The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 6 October 2022 at 09.30 – 12.15
Venue: Kao Park Boardroom

	Item	Subject	Action	Lead	
01 Opening administration					
09.30	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	4
	1.4	Matters arising and action log	Review	All	16
09.35	Staff Story: 'My journey as an audiologist with hearing loss'				
02 Chair and Chief Executive's reports					
10.00	2.1	Chair's report	Inform	Chair	18
10.05	2.2	CEO's report including: • COVID-19 update • ICS/ICB update	Inform	Chief executive	21
03 Risk					
10.15	3.1	Significant risk register	Review	Medical director	25
10.25	3.2	Board assurance framework 2022-23 *Diligent Resources: PAHT Board Assurance Framework 2022/23*	Review/ Approve	Head of corporate affairs	32
04 Patients					
10.30	4.1	Report from Quality and Safety Committee 30.09.22: • Part I • Part II – Maternity Oversight	Assure	Committee Chairs	 37 41
10.35	4.2	Maternity Incentive Scheme: • Mid-Year Midwifery Establishment Review • Maternity SI Update • Maternity Digital Strategy	 Assure Inform Approve	Director of nursing and midwifery	 43 47 50
10.45	4.3	Nursing, midwifery and care staff levels including nurse recruitment	Assure	Director of nursing and midwifery	81
10.55	4.4	Learning from deaths (Mortality)	Assure	Medical director	101
	4.5	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
		BREAK			
05 People					

11.15	5.1	Report from People Committee 26.09.22	Assure	Committee Chair	107
06 Performance/pounds					
11.25	6.1	Report from Performance and Finance Committee 29.09.22	Assure	Chair of Committee	109
11.30	6.2	Integrated performance report	Discuss	Chief Information Officer	113
07 Strategy/Governance					
11.35	7.1	Report from Strategic Transformation Committee 26.09.22	Assure	Chair of Committee	191
11.40	7.2	Report from Senior Management Team Meetings	Assure	Chair of Committee	174
11.45	7.3	Well led review: Annual self- assessment	Assure	Director of nursing	175
11.55	7.4	Report from Audit Committee: 05.09.22	Assure	Chair of Committee	179
12.00	7.5	Corporate Trustee: • Report from CFC.16.09.22	Assure	Chair of CFC	181
08 Questions from the public					
12.05	8.1	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
09 Closing administration					
	9.1	Summary of actions and decisions	-	Chair/All	
	9.2	New risks and issues Identified	Discuss	All	
	9.3	Any other business	Review	All	
12.15	9.4	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	

The Princess Alexandra Hospital NHS Trust

Purpose:

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

Quoracy:

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

Ground Rules for Meetings:

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

Board Membership and Attendance 2022/23			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chair	Hattie Llewelyn-Davies	Chief Executive	Lance McCarthy
Vice Chair	Helen Glenister	Director of Nursing & Midwifery and Deputy CEO	Sharon McNally
Non-executive director	George Wood	Chief Operating Officer	Stephanie Lawton
Non-executive director	Colin McCready	Medical Director	Fay Gilder
Non-executive director	Helen Howe	Interim Director of Finance	Tom Burton
Non-executive director	Darshana Bawa	**Executive Members of the Board (non-voting)**	
Associate Non-executive director	Dr. John Keddie	Director of Strategy	Michael Meredith
Associate Non-executive director	Anne Wafula-Strike	Director of People	Gech Emeadi
Associate Non-executive director	Dr. Rob Gerlis	Director of Quality Improvement	Jim McLeish
Associate Non-executive director	Elizabeth Baker	Chief Information Officer	Phil Holland
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public via MS Teams
Thursday 4 August 2022 from 09:30 to 12:30

Present:	
Hattie Llewelyn-Davis	**Trust Chair (TC)**
Liz Baker (non-voting)	Associate Non-Executive Director (ANED-LB)
Darshana Bawa (non-voting)	Associate Non-Executive Director (ANED-DB)
Tom Burton	Director of Finance (DoF)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Rob Gerlis (non-voting)	Associate Non-Executive Director (ANED-RG)
Fay Gilder	Medical Director (MD)
Helen Glenister	Non-Executive Director (NED-HG)
Phil Holland	Chief Information Officer (CIO)
Helen Howe	Non-Executive Director (NED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Stephanie Lawton	Chief Operating Officer (COO)
Lance McCarthy	Chief Executive Officer (CEO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)
In attendance:	
Christine Craven	CQC
Antoinette Smith	CQC
Laura Warren	Associate Director – Communications (AD-C)
Finola Devaney	Director – Clinical Quality Governance (D-CQG)
Patient Story:	
Anne Weersing	Patient
Emma Hounsell	Surgical Matron
Shaheen Hosany	Acting Associate Director of Nursing – Surgery
Shahid Sardar	Associate Director – Patient Engagement
Members of the Public	
Camilla Leach (for part)	Bipolar UK
Apologies:	
Colin McCready	Non-Executive Director (NED-CM)
Secretariat:	
Heather Schultz	Head of Corporate Affairs (HoCA)
Lynne Marriott	Board & Committee Secretary (B&CS)

01 OPENING ADMINISTRATION	
1.1	The Trust Chair (TC) welcomed all to the meeting, particularly colleagues from the CQC, Tom Burton the newly appointed substantive Director of Finance (DoF), the Director of Clinical Quality Governance and Anne Weersing (Patient Story). She informed members that Non-Executive Director John Hogan (NED-JH) had resigned from the Board the previous month for personal reasons and she noted her gratitude to NED-JH for his contribution to the Trust and to the Board. It was also noted that Associate NED Anne Wafula-Strike (ANED-AWS) would leave the meeting between 1130-1230. The TC then requested that Board members introduce themselves.
1.1 Apologies	
1.2	Apologies were noted as above.
1.2 Declarations of Interest	
1.3	It was noted that the Chief Operating Officer (COO) was now a Trustee of St. Francis Hospice, Romford.
1.3 Minutes of Previous Meeting	

1.4	These were agreed as a true and accurate reflection of the meeting held on 02.06.22 with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising and the action log was noted. In terms of action ref: TB1.09.06.22/07 the Medical Director (MD) informed members she had checked with the Divisional Directors and their view had been there were no recurring challenges or issues in terms of receiving medical records from the Lister Hospital.
Patient Story: Anne's Story	
1.6	This item was introduced by the Director of Nursing & Midwifery (DoN&M) who welcomed patient Anne Weersing (AW) to the meeting. She thanked her for her bravery in terms of presenting her story that day and also for her engagement with the Trust's Patient Experience team over the previous year. The key issues for her that day were the hospital's response/approach when things didn't go right for patients and the support provided following that. She would also be keen to hear from the teams involved as to what had been learned from the complaint. The Associate Director of Patient Engagement (AD-PE) added that the story raised for him, questions as to how respected the patient voice was in the organisation and the potential issue of over-reliance on technology.
1.7	AW informed members she was a long-standing sufferer of urethral stenosis and bladder under-activity which led to chronic urine retention. On 29.05.21 she had attended the Trust for a routine elective day surgery procedure. She had met the treating consultant for the first time in the pre-operative consultation on the day and he had declared that the diagnosis of urethral stenosis was incorrect. Previous procedures and diagnoses had been made at a different hospital and the consultant that day did not have access to her notes. Her request to be allowed home with a catheter in place (following previous complications with dilatations) was refused. It was later discovered that discharging her home without a catheter was against Trust policy.
1.8	The procedure went well and AW had been discharged to the day stay recovery unit later that afternoon. Over the next few hours AW drank about 2.8 litres of fluid but was unable to pass urine. She knew then (from previous experience) that she was going into urinary retention and she let the nurses know. As a nurse herself she suggested a fluid balance chart be started but was told those had been replaced by bladder scanners. She also asked for some pain relief but was told pain was to be expected after the procedure and she should try to walk around to relieve that.
1.9	Two bladder scans were then performed over the next few hours which showed low amounts of urine in the bladder. She was then told she was ready for discharge and her husband arrived around 17:30 to find her crying in pain and in distress. Various attempts were made to bleep the medical team, on-call urology registrar and on-call surgical team to catheterise her. The latter responded but were in the ED. The on-call matron was also bleeped for approval for the nursing staff to perform the catheterisation but that was denied due to nature of the procedure and she was catheterised by a doctor later that evening.
1.10	AW confirmed she was then transferred to a ward overnight where her catheter drained over three litres of water. This had caused AW significant pain and the bladder had in fact ruptured. The following morning she had been visited by the same consultant who had been surprised to see her and to learn that she had gone into acute urinary retention. Her request to go home with a catheter was refused on the grounds that it was not safe for AW to remove the catheter herself. Later that day the catheter was removed by a nurse and AW managed to pass urine but with intense pain. She was discharged home later that day.
1.11	Over the next 14 hours AW became aware something was not right which resulted in her then being admitted to Addenbrooke's hospital for three nights where a scan revealed a 7mm tear in her bladder. Three further weeks of conservative treatment then followed. Following this her confidence in the NHS was shattered, her mental health poor and she had shown signs of PTSD. She had found the PAHT complaints process frustratingly slow to the extent she had ended up contacting the Ombudsman eight months after first submitting her complaint to the Trust. Just prior to Easter 2022 she had been offered a resolution meeting

	with Trust colleagues which both she and her husband had found wholly cathartic and she had then received a final response letter from the Lead Urology Consultant confirming that the care she had received which had resulted in the bladder rupture was far below the standard expected by the organisation.
1.12	The DoN&M thanked AW for sharing what was a harrowing story and she asked for some reflection from surgical colleagues. In response the Surgical Matron (SM) updated that the Lead Urology Consultant had spoken with the consultant in question. The nurses involved had undertaken a reflective piece and the bleep system involved at the time had recently been updated to a new more efficient one. Continence nurses had since changed processes around use of the bladder scanner and fluid charts were now recorded on a recently introduced electronic system in ED known as Nerve Centre. AW commented that it meant a lot to her to hear that changes had taken place, particularly the process around the use of the bladder scanner and not forgetting basic training skills for example in terms of basic patient examination.
1.13	In response to the above the TC requested that a report on lessons learned and the embedding of those be fed back through the Quality & Safety Committee (QSC) in October. The DoN&M agreed.
ACTION TB1.04.08.22/11	**A report on lessons learned and embedding of those lessons from the Patient Story (TB1.04.08.22) to be presented to October QSC. Lead: Director of Nursing & Midwifery**
1.14	ANED Rob Gerlis (ANED-RG) highlighted that for him the lack of physical patient examination was worrying along with the high handed approach of staff.
1.15	NED George Wood (NED-GW) commented that he had been shaken by what he had heard. The time taken to address the complaint troubled him and he requested a review of that process be included in the paper to QSC. He thanked AW for bringing her story and confirmed the organisation would now put things right to ensure mistakes were not repeated. In response AW reiterated how cathartic she had found the resolution meeting. It was very important for patients to be listened to.
ACTION TB1.04.08.22/12	**A review of the Trust's complaint process to be added to the report on lessons learned from the Patient Story (TB1.04.08.22). Lead: Director of Nursing & Midwifery**
1.16	NED Helen Glenister (NED-HG) commented there was much wider learning for the organisation and she agreed there also needed to be further consideration of the complaints process. As Chair of QSC she would very much welcome the report described above to ensure this experience was not repeated.
1.17	NED Helen Howe (NED-HH) agreed about the wider learning. Listening and respect for the patient were key and if a shift in culture was required then then that was what should happen. She noted that patient stories should be shared across the organisation particularly amongst juniors.
1.18	ANED John Keddie (ANED-JK) stated he had found the story hard to listen to. 'Patient at heart' was the Trust's first, of three, values and the hospital had not got that right. He would follow up tirelessly now how people lived the Trust values and treated patients. In response AW commented that she had been pleased to hear the nurses involved had been asked to write a reflective piece. She questioned whether the consultant involved in her care would also write a reflective piece.
1.19	At this point in the meeting the Medical Director (MD) confirmed the story had shocked her and the Board. The incident would be recorded on internal systems (Datix) and declared as a serious incident (SI). There had been a series of failings in the case starting with the assessment. The consultant would be scrutinised following the 'Just Culture' approach and she was deeply sorry for AW's experience. The consultant would now be required to write a reflection and it would be included in their appraisal. The Surgical Matron confirmed that AW's experience had been recorded on Datix and presented to the Trust's Incident Management Group.

1.20	ANED Anne Wafula-Strike (ANED-AWS) commented she was truly sorry to hear about the experience and she thanked AW for articulating what had happened so that the Board was aware.
1.21	The CEO then also reiterated his thanks to AW for articulating a poor set of experiences in the hospital. It showed the power of a story when things didn't go well and he had been pleased to hear of the positive response from the surgical team. The key piece now would be to take all the actions away to prevent a similar experience for others and also to take the broader learning around communication and behaviour generally and for that to be followed through and articulated to colleagues. He noted that Patient Stories were shared at divisional level. He was pleased to update that the previous week had seen the start of a programme of work to address culture and behaviours in theatres of which communication, speaking up and common sense were key elements. He would also now be looking to the Patient Experience team to understand how the complaints process (responsiveness) could be improved. He thanked AW for her time and apologised again on behalf of the organisation for her experience.
1.22	The TC summarised by confirming that a piece of work would now be undertaken and reported back via QSC in terms of addressing the issues/themes heard that morning. A copy of that report would be made available to AW. Responsiveness to complaints would also be reviewed and the MD would follow-up on the status of the incident process and in terms of the individual consultant.
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	This report was presented by the TC and taken as read. The TC flagged that report had been written using the objectives agreed for her at the beginning of the financial year. Members had no comments.
2.2 CEO's Report	
2.2	The CEO presented his paper and reiterated the Board's congratulations to Tom Burton on his recent appointment to the role of Director of Finance (DoF). He continued that the organisation remained under significant pressure in terms of the demand for urgent care services with continuing and sustained record levels of attendances putting a strain on the organisation and staff alike. Despite that a huge thanks to IT, Quality First, ED and UEC colleagues for the recent implementation of Nerve Centre which was embedding well in ED and enabling the organisation to implement the Manchester Triage system which was important for patient safety and supporting two of the outstanding issues in the current CQC notice.
2.3	The CEO continued that in terms of COVID numbers, new infections were reducing in the community with a similar position being seen in the hospital. There were currently just over 40 positive inpatients which was about half of the numbers that had been seen three weeks previously. Managing those patients safely to avoid nosocomial outbreaks was however adding pressure and flow issues. In terms of recovery he thanked the COO and her team for driving that programme which was now running at 110%-120% of pre-pandemic activity levels and was the strongest in the ICS and the second strongest regionally.
2.4	In terms of the new hospital he hoped colleagues had seen the piece on BBC Look East the previous evening which in his view had been very fair and had shone a light on the absolute requirement for a new hospital in Harlow and would support ongoing conversations with the organisation's people and local population.
2.5	In terms of the broader work outside of the hospital he reminded members that the ICS was now a formal entity and a huge amount of work had already been done at both place and system level. The key activities were provided in the paper but there had been a huge amount of system governance work at ICS level but also in terms of acute providers working together on improvements for patients.

2.6	The CEO then highlighted a selection of some of the improvements and achievements since the Board had last met which showed how the organisation was really turning 'This is Us' into action. He thanked Board colleagues for their participation in the 'This is Us' events: • Sessions 2 and 3 of the 6-month PAHT 2030 Ready OD programme to support senior leaders to work in a way that enabled all colleagues to be the best that they could be to implement the transformational changes to underpinned PAHT 2030. • Staff engagement and recognition week; 'This is Us week' (27 June to 2 July) with a series of events to celebrate, recognise and develop the organisation's people, including Our Amazing People awards aligned with Trust values and long-service awards for colleagues who had worked either 20 or 25 years at PAHT. • Health and wellbeing and equality events as part of 'This is Us' week. • Ongoing development of apprenticeship opportunities for all colleagues with 10 new apprenticeships started including, chefs, administration, nursing and coaching. There were now 81 colleagues on apprenticeship schemes.
2.7	As a final point there had been some very positive feedback on the organisation's new on-boarding process with people feeling much more welcomed into the organisation. The culture/behaviour programme had also started in theatres as discussed the previous month in order to support staff and help create an enhanced environment for all.
2.8	In response to a question from NED-HG the CEO confirmed there had been a significant amount of positive feedback following 'This is Us' week. Staff had felt valued and had been displaying their certificates with pride. The Director of People (DoP) added that a survey had been circulated immediately following the event and the key for her had been the variety of events organised and that the visibility of the Board had been very much appreciated.
2.9	In response to a question from ANED-LB around apprenticeships the DoP confirmed the organisation had a dedicated Apprenticeship Manager who linked in with the community and local colleagues. The EDI champions and Head of EDI in turn linked into that to ensure opportunities for more diverse groups, with a particular focus on those with disabilities.
2.10	At this point NED-HH flagged that she had attended the junior doctor Trust Induction the previous day and commented how useful she felt that cohort of staff had found the session about the role of the Board and its responsibilities. The CEO agreed, noting that learning was important for staff in all roles. ANED-RG also agreed and that should include the junior doctors' learning about their part in terms of place, primary care and the community. He acknowledged however they were rotating (which was pressurising) and that was a hard balance for them. The CEO agreed and highlighted he had heard from some of the juniors the on-boarding session had been the best they had experienced and they had felt very welcomed into the organisation.
03 RISK/STRATEGY	
3.1 Significant Risk Register	
3.1	This update was presented by the MD who immediately drew members' attention to item 3.1.1. This related to the risk that the organisation was storing CTGs on paper due to a delay in securing an electronic solution again due to the decision around the preferred provider of the Trust's new EHR system. This risk was now moving forward with the recent Board agreement on a preferred EHR provider.
3.2	In terms of medical cover for the Anaesthetic Service there had now been agreement in Surgery that the service was more stable in terms of staffing and the risk score would now be lowered.
3.3	In terms of the risk around the Aseptic Unit, that score had been increased to 20 due to growths on routine screening plates and the lack of capacity to secure chemotherapy from outside the organisation.
3.4	There was one new risk with a score of 16 which related to the demand for Paediatric Outpatients outstripping the organisation's ability to deliver that service but mitigations were in place and described in the paper.

3.5	In response to a question from ANED-RG in relation to whether the recent pay non-award for junior doctors presented a risk to the organisation, the MD responded it was certainly a 'horizon scanning' risk.
3.6	In response to a question from NED-HH, the MD confirmed that the SRR would be refreshed (and renamed Corporate Risk Register) following completion of the risk appetite work by the Board in October. The Head of Corporate Affairs (HoCA) then confirmed that the BAF would also be refreshed in line with the changes to the Risk Management Strategy and risk appetite statement and it would also have a new format as it moved over to Datix.
3.7	NED-HG then asked about system working for women living in East Hertfordshire who wished to have their babies at PAHT (item 3.1.2) and commented she would welcome more detail about the outcomes and a timeframe. In response the MD stated that the risk was broader than just women living in East Hertfordshire, it related to all women out of area. She would ask the FAWS team for a timeline recognising the work was complex.
ACTION **TB1.04.08.22/13**	**Request a timeline for completion of the system work around out of area women having their babies delivered at the Trust.** **Lead: Medical Director**
3.8	In response to a question from NED-GW around capacity within the ICS to support the demand on the Trust's Paediatric Outpatients, the MD confirmed the issue related to neighbouring hospitals having shut to new referrals making the position more challenging for the Trust as a number of the referrals were from out of the area. The COO added that new referrals were triaged and clinically prioritised but many came from outside of the ICS. Work was ongoing with the ICS to support the backlog. The Director of Quality Improvement (DoQI) confirmed the position was also reviewed at the Outpatient EOG and colleagues were being encouraged to move some of the activities to virtual appointments in order to support clearance of the backlog.
3.9	The TC summarised by stating the SRR/BAF would both be revised on completion of the risk appetite work, the Board noted the wider risk in terms of pay, particularly for junior doctors and it also noted the complications around cross-border working in terms of maternity patients.
3.2 Board Assurance Framework (BAF) 2022/23	
3.10	This item was presented by the HoCA. The risks had all been reviewed at Board Committees that month and the new reporting format was presented in line with the agreement at the June Board to have a shortened version of the BAF with the full version added to Diligent Resources. The recommendation that month was that none of the risk scores should change. Controls and other aspects of the risks had been updated and the summary of the risks was in the dashboard with the target risk score now included in the dashboard as requested by the Board at the June meeting.
3.11	The Board noted the BAF and looked forward to the new format.
04 PATIENTS	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	This item was introduced by NED-HG who reminded members there were now two parts to QSC with Part II now overseeing aspects of maternity services. Part II had been chaired by the TC. **QSC.29.07.22:** Members noted the decision for quarterly divisional reporting to QSC to cease, with strengthened oversight to now take place at the Patient Safety Group (PSG) with any escalations reported via the PSG Chair's Report to QSC. Deep dives would continue where appropriate. There had also been agreement that reporting on Learning from Deaths would now be bi-monthly to coincide with reporting to Public Board.
4.2	**QSC (Part II).29.07.22**: The TC highlighted issues around the team being able to achieve MIS Safety Action 2 due to IT issues. IT colleagues were aware of those but it should be noted that currently the organisation was not fully compliant with that action.
4.2 Maternity Incentive Scheme	

4.3	This item was presented by the DoN&M and it was noted that all reports (Perinatal Mortality Review Tool Update, Maternity Quarterly Assurance (including Maternity SI report), Pre-term birth Deep Dive and Annual Maternity SI Thematic Review had all been presented to QSC (Part II) the previous week. There was also a requirement for those papers to be presented to the Trust Board.
4.4	She drew members' attention to P64 of the pack (Pre-term Deep Dive) and the long range target of March 2023 for the development of a pre-term birth clinic. She confirmed that patients were triaged into clinics, the issue was more around the space/digital enabler of that. The service however was currently safe.
4.5	In response to a question from NED-HH around the follow-up of children born following non-administration of magnesium sulphate, the DoN&M agreed to follow that up outside the meeting and report back to QSC.
ACTION TB1.04.08.22/14	**Provide an update to QSC II on any follow-up of children born following non administration of magnesium sulphate Lead: Director of Nursing & Midwifery**
4.6	In response to a question from NED-GW in relation to sharing SIs across the ICS the DoN&M confirmed that the organisation reported into the local LMNS, the Director of Midwifery would be vice chair of that from the autumn, the regional maternity partner and regional team sat on QSC (Part II) and NED-HG in her capacity as NED Maternity Safety Champion had established collaborative working across the ICS in terms of the three acute Maternity Champions.
4.7	The TC summarised by stating that the Board was assured on the reports presented.
4.3 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
4.8	This item was presented by the DoN&M who drew members' attention to the overall improvement in fill rates and a huge increase in care hours per patient day (CHPPD) compared to three years previously.
4.9	ED fill rates were included in the report but did not form part of the Unify submission and there had been a deep dive into those at the People Committee (PC). The number of wards rated red in terms of fill rate were reducing in line with recent recruitment and the reduction in COVID absence. One ward (John Snow) still flagged and was an elective surgical ward. Fill there was reduced but this was in line with redeployment of staff due to fluctuating activity levels within the service. The DoN was pleased to report that overall redeployment levels were coming down (2.5% in June). Maternity was also included in the paper.
4.10	In terms of numbers overall vacancy rates were currently at 7% which was a significant improvement and in line with the investment agreed by the Board in January that year. There was also a healthy pipeline of new staff but some caution that turnover rates were going up (currently at 15%) with indications those were at circa 20% in the ICS. Proposals were being worked up in the background to address that.
4.11	At this point the TC informed members that QSC (Part II) had wanted the Board to recognise the amazing recent midwifery recruitment drive.
4.12	In response to a question from ANED-RG, the DoN&M agreed to provide some figures for Maternity diverts albeit the Trust did not often divert but was usually on the receiving end. This would be reported back via QSC (Part II).
ACTION TB1.04.08.22/15	**Provide some additional detail around maternity diverts and report back to QSC (Part II). Lead: Director of Nursing & Midwifery**
4.13	As a final point NED-HH confirmed that the People Committee (PC) had requested similar assurance around staffing, in terms of a report, for the medical profession.
4.4 Interim Mid-Year Nursing & Maternity Establishment Review	
4.14	The DoN&M introduced the paper and reminded members that a six monthly check-in was undertaken on establishment with decisions made as part of the trend. In December the Board would receive a further review showing trends and whether any decisions should be taken around establishment. As part of the review she was pleased to report that no wards

	had been identified with a significant deficit in fact some were now on a watch list to move or reduce their establishment.
4.15	In response to the above the CEO commented the report showed a number of things but particularly the hard work from the DoN&M/Deputy DoN&M in terms of establishment reviews, the outputs of which were now coming to fruition. That linked to the substantial investment made in nursing recruitment over the previous two and half years as a result of those reviews which in turn linked to the improvements in fill rates and CHPPD. He reminded colleagues that PAF had agreed to undertake some work to look at establishment over time, temporary staff usage, recruitment rates, vacancy rates and bank spend in order to agree local targets. That would be further discussed at the Board Development session in September.
4.5 Learning from Deaths Update	
4.16	The MD presented her report and was pleased to confirm she had met with Telstra that week and could confirm that for the thirteenth consecutive month all mortality indices were 'as expected', including SHMI.
4.17	She then provided assurance around the process for significant diagnostic outliers/CUSUM alerts and that every single case would be reviewed with the clinician in terms of coding and where quality of care could be improved.
4.18	She was also pleased to report that the organisation was taking on more community deaths and had employed a number of Medical Examiners who were also GPs providing a good mix of hospital and general practitioners for mortality scrutiny.
4.19	Members agreed there was good assurance around mortality.
4.6 Deep Dive: Improvement in Mortality Indices	
4.20	The MD informed members that Telstra had been asked to provide some insight into why the organisation's mortality had improved and if that could relate just to coding. The report described improvements in coding but also in quality of care and provided specific indicators to evidence the improvements in mortality did not just relate to improvements in coding.
4.21	She drew members' attention to point 3.1 and explained why expected deaths going up was a reflection on coding. The more comorbidities a patient had the higher their risk of death so the reason the expected death rate rose was also a reflection on improved levels of coding. She reminded members that due to the sustained improvements in mortality, reporting to QSC would now reduce to bi-monthly and be in line with reporting to the Board.
4.22	In response to the above ANED-DB commented that the improvements, hard work and progress should be recognised by the Board.
4.23	In response to the above the DoQI highlighted the significant progress made over the previous two years and that the mortality improvement programme was still in play. It was reassuring to see the position validated externally. He also flagged the improvements in length of stay leading to better outcomes for patients staying longer in hospital. He provided assurance the work would continue.
4.24	The CIO then commented that improved coding only helped to support wider population health management in terms of disease/pathway management and he congratulated colleagues on the improvements to date.
4.25	NED-HH then flagged the importance of understanding the difference between good documentation by doctors and coding by coders. The latter would always be limited by the former. She also flagged that whilst reporting to QSC would now be bi-monthly, the Strategic Learning from Deaths Group would continue to meet monthly.
4.26	As a final point the MD confirmed there was now a very open and engaging approach to looking at learning from deaths to make improvements in care.
4.27	The TC summarised by thanking the MD for requesting the deep dive which had been very useful and supported the organisation's own data. The importance of coding was noted and there was agreement around reducing the reporting to QSC to bi-monthly. It was agreed a thank you card would be sent to colleagues for all their amazing hard work to date.

ACTION **TB1.04.08.22/16**	**'Thank you' card to be sent to Mortality team for all their hard work in improving performance against mortality indicators.** **Lead: Trust Chair**
Break 1132 - 1140	
05 PEOPLE	
5.1 Report from People Committee (PC)	
5.1	This update was presented by NED-HH as Chair of the PC. She updated that in terms of the People Report she had asked for brackets to be added after 'temporary staffing' for clarity but it was true to say that there was sometimes an enhancement on bank staff on the normal rate so that was not a complete story but she wanted to emphasise the importance of managing agency and maximising bank use.
5.2	There had been some good news in terms of the outputs of the Pulse Survey (undertaken every three months) where there had been an improvement in seven of the nine questions asked. The UEC deep dive had evidenced gaps in middle grade doctors but with assurance around ongoing work to try to address that. In terms of the Equality & Strategic Framework, that had been provided and the plan for it would follow in the autumn. The Annual Report on Medical Revalidation and accompanying compliance statement had been endorsed for Board approval.
5.3	In response to a question from ANED-DB it was confirmed that the drop-off in staff appraisal rates was overseen at the PC and also at the divisional Performance Review Meetings.
5.2 Freedom to Speak Up (FTSU) Report	
5.4	This update was presented by the DoP who confirmed the paper was the first produced by the new Lead FTSU Guardian (FTSUG) and included lessons learned on data quality from previous reports. The data within the paper now came from a new database set up by the new Lead FTSUG providing additional information on who was raising concerns and especially around protected characteristics.
5.5	The report was showing an increase in concerns being raised which in some ways was good in that people felt they could do that, but over time the organisation would want to see a reduction in numbers. The main reason for raising concerns remained bullying and harassment. Despite having six guardians, four of whom were clinical, not many patient safety concerns were being raised but if that was triangulated with the Datix system, the organisation did have a good culture in terms of raising safety concerns via Datix.
5.6	There had been some improvement in terms of the management of individual cases, but there was more to be done around taking on board actions on a Trust-wide basis to address actual themes. However, members would be aware of the events put on for staff as part of 'This Is Us' week, PAHT2030 Ready tackling behaviours and the current interventions in Theatres/Anaesthetics.
5.7	In response to a question from ANED-DB the DoP confirmed there had been a FTSUG from an ethnic minority but that individual had recently left the Trust. The Lead Guardian was working with the Head of Equality & Inclusion to address the gap and regularly attended REACH (staff network for race, equality and cultural heritage).
5.8	In response to a question from ANED-RG it was agreed that bullying and harassment was a concern in certain departments only (and was not across the organisation) and the PAHT2030 programme was providing support and development for leaders in terms of how they communicated with staff.
5.9	ANED-LB stated she very much welcomed the Strategy which she felt was very accessible. The key for her would be ensuring the Board's role in responding to all the concerns that staff raised through various channels.
5.10	In response to the above NED-HH commented there was some good networking that went on behind the scenes including engagement with the junior doctors, liaison with the Health & Wellbeing team, joint working between FTSUGs and mental health advisors and the Guardian of Safe Working was also involved too.

q

5.11	NED-GW then commented that in terms of the patient story earlier, whilst it had been very uncomfortable to hear, he had welcomed the Executives' transparency and it was good for staff to see the organisation was serious in terms of listening and changing the culture in the organisation.
5.12	The DoP then presented the FTSU Strategy which captured the vision and strategy for the future and linked to the overall cultural piece in terms of PAHT2030. It articulated what reporting would look like but more importantly how lessons would be learned. It had been through various internal channels, SMT and PC and endorsed at each of those points.
5.13	In line with the recommendation the Board approved the FTSU Strategy.
5.14	As a final point the DoP informed colleagues that the Lead FTSU was retiring that summer, would take two months off but would return in December. In the interim another guardian would step into the lead role and there would also be some support from the EoE region.
5.3 Medical Revalidation Annual Report and Statement of Compliance	
5.15	This paper was presented by the MD and gave a summary of Appraisal & Revalidation and related to the completed round of appraisals for 2021/22 for the permanent medical staff of the Trust. It set out a summary of the process for the annual appraisal, compliance data and how that was monitored and assessed to ensure it was quality assured. Dr Fiona Hikmet would take over the role of Responsible Officer later that year.
5.16	The MD continued that 351 of 355 doctors had been appraised, and one of the four outstanding had an exemption. In response to a question from ANED-RG the MD confirmed that appraisal was a condition of employment and a GMC process would be applied to any individuals who did not engage with the process.
5.17	In line with the recommendation the Board approved the Medical Revalidation Statement of Compliance.
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	This update was presented by the DoF. He updated that PAF had noted the current financial position which remained in deficit. Initiatives were underway to look at bank/agency spend and outsourcing costs. Another key discussion had been around the cost improvement programme and work had launched that week to set out to teams why the challenge existed and what the drivers were. The capital programme was being refreshed following some recent allocations and there had been an analysis of the drivers behind income flows and the current regime. The BAF risks around capital and revenue remained at a score of 12 and there was good performance around the ERF trajectory with recognition that was however a national challenge.
6.2	In response to a question from NED-HH in relation to CIPs, the DoF agreed that over the years most of the 'low hanging fruit' had probably been picked however there were still opportunities, particularly around bank/agency usage but he acknowledged the year ahead would be challenging in terms of CIP delivery.
6.2 Integrated Performance Report (IPR)	
6.3	This item was presented by the CIO and the two key headlines were as follows: • Good progress in terms of Cancer 2WW which had now come out of special cause variation and was back in common cause variation. • Increase in staff turnover but clear mitigations in place.
6.4	The COO then updated that in terms of recovery, that week had seen the launch of the new weekly performance meetings with the divisional teams, DoF and Finance BPs to look at how the organisation could be more efficient in terms of supporting its recovery programme. ED attendances remained high and work had started that week on winter planning. A regional NHSEI event a couple of weeks previously had initiated some work in the ICS around supporting patients waiting for an ambulance and also supporting those who arrived by ambulance.

6.5	The COO continued that requests for winter funding allocations had been submitted and those would be forwarded down to the ICS to be shared out. As stated above the Cancer 2WW position was good news and the Trust was also now second best in the region for the 62 day pathway recovery.
6.6	In response to a question from NED-GW the CIO confirmed that the Trust captured data for both ED 12 hour waits and the overall discharge rate and both could be included in the IPR. Both were overseen at the Urgent Care Board. The COO added there had been a conversation with the UEC team at their PRM on those patients in the department for longer than 12 hours and she provided assurance that all would go through a harm review process and data was reported to both the ICS and nationally.
ACTION TB1.04.08.22/17	**Both 12 hour waits and overall discharge rate to be included in the IPR. Lead: Chief Information Officer/Chief Operating Officer**
6.7	In response to a question from ANED-DB it was confirmed that complaints were overseen by QSC but the CIO agreed to discuss outside the meeting the internal KPIs for how many should be open at any one time and the timescales for closing those.
ACTION TB1.04.08.22/18	**Discuss further the internal KPIs around numbers of open complaints and closure timescales. Lead: Chief Information Officer/Director of Nursing & Midwifery**
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee (STC)	
7.1	This update was provided by ANED-LB, Acting Chair of STC. She updated the Committee had discussed the cases for both a Community Diagnostic Centre and the Aseptic Unit. The rollout of Alertive (new bleep system) had gone well and was already having a positive impact on time savings and financially.
7.2	The STC had also discussed clinical transformation and the fact that a number of clinical strategies were in development, some of which would be ready by the end of the year, and some in the following year. The national New Hospital Programme would be looking to prioritise new builds across the whole programme. In terms of EHR, contract negotiations were now beginning in earnest and there had also been a report from the West Essex Healthcare Partnership providing some interesting data on health characteristics locally.
7.2 Report from Senior Management Team (SMT)	
7.3	This update was provided by the CEO and the paper contained the headline discussion items from the previous two meetings. Members had no comments.
08 QUESTIONS FROM THE PUBLIC	
8.1	There were no questions from the public.
09 CLOSING ADMINISTRATION	
9.1 Summary of Actions and Decisions	
9.1	These are noted in the shaded boxes above.
9.2 New Issues/Risks	
9.2	It was noted the issue around junior doctor pay was a potential future risk.
9.3 Any Other Business (AOB)	
9.3	The TC informed members there had been agreement to post a short video summary of Public meetings on the Trust's website. She would undertake the first one following the meeting that day and any thoughts as to their content would be welcomed.
9.4 Reflections on Meeting	
9.4	ANED-DB commented that whilst the patient story had been disturbing it had been important for the Board to hear it and was a reminder that however great systems were, the NHS was a people service and the patient voice needed to be heard.

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9.5	The CIO reflected on the complexities of healthcare, evidenced that day by the patient story but also by the improvements in mortality. A focus needed to be maintained at all times and for the organisation to keep learning and improving.
9.6	ANED-JK reflected that it was important to highlight where papers had already been discussed at Board Sub-Committees as often the conversation around some items appeared a little subdued. The TC agreed but hoped that the assurance reports from those Committees would support some of that.
9.7	The TC thanked CQC colleagues for attending and the meeting closed at 12:22.

Signed as a correct record of the meeting:	
Date:	08.09.22
Signature:	
Name:	Hattie Llewelyn-Davies
Title:	Trust Chair

ACTION LOG: Trust Board (Public) 06.10.22

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.07.10.21/07	Risk Management Approach/Appetite	Provide an update to Trust Board (for Q1) on progress with revising the risk management approach and risk appetite.	DoN&M MD	~~Q1 2022/23~~ TB1.06.10.22	Second Board workshop took place on 07.07.22. Further review of strategy to Board planned for October for possible agreement/sign-off.	Open
TB1.04.08.22/11	Patient Story: Lessons Learned	A report on lessons learned and embedding of those lessons from the Patient Story (TB1.04.08.22) to be presented to October QSC.	DoN&M	QSC.28.10.22	Added to QSC action log and report to be presented to QSC in October 2022.	Proposed for closure
TB1.04.08.22/12	Patient Story: Complaints Process	A review of the Trust's complaint process to be added to the report on lessons learned from the Patient Story (TB1.04.08.22).	DoN&M	QSC.28.10.22	Added to QSC action log.	Proposed for closure
TB1.04.08.22/13	Out of Area Women (Maternity)	Request a timeline for completion of the system work around out of area women having their babies delivered at the Trust.	DoM	QSC2.30.09.22	Item added to QSC (Part II) action log. Discussed at QSCII.30.09.22, agreed that action will remain open until the outcome of a meeting to be held on 13.10.22 is clear. Issue is being monitored at QSC II.	Proposed for closure
TB1.04.08.22/14	Paediatric Follow-Ups (magnesium sulphate)	Provide an update to QSC (Part II) on any follow-up of children born following non administration of magnesium sulphate.	DoN&M	QSC2.30.09.22	Added to QSC2.30.09.22 action log and proposed for closure.	Closed

ACTION LOG: Trust Board (Public) 06.10.22

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.04.08.22/15	Maternity Diverts	Provide some additional detail around maternity diverts and report back to QSC (Part II).	DoN&M	QSC2.30.09.22	Added to QSC2.30.09.22 action log and proposed for closure.	Closed
TB1.04.08.22/16	'Thank you' Card	'Thank you' card to be sent to Mortality team for all their hard work in improving performance against mortality indicators.	TC	TB1.06.10.22	Actioned.	Closed
TB1.04.08.22/17	IPR: 12 hour waits/overall discharge rate	Both 12 hour waits and overall discharge rate to be included in the IPR.	CIO	TB1.06.10.22	12 hour waits are included, discharge rate will be included in the IPR refresh by the end of the calendar year.	Closed
TB1.04.08.22/18	Complaints KPIs	Discuss further the internal KPIs around numbers of open complaint and closure timescales.	CIO DoN&M	TB1.06.10.22	There are measured KPIs within the Complaints Dashboard and this is presented at the bi-monthly Patient Experience Group.	Closed

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors - 6th October 2022

Agenda item:	2.1							
Presented by:	Hattie Llewelyn-Davies							
Prepared by:	Hattie Llewelyn-Davies							
Date prepared:	27th September 2022							
Subject / title:	Chair's Report							
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	
Key issues:	To inform the Board and other colleagues about my work; to increase knowledge of the role; to evidence accountability for what I do.							
Recommendation:	The Board is asked to discuss the report, give feedback for future content and note it.							

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

Previously considered by:	Not applicable
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	The work on succession planning is guided by the Trusts commitment to EDI and its recruitment policies. The work on resilience is guided by the same principles.
Appendices:	None

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1.0 Purpose

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

2.0 Succession Planning for Non-Executive Members:

NHS Non Executives are appointed with an absolute maximum term of office of six years, extendable only in exceptional circumstances. The Board constantly needs to be aware of the end dates for each Non Executive and to plan for recruiting to vacancies and ensuring that the board comprises of people with the right experience, skills and values to enable PAHT to thrive. The Board will consider in its Remuneration and Nomination Committee later in the day, a review led by me of all terms of appointment and the proposed composition of the board over the next few years. The outcome will be updated on our website once the decisions are made. The requirement to do this is widely seen as best practice and was an issue arising from the external Well Led Review undertaken just over a year ago.

3.0 Annual General Meeting:

Our Annual general Meeting was held in the Trust's Training and Development Centre on 26th September. We were delighted to have roughly 90 people present either virtually or in person. Some excellent questions and challenges were made by those present.

Sadly there was a problem with the Internet links and for those attending virtually the links dropped several times. Our CIO has reviewed what went wrong and will update the Board at the meeting. The recording of the meeting was made available on the website for anyone to watch within a couple of hours of the meeting ending.

I would like to thank everyone involved in making the event such a success, including our catering staff for a great buffet lunch.

4.0 Staff Welfare and Resilience:

One of the issues most concerning to the Board at present is the impact of the cost of living on our staff and our local population. I'm delighted to report the great work of our health and wellbeing steering group in spearheading many initiatives to support our people including free staff car parking, increased excess mileage rates, bus and train discounts and, via Harlow Hub, access to foodbank vouchers and school uniform exchange. The focus on both physical and psychological health continues with support provided by the staff health and wellbeing team, the Here for You psychological support service and the Vivup employee assistance programme.

5.0 The System:

One of the priorities that the Board agreed for me during my first year in post was to continue to play a strong role in wider system and developing the role of the Integrated Care System. I have continued to play an active role both formally and

informally in supporting colleagues in this work and will continue to do so. For example, I currently mentor two chairs in the region. We look forward to welcoming Clare Panniker (our regional Director) to the Trust on 17th October 2022.

On the national stage I am delighted to be on the interview panel to appoint the new CEO of NHS Providers, whose job is to represent the NHS to government and other stakeholders.

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

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

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 6 October 2022

Agenda item:	2.2							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	29 September 2022							
Subject / title:	CEO Update							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report updates the Board on key issues since the last public meeting: - COVID-19, recovery and Urgent and Emergency Care - Winter - Political Developments - Integrated Care System and Board developments							
Recommendation:	The Trust Board is asked to note the CEO report and the progress made on key items.							

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

Previously considered by:	n/a
Risk / links with the BAF:	CEO report links with all the BAF risks
Legislation, regulatory, equality, diversity and dignity implications:	COVID-19 item - regular clinical reviews of all patients waiting for elective care are undertaken to reprioritise if required and address any potential E&D impact caused by long waits. HCP health inequalities focus supporting EDI.
Appendices:	None

Chief Executive's Report
Trust Board: Part I – 6 October 2022

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

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

1.1 COVID-19 Recovery

We are continuing to work closely with place-based, system, IS and outsourcing colleagues to maximise every opportunity for our longest waiting and most urgent patients to receive the interventions they require in a timely manner.

We are making strong progress in recovering all of our services with our planned activity in many areas now greater than pre-pandemic levels. More detail is available in the Integrated Performance Report.

1.2 COVID-19 booster vaccination

The national autumn COVID-19 booster vaccination programme started on 1 September for the most vulnerable. NHS workers are able to access the booster through the national programme and PAHT will be running a local COVID-19 booster vaccination for all colleagues within the next couple of weeks, as soon as we have receipt of the vaccinations themselves.

