The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 8 June 2023 at 09.30 – 12.20
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	15
09.35	**Staff story: Neurodiversity – through the eyes of a staff member and their manager**				
02 Chair and Chief Executive's reports					
10.00	2.1	Chair's report	Inform	Chair	17
10.05	2.2	CEO report	Inform	Chief executive	22
03 Risk					
10.20	3.1	Significant risk register	Review	Chief nurse	31
10.30	3.2	Board assurance framework 2023-24 *Diligent Resources: BAF 23/24*	Review/ Approve	Head of corporate affairs	37
04 Patients					
10.35	4.1	Report from Quality and Safety Committee 26.05.23: • Part I • Part II – Maternity Oversight • QSC Terms of Reference 2023/24	Assure Approve	Committee Chairs	 40 46 48
10.45	4.2	Maternity: • SI report • Maternity Incentive Scheme	Assure	Chief nurse/ Interim Director of midwifery	55 Verbal
11.00	BREAK 1100-1110				
11.10	4.3	Nursing, midwifery and care staff levels including nurse recruitment	Assure	Chief nurse	59
11.20	4.4	Learning from deaths (Mortality)	Assure	Chief Executive	65
11.30	4.5	Electronic Health Record	Assure	Chief Information Officer	72
05 People					
11.35	5.1	Report from People Committee 01.06.23	Assure	Committee Chair	75

06 Performance/pounds					
11.40	6.1	Report from Performance and Finance Committee 25.05.23	Assure	Chair of Committee	78
11.45	6.2	Finance update	Assure	Director of finance	83
11.55	6.3	Integrated performance report	Discuss	Chief Information Officer	92
07 Strategy/Governance					
12.05	7.1	Report from Strategic Transformation Committee 22.05.23	Assure	Chair of Committee	103
12.10	7.2	Report from Audit Committee 23.05.23	Assure	Chair of Committee	107
12.15	7.3	Report from Senior Management Team Meetings held in May 2023	Assure	Chair of Committee	110
08 Questions from the public					
	8.1	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
09 Closing administration					
	9.1	Any unresolved issues			
	9.2	Review of Board Charter			
	9.3	Summary of actions and decisions	-	Chair/All	
	9.4	New risks and issues Identified	Discuss	All	
	9.5	Any other business	Review	All	
	9.6	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	
12.20		Close			

Date of next meeting: 5th October 2023

The Princess Alexandra Hospital NHS Trust

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

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

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Trust Board Meeting in Public at Kao Park
Thursday 6 April 2023 from 09:30 to 13:00

Present:	
Hattie Llewelyn-Davis	Trust Chair (TC)
Liz Baker (non-voting)	Associate Non-Executive Director (ANED-LB)
Darshana Bawa	Non-Executive Director (NED-DB)
Tom Burton	Director of Finance (DoF)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Rob Gerlis (non-voting)	Associate Non-Executive Director (ANED-RG)
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	Chief Nurse (CN)
Michael Meredith (non-voting)	Director of Strategy (DoS)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)
In attendance:	
Helen Glenister	Non-Executive Director (NED-HG) (previous)
Jo Keable	Interim Director of Midwifery
Shaheen Hosany	Head of Nursing - Surgery
Laura Warren	Associate Director – Communications (AD-C)
Staff Story:	
Shahid Sardar	Associate Director – Patient Engagement
Frankie Arnone	
Members of the Public	
Ann Nutt	Chair of Patient Panel
Kerry Murphy	Pfizer
Apologies:	
Fay Gilder	Medical Director (MD)
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.
1.1 Apologies	
1.2	Apologies were noted as above.
1.2 Declarations of Interest	
1.3	No declarations of interest were made.
1.3 Minutes of Previous Meeting	
1.4	These were agreed as a true and accurate record of the meeting held on 02.02.23 with no amendments.
1.4 Matters Arising and Action Log	
1.5	There were no matters arising and the action log was noted.
Patient Story: E-Consent – the positive impact of technology on patient experience	
1.6	This item was presented by the Chief Information Officer (CIO). He informed members the story that month centred on a patient who would describe her experience of an elective procedure at the Trust using *electronic two stage consent* and the benefits as she saw them. The story was in the form of a recorded interview and had been prepared by the Chief

	Clinical Information Officer (CCIO) who could not be present that day (due to a busy endoscopy list). There was support therefore from the ICT Project Manager (ICT-PM), CIO and Associate Director of Patient Engagement.
1.7	By way of background/context the CIO informed members that Concentric was an electronic consent solution that allowed the digitisation of paper consent forms, enabling patients to digitally consent not only in the hospital setting but also at home. Patients could receive personalised information about their procedure in advance and prepare for a more informed discussion with their clinician.
1.8	By way of a recorded interview Patient GL then took members through her experience of using e-consent in relation to a stoma operation. The key benefits as she perceived them were: • Following a face-to-face discussion with her clinician, the details of her operation had arrived electronically on her mobile telephone two days later – therefore no delays/no postal issues. • She had been able to take time to read the detail at home (including possible life changing implications) and to share those with family members who would be tasked with her care post-operatively. • The information had provided additional links to further information where even more detail could be accessed. • Because all the information had been in electronic format she had been able to use it as a reference post-operatively to keep a check on her recovery and be assured that things were progressing normally.
1.9	From the CCIO's perspective clinicians spoke to patients in clinic before their operation but often surgery could be life changing and elements could not always be picked up by a quick discussion in clinic or in the few brief moments before entering the operating theatre.
1.10	E-consent certainly reduced clinic time, patient anxieties, length of stay and nursing time (hands-on or by telephone). Personally she would be continuing to use e-consent and would be encouraging other staff to use it too.
1.11	As a final point the CCIO informed members that the next step would be to use e-consent for cancer patients/chemotherapy and patient GL's experience would energise her going forward.
1.12	In closing the CIO thanked colleagues for their participation in the recording and was pleased to report that the rating for e-consent from 2k patients so far was 4.8/5 and the system was now being used in all surgical specialties (including day case, minor ops' and main theatres).
1.14	In response to the above Associate Non-Executive Director Rob Gerlis (ANED-RG) asked how, without face-to-face consent, patients could raise any questions/concerns they had. In response the ICT-PM confirmed there was always the opportunity for the patient to telephone their clinician or to make an additional appointment by telephone. The email the patient received with the consent detail included a contact telephone number for all queries. Processes had been tried and tested and were working for patients.
1.15	The Director of Finance (DoF) then asked how the electronic process would work for that cohort of the patient population who were less IT literate. In response the CIO informed colleagues it was never assumed that one process worked for all - a paper option still remained.
1.16	NED George Wood (NED-GW) thanked colleagues for a very informative presentation and asked at what point, given local health inequalities, money would be invested in terms of providing electronic devices for patients. In response the CIO confirmed there had been some conversations already around that in West Essex and he agreed there were some real opportunities now to support patients in the community. NED-GW responded that another benefit would be in terms of cancer follow-ups and reducing the need for patients to attend tertiary centres in London or further afield. The CIO confirmed that cancer would be the next phase of the work.
1.17	Associate NED Anne Wafula-Strike (ANED-AWS) agreed with the comments made by NED-GW and the opportunities to support patients particularly given 26% of adults in the local population had no qualifications. The CIO agreed the organisation (as an anchor institution)

	had a responsibility to do that to enable them to interact with their healthcare record and a conversation was already underway with the voluntary sector on how to do more.
1.18	NED Helen Howe (NED-HH) also agreed with the comments above in relation to the patient population and suggested having more facilities in the community where people could drop-in and have access to electronic devices. NED Helen Glenister (NED-HG) commented it was also about system working but agreed it required some further discussion.
1.19	At this point the Chief Nurse (CN) asked whether there were plans for one application to be available. In response the CIO confirmed there was a high level plan currently but it would require some significant work to pull all portals into one app'.
1.20	The Chair of the Patient Panel (CoPP) cited an example of those who couldn't read or those for whom English was not their first language. In response the ICT-PM confirmed that a translator could be used and their details added to the form. Text-to-talk technology could also be used.
1.21	In response to the above the CEO commented that the main focus was trying to get away from a clinician/patient conversation on the day of surgery. However, an operation would never be carried out without consent and there would always be some form of back-up to consent and ensuring a conversation with a patient prior to their procedure.
1.22	The TC thanked all those involved in the patient story.
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	The TC introduced her report and the paper was taken as read. She highlighted the importance of the NEDs' visits to various areas of the organisation particularly in terms of staff welcome and resilience.
2.2	Since writing the paper she was pleased to update that her appraisal had been undertaken by NED-GW (which would now feed into the CEO appraisal) and four objectives had been agreed for the coming year which she would share in writing with colleagues. (They were: improving performance and external ratings, strong and influential role in the ICS, developing roles with the Executive and leadership team and investigating ways to increase the input from people with protected characteristics).
2.3	As indicated in the paper she was sad to see the departure of NED-HG and expressed her sincere thanks to NED-HG for her service on the Board. Her replacement, Kim Handel, would start her induction on return from leave in the middle of April.
2.2 CEO's Report	
2.4	The CEO presented his update and the paper was taken as read. Updates were provided on key areas as below.
2.5	CQC inspection of Urgent and Emergency Care services He reminded Board members that the Trust had written formally to Care Quality Commission (CQC) colleagues in the autumn, asking them to consider removing the Section 31 improvement notice on Urgent and Emergency Care services, as a result of the changes and developments that had been put in place. The organisation had been working closely with CQC colleagues since the notice was issued, providing regular information and data to show and track progress against the actions aligned to improvement against the four concerns. CQC colleagues had welcomed the Trust's request.
2.6	The CEO continued that on 29.03.23 five inspectors had attended the ED as part of a focussed inspection aligned to the Section 31 notice. The inspection team had provided verbal feedback during the evening of 29.03.23 outlining that: • They could feel the positive difference in the department and see the difference. • Great improvements had been made in relation to the management of Mental Health patients. • Having an RMN on shift and mitigating mental health risks were gold standard practice. • The Manchester triage tool was in place, well embedded and working well. • There was evidence of good collaborative team working.

	• Screening assessments were good. • Risk assessments, post screening, were not completed robustly and consistently. • Some observations were not undertaken consistently in line with Trust policy. • Some observations were not acted upon. • The RAT process was good but was taking too long, causing some delays to patients. • The Trust should look to stream pre-triage to reduce waiting times for initial assessment. • A lack of PGDs in triage was causing some unnecessary delays.
2.7	The department had been two nurses down on shift which would have caused some pressures although the CQC had recognised that colleagues were moved around the department to address the acuity pressures. CQC colleagues had not raised any immediate concerns and that was repeated in the letter that they had then sent post inspection on the evening of 30.03.23.
2.8	The CEO continued that the CQC had requested additional information and would then undertake Well-Led interviews with a select group of UEC colleagues.
2.9	The Chief Nurse (CN) then continued there had been 18 RNs on shift that day in the ED so compliance for the day was 89%. The organisation had been reporting staffing numbers in the Hard Truths paper to People Committee/Board. Redeployments were tracked in line with the Trust's Safer Staffing Policy.
2.10	Most pleasing for the CN had been the shift in culture that had been seen in the department. She acknowledged there was still work to do on overarching risk assessments and part of the governance arrangement around the notice was that Executive colleagues met with the division to go through their datasets. The organisation recognised it was not where it needed to be in terms of its data sets but in September 2021 30% of patients had ongoing risk assessments and in the latest data set that was now 88% - a significant improvement on August 2021.
2.11	In response to the above the COO noted that she had met with UEC colleagues the previous day and had learned that staff had been pleased with the initial feedback. She emphasised the department had not been built for the number of attendances it was now seeing and streaming away from the department remained a critical part of the work so that as many patients as possible were seen in a different setting where appropriate.
2.12	In response to points raised by the TC and NED-HH in relation to CQC's concerns around the speed of the RAT process, the COO confirmed that had been because of the volume of patients arriving by the hour.
2.13	At this point NED Helen Glenister (NED-HG) commented that improvement was being seen in terms of risk assessments but asked whether technology would be able to support improvements in observations particularly in terms of alerts for time breaches. In response the CIO confirmed that Nervecentre would be integrated into the new EHR.
2.14	Strategic Objectives 2023/24 and Appraisals The CEO informed members this section was to reaffirm the strategic objectives for the year ahead which continued to be based around the organisation's 5Ps. Every year there were slight tweaks to the statements and that year was no different with small changes made to ensure health inequalities were included and the results of the Staff Survey. There was a healthcare partnership element too.
2.15	The new appraisal process as part of *This is Me at PAHT* had started with the annual appraisal of the Chair and continued with the CEO appraisal and all Executive Director colleagues' appraisals over the next three weeks. The cascade of all appraisals and personal objective setting across the Trust would be completed by the end of September 2023 for all colleagues.
2.16	In response to the above NED-HH flagged that EHR had not been mentioned in the objectives The CEO responded by stating that EHR underpinned all the 5Ps as an enabler to the organisation being able to deliver against each of its objectives.
2.17	The Board approved the minor changes to the organisation's strategic objectives for 2023/24.
2.18	Junior Doctor Industrial Action

