The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 5 December at 09.30 – 12.15
Venue: Kao Park Boardroom, Kao Park, London Road, Harlow CM17 9NA

	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	18
02 Chair and Chief Executive's reports					
09.35	2.1	Chair's Report	Inform	Chair	21
09.40	2.2	CEO's Report	Inform	Chief Executive	26
		Opportunity for members of the public to ask questions about the board discussions or have a question answered			
03 Risk					
09:55	3.1	Corporate Risk Register	Review	Medical Director	33
10.05	3.2	Board Assurance Framework 2024-25 *Diligent Resources: BAF 2024/25*	Review/ Approve	Head of Corporate Affairs	38
04 Patients					
10.15	4.1	Reports from Quality and Safety Committee 29.11.24: • Part I • Part II	Assure	Committee Chairs	 43 49
10.25	4.2	Maternity Reports: • Serious Incident (SI) Report • Quarterly Maternity Assurance Report • 6 Monthly Staffing Update	Assure	Chief Nurse/ Director of Midwifery	 52 56 68
10.40	4.3	Nursing, Midwifery and Care Staff Levels	Assure	Chief Nurse	76
		Break:10.50 – 11.00			
11.00	4.4	Learning from Deaths (Mortality) Report	Assure	Medical Director	92
11.10	4.5	Electronic Health Record (EHR) Update	Assure	Chief Information Officer	98
05 People					

11.20	5.1	Report from People Committee 25.11.24	Assure/ Approve	Committee Chair	101
11.25	5.2	Freedom to Speak Up	Assure	Interim Chief People Officer	106
06 Performance/pounds					
11.35	6.1	Report from Performance and Finance Committee 28.11.24	Assure	Chair of Committee	112
11.40	6.2	M7 Finance Update	Assure	Director of Finance	119
11.50	6.3	Integrated Performance Report (IPR) M7	Discuss	Chief Information Officer	128
12.00	6.4	Report from Audit Committee 02.12.24	Assure	Chair of Committee	144
07 Strategy/Governance					
12.05	7.1	Report from Leadership Management Team (LMT) Meetings held in November 2024	Assure	Chair of Committee	146
		Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
08 Closing administration					
	8.1	Any unresolved issues			
	8.2	Review of Board Charter			
	8.3	Summary of actions and decisions	-	Chair/All	
	8.4	New risks and issues identified	Discuss	All	
	8.5	Any other business	Review	All	
	8.6	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	
12.15		Close			

Date of next meeting: 6 February 2025

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 2024/25			
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	Thom Lafferty
Non-executive Director	George Wood	Chief Nurse	Sharon McNally
Non-executive Director	Colin McCready	Chief Operating Officer	Stephanie Lawton
Non-executive Director (SID)	Darshana Bawa	Medical Director	Fay Gilder
Non-executive Director	Elizabeth Baker	Director of Finance	Tom Burton
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	Ralph Coulbeck	Interim Chief People Officer	Giovanna Leeks
NExT Non-executive Director	Bola Johnson	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 3 October 2024 from 09:30 to 13:00

Present:

Hattie Llewelyn-Davis	**Trust Chair (TC)**
Oge Austin-Chukwu	Non-Executive Director (NED - OA)
Liz Baker	Non-Executive Director (NED-LB)
Darshana Bawa	Non-Executive Director (NED-DB)
Tom Burton	Director of Finance (DoF)
Ralph Coulbeck (non-voting)	Associate Non-Executive Director (ANED-RC)
Fay Gilder	Medical Director (MD)
Phil Holland	Chief Information Officer (CIO)
Stephanie Lawton	Chief Operating Officer (COO)
Giuseppe Labriola	Interim Chief Nurse (I-CN)
Giovanna Leeks	Interim Chief People Officer (I-CPO)
Colin McCready	Non-Executive Director (NED-CM)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Interim CEO (I-CEO)
Michael Meredith (non-voting)	Director of Strategy (DoS)
George Wood	Non-Executive Director (NED-GW)

In attendance/Observing:

Polly Read	UEC Associate Director of Nursing
Jenny Abel	UEC Associate Director of Operations
Monica Bose	Divisional Director – Clinical Support Services
Laura Warren	Associate Director Communications
Ann Nutt	Chair of Patient Panel
Linda Machakaire	Director of Midwifery
Samantha Gooden	Interim Deputy Chief People Officer

Members of the Public
n/a

Apologies:

Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)

Secretariat:

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

01 OPENING ADMINISTRATION	
1.1	The Trust Chair (TC) welcomed all to the meeting. It was noted that the Director of Finance (DoF) and Director of Strategy (DoS) would join the meeting around 10:00 as they were participating in an external meeting.
1.1 Apologies	
1.2	Apologies were noted as set out above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Previous Meeting	
1.4	These were agreed as a true and accurate record of the meeting held on 06.06.24 with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising. In terms of the action log it was agreed that those items proposed for closure could be closed. It was noted that in terms of paediatric staffing, the full nursing establishment review would be presented to the Board in January 2025. The Chief

	Information Officer (CIO) then informed members that in relation to the scoping of a cyber attack risk, whilst this would come to PAF in December (due to conflicting work pressures with Alex Health), the work would continue in the meantime.
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	The TC presented her update which was taken as read and members had no comments. The TC highlighted some of the NED walkabouts had recently been cancelled so there would now be a re-think in terms of how these were organised and advertised. Non-Executive Director Darshana Bawa (NED-DB) was about to pilot the first ED walkaround, a requirement of the recently received national letter around corridor care.
2.2 CEO's Report	
2.2	This update was presented by the Interim CEO (I-CEO) and the paper was taken as read. She drew members' attention to the first paragraph of the paper and reiterated her thanks to Executive team colleagues for their continued dedication and wonderful support whilst she temporarily led the organisation up to the arrival of its new CEO on 04.11.24. She also thanked the organisation's amazing people for their on-going commitment to the delivery of compassionate and skilled care to patients.
2.3	In terms of the 2023 Inpatient Survey Results, the I-CEO reaffirmed the hospital's commitment to ensure patient experience was recognised. Patient experience impacted on outcomes but was also entwined with staff experience too. The outcome of the survey showed that whilst good progress was being made, there was more to do and she reaffirmed her commitment, and that of all teams, to continuous learning and improvement.
2.4	The I-CEO continued that in May 24, Dr Penny Dash had been asked to conduct a review into the operational effectiveness of the Care Quality Commission (CQC). The interim report had been published in July, highlighting a number of opportunities for improvement. A substantive report would be published later that autumn with recommendations on how the independent regulator would take forward regulatory assessments.
2.5	The I-CEO then reminded members that in September 24, the government had published the commissioned Independent Investigation of the National Health Service in England, led by Lord Darzi. The report had assessed patient access, quality of care and the overall performance of the health system. The report recognised and validated the challenges faced by the NHS, the impact on the nation's population and the emotional burden faced by staff working within the NHS.
2.6	The I-CEO then updated that since the Board's last public meeting, the organisation had suffered the sad and tragic death of Ogechi Emeadi (Gech) after a short illness. Gech had been the Trust's Chief People Officer for six years. She had been a talented, well-respected leader at PAHT and across the NHS. Gech had left a strong legacy through her delivery of health and well-being support, championing clear and strong values and a positive culture of inclusivity; she remained continually in colleagues' thoughts.
2.7	On Saturday 14.09.24 the I-CEO had attended the Cultural Celebration for the organisation's people. This had been brilliantly organised by the Trust's REACH network and had brought together over 300 people to celebrate the diversity of the hospital's people. The event had also held a poignant tribute to Gech.
2.8	At this point the I-CEO took the opportunity to thank Giovanna Leeks and Giuseppe Labriola for stepping into the Chief People Officer/Chief Nurse roles respectively. She also thanked Jo Ward for stepping into the role of Interim Deputy Chief Nurse.
2.9	The I-CEO continued that across the current calendar year a number of PAHT people and teams had been shortlisted for national awards. The most recent national recognition had been for two of the organisation's nurses who had been shortlisted in the Nursing Times Workforce Awards which would take place on 28.11.24.
2.10	At this point the I-CEO flagged that the RCN membership had rejected the recent 5.5% pay award and next steps were now awaited.

2.11	The I-CEO continued that the results of the general election that had taken place in July (2024) had changed the political landscape for the geography that PAHT served. Of the five MPs covering the area there were three new Labour MPs and two pre-existing conservative MPs.
2.12	As a final point the I-CEO commented that the organisation was excited for the arrival of Thom Lafferty, its new CEO on 04.11.24.
2.13	The TC thanked the I-CEO for her update and also thanked her personally for leading the organisation up to the arrival of its new CEO.
03 RISK/STRATEGY	
3.1 Corporate Risk Register (CRR)	
3.1	This update was presented by the MD who informed members that no new risks had been added to the CRR in the last few months.
3.2	In response to a question from Non-Executive Director Darshana Bawa (NED-DB), the MD responded that the risk she had referenced related to HAZMAT decontamination capacity and capability. This would now be removed from the risk register because there was now a new storage facility, training had been rolled out and new equipment had been purchased.
3.2 Board Assurance Framework (BAF) 2023/24	
3.3	This update was presented by the Head of Corporate Affairs (HoCA). She advised that the wording for risk 2.3 (People risk) had been updated as reflected at Appendix B of the paper. This change had been discussed at People Committee (PC) on 30.09.24. Other risk scores had not changed that month. At this point she flagged that the HEE engagement visit had taken place on 02.10.24 and depending on the outcome of that visit, the risk score for risk 2.1 (GMC enhanced monitoring) may require further review.
3.4	The Director of Quality Improvement (DoQI) asked whether there was an opportunity to reduce the score for the risk related to industrial action. The Chief Operating Officer (COO) confirmed this had been discussed and she was just awaiting the final outcome on the resident doctors' pay deal.
3.5	The Board approved the revised wording for risk 2.3.
04 PATIENTS	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	<u>Report from QSC.27.09.24</u> Non-Executive Director Oge Austin-Chukwu (NED-OA) informed members the Committee had noted the significant improvements in the area of mental health and in terms of the Trust's strategy for this. In terms of infection control, there were higher thresholds for organisations, and performance in relation to Clostridium-difficile continued to be a challenge. This picture was mirrored nationally. There had been an improvement in the number of open complaints and the challenge continued in terms of the number of daily attendances at the front door.
4.2	At this point the Interim Chief Nurse (I-CN) drew members' attention to item 3.1 in the paper which referred to the position in relation to pressure ulcers. He informed members that a pressure ulcer strategy was in place which was driving improvements in performance and there was robust governance around this.
4.3	<u>Report from QSCII.27.09.24</u> Associate NED Ralph Coulbeck (ANED-RC) informed members that in terms of the Maternity Safety & Support Programme (MSSP), the service had achieved what it needed to but a decision had been taken to remain on the programme for an extended period of time (six months) to receive some support for obstetrics to improve the culture there. He also flagged the new risk to delivery of the Maternity & Perinatal Incentive Scheme (MPIS) in terms of standard 1. There had been a minor breach of the reporting timeframes (due to staff sickness) and the service was now seeking clarification in terms of mitigations around that. This now required input from MBRRACE in terms of whether the organisation's case would be accepted.

4.2 Maternity Reports	
4.4	Maternity PSII Update This update was presented by the Director of Midwifery (DoM). She informed members that no PSIIs had been declared since May and a summary of ongoing themes over the previous two years was shown in table 3.
4.5	Maternity Assurance Report The DoM informed members that the number of open incidents had increased to 50% for incidents reported in Q1. Escalation had occurred within the division to address the backlog and all incidents had been reviewed, with the majority being no or low harm. A new Governance Consultant would be in place by November which would support the backlog.
4.6	In terms of the Perinatal Mortality Review Tool (PMRT) the service performed a review of cases on a monthly basis as a multi-disciplinary panel. All cases currently were within the reportable timeframes for MPIS Year 6.
4.7	In relation to the Savings Babies Lives (SBL) Care Bundle, version 3 had been published in July 2023, with the introduction of a new element, diabetes. For MPIS year 6 an assessment was currently underway to review current compliance with each element. It was predicted that the service would be compliant by the submission date in March 2025.
4.8	In terms of the Maternity & Perinatal Incentive Scheme (MPIS) the DoM highlighted that four of the safety actions were currently at risk but a lot of work was now taking place around these in order to be able to declare compliance by March 2025.
4.9	The Chief Operating Officer (COO) then flagged it was worth noting at this point that in terms of governance roles in the service, a consultant had now expressed interest in one of the roles and the Divisional Director and AMD for Strategy (who was currently supporting the service) were supporting with another vacant role. In terms of the resident doctor rota gaps, an additional two registrars had now been appointed for ten weeks to support triage and Labour Ward.
4.10	NED Liz Baker (NED-LB) then flagged the challenge referenced in the paper in relation to the migration from ESR to 'This Is Me' and asked whether there was any learning. The Chief Information Officer (CIO) responded that the data migration was very specific to the dataset but there would be a lessons learned process which, if appropriate, would be applied to Alex Health.
4.11	The Director of Quality Improvement (DoQI) then flagged that a number of roles were out to recruitment due to maternity leave and he asked about the levels of confidence in terms of being able to recruit to those roles. The DoM responded that one role had been appointed to and the other role would now be offered as a development role to a previously unsuccessful candidate, with a four month review term.
4.12	In response then to a question from NED-DB in relation to one of the two PSIIs that had been declared, the DoM responded this was now being investigated by MNSI. The learning had already been picked up and disseminated to staff.
4.13	NED-DB asked for some additional detail in terms of actions to address the number of open incidents. The I-CN responded that the service undertook rapid reviews of any incidents to identify the immediate learning. The team reviewed incidents recorded on Datix on a daily basis to pick up immediate concerns and whilst incidents might not be closed as quickly as colleagues would like, there was always an initial review as part of the Trust's Incident Management process. NED-DB asked whether other factors were triangulated, such as fill rate, to determine the broader picture. The Interim CEO (I-CEO) responded that the role of QSCII was to look at the broader picture, the dashboard and the metrics. She suggested therefore that QSCII consider any increasing level of risk being seen in Maternity. ANED-RC responded that in essence that was what informed the QSCII agenda but the TC requested the specific element as described above to form the action.
ACTION **TB1.03.10.24/16**	**QSCII to consider any increasing level of risk being seen in Maternity.** **Lead: Director of Midwifery**
4.14	At this point the CIO reminded members there had been issues with the maternity dataset in the past in terms of the MPIS. As assurance he confirmed the dataset had now passed

	through Alex Health and had cleared testing which was good news. At this point he highlighted he was confused by the two maternity reports under discussion that day as the top incident themes differed in the two papers. The DoM responded that the PSII paper provided the whole picture up to August and the Assurance Report provided a quarterly picture. It was agreed therefore that this would be clarified in future reporting. The I-CEO stated this had also confused her so she would welcome the clarity in future reporting.
ACTION TB1.03.10.24/17	**Maternity Reports to Board: Clarify the reporting period in relation to incident themes in individual reports. Lead: Director of Midwifery**
4.15	The I-CN then informed members that the quarterly Assurance Report provided data from April to June and the PSII paper was purely looking at August data. The I-CEO acknowledged the assurance but requested absolute clarity in future reporting.
1007 Director of Finance (DoF) and Director of Strategy (DoS) arrive.	
4.16	NED Colin McCready (NED-CM) then asked about current confidence in terms of achieving the ten MPIS safety actions. The DoM responded the position was much the same as in the previous year. She did have confidence and she was aware of the work required to achieve full compliance.
4.17	The TC summarised by stating that the Board noted the service would remain on the MSSP for the time being and she requested the DoM thank her team/colleagues for the huge improvements that had been made.
ACTION TB1.03.10.24/18	**Board thanks to be extended to Maternity colleagues for all their hard work in relation to the Maternity Safety & Support Programme. Lead: Director of Midwifery**
4.3 Nursing & Midwifery Establishment Review (mid-year)	
4.18	This update was presented by the I-CN. He informed members that a mid-year establishment review had been undertaken in March 2024, the methodology for which detailed that a 14.80 WTE increase in the establishment was required. He highlighted that no changes to an establishment should take place until there were two consecutive reviews. The full year establishment review was due to be completed in September 2024, reporting to Board in January 2025.
4.19	The I-CN continued there were no recommended changes to the establishment at this time – all nursing and quality indicators had been reviewed and there were no concerns identified. There continued to be a robust process for reviewing Trust-wide staffing three times a day and redeploying staff where necessary. A full review of midwifery staffing would be completed by Birthrate Plus in Autumn 2024.
4.20	ANED-RC commented that he was struck by the 14.8 WTE headline and asked where potentially this shortfall might be, and were mitigations in place at this point. The I-CN noted the three times daily staffing review which also looked at acuity. The senior nurse would then deploy colleagues from other wards. If this was not possible then healthcare support workers would provide that care. This would generally be on medical wards so potentially Tye Green, Kingsmoor and Winter Wards. The I-CEO added it was also about the methodology. An establishment was not changed on one data point alone. The next datapoint would be critical in terms of any required investment but currently staff were being moved around to ensure acuity was met on a daily basis.
4.21	The TC summarised that the Board noted the headlines and would await the full annual review in January.
4.4 Nursing Midwifery & Care Staff Levels	
4.22	This item was presented by the I-CN. He informed members that fill rates in August had remained stable with no ward below 75% of the template. He drew members' attention to the overall increased percentages in some wards due to levels of enhanced care there (registered mental health nurses/supernumerary staff). In particular this was seen on Henry Moore Ward with an increase in elective activity and also ITU. August had seen an increase in use of mental health support workers which had reduced again in September.

4.23	The Trust would be joining the NHSE Enhanced Therapeutic Observational Collaborative in October which would look at how to provide enhanced care and what colleagues could do differently to learn from each other. PAHT care hours per patient per day were comparable with system peers and the team was now looking at improved governance, how to capture some of those red flag events discussed at the huddles and how best to record those.
4.24	The DoQI then highlighted that red flags appeared to be on an upward trajectory over summer. He asked if that was forecast to continue to winter. The I-CN responded that the pilot on Winter Ward would help with the recording on the system in one place to improve oversight.
4.5 Adult Inpatient Survey Results	
4.25	This update was presented by the I-CN. He reminded members that in November 2023, 506 Trust patients had responded to the national inpatient survey with a response rate of 43.6%. PAHT was mid-point in a two-year national inpatient survey improvement programme, with evidence of improvement over one year, with 19 questions rated the same as the national average. Improvements were in privacy, dignity and being asked to give views on quality. 26 questions were rated worse and 17 of those related to admission, discharge and transfer. Improvement programmes were underway led by patient experience, divisional leaders and Quality First. Admission, discharge and transfer would be the focus of the work over the next year via a task and finish group but there would need to be system/partner input too to make improvements.
4.26	In response to a question from NED-CM, the I-CN responded that the results from the 2024 survey would be available in September 2025. He was optimistic those results would show some improvement, particularly in 'quick win' areas such as discharge and 'noise at night'. In response to a further question around the delay in releasing the results, it was noted the survey was run by Picker and it took time for them to undertake the required benchmarking.
4.27	In response to the above NED-GW voiced his discontent in terms of the time taken to release the results and the associated loss of time in terms of being able to act on those. The I-CN responded that what was important was being able to review local data, which the Trust did, to identify trends/areas of potential concern.
4.28	The DoS then asked how the hospital's environment impacted on the results. The I-CN responded his view would be this had a big part to play in terms of responses, particularly where wards required refurbishment.
4.29	ANED-RC commented he also had concerns around the delay in release of data from the survey and agreed sources of nearer-term information were vital to the organisation. The Interim Chief People Officer (I-CPO) agreed but added the same provider was also responsible for the Staff Survey with the same delays in terms of data release.
4.30	The TC reflected on the concerns above and commented there was little, in her view, the Trust could do as a single entity but it might be worth writing to NHS Providers to ask them to pick this up with NHSE. She would be happy to undertake this on behalf of the Board.
ACTION **TB1.03.10.24/19**	**Ask NHS Providers to pick up with NHSE the issue around the length of time taken to release survey data (Inpatient Survey/Staff Survey).** **Lead: Trust Chair**
4.31	The I-CEO then added it was critical that the organisation did not rely on survey results to inform its way forward. There were numerous other sources of intelligence available in terms of walkabouts, complaint themes and PALS cases and it was about using this information wisely to inform the big ticket priorities.
4.32	At this point the TC asked what the Inpatient Survey results evidenced for patient experience for those with protected characteristics. The I-CN responded there was a summary in terms of the breakdown for males/females but not in terms of individual questions. The TC responded this was potentially a big loss because she would suspect there would be patient cohorts that were less satisfied than others. It was noted that the highest responders were 'white females over 65'. The I-CPO commented this was why it was necessary to go to other data sources (e.g. Maternity) to provide a clearer overall picture.

4.33	In response to the above the TC requested a summary paper back to the Board on how to pull together all the individual sources of data to ensure nothing was missed, and in order to provide a clearer overall picture.
ACTION TB1.03.10.24/20	**Provide a summary paper to Board with a plan for pulling together individual data sources to provide a clear picture on areas for improvement. Lead: Chief Nurse**
4.6 Nursing Midwifery & Allied Health Professionals Strategy	
4.34	This item was presented by the I-CN. This was the second such strategy and had been developed with the professions. The vision and values of nursing, midwifery and allied health professionals were represented by four strategic priorities. The strategy was aligned with the national priorities and a tactical work plan would be developed in terms of delivery which would be overseen by the Nursing, Midwifery & Allied Health Professionals Senior Leadership Group and People Committee (PC).
4.35	The I-CEO added the next step would be to drive the strategy forward. The vacancy rate was now very much improved so it was an exciting time for the organisation. She highlighted nursing research at this point and the research strategy which would bring together all the great work that was happening in the organisation.
4.36	In response to a question from NED-DB, the I-CN confirmed there were milestones/timelines in place which were being tracked on PM3 and overseen at senior leadership team meetings.
4.37	The TC reflected it was a powerful strategy and she commended colleagues on its development.
4.38	NED-CM then asked for some additional detail on the 'bronze' level of accreditation. The I-CN responded this related to the ward accreditation process looking at quality standards and assessing ward areas. This went from 'bronze' up to 'gold' and was a local assessment process unique to PAHT.
4.39	The TC thanked colleagues for their update.
4.7 Learning from Deaths Update	
4.40	This item was presented by the MD and key headlines were as follows: • HSMR for the period May-23 to Apr-24 is 91.33 was 'lower-than-expected' based on 26,304 super-spells and 811 deaths (crude rate 3.08%). The Trust had now reported four of the last six rolling periods as "lower-than-expected". • The backlog of SJRs had reduced especially in UEC and Medicine. • Medical Certificate of Cause of Death (to be issued within 72 hours of death): A new process had been introduced by the national team which was more detailed. Colleagues were working to improve performance against the target.
4.41	In response to a question raised by NED-CM in relation to the graph at figure 2, it was noted there was no legend (which would be corrected) but 'expected deaths' was the red line and 'observed deaths' was the blue line.
ACTION TB1.03.10.24/21	**Learning from Deaths Update: Provide a legend for the graph at figure 2. Lead: Medical Director**
4.42	NED-OA highlighted the good news that despite continued challenges in terms of attendances, Trust mortality rates remained 'lower than expected'. The MD acknowledged the point and confirmed that the sickest patients were always seen first. It was pleasing to note that mortality across the day of admission was the same (not worse) at weekends and there were reduced admissions and shorter stays which evidenced the improved shift in care provision. This was positive given acuity was high.
4.43	The TC commended colleagues on the position that had been achieved over recent years. The MD responded that this was a programme of work that had been set-up by the DoQI which had been of high quality with positive results. Much of the focus had been on ensuring the data reflected the type of patients being cared for and that focus would continue, along with the focus on documentation.
Questions from the Public	

4.44	The Chair of the Patient Panel (CoPP) requested the Panel's condolences be passed to the family of Ogechi Emeadi on her recent passing.
4.45	The CoPP then flagged that in relation to one of the Maternity papers at item 4.2, no timeline had been provided for the completion of outstanding policies. The DoM responded that those had all now been assigned to a consultant so her suggestion would be a deadline of November 2024.
4.46	As a final comment the CoPP informed the Board she was currently involved in some work to refresh the inpatient survey questions and would be happy to bring up the diversity/equality point raised above by the TC, as that had also been a concern to her.
Break 1046 to 1100	
4.8 Electronic Health Record Update	
4.47	This update was presented by the CIO. He reminded members that cutover was exactly four weeks away, at which point current systems would be turned off. Operational and technical full dress rehearsals had now been completed, both of which had provided learning to support success at go-live.
4.48	The CIO continued that all the data migration fixes had been applied successfully. The fixes for order comms were now almost complete for pathology and for statutory reporting there were only two left to complete. 42 of 44 statutory reports would be fully tested by the end of that week.
4.49	Overall his view was the programme was in a good place. There were a few small elements that required some work including operational cutover planning issues. It would be key to ensure a detailed cutover plan was in place to allow the programme to proceed through the Activate gateway the following week. Staff training continued to progress well.
4.50	In terms of the critical path, go-live would be over the weekend of 02/03.11.24 and a detailed command structure was in place over this period to provide 24/7 support/assurance throughout the hospital. There would be a significant amount of navigators/floor-walkers in position including colleagues from Oracle Health (OH). He emphasised that go-live was not expected to be without its challenges but as far as possible the right amount of support would be in place. His thanks at this point went to Trust colleagues for their continued engagement with the programme and colleagues in the programme team itself for their continued drive to go-live. There had been positive verbal feedback from NHSE around the go-live which was encouraging and their formal report on that was awaited in the following week.
4.51	NED-GW then asked about OH support post go-live. The CIO responded there would be six weeks' support after go-live.
4.52	The DoS then highlighted that this would be the last Trust Board prior to go-live and for assurance he asked the CIO to talk colleagues through how the decisions around whether or not to go-live had/would be made. The CIO responded that the Activate gateway had a series of criteria, through which the Board had been taken at its previous meeting. These criteria were clearly set out and assurance would need to be provided against those, which included work-off plans, training, testing and operational readiness. The Programme Board would have sight of all of this to enable it to make the 'go/no-go' decision and there would be decision points through cutover to support this final decision. The Programme Board was chaired by the I-CEO with representation including a NED, OH, Executive team, CCIO, CNIO and himself as SRO.
4.53	NED-OA then asked about the messaging to partners. The CIO responded a detailed comms plan was in place. The CNIO was a member of a group at place thereby linking into primary care and other providers to ensure that interface.
4.54	The Divisional Director for CSS (DD-CSS) then commented engagement with the programme amongst colleagues had been excellent. She acknowledged staff had lots of questions but at the same time they were also hugely enthusiastic. It had, in her view, been a great organisational effort with robust communications and excellent engagement.
4.55	At this point, and as assurance, the COO added that in terms of communication over the go-live weekend, there were detailed plans in place in terms of managing patients arriving at the

	front door and colleagues had also reached out to the East of England, other acutes and the ambulance service so that patients could be supported and there was as much mutual aid as possible.
4.56	NED-GW then asked whether there were any specific areas where colleagues had particular concerns around go-live. The DoQI responded that those had been recognised early on and additional support for colleagues had been agreed.
4.57	The I-CEO commented that as chair of the Programme Board she was able to provide assurance there was an extremely robust governance process in place in terms of the decision-making supported by the gateway process.
4.58	ANED-RC highlighted nursing leadership would be key because the biggest change would be for this cohort of colleagues given some doctors were already familiar with the system. The I-CN responded that take up of training amongst Nursing Midwifery & AHP colleagues was good and there was genuine excitement about the move to Alex Health.
4.59	The TC summarised by stating the programme was currently in a good position for go-live, and a robust decision-making process was in place ahead of this. She thanked the CIO and his team for achievements/progress to date.
05 PEOPLE	
5.1 Report from People Committee (PC)	
5.1	This update was presented by NED-DB and was verbal given the meeting had taken place earlier that week. The Health Education England Improvement Plan response had been considered, noting the huge amount of work undertaken to date and that whatever the outcome of the NHSE visit, colleagues should be proud of the achievements to date. The MD responded it had been a tough session and she requested the Director of Medical Education and Guardian of Safer Working be sent a Board 'thank you' for their work around the improvement plan.
ACTION TB1.03.10.24/22	**Board thanks to be sent to Director of Medical Education/Guardian of Safer Working. Lead: Board & Committee Secretary**
5.2	In terms of GMC enhanced monitoring, PC had noted the position remained the same. The annual report into medical revalidation had been reviewed and endorsed for Board approval with minor amendments. The WRES/WDES reports had been discussed along with the Nursing Establishment Review. There had been agreement on a change of wording to BAF risk 2.3 (inability to recruit, retain and engage our people) and the draft People Strategy had been discussed with agreement it be brought back to November's meeting for approval and then to Board in December. There had been positive progress on all 'people' metrics and the Exit Survey pilot results were noted. Freedom to Speak Up had been an agenda item but would be discussed further at the private session of the Board later that day.
5.3	In terms of the Committee's revised terms of reference, the Board then approved the recommended changes which related to revisions to members'/attendees' job titles and to reflect the addition of some new colleagues.
5.2 Workforce Race Equality Standard (WRES)	
5.4	This update was presented by the I-CPO. She informed members this was an annual report which would be published (following Board approval). In summary there had been a 4% increase in the ethnic representation across boards which was positive. In addition 40% of senior leaders (Band 8A and above) were now from a BME background against the national target of 19%.
5.5	The I-CPO continued that a couple of indicators showed some contradiction so deep dives had been undertaken here. The first was around CPD, where it appeared the organisation was performing okay, whereas for 'career progression' this showed the opposite. The perception was 'career progression' was inaccessible. The second element was bullying and harassment and the perception of this. Nationwide the picture was positive for the NHS but the Trust was not currently where it wanted to be on this indicator and was looking at ways to further address this.

5.6	At this point NED-GW asked a question related to Freedom to Speak Up (FTSU) cases and any differences in numbers of concerns raised by white or BME colleagues. The I-CPO agreed to check the data but the data was showing that BME colleagues felt they had a voice and at PAHT staff felt able to speak up. In terms of the data/numbers she would circulate that after the meeting.
ACTION TB1.03.10.24/23	**WRES Report: Provide a comparison of the numbers of FTSU cases raised by white versus BME staff. Lead: Interim Chief People Officer**
5.7	NED-GW also requested the data for FTSU cases related to bullying and harassment.
ACTION TB1.03.10.24/24	**WRES Report: Provide a breakdown of FTSU cases relating to bullying and harassment for white versus BME staff. Lead: Interim Chief People Officer**
5.8	NED-DB then highlighted it had been challenging to recruit FTSU ambassadors from BME colleagues. She also highlighted that the data for indicator no. 5 (staff experiencing bullying from patients or the public) was higher for ethnic minority groups.
5.9	The DoQI then reflected on the number of staff with long term health conditions. He asked whether there was any focus currently on staff health and any support that may be required here, particularly in relation to the aging aspect of these colleagues.
5.10	In response to the above the I-CPO commented that more staff now had stress-related issues which was a picture being mirrored nationally and psychological support was being offered.
5.11	NED-OA commended the fact that 40% of senior colleagues were from a BME background. She asked however what this percentage would be if medical/dental/nursing colleagues were removed. The I-CPO responded the position would still be good if medical/dental colleagues were removed but she would look into removing nursing colleagues.
ACTION TB1.03.10.24/25	**Provide the percentage of senior colleagues from a BME background excluding medical, dental and nursing colleagues. Lead: Interim Chief People Officer**
5.12	ANED-RC then flagged, in terms of the action plan that there was a balance between policing and celebration. He asked if there was a plan to focus on the cultural issues. The I-CPO responded that the action plan was about how better data could be gleaned. In addition the People Strategy was being finalised and part of that was about equality/diversity/inclusion.
5.13	The I-CN then informed members that the organisation had done well in terms of nurse recruitment and had commissioned work with Safe Spaces to look at the experience of international nurses. That report should be available in the next couple of weeks, so could run alongside the WRES data – so that data would be there/available.
5.14	The TC thanked colleagues for their update, noting there were wider issues, including celebration.
5.3 Workforce Disability Equality Standard (WDES)	
5.15	This update was also presented by the I-CPO. She acknowledged that the data was an issue as there was a lack of information on ESR about disability status. When triangulated with the Staff Survey, it was evident that colleagues were more at ease with declaring their disabilities there. She highlighted that for bullying and harassment the position had improved but was not where it needed to be.
5.16	NED-GW then asked what was being done to address bullying and harassment. The I-CPO responded training was in place to fully understand people's perceptions and understanding of bully and harassment. Training was also available on the just culture process. In terms of areas of concern, she stated there were some areas of the organisation where staff were under pressure with higher staff turnover and higher sickness.
5.17	In line with the recommendation the Board was content to approve the WDES action plan.
5.4 Annual Report on Medical Revalidation and Compliance Statement	
5.18	This update was presented by the MD. She reminded members that the Responsible Officer (RO) in each designated body had a duty under the regulations to assure and improve their

	professional standards function for doctors with whom they held a prescribed connection. The report as presented that day was a summary of Appraisal & Revalidation metrics (for doctors not in training) and processes from 01.04.23 to 31.03.24. The paper had already been presented to the People Committee (PC).
5.19	It was noted the report had changed and was now more detailed including sections on governance and culture. The MD then highlighted that 95% of doctors had been appraised on time during the period and zero had an unapproved or missed appraisal.
5.20	In line with the recommendation from PC, the Board approved the compliance statement for submission to the East of England.
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	Report from PAF.26.09.24 NED-CM informed members there had been a detailed discussion around the Community Diagnostic Centre (CDC) and, as referenced above, the score for the BAF risk around industrial action would remain unchanged for the time being. There had been a good conversation around the Lord Darzi Report and also on capital. PAF had received an update on ICS procurement and performance was on track in terms of savings and contract management and there had been particular progress on the inventory management system. In relation to PQP, non-recurrent savings were behind plan and in terms of health and safety there were some actions to address around fire safety.
6.2 M5 Finance Update	
6.2	This item was presented by the DoF acknowledging that much of the position had been discussed at item 6.1 above. The position had been ahead of plan in relation to non-recurrent support but the big success to note was around vacancy controls and the reduction in agency usage. Regionally the Trust was amongst the best here.
6.3	The DoF continued that it should be noted whilst the position was currently positive, pressures including winter and a new electronic health record were around the corner and the latter would reduce planned activity over coming weeks. A further positive was the level of elective work delivered despite the theatre disruption during August, with performance here being to plan.
6.4	The TC offered her thanks to the DoQI/I-CPO for the agency reductions, with thanks also more generally for the delivery of elective work.
6.3 M5 Integrated Performance Report (IPR)	
6.5	This update was presented by the CIO who informed members that the full IPR had been discussed at relevant Board Committees that month. The version presented that day was a summary.
6.6	There were four key headlines as follows: **Appraisal rates:** Performance was in positive special cause variation but colleagues should be aware of the plateau and the fact that a number of appraisals were coming up for renewal. **Vacancy Rate:** This was on a positive trajectory and had been in positive special cause variation for some time. This was a positive message in terms of the triangulation with patient experience and was an important indicator in terms of mortality. **Referral to Treatment:** There had been a fabulous effort here in terms of the reduction in 65 week waits which had reduced from over 1k patients in October 2023. 18 week performance remained steady at 50% with the number of patients waiting more than 78 weeks decreasing to 5 from 24. **Ambulance Handover (within 15 minutes):** There had been a significant improvement here with performance currently at 25-30% compared to under 10% in 2022.
6.7	The DoQI then highlighted that in terms of the elective recovery plan, ENT and Ophthalmology were both now ahead of plan.
6.8	ANED-RC asked for some additional detail around urgent care performance, compared to other Trusts. The COO said the organisation was struggling compared to the EoE and

	nationally and was currently not achieving the 4 hour trajectory. The ED team was working hard on its internal improvement plan with a focus on the non-admitted and paediatric pathways.
6.9	The I-CEO then reflected on the risk at the front door in terms of the health and wellbeing of staff now and over winter and asked the COO for some additional detail in terms of the organisation's position in tier 2 for elective, cancer and diagnostics. The COO responded that in terms of tiering the organisation was currently in tier 2 (for elective, cancer and diagnostics) which meant fortnightly oversight meetings with NHSE and the ICB. There had been a number of positive conversations through these meetings and in terms of activity, the team had done well to reduce the 65 week wait position. The Trust had been asked to provide worst and best case scenarios for patients on the trauma and orthopaedic, ENT and gynaecology pathways. She was very proud of the work done by the teams
6.10	The COO continued that in terms of 78 week waits, performance in August had finished with one outstanding patient. This patient (who had moved out of area) had been supported. For September two patients had breached, both of whom had now had their surgery. It continued to be a very challenging position. The organisation had started the year in April with 5k patients on the 65 week pathway so it had taken an enormous effort to reach the current positions.
6.11	In terms of cancer, the COO informed members that the organisation's fair share position had improved for the 62 day target from 112 to 109 patients as of that morning. There was still more to do but clear plans were in place and the focus now would be on the urology and skin pathways.
6.12	For diagnostics the two concerns were non-obstetric ultrasound (national shortage of sonographers) and cystoscopy. However, the COO was pleased to confirm that through national funding a recovery plan was now in place here.
6.13	In terms of urgent and emergency care the system as a whole remained in tier 2. There were no fortnightly meetings with NHSE because there was recognition partners were working together as a system. NHSE did however attend the HWE Urgent Care Board. There had been an offer of support from the regional team in the form of a senior clinician to work alongside the UEC Divisional Director.
6.14	The I-CEO then summarised there had been a huge amount of work in the organisation and a huge amount of oversight on operational performance. There were pressures in terms of the finances and the front door activity but she provided assurance that staff health and wellbeing would remain a focus and she thanked those NEDs who had been undertaking walkabouts.
6.15	The TC thanked colleagues for a good discussion.
6.4 Emergency Preparedness Resilience Response (EPRR)	
6.16	This update was presented by the COO and the paper, which was the annual report to Board in line with the Civil Contingencies Act, was taken as read.
6.17	The COO continued she was pleased to update there were no areas of non-compliance across the core standards. There were seven areas of partial compliance and a plan in place for sign-off of these by the ICS at the end of October, prior to onward submission to NHSE.
6.18	ANED-RC flagged that the new EHR would bring new EPRR risks so there would need to be a forward look to ensure plans were up to date and clinical frontline systems were backed up. The CIO responded that all plans were being refreshed, including for applications and software.
6.19	The TC summarised the report was noted, including the links to EHR implementation and the impact there.
Questions from the Public	
6.20	There were no questions from the public.
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee (STC)	

7.1	This update was presented by NED-LB. She informed members it had been a good meeting. The first part had been attended by the West Essex Place Director and the second half had been focussed on a review of the PAHT2030 work-streams. The East & North Hertfordshire Place Director had been unable to attend the meeting but going forward the plan was for the two Place Directors to attend alternate meetings. The WE Place Director had provided an update on the three priorities which had been agreed by the Healthcare Partnership: Adult Mental Health, UEC and Frailty.
7.2	In terms of the ENH HCP development programme, areas of work were similar to those within West Essex, with a big focus on frailty.
7.3	In terms of the HCP development plan, there were three areas of focus for the approach to developing the West Essex HCP. 1. Development of WE HCP in 24/25 to clarify the governance, responsibility and accountability, reporting flows. 2. To design an HCP led process for 25/26 operational planning leading to a West Essex integrated delivery plan supported by all partners. 3. Discussion and agreement of further delegated functions for 25/26 including financial delegation and development of horizontal & vertical integration plans for implementation in 26/27.
7.4	In summary the position was positive in terms of the plan going forward for the HCP with the operating model embedded into that. The inclusion now of the external perspective was useful and what the organisation had wanted.
7.2 Report from LMT Meetings Held in September	
7.5	The I-CEO presented this item and the list of agenda items at LMT meetings in September was noted. Members had no comments.
7.3 Corporate Trustee: Report from Charitable Funds Committee	
7.6	The TC introduced the paper which was taken as read. Members had no comments and the paper was noted.
08 QUESTIONS FROM THE PUBLIC	
8.1	The Chair of the Patient Panel (CoPP) highlighted that in terms of the paper at item 7.3 above, it had stated 'The total income received at M3 24/25 was 275% of the amount received at the same period last year' but no figure had been provided. The DoF agreed to provide that figure.
ACTION TB1.03.10.24/26	**Report from the Corporate Trustee: Provide the total income for M3 24/25. Lead: Director of Finance**
8.2	The CoPP then flagged a concern referenced in the Report from QSC in terms of the logging of compliments and the plan for that to be resolved by October. She asked for an update on this. The I-CN responded an improvement plan was in place but the work had only started at the beginning of October. The I-CEO that what was key was the interface between the departments/wards and the PALS team because complaints often came in via the central team. She acknowledged the requirement for a balance of complaints versus compliments.
8.3	The TC requested an update at the next Public Board in December on the progress in terms of logging compliments. The CIO responded this could be added to the IPR.
ACTION TB1.03.10.24/27	**Compliments to be added to the IPR. Lead: Chief Information Officer/Chief Nurse**
09 CLOSING ADMINISTRATION	
9.1 Any Unresolved Issues?	
9.1	There were no unresolved issues.
9.2 Review of Board Charter	
9.2	It was agreed that the Board had adhered to its charter.
9.3 Summary of Actions and Decisions	
9.3	These are noted in the shaded boxes above.
9.4 New Issues/Risks	

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9.4	None.
9.4 Any Other Business (AOB)	
9.5	There were not items of AOB.
9.5 Reflections on Meeting	
9.6	Members agreed there had been some good discussion, good challenge, areas of positive improvement and some reasonable resolutions.
	The meeting closed at 12:25.