1.3 Urgent and Emergency Care

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

Our new electronic health record in ED (Nervecentre) continues to be embedded well by colleagues. It has supported timely triage based on the Manchester triage system, a key requirement within our CQC improvement notice, and improvements in this can be clearly seen in our IPR. Nervecentre is also supporting the improvements made by the ED teams in clinical risk assessments and care planning.

(2) Winter

All the expectations are that the NHS will have a winter like we have never seen before in terms of pressures and demands due to:

- Unknown covid and flu cases
- Respiratory conditions expected to be a worse challenge than normal
- Cost of living impact on health of residents
- Start point worse than previous years with higher occupancy levels due to discharge pressures and covid numbers and higher demand on urgent care

National modelling suggests that as many as an additional 14,000 beds may be needed across the country to support the NHS in safely getting through winter. For PAHT and the local West Essex health and care partnership, this equates to the equivalent of approximately 45 – 50 beds.

We have been worked with colleagues in the wider health and care partnership as well as colleagues internally to minimise non-clinical / wasted time of our clinicians, reduce duplication and maximise efficiency of processes and decision making, as well as support changes to clinical pathways.

Key actions that local teams are leading on include:

- Reducing admissions through use of SDEC, improved specialty decision making in ED and enhanced frailty assessment
- Improved timely daily decision making on inpatient wards to support timely discharge
- Ongoing use or virtual ward capacity in conjunction with community services colleagues to support timely discharge and management of patients in the most appropriate space
- Strong focus on the impact of deconditioning and actions to prevent this
- Enhancement of the governance structures including the cell structure used during the management of the COVID-19 pandemic and supporting discussions and decisions for patients no longer meeting the criteria to reside.

(3) Political developments

Since the last Board meeting there have been a number of changes in key political roles affecting the country and the NHS.

Liz Truss was appointed as the country's Prime Minister following the leadership contest within the conservative party.

One of the first appointments made to her cabinet was Therese Coffey as the health and social care secretary as well as deputy prime minister, replacing Steve Barclay in the former role.

Since this time, there have been a number of changes made to the health advisor teams and the ministers. DHSC ministers are:

- Robert Jenrick – Minister of State
- Will Quince – Minister of State
- Caroline Johnson – Parliamentary Under Secretary of State
- Neil O'Brien – Parliamentary Under Secretary of State
- Nick Markham – Parliamentary Under Secretary of State

The focus of the new ministerial team has remained very largely the same as the previous team with a strong initial drive around ensuring the NHS is as fit as possible for winter and supporting the ongoing recovery of services impacted on by the COVID-19 pandemic. Therese Coffey's initial speech highlighted the A, B, C and D of Ambulances, Backlogs, Care and Doctor and Dentists and since this time there has been clarification of the maintenance of the 4-hour urgent care standard and a push to ensure everyone can see their GP with a routine issue, within 2 weeks.

(4) Integrated Care System and Board developments

Hertfordshire and West Essex (HWE) Integrated Care System (ICS) continues to develop and drive some changes across the wider system. As well as supporting winter planning the system is also supporting the development of a range of options for a system-wide elective hub to underpin covid recovery and driving the better use of information and data across all agencies.

Acute Provider Collaborative discussions have progressed well since we last met with a clear strategy emerging focussed around our more hard pressed or fragile specialties. There is also good coordination of the development of local Community Diagnostic Centres models.

At a more local level the West Essex Health and Care Partnership also continues to develop well with a current focus on how we address the variations in health inequalities across our local populations and support influencing the wider determinants of ill health.

Author: **Lance McCarthy, Chief Executive**
Date: **29 September 2022**

The Princess Alexandra Hospital NHS Trust

TRUST BOARD – 6 OCTOBER 2022

3.1

Agenda item:	3.1							
Presented by:	Fay Gilder – Medical Director							
Prepared by:	Lisa Flack – Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Quality Governance							
Date prepared:	26 September 2022							
Subject / title:	Significant Risk Register							
Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper presents the significant risk register (SRR) for all our services. The significant risk register (SRR) is a snapshot of risks across the Trust and was taken from registers on 2 September 2022. This paper includes all items scoring 15 and above. The overall number of significant risks on the register has increased from 66 to 70 (table 1 and section 2). There are no new risks with a risk rating of 20, three new risks with score 16 and two with score of 15. The main themes for the 9 risks scoring 20 on the SRR are: • Four are our performance risks, (reduced by two, removed duplicates from surgical register if already an operational risk): o two ED access standards o one regarding referrals to treatment standards o one for cancer-waiting times standard. • Two for our patients: electronic storage of maternal CTG reports and system wide midwifery care with East Hertfordshire. • Two for our places regarding refurbishment of the maternity unit and the pharmacy aseptic unit • One for our people - consultant cover in obstetrics • Actions taken and mitigations in place for each of these risks are detailed in section three. Three new risk scoring 16 are: • Two for our people: critical care staffing and information governance training compliance • One for our places regarding need for a decant facility, detailed section 4. Two new risks scoring 15 are: • Our people: maternity basic life support training compliance and neurology staffing, detailed in section 5							
Recommendation:	Trust Board is asked to review the contents of the significant risk register and approve the new risks.							
Trust strategic objectives: please								

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indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**
	√	√	√	√	√

Previously considered by:	This paper was reviewed by the Risk Management Group on14/9/22 & Senior Management Team on 20/9/22
	Divisions and corporate teams review their risks at their local governance meetings. Teams escalate new risks and those that they require assistance with to RMG on a monthly basis.
Risk / links with the BAF:	There is crossover for the risks detailed in this paper and on the BAF
Legislation, regulatory, equality, diversity and dignity implications:	Management of risk is a legal and statutory obligation. This paper has been written with due consideration to equality, diversity and inclusion.
Appendices:	Nil

The Princess Alexandra Hospital NHS Trust

3.1

1.0 Introduction

This paper details the significant risk register (SRR) across the Trust; the registers were taken from the web-based Risk Assure system on 2 September 2022 and updated since the risk management group meeting. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

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

2.0 Context

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

There are 70 (66 on previous paper) significant risks on the risk register, an increase of 4 from the the paper discussed in August 2022 Trust Board. The breakdown by service is detailed is in table 1.

Table 1 – Significant Risks	**Risk Score**				
	15	**16**	**20**	**25**	**Totals**
Covid-19	2 (1)	1 (1)	0 (1)	0 (0)	**3 (3)**
Cancer & Clinical Support	5 (2)	10 (10)	1 (1)	0 (0)	**16 (13)**
Communications	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Estates & Facilities	2 (2)	3 (3)	0 (0)	0(0)	**5 (5)**
Finance	0(0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Health Safety and Resilience	1(1)	0 (0)	0(0)	0 (0)	**1 (1)**
Information Data Quality and Business Intelligence	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
IM&T	1 (1)	2 (2)	0 (0)	0 (0)	**3 (3)**
Integrated Hospital Discharge Team	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Learning from deaths	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Nursing	0 (0)	1 (0)	0 (0)	0 (0)	**1 (0)**
Operational	2 (2)	1 (1)	4 (4)	0 (0)	**7 (7)**
Research, Development & Innovation	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Workforce - training	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
FAWs Child Health	2 (2)	3 (2)	0 (1)	0 (0)	**5 (5)**
FAWs Women's Health	4 (3)	4 (4)	4 (4)	(0)	**12 (11)**
Safeguarding Adults	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Medicine	0 (0)	1 (0)	0 (0)	0 (0)	**1 (0)**
Surgery	1 (0)	1 (1)	0 (3)	0 (0)	**2 (4)**
Urgent & Emergency Care	3 (3)	4 (4)	0 (0)	0 (0)	**7 (7)**
Totals	**25 (19)**	**36 (33)**	**9 (14)**	**0 (0)**	**70 (66)**

(The scores from paper presented at RMG/ SMT in July and Trust Board in August 2022 are detailed in brackets)

3.0 Summary of risks scoring 20 and above

There are 9 risks with a score of 20. A summary of these risks and mitigations is below:

3.1 Our Patients

Family and Women's

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

- The Trust needs electronic storage of CTG to cover antenatal and intrapartum care, (20202/06/01 raised in June 2020, score adjusted as software programme requires investment). Phase 2 requires electronic storage of CTG both antenatally and intrapartum.
  Action: Currently all notes are available on paper and the team make copies where there is a known outcome that the CTG will be required for a review post-delivery as per department standard operating procedure. Presentation about centralised monitoring completed in February and reviewing regarding CTG storage centrally. FAWs governance meeting reviewed this risk on week commencing 19/9/22 and decided to keep score at 20 for review again in October.

3.1.2 System working for women living in East Hertfordshire

- Women that wish to deliver at PAHT and who live in East Herts will have their midwifery antenatal and post-natal care delivered by East Herts midwives. Both trusts do not undertake the same foetal growth monitoring and their records are kept separate. This reduces compliance with continuity of carer (2022/01/01 raised 21 January 2022).
  Action: PAHT midwifery staff are working with the governance team at East Hertfordshire community CCG. Risk discussed at Trust board and across the Local Midwifery Network Service. We continue to monitor any incidents that occur due to cross border working. FAWs governance meeting reviewed this risk on week commencing 19/9/22 and decided to keep score at 20 for review again in October.

3.2 Our People

Family and Women's teams

3.2.1 Consultant cover in obstetrics

- Consultant cover improved and achieves 90 hours per week with extra ward rounds in place as recommended in the Ockenden report. Our unit delivers 3,800 babies per annum which means we should have 60 hours of cover, but we are aspiring to be better than the minimum. Due to unknown situations there may be occasions when consultants cannot be in the trust within 30 minute timeframe. The national requirement of 98 hours consultant cover for units with 4,000-5,000 deliveries per annum. There is a high potential for obstetric consultants needing to be called into the trust (2020/10/01 December 2020).
  Action: All consultant job plans have been reviewed and job descriptions amended. Recruitment is planned for further substantive roles, as staff are due to come off the on-call rota for health reasons. We are unlikely to be at 98 hours in the short term. A hot week consultant role is in place, to ensure there are twice daily ward rounds on labour ward as per Ockenden recommendations. FAWs governance meeting reviewed this risk on week commencing 19/9/22 and decided to keep score at 20 for review again in October.

3.3 Our Performance

3.3.1 ED performance

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

- Compliance with the statutory standard for the Emergency department (ED) (001/2017 on operations team register since April 2014)
- Achieving the standard of patients being in ED for less than 12 hours (002/2016 raised July 2016 on operational team register)

Actions: Daily monitoring of previous days breaches, numbers & patterns of Attendance to facilitate changes to ED pathway and improve performance. ED board rounds daily and daily huddle to review treatment plans and pathways (7 days per week). Internal professional performance standards agreed and implemented. Electronic tracking process in place to ensure escalation to consultant and nurse in charge if patient is not meeting internal professional standards. East of England escalation process in place to reduce ambulance offload delays.

3.3.2 Cancer access standard

- Not achieving 85% of all patients referred by GP to receive treatment within the cancer 62-day standard (005/2016 on register since July 2016)

Actions: Recovery action plan for each tumour site is monitored with robust tracking. Revised patient target list (PTL) has granular information for oversight of individual patients on cancer pathway to ensure action detailed weekly by patient on the pathway.

3.3.3 Referral to treatment constitutional standards

- Risk of 52-week breaches because of the pandemic, pauses to OPD clinics and elective surgical activity. The numbers of patients waiting between 40 to 52 weeks is monitored and tracked by operational teams (Operational register 006/2017)

Action: Weekly recovery performance meeting with executive directors monitors activity levels to improve utilisation and trajectories planned. Detailed monthly dashboards shared. Refreshed PTL meetings with outpatient bookers attending to escalate relevant cases to divisional teams. Current focus on 100 week cases and then focus on 96 weeks. Patients booked in order of clinical priority, monitoring of PTL continues weekly, with cancer PTL reviewed daily. Working with STP partners to manage paediatric urology and plan to address longer term service provision underway with Addenbrooke's and E&N Herts.

3.4 Our Places

3.4.1 Maternity Unit

- The maternity unit requires refurbishment which has been highlighted through external visits as part of the Ockenden assurance assessment, reviews within the maternity incentive scheme and from feedback received from service users (Reference: 2022/04/01).

Action: Development plan is being created to share with the maternity leads and options appraisal has been shared with SMT.

3.4.2 Pharmacy

- Aseptic unit to produce chemotherapy

The Trust requires a new aseptic unit (reference Pharm/2014/06 on risk register since December 2014, score increased from 16 to 20 in July 2022)

following discussion at the infection prevention & control committee due to growths on routine screening plates and lack of capacity to obtain chemotherapy from outside the trust.
Action: Funding has been approved for the new unit by Trust board in August 2022 with a planned date for completion of new aseptic unit by 31/3/22.

3.5 Our Pounds: Nil

4.0 Three new risks with a score of 16 has been raised since 1 July 2022

4.1 Our People

4.1.1 NEW: Staffing for Critical care

There is a risk that there are insufficient consultants to cover the critical care rota due to vacancy and need to expand the number of people available. With staff currently on rota due to return to anaesthetics and one to retire. (CC001/2022 approved by divisional governance meeting to put in register in July 22)
Action: Three locum posts offered with tentative start dates in place, out to advert for substantive posts.

4.1.2 NEW: Information governance training compliance

Non-compliance against national standard of 95% Trust staff to have undertaken annual information governance training. A further 12% of staff need to complete the training during August and September 2022. (IG047 raised in July 2022)
Action: Executive oversight with compliance being monitored. Non-compliant staff will receive correspondence from the Chief information officer, Medical director and Information governance team.

4.2 Our Places

4.2.1 NEW: Decant facility

There is a risk that there will be disruption to services including reduced or paused services when there is a requirement to undertake emergency or planned urgent maintenance work. This is necessary due to the poor state of the estate. (DecantJul22 raised in July 2022)
Action: Nightingale ward is currently used as decant ward when not in use for escalation services. Feasibility study for a decant facility is to be undertaken and reported within the capital plan.

5.0 Two new risks with a score of 15 have been raised since 1 July 2022

5.1 Our People

5.1.2 NEW: Staff compliance for basic life support

Compliance for FAWs women service is lower then trust standard of 90%. Medical staff compliance is 52% and Midwifery compliance is 81% (2022/05/02 approved by divisional governance for raising in register in July 2022)
Action: Practice development team reviewing compliance regularly

5.1.3 NEW: Staffing for Neurology

To have a fully staffed neurology service of consultants and junior doctors to meet the needs of PAH in and outpatients (Neuro005 approved by divisional governance to raise to register in July 2022)

Action: clinics reduced to enable clinicians to review ward inpatients to prevent discharge delays, locum doctors being sourced on sic month contracts. Vacancy for recruitment has been approved

6.0 Recommendation

Trust Board is asked to review the contents of the significant 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 – 6 October 2022

3.2

Agenda item:	3.2
Presented by:	Heather Schultz – Head of Corporate Affairs
Prepared by:	Heather Schultz – Head of Corporate Affairs
Subject / title:	Board Assurance Framework 2022/23

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

Key issues:	The Board Assurance Framework is presented for review and approval. The revised reporting format was endorsed by the Board at the meeting held in June and the summary dashboard is included in the papers as Appendix B with the detailed BAF available to Board members in the resources section of Diligent. The risks have been updated with executive leads and reviewed at the relevant committees during September 2022. Following review at PAF it is recommended that the score for Risk 5.2 Capital is reduced to 8 which is the target risk score. The risk is attached for review and the Director of Finance is the executive lead for the risk. BAF risk 3.2 (Financial and Clinical Sustainability across health and social care system) is attached for consideration by the Board (the Board is responsible for reviewing this system risk).
Recommendation:	The Board is asked to: • Note the updates to the risks and approve the reduced score for Risk 5.2 Capital.

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

Previously considered by:	STC, QSC, PC and PAF in September 2022.
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance and risk management processes. The controls and mitigating actions outlined in the risks are designed to support delivery of the Trust's strategic objectives and promote an organisational culture that drives improvements in equality, diversity and inclusion.
Appendices:	Appendix B – BAF dashboard, Appendix C BAF risk 3.2, Appendix D – BAF risk 5.2

Board Assurance Framework Summary 2022.23

Risk Ref. Committee	Risk description	Year- end score (Apr 22)	June 22	August 22	Oct 22	Dec 22	Feb 23	Year-end score (Apr 23)	Trend	Target risk score	Executive lead
	Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population										
1.0 QSC	COVID-19: Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered.	16	12	12	12				↔	8	CEO/ DoN&M
1.1 QSC	Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience.	16	16	16	16				↔	12	DoN&M/ MD
1.2 STC	EPR: The current EPR has limited functionality resulting in risks relating to delivery of safe and quality patient care.	16	16	16	16				↔	12	DoIMT/ CIO
1.3 PAF	Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.	15* New risk	15	15	15				↔	10	COO
	Strategic Objective 2: Our People – we will support **our people** to deliver high quality care within a compassionate and inclusive culture that continues to improve how we attract, recruit and retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.										
2.3 WFC	Workforce: Inability to recruit, retain and engage our people	16	16	16	16				↔	8	DoP
	Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.										
3.1 PAF	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20	20	20				↔	8	DoS
3.2 Trust Board	Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	16	16	16	16				↔	12	DoS
3.5 STC	There is a risk that the new hospital will not be delivered to time and within the available capital funding.	16	16	16	16				↔	9	DoS
	Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators										
4.2 PAF	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	16	16	16	16				↔	12	COO
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.										
5.1 PAF	Finance – revenue: Risk that the Trust will fail to meet the financial plan due to the following factors: An indicative annual budget for 22/23 has been established. A deficit plan has been submitted but national, allocations are not yet known and are linked to system envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement, with additional deficit expenditure to reflect	12	12	12	12					8	DoF

Board Assurance Framework Summary 2022.23

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

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2022-23**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iii) The resources required for delivery at a programme and workstream level have not been defined or secured iv) The current governance structure is under development given the shift in focus from planning to delivery. v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS Trust Board	i) ICS workstreams with designated leads ii) System leaders Group iii) ICS governance structure iv) ICS priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) ICS Estates Strategy being developed. viii) ICS Clinical Strategy in place ix) ICS wide Strategy Group x) System agreement on governance and programme management	ICS CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) ICS Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and ICS updates (Board session on ICS governance Dec 21, June 2022)	**4 X 4= 16**	Lack of ICS demand and capacity modelling. **ACTIONS:** System leadership capacity to lead ICS -wide transformation		21/09/2022	**No changes to risk rating.**	**4x3=12 December 2022**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2022-23**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive Assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
	Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way													
BAF 5.2		Finance : Risk that the Trust will fail to deliver the 2022/23 Capital programme within the Capital Resource Limit and ICS allocations.	**Causes:** The main causes of risk to delivery are (i) An over-subscribed capital programme. (ii) Operational pressures that may constrain the delivery of a capital scheme. (iii) Confirmation of external funding sources within a timeframe to allow projects to be completed including adequate planning and procurement preparation. (iv) Incomplete and/or untimely production of business cases that do not facilitate required approvals. (v) Three year funding settlements that do not support development of longer term / 5 year plans and management of a plan over financial years. (vi) As the ICS takes on increasing responsibilities for capital planning the Trust will be competing for capital resource across the ICS. (vii) The development of the New Hospital will continue to be a significant programme of work. (viii) Costs for building projects are increasing therefore adding pressure to the capital programme. (ix) The capital programme has an overplanning margin wich increases the risk of breaching the CRL if all projects deliver. (x) Late in the financial year arrival of PDC and 'boom/bust' accounting.	**4 X4 = 16**	**Exec leads:** DoF **Groups:** Capital Working Group, SMT, EMT and Performance and Finance Committee, New Hospital Committee	**Key Controls:** (i) The Trust has developed a 'Risk based' prioritised capital programme which is agreed through the capital working group, SMT, PAF and the Board. The CWG meets monthly to monitor progress on pre agreed schemes. (ii) The Risk Management Committee detail all risks that require capital investment. (iii) The Trust undertakes a six facet survey which informs all backlog maintenance risks and how this element of capital is spent. (iv) Business cases are required for all capital investment. (v) All capital projects have a senior responsible officer and project lead and report into Divisional /Corporate areas. (vi) Applications for external funding for additional, ad hoc capital. (vii) Discussion with system partners to ensure that the Trust does not breach its CRL as capital allocations can be moved across the system.	**Sources of Assurance :** (i) Frontloaded capital trajectories that monitor expected performance against plans, including cashflow forecasts. (ii) YTD and forecast reports detailing progress. (including New Hospital) (iii) Internal audit reports. (iv) A prioritised capital programme that allows for flexibility and longer term planning. (vi) Business case review process verifies investments are strategic/operational and meet the Trust's requirements to achieve its objectives. vii) Capital Working Group review of progress and forward look determined. Likely availability of excess capital within the system to ameliorate short term delivery risk.	**Positive/Negative Assurances** (i) Delivery against YTD and forecasted plans. (ii) Business cases approved timely. (iii) Reduction in non-compliant waivers. (iv) Approval of external funding and receipt of PDC/MoU v) Monthly Capital updates to PAF	**4x2=8**	**Gaps in Control**: (i) Compliance with business case and approval process as this is a realtively new process and is currently being embedded within the organisation.	**Gaps in Assurance:** (i) Improvements in forecasting trajectories and development of longer term capital programme.	21/09/2022	**Score reduced from 12 to 8.**	**4 x 2 =8 (Q4 2022/23)**
			Effects: (i) Risk to under/overshoot of CRL.							**ACTIONS:** (i) Business Development Group is being initiated in line with the revised Capital and Revenue investment guidance				

BOARD OF DIRECTORS:	**Trust Board 6 October 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**30 September 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
1.6 Quality PMO report re CQC Quality Improvement Compliance	Y	N	N	There was good overall progress however there were 2 red-rated items. S5 (e-consent, consent on the day of surgery) and S3/N (Safeguarding Training) where it was considered there was currently insufficient assurance. External peer review panels were not held in August, delaying a number of actions (12) potentially moving from green to blue (embedded) and a scheduled peer review panel on 15.09.22 would aim to address that.
2.1 Infection Prevention & Control Update	Y	Y	N	It was agreed that hand hygiene needed to remain a focus particularly in terms of auditing. It was noted, the Statutory Mandatory Training Oversight Group had not agreed with the proposal for Fit testing to be part of the Central Monitoring system for statutory mandatory training and had asked that this request now be taken through the Health & Safety Committee.
2.1 BAF Risk 1.0 (COVID)	Y	Y	N	It was agreed at the Committee that despite the recommendation to reduce the risk score to 8, it should remain at 12 as cases were currently on the increase.
2.2 Reports from Feeder Groups	Y	N	N	Concerns had been raised at the AGM that week around difficulties for patients in getting through on the telephone to re-arrange outpatient appointments. QSC noted that some immediate measures had already been put in place including

BOARD OF DIRECTORS:	**Trust Board 6 October 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**30 September 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				additional staff to answer calls and a call back function was also being explored. The issue appeared to have arisen due to increasing the number of appointments to support local recovery.
2.3 Learning from Deaths Update	Y	Y	N	HSMR remained 'within expected' at 100.5 Some work would now be undertaken via the West Essex End of Life Group to improve the visibility of DNACPR (Do Not Attempt Cardiopulmonary resuscitation) Forms in the community.
2.4 BAF Risk 1.1 (Clinical Outcomes)	Y	N	N	It was agreed that the risk score would remain at 16.
2.6 Patient Safety Report	Y	N	N	The inclusion of EDI data was welcomed and QSC also noted the improvement in terms of outstanding reviews of NICE guidance.
2.7 Claims Deep Dive	Y	N	N	QSC was assured the organisation was learning from claims and it was agreed there would be some future discussion at the Strategic Transformation Committee around the benefits a new EHR would offer in terms of reducing the number of claims but also the mitigating steps to be taken until such a system was in place.

BOARD OF DIRECTORS:	**Trust Board 6 October 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**30 September 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.1 M5 Integrated Performance Report	Y	Y	N	It was agreed that reporting against targets relating to maternity elements (c-section) would be discussed further in QSC (Part II). It was noted that the national targets around Continuity of Carer had been stepped down.
3.2 Update on 2 Stage Consent	Y	Y	N	The Divisional Director for Surgery presented the Quality Improvement Project scoping the current consent practices across the organisation, to develop recommendations and to achieve improvement. Delivery of an e-consent solution was underway and would be implemented in Orthopaedics in October 22, with further rollout across surgical specialities by the end Q4 22/23.
3.3 Ambulance Handover Deep Dive	Y	Y	N	The Committee was assured that patient safety was not an issue for those experiencing long handover waits but it was agreed that in terms of quality of experience, that was impacted by the longer than recommended waits.
The following papers were also discussed:				Report from Clinical Effectiveness Group Report from Clinical Compliance Group Report from Strategic Learning from Deaths Group Report from Patient Safety Group Report from Patient Experience Group Update from the Patient Panel Oversight of Patient Waiting Lists

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**Trust Board 6 October 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Helen Glenister - Committee Chair**			
DATE OF COMMITTEE MEETING:	**30 September 2022**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				Research & Development Annual Report Horizon Scanning

BOARD OF DIRECTORS:	**Trust Board 6 October 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Rob Gerlis - Committee Chair**			
DATE OF COMMITTEE MEETING:	**30 September 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
1.6 QSC (Part II) Effectiveness Review	Y	Y	N	The outcome of the review was discussed; key findings were that deep dive items will be added to the workplan, information from the CMO for England will be included in reports going forward and a review the number of attendees will take place in six months' time. The Terms of Reference remain unchanged.
2.1 Maternity Dashboard	Y	N	N	There had been a productive meeting with Deloitte that morning around dashboard reporting including exploring the possibilities of ethnicity data to pull out health-related outcomes. It was hoped the recent intake of midwives would alleviate the intermittent closures of the Birthing Unit. The Committee was informed of the imminent rollout of e-Consent in the service and consultant staffing was also looking more secure following recent appointments.
2.2 Midwifery Staffing	Y	N	N	The committee noted there were no recommended changes to midwifery staffing. In view of recommendations from Ockenden, specialist midwifery staffing has to be reviewed and the committee will be updated on that in October 2022.

BOARD OF DIRECTORS:	**Trust Board 6 October 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Rob Gerlis - Committee Chair**			
DATE OF COMMITTEE MEETING:	**30 September 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 Monthly SI Report/Quarterly Assurance Report	Y	N	N	The committee noted that no new maternity incidents had been declared since the last report, one maternity incident had been closed since the last report and six SI's are currently under investigation. The report is on the Trust Board agenda.
2.4 Maternity Incentive Scheme	Y	N	N	The committee was assured on progress against the ten safety actions with a partial concern noted for safety action 2 as previously reported to Board. Monthly monitoring continues and next steps include a peer assurance review and use of PM3 for storage of evidence.
2.5 Maternity Champions' Report	Y	Y	N	IT remains one of the leading issues and this has been escalated. The positive impact of the Fetal Monitoring lead midwife was noted particularly in relation to ensuring that equipment and training has improved safety.
2.6 Horizon Scanning	Y	N	N	It was agreed the Trust was making good progress.
3.4 Maternity Digital Strategy	Y	N	Y (referred to Trust Board for approval).	The Committee approved the strategy and recommended it to Board for approval.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 October 2022

Agenda item:	4.2
Presented by:	Giuseppe Labriola, Director of Midwifery
Prepared by:	Giuseppe Labriola, Director of Midwifery
Date prepared:	19th September 2022
Subject / title:	Interim mid-year midwifery establishment review

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

Key issues:	NHS Resolution's, Maternity Incentive scheme requires that The Princess Alexandra Hospital NHS Trust (PAHT) demonstrates an effective system of midwifery workforce planning. This review should take place every six months. This review has been completed and there are no recommended changes to midwifery staffing. However, in view of recommendations from Ockenden, specialist midwifery staffing needs to be reviewed and the committee will be updated with progress in October 2022.
Recommendation:	The Board is asked to note the information within this report.

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

Previously considered by:	Divisional Board 28.09.22 Included within interim mid-year nursing and midwifery establishment review – considered by Workforce Committee 28.03.22 and Trust Board 07.04.22 QSC2.30.09.22
Risk / links with the BAF:	BAF: 2.1 Workforce Capacity
Legislation, regulatory, equality, diversity and dignity implications:	NHS Resolution – Maternity Incentive Scheme Year 4 (2022-23) There are no ED&I implications identified in this report
Appendices:	1. Midwifery Workforce Review

1.0 Purpose

modern • integrated • outstanding

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NHS Resolution's, Maternity Incentive scheme requires that PAHT demonstrates an effective system of midwifery workforce planning. Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in use in the United Kingdom's maternity units for a significant number of years.

PAHT had a formal midwifery workforce review completed by BR+ in November 2021, detailing an uplift of midwifery staffing was required. This was approved and funded by Trust Board in February 2022.

The aim of this report is to provide assurance to the Trust Board that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels.

2.0 Context

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

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

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

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

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

A ward acuity tool has been developed by BR+ which PAHT purchased and implemented in 2021. This acuity tool proactively assesses the clinical needs of women/people on the ward (Labour Ward, Antenatal Ward, Postnatal Ward and Birth Centre) and matches against the staff available. The tool calculates the staff hours needed based upon the client need and compares them with the staff hours available on that shift.

Since July 2022, the Quality and Safety Committee (Maternity Assurance) have been receiving these staffing reports monthly in order to provide assurance on safe staffing levels within maternity.

3.0 Midwifery workforce at PAHT

BR+ methodology includes a review of the acuity and activity within the population denoting the number of Whole Time Equivalents (WTE) required to safely run a maternity service as it takes into consideration activity and acuity, as well as specialist midwifery services and managerial responsibilities. BR+ recommended that PAHT should be funded to a midwife to birth ratio of 1:23

In 2021, a full workforce review was completed by the director of midwifery. The methodology of this review involved reviewing each cost centre to determine funded posts, alongside establishing what was recommended by BR+ for midwifery staffing, and using professional judgement to determine the staffing levels needed for all midwifery areas. The BR+ report and the workforce review identified that 22.74 WTE posts (midwives, support workers, specialist and managerial posts) were needed for the maternity service. This was approved and funded by the Trust board in February 2022

The baseline of the workforce review is still current and describes a three year plan for the midwifery workforce (Appendix 1).

Reviewing the birth rate for 2021/2022, has demonstrated an increase in births (maternities) to 3,869 from 3,788 as detailed in Table 1.

Table 1. Births by financial year

Financial Year	Births (maternities)
2022/2023	3,900
2021/2022	3,869
2020/2021	3,788

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

4.0 Recommendation

The maternity service has the required funded establishment for the level of acuity and activity within the service. However, in line with the Ockenden report, there is a requirement to review the specialist midwifery staffing alongside the Immediate Essential Actions. This may mean that additional investment,

utilising the maternity incentive scheme funding and national transformation monies, is used to fund additional specialist roles. An update will be provided to this committee in October 2022.

A further workforce review for the maternity service is to be completed in December 2022.

Author: Giuseppe Labriola, Director of Midwifery
Date: 19th September 2022

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 October 2022

Agenda item:	4.2							
Presented by:	Giuseppe Labriola, Director of Midwifery							
Prepared by:	Erin Harrison, Head of Maternity Governance and Assurance							
Date prepared:	19th September 2022							
Subject / title:	Overview of Serious Incidents within maternity services							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards. There were 0 new maternity incidents declared since the last report There was 1 maternity incident closed since the last report Maternity services currently have 6 SI's under investigation (0 HSIB).							
Recommendation:	To provide assurance to the Quality and Safety Committee (Maternity Assurance) that the maternity service are continually monitoring compliance and learning from Serious Incidents.							

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

Previously considered by:	Patient Safety Group 13/09/22 Divisional Board 28/9/2022 – QSC2.30.09.22
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the Ockenden report that was published in December 2020 with recommendations for maternity services.
Appendices:	1. Open Serious Incidents under investigation

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4.2

1.0 Purpose

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

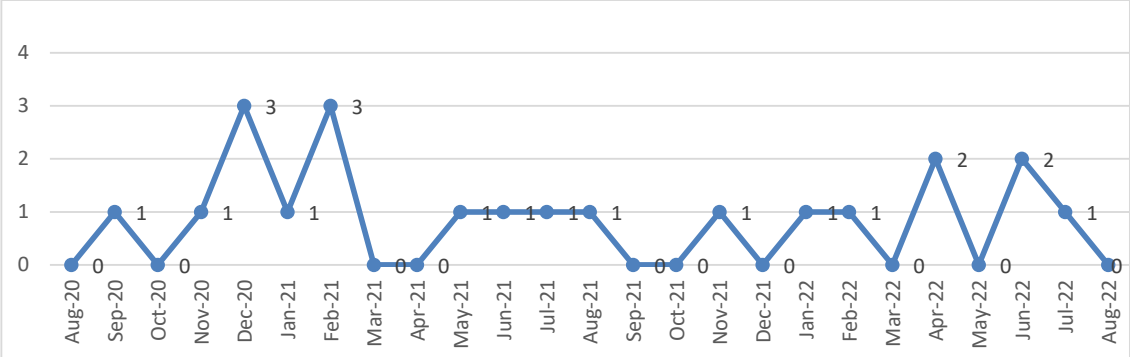
2.0 Background

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

3.0 Analysis

Maternity currently have 6 SI's under investigation, 0 of which are being investigated by Healthcare Safety Investigation Branch (HSIB). Table 1 details the trend of declared SI's within the last 24 months to August 2022.

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



There were 0 new serious incidents declared in August 2022.

Table 2. Serious Incidents declared, submitted and closed for August 2022

Serious Investigations		
Number Declared for August 2022		**0**
Number Submitted for August 2022		**1**
Number Past CCG Deadline as of August 2022 (Not including HSIB/Approved Extensions)		**0**
New Serious Investigations declared		
Ref	**Summary**	**Learning Points**
Closed Serious Investigations		
Paweb 108939 HSIB	Difficult delivery and breech extraction. 9 minutes from knife to uterus until baby delivered. Therapeutic cooling for 72 hours. No Hypoxic Ischemic Encephalopathy noted on Magnetic Resonating Image (MRI).	• No safety recommendations made surrounding this incident • Documentation issues which are being acted upon within the Divisional training programme.

4.0 Themes

Table 3 details the top themes identified in maternity SI's within the last 24 months to August 2022

Table 3. Top Themes

Total Number of SI's	Theme	Number
21	Cardiotocography (CTG) interpretation	7
	Obstetric Haemorrhage	6
	Neonatal death	4
	Delay in care	4
	Compliance with guidance	3
	Hypertension	3
	Intrauterine death	3
	Escalation	3
	Hypoxic ischaemic encephalopathy	3
	Laceration at caesarean	1
	Fetal growth	1
	Cross Border Working	1

5.0 Oversight

All highlighted concerns have been escalated at Divisional level. All incidents are discussed at the Divisional Governance Meeting and Trust Incident Management Group and escalated where relevant for further investigation. A maternity assurance committee has been established (February 2022) to provide assurance for quality and safety of the maternity service.

A Maternity Improvement Board was commenced on 12th August 2021 with 9 key work streams:

- Induction of Labour
- Post-Partum Haemorrhage
- Maternity Triage and Assessment
- Fundamentals of Care (Assurance, daily routines and documentation)
- LocSSips
- Estates transformation and transitional care
- Handover, ward rounds and huddles
- Caesarean Section
- Culture

Each work stream has an identified lead and progress is reported back to the Maternity Improvement Board. This reports into the monthly executive maternity assurance committee.

6.0 Recommendation

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

Author: Erin Harrison,Head of Maternity Governance and Assurance **Date:** 19th September 2022

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 October 2022

4.2

Agenda item:	4.2							
Presented by:	Giuseppe Labriola, Director of Midwifery							
Prepared by:	Sahra-Luise Tormos, Digital Midwife							
Date prepared:	20.09.2022							
Subject / title:	Maternity Digital Strategy compliance with CNST safety Action 2							
Purpose:	**Approval**	√	**Decision**	√	**Information**	√	**Assurance**	
Key issues:	Better Births (2016) recognised the important role that digital technology can play in transforming maternity services and made several recommendations on how it should be harnessed. In January 2018, A new priority and expectation was given for NHS Digital and NHS England to progress with the implementation of Electronic Health Records (EHR) for pregnant women, as a demonstrator for wider citizen enablement. As part of the NHS Long Term Plan, 100,000 women were expected to have access to their digital care record by March 2020, with this expectation extending to all women by 2024. The 2021 Maternity Digital Maturity Assessment (DMA) identified that HWE LMNS (Hertfordshire West Essex Local Maternity and Neonatal Services) are digitally immature with maternity services being dependent on paper systems to deliver care. Significant investment across the system is needed to ensure service provision meets the needs of the Maternity Transformation Programme.							
Recommendation:	NHS England and Improvement (NHSEI) has requested that NHS Organisations and LMNS' have a digital maternity strategy in place by October 2022, which is further supported by the Clinical Neglgence Sceme for Trusts (CNST) Discount Scheme Safety Action 2 (Year 4) Standard 1 requirement.							

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

Previously considered by:	Trust IT Strategy in place HWE LMNS Programme Board 15.9.22/QSC2.30.09.22
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with CNST Safety Action 2 in the delivery of a digital maternity strategy that incorporates

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	NHS England's What Good Looks Like Framework 7 success measures (NHSE, 2021) and ensures the delivery of real benefits through digital enablement as outlined in the Maternity Transformation Programme (NHSE, 2017) and NHS Long Term Plan (NHSE, 2019) and HWE LMNS Equity and Equality Action Plan (2022).
Appendices:	PAHT Digital Maternity Strategy

1.0 Purpose/issue

In order to meet the requirements of the NHS Resolution 10 steps to safety Maternity Incentive Scheme year 4 compliance standards, Safety action 2, criteria 1, NHS organisations are required to provide national assurance through their LMNS and Integrated Care Boards (ICB) that they have already procured, or have a fully funded plan to procure, a Maternity Information System complying with the forthcoming commercial framework (proved by NHS Digital) and are complying with Information Standard Notices DCB1513 and DCB3066. Trusts are to provide assurances of investment in the digital maternity transformation programme with ongoing plans in place to make improvements to digital care delivery platforms and data quality. As part of these board assurances NHS Organisations and LMNSs are required to have an up-to-date digital maternity strategy, that aligns to their wider organisation, LMNS and ICS strategies.

These strategies are to reflect NHS England's What Good Looks Like Framework (WGLL) 7 success measures (NHSE, 2021) and have clearly defined goals and priorities that evidence how real benefits will be delivered through digital enablement as outlined in CNST Safety Standards, the Maternity Transformation Programme (NHSE, 2017), NHS Long Term Plan (NHSE, 2019) and HWE LMNS Equity and Equality Action Plan (2022).

2.0 Background

Better Births (2016) recognised the important role that digital technology can play in transforming maternity services and made several recommendations on how it should be harnessed. In January 2018, a new priority and expectation was given for NHS Digital and NHS England to progress with the implementation of EHR for pregnant women/birthing people, as a demonstrator for wider citizen enablement. As part of the NHS Long Term Plan (2019), 100,000 women/birthing people were expected to have access to their digital care record by March 2020, with this expectation extending to all women/birthing people by 2024.

To ensure PAHT can meet this expectation, we have secured funding through the Maternity Technology Fund, to invest in digital leadership and financially support our organisations in the procurement of maternity specific EHR and digital maturity projects.

The PAHT Maternity Digital Strategy provides a framework in how we will support the collective digital investment decisions being made across the system, ensuring we are able to meet the digital maternity transformation goals.

3.0 Analysis

Current Situation

Digital systems and data tools that are not fit for purpose, do not support staff to do their jobs well and create barriers to the provision of safe effective care. The 2021 Maternity Digital Maturity Assessment (DMA) identified that PAHT are digitally immature with maternity services being dependent on paper systems to deliver care. Significant investment across the system is needed to ensure service provision meets the needs of the Maternity Transformation Programme.

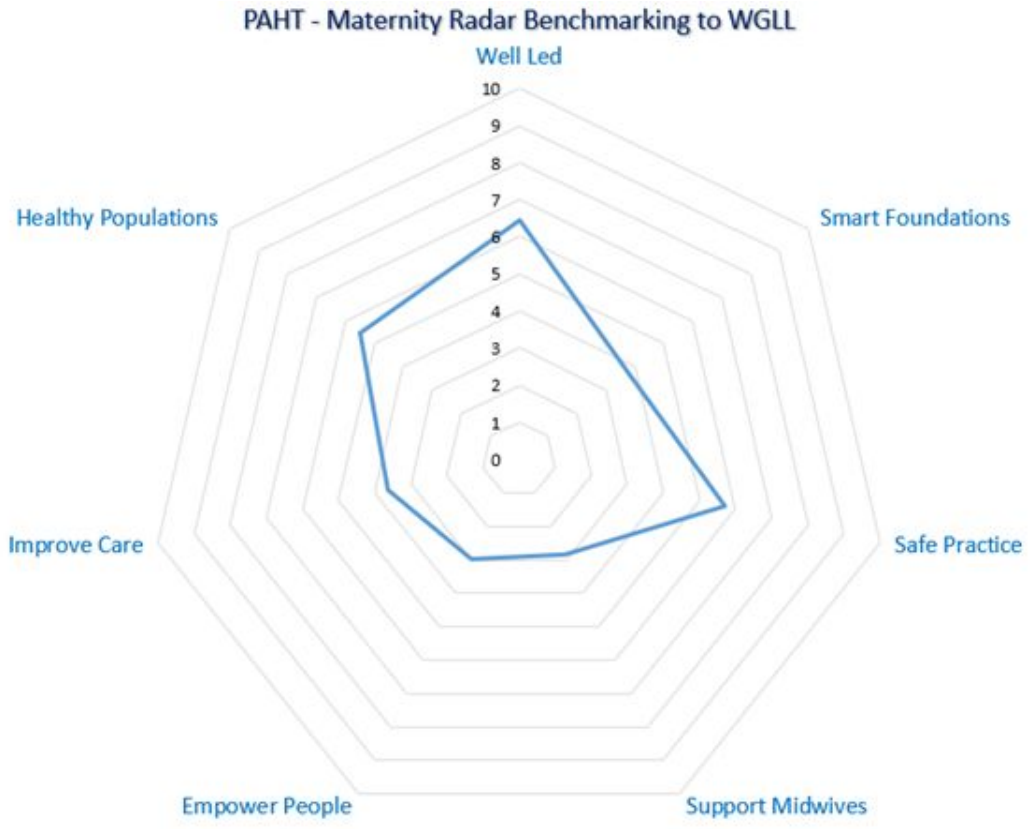
PAHT serves a diverse population, with some of our communities living in the lowest quintile of deprivation (ONS, 2021). 15% of our birthing population are identified as Black, Asian or Mixed ethnicity. Paper systems provide information in generic formats, which impacts the ability to create personalised care plans, that are evidenced to be essential when delivering care that fully supports a diverse population and ensures the equity and equality of our maternity service. Current hand held paper notes and poor digital integration of hospital IT applications means multiple log ins. This leads to duplication of information recorded and additional administrative burden, particularly in community settings. This can increase the risk of information being unavailable, cause delays in care provision and information sharing, which may impact patient safety.

However, there are several significant digital investment programmes currently underway within PAHT. These include the implementation of a new maternity EHR, as well as the implementation of the shared care record, which is transforming the delivery of care across our geographical boundaries.