	The CEO informed colleagues that on 23.03.23 formal notification had been received of a further 96 hours of industrial action from junior doctors, in the form of a full stoppage of work, running from 7.00am on 11.04.23 until 7.00am on 15.04.23. The impact of that straight after the Easter Bank Holidays was likely to be more disruptive in terms of the planning and preparation, the cancellation and postponement of activity and the potential patient safety risk caused.
2.19	The COO was able to provide assurance that the usual incident management structures were already in place to manage patient safety over the duration of the strike.
2.20	The TC thanked all staff involved for their support over the strike periods and it was noted there had been no safety incidents during the industrial action period in March.
2.21	NHS Provider Licence / PAHT Establishment Order The CEO updated colleagues that on 27.03.23 NHS England (NHSE) had launched the new NHS provider licence, together with their response to the recent provider licence consultation. The new provider licence for PAHT aimed to 1) support effective system working 2) enhance the oversight of key services provided by the independent sector 3) address climate change and 4) makes a number of necessary technical amendments. Compliance against the licence conditions would be reported to Audit Committee and Board annually.
2.22	Other headlines • **Establishment Order:** The CEO confirmed that the request for a change to the organisation's Establishment Order had been agreed by ministers for health, signed by the SoS for Health and Social Care and published on 23.03.23. • **Hewitt Review:** The Hewitt review, set up to consider the oversight and governance of Integrated Care Systems and Boards, had been completed. . • **Equality, Diversity and Inclusion (EDI) Improvement Plan / NHS Long Term Workforce Plan:** These were still awaiting publication but would include additional high impact actions in the EDI Improvement Plan which would be welcomed and aligned with the Trust's conversations on EDI. • **New Hospital Programme:** A national announcement had been expected for some time on the timing and funding of the Reinforced Autoclaved Aerated Concrete (RAAC) and Cohort 3 organisations that were part of the New Hospital Programme (NHP). It was disappointing this had not happened in March as expected, and it now looked likely that any formal announcement would not be made before early May 2023. • **Local/National Staff Survey Results:** These had now been published and would be discussed at the private session later.
2.23	The TC thanked the CEO for his update.
03 RISK/STRATEGY	
3.1 Significant Risk Register (SRR)	
3.1	This update was presented by the CN (on behalf of the Medical Director). She was pleased to report that the overall number of significant risks on the register has reduced from 73 to 68 Two new risks scoring 16 had been raised since the previous report and were 1) People: Neurology medical workforce and 2) Performance: Neurology appointments. She continued there were currently ten risks with a score of 20, three of which were new/increased. One of the three related to Pharmacy staffing and that the team would be unable to provide a robust service all wards due to staffing vacancies and a lower budget against the national average which was impacting on retention.
3.2	In terms of the Neurology risks referenced above, NED-DB asked for some additional detail. In response the COO informed members that Neurology was a fragile service where the organisation struggled to recruit. Colleagues had been looking at how to use virtual capacity to make posts more attractive and what opportunities there were across the ICS because all three acutes struggled with that service. Some additional capacity could be released by reviewing job plans but this was still work in progress. The DoQI added this area featured in the PQP programme in terms of modernisation to gain efficiencies.
3.3	In relation to the risks around Pharmacy, NED-HH asked whether there might be opportunities for individuals to work at home to review prescriptions which may be attractive

	to colleagues who had previously retired. In response the CN stated that she was unsure of the detail but did know the team was looking at options for a more sustainable workforce.
3.4	The TC thanked the CN for her update.
3.2 Board Assurance Framework (BAF) 2022/23	
3.5	This update was provided by the Head of Corporate Affairs (HoCA). She informed members it was proposed to reduce the risk score for BAF risk 1.0 COVID from 12 to 8. The risk would then be removed from the BAF as it had achieved its target risk score. The CN was the Executive lead for that risk and Quality and Safety Committee had reviewed the risk and supported the reduction in risk score. The remaining risk scores had not changed that month.
3.6	Members had no comments/questions. In line with the recommendation the Board approved the reduction in the risk score for BAF risk 1.0 (COVID) and noted the updates to the remaining risks.
04 PATIENTS	
4.1 Reports from Quality & Safety Committee (QSC)	
4.1	QSC.31.03.23 – Chair: NED Helen Glenister (NED-HG) NED-HG updated that some concerns around data for antibiotic usage had been raised and would now be investigated by the team because this did not align with the relatively low numbers of case of Clostridium-difficile. Some detail around the wearing of masks was provided in the report and QSC had agreed there needed to be a renewed focus on the communications to both staff and patients around that. In relation to mortality, issues with the data continued and a deep dive into coders was requested (to be undertaken by the People Committee). The six monthly report on Research & Development was hugely positive (as ever) and she encouraged Board colleagues to read that paper in its entirety. In terms of the Quality Improvement Programme it had been pleasing to note that one of the red-rated projects had now moved to amber and the deep dive requested into current amber projects had been reassuring in terms of the progress made. In relation to the Quality Account QSC had noted the proposed timetable for 2022/23 Quality Account and that it was recommended QSC receive the final version for approval and Audit Committee received an update. NED-GW as Chair of Audit Committee was content with this suggestion. The Board granted delegated authority to QSC to approve the Quality Account
4.2	QSC2.31.03.23 (Maternity Oversight) – Chair: Associate NED Rob Gerlis (ANED-RG) ANED-RG updated that in terms of the maternity dashboard, the red rated KPIs were discussed and it was agreed that the recovery trajectory for 'continuity of carer' would be presented to the next meeting. Labour Ward staffing was improving and the recruitment pipeline for midwives was commended. The Committee received a presentation on the engagement of short-term locums in maternity care and was assured around the processes as well as compliance with safeguarding training requirements. There had been one new maternity incident declared in-month and currently eight SIs were under investigation (0 with HSIB). The actions taken in response to the issues surrounding Entonox were noted. Entonox was now available in two rooms in the birth centre and provision in the Labour Ward had improved. The permanent solution was also in progress.
4.3	In response to the above the CN flagged that whilst it was recognised that targets in relation to 'continuity of carer' had been paused by NHSE, she had requested the team focus on reinstating a trajectory for that marker for high risk groups.
4.2 Maternity Updates	
4.4	Maternity Annual Report This update was presented by the CN. The paper was a review of the period February 2022 to February 2023 since the inception of Quality & Safety Committee (Part II Maternity Oversight). It included areas where the Committee had requested deep dives and feedback on peer reviews and updates on status against national priorities and action plans. The service remained under the Maternity Safety & Support Programme but colleagues were currently establishing a sustainability plan with the view to coming off that programme in

	coming months. The report was a good news story for the service and its future direction of travel.
4.5	In response to the above NED-GW highlighted that he didn't fully understand the detail around PAWeb114439. The CN agreed to discuss that further with him (in conjunction with the Interim Director of Midwifery - IDoM) outside the meeting. ***Post Meeting Note:*** NED-GW's query was discussed and answered during the meeting break.
4.6	In response to the above the TC thanked the SM for the update and requested the IDoM feed-back the Board's thanks to the whole team.
4.7	Maternity Serious Incident (SI) Report The CN updated that the paper had been discussed fully at Committee but she drew members' attention to the SI declared in month which was a never event.
4.8	The TC thanked the CN for her update and confirmed the Board noted the never event.
4.9	As a final point and in response to a question from ANED-RG, the CN was pleased to confirm that an appointment had been made to the post of Director of Midwifery (DoM) and her thanks went to the IDoM for picking up that role in the interim.
Break 1102 - 1112	
4.3 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
4.10	The CN took the report as read and highlighted that the overall fill rate for February had been 92.5% with RN fill rate increasing by 1.8% to 87.6% and care staff fill rates decreasing by 0.1% to 107.2%. The report included the fill rate for Critical Care for the first time and this would be a regular inclusion to meet NQB requirements in terms of reporting on Trust-wide nursing fill rates. As a final point it was noted that the ED fill rate had increased in February although day fill remained low at 76.5%.
4.11	At this point NED-HH acknowledged the work undertaken by the outgoing Deputy CN on this paper and that her retirement would be a great loss to the organisation. The CN agreed and expressed her thanks to Sarah Webb, Deputy Chief Nurse.
4.12	In response to the report ANED-RG highlighted that whilst the position was positive, it would need to be sustainable and link in to housing needs and celebrating the town as a great place to work. The CN acknowledged the point and added that to bring nursing vacancies down to 1%-2% by the end of March 2024 would require the organisation to recruit another 160 international nurses so there was still a significant amount of recruitment to be done.
4.13	The Board was assured in regard to the provision of safer nurse and midwifery staffing and that processes were in place for continuously managing and monitoring staffing levels.
4.4 Learning from Deaths (Mortality)	
4.14	In the absence that day of the Medical Director, this update was presented by the CEO. He immediately drew members' attention to figure 1/p3 which described the rise to 'above expected' for HSMR for May, June, July and August, with a reduction in September and back down to 'as expected' in October.
4.15	It was believed this was due to the challenge that the organisation had had with its data submission and he drew colleagues' attention to figure 2. He highlighted the number of residual codes (uncoded spells) For the months mentioned above, between 16%-25% of hospital spells at PAHT were not coded.
4.16	The CEO continued that coding teams nationally were challenged in terms of staffing. The Trust had contracted some additional coders and the backlog had now been addressed but it was too late for the data to be reflected until the national refresh in May 2023.
4.17	In section five of the report members could see the ongoing process around structured judgement reviews (SJRs) albeit there was currently a small backlog - the MD had appointed to the role of Associate Medical Director for Mortality. Section six evidenced that the Medical Examiner process continued to work well in terms of scrutinising deaths and providing learning for the future.

4.18	In summary there were no undue concerns about the position which related to incomplete coding however the organisation continued to review the notes for those diagnostic groups where it was an outlier.
4.19	In response to the above NED-HH suggested It would be useful t to have a footnote to the graphs which reminded colleagues there had been a denominator issue and it would take until July/August to see the true position. The CEO agreed that was a good suggestion.
4.20	The TC thanked the CEO for his update and noted the request for the deep dive into Coding team requirements.
05 PEOPLE	
5.1 Report from People Committee (PC)	
5.1	PC.27.03.23 – Chair: NED Helen Howe (NED-HH) In terms of the People Report it was noted that non-direct engagement booking was no longer permitted which had led to an increase in temporary staffing but overall this was a positive change. The Committee had been assured on progress being made in relation to the GMC enhanced monitoring process. The HEE Engagement for Surgery Visit in January 2023 had been postponed due to the junior doctor strike and the Medical Workforce Review and Multi-professional Educational review had been commissioned. The Committee had supported the approach to re-band Band 2 HCSW posts to Band 3 where the current job description met the Band 3 profile and had agreed that other staff groups should now be reviewed. The Committee had been assured in regards to the current level 3 safeguarding training position and the steps being taken to improve training compliance. It was noted there was to be an expected 20-30% increase in compliance at the next reporting period. The Health & Wellbeing Strategy would be presented to the Committee in May.
5.2 Gender Pay Gap	
5.2	This update was presented by the Director of People (DoP) who reminded colleagues that gender pay gap reporting legislation was distinct from equal pay. Equal pay was concerned with men and women earning equal pay for the same or similar work whereas the gender pay gap was about the difference between the average pay for men and women within an organisation. Key headlines were: • The gender pay gap as at 31.03.23 reported men had higher mean and median average pay than women. • The difference between mean pay of men and women was 24% and that of median average pay was 16%. • Whilst medical and dental staff were separated from agenda for change staff and very senior managers, the mean gap was that women earned 1% less than men and the median gap was in favour for women earning 5% more than men. • The medical and dental mean and median pay gap was 10% and 15% in favour of men.
ACTION **TB1.06.04.23/01**	**Consideration to be given to the mentoring of female colleagues.** **Lead: Director of People**
5.3	In response to a question from NED-HH in terms of how the Trust compared with others in terms of the gap, the DoP confirmed it was in line with others. In most NHS organisations the gap was coming down but was still sizeable. In response to a further question it was confirmed provision was made within the organisation for childcare and the DoP agreed to clarify the implication of the recent budget on that provision.
ACTION **TB1.06.04.23/02**	**Clarify the impact of the recent budget on childcare provision for staff.** **Lead: Director of People**
5.4	The TC thanked the DoP for her update, noting the action in terms of mentoring/coaching.
5.3 Staff Survey Results	
5.5	This item was presented by the DoP who informed members that the staff survey results were sobering and it had been difficult to recognise that many people in the organisation were not having the experience they should be having, which had an impact on patient care.

	She as an individual, and the Executive team, were committed to hearing the voices of staff but more importantly to acting on what they were saying.
5.6	The DoP briefed members on the three sections in the paper: 1) The results, split into categories 2) How the results had been shared and 3) What action was being taken. Information was provided on how the results compared to the previous year and also provided benchmarking data for the three previous years against other acute trusts.
5.7	In response to the above NED-HH highlighted that the culture dashboard would be a key indicator going forward in terms of progress against actions. She acknowledged it could take years to shift culture but the organisation would need to keep on challenging itself as to whether or not it was doing the right things to get results/improvements. The DoP agreed and added there was disparity of experience between departments so the data must be used to track where those poorer experiences were.
5.8	NED-GW commented that his concerns were around the impact of the results on recruitment and retention and the budget for the coming year (based on recruitment rates). His suggestion would be to focus on exit interviews to pick up any themes. The DoP acknowledged the comment and confirmed work was underway (reporting via the PC) around gaining traction on recruitment in order to have a pipeline of people locally. The new on-boarding process had been well received and the focus now should move towards career opportunities and development.
5.9	In response to a question from ANED-AWS in relation to appraisals, the DoP was able to provide assurance that the whole process had been redesigned with a more structured framework in place including deadlines and regular 'check-ins'. She recognised that staff experience was directly impacted by relationships with line managers.
5.10	At this point NED-DB flagged the data for international nurses was skewing the picture and her suggestion would be to delve deeper into that and into different cohorts of staff. The CN agreed but commented this had been done the previous year but it was challenging because only a third of staff were responding and there was no correlation between a bad experience and 'non-white' staff. For nursing and midwifery colleagues who identified as black, what was evident was their concerns around insufficient staff numbers but that didn't correlate with recent investments (£3m over last three years) into the nursing workforce and the reduction in falls an pressure ulcers.
5.11	ANED-LB commended colleagues on the work around development and leadership but was concerned to note a rising trend in staff being witness to errors. In response the DoP commented the desire was for staff to feel able to speak up and report incidents but she had seen no triangulation in terms of increased Datix reports or references in the Freedom to Speak Up Guardian reports. The CN agreed and that the data was reported up to QSC and she could confirm there was no increasing trends in terms of harms.
5.12	The DoP summarised that she was confident the organisation was doing the right things to address what its people were saying; it was heart-breaking to hear some of the experiences that staff were highlighting.
5.13	The TC then summarised that colleagues felt saddened by the results but recognised the data needed to be better understood and made relevant to individual areas. Progress would be slow but the organisation was committed to listening to its people and making change.
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee (PAF)	
6.1	This item was presented by the DoF. Members had no comments/questions.
6.2 Finance Update	
6.2	The DoF informed members that that Trust had reported a deficit of £0.7m in month and £15.9m YTD. The Trust's FY deficit forecast had improved to £12.7m, the £1.5m movement reflected an ICS income reallocation for Mental Health and Community support recognising the winter pressures and bed capacity challenges through the delayed discharging of patients.