Signed as a correct record of the meeting:	
Date:	05.12. 24
Signature:	
Name:	Hattie Llewelyn-Davies
Title:	Trust Chair

ACTION LOG: Trust Board (Public) 05.12.24

NHS
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Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.06.24/14	Board Assurance Framework	Consider adding the risk of a cyber attack to the BAF.	CIO	TB1.05.12.24	Risk is being scoped and will be presented to December PAF.	Proposed for closure
TB1.03.10.24/16	Maternity	QSCII to consider any increasing level of risk being seen in Maternity.	DoM	QSCII.20.12.24	Added to QSCII action log.	Closed
TB1.03.10.24/17	Maternity Reports	Maternity Reports to Board: Clarify the reporting period in relation to incident themes in individual reports.	DoM	TB1.05.12.24	Reporting periods to be clarified in the reporting going forward.	Closed
TB1.03.10.24/18	Maternity	Board thanks to be extended to Maternity colleagues for all their hard work in relation to the Maternity Safety & Support Programme.	DoM	TB1.05.12.24	Actioned.	Closed
TB1.03.10.24/19	Survey Feedback	Ask NHS Providers to pick up with NHSE the issue around the length of time taken to release survey data (Inpatient Survey/Staff Survey).	TC	TB1.05.12.24	Email sent to new interim CEO of NHS Providers – response awaited.	Open
TB1.03.10.24/20	Data Sources	Provide a summary paper to Board with a plan for pulling together individual data sources to provide a clear picture on areas for improvement.	CN	TB1.05.12.24	Added to QSC agenda for January 2025.	Proposed for closure

ACTION LOG: Trust Board (Public) 05.12.24

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.03.10.24/21	Learning from Deaths Update	Learning from Deaths Update: Provide a legend for the graph at figure 2.	MD	TB1.05.12.24	Actioned.	Closed
TB1.03.10.24/22	Board Thanks	Board thanks to be sent to Director of Medical Education/Guardian of Safer Working.	B&CS	TB1.05.12.24	Actioned.	Closed
TB1.03.10.24/23	Workforce Race Equality Standard	WRES Report: Provide a comparison of the numbers of FTSU cases raised by white versus BME staff.	I-CPO	TB1.05.12.24	Unfortunately the Trust does not hold data on ethnicity for FTSU cases. Work is ongoing to look at how best to approach but with many cases being raised anonymously the data will always be skewed.	Proposed for closure
TB1.03.10.24/24	Workforce Race Equality Standard	WRES Report: Provide a breakdown of FTSU cases relating to bullying and harassment for white versus BME staff.	I-CPO	TB1.05.12.24	Unfortunately the Trust does not hold this information. Work is ongoing to look at how best to approach but with many cases being raised anonymously the data will always be skewed.	Proposed for closure
TB1.03.10.24/25	Workforce Race Equality Standard	Provide the percentage of senior colleagues from a BME background excluding medical, dental and nursing colleagues.	I-CPO	TB1.05.12.24	29%.	Proposed for closure
TB1.03.10.24/26	Corporate Trustee	Report from the Corporate Trustee: Provide the total income for M3 24/25.	DoF	TB1.05.12.24	£162k.	Proposed for closure

ACTION LOG: Trust Board (Public) 05.12.24

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.03.10.24/27	Compliments	Compliments to be added to the IPR.	CIO CN	TB1.05.12.24	Compliments have been regularly recorded since 01.10.24. Oct - 35 and Nov -11 to date. Following a review of the data capture processes, we cannot be consistent in applying statistical process control methodology due to the ad hoc nature of how compliments are received. This means spikes in trends can often be seen which may or may not reflect what is actually happening. For this reason, it is proposed this KPI be removed from the IPR. Compliments will be monitored locally through divisional governance.	Proposed for closure

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors – 5th December 2024

Agenda item:	2.1
Presented by:	Hattie Llewelyn-Davies
Prepared by:	Hattie Llewelyn-Davies
Date prepared:	22.11.2024
Subject / title:	Chair's Report

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

Key issues:	To inform the Board about my work; to increase knowledge of the role; to evidence accountability for what I do as Chair of the Trust.
Recommendation:	The Board is asked to discuss and 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	x

Previously considered by:	Not applicable
Risk / links with the BAF:	Aligns with BAF risks relating to our patients and people.
Legislation, regulatory, equality, diversity and dignity implications:	As the NED EDI Champion this continues to guide my work in all the areas noted below. I am proud that the Board has an equalities workshop after the public board today. My role as Freedom to Speak up Guardian informs my work in this area and work on improved reporting in this area is underway.
Appendices:	Walkabout Action Notes. Board Development Programme.

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 Recruitment of the Chief Executive:

It is my great pleasure to welcome Thom Lafferty to PAHT. Thom began with us at the beginning of November and has been very busy meeting all our partners and stakeholders and getting to meet as many of our PAH people as possible. His report follows mine on the agenda, I am sure he will cover his first impressions of PAHT.

On behalf of the whole Board I also want to record our thanks to Sharon McNally, who covered the CEO role between Lance leaving and Thom joining us. As always Sharon did an amazing job with grace and skill. We all owe her a debt of gratitude. We are incredibly lucky to have her as our deputy CEO and Chief Nurse.

3.0 Board Updates:

As reported in my last chair's report we were asked to meet with and appoint a NEXT Director to join our board. It is a real pleasure to welcome Bolanle (Bola) Johnson to her first Board Meeting in Public. Bola is with us for an initial period of six months but we very much hope she will stay longer than that. Bola lives locally and is highly skilled and experienced in risk management in the financial sector.

We are about to go out to recruit a new Associate NED with a background as an acute clinician.

I am pleased to confirm that my tenure as Chair is being extended until September 2025.

From this month, Anne Wafula Strike will be stepping down as a member of QSC but will continue to be a member of the People Committee and Charitable Funds Committee.

4.0 System involvement:

I continue to be involved with the ICS and wider system. We have a number of ICS meetings and one regional meeting as well in the last quarter.

I have been invited to sit on the appointment panel for the New Chair of West Herts Hospitals Trust at the beginning of December.

I continue to attend the first hour of the Patient Panel monthly meetings to ensure liaison between the Board and the Patient Panel.

I continue to be active in the NHS Disabled Directors Network as a member of its steering group. Examples of our experiences are available on the DNDN LinkedIn page.

I am also pleased to have been invited to join the NHSE steering group re-designing the training national for aspiring CEO's. (I am told that my experience of chairing Trusts with four first time CEO's in the NHS puts me in a unique position to do this.)

5.0 Staff resilience and Board visibility:

The NEDs continue to do regular visits to our services. Attached is the action note that has arisen from our regular visits. My thanks go to all the staff teams who have hosted our visits.

In response to a new national initiative, we have established a programme of monthly visits to our Emergency Teams and Urgent Treatment Centre. Reports from these are included in the attached report.

Two of the Non-Executives also joined me in a walkabout to see how the launch of our new Electronic Health Record was going. It was an inspiring visit; to see staff from across the organisation working together to resolve issues as they cropped up. It is hard to adequately express the thanks the board owes to everyone in the organisation for the way they have implemented this massive change which will enable us to provide far better and safer services to our service users.

The implementation has been brilliantly led by a team of people led by Phil Holland, but I know he will say it was an amazing effort by everyone that works in PAHT that made it possible. We will continue to implement our new EHR and develop its use over the next few months but I wanted to note with pride the smooth implementation to date. Thank you all!

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

Author: **Hattie Llewelyn-Davies, Trust Chair.**
Date: **22.11.24**

Chair's action matrix: version 5.2

Team: PAHT Chair and non-executive directors

Updated: November 24

Non-Executive Directors initials:		Key for others
HLD: Hattie Llewellyn-Davies (Chair) GW: George Wood CM: Colin McCready OA-C: Oge Austin-Chukwu (Assoc.)	BJ: Bolanle Johnson (Associate) DB: Darshana Bawa (sen. Ind.) AWS: Anne Wafula-Strike MBE (Associate) LB: Liz Baker RB: Ralph Coulbeck (Assoc.)	PP: Patient Panel FtSUG: Freedom to Speak Up Guardian

Visit Date	Attendees	Venue	Feedback	Lead	Deadline	Action
06/11/2024	LB	ED	Good Electronic Health Records transition, however the ED remains under significant pressure.	Divisional Director	NA	On going monitoring of impact on high attendance on staff and patients.
09/10/2024	DB	ED	Safety and effectiveness, patient privacy and dignity, with staff speaking up the focus.	ADON	12/24	Process for speaking up and escalating concerns raised and addressed by ADON.
19/08/2024 10/09/2024	NA	Colposcopy	Cancelled	NA	NA	NA
10/07/2024	HLD	Outpatient call centre	Best visit. Evidence based, massive progress made, ambitious for reducing waits.	NA	NA	Potential follow up with QSC, to be confirmed.
16/05/2024	LZ & DB	Fracture clinic	A very positive visit – the staff were open with us and made us feel very welcome.	ADPE	Sep 2024	Security and Outpatient appointment issues. Shared as requested. OPA follow up visit planned. Completed

19/04/2024	GW, LB, OA, RG, AWS	Children's ED	Excellent impression of location and work, clear ideas for development as noted in actions. Escalated as needed.	ADPE	NA	Identified needs related to asthma and allergies, security, mental health with related issues of estates and portering. Escalated as needed.

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 5th December 2024

Agenda item:	2.2							
Presented by:	Thom Lafferty - CEO							
Prepared by:	Thom Lafferty - CEO							
Date prepared:	28 November 2024							
Subject / title:	Chief Executive Officer report							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Executive Summary	This report provides an update since the last Board meeting on the key changes, challenges and successes. The report is framed around our 5 strategic priorities: Patients, People, Performance, Places and Pounds.							
Recommendation:	The Trust Board is asked to note the update.							

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

Previously considered by:	N/a
Risk / links with the BAF:	CEO report links with all the BAF risks.
Legislation, regulatory, equality, diversity and dignity implications:	– Regulatory – Board requirement to assure itself of suitable practices and processes in place to minimise the risk to patient safety in relation to long waits for planned care and urgent care – Regulatory – recognition of our inability this year to meet our regulatory requirement to breakeven financially without support – EDI – impact of long waits for planned and urgent care on our different populations and the potential for a disproportionate impact – 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, for example, access to and ability to use digital enhancements (Alex Health)
Appendices:	None

Chief Executive's Report
Trust Board: Part I – 5 December 2024

1.0 Introduction and Personal Reflections

As I approach the end of my first month as Chief Executive Officer (CEO) of Princess Alexandra Hospital NHS Trust (PAHT), I would like to express my gratitude to all the many members of staff and stakeholders who have made me feel so welcome to the organisation and to the west Essex place.

Whilst I am clear that both internally within our organisation and externally within our Integrated Care System (ICS), we need to work together to drive significant change and transformation to respond to our evolving population's needs. The starting point for this is a positive 'people culture' and value-base and I feel very fortunate to have inherited an organisation where these aspects are well established.

I would to particularly thank Sharon McNally, Deputy CEO and Chief Nurse, for her leadership of PAHT as Interim CEO prior to my coming into post on 4 November 2024. Sharon's compassion, care and astuteness has served the organisation extremely well over recent months and it has been fantastic to work alongside Sharon since commencing in post.

Hattie Llewelyn-Davies

I am delighted that our Chair, Hattie Llewelyn-Davies has been reappointed by NHS England as Chair of PAHT until 12 September 2027. I am clear that Hattie's leadership of the PAH Board and her ambassadorial role across our ICS and East of England region is critical in guiding our Trust and place through the challenging agenda we face.

On a more personal note, I am deeply grateful for the support that Hattie has offered me in advance of commencing in post at PAHT and during my first month as CEO.

This report provides an update since the last Board meeting on the key changes, challenges and successes.

2.0 Our Patients

2.1 Alex Health implementation

At the beginning of November, we went live with Alex Health, our Integrated Health Record. The 'go live' process was delivered as per the agreed plan with a detailed governance process in place. This is a significant milestone for PAHT, and provides the digital foundation for the delivery of the digital element of PAHT 2030; moving us from 'analogue to digital'.

Initial feedback from Oracle, the supplier, and internally from our people who are using the system is, on the whole positive. However, with any complex change such as this, there are areas of the system that are not working as intended which continue to be a focus of the Programme Team.

2.2 New Hospital Programme

We continue to develop plans for our new hospital while we await the outcome of the Government's review of the entirety of the New Hospital Programme. We are currently refreshing our clinical model, updating the demand and capacity analysis and aligning this to the emerging national model, as well as reviewing our site options.

We expect a decision on our programme and on the associated funding for 2025/26 in the New Year.

3.0 Our People

3.1 ‘This is Us’ Staff Awards

It was a joy and a privilege to be involved in the ‘This is Us’ staff awards which took place at the Marriott Hotel in Waltham Abbey on 26 November.

The awards were an opportunity to celebrate the heart of our organisation— our people. As part of the ceremony, we celebrated the achievements of staff across two core categories:

1. Long Service Awards- Honouring those who exemplify loyalty and dedication to the NHS, embodying a lifelong vocational calling that impacts lives every single day.

2. Our Amazing People Awards- Spotlighting the extraordinary individuals who go above and beyond, recognised by their colleagues, patients, and loved ones for their outstanding contributions.

For me, the NHS is more than a healthcare system, it’s a community of people who truly make it the nation's most treasured institution. In times of rapid change and challenges, the resilience and adaptability of NHS staff continue to inspire. From navigating new technologies to embracing evolving healthcare models, our amazing people prove that nothing is beyond our reach.

3.2 Draft People Strategy

The current People Strategy runs from 2019-2024. We are currently working with teams to refresh the document, led by Giovanna Leeks, Interim Chief People Officer.

The new Strategy will emphasise the role of our workforce in driving transformation and improvement and will enable our people to deliver **modern**, **integrated** and **outstanding** care that supports our communities to live healthy, happy lives, working with our partners at place and across the ICS.

The work will be guided by our values of **patient at heart**, **everyday excellence** and **creative collaboration**. Our new People Strategy will cover a five-year period and help to move the organisation towards a culture of improvement; providing a nurturing environment where our people are engaged, grow and thrive.

We are aiming to bring the Strategy to the Board in Q4 2024/25, ready for launch in 2025/26.

3.3 Staff Survey Update

The window for completing the Staff Survey closed on 29 November. At the time of writing, 44% of our staff had completed the Survey.

Whilst this places us around the national average for survey responses, we will take time to consider how we can increase staff engagement with the survey in future years. From my perspective, it is so important that staff feel able to express their views and ideas freely, allowing us to identify key themes and areas in which we need to invest time in better supporting our staff.

We will receive a first cut over the results data in December, with an analysis coming to the Board post-validation in Q4 2024/25.

3.4 GMC Enhanced Monitoring

The Trust has formally been taken out of General Medical Council Enhanced Monitoring as of 26th November 2024.

We were put into enhanced monitoring in October 2022 due to concerns regarding the quality of education and training of our resident doctors. The Medical Education and training team, Preethi Gopinath, Director of Medical Education, Dr Nik Cholidis, Foundation Training Programme Director, Judith Butcher, Medical Education Manager and our Guardian of Safe Working, Dr Salma Al- Ramadhani, have worked tirelessly with colleagues across the Trust to improve the quality of medical education delivered across the trust.

Over the last two years we have seen significant improvement in our National Training Survey with high response rates (81% this year). A site visit was undertaken in October where five specialities were inspected. There remain concerns in a small number of specialities, but overall the GMC and NHSE workforce training and education colleagues are confident of the sustained improvements that have been evidenced.

Many congratulations to the Medical Education team for this significant achievement.

3.5 NHS Manager Regulation

The Secretary of State formally launched the consultation on NHS manager regulation on the 27th November. The consultation has been launched in the context of the Secretary of State's address to the NHS Providers conference in early November.

It emphasises that healthcare managers and leaders are crucial members of all healthcare teams, influencing the quality of care, the outcomes for patients and the experience of the workforce and culture, but with that responsibility comes accountability. The work ultimately aims to transform NHS leadership and management over the next two years.

Our Interim Chief People Officer is currently reviewing how the new proposals can be incorporated into our own approach for developing and supporting leaders.

4.0 Our Operational Performance

Whilst we remain under Tier 2 monitoring for performance against our planned care and cancer care access standards, we continue to have a strong improvement focus across both our operational and our financial performance.

The key drivers and detailed information supporting the operational pressures are outlined in the Integrated Performance Report and associated items on the Board agenda later.

4.1 The New National Oversight Framework & Putting our Best Foot Forward

Aligned to the new NHS Manager Regulation at 3.4, the Government is also set to launch its new National Oversight Framework, which will set out how the performance of providers and health and care systems' will be assessed in future; with regulatory oversight provided by NHS England.

In anticipation of this initiative, Stephanie Lawton, Chief Operating Officer and Phil Holland, Chief Information Officer, are working with our Communications team on a new high-level presentation of the most key-critical performance indicators which will aim to:

1. Highlight areas of strong performance
2. Identify areas of under-performance, our plans to address and prospective improvement trajectories.

In both cases, it is vital that we, as a provider subject to the framework can 'put our best foot forward' and raise the profile of our organisational achievements.

Headlines for our performance includes:

4.2 Planned care

We have continued to make improvement with our routine elective recovery and achieved zero 78+ week waits at the end of October. We are now striving to meet our agreed trajectory against the national expectation for zero 65+ week waits by end December.

The additional 'Vanguard' theatre continues to provide additional capacity for our patients, focusing on Ophthalmology and we are reviewing options for extended utilisation in other specialties. The new theatre has enabled more patients to be seen in our Alexandra Day Unit, which is contributing to our ongoing achievement of the 28-day faster diagnostic cancer standards. In terms of the improvement in diagnostics, our imaging teams continue to deliver exceptional performance in both MRI and CT, achieving 100% of national standards.

4.3 Urgent Care

Our urgent care performance and flow continues to be challenged, with the demand for our services remaining high. We continue to work closely with our partners in primary and community care to enhance and maximise patient flow and ensure the most appropriate pathways are utilised.

Testing of our winter plans both internally and externally with system colleagues has been completed, with a clear focus on utilisation of the Urgent Treatment Centre (UTC), Same Day Emergency Care (SDEC) and paediatric pathways. Community colleagues, alongside the virtual hospital team are continuing to support the discharge of patients. The Trust internal urgent and emergency care improvement plan is currently being reviewed and strengthened as we approach the peak of winter.

5.0 Places & Partnerships

5.1 Primary Care Engagement

At PAHT, we have a vision to provide Modern, Integrated and Outstanding care to the local population we serve.

I am clear that, in order to achieve this, we as the acute provider need to shift our organisational thinking and culture to one which places greater emphasis on responding to local population health need, working with colleagues at place so that our residents experience health and care that is seamless, effective and proportionate to need.

Moreover, we need to grasp the national challenge set by the incoming Government to move the focus of healthcare from the acute environment to the local community, whilst placing an increased emphasis on prevention, rather than reactive clinical intervention. As per the Fuller stocktake published last year, the primary/secondary care interface and the effectiveness of establishing sufficiently resourced Integrated Neighbourhood Teams (INTs) within Primary Care Networks (PCNs) is integral to this if we are to transform care provision.

To support this ambition, I have written to each Primary Care Network (PCN) Clinical Director in our localities in order to explore what we could do as a Trust to accelerate the work already underway locally. Our Medical Director, Dr Fay Gilder, plans to meet each Clinical Director to this end over the next two months.

5.2 From Acute to Community, reviewing our Clinical Strategy

We are currently in the process of refreshing our clinical strategy with a focus on how we meet the needs of our patients, working in collaboration with our system partners (health, social care and CVS) and a focus on early intervention and prevention (the left shift). This builds on the work developing the local Health and Care Partnership (HCP) with a real focus on which services should be delivered on the main hospital site and which services would be better delivered in a community setting.

The review will not be restricted to location, but will look at how we should work in collaboration with other partners to make sure they get the support they need, and we make sure we get the support we need to meet the challenges of an aging population and increasing demand. We are expecting this work to be completed in the new year supporting the development of the business case for our new hospital.

5.3 Acute Provider Collaborative

Running alongside the development of our clinical strategy we are working closely with the other acute trusts in the ICS as well as Bedford, Luton and Milton Keynes, exploring the opportunities for closer collaboration.

The scope of the work is focused upon:

i) Supporting 'fragile' clinical services
ii) Developing centres of clinical excellence
iii) Collaboration on corporate services.

To enable work to commence on i) and ii), we are working jointly on a framework to review our current elective service offer.

6.0 Our Pounds

6.1 2025/26 Business Planning Update

Business planning for 2025/26 has begun in earnest while we await further guidance from the National team following the budget in October. We have been asked to assume that the financial outlook in the next year will be as challenging as the year that has just passed.

We understand that there may be changes to the elective recovery fund (ERF) mechanism and are currently trying to ascertain further detail.

Within the ICS, we are endeavouring to undertake planning at a place level and are exploring what this means from a delegated budget perspective relative to our peers.

6.2 Month 7 Financial Performance

The Trust achieved a surplus of £1.3m in Month 7 (M7), maintaining the year-to-date (YTD) deficit of £5.4m as per the plan. This position was bolstered by £3.3m of system support funding initially planned for Month 11 and benefits from unutilised accruals for bank and agency pay awards. Adjustments for pay awards and additional inflation funding were reflected in the updated income and pay budgets.

However, without the early system support and other in-month adjustments, the Trust's underlying position would reflect a £3.5m adverse variance to the YTD plan.

Capital expenditure forecasts indicate a potential overspend of £1.5m, pending further PDC funding or adjustments to the forecast. While the Trust's cash position remains stable at £26.5m as of October 2024, achieving the year-end deficit target will be critical to maintaining the forecasted cash balance of £6.5m by 31 March 2025. Further detail can be found in the Finance Report.

Thomas Lafferty, Chief Executive
November 2024

The Princess Alexandra Hospital NHS Trust

TRUST BOARD (Public) – 5 December 2024

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:	29 November 2024
Subject / title:	Corporate Risk Register

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

Key issues:	This paper presents a summary for Trust risks scoring 15 and above for all our services. It is unchanged from the paper submitted to Board 3 October 2024 due to the fact that risk management group has been stood down during the go-live period for the very recent implementation of Oracle Millenium electronic health record. Risks have continued to be reviewed by the chair of Risk Management Group ensuring oversight of key risks during this period. The overall number of risks approved for inclusion onto the corporate risk register that score 15 and above is 30 and can be seen in table 1. Table 2 details the numbers of risks by category and those that breach the Trust appetite tolerance. Section 3 provides detail of the three risks scoring 20 approved for placement on the Corporate risk register (CRR). None of these risks are new. • Quality - safety – emergency access standard (risk id 85) and referral to treatment constitutional standard (risk id 497) Section 4 - There are no new risks scoring 16 that have been approved by RMG / LMT as RMG was stood down this month. Section 5 - There are no new risks scoring 15 that have been approved by RMG / LMT as RMG was stood down this month.
Recommendation	Trust board is asked to review and discuss the contents of the corporate risk register

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

Previously considered by:	Risk Management group 10-9-24 Leadership Management group 24-9-24

	Divisions and corporate teams review their risks at their local governance meetings. Teams escalate new risks, closed risks and those that they require assistance with for discussion at Risk Management Group on a monthly basis.
Risk / links with the BAF:	There is a direct link between the risks detailed in this paper and on the BAF
Legislation, regulatory, equality, diversity and dignity	Management of risk is a legal and statutory obligation. This paper has been written with due consideration to equality, diversity and inclusion.
Appendices:	Nil

1.0 Introduction

This paper details risks scoring 15 and above on the Corporate Risk Register.

The Trust Risk Management Group (RMG) meets monthly and reviews risk by exception on rotation according to the annual work plan (AWP). As stated above, RMG was stood down over the period of the go-live of Oracle Millenium (AlexHealth), our new electronic health record. The next meeting will be held 10 December 2024.

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

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

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

In addition to the corporate risk register there is an operational risk register that includes risks that are being managed locally within our corporate and divisional teams. Operational registers also include risks that meet the criteria for the corporate register that have not yet been

- submitted to RMG
- re-submitted to RMG following divisional / corporate team review of feedback from RMG / LMT
- are new and awaiting review by the RMG.

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

2.0 Context

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

There are 31 risks that meet the criteria and have been approved for inclusion onto the corporate risk register. RMG continues with the review of corporate and divisional risks escalated for inclusion onto the corporate register.

A separate paper is completed and submitted to the Leadership Management Team (LMT) meeting to ensure all leaders are sighted to these risks, it is this group that RMG submits the recommendation for items to be placed on the corporate register. LMT will discuss and agree requests or ask services to complete a review with feedback for those risks not approved.

The annual work plan will continue to be reviewed and updated to ensure that it reflects learning from this new way of working.

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

Table 1 - Risks scoring 15 or more	Risk Score				
	15	16	20	25	Totals
Cancer & Clinical Support	0 (1)	6 (6)	0 (1)	0 (0)	**6 (8)**
Corp - Estates & Facilities	1 (1)	0 (0)	0(0)	0 (0)	**1 (1)**
Corp - IM&T	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Corp - Emergency Planning & Resilience	0 (0)	0 (0)	0(1)	0 (0)	**0(1)**
CHAWs Child Health	0 (0)	2 (2)	0 (0)	0 (0)	**2 (2)**
CHAWs Women's Health	1 (1)	1 (1)	0 (0)	0 (0)	**2 (2)**
Medicine	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Surgery	0 (0)	2 (3)	0 (0)	0 (0)	**2 (3)**
Urgent & Emergency Care	2 (2)	1 (1)	0(0)	0 (0)	**3 (3)**
Trust wide	2 (2)	9 (10)	2 (2)	(0)	**13 (14)**
Totals	**6 (7)**	**22 (24)**	**2 (4)**	**0 (0)**	**30 (35)**

The numbers of corporate register risks and those risks with a current score less than 15 that exceed their risk appetite tolerance is recorded in table 2. This is detailed by risk category. Divisions and services consider those risks that breach appetite and score less than 15 and are able to submit these by exception to the RMG who will consider.

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	18 (20)	67 (62)	12 (5)	19 (16)	2 (2)	**118 (105)**
Quality – Patient Experience	≥ 12		11 (9)	0 (0)	2 (2)	(0)	**13 (11)**
Quality – Clinical Effectiveness	≥ 12		15 (16)	2 (1)	4 (1)	0 (1)	**21 (19)**
People	≥ 15			2 (0)	4 (3)	1 (0)	**7 (3)**
Statutory Compliance & Regulation	≥ 12		11 (11)	2 (1)	(0)	3 (1)	**16 (13)**
Finance	≥ 12		5 (3)	0 (0)	0 (0)	0 (0)	**5 (3)**
Reputation	≥ 15			0 (0)	0 (0)	0 (0)	**0 (0)**
Infrastructure	≥ 15			1 (0)	1(1)	(0)	**2 (1)**
Information and Data	≥ 10	0 (0)	7 (7)	0 (0)	1 (0)	1 (0)	**9 (7)**
Systems and Partnerships	≥ 15			0 (0)	1 (1)	0 (0)	**1 (1)**

3.0 Summary of risks scoring 20

There are 3 risks with a score of 20 on the corporate risk register. A summary of these risks and action & mitigations is below, information is taken from divisional risks:

3.1 Quality – Safety:

3.1.1 Emergency care access standard

- There is a risk that patients may deteriorate as a result of failing to deliver the ED four-hour access standard.
  Risk id 85: is a Trust wide risk and is on the corporate risk register.
  Actions / mitigations: Use of the Manchester Triage tool and Nerve Centre to improve clinical information and prioritisation of patients. Improvement trajectory agreed and oversight by the Urgent Care Board.