Digital Maturity Assessment for PAHT

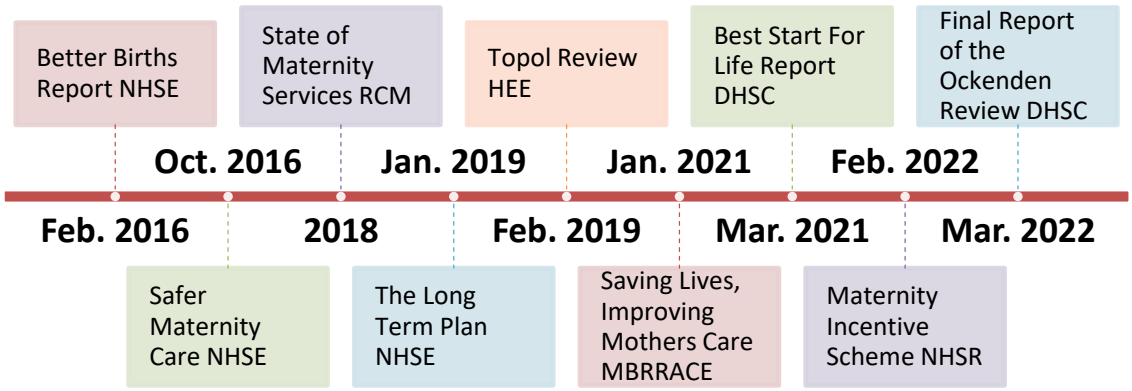
PAHT will ensure improvements are based on the needs of our population, the findings from the NHS England DMA and the maternity WGLL radar benchmarking, which was undertaken by PAHT.

The radar chart below, shows the current position PAHT maternity services are in and has developed the strategic plans as well as the strategic goals and priorities within the Maternity Digital Strategy.



Priorities

PAHT Maternity Digital Strategy has been developed collaboratively with maternity voices partnerships, staff and stakeholders and incorporates the National Maternity Drivers (figure 1) that have shaped the maternity transformation programme. The strategy incorporates programmes of work already undertaken and planned, these align to the trusts digital strategies (figure 2) and Inetgrated Care System (ICS) Digital Strategy (2022), all of which ensure digital transformation supports a diverse population and ensures the equity and equality of our maternity service.



(Figure 1)

PAHT Maternity Digital Strategy reflects the NHS England's WGLL 7 success measures (NHSE, 2021) and have clear defined goals and priorities that evidence how real benefits will be delivered through digital enablement. Organisational priorities are linked in with the LMNS priorities and align to the five themes of the ICS Digital strategy (figure 2).

(Figure 2)

Benefits Realisation

Women/Birthing people accessing maternity services will be able to access information about themselves and interact digitally with their clinical and care professionals when it is appropriate and convenient to do so, enabling them to make personalised care plans, using the tools that reflect society's expectations in the 2020s.

The Maternity Digital Strategy, to improve the digital maturity of PAHT, describes how we will use the 7 success measures of the WGLL framework, to ensure the delivery of digital maternity transformation across our system.

We have set a clear direction and ambitious goal, that will benefit the communities we serve, as well as our colleagues and stakeholders.
We will ensure our families have convenient access to services and their records and ensure relevant information follows each woman/birthing person, regardless of where they are being treated.
We will ensure improvements in population health by adapting our services to new opportunities as they emerge, learning from others and sharing our successes and our experiences across PAHT, geographical borders and beyond.

4.0 Oversight

The report details the requirements of the NHS Resolution 10 steps to safety MIS (Maternity Incentive Scheme) year 4 compliance standards, Safety action 2, criteria 1, to have a digital maternity strategy in place, that has been approved through Trust and ICB, which incorporates plans to procure and implement a Maternity Information System, along with plans to make improvements to digital care delivery platforms and data quality.

PAHT have worked collaboratively with the individual organisations and the ICB to ensure that improvements in digital maturity can be achieved system wide.

The strategy all reflect NHS England's WGLL 7 success measures (NHSE, 2021) and all have clearly defined goals and priorities that evidence how real benefits will be delivered through digital enablement as outlined in CNST Safety Standards, the Maternity Transformation Programme (NHSE, 2017), NHS Long Term Plan (NHSE, 2019) and HWE LMNS Equity and Equality Action Plan (2022).

5.0 Recommendation

It is requested that the Board accept the report with the information provided and approve the PAHT Maternity Digital Strategy, to evidence compliance with the CNST Safety standards and National Maternity Digital Transformation Programme.

Author: Belinda Harvery (Informatics Lead) and Sahra-Luise Tormos (Digital Midwife)
Date: 20.09.2022

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4.2

The Princess Alexandra Hospital NHS Trust

Maternity Digital Strategy 2022 – 2025

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Contents

Summary

Digital technology and advancements are changing how maternity care is delivered. This is further driven by consumers expectations to have greater visibility of clinical maternity records, as well as personalised pregnancy and birth information which will empower our pregnant women and birthing people to make informed choices about the care they wish to receive. As Princess Alexandra Hospital Trust (PAHT) embark on a digital transformation journey, the digitalisation of maternity services also enables us to reimagine patient care and experiences in line with the wider vision of the organisation.

Our Vision: "We want to be the most technological and digitally-enabled hospital in the UK, allowing us to transform the care we deliver and experience of our people" – Lance McCarthy.

Our digital maternity strategy aligns with our organisational strategies, considering how digital can enable our PAHT2030 goals. Our strategy has been developed collaboratively with our maternity voices partnership (MVP), staff, stakeholders, and has been informed by the national maternity digital transformation programme, using the What Good Looks Like Framework (WGLL). Our maternity digital strategy supports collaboration with the Local Maternity and Neonatal System (LMNS), incorporates the National Maternity Drivers (figure 1) that have shaped the maternity transformation programme, and aligns with the significant amount of work done to date by PAHT on digital transformation.

National Maternity Drivers

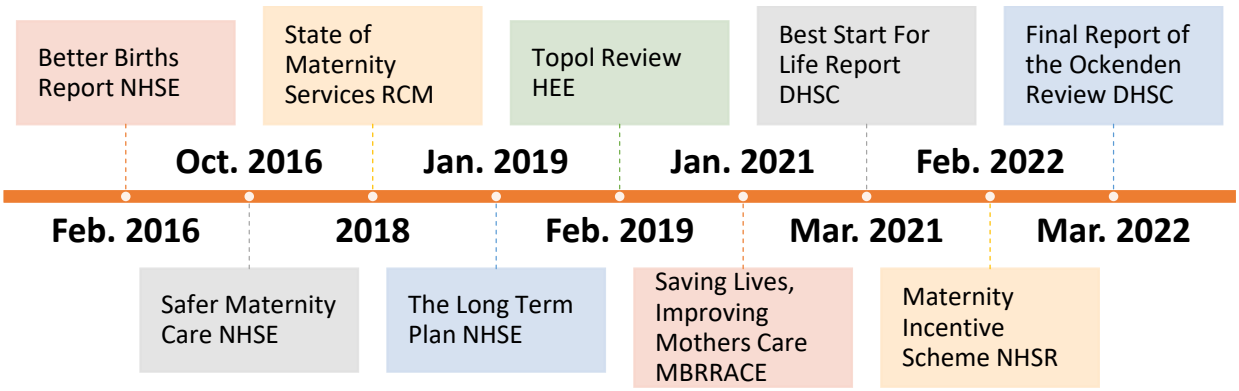

Figure 1, National Maternity Drivers

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1. Introduction

The previous Health Secretary, Sajid Javid, emphasised the power of digital to drive a new era of recovery and reform following the Covid-19 pandemic, and focusses on 4 priorities:

- making sure the NHS is set up properly for success
- levelling up across the NHS and social care
- pursuing personalisation
- making big breakthroughs on emerging technologies and data

The Better Births report (2016) recognised the important role that digital technology can play in transforming maternity services and made several recommendations on how it should be harnessed. Which includes:

> "*Investing in electronic, interoperable maternity records to reduce the administrative burden of information recording and sharing; providing all women [and birthing people] with access to comprehensive digital sources of information via a digital tool; a digital tool or personal health record that interfaces with professionally held electronic maternity records so that the woman can access their records and receive personalised information and the technological solutions must be accessible to women [and birthing people], families and professionals, particularly outside of the hospital setting*" (Better Births, 2016).

Led by NHS Digital, the Maternity Transformation Programme (MTP) is working to implement this vision by working with Local Maternity Systems to meet the national objective of improving outcomes in maternity services in England.

The Clinical Negligence Scheme for Trusts (CNST) stated that by October 2022 Safety Action 2 (Year 4) Standard 1, Trusts have an up-to-date digital strategy for their maternity services which aligns with the wider Trust Digital Strategy and reflects the 7 success measures within the WGLL Framework. The strategy must be shared with Local Maternity Systems and be signed off by the Integrated Care Board (ICB). As part of this, dedicated Digital Leadership should be in place and the Trust should have engaged with the NHS England and Improvement (NHSEI) Digital Child Health and Maternity Programme.

The PAHT Maternity Digital Strategy reflects the WGLL framework. This provides a vision which outlines the 7 success measures that establish best practice for ICBs and organisations to accelerate digital transformations. The framework identifies how this applies specifically to nursing and has been adapted for use by midwives and midwifery leaders. It provides objectives and a blueprint of how leaders can facilitate digital transformation locally and for the profession. This provides the impetus for the professionalism of digital maternity leadership and midwifery roles within organisations.

2. Digital Strategy Guiding Principles

Our guiding principles align with our Trust digital strategy and the Integrated Care System (ICS) digital strategy themes, which ensures our workforce have the skills to utilise digital technologies and transformation services. They have mapped the strategic objectives set in the pursuit of being the most digitally-enabled hospitals in the UK, and will ensure investment priorities are aligned with our strategic ambitions.

"our teams come together to deliver effortless integrated digital experience without boundaries to improve health and care outcomes for all people"
(ICS, 2022)

Trust	 **Patient co-design** Our patients and their carers will be placed at the heart of the selection, design, and optimisation of our digital solutions.	 **Digitally confident workforce** We will support our staff in embracing digital to improve their working lives.	 **Inclusivity and reduction of health inequalities** We will drive inclusivity by leveraging opportunities enabled by digital technology to reduce, not further exacerbate, inequalities.	 **Intuitive, user-friendly design** We will ensure digital solutions adopted will be simple and easy to use.	 **Working together with our partners** As a population-focussed organisation, we will collaborate with our partners to develop joint solutions to address system challenges.
ICS	**Digital Direct Care** Proven Digital Care Enablers Our goal is to use digital technology to help keep people well in their homes, offer choice, and improve their overall life chances through healthcare at the residents' fingertips, at the same time addressing the twin challenge of demand and capacity across the system.	**Digital Platforms** Essential Strategic Digital Platforms Our goal is to bring together the essential connectivity, information, intelligence and data for all care settings as needed by service users, residents and care professionals to improve the overall health and well-being of our population.	**Digital Skills** Digital Inclusion and Workforce Capability Our goal is to improve the inclusion of our population in accessing their health and care needs digitally where appropriate and will build a digitally confident and skilled workforce.	**Digital Innovation** Local Digital Care Innovation We will realistically strive to lead digital innovation partnering with AHSNs, universities, and the private sector to identify and adopt new technologies that offer scalable benefits to support our ICS challenges and workstream priorities.	**Digital Collaboration** Multi-disciplinary support through digital collaboration Our goal is to work together to maximise the opportunities to coordinate system wide digital solutions, and provide the right care at the right time, through multi-disciplinary health and social care teams.

3. Our Digital Maternity Vision and Strategy

Our vision is to have a maternity system that captures the complexity of maternity pathways and cross border working, that incorporates the complex needs of our population and supports those who are disadvantaged. This includes continued engagement, collaboration and communication with all people who use our services, as their contributions will improve on our processes, to deliver on technology enablers, and improve digital literacy.

This requires a seamless healthcare system that is easily accessible across all healthcare settings and for all women and birthing people under our care. This will enable clinicians and pregnant people to view a maternity record, at any point throughout the perinatal period, both inside and outside of our ICS, using technology that interfaces with shared care records.

"Safety remains our highest priority throughout our strategy for all our women [and birthing people]. Achieving the maternity incentives scheme will ensure we are delivering safer maternity care for our women [and birthing people]"

Princess Alexandra Hospital NHS Trust 'PAHT Digital Strategy' 2020-2030

Our maternity digital strategy links in with the Trust digital strategy four strategic themes, with defined priorities and supporting enablers (figure 2). These themes outline the activities the organisation will target to achieve our vision of being the most digitally-enabled hospital in the UK, and reflect the local and national ambition for a digitally advanced maternity service.

Vision	*We will be the most technological and digitally-enabled hospital in the UK, allowing us to transform the care we deliver and the experience of our people.*				
Trust Objectives	Our Patients	Our People	Our Performance	Our Places	Our Pounds
Strategic Themes	**1. Innovative patient care models**	**2. Enhanced staff experience**	**3. Insight-driven care and operations to maximise quality and efficiency**	**4. Integrated and interoperable health care**	
Our Digital Strategic Priorities	1.1 Support patients with access and skills to manage their holistic health record	2.1 Provide robust, reliable, user friendly and trusted IT and hardware	3.1 Cultivate continuous organisational improvement, learning, and curiosity	4.1 Ensure all our information is available to our partners	
	1.2 Treat more patients at home rather than the hospital	2.2 Release time to care and service delivery	3.2 Establish trust in our data	4.2 Facilitate efficient system-level co-ordination and improved communication	
	1.3 Target health promotion activities	2.3 Enable self-service access to intuitive systems	3.3 Transform our supply chain, logistics and back-end office processes	4.3 Make data available for building partnerships	
	1.4 Maximise healing environments	2.4 Maximise staff well-being	3.4 Optimise resource management	4.4 Bring together external data and wider system intelligence	
	1.5 Adopt innovative new models of care	2.5 Revolutionise training	3.5 Design, build and operate a smart building	4.5 Align our strategic ambitions and co-ordinate efforts across the system	
Enablers required to deliver our strategy	Leadership, governance and programme management				
	Partnership working				
	Change management and organisational design				
	Technical infrastructure				

Figure 2, Digital Strategy Overview

4. Background and Local Context

The 2021 Maternity Digital Maturity Assessment (DMA) identified that The Princess Alexandra Hospital NHS Trust are digitally immature, that significant investment is needed to ensure service provision meets the needs of the Maternity Transformation Programme, with digital maturity across the system, which is required to be achieved by March 2024.

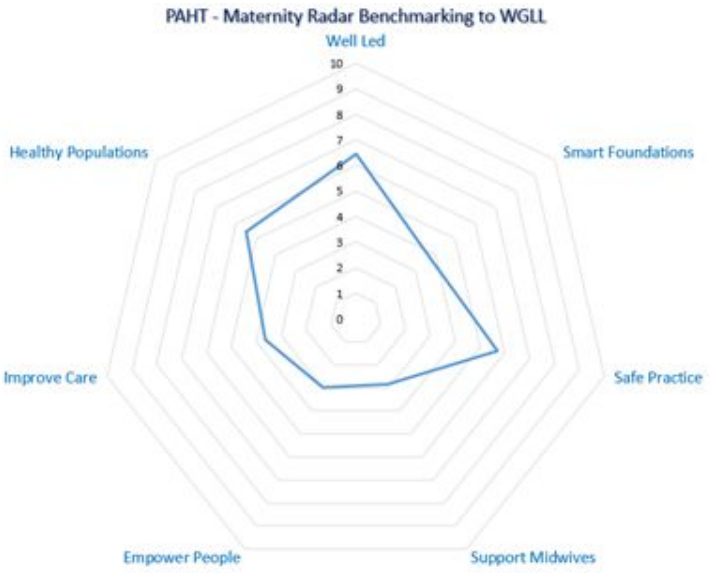
PAHT serves a diverse population, with some of our communities living in the lowest quintile of deprived (ONS, 2021) and 15% of our birthing population being identifying as Black, Asian or Mixed ethnicity. As Harlow has some of the highest deprived areas, this impacts on people not having access and low understanding on digital literacy, compared to other areas. Improvement on digital literacy is required, so our people can access and understand our services.

Digital systems and data tools that are not fit for purpose, do not support staff to do their jobs well and create barriers to the provision of safe effective care.

Current hand-held paper notes and poor digital integration of hospital IT applications means multiple log-ins, duplication of information recorded and consequent additional administrative burden. This is particularly true in community settings, increasing the risk of information being unavailable or inaccessible leading to delays or omissions in care provision and information sharing that impacts patient safety, particularly when working across geographical boundaries.

Paper systems provide generic information in generic formats, which impacts the ability to create personalised care plans, that are evidenced to be essential when delivering care that fully supports a diverse population, and ensures the equity and equality of our maternity service.

PAHT have reassessed their digital maturity within maternity services using the 7 WGLL success measures, following the utilisation of the Unified Tech Funding. This assessment informs us of our current challenges and areas to focus for improvement.



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5. Maternity Mapping to the What Good Looks Like Framework

The WGLL framework draws on local learning and builds on established good practice, to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely. This will improve the outcomes, experience and safety of women, birthing people and children under our care.

WGLL is directed at all NHS leaders, as they work with their system partners, and sets out what good looks like at both a system and organisation level. It describes how arrangements across a whole ICS, including all its constituent organisations can support success.

WGLL is included in the ICS design framework, the NHS Operational Planning and Contracting Guidance, and a Plan for Digital Health and Social Care. It is reflecting the expectations that the standards in the WGLL framework will be used to accelerate digital and data transformation.

The WGLL framework has 7 success measures:

1. Well led
2. Ensure smart foundations
3. Safe practice
4. Support people
5. Empower citizens
6. Improve care
7. Healthy populations

	What Good Look Like for West Essex	How PAHT will achieve this
Well Led	ICS: Hertfordshire and West Essex (HWE) ICS has a clear strategy for digital transformation and collaboration. Leaders across the ICS collectively own and drive the digital transformation journey, placing citizens and frontline perspectives at the centre. All leaders promote digitally enabled transformation to efficiently deliver safe and high-quality care. Integrated Care Boards (ICBs) build digital and data expertise and accountability into their leadership and governance arrangements and ensure delivery of the system-wide digital and data strategy. Organisation: PAHT boards are equipped to lead digital transformation and collaboration. They own and drive the digitally enabled transformation journey, placing citizens and frontline perspectives at the centre.	1. Having a recognised Maternity Informatics Lead and Digital Midwife with accountability, expertise, who has allocated work time to lead transformation changes and is linked in at Trust Board level. 2. To have a Maternity Informatics Team which includes a Maternity Informatics Lead, Digital Midwife, Maternity Clinical IT Analyst and Maternity Data Quality Adminstrator. 3. Maternity Informatics Team to collaborate with the organisation to have a unified vision of digitally enable care, that achieves midwifery data and digital requirements. 4. Ensure the digital strategy has wide input from clinical representatives from across the organisation, this includes front end users to identify digital solutions and improve care. 5. Working with Chief Nurse informatics Officer (CNIO), LMNS Digital Midwife Lead, Integrated Care Board (ICB) and any other key stakeholders. 6. To involve front end users to identify digital solutions and improve care, by means of service user/staff feedback, surveys and forums with actions and outcomes recorded. 7. To work with the IT department to support implementation of digital technologies, such as Wifi capability, hardware, software, storage, archives and back-up systems, that focuses on the issues, actions, solutions and completion around digital technologies. 8. To work with Trust Informatics Team which will include Division Information Management, Data Quality and Business Intelligence. 9. Ensure that the strategy is financially sustainable by utillising national and local funding opportunities.

Ensure Smart Foundations	ICS/Organisation: Digital, data and infrastructure operating environments are reliable, modern, secure, sustainable and resilient. Across our ICS, all organisations have well-resourced teams who are competent to deliver modern digital and data services.	1. The maternity organisation is involved throughout the process to design, review, implement and evaluate technology, which includes data collection and analysis. 2. To share best practice across the organisation and regions, which includes consistent coding and structured maternity terminologies. 3. Maternity users can see the impact of data they generate on people, the wider systems and care outcomes. 4. The new Electronic Health Record (HER) system to have modern infrastructure, so clinical documentation is accurately recorded, to support effective midwifery practice which encompasses maternity governance. 5. Digitally generated data is collected from the new EHR and used to improve care and processes, this includes safe experimental changes to obtain success.
Safe Practice	ICS: Organisations across HWE ICS maintain standards for safe care, as set out by the Digital Technology Assessment Criteria for health and social care (DTAC). They routinely review system-wide security, sustainability and resilience. Organisation: PAHT maintain standards for safe care. They routinely review digital and data systems to ensure they are safe, robust, secure, sustainable and resilient. Digitally-enabled outcome-driven transformation is at the heart of safe care.	1. The Maternity Digital Team is able to receive required digital lead/clinical safety training and apply this into practice to improve/maintain safety. 2. Robust training, education and support is given to all staff, which includes risks associated with data, digital solutions, how it enables safe practice, how to escalate and address clinical risks/incidents to improve digital enabled care. Staff attendance of training will be monitored in line with Trusts compliance. 3. Regular review of digital incidents/errors, if themes arise to share at ICB, Regional and National levels, and solutions sought. 4. The new EHR system will adhere to all National Data/Safety Standards (DCB0129 and DCB0160) and needs to work for the specific Trust requirements to deliver care.

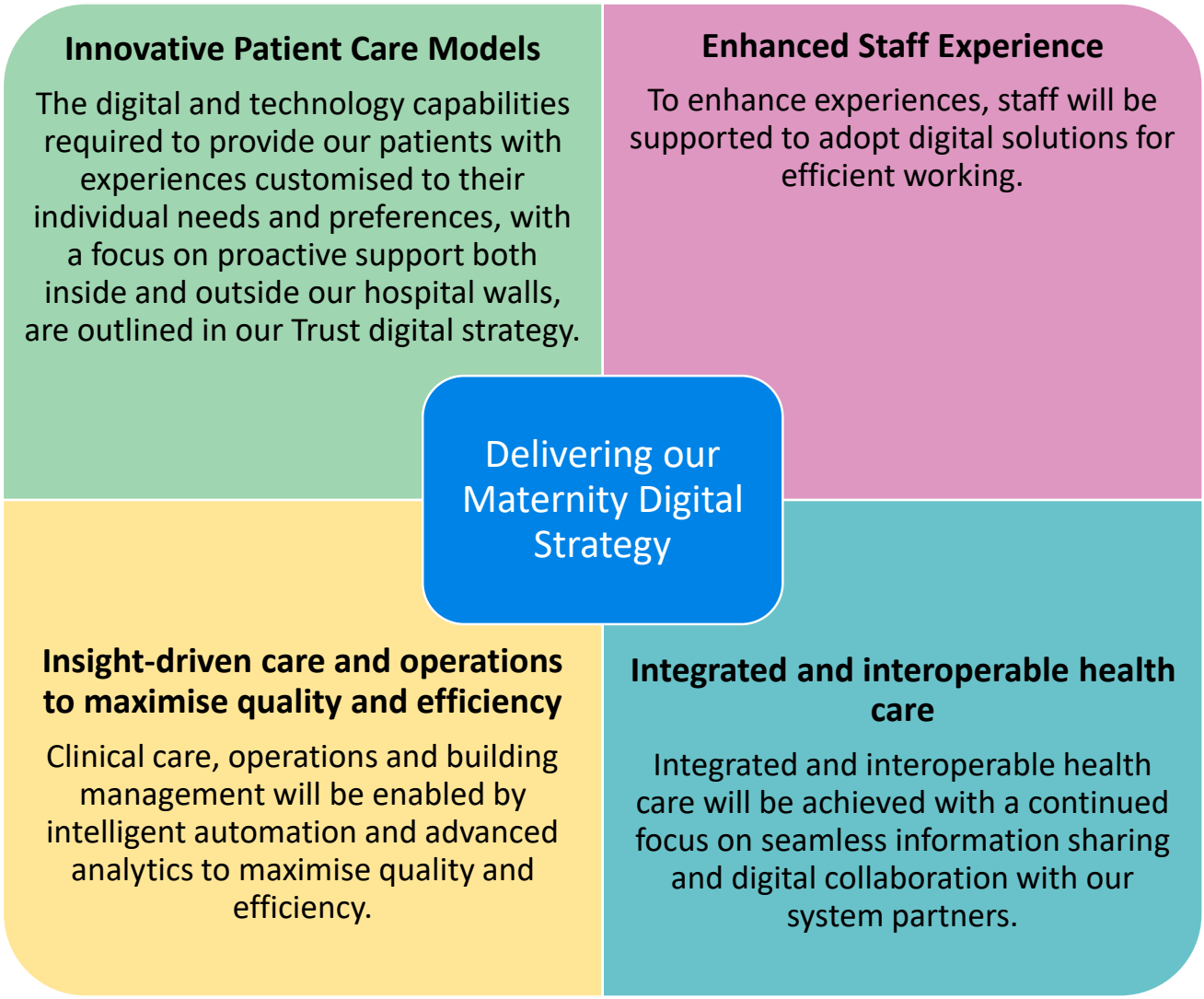
		5. Ensure patient information is kept to Governance/Safeguarding standards, this includes online and offline working. 6. To ensure women and birhting people delivering elsewhere have access and clinical information available at the same level as those delivering at PAH. 7. The Maternity Digital Strategy aligns with PAHT other digital strategies.
Support People	ICS/Organisation: Our workforce is digitally literate and able to work optimally with data and technology. Digital and data tools and systems are fit for purpose and support staff to do their jobs well.	1. Maternity Informatics Lead and Digital Midwife are trained with the key skills to work in a digitally enabled environment. 2. Maternity Informatics Lead and Digital Midwife can access relevant training to lead digital transformation to enable safe and effective practice. 3. Able to share best practice and case studies in digitally enabled care from across the ICB. 4. All staff have the digital and data literacy skills necessary to make best use of technology and data. This includes supporting staff who have digital difficulties, by using a Digital Literacy Self Assessment Diagnostic tool and use of a training needs analysis, as well as fully functional technology and equipment that supports interoperable working. 5. Regular user experience and feedback sessions to be held to understand the successes and challenges faced when delivering digitally enabled maternity care.
Empower Citizens	ICS/Organisation: Women and birthing people are at the centre of service design and have access to a standard set of digital services that suit all literacy and digital inclusion needs. Women and birthing people can access and contribute to their healthcare information, taking an active role in their health and well-being.	1. The new EHR is able to allow data to flow between all maternity health care providers and services. This can be shared, easily accessed and has interaction between our clinicans and service users. This would incorporate the use of national tools and services NHS.uk, NHS login and the NHS App, along with any additional local digital services. 2. The new EHR completely embeds the specific Trust and National requirements of care required. It is flexible and

		suitable to collect the data, send data and information out with ease. It will tailor digital information to the woman's symptoms/conditions, so they have the tools to manage their care more effectively, this starts from pre-conception throughout the perinatal period and beyond. 3. Maternity Voices Partnership (MVPs) are included to inform their findings to design digitally enabled care which reduces disparity of services. 4. Women and birthing people are encouraged to take part in the service design and information provided, identification of digital literacy issues, support those at risk of digital exclusion, and be supported to harness their care by using the digital technologies implemented. 5. The Maternity Informatics Team will work collaboratively with the LMNS and wider organisation to improve digital poverity/literacy, which will be used to inform care delivery.
Improve Care	ICS: HWE ICS embeds digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing. Digital solutions enhance services for patients and ensure that they get the right care when they need it and in the right place across the whole ICS. Organisation: Health and care practitioners embed digital and data within their improvement capability to transform care pathways, reduce unwarranted variation and improve health and wellbeing. Digital solutions enhance services for patients and ensure that they get the right care when they need it and in the right place.	1. All staff, women and birthing people to be included in the development and implementation, that includes information and skills to support digitally enabled care pathways, that is within a consistent system-wide approach to personalised care and support plans. 2. All staff are able to access and view women and birthing people's profile, culture, health, care plans and have easy access to refer them from one department to another, e.g. from Maternity to Endocrinologist, Haematologist etc. 3. Shared learning between the organisation, regional and national levels, so improvements can be made across the board. 4. Resources/Data Quality/Audits are provided by relevant departments to develop local programmes that improve quality outcomes to support accreditation. 5. All staff are included in the development of evidence-based clinical decisions, use data to support improvements and

		maternity-led research. This includes creating a positive data-driven culture. 6. Opportunities within the organisation where data and digital solutions can support midwife-led improvements are identified and implemented.
Healthy Populations	ICS: HWE ICS uses data to design and deliver improvements to population health and wellbeing, making best use of collective resources. Insights from data are used to improve outcomes and address health inequalities. Organisation: PAHT use data to inform their own care planning and support the development and adoption of innovative ICS-led, population-based, digitally-driven models of care.	1. Coproduction with MVPs are included in the health management in developing the data intelligent platforms. 2. Maternity Public Health England is integrated into the new EHR system, e.g. smoking, diabetes, vaccinations etc. 3. Ensure that the new EHR is compliant with the MDSD v2 DCB1513 and Maternity Record Standard DCB3066 and any future national requirements. The new EHR system is up to date with the national Information Standard compliant, which includes MSDS, SNOWMED coding, and compliance with CNST discount scheme, which includes the dedicated team to review the monthly MSDS submissions. 4. Working collaboratively with multidisciplinary and multiagency teams to identify any data collection gaps and use data to inform population health needs.

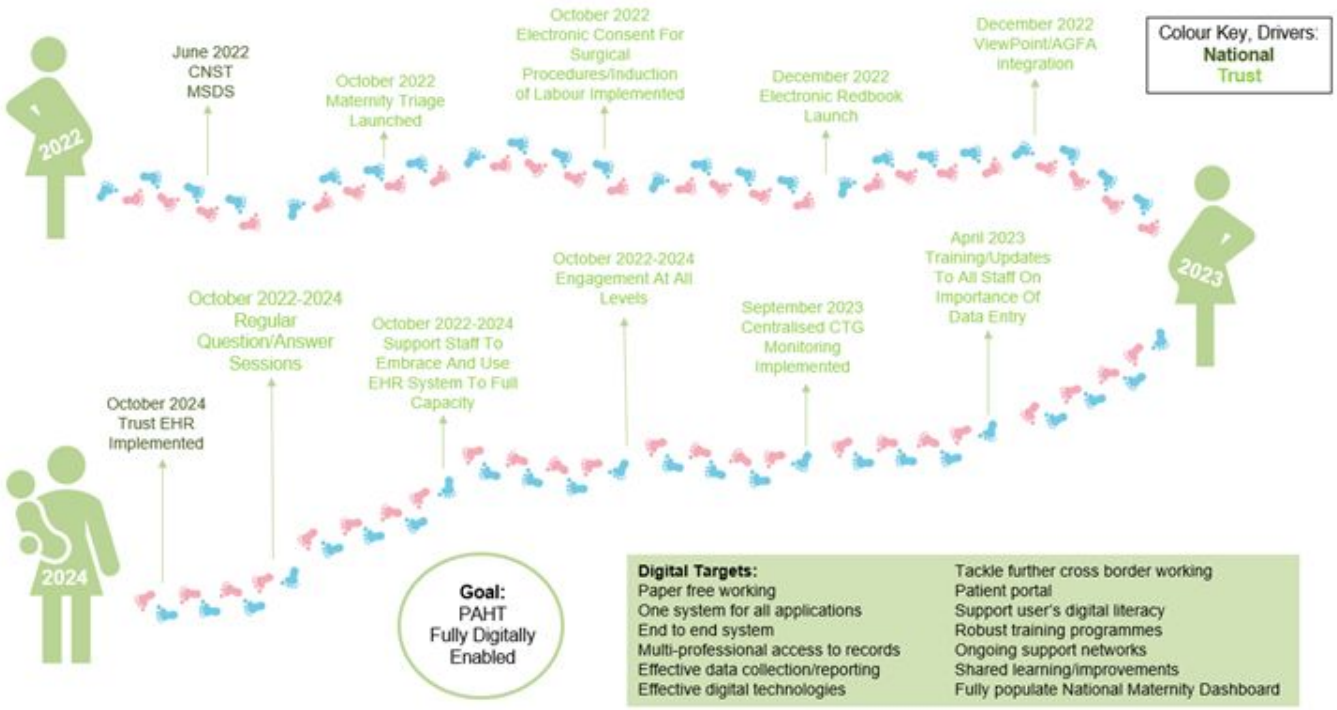
6. Delivering Our Maternity Digital Strategy

Our strategic ambitions align with the Trust digital strategy and require significant transformation and investments in digital capabilities. The implementation of a new Electronic Health Record (EHR) will ensure we meet the national requirements of the maternity transformation programme. We will develop and embed digital capabilities to deliver the transformation we set out in our organisation strategic priorities.



7. Maternity Digital Strategy Roadmap

The digital capabilities that will deliver the strategic priorities and themes for the overarching vision are set out in our Maternity Digital Strategy Roadmap. The following shows how we want to achieve our goals and targets over the upcoming years. Our women, birthing people and staff experiences will be included at every phase, and help shape the innovations at each stage to help us achieve the themes of our strategy.



8. Next Steps

We will continue focusing our efforts in the first phase of our Trust digital strategy, **Establishing our Digital Foundations**. This phase will prioritise the successful implementation of the new EHR system for PAHT, as well as implementing the initial digital capabilities, all supported by our key strategic digital enablers.

Appendix

A.1 Programme of Work and Priorities

Current State:

- We are currently in the procurement stage of selecting and purchasing a new Electronic Health Records system.

Achievements to Date: (Funding from the Maternity Tech Fund)

- Three additional staff for one year fixed term secondments, from April 2022.
- Additional laptops and other IT equipment.
- Funding for connectivity between Viewpoint and CRIS ultrasound scan appointments and images (implementation in progress).
- Funding for centralised Cardiotocography (cCTG) monitoring (implementation in progress).

Priorities for the Immediate future:

- To achieve the CNST Discount Scheme Safety Year 4 Action 2 and the other digital requirements set out by CNST (outstanding Trust EHR jobs that are required to be compliant with requirements).
- Provide appropriate electronic equipment to facilitate care in hospital and community settings, this also includes for midwives and maternity support workers (MSWs) working in remote and in rural settings.
- Collect and use maternity data to support the ongoing improvement in the safety and quality of care.

Priorities for the Mid term future:

- Paper free working, which includes digitalisation of all patient communication.
- Development in clinicians' digital recording of clinical coding.
- Patient accessible Maternity Electronic Health Records. Nationally by October 2024 we should have an end to end system (Hand held notes are no longer used as per National Recommendations).
- National midwifery drivers implemented (Maternity Transformation Programme).
- An electronic consent process.
- An electronic process for planned surgical procedures and and inductions of labour.
- New maternity triage systems (in progress).
- Implementation of eRebook and to tactile cross border working (in progress).
- To develop a digital and accessible service that is flexible for our women, birthing people and staff.

Priorities for the Long term future:

- For the new maternity Electronic Health Record to go live; estimated go live in 2024.
- Provide access to personalised health information in a digital format.
- The records to be contemporaneously recorded electronically in all aspects of care provided to women and birthing people. From pre-conception, booking, antenatal care, intrapartum and postnatal care throughout community and hospital settings. This would need to also include those who are booked to deliver at another hospital.
- Enable women and birthing people to access all their records in a digital format, while ensuring that they who do not have access to digital technology are not disadvantaged.
- Ensure midwives and MSWs are familiar with relevant digital services and have the confidence to signpost women and birthing women wishing to use digital resources for their own needs.
  Avoid unnecessary duplication/errors, by having an electronic system that collects information/data at the initial input point and auto-populated throughout the records for that current care journey.

A.2 Feedback

Maternity Voices Partnership Feedback:

"Looks like some fantastic changes are coming, that will better enable staff too".

Maternity Voices Partnership (August 2022)

Maternity Staff Online Survey Results:

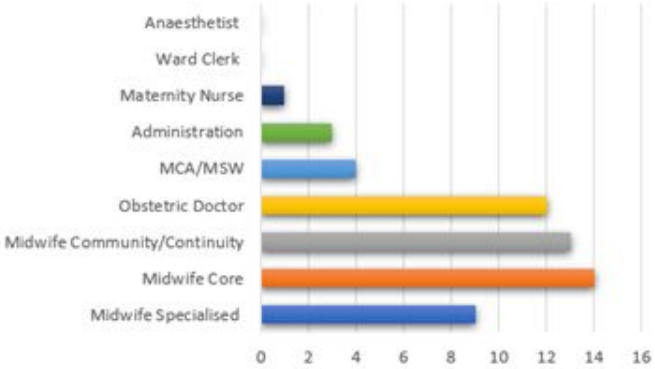
We asked our staff to complete an online survey for feedback. We informed them that:

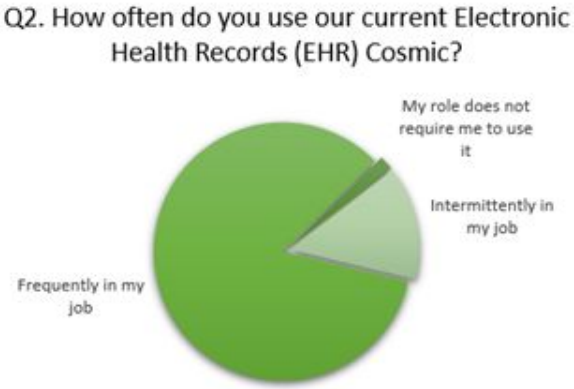
'Our trust has been working towards using computer systems more to record care, but we also currently still use a lot of paper documentation. Digital technology and advancements are changing on how maternity care is delivered, with further drive from consumer expectations to have visible clinical maternity records, along with personalised care plans to empower our [women and birthing people]. The digitisation of maternity services will enable us to further develop patient care and experiences in line with the wider vision of the organisation.

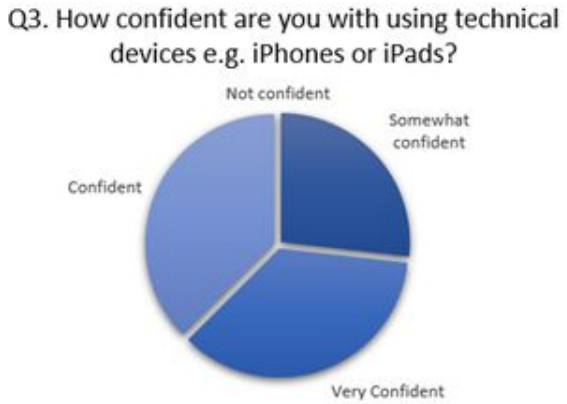
It is important with any digital transformation that time is invested to ensure that digital services meet the needs of the maternity services and experience for the women [and birthing people] under our care. We need a Maternity Digital Strategy to support us through making these changes a reality.
Your feedback and input throughout the processes is vital to help shape and develop future care.

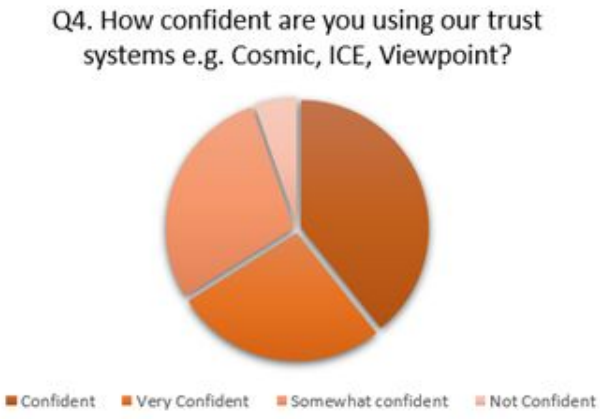
Our Staff had the opportunity in August 2022 to provide some feedback towards building our strategy and see what their thoughts are towards the Trust working towards a New Electronic Health Records System.'

These are the findings:


Q1. What is your main role?
Anaesthetist
Ward Clerk
Maternity Nurse
Administration
MCA/MSW
Obstetric Doctor
Midwife Community/Continuity
Midwife Core
Midwife Specialised
0
2
4
6
8
10
12
14
16


Q2. How often do you use our current Electronic Health Records (EHR) Cosmic?
My role does not require me to use it
Intermittently in my job
Frequently in my job


Q3. How confident are you with using technical devices e.g. iPhones or iPads?
Not confident
Somewhat confident
Confident
Very Confident

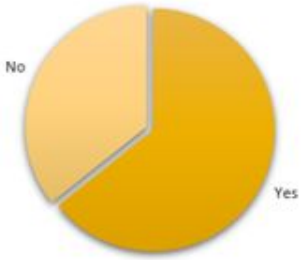

Q4. How confident are you using our trust systems e.g. Cosmic, ICE, Viewpoint?
Confident
Very Confident
Somewhat confident
Not Confident


Q5. With our current EHR where do you find you have connectivity issues?
PAH onsite locations
PAH offsite locations
Patient's home
Own home

Q6. What do you think are our common EHR corrections/errors?

Q7. Are you aware of the Maternity Services Data Set?

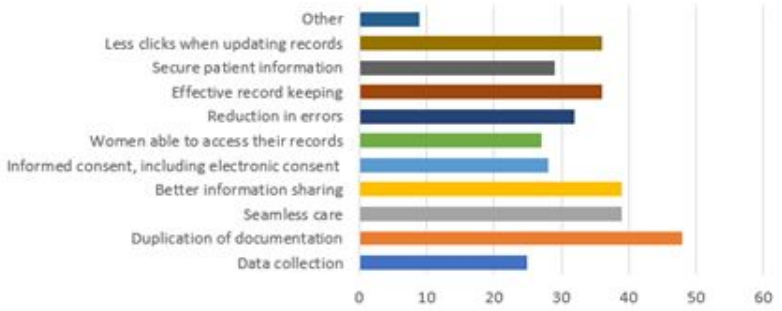
Q8. Are you aware of CNST (Clinical Negligence Scheme for Trusts)?



Q9. How do you rate our current maternity EHR system?

2.02 Average Rating

Q10. What would you like to see improve within practice by using digital systems?

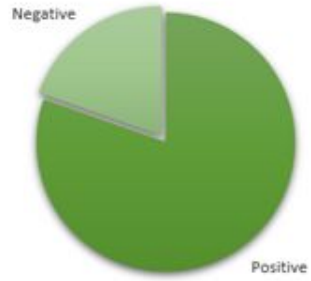


Q11. Question 10 'Other' comments

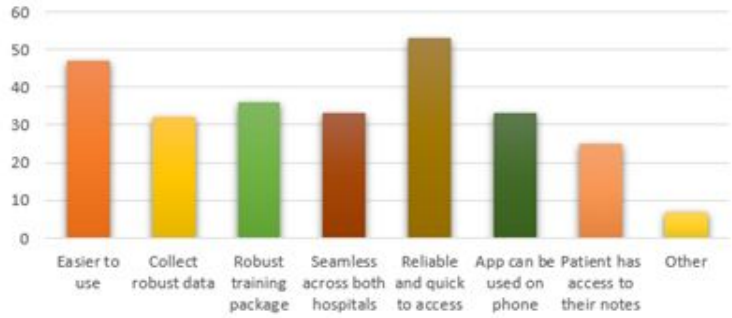
Q12. How do you feel personally about moving towards fully digital maternity notes in the near future?

Q13. Do you feel using a fully paperless EHR system, would improve the care you provide to women?

Q14. Do you think moving toward paperless working will have a positive or negative affect on the service?



