Absence**	Has returned to common cause variation following a return to performance below the mean
Performance		
Performance	**RTT**	Performance remains in special cause variation, with performance static at a similar level for over 12 months. Recovery actions continue to be in place, with patients being treated in clinical priority.
Performance	**Cancer 2 week wait**	Remains in special cause variation, but performance remains near the mean
Performance	**Cancer 62 day**	Returned to special cause variation due to the last data point being below the lower control limit. Focus is being placed on the long wait patients, which is having an impact on the overall performance
Performance	**Four hour standard**	Remains in special cause variation. A number of indicators are in special cause variation highlighting the continued pressure on the service
Performance	**Diagnostics**	Whilst performance remains in special cause variation, we have seen the second month of improvement back towards the mean
Performance	**52 week waits**	Still in special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained relatively constant for the last eight months following a small increase in July.
Performance	**Ambulance handovers**	Now in common cause variation we can see that 18% of ambulance handovers were in less than 15minutes
Performance	**Stranded Patients**	The number of patients with a length of stay over 7 days has reduced to near the mean for the first time since June 2022. However, the indicator remains in special cause variation
Pounds		
Pounds	Surplus	Surplus has moved from special cause concerning variation to common cause variation.
Pounds	CIP	Continues in common cause variation but has flucuated over the past 5 months.
Pounds	Capital Spend	Continues in commmon cause variation but is below the target line.
Pounds	Cash	
Places		
Places		**No information received**

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Recommendation:	The Board is asked to note and discuss the contents of this report				
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	X	X	X	X	X

Previously considered by:	PAF.28.09.23 and QSC.29.09.23
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:	M5 IPR

6.3

NHS
The Princess Alexandra Hospital
NHS Trust

Integrated Performance Report for August 2023

As at 20/09/2023

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Executive Summary

The Princess Alexandra Hospital NHS Trust

Pounds		
Pounds	**Income/Activity**	Planned care of Elective and Day Case continue to be behind plan in part related to industrial action. There is a risk of not meeting our Elective Recovery Fund (ERF) targets resulting in financial clawback from the commissioners.
Pounds	**Capital Spend**	The Trust total revised Capital resourcing for 2023/24 is £30.3m, this includes external PDC including the new hospital project, CDC, EHR, and others. As at Month 3 the year to date capital spend total is £1.3m.
Pounds	**Cash**	The Trust's cash balance is £26.7m. The cash reserves which were boosted due to the national Covid support received by the Trust have started reducing as we continue to run with a deficit. There remains focus on the level of unpaid invoices and maintaining the Trust's improved 30 day BPPC performance.
Pounds	**Surplus \ Deficit**	The Trust reported a deficit of £1.6m in June (Month 3) and year to date deficit of £7.0m. We will continue to work with each divisional team to review and challenge spend with specific focus on temporary staffing to ensure we can begin to reduce the usage.
Pounds	**PQP**	The 23/24 PQP target is £16.7m with a YTD planned savings at month 3 of £1.8m. Actual delivery is on track at £1.9m YTD.
People		
People	**Appraisals**	Remains in common cause variation for the fifth consecutive month, and performance at the highest level since March 2020
People	**Statutory and Mandatory Training**	Consistantly failing the target and has seen a fall against the standard again this month.
People	**Sickness Absence**	Has remained in common cause variation

Patients		
Patients		All metrics are within variation
Places		
Places	**Housekeeping**	the new Synbiotix system has now been rolled out for the food ordering service on the wards. Feedback to date on the system is good.
Places	**Catering**	Meal number are increasing due to the increase in patient numbers acro
Places	**Places Summary**	ED CQC - fabric works. Plan to be agreed with end users for least imapct on service for all users but complete in a timely manner ahead of CQC visit
Places		Fleming Ward - agreement to proceed with a full upgrade option working with newly appointed P23 contractor on CDC at SMH with completion before xmas 2023
Places		Medical Gas infrastructure - final phase of AVSU renewal programme

Executive Summary

The Princess Alexandra Hospital NHS Trust

	Performance	
Performance	**Referral to Treatment**	Performance remains in special cause variation, with performance static at a similar level for over 12 months. Recovery actions continue to be in place, with patients being treated in clinical priority.
	Cancer 2 week wait	Performance has returned to common cause variation for a single data point, but after 8 months of being in special cause variation
	Cancer 62 day pathway	Performance is back in common cause variation after a single data point in special cause variation following one month below the lower control limit. 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. A number of indicators are in special cause variation highlighting the continued pressure on the service. Performance data is currently for March
	Diagnostics	Performance has returned to common cause variation for a single data point, but after 7 months of being in special cause variation

	Performance	
	52 week waits	Still in special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained relatively constant for a significant period
	Stranded Patients	The number of patients with a length of stay over 7 days has reduced to near the mean for the first time since June 2022. However, the indicator remains in special cause variation. Performance data is currently for March
	Ambulance handovers	Now in common cause variation we can see that 20% of ambulance handovers were in less than 15minutes which is the first time since 2021.

Section summaries

The Princess Alexandra Hospital NHS Trust

Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Income/Activity	Planned care of Elective and Day Case continue to be behind plan in part related to industrial action. There is a risk of not meeting our Elective Recovery Fund (ERF) targets resulting in financial clawback from the commissioners.	For information	
Capital Spend	The Trust total revised Capital resourcing for 2023/24 is £30.3m, this includes external PDC including the new hospital project, CDC, EHR, and others. As at Month 3 the year to date capital spend total is £1.3m.	For information	
Cash	The Trust's cash balance is £26.7m. The cash reserves which were boosted due to the national Covid support received by the Trust have started reducing as we continue to run with a deficit. There remains focus on the level of unpaid invoices and maintaining the Trust's improved 30 day BPPC performance.	For information	
Surplus \ Deficit	The Trust reported a deficit of £1.6m in June (Month 3) and year to date deficit of £7.0m. We will continue to work with each divisional team to review and challenge spend with specific focus on temporary staffing to ensure we can begin to reduce the usage.	For information	
PQP	The 23/24 PQP target is £16.7m with a YTD planned savings at month 3 of £1.8m. Actual delivery is on track at £1.9m YTD.	For information	

Section summaries

Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
	All metrics are within variation		

Section summaries

The Princess Alexandra Hospital NHS Trust

Places Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Housekeeping	the new Synbiotix system has now been rolled out for the food ordering service on the wards. Feedback to date on the system is good.	For information	N/A
Catering	Meal number are increasing due to the increase in patient numbers across the trust.	For information	N/A
	Food waste figures are unavailable this month while the new system is embedded	For information	N/A
Places Summary	ED CQC - fabric works. Plan to be agreed with end users for least imapct on service for all users but complete in a timely manner ahead of CQC visit	For information	N/A
	Medical Gas infrastructure - final phase of AVSU renewal programme	For information	N/A
	Continued external support for HV/LV AP role pending internal appointment to reduce expenditure and provide on site support for many electrical infrastructure works involving shutdowns etc	For information	N/A
	Continued external medicla gas AP support during many infrastructrue remedial works until internal role appointed	For information	
	Fleming Ward - agreement to proceed with a full upgrade option working with newly appointed P23 contractor on CDC at SMH with completion before xmas 2023	For information	

Section summaries

The Princess Alexandra Hospital NHS Trust

Performance	Board Sub Committee: Worforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
RTT 18 weeks performance	The ongoing impact of industrial action is putting pressure on capacity to clear the longest waiting routine patients. 104, 78 and 52 week waiting patient numbers are increasing. Ongoing close review of these patients and re-booking as quickly as possible.	For recognition	31/03/2024
6ww diagnostics	Steady small improvement in the Trust overall standard and excellent radiologyperformance, CT 99%, MRI 94% and Ultrasound 85%. Risks with Audiology (18%) but improvement plan in progress with locum staff and potential out-source option. (National standard 95% by 31/3/25)	For recognition	31/03/2025
Urgent Care	Continued pressure at the front door with high attendances and reduced bed capacity. Improvement plans in progress	For information	31/03/2024
Cancer	Ongoing pressure of reduced capacity from industrial action & bank holidays however steady improvements in 28 day diagnosis standard to mitigate clinical risk of long waits. Number of patients waiting over 62 days has started to decrease in July (data in IPR is May)	For increased visibility and awareness	31/03/2024