3.1.2 Referral to treatment constitutional standards

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

4.0 There are no new risks scoring 16 added to the corporate risk register

5.0 There are no new risks scoring 15 added to the corporate risk register.

6.0 Recommendation

Trust board is 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 December 2024

3.2

Agenda item:	3.2
Presented by:	Heather Schultz – Head of Corporate Affairs
Prepared by:	Heather Schultz – Head of Corporate Affairs
Subject / title:	Board Assurance Framework 2024/25

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

Key issues:	The Board Assurance Framework (BAF) is presented for review and approval. The risks have been updated for 2024/25 with executive leads and reviewed at the relevant committees during November 2024. There are 2 risks proposed for closure this month; risk 1.2 EPR (Cosmic) and risk 4.3 Industrial action – both are attached as appendices. The remaining risk scores have not changed this month and are summarised in Appendix C. The full BAF is available in the resources section of Diligent.
Recommendation:	The Board is asked to: - Approve the closure of Risks 1.2 and 4.3 - Note the remaining BAF risk scores

Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	x	x	x	x	x
Previously considered by:	QSC, PC and PAF in November 2024.				
Risk / links with the BAF:	As attached.				
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance in relation to risk management. The controls and mitigating actions outlined in the risks are designed to support delivery of the Trust's strategic objectives and promote an organisational culture that drives improvements in equality, diversity and inclusion.				
Appendices:	Appendix A – BAF risk 2.1 Appendix B – BAF risk 4.3 Appendix C – BAF summary dashboard				

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/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequities in our local population **Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way**													
BAF 1.2		**EPR** The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	Causes: i) Poor clinical engagement with the system, due to lack of usability and limited functionality. ii) Timely system fixes/enhancements iii) Static functionality	**5 X 4= 20**	Chief Information Officer **STC**	i) Fortnightly DQ meetings being held ii) Increased training application support, mobile training support, RTT validators & staff awareness sessions. iii) Performance Mgt Framework in place. iv) User Training programme. v) Access Policy vi) Functionality enhanced through deployment of alternate solutions (e-Obs, Portal, Meds management, Nervecentre, Alertive) vii) Development of capacity planning tools/information viii) Weekly ICT/COSMIC meetings ongoing	i) Access Board Elective Programme Board ii) STCand PAF meetings iii) Weekly meetings with Cambio iv) Weekly DQ meetings v) Monthly performance reviews	i) Weekly Data Quality reports to Access Board Elective Programme Board and daily DQ reports to organisation ii) Quarterly E-Health reports to PAF	**4 X 4= 16**	i) Resource availability ii) Capacity within operational teams to ensure completeness of data quality iii) Elements of system remain onerous (completion of discharge summaries) iv) External system support post full contract expiry v) Compliance with refresher training vi) Cambio delivery schedule slippage	Reporting mechanism on compliance of new staff/interims/junior doctors with the system and uptake of refresher training. Supplier requests to remove contractual requirement to comply with national standards e.g. ISNs - 2 risks associated 1) exposes PAH to technical compliance issue as supplier not compelled to comply and 2) financial risk	Nov-24	**Risk score reduced to 12 and risk to be closed.**	**4x3=12 end of 2024**
			Effects: i)Patient safety if data lost, incorrect, missing from the system. ii) National reporting targets may not be met/ missed. iii) Financial loss to organisation through non-recording of activity, coding of activity and penalties for not demonstrating performance iv) Inability to plan and deliver patient care appropriately							**ACTIONS:** Continue to engage with Cambio up to contract end date				

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2024-25**											
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 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators													
Risk 4.3		Industrial action: There is a risk that patient safety will be impacted by further industrial action	Causes: Pay disputes leading to ongoing periods of industrial action	4x5=20	**Exec leads: COO, MD and CN Committee** : Performance and Finance Committee/Quality amd Safety Committee	Industrial Action (IA) team set up to lead the preparation & delivery of IA to release the operational teams back to business as usual Clinical and operational teams working to mainatin patient safety during periods on industrail action Identifying learning from IA in After Action Reviews that can be turned into new improved business as usual and improvements in delivery of safe care Incident management structure in place during periods of IA EPRR framework	Cell meetings, IMT meetings SMT and PAF meetings	Monthly, weekly and daily monitoring of elective backlogs in RTT & cancer, and of urgent & emergency care standards. Reporting at speciality, divisional, Access & Cancer Board, SMT/LMT, DRM, & Board sub-committee level.	4x5=20	Deviation from cell structures due to pace	None noted.	01/11/2024	**Risk score reduced to 8 and risk to be closed.**	**4x2=8 Nov 2024**
			Effects: Reduced capacity of operational teams to deliver business as usual and operational improvements in order to provide patients with effective & efficient services Deteriorating performance recovery. Increased elective backlogs and deteriorating urgent care performance. Poor patient experience and risk of harm to patients Deterioration in productivity and PQP delivery											

Board Assurance Framework Summary 2024.25

Risk Ref. Committee	Risk description	Year- end score (Apr 24)	June 24	October 2024	December 2024				Trend	Target risk score	Executive lead
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide **our patients**, integrating care with our partners and reducing health inequities in our local population										
1.1 QSC	Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience.	16	16	16	16				↔	12	I-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				**Proposed for closure**	12	CIO
1.3 PAF	Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.	15	15	15	15				↔	10	COO
1.4 STC	EHR There is a risk to the delivery of safe and high quality care caused by the Trust relying on an unsupported and unstable EHR if Alex Health is not deployed by October 2024 and is delayed beyond the end date of the Cambio support contract	16	16	16	16				↔	12	CIO
	Strategic Objective 2: Our People – we will support **our people** to deliver high quality care within a culture that supports engagement, recruitment and retention and results in further improvements in our staff survey results as we strive to be a model for equality, diversity and inclusion										
2.1 PC	GMC enhanced monitoring: There is a risk that the GMC/HEE will remove the Trust's doctors in training. This is caused by concerns regarding the quality of their experience, supervision and training. Removal of the doctors will result in the Trust being unable to deliver all of its services.	20	20	20	20				↔	10	MD
2.3 PC	Workforce: Inability to recruit, retain and engage our people in certain areas/specialties across the Trust	16	16	16	16				↔	8	I-CPO
	Strategic Objective 3: Our Places – we will maintain the safety of and improve the quality and look of **our places** and will work with our partners to develop an OBC for a new hospital, aligned with the development of our local Health and Care Partnership										
3.1 PAF	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20	20				↔	8	DoS
3.2 STC	System pressures: Capacity and capability to deliver long term financial and clinical sustainability at PAHT due to pressures in the wider health and social care system	16	16	16	16				↔	12	DoS
3.5 STC	New hospital: There is a risk that the new hospital will not be delivered to time and within the available capital funding.	20	20	20	20				↔	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:	12	12	12	12				↔	8	COO

Board Assurance Framework Summary 2024.25

	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.										
4.2 PAF	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	20	20	20	20				↔	12	COO
4.3 PAF/ (QSC for patient harms)	Industrial action: There is a risk that patient safety will be impacted by further industrial action	20	20	20	8				**Proposed for closure**	8	COO/MD/CN
	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	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 £23m inclusive of a CIP requirement of c. £18.5m in 2024/25 and ERF delivery at c. 115% of 2019/20. The original plan was proposed at £30m and has only been revised down by agreed stretches relating to ERF. We have articulated the risk we are bearing as a provider. 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.	16	12	12	12				↔	8	DoF

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 December 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**29.11.24**			
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 Update	Y	Y	N	Key highlights were: • Two cases of Endophthalmitis in Ophthalmology but actions underway to establish why this had happened. • Increasing trend of CPE (Carbapenemase producing Enterobacteriaceae) on screening. A worrying trend but one to be expected given antimicrobial resistance cannot be stopped, only controlled. • *C.difficile* remained a key priority for the Trust – cases nationally are increasing. • The ability to electronically record and identify staff who are fit tested was noted and the improvement welcomed. Further work to have visibility of overall compliance rates remained a focus. • Early issues with the IPC oversight within our electronic health record were noted and the collaborative work to understand the risk, mitigation and solutions.
2.2 Learning from Deaths Update	Y	Y	N	The paper again demonstrated a very stable position for the Trust. The paper is on the Board agenda.
2.3 Patient Safety Monthly Report	Y	Y	N	Key headlines for October were: • 1141 incidents reported in October. • 661 (58%) incidents open >30 days.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 December 2024**			**AGENDA ITEM: 4.1**
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REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**29.11.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• 12 open serious incidents/patient safety incident investigations. • One PSII raised in October. • CQC enquiries: 3 patient experience and care concerns raised. • 5 new inquests requested and 7 inquests held. • National Audit: Current compliance reviewed with key focus on requirement to complete the assessments against the recommendations.
2.4 Report from Patient Experience Group (PEG)	Y	Y	N	Key items to note were: • Patient Satisfaction Survey: Task & Finish group established to focus on inpatient survey. • Paediatric & Neonate Complaints and PALs: Address consistency in closure, including faster response times and improved learning dissemination. • QSC to note and commend the use of the “pants and tops approach” to recording compliments in Paediatrics & Neonates.
2.5 4 Monthly Patient Experience Update	Y	Y	N	Key headlines for the 4 months to October were: **Complaints**

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 December 2024**			**AGENDA ITEM: 4.1**
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REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**29.11.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• 112 cases open. Since April 2024 – 155 received, 139 closed. • Surgery and Medicine open cases, 65 (prev. 34) and Medicine 18. • 1 case older than 12 months (prev. 8) and oldest case CHAWS – August 2023. • 6 open PHSO cases and 26 complaints have come from PALS systems. **PALS** • 924 cases open (up from 731), 659 in Surgery. • Sustained increase in elective specialty cases and themes of delay. • 248 compliments received since April 2024 led by Surgery (83) **Friends and Family test data** • Low point with overall FFT at 70% in November – possibly EHR go-live related, following high of 81% in August. Work underway with additional resourcing to address the volume of PALs/Complaints cases in Surgery and also to manage elective wait time expectations.
2.6 QPMO Update	Y	Y	N	This was a verbal update as the group had not met in-month due to Alex Health go-live. Significant progress had been made in relation to L3 safeguarding training (still

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 December 2024**	**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**	
REPORT FROM:	**Oge Austin-Chukwu**	
DATE OF COMMITTEE MEETING:	**29.11.24**	

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				amber but improved), and performance against the ED 4 hour standard remained as 'red'. It was noted that a new reporting format would be developed going forward.
2.7 Update from Patient Panel	Y	Y	N	The recent aspects of the work of the Patient Panel were noted, along with congratulations to its Chair for her recent award of a British Empire Medal.
2.8 BAF Risk 1.1 (Clinical Outcomes)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
3.1 M7 Integrated Performance Report	Y	Y	N	All key indicators were discussed during the meeting. The work to reflect the revised patient metrics in the report would now re-start following the recent go-live of the new electronic patient record.
3.2 Report Against Operating Plan (update on all recovery standards)	Y	Y	N	Key headlines were: • Activity levels had seen the continuation of the upward trend in Outpatient first attendances, day cases and elective activity. • 62 day cancer performance: Performance improving and consistently over 50% for the last 5 months. • Diagnostics performed within 6 weeks of referral had improved slightly to 70.16% from 68.27%. MRI, CT and

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 December 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**29.11.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				flexi-sigmoidoscopy achieved 100%. Concerns for ongoing demand for echos, audiology and cystoscopy. • Long waiting elective recovery remained a high priority with a focus on sustaining delivery of zero 78+ week patients (0 for October) and on delivering the next national milestone of zero 65+ week patients by 22/12/24. • Mitigation plans/risk assessments requested to identify the impact of Alex Health deployment on recovery milestones/ASIs. • Urgent Care: Performance continued to be challenged. 56% achieved against the 4-hour standard in October compared to 60.9% in September. • The Trust remains in Tier 2 monitoring for cancer/routine elective standards.
Horizon Scanning Update	Y	Y	N	Areas to note were: **CQC State of Care report 2024:** Published 25.10.24 and focusses on an increase in difficulties accessing primary, dental care and mental health services. **AlexHealth – oversight of patient safety and experience:** Any patient safety incidents will be reviewed daily with oversight at weekly IMG meetings. Patient impact is monitored via the Patient Experience Group.

BOARD OF DIRECTORS:	**Trust Board (Public) – 5 December 2024**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Oge Austin-Chukwu**			
DATE OF COMMITTEE MEETING:	**29.11.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				Health Services Safety Investigations Body: The HSSIB has published its report on improving the effectiveness of quality and safety recommendations in the NHS. No direct actions for trusts, but a recommendation for the DoH to look at ways to increase the collaboration/effectiveness in how safety recommendations made to the healthcare system are developed/implemented.

BOARD OF DIRECTORS: **Trust Board 05.12.24** **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: **Quality & Safety Committee (Part II)**

REPORT FROM: **Ralph Coulbeck, Committee Chair/Associate Non-Executive Director**

DATE OF COMMITTEE MEETING: **29 November 2024**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 Monthly Maternity Report and 2.2 Maternity Dashboard	Y	Y	N	The red flags (12 in month) were highlighted in relation to midwifery staffing. In regards to transformation, the Maternity Triage Transformation Project was highlighted. Highlights from the dashboard included; • Still birth rate below regional and national average at 2.4 per 1000 • Important to understand fluctuations in population stillbirth rate in Black and Asian women as it is 0 per 1000 some months, and 18.2 and 17.5 per 1000 in August and September. The higher stillbirth rate amongst this group is recognised nationally. All stillbirths are investigated by a multidisciplinary team using the national Perinatal Mortality Review Tool which draws out any learning or themes. The delay in the urgent review of intravenous antibiotic prophylaxis in babies born before 34 weeks was due to issues accessing the notes. This was expected to be resolved in the next week and it was agreed this would be brought to December's meeting.
2.3 Midwifery Staffing – 6 Monthly Report (Safety Action 5 – MIS Year 6)	Y	Y	N	The funded establishment would be met with the current job offers bringing vacancies to 'zero'. The following was highlighted: • Temporary staffing usage under control • Training and staff development offers are robust and based on need, including for maternity support workers • 3-yearly workforce review was underway • Sustainability of specialist roles under consideration with the workforce review

BOARD OF DIRECTORS: **Trust Board 05.12.24** **AGENDA ITEM: 4.1**

REPORT TO THE BOARD FROM: **Quality & Safety Committee (Part II)**

REPORT FROM: **Ralph Coulbeck, Committee Chair/Associate Non-Executive Director**

DATE OF COMMITTEE MEETING: **29 November 2024**

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.4 Maternity Patient Safety Incidents	Y	Y	N	There had been no new maternity incidents declared since the last report for July 2024. There had been no maternity PSII closed since the last report. Maternity services currently had 6 investigations ongoing (1 MNSI). The report is on the Board agenda.
2.5 Culture Update	Y	Y	N	The following items were discussed: • The conclusion of the QUAD Development programme was noted and the development of aspirations for the maternity service following the culture champions meeting in July. • The newly developed house rules were discussed and it was agreed a timeline for implementation would be brought in January • Successful Black History Month celebration and launch of Cultural Intelligence Workshop • Staff training and development in SCORE Survey results briefing and interpretation to continue. • Staff Survey analysis to be undertaken. • Patient experience of staff interaction to be better understood. • Triangulation of ongoing work to inform Culture strategy/Culture Programme of work.
2.6 Maternity Assurance Report	Y	Y	N	The key areas discussed were: • There were no PSII's reported in the quarter. One new inquest opened. • Clinical Guidelines and NICE Assessments continued to be updated • MIS update (to end Sept 24) noted the risk to delivery of one standard (safety action 1). The service is continuing to work towards the requirements of MIS Year 6

BOARD OF DIRECTORS:	**Trust Board 05.12.24**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Ralph Coulbeck, Committee Chair/Associate Non-Executive Director**			
DATE OF COMMITTEE MEETING:	**29 November 2024**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**

Other items noted:

- Maternity and Neonatal Safety Champions report
- Maternity Safety Support Programme
- Horizon scanning

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 December 2024

4.2

Agenda item:	4.2
Presented by:	Erin Walters, Head of Maternity Governance and Assurance
Prepared by:	Erin Walters, Head of Maternity Governance and Assurance
Date prepared:	03 November 2024
Subject / title:	Overview of Patient Safety Incidents within maternity services

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

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. The Trust has transitioned from the Patient Safety Framework to the Patient Safety Incident Response Framework and therefore the service has a combination of Serious Incidents (SI's) and Patient Safety Incident Investigations (PSII's). There have been 0 new maternity PSII declared since the last report for September 2024. There have been 0 maternity PSII closed since the last report (September 2024). Maternity services currently have 6 investigations ongoing. SI's - 3 PSII's - 2 MNSI - 1
Recommendation:	To provide assurance to the Board that the maternity service is continually monitoring compliance and learning from Serious Incidents and Patient Safety Incident Investigations.

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

Previously considered by:	N/A
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the Ockenden Interim Report that was published in December 2020 with recommendations for maternity services. To also monitor outcomes of those in black and brown ethnicities (known to have poorer outcomes), and vulnerable groups. **Mothers and Babies: Reducing Risk through Audits and Confidential Enquires** MBRRACE Report (October 2023)
Appendices:	1. Open Serious Incidents/Patient Safety Incident Investigations under investigation

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4.2

1.0 Purpose

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

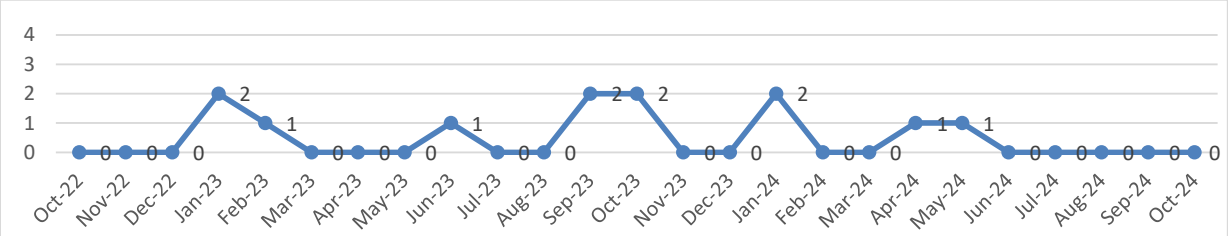
2.0 Background

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. With the implementation of PSIRF the service will continue this practice by reporting Patient Safety Incident Investigations.

3.0 Analysis

Maternity currently have 6 investigation ongoing, 1 of which is being investigated by Maternity and Neonatal Safety Investigations (MNSI) formally Healthcare Safety Investigation Branch (HSIB). Table 1 details the trend of declared Patient Safety Investigations within the last 24 months to October 2024.

Table 1. Comparison of Patient Safety Investigations reported for Maternity in last 24 months (to October 2024)



There were 0 new Maternity Patient Safety Incident Investigation (PSII) declared in October 2024

Table 2. Serious Incidents declared, submitted and closed for October 2024

Investigations	
Number Declared for October 2024	0
Number Submitted for October 2024	1
Number Past ICB Deadline as of October 2024 (Not including MNSI/Approved Extensions)	5

New Investigations declared in October 2024			
Ref	Ethnicity	Summary	Learning Points
Investigations closed in October 2024			

Line about Table 2

4.0 Themes

Table 3 details the top themes identified in maternity SI's within the last 24 months to October 2024.

Table 3. Top Themes

Total Number of SI's	Theme	Number
12	Neonatal death	7
	Hypoxic ischaemic encephalopathy (HIE)	3
	Cardiotocograph (CTG) interpretation	3
	Obstetric Haemorrhage	2
	Cross Border Working	2
	Delay in care	2
	Intrauterine death	2
	Retained Object	2
	Escalation	2
	Medical Equipment	2
	Screening Incident	1
	Therapeutic Cooling	1
	Birth Injury	1

5.0 Oversight

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

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

Currently, the division is undertaking a review of the governance pathways and reporting structures to strengthen and develop the existing system so that it aligns further with local and national governance objective. Midwifery governance staffing has been by maternity leave. Recruitments to replace the two posts we completed but they did not commence for some time due to unforeseen long-term sickness. Medical Patient Safety and Quality role recruited into mid-November, subject to job-planning. Pathways being strengthened with support from Director from Patient Safety and Quality.

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

The Princess Alexandra Hospital NHS Trust

7.0 Recommendation

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

Author: Erin Walters, Head of Maternity Governance and Assurance
Date: 03 November 2024
Approved – 22 November 2024

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 December 2024

4.2

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery and Gynaecology
Prepared by:	Erin Walters – Head of Maternity Governance and Assurance
Date prepared:	18.11.2024
Subject / title:	Women's Health Assurance Report – Quarterly review July – September 2024 (Q2)

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

Key issues:	This paper provides a quarterly assurance report for maternity services. The key areas of note are: There were no PSII's reported in the quarter • Clinical Guidelines and NICE Assessments • Number of outstanding Datix is showing a positive decreasing trajectory and robust governance remains to ensure timely learning and investigation • An MIS update (to end Sept 24) is included and notes risk to delivery of 2 standards (1 & 8). The service is continuing to work towards the requirements of MIS Year 6, SBLCBv3, Three Year Delivery Plan for Maternity and Neonatal Services 2023 and the Ockenden IEA. Escalation will occur through board where non-compliance is anticipated or found to occur. • An update to key roles in Governance Structure is included within section 4.
Recommendation:	To provide assurance to the Board that the maternity and gynaecology services are continually monitoring compliance and learning from complaints and incidents.

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

Previously considered by:	
Risk / links with the BAF:	BAF 1.1

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Legislation, regulatory, equality, diversity and dignity implications:	To maintain compliance with the Maternity Incentive Scheme Year 6. (NHSE, 2024) Application of Patient Safety Incident Response Framework (PSIRF) Saving Lives, Improving Mothers' Care 2020-2022, (MBBRACE UK, 2024) UK perinatal deaths of babies born in 2022 (MBRRACE-UK, 2024)
Appendices:	N/A

The Princess Alexandra Hospital NHS Trust

1.0 Purpose/issue

This paper is to provide assurance to the Board surrounding Governance within Maternity Services. This paper will include both local and national data to demonstrate assurance and compliance to the committee.

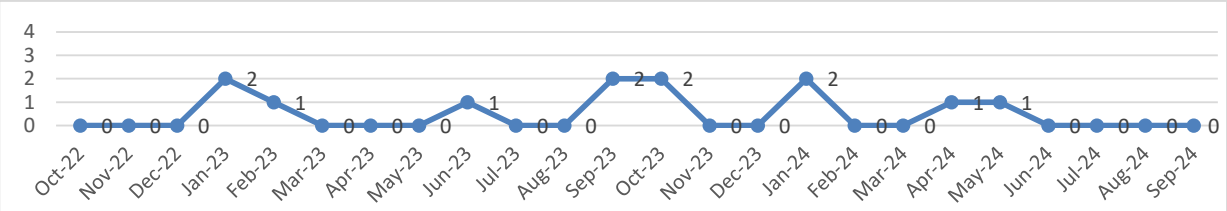
2.0 Background

Within maternity there is an inpatient area which covers 4 wards. Outpatient community services cover a varied demographic area from Harlow to Uttlesford and areas of East Hertfordshire. There is a Maternity Triage which run 24 hours a day to stream service users to the appropriate location based on their needs.

3.0 Analysis

Serious Incidents

Table 1. Comparison of SI's/ PSII's reported for Maternity in last 24 months (to September 2024)



Patient Safety Incident Investigations Declared July - September 2024			
Ref	**Ethnicity**	**Summary**	**Learning Points**
The were no new patient safety incident investigations declared in Q2			

4.0 Themes

The themes at PAHT are consistent with PSII nationally where CTG interpretation, escalation, and delays in care feature. Some of the themes cross over i.e. more than one can apply to the same incident. The neonatal death rate at PAHT is below regional and national average as illustrated on the dashboard.

Table 3. Top Themes

Total Number of SI's	Theme	Number
12	Neonatal death	7
	Hypoxic ischaemic encephalopathy (HIE)	3
	Cardiotocograph (CTG) interpretation	3
	Obstetric Haemorrhage	2
	Cross Border Working	2
	Delay in care	2
	Intrauterine death	2
	Retained Object	2
	Escalation	2
	Medical Equipment	2
	Screening Incident	1
	Therapeutic Cooling	1
	Birth Injury	1

Clinical Incidents

Current Clinical incidents open and closed

The number of open incidents has decreased to 59% for incidents reported in quarter 2. Governance processes include daily Datix multi-disciplinary review meetings where all incidents over the previous 24 hours are reviewed and responded to in respect of actions and escalation through to Incident Management Group as required. A task and finish group is being set up to ensure timely investigation and closure of incidents.

Table 3 – Q1 review of clinical incidents (Datix)

Clinical Incidents (DATIX)	
Number of Incidents Submitted Last Quarter **Quarter one**	427 ↓ 477
Number of Incidents Moderate Harm or Above	21 ↓
DoCs Outstanding	None
Number of Open Incidents	325 (20 moderate harm, 1 death)
Number of Incidents Submitted for last financial year April 2023 – March 2024	1874
Percentage of Open Incidents	59% ↓

Table 4. Legal Cases overview July- September 2024 (Q2)

The Princess Alexandra Hospital NHS Trust

New Claims

0 new claims in quarter 2

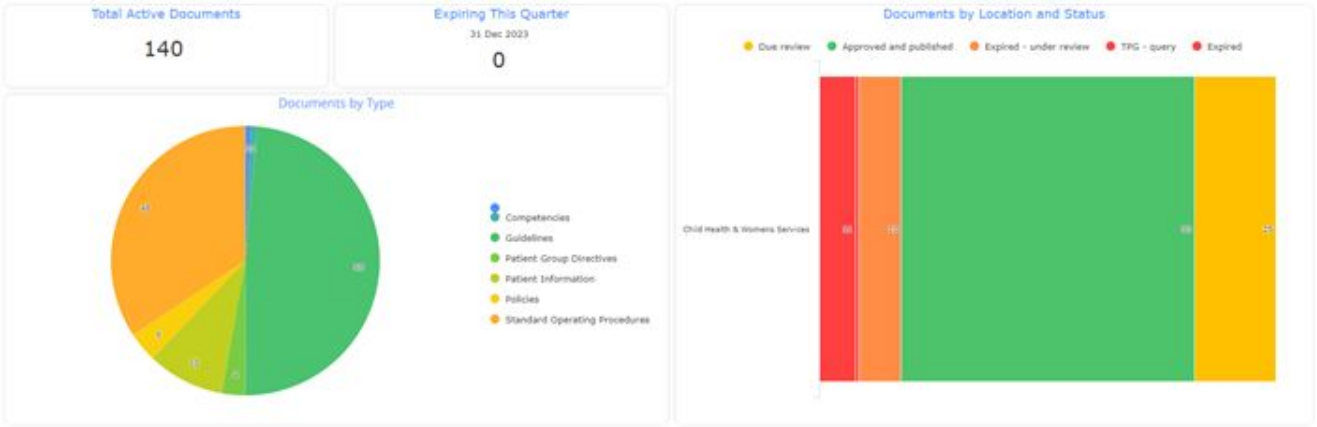
Closed Claims

Ref	Claim date	Incident date	Closed date	Directorate	Specialty	Description	Damages	Plaintiff's Costs	Defence Costs	Incidents/ Complaints	Actions
1652	08/09/2023	13/02/2021	06/08/2024	Child Health and Women's Services (formerly FAWS)	Obstetrics - Maternity	Alleged failure of informed consent	£0.00	£0.00	£2,180.00	PAweb95232	Legal Services to consider learning and circulate to division if necessary

Inquests Opened

Ref	Opened date	Incident date	Directorate	Age	Sex	Investigation	Awaiting
2163/og	04/07/2024	20/04/2024	Obstetrics	3 days	M	MSNI investigation	To request statement

Guidelines



Audit

Audit Schedule 2024-2025 has been agreed, the programme can be shared upon request.

- 5 National Audits
- 27 audits relating to national directives
- 16 local audits
- 1 ongoing spot check audit

Risk Register

Women's health services have 24 risks open on the register. Of these risks 3 score >15:

ID	Specialty	Description	Rating (current)	Controls	Comments
640	Obstetrics	There is a risk that the theatre table cannot go into the correct lithotomy position. This causes a risk to patient safety for mothers and unborn babies when birth via caesarean section or instrumental births are required.	16	Escalated to EBME to source a theatre operating table Able to loan lithotomy leggings from main theatre when needed.	27.11.24 This has been approved in Capital funding an order will be placed imminently
614	Obstetrics	There is a risk that a patient, visitor or staff member may collapse in ANC (currently on the first floor). The Antenatal Clinic is accessed via a set of stairs and a lift which cannot be used during an emergency, and does not fit a stretcher. This could lead to delay in treatment.	15	Live drill of patient collapse in ANC which identified a total time of 35 minutes to transfer the patient EVACUsafe chair installed at the top of the stairs Ski Mat installed in the waiting room	Training completed on equipment. Long term solution under review.
647	Obstetrics	There is a risk that maternity is currently only partially compliant with the safety alert issued on the 31st January 2024. The NRFit connector is used routinely for spinals in maternity theatres, however, maternity remain uncompliant as a universal Luer lock connector is used for epidural top up and a combined spinal/epidural. This commonality of connector carries significant risk of accidental wrong route administration of medication. The potential for a fatal outcome from this, especially if medication for intravenous administration is given via the intrathecal or epidural route, is well known and previous patient safety alerts have been issued.	15	Safety alert issues 31st January 2024 has been widely shared throughout maternity and is included in mandatory teaching to midwives Maternity currently use NRFit for spinals (this is done by an anaesthetist who is familiar with NRFit) Contact pharmacy to ascertain if ready made epidural “top ups” are NRFit compliant	Service currently reviewing available options.

Perinatal Mortality Review Tool Summary

PMRT was launched in January 2018 with the aim of standardising perinatal reviews across NHS maternity and neonatal units in England, Wales and Scotland. The tool is used to support a systematic, multidisciplinary, high quality review and to ensure that parents are involved in the process. This enables a structured process of review, learning, reporting and actions to improve future care and to come to a clear understanding of why each baby died, accepting that this may not always be possible

even when full clinical investigations have been undertaken which in turn involves a grading of the care provided. Reports will be published and shared with the family and placed in the medical notes.

PAHT perform a review of cases on a monthly basis which is undertaken as a multidisciplinary panel including midwives, obstetricians, neonatologists and external experts. Table 5 shows the current open cases for PAHT. All cases are within the reportable time frames for MIS Yr 6.

Table 5. Perinatal Mortality Review Tool Open Cases (Data shown for Q1)

	Parents informed/ asked for feedback	MNSI	PSII	Notification complete Target 7 working days	Review started Target 2 months	Publication Target 6 months	PMRT MDT panel date
**1	08.04.2024 28.05.2024	N	EEAST	08.04.2024	08.04.2024	30.07.2024	19.06.2024
**2.	17.04.2024 19.04.2024	N	N	18.04.2024	19.04.2024	30.07.2024	17.07.2024
**4	28.05.2024 10.06.2024	N	N	22.05.2024	20.06.2024	In Progress	17.07.2024
**5	20.08.2024	N	N	01.06.2024	25.06.2024	In Progress	21.08.2024
**6	17.06.2024 09.08.2024	N	N	17.06.2024	26.07.2024	In progress	21.08.2024

For Q1 PAHT are 100% compliant with standards b) and c) of MIS Safety Action 1

- 100% of parents were informed a review of care was taking place and were asked for their feedback regarding their care (target 95%)
- 100% of reviews were commenced within 2 months of the death (target 95%)
- Two reviews have been completed and three are on track to be completed within the 6-month target (target 60%)

MBRRACE-UK Real Time Data Modelling for past 6 months

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

Table 6. MBRRACE Reportable Cases

MBRRACE-UK Real Time Data Modelling for Past 6 Months

Reported deaths to MBRRACE which included: Antepartum stillbirths: 5 (between 24- and 40-weeks' gestation) Intrapartum stillbirth: 0 Neonatal death: 3 all below 31 weeks gestation

Staffing

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

Staffing				
Staff feedback from frontline champions and walk-abouts: No significant concerns raised. The walkthrough identified some estates work that was required across inpatient services and nervousness from staff surrounding the implementation of the new electronic health records.				
Consultant Obstetric Cover on the Labour Ward	87 hours cover (RCOG recommendation is 98 hours)			
Junior Doctor Rota Gaps	No rota gaps – Currently recruiting to implement a 2 tier rota (2 registrars per shift)			
Midwifery and Neonatal Staffing		Jul-24	Aug-24	Sep-24
	No. of vacancies in WTE	13.25	12.01	14.49
	Midwives on maternity leave in WTE	10.79	8.79	6.99
	Bank and (Agency) usage in WTE	14.33 (0.07)	17.58 (0.00)	15.71 (0.63)
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	NHS Staff survey (2024) underway.			
Proportion of speciality trainees responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	GMC Survey 2024 – clinical supervision out of hours was on the 84th percentile (within interquartile range)			

Training Compliance

PROMPT, Neonatal Life Support and Fetal Monitoring study days are all multidisciplinary and in person. Staff vacancies and industrial action have all impacted compliance this quarter. Mitigations are in place to support attendance and increase study days however releasing the perinatal team from clinical commitments remains a complex challenge.

Migration from Electronic Staff Record (ESR) to This is Me System (TiMS) has been challenging as reporting and data access is limited. Director of Midwifery has met with the Learning Team Lead to look at possible solutions. The Division is aware that this is a Trust wide issue and not specifically a concern just for Child Health and Women's Services.

MIS Progress

Year 6 was launched in May 2024. The 10 Safety Actions have not changed since last year's scheme however there has been changes within the safety actions for services to implement and the inclusion of further evidence required. This includes working with the Integrated Care Board and the Local

Neonatal and Maternity System for assurance. The table below is the current status of the Safety Actions to NHS Resolutions.

Table 10. MIS Progress Year 6 projection

MIS Progress Year 6			
SA 1	Potential for risk Perinatal Mortality Review Tool	SA 6	Action will be met
SA 2	Action will be met	SA 7	Action will be met
SA 3	Action will be met	SA 8	Action will be met
SA 4	Potential for risk Certificate of competence	SA 9	Action will be met
SA 5	Action will be met	SA 10	Action will be met

Ockenden

Following the publication of Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust on 11 December 2020, all Trusts providing maternity services were required to undertake an immediate response looking at 7 immediate and essential safety actions (IEA) and workforce planning (WF). The final report was released in March 2022.

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

As of September 2024, PAHT maternity services are compliant with 80/89 recommendations of the Ockenden Interim Report (2020). The maternity team are currently working towards compliance with the remaining 8/89 recommendations with related actions.

Out of the 9 open actions, they all remain on target and are due to be completed by 2024/2025. This is evidenced by the sustainability plan which is reported locally, regionally and nationally.

Three-year delivery plan for maternity and neonatal services

This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.

For the next three years, services are asked to concentrate on four themes:

1. Listening to and working with women and families, with compassion
2. Growing, retaining, and supporting our workforce

3. Developing and sustaining a culture of safety, learning, and support
4. Standards and structures that underpin safer, more personalised, and more equitable care.

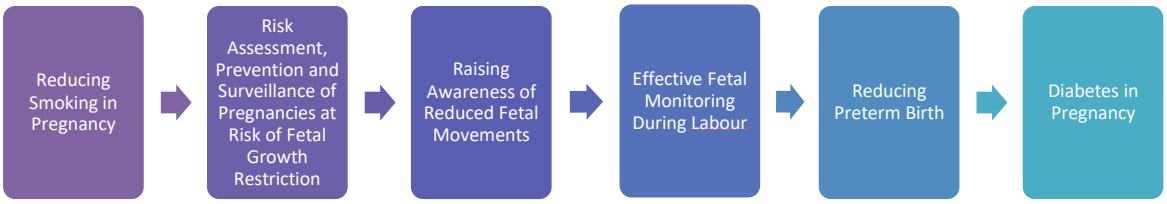
Delivering this plan will continue to require the dedication of everyone working in NHS maternity and neonatal services in England who are working tirelessly to support women and families and improve care. The plan was published at the end of March 2023.

As of September 2024, PAHT maternity services are compliant with 36/46 recommendations of the Three-Year Delivery Plan. The maternity team are currently working towards compliance with the remaining 10 actions.

Out of the 10 open actions, they all remain on target and are due to be completed by the end of 2026. This is evidenced by the sustainability plan which is reported locally, regionally and nationally.

Saving Babies Lives Care Bundle v3

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



For MIS year 6 an assessment is currently underway to review current compliance with each element. It is predicted that the service will be compliant by the submission date in March 2025. The service met with partners from the local maternity and neonatal system (LMNS) on 17 September 2024 to benchmark our current compliance. This will be shared at Quality Safety Committee.

Maternity Self-Assessment Tool

The National Maternity Self- Assessment Tool provides support to all trusts seeking to improve their maternity service rating from 'requires improvement' to 'good', as well as a supporting tool to support trusts looking to benchmark their services against national standards and best practice guidance.

Action Outstanding	Progress
All actions have been completed. There is a sustainability plan in place to continue to monitor compliance. This also forms part of the evidence that has been submitted to NHS England as part of the Maternity Services Support Programme exit plan.	
0/185 actions remain open	

Complaints/PALS

Table 12. Current open complaints/PALs and Service User Feedback

Complaints	Pals	Compliments
July 0 **August 2** **September 2**	**July 7** **August 6** **September 6**	**July 0** **August 0** **September 0**
Themes		
Deep dive presented to Patient Experience Group and leading cause for complaint is poor pain control and communication.		
Service User Feedback		
No formal feedback recorded through Patient Experience Team for Q2.		

4.0 Oversight

All highlighted concerns have been escalated at Divisional board. All incidents are discussed at the Divisional Patient Safety and Quality Group and Trust Incident Management Group and escalated where relevant for further investigation.

The service are continuing to work towards the requirements of MIS Year 6, SBLCBv3, Three Year Delivery Plan for Maternity and Neonatal Services 2023 and the Ockenden IEA. Escalation will occur through board where non-compliance is anticipated or found to occur.

Work is ongoing to strengthen the governance and assurance processes within Division. There are some key roles within the structure that are awaiting appointments:

Lead Midwife for Patient Safety and Quality currently on maternity leave - role currently going through the recruitment process, appointed awaiting start date.

Lead Midwife for Quality and Compliance on Maternity leave - role currently going through the recruitment process, now being undertaken as a developmental role.

Governance Consultant has stepped down from the role. Awaiting a replacement, expression of interest has been received.

Pending recruitment process, potential for significant gaps in the Governance Structure with only the Head of Maternity Governance and Assurance in post.

The Princess Alexandra Hospital NHS Trust

5.0 Recommendation

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

Author: Erin Walters – Head of Maternity Governance and Assurance
Date: 18.11.2024

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 December 2024

Agenda item:	4.2
Presented by:	Linda Machakaire – Director of Midwifery, Gynaecology and Assistant Chief Nurse
Prepared by:	Linda Machakaire
Date prepared:	15 November 2024
Subject / title:	Midwifery and Maternity Support Worker Staffing – 6-Month Report

Purpose:	Approval		Decision		Information	X	Assurance	X

Key issues: please don't expand this cell; additional information should be included in the main body of the report	• Funded establishment (Midwife to Birth Ration of 1:23) will be met with current job offers bringing vacancies to 'zero' • Temporary staffing usage under control • Training and staff development offers are robust and based on need, including for maternity support workers • 3-yearly workforce review underway • Sustainability of specialist roles under consideration with the workforce review; may require some investment
Recommendation:	For the Board to accept the report as a current reflection of maternity staffing, and support the ongoing efforts to provide an adaptable workforce that is adequately resourced and trained to deliver a high-quality service.

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:	QSCII June 2024
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme Year 6. NHSE Core Competency Framework 2023 Safe Midwifery Staffing for Maternity Settings NICE 2015 Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. Safe sustainable and productive staffing Standards for Competence for Registered Midwives NMC 2020 Maternity Workforce Strategy – Transforming the Maternity Workforce – Health Education England, 2019
Appendices:	1. Birthrate Plus® Labour Ward Metrics

The Princess Alexandra Hospital NHS Trust

Purpose

This paper is to give key stakeholders the information and assurance regarding the current position on midwifery and maternity support worker staffing at the Princess Alexandra Hospital NHS Trust (PAHT) as part of a six-monthly review for the purposes of ensuring our maternity service has adequate staffing to provide quality care for mothers and babies, and meeting recommendations from Safe Midwifery Staffing for Maternity Settings (NICE, 2015) and the Maternity Incentive Scheme Year 6 (NHSE, 2024).

It will also provide a forward look at future requirements.

1.0 Current Staffing Levels

Tables 1. and **2**. below outline the current midwifery and maternity support worker staffing levels. The funded establishment was set (and met) against the last workforce review completed in November 2021 by Birthrate Plus®, the maternity workforce planning tool that was developed in collaboration with the Royal College of Midwives.

The maternity service is currently performing a Birthrate Plus® workforce review which is recommended for completion every 3 years. This should be complete in early spring 2025. As at Month 7, the maternity service has offered approximately 16wte to qualifying student midwives which will *completely* eliminate the current vacancies. This has been supported by the Executive Management Team in recognition of the turnover rate, and the importance of maintaining a healthy midwifery pipeline.