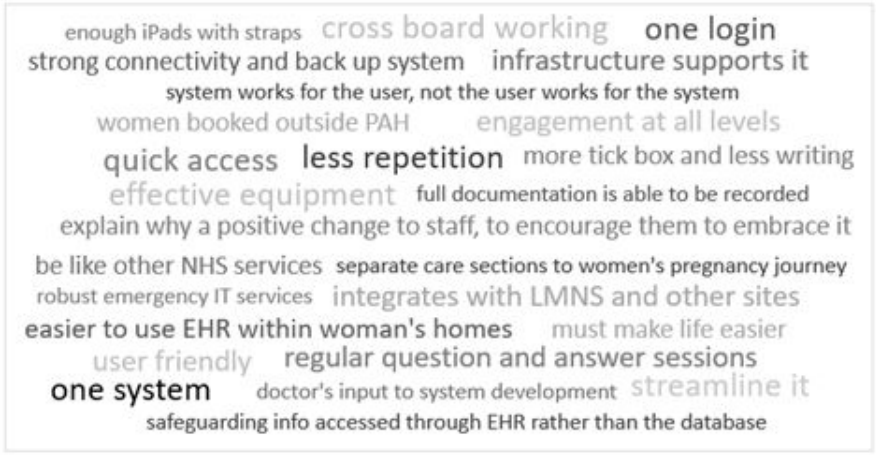
Q15. Our trust is working towards using a new EHR system, what would you like to see?



Q16. Question 15 'Other' comments

Q17. What would be most helpful to support you as we become more reliant on digital systems?

Q18. Do you have any other thoughts or suggestions regarding digital adoption within Maternity?



Q19. How can the trust support you in building confidence with using IT and digital devices in practice?

Q20. Would it be helpful to have digital updates on Maternity study days?

Q21. Following on from your Cosmic Training with our current EHR system, do you feel you could benefit with some more specific cosmic training towards your role?

A.3 Maternity Digital Strategy Working Group

Thank you to our senior leaders for developing our Digital Strategy together.

Trust Internal Members:

Role	Name
Chief Information Officer (CIO)	Phil Holland
Chief Clinical Information Officer (CCIO)	Helen Pardoe
Director of Information and IT	Lynne Fenwick
Chief Nurse informatics Officer (CNIO)	Joanna Eley
Director of Midwifery (DoMs)	Giuseppe Labriola
Head of Midwifery (HoMs)	Joanne Keable
Director of Operations	Andrea Philip
Business Change Manager	Rob Fisher
Maternity Transformation Programme Manager	Elita Mazzocchi
Divisional Director for Family and Women's Services, Consultant Obstetrician and Gynaecologist	Mr Alexander Field
Deputy Director of ICT	Jeffrey Wood
ICT Business Partner	Joanne Groarke
ICT Portfolio Manager	Sarah Wilcox
ICT Business Partner	Paul Richardson
Head of Technical Services	Stuart Hanlon
IT Transformation Manager	Sarah-Louise Lacey
Clinical Applications Manager	Lisa Hedgecock
Clinical Applications Support Manager	Malcolm Hundley
ICT Testing Manager	Liz Barber
ICT Training Manager	Jackie Nineberg
Data Quality Manager	Justine Lazell
FAWs Information Manager	Vairavipillai Srirangan
Governance Lead Midwife	Erin Harrison
Named Midwife for Safeguarding	Christine Curtis

Maternity Informatics Team:

Role	Name
Family and Women's Services (FAWs) Informatics Lead	Belinda Harvey
Digital Midwife	Sahra-Luise Tormos
Maternity Clinical Analyst	Kelly McAulay
Maternity Data Quality Adminstrator	Sunidhar Nagelli
FAWs Data Input Clerk	Rachel Bell

Trust External Members:

Role	Name
ICS Digital Lead	Adam Lavington
LMNS Digital Midwife Lead	Claire Eyre
Maternity Voices Partnership	Chloe Ribeio / Verity Bayfield Noakes

A.4 References

Department of Health and Socal Care (DHSC) (2022), *Speech by Health and Social Care Secretary Sajid Javid at the HSJ Digital Transformation Summit*. Avilable at: Speech by Health and Social Care Secretary Sajid Javid at the HSJ Digital Transformation Summit - GOV.UK (www.gov.uk), (accessed June 2022)

National Maternity Review (2016), *Better Births, Improving outcomes of maternity services in England*. Available at: national-maternity-review-report.pdf (england.nhs.uk), (accessed June 2022)

NHS England (NHSE) (2021), *Health Systems Support Framework*. Available at: NHS England » Health Systems Support Framework, (accessed July 2022)

NHS England (NHSE) (2019), *Key documents for integrated care systems*. Available at: NHS England » Key documents for integrated care systems, (accessed June 2022)

NHS England (NHSE) (2017), *Maternity Transformation Programme*. Available at: NHS England » Maternity Transformation Programme (MTP): Harnessing Digital Technology (accessed July 2022)

NHS England (NHSE) (2019), *NHS Long Term Plan*. Available at: NHS Long Term Plan, (accessed June 2022)

NHS England (NHSE) (2021), *What Good Looks Like Framework*. Available at: What Good Looks Like framework - What Good Looks Like - NHS Transformation Directorate (england.nhs.uk)

NHS England Transformation Directorate (2021), *Digital Technology Assessment Criteria for health and social care (DTAC).* Available at: Digital Technology Assessment Criteria (DTAC) - Key tools and information - NHS Transformation Directorate (england.nhs.uk), (accessed August 2022)

NHS Resolution (May 2022), *Maternity incentive scheme – year four*. Available at: MIS-year-4-relaunch-guidance-May-2022-converted.pdf (resolution.nhs.uk), (accessed July 2022)

Office for National Statistics (ONS) (2021), *Main Figures*. Available at: Home - Office for National Statistics (ons.gov.uk), (accessed April 2022)

Papas Education (2020), *Digital Literacy Self-Assessment tool*. Available at: Digital Literacy Self-Assessment tool – Papas Education, (accessed August 2022)

Royal College of Midwives (2021), *Position Statement, Digital Technology in maternity care.* Available at: rcm-position-statement-digital-technology-in-maternity-care.pdf, (accessed June 2022)

Trust Board – 6 October 2022

Agenda item:	4.3
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery, Giuseppe Labriola, Director of Midwifery
Date prepared:	21.9.2023
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels for August 2023 and an update to Nursing and Midwifery Workforce Position – Hard Truths Report

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	Part A: Overall staffing risk rating in month: achievement across our overall fill rate is stable (93.2%), with an RN/M overall fill of 88.3% and a HCSW overall fill of 104.2%. Part B: Maternity staffing: detailed overview of the maternity staffing and key actions in place. Part C: Turnover rates for nursing are stabilising. Recruitment work is ongoing utilising NHSE & ICS best practise with healthy pipelines of both RN and HCSW
Recommendation:	The Board is asked to note the information within this report.

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

Previously considered by:	Workforce Committee: 26/9/22 – front sheet updated.
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Divisions have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18

Appendices:	**Appendix 1:** Registered fill rates by month against adjusted standard planned template. RAG rated. **Appendix 2a:** Ward staffing exception reports. **Appendix 2b:** Red Flags (NICE) **Appendix 2c:** Red Flag data **Appendix 2d:** Staffing Incidents trend data **Appendix 2e:** Staffing Incidents by ward **Appendix 3a:** Care Hours Per Patient Day (CHPPD) Model Hospital Data **Appendix 3b:** Ward Level CHPPD **Appendix 4:** Temporary staffing demand and fill rate data **Appendix 5** Maternity Dashboard – see additional paper

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

1.0 BACKGROUND

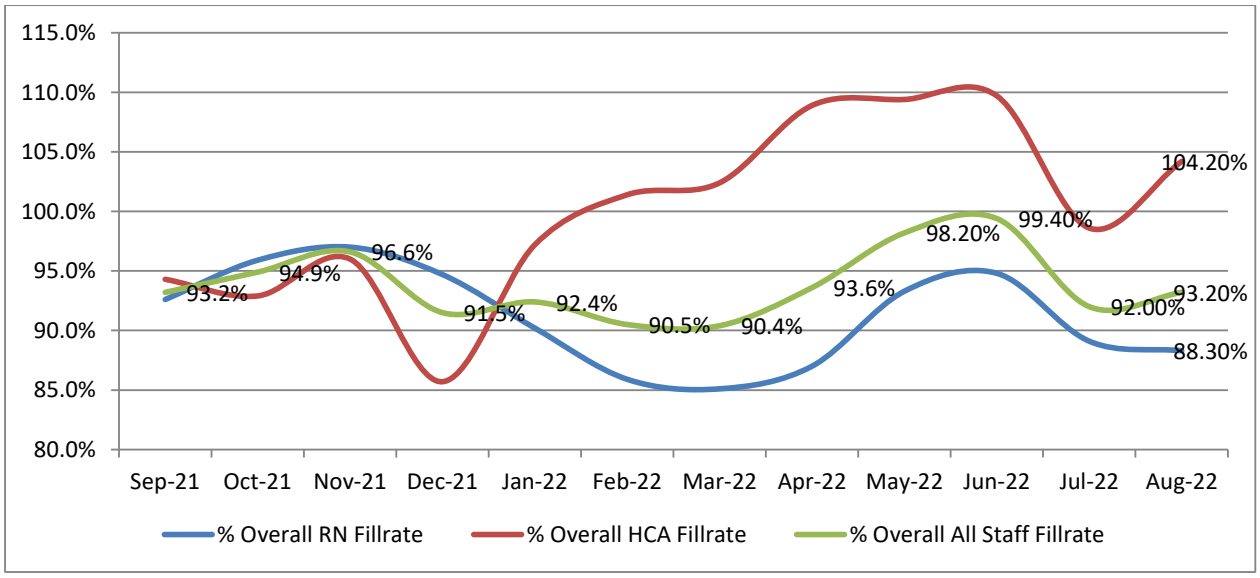
The report is collated in line with The National Quality Board recommendations (June 2016).

2.0 ANALYSIS

2.1 Fill rates for areas submitted to UNIFY:

There was an increase in fill in August compared to July by 1.2%. Overall care staff fill rates increased by 5.6% to 104.2% with RN fill rate decreasing by 0.8% to 88.3%.

Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
In Patient Ward average July 2022	89.4%	94%	92.4%	104.2%	89.1%	98.6%	92%
In Patient Ward average August 2022	85.7%	101.8%	91.6%	107.2%	88.3%	104.2%	93.2%
Variance July 2022 – August 2022	↓3.7%	↑7.8%	↓0.8%	↑3.0%	↓0.8%	↑5.6%	↑1.2%



2.2 Fill rates for areas not covered by UNIFY:

	Day		Night	
A&E Nursing	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
June 2022	91.5%	80.9%	97.4%	86.3%
July 2022	89.3%	78.5%	93.6%	86.7%
August 2022	90.8%	74.7%	96.3%	77.5%

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

2.3 Fill rates by ward:

Locke Ward reported average fill rates below 75% for HCA against the standard planned template during August. While the overall fill rate was 87.4%%, the RN fill was 70.3% with the HCA 134%.

Appendix 1. Shows the fill rates by ward against the standard but revised planned templates

Date	Ward name	% RN overall fill	% overall ward fill
May-22	No Wards		
Jun-22	John Snow		74.7%
July 22	Nightingale*	70.4%*	72.2%*
	Locke	74%	84.1%
August 22	Locke	70.3%	87.4%

NB: Nightingale ward was opened for 7 days only with small number of patients. Fill rates are not reflective.

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

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

(Appendix 2c) The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards (excluding Maternity) increased to 176 (↑3) against July. If a nursing red flag event occurs for number of staff on duty to meet the care needs of patients, staff escalate the situation and if appropriate complete a Datix.

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

The trend in reports completed in relation to nursing and midwifery staffing is included below and shows that the number of incidents recorded had decreased in month to 46 (↓12), Tye Green raised 7, with Lister 6 and Harold and Harvey both raising 5 Datix reports in relation to staffing levels. ***(Appendix 2e).***

2.5 Care Hours per Patient Day* (CHPPD):

There has been a reduction in Trust overall CHPPD over the past two months with August CHPPD being 7.0. The Trust total CHPPD compared to the latest Model hospital national median data, shows the Trust having 7.0 in August and there has been no update on the national median being since April 2022 **Appendix 3a** shows the Trust comparative CHHPD data via the Model Hospital portal based on April 2022 data

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

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

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

August 2022

	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts	Change in fill from previous month
RN	3571	2224	62.3%	544	15.0%	77.5%	803	22.5	↓1.5%
HCA	1911	1579	82.6%	0	0%	82.6%	332	17.4%	↓0.4%
RMN	379	32	8.4%	291	76.8%	85.2%	56	14.8%	↑4.9%

In August, there was a reduction in registered nursing demand ↓189 shifts compared to July; there was a reduction in fill rate from 79% in July to 77.5% in August.

To support patients requiring enhanced care there has been increased demand for RMNs. These shifts are created by Matron or above level to add a level of assurance regarding the need. The Trust has appointed a RMN lead nurse who will work in conjunction with the Lead Nurse for Falls & Enhanced Care and the Interim Safe Staffing Lead to ensure that the requirement is validated and the patients' needs can only be meet by a RMN.

In August there was a reduction in RMN demand ↓23 shifts requested in August compared to July; there was a reduction in fill rate from 83% in July compared to 82.6% in August ***(RMN shift data Appendix 4)***

2.7 Redeployment of staff:

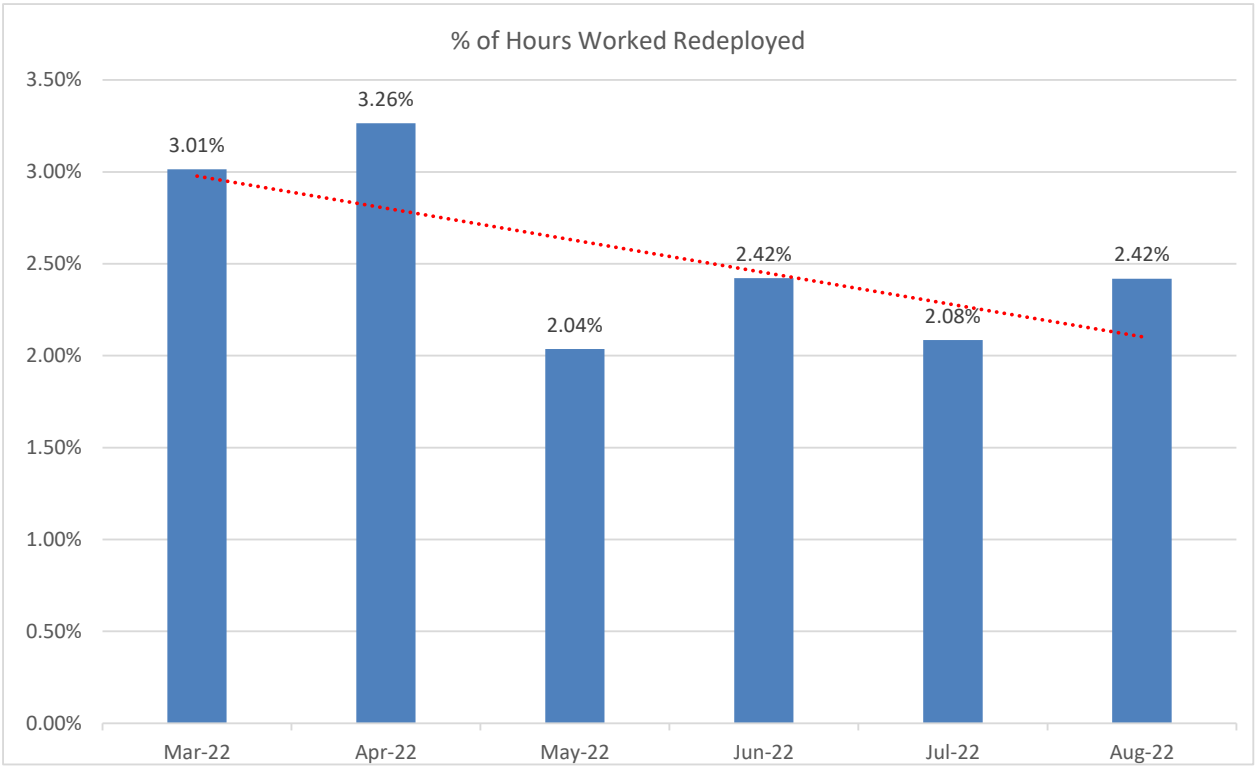
The table below shows how the Trust is supporting safe staffing through redeployment of staff to meet acuity and dependency. The data does not capture the moves of bank or agency staff; (including multi post holders). Also excluded are the Maternity Wards and the Enhanced Care Team.

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

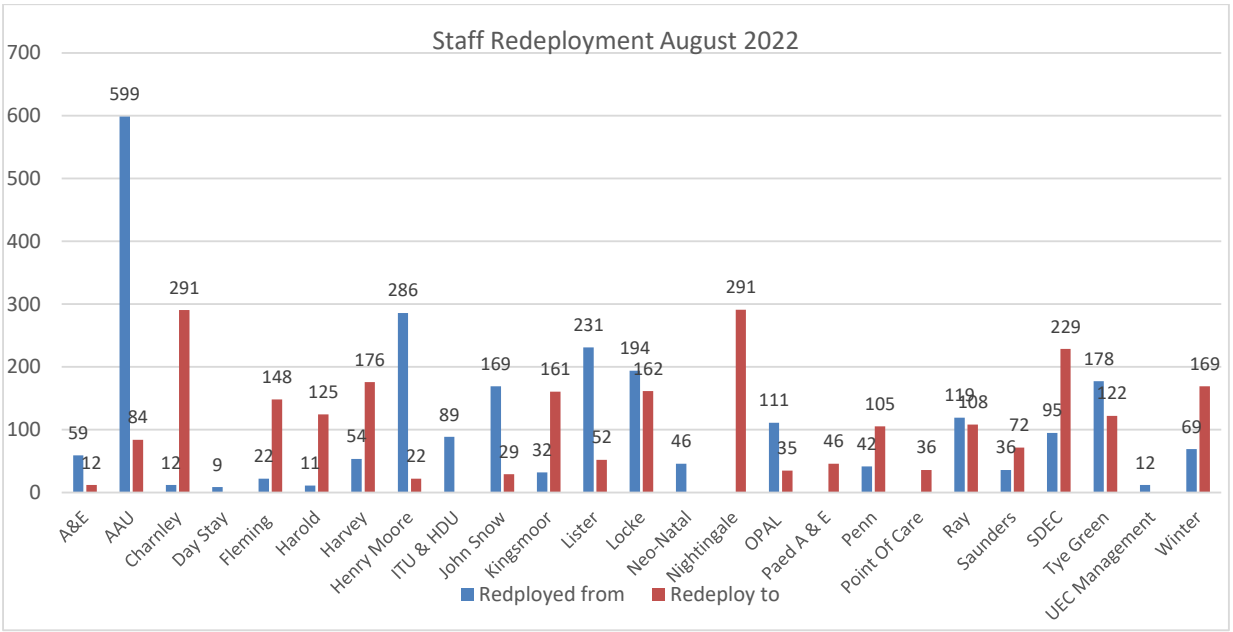
The senior nursing leadership teamwork closely with ward managers and teams to ensure there is understanding of the rationale for moves and to ensure there are positive conversations.
The data shows the number of hours of staff worked, the hours redeployed and the percentage of hours worked redeployed to support safe staffing.

The graph shows the trend over the past 6 months, which shows a slight increase in August.

Date	Total Hours Worked	Total Hours Worked Bank / Agency	Total Hours Worked Excluding Bank & Agency	Total Hours Redeployed	Total Hours Not Redeployed	% of Hours Worked Redeployed
Mar-22	111821.2	25239.2	86582.0	2609.6	83972.4	3.01%
Apr-22	117185.3	30586	86599.3	2827	83772.3	3.26%
May-22	136878	35846	101032.0	2057	98975.0	2.04%
Jun-22	119226.1	34626	84600.1	2049	82551.1	2.42%
Jul-22	164004	2694	161310.0	3363	157947.0	2.08%
Aug-22	131738	29531	102207.0	2472	99735.0	2.42%



The following graph shows the hours moved from ward to ward during August 2022. The highest exporter of staff was AAU. Staff are redeployed within the surgical division in the first instance to support skills retainment.



Part B Maternity staffing

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

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

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

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

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

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

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

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

Intrapartum acuity:

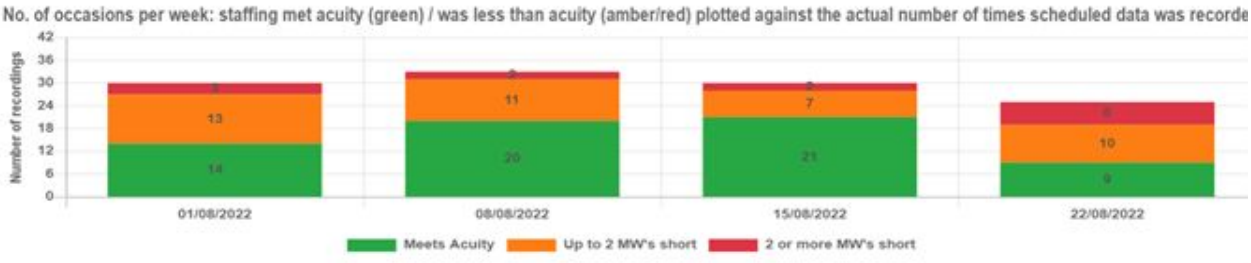
The maternity service implemented the use of the Birthrate Plus intrapartum acuity tool in 2021. The data is inputted into the system every 4 hours by the Labour Ward Co-ordinator and measures the acuity and the number of midwives on shift to determine an acuity score. Birthrate Plus defines acuity as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

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

During the reporting period of August the Labour Ward did not achieve a 85% confidence factor in the month – 54% of recordings were made where staffing met acuity. 69% compliance of the tool was achieved. The majority of negative acuity is amber with up to 2 midwives short with a much smaller percentage of occasions being red which equates to 2 or more midwives short.

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

Table 3. Intrapartum Acuity



Red flags:

In total there were 12 red flags recorded during this reporting period, an increase from the previous month and a slight decrease in management actions. In this reporting period delay in the induction of labour process (n=31 38%) compared to the previous month (n=0), the co-ordinator not able to maintain supernumerary status (n=3, 33%), delay or time cancelled critical activity (n=2, 17%) and missed or delay care (n=4, 33%). All delays for induction of labour and the inability for the co-ordinator to be supernumerary will be incident reported via the DATIX system and thoroughly reviewed.
Action: The Triage service is planned to open at the end of September. Birth rate plus training to support accurate data collection and analysis is on the 13th September

1:1 care in established labour:

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

Supernumerary status of the coordinator :

Supernumerary status of the coordinator is defined as the coordinator not having a caseload. The acuity tool has time built in for the coordinator to be supernumerary when it is recorded. The data identifies that the coordinator was not supernumerary on 3 occasions (33%) during the reporting period.

Action: The inability for the co-ordinator to be supernumerary will be incident reported via the DATIX system and thoroughly reviewed. Birth rate plus training to support accurate data collection and analysis is on the 13th September. There are national discussions with the Royal College of Midwives to provide clarity on the definition of the supernumerary status of the co-ordinator. The guidance will form part of the updated definition within the maternity incentive scheme year 4 safety actions. It is anticipated this will be provided to maternity services in October 2022.

Specialist Midwives:

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

During this reporting period there were 346 management actions taken. The majority of these related to redeploying staff internally (n=72, 21%), additional staff sourced from bank/agency (n=72, 21%), staff unable to take breaks (n = 15, 4%) and escalation to the manager on call (n=15, 4%). On (n=23, 7%) occasions the on call continuity of carer midwives were in the maternity unit to support and the birth centre closed (29%).

Action: 21 newly qualified midwives are due to commence either as Band 4 (awaiting Nursing and Midwifery Council Registration) or Band 5 Midwife in September 2022. A Lead PMA for retention and wellbeing has been appointed, to commence end of October and a further Lead Practice Development Midwife (30 hours) in addition to the Practice Development Midwife team, to support preceptors has also been appointed. Reminder sent to all Labour ward co-ordinators to DATIX when unable to maintain supernumerary status

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

August	Red flags	1:1 care not met (number)	Supernumerary not met (number)	Management actions (number)	Acuity % Positive	Red %	Amber %	Assessment periods	Confidence Factor %
Labour Ward	9	0	3	349	45%	11%	44%	144/186	77%

Maternity inpatient wards:

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

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

August	Red flags	Extra Care breakdown	Management actions (number)	Acuity % Positive	Red %	Amber %	Assessment periods	Confidence Factor %
Antenatal Ward	41	48% exceptional care needs 52% safeguarding	18	22%	0%	56%	59/93	63.44%
Postnatal Ward	1	84% extra care babies, 6% exceptional care needs 5% Sepsis	2	29%	0%	35%	72/93	77.42%

Antenatal Ward - During this reporting period there were 18 management actions taken. The majority of these related to redeploying staff from community/internally (n=2, 12%) and specialists/managers

working (n=9, 50%), which is a 50% increase from last month. In total there were 41 red flags recorded during this reporting period. The majority of these related to delays in time critical activity (n=28, 68%) and delay in admission and beginning of induction process (n=10, 24%) and delay in providing pain relief (n=2, 5%)

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

Action: Phase one of transitional care has commenced on the Postnatal ward. The Induction of Labour workstream has been impacted by the specialist midwives and managers working clinically as indicated by the management actions. This work will recommence and the new midwives have now received start dates and induction programs. The Triage service has a start date planned for the end of September 2022 this will be confirmed following a risk assessment for "Go Live" to ensure the safety of the service. The Pre-term birth clinic has commenced, this service will ensure that personalised care plans and risk assessments are in place and shared.

C: Workforce:

4.0 Nursing Recruitment Pipeline:

Registered Nurse pipeline for 2022/23.

The data for nurse pipeline is undergoing validation this month however turnover is steady for the third month in a row at 15.58% and recruitment activity is ongoing with a steady supply of international nurses and UK trained nurses joining the Trust each month. Recruitment for international nurses is ongoing and the Trust is working with new agencies to expand pool. Further NHSI funding has been made available to support recruitment costs and this has been increased to £7k per nurse.

Healthcare Support Worker pipeline

HCSW vacancy rate in August was 13%. Recruitment activity continues and the Trust is engaging with NHSI&E support programmes.

Establishment V Staff in Post												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-22	Feb-22	Mar-22
Funded Establishment WTE	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64
Staff in Post WTE	373.00	375.00	376.00	364.10	367.10	372.10	382.10	392.10	402.10	412.10	417.10	422.10
Vacancy WTE	50.64	48.64	47.64	59.54	56.54	51.54	41.54	31.54	21.54	11.54	6.54	1.54
Actual B2/B3 Vacancy Rate	12.0%	11.5%	11.2%	14.1%	13.3%	12.2%	9.8%	7.4%	5.1%	2.7%	1.5%	0.4%

Actual/Projected Starters Pipeline												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total Starters	8	10	9	8	10	10	15	15	15	15	10	10

Projected Leavers WTE												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total Band 2/3 Leavers	**10**	**8**	**8**	**9**	**7**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
HCSW Turnover %	23.89%	23.53%	24.71%	26.98%	26.12%							

5 RECOMMENDATION

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

Author: Sarah Webb, Deputy Director of Nursing and Midwifery
Date **16.9.2022**

Appendix 1

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

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

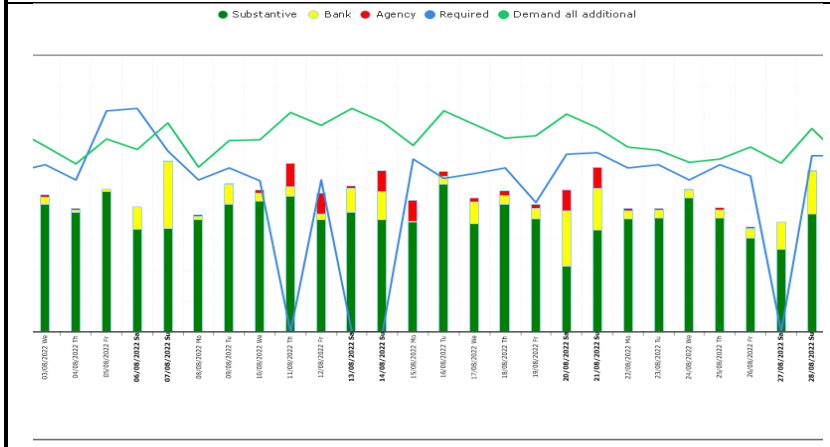
	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
ITU & HDU	87.7%	141.9%	88.0%	106.3%	87.8%	124.1%	90.6%
Saunders Unit	82.4%	109.3%	89.2%	123.9%	85.3%	114.9%	95.9%
Nightingale	58.5%	49.5%	50.0%	42.9%	54.5%	46.3%	51.2%
Penn Ward	96.5%	98.5%	91.3%	139.4%	94.3%	114.0%	101.3%
Henry Moore Ward	98.8%	112.5%	100.0%	77.4%	99.3%	96.4%	98.3%
Harvey Ward	75.2%	104.7%	89.4%	109.5%	81.0%	107.0%	90.4%
John Snow Ward	102.5%	55.6%	100.0%	84.8%	101.3%	64.7%	85.5%
Charnley Ward	82.0%	115.5%	80.0%	112.4%	81.0%	114.0%	90.5%
AAU	122.0%	121.4%	109.7%	109.3%	115.8%	115.7%	115.8%
Harold Ward	93.9%	68.3%	112.4%	110.2%	101.9%	85.4%	95.5%
Kingsmoor General	82.3%	80.9%	93.5%	101.7%	87.1%	89.4%	88.1%
Lister Ward	74.6%	96.9%	97.6%	109.2%	83.3%	102.8%	90.6%
Locke Ward	64.0%	132.4%	78.4%	137.7%	70.3%	134.9%	87.4%
Ray Ward	95.9%	117.2%	100.3%	131.2%	97.8%	123.9%	105.8%
Tye Green Ward	74.1%	93.6%	91.2%	101.5%	81.5%	96.8%	87.5%
OPAL	91.8%	189.0%	116.1%	108.9%	101.0%	137.2%	114.4%
Winter Ward	73.1%	102.0%	86.3%	107.6%	78.1%	104.7%	88.0%
Fleming Ward	73.2%	105.4%	98.8%	108.2%	83.4%	106.7%	90.5%
Neo-Natal Unit	89.9%	128.3%	94.5%	109.7%	92.2%	119.0%	96.7%
Dolphin Ward	85.2%	84.1%	88.7%	94.8%	86.8%	87.7%	87.0%
Total	73.9%	99.8%	93.1%	109.6%	81.7%	104.1%	88.3%

Appendix 2a: Ward staffing exception reports

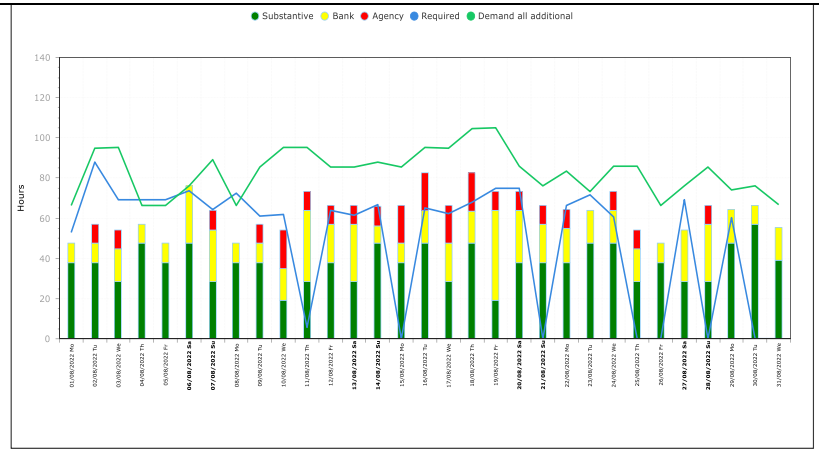
Reported where the fill is < 75% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes. Please note further review of data sets will enable a more robust and detailed analysis going forward (August data)

Report from the Associate Director of Nursing for the HCG								
Ward	Analysis of gaps				Impact on Quality / outcomes			Actions in place
Locke	76% fill rate for RNs in August.				No impact detected outside of previous pattern of quality measures.			Staff member covering ward manager responsibilities over July and August worked clinically to support the ward this is not reflected in their rostered hours. Locke Ward also had matron support who worked alongside staff clinically. Locke Ward had a number of Band 4 nurses working in a supernumery capacity, our PDN team were able to support them clinically to care for patients and support the shortfall in RN hours
Quality Metric	PU	Falls	Staffing Datix	SIs	Drug Errors	Complaints	PALS	
Number in month	2	4	1	0	0	2	2	

Required vs Actual Day



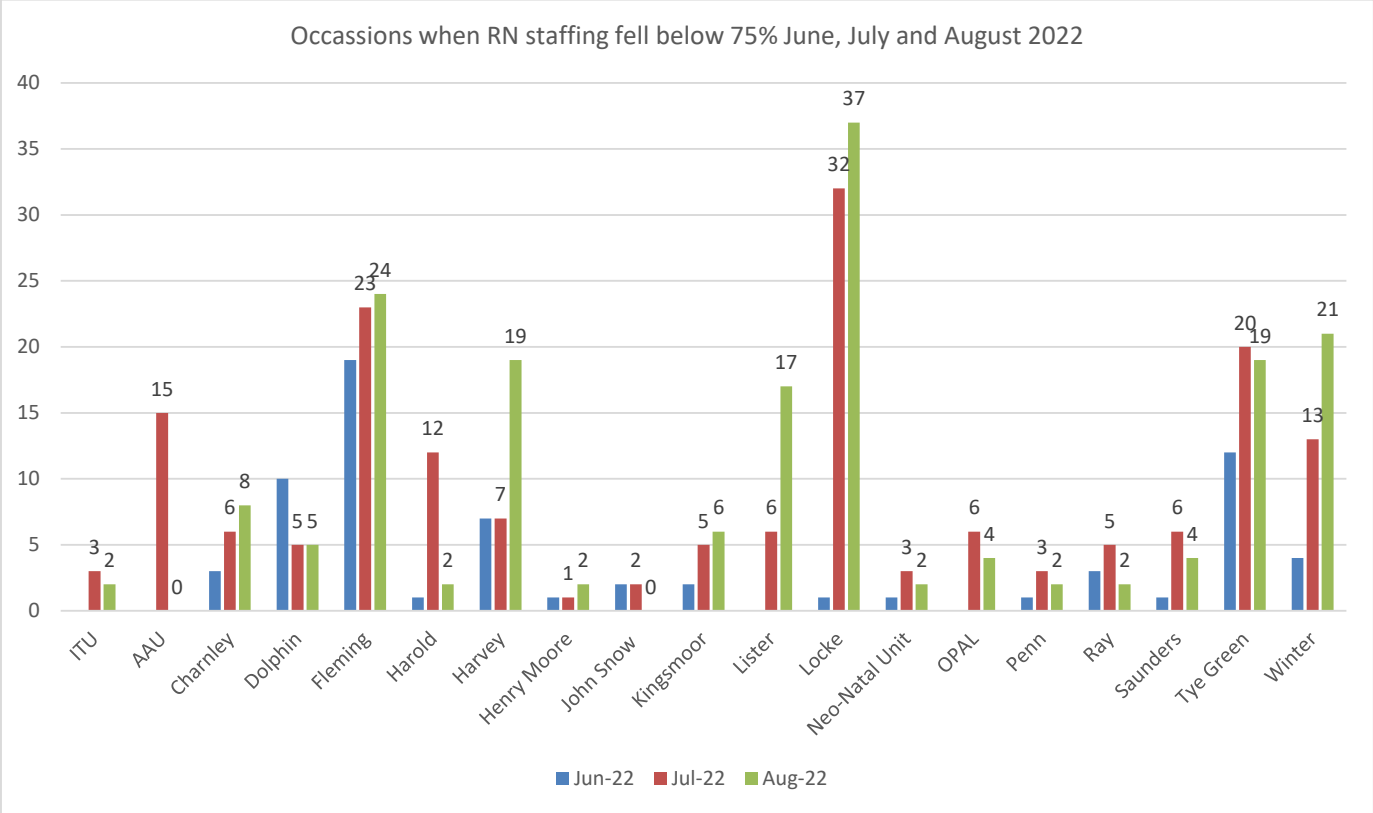
Required vs Actual Day



Appendix 2b: Red flag data

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

The graph below demonstrates the number of occasions/shifts where the reported fill rate has fallen below 75% by ward over the past three months.



Appendix 2c: Nursing Red Flags (NICE)

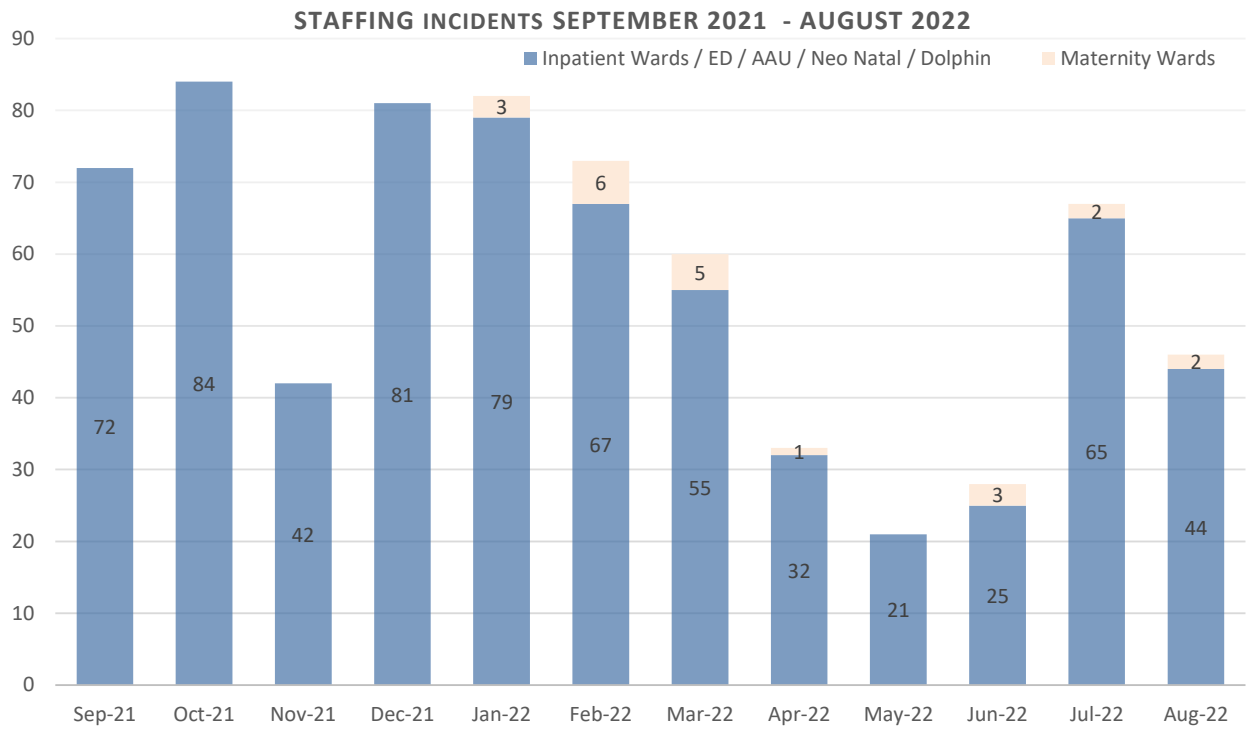
The National Institute for Health and Care Excellence (NICE) guideline Safe staffing for nursing in adult inpatient wards in acute hospitals (2014)1 recommends red flags relating to adult inpatient wards.
Recommendations for the registered nurses on wards who are in charge of shifts are:

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

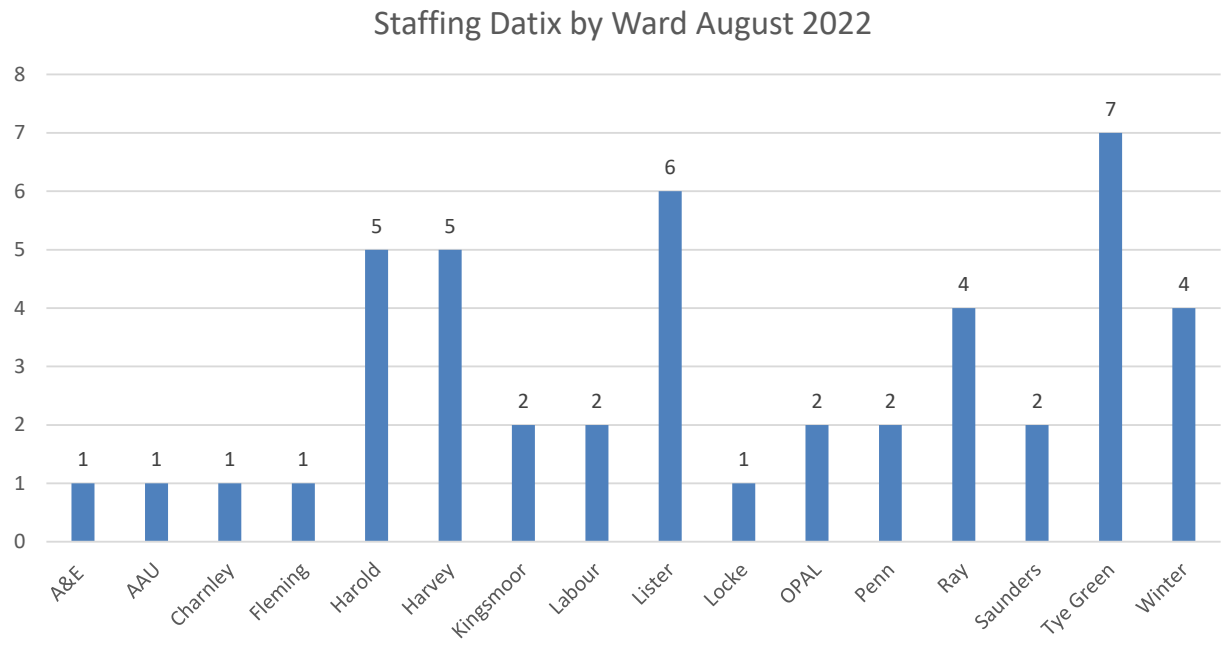
Nursing red flags

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

Appendix 2d: Staffing Incidents Trend Data



Appendix 2e: Staffing Incidents by ward August 2022



Appendix 3 Care Hours per Patient Day (CHPPD):

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

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

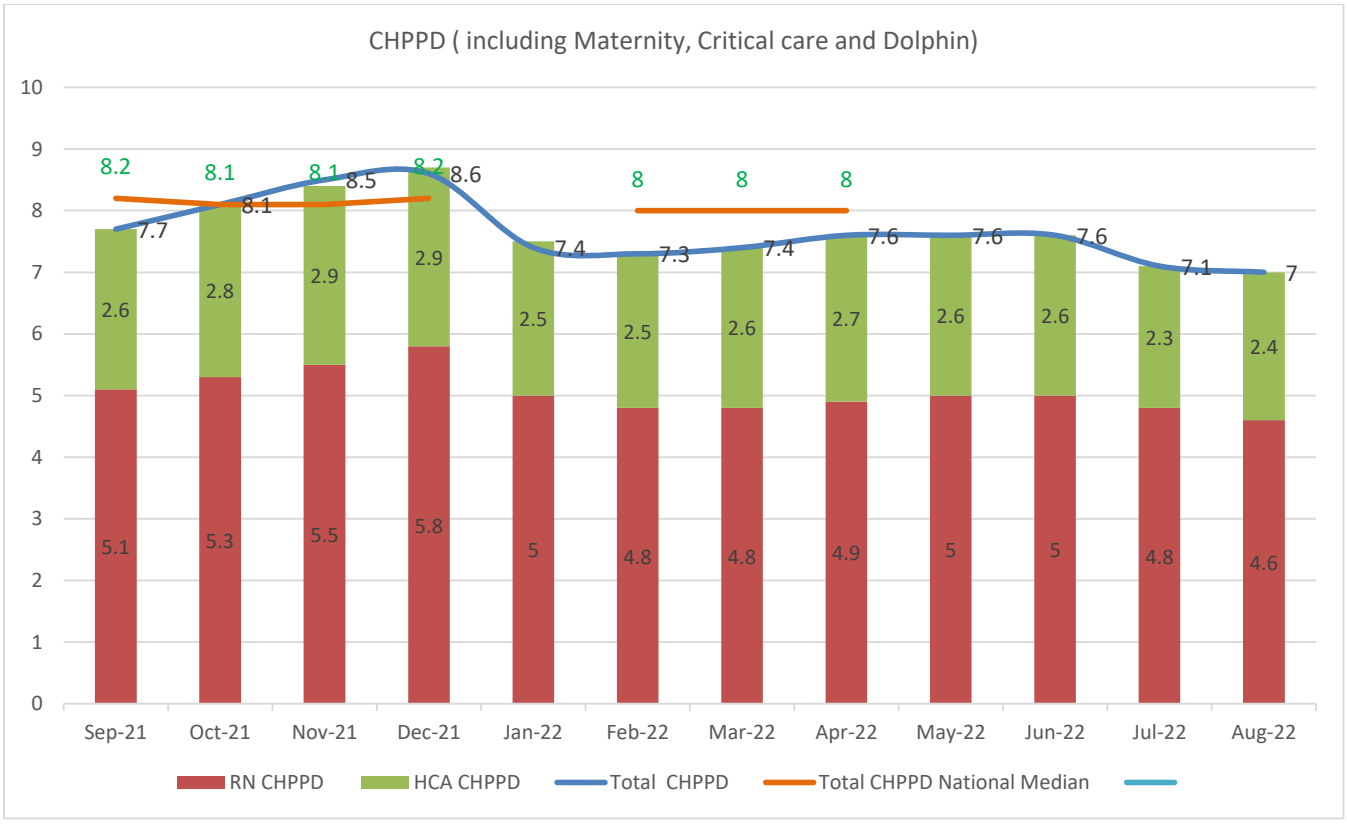
Care Hours per Patient Day* (CHPPD) is calculated every month by adding together the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants.

Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average.
Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day

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

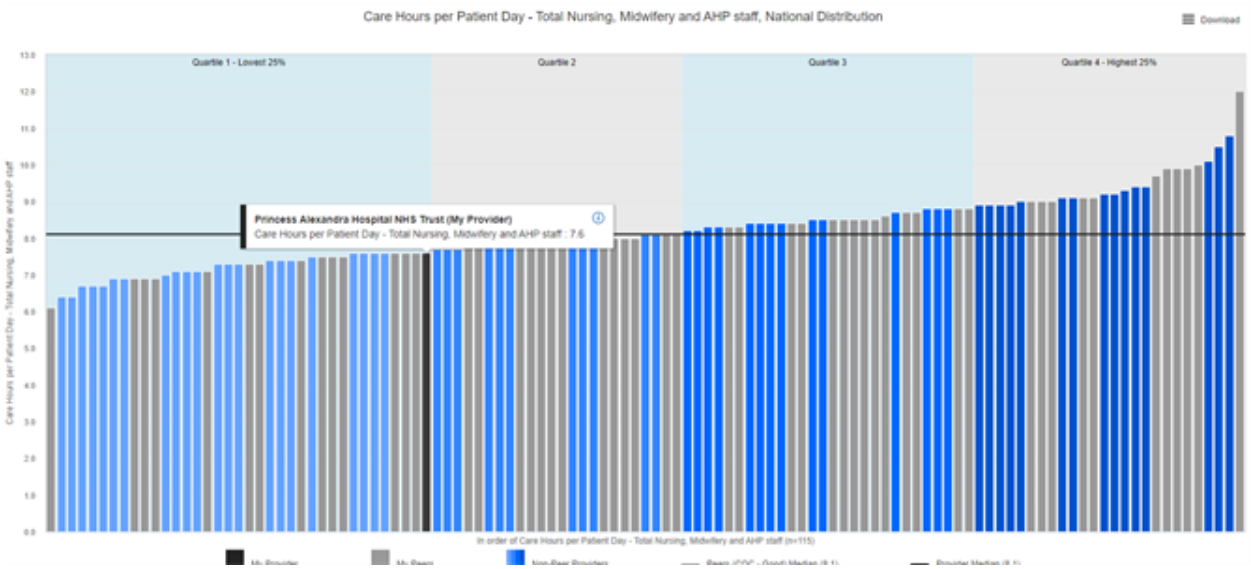
The accuracy of this report is dependant of the rosters being up to date and accurate bed occupancy numbers.

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



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

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



Appendix 3b

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

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total (including Maternity)	**4.6**	**2.4**	**7.0**

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Ward Total	**4.5**	**2.4**	**7.0**
ITU & HDU	29	3.4	32.4
Saunders Unit	3.3	2.5	5.8
Nightingale Ward	2.8	1.6	4.5
Penn Ward	3.7	2.5	6.1
Henry Moore Ward	5.1	2.5	7.6
Harvey Ward	3.3	2.5	5.8
John Snow Ward	5.2	2.5	7.7
Charnley Ward	3.5	2.0	5.5
AAU	6.1	2.1	8.2
Harold Ward	4.1	2.2	6.4
Kingsmoor General	3.3	2.6	6.0
Lister Ward	3.5	2.6	6.0
Locke Ward	3.3	2.3	5.6
Ray Ward	3.7	2.1	5.8
Tye Green Ward	3.5	2.7	6.2
OPAL	3.8	3.0	6.8
Winter Ward	3.3	2.6	5.9
Fleming Ward	3.4	1.9	5.4
Neo-Natal Unit	9.3	2.4	11.8
Dolphin Ward	9.8	3.3	13.2

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Maternity Ward Total	**5.1**	**2.5**	**7.6**
Labour Ward	9.9	2.9	12.8
Birthing Unit	18.6	9.4	28.0
Samson Ward	2.2	2.2	4.4
Chamberlen Ward	4.5	1.7	6.2

Appendix 4: Temporary Staffing Demand & Fill Rate

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

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

RN temporary staffing demand and fill rates: ***(July 2022 data supplied by NHSP 1.9.2022)***

Last YTD month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
March 2022	3842	2519	65.6%	534	13.9%	79.5%	789	20.5%
April 2022	2815	1950	69.3%	176	6.3%	75.5%	689	24.5%
May 2022	3054	2168	71%	486	15.9%	86.9%	400	13.1%
June 2022	3327	2274	68.3%	487	14.6%	83%	566	17%
July 2022	3760	2391	63.6%	575	15.3%	79	794	21.1%
August 2022	**3571**	**2224**	**62.3%**	**544**	**15.0%**	**77.5%**	**803**	**22.5**
August 21	2585	1880	72.7%	434	16.8%	89.5%	271	10.5%1911

HCA temporary staffing demand and fill rates: ***(July 2022 data supplied by NHSP 1.9.2022)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
March 2022	1893	1520	80.3%	0	0%	80.3%	373	19.7%
April 2022	1776	1442	81.2%	0	0%	81.2%	334	18.8%
May 2022	1648	1470	89.2%	0	0%	89.2%	178	10.8%
June 2022	1751	1496	85.4%	0	0%	85.4%	255	14.6%
July 2022	1911	1587	83%	0	0%	83%	324	17%
August 2022	**1911**	**1579**	**82.6%**	**0**	**0%**	**82.6%**	**332**	**17.4%**
August 2021	1642	1456	88.7%	0	0%	88.7%	186	11.3%

RMN temporary staffing demand and fill rates: ***(July 2022 data supplied by NHSP 1.9.2022)***

Last YTD month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
March 2022	428	20	4.7%	337	78.7%	83.4%	71	16.6%
April 2022	478	45	9.4%	276	57.7%	67.2%	157	32.8%
May 2022	336	48	9.8%	255	75.9%	85.7%	48	14.3
June 2022	291	32	11.0%	223	76.6%	87.6%	36	12.4%
July 2022	402	34	8.5%	289	71.9%	80.3%	79	19.7%
August 2022	**379**	**32**	**8.4%**	**291**	**76.8%**	**85.2%**	**56**	**14.8%**
August 2021	212	12	5.7%	170	80.2%	85.8%	30	14.2%

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 October 2022

4.4

Agenda item:	4.4							
Presented by:	Fay Gilder | Medical Director							
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Information Team							
Date prepared:	September 2022							
Subject / title:	Learning from deaths and Mortality Paper – August 2022 data							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	This paper provides assurance on the learning from death process and highlights key pieces of learning and updates on the current programme of work to improve clinical practice and patient outcomes.							
Recommendation:	To note the progress being made on the learning from death process and the improvement work to address this.							

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

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

The Princess Alexandra Hospital NHS Trust

4.4

1.0 Purpose/issue

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

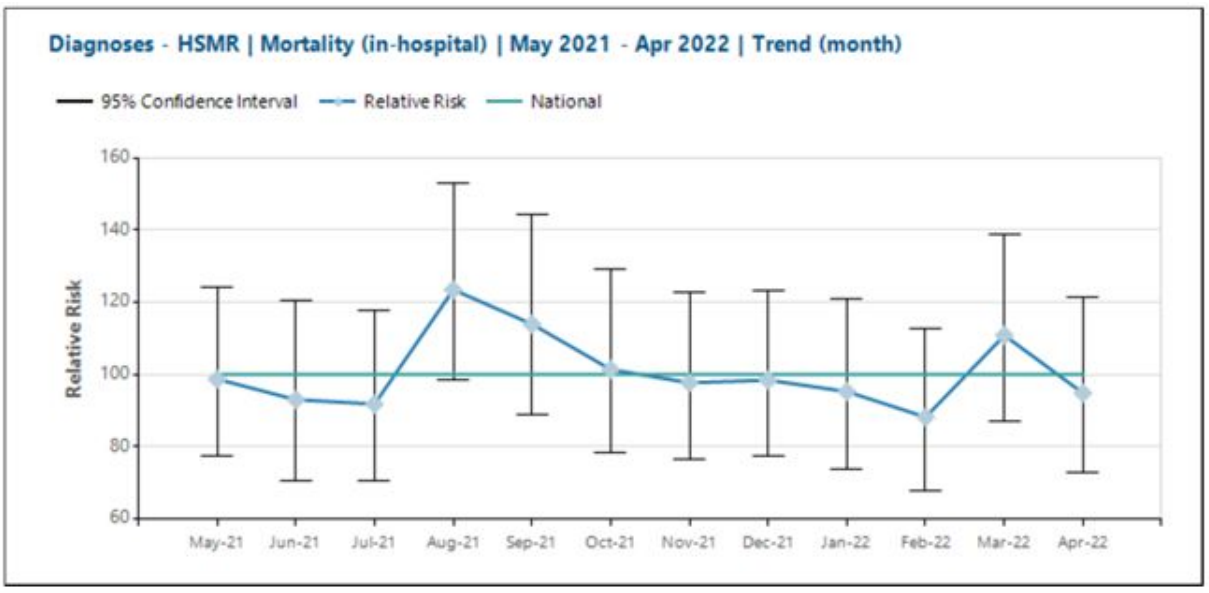
2.0 Background

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

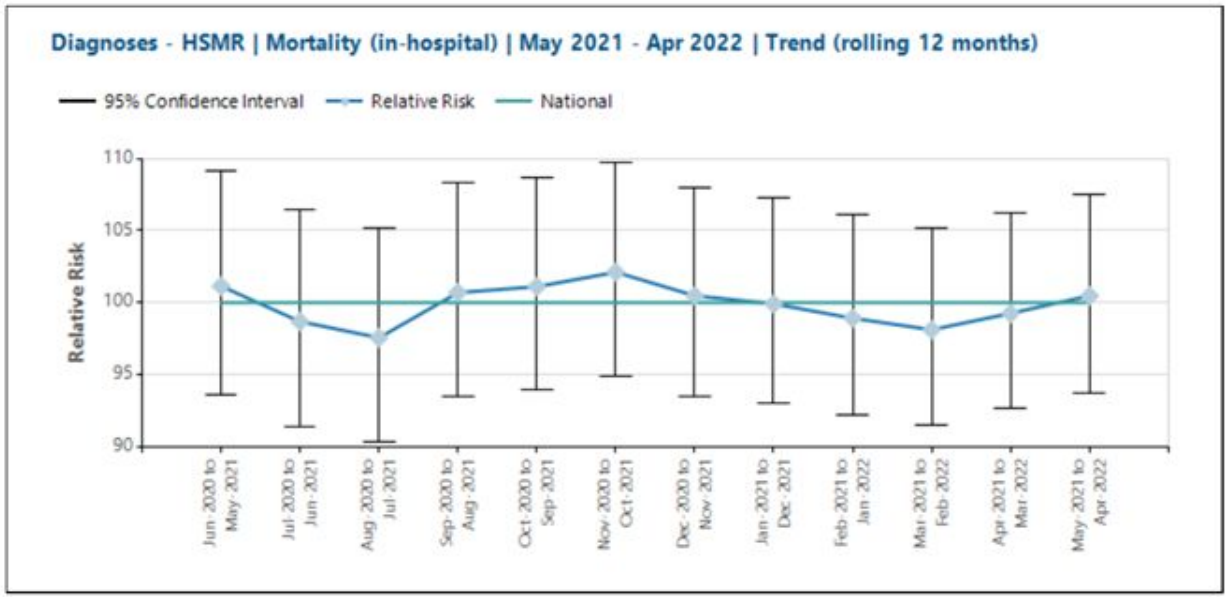
3.0 Current Telstra/ NHS Data Headlines

Metric	Result
HSMR	100.5 "within expected"
HSMR position vs. peers	Regional peer group = 12 trusts: • 8 higher-than-expected • 4 within expected • 2 lower-than-expected Region as a whole = 103.3 "higher-than-expected" (101.8 – 104.8)
All Diagnosis SMR	99.9 "within expected"
Significant Diagnosis Groups	• Alcohol-related mental disorders (212 superspells; 5 deaths) • Cardiac dysrhythmias (371 superspells; 18 deaths)
CUSUM breaches	• Lung disease due to external agents (Dec-21) • Lymphadenitis (Nov-21) • Fracture of neck of femur (hip) (Sep-21)
SHMI position	(Apr-21 to Mar-22) 99.29 "within expected"

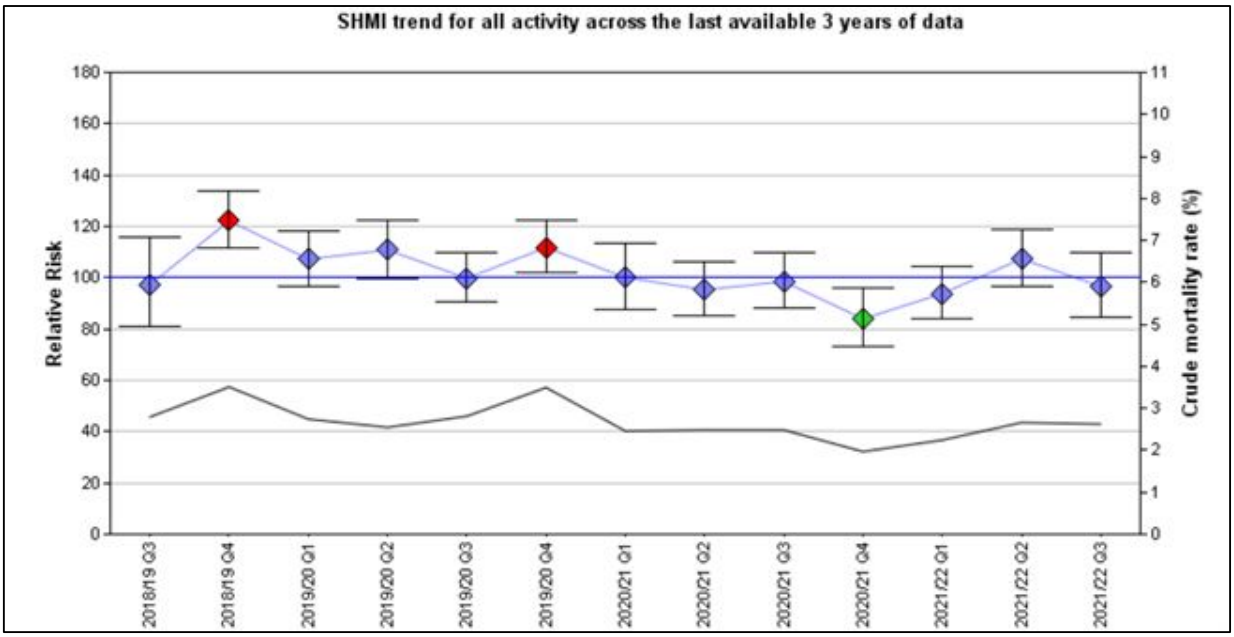
3.1 Hospital Standard Mortality Rate (HSMR) - Rolling 12 Months



3.2 Hospital Standard Mortality Rate (HSMR) – Monthly



3.3 Summary Hospital-level Mortality Indicator (SHMI)



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

3.5 Standardised Mortality Ratio (SMR)

3.6 Standardised Mortality Ratio (SMR) outlying groups

There are two outlying groups:

- Alcohol-related mental disorders, and
- Cardiac dysrhythmias

The patient notes will be audited looking at coding and quality of care with findings presented to October 2022 SLFDG

4.0 Mortality Programme Updates

4.1 Acute Kidney Injury

Progress:

Continued AKI teaching in both the FY1 and FY2 education programmes.
New project is underway to develop an e-referral system for patients to the Renal Team at the Lister Hospital.

Next Steps or Timeline:

Appointment of new Deputy Clinical Lead
Appointment of new lead nurse within the Trust now that funding has been approved

5.0 Learning from deaths process update

5.1 Mortality Narrative

There were 87 deaths in August 2022.

22 cases referred for SJR's.

There are 56 outstanding SJRs (over 6 weeks of the patients' death.) There continues to be a working trajectory to complete the backlog of SJR's over 6 weeks whereby they will be cleared by October 2022. Time has been set aside for the Mortality Lead Consultant in ED to undertake the backlog of ED SJRs in September 2022, as well as a dedicated SJR champion to clear the Medical backlog

5.2 Key Learning to be addressed

5.2.1 Learning from SJR's:

Visibility of community DNACPR is limited and held in a variety of data locations. Dr Hegarty to raise with West Essex End of Life steering group and discuss possible solutions.

'No harm' learning indicated that some tests are done that do not inform management – fed back to the team.

5.2.2 Monthly M&M meetings key learnings

DNACPR and TEP forms not countersigned – reminder to staff regarding the importance of this documentation
Admissions of patients with AKI from a nursing home. This appears to be a recurring theme and data is being collected to inform future discussions with the community.
Evidence of good family discussions

Many M&M meetings were cancelled due to clinical duties and staff leave. This was previously anticipated.
There is evidence of cross speciality learning via the M&M meetings and process

All learning is discussed with the MDT for sharing

5.2.3 Second Review Panel Cases

There were no cases presented to the second review panel.

6.0 Medical Examiner (ME) Headlines

During August 2022 there were 87 deaths, 100% scrutinised between 10 Medical Examiners.

18 cases were referred to the Coroner:

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

New Developments:

A new interim Lead ME, Dr Rashael Gerrard is in post.

The service is looking at how we work to enable the national mandate that all perinatal deaths are scrutinised.

6.1 National Medical Certificate of Cause of Death (MCCDs)

National MCCDs issued within 72 hours: (National Target)

84% of MCCDs were completed within 72 hours due to delays in doctors' availability to complete the MCCD.

7.0 Risks

It was agreed at the SLFDG that the following risks had reached their target risk score. They have been archived and removed from the Learning from Death Risk Register.

- There is a risk that the trust is not learning from sepsis deaths due to sepsis being flagged as a historical mortality outlier by Dr Foster
- There is a risk that the trust is not learning from AKI deaths due to AKI being flagged as a historical mortality outlier by Dr Foster.
- There is a risk that the trust is not learning from deaths due to the HSMR data showing that the trust has a higher than expected number of deaths via Dr Foster data.

8.0 Recommendation

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

BOARD OF DIRECTORS: Trust Board (Public) 6 October 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 26 September 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 People Report	Yes	N	N	PC received assurance on the progress being made to improve workforce metrics/KPIs. The following was highlighted; increase in vacancy rate due to increase in establishments, decrease in agency spend and an increase in rolling turnover.
2.2 PAHT2030 Culture Milestones	Yes	N	N	PC noted significant improvement made in regards to the 6 culture related KLOEs and thanked the PMO and team for the hard work to drive the changes and improvements.
2.3 Safer Nurse Staffing Report	Yes	N	N	PC were assured in regards to the provision of safe nursing and midwifery staffing and that processes are in place for managing and monitoring staffing levels. The Committee noted the potential risk of accommodation costs and availability due to the increase in the international nurse recruitment drive.
2.4 BAF Risk 2.3 (Workforce)	Yes	N	N	Risk score to remain unchanged at 16; the controls had been updated and it was agreed to include a gap in control around direct engagement.
2.6 Health and Wellbeing Report	Yes	N	N	Recent health and wellbeing initiatives were noted including; the upcoming East of England wellbeing festival which had been rescheduled to October.
3.1 Communications Update	For Information	N	N	PC noted the recent communications activities including; the BBC Look East media piece on the need for the new hospital which included an interview from the Director of Strategy.

BOARD OF DIRECTORS: Trust Board (Public) 6 October 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 26 September 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
4.1 Learning and OD Update	Yes	N	N	PC were assured in regards to the measures being taken to address statutory and mandatory training compliance and the proposals for non-compliance which had been discussed with the Senior Management Team. The Committee noted the quarter 2 pulse staff survey results; which saw an increase in score for 6 out of the 9 core engagement questions.
4.2 Horizon Scanning	Yes	N	N	PC noted the emerging people issues including; the new medical doctor degree apprenticeship and the preparation for industrial action.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 6 October 2022**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**29 September 2022**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 M3 Financial Results	Yes	Y	N	The Trust reported a deficit of £1.7m in month 5 and £10.2m YTD. It continued to incur the higher levels of expenditure relating to elective recovery (including outsourcing and insourcing), high use and cost of agency staff and COVID-related costs remained above pre-pandemic levels. PAF was assured there was control in terms of finances but acknowledged the current financial position was not where the Trust wanted to be. PAF requested that cost drivers and levers are included in reports going forward.
2.2 Financial Forecast	Partial	Y	N	The paper set out the current forecast along with the opportunities and risks in terms of achieving break even. Members noted the existing financial position and agreed the next steps to develop a more robust forecast and approach to exercising more financial controls where necessary.

BOARD OF DIRECTORS:	**Trust Board (Public) – 6 October 2022**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 September 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.3 Capital Update	Y	N	N	As at M5, YTD capital spend totalled £3.3m with a further £3.0m of commitments. £2.4m related to Estate schemes, £0.6m ICT, Medical Equipment of £0.3m and New Hospital project spend of £0.3m. The Trust had received a VAT refund on previous capital spend of £0.5m in M5 which it could potentially use on further capital works, subject to agreement of changes to the Trust's CRL.
2.4 CIP Update	Partial	Y	N	£2.2m of savings had been delivered for 2022/23 which remained lower than the full year CIP plan of £11.7m. A total of 97 schemes were in development with a weekly executive focus on four key schemes: Agency & bank spend, procurement, clinical efficiency and reduction in in-sourcing spend. PAF was assured by the work to date but noted the large gap to be closed and emphasised the need for pace.
2.7 BAF Risks 5.1 (Revenue) and 5.2 (Capital)	Y	N	N	PAF agreed that the score for risk 5.1 (revenue) should remain at 12 but that the score for risk 5.2 (capital) should be reduced to 8 bearing in mind the current funding envelope, the capital funds that would become available before year-end and the lower current capital spend than in the previous year.

BOARD OF DIRECTORS:	**Trust Board (Public) – 6 October 2022**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**29 September 2022**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.1 M5 Integrated Performance Report	Y	N	N	Of note were the increase in stranded patients and the significant decrease in time from arrival to triage which correlated with the implementation over the summer of ED NerveCentre/Manchester Triage Tool. Performance with the latter was now back in common cause variation.
3.2 BAF Risk 1.3 (Recovery Programme)	Y	N	N	PAF agreed that the risk score should remain at 15.
3.3 BAF Risk 4.2 (ED 4 Hour Standard)	Y	N	N	PAF agreed that the risk score should remain at 20.
3.4 Stranded Patients/Length of Stay (LoS) Update	Y	Y	N	Since April 2022 the organisation had seen the numbers of patients with a LoS over seven days rising. Within that there was also a rising cohort of patients who had a LoS over 21 days. The paper provided information on the plans to achieve an improvement trajectory for reducing the number of patients with a LoS 7, 14 and 21 days, and for overall LoS reduction.
4.1 New Hospital Update	Y	Y	N	The Trust continued to support the national New Hospital Programme (NHP) with the development of standards and

BOARD OF DIRECTORS:	**Trust Board (Public) – 6 October 2022**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**29 September 2022**			

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				guidance, particularly in the Hospital 1.0 design and the commercial strategy. A submission had been made to NHP identifying potential future requests for funding to cover early and enabling works over the coming three year period.
4.4 BAF Risk 3.1 (Estate and Infrastructure)	Y	N	N	PAF agreed that the risk score should remain at 20.
5.3 Health & Safety Bi-Monthly Update	Y	N	N	The summary of activity was noted.
Others items presented/discussed				• Finance Modernisation Programme Update • Update from Business Case Review Group • Oversight of Patient Waiting Lists • Estates & Facilities Quarterly Report • 4 Monthly Update: Trust's Sustainable Development Management Plan and Carbon Reduction and Sustainability Strategy

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 6 October 2022

Agenda item:	6.2
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	26 September 2022
Subject / title:	M3 2022/23 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	x

Key issues:

Patients		
Patients	**Pressure Ulcers**	After a spike in June for grade 3, 4 and unstageable pressure ulcers, we have seen performance return to common cause variation (showing the value of assuring performance
	PPH	Follwing a spike in June, we have seen PPH over 1500 mls levels return to common cause variation, and at a level not seen since July 2020
People		
People	**Appraisals**	Still in special cause variation, with performance consistently at or near 80%
	Statutory and Mandatory Training	In specal cause variation, and showing a statistically consistent trend. Performance has reduced to 86%, and below the target of 90%.
	Sickness Absence	In common cause variation and continues to perform at or near the target. However, we have seen a spike in sickness in August, although remaining in common cause variation
Performance		
Performance	**RTT**	Performance remains in special cause variation, but recovery actions continue to be in place, with patients being treated in clinical priority.
	Cancer 2 week wait	Remains in common cause variation for a fourth month with performance continuing near the mean
	Cancer 62 day pathway	Performance remains in negative special cause variation near the lower control limit. Focus is being placed on the long wait patients, which is having an impact on the overall performance
	Four hour standard	Remains in special cause variation. However, since the implementation of Nervecentre ED we have seen a signifcant drop in the time from arrival to triage - a significant safety indicator
	Diagnostics	Performance remains in common cause variation for the seventh consecutive month
	52 week waits	Still is special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained constant for the last two months following a small increase in July
	Stranded Patients	The number of patients with a length of stay over 7 days has exceeded the upper control limit for the last two months and continues to be in special cause variation
Pounds		
Pounds	Surplus	The Trust reported a deficit of £1.7m in August (Month 5) and a year to date deficit of £10.2m against deficit of £0.2m in month and a surplus of £0.1m year to date. We continue to review the Trust underlying position and identify major drivers of the deficit. Work is ongoing with divisional leads to review our spend profile and where anticipated future expenditure can be challenged.
	CIP	The Trust CIP target for the year is £11.7m and planned delivery for month 5 is £0.7m (£2.7m year to date). £2.4m of CIP (full year) have been identified and delivery is being assessed and will be reported in month 6
	Capital Spend	The Trust total revised CRL for 2022/23 is £15.2m. This includes element of the new hospital PDC of £1.1m. As at Month 5, year to date actual capital spend totals £3.3m.
	Cash	The Trust continues to have a healthy cash balance of £42.7m. There is a continued push to reduce aged payables & maintain the improved Trust's performance against the Better Payment Practice Code.
Places		
Places	Catering Food Waste	Remains at or below the national target

6.2

Your future | Our hospital

respectful | caring | responsible | committed

The Princess Alexandra Hospital NHS Trust

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

Previously considered by:	PAF.29.09.22 and QSC.30.09.22.
Risk / links with the BAF:	All BAF Risks.
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified, the IPR demonstrates a full view of service delivery to ensure we take into account equality, diversity and dignity
Appendices:	M5 IPR

6.2

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report for August 2022

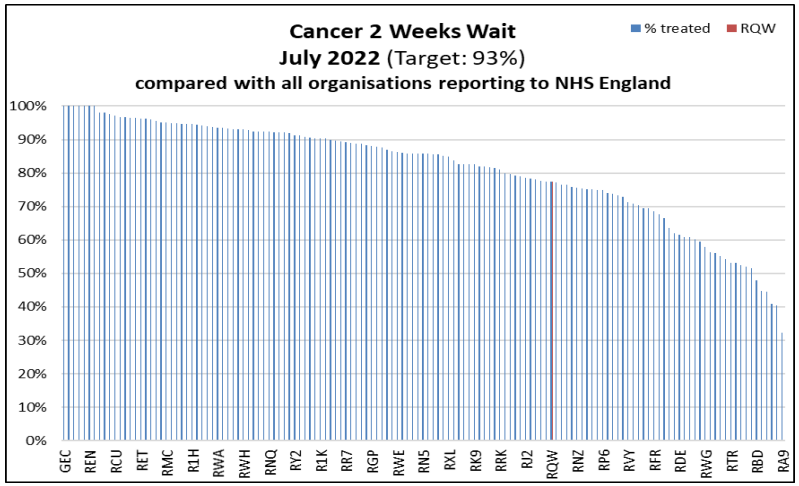
modern • integrated • outstanding

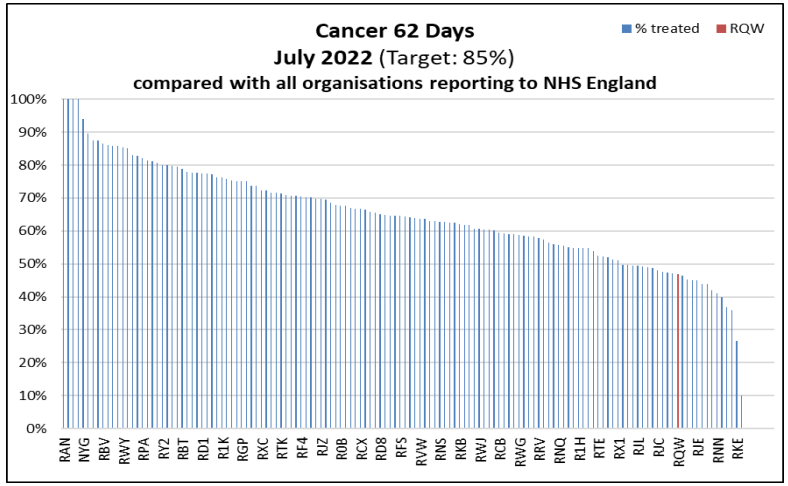
patient at heart • everyday excellence • creative collaboration

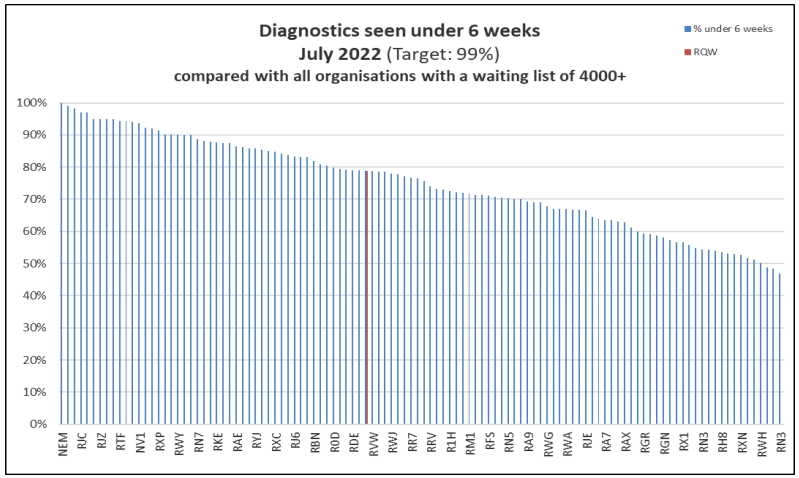
Performance Summary

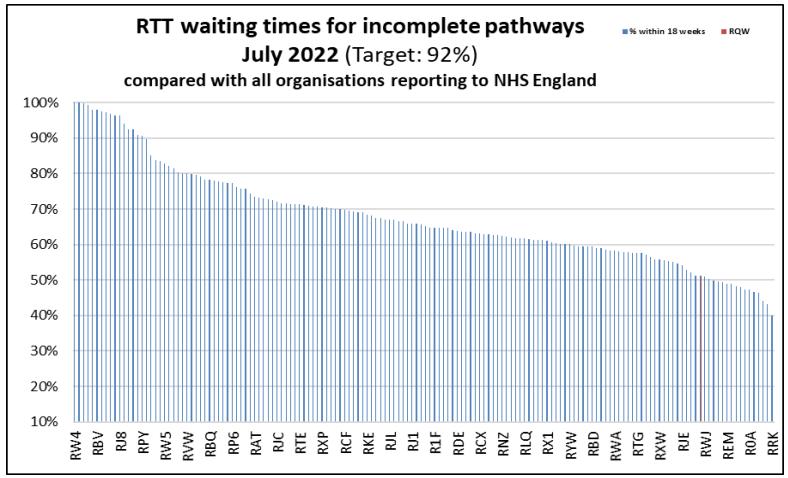
Patients			**People**		
Patients	**Pressue Ulcers**	After a spike in June for grade 3, 4 and unstageable pressure ulcers, we have seen performance return to common cause variation (showing the value of assuring performance via statistical process control)	People	**Appraisals**	Still in special cause variation, with performance consistently at or near 80%
Patients	**PPH**	Follwing a spike in June, we have seen PPH over 1500 mls levels return to common cause variation, and at a level not seen since July 2020	People	**Statutory and Mandatory Training**	In specal cause variation, and showing a statistically consistent trend. Performance has reduced to 86%, and below the target of 90%.
			People	**Sickness Absence**	In common cause variation and continues to perform at or near the target. However, we have seen a spike in sickness in August, although remaining in common cause variation
			Performance		
Pounds			Performance	**RTT**	Performance remains in special cause variation, but recovery actions continue to be in place, with patients being treated in clinical priority.
Pounds	**Surplus**	The Trust reported a deficit of £1.7m in August (Month 5) and a year to date deficit of £10.2m against deficit of £0.2m in month and a surplus of £0.1m year to date. We continue to review the Trust underlying position and identify major drivers of the deficit. Work is ongoing with divisional leads to review our spend profile and where anticipated future expenditure can be challenged.	Performance	**Cancer 2 week wait**	Remains in common cause variation for a fourth month with performance continuing near the mean
Pounds	**CIP**	The Trust CIP target for the year is £11.7m and planned delivery for month 5 is £0.7m (£2.7m year to date). £2.4m of CIP (full year) have been identified and delivery is being assessed and will be reported in month 6	Performance	**Cancer 62 day pathway**	Performance remains in negative special cause variation near the lower control limit. Focus is being placed on the long wait patients, which is having an impact on the overall performance
Pounds	**Capital Spend**	The Trust total revised CRL for 2022/23 is £15.2m. This includes element of the new hospital PDC of £1.1m. As at Month 5, year to date actual capital spend totals £3.3m.	Performance	**Four hour standard**	Remains in special cause variation. However, since the implementation of Nervecentre ED we have seen a signifcant drop in the time from arrival to triage - a significant safety indicator
Pounds	**Cash**	The Trust continues to have a healthy cash balance of £42.7m. There is a continued push to reduce aged payables & maintain the improved Trust's performance against the Better Payment Practice Code.	Performance	**Diagnostics**	Performance remains in common cause variation for the seventh consecutive month
			Performance	**52 week waits**	Still is special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained constant for the last two months following a small increase in July
Places			Performance	**Stranded Patients**	The number of patients with a length of stay over 7 days has exceeded the upper control limit for the last two months and continues to be in special cause variation
Places	**Catering Food Waste**	Remains at or below the national target			

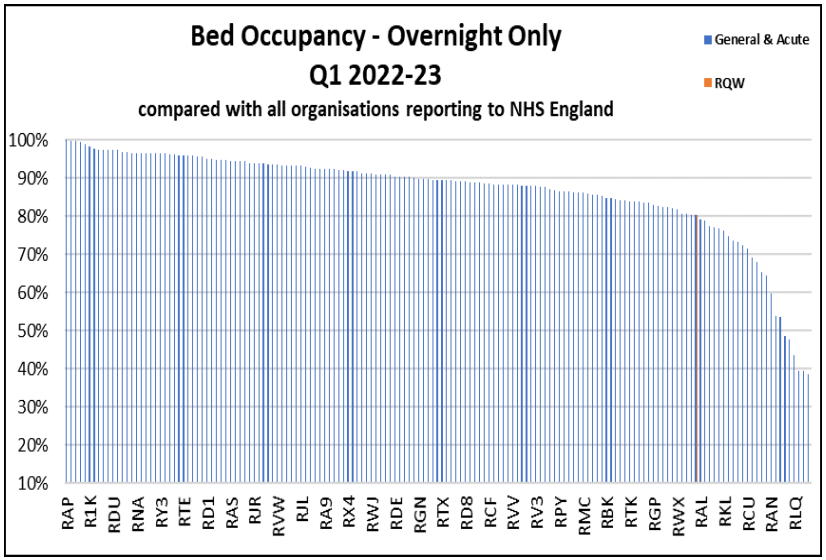
National Benchmarking

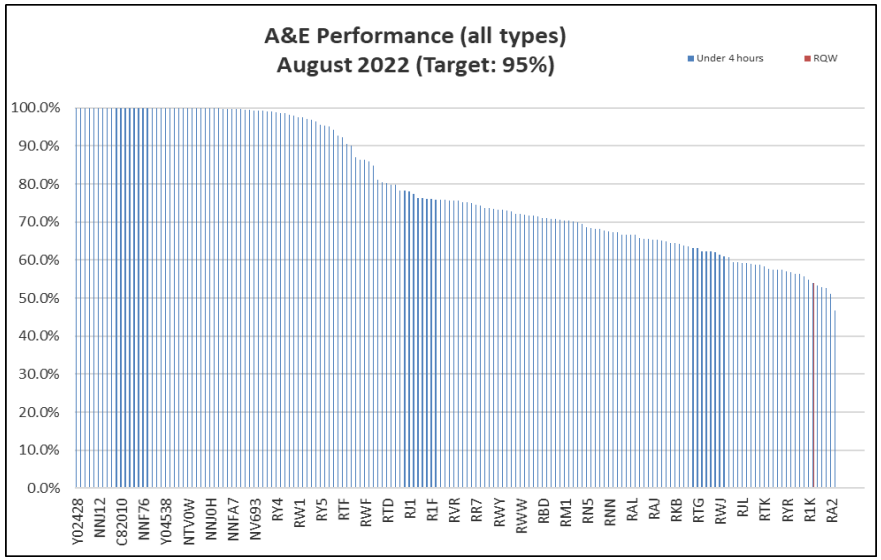









Bed Occupancy - Overnight Only
Q1 2022-23
compared with all organisations reporting to NHS England
General & Acute
RQW
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
RAP R1K RDU RNA RY3 RTE RD1 RAS RJR RVW RJL RA9 RX4 RWJ RDE RGN RTX RD8 RCF RVV RV3 RPY RMC RBK RTK RGP RWX RAL RKL RCU RAN RLQ


A&E Performance (all types)
August 2022 (Target: 95%)
Under 4 hours
RQW
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Y02428 NNJ12 C82010 NNF76 Y04538 NTV0W NNJ0H NNFA7 NV693 RY4 RW1 RY5 RTF RWF RTD RJ1 R1F RVR RR7 RWY RWW RBD RM1 RN5 RNN RAL RAJ RKB RTG RWJ RJL RTK RYR R1K RA2


Benchmarking

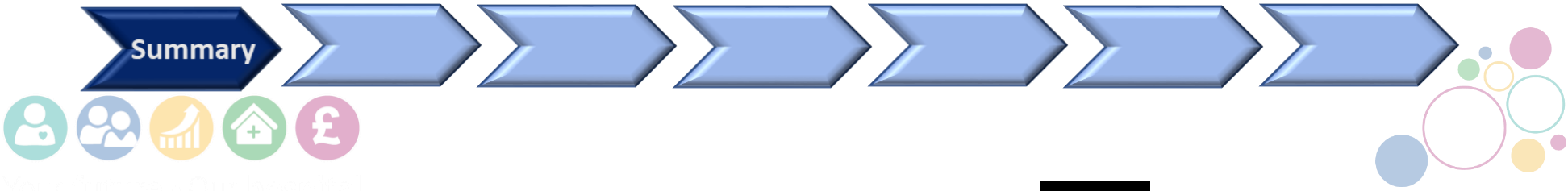
The difference between common and special cause variation

Common Cause Variation

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

Special Cause Variation

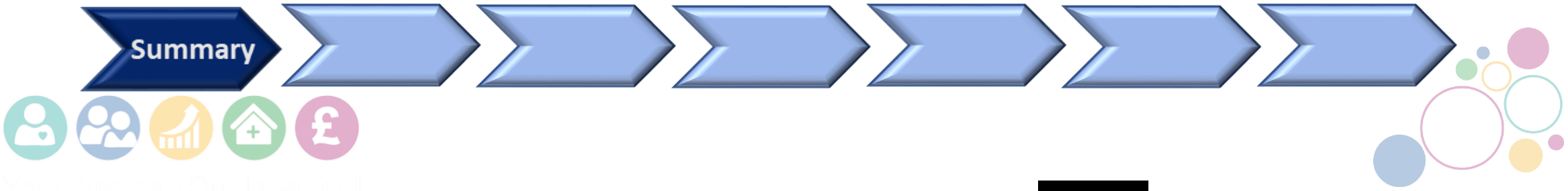
- Is due to irregular causes that are not inherent in the design of the process
- Results in an unstable process that is not predictable
- Also known as non-random or assignable variation
- Shown as blue or orange markers on our SPC charts