Section summaries

People Summary	Board Sub Committee: People Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Sickness	Sickness absence workshops for managers are scheduled and taking place within divisions. Individual long term cases and actions discussed at management level	For information	Q2
Appraisal	Time constraints cites as reasons for non-compliance. 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	Vacancy rate impacted by high level of vacancies within Nursing & Midwifery, Estates & Ancillary and A&C staff groups. Recruitment action plans continue to be agreed with divisions; recruitment team attending local job centre to highlight working for the Trust and to promote vacancies.	For information	Q3
Turnover	Leaving reasons are being linked to relocation due to cost of living and health and wellbeing. There is continued promotion of the trusts health and wellbeing offer including sessions on budgeting and access to Citizen's Advice sessions held on site. The trust have also undertaken a number of cost of living initiatives such as continuing free parking and access to Harlow community hub and food back. PAHT are part of the retention pathfinder programme within the ICS	For information	Q3

Section summaries

NHS
The Princess Alexandra Hospital
NHS Trust

Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Income/Activity	Planned care of Elective and Day Case continues to be behind plan in part related to industrial act. There is a risk of not meeting our Elective Recovery Fund (ERF) targets resulting in financial clawback from the commissioners. Coding activity on time is key to the Trust receiving the appropriate income.	For information	
Capital Spend	The Trust total revised Capital resourcing for 2023/24 is £30.3m, this includes external PDC including the new hospital project, CDC, EHR, and others. As at Month 5 the year to date capital spend is £3.2m behind plan.	For information	
Cash	The Trust's cash balance is £23.3m. The cash reserves which were boosted due to the national Covid support received by the Trust have started reducing as we continue to run with a deficit. There remains focus on the level of unpaid invoices and maintaining the Trust's improved 30 day BPPC performance.	For information	
Surplus / Deficit	The Trust reported a deficit of £9.6m YTD in August (Month 5) against a YTD planned deficit of £3.4m. We will continue to work with each divisional team to review and challenge spend with specific focus on temporary staffing to ensure we can begin to reduce the usage. The impact of Industrial Action is also contributing to this increased deficit.	For information	
PQP	The 23/24 PQP target is £16.7m with a YTD planned savings at month 5 of £4.1m. Actual delivery is on track at £4.2m YTD.	For information	

Key Performance Indicators In Special Cause Variation

The Princess Alexandra Hospital NHS Trust

5P Section	KPI	SPC status	Performance	BAF Risk Reference	Current Risk Score	Target Risk Score
Patients	Serious Incidents		1	1.1	16	12
Patients	Falls total		17	1.1	16	12
Patients	Pressure Ulcers per 1000 bed days		2	1.1	16	12
Patients	Smoking rates at delivery		5.0%	1.1	16	12
People	Vacancy Rate		11.2%	2.3	16	8
People	Voluntary Turnover		13.7%	2.3	16	8
Performance	Referral to Treatment		54%	1.3	15	10
Performance	52 week waits		2516	1.3	15	10
Performance	4 hour standard		54%	4.2	16	12
Performance	Ambulance handovers less than 15 mins		18%	4.2	16	12
Performance	Patients over 12 hours in ED from arrival		863	4.2	16	12
Performance	Patients over 7 days length of stay		169	4.2	16	12

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

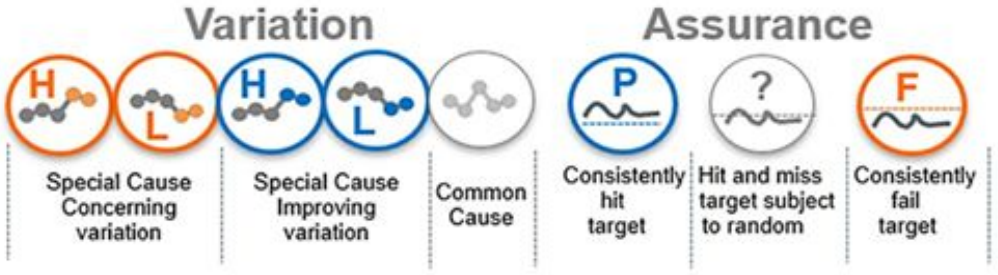
Special Cause Variation

- 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

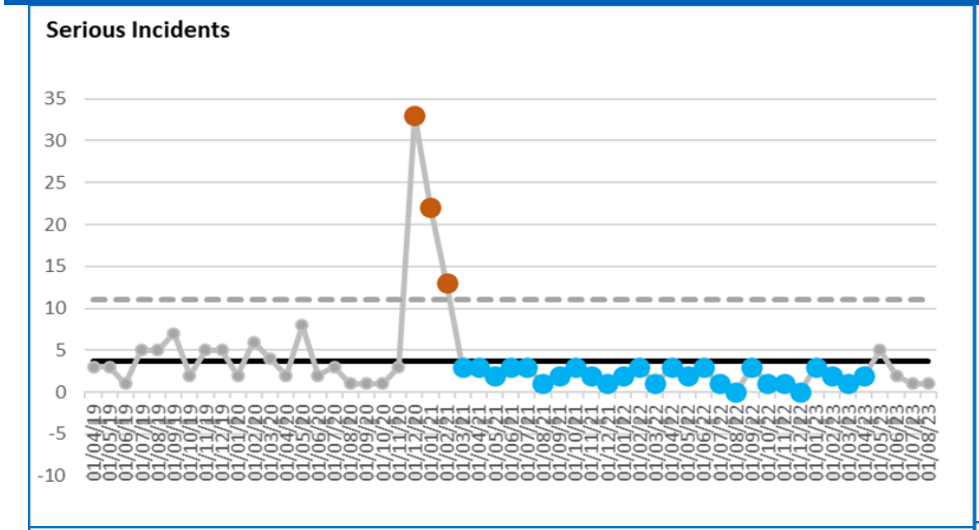
- A single point outside of the upper or lower control limits
- A run of points above or below the average (mean) line.
- Six consecutive points increasing or decreasing
- Two consecutive points near the upper or lower process control limits