Table 1 – Midwifery levels as at Month 7 – October 2024

Banding	Funded	In-post		Variance
Band 5	0.00	27.04		-27.04
Band 6	125.39	88.09		37.30
Band 7	39.98	36.83		3.15
TOTAL	**165.37**	**151.96**		**13.41**

Table 2 – Maternity Support Worker levels as at Month 7 – October 2024

Banding	Funded	In post		Variance
Nurse Band 2	0.00	0.00		0.00
Nurse Band 3	17.38	0.80		16.58
Nurse Band 4	7.19	3.29		3.90
Midwife Band 2	5.19	2.00		3.19
Midwife Band 3	29.86	37.38		-7.52
Midwife Band 4	0.16	0.00		0.16
TOTAL	**59.78**	**43.47**		**16.31**

Maternity Support Workers

Trust-wide, PAHT has invested in Health Care Support Workers, known as Maternity Support Workers (MSWs in this service) to match the national job profiles from Band 2 to Band 3. The last few months have been a period of transition but this has been welcomed as a positive step towards retaining our current workforce and providing a means of career and professional development.

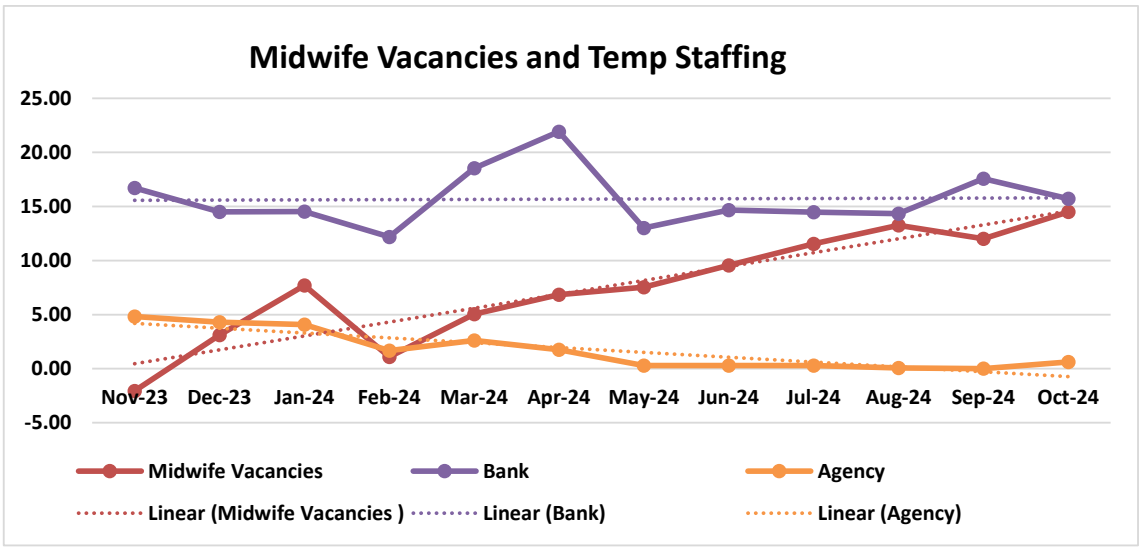
The maternity leadership met with the MSWs to communicate this transition period and co-plan how to enable staff to gain further skills that will facilitate an ability to work in all parts of maternity and contribute towards their overall development. MSWs are able to work in the low-risk pathways within midwifery-led care-environments, and consider apprenticeship route to enter the midwifery register. Current MSW vacancies are being recruited into.

Temporary Staffing

Staffing shortfalls, whether from long or short-term absence, are met via the redeployment of staff, temporary staffing, mainly through Bank, but Agency Midwives on occasion. There are robust systems in place to ensure that staff-planning and addressing shortfalls has senior oversight. Rosters are released 8 weeks in advance whenever possible. Twice weekly meetings review current requirements and provide a lookahead. Any pressure areas are addressed in advance to ensure that the staffing resources available can meet demand.

Image 1. below demonstrates the utilisation of temporary staffing in the last twelve months. Despite increasing vacancies, the maternity service has been able to maintain 'grip and control' over temporary staffing usage.

Image 1: Midwife Bank and agency usage for 12 months



2.0 Workforce assessment

Using the Birthrate Plus® tool, the maternity service is able to make a dynamic assessment of staffing versus workload every 4 hours and thus, when needed, can have a weekly, monthly, or six-monthly overview (**Appendix 1**). The Quality and Safety Committee Part II (maternity focused) receives a monthly overview at each meeting where overall staffing numbers, vacancies, red-flags and temporary staffing are discussed. **Figure A.** in **Appendix 1** demonstrates that the compliance for data completion on Birthrate Plus® for that period was 81.34%. It also highlights the peak times where the entries are *not/* least made which is 14:00 and 18:00.

The funded establishment is determined not only by activity that a maternity service undertakes, but also on its staff being able to take time off (annual leave), have study leave and training, and makes allowances for inevitable sickness absence. This allowance is called “headroom” and is set at 22% for PAHT maternity services, split as below:

- Annual leave – 15%
- Study Leave – 2%
- Sickness Absence – 3%
- Maternity Leave – 2%

With robust workforce planning that utilises all tools available, and a sustained focus on wellbeing and flexibility of work patterns, sickness absence should be kept at a minimum.

Staffing related factors in the past six months are detailed in **Figures B.** and **C**. in **Appendix 1**. The former informs that staffing was matched to workload 63% of the time, and also 2 or more Registered Midwives short 7% of the time. The escalation pathway is utilised flexibly to manage staffing shortfalls through the use of temporary staffing, the redeployment of staff, or the halting of planned activity. This is accomplished and managed daily via a multi-disciplinary approach.

3.0 Training and professional development

Maternity services utilise the NHSE Core Competency Framework (CCF) first introduced in 2020 as part of the Maternity Transformation Programme. The Mandatory Midwifery Training at PAHT is based on this CCF, and the Royal College of Midwives (RCM) guidelines on continuing professional development. The preceptee midwives, and the internationally educated midwives receive more focused and individualised support from the two Preceptee Support Specialist Midwives, the Clinical Support Facilitator, and the Practice Development Midwife. As the Education Team, and under the line-management of the Head of Maternity Governance and Assurance, they are responsible for all the training and support of staff in the clinical areas, conducting simulations, proposing training props, and overseeing the process of continual professional development (CPD) by signposting staff to courses, how to apply, and ensuring the funding is secured.

Currently, the maternity service is supporting three midwives to complete a master's degree line of study, the non-medical prescriber course; two support staff are completing the apprenticeship in midwifery. PAHT maternity is the first in the region to do so.

4.0 Staff Wellbeing and Retention

The staff turnover rate reflected in Table 4. is on average currently 11.2% per month 2024/ 2025, year to date. It has been similar over the past three years (excluding 2022, which saw an increase in staff leaving nursing and midwifery post COVD-19) averaging 11.7% and 10.2% respectively. Understanding why *our* staff leave is and on-going piece of work within maternity and Trust-wide. These include leaving to move back closer to family, and to where accommodation is cheaper.

In the past year, lack of training opportunities has *not* presented as a reason for leaving PAHT maternity services. A comparison with similar units in the region needs to be undertaken to compare turnover rates, and have a deeper understanding of the reasons behind them.

All staff at PAHT are supported via a Staff Health and Wellbeing (SHAW) and the senior leadership ensure they publicise this service at every opportunity e.g. return to work interviews, when staff escalate problems with work/ life harmony or when an incident occurs. A regular message that is reiterated is the presence of (and access to) Freedom to Speak Up Guardian, and/ or Ambassadors.

As part of ongoing support of staff, communication and collaboration, the maternity team hold monthly Maternity Unit Meetings where staff are encouraged to attend an online meeting for the very purpose of receiving important updates, sharing best practice and addressing challenges. This is a well-attended meeting which is recorded enabling those who cannot attend live, to watch at their own convenience.

Currently, staff are in the process of completing the yearly NHS Staff Survey with the division of Child Health and Women's Services at just over 40%. With just a week left at time of paper-submission, the senior team are actively engaging staff to complete the survey.

Table 4 – Midwifery voluntary turnover rates – 6 months

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
10.30%	12.10%	11.46%	12.60%	11.54%	9.84%

5.0 Future Staff Projections

As previously stated, the maternity department is currently undertaking a workforce review by Birthrate Plus® to assess the current workforce requirements using evidence.

The parts of the service that are known to have grown are summarised below:

- The activity through the Maternity Triage has increased significantly in the last year due to a number of reasons which include the change of attendance to Maternity Triage (as opposed to Early Pregnancy Unit and Emergency Department)

- The need for more specialised roles which includes Multiple Births, Maternal Medicine, and Preterm Birth as recommended in the Ockenden Final Report, 2022, the Three year delivery plan for maternity and neonatal services (NHSE, 2023). The maternity leadership has been creative and proactive in trying to meet the demand via external funding, or temporarily moving unused establishment to fund the Perinatal Mortality Review Tool Specialist Midwife role for a fixed-term period, for example. The sustainability of such roles is dependent on maternity being able to build a case for funding to meet the needs of the service and national recommendations.

- The psychosocial support for women/ service users has increased over the last few years which translates as more midwifery time invested. This change in complexities will be evidenced to make a case for change where needed.

6.0 Recommendations

For the Board to accept the report as a current reflection of maternity staffing, and support the ongoing efforts to provide an adaptable workforce that is adequately resourced and trained to deliver a high-quality service.

Author: Linda Machakaire Director of Midwifery, Gynaecology and Assistant Chief Nurse
Date: 15 November 2024

The Princess Alexandra Hospital NHS Trust

Appendix 1 - Birthrate Plus® Labour Ward Metrics

Figure A: Compliance in May – October 2024

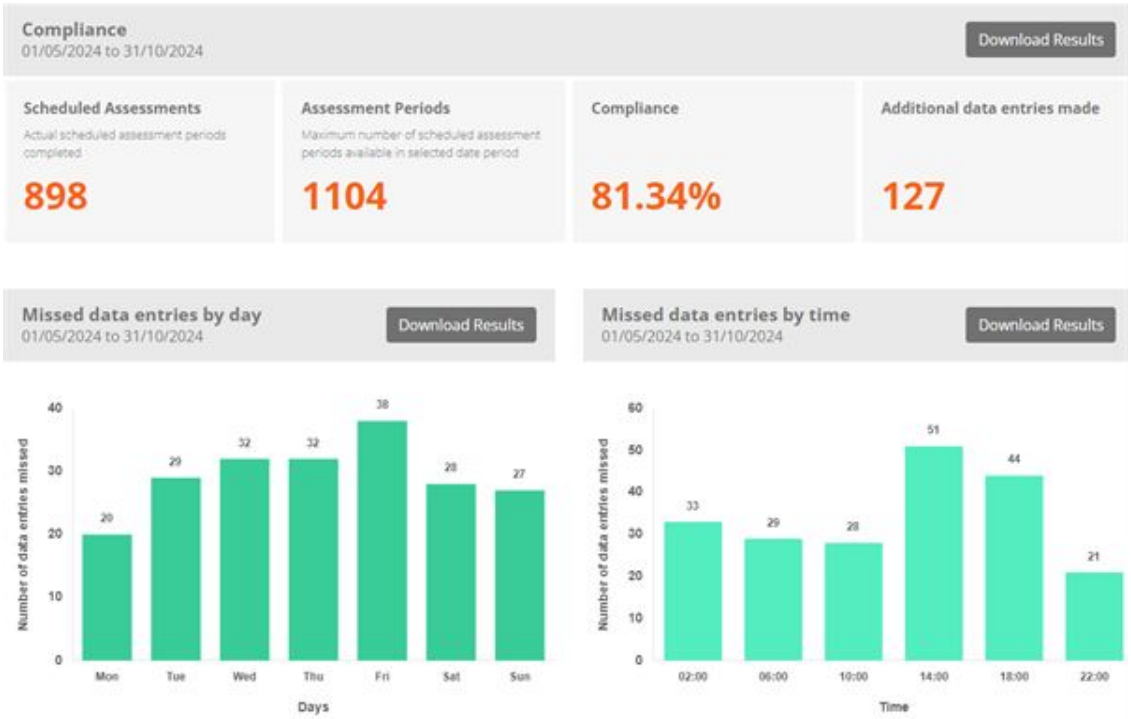
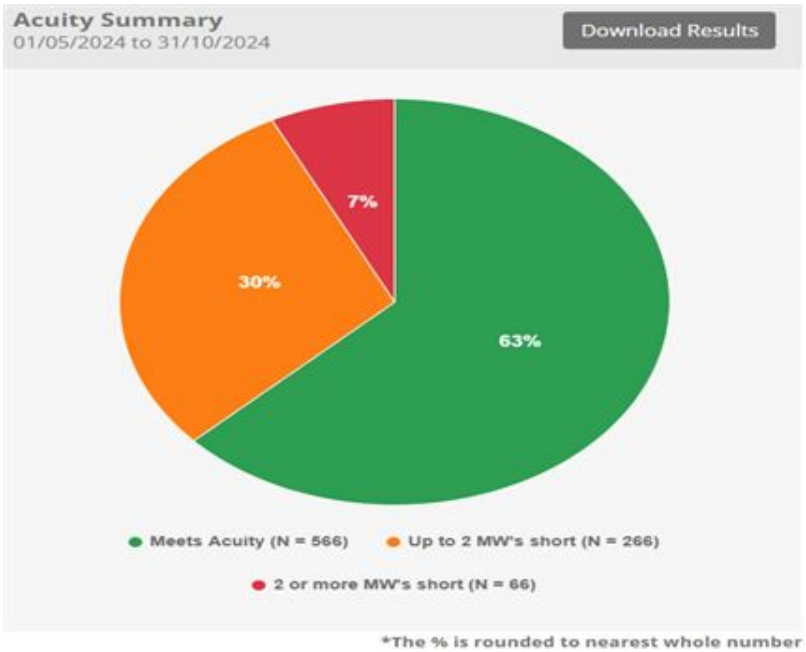


Figure B: Staffing Summary for May – October 2024



modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

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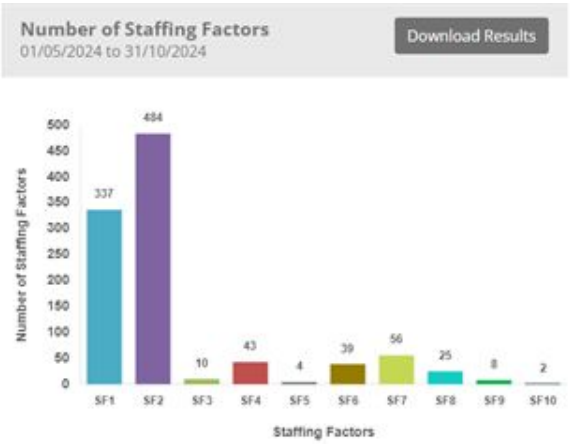
4.2

Figure C: Staffing Factors in May – October 2024

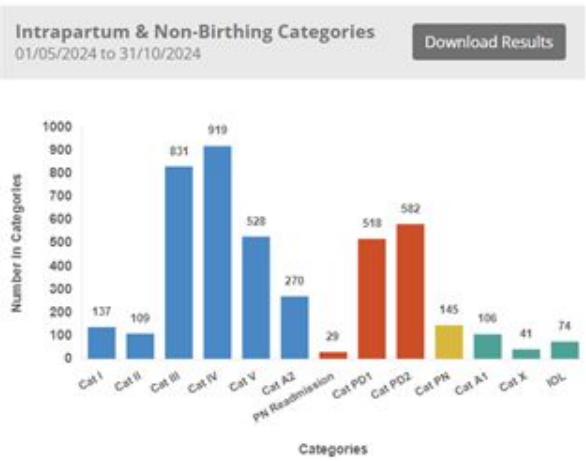


Number of Staffing Factors
01/05/2024 to 31/10/2024 — Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected MW absence/sickness	337	33%
SF2	Unable to fill vacant shifts	484	48%
SF3	Midwife on transfer duties	10	1%
SF4	Midwife redeployed to other area	43	4%
SF5	Nurse redeployed to other area	4	0%
SF6	Support staff less than rostered numbers	39	4%
SF7	MW scrubbed in theatre	56	6%
SF8	Caseload MW present	25	2%
SF9	Caseload MW unavailable	8	1%
SF10	No support staff available	2	0%
TOTAL		1008	

*The % is rounded to nearest whole number

Figure D: Care Categories in May – October 2024



Intrapartum & Non-Birthing Categories
01/05/2024 to 31/10/2024 — Download Results

Categories	Number in Categories	Percentage
Cat I	137	3%
Cat II	109	3%
Cat III	831	19%
Cat IV	919	21%
Cat V	528	12%
Cat A2	270	6%
PN Readmission	29	1%
Cat PD1	518	12%
Cat PD2	582	14%
Cat PN	145	3%
Cat A1	106	2%
Cat X	41	1%
IOL	74	2%
TOTAL	4289	

*The % is rounded to nearest whole number

Trust Board (Public) – 5 December 2024

Agenda item:	4.3
Presented by:	Giuseppe Labriola – Deputy Chief Nurse
Prepared by:	David Dellow – Safe Staffing Lead and Jo Ward – Deputy Chief Nurse
Date prepared:	14.10 2024
Subject / title:	Report on Nursing and Midwifery staff levels for September 2024.

Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	No ward reported average fill rates below 75% for RN's against the standard planned template during the reporting period. Increase in overall fill rates is multifaceted with a combination of enhanced care needs and supernumerary time driving this. The full year establishment review currently underway will provide oversight and recommendations for practice.							
Recommendation:	The committee are asked to note the information within this report.							

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

Previously considered by:	PC.25.11.24
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All divisions have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	**Appendix 1:** Ward and divisional fill rates by month against adjusted standard planned template. RAG rated. **Appendix 2**: Ward and divisional CHPPD data **Appendix 3:** Nursing Red Flags (NICE 2014) **Appendix 4:** Occasions when registered staffing fell below 75% trend **Appendix 5:** Substantive staff redeployment trend **Appendix 6:** Falls SPC charts **Appendix 7:** Pressure Ulcers SPC charts **Appendix 8:** Complaints, PALS and Compliments Trend

1.0 Introduction

This paper illustrates how PAHT's nursing and midwifery staffing has been deployed for the month of September 2024. It evidences how planned staffing has been successfully achieved and how this is supported by nursing and midwifery recruitment and deployment.

2.0 Background

The National Quality Board (NQB 2016) recommend that monthly, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly. This paper will identify safe staffing and actions taken in September 2024. The following sections identify the processes in place to demonstrate that the Trust proactively manages nursing and midwifery staffing to support patient safety.

3.0 Inpatient wards fill rate

The Trust's safer staffing submission has been submitted to NHS Digital for September 2024 within the data submission deadline. Table 1 shows the summary of the overall fill rate for this month. Appendix 1 illustrates a ward-by-ward breakdown for this period. Table 2 shows a summary of overall fill rate percentages for a rolling 12-month period.

John Snow Ward continues to have fluctuating capacity based on activity and has not consistently been sending 1 of the 2 day HCA shifts to NHSP due to this. These continue to impact on the number of HCA shifts being redeployed from the ward during September, both of these factors continue to impact on the HCA fill rate for day and night. As part of the full year establishment review this will be reviewed and a recommendation made based on predicted activity for in-patient elective orthopaedic surgery.

Henry Moore Ward has an increased fill rate due to opening of additional elective surgical beds and a Level 1 area for post-operative patients. This is being reviewed as part of the full year establishment review.

Maternity continue to robustly review staffing through twice weekly staffing reviews and use of Birthrate Plus. Safety is maintained by daily staffing huddles and staff deployment according to acuity, while support is provided by specialist practitioners and Matrons being redeployed as required.

The impact of staffing requirements for patients requiring enhanced care is shown in the number of wards which continue to have greater than 100% fillrate, this is especially demonstrated in wards such as AAU, Charnley and Harvey night fillrate for HCAs. The fillrate is based against the standard ward template.

The full year establishment review will review the continued demand above established templates for enhanced care need and will make a recommendation for how this demand is planned for going forward.

Greater than 100% fill rate for RN shifts is attributable to RMN 1:1 requirement or supporting the induction of newly qualified/registered RNs.

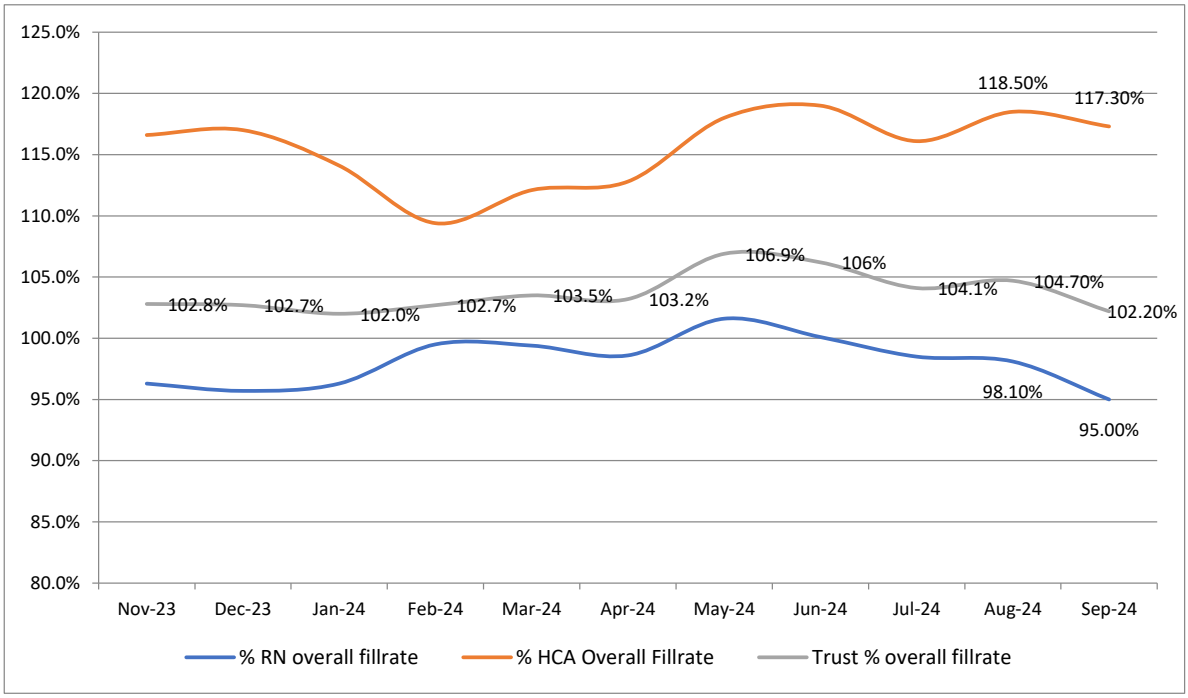
We continue to utilise NHS Professionals (NHSP) and agency to mitigate vacant shifts, though continue to reduce our temporary staffing pools. Enhanced control measures have been put in

place regarding the creation of additional duties. In addition, our senior nurses and midwives are also supporting individual areas if required. SafeCare data continues to be collected three times a day to improve staffing governance across the organisation.

Table 1. Overall fill rate

Average day fill rate - registered nurses/midwives	Average day fill rate - care staff	Average night fill rate - registered nurses/midwives	Average night fill rate - care staff	% Registered overall fill rate	% HCSW overall fill rate	% Overall fill rate
91.6%	110.0%	99.1%	126.3%	95.0%	117.3%	102.2%

Table 2. Inpatient fill rate including Maternity Wards Trend



4.0 Care Hours Per Patient Day (CHPPD)

CHPPD allows comparison of a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals. It can be used to look at variation between similar wards to ensure the right staff are being used in the right way and in the right numbers.

The hours worked during day and night shifts by registered nurses and midwives and healthcare assistants are added together. This figure is then divided by the number of patients at midnight, this then gives the total CHPPD. The number of registered and unregistered hours can be divided by the number of patients to understand the registered and unregistered CHPPD.

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

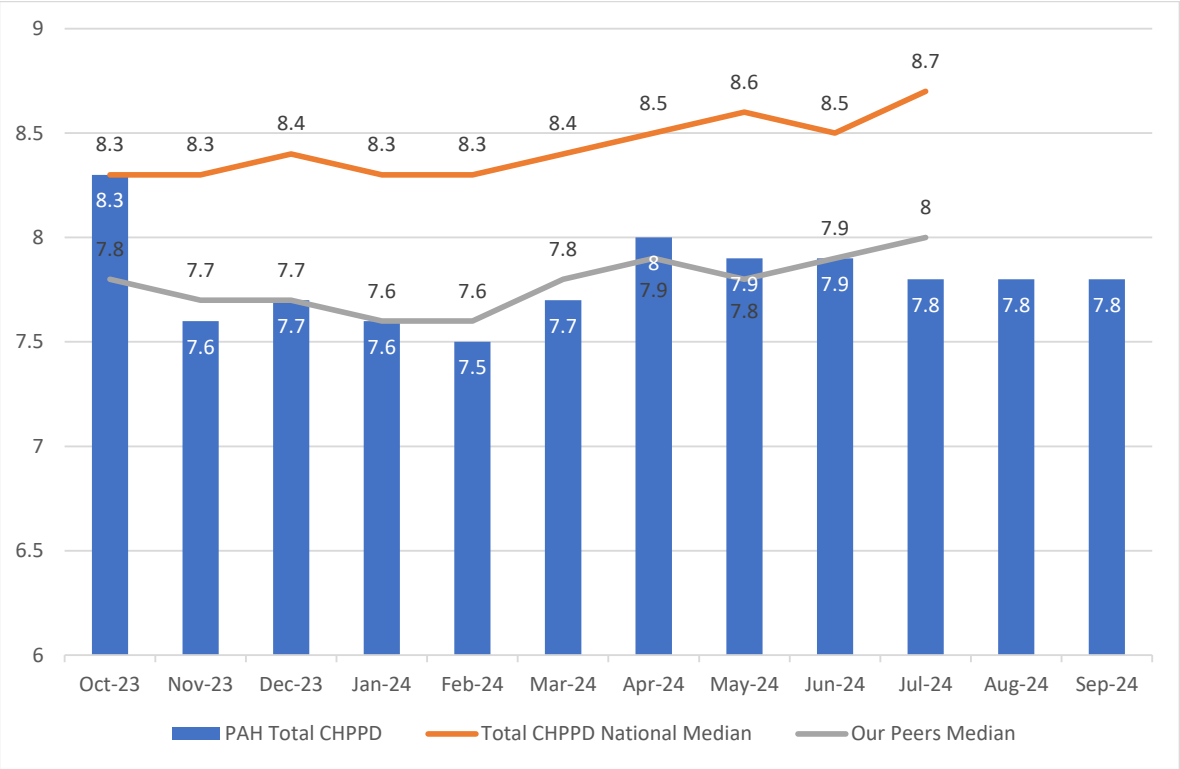
Table 3. Overall Care Hours Per Patient Day (CHPPD) September 2024

Registered CHPPD	Unregistered CHPPD	Total CHPPD
5.0	2.9	7.8

The Model Hospital data for July 2024 shows the Trust with a CHPPD of 7.8 against the national median of 8.7**.** Table 4 also now shows the Trusts total CHPPD against our peers (East and North Hertfordshire NHS Trust and West Hertfordshire Teaching Hospitals NHS Trust)

Appendix 2 shows the individual ward and divisional CHPPD for September 2024

Table 4. CHPPD Trend



5.0 Quality Indicators

5.1 Nursing Red Flags

Nursing red flags prompt an immediate response by the registered nurse in charge of the ward. The response may include allocating additional nursing staff to the ward or other appropriate responses. Appendix 3 details the NICE (2014) definition of Nursing Red Flags. Currently this information cannot be monitored for all nursing red flags on the DATIX incident reporting system. Following a meeting on the 4th September chaired by the Deputy Chief Nurse (Interim) to discuss capturing Red Flags going forward it was decided that, due to the current configuration of SafeCare and the implementation of Alex Health we will delay introducing a new process to support additional oversight of Red Flags until Alex Health has been implemented.

In the interim a trial of using SafeCare to capture Red Flags has started on Winter Ward to support an informed decision about how the process will work following the launch of Alex Health.

This report already captures staffing of less than 75% and less than 2 RNs on a shift.

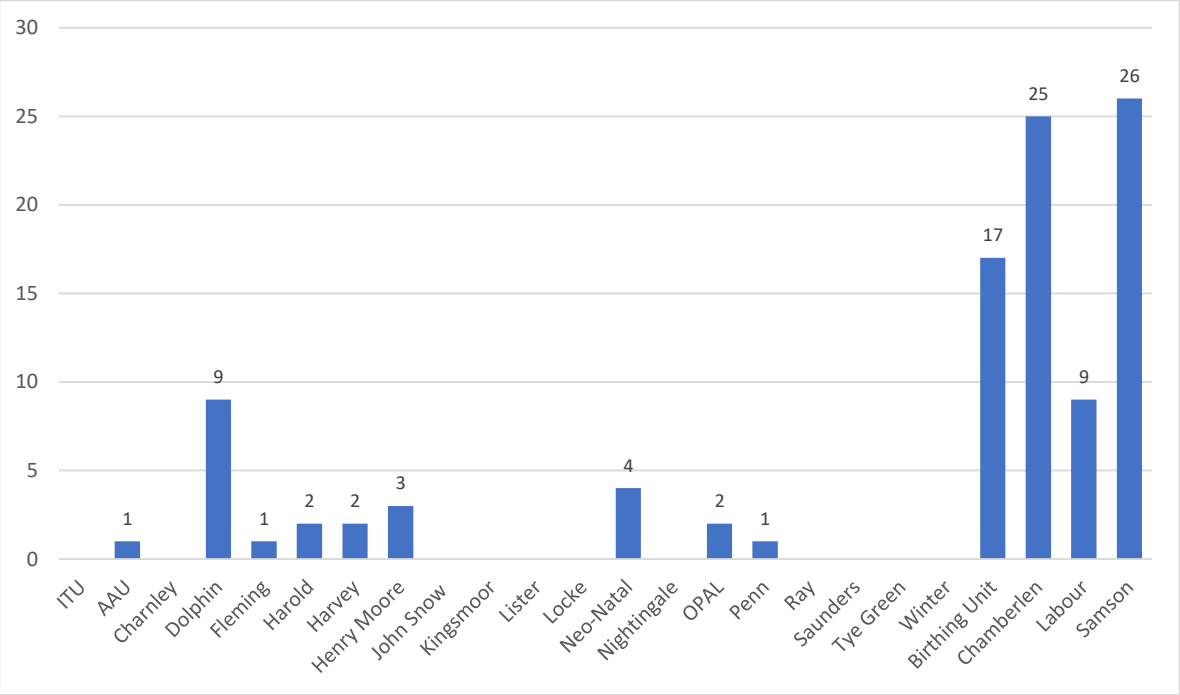
The Trust has a robust Red Flag three times daily staffing review process where issues are raised, discussed and escalated.

A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available, compared with the actual requirement for the shift is a nursing red flag.

The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards is available in Table 5. This increased by 16 occasions in September to 118. The majority of this was in Maternity which rose from 77 in August to 88 in September.

Appendix 4 details the staffing red flags trend.

Table 5. Occasions when registered staffing fell below 75% of standard template



5.2 Falls

Table 6. Number of falls, unwitnessed falls and falls with harm in September, with the top 3 wards being highlighted

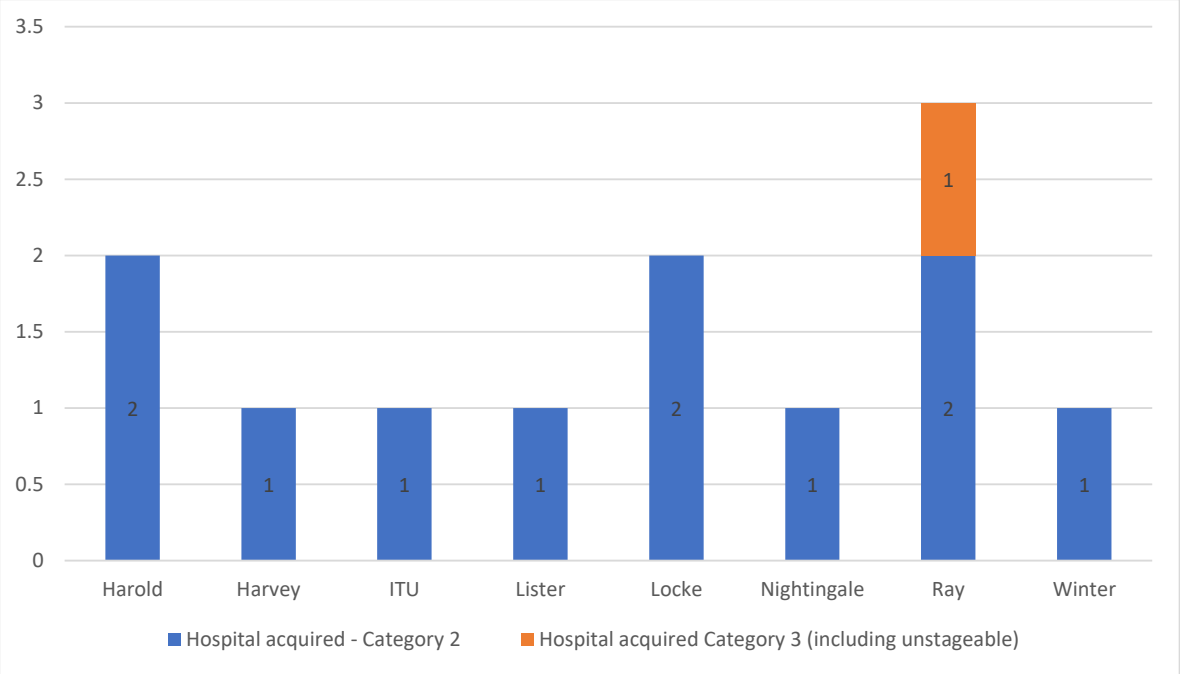
	Total falls in month	Top 3 wards		
Total falls	82	Winter 13	Lister 8	Kingsmoor & Tye Green 7
Unwitnessed falls	61	Winter 9	Tye Green 7	Lister 6
Falls with harm *	18	A&E & Harold 3	AAU, Fleming, Lister & Locke 2	

**subject to change following review at Falls Incident Oversight Group*

The Trust falls reduction strategy and workplan (2024/2025) remains in place and mandatory falls training has increased to 94%.

5.3 Pressure Ulcers

Table 7. Number of Hospital Acquired Pressure Ulcers (HAPU) Cat 2 and Cat 3 Pressure Ulcers (including unstageable)



In September there was a significant decrease in HAPU, with 12 HAPU's in September compared to 26 last month.

This month, the highest number of HAPUs developed on Ray (3) followed by Harold and Locke with 2 each.

September started a tissue viability initiative whereby newly identified hospital acquired vulnerable skin is assessed by the pressure ulcer prevention practitioner ensuring appropriate care is in place and providing on the spot prevention teaching for staff.

The tissue viability's main focus remains around teaching staff about the new pressure ulcer risk assessment tool 'Purpose T' which will be implemented with AlexHealth and continuing to highlight the importance of pressure ulcer prevention.

5.4 Complaints, PALS and Compliments

Table 8. Number of new Complaints, PALS and Compliments in September with top three wards highlighted

	Total in month	Top 3 wards		
New complaints	21	A&E 5	Harvey 3	ADU and Labour 2
PALs	64	A&E 21	Lister, Paeds ED and Ray 5	
Compliments	0			

The 3 main PALS themes for September were:

- Delay – 36.85%, Communication – 25.14%, Cancellations - 8.25%

Complaints themes for September were as follows

- Medical Care - 19.81% Nursing Care – 16.98% and Communication and Delays both 15.09%

Appendix 8 shows the trend for complaints, PALs and compliments.

Datix reports in relation to lack of suitability trained / skilled staff was 43 for September, with Tye Green raising 7 and Ray and Winter Wards raising 4 each.

6.0 Redeployment

Redeployment of staff continues to be undertaken to support safe staffing as part of the daily staffing huddles. Table 10 details the trend in September with ITU redeploying the highest number of substantive staff with Tye Green being the next highest. The highest net receiver of staff was Henry Moore followed by A&E and Penn Ward. Appendix 5 demonstrates the number of substantive staff redeployments per month trend.