How is special cause variation defined and identified

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

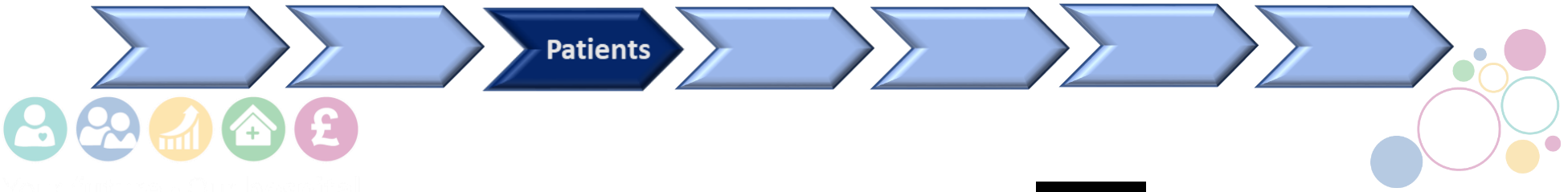
- A single point outside of the upper or lower control limits
- A run of points above or below the average (mean) line.
- Six consecutive points increasing or decreasing
- Two consecutive points near the upper or lower process control limits



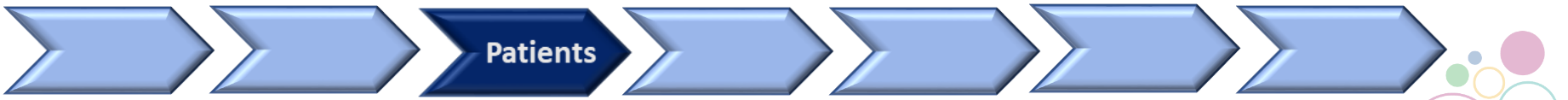
Patients

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

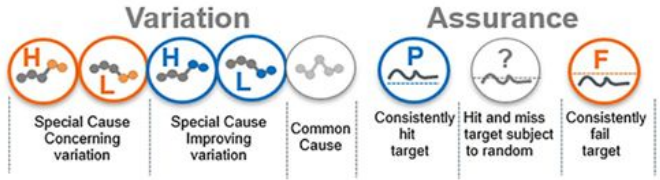
Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Delivery in BU or Home	Number of births in the birthing unit or home are 2.4% against a target of 20%. This is due to maintaining safe staffing over a challenging period and maintaining. We have new midwifes commencing in post over the next two months which assist to keep all pathway open.	For information	Q4 22/23

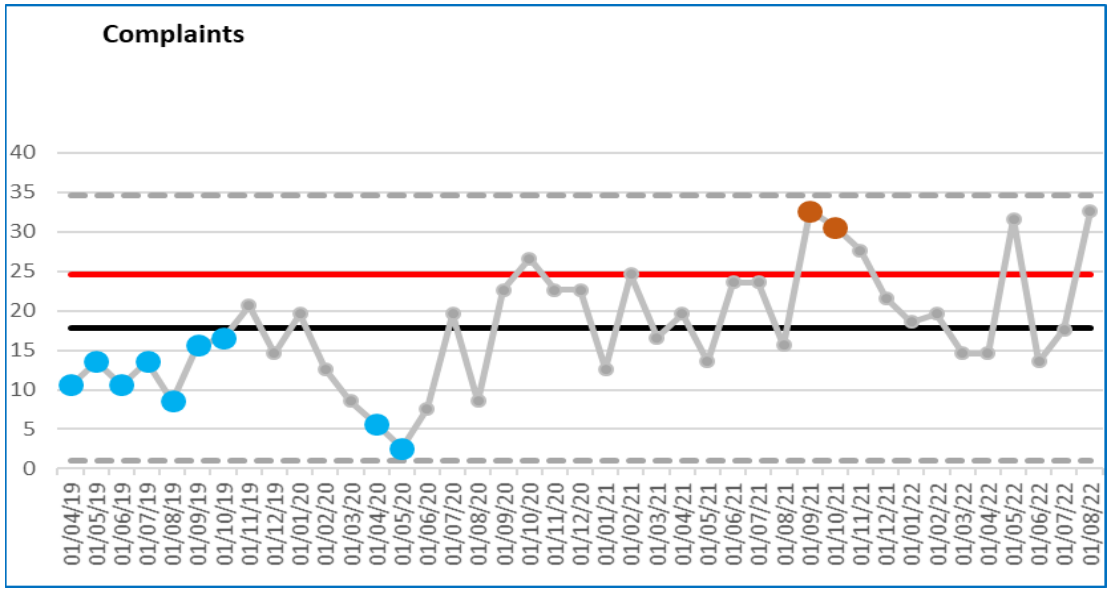


KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
Complaints	Aug 22	33	25			18	1	35
Compliments	Aug 22	76	50			116	-95	327
PALS	Aug 22	338	none			282	151	413
Complaints closed within target	Aug 22	5	none			5	-3	14
% of complaints where an extension has been agreed	Aug 22	47%	none			43%	10%	76%
Mixed Sex Accommodation Breach	Aug 22	12	0			7	-4	18
Serious Incidents	Aug 22	0	none			4	-4	12
MSSA	Aug 22	0	none			1	-1	3
CDIFF	Aug 22	7	none			5	-3	13
Hand Hygiene	Jul 22	91%	none			92%	77%	108%
eColi	Aug 22	1	none			1	-1	4
Klebsiella	Aug 22	1	none			1	-1	3
Pseudomonas	Aug 22	1	none			0	-1	1
Falls per 1000 bed days	Aug 22	6	9			8	6	11
Falls total minor, moderate & severe	Aug 22	17	13			24	10	38
Pressure Ulcers per 1000 bed days	Aug 22	3	3			4	1	7
Pressure Ulcers: grade 3, 4 & unstageable	Aug 22	5	3			4	-3	12
Total number of mothers delivering in birthing unit/home	Aug 22	2%	20%			11%	-1%	22%
Number of mothers delivering in Labour Ward/Theatres	Aug 22	97%	75%			89%	76%	101%
Number of women due to deliver at PAH adjusted for misc/TOPs	Aug 22	358	375			330	271	388
Smoking rates at booking	Aug 22	7%	none			9%	3%	15%
Smoking rates at delivery	Aug 22	7%	6%			10%	5%	15%
Breast feeding rates at delivery	Aug 22	74%	74%			76%	66%	85%
Total Planned C-Sections	Dec 21	20%	none			15%	8%	23%
Total Unscheduled C-Sections	Dec 21	21%	none			18%	13%	24%



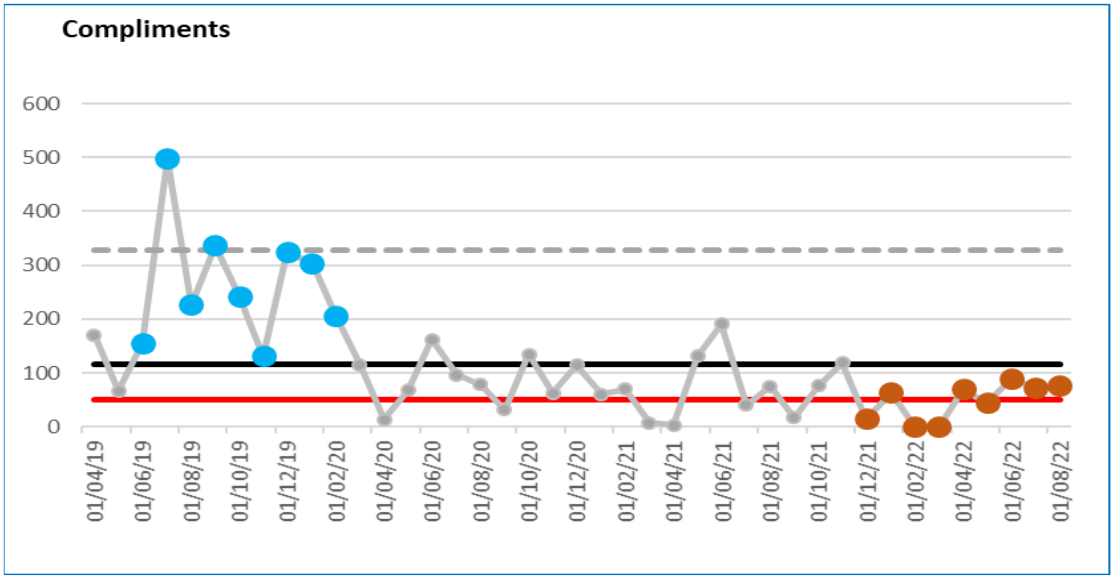
KPI	Latest month	Measure	National target	Performance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
PPH over 1500mls	Aug 22	2%	none			4%	1%	7%
CTG training compliance midwives	Aug 22	94%	85%	H	?	72%	53%	90%
CTG training compliance doctors	Aug 22	63%	85%		?	75%	51%	100%
Still births	Aug 22	1	none			1	-2	3
Patients detained under MHA	Aug 22	0	none			0	-1	2
Patients detained under section 136	Aug 22	1	none			1	-2	3
Mental health patient incidents	Aug 22	9	none			12	0	24
Mental health patient complaints	Aug 22	0	none			0	-1	1
Mental health patient PALS	Aug 22	3	none			2	-1	5
Patients with LD and Autism accessing inpatient services	Aug 22	26	none			25	5	45
Patients who died in their preferred place of death	Jan 22	54%	none			57%	21%	92%
C-DIFF Hospital onset healthcare associated	Aug 22	5	none			2	-3	7
C-DIFF Community onset healthcare associated (Acute Admissio	Aug 22	1	none			1	-1	3
C-DIFF Community onset indeterminate association (Acute Adm	Aug 22	0	none			1	-1	2
C-DIFF Community onset community associated (No acute conta	Aug 22	1	none			1	-3	5
Covid-19 new positive inpatients	Aug 22	124	none			139	-106	384
MRSA	Aug 22	0	0	L	?	0	0	0
Births	Jul 22	309	none	L		324	272	376
Instrumental births	Jun 22	32	none			32	32	32
Pre- term births	Jun 22	28	none			28	28	28
Continuity of carer	Jun 22	23%	none			23%	23%	23%
Women booked in month			none					





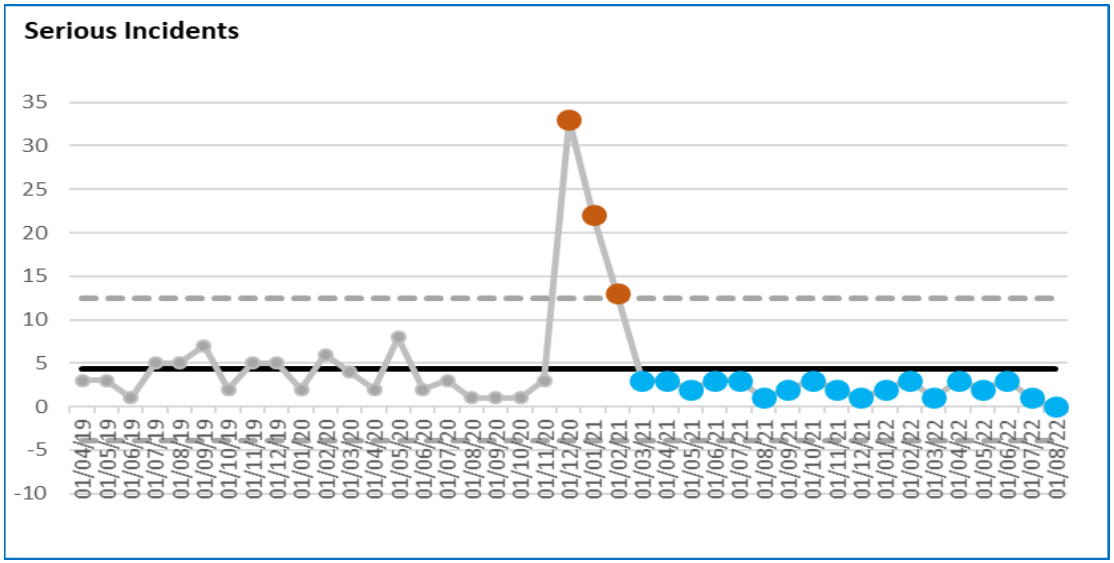
Aug-22
33
Variance Type
Common cause variation
Target
25
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Complaints	Common cause variation	Complaints increases reflects operational issues.	Objective to return to pre-pandemic levels. Case management support. Process workshops and divisional PSQ recruitment ongoing.	No cases older than 6 months by March 2023.



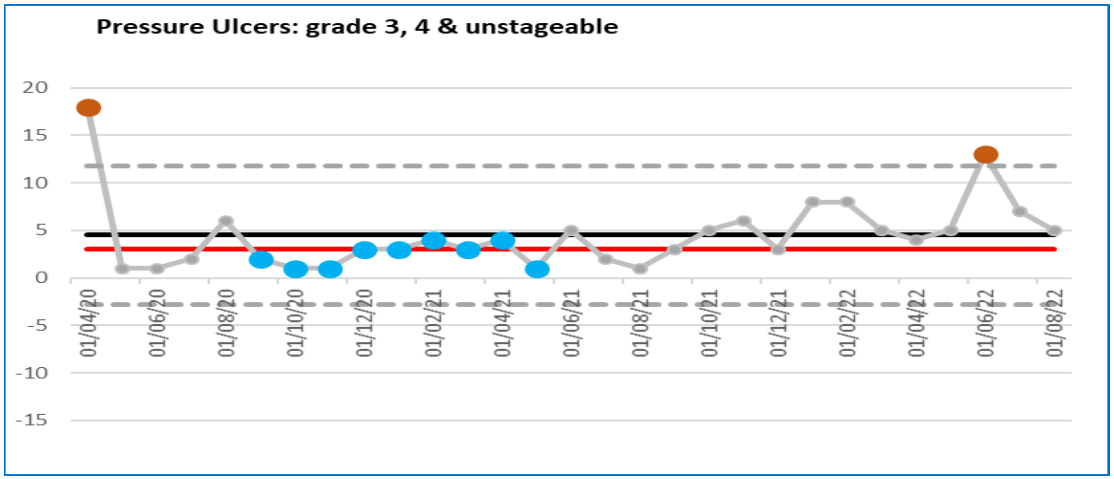
Aug-22
76
Variance Type
Special cause variation
Target
50
Target Achievement
Hit & miss target subject to random variation

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



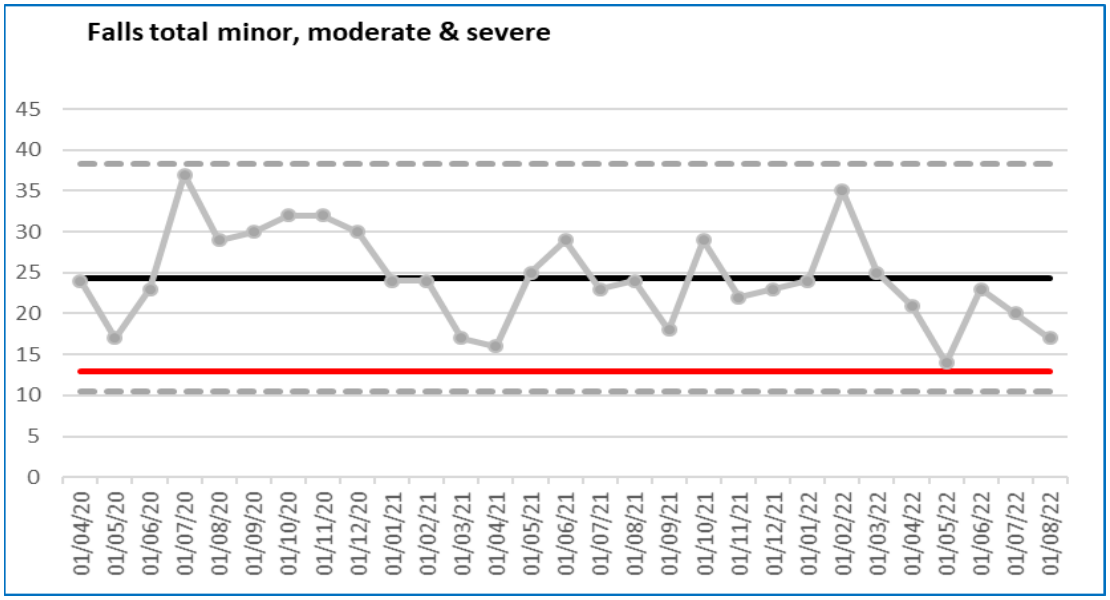
Aug-22
0
Variance Type
Special cause improving variation
Target
The trust does not have a target submission no. for SIs each month
Target Achievement
Our level of serious incidents reported per month is consistent

Background	What the chart tells us	Issues	Actions	Mitigation
Serious Incidents (SIs)	Trust reporting numbers for serious incidents raised each month is consistent & month on month	Where an incident meets the national reporting criteria to be raised externally as a serious incident (SI) it will be raised. There is no internally set target	Incident management group meets twice a week to review new incidents & those with completed investigations. No serious incidents were raised during August 2022. In month one SI was closed. The trust has 13 investigations of serious incidents open at this time.	Daily local review of incidents by each divisional team is completed with appropriate second stage review at the incidents management group. IMG submits a monthly report on both incident themes & serious incidents onto the Patient Safety Group.



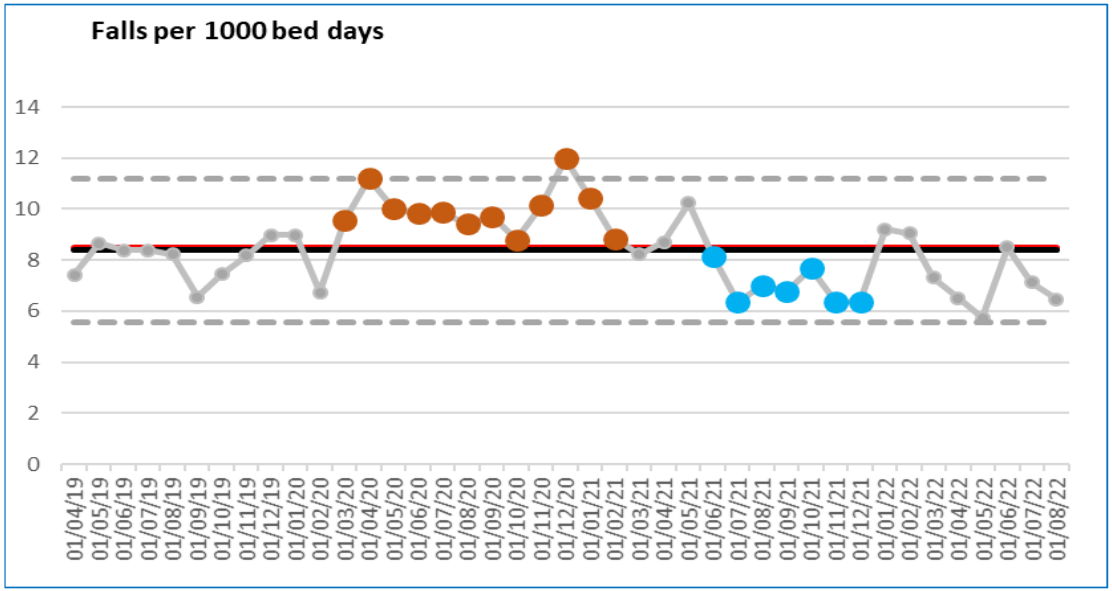
Aug-22
5
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers: grade 3, 4 & Unstageable	Common cause variation while hit & missing the target	There were a total of 34 hospital acquired pressure ulcers (HAPUs) in August 2022, 13 less than July. There were 8 moderate harms this month (3 x category 3 and 5 x unstageable) in total the same as last month and all are under investigation. All remaining PU's were minor harms predominantly on the heels/feet and sacrum except 1 mucosal PU. 4 patients sustained more than one pressure ulcer during admission and of the 34 total HAPUs, 8 were medical device related confirmed minor harms. 2 patients who developed a pressure ulcer were sadly nearing end of life. The highest number of HAPUs were equalled between 3 wards with 5 HAPUs on: Tye Green & Harold, and Critical Care where all 5 HAPUs developed due to oxygen related medical devices. The other 3 medical device related HAPUs developed from catheter (1) incontinence pad (1) and 1 from plaster of Paris cast which was deemed a moderate harm.	As part of the Tissue Viability Training programme the pressure ulcer study day in September was a great success with very positive feedback from all 23 Registered Nurses especially the 'practical interventions and tips' for preventing pressure ulcers. New pressure ulcer training dates for 2023 will be added to Alexnet once the training needs analysis for clinical staff has been completed aligned to the Pressure Ulcer Prevention Strategy. TVN's will continue to conduct SSKIN audits and assist in the investigations for harm free care to highlight trends for action planning. All resources continue to be available via AlexNet, Youtube, ward folders and Xdrive.	



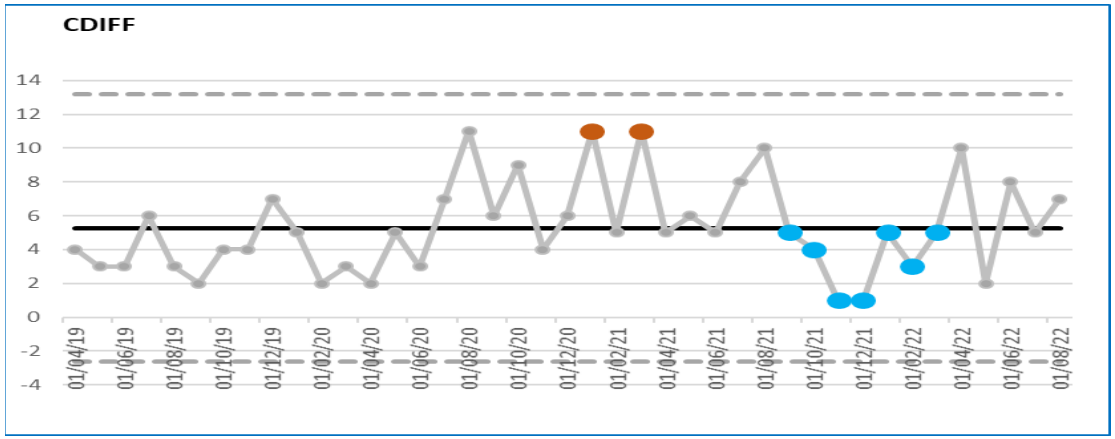
Aug-22
17
Variance Type
Common cause variation
Target
13
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Falls total minor, moderate & severe	Common cause variation & hit and miss target subject to random variation	A new falls prevention strategy has been developed for the financial year 2022/23. The Trust remains committed to reducing falls with harm by 50% by the end of 2022/23	New falls strategy in place for 2022/23.New method for validating falls with harm is in place	Nil at this point



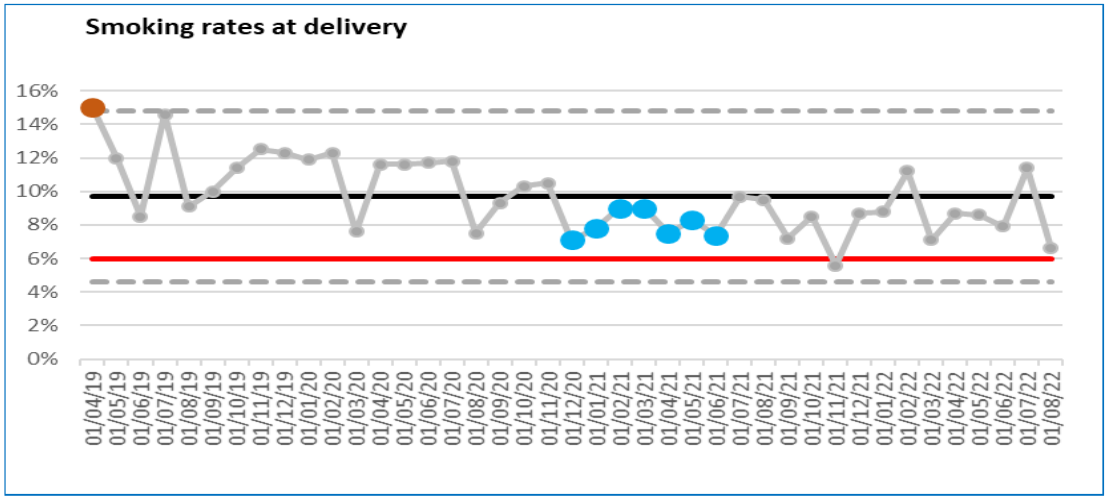
Aug-22
6.46
Variance Type
Common cause variation
Target
8.5
Target Achievement
Hit & miss target subject to random variation

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



Aug-22
7
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

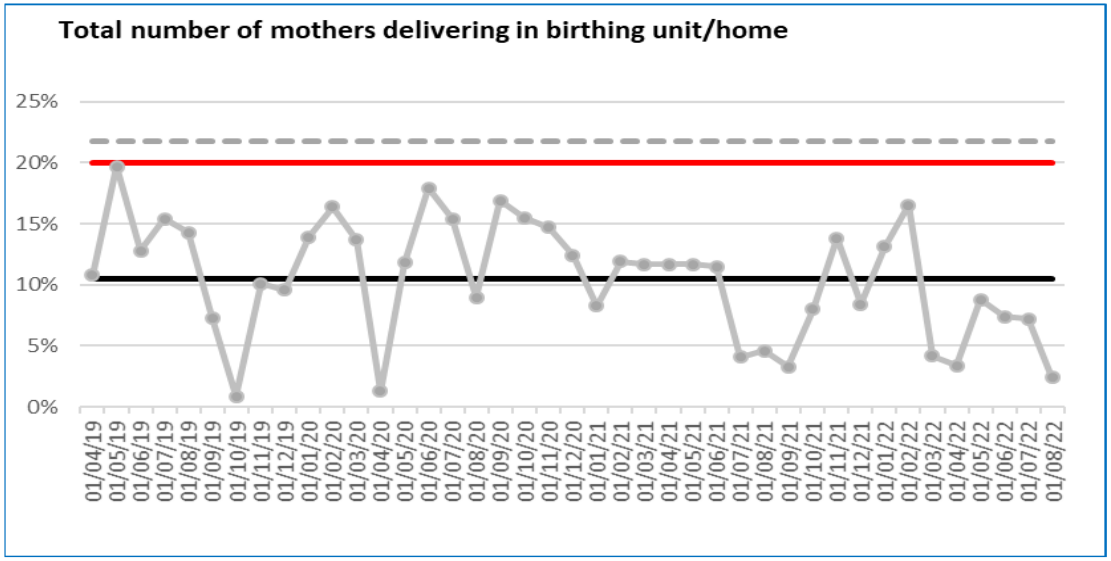
Background	What the chart tells us	Issues	Actions	Mitigation
C.difficile	Common cause variation	1.The Trust is the highest prescriber of antibiotics per 1000 admissions in the East of England (EoE). Although it is acknowledged there are multi-factorial root causes of C.difficile cases, reductions in overall and broad-spectrum antibiotic use should help reduce cases, which is monitored through the Antimicrobial Stewardship (AMS) meetings. The AMS team are considering reducing the use of Co-amoxiclav and Piperacillin- tazobactam by stating alternatives in the Trust antibiotic policy at the next update over the next few months. 2. incident reviews have highlighted that there are some practices which require improvement, including documentation of duration and indication of antibiotics, inappropriate use of antibiotics and below the expected standards of compliance (95%) for PPE, hand hygiene and environmental audits.	Focus of actions: 1.Antimicrobial prescribing 2.Environment /cleanliness 3.Prompt isolation 4.Hand hygiene 5.PPE 6.Prompt stool specimen collection 7.Commode & dirty utility audits 8.Increased teaching / cascading of key messages /attending ward manager meetings/ IPC Associates 7.Introduction of sporicidal wipes for commode cleaning in all clinical areas 8.Ribo-typing of C.difficile specimens to support in detecting possible outbreaks or clusters of infection 9.RCA process (Incident Panel) to review cases and shared learning .	1. Monitoring of cases (Infection Prevention & Control Committee & Trust Dashboard) 2. RCA reviews of all cases; this is undertaken by the IPC Team, DIPC/Microbiology Consultant, Antimicrobial pharmacist, senior medical & nursing colleagues caring for the patient - shared learning is achieved through the reviews 3. Antimicrobial Stewardship Committee is responsible for the monitoring of antibiotic prescribing 4. IP&C Associate team in place who are supporting the IPC team in delivering the key messages 5. Appeals panel in place (led by CCG) to appeal against cases that have been considered to be 'unavoidable' 5. Although cases increased, severity of infection did not; there have not been any deaths where C.difficile has been the cause of death



Aug-22
6.6%
Variance Type
Special cause variation
Target
6%
Target Achievement
Hit and miss target subject to random variation

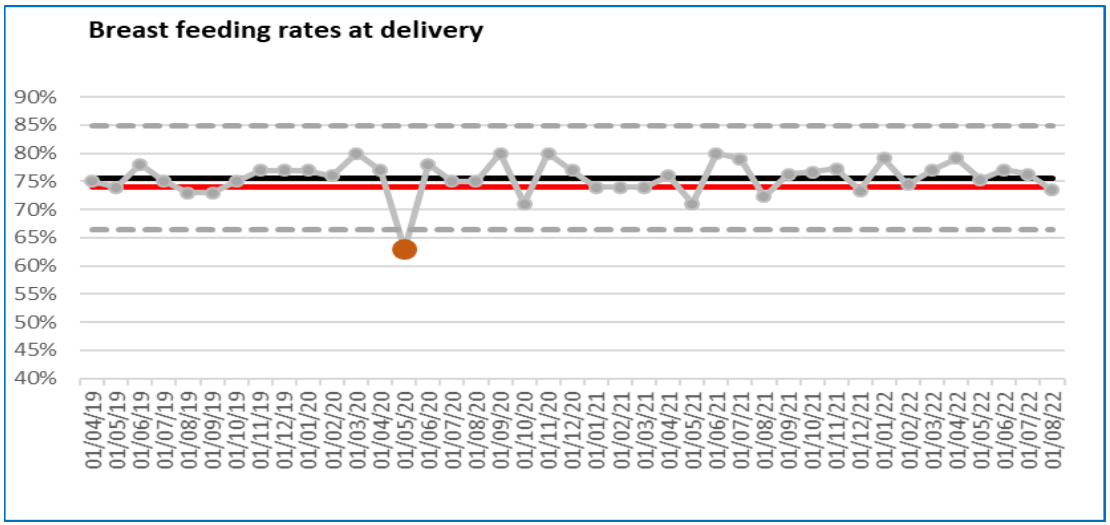
Background	What the chart tells us	Issues	Actions	Mitigation
Smoking rates at delivery	Special cause variation and inconsistently hit & missing target	Smoking rates at delivery	A new in house Maternity Stop Smoking Advisor has commenced and is offering face to face appointments with women to assist them to stop smoking.	A new daily Report is in place to enable the Advisor to identify women who may benefit from early intervention and contact them straight after their initial Midwife Booking Appointment

Patients



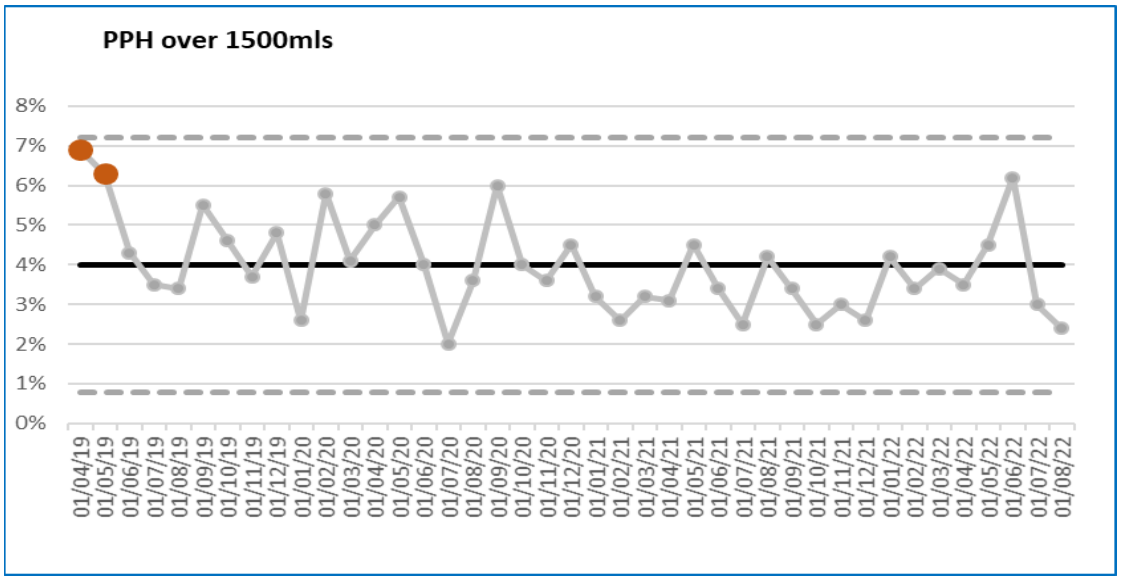
Aug-22
2.4%
Variance Type
Common cause variation
Target
20%
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Total no. of mothers delivering in birthing unit/home	Common cause variation & hit & missing target	Mothers delivering in birthing unit/home		Midwives are being re-deployed to the most appropriate area in terms of maintaining safe staffing levels – resulting in periodic closure of the Birth Unit to maintain safe staffing



Aug-22
73.5%
Variance Type
Common cause variation
Target
74%
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Breast feeding rates at delivery	Common cause variation & inconsistently hit & missing target	Breast feeding rates at delivery	A 'Baby Friendly Strategic Group has been established, chaired by the Head of Midwifery. PAH is working towards the BFI Gold standard Award.	Recent initiative include; to reduce the number of unknown method of baby feeding at delivery alongside other Baby Feeding data quality initiatives



Aug-22
2.40%
Variance Type
Common cause variation
Target
Not set
Target Achievement

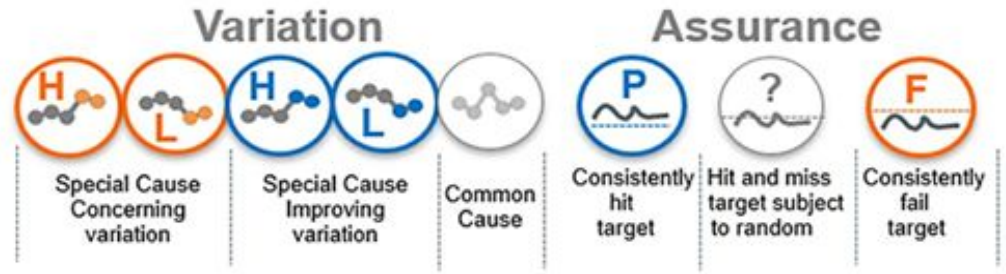
Background	What the chart tells us	Issues	Actions	Mitigation
PPH over 1500mls	Common cause variation	PPH over 1500mls	All massive obstetric haemorrhages are reviewed to ensure the appropriate management was followed, including a thematic review of high risk factors. All massive obstetric haemorrhages are reviewed to ensure the appropriate management was followed, including a thematic review of high risk factors.	Mitigation The labour admission risk assessment tool has been reviewed to ensure it is as effective as possible. A new PPH checklist is currently undergoing peer review with the hope to be implemented and embedded to ensure the tool is utilised.

Places

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

Places Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Facilities	Housekeepers recruitment and new induction on going	For information	
	As a result of the supervisors away day (part of staff engagement action plan)working party with all stakeholder so be arranged for new portering roster	For information	
	Main Kitchen –recruitment issues 2 x Band 3 Chefs, 1 x Band 4 Head Chef, 2 x Kitchen Ast. department still reliant on NHSP, need to look at recruitment and retention.	For escalation	
	Re-advertisement of Catering Manager position (August)	For information	
Capital & Estates	UKPN resilience works – Works ordered with targeted December 22 completion date with legal approvals with landlords .	For information	
	Development feasibility works for Maternity wards - refurbishment paused with full condition survey undertaken for actions moving forward to meet HCG criteria and Estates Strategy	For information	
		For information	
	Aseptic Suite in Arendal House - works started	For information	

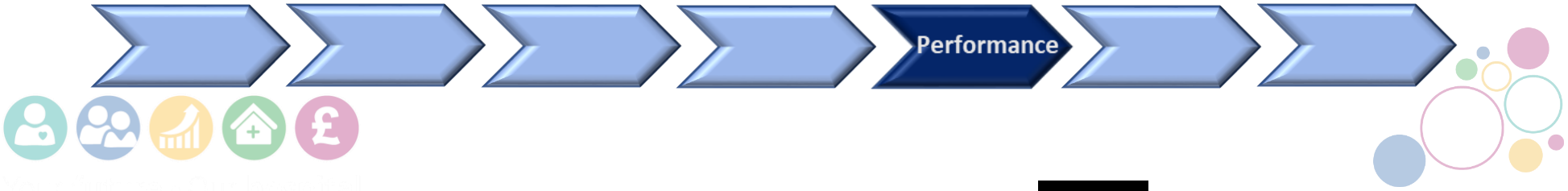
KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Estates Responsiveness (Priority 2 - Urgent)	Aug 22	95%	95%			95%	91%	99%
Meals Served	Aug 22	42302	42120			37968	26214	49722
Catering Food Waste	Aug 22	3%	4%	L		5%	-1%	10%
Domestic Services (Cleaning) Very High Risk	Aug 22	98.0%	98.0%	H		97.8%	94.7%	100.8%
Domestic Services (Cleaning) High Risk	Aug 22	96.5%	95.0%			96.7%	93.4%	100.1%



Performance

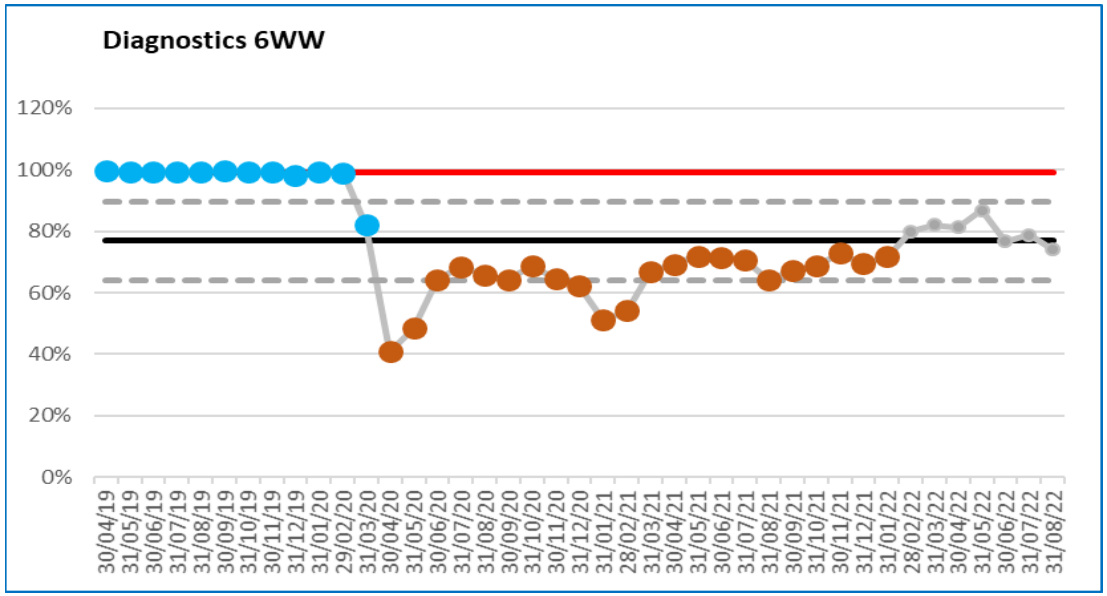
*We will meet & achieve **our performance** targets, covering national & local operational, quality & workforce indicators.*

Performance	Board Sub Committee: Performance & Finance Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
RTT Breaches	The Trust has achieved the national requirement of no patients waiting longer than 104 weeks in August and expected to be maintained thereafter. A trajectory and action plan for eliminating waits of longer than 78 weeks by 31/3/23 is in place. 52 week waits remain steady and expected to decrease with the 78 week recovery actions.	For increased visibility and awareness	31/03/2023
Diagnostics	CT performance has exceeded the national target of 95% by 31/3/23, achieving 99% in August. Other modalities are improving despite significant staffing challenges due to vacancy & summer holiday shortages.	For recognition	31/03/2023
Urgent Care Standards	The ED 4 hour standard and Ambulance handover standards continue to be poor however the implementation of NerveCentre has shown early improvements in triage and other clinical metrics, improving the safety of patients. The demand continues to be high and capacity improvements are being developed in readiness for winter.	For increased visibility and awareness	
Cancer	The number of patients waiting more than 62 days for treatment has increased slightly over the summer and due to the comupter access issues in September, although improvements are now being consistently delivered from mid September. A substantive cancer manager has commenced and a full recovery action plan is in place.	For information	



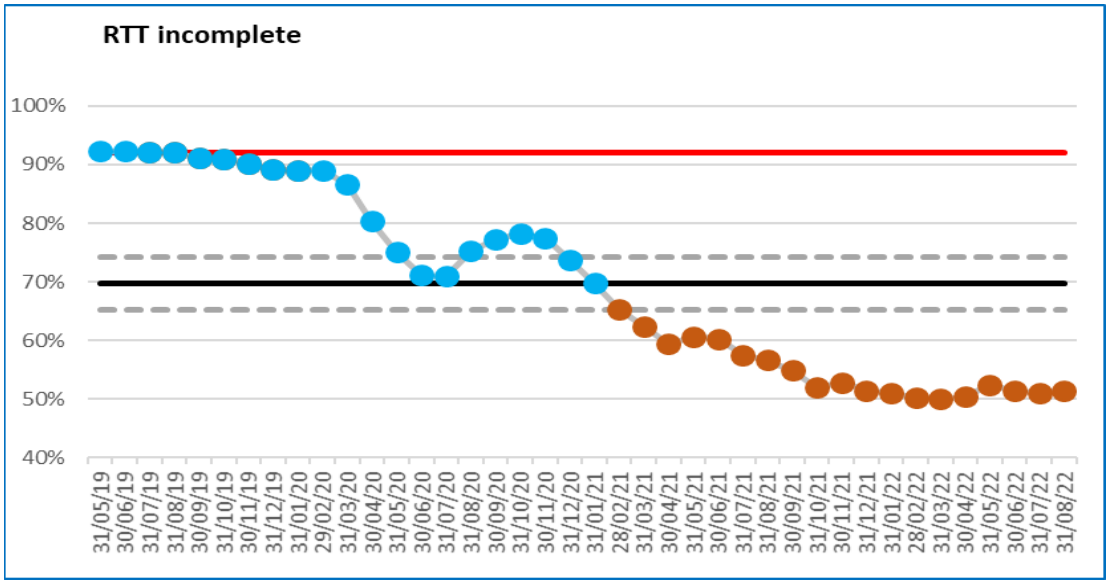
KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 1 metrics								
RTT incomplete	Aug 22	52%	92%			70%	65%	74%
RTT admitted	Aug 22	44%	90%			51%	27%	75%
RTT Non admitted	Aug 22	76%	95%			86%	83%	89%
RTT PTL vs RTT PTL & ASIs	Aug 22	81%	none			92%	89%	95%
Cancer 31 days First	Jul 22	91%	96%			93%	83%	102%
Cancer 31 days Subsequent Drugs	Jul 22	100%	98%			99%	91%	106%
Cancer 31 days subsequent surgery	Jul 22	100%	94%			92%	57%	127%
Cancer 2WW	Jul 22	77%	93%			81%	62%	100%
Cancer 62 day shared treatment	Jul 22	47%	85%			66%	47%	86%
Cancer 62 day screening	Jul 22	75%	90%			64%	11%	118%
Cancer 62 Day Consultant Upgrade	Jul 22	55%	90%			83%	60%	106%
Cancer 28 day faster diagnosis	Jul 22	72%	75%			66%	51%	82%
4 Hour standard	Aug 22	54%	95%			73%	65%	80%
ED attendances	Aug 22	10890	none			9253	7178	11328
ED Admitted performance	Aug 22	20%	95%			44%	30%	59%
ED non admitted performance	Aug 22	60%	95%			80%	73%	88%
ED Arrival to Triage	Aug 22	30	15			47	28	65
ED Triage to examination	Aug 22	212	60			103	76	131
ED Examination to referral to specialty average wait	Jul 22	23	45			101	82	120
ED referral to be seen average wait	Aug 22	30	30			78	53	104
Seen by specialty to DTA	Aug 22	116	60			97	74	120
DTA to departure	Aug 22	363	30			227	91	364
Ambulance handovers less than 15 minutes	Aug 22	10%	100%			25%	13%	36%
Ambulance handovers between 15 and 30 mins	Aug 22	33%	0%			40%	31%	49%
Ambulance handovers between 30 and 60 mins	Aug 22	32%	0%			23%	13%	33%

KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 2 metrics								
Ambulance handovers > 60 mins	Aug 22	25%	0%			12%	2%	22%
Diagnostics 6WW	Aug 22	74%	99%			77%	64%	90%
Patients with a Length of Stay more than 7 days	Aug 22	215	80			155	102	207
Bed occupancy	Aug 22	90%	85%			89%	81%	96%
Discharges between 8am and 5pm	Aug 22	712	none			715	474	956
Discharges between 5pm and 8am	Aug 22	809	none			707	452	961
LOS non elective	Aug 22	5.6	5.1			4.0	3.2	4.9
LOS elective	Aug 22	3.4	4.2			2.4	0.8	4.0
Short Notice clinical cancellations	May 22	4	none			42	-31	116
OP new to follow up ratio	Aug 22	2.1	2.3			2.1	1.8	2.5
OP DNA Rate	Aug 22	6.4%	8.0%			4.9%	3.8%	6.1%
52 Week waits	Aug 22	1909	0			891	605	1177
Proportion of Majors Patient treated within 4 hours in ED Paeds	Aug 22	38%	95%			77%	61%	93%
Patients with a Length of Stay more than 21 days	Aug 22	66	25			46	21	71
12 Hour waits in ED from Arrival	Aug 22	1418	0			583	247	919
12 Hour Trolley waits in ED from DTA	Aug 22	124	0			83	-15	181



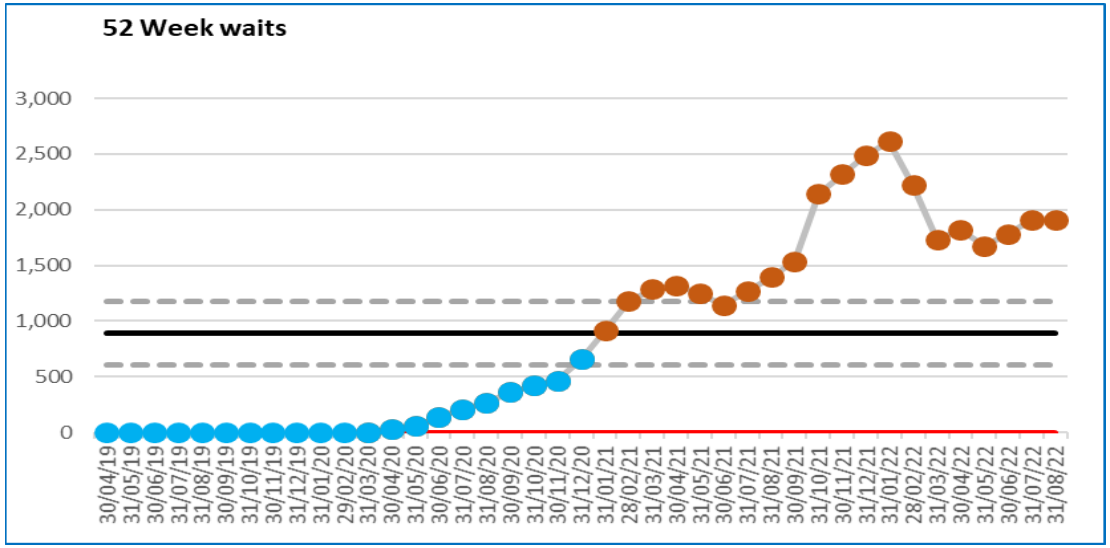
Aug-22
73.97%
Variance Type
Special cause variation
Target
99.00%
Target Achievement
Consistently failing target

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



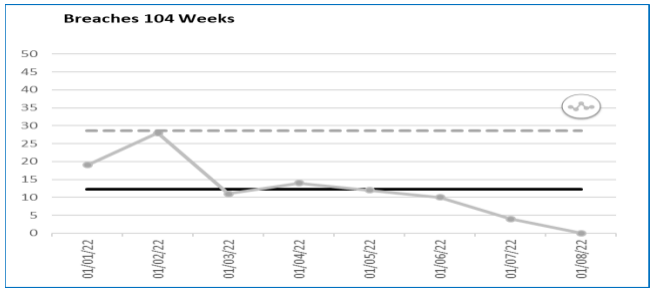
Aug-22
51.5%
Variance Type
Special cause variation
Target
92%
Target Achievement
Consistently failing target

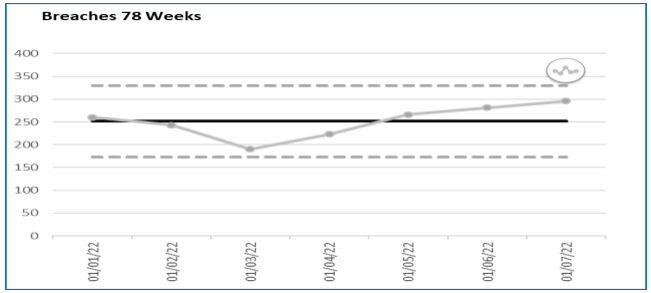
Background	What the chart tells us	Issues	Actions	Mitigation
RTT Incomplete	Special cause concerning variation and consistently failing target	The performance against the RTT standard has been below the target and statistical mean for 12 months as a result of covid activity pressure pausing elective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

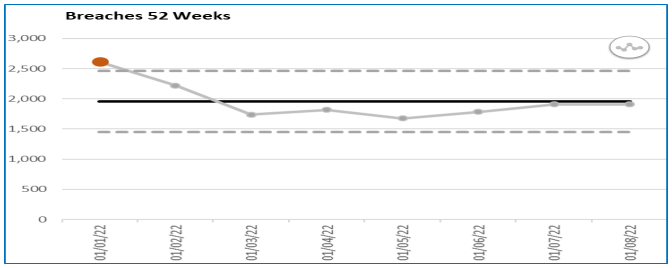


Aug-22
1909
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
52 week waits	Special cause concerning variation and consistently failing target	Booking in clinical priority order instead of chronological order has led to increasing numbers of long waiting lower priority patients. Balance between emergency & elective capacity is an ongoing challenge. Challenge of anaesthetic workforce availability restricting the number of elective lists.	Patients that will be over 104 weeks by 31/3/22 booked along with urgent & cancer patient as a priority. Ongoing outsourcing of lower clinical priority patients to Independent sector. ICS bid for 22/23 elective recovery capital accepted an two options for a segregated elective hub being drawn up. Elective ward capacity increased to 2 wards. Admitted & non admitted demand & capacity work commenced to inform recovery plan for 22/23.	Clinical review of long waiting patients being implemented with interim & treatment harm review process to monitor for potential harm. Numbers of patients over 78 weeks reducing & potential patients over 104 weeks all have appointments/treatment plans.

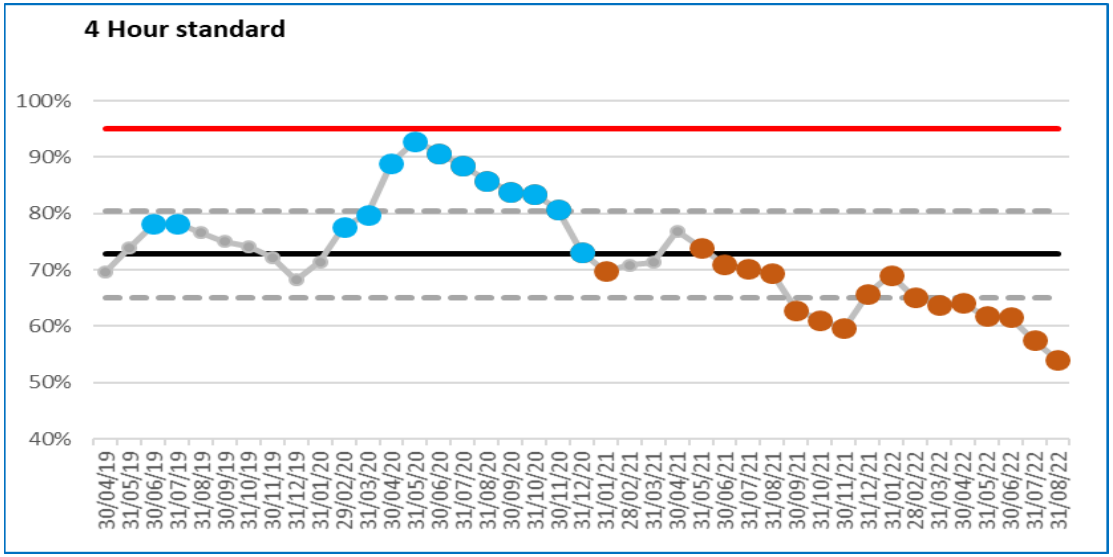






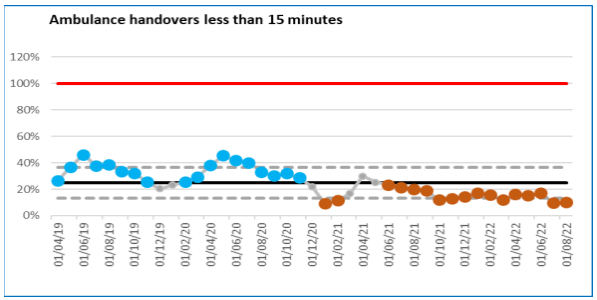
Aug-22
H
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target
F

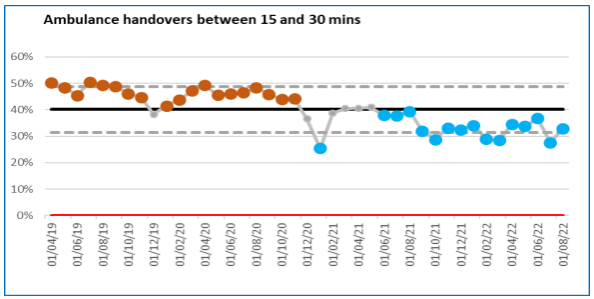
Background	What the chart tells us	Issues	Actions	Mitigation
Breaches	Special cause concerning variation and consistently failing target			

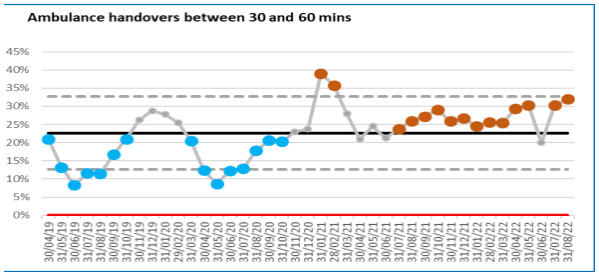


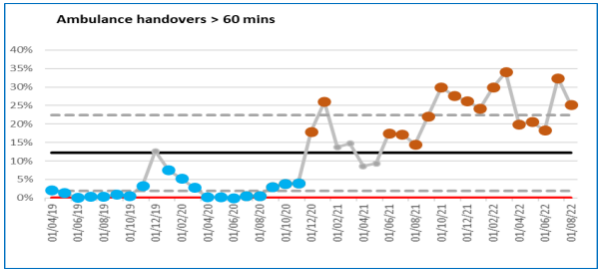
Aug-22
53.98%
Variance Type
Special cause variation
Target
95%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Four hour standard	Special cause concerning variation and consistently failing target	The performance against the four hour standard has been consistently below the statistical mean for four months & close to the lower control limit. Significant increases in attendances has exacerbated the pressure on the emergency pathways.	Executive and divisional oversight continues through the Urgent Care Board & CQC Quality Project workstream. Internal, Regional and national discharge projects in place. Response to the national "100 day challenge" being prepared to improve flow and ED performance.	Safety huddle in ED 3 times a day to review safety and pressure in the department and to escalate where additional support is required. Additional UTC hours & services. Weekly regional discussion on pressure points. Evening ICS system call to support emergency areas out of hours.



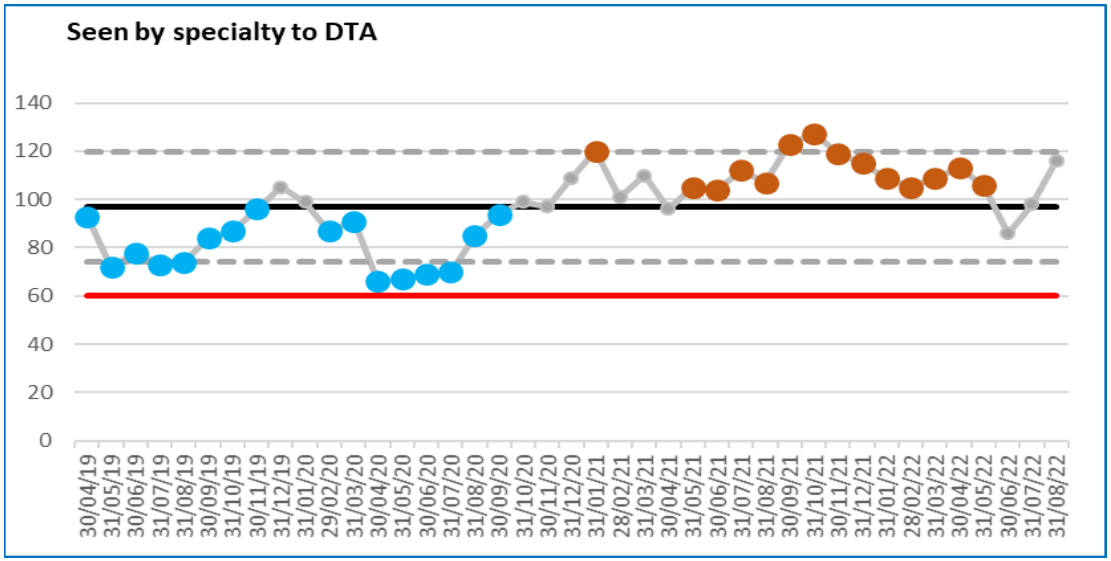






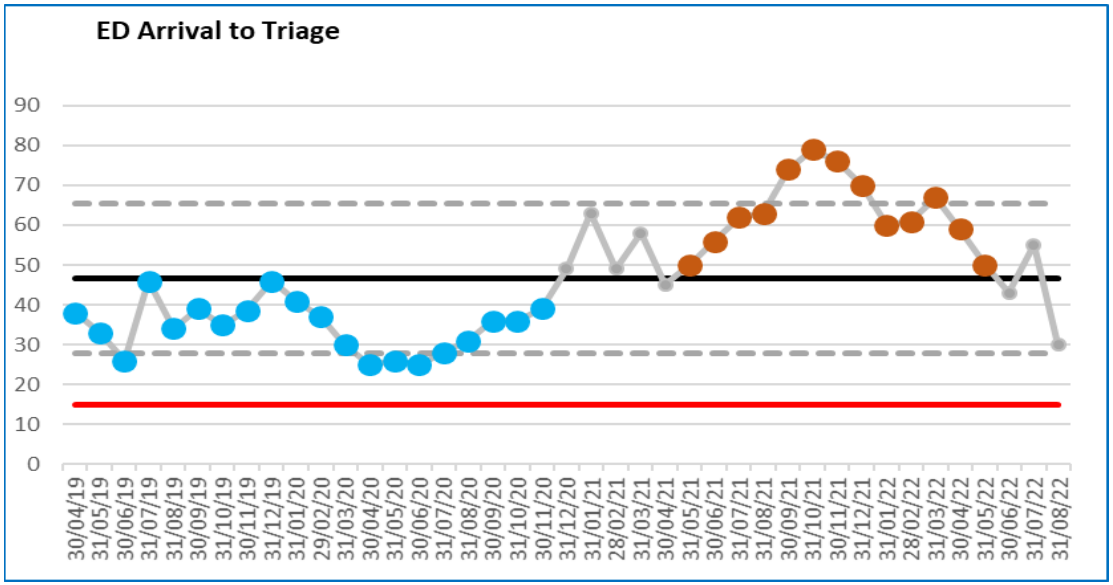
Aug-22
32.0% 30-60 min
Variance Type
Special cause variation
Target
0%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Ambulances handovers between 30 and 60 minutes	Special cause concerning variation and consistently failing target	The % of ambulance conveyances over 30 minutes has increased above the statistical average. Increased ambulance activity, increased attendances and delays in bed availability for admissions from the emergency department.	Ongoing improvement programme monitored through Urgent Care Board. Daily system call with EEAST to enact load levelling and manage volume across the acute Trusts. Drop & Go service maintained despite extreme pressure. Improved staffing enabling the 4th Rapid Assessment & Triage team to assess faster	Safety huddle led by EPIC and NIC to review entire department 6 times a day. SOP in place for ambulance patients. Ongoing review of capacity across the emergency department



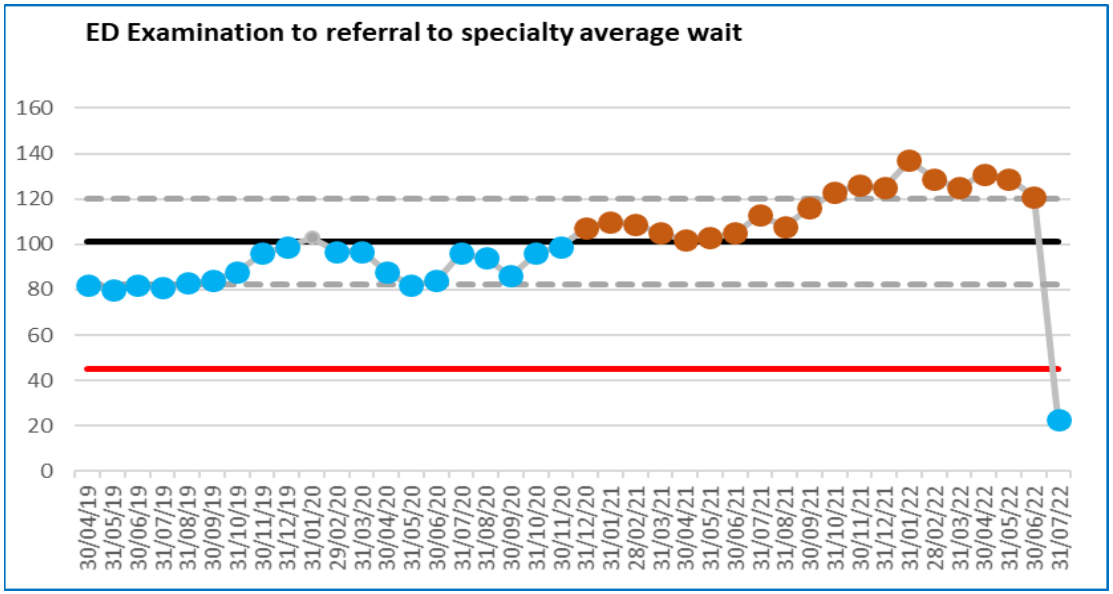
Aug-22
116 minutes
Variance Type
Special cause variation
Target
60 minutes
Target Achievement
Consistently failing target

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



Aug-22
30 minutes
Variance Type
Special cause variation
Target
15 minutes
Target Achievement
Consistently failing target

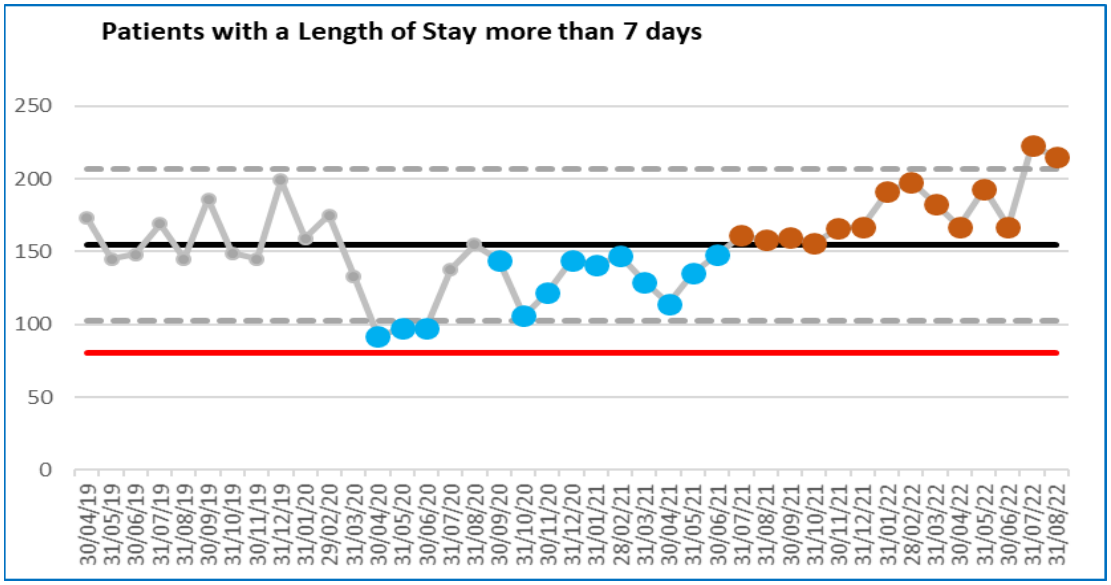
Background	What the chart tells us	Issues	Actions	Mitigation
Seen by specialty to DTA	Special cause concerning variation and consistently failing target	The average time from being seen by specialty to decision to admit has been consistently increased over the statistical average for 8 months	IPPS measurements of time to streaming & triage through Urgent Care Board. UTC expansion and location change to take all walk-in attendances and stream to appropriate service. Expansion to 4 RAT teams as staff vacancy has decreased and skill mix is improving	Close review through breach analysis at Urgent Care Board



Jul-22
23 minutes
Variance Type
Special cause variation
Target
45 minutes
Target Achievement
Consistently failing target

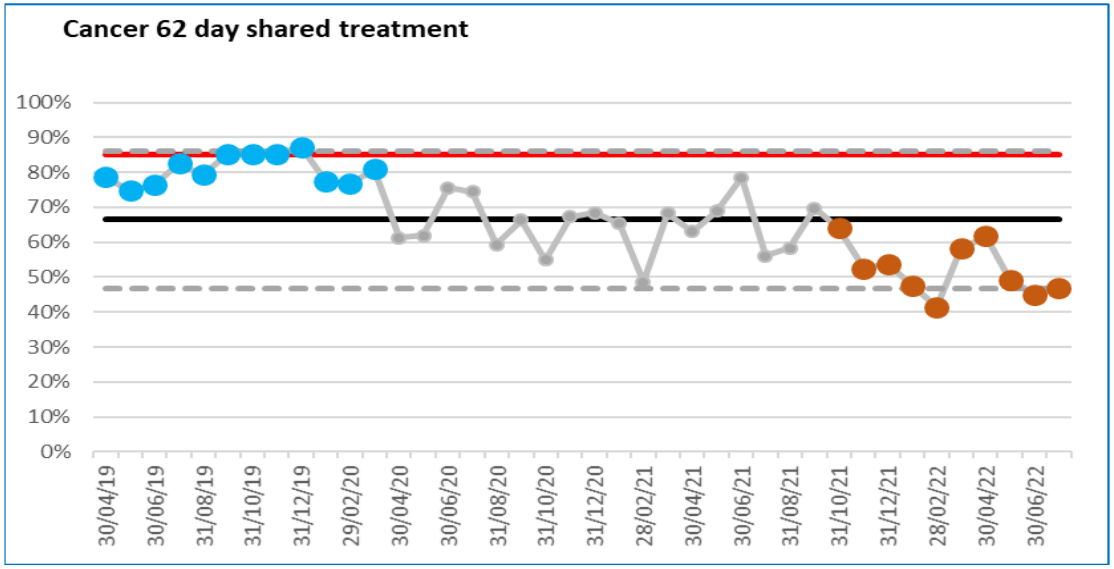
the specialty field is not really utilised in Nerve Centre at present

Background	What the chart tells us	Issues	Actions	Mitigation
ED examination to referral to specialty average wait	Special cause concerning variation and consistently failing target	The implementation of ED Nervecentre has impacted the collection of this measure.	ED Nervecentre data collection issue being resolved. IPPS measurements of performance through Urgent Care Board. Divisional attendance at ED Huddles being monitored and escalated.	Close review through breach analysis at Urgent Care Board



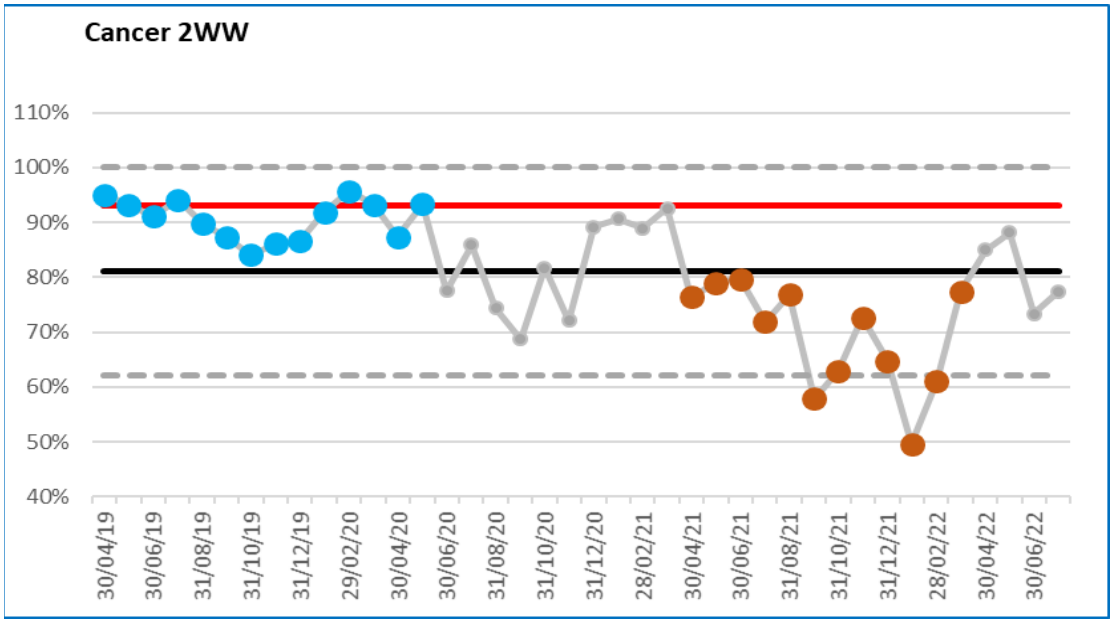
Aug-22
215
Variance Type
Special cause concerning variation
Target
80
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Occupied beds with stranded patients	Special cause concerning variation & consistently failing target	The performance against the target for stranded patients has failed consistently, however, we have shown common cause variation for the last 12 months	Daily patient panel review to understand discharge constraints. HIT Team review of patients appropriate for discharge extended across weekends. Close working with community bed providers & commissioners ensuring effective bed usage. Closure of Gibberd ward compensated by bridging capacity. National improvement programme continues, with focus on partner organisations including ambulance trust in April.	Review via daily bed meetings, daily system meetings & weekly capacity planning meetings. EDD review underway. Use of nerve centre to track patient EDDs & support for discharge in place.



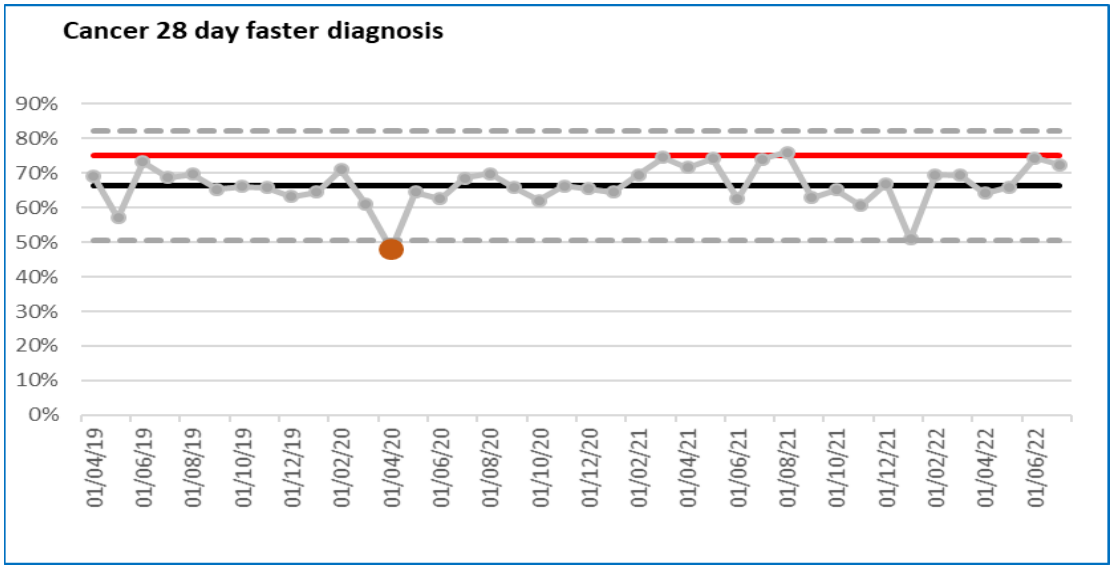
Jul-22
46.81%
Variance Type
Common cause variation
Target
85%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 62 day shared treatment	Common cause variation and hitting and missing target radomly	The performance against the target has failed for over 12 months.	The Trust has continued to focus on diagnosing & treating the backlog of patients that developed over the Covid period & the 62 day performance reflects the increased numbers of patients treated after 62 days in their pathway. The backlog of patients over 62 days continues to decrease and is close to the submitted trakectorry. Theatre capacity is due to ncrease in July & August which will enable more diagnostics and treatment capacity.	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting. Prioritisation of cancer patients in booking diagnostics & treatments. Clinician discussions at Cancer Board to escalate concerns and review cancer conversion rates which remain steady.



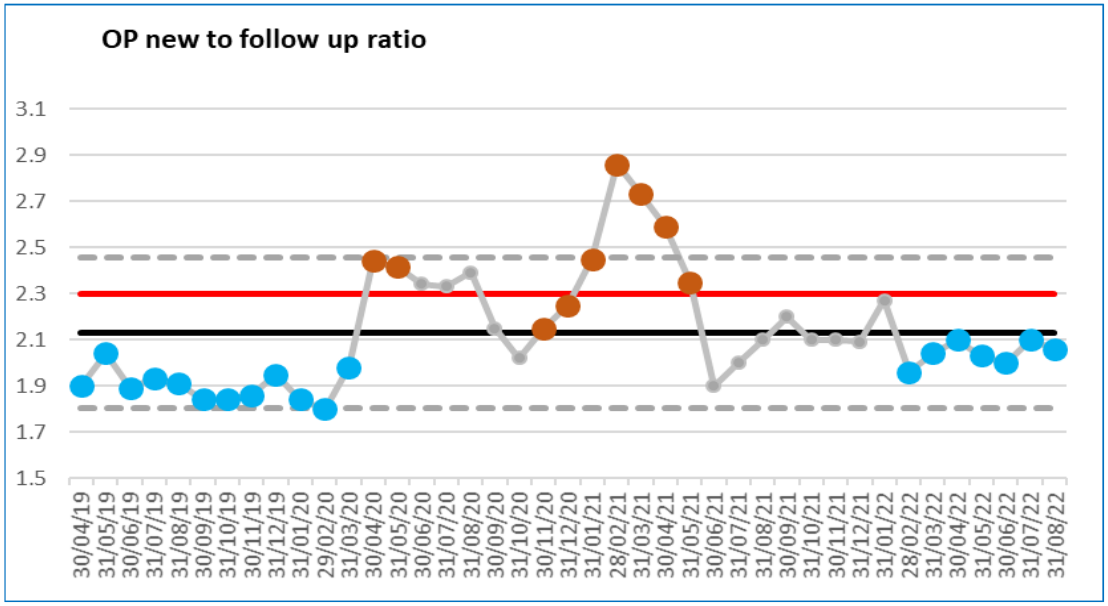
Jul-22
77.42%
Variance Type
Special cause concerning variation
Target
93%
Target Achievement
Inconsistently passing and falling short of target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 2 week wait	Special cause concerning variation & inconsistently passing and falling short of the target	Ongoing increased referrals in February - 11% higher than January	5 of the 10 tumour sites achieved the national standard including breast & dermatology. Close review of capacity versus demand, escalation to services if mismatched. Straight to test in lower GI endoscopy booking improvements continuing. CQUIN actions for Lung and Urology will create improvements.	Close review of 28 day diagnosis standard for each tumour site failing 2ww. Dermatology achieving 62 day performance. Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to Cancer Board & executive reporting.



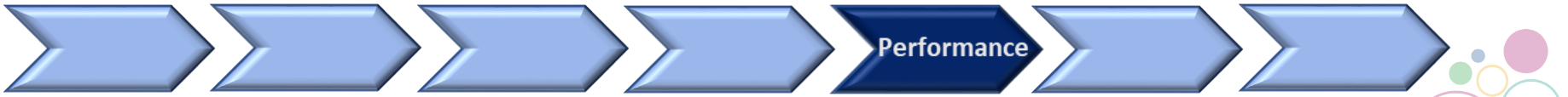
Jul-22
72.27%
Variance Type
Common cause variation
Target
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 28 day faster diagnosis	Common cause variation and hitting and missing target radomly	The performance against the target has failed for over 12 months.	28 day Faster Diagnosis Improvement Manager delivering Frailty pathway, success with Lower GI triage process and improved data recording following clarification of CWT Guidance. Development of Lung, Upper GI and Prostate faster diagnosis pathways with the CQUIN work commencing.	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting. Prioritisation of cancer patients in booking diagnostics & treatments. Clinician discussions at Cancer Board to escalate concerns and review cancer conversion rates which remain steady.



Aug-22
2.06
Variance Type
Common cause variation
Target
2.3
Target Achievement
Inconsistently passing and falling short of target

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

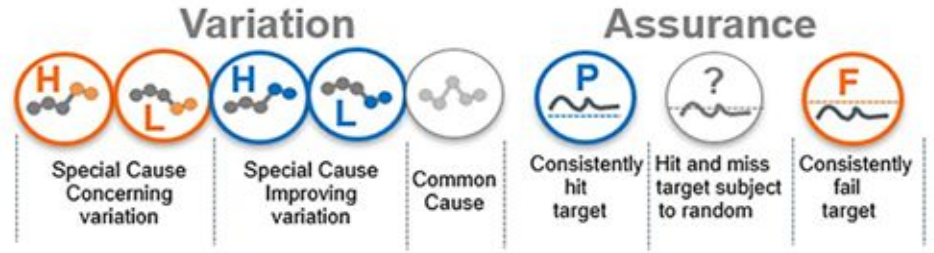


People

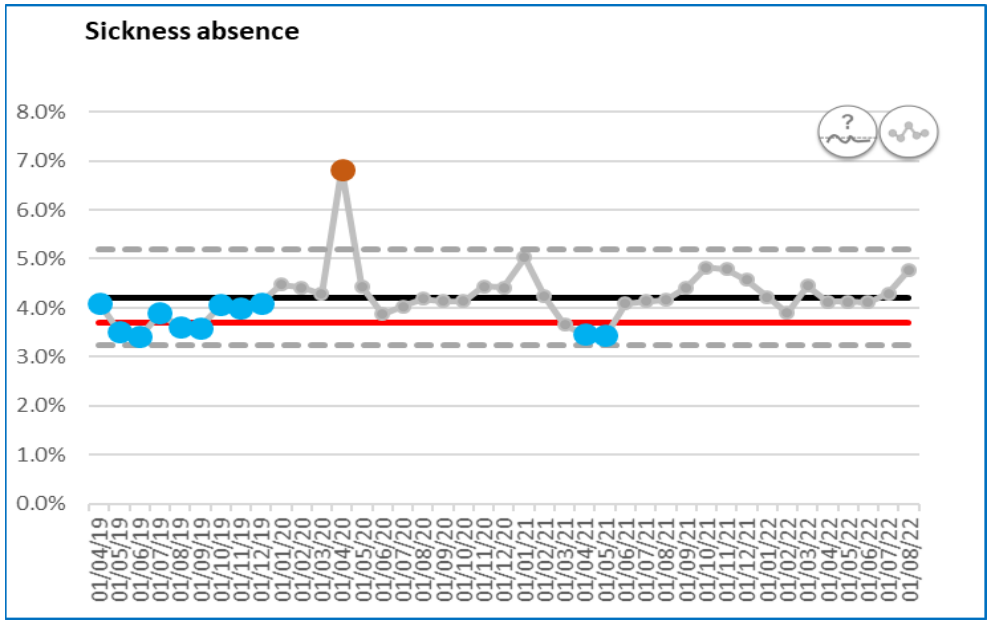
*We will support **our people** to deliver high quality care within a culture that continues to improve how we attract, recruit & retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.*

People Summary		Board Sub Committee: Worforce Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Sickness	Sickness absence worshops for managers are scheduled and taking place within divisions. Individual long term cases and actions discussed at management level	For information	Q2
Appraisal	Time contraints cites as reasons for non-compliance. Individualised reports sent to triumvirate and managers. Managers asked to book outstanding appraisals within the next month Compliance rates are addressed at PRMs	For information	Q2
Stat and Mand Training	Compliance remains static, challenges of protected time to complete training cited. There is a blended approach to training, delivered both via teams and face to face in the learning and education facility.	For information	Q2
Vacancy	Midwifery, Nursing and A&C continue to hold the highest vacancy rates. International radiographer cohort started in August. Recruitment action plans continue to be agreed with divisions; recruitment team attending local job centre to highlight working for the Trust and to promote vcancies.	For information	Q3
Turnover	Leaving reasons are being linked to cost of living and health and wellbeing. There is continued promotion of the trusts health and wellbeing offer such as wellbeing workshops and Here for you sessions. The tust have also undertaken a number of cost of living initiatives such as continuing free parking and access to harlow community hub and food back. The recruitment and L&OD team linking in with Anglia Ruskin to pronote vacancies to attract newly qualified nurses. PAHT are part of the retention pathfinder programme within the ICS	For information	Q3

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Appraisals - non medical	Aug 22	80.0%	90.0%	L	F	81.4%	76.6%	86.3%
Agency staffing spend	Aug 22	8.2%	15.0%	H	P	5.3%	2.5%	8.0%
Bank staffing spend	Aug 22	12.3%	15.0%		P	11.8%	9.4%	14.1%
Vacancy Rate	Aug 22	10.6%	8.0%	H	?	9.4%	7.9%	10.8%
Staff turnover - voluntary	Aug 22	17.1%	12.0%	H	?	12.2%	11.3%	13.1%
Sickness absence	Aug 22	4.8%	3.7%		?	4.2%	3.2%	5.2%
Statutory and Mandatory training	Aug 22	86.0%	90.0%	L	?	88.2%	85.7%	90.7%



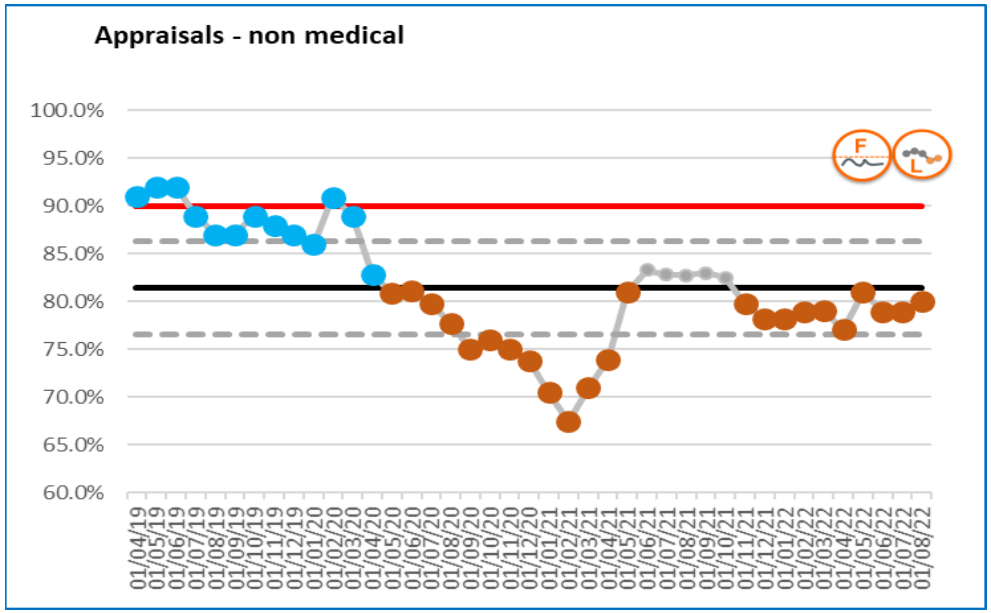
People



Aug-22
4.76%
Variance Type
Common cause variation
Target
4%
Target Achievement
Inconisistently passing & falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Sickness absence	Variation indicates inconsistently passing & falling short of the target	Sickness absence rates across the trust remain static. Reasons for absense continue to be linked to mental health and MSK	Sickness absence worshops for managers are scheduled and taking place within divisions. Individual long term cases and actions discussed at management level	Absences recorded contemporaneously and advice & guidance to managers on COVID & testing guidelines