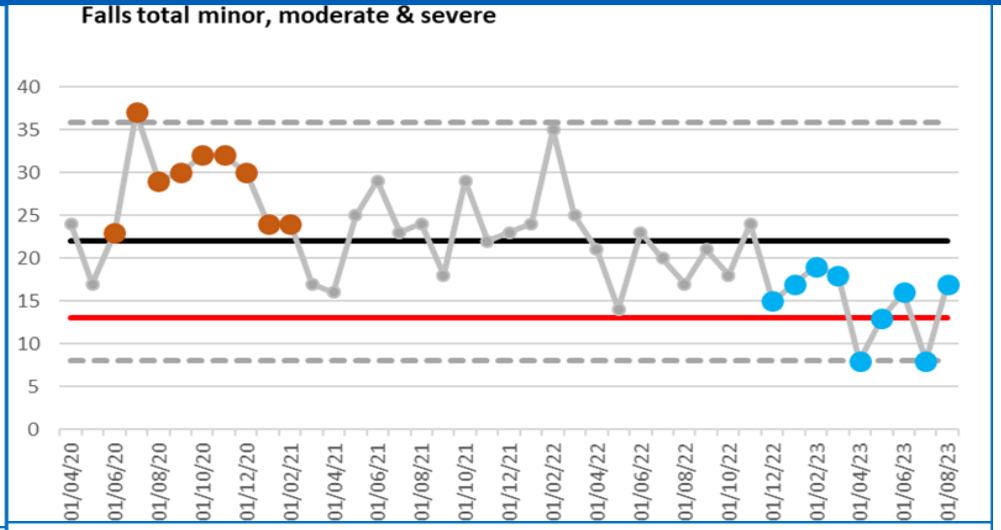


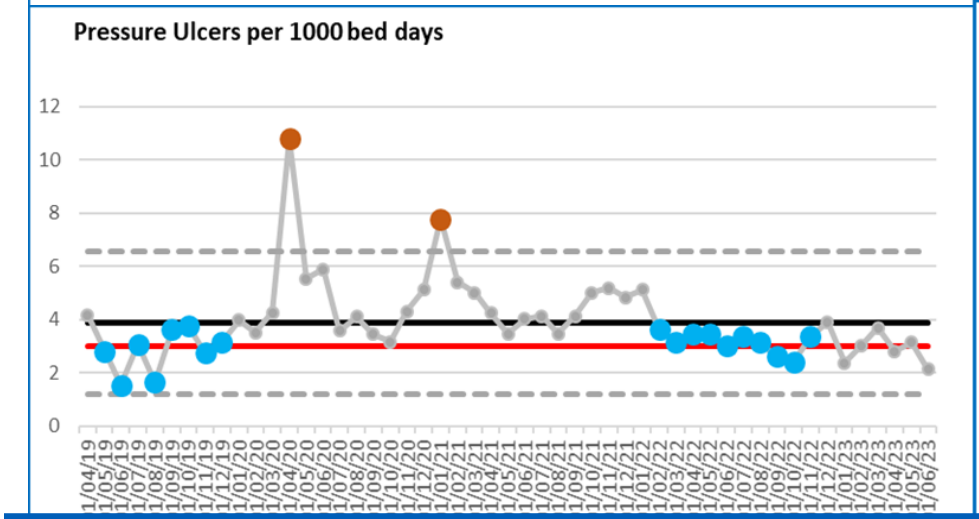
Summary

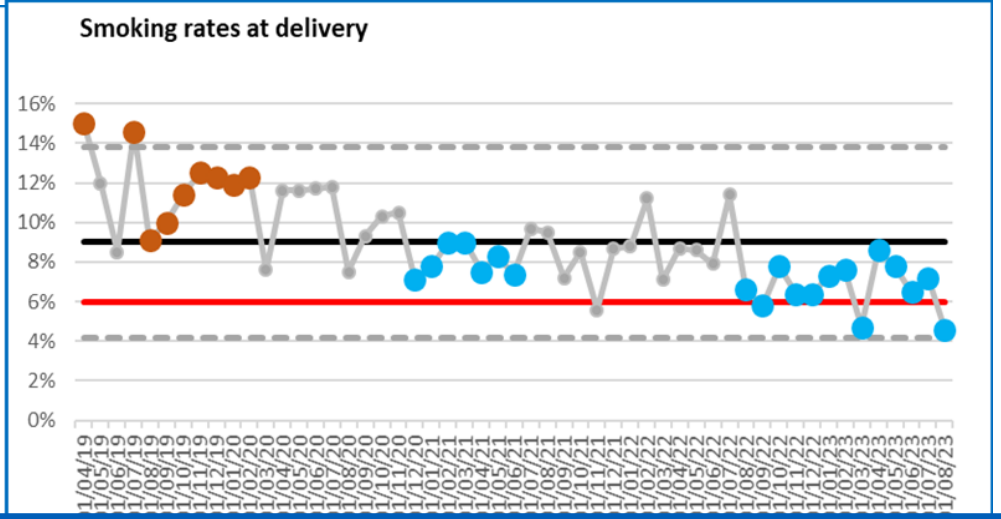
Patients section measures in special cause variation

The Princess Alexandra Hospital NHS Trust









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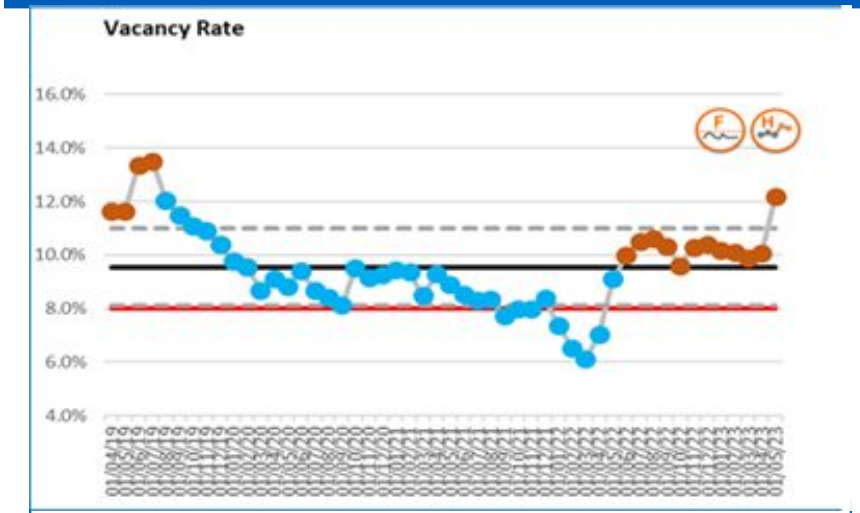
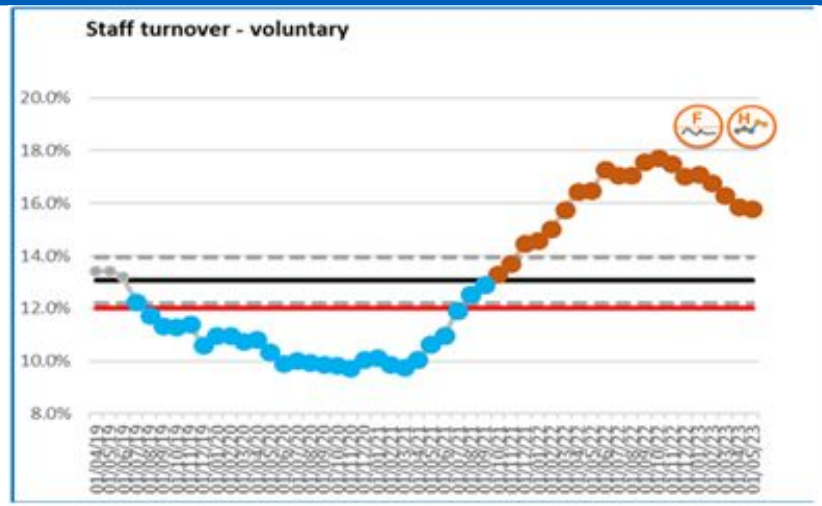
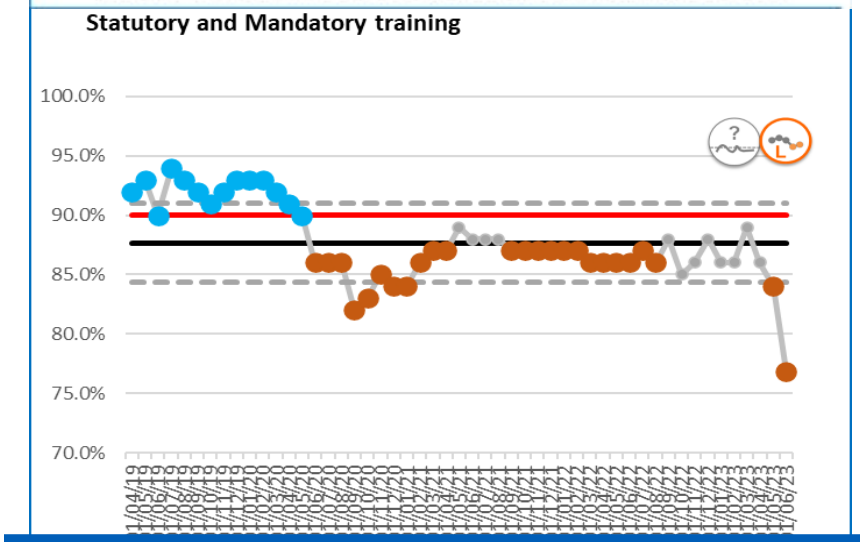
People section measures in special cause variation