Table 10. Hours of substantive staff redeployed September 2024

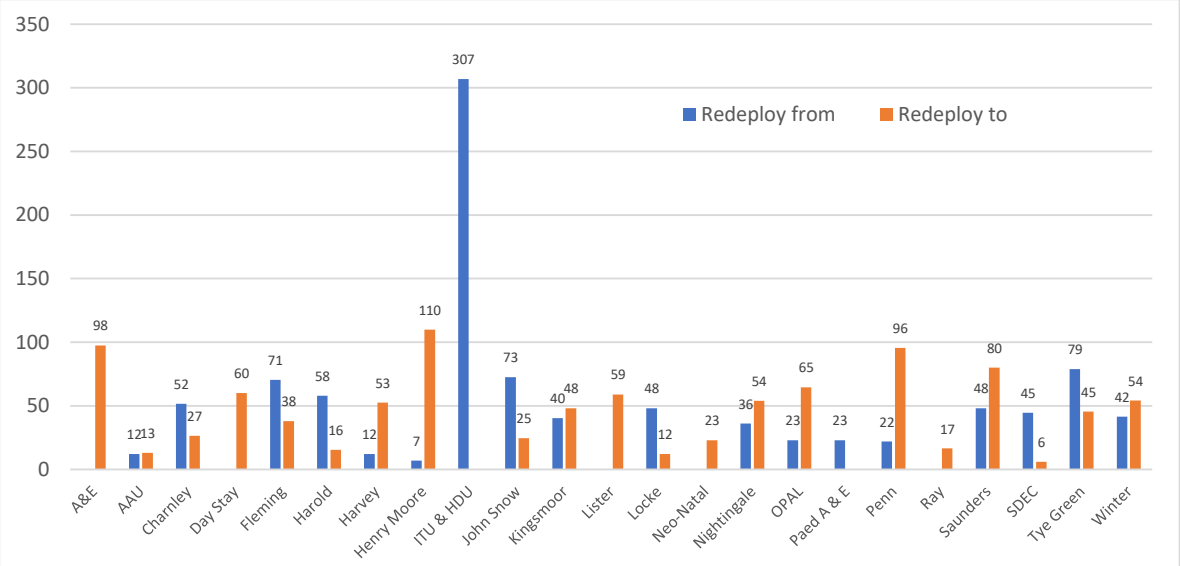


Table 11 shows the hours of substantive staff moved as a percentage of total hours worked.

Table 12 shows the hours of all staff including bank and agency, excluding the Enhanced Care Team, Bank Pool and Rapid Response Pool staff.

Table 11. % of substantive staff redeployed as % of total hours worked

Substantive staff hours redeployed	Total hours worked (inc bank and agency)	% of total hours worked / substantive staff redeployed
995	134996	0.7%

Table 12. % of staff redeployed as % of total hours worked

All staff hours redeployed (including bank and agency but excluding Enhanced Care Team, Bank Pool and Rapid Response Pool)	Total hours worked (inc bank and agency)	% of total hours worked / staff redeployed (including bank and agency but excluding Enhanced Care Team, Bank Pool and Rapid Response Pool)
2225	134996	1.64%

The data detailing nurse redeployment indicates that the numbers of staff reassigned are minimal and continues to not be a cause of concern. The redeployment process is efficiently managed with improved governance and oversight.

7.0 Conclusion

This paper will evolve in the future to include the impact of staffing including additional nursing and midwifery sensitive indicators such as compliance with nationally mandated staffing such as CNST provision in midwifery. The paper will also demonstrate initiatives underway to review staffing establishments and activities to ensure nursing and midwifery workforce is deployed in the most cost-efficient way. This is due to be reviewed following the full year establishment review undertaken in October 2024 and maternity workforce review using Birth Rate plus which commenced in October 2024 and due for completion in early 2025.

8.0 Recommendation

The committee are asked to note the information in this report to provide assurance on the daily mitigation of nursing and midwifery staffing.

Appendix 1: Ward level data: fill rates September 2024. *(Adjusted Standard Planned Ward Demand)*

>100%	95 – 100%	75-95%	<75%

	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 (%)**	**% Registered overall fill rate**	**% HCSW overall fill rate**	**% Overall fill rate**
Harvey	**83.7%**	**162.0%**	**100.5%**	**163.1%**	**90.6%**	**162.6%**	**116.6%**
Henry Moore	**118.0%**	**140.2%**	**147.1%**	**152.5%**	**129.6%**	**146.1%**	**136.8%**
ITU & HDU	**87.1%**	**74.3%**	**92.4%**	**86.7%**	**89.8%**	**80.5%**	**88.9%**
John Snow	**104.0%**	**53.9%**	**100.0%**	**54.6%**	**102.1%**	**54.1%**	**81.3%**
Penn	**106.8%**	**106.6%**	**116.7%**	**136.3%**	**111.0%**	**117.9%**	**113.5%**
Saunders	**91.5%**	**105.6%**	**120.4%**	**126.7%**	**102.3%**	**113.6%**	**106.6%**
Surgery Total	***95.3%***	***109.6%***	***106.3%***	***129.7%***	***100.2%***	***117.9%***	***105.5%***
Fleming	**86.0%**	**96.6%**	**100.0%**	**108.1%**	**91.9%**	**102.1%**	**95.0%**
Harold	**92.1%**	**96.2%**	**100.8%**	**110.0%**	**95.9%**	**102.8%**	**98.1%**
Kingsmoor	**93.1%**	**125.0%**	**117.8%**	**137.2%**	**102.5%**	**130.9%**	**113.1%**
Lister	**94.2%**	**131.3%**	**98.3%**	**136.4%**	**96.0%**	**133.7%**	**111.0%**
Locke	**94.7%**	**123.1%**	**102.5%**	**136.4%**	**98.0%**	**129.4%**	**110.5%**
Nightingale	**112.5%**	**84.5%**	**105.0%**	**193.3%**	**108.9%**	**118.7%**	**113.1%**
Opal	**99.9%**	**113.9%**	**99.9%**	**119.5%**	**99.9%**	**116.6%**	**106.6%**
Ray	**92.5%**	**105.7%**	**100.9%**	**166.3%**	**96.0%**	**128.7%**	**107.7%**
Tye Green	**89.9%**	**95.0%**	**99.5%**	**115.8%**	**94.0%**	**103.5%**	**97.7%**
Winter	**93.5%**	**136.2%**	**100.9%**	**127.3%**	**96.6%**	**131.9%**	**110.7%**
Medicine Total	***93.3%***	***111.5%***	***102.3%***	***130.8%***	***97.2%***	***120.2%***	***105.8%***

AAU	88.3%	143.1%	103.9%	151.0%	95.3%	146.9%	106.1%
Charnley	93.0%	147.2%	99.4%	157.5%	96.1%	152.1%	112.1%
UEC Total	***90.1%***	***145.2%***	***102.0%***	***154.2%***	***95.6%***	***149.5%***	***108.6%***
Birthing	90.8%	74.7%	74.4%	87.0%	82.9%	80.6%	82.1%
Chamberlen	80.2%	86.9%	75.3%	93.0%	77.8%	89.9%	80.8%
Dolphin	79.6%	66.7%	86.5%	94.3%	82.6%	75.9%	81.0%
Labour	92.5%	87.1%	88.4%	100.0%	90.5%	93.3%	91.1%
Neo-Natal Unit	84.5%	100.0%	88.3%	87.0%	86.4%	93.5%	87.6%
Samson	76.6%	115.7%	85.6%	107.4%	80.9%	111.8%	96.3%
CHAWS Total	***84.8%***	***91.8%***	***84.9%***	***98.1%***	***84.9%***	***94.7%***	***87.6%***
Total	91.6%	110.0%	99.1%	126.3%	95.0%	117.3%	102.2%

Appendix 2: Ward level data: CHPPD September 2024.

Care Hours Per Patient Day (CHPPD)			
Ward	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total	**5.0**	**2.9**	**7.8**
Harvey Ward	3.7	4.2	7.9
Henry Moore Ward	4.4	3.5	7.9
ITU & HDU	28.0	3.2	31.2
John Snow Ward	6.8	2.8	9.5
Penn Ward	3.9	2.9	6.8
Saunders Unit	3.9	2.7	6.5
Surgery Total	***6.1***	***3.2***	***9.3***
Fleming Ward	3.7	2.0	5.7
Harold Ward	4.6	2.3	6.9
Kingsmoor General	4.1	2.8	6.8
Lister Ward	3.7	3.1	6.8
Locke Ward	3.7	2.9	6.6
Nightingale Ward	3.3	2.6	5.9
Opal Unit	4.5	3.5	8.0
Ray Ward	3.9	3.1	7.0
Tye Green Ward	4.3	3.2	7.4
Winter Ward	4.3	3.2	7.5
Medicine Total	***4.0***	***2.8***	***6.9***
AAU	6.5	2.5	9.0
Charnley Ward	4.6	2.7	7.3
UEC Total	***5.5***	***2.6***	***8.1***
Birthing Unit	17.2	10.1	27.2
Chamberlen Ward	4.9	1.8	6.7
Dolphin Ward	8.9	2.7	11.6
Labour Ward	12.8	3.3	16.1
Neo-Natal Unit	7.5	1.6	9.2
Samson Ward	1.9	2.5	4.4
CHAWS Total	***6.2***	***2.6***	***8.8***

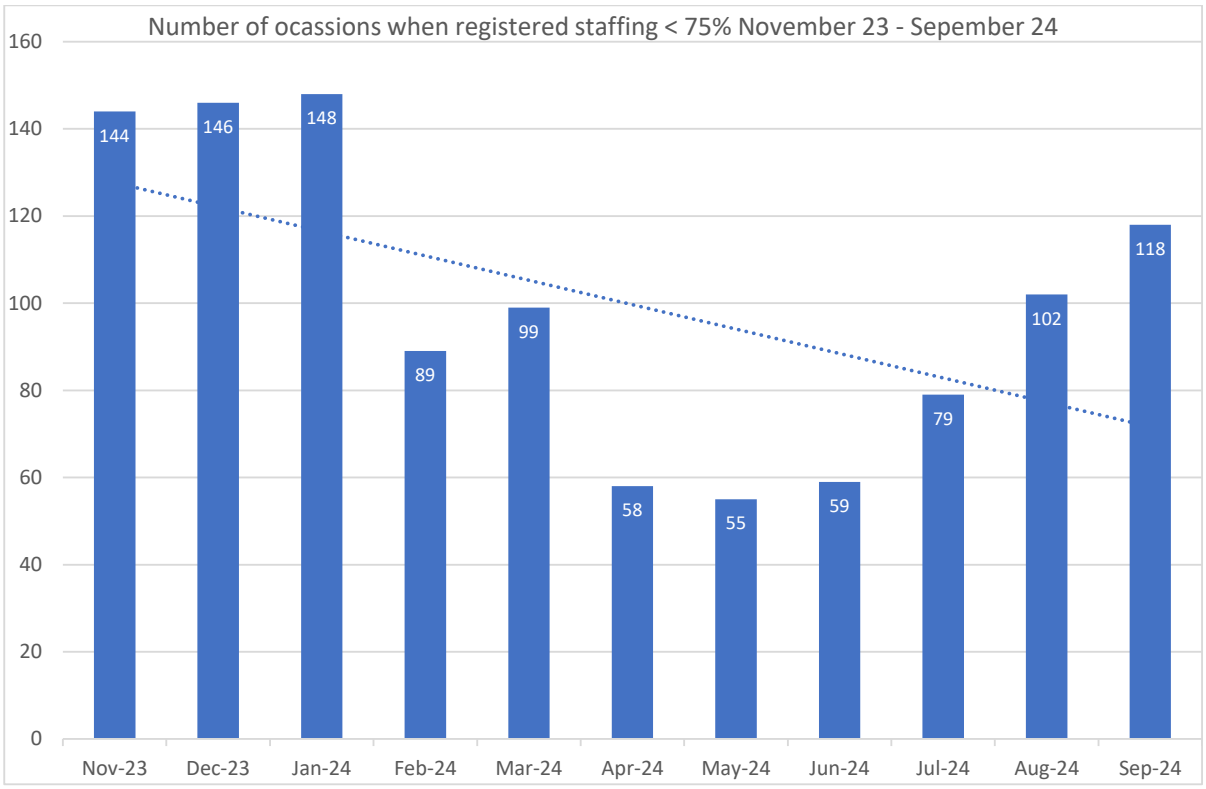
Appendix 3. Nursing Red Flags (NICE 2014)

Box 2: Nursing red flags

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
  - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
  - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
  - Placement: making sure that the items a patient needs are within easy reach.
  - Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Less than 2 registered nurses present on a ward during any shift.

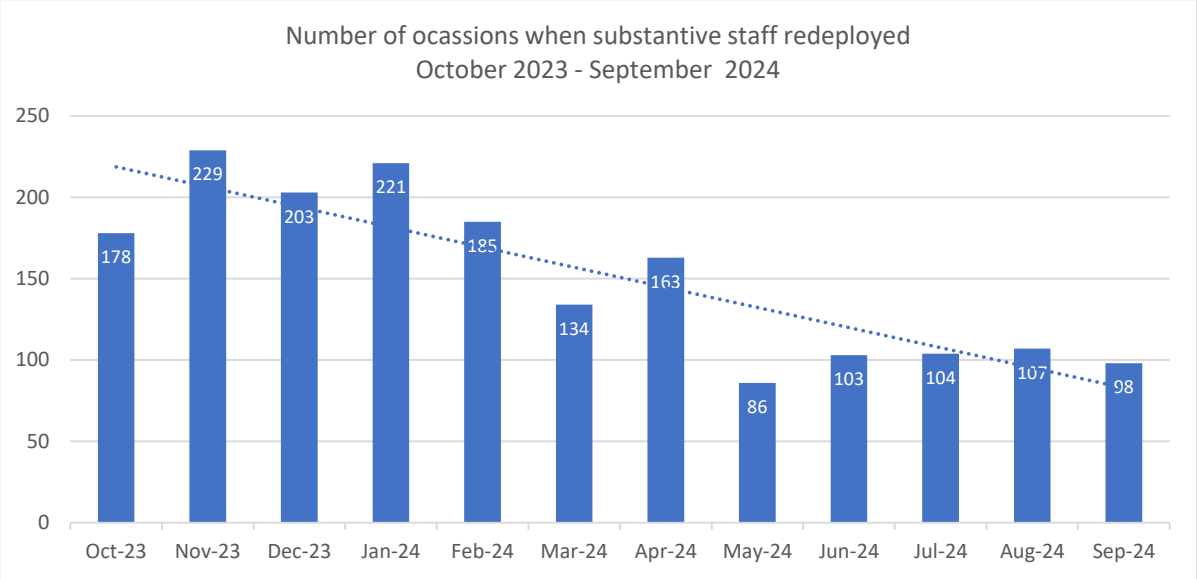
Note: other red flag events may be agreed locally.

Appendix 4: Staffing Red Flags Trend Data

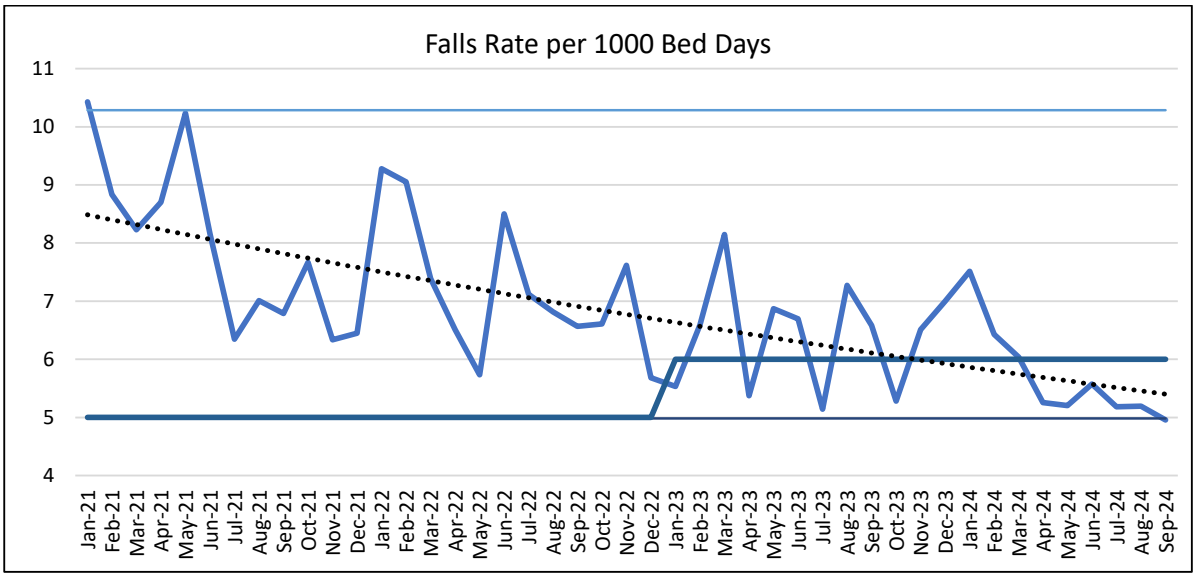


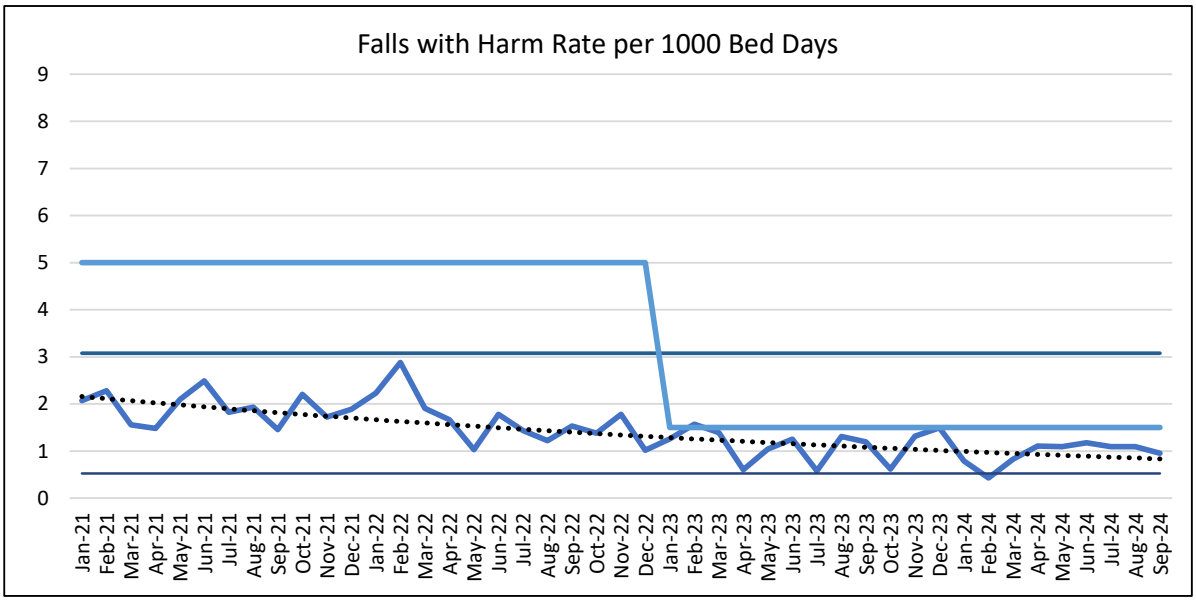
Appendix 5: Substantive staff redeployment trend

This reports looks at the number of shifts substantive staff working a shift are redployed, it does not include the shifts when agency, bank or multi post holders are redeployed.

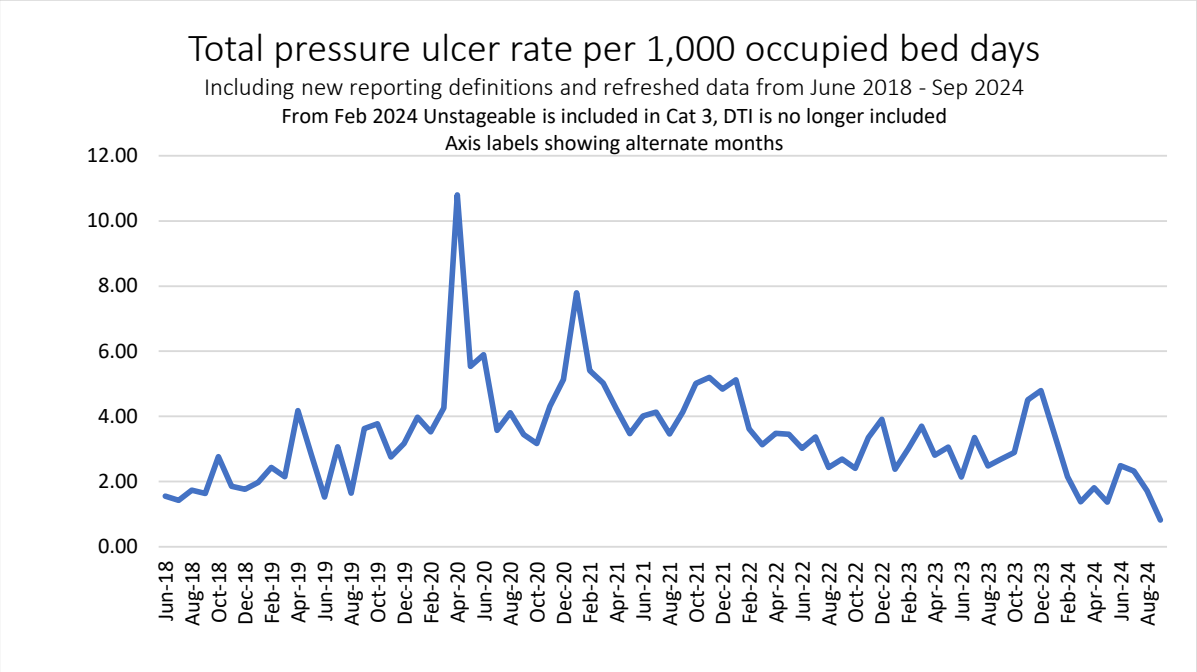


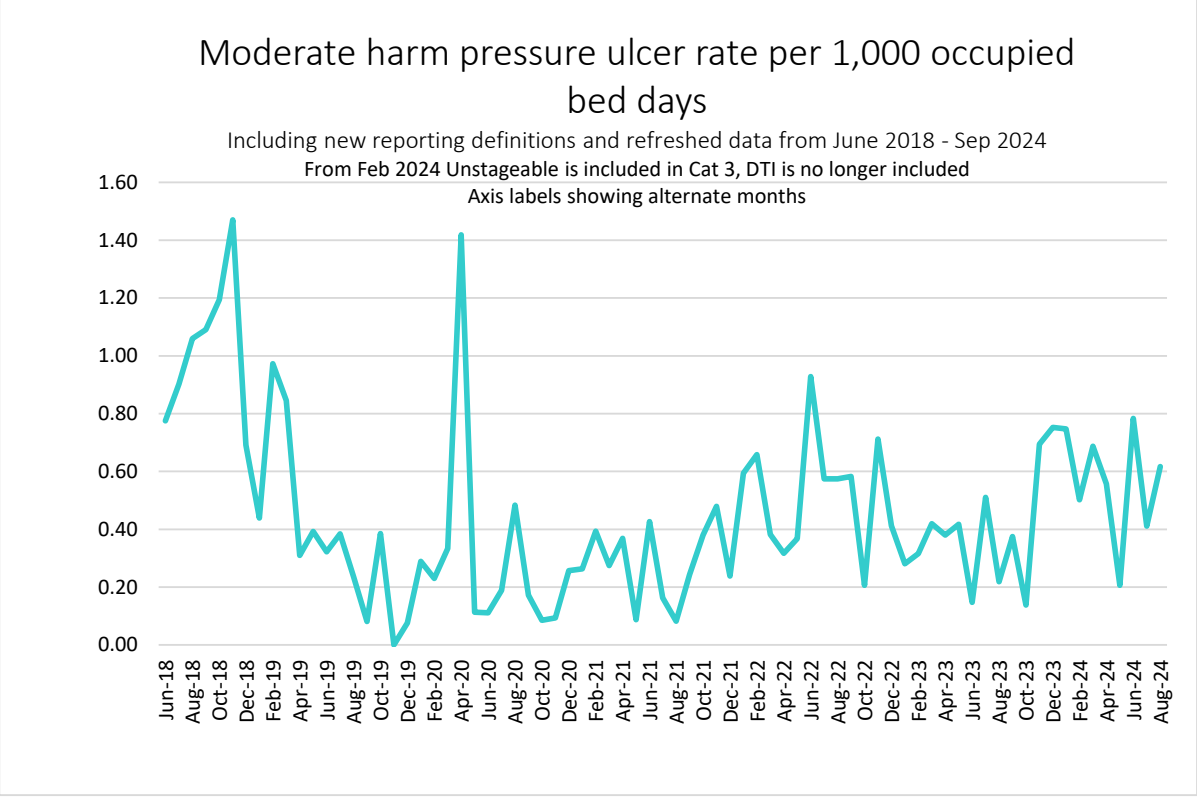
Appendix 6: Falls Rate per 1000 bed days



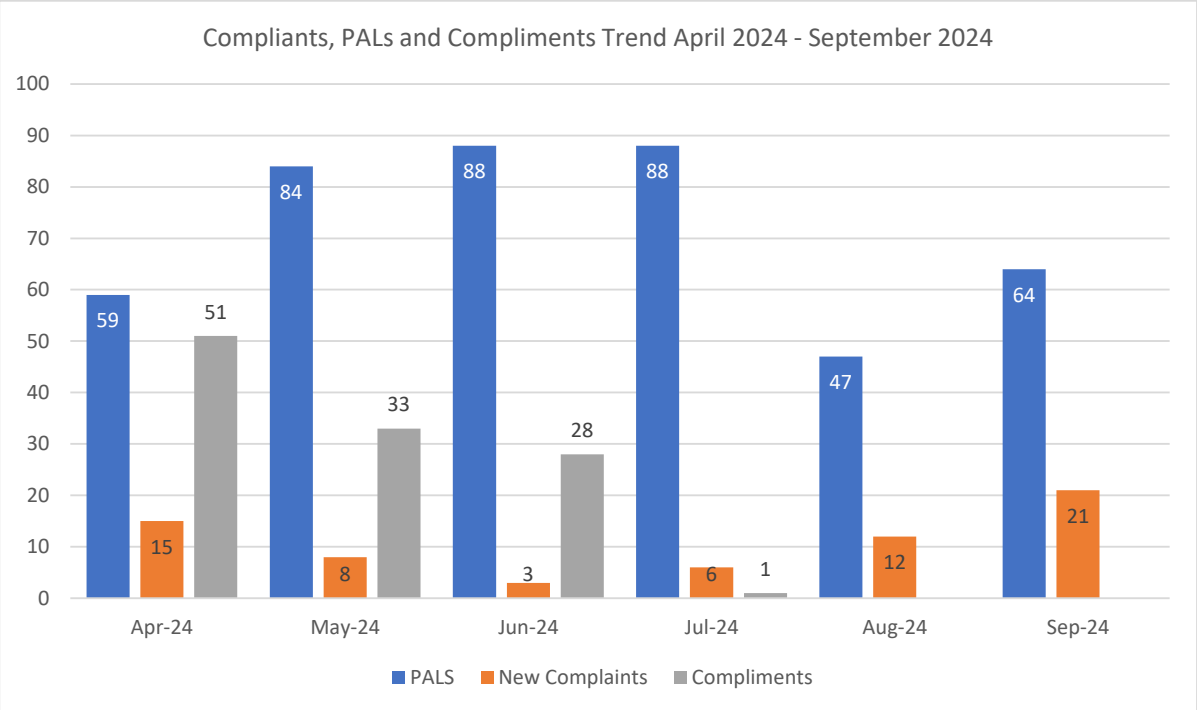


Appendix 7: Total Pressure Ulcer Rate per 1000 bed days and Moderate Harm Pressure Ulcer Rate per 1000 bed days trend.





Appendix 8: Complaints, PALS and Compliments Trend Data



The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 December 2024

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:	20th November 2024
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. The strategic learning from deaths group was stood down for November 2024 hence abbreviated content
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 / QSC.29.11.24
Risk / links with the BAF:	BAF 1.1 Variation in outcomes resulting in poor clinical quality, safety and patient experience.
Legislation, regulatory, equality, diversity and dignity implications:	*'Learning from Deaths'* - National Quality Board, March 2017 *This paper has been written with due consideration to equality, diversity and inclusion in respect of our patients, people and potential providers.*
Appendices:	

The Princess Alexandra Hospital NHS Trust

4.4

1.0 Purpose

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

3.1 Background

Telstra provide an in-hospital mortality report for all inpatient admissions. This report covers the 12 month time period Jul 2023 – June 2024.

3.2 Analysis

Hospital standardised mortality ratio (HSMR) overview

Figure 1 – HSMR Monthly Trend Jul 23 - June 24 HSMR for June 24 is 'within expected'

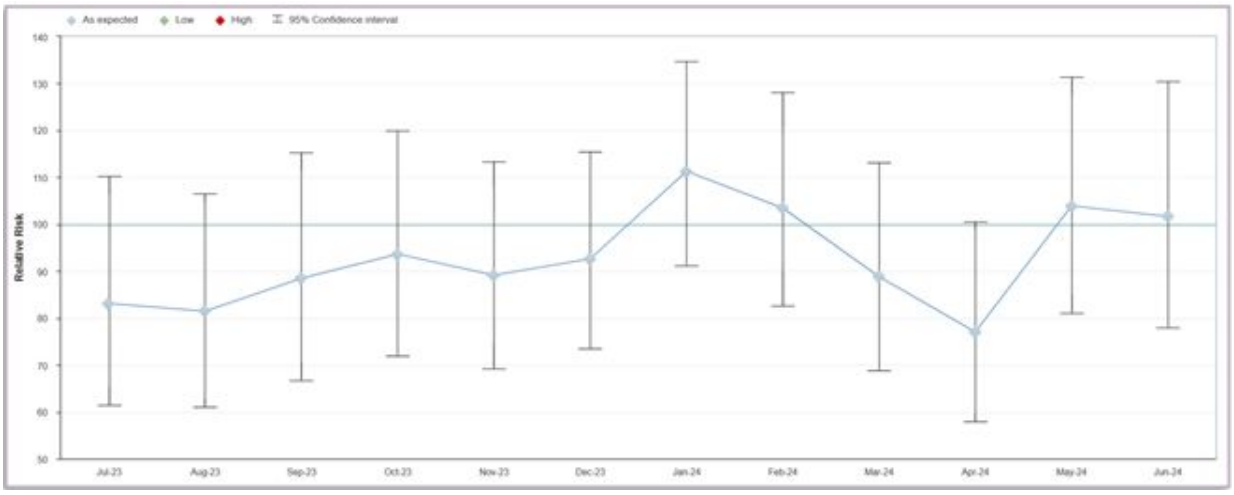


Figure 2 – HSMR 12 month rolling trend Jul 23 – June 24 which is 'within expected'

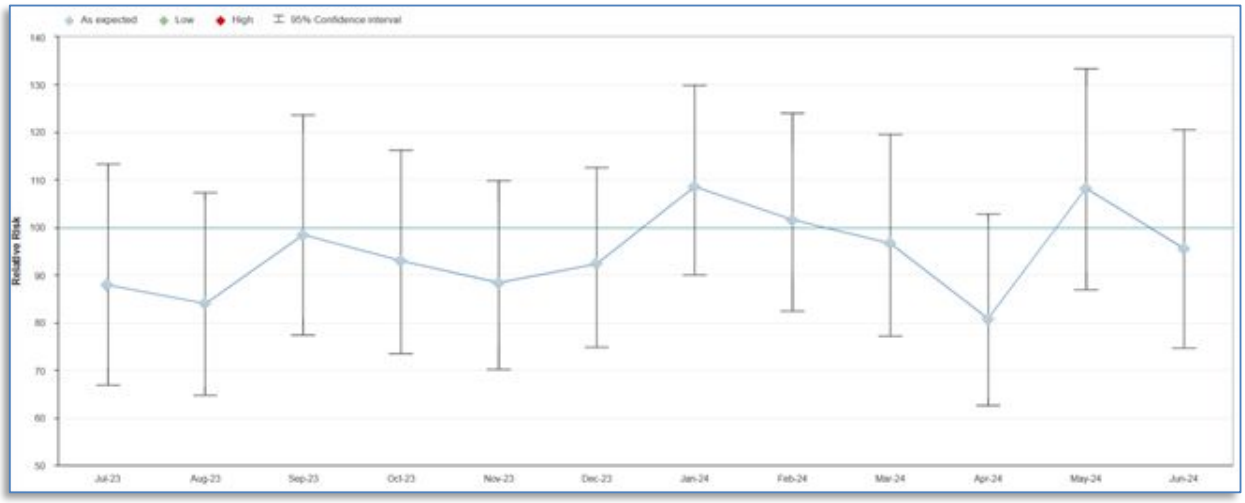


Figure 3 – Expected V's Observed Deaths (Jul-23 to Jun-24)

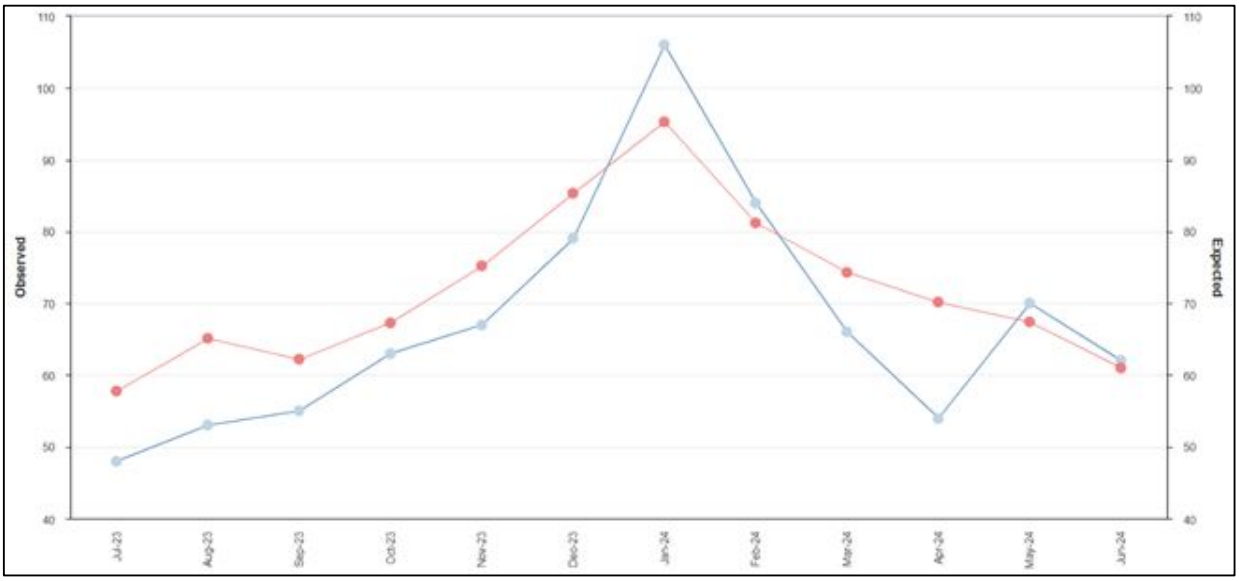
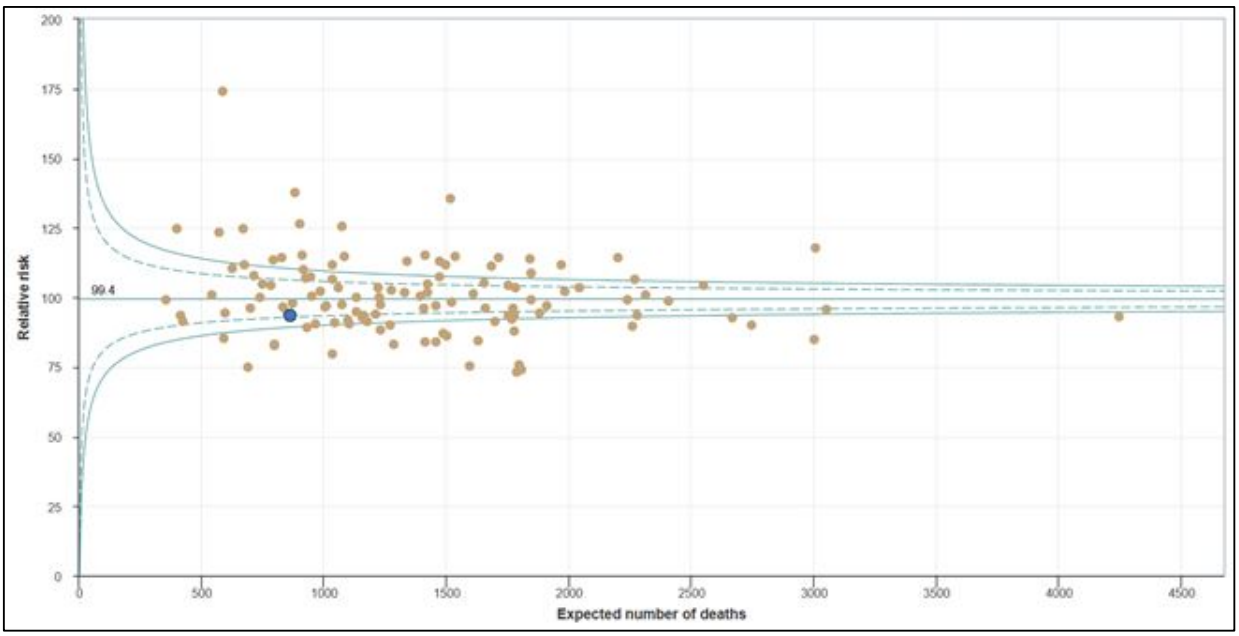


Figure 4 - HSMR 12 Month Peer Comparison: National
(PAH = blue; National acute non-specialists = brown)



The rolling 12 month HSMR (figure 2) for the period Jul-23 to Jun-24 is 93.6 **'within expected'** based on 21, 466 superspells and 788 deaths (crude rate 3.7%).