6.3 M11Integrated Performance Report (IPR)	
6.3	This item was presented by the CIO who informed members the full report had also been shared at QSC/PAF. Most areas were static that month. There were some improving KPIs around sickness, appraisal and voluntary turnover. He informed members that from the following month the report would start to change in line with discussions at the recent Board development session and would be more timely in terms of meeting packs.
6.4	At this point the COO commended operational/clinical colleagues in terms of patients waiting of 78 weeks. In September 2022 there had been 2685 patients waiting and as of that day there were 15 all with plans for treatment in April. Despite huge pressures colleagues had worked exceptionally hard and the focus would now turn to those waiting over 64 weeks.
6.5	In response to a request from NED-GW it was agreed to send an acknowledgement of thanks to those teams.
ACTION TB1.06.04.23/03	**Board thanks to be sent to operational/clinical teams for their work in relation to 78 week waits. Lead: Head of Corporate Affairs**
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee (STC)	
7.1	ANED-LB (as STC chair) informed members that it had been agreed that going forward the agenda for the meetings would be divided into two. The first session would address core agenda items and the second would be an opportunity for a more in-depth/detailed discussion on a pre-agreed topic with the chance to invite external stakeholders/partners/subject matter experts to speak.
7.2	In response to the above NED-HH asked whether other NEDs could listen in to part 2 of the meeting. ANED-LB responded she would very much welcome that.
7.2 Report from Senior Management Team (SMT)	
7.3	The CEO presented this paper and members noted the key items discussed at March meetings. There were no items to escalate and members had no comments.
7.3 Report from Audit Committee (AC)	
7.4	As Chair of AC, NED-GW informed colleagues that in terms of external audit, the Committee had noted the audit plan for 22/23 and in particular that a higher level of planned materiality had been reported following a review of the audit approach (2.5%). It was highlighted a successful interim audit had been completed and the value for money risk assessment would be presented to the May Audit Committee.
7.4 Corporate Trustee: Report from Charitable Funds Committee (CFC)	
7.5	This item was presented ANED John Keddie (ANED-JK) as Chair of CFC. The paper was taken as read with only one item to escalate, namely that the recent appointment to Head of Charity role had been declined so that role was now back out to advert.
08 QUESTIONS FROM THE PUBLIC	
8.1	There were no questions from the public.
09 CLOSING ADMINISTRATION	
9.1 Any Unresolved Issues?	
9.1	It was agreed there had been some unresolved issues but those could not be concluded at the Board.
9.2 Review of Board Charter	
9.2	It was noted that work was underway to provide a printed version of the charter. Members agreed it had been a good meeting which had displayed behaviours the Board had committed to.
9.3 Summary of Actions and Decisions	

9.3	These are noted in the shaded boxes above.
9.4 New Issues/Risks	
9.4	There were no risks. Industrial action was an ongoing risk.
9.4 Any Other Business (AOB)	
9.5	The CEO was pleased to report that the Imaging team had been shortlisted for two awards for their work around AI. The CIO had been shortlisted for HSJ's Digital Leader of the Year and the Communications team had also been shortlisted for a couple of awards.
9.6	The CN requested her personal thanks be noted to her Deputy (Sarah Webb) who would be retiring at the end of the month. Her support had been instrumental in terms of strengthening governance and the establishment and she had had a significant impact during her time with the organisation. It was agreed the Board would extend their thanks too.
ACTION **TB1.06.04.23/04**	**Board thanks to be sent to Deputy Chief Nurse.** **Lead: Head of Corporate Affairs**
9.5 Reflections on Meeting	
9.7	The TC reflected there had been some big items to discuss but she felt those had been afforded appropriate time.
9.8	The TC and CN both then offered their personal thanks to NED-HG on her departure from the organisation. She had been seen as the backbone of the Board and instrumental as Chair of QSC and in her role as Maternity and Neonatal Safety Champion. She had always been supportive to colleagues, offered professional curiosity and respectful challenge and her work and passion had moved the patient agenda forward significantly. Her approach, style and camaraderie would be very much missed.
9.9	NED-GW echoed the sentiments above and added that NED-HG had provided some stabilisation during COVID and regulatory inspections, always put patients/people ahead of paper and his view would be the organisation was now in a much safer place as a result of her dedication and hard work.
9.10	In response NED-HG thanked colleagues for their very kind words. Her reason for joining the organisation had been a focus on supporting to make improvements when her local hospital had been placed in special measures and after being struck by how kind, helpful and confident staff were during a visit. She had been part of three CQC inspections and improvements were now evident in the organisation and she had had the pleasure of working with wonderful colleagues over the duration of her appointment. As a local resident she wished the Board/organisation well for the future.

Signed as a correct record of the meeting:	
Date:	08.06.23
Signature:	
Name:	Hattie Llewelyn-Davies
Title:	Trust Chair

ACTION LOG: Trust Board (Public) 08.06.23

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.06.04.23/01	Gender Pay Gap report/Mentoring	Consideration to be given to the mentoring of female colleagues.	DoP	TB2.08.06.23	To be added to the Gender Pay Gap report (that female VSMs are coaching and mentoring female colleagues) and republished on the Trust's website.	Proposed for closure
TB1.06.04.23/02	Budget: Childcare Provision	Clarify the impact of the recent budget on childcare provision for staff.	DoP	TB2.08.06.23	Highlights from the Spring Budget on childcare (also reported to PC in March) were: Childcare was a central focus of the Budget. The government has announced a number of measures to help with the cost of childcare, including: • Providing 30 hours a week of free childcare for 38 weeks a year, for eligible working parents of children aged 9 months to 3 years. • Uplifting the hourly funding rate paid to providers to deliver the existing free hours offered in England; • Providing free childcare for eligible working parents of children from 9 months until they start school. • Launching a wraparound pathfinder scheme to support the expansion of school-based childcare provision either side of the school day; • Support for childcare costs in Universal Credit will be made available upfront and the	Proposed for closure

ACTION LOG: Trust Board (Public) 08.06.23

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
					maximum potential benefit for parents will be increased.	
TB1.06.04.23/03	Board Thanks	Board thanks to be sent to operational/clinical teams for their work in relation to 78 week waits.	B&CS	TB2.08.06.23	Actioned.	Closed
TB1.06.04.23/04	Board Thanks	Board thanks to be sent to Deputy Chief Nurse.	B&CS	TB2.08.06.23	Actioned.	Closed

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors – 8 June 2023

Agenda item:	2.1							
Presented by:	Hattie Llewelyn-Davies							
Prepared by:	Hattie Llewelyn-Davies							
Date prepared:	30th May 2023							
Subject / title:	Chair's Report							
Purpose:	**Approval**		**Decision**		**Information**	X	**Assurance**	
Key issues:	To inform the Board about my work; to increase knowledge of the role; to evidence accountability for what I do as Chair of the Trust.							
Recommendation:	The Board is asked to note the report.							

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

Previously considered by:	Not applicable
Risk / links with the BAF:	Not applicable.
Legislation, regulatory, equality, diversity and dignity implications:	As the NED EDI Champion this continues to guide my work in all the areas noted below.
Appendices:	Walkabout action plan

1.0 Purpose/issue

This report outlines what is at the top of my agenda and what I have been doing in the last few months.

The aim of the report is to make my role as Chair more accountable to my colleagues and more transparent for our partners and local population.

2.0 Succession Planning and Board Development:

Very sadly John Keddie is due to step down from the board at the end of June and he will be missed. John has an enormous commitment to Harlow and it is really good to have the news that PAHT is to have the funding for the new hospital before he steps down.

John has been a great board member, always willing to challenge NHS thinking and our assumptions of the right way to do things. He has helped the Trust to be clear about what it is committed to doing and ensured that everything has been thought through properly. He has also done a great job in chairing the Trust's charity committee and helping to get that on a sound financial footing. John will be missed by us all. We are in the process of recruiting a new associate director to fill the gap John leaves at the moment.

We have continued with the work of developing our governance and the skills of the board. It has been time for all the NEDs to have their annual appraisal and for the committees to review their effectiveness.

3.0 External Work:

I am currently mentoring two NHS chairs, one who is in an acute in the Midlands, and one who is chairing two different Trusts in the South East. Both are as part of the new NHSE scheme providing mentors for newly appointed NEDs and Chairs.

My last meeting with NHS Providers is this month. I shall step down with sadness, since I have learnt a lot from my role. I am proud to report that my role chairing their finance committee means they are in better financial health than when I joined the board.

On a more local level in addition to the regular meetings of the ICB Chairs, we had our first system wide board conference for us all. It was great to meet colleagues from across the system and learn more about what each Trust is doing.

4.0 Staff Welfare and Resilience:

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

I have spent a fascinating half day shadowing in our ICU and our next NED visit is to Gibberd Ward.

5.0 Finally:

I cannot write this report without saying how proud I am of everyone at PAHT, the news that we have the funding for the new hospital and have had the conditions on our licence (Section 31) removed by the CQC all coming on one day has been incredible. Thank you to the PAHT teams, patients and members of our local community for your support and work to get us there.

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

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

Appendix 4: Chair's action matrix

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

Updated: June 23

Non-Executive Directors initials:		Others
HLD: Hattie Llewellyn-Davies (Chair) GW: George Wood (senior independent) HH: Helen Howe HG: Helen Glenister	DB: Darshana Bawa AWS: Anne Wafula-Strike (associate) JK: John Keddie (Associate) LB: Liz Baker (Associate) RG: Rob Gerlis (Associate)	PP: Patient Panel FtSUG: Freedom to Speak Up Guardian

Visit Date	Attendees	Venue	Feedback	Lead	Deadline	Action
17/05/2023	HLD, HH, DB	Dementia environments	Identification of dementia friendly environments as an issue	Corporate	06/23	CAG to share actions from the visit following discussion with PEG and PLACE results.
04/04/2023	HH, DB	Sterile services	Joined staff morning huddle, positive staff and morale, space an issue. Innovation supported.	SCC	NA	No action identified. Positive feedback and data being shared by sterile services team.
27/03/2023	GW, HG	St Margaret's Hospital	OPD and Birchwood House staff met, positive staff engagement. Estates issues noted.	CSS	05/23	Aging NHS PropCo Estate noted and escalated to internal teams for review. Open.
08/02/2023	HLD, HG, AN, PP, FtSUG	OPAL Unit	Exemplary system working practice. Staff and patient voices heard and acknowledged.	Medicine	NA	No actions identified other than positive feedback which has been provided to the teams. Closed.
21/11/2022	HLD, GW, HH, AWS	Pathology, Clinical Biochemist	Staff voices heard Highlighted some minor estates issues.	CSS	12/23	Issues reviewed and closed.
27/10/2022	GW, HLD, HH	Lister Ward, Dementia and delirium clinical nurse specialist	Staff and patient voices heard – patient at the heart, some excellent collaborative work observed	Medicine	NA	No actions identified. Positive feedback to the teams. Closed.

05/09/2022	HLD, GW, AWS, AN	Harvey Ward, Medical Matron	Staff and patient voices heard – collaborative engagement. Estate concerns identified and rectified	Medicine	02/23	Estate work on going as part of a longer-term plan. Closed.
28/07/2022	GW, CM, JK	Williams Day, Head of cancer nursing	Staff and patient voices heard – award from RCN recognised with the team.	CSS	NA	No actions required. Closed.
24/06/2022	HLD, DB	Pharmacy, Chief pharmacist	Staff voices heard and estates issues identified.	Pharmacy	NA	Estate work on going as part of a longer-term plan. Closed.
12/05/2022	HG, LB, JK, CM, AN	Mortuary, Mortuary manager	Staff voices heard and recognised the work that teams have been doing and the new environment.	CSS	NA	No actions required. Closed.
06/04/2022	HLD, HW, DB, AWS, AN	Maternity, Associate director of operations for FAWS (ADO)	Staff voices heard – identified areas for focus	CHAWS	05/22	The issue was resolved 05/22. Closed.
07/03/2022	HLD, HD, HH, AN	Eye Unit, Clinical manager	Staff and patient voices heard – estates areas for focus identified.	Surgery	05/22	Addressed by 15/05/22
21/02/2022	HLD, GW, AN	Children's ED, Dolphin, AD children and women services	Staff and children's voices heard- identified some really positive areas of practice and engagement	CHAWS	NA	No actions required. Closed.
10/12/2021	JH, DB, AN	Urgent care pathway, AD urgent and emergency care	Staff and patient voices heard – positive engagement with teams and collaborative working.	UEC	NA	No actions required. Closed.

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 8 June 2023

Agenda item:	2.2
Presented by:	Lance McCarthy - CEO
Prepared by:	Lance McCarthy - CEO
Date prepared:	1 June 2023
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: - CQC inspection of UEC - New Hospital full funding announcement - Junior doctors' industrial action - Other key headlines / developments for noting, including progress against PAHT 2030 priorities
Recommendation:	The Trust Board is asked to note the CEO report and the progress made on key items, particularly in relation to: – quality of care provision (CQC, trauma network, elective recovery) – delivery of our strategy, PAHT 2030 (new hospital, EHR, culture, transforming our care)

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:	– Regulatory – lifting of the Section 31 improvement notice from the CQC in relation to our provision of urgent and emergency care services – EDI – impact of the next junior doctors strike on our patients and the potential for a disproportionate impact on some of our patients – EDI – ongoing need to ensure that our recovery plans and our PQP plans are quality and equality impact assessed to prevent any unintended consequences or unequal impact on colleagues or patients – EDI – all the developments to our culture are underpinned by a proactive recognition of the need to ensure and to support EDI for all

Appendices:	– CQC letter, dated 25 May 2023

Chief Executive's Report
Trust Board: Part I – 8 June 2023

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

(1) CQC inspection of Urgent and Emergency Care services

The Board will recall that on 29 March 2023, 5 inspectors attended our ED as part of a focussed inspection aligned to the Section 31 improvement notice. This was followed up with a set of well-led interviews at the end of April.

I received formal notification on 25 May 2023 of the CQC's decision to remove the 4 conditions from our registration as a service provider in respect of a regulated activities for providing urgent and emergency care (UEC) services and to lift the Section 31 improvement notice. A copy of this letter is attached.

This is a great step forward for all of our population requiring UEC and is testament to the hard work and dedication of our ED and UEC teams and the quality improvements and changes they have implemented in the service over recent months.

I received the draft report from the inspection from CQC colleagues on 1 June, which is currently going through a process of factual accuracy checking. The final report will be published by CQC colleagues towards the end of the month, at which point we will circulate it and publish it on our website.

(2) New hospital full funding announcement

The Rt Hon Steve Barclay MP, SoS for Health and Social Care reconfirmed in the House of Commons on 25 May that full funding for our new hospital has been approved as part of major funding package for the New Hospital Programme (NHP) and the development of 40 new hospitals across the country, and will be built by 2030.

This is fantastic news for our population, our patients and our people and we can now push ahead with our plans to purchase the land for the new hospital and to finalise our business cases.

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

I'd like to express my personal thanks to the Rt Hon Robert Halfon MP for his tireless work and support for a new hospital, to Harlow Council, Epping Forest District Council and Essex County Council colleagues, HWE ICB colleagues and all provider colleagues across the ICS for their ongoing support and to all clinical and non-clinical colleagues who have been so influential to get us to this point.

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

The new hospital is a fundamental part of, and one of our 5 key priorities to deliver our strategy, PAHT 2030, and our vision of being Modern, Integrated and Outstanding. Together with the implementation of our Electronic Health Record, the digital and cultural transformations across the Trust and the

improvements in care and quality improvement initiatives in place, we are making strong progress to achieving our vision.

(3) Junior Doctors' Industrial Action

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

For Agenda for Change colleagues, agreements on 2022/23 backdated one-off payments and 2023/24 pay rises have been agreed between the government and unions and colleagues will receive these pay increases next month.

The doctors' unions remain in dispute with the government with regard to pay for doctors in training (junior doctors) and recently announced a 3rd set of dates for industrial action from 07.00 Wednesday 14 June to 07.00 Saturday 17 June.

As with the two previous sets of junior doctor industrial action, colleagues are planning and preparing meticulously for these three days, taking the learning from what worked well and what worked less well previously. It will lead to the cancellation and rebooking of many patients (possibly 2,000 appointments from across outpatients, diagnostics and planned care), the undertaking of different roles and different shifts from normal and the multi-disciplinary working across all areas to keep our patients safe.

We have had no patient safety concerns from previous periods of industrial action but there is increased risk of this during this period and we are particularly concerned about the impact this will have on our provision of cancer services and our ongoing elective recovery improvements.

We will continue to provide enhanced oversight and command and control incident management structures to minimise any impact on our patients from these other strikes, and we will continue to work in partnership with local and regional union representatives to minimise the risk to patients.

(4) Other key headlines / developments for noting

Other key items of note for the Trust Board include:

PAHT 2030 'Transforming our Care' priority:

- Colleagues from the Regional Trauma Network visited us on 26 May. The team were extremely positive about the changes we have made here to our trauma provision, noting improvements in every clinical indicator and identifying PAHT as being the 2nd best performing unit in the East of England Region. This indicates a genuine transformation in our service provision for our patients and I wanted to say a personal thank you to all colleagues involved in turning this round over the last few years.

- We continue to drive our Patient, Quality and Productivity (PQP) plans hard to support and underpin our drive towards PAHT 2030, the operating plan for 2023/24 and our financial efficiency requirements. These have been and will continue to be discussed in detail in the Performance and Finance Committee.

PAHT 2030 'Culture' priority

- In response to our most recent national staff survey, all department across the Trust have been undertaking a series of Feedback to Action events to talk through the local and Trustwide results with colleagues. Recognising that the experiences of colleagues is variable dependent on where in the organisation they work, local plans are being developed and implemented to address these variances in addition to ongoing Trustwide developments to support the experiences and health and wellbeing of all colleagues. Progress against these will be overseen by the People Committee.

- *'This is Us Week'* is back and starts in w/b 26 June. Aligned to our 5P strategic objectives, each day has a different theme as we support, recognise and celebrate our colleagues and their achievements over the last year. A range of guest speakers, informative and educational events, fun and competitive games and Long Service Awards and Our Amazing People Awards are planned throughout the week.

- Since we last met as a Board, we have launched our new *'This is Me System (TiMS)'* supporting colleagues with easy and straightforward oversight of their training needs and status and their appraisal information. The intuitive system is being well used and will facilitate training compliance and support the ongoing improvement in high quality appraisal conversations and individual development plans.

- Our Learning and OD team continue to introduce a range of new programmes to support colleagues in all professions across the Trust. Our new *Ready to Learn* and *Ready to Manage* programmes are becoming embedded and are receiving excellent feedback. Our *New Employee Forum* is coming up to its first anniversary and also continues to receive excellent feedback from all new starters and is shortly to be enhanced with a similar event for colleagues as their reach the end of the first 12 months working at PAHT. Our revised and updated *New Consultant Development Programme* is also about to be launched in the autumn to support all new consultants at PAHT, initially those who have joined over the last three years.

- June is Pride Month and we will be supporting and celebrating this across the Trust aligned with our drive to ensure equality, diversity and inclusion for all of our people and our patients.

Other

- Working closely with HWE ICB colleagues we have submitted a balanced financial plan for the system for 2023/24. Within this we have submitted a deficit plan of £5.1m for the current financial year.

- Many Board members attended the inaugural HWE System Partners Conference in Latton Bush on 24 May. It was a great opportunity to hear from Patricia Hewitt and her views on the development of ICSs and ICBs in light of her recent review; to hear from colleagues across the system about some of the transformation and joined up care that is happening and to develop ongoing relationships with community, voluntary, council and NHS colleagues.

- Recovery of our elective, diagnostic, cancer and planned activity continues well. Expectations, from the operating plan have been built into our business plan for the forthcoming year and the operational teams are working hard to ensure we can operationalise our plans at pace. More information on current performance is provided in the Integrated Performance Report.

- Our Annual General Meeting is scheduled for 6 July (12.00 – 14.00) at Kao Park. It will be an opportunity to look back on the achievements of 2022/23 and look forward to the year ahead. It would be fantastic to see as many members of the public and colleagues who can make it. Refreshments will be provided.

Author: **Lance McCarthy, Chief Executive**
Date: **1 June 2023**

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Telephone: 03000 616161
www.cqc.org.uk

The Princess Alexandra Hospital NHS Trust
Hamstel Road
Harlow
Essex
CM20 1QX

For the attention of the Chief executive.

25 May 2023

Care Quality Commission Health and Social Care Act 2008

Notice of decision to remove conditions from your registration as a service provider in respect of a regulated activities

Applicant: The Princess Alexandra Hospital NHS Trust

Regulated activities: Treatment of disease, disorder or injury

Our reference: RGP1-13538456796

Account number: RQWG0

Dear Lance,

We are serving this notice under Section 31 of the Health and Social Care Act 2008.

I am writing regarding our proposal to remove conditions from your registration as a service provider in respect of the above regulated activities.

We will remove the following conditions for the regulated activities stated above:

Urgent and emergency services:

1. The Registered Provider must ensure there are sufficient numbers of suitably qualified, skilled, competent and experienced nursing staff at all times to meet the needs of patients within all areas of the Emergency Department at the Princess Alexandra Hospital.

2. The Registered Provider must operate an effective system which will ensure that every patient attending the Emergency Department at the Princess

Alexandra Hospital has an initial assessment of their condition to enable staff to identify the most clinically urgent patients and to ensure they are triaged, assessed and appropriately streamlined.

3. The Registered Provider must devise a process and undertake a review of current and future patients clinical risk assessments, care planning and physiological observations, and ensure that the level of patients' needs are individualised, recorded and acted upon. This must include, but not limited to skin integrity, falls, and mental health assessments.

4. The registered provider must ensure that it implements an effective system with the aim of ensuring all patients who present to the emergency department at the Princess Alexandra Hospital patient observations are completed within 15 minutes of arrival and as appropriately thereafter in line with trust policy.

Statement of reasons

The reason for removing the above conditions is that after reviewing all the evidence submitted by the trust and following the focused inspection on 29 March 2023 service improvements were found and shortfalls identified will be addressed with requirement notices.

The conditions will be removed from the following location:
The Princess Alexandra Hospital NHS Trust
Hamstel Road
Harlow
Essex
CM20 1QX

If you do not agree with our decision, you have the right to make an appeal to the First-tier Tribunal (Health, Education and Social Care Chamber) under Section 32of the Health and Social Care Act 2008. You should make your appeal using the correct appeal application form which can be downloaded from the Tribunals Service website (https://www.gov.uk/courts-tribunals/first-tier-tribunal-care-standards) or copies can be sent to you by contacting the Tribunals Service using the details below.

You must make your appeal in writing within 28 days of the date this notice was served on you and send it to:

HM Courts & Tribunals Service
Care Standards
1st Floor
Darlington Magistrates' Court
Parkgate
Darlington
DL1 1RU
Tel: 01325 289350
Fax: 01264 78501cst@justice.gov.uk

If you do not want to make an appeal against our decision, please let us know in writing before the end of the 28 day period. If you do not make an appeal, our decision will become final as soon as we receive your letter or at the end of the 28 day period, whichever is sooner. If you do make an appeal, the final outcome will depend on the decisions made by the Tribunal.

You should contact the Tribunal Service if you have any questions about the tribunal process or making an appeal.

CQC is also obliged under Section 28(5) of the Health and Social Care Act 2008 to serve a copy of this notice on the <registered provider / registered manager> of the regulated activities it relates to.

If you have any questions about this notice, you can contact our National Customer Service Centre using the details below:

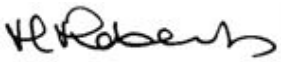
Telephone: 03000 616161

Email: Enquiries@cqc.org.uk

Write to: Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote our **reference number** at the top of this notice, as it may cause delay if you are not able to give it to us.

Yours sincerely



Hazel Roberts
Deputy Director of Operations- East of England

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 8 June 2023

3.1

Agenda item:	3.1							
Presented by:	Fay Gilder – Medical Director							
Prepared by:	Lisa Flack – Compliance and Clinical Effectiveness Manager & Sheila O'Sullivan – Associate Director of Quality Governance							
Date prepared:	23 May 2023							
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 4 May 2023 and updated during May. This paper includes all items scoring 15 and above. The overall number of significant risks on the register has reduced from 67 to 56 (table 1 and section 2). Seven risks scoring 20, a reduction of three from last paper: • Five risks are for our performance covering three for Emergency department (ED), one for cancer access standard, and one for or referrals to treatment standard. These five risks have been on our registers for several years. • One risk for our places, existing risk for electrical infrastructure. • One for our people – pharmacy staffing to cover the wards Actions and mitigations for each risk are detailed in section three. One new risk scoring 16 raised since 1.3.2023: • One for our people: ICT team staffing workforce One new risk with a score of 15 raised since 1.3.23. • Fire alarm system that is serviceable and needs replacement							
Recommendation:	Trust Board are asked to review the contents of the significant risk register.							

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

Previously considered by:	Nil

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

	Divisions and corporate teams review their risks at their local governance meetings. Teams escalate new risks and those that they require assistance with for discussion at Risk Management Group on a monthly basis.
Risk / links with the BAF:	There is 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 and Datix systems on 4 May 2023. This paper will continue to be updated during May as risk is managed as a dynamic process across services. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including all significant risks.

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

The Risk Management Group meeting in May will be the first time that we commence the discussion and management of risks using the Risk Management Strategy and Policy completed in 2022 & 2023. Going forward we will be asking divisions to review their risks and confirm which need to be escalated onto:

- The corporate risk register
- A Trust wide risk register
- Breach their risk appetite threshold
- Cannot be managed locally
- Have a consequence score of 5

With this in mind, future significant risk registers will no longer be in this format. The discussions at risk management group and senior management team meetings will evolve over the coming months and so the content of future papers will change as we adapt to the new approach.

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 56 significant risks on the risk register, a reduction of 10 from the paper discussed at Trust Board in April 2023.

The breakdown by service is detailed is in table 1.

Table 1 – Significant Risks	**Risk Score**				
	15	**16**	**20**	**25**	**Totals**
Covid-19	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Cancer & Clinical Support	0 (2)	6 (9)	1 (2)	0 (0)	**7 (13)**
Communications	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Estates & Facilities	6 (3)	4 (5)	1 (1)	0 (0)	**11 (9)**
Finance	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Health Safety and Resilience	1 (0)	0 (0)	(0)	0 (0)	**1 (0)**
Information Data Quality and Business Intelligence	0 (0)	0 (1)	0 (0)	0 (0)	**0 (1)**
Information Governance	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**

IM&T	0 (1)	1 (0)	0 (0)	0 (0)	**1 (1)**
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 (1)	0 (0)	0 (0)	**1 (1)**
Operational	2 (4)	1 (2)	4 (4)	0 (0)	**7 (10)**
Workforce – training	2 (2)	0 (0)	0 (0)	0 (0)	**2 (2)**
FAWs Child Health	2 (1)	1 (4)	0 (0)	0 (0)	**3 (5)**
FAWs Women's Health	4 (5)	4 (4)	0 (0)	0 (0)	**8 (9)**
Safeguarding Adults	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	0 (1)	0 (0)	0 (0)	**0 (1)**
Medicine	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Surgery	3 (3)	2 (2)	0 (0)	0 (0)	**5 (5)**
Urgent & Emergency Care	1 (2)	5 (2)	1 (3)	0 (0)	**7 (7)**
Totals	**23 (25)**	**26 (32)**	**7 (10)**	**0 (0)**	**56 (67)**

(The scores from paper presented at RMG/ SMT in March and Trust Board in April 2023 are detailed in brackets)

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

It should be noted that not all teams have moved their risks onto the Datix risk module from the Allocate system, however the vast majority are completed. Support has been offered to those who are yet to complete this work.

2.2 Movement towards presenting the corporate risk register instead of a significant risk register

As we are transitioning to the new risk management strategy and the corporate risk register is not complete, the significant risk register for this month has been used.
This month's risk management group was the first where we discussed risks that are to be recommended to be placed on corporate and Trust wide registers. Therefore, the escalation report for discussion at this meeting will be changing.

3.0 Summary of risks scoring 20

There are 7 risks with a score of 20, two of which are new/increased. A summary of these risks and mitigations is below, information taken from divisional risk registers:

3.1 Our Patients - Nil

3.2 Our People

Pharmacy staffing

- There is a risk that pharmacy will be unable to provide a robust service to all wards due to staffing vacancies. (Risk reference: Datix id 130)
  Action: Temporary workers in place within the cap rate. Recruitment ongoing and looking at alternative roles. Developing a bid to take on additional pre-registration pharmacists and monitoring the recruitment pipeline.
  Mitigation: As above and vacancy rate discussed and monitored by division.

3.3 Our Performance

Five risks for the urgent and emergency care department

3.3.1 Three risks regarding achieving the four-hour Emergency Department access standard:

- Compliance with the statutory 4-hour standard on the operational risk register for the Emergency department (ED) (Risk reference: on operational register Datix id 85).
- Achieving the standard of patients being in ED for less than 12 hours (Risk reference: Allocate: 002/2016 raised July 2016 on operational register).
- Deliver safe high-quality care when not meeting the national four-hour access standard on the urgent & emergency care register (Risk Reference: Datix id 310, Allocate ED012, raised in July 2016 with score amended in December 2022).
  Actions: Expand the skill base of nursing staff through our training programme, expand consultant presence until 22.00 hours, with use of rapid assessment, triage and adult assessment unit. Continuous review of escalation areas.
  Mitigations: 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. Monitoring of performance against internal professional standards and deviations escalated. 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 (Risk reference: Datix id 498 on register since July 2016).
  Actions: Tumour site recovery action plans are monitored and tracked. Speciality level recovery plan in place monitored daily, and reviewed at tumour site weekly meeting.
  Mitigations: Revised patient treatment list (PTL) has granular information for oversight of individual patients on cancer pathway to ensure action detailed weekly by patient on the pathway. Revision of the recovery trajectory set for 22/23.

3.3.3 Referral to treatment constitutional standards

- Risk of 52-week breaches because of the pandemic, pauses to out-patients department clinics and elective surgical activity. (Risk reference: Datix id 497 raised February 2017).
  Action: Refreshed PTL meetings with outpatient bookers attending to escalate relevant cases to divisional teams. Patients booked in order of clinical priority, monitoring of PTL continues weekly, with cancer PTL reviewed daily.
  Mitigation: Weekly recovery performance meeting with executive directors monitors activity levels to improve utilisation and trajectories planned. Detailed monthly dashboards shared.

3.4 Our Places

3.4.1 Electrical infrastructure

- The current electrical infrastructure does not have the ability to cope with new developments on site, that are required to meet compliance with regulations, and have adequate high voltage electrical supply to meet demands imposed by enlarged redeveloped estate. Infrastructure needs to be resilient with backup systems that can be checked monthly (Risk reference: Datix id 366, raised October 2022 and score increased in January 2023 due to a generator failing to take over provision of electrical supply).
  Action: Gap analysis has been completed with a business case completed and plans for discussion at a future capital funding group meeting. A five-year

programme is in place to develop site resilience. A business case is being developed to ensure infrastructure for safe electricity.
Mitigations: Monthly generator tests completed and oversight of maintenance of the plant.

3.5.1 Our Pounds: Nil

4.0 One risk with a score of 16 have been raised since 1/3/2023

4.1 Our People

- **NEW: Insufficient IT staff resources**
  As a result of insufficient WTE staff members working within the ICT team, there are delays to projects, a higher level of risk of system failures, cyber-attacks, delays resolving issues affecting clinicians time to care and risk to the delivery of the Trusts PAHT 2030 strategy (Risk Reference: Datix id 401 raised 5/5/23)
  Action: Temporary staffing can be sourced but these staff come at premium costs against substantive staff budgets. Business case to be put forward for additional roles to align with additional IT systems being used and significant increase in numbers of PC /iPad usage across the trust.
  Mitigation: Prioritisation given to core services, patient affecting systems and cyber security.

5.0 One new risk with a score of 15 raised since 1/3/2023

NEW: Serviceable Fire System

- Currently, we have a serviceable fire system however, there is a risk due to the age of some parts of the system (panel, detectors, etc) with some equipment shortly to become obsolete. Warranty on parts replacement is in place with cover for up to 5 years if available. (Risk Reference: Datix id 388 raised March 2023)
  Action: A plan to replace the panels and detectors in a specific order is present. A paper to be submitted to the Capital Working Group is being developed with request for emergency funding.
  Mitigation: Considerable numbers of mitigations are in place to reduce the impact of this risk which is monitored by the fire safety group, gradual replacement of fire doors is planned, with a contract in place to cover priority replacement, system serviced regularly, fire stopping survey, staff training.

6.0 Recommendation

Trust board are 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 – 8 June 2023

3.2

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

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

Key issues:	The Board Assurance Framework (BAF) is presented for review and approval. The risks have been updated with executive leads and reviewed at the relevant committees during May 2023. The risk scores have not changed this month and are summarised in Appendix B. Minor changes to the wording of risks 4.1 and 5.1 have been made and are reflected in red font in Appendix B. The full BAF is available in the resources section of Diligent.
Recommendation:	The Board is asked to: - Note the updates to the risks.

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

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

Board Assurance Framework Summary 2023.24

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

Board Assurance Framework Summary 2023.24

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

BOARD OF DIRECTORS:	**Trust Board (Private) – 8 June 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies (Acting Chair)**			
DATE OF COMMITTEE MEETING:	**26 May 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
1.6 Committee Effectiveness Review	Y	Y	N	The Committee's Annual Effectiveness Review 22/23 was presented for discussion and approval. The overall outcome of the review was positive with some actions agreed to address areas requiring improvement. Revised terms of reference were also approved with one small amendment in terms of membership; it was agreed 'Deputy Medical Director (Quality)' would be corrected to 'Associate Medical Director (Quality)'. **The Terms of reference are attached as Appendix 1 and are recommended to the Board for approval.**
2.1 Infection Prevention & Control Update	Y	Y	N	In terms of the majority of organisms, a maintenance phase had now been reached, with the exception of measles (in the community) which would need to be collectively addressed with community colleagues. COVID numbers continued to reduce despite a small rise in cases that week. IPC target thresholds for 2023/24 had now been received and were lower than for the other two ICS acutes due to the robust performance of PAHT during the previous year. QSC was pleased to hear that following discussion at the previous meeting, the Water and Ventilation Groups were now being re-established.

BOARD OF DIRECTORS:	**Trust Board (Private) – 8 June 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies (Acting Chair)**			
DATE OF COMMITTEE MEETING:	**26 May 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.2 Learning from Deaths Update	Y	Y	N	QSC noted that the 12 month rolling trends for both HSMR and SMR were showing as 'above expected'. There had been a focussed piece of work to look at why this may be with the conclusion that it was not down to issues with care, and may be due to a reduced depth of coding during a period when contracted coders had been brought in. The Trust's own team was now back up to full complement and it was likely the next report would see an improvement.
2.3 Report from Clinical Effectiveness Group (CEG)	Y	Y	N	In terms of Audit and NICE assessment there was recognition that to deliver evidence the organisation was clinically effective, there had been a stepped increase in how much work now needed to be completed in comparison with the position 2-5 years ago. A discussion would take place to look at how the organisation could support the divisional leads and teams to complete that work.
2.4 BAF Risk 1.1 (Clinical Outcomes)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 16.
2.5 Quality Programme Management	Y	Y	N	Focus remained on addressing red items and progressing ambers. The 2 red-rated items remained as: • S2 (ED 4 Hr standard) sustained lower quartile performance.

BOARD OF DIRECTORS:	**Trust Board (Private) – 8 June 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies (Acting Chair)**			
DATE OF COMMITTEE MEETING:	**26 May 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
Office (QPMO) Update				• S3/N (Safeguarding Training) where it was considered there was currently insufficient assurance and grip, remain a cause of concern. In terms of the former, improvements were starting to be seen in terms of movement towards the national recovery plan trajectory of 76%, and in terms of the latter the format of training had moved away from the requirement for face-to-face and it was anticipated performance there would start to improve quickly. QSC noted that the organisation had been informed the previous day that the CQC intended to remove the conditions on its licence at the front door (section 31) which had been in place since August 2021.
2.6 Report from Patient Safety Group	Y	Y	N	Key points to note were that 1) There had been an increase in medication incidents but a decrease in levels of harm associated with those and 2) Divisional attendance at the Medicines Optimisation Group was poor so colleagues had been requested to ensure divisional representation on that group. As a final point it was noted that the Anticoagulation Team had been congratulated on the implementation of a new system which had demonstrably improved patient safety in that service.

BOARD OF DIRECTORS:	**Trust Board (Private) – 8 June 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies (Acting Chair)**			
DATE OF COMMITTEE MEETING:	**26 May 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.7 Annual Patient Safety & Quality Governance Report	Y	N	N	Key headlines were: • The Trust had reported an increase of 13% in incidents (13,901), with harm levels remaining consistent. No deaths incidents had been reported in 2022/23. • There had been 18 SIs and three never events in-year. • The organisation had seen a decrease in the number of open claims by 17% and also a decrease in both newly reported claims by 43% and the contribution made to NHSR had seen an 11% reduction in-year. • The Trust had participated in 61 national audits and 94 local audits. • 202 NICE guidances had been published during 2022/23 with 35 yet to be assessed and 162 currently under review. • Trust Policy Group had processed 330 procedural documents, an increase of 94 on the previous year. 80% of procedural documents were in date, an increase of 3% on the previous year.
2.8 Sharing the Learning 4 Monthly Update	Y	Y	N	Learning from incidents, SIs, a never event and a structured judgement review was presented from across all divisions. Going forward any learning from the Cardiac Arrest Panel review meeting would be presented.

BOARD OF DIRECTORS:	**Trust Board (Private) – 8 June 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies (Acting Chair)**			
DATE OF COMMITTEE MEETING:	**26 May 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.9 Report from Patient Experience Group	Y	Y	N	The key escalation was around the recent PLACE assessment and that the formal report had not yet been received into the organisation. It was agreed to use this as an opportunity to pre-empt a piece of work around privacy and dignity.
2.10 Report from Vulnerable People Group	Y	Y	N	There were no escalations from the Group. Key points for noting were: • PAHT had been identified as an outlier in the National LD/ Autism Audit (year 4). A proactive retrospective review of Trust 22/23 data was being undertaken and would be overseen by the LD Steering Group. • In relation to Oliver McGowan training the organisation was linked into the ICS work in terms of its implementation. • A delay to the national implementation of Liberty Protection Safeguards (currently Deprivation of Liberties) was noted. Colleagues agreed to consider the presentation of a deep dive into LD for a future QSC meeting.
2.11 Update from Patient Panel	Y	Y	N	A summary of the recent work of the Panel was noted (for which the Panel was thanked) and it was agreed the work to encourage people from an ethnic minority to be part of the organ donation list would remain on the QSC radar.

BOARD OF DIRECTORS:	**Trust Board (Private) – 8 June 2023**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (QSC)**			
REPORT FROM:	**Hattie Llewelyn-Davies (Acting Chair)**			
DATE OF COMMITTEE MEETING:	**26 May 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.1 M1 Integrated Performance Report	Y	Y	N	There were no key areas to escalate to QSC. Work would continue the following week to ensure the right patient metrics were included in the report.
4.1 Horizon Scanning Update	Y	Y	N	QSC noted the following key headlines: • There would be further BMA industrial action from 14-17 June. • As part of its transformation the CQC would be changing how it worked and how it regulated. The key lines of enquiry (KLOEs) would be replaced with 'quality statements' focusing on key topic areas and setting out a commitment on the part of the provider.
4.2 Draft Quality Account	Y	Y	N	The draft Quality Account (QA) was noted and that a request would be made to the Trust Board for delegated authority for QSC to undertake the final sign-off at its meeting on 30.06.23. The QA would need to be published on the Trust's website by the deadline of 30.06.23.

BOARD OF DIRECTORS:	**Trust Board (Public)**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Rob Gerlis - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 May 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.1 Maternity Report (dashboard)	Y	Y	N	Birth centre births reduced in month (closed on 9 occasions). SPC charts were included for KPIs; smoking rates, PPH, homebirths, breast feeding. Red flags for staffing on labour ward have reduced and rag status remains static. Maternity and neonatal three year plan initial gap analysisundertaken.
2.2 Maternity Serious Incident Report	Y	N	N	No new maternity incident declared since the last report, 2 maternity incident closed since the last report and 4 SI's under investigation (0 HSIB).
2.3 Deep Dive: Pre-term Births	Y	N	N	A report outlining the preterm birth rate (<27 weeks gestation) at PAHT was discussed along with national data sets and steps taken to reduce the incidence. Patient demographics will be included in future reports.
2.4 Single Delivery Plan	Y	Y	N	In March 23, the NHS three year delivery plan for maternity and neonatal services was published. The plan was presented and a gap analysis across the LMNS and across the Trust's maternity services is underway and will report into QSC once finalised.

BOARD OF DIRECTORS:	**Trust Board (Public)**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality & Safety Committee (Part II)**			
REPORT FROM:	**Rob Gerlis - Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 May 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
2.5 Maternity and Neonatal Safety Champions' Report (to include end of year review).	Y	N	N	Recent walkabouts were noted. The annual report included a summary of issues raised to the champions as well as improvements made in relation to IT, estates and staffing. Improvements in engagement from neonates and maternity were noted and the significance of EDI was also discussed.
2.6 Horizon Scanning: External	Y	N	N	Technical guidance for the 3 year single delivery plan is awaited, MIS guidance is expected to be published by 31 May 2023. Good collaboration between the regional team and the Trust's Maternity team was noted.

The Princess Alexandra Hospital NHS
NHS Trust

QUALITY & SAFETY COMMITTEE

TERMS OF REFERENCE 2023/24

PURPOSE:

The Quality & Safety Committee (QSC) functions as the Trust's umbrella clinical governance committee. It enables the Board to obtain assurance that high standards of care are provided by the Trust and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to enable it to deliver a quality service ~~according to each of the dimensions of quality set out in *High Quality Care for All* and enshrined through~~ under the the Health & Social Care Act 2012:

- **Clinical Effectiveness** – consistently achieving good clinical outcomes and high levels of productivity through evidence-based clinical practice.
- **Safety** – achieving high and improving levels of patient and staff safety and identifying, prioritising and managing risk arising from the delivery of clinical care.
- **Patient Experience** – promoting safety and excellence to deliver an excellent patient experience as measured by direct interaction with, and feedback from, those using the Trust's services.

DUTIES:

The following comprise the QSC's main duties as delegated by the Board of Directors:

Evidence-Based Clinical Practice

1. To receive assurance on action taken to improve mortality rates as part of the Trust's mortality review process and to receive a monthly update on Learning ~~From~~ from Deaths.

2. To ensure there is a well-functioning and effective process for considering and implementing guidance from the National Institute for Health and Clinical Excellence (NICE) and National Service Frameworks, recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and responding to National Patient Safety Agency (NPSA) Alerts.

3. To receive assurance in respect of the delivery of any action plans arising from reviews or investigations into safety and or quality by healthcare regulators, inspectorates, accrediting bodies or Royal Colleges.

Compliance

1. To monitor the Trust's compliance with the Care Quality Commission's (CQC) registration criteria and oversee any remedial action required

~~2. To ensure the Trust complies with the NHS Resolution risk management standards and the Maternity Incentive Scheme standards.~~

~~3.~~2. ~~To undertake quarterly "deep-dives" into the work of each division via a Quality & Safety Performance Report to review quality and safety performance according to the CQC domains with the Triumvirate in attendance for their presentation~~.

~~4.~~3. To ensure the Trust complies with recommendations from the National Quality Board.

~~5.~~4. To receive regular reports on the Trust's infection control arrangements and receive assurance on remedial measures taken to handle the outbreak of infection.

~~6.~~5. To receive regular reports on the Trust's compliance with Safeguarding requirements and matters concerning Liberty Protection Safeguards, Mental Health and Mental Capacity Act.

~~7.~~6. To receive recommendations on the Trust's annual Quality Account priorities and monitor their in-year progress.

Audit

1. To receive the annual Clinical Audit Programme and ensure that it is in line with the audit needs of the Trust prior to commending it for approval by the Board. Monitor its in-year progress including actions taken to address audit concerns.

2. To make recommendations concerning the annual programme of Internal Audit work to the extent that it applies to matters within the remit of the QSC and consider the major findings of quality related Internal Audit reports (including the management response).

3. To be assured that recommendations from all clinical audits are robustly implemented in practice and desired outcomes are achieved.

Research and Development

1. To ensure the Trust has an effective Research and Development Strategy in place and produces an annual Research and Development Report to the ~~Trust Board~~ Committee.

2. To review governance arrangements for Research and Development activity within the Trust including Clinical Ethics.

3. ~~To receive six monthly reports from the Research & Development Group~~.

Learning when Things Go Wrong

1. To review the risks allocated to the QSC from the Board Assurance Framework and receive assurance that actions are in place to effectively manage and control the risks identified.

2. To ensure there are clearly defined and well understood processes for escalating safety and quality issues and meeting the Trust's obligations in respect of Duty of Candour with patients and families.

3. To consider regular reports identifying the trends and themes arising from claims, litigation, incidents (including SIs) and complaints and the management actions being taken to reduce risks and learn lessons.

Records and Confidentiality

~~To oversee the Trust's policies and procedures in respect of the use of clinical data and patient identifiable information to ensure that this is in accordance with all relevant legislation and guidance including the Caldicott Guidelines and the Data Protection Act.~~

~~2.~~1. To review, on an annual basis, the Trust's systems for the Management of Medical Records.

Patient Experience

1. To review the Trust's arrangements for managing complaints and PALS contacts.

2. To ensure the Trust has an effective system for patient feedback (including Friends and Family Test, patient environment and amenities) and patient involvement.

3. To undertake a review of the findings of any national patient surveys including any relevant action plans.

General Governance

1. To consider matters referred to the QSC by the Board or by the groups which report to it.

2. Every year, to set an annual Work Plan and conduct a review of the Committee's effectiveness (including the achievement of the Work Plan and a review of the Committee's terms of reference) and report this to the Board.

3. To ensure a system is in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest.

4. To review any relevant Trust strategies relevant to the Committee's terms of reference (e.g. those associated with clinical quality, clinical effectiveness, health and safety, patient experience) prior to approval by the Board and monitor their implementation and progress.

5. To consider the arrangements for the assessment by the Medical Director and Director of Nursing, Midwifery & Allied Health Professionals on the safety and quality impact of the schemes within the Trust's Cost Improvement and Transformation Programme.

6. On behalf of the Performance & Finance Committee, to consider the clinical and safety aspects of all business cases worth more than £1m prior to their consideration by the Trust Board.

Maternity Oversight:

1. To receive assurance on the clinical and safety aspects of Maternity services, reports from the Maternity Safety Champions and the work streams and divisional actions required to respond to national, regional and local improvement priorities in relation to Maternity services. These include but are not limited to:

- The 3 year maternity, neonatal 3 year delivery plan (March 23), incorporating national learning including the Kirkup and Ockenden Report ~~The Ockenden Report~~
- Maternity Incentive Scheme
- Care Quality Commission inspection reports
- Continuity of Carer Implementation
- Maternity Transformation
- Maternity Serious Incidents
- Maternity Dashboard
- Health Education England reports
- National Maternity Surveys

- HSIB learning and reports

2. Assurance will be presented to a separate session of QSC known as QSC Part II: Maternity Oversight ~~for a period of six months from February 2022, following which a review will take place.~~

ACCOUNTABLE TO: Trust Board.

REPORTING: A highlight report prepared by the QSC Chair~~man~~ supported by the Chief Nurse ~~Director of Nursing, Midwifery & Allied Health Professionals~~ will be presented to the next meeting of the Board.

A highlight report from QSC Part II will be presented to the next meeting of the Board. ~~The report shall set out areas requiring the Board's attention and report on the level of assurance provided by the QSC meeting including the Part II session regarding Maternity services; it shall also demonstrate progress against the QSC Annual Work Plan.~~

CHAIRMAN: Non-Executive Director/s.

The QSC Part II meeting will be chaired by a Non-Executive Director who is not the Non-Executive Maternity Safety Champion.

COMPOSITION OF MEMBERSHIP: The QSC is comprised of Executive and Non-Executive Directors appointed by the Board. The agreed QSC membership is:

- Chair - Non-Executive Director
- Non-Executive Director
- Non-Executive Director
- Chief Nurse ~~Director of Nursing & Midwifery and Allied Health Professionals~~
- Medical Director
- Chief Operating Officer
- Director of Quality Improvement
- Director of Clinical Quality Governance
- ~~Deputy~~ Associate Medical Director (Quality)
- Deputy Chief Nurse ~~Director of Nursing~~

The agreed QSC Part II: Maternity Oversight membership is:

- Chair - Non-Executive Director
- Chief Nurse ~~Director of Nursing & Midwifery~~
- Chief Operating Officer
- Director of Quality Improvement
- Medical Director
- Non-Executive Director (Maternity Safety Champion)
- ~~Director of Finance~~Director of People (Maternity Safety Champion)
- Director of Midwifery
- Divisional Director (CHaWS)
- Associate Director of Operations (CHaWS)
- Director of Clinical Quality Governance
- ~~Deputy~~ Associate Medical Director (Quality)
- Deputy Chief Nurse ~~Director of Nursing~~

- Maternity Transformation Programme Manager

The Chair~~man~~ of the QSC and QSC Part II: Maternity Oversight shall be appointed by the Chair~~man~~ of the Trust Board; ideally s/he shall have recent and relevant experience of NHS quality and safety.

If not already a member of the QSC, the Audit Committee Chair~~man~~ may attend any meeting of the QSC.

The Chair~~man~~ and Chief Executive of the Trust shall be ex officio members and will be invited to all meetings.

One of the NED members of QSC shall also be a member of the Trust's Audit Committee.

Other members of the Executive Team or management may be called to attend the meeting if required.

All members will have one vote. In the event of votes being equal, the Chair~~man~~ of the QSC will have the casting vote. Deputies attending the QSC on behalf of a member of the Committee are not entitled to exercise a vote.

ATTENDANCE:

Members are expected to make every effort to attend all meetings of the QSC and it is expected that they will attend nine out of eleven Committee meetings within each reporting year. An attendance register shall be taken at each meeting and an annual register of attendance will be included in the QSC's annual report to the Board.

The Chair~~man~~ and Chief Executive in their capacity as ex officio members are expected to attend five out of eleven Committee meetings in each reporting year.

The Chair of the Patient Panel will be a lay member of the QSC.

In addition to the members identified above , the following will be invited to attend when there is a deep dive into a relevant division or topic discussion

- Divisional Directors
- Associate Directors of Nursing
- Associate Director of Governance & Quality
- Associate Director, Patient Engagement & Experience Team

In addition to the QSC Part II: Maternity Oversight members, the following will be invited to attend:

- Regional Chief Midwife
- Maternity Improvement Advisor NHSE~~/I~~
- Regional Obstetric Lead

- ~~Maternity Commissioner – West Essex CCG~~
- ~~Quality Lead – West Essex CCG~~
- ~~Regional Maternity Quality Lead~~
- Head of Children, Young People & Maternity Commissioning (West Essex) Hertfordshire and West Essex ICB
- Clinical Quality Assurance Lead SET CAMHS, Children, Young People and Maternity Services Hertfordshire and West Essex ICB
- Regional Maternity Quality Lead – NHS England, East of England

Where considered appropriate and necessary, the Internal Auditors may be invited to attend meetings to present reports of any audits conducted by them in respect of issues within the scope of the QSC.

DEPUTISING ARRANGEMENTS:

In the absence of the Chair of the Committee, another Non-Executive Director appointed by the members of the Committee will chair the meeting.

Other deputies may attend on behalf of executive members but must be suitably briefed and, where possible, designated and notified in advance.

QUORUM:

The quorum for any meeting of the QSC shall be the attendance of a minimum of two members of which one shall be a Non-Executive Director and one shall be either the Chief Nurse ~~Director of Nursing, Midwifery & Allied Health Professionals~~ or the Medical Director.

DECLARATION OF INTERESTS:

All members, ex-officio members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

LEAD EXECUTIVE

Director of Nursing, Midwifery & Allied Health Professionals.

MEETING FREQUENCY:

Meetings of the QSC shall be held:

- Monthly
- Usually on the fourth Friday of Board cycle
- At such other times as the Chair~~man~~ of the QSC shall require.

MEETING ORGANISATION:

- Meetings of the Committee shall be set before the start of the financial year.
- The meeting will be closed and not open to the public (though lay members will be permitted to attend).
- The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee.
- A draft agenda shall be developed by the Head of Corporate Affairs and Lead Executives and agreed by the Committee Chair at least ten clear days* before the next Committee meeting.
- All final Committee reports must be submitted six clear days* before the meeting.
- The agenda and supporting papers shall be forwarded to each member of the Committee and planned attendees three clear days* before the date of the meeting.
  *'clear day' means any day which is not a Saturday or Sunday or a public or bank holiday.

AUTHORITY:

The QSC is constituted as a Committee of the Trust Board. Its constitution and terms of reference shall be as set out above, subject to amendment by the Board as necessary.

The QSC is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to co-operate with any request made by the QSC.

The Princess Alexandra Hospital NHS
NHS Trust

	The QSC is authorised by the Trust Board to request the attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this necessary.
TERMS OF REFERENCE:	The terms of reference of the QSC shall be reviewed at least annually and presented to the Trust Board for approval.
DATE APPROVED:	By QSC: May 2023 ~~March 2022~~ By Trust Board: ~~April 2022~~ June 2023

4.1

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 8 June 2023

4.2

Agenda item:	4.2							
Presented by:	Joanna Keable, Interim Director of Midwifery							
Prepared by:	Erin Walters, Head of Maternity Governance and Assurance							
Date prepared:	03rd May 2023							
Subject / title:	Overview of Serious Incidents within maternity services							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards. There was 0 new maternity incident declared since the last report There were 2 maternity incident closed since the last report Maternity services currently have 4 SI's under investigation (0 HSIB).							
Recommendation:	To provide assurance to the Board that the maternity service is continually monitoring compliance and learning from Serious Incidents.							

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

Previously considered by:	QSCII.26.05.23.
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

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

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

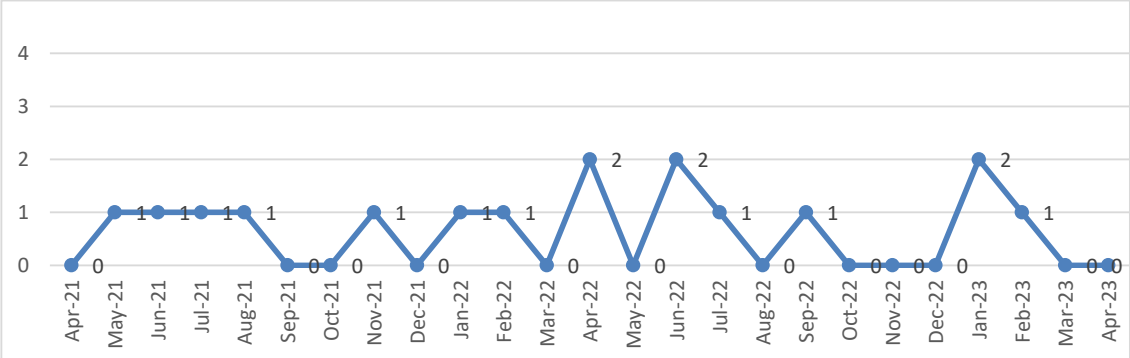
2.0 Background

The Ockenden 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 4 SI's under investigation, 0 of which are being investigated by Healthcare Safety Investigation Branch (HSIB), the detail can be found in Appendix 1. Table 1 details the trend of declared SI's within the last 24 months to April 2023.

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



There were 0 new serious incident declared in April 2023.

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

Serious Investigations			
Number Declared for April 2023			**0**
Number Submitted for April 2023			**2**
Number Past CCG Deadline as of April 2023 (Not including HSIB/Approved Extensions)			**0**
New Serious Investigations declared			
Ref	**Ethnicity**	**Summary**	**Learning Points**
Closed Serious Investigations			
Paweb ####39 **June 2022** 2022/###68	White British	A pregnant woman attended the emergency department at 22+1 weeks gestation with a history of abdominal pain, dizziness and feeling unwell for 3 days. The mother collapsed whilst in the emergency department, the baby was born with signs of life. Neonatal resuscitation was commenced	• Case to be used for Perinatal Mortality and Morbidity Meeting • Review of gestation and pathways between ED and Maternity • Communication between ED and Labour Ward

		The Paediatric and Neonatal Decision Support and Retrieval Service (PANDR) declined transfer as the baby had not met the transfer criteria as per post birth requirements. The baby died approximately 4 hours later.	
Paweb ####72 **July 2022** 2022/#####	White British	Baby boy born following induction of labour due to irregular maternal antibodies (Anti-C and Anti-E). Baby was diagnosed as DAT positive (risk that he/she could develop anaemia due to maternal antibodies) and was discharged home on day 1 with a prescription for folic acid. Due to concerns, the mother attended a clinic on day 17 and was immediately advised to attend the emergency department. Baby was diagnosed with haemolytic disease of the newborn and required urgent admission, a total of 5 blood transfusions and treatment for low saturations and tachycardia.	• Communication surrounding paediatric plan • Communication between the midwifery team and the family • Case booked for perinatal mortality and morbidity review

4.0 Themes

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

Table 3. Top Themes

Total Number of SI's	Theme	Number
16	Cardiotocograph (CTG) interpretation	7
	Obstetric Haemorrhage	6
	Neonatal death	5
	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
	Medical Equipment	1
	Screening Incident	1

5.0 Oversight

All highlighted concerns have been escalated at Divisional level. All incidents are discussed at the Women's Weekly Assurance Meeting, 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.

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

Current work streams include:

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

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

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

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

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

6.0 Recommendation

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

Author: Erin Walters – Head of Maternity Governance and Assurance
Date: 03rd May 2023

Trust Board (Public) – 8 June 2023

Agenda item:	4.3
Presented by:	Giuseppe Labriola – Deputy Chief Nurse
Prepared by:	David Dellow – Safe Staffing Lead and Giuseppe Labriola – Deputy Chief Nurse
Date prepared:	12.5.2023
Subject / title:	Report on Nursing and Care Staff Levels for April 2023– Hard Truths Report

Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The overall fill rate for April was 97.4%. Registered Nurse (RN) fill rate increasing by 1.0% to 90.4% and care staff fill rates increased by 4.7% to 112.3%. No wards reported average fill rates below 75% for RN against the standard planned template during April. This is the first time in 7 months.							
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:	PC.01.06.23
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Divisions have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18
Appendices:	**Appendix 1:** Registered fill rates by month against adjusted standard planned template. RAG rated. **Appendix 2**: ITU / HDU compliance with Guidelines for the provision of Intensive Care Services

There was an upward trend in average fill rates in April; with the overall fill rates for February being 97.4%. RN fill rate increasing by 1% to 90.4% and care staff fill rates increasing by 4.7% to 112.3%. Nightingale ward continues to be open as part of winter escalation plans.

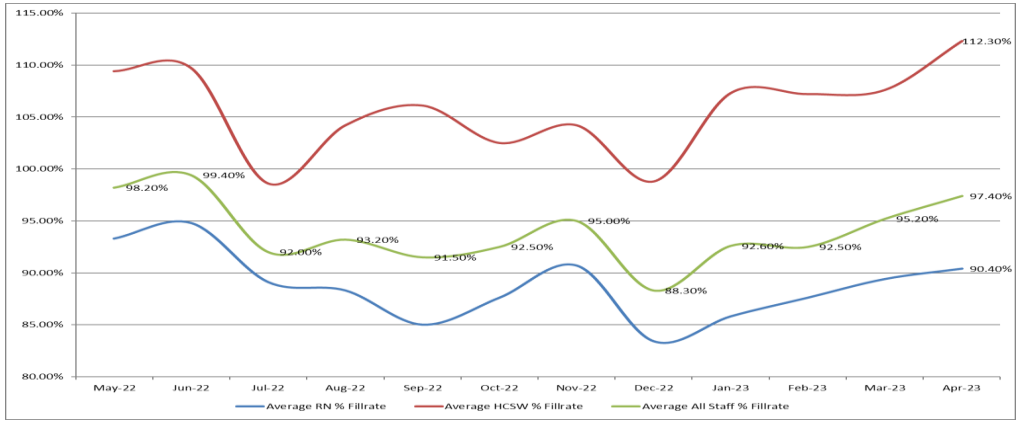
The Acute Admissions Unit (AAU) continues to be an area of concern with 39% Band 5 vacancy rate. The ward is being supported and prioritised for new starters from International pipeline and as well a number of other measures to ensure fill rates and skill mix meet demand and acuity. 6 new RN's are due to commence in May. Additionally, the chief nurse has held a round table review to support safe staffing.

We continue to utilise NHS Professionals (NHSP) and agency to mitigate vacant shifts and enhancements for NHSP shifts continue to promote improved fill rates. The Practice Development Nurse across Acute Medicine is providing enhanced support to AAU with additional support when required from the central Practice Development Team.

Emergency Department (ED) fill increased in April with the day fill over 92%. There was a slight decrease in fill rates for care staff in April due to an increase in short term sickness for Healthcare Support Workers.

Critical care fill rates in April - the unit had more than the required numbers of staff for acuity of patients on 17 occasions during the day (green bars) and 21 occasions at night. The numbers on the left of the graph and strength of the bars denotes by how many staff. There were 15 occasions in the month when staffing fell below the required staffing levels across day and night. On three occasions this was by 2 staff. On these occasions, the Intensive Therapy Unit (ITU) team were supported by the Critical Care Matron, Practice development nurse and the supervisory nurse in charge working in the clinical numbers to support delivery of safe patient care. Regular reporting and comparison month on month will help to provide a benchmark for this variation. Regular reporting and comparison month on month will help to provide a bench mark for this variation. See Appendix 3 for background on how safe staffing is calculated for critical care areas.

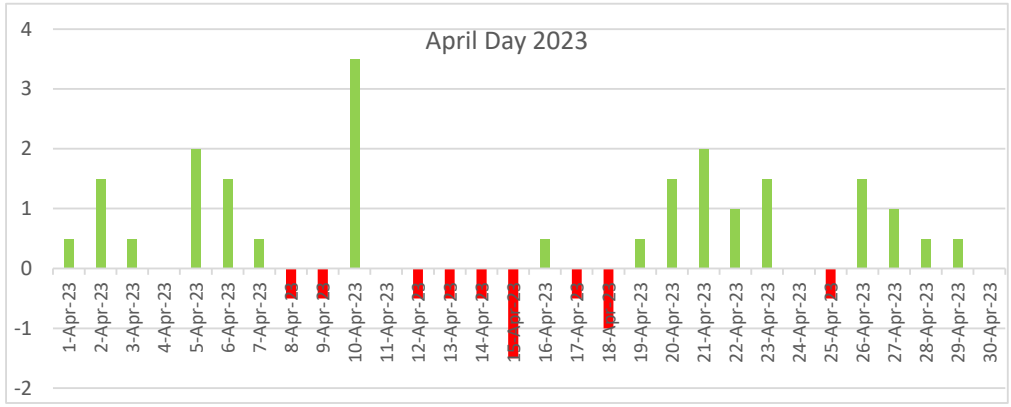
Inpatient Fill rate



ED Fill rate

	Day		Night	
A&E Nursing	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Feb-23	76.50%	93.40%	91.40%	95.30%
Mar-23	77.90%	90.50%	90.70%	90.90%
Apr-23	92.00%	88.10%	92.30%	84.70%

Critical Care Fill rate



The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards (excluding Maternity) decreased to 189 (↓9) against March, (December had 383 occasions). If a nursing red flag event occurs for number of staff on duty to meet the care needs of patients, staff escalate the situation and if appropriate complete a Datix.

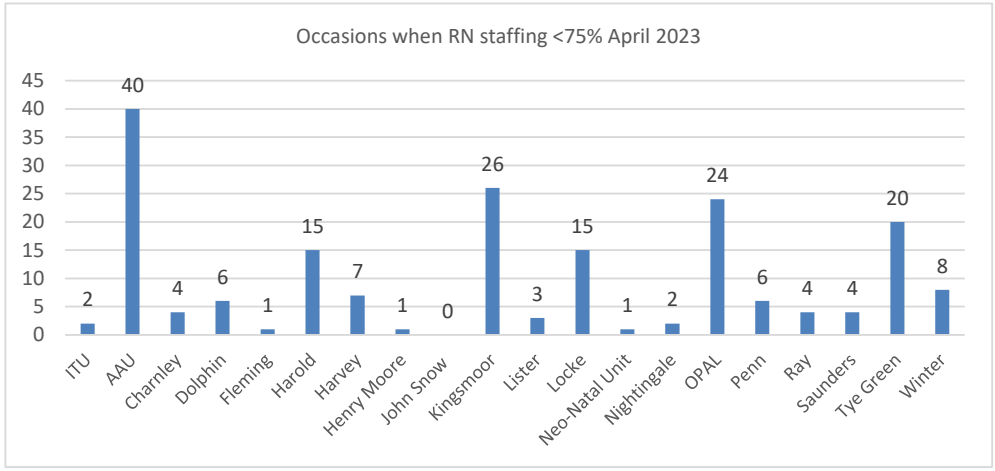
Datix reports in relation to staffing levels decreased to 30 (↓26) against March and 38 in February. AAU raised 10, with Fleming Ward and Saunders Ward raising three each.

No wards reported average fill rates below 75% for RN against the standard planned template during April. This is the first time in 7 months. Details on the impact on care can be found below.

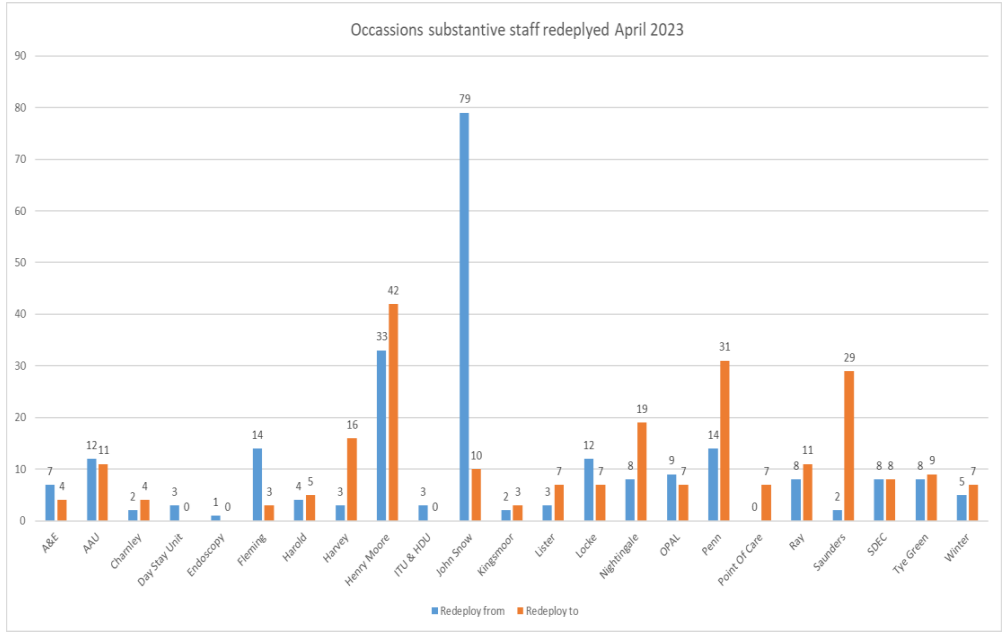
Redeployment of staff continues to be undertaken to support SafeCare as part of the daily huddles. In April, staff were moved from elective surgical wards (John Snow Ward and Henry Moore Ward), with John Snow Ward being closed for a number of days. Fleming ward have very low vacancies. Highest net receivers of staff were Penn and Saunders wards

Following the ward managers awayday a small working group are developing a buddy ward redeployment SOP, this is being reviewed with our band 6 nursing staff during May.

Occasion when RN staffing <75%

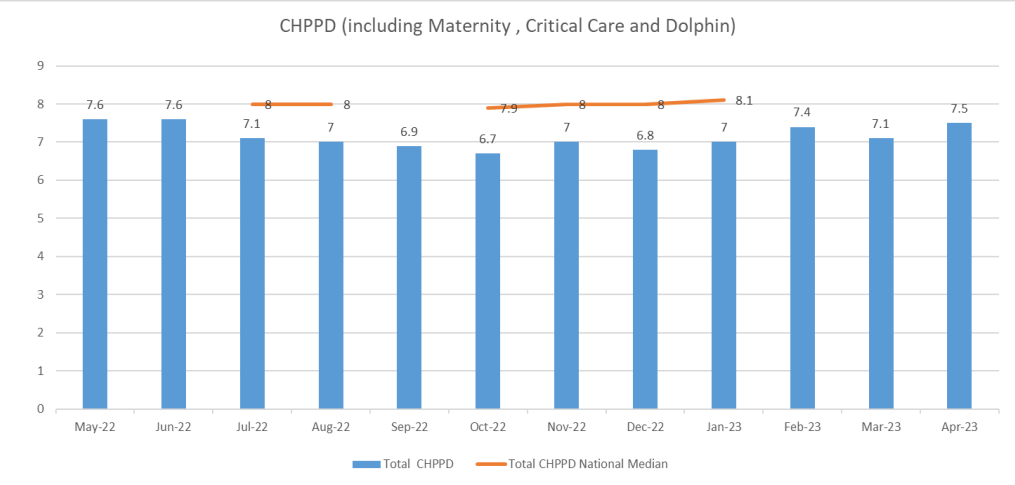


Redeployment



Overall Care Hours Per Patient Day (CHPPD) was 7.5 for April 2023. The Model Hospital data for January 2023 shows the Trust with a CHPPD of 7.0 against the national median of 8.1.

CHPPD



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

	Day	Day		Night				
Ward name	Total monthly **planned** staff hours	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**	**% overall HCSW**	**% overall ward fill**
ITU & HDU	3450	**90.4%**	**84.3%**	**95.0%**	**99.1%**	**92.7%**	**91.7%**	**92.6%**
Saunders Unit	1800	**86.0%**	**108.9%**	**116.9%**	**150.3%**	**97.5%**	**124.6%**	**107.7%**
Nightingale	720	**106.0%**	**69.3%**	**103.2%**	**79.7%**	**104.6%**	**74.3%**	**89.5%**
Penn Ward	1800	**85.0%**	**108.8%**	**90.0%**	**162.7%**	**87.1%**	**129.2%**	**102.2%**
Henry Moore Ward	672	**118.7%**	**67.2%**	**114.3%**	**66.7%**	**116.6%**	**66.9%**	**92.0%**
Harvey Ward	1440	**83.2%**	**100.8%**	**103.2%**	**108.0%**	**91.3%**	**104.2%**	**96.0%**
John Snow Ward	504	**106.5%**	**42.3%**	**101.4%**	**64.7%**	**104.1%**	**49.1%**	**80.2%**
Charnley Ward	1800	**84.4%**	**138.9%**	**86.7%**	**139.2%**	**85.5%**	**139.0%**	**100.8%**
AAU	2880	**72.0%**	**102.6%**	**84.2%**	**126.9%**	**77.4%**	**114.2%**	**85.2%**
Harold Ward	2520	**79.1%**	**102.0%**	**93.3%**	**128.7%**	**85.4%**	**114.8%**	**94.6%**
Kingsmoor General	2160	**68.2%**	**117.7%**	**96.6%**	**133.5%**	**79.0%**	**125.3%**	**96.2%**
Lister Ward	1800	**83.1%**	**103.7%**	**95.2%**	**125.6%**	**88.3%**	**114.2%**	**98.6%**
Locke Ward	1800	**74.8%**	**97.2%**	**91.6%**	**109.6%**	**81.9%**	**103.1%**	**90.4%**
Ray Ward	1800	**105.0%**	**123.2%**	**126.0%**	**176.8%**	**113.9%**	**143.5%**	**124.5%**
Tye Green Ward	2160	**72.8%**	**111.1%**	**80.8%**	**118.9%**	**76.3%**	**114.3%**	**91.1%**
OPAL	1080	**92.7%**	**118.0%**	**81.2%**	**116.6%**	**87.2%**	**117.3%**	**99.3%**
Winter Ward	1800	**81.1%**	**114.6%**	**96.3%**	**139.1%**	**87.5%**	**126.3%**	**103.0%**
Fleming Ward	1800	**84.8%**	**114.2%**	**99.2%**	**131.4%**	**90.9%**	**122.4%**	**100.5%**
Neo-Natal Unit	1725	**98.7%**	**98.6%**	**98.7%**	**96.7%**	**98.7%**	**97.6%**	**98.5%**
Dolphin Ward	1725	**90.4%**	**78.3%**	**99.9%**	**88.7%**	**94.6%**	**81.7%**	**91.4%**
Total	**40836**	**86.6%**	**105.2%**	**95.0%**	**121.0%**	**90.4%**	**112.3%**	**97.4%**

Appendix 3: ITU / HDU compliance with Guidelines for the provision of Intensive Care Services (Version 2.1 July 2022)

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

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

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

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

All shifts include a supervisory nurse.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 8 June 2023

4.4

Agenda item:	4.4
Presented by:	Fay Gilder | Medical Director
Prepared by:	Nicola Tikasingh | Lead Nurse for Quality and Mortality Information Team Fay Gilder | Medical Director
Date prepared:	16 May 2023
Subject / title:	Learning from deaths and Mortality Paper

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

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

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

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

The Princess Alexandra Hospital NHS Trust

4.4

1.0 Purpose/issue

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

2.0 Background

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

3.0 Current Telstra update on mortality indices for Princess Alexandra Hospital (PAHT)

3.1 Background

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

3.2 Analysis

REPORT HEADLINES

Data Period: Jan 2022 - Dec 2022

Metric	Result
HSMR	110.16 "higher-than-expected" (103.0 – 117.8)
HSMR position vs. peers	Regional peer group = 14 acute trusts: • 9 higher-than-expected • 1 within expected • 4 lower-than-expected Region as a whole = 105.6 (higher-than-expected) (104.1 – 107.0) **Trust are not statistically significantly different than current peer group*
All Diagnosis SMR	108.1 "higher-than-expected"
Significant Diagnosis Groups	• Diabetes mellitus with complications (196 superspells; 14 deaths)
CUSUM breaches	• Disease of mouth, excluding dental (1 death) (Nov-22) • Essential hypertension (1 death) (May-22) • Lung disease due to external agents (2 deaths) (Dec-21)
SHMI position	(Dec-21 to Nov-22) 105.89 "as expected"

Figure 1 – HSMR Monthly Trend

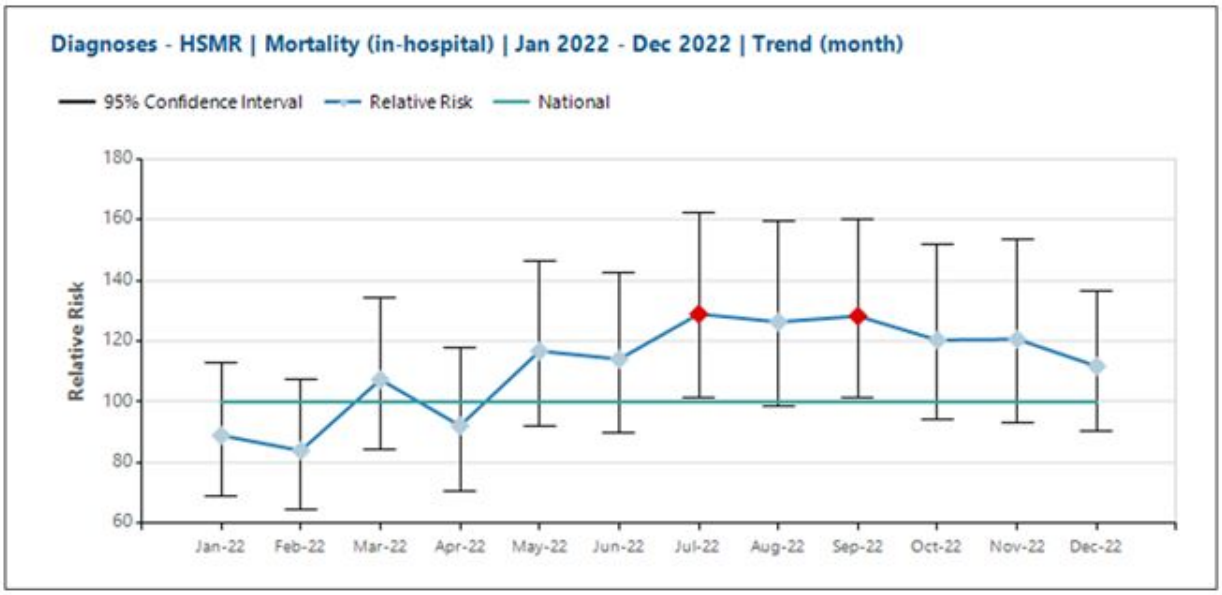
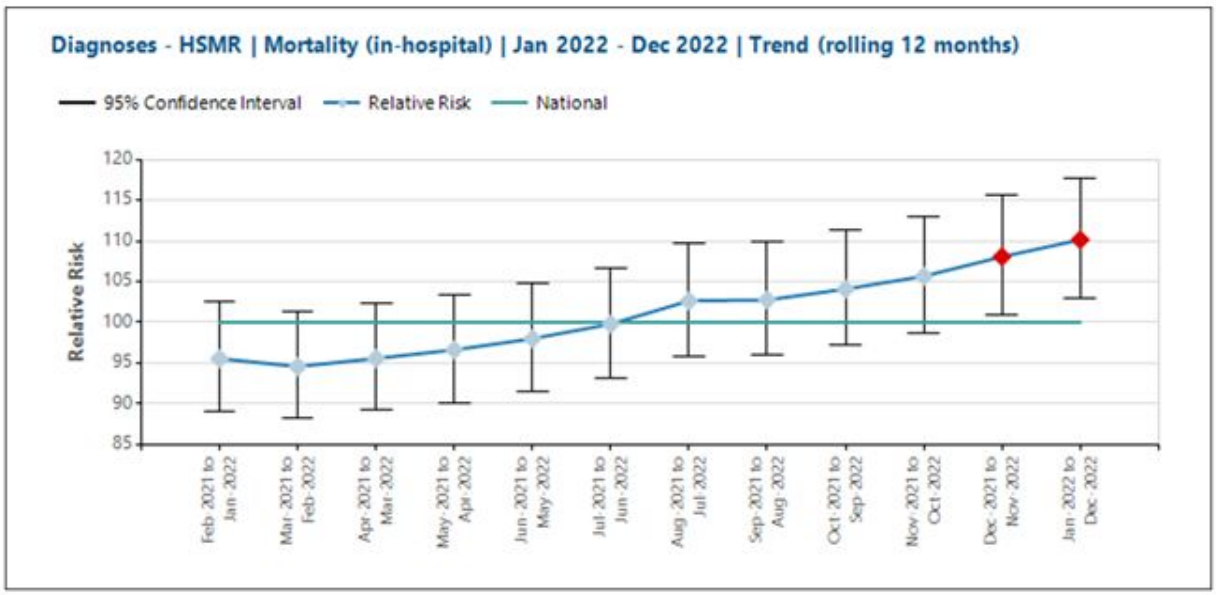


Figure 2 HSMR 12 month rolling trend



The Princess Alexandra Hospital NHS Trust

4.4

STANDARDISED MORTALITY RATIO OVERVIEW

Key points

SMR for Dec-22 is 101.0 and "within expected", based on 4923 superspells and 110 deaths (crude rate 2.2%).

SMR for the period Jan-22 to Dec-22 is 108.1 and "higher-than-expected", based on 68,161 superspells and 1108 deaths (crude rate 1.6%).

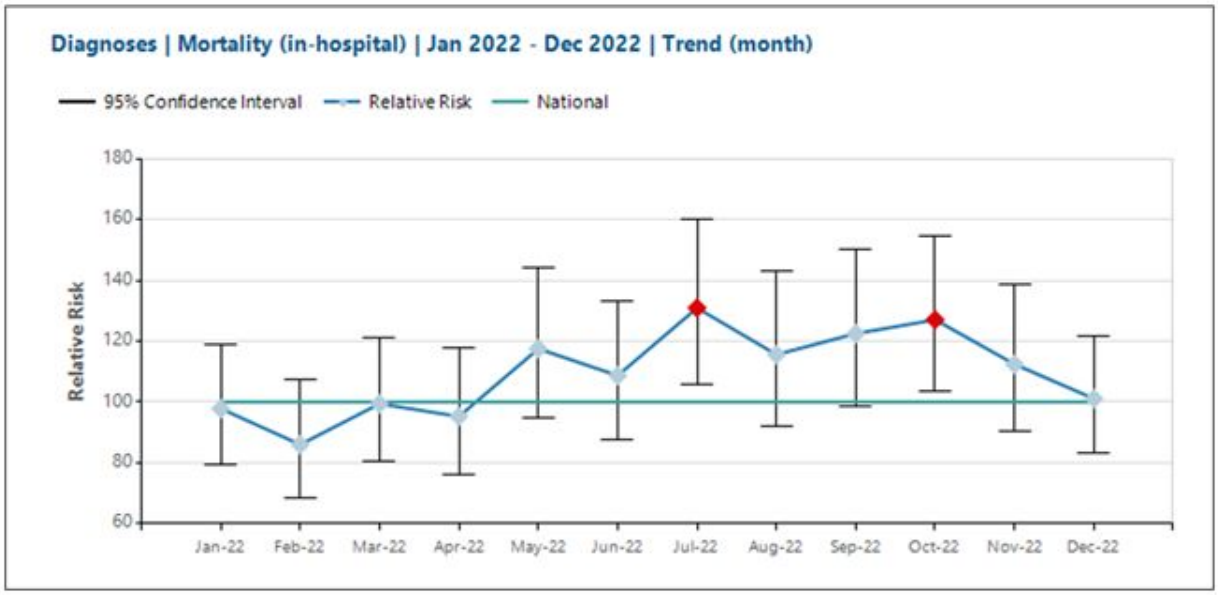


Figure 4 – SMR Monthly Trend

SMR Statistically Significant Diagnosis Groups

Diagnosis group	Code	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All		196	100.0 %	197	14	7.1 %	6.4	3.3 %	7.6	218.5	119.4	366.7
Diabetes mellitus with complications	50	196	100.0 %	197	14	7.1 %	6.4	3.3 %	7.6	218.5	119.4	366.7

Figure 5 - SMR Statistically Significant Diagnosis Groups January 2022 – December 2022

After discussion with Telstra – it has been agreed to review the notes of all diagnostic outliers referred to here (diabetes mellitus with complications).

3.3 Summary

Analysis of the impact of uncoded spells (as denoted by a residual code) shows the monthly HSMR from April-September as 'above expected. Fully coded data has been submitted for al months commencing September 2022. In month HSMR and SMR for December is 'as expected'.
The SMR diagnostic outlier (diabetes mellitus) will be investigated.
12 monthly rolling SHMI is 'as expected'.

Telstra are now in possession of PAH local data and are performing analysis on that which will reveal the HSMR position with the corrected denominator.

4.0 Mortality Programme Updates

An update was provided on the Fractured Neck of Femur Project Group:
The Trust is no longer a mortality outlier however elements of the pathway are still not meeting national standards. Work is ongoing to address this.

Actions Implemented to Date:

ALERTIVE group running successfully
Fascial iliaca block (FIB) kits have been regularly stocked and available in ED
Process map been finalised and QR code with femur fracture poster been updated
"Time to Tye Green" with call to action poster (screenshot of monthly update shared to all teams) has been updated monthly
Trauma list process and (trauma list priority guidance) been shared to all ortho and theatre booking staffs
Femur fracture SOP been approved and finalised
Quality improvement team has carried out meetings with ED regarding FIB feedback and delays been shared with doctors
Mortality reviews been completed and updated in timely manner

Work in Progress:

Audit for compliance with FIB checklist -awaiting QI team to provide feedback
ED team to share process for how they are alerted when x-ray image is ready
Wound audit to be carried out jointly by ortho and hip fracture nurse
To organise breakfast club consistently once therapy staffing better
Working closely with site team in keeping an escalation bed available
To include transfer of care team in hip fracture meeting due to number of patients with LOS >14 been higher in past months
Due to dependency of ward, recruiting and retaining staff has been challenging
(Working closely with PDT concerning recruitment and training)

5.0 Learning from deaths process update

5.1 Mortality Narrative

There were 95 deaths in April 2023.
12 cases were referred for SJR's

There are 86 outstanding SJRs (over 6 weeks of the patients' death.)

There were 5 Covid related deaths:
- 5 x Community Acquired
- 0 x Indeterminate
- 0 x Probable
- 0 x Definite

There were no cases presented to the second review panel.

5.2 Work Initiated from SJRs and Mortality Improvement Concepts

- SPCT coding – review of how coding is captured and how this can be improved due to palliative care coding being low. Working group set up.

- New criteria is in place to filter patients who have returned to hospital within 30 days and died – this will reduce the number of SJRs being put forward and allow the junior doctors to review cases that are of a lesser concern.

- Level 2 Mortality Reviews to be completed on SMART. This form is now on the SMART system and has started being used in some areas within Medicine Division. Roll out in place for Medicine Directorate.

- Attachment of documents to SMART system e.g. SI reports, PM reports – this is in progress with the SMART team.

- Administration form onto SMART to capture M&M meeting details, attendees, date, times, cases reviewed and actions set - this is in progress with the SMART team.

- Junior doctors to be involved in all M&M meetings and actively take part in M&M reviews (level 2). This is taking part in many M&M meetings within Medicine and there is a roll out plan for all areas to introduce this.

- Review and update of Learning from Deaths Policy – this will be sent out for peer review in June 2023 before ratification and endorsement.

- Yellow Card Scheme – this is being reviewed with an aim to raise the profile of this as there are concerns that this is not being used in line with national guidance. 09/05/22 – Discussion with Steven De-Giovanni with a plan to send out communications, teaching at grand round, SPF and M&M meetings.

- Sepsis audit is being undertaken to understand why triggering as an outlier – to be presented at next month's LFDG.

- Alcohol detox audit is being undertaken in order to identify better ways of supporting readmission for alcohol detox and support that is required in the community.

- Re-launch of M&M in oncology including patients who die within 30 days of receiving SCAT – still awaiting SACT data.

- Ethical challenges with nutrition and swallowing (NBM a/w SALT Ax, Risk Feeding issues) – Discussed at the end of life steering group and to be followed up as a working group through the nutrition steering group.

6.0 Medical Examiner (ME) Headlines

100% of deaths scrutinised between 9 Medical Examiners.

24 cases were referred to the Coroner:
Of these, 9 Form A's were issued (COD agreed with coroner).
9 post-mortems were requested
No death certificates were issued by the GP.

Ongoing Developments:

A new proforma is being used on a trial basis on Harold Ward to provide Causes of Death and contact details for the MEO/ME ahead of scrutiny. The aim is to facilitate enhanced communication between teams which will allow the scrutiny and certification process to be more efficient for all involved. Results so far have been mixed with notes still arriving absent of the proforma.

Talks are in place to develop a new system between the A&E department and ME service for patients who die within hours of admission. The aim is to reduce the number or breaches associated with delays obtaining a certifying Drs who is off site post shift.

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

7.0 Risks

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

8.0 Recommendation

For the 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.

The Princess Alexandra Hospital NHS Trust

Trust Board 08 June 2023

4.5

Agenda item:	4.5
Presented by:	Phil Holland – Chief Information Officer (CIO), EPR Programme SRO
Prepared by:	Lynne Fenwick – Director of Information & IT, EHR Programme Director
Date prepared:	01 June 2023
Subject / title:	EHR Programme Update – Public Board

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	Following the signing of the contract with Cerner February 2023, the programme plan is being worked through with Cerner and current deployment date is falling early October 2024. The underlying detailed delivery plan is being developed and to support the next phase of the programme and revised governance arrangements have been agreed by the EHR Programme Board. Recruitment into key roles for the next phase is underway, with key programme management posts filled, including medical and clinical. A formal launch is being planned for the week commencing 17th July, and the branding approach agreed. This aligns with the Trusts existing PAHT2030 strategy and New Hospital Programme branding and underpinned by a communication and engagement plan calling on our people to get involved in shaping their future.
Recommendation:	Trust Board note and support the key activities underway as we move forward with the implementation planning.

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:	EHR Programme Board – 23 May 2023
Risk / links with the BAF:	1.2 EPR
Legislation, regulatory, equality, diversity and dignity implications:	Requirement for equitable and legally compliant process for Potential Providers. Inclusion of