The Princess Alexandra Hospital NHS Trust

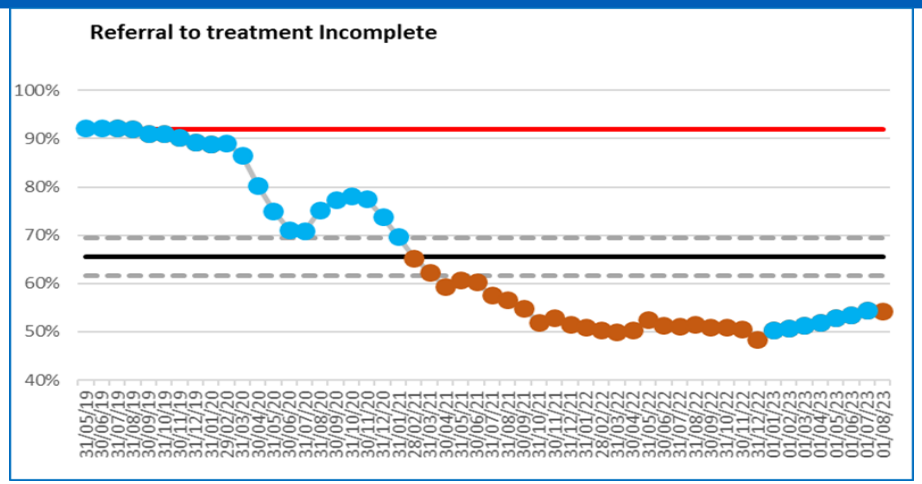


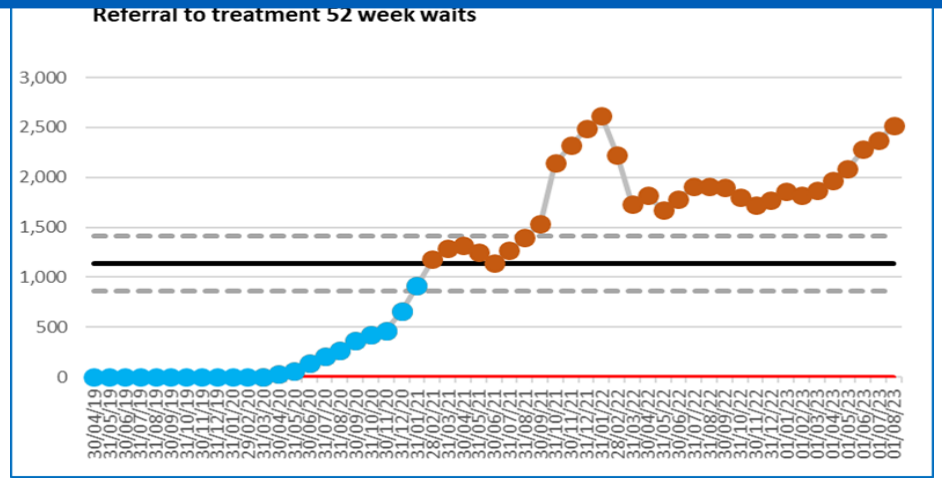


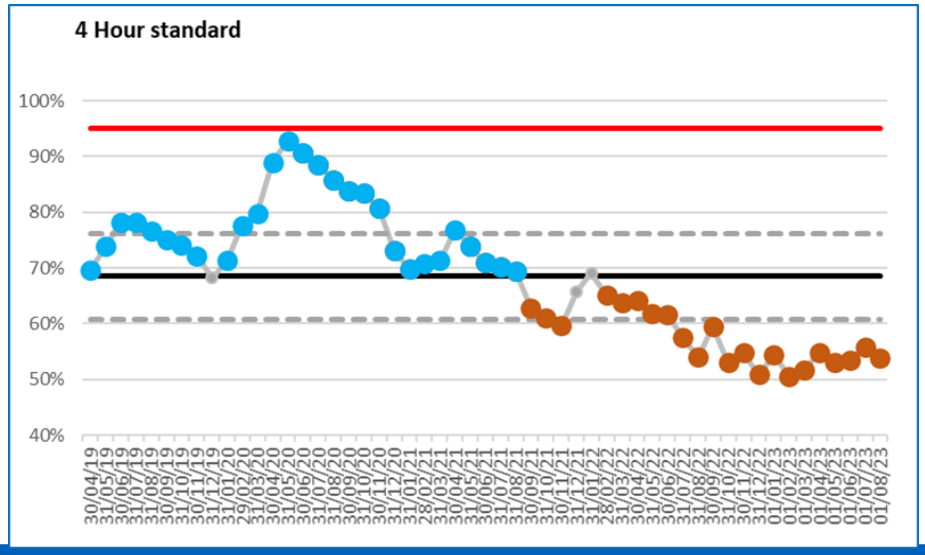


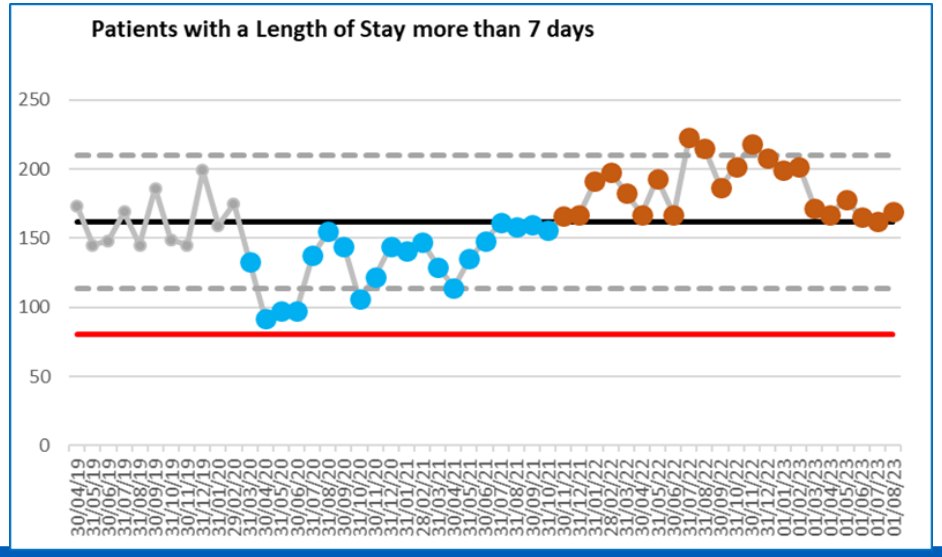
Performance section measures in special cause variation (1)