Standardised Mortality Ratio (SMR) overview

Figure 5 – SMR for June 24 – which is 'within expected'

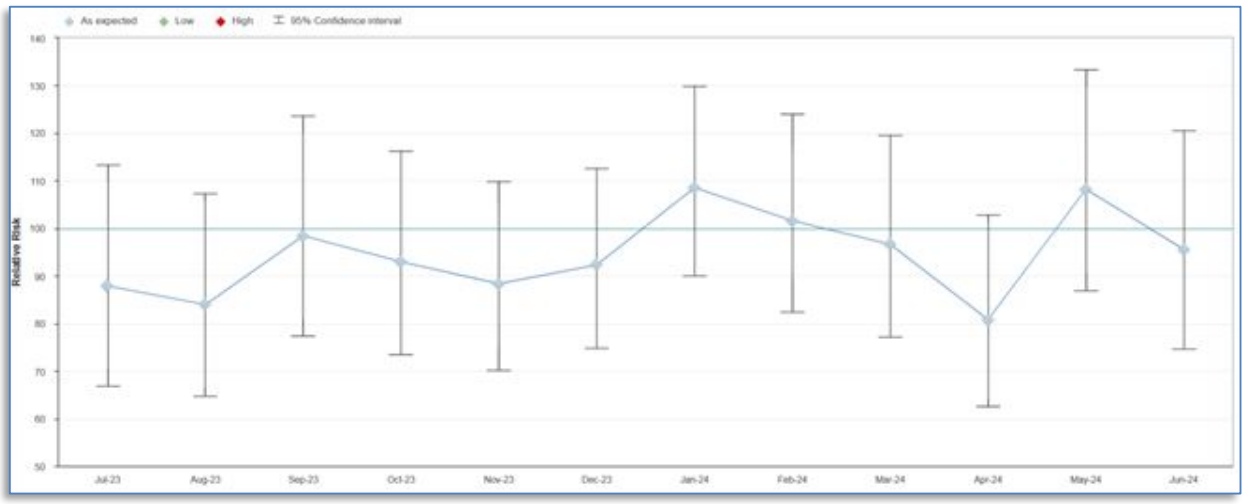
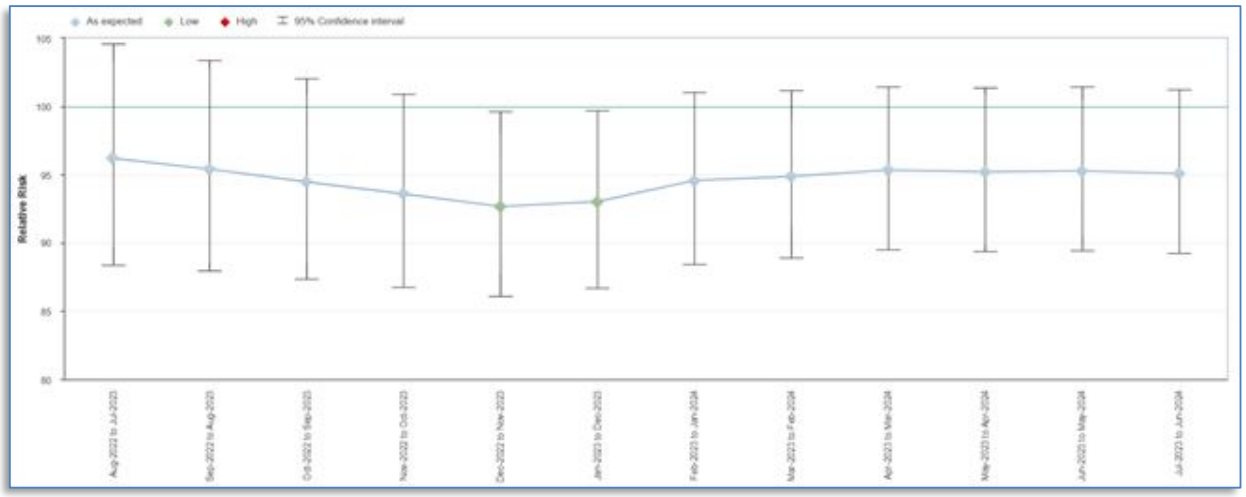


Figure 6 – 12 month rolling SMR Jul 23 – Jun 24 which is 'within expected'



3.3 Summary

Figures 1, 2, 5 and 6 highlight the stability of the trusts HSMR and SMR position, currently sitting as 'within expected'.

Figure 3 details the HSMR observed deaths (blue) vs. expected deaths (red) shows a very similar pattern over the last year; with expected frequently higher than observed deaths.

There is one new outlier to report this month: fluid and electrolyte disorders.
Among a brief investigation into patient deaths where fluid and electrolyte disorders is the primary diagnosis, there is a theme of reporting of multiple admissions among older patients with multiple comorbidities and frailty recorded. These cases will be reviewed as part of the clinical coding audit and reported directly to the Strategic Learning from Deaths Group. (SLFDG)

4.0 Mortality Programme Updates

There were no programme updates due to the SLFDG not meeting during the reporting month.

5.0 Learning from deaths process update

5.1 Mortality Narrative

- There were 91 deaths in October 2024.
- 8 cases referred for SJR's
- There are 133 outstanding SJRs (over 6 weeks of the patients' death).
- This continues to be a significant improvement for the Medicine Division who have worked very hard on the backlog as well as new SJR's.
- The Urgent and Emergency Care Directorate have been consistently on track with completion of SJR's.
- There has been no improvement within the Surgical and Critical Care Division and their SJR's continue to increase month on month. This is being escalated to the divisional review meeting November 2024.
- The Divisonal Directors for each Division receive a monthly report with the breakdown of outstanding SJR's.

5.2 Deaths Investigated Under the Patient Safety Incident Response Framework

Figure 5 – Avoidable Deaths (June 2024)

Surgical Division:
• Complications with surgery. SJR completed. Pending investigation and second review panel.

Medical Division:

- Nil

5.3 Cases for the second review panel

- Surgical division - A round table meeting has been held and awaiting a meeting date to discuss the case at second review panel.

5.4 Themes and Issues Identified from Reviews and Investigation

- Nil

5.5 Actions Taken in Response to Avoidable Deaths

- Nil

6.0 Medical Examiner (ME) Headlines

6.1 Scrutiny Update

100% were scrutinised by 7 Medical Examiners.
21 cases were referred to the Coroner:

Post-mortems were requested for the following:

- Unclear Cause of Death x 7
- Safeguarding: neglect x 1

There were no independent post-mortems.

There were 4 inquests.

National MCCDs issued within 72 hours: (National Target)
Unfortunately, due to staffing pressures information regarding attainment of National target is unavailable. We are unable to report how many certificates failed to be issued within 72 hours due to delays in doctors attending to complete the paperwork. New Medical Examiner Officers are starting in December.

6.2 Ongoing Developments

- SMART (mortality database) training continues to be provided for new junior doctors across many specialities
- SMART – ongoing work with the team to develop:
    - Dashboard to pull off issues raised for Nurse review
    - An 'actions' section to be included in Administrative form for M&M meetings
    - Allow SJRs to be linked to the Administrative form on SMART
- New working group started with Quality First to make better use of data collated in SMART since launch at the trust.
- #NoF learning from deaths to now be shared at care of the elderly M&M meetings as an aggregated presentation every quarter.

7.0 Risks

The risk in relation to issues with the #NoF pathway was removed from the 'learning from deaths' risk register and suggested placement on Medicine risk register. The mortality data does not show that there is a risk in relation to mortality for patients attending with femoral fractures, however there are still delays in the pathway, breeching national targets.

8.0 Recommendation

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

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 December 2024

Agenda item:	4.5							
Presented by:	Phil Holland – CIO and Alex Health SRO							
Prepared by:	Phil Holland – CIO and Alex Health SRO							
Date prepared:	28 November 2024							
Subject / title:	Alex Health (AH) Programme Update							
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 paper provides the monthly update on the programme relating to the cutover from legacy systems, our go live, and early life support following implementation.							
Recommendation:	For information and assurance.							

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:	1.2 EPR and 1.4 EHR
Legislation, regulatory, equality, diversity and dignity implications:	The programme is ensuring that all personal data is protected and processed in accordance with relevant data protection, security, and privacy laws, such as the UK General Data Protection Regulation (UKGDPR) and the Data Protection Act 2018. It will also ensure that patient rights to privacy are respected, and their personal data is used in accordance with their wishes. We are also ensuring that all staff members are treated fairly and equally regardless of their race, gender, religion, disability, or any other protected characteristic. We continue to ensure that the implementation allows for appropriate access for all individuals and ensures necessary dignity and diversity implications are factored into the programme, such as enabling all access through the new patient portal and providing specific training to enable access to our new digital system.
Appendices:	None

Introduction

This paper will outline progress over the last 4 weeks, delivery of cutover and early life support.

Programme Progress

Since the last board meeting significant progress has continued as we tracked to and beyond our go live over the 2/3 and 4 November. This has been due to the delivery of the following:

- Formal national approval for our go live plan
- Programme Board decision to go live
- Completion of the Activate Gateway
- Completion of cutover activities
- 90% of all staff fully trained in Alex Health at go live
- Completion of early life support and move into transition phase

Plans for the next period

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

- Delivery of transition from early life support to stabilisation, as we move responsibilities from the programme into business as usual functions
- Completion of detailed sustainment model
- Ongoing management of key risk and issues that are raised through ongoing post go live governance.

Early Life Support Management

From the commencement of the cutover process on Thursday 31 October, we had a full 24/7 command structure in place, this covered:

- Programme management
- Clinical delivery
- Operational management
- Application service delivery and management
- Communications

The command structure continues to collate, coordinate and manages all risks, issues and wider feedback from within the organisation to ensure we are maintaining clinical and patient safety. This feedback has mainly come from our Navigators, Floorwalkers and through our Service Desk.

Risks Since Go Live

As is expected with any change of this scale, there are areas of the system that are not working as we expected. Our main risks that we are managing on a daily basis are as follows:

- Outpatient clinic set up. A number of appointments have migrated into incorrect clinics and need resolving. The work to make the necessary change is being led by the Programme Director, supported by the Programme's Operational Lead
- Utilisation and familiarisation. We continue to support an amount of our people with understand how Alex Health works. We are doing this through the support of our

training partner. In addition, we are supporting our Navigators to continue to increase their knowledge so the expertise remains within the organisation

- Transition of system support from the Programme to Business As Usual. In this phase there is, on occasion, a lack of clarity as to where the responsibility for task resolution sits on a day to day basis.

Conclusion

The Trust Board is asked to consider and note the content of this report.

Phil Holland
Chief Information Officer and Alex Health SRO

BOARD OF DIRECTORS: Trust Board 5th December 2024 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa Non-Executive Director

DATE OF COMMITTEE MEETING: 25th November 2024

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 Guardian of Safer Working Hours Report	Yes	Yes	No	In the 3 month period July to September 2024, 133 exception reports were received, the majority due to working over hours. 16 immediate patient safety concerns were reported with associated actions taken to address the concerns. This was an exceptionally high number of exception reports over 3 months and was usually seen over a 12 month period. Acute medicine had the most exception reports with 45 reports followed by diabetes and endocrinology with 34 reports and general surgery with 24 reports. Fourteen patient safety issues were raised in Diabetes and Endocrinology related to reports of low staffing levels and high workload.
2.2 GMC Enhanced Monitoring	Yes	Yes	No	Following the visit on the 1st October NHSE had provided a report and improvement plan which had been returned with comments. NHSE's response was awaited, a further update would be brought to the Committee in January.
2.3 BAF Risk 2.1: (GMC enhanced monitoring)	Yes	No	No	The risk score remained unchanged at 20 as monitoring was still in place.
2.4 People Report	Yes	Yes	No	The vacancy rate has decreased to 6.55% and the sickness level was just above target at 4.66% with rolling sickness decreasing to 4.54%. Bank and agency expenditure remained a key focus and on a downward trajectory with only 41WTE over establishment. Diverse representation at senior roles remains at 39.92% (national KPI is 19%), and is

BOARD OF DIRECTORS: Trust Board 5th December 2024 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa Non-Executive Director

DATE OF COMMITTEE MEETING: 25th November 2024

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				at 18.8% excluding all medical, clinical and nursing roles. Flu vaccine uptake was low at 23.65%, efforts continue to promote and improve the take-up rate.
2.5 Learning and OD Update	Yes	Yes	No	Appraisals and statutory and mandatory training compliance were discussed with compliance at 58% and 87% respectively. 350 nominations had been received for the Amazing People Awards. CPD planned spend was under spend for 2023 and this was being reviewed to ensure divisions had submitted all requests. An initiative with the ICB to improve gifting of the apprenticeship levy had been established.
2.6 Update on TiMs	Yes	Yes	No	The Committee was assured that the learning management system was fit for purpose and compliance data is accurate. The recruitment of a substantive learning platform manager was required to support the ongoing management of the system.
2.7 Appraisal Deep Dive	Yes	Yes	No	• It was confirmed that the learning management system was recording appraisal data correctly. Non-compliance was due to either not completing appraisal conversations, or not completing the MS form after conversations had occurred. • A structural review of the appraisals process will take place, as this is one of the key NHSE KPIs. The following urgent actions will take place to address non-compliance:

BOARD OF DIRECTORS: Trust Board 5th December 2024 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa Non-Executive Director

DATE OF COMMITTEE MEETING: 25th November 2024

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				• A review of the banding window • Simplify the digital appraisal workflow • Provide reports by staff group as well as division • Continue the appraisal workshops and one to one support • Continue to raise awareness of the need to complete the MS form
2.8 Staff Survey	Yes	Yes	No	Current response rate (as of the 22/11/24) was 42.36%. The feedback to action programme would continue this year.
2.9 EDI Delivery Plan	Yes	Yes	No	The report outlined the Equality, Diversity & Inclusion (EDI) reports to be delivered for 2024 to 2025. The Committee agreed the monitoring and accountability of the EDI Delivery Plan 2024 - 2025. This will be achieved through the EDI Steering Group Chair, providing quarterly progress updates to the Committee. The EDI Steering Group Terms of Reference were approved.
2.10 Freedom to Speak Up Report	Yes	Yes	No	The report highlighted themes of concerns raised in quarters 1 & 2 with behaviours still the highest referral reason. All polices that relate to staff being able to speak up and raise concerns are being reviewed and going forward there will be one overarching policy. An updated draft report for this will be shared in due course, and is on the Board agenda.
2.11 Safer Nurse Staffing Report	Yes	No	No	The overall fill rate remained stable. No ward reported average fill rates below 75% for RN's against the standard planned template during the reporting period. Increase in

BOARD OF DIRECTORS: Trust Board 5th December 2024 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa Non-Executive Director

DATE OF COMMITTEE MEETING: 25th November 2024

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				overall fill rates is multifaceted with a combination of enhanced care needs and supernumerary time was driving this. The full year establishment review was currently underway and will provide oversight and recommendations for practice. The report is on the Board agenda.
2.12 BAF Risk 2.3 Workforce: Inability to recruit, retain and engage our people in certain areas/specialties across the Trust	Yes	No	No	The score was reviewed and remained at 16.
2.13 People Strategy	Yes	Yes	No	The Committee reviewed the draft strategy and a final version would be presented in January for approval. Final sign off would be at Trust Board in February.
2.14 Voluntary Services Report	Yes	No	No	The Committee was assured on the progress against the voluntary service strategy.
2.15 Horizon Scanning	Yes	No	No	The following items were addressed: 1. Sexual misconduct framework 2. Apprenticeships- Skills England is the new arms-length body that will bring together key partners to meet the skills need of the future 3. NHSE's Medical arm are making non-recurrent funding available to take forward specific to workforce development initiatives which will help the NHS to directly support the delivery of the 'Train' and 'Retain' actions from the LED Blueprint for Change.

BOARD OF DIRECTORS: Trust Board 5th December 2024 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee

REPORT FROM: Committee Chair – Darshana Bawa Non-Executive Director

DATE OF COMMITTEE MEETING: 25th November 2024

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
3.1 Communications Update	Yes	No	No	An update on the activity of the Communications team was noted including; 1. Final procurement stage for new website 2. The transition from X to Threads and a targeted content engagement plan for LinkedIn

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 5 December 2024

5.2

Agenda item:	5.2								
Presented by:	Giovanna Leeks - CPO								
Prepared by:	Lindsay Hanmore – Lead Freedom to Speak Up Guardian								
Date prepared:	October 2024								
Subject / title:	Freedom to Speak up Report								
Purpose:	**Approval**		**Decision**		**Information**		**Assurance**		
Key issues:	The purpose of this paper is to update and provide analysis on the Trust's freedom to speak up (FTSU) data. It will highlight themes of concerns raised in Quarters 1 & 2 2024-25, actions being taken to address concerns and what actions are being taken to raise awareness of speaking up. It also briefly highlight next steps in terms of FTSU review								
Recommendation:	For noting of concerns raised Q1 & Q2 and actions taken on the concerns raised.								
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**				
	√	√							

Previously considered by:	Staff Health and Well Being Group LMT People Committee 25.11.24 JSCC
Risk / links with the BAF:	2.3 Inability to recruit
Legislation, regulatory, equality, diversity and dignity implications:	Freedom to speak up principles are contained with the NHS Contract
Appendices:	n/a

The Princess Alexandra Hospital NHS Trust

5.2

1.0 Purpose/issue

The purpose of this paper is to update and provide analysis on the Trust's freedom to speak up data. It will highlight themes of concerns raised in Quarters 1 & 2 2024-25, actions being taken to address concerns and what actions are being taken to raise awareness of speaking up.

2.0 Background

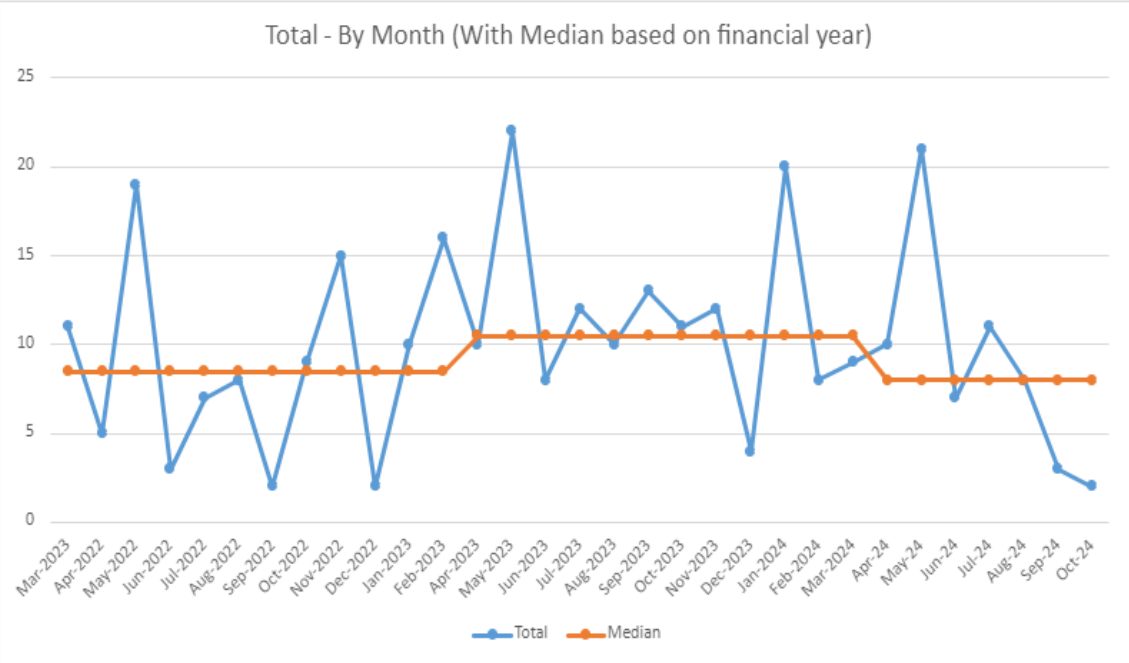
Freedom to speak up principles are contained with the NHS Contract. Good "speak up" cultures are linked with improved patient safety and quality, higher staff well being and retention with lower levels of dissatisfaction. Since the trial of an anonymous feedback form there will be some data that is captured under the "unknown" category.

3.0 Data and analysis

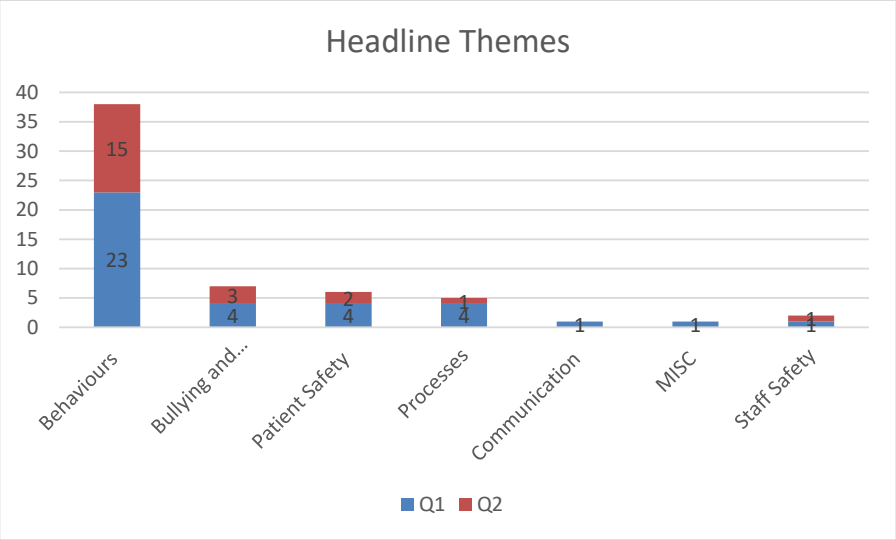
3.1 Number of referrals

From the data presented below we can clearly see that the period between April 2023 and march 2024 provided us with a higher than average concerns being raised at PAH. From April 2024 our median has gone back to pre-April 2023.

We are currently undergoing a review of this data to understand the reasons for the decrease and will bring this back to People Committee on our next report.



3.2 Breakdown of referral themes for Q.1&2 2024-25

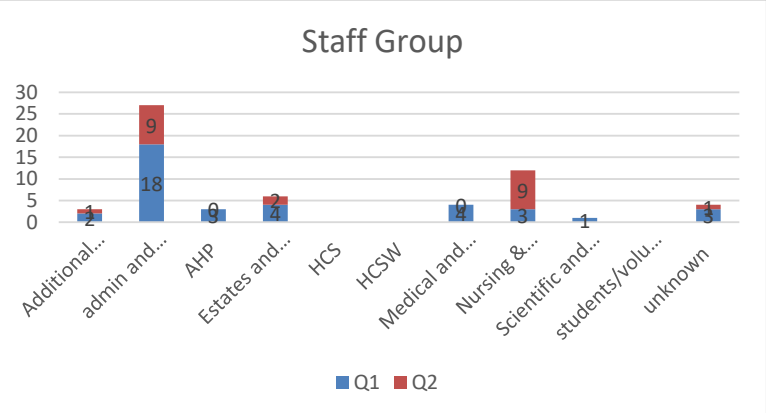


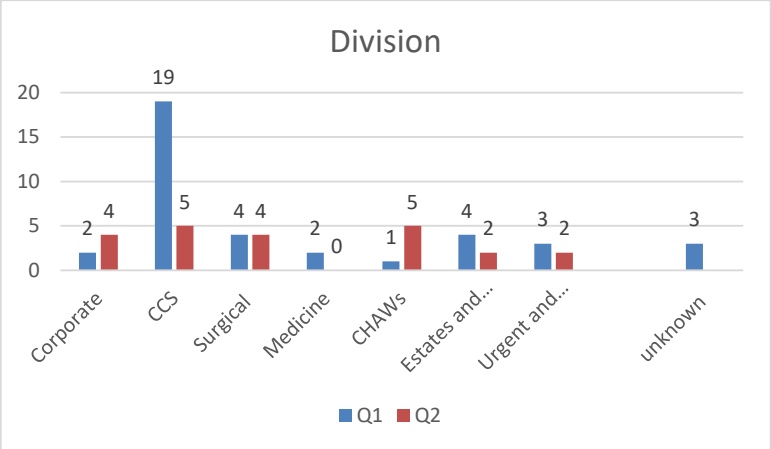
Behaviours remains the highest referral reason and this is separate from bully and harassment. Poor behaviours include how they are made to feel by a colleague, another member of staff or their line manager. This is usually related to poor interactions. These are often resolved through local resolution, mediation and very occasionally referral to the people team for a formal grievance to be raised.

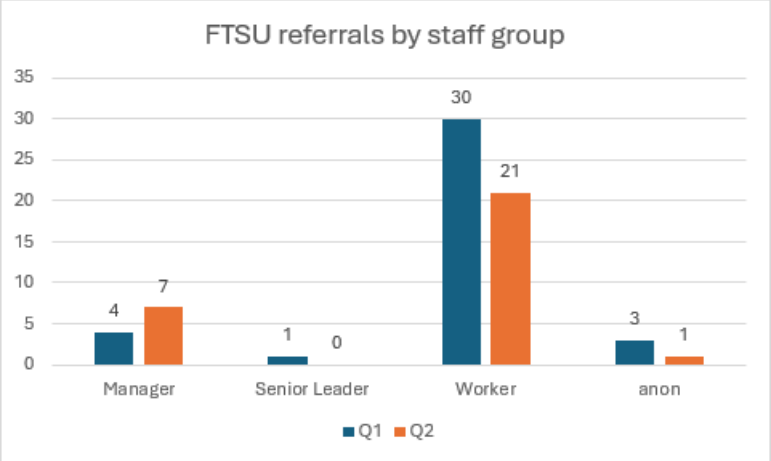
Any staff or patient safety issues are always escalated to appropriate division to action and are resolved by implementing actions recommended from investigations and improved communications between teams.

All concerns raised are followed up to ensure the referrer is comfortable to close the referral once actions have been completed. This is then recorded by the guardian as closed on the database with the actions taken.

3.3 Referrers







Some divisions do have a small number of referrals from their staff. It is difficult to know if this is because there is a good speaking culture within their divisions or if staff do not feel comfortable to speak up. When this paper is shared with the Triumvirates, the senior teams within each Division are asked to consider this and to reach out to the guardians for any support they may need to raise the profile of speaking up.

To date no further support has been escalated by the senior leadership with the guardians.

3.4 Referrer Feedback from previous year

The guardians reach out quarterly to gain feedback from anyone who has made a referral. The numbers of responses vary but when received are generally very positive. Of the 8 feedback forms received for Q1 it was all positive feedback. This included the easiness of contacting a guardian and also how people were reporting improvements in their own health and well-being following discussions with a guardian.

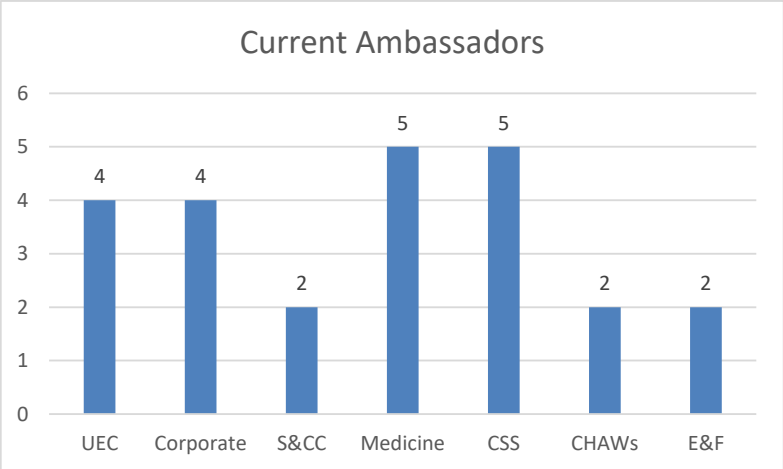
4.0 Actions

4.1 Freedom to Speak up Ambassadors

We have trained a total of 27 ambassadors, three have left the Trust and another is on maternity leave. For those 23 remaining, they are from a wide range of ethnic and professional backgrounds. There is a split of ambassadors from the Divisions and this information is shared with the Divisions to support the update for future cohorts to ensure equity of support. However, ambassadors can support and signpost any member of staff. However people from the same area of work or Division tend to use a local ambassador in the first instance.

All the ambassadors are allocated one of the guardians as a supervisor but they have been informed that they can speak to any of the guardians for advice and support. The guardians reach out regularly with the ambassadors they are responsible for and the lead guardian arranges bi monthly group meetings with all the ambassadors to enable them to share their stories confidentially and to discuss and areas of support required.

We have further training planned at the end of November and hope to receive requests from staff from all the Divisions.



4.2 Anonymous feedback

We continue to facilitate anonymous feedback as it gives further confidence on staff to raise concerns, make them feel safer and overall shows to our staff that we care about everyone's safety and wellbeing.

This anonymous format was introduced internally to ensure those staff who did not feel comfortable to speak to a guardian directly could raise their concerns. We may also receive concerns raised externally, i.e. regulators, which are also considered as anonymous concerns.

On concerns raised internaly we report back to the relevant team leaders or Triumvirate, as appropriate, around the concerns raised and we ask for what actions they are taking as relevant so we can assure that the concerns are being dealt with accordingly and report concerns back via reporting as well to the wider trust via meetings and committees.

On concerns raised externally we conduct an independent fact finding and if appropriate we will commission an external independent investigation. All outcomes are then feedback to the external agency.

On some occasions the referrer is requested to remain anonymous, but the guardian is aware of their identity.

4.3 Raising Awareness

The guardians are working closely with the communications team on a comprehensive plan which includes updating Alex.Net, posters, screen savers and information with updated NGO branding, regular updates focusing on outcomes, the guardians and ambassadors.

This work will be done by regular communications in In Touch, with a different focus each week. It will include interviews with guardians, ambassadors and sharing of stories.

The SHAW team are also supporting with the sharing of cards to hand out to staff so they can easily access information on how to contact a guardian - The plan was to launch during Speak up month, October 2024 – however this got slightly pushed back due to capacity from the communications team, who were fully supporting Alex Health to be launched.

The guardians and the ambassadors continue to raise the profile of speaking up and deliver training and drop in sessions across the organisation, including attending meetings where they are tabled and ad hoc ones.

5.0 Considerations

To ensure the Trust continues to develop a safe speaking up culture the guardians and ambassadors support individuals through any referral process ensuring that they are confident there will be no repercussions.

6.0 Recommendation

For the Board to note the concerns raised Q1 & Q2 and actions taken on the concerns raised.

Author: Lindsay Hanmore – Lead Freedom To Speak Up Guardian
Date October 2024

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board – 5 December 2024**	**AGENDA ITEM: 6.2**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**28.11.24**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 M7 Integrated Performance Report (IPR)	Y	Y	N	Key headlines in-month were: **Referral Elective Standards**: 18 week performance had decreased slightly to 47.2%. As at the end of October the Trust had zero 78+ choice breaches and 138 x 65+ week breaches. Work would continue to maintain and improve on this position with a focus also on the next milestone of zero 65+ breaches by 22.12.24. **Cancer:** The 28 day faster diagnosis performance was 78.3% for September with October's unvalidated position at 78.7%. 62 day finalised performance for September was 51.1% against a trajectory of 60%. October's unvalidated performance was currently 52.5%. **Diagnostics:** Diagnostics performed within six weeks of referral had improved slightly in October to 70.16%. MR, CT and flex-sigmoidoscopy achieved 100%. There are current concerns in relation to the demand for echoes, audiology and cystoscopy but with recovery plans in place.

BOARD OF DIRECTORS:	**Trust Board – 5 December 2024**			**AGENDA ITEM: 6.2**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28.11.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.2 Report Against Operating Plan	Y	Y	N	Key headlines were: • Activity levels had seen the continuation of the upward trend in Outpatient first attendances, day cases and elective activity. • 62 day cancer performance: Performance improving and consistently over 50% for the last 5 months. • Diagnostics performed within 6 weeks of referral had improved slightly to 70.16% from 68.27%. MRI, CT and flexi-sigmoidoscopy achieved 100%. Concerns for ongoing demand for echoes, audiology and cystoscopy. • Long waiting elective recovery remained a high priority with a focus on sustaining delivery of zero 78+ week patients (0 for October) and on delivering the next national milestone of zero 65+ week patients by 20/12/24. • Mitigation plans/risk assessments requested to identify the impact of Alex Health deployment on recovery milestones/ASIs. • Urgent Care: Performance continued to be challenged. 56% achieved against the 4-hour standard in October compared to 60.9% in September. PAF noted this significant risk. • The Trust remains in Tier 2 monitoring for cancer/routine elective standards.

BOARD OF DIRECTORS:	**Trust Board – 5 December 2024**			**AGENDA ITEM: 6.2**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28.11.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 BAF Risk 4.1 (Seasonal Pressures)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 12.
2.4 BAF Risk 1.3 (Recovery Programme)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
2.5 BAF Risk 4.2 (ED 4 Hour Standard)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.
2.6 BAF Risk 4.3 (Industrial Action)	Y	Y	N	In line with the recommendation it was agreed this risk would now be closed, subject to any change in position nationally.
2.7 Cyber Security 6 Monthly Update 2.8 Dark Trace 6 Monthly Update	Y	Y	N	The Trust continues to manage its cyber security, the risks that continue to exist/develop, and the mechanisms to support the organisation in protecting its systems and data.

BOARD OF DIRECTORS:	**Trust Board – 5 December 2024**			**AGENDA ITEM: 6.2**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28.11.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.1 M7 Integrated Finance Report	Y	Y	N	The Trust has a surplus plan of £0.1m for M7 and a year-to-date (YTD) deficit plan of £5.4m. In M7, the Trust achieved a surplus of £1.3m, bringing the YTD actual deficit to £5.4m, resulting in no variance to the YTD plan. M7 included backpay for pay awards and additional inflation funding. However, this position includes £3.3m of income not planned for at M7 (system support funding planned for M11) and benefits in month from accruals relating to bank and agency pay awards not required and improved ERF values for Q1. With the system support phased in line with the plan, the Trust would be £3.3m adverse to plan YTD. Capital expenditure is forecast to overspend by £1.5m noting that there are potential movements in the forecast spend and potential for further PDC funding. The Trust is forecasting a deficit currently towards year end but this is being kept under review.
3.2 Income Deep Dive	Y	Y	N	The report provided further in-depth review of the income position at M7 and highlighted the reasons for the £8.8m YTD income overperformance along with Elective Recovery Funding (ERF) performance by specialty and point of delivery. PAF noted the Trust had invested in a Surgical Robot at the end of 2023/24 and the benefit seen in length of stay had been calculated as £316k YTD.

BOARD OF DIRECTORS:	**Trust Board – 5 December 2024**			**AGENDA ITEM: 6.2**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28.11.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.3 Capital Update	Y	Y	N	Trust total funding for 24/25 is £40.1m including £25.8m of external funding for specific projects (i.e. New Hospital, CDC, UEC and EHR). Total capital expenditure YTD is £19.0m made up of £12.0m of actuals and £7.0m of committed expenditure. There is currently an over commitment of c. £2.7m against the Trust's CRL programme, predominantly due to Alex Health pressures (which are to be confirmed), offset by expected delays relating to the power infrastructure which has led to an underspend. Planning for future years was discussed in the meeting; the capital envelope for 2025/26 will be extremely challenging due to pressures arising from the CDC project. A more up to date capital forecast will be reviewed by PAF in December.

BOARD OF DIRECTORS:	**Trust Board – 5 December 2024**	**AGENDA ITEM: 6.2**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**28.11.24**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.4 Quarterly Procurement Update	Y	Y	N	Key headlines were: • Savings forecast for FY24/25 (£975k) maintained above baseline target. • Overall operational performance continued to be strong and Inventory Management System progressing well. • Business Case Inventory Management System at ENHT submitted. • Enhanced partnership with NHS Supply Chain and Contract Management Policy first draft ready for initial review. • New Procurement Act to go-live end February 2025.
3.5 PQP Report	Y	Y	N	(A summarised paper again due to PMO support provided to Alex Health go-live). In September/October, the PQP programme delivered £1,084k in savings for the month, totalling £6,244,967 year-to-date against a target of £10.8m. Despite identifying £12,925,017 in potential savings with plans in place, significant budget overspends in divisions such as Medicine, UEC, and CSS hindered overall progress. Recovery plans have been developed and sessions with divisional teams are planned.
3.6 BAF Risk 5.1 (Finance/Revenue)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.