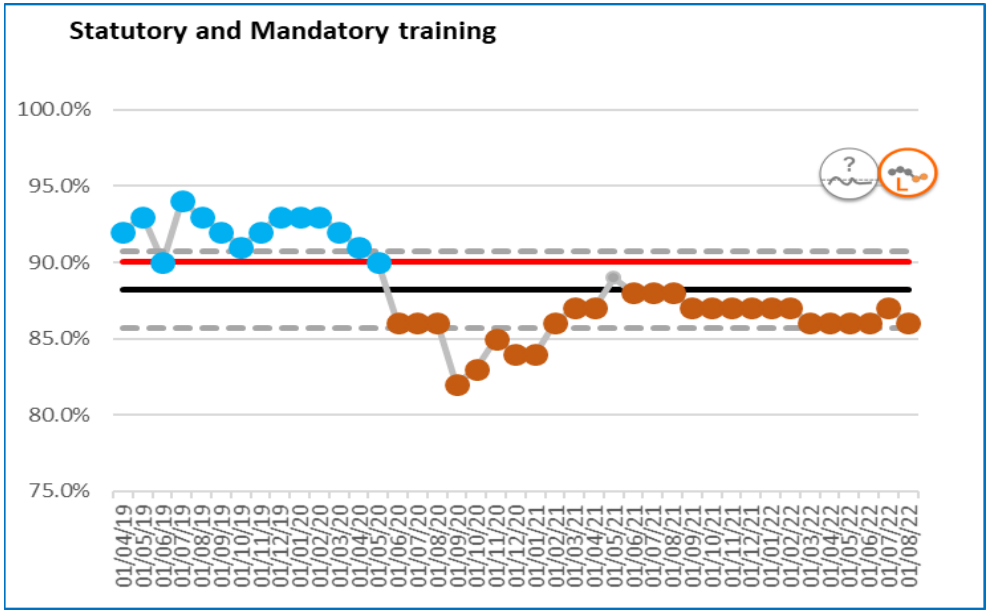
People



Aug-22
80.00%
Variance Type
Common cause variation
Target
90%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Appraisal non medical	Common cause concerning variation & consistently falling short of target	Overall appraisal rates are improving	Individualised reports sent to triumvirate and managers. Managers asked to book outstanding appraisals within the next month Compliance rates are addressed at PRMs	Compliance rates discussed at monthly divisional board meetings & performance review meetings with actions agreed. People information team able to support any challenges with MyESR

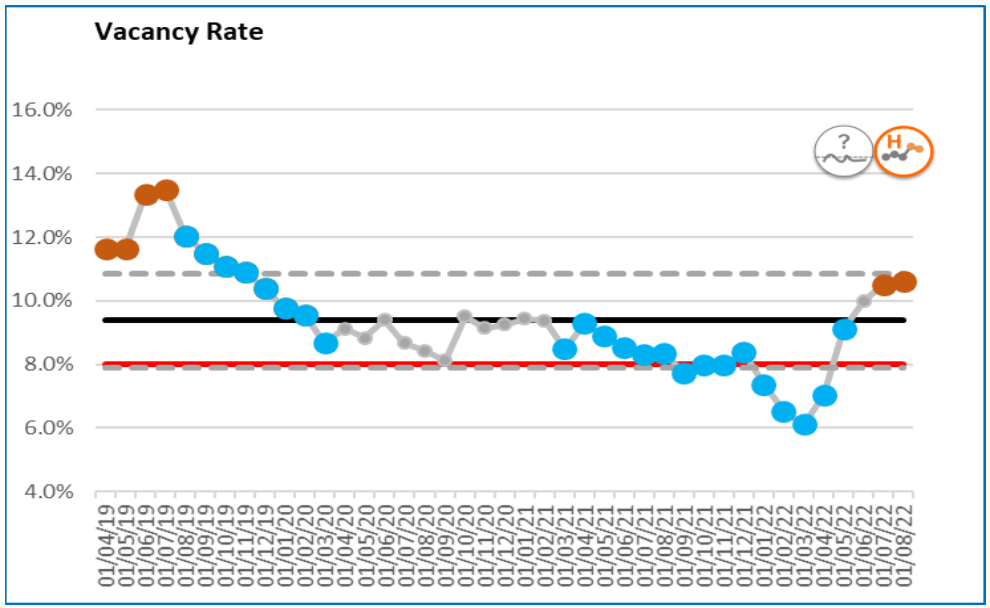
People



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

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

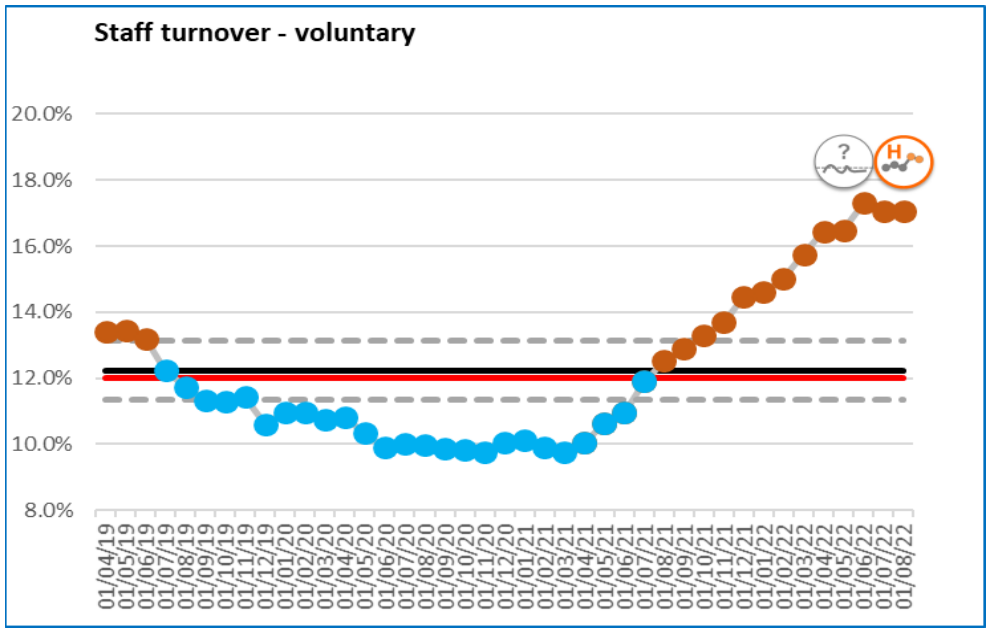
People



Aug-22
10.60%
Variance Type
Special cause variation
Target
8.00%
Target Achievement
Consistently failing

Background	What the chart tells us	Issues	Actions	Mitigation
Vacancy Rate	Special cause improving variation & consistently failing target	Midwifery, Nursing and A&C continue to hold the highest vacancy rates. International radiographer cohort started in August. Recruitment action plans continue to be agreed with divisions; recruitment team attending local job centre to highlight working for the Trust and to promote current vacancies.	Recruitment team are attending the local job centre with regular sessions to highlight working for the Trust and to promote current vacancies.	Vacancy rates are discused in monthly divisional meetings and PRMs

People



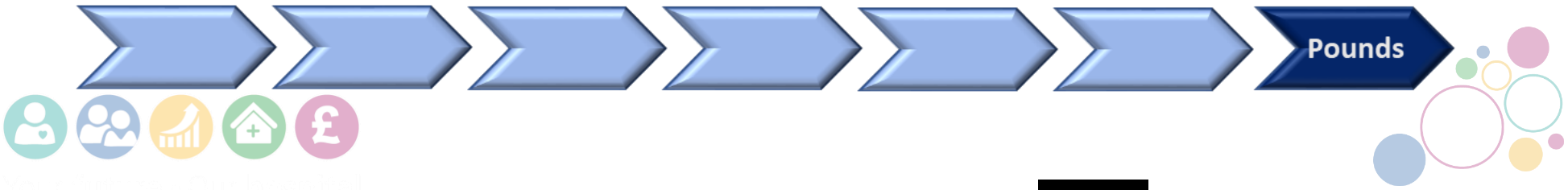
Aug-22
1705.00%
17.05%
Variance Type
Special cause variation
Target
12.00%
Target Achievement
Consistently failing

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

Pounds

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

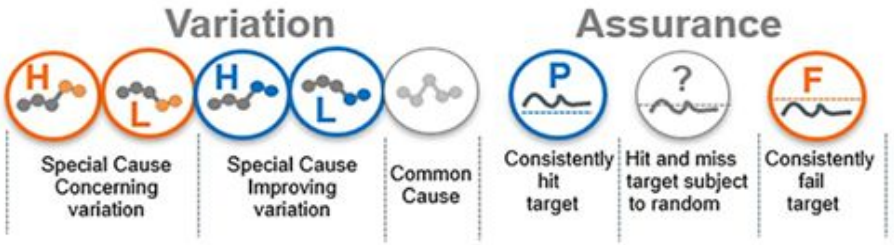
Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Surplus	The Trust reported a deficit of £1.7m in August (Month 5) and a year to date deficit of £10.2m against deficit of £0.2m in month and a surplus of £0.1m year to date. We continue to review the Trust underlying position and identify major drivers of the deficit. Work is ongoing with divisional leads to review our spend profile and where anticipated future expenditure can be challenged.	For information	
CIP	The Trust CIP target for the year is £11.7m and planned delivery for month 5 is £0.7m (£2.7m year to date). £2.4m of CIP (full year) have been identified and delivery is being assessed and will be reported in month 6	For information	
Capital Spend	The Trust total revised CRL for 2022/23 is £15.2m. This includes element of the new hospital PDC of £1.1m. As at Month 5, year to date actual capital spend totals £3.3m.	For information	
Cash	The Trust continues to have a healthy cash balance of £42.7m. There is a continued push to reduce aged payables & maintain the improved Trust's performance against the Better Payment Practice Code.	For information	

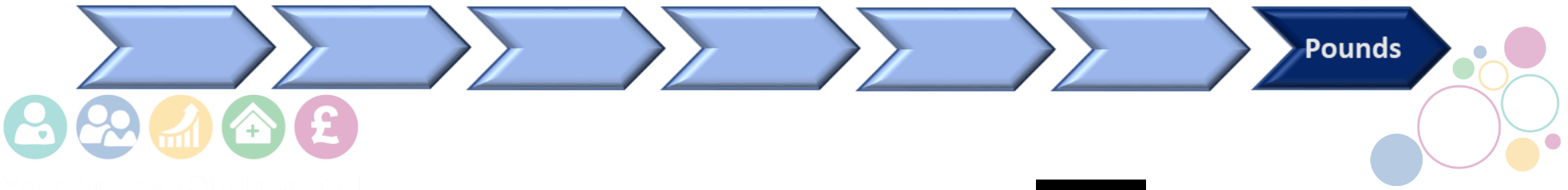


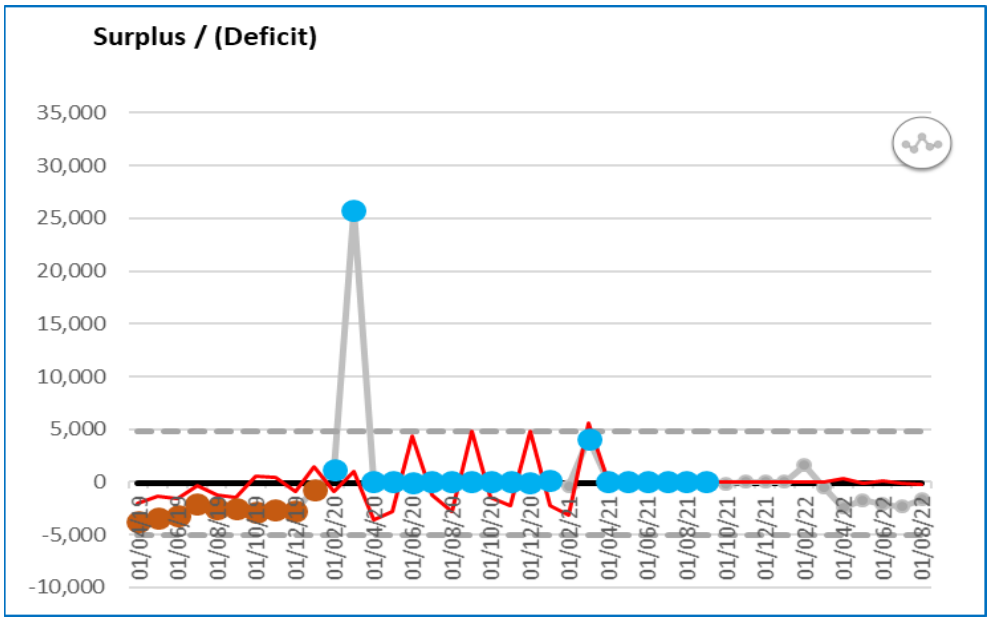
Our Pounds

Export to power point

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Surplus / (Deficit)	Aug 22	-1653	0			-113	-5064	4838
EBITDA	Aug 22	-256	0			1070	-3876	6016
CIP	Aug 22	0	0			519	-485	1524
Income	Aug 22	27999	0			26542	16697	36386
Operating Expenditure	Aug 22	28255	0	H		26375	20400	32349
Bank Spend	Aug 22	2287	0			2025	1319	2732
Agency Spend	Aug 22	1529	0	H		917	445	1390
Capital Spend	Aug 22	233	0			2346	-3520	8213
Cash Balance Actual	Aug 22	42726	75000000	L	F	4600996	-1469411	10671402



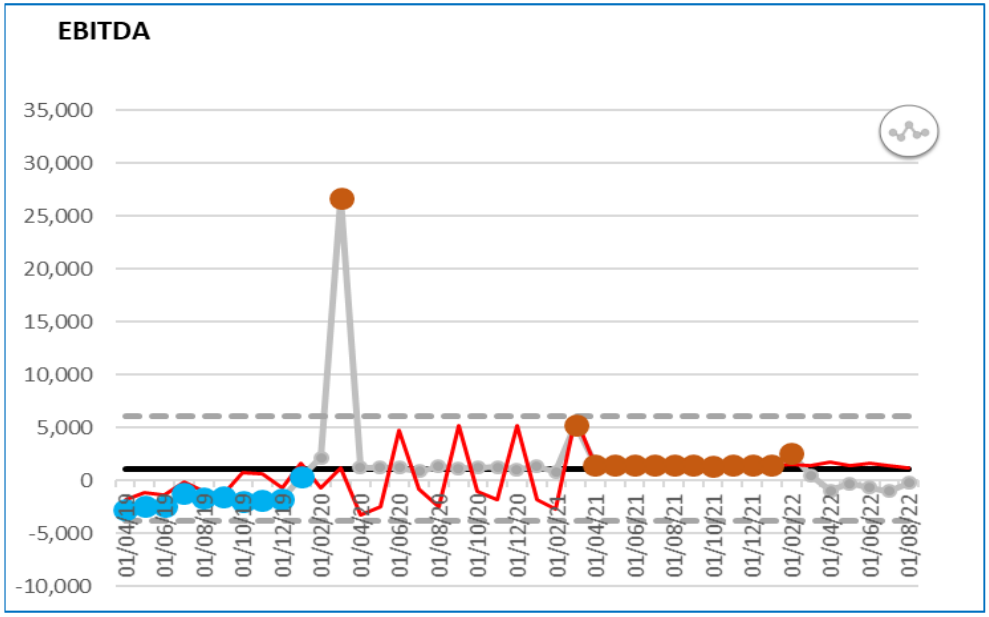




Aug-22
-1653
Variance Type
Special cause concerning variation
Target
0
Target Achievement
Consistently failing target

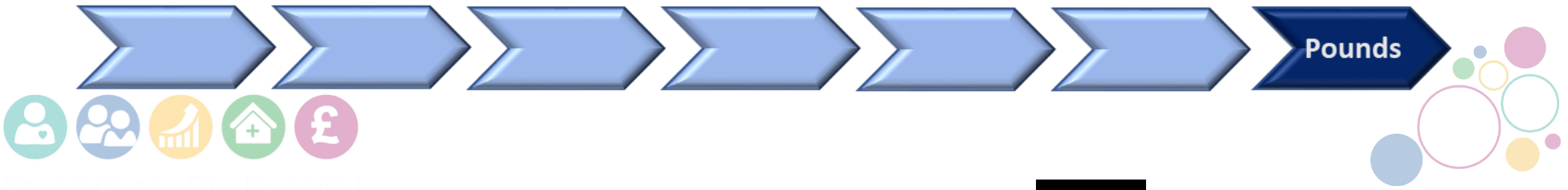
Background	What the chart tells us	Issues	Actions	Mitigation
Surplus/Deficit	Special cause concerning variation & inconsistently passing and falling short of the target			

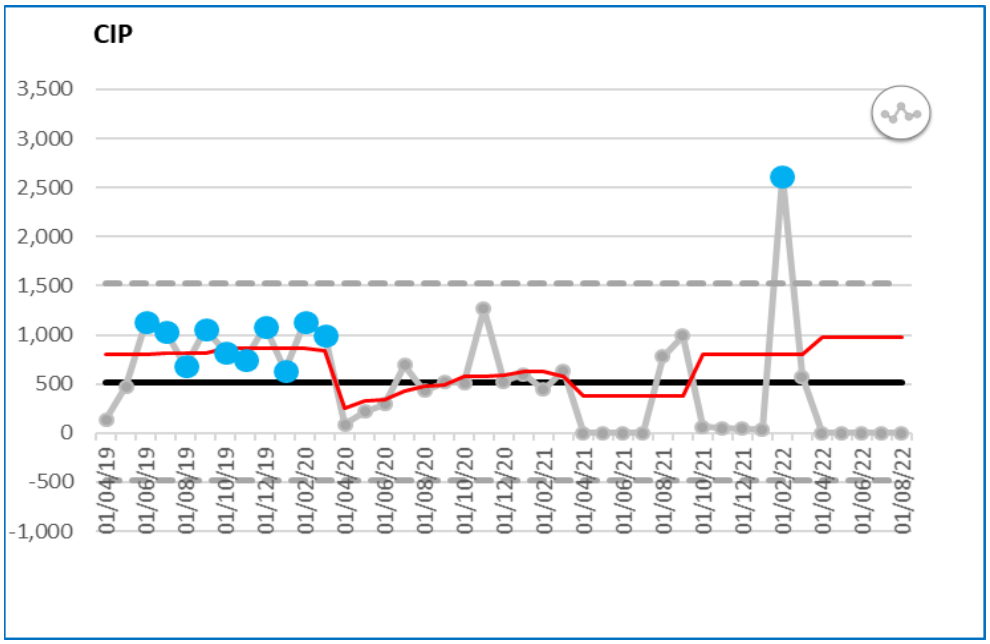
Pounds



Aug-22
-256
Variance Type
Special cause concerning variation
Target
1450
Target Achievement
Inconsistently passing and falling short of the target

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

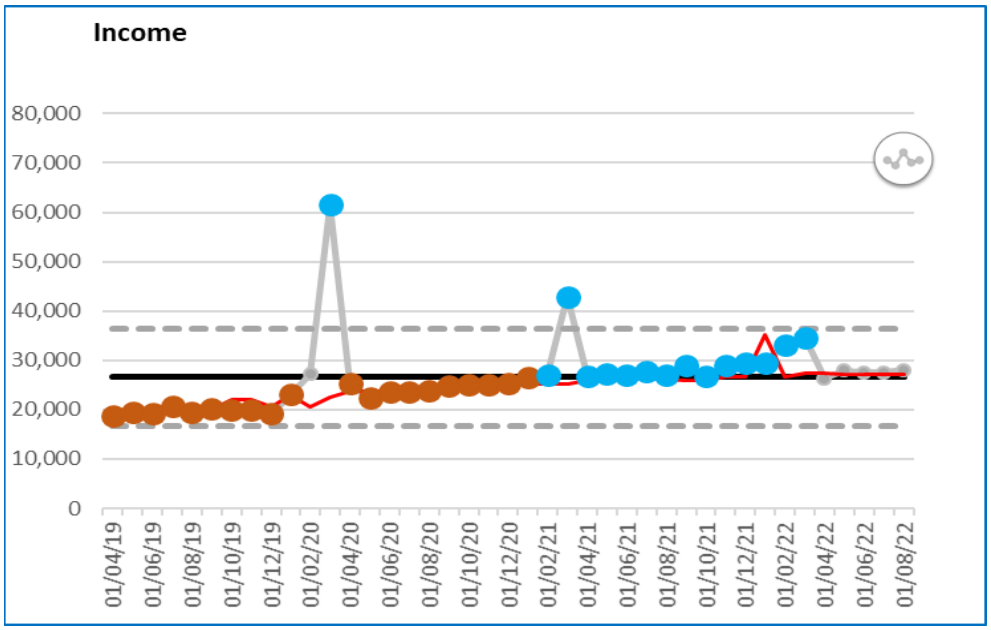




Aug-22
0
Variance Type
Common cause variation
Target
801
Target Achievement
Inconsistently passing and falling short of the target

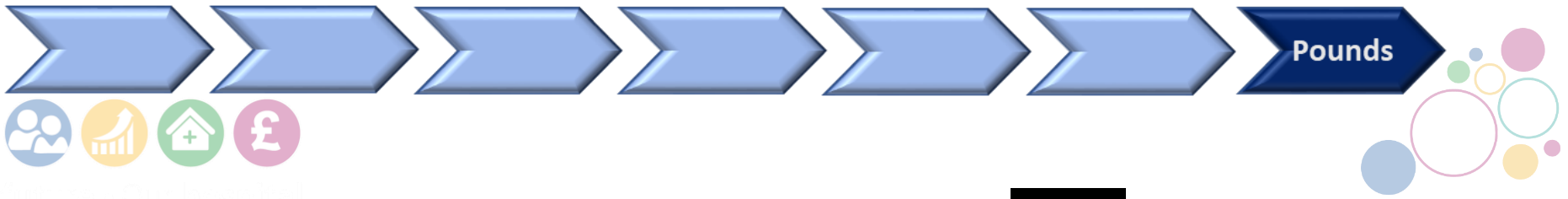
Background	What the chart tells us	Issues	Actions	Mitigation
CIP	Common cause variation and inconsistently passing and falling short of the target			

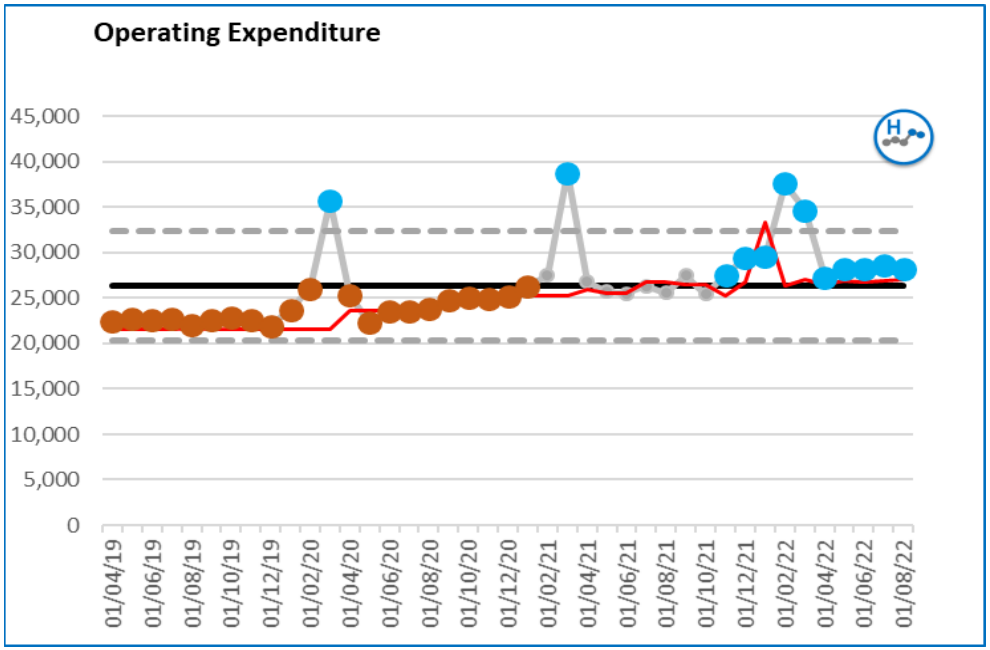
Pounds



Aug-22
27999
Variance Type
Special cause improving variation
Target
26684
Target Achievement

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

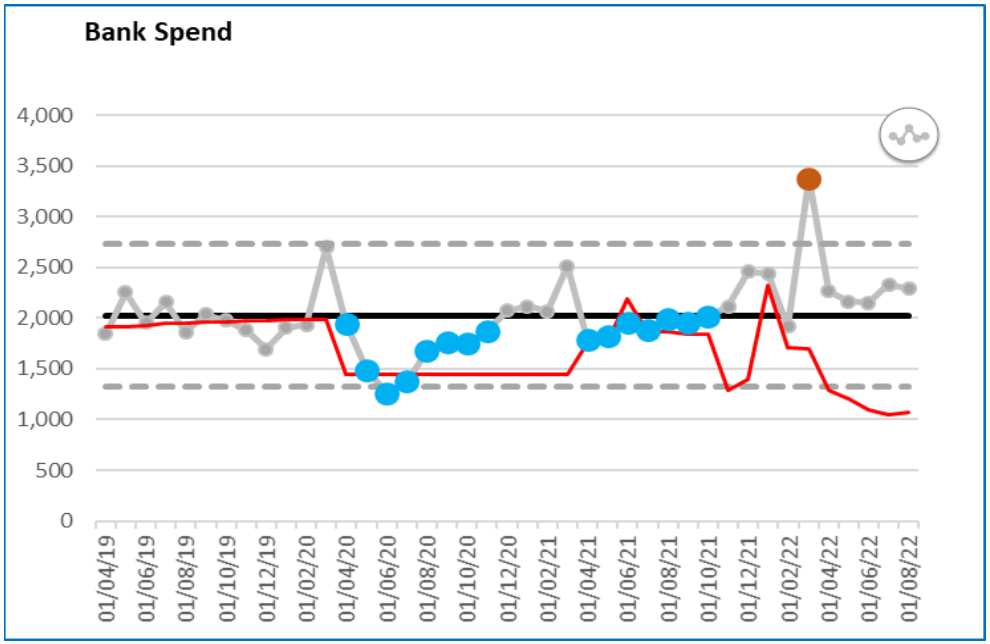




Aug-22
28255
Variance Type
Common cause variation
Target
26709
Target Achievement

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

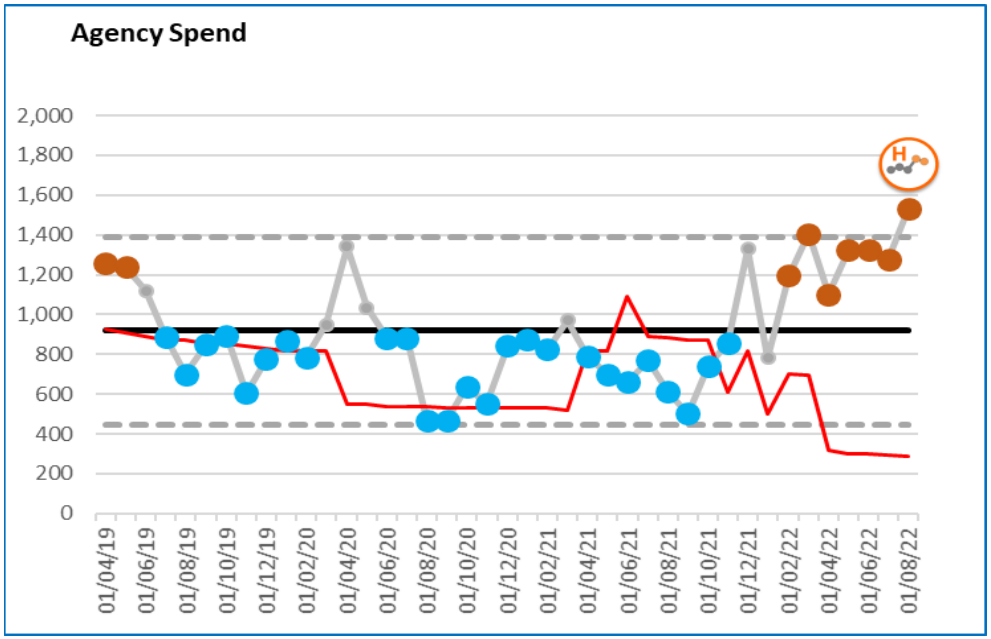
Pounds



Aug-22
1069
Variance Type
Special cause variation
Target
1110
Target Achievement
Inconsistently passing and falling short of the target

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

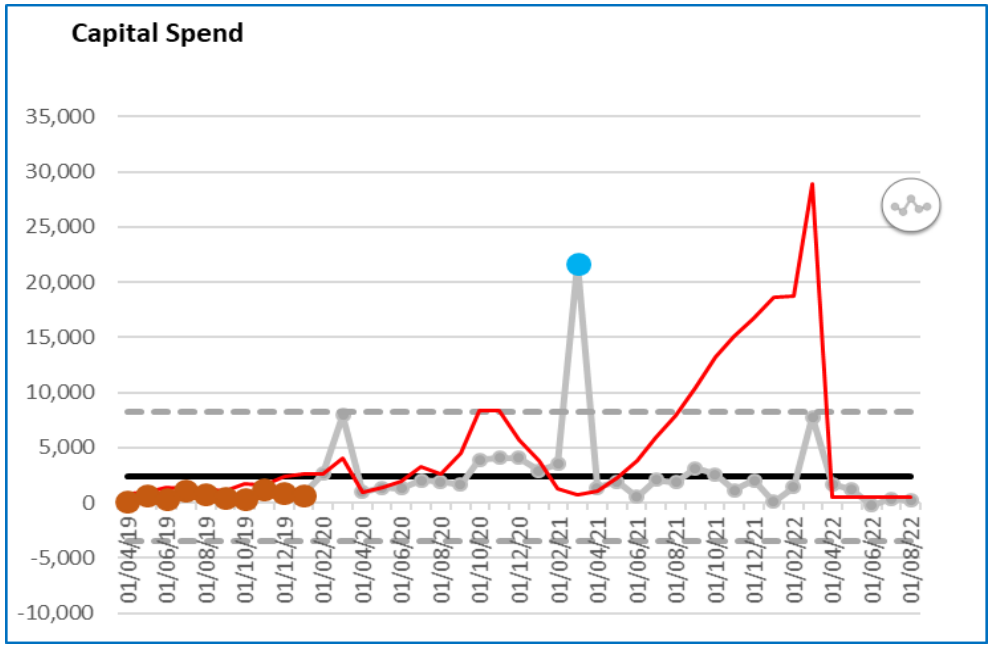
Pounds



Aug-22
1529
Variance Type
Common cause variation
Target
1107
Target Achievement
Inconsistently passing and falling short of the target

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

Pounds



Aug-22
233
Variance Type
Common cause variation
Target
18682
Target Achievement
Inconsistently passing and falling short of the target

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

Pounds

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**6 October 2022**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**	
REPORT FROM:	**Hattie Llewellyn-Davies - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26 September 2022**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 PAHT2030 Update	Y	Y	N	The Digital Health and Our Culture strategic priorities were generally meeting their delivery plan actions and were RAG rated green. The Transforming Our Care strategic priority was rated amber and the Corporate Transformation and Our New Hospital strategic priorities carried significant risk of delivery within the original timescales and were rated red.
2.2 New Hospital Update	Y	Y	N	The Trust continued to support the New Hospital Programme (NHP) with development of standards and guidance, particularly in the Hospital 1.0 design and the commercial strategy. A submission has been made to NHP identifying potential future requests for funding to cover early and enabling works over the coming 3 year period. A strategy had been developed to reinvigorate internal and external interest in the hospital which would start with a focussed engagement piece on cancer day-care provision.
Item 2.3	Y	Y	Y	The meeting considered the item at 2.3 and agreed to the proposed course of action. This was treated as a confidential item and will be discussed in the private Board meeting on 06.10.22.
2.4 BAF Risk 3.5 (New Hospital)	Y	N	N	It was agreed the risk score would remain at 20.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**6 October 2022**			**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**			
REPORT FROM:	**Hattie Llewellyn-Davies - Committee Chair**			
DATE OF COMMITTEE MEETING:	**26 September 2022**			

Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 Digital Transformation Update	Y	Y	N	The Committee was pleased to hear of the progress to date particularly in terms of Artificial Intelligence and Robotics. It agreed however the next iteration of the paper should include clarity on benefits in terms of clinical outcomes, costs and staff experience.
2.6 Electronic Health Record (EHR) Update	Y	Y	N	The procurement process was now complete and contractual negotiations underway with the preferred supplier. A full business case was in development and on course to be submitted to Trust Board for consideration in November.
2.7 BAF Risk 1.2 (EHR)	Y	N	N	It was agreed the risk score would remain at 16 and would be unlikely to change until the new EHR was implemented.
3.1 Strategic/System Update	Y	Y	N	The paper noted the elements of the ICS partnership that were continuing to develop in terms of new relationships and clinical pathways. The paper detailed the work currently underway to address health inequalities across the region but particularly in West Essex.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:		**6 October 2022**		**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:		**Strategic Transformation Committee (STC)**		
REPORT FROM:		**Hattie Llewellyn-Davies - Committee Chair**		
DATE OF COMMITTEE MEETING:		**26 September 2022**		
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.2 Report from West Essex Health Care Programme Board	Y	Y	N	The Board had received updates on Intermediate Care and Health Inequalities Funding. It would be developing a formal work plan going forward and updating its terms of reference at which point core membership would be reviewed.
4.1 Community Diagnostic Centre (CDC) Business Case	Y	Y	N	A decision on the business case had been delayed putting potential opening of the centre back to March 2024. STC requested that transport links for patients to the centre and indeed to all Trust premises continued to be seen as a priority in terms of future discussions.
4.2 Outcomes Framework	Y	Y	N	STC supported the proposals and next steps for the development of an Outcomes Framework to support delivery of the five PAHT2030 priorities.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board –6th October 2022 **Item No: 7.2**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy – Chairman
DATE OF MEETINGS: **06.09.22 and 20.09.22**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at SMT meetings in September

6 September 2022:

- EHR Benefits
- Recovery Dashboard
- Nutritional strategy update
- Statutory and Mandatory Training Group Update
- Business Miles
- Finance Update

20 September 2022:

- Imaging Workforce Business Case
- Quality Briefing
- Quality PMO report
- CQUINs
- ICS medicine optimisation strategy
- Liberty Protection Standards
- Winter Planning
- Industrial Action
- Divisional Review
- Annual Staff Survey 2022 Plan
- Quarterly Staff Survey Results Q2
- Recovery Snapshot
- Significant Risk Register
- Restaurant Options
- Kitchen update following inspection
- Car Parking

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) - 6 October 2022

7.3

Agenda item:	7.3
Presented by:	Finola Devaney – Director of Quality and Clinical Governance
Prepared by:	Finola Devaney - Director of Quality and Clinical Governance Sharon McNally – Director of Nursing, Midwifery and AHPs
Date prepared:	15 August 2022
Subject / title:	Trust Board Well Led Self-assessment

Purpose:	Approval		Decision		Information	X	Assurance		

Key issues:	• The Trust Board undertook a Well Led self-assessment in July 2022, utilising the CQC Well Led self-assessment tool. • The Trust Board rated themselves as Good with elements requiring improvement. This is mapped under section 3, page 3. • The outcome of the self-assessment will inform our improvement journey to achieve a sustained good well led rating and drive to achieving outstanding.
Recommendation:	To agree the self-assessment ratings and next steps.

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:	EMT 15/9/22: Requires improvement element of well led self-assessment mapped to our strategic intent.
Risk / links with the BAF:	Linked to all CQC fundamental standards
Legislation, regulatory, equality, diversity and dignity implications:	This paper has been written with due consideration to equality, diversity and inclusion in respect of our patients, people and potential providers.
Appendices:	Nil

1.0 Purpose

Under the NHS England (2017) 'Developmental reviews of leadership and governance using the well-led framework', it is recommended that Trusts undertake annual self-assessments against the Well Led Framework published by CQC in June 2017.

Trusts are required to commission an external review of the Well-led Framework every 3-5 years. Princess Alexandra Hospital NHS Trust external review was in 2021 with the commissioned of Deloitte to undertake a full well led review, their report was published in September 2021.

CQC undertook a Trust wide well led inspection in August 2021 with the report published in November 2021, rating the Trust as Requires Improvement (RI) for Well Led.

Board members participated in a workshop on 7 July 2022 and completed the Trust's self-assessment against the framework for 2021/22.

The self-assessment ratings for the 8 KLOE's (Key Lines of Enquiry) are summarised below:

- 5 of the KLOE were assessed as good, with 3 as RI
- an overall rating of good was agreed,
- rates reflect similar position as in 2020

Of note, whilst 3 ratings remained assessed as RI, significant progress against the KLOE were recognised with associated actions and oversight in place. This is detailed under section 3.

2.0 Self-assessment ratings:

KLOE	Rating assigned in 2018/19	Rating assigned in 2019/20	Rating assigned in 2021/22
1. Is there the leadership capacity and capability to deliver high quality, sustainable care?	Good	Good	Good
2. Is there a clear vision and credible strategy to deliver high quality sustainable care to people, and robust plans to deliver?	Good	Good	Good
3. Is there a culture of high quality, sustainable care?	Requires Improvement	Requires Improvement	Requires improvements
4. Are there clear responsibilities, roles and systems of accountability to	Requires Improvement	Requires Improvement	Requires improvement

support good governance and management?			
5. Are there clear and effective processes for managing risks, issues and performance?	Good	Good	Good
6. Is appropriate and accurate information being effectively processed, challenged and acted on?	Good	Requires Improvement	Requires Improvement
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	Good	Good	Good
8. Are there robust systems and processes for learning, continuous improvement and innovation?	Requires Improvement	Good	Good

3.0 Progress and monitoring against Requires Improvement KLOE

KLOE	Progress noted	To move to Good requires
3. Is there a culture of high quality, sustainable care?	This is Us has been launched in 2022 as part of our continued staff engagement programme. Our PAHT2030 strategy launched in 2021, which aligns with our Quality & Patient Safety Strategy launched in 2022.	Continuing to embedding of the This is Us programme linked to our PAHT 2030 strategy.
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?	Trust wide divisional restructure was undertaken in September 2021. Revised governance structures in place.	Continued divisional embedding of the changes and structures.
6. Is appropriate and accurate information being effectively processed, challenged and acted on?	Launched the Digital Strategy in 2021 aligned to the PAHT2030 strategy. Revised integrated performance reports using statistical process control tool introduced in 2021.	Continued development of the divisional integrated performance reports. Key milestones agreed to support our roadmap to becoming an outstanding organisation.

4.0 Recommendations:

Consider the self-assessment ratings, and agree next steps to address the KLOEs rated as requires improvement and progress the KLOE rates requires improvement.

5.0 Next steps:

- Correlate the evidence against each of the KLOE rating, agree the central repository for information with support from PM3 and Quality Project Management Office.
- Review the areas of requires improvement and support progress against compliance and outline areas of work already in progress, such as the PAHT 2030 This is Us – Culture work and the divisional restructure to support improved governance
- Divisions currently undertake well led review and report to the Clinical Compliance Group bi Monthly, Agreed in the August Clinical Compliance Group for the Director of Clinical Quality & Governance to undertake divisional well led self-assessments by end of December 2022 and report into Senior Management Team
- Over sight of the compliance against the CQC quality standards will report into the Clinical Compliance Group and into Quality and Safety Committee.

Author: Finola Devaney - Director of Quality and Clinical Governance
Sharon McNally – Director of Nursing, Midwifery and AHPs

Date: 15 August 2022.

BOARD OF DIRECTORS: Trust Board (Public) 6 October 2022 **AGENDA ITEM: 7.4**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Committee Chair

DATE OF COMMITTEE MEETING: 05 September 2022

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
1.6 Annual Committee Effectiveness Review including; Terms of Reference	Yes	No	N/A	The Committee discussed the effectiveness review and recommend the revised Terms of Reference (Appendix 1) to the Board for approval. The annual report from the Audit Committee to the Trust Board would be submitted to Audit Committee in December 2022 and to the Trust Board in January 2023.A refresher training session for Audit members and executive attendees is being scheduled.
2.1 External Audit Progress Update	Yes	Yes	No	External Audit had held a 21/22 audit debrief session with the Trust's Finance team and commenced planning discussions with the Trust to consider approach to the 2022/23 audit. This included changes in approach required as a result of revised auditing standards being introduced, in particular covering fraud risk assessments and IT systems/controls.
3.1 Internal Audit Progress Report	Yes	Yes	No	Internal Audit noted progress had been made in relation to the HFMA Financial Sustainability review and the deadline for completion had been moved to the end of November. The additional special project review was in progress and would be reported to an Extraordinary Audit Committee in September and Trust Board 6 October.

BOARD OF DIRECTORS: Trust Board (Public) 6 October 2022 **AGENDA ITEM: 7.4**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Committee Chair

DATE OF COMMITTEE MEETING: 05 September 2022

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
3.2 Counter Fraud Progress Report	Yes	No	N/A	Good progress was being made in regards to counter fraud plans and activity. There were planned discussions with the finance team on the risk from mandate fraud, in response to recent unsuccessful fraud attempts.
3.3 Waivers, Losses, Special Payments and Debt Write Offs	Yes	No	N/A	During the period 1st May 2022 to 31st July 2022: • The value of losses and special payments totalled £35k (4 cases); • No debts written off in this period. • 30 waivers totalled £2,940k of which 4 (£779k) were non-compliant.

BOARD OF DIRECTORS:	**Trust Board (Public) 6th October 2022**			**AGENDA ITEM: 7.5**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**John Keddie – Committee Chair**			
DATE OF COMMITTEE MEETING:	**16 September 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Breast Fund Update	Yes	No	No	The Committee approved the following events; • Shoot May 2023 • Camino Trek 2023
2.2 Charity Update	Yes	No	No	The Committee received an update on recent charity activities from the past three months, including the spring appeal, tap to donate machines and the upcoming London Marathon and the 2022 Royal Parks Half Marathon, both taking place in October. The spring door drop appeal raised £5,309.50. This does represent a net loss to the charity, however good qualitative data about the donor base was gained.
2.3 Draft Charity Strategy	Yes	Yes	No	The draft strategy was received for review and comments. Committee members and key stakeholders would send comments by 14 October, with a view to producing a final document at the December meeting.
2.4 Charity Risk Register Update	Yes	No	No	The Committee noted the addition of new risks relating to following areas: • Awareness of all fundraising by staff for the Trust • Head of charity role
2.5 Draft Charitable Funds Annual Report & Accounts	Yes	No	No	The draft 2021/22 annual report and accounts were received and it was noted a full audit examination was currently being undertaken by KPMG and the final audit report will be presented at the next meeting. The report and accounts were recommend to the Corporate Trustee for approval subject to any amendments being identified by external audit. The report and accounts will be presented to the Corporate Trustee at the November meeting.

BOARD OF DIRECTORS:	**Trust Board (Public) 6th October 2022**			**AGENDA ITEM: 7.5**
REPORT TO THE BOARD FROM:	**Charitable Funds Committee**			
REPORT FROM:	**John Keddie – Committee Chair**			
DATE OF COMMITTEE MEETING:	**16 September 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.6 Restricted Funds Update	Yes	No	No	An update was received on the progress being made with restricted funds. It was noted fund holders had been contacted and it was being looked into which funds could be moved into the general fund.
2.7 Reserve Policy and Limit/Level Review	Yes	No	No	The Committee reviewed and approved the Reserves Policy and approved that the Reserves Level be would be 6 months of the Charities operating costs for 2022/23; this was £180k.
2.8 Investment Policy Review and Strategy	Yes	No	No	The Committee reviewed and approved the Investment Policy. It was noted going forward investments and performance would be reported at each meeting.
2.9 Charitable Funds Policy Review	Yes	No	No	The Committee reviewed and approved the Charitable Funds Policy. It was noted that the development of the Charitable Funds Strategy (including fundraising) may identify that the Policy required further amendment before the next designated formal review date.
2.10 Charitable Funds Finance Report	Yes	No	No	The Committee noted the following updates: • At M5 the Charitable fund totalled £960k • Donations totalling £124k had been received by the Charity up to 31 August 2022. • Total fundraising income up to 31 August 2022 was £160k. £88k expenditure had been incurred up to 31 August 2022.