The Princess Alexandra Hospital NHS Trust









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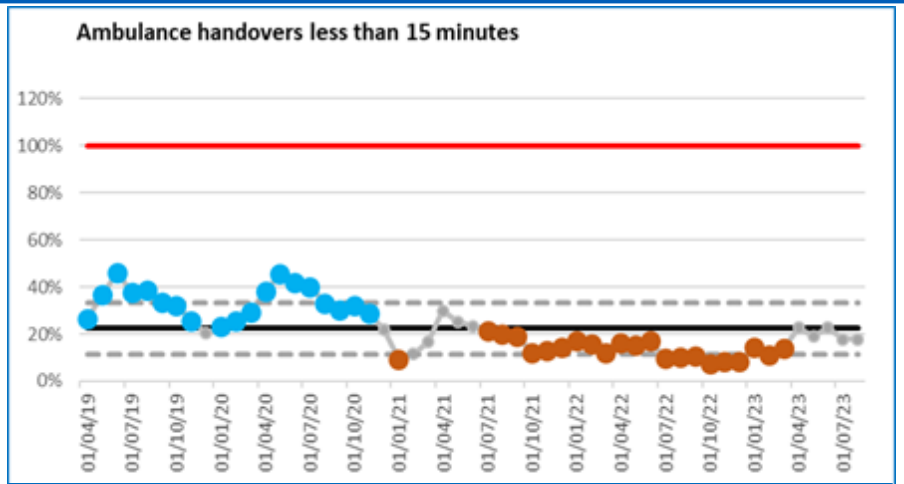
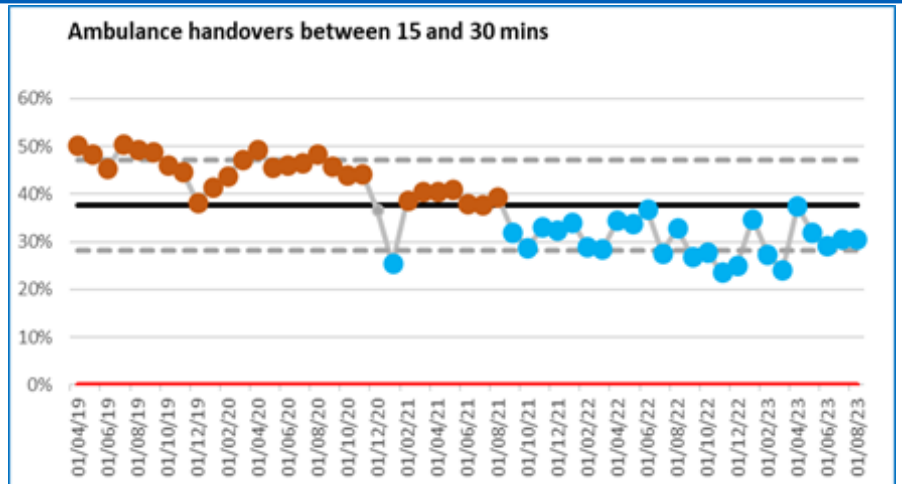
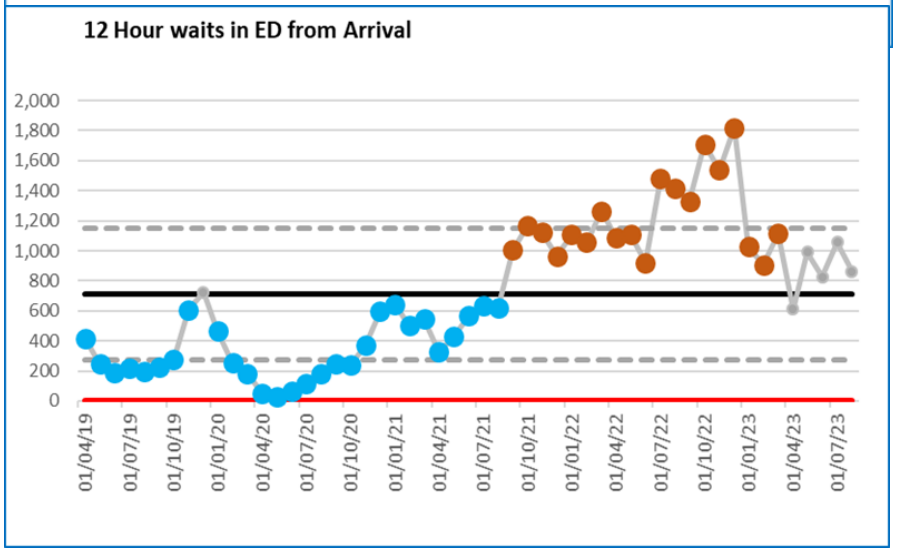
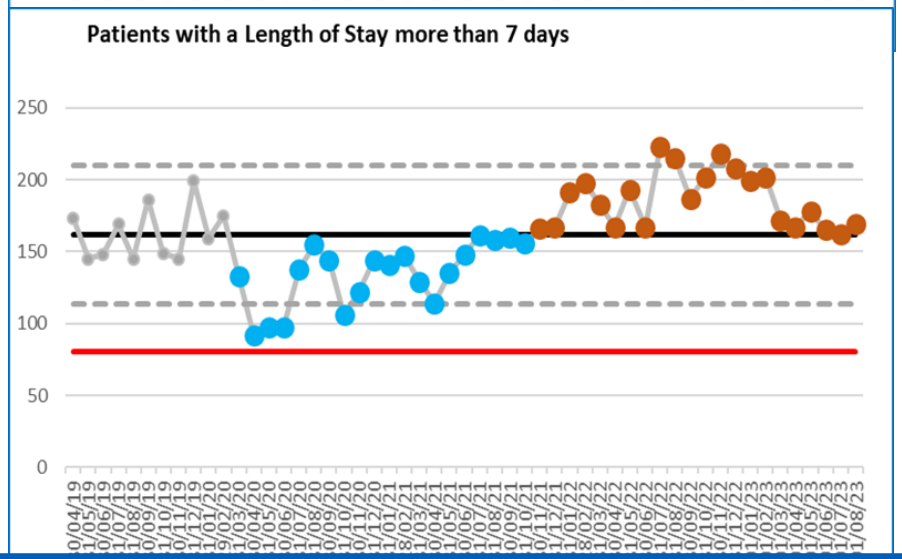
Performance section measures in special cause variation (2)

The Princess Alexandra Hospital NHS Trust









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The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 October 2023

Agenda item:	6.4
Presented by:	Steph Lawton
Prepared by:	Performance & Planning team & John Anderson
Date prepared:	20th September 2023
Subject / title:	Protecting & Expanding Elective Care Capacity Board Assurance

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

Key issues:	NHSE wrote to Trusts in early August to seek assurance against a set of activities that will drive outpatient recovery at pace. They suggested that Boards discuss and challenge this work appropriately and undertake a board self-certification process and have it signed off by trust chairs and chief executives by 30 September 2023. The Trust is assured for 11 requirements, has limited assurance for 2 areas but plans are in place to address these actions.
Recommendation:	To approve the self-assessment as requested by NHSE in their letter dated 4 August 2023.

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:	EMT.20.09.23 and PAF.28.09.23
Risk / links with the BAF:	1.1 Variations in clinical quality of care
Legislation, regulatory, equality, diversity and dignity implications:	No legislatory implications, EDI and Dignity implications included in the assurance assessment.
Appendices:	Detailed Board Assurance Template

The Princess Alexandra Hospital NHS Trust

1. Introduction:

NHS England wrote to Trusts on 4th August to outline the next steps in to enable outpatient recovery and transformation. Having met with royal colleges, specialist societies and patient representatives to agree a way forward. Trusts are therefore asked to undertake the following 3 key actions:

- Revisit our plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.
- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied

The completed Board Assurance Template can be seen in the Appendix to this report.

2. Areas of concern

The Trust is compliant in all areas. The Board are asked to note however, the increasing demand on outpatient services and impact of industrial action on clinic cancellations.

3. Areas of limited assurance

Areas of limited assurance are:

i. Within PIFU, where patients are on long term condition pathways, the process is being piloted. It is acknowledged that the patient tracking with COSMIC may cause some challenges, which means we have to consider how this is progressed as Alex Health is rolled out. There is a need for more specialities to utilise PIFU and detail the discussions why patients would be not suitable in divisional board discussions.

ii. The Trust is not currently outsourcing any activity, but is discussing the transfer of foot & ankle patients to a local independent provider and is co-operating with the national requirement to roll out the "DMAS" digital mutual aid software and the patient initiated version that is due to be released in October.

4. Recommendations

The Board is asked to approve the self-assessment as requested by NHSE.

Author: Elizabeth Podd, Head of Performance & Planning
Date: 20h September 2023

The Princess Alexandra Hospital NHS Trust

Appendix: Assurance Data Collection:

Assurance area	Evidence
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.	Validation rates are submitted weekly as part of the Waiting List Minimum Dataset (WLMDS) return (no direct comparison to pre-covid validation levels available however as this was not previously a mandatory captured data field). DQ errors requiring validation (including administrative or clinical) are identified through internal monitoring of the Trust RTT validation programme, internal Data Quality reports (generated from the Information Team), PTL meetings and use of the LUNA system.
b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation.	The Trust has to date contacted all non-admitted patients who are waiting at 33 weeks and above and for admitted, all 52 weeks and above via a text message platform; Envoy. The text message survey will be sent to all patients waiting 12-33weeks (including paediatrics and those on an ASI list) in the coming weeks. The Trust does not foresee any challenges to achieving this ambition.
c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	The Trust Access Policy is available to both staff and patients on the Trust Intranet page. The current Access Policy is in its renewal phase and is in the process of being re-written collaboratively with provider and ICB colleagues. This will ensure all three Trusts within our ICS are consistent with the application of RTT rules and policies and management of patient pathways. Discussion of our longest waiting, clinically urgent patient pathways at weekly PTL meetings also ensures activity and treatments are planned in line with RTT rules and guidance.
d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	The Quality and Safety committee receives a bi-monthly report on both review lists and ASI numbers that discusses the clinical risk and mitigating actions that are enacted. The Trust carried out demand and capacity reviews as part of the annual planning cycle and is refreshing the current demand and capacity models ready for 2024/2025 planning.

2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.	The Trust operational teams are liaising with clinical leads to determine the plan for booking this cohort of patients by 31/10/23. Actions include: • Validation of the cohort of patients using Envoy questionnaire • Booking all available 1st out-patient activity to 31/10 with cohort patients • Conversion of unbooked follow-up capacity to first appointments • Cancellation of lower waiting patient appointments & replacement with cohort patients • Creating additional capacity to be booked into • Use of mutual aid where available
b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	The trust currently utilises insourcing for Dermatology, Non Obstetric Ultra Sound and Audiology.
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.	Performance & Finance Committee receive details of follow-up activity in the IPR, the transformation projects such as Out-Patient Improvement through the Transformation Committee, the plans to reduce Review lists & ASIs through the Quality & Safety Committee.
b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.	Working with Quality 1st and clinicians to implement PIFU, data is tracked via Qliksense for live updates, currently 4 specialities are above the 5% target and 4 more are close to achieving by year end. Q1st are working with BCMs and specialties to explore how PIFU could be widened to support non-responders on the waiting lists. Long term condition pathways, which will also support the cancer pathways is in pilot phase. Once the pilot is signed off then this will be rolled out across appropriate pathways. The patient tracking within Cosmic may cause challenges which mean we have to consider how we progress this when Alex Health is implemented.

c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments.	Outpatient Management Group (OMG) platform used to address and challenge DNA across all specialities /divisions. An action plan has been agreed across all services. The access policy being reviewed. DNA rates on new are below national average.
d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking data (via the Model Health System and data packs) to identify further areas for opportunity.	The national offer of telephone advice and guidance is available through Consultant Connect (CC) as part of the ICS contract. Working in partnership with our ICB colleagues to increase the local provision and offer of telephone advice and guidance through the CC platform. A local offer is in place for ENT, Gastro, Respiratory and Diabetes. Discussions taking place in Paediatrics, Gynaecology and Cardiology to explore what could be supported in a local offer through CC. RAS – Referral assessment service. This provides triage and advice and guidance where referrals are sent back to the GP. A pilot is in place for Ophthalmology currently with Stellar referrals going through this pathway. Once the pilot is signed off this will be opened out to all Ophthalmology referrals and will then onboard Paediatrics and Cardiology. Working with the specialties we will be agreeing a roll out plan over the next 4-6 weeks to onboard all appropriate specialties.
e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	This is part of the clinical strategies from each division and part of the service reviews that each speciality will carry out. In CSS this will be by the monthly service review meetings (SRMs). An outpatient PQP programme is in place which aims to support improvements in capacity through reducing cancellations, additional sessions and improving booking practice.
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

6.4

Classification: Official

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 August 2023

6.4

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the ‘call to arms’, colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Publication reference: PRN00673

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month**.**

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

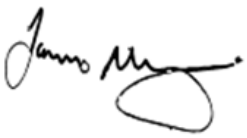
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	Assured?
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**5 October 2023**			**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**			
REPORT FROM:	**Liz Baker - Chair**			
DATE OF COMMITTEE MEETING:	**25 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
1.4 Action Log/Review of Risk	Y	N	N	In response to a previous action an outline of how the PMO maintained oversight and managed risks associated with the PAHT2030 programme was presented. This included the process followed by the PMO and wider Trust to manage and mitigate identified risks.
1.5 Annual Work Plan	For noting	N	N	This paper provided an update on developments over the summer on the work plan for the Trust's Strategic Transformation Committees along with a proposal to adjust the work plan in-year. This proposal was approved.
2.1 PAHT2030 Update	Y	Y	N	Key headlines were: • Although 2022 milestones remained incomplete, they remained on schedule in accordance with revised milestone deadlines and good progress was being made. • Transforming Our Care 2022 milestone had moved from amber to green as clinical strategies and delivery plans were developed. This was expected to complete and close (blue) by the end of October. • 2023 milestones were in place for Transforming Our Care, Our Culture, New Hospital, Corporate Transformation, Digital Health with all currently RAG-rated green.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**5 October 2023**			**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**			
REPORT FROM:	**Liz Baker - Chair**			
DATE OF COMMITTEE MEETING:	**25 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				It was agreed going forward to provide some evidence on the cover sheet of the outputs from the actions being taken.
2.2 PAHT2030 Digital Transformation Update	Y	Y	N	The Alex Health programme continued at pace to ensure gateway deadlines were met which would enable October 2024 go-live. Current and future state reviews for processes had recently been undertaken and had now commenced data collection activities to support and test the future state. There were a number of issues which required attention but the majority of those related to resourcing on both sides (Trust/Oracle Health). It was anticipated resourcing would remain a risk for the duration of the programme. STC also noted the hugely positive feedback from a visit to the international Oracle Conference and the plans to cascade that and also the learning to the wider organisation.
2.3 New Hospital Update	Y	Y	N	Key headlines were: • A revised delivery programme had been developed which currently showed the new hospital as operational in Q4 2030. • The first phase of NHP's Prioritisation and Preparation exercise had been completed. The second phase had begun which required the completion of a detailed questionnaire about the Trust's proposed development. In parallel KPMG was undertaking a review of acute provision in the East of England.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:		**5 October 2023**		**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:		**Strategic Transformation Committee (STC)**		
REPORT FROM:		**Liz Baker - Chair**		
DATE OF COMMITTEE MEETING:		**25 September 2023**		
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• Lord Markham had visited the current site on 21.09.23.
2.4 BAF Risk 1.2 (EHR)	Y	Y	N	It was agreed that the risk narrative would be reviewed ahead of the next meeting.
2.4 BAF Risk 3.5 (New Hospital)	Y	Y	N	It was agreed that the risk narrative would be reviewed ahead of the next meeting.
3.1 Strategic/System Update and Report from West Essex Health Care Partnership (WEHCP)	Y	Y	N	Covered under item 4.1 below.
3.2 Stakeholder Update	Y	Y	N	STC noted that the Harlow Growth Board had been cancelled in September. There was ongoing and positive engagement with the CEO of Epping Forest Council in relation to the land for the new hospital and in terms of keeping local partners in touch with the current position around that.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**5 October 2023**			**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**			
REPORT FROM:	**Liz Baker - Chair**			
DATE OF COMMITTEE MEETING:	**25 September 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.3 BAF Risk 3.2 System Pressures	Y	Y	N	The risk score remained unchanged at 16.
4.1 Discussion Topic: Mapping of Place (Part II)				
	Key areas of discussion: • Should HCPs focus on tackling ill health and the impact that housing/education had on health and the knock-on impact to health services given 80% of the population's health was not managed directly by healthcare services. This was not the traditional role of healthcare providers so how would it be resourced? • Should another governance structure be established to manage things differently or should ICSs/HCPs be used to now drive things in a different direction. • Is primary care missing from the discussions? • Is local engagement with partners around housing, employment and lifestyle choices sufficiently robust? • Could Trust recruitment processes be transformed to support the local population in applying for employment at the hospital? • Could rich local council data be used more effectively to glean a better understanding of the local population and its requirements in terms of healthcare services?			

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:		**5 October 2023**		**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:		**Strategic Transformation Committee (STC)**		
REPORT FROM:		**Liz Baker - Chair**		
DATE OF COMMITTEE MEETING:		**25 September 2023**		
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
	Next steps: • Agreed to hold a discussion around the WEHCP's role in East Hertfordshire and for a report from the Hertfordshire Provider Board to be a standing agenda item at STC going forward. • Consider resourcing required to progress this work.			

BOARD OF DIRECTORS: Trust Board (Public) 5 October 2023 **AGENDA ITEM: 7.2**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Committee Chair

DATE OF COMMITTEE MEETING: 11 September 2023

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Auditor's Annual Report 2022/23	Yes	Yes	No	The Committee noted the annual report.
2.2 PAH Reflections on Year-end Process 22/23	Yes	Yes	No	The DoF reported that the Trust identified areas it could improve upon and would undertake work prior to the next financial year end to complete the work as part of a package of overall improvement measures.
3.1 Internal audit: • Q2 Progress Report • IA Follow Up Report • 22/23 Medical Rostering • 22/23 KFS – GRNI • 22/23 Aseptic review Standards Return	Yes	No	N/A	The following audits have been completed: • Aseptic Unit (advisory review) • Key Financial Controls – Goods Receipt/Invoice Receipt (GR/IR) • Medical Rostering A deep dive into the Aseptic unit audit will be discussed in December 2023
4.1 Waivers, Losses, and Special Payments	Yes	Yes	N/A	During the period 1st April 2023 to 30th June 2023: • The value of losses and special payments totalled £10k (4 cases) • No debts written off this period.

BOARD OF DIRECTORS: Trust Board (Public) 5 October 2023 **AGENDA ITEM: 7.2**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Committee Chair

DATE OF COMMITTEE MEETING: 11 September 2023

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				• 37 waivers totalled £1.35m of which 10 (£339k) were non-compliant
1.5 Annual Committee Effectiveness Review and Terms of Reference	Yes	Yes	No	The Committee highlighted two elements: • The request to review ICB's Board Assurance Framework at the November/December meeting. • The second point was that Committee members should meet privately with internal and external auditors, annually. It was resolved that the Committee would meet privately with the external auditors in November and the internal auditors in December respectively. The Committee noted the report and approved the terms of reference attached as **Appendix 1.**

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE

TERMS OF REFERENCE 2023/24

PURPOSE:

The Audit Committee (the Committee) shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance.

For the purposes of procuring the Trust's External Auditor, the Trust Board has nominated the Audit Committee to acts as its Auditor Panel in line with Schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

DUTIES:

The following comprise the Committee's main responsibilities:

Annual Work Plan and Committee Effectiveness

Agree an annual work plan with the Trust Board based on the Committee's purpose (above) and conduct an annual review of the Committee's effectiveness and achievement of the Committee work plan for consideration by the Trust Board.

Governance, Internal Control and Risk Management

The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee shall:

1. Review the risk and control related disclosure statements prior to endorsement by the Board; this shall include the Annual Governance Statement, Head of Internal Audit opinion, External Audit opinion and/or other appropriate independent assurances.
2. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
3. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's corporate objectives.
4. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks; this shall include Clinical Audit programme overseen by the Trust's Quality & Safety Committee.
5. Review the adequacy and effectiveness of policies and procedures:
    a. by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern
    b. to ensure compliance with relevant regulatory, legal and conduct requirements.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

1. Reviewing and approving the Internal Audit Strategy and annual Internal Audit Plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework).
2. Considering the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring co-ordination between the work of internal audit and external audit to optimise audit resources.
3. Conducting a regular review of the effectiveness of the internal audit function.
4. Periodically consider the provision, cost and independence of the internal audit service (not more than every five years unless circumstances require otherwise).

External Audit

The Committee shall review the findings of the external auditors and consider the implications and management's response to their work. In particular the Committee shall:

1. Discuss and agree with the external auditor, before the audit commences, the nature and scope of the external audit as set out in the annual plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.
2. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board;
3. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).
4. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.
5. Review the performance of the external audit service and report to the Public Sector Audit Appointments Ltd (PSAA) on any matters relating to the external audit service.

Annual Report and Accounts Review

The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board. The Committee shall review the annual report and financial statements before submission to the Board, particularly focusing on:

1. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
2. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
3. Changes in, and compliance with, accounting policies, practices and estimation techniques.
4. The meaning and significance of the figures, notes and significant changes.

5. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
6. Explanation of estimates or provisions having material effect.
7. The schedule of losses and payments.
8. Any unadjusted (mis)statements.
9. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
10. The letter of representation.

Annual Quality Account

The Committee shall seek assurance that:

1. The reporting in the Trust's Quality Account is in line with the Trust's quality priorities and performance and consistent with other sources of assurance on quality available to the Committee
2. The Quality Account presents a fair and balanced representation of the Trust's quality performance
3. The priorities for quality focus concur with those of the Trust's patients and its plans
4. External audit opinion confirms that the Quality Account meets statutory guidelines.

Governance Manual

1. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
2. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
3. Review the schemes of delegation and authority.

Management

The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

Counter Fraud/Bribery/Corruption Arrangements

The Committee shall ensure that the Trust has in place:

1. Adequate measures to comply with the Government Functional Standard GovS 013: Counter Fraud.
2. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
3. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with the Secretary of State's Directions on Fraud and Corruption.

The following comprise the Auditor Panel's main responsibilities:

Procurement of External Audit

In its capacity as Auditor Panel, the Committee shall:
1. Agree and oversee a robust process for selecting the external auditors in line with the Trust's procurement processes and rules.
2. Advise the Board on the selection and appointment of the External Auditor.
3. Ensure that any conflicts of interest are dealt with effectively.
4. Advise the Board on the maintenance of an independent relationship with the appointed External Auditor.
5. Advise the Board on whether or not any proposal from the External Auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.
6. Approve the Trust's policy on the purchase of non-audit services from the appointed external auditor.
7. Advise the Board on any decision about the resignation or removal of the External Auditor.

ACCOUNTABLE TO: Trust Board.

REPORTING ARRANGEMENTS: A regular written report from the Committee shall be produced for the Board of Directors by the Committee Chairman and Lead Executive. It shall highlight areas of focus from the last meeting and demonstrate progress against the Committee annual work plan.

The Committee shall report to the Board of Directors at least annually:

- on its work in support of the Annual Governance Statement, (specifically commenting on the fitness for purpose of the Assurance Framework)
- the extent to which risk management processes are embedded within the organisation
- the integration of governance arrangements
- the appropriateness of evidence compiled to demonstrate fitness to register with the Care Quality Commission
- the robustness of the processes behind the Quality Account and the development of the Quality Report through a report from the Quality & Safety Committee.

The Chair of the Auditor Panel shall produce a report from the Panel outlining how it has discharged its duties.

CHAIRMAN Non-Executive Director.

COMPOSITION OF MEMBERSHIP: Members of the Committee shall be appointed from amongst the Non-Executive Directors and shall consist of not less than three members including the Committee Chairman, at least one of whom shall have recent and relevant financial experience.

The Trust Chair will not be a member of the Committee. Members of the Performance & Finance Committee and the Quality & Safety Committee shall be among the members of the Audit Committee.

The Auditor Panel shall comprise the entire membership of the Audit Committee. All members of the Auditor Panel will be independent Non-Executives Directors.

ATTENDANCE

Members are expected to make every effort to attend all meetings of the Committee and it is expected that they shall attend the majority of Committee meetings within each reporting year. An attendance record will be held for each meeting and an annual register of attendance will be included in the Committee's annual report to the Board.

In addition to the members of the Committee, the following will be invited to attend each Committee meeting:

- Director of Finance and Deputy Director of Finance
- Executive Lead for Risk Management
- Representatives from Internal Audit, External Audit and the Local Counter Fraud Service.

At least once a year, the Committee shall meet privately with the internal and external auditors.

The Chief Executive shall be invited to attend the Committee at least annually to discuss the process for assurance that supports the Annual Governance Statement. This shall be when the Committee formally considers the annual reports and accounts prior to Board approval.

To ensure appropriate accountability, other Executive Directors and, if required, members of the management team will be invited to attend when the Committee is discussing areas of risk or operation that are their responsibility.

The Chair of the Auditor Panel may invite Executive Directors and others to attend meetings of the Panel. However, these attendees will not be members of the Auditor Panel.

DEPUTISING ARRANGEMENTS

In the absence of the Committee Chairman, the Audit Committee shall be chaired by one of the Non-Executive Director members of the Committee.

Other deputies may attend but must be suitably briefed and designated and notified in advance, where possible.

QUORUM:

The quorum for any meeting of the Committee shall be the attendance of a minimum of two members. Each member shall have one vote and in the event of votes being equal, the Chairman of the Committee shall have the casting vote.

The quorum for any meeting of the Auditor Panel shall be the attendance of a minimum of two members.

DECLARATION OF INTERESTS

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

MEETING FREQUENCY:

There shall be four meetings of the Committee each year with additional meetings where necessary. This includes a meeting to focus on the pre-Board consideration of the Annual Reports and Accounts which will only consider usual business by exception.

The Auditor Panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the Committee.

The Princess Alexandra Hospital NHS Trust

MEETING ORGANISATION

Audit Committee

- Meetings of the Committee shall be set before the start of the financial year.
- The meeting shall be closed and not open to the public.
- The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees not less than five clear days* before the date of the meeting.

Auditor Panel

- The meeting shall be closed and not open to the public.
- The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees not less than five clear days* before the date of the meeting.
- The agenda items for discussion by the Auditor Panel shall be clearly distinguished from the items for discussion by the Committee.
- The minutes of the Auditor Panel shall be separate from the minutes of the Committee.

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

AUTHORITY

The Committee is constituted as a Committee of the Trust Board. Its constitution and terms of reference shall be as set out above, subject to amendment by the Board as necessary.

The Committee and the Auditor Panel are authorised by the Board of Directors to investigate any activity within these terms of reference. They are authorised to seek any information they require from any employee, and all employees are directed to co-operate with any request made by the Committee and Auditor Panel.

The Committee and the Auditor Panel are authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if they consider this necessary and to seek advice and support from the Head of Corporate Affairs and external experts as required.

TERMS OF REFERENCE

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

DATE APPROVED

By Committee: 11 September 2023
By Trust Board:

TO BE REVIEWED ANNUALLY

Next review due: September 2024

The Princess Alexandra Hospital NHS Trust

AUDIT COMMITTEE MEMBERSHIP

Membership and Those in Attendance	
Members	
George Wood	**Non-Executive Director and Committee Chair**
Helen Howe	Non-Executive Director
Colin McCready	Non-Executive Director
Darshana Bawa	Non-Executive Director
In Attendance	
Tom Burton	Director of Finance
Beth Potton	Deputy Director of Finance
Lance McCarthy	Chief Executive Officer
Fay Gilder	Chief Medical Officer (Executive risk lead)
In Attendance (Internal & External Audit)	
James Shortall	BDO (LCFS)
Greg Rubins	BDO (Internal Audit Partner/Head of Internal Audit)
Aaron Winter	BDO (Director of Internal Audit)
Dean Gibbs	KPMG
Amy Thompson	KPMG
Secretariat	
Heather Schultz	Head of Corporate Affairs

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 5 October 2023 **Item No: 7.3**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy
DATE OF MEETINGS: **05.09.23 & 19.09.23**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at SMT meetings in September 2023:

5 September 2023:

- Reports from feeder groups: Cancer Board, Information Governance Steering Group, MSK Board, Risk Management Group, System Access Board, Urgent Care Programme Board
- Lucy Letby verdict and PAHT approach
- Planned clinical strategy committee in CSS
- Feedback to Action – improvement action updates
- TiMS appraisals – next steps
- Change Freeze – Update
- Space utilisation update
- Finance

19 September 2023 (reduced agenda due to industrial action):

- Reports from Divisional Board meetings
- Reports from feeder groups: GMC Enhanced Monitoring Group, Nursing, Midwifery and Allied Health Professionals, ICT Programme Board
- EDI Strategy
- Security
- Finance: Month 4

BOARD OF DIRECTORS:	**Trust Board 5 October 2023**			**AGENDA ITEM: 7.4**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**Helen Howe – Committee Chair**			
DATE OF COMMITTEE MEETING:	**15 September 2023**			
Agenda Item:	**Committee assured.** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 Breast Fund Update	Yes	No	No	The Committee received an update on three previously approved events in 2023 that would be completing in the next months. a. Camino September 2023 b. Breast Cancer Awareness Month October 2023 c. Snowball December 2023 CFC received a request for approval of 4 new fundraising events for the Breast fund over 2023/2024 and heard about a further recent one for 2025 which will be received at the next meeting. a. Bollywood March 2024 b. Mamma Mia April 2024 c. The Angkor Wat - Cambodia October 2024 d. Royal Berkshire Charity Shoot May 2024 Fundraising for the Breast Fund remains very successful.
2.2 Charity / Fundraising Update	Yes	No	No	The Committee have agreed to proceed with a further recruitment process for the Head of Charity. Admin support has been organised in the interim.
2.3 Charity Risk Register Update	Yes	No	No	The risk register was reviewed; no new risks had been added since the last meeting. The major risk still being the inability to recruit the head of charity.

BOARD OF DIRECTORS:	**Trust Board 5 October 2023**			**AGENDA ITEM: 7.4**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**Helen Howe – Committee Chair**			
DATE OF COMMITTEE MEETING:	**15 September 2023**			
Agenda Item:	**Committee assured.** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.4 Dementia Sensory Garden SSOC Update	Yes	No	No	The Dementia Sensory Garden site was not yet agreed. The Committee agreed this could be finalised and work can proceed as long as the funds are secured and liaison with Estates is in place. Horticultural and design skills have been secured.
3.1 Charitable Funds Finance Report	Yes	No	No	A full set of accounts were available. Total fund balances at M3 is £847k (£888k as at 31st March 2023). Work on dormant funds is not urgent. In due course there would be need to address and consider some transfer to the general fund after careful application of the donor wishes and charity commission rules. Discussion took place on Covid charity income unspent (£83k). It was decided to transfer to the General Fund but track spending by type, including health and wellbeing
3.2 Charitable Funds Strategy and Action Plan Review	Yes	Yes (Finance)	Yes (HR)	The Charity Strategy is not being progressed in the absence of an appointee to the Head of Charity. The Committee will explore whether to proceed with the Grant Management System identified by the last Head of Charity. To consider engaging with a member of the Patient Panel.

BOARD OF DIRECTORS:	**Trust Board 5 October 2023**			**AGENDA ITEM: 7.4**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**Helen Howe – Committee Chair**			
DATE OF COMMITTEE MEETING:	**15 September 2023**			
Agenda Item:	**Committee assured. Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.3 Draft Annual Report and Accounts.	Yes	No	No	The audited Annual Report and Accounts would be available for approval at the next Charitable Funds Committee (CFC) Meeting in December.
3.4 Charitable Funds Requests including Governance around Funding Decisions: 1) Funding for Carers' Lead for 6 months 2) New Vending Machine Ratification: 3) Patients' Christmas Presents 4) Volunteers' Christmas Lunch	Yes	Yes (Process needed)	Yes (Finance)	Two new bids for funding were received: Funding for Carers' Lead for 6 months and New Vending Machine. Neither was approved at this time. The former would require a business case and may be BAU. The latter on vending machine should self-fund, if needed. Two other bids for Patient Christmas presents and a Volunteers' Lunch were approved. A process to organise the spending to be addressed.
3.5 Use of CFC Funds for Staff Courses	Yes	Yes	Yes (EMT)	There was discussion on the principle of the charity funding staff education and training. This would be raised at EMT. There was some concern as funds are limited.

BOARD OF DIRECTORS:	**Trust Board 5 October 2023**			**AGENDA ITEM: 7.4**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**Helen Howe – Committee Chair**			
DATE OF COMMITTEE MEETING:	**15 September 2023**			
Agenda Item:	**Committee assured.** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
4.3 New Risks and Issues Identified	Yes	No	No	The absence of the Head of the Charity was noted as a new risk
4.5 AOB	Yes	No	No	Under AOB two issues were raised A significant donation from the Julius Trust is under discussion. This was raised by DoS and update due by next CFC. A major fund-raising objective related to a robot for use in surgery is under discussion. This was raised by the DoF.