BOARD OF DIRECTORS:	**Trust Board – 5 December 2024**			**AGENDA ITEM: 6.2**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**28.11.24**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.1 Community Diagnostic Centre	Y	Y	N	PAF approved entering into associated lease agreements. Additional detail on the project would be provided to Trust Board members following a full Executive conversation and prior to its meeting the following week.
4.2 Health & Safety 6 Monthly Update	Y	Y	N	Progress on estates-related issues was acknowledged to be behind trajectory given current workforce issues within the team. There would be better visibility on this area at December's PAF, following a detailed paper due for presentation to the Trust Board the following week.
4.3 BAF Risk 3.1 (Estate & Infrastructure)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.

The Princess Alexandra Hospital NHS Trust

6.2

Agenda item:	6.2								
Presented by:	Tom Burton, DoF								
Prepared by:	Beth Potton, DDoF								
Date prepared:	26 November 2024								
Subject / title:	Month 7 Financial Performance								
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	In M7, the Trust had a surplus plan of £0.1m for Month 7 (M7) and a year-to-date (YTD) deficit plan of £5.4m. In M7, the Trust achieved a surplus of £1.3m, bringing the YTD actual deficit to £5.4m, resulting in no variance to the YTD plan. M7 included backpay for pay awards and additional inflation funding. The income and pay budgets have been updated to reflect these pay awards. However, this position includes £3.3m of income not planned for at M7 (system support funding planned for M11) and benefits in month from accruals relating to bank and agency pay awards not required and improved ERF values for Q1. With the system support phased in line with the plan, the Trust would be £3.3m adverse to plan YTD. Capital expenditure is forecast to overspend by £1.5m noting that there are potential movements in the forecast spend and potential for further PDC funding.								
Recommendation:	The Board is asked to note the month 7 financial result and the high-level forecast outturn position.								
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**				
	X	X	X	X	X				

Previously considered by:	Paper to EMT, Paper to LMT, Paper to PAF
Risk / links with the BAF:	BAF risks 5.1 and 5.2.
Legislation, regulatory, equality, diversity, and dignity implications:	No impact on EDI identified.
Appendices:	See finance report attached

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

Summary finance notes

- In M7, the YTD plan is now a deficit of £5.4m with actuals of £5.4m. The Trust is reporting achievement of the YTD plan. However, this does include £3.3m of system funding not planned for until month 11 (February) and a benefit from the release of a bank and agency pay award accrual. Without these adjustments the position would be £3.5m adverse to plan. See table 1 below.

- The cash position at the end of October 2024 (M7) was £26.5m. The Trust has benefited from the receipt of the £12.7m system deficit support funding and support of cash advances for pay awards. Cash remains under constant review and with achievement of the year end plan of £5m deficit we are anticipating holding a cash balance on 31st March 2025 of £6.5m.

Table 1: M7 24/25 position including system support

	FY Budget	Oct-24			YTD		
		Budget	Actual	Variance	Budget	Actual	Variance
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Income							
NHS & non-NHS Income	376.0	38.1	40.7	2.6	216.3	223.9	7.6
Pass through Income	19.2	1.6	1.8	0.2	11.2	12.4	1.2
Income Total	395.2	39.7	42.4	2.8	227.5	236.3	8.8
Pay							
Substantive	(257.2)	(27.7)	(25.5)	2.1	(149.6)	(135.9)	13.7
Bank	(7.7)	(0.5)	(2.0)	(1.5)	(4.8)	(18.0)	(13.2)
Agency	(6.8)	(0.4)	(0.7)	(0.3)	(4.3)	(6.0)	(1.7)
Pay Total	(271.7)	(28.6)	(28.2)	0.4	(158.7)	(159.9)	(1.2)
Non-Pay							
Drugs & Medical Gases	(11.1)	(0.9)	(1.0)	(0.1)	(6.3)	(6.4)	(0.1)
Pass through expenditure	(19.4)	(1.6)	(1.7)	(0.1)	(11.3)	(12.2)	(0.9)
Supplies & Services - Clinical	(16.2)	(1.4)	(1.6)	(0.3)	(9.4)	(11.1)	(1.7)
Supplies & Services - General	(5.6)	(0.5)	(0.5)	(0.0)	(3.2)	(3.1)	0.1
All other non pay costs	(54.9)	(4.8)	(6.2)	(1.4)	(31.5)	(37.5)	(6.0)
Non-Pay Total	(107.1)	(9.2)	(11.1)	(1.9)	(61.8)	(70.3)	(8.5)
Financing & Depn							
Depreciation	(16.4)	(1.4)	(1.5)	(0.1)	(9.6)	(9.1)	0.5
PDC & Interest	(5.2)	(0.4)	(0.4)	0.0	(3.0)	(2.7)	0.4
Financing & Depn Total	(21.7)	(1.8)	(1.9)	(0)	(12.6)	(11.7)	0.9
Total	(5.3)	0.1	1.3	1.2	(5.6)	(5.6)	(0.0)
Technical Adjustment	0.3	0.0	0.0	0.0	0.2	0.2	0.0
Grand Total	(5.0)	0.1	1.3	1.2	(5.4)	(5.4)	0.01

- The capital programme risks overspending in the current year. As ever with the NHS capital programme, this position fluctuates, pending the deployment of national capital when bid for and in line with additional funding being made available from national sources.

October - Month 07

Financial Performance

Summary financial results

The Princess Alexandra Hospital NHS Trust

- The Trust declared a surplus of £1.3m in month 7 of 24/25 against a planned surplus of £0.1m, therefore a £1.2m favourable variance to plan. Year to date the planned deficit was £5.4m with actual performance now delivering to plan, however there is £3.3m income in the position to date which was not planned until M11 and a benefit of £0.2m relating to bank pay awards, therefore there is an underlying adverse variance to plan of £3.5m.
- The favourable position in month is predominantly due to the recognition of the system support funding which is planned to be recognised in M11, but we are recognising in twelfths, recognition of both resident doctors' 23/24 pay award and 23/24 Elective Recovery Fund (ERF) of £0.9m and £0.7m respectively . The system support improves the in-month position by £0.5m and YTD position by £3.3m, of which we will see the adverse impact on our variance in M11 where the plan remains. It will not affect our overall year end position but does make the trust look artificially better until we reach M11; this has been factored into our forecasts.
- In month 7, the Trust has reported a favourable income position of £2.8m against plan driven by:
    - £0.5m system support
    - £0.9m Resident Doctor 23/24 pay award
    - £0.4m cancer Service Development Fund support (offset within expenditure)
    - £1m ERF movement including benefit from NHSE Q1 actuals
    - £0.2m benefit from the updated education schedule
- The activity to be delivered through Vanguard commenced at the end of August. The Trust has increased income but not achieved the planned income in month to the levels expected but has also not incurred the fully budgeted expenditure value, we expect this to ramp up in the coming months.
- The Trust had a PQP target of £1.5m in month 7 of which £1.7m was delivered, the YTD position shows delivery of £8.0m versus a plan of £10.8m YTD. Delivery is behind plan, and to deliver the financial position at the year end, robust recovery plans are required. Divisions have presented recovery plans at the PQP meetings that took place throughout September, however, there remains an unidentified gap between these plans and the forecast year end position which will need addressing. A number of additional activity recovery options have also been identified which are being considered at a Trust level as part of wider financial recovery.
- Areas of overspend contributing to the underlying adverse variance to plan (once accounting for the system support income), despite some PQP delivery, include high outsourcing and clinical consumable costs within CSS. The pay position remains in excess of budget however agency costs are reducing.

Summary financial results

The Princess Alexandra Hospital NHS Trust

	FY Budget £'m	Oct-24 Budget £'m	Oct-24 Actual £'m	Oct-24 Variance £'m	YTD Budget £'m	YTD Actual £'m	YTD Variance £'m
Income							
NHS & non-NHS Income	376.0	38.1	40.7	2.6	216.3	223.9	7.6
Pass through Income	19.2	1.6	1.8	0.2	11.2	12.4	1.2
Income Total	**395.2**	**39.7**	**42.4**	**2.8**	**227.5**	**236.3**	**8.8**
Pay							
Substantive	(257.2)	(27.7)	(25.5)	2.1	(149.6)	(135.9)	13.7
Bank	(7.7)	(0.5)	(2.0)	(1.5)	(4.8)	(18.0)	(13.2)
Agency	(6.8)	(0.4)	(0.7)	(0.3)	(4.3)	(6.0)	(1.7)
Pay Total	**(271.7)**	**(28.6)**	**(28.2)**	**0.4**	**(158.7)**	**(159.9)**	**(1.2)**
Non-Pay							
Drugs & Medical Gases	(11.1)	(0.9)	(1.0)	(0.1)	(6.3)	(6.4)	(0.1)
Pass through expenditure	(19.4)	(1.6)	(1.7)	(0.1)	(11.3)	(12.2)	(0.9)
Supplies & Services - Clinical	(16.2)	(1.4)	(1.6)	(0.3)	(9.4)	(11.1)	(1.7)
Supplies & Services - General	(5.6)	(0.5)	(0.5)	(0.0)	(3.2)	(3.1)	0.1
All other non pay costs	(54.9)	(4.8)	(6.2)	(1.4)	(31.5)	(37.5)	(6.0)
Non-Pay Total	**(107.1)**	**(9.2)**	**(11.1)**	**(1.9)**	**(61.8)**	**(70.3)**	**(8.5)**
Financing & Depn							
Depreciation	(16.4)	(1.4)	(1.5)	(0.1)	(9.6)	(9.1)	0.5
PDC & Interest	(5.2)	(0.4)	(0.4)	0.0	(3.0)	(2.7)	0.4
Financing & Depn Total	**(21.7)**	**(1.8)**	**(1.9)**	**(0)**	**(12.6)**	**(11.7)**	**0.9**
Total	**(5.3)**	**0.1**	**1.3**	**1.2**	**(5.6)**	**(5.6)**	**(0.0)**
Technical Adjustment	0.3	0.0	0.0	0.0	0.2	0.2	0.0
Grand Total	**(5.0)**	**0.1**	**1.3**	**1.2**	**(5.4)**	**(5.4)**	**0.01**

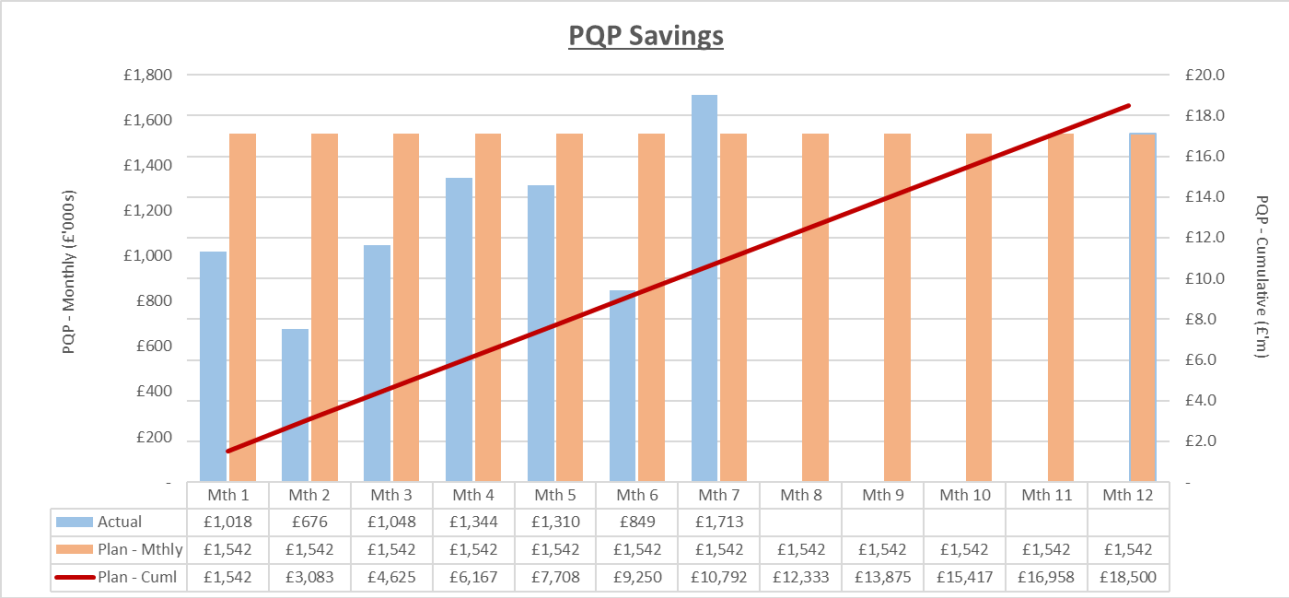
PQP

The Princess Alexandra Hospital NHS Trust

The Trust PQP plan for the year is £18.5m. The plan has been phased in twelfths to ensure continued focus on delivery of the £18.5m by the year end.

In month 7, the Trust delivered £1.7m PQP against a plan of £1.5m. Whilst some divisions are delivering PQP this financial year (Surgery, Corporate, Estates & Facilities and CHAWS) there are some divisions that are not delivering, and in addition to this have exceeded their budgets. Delivery is behind plan, and to deliver the financial position at the year end, robust recovery plans are required.

Currently £12.9m of schemes have financial values against them. Work is continuing to assign a financial value to the schemes that have been identified as well as continued progress on identification of the schemes that will deliver the full extent of the plan.



	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	£1,018	£676	£1,048	£1,344	£1,310	£849	£1,713					
Plan - Mthly	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542	£1,542
Plan - Cuml	£1,542	£3,083	£4,625	£6,167	£7,708	£9,250	£10,792	£12,333	£13,875	£15,417	£16,958	£18,500

Statement of Financial Position

The Princess Alexandra Hospital NHS Trust

Statement of Financial Position

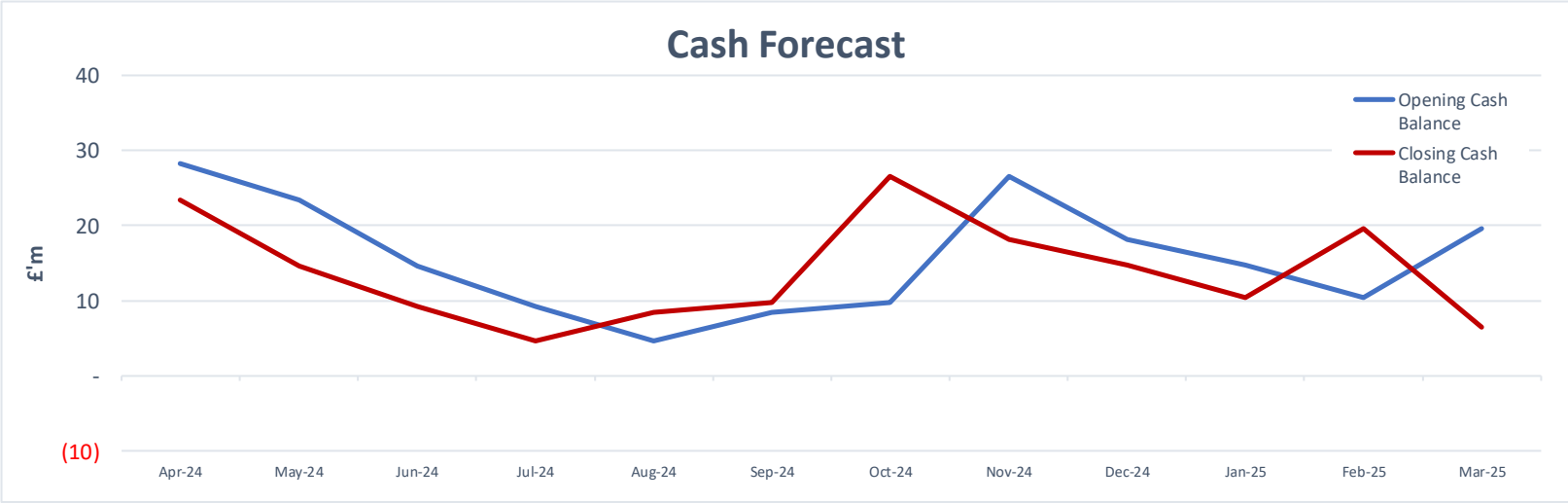
Statement of Financial Position	Mar-24 £'m	Sep-24 £'m	Oct-24 £'m	Movement In Month £'m	Movement YTD £'m
Non-current assets					
Property, plant & equipment	179.1	177.4	177.3	(0.1)	(1.9)
Right of use assets	41.7	40.5	40.3	(0.2)	(1.4)
Intangible assets	20.1	24.9	26.4	1.5	6.3
Trade & other receivables	1.1	1.1	1.1	-	-
Non-current assets	**242.0**	**243.8**	**245.0**	**1.2**	**3.0**
Current assets					
Inventories	5.0	5.0	5.0	-	-
Trade & other receivables	15.0	26.7	24.7	(2.0)	9.7
Cash & cash equivalents	28.2	9.8	26.5	16.7	(1.7)
Current assets	**48.2**	**41.5**	**56.2**	**14.7**	**8.0**
Total assets	**290.3**	**285.3**	**301.2**	**15.9**	**10.9**
Current liabilities					
Trade & other payables	(51.5)	(47.9)	(62.8)	(14.9)	(11.3)
Provisions	(0.9)	(0.9)	(0.9)	-	(0.0)
Borrowings	(2.4)	(2.2)	(2.2)	-	0.2
Current liabilities	**(54.8)**	**(51.0)**	**(65.9)**	**(14.9)**	**(11.1)**
Net current assets/ (liabilities)	**(6.6)**	**(9.5)**	**(9.7)**	**(0.2)**	**(3.2)**
Total assets less current liabilities	**235.5**	**234.2**	**235.3**	**1.0**	**(0.2)**
Non-current liabilities					
Trade & other payables	-	-	-	-	-
Provisions	(0.9)	(0.9)	(0.9)	-	0.1
Borrowings	(39.2)	(38.1)	(37.9)	0.2	1.4
Total non-current liabilities	**(40.2)**	**(38.9)**	**(38.7)**	**0.2**	**1.4**
Total assets employed	**195.3**	**195.3**	**196.6**	**1.2**	**1.2**
Financed by:					
Public dividend capital	356.3	363.2	363.2	-	6.8
Income and expenditure reserve	(172.4)	(179.3)	(178.0)	1.3	(5.6)
Revaluation reserve	11.4	11.4	11.4	-	-
Total taxpayers' equity	**195.3**	**195.3**	**196.6**	**1.3**	**1.2**

- Non-Current Assets PPE has decreased by £0.1m and it is due to PPE depreciation. The decrease of £0.2m in ROU assets represents ROU depreciation.
- Trade and Other Receivables has decreased by £2m and is mainly due to receipt of £2.5m from the HWE ICB for Frontline digitalisation netting of against £0.3m and 0.2m invoices raised to Essex Partnership NHS FT and HWE ICB for Cancer Alliance, respectively.
- Cash balances has increased by £16.7m and this is driven by receipt of £15.8m from NHS HWE ICB for Non-recurrent deficit support and receipt of £0.9m from NHS England for pay award.
- Trade and Other Payables - the increase of £14.9m is largely due to deferred income from HWE ICB for additional system deficit support of £5.4m, NHSE education funding of £3.0, other system support of £2.3m, cash advance of £1.2m, and other receivables of £1.1m. In addition, there is an unpaid invoices of £3.1m to NHS Professional Services Ltd.
- Borrowings decrease representing payment of ROU lease repayment & Interest charge

Cashflow

The Princess Alexandra Hospital NHS Trust

	<----------Actual---------->							<----------Forecast---------->				
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Opening Cash Balance	28,242	23,358	14,653	9,261	4,701	8,401	9,755	26,495	18,145	14,751	10,392	19,651
Closing Cash Balance	23,358	14,653	9,261	4,701	8,401	9,755	26,495	18,145	14,751	10,392	19,651	6,465



An increase of £16.7m is driven by receipt of £15.8m from NHS HWE ICB for non-recurrent deficit support & pay award and receipt of £0.9m from NHS England for pay award.

Capital Analysis 24/25

The Princess Alexandra Hospital NHS Trust

	Month 7			YTD			Forecast		
	In-Month Forecast £'m	In-month Actual £'m	Variance £'m	Forecast £'m	Actual £'m	Variance £'m	Plan & profile £'m	FY Forecast	Variance £'m
Internally Funded Schemes									
Estates									
Dispensing Robot (Pharmacy)	83	-	83	583	-	583	1,000	955	45
New UPS/IPS to critical areas - Phase 1 Main theatres/ED/ITU/HDU	130	9	121	909	95	814	1,559	1,114	445
Estates	21	37	(16)	146	82	64	250	295	(45)
Estates BLM	-								
Drainage - Internal and external works	10	-	10	73	56	17	125	125	-
Sitewide building management system upgrade installation works	29	-	29	204	4	200	350	350	-
Statutory Fire	50	45	5	350	126	224	600	600	-
HVAC	63	6	56	438	246	192	750	750	-
Environmental - localised refurbishment works & asbestos removal	42	76	(34)	292	425	(133)	500	500	-
Fleming Ward	14	-	14	29	-	29	100	100	
EHR, ICT & Info	-								
ICT & Information Schemes									
EHR	322	293	29	2,579	293	2,286	7,738	10,943	(3,205)
Corporate									
Corporate schemes	1	4	(3)	10	22	(12)	17	17	-
Medical Equipment	-								
Medical Equipment (Surgery)	8	12	(4)	53	26	27	90	104	(14)
Medical Equipment (CSS)	13	-	13	93	5	88	160	160	-
23-24 schemes	-	(141)	141	-	878	(878)	-	878	(878)
Medical Equipment (Medicine & UEC)	5	-	5	34	-	34	58	58	-
Medical Equipment (CHAWS)	8	12	(4)	58	-	58	100	100	-
CRL to be allocated to plan	-	-	-	-	-	-	900	-	900
YTD Total	**800**	**353**	**447**	**5,851**	**2,258**	**3,593**	**14,297**	**17,049**	**(2,752)**
Externally Funded Schemes									
New Hospital (CPO)	-	-	-	-	-	-	-	-	-
New Hospital (OBC)	178	376	(197)	1,249	971	278	2,141	2,141	-
New Hospital Enabling Works	-	-	-	-	-	-	-	-	-
CDC	788	567	221	5,518	1,618	3,900	9,460	8,727	733
CDC Substation	167	-	167	500	-	500	2,000	2,000	-
EHR	1,709	1,359	350	6,836	6,836	-	6,836	6,836	-
ICS East Imaging	56	12	44	223	209	14	335	335	-
UTC Works	292	-	292	1,458	102	1,356	3,500	3,500	-
Tye Green Lift	-	-	-	125	-	125	1,500	1,000	500
IMS Storage	3	12	(9)	24	24	(1)	30	30	-
YTD spend on External Schemes	**3,192**	**2,326**	**866**	**15,933**	**9,760**	**6,173**	**25,802**	**24,569**	**1,233**
Total - Internal and External	**3,992**	**2,679**	**1,313**	**21,784**	**12,018**	**9,766**	**40,099**	**41,618**	**(1,519)**

The Princess Alexandra Hospital NHS Trust

Trust Board Public –5 December 2024

Agenda item:	6.3
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Antoinette Woodhouse – Head of Information
Date prepared:	28th November 2024
Subject / title:	Integrated Performance Report

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

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

Patients	**Patients**	
	Overarching	All patient metrics within standard variation. A strong oversight and focus on safety and outcome patient performance metrics is in place over the implementation period of Alex Health. Other areas of focus include management & improvement of our PALS enquiries aligned to our patient experience improvement work.
People	**People**	
	Attraction	Developing and implementing a workforce and resourcing plan which celebrates our employer brand and diversity.
	Health & Wellbeing	Aligning and embed a HWB culture which is consistent with our vision, values and corporate goals.
	Talent Management	Investing appropriately in leadership and team development to attract and retain talent.
Performance	**Performance**	
	Referral Elective Standards	18-week performance has decreased slightly to 47.2% but the Trust continues to work hard in securing diagnostic, outpatient and treatment activity for our longest waiting and highest clinical priority patients. As at the month end position for October, the trust ended on 0 x 78+ week choice breaches and 138 x 65+ week breaches. We will continue to work hard to maintain and improve on this position, as well as looking toward the next milestone of 0 x 65+ breaches by 22/12/2024. Speciality trajectories to achieve this target are in place with actions such as increased capacity and transfer of patients to the independent sector in place.
	Cancer Standards	The 28-day faster diagnosis performance standard was 78.3% in September, with October's unvalidated position currently at 78.7%, validations are on-going and there is high confidence we will continue to achieve this standard in October. The 62-day finalised performance for September was 51.1% against a trajectory of 60%. Performance at service level is variable given our reliance on tertiary centres for both treatments and SMDT discussions and diagnostics, and September's improvement in the backlog clearance and hitting our fair shares target has had an impact on our 62-day performance as expected. October's unvalidated performance is currently 52.5%. The tumour sites have individual recovery action plans to reduce the backlog further and return to 62-day performance and focussed bi-weekly escalation meetings are in place to support.
	Diagnostics	Diagnostics performed within 6 weeks of referral has improved slightly for October to 70.16% from 68.27% in September. MRI, CT and Flexi sigmoidoscopy achieved 100%. There are concerns in ongoing demand for Echos, Audiology and cystoscopy and capacity pressures but all modalities have a recovery plan in place.
Pounds	**Pounds**	
	Capital Spend	The Trust total Capital resourcing for 2024/25 is £40.5m, this includes external PDC including the new hospital project, CDC, EHR, and others. The capital plan was approved at the May 2024 CWG meeting and approved at Trust Board due to the amounts involved.
	Cost Improvement Plan	The 2024/25 PQP target is £18.5m. The YTD PQP plan is £10.8m, of which £8.0m has been delivered, this is predominantly within Corporate, Surgery, Estates and Facilities and some within CHAWS.
	Income / Activity	The Trust put in Elective Recovery Fund weighted value of 117.85% of 2019/20 baseline . The Trust's ERF performance is above plan as at the end of October. NHSE has given actual ERF performance to Q1 which shows 111.6% on 2019/20 activity. Industrial Action earlier in the year and the closure of two theatres due to estate issues in August contribute have suppressed ERF performance. The pay award income has been paid in Month 7 with expenditure offset in actual pay. The system support funding has been put into the position (£3.2m). This was planned to be received in February M11 and therefore artificially improves the position.
	Surplus / Deficit	The Trust reported a surplus of £1.3m in month 7 against a plan of £0.1m surplus. The YTD position is now a deficit of £5.4m which is on plan. The in month and YTD position includes system support funding which is planned for in M11, but being recognised in twelfths, therefore artificially improving the YTD position. The in month position includes a benefit on the pay award budget which has been adjusted and paid in M7.
	Cash	The Trust's cash balance is £26.5m. 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. The focus is now on reducing the level of unpaid invoices and maintaining the Trust's improved 30-day BPPC performance.
Places	**Places**	
	Facilities	Exec report for provision to staff, to be presented. Working on PAM to ensure all paperwork is available for submission. CPD training to be booked. Training booked, primarily aimed at the catering and domestic teams. Reviewing the rota's for all teams. New project: Post usage in the Trust and move more processes online.
	Estates	Additional Micad training has been provided for the engineers and an admin team to improve the overall performance. Closely working with Micad develop team to improve the performance of system.
	Capital	Completion of draft for 5 year and 10 year Capital and estates plan in to Finance and Senior team. Completion of BLM and other capital funded streams - briefing documents awaited from Estates team via SHofE for full year end completion based on risk. Supporting ED team on UEC funding spend by year end - full briefing pack awaited from Project Team. Supporting Pharmacy team turnkey works for new dispensing robot for year end spend. Supporting CHAWS division on urgent works in Maternity areas for year end spend.

The Princess Alexandra Hospital NHS Trust

Recommendation:	PAF is asked to note and discuss the contents of this report				
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	X	X	X	X	X

Previously considered by:	
Risk / links with the BAF:	Links to all BAF Risks
Legislation, regulatory, equality, diversity and	No regulatory issues/requirements identified, the IPR demonstrates a full view of service delivery to ensure we take into account equality, diversity and dignity
Appendices:	M7 IPR

6.3

Integrated Performance Report:

October 2024

As at 28/11/2024

Executive Summary

NHS
The Princess Alexandra Hospital
NHS Trust

Patients

Patients

Overarching	All patient metrics within standard variation. A strong oversight and focus on safety and outcome patient performance metrics is in place over the implementation period of Alex Health. Other areas of focus include management & improvement of our PALS enquiries aligned to our patient experience improvement work.

Pounds

Capital Spend	The Trust total Capital resourcing for 2024/25 is £40.5m, this includes external PDC including the new hospital project, CDC, EHR, and others. The capital plan was approved at the May 2024 CWG meeting and approved at Trust Board due to the amounts involved.
Cost Improvement Plan	The 2024/25 PQP target is £18.5m. The YTD PQP plan is £10.8m, of which £8.0m has been delivered, this is predominantly within Corporate, Surgery, Estates and Facilities and some within CHAWS.
Income / Activity	The Trust put in Elective Recovery Fund weighted value of 117.85% of 2019/20 baseline . The Trust's ERF performance is above plan as at the end of October. NHSE has given actual ERF performance to Q1 which shows 111.6% on 2019/20 activity. Industrial Action earlier in the year and the closure of two theatres due to estate issues in August contribute have suppressed ERF performance. The pay award income has been paid in Month 7 with expenditure offset in actual pay. The system support funding has been put into the position (£3.2m). This was planned to be received in February M11 and therefore artificially improves the position.
Surplus / Deficit	The Trust reported a surplus of £1.3m in month 7 against a plan of £0.1m surplus. The YTD position is now a deficit of £5.4m which is on plan. The in month and YTD position includes system support funding which is planned for in M11, but being recognised in twelfths, therefore artificially improving the YTD position. The in month position includes a benefit on the pay award budget which has been adjusted and paid in M7.
Cash	The Trust's cash balance is £26.5m. 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. The focus is now on reducing the level of unpaid invoices and maintaining the Trust's improved 30-day BPPC performance.

People

People

Attraction	Developing and implementing a workforce and resourcing plan which celebrates our employer brand and diversity.
Health & Wellbeing	Aligning and embed a HWB culture which is consistent with our vision, values and corporate goals.
Talent Management	Investing appropriately in leadership and team development to attract and retain talent.

Performance

Performance

Referral Elective Standards	18-week performance has decreased slightly to 47.2% but the Trust continues to work hard in securing diagnostic, outpatient and treatment activity for our longest waiting and highest clinical priority patients. As at the month end position for October, the trust ended on 0 x 78+ week choice breaches and 138 x 65+ week breaches. We will continue to work hard to maintain and improve on this position, as well as looking toward the next milestone of 0 x 65+ breaches by 22/12/2024. Speciality trajectories to achieve this target are in place with actions such as increased capacity and transfer of patients to the independent sector in place.
Cancer Standards	The 28-day faster diagnosis performance standard was 78.3% in September, with October's unvalidated position currently at 78.7%, validations are on-going and there is high confidence we will continue to achieve this standard in October. The 62-day finalised performance for September was 51.1% against a trajectory of 60%. Performance at service level is variable given our reliance on tertiary centres for both treatments and SMDT discussions and diagnostics, and September's improvement in the backlog clearance and hitting our fair shares target has had an impact on our 62-day performance as expected. October's unvalidated performance is currently 52.5%. The tumour sites have individual recovery action plans to reduce the backlog further and return to 62-day performance and focussed bi-weekly escalation meetings are in place to support.
Diagnostics	Diagnostics performed within 6 weeks of referral has improved slightly for October to 70.16% from 68.27% in September. MRI, CT and Flexi sigmoidoscopy achieved 100%. There are concerns in ongoing demand for Echos, Audiology and cystoscopy and capacity pressures but all modalities have a recovery plan in place.

Places

Places

Facilities	Exec report for provision to staff, to be presented. Working on PAM to ensure all paperwork is available for submission. CPD training to be booked. Training booked, primarily aimed at the catering and domestic teams. Reviewing the rota's for all teams. New project: Post usage in the Trust and move more processes online.
Estates	Additional Micad training has been provided for the engineers and an admin team to improve the overall performance. Closely working with Micad develop team to improve the performance of system.

Capital

Completion of draft for 5 year and 10 year Capital and estates plan in to Finance and Senior team. Completion of BLM and other capital funded streams - briefing documents awaited from Estates team via SHofE for full year end completion based on risk. Supporting ED team on UEC funding spend by year end - full briefing pack awaited from Project Team. Supporting Pharmacy team turnkey works for new dispensing robot for year end spend. Supporting CHAWS division on urgent works in Maternity areas for year end spend.

Section summaries

NHS
The Princess Alexandra Hospital
NHS Trust

Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Overarching	All patient metrics within standard variation. A strong oversight and focus on safety and outcome patient performance metrics is in place over the implementation period of Alex Health. Other areas of focus include management & improvement of our PALS enquiries aligned to our patient experience improvement work.		

Section summaries

The Princess Alexandra Hospital NHS Trust

People Summary	Board Sub Committee: Workforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Attraction	Developing and implementing a workforce and resourcing plan which celebrates our employer brand and diversity.		
Health & Wellbeing	Aligning and embed a HWB culture which is consistent with our vision, values and corporate goals.		
Talent Management	Investing appropriately in leadership and team development to attract and retain talent.		

Section summaries

NHS
The Princess Alexandra Hospital
NHS Trust

Performance	Board Sub Committee: Workforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Diagnostics	Diagnostics performed within 6 weeks of referral has improved slightly for October to 70.16% from 68.27% in September. MRI, CT and Flexi sigmoidoscopy achieved 100%. There are concerns in ongoing demand for Echos, Audiology and cystoscopy and capacity pressures but all modalities have a recovery plan in place.		
RTT Elective standards	18-week performance has decreased slightly to 47.2% but the Trust continues to work hard in securing diagnostic, outpatient and treatment activity for our longest waiting and highest clinical priority patients. As at the month end position for October, the trust ended on 0 x 78+ week choice breaches and 138 x 65+ week breaches. We will continue to work hard to maintain and improve on this position, as well as looking toward the next milestone of 0 x 65+ breaches by 22/12/2024. Speciality trajectories to achieve this target are in place with actions such as increased capacity and transfer of patients to the independent sector in place.		
Cancer standards	The 28-day faster diagnosis performance standard was 78.3% in September, with October's unvalidated position currently at 78.7%, validations are on-going and there is high confidence we will continue to achieve this standard in October. The 62-day finalised performance for September was 51.1.0% against a trajectory of 60%. Performance at service level is variable given our reliance on tertiary centres for both treatments and SMDT discussions and diagnostics, and September's improvement in the backlog clearance and hitting our fair shares target has had an impact on our 62-day performance as expected. October's unvalidated performance is currently 52.5%. The tumour sites have individual recovery action plans to reduce the backlog further and return to 62-day performance and focussed bi-weekly escalation meetings are in place to support.		

Introduction

About this pack

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

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

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

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

Contents

Key Performance Indicators of Interest

The Princess Alexandra Hospital NHS Trust

5P Section	KPI	SPC Status	Performance	BAF Risk Reference	Current Risk Score	Target Risk Score
Patients	Tissue viability (Pressure Ulcers) per 1000 bed days		0	1.1	16	12
	Serious Incidents		1	1.1	16	12
	Falls per 1000 bed days		4.35	1.1	16	12
	PPH over 1500mls		2.00%	1.1	16	12
People	Statutory & Mandatory training		87.0%	2.3	16	8
	Vacancy Rate		7.0%	2.3	16	8
	Voluntary Turnover		10.0%	2.3	16	8
	Appraisals - non-medical		58.0%	2.3	16	8
Performance	RTT over 65 week waiters*		137	1.3	16	12
	4 hour standard		56.3%	4.2	20	12
	Cancer 28 day faster diagnosis*		78.4%	1.3	16	12
	Diagnostics within 6 weeks*		70.2%	4.2	20	12

Patients section measures of interest

SPC for C.29 - Tissue Viability - (Pressure Ulcers Grade 3 or Above) per 1000 Bed Days

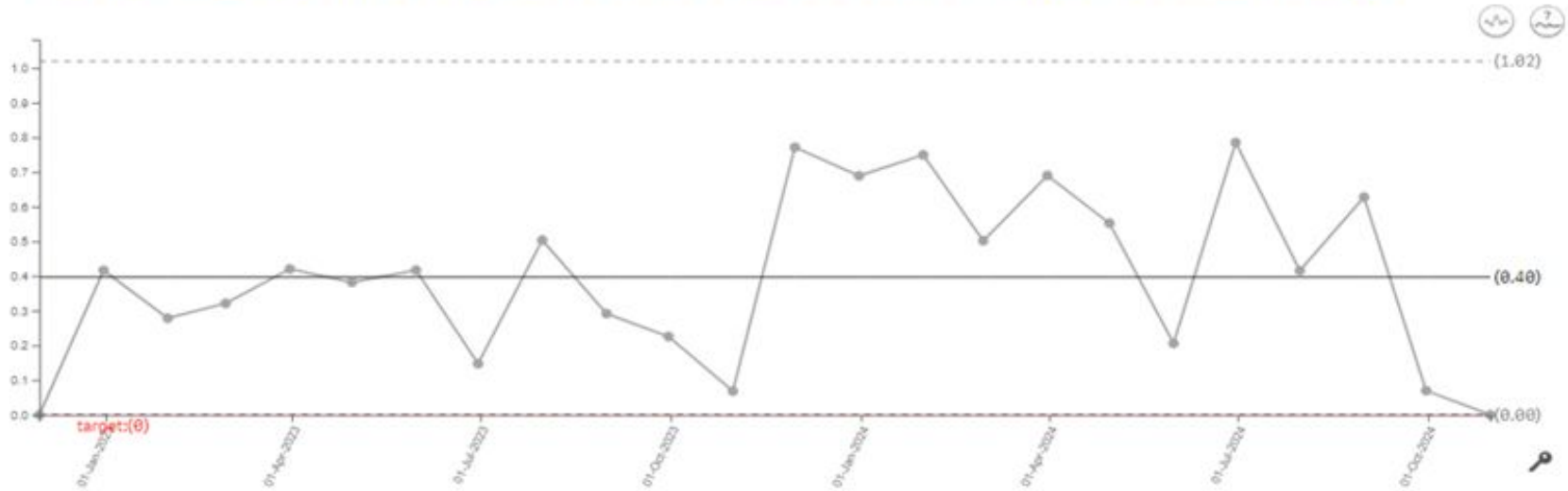
Previous month ...
October-2024

0.00

Month to date v...
November-2024

0.00

Target
October-2024
Target is at Trust-wide level



SPC for D.40 - Falls with Harm per 1000 Bed Days

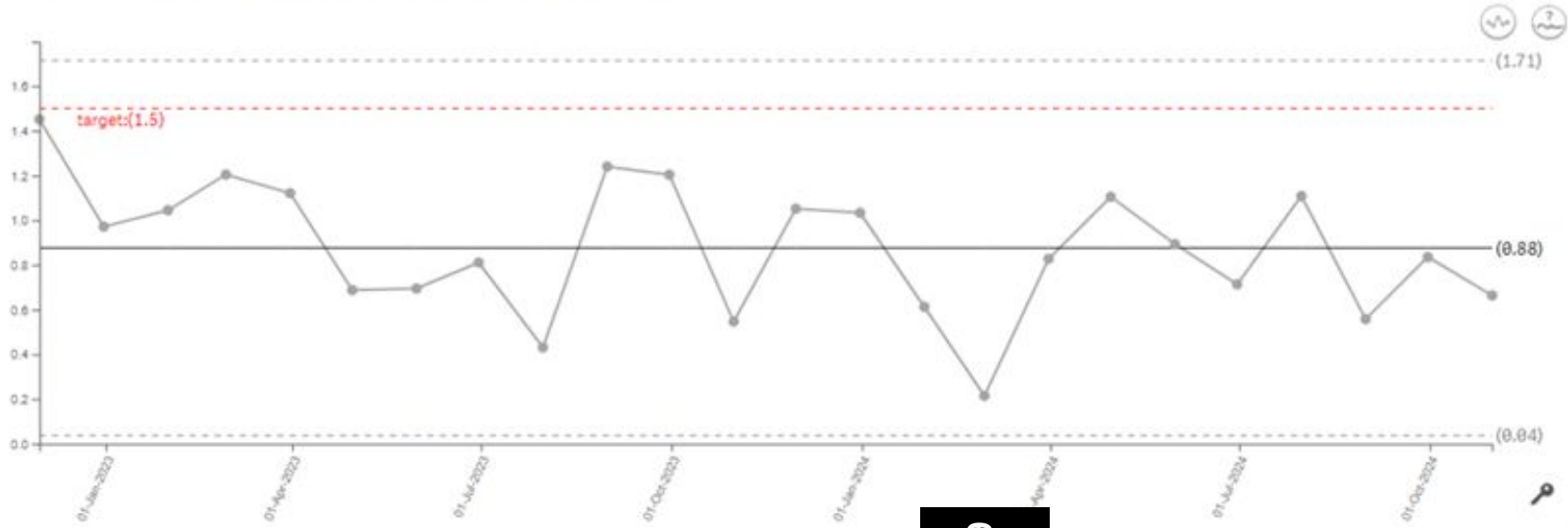
Previous month ...
October-2024

0.66

Month to date v...
November-2024

0.76

Target
October-2024
Target is at Trust-wide level



6.3

People section measures of interest

SPC for D.28 - Appraisals - non medical

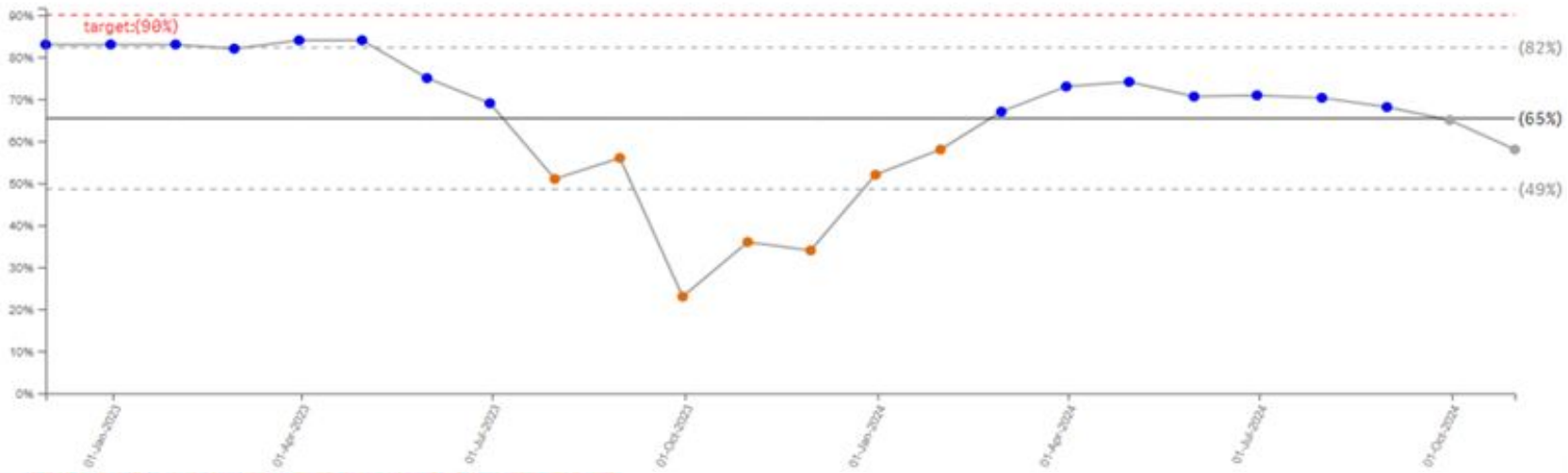
Previous month ...
September-2024

65.0%

Month to date v...
October-2024

58.0%

Target
October-2024
Target is at Trust-wide level



SPC for D.29 - Statutory & Mandatory training

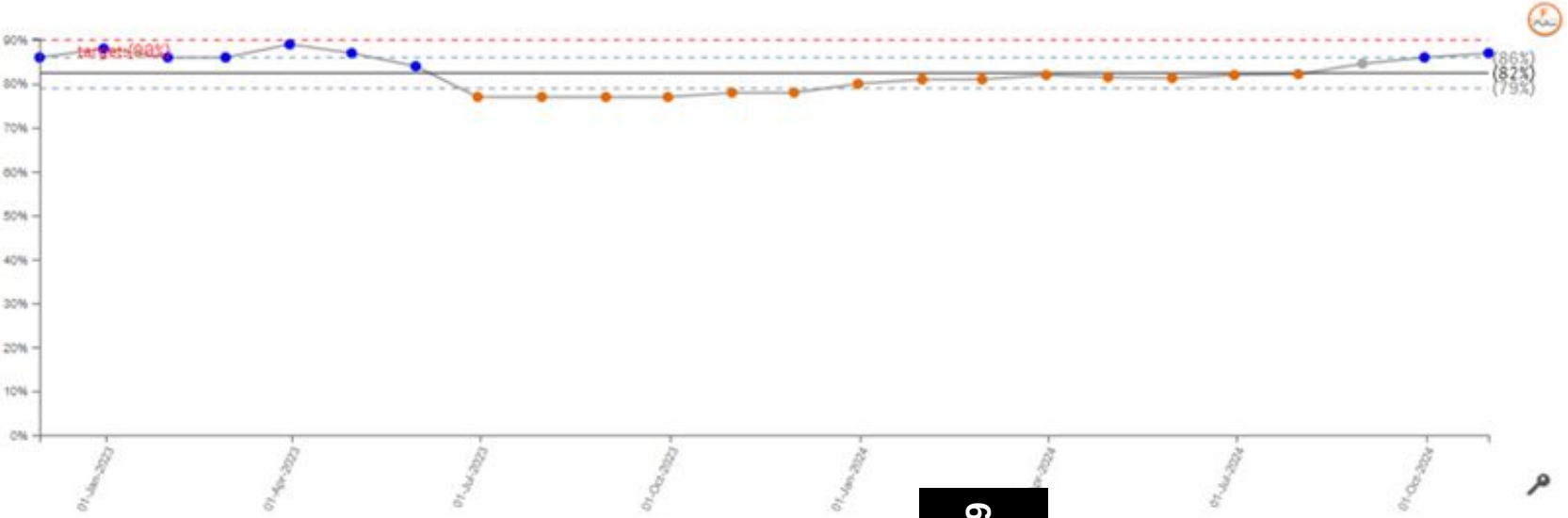
Previous month ...
September-2024

86.0%

Month to date v...
October-2024

87.0%

Target
October-2024
Target is at Trust-wide level



People section measures of interest

SPC for D.27 - Vacancy Rate

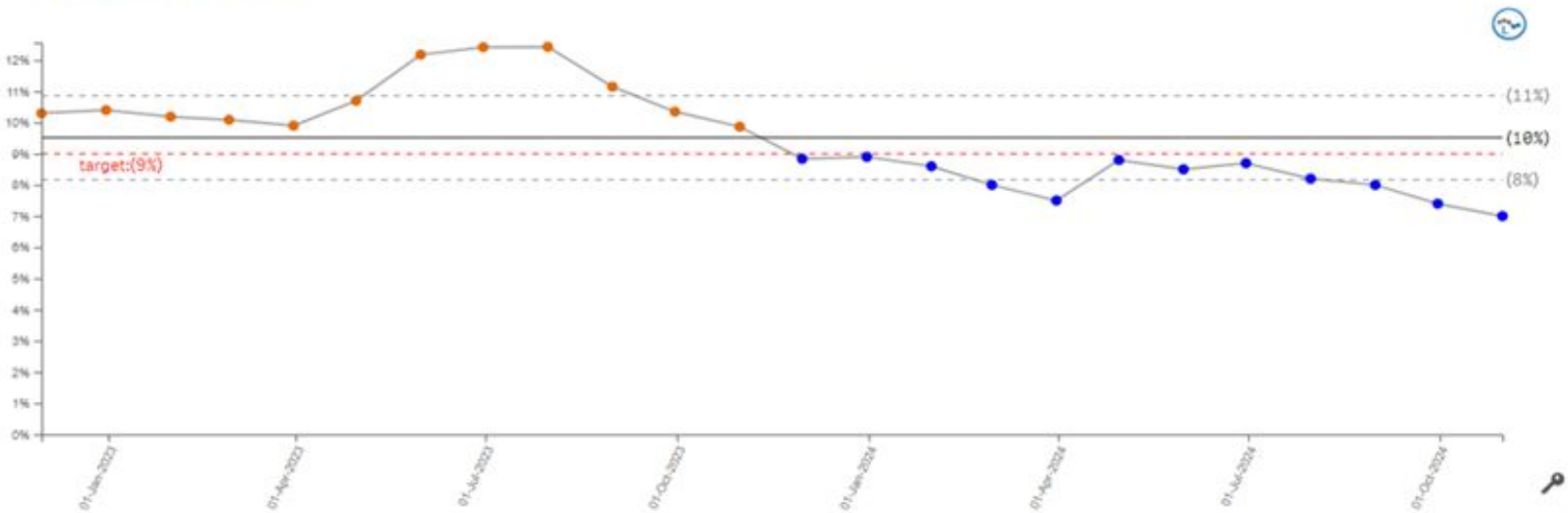
Previous month ...
September-2024

7.4%

Month to date v...
October-2024

7.0%

Target
October-2024
Target is at Trust-wide level



SPC for D.24 - Staff Turnover Voluntary

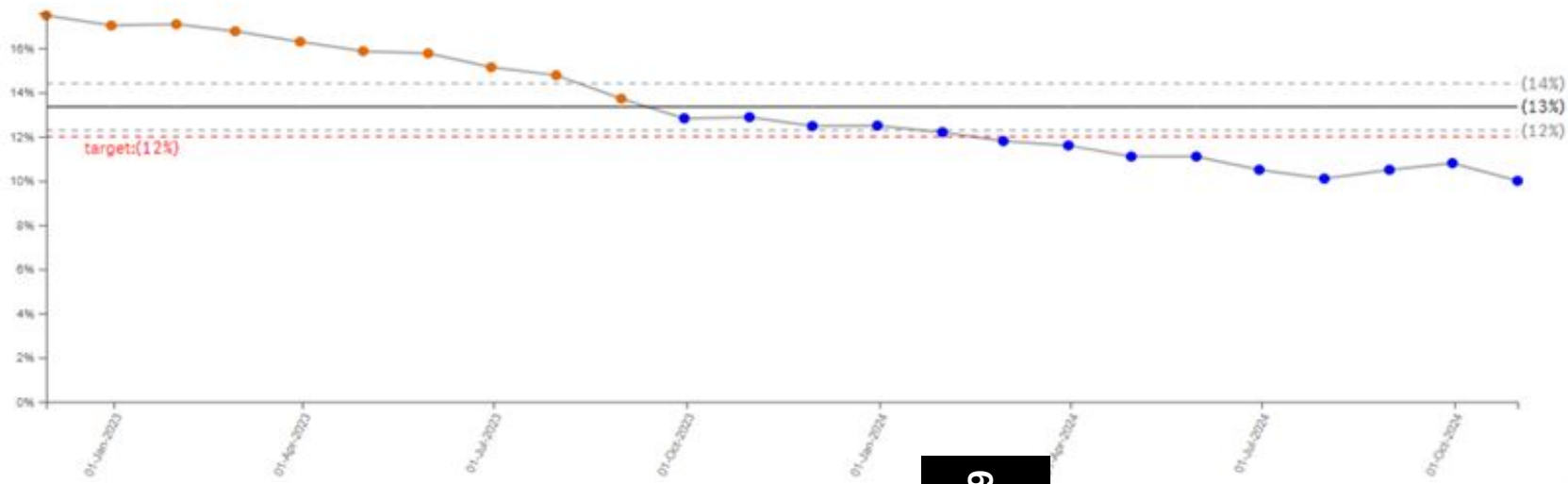
Previous month ...
September-2024

10.8%

Month to date v...
October-2024

10.0%

Target
October-2024
Target is at Trust-wide level



People section measures of interest

NHS
The Princess Alexandra Hospital
NHS Trust

SPC for D.25 - Agency Staffing Spend

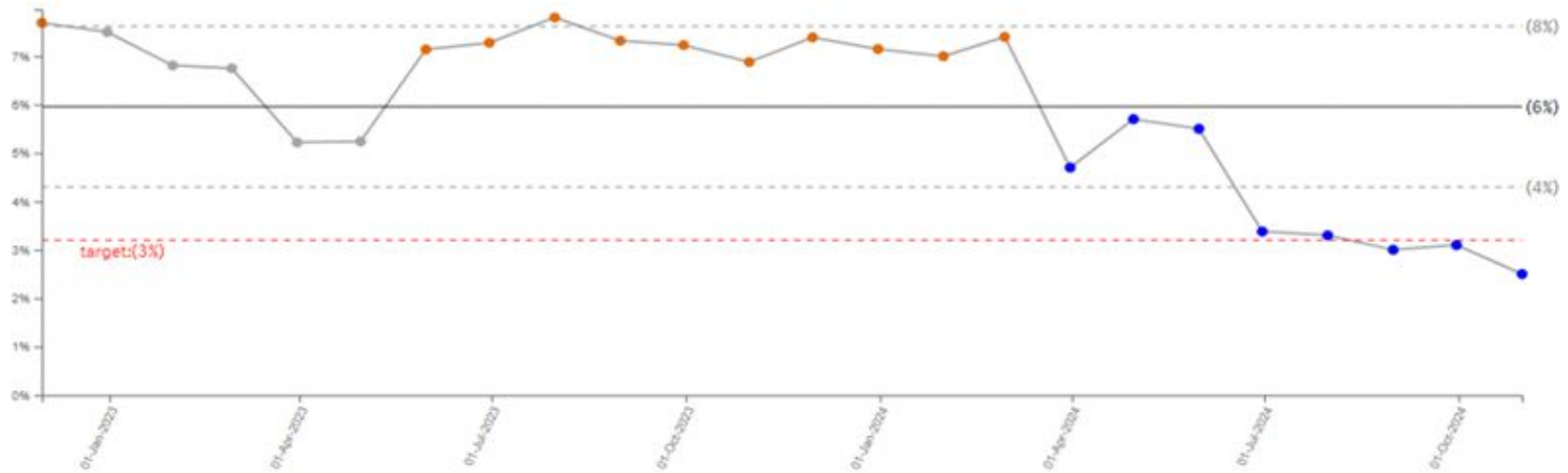
Previous month ...
September-2024

3.1%

Month to date v...
October-2024

2.5%

Target
October-2024
Target is at Trust-wide level



SPC for D.26 - Bank Staffing Spend

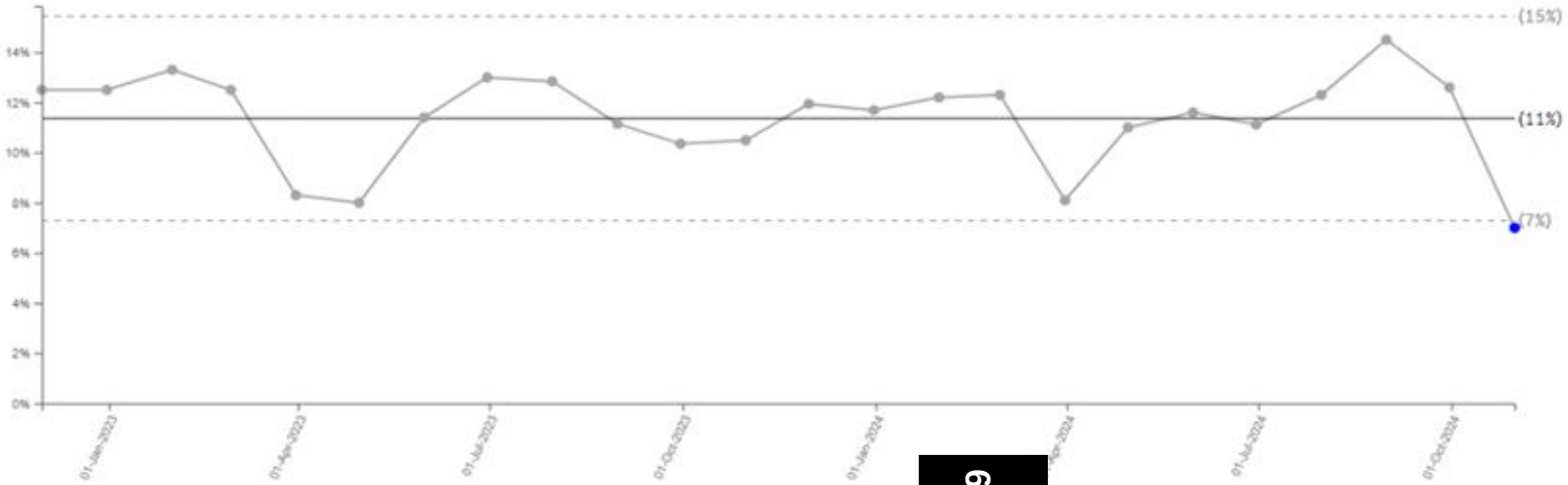
Previous month ...
September-2024

12.6%

Month to date v...
October-2024

7.0%

Target
October-2024
Target is at Trust-wide level



Performance section measures of interest

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

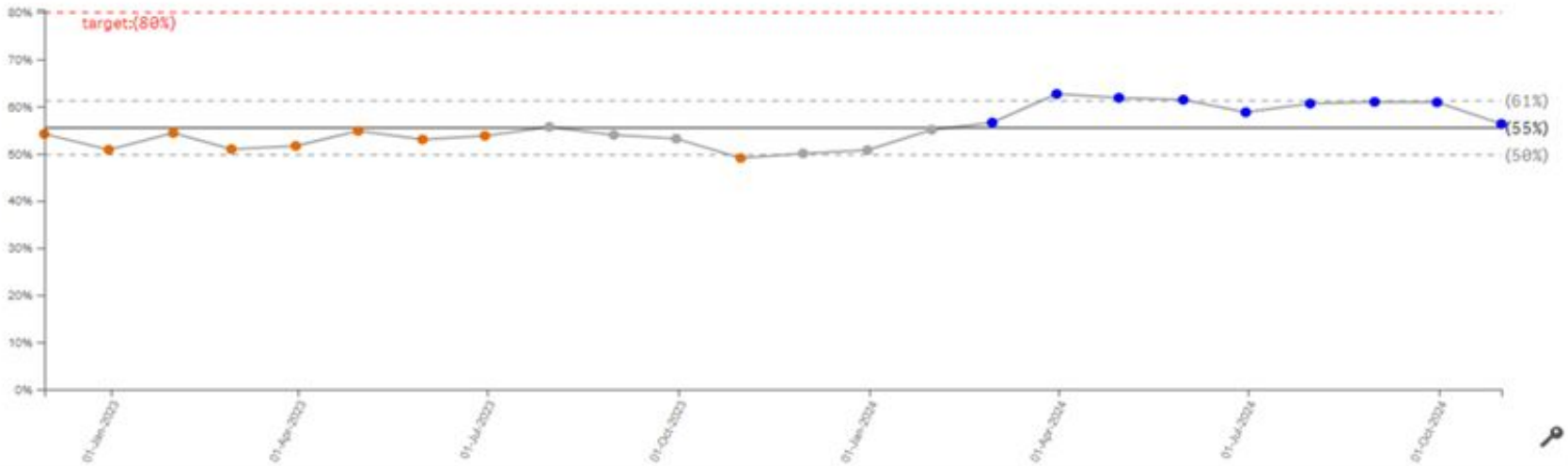
Previous month ...
September-2024

60.9%

Month to date v...
October-2024

56.3%

Target
September-2024
Target is at Trust-wide level



SPC for A.17 - Proportion of Ambulance Handovers less than 15 minutes

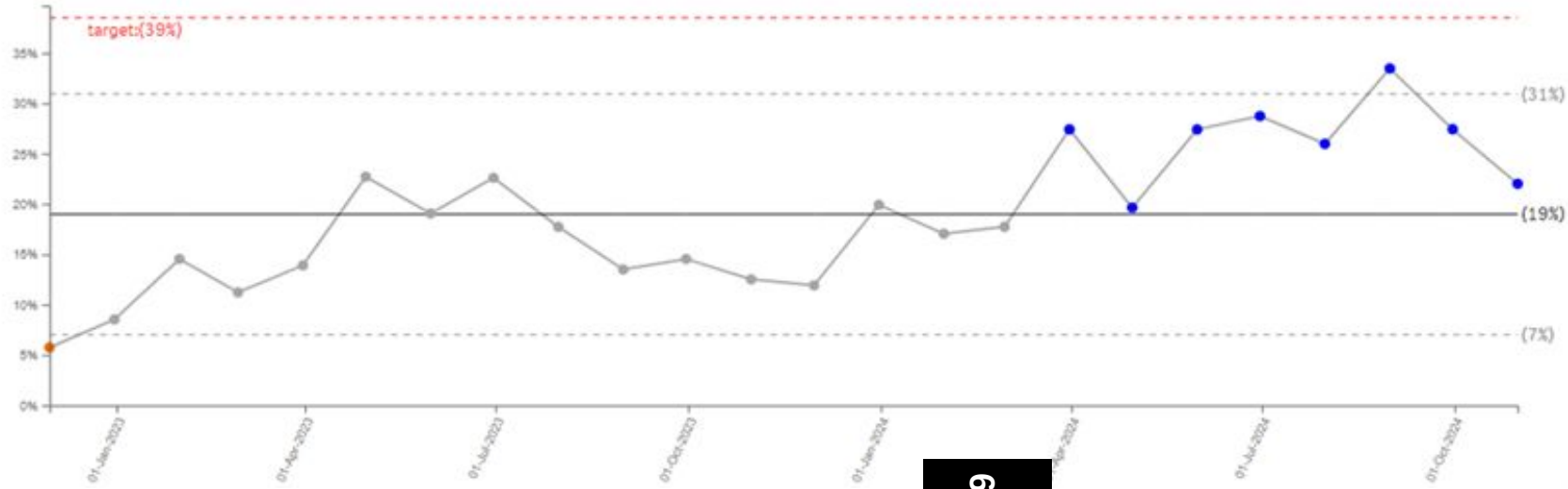
Previous month ...
October-2024

22.0%

Month to date v...
November-2024

12.8%

Target
October-2024
Target is at Trust-wide level



6.3

Performance section measures of interest

SPC for D.41 - RTT over 65 week waiters

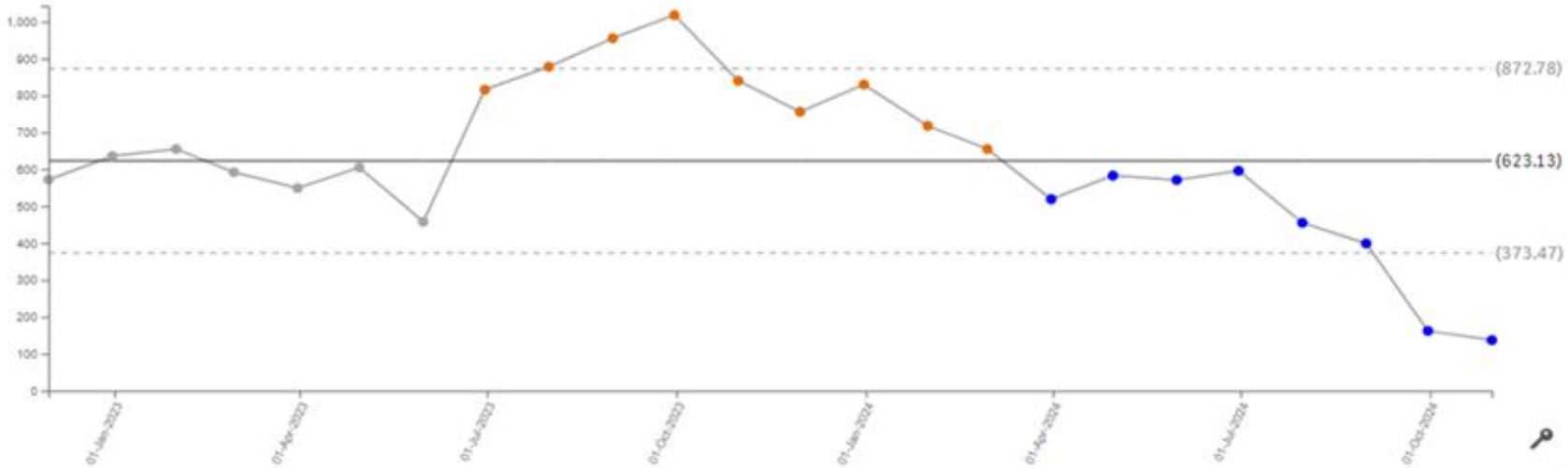
Previous month ...
September-2024

162

Month to date v...
October-2024

137

Target
October-2024
Target is at Trust-wide level



SPC for D.37 - RTT over 78 week waiters

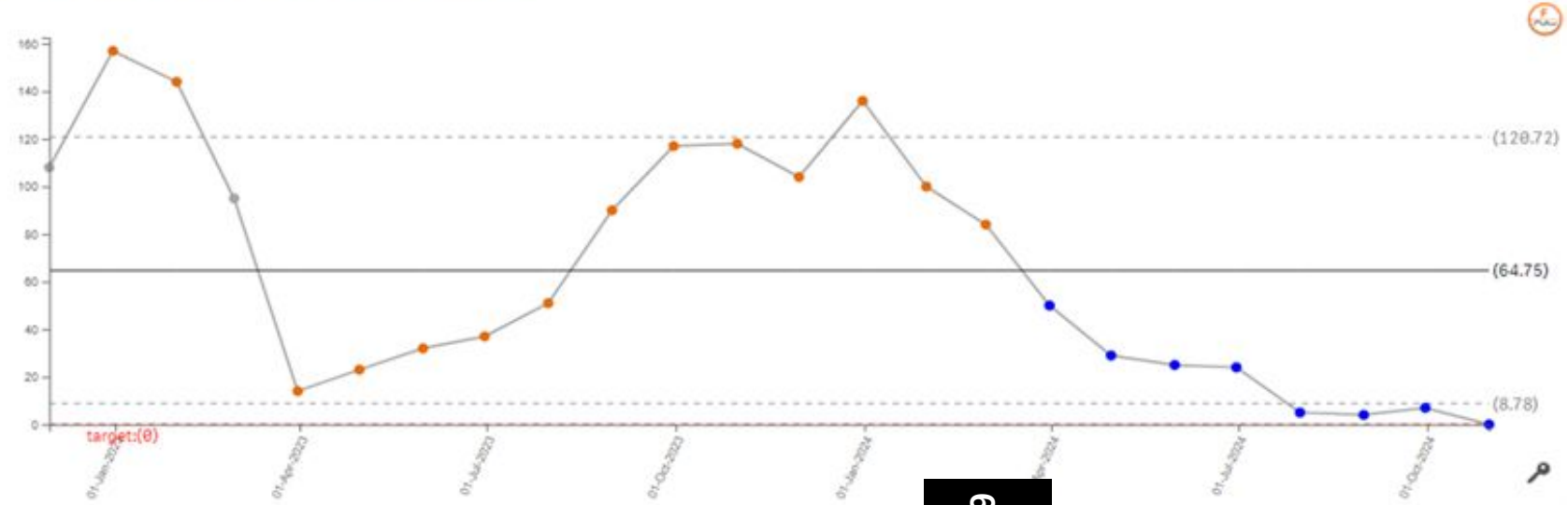
Previous month ...
September-2024

7

Month to date v...
October-2024

0

Target
October-2024
Target is at Trust-wide level



Performance section measures of interest

SPC for C.16 - Diagnostic times - Patients seen within 6 weeks

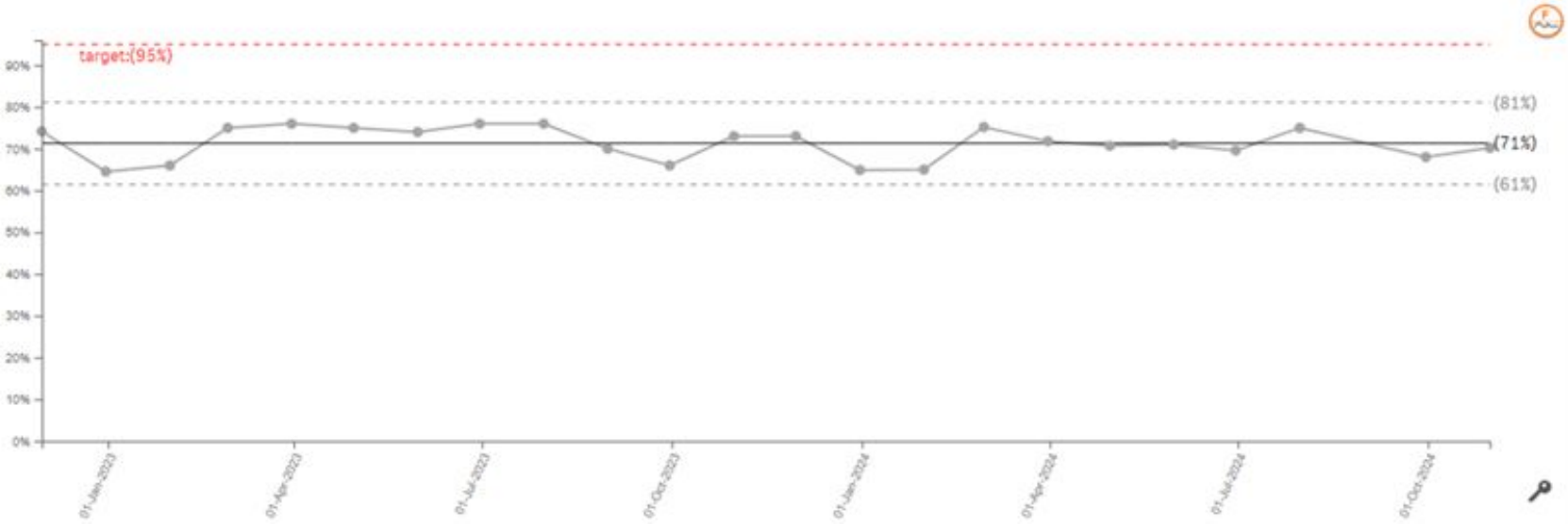
Previous month ...
September-2024

68.0%

Month to date v...
October-2024

70.2%

Target
October-2024
Target is at Trust-wide level



BOARD OF DIRECTORS: Trust Board 5th December 2024 **AGENDA ITEM: 6.4**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Non-Executive Director – Committee Chair

DATE OF COMMITTEE MEETING: 2 December 2024

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 External Audit Update	Yes	Yes	No	An update was received on the early reflections on the audit risks. The valuation of land and buildings and the valuation of intangible assets was discussed.
3.1 Internal Audit Progress Report and 3.2 Follow up on Recommendations.	Yes	Yes	Yes (PAF and QSC)	The Committee was assured on the progress of the 2024/25 audit, one report had been finalised. In regards to the 2023/24 audit the two remaining reports had been finalised. Reports Finalised: • Discharge and Patient Flow 23/24 – Moderate (Design) & Limited (Effectiveness) Assurance • Management of Capital Projects 23/24 – Moderate (Design) & Moderate (Effectiveness) Assurance • Management of PQPs 24/25 – Moderate (Design) & Moderate (Effectiveness) Assurance It was agreed that the recommendations from the Discharge and Patient Flow audit would be discussed at QSC and PAF.
3.3 Counter Fraud Progress Report	Yes	No	No	The Committee was assured in regards to the progress against the 2024/25 counter fraud plan.
4.1 Waivers, Losses, Special Payments	Yes	No	No	During the period 1st July 2024 to 30th September 2024: • The value of losses and special payments totalled £28k (7 cases). • £404k debt is being proposed to be written off in Q3 2024/25.

BOARD OF DIRECTORS: Trust Board 5th December 2024 **AGENDA ITEM: 6.4**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Non-Executive Director – Committee Chair

DATE OF COMMITTEE MEETING: 2 December 2024

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				• 20 waivers totalled £829k of which 1 (£18k) was non-compliant.
4.2 Annual Accounts 2024/25 - Reporting Timetable	Yes	No	No	The Committee reviewed the updated financial year annual report and accounts timetable. The final submission deadline is the 30th June 2025.
4.3 Clinical Audit Report				The Committee was assured on the progress of clinical audit in 2024. The action plan following the recommendations was noted and learning from the audits is being discussed.

The Princess Alexandra Hospital NHS
NHS Trust

Item No: 7.1

REPORT TO BOARD FROM:	Leadership Management Team (LMT)
CHAIR:	Thom Lafferty, CEO
DATE OF MEETING/S:	26th November 2024
AGENDA ITEM:	

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at the LMT meeting on **26th November**

- **CEO Update**: Verbal update provided by CEO. Announcement expected in January from the Government on the status of our new hospital programme. CEO is meeting with key stakeholders & PCNs across Harlow, west Essex and surrounding Hertfordshire areas as part of his introductory programme.
- **Risk Management Group:** Item deferred to LMT 10th December.
- **Winter Planning:** winter planning session to take place in week commencing 2nd December 2024 to improve patient flow and increase discharges.
- **Alex Health update:** currently in stabilisation phase and on track. Training continues.
- **Finance and Capital:** the month 7 position was discussed and FYE trajectory is being reviewed.
- **Performance update: Tiering:** The Trust remains in tier 2. Fortnightly meetings with NHSE continue.

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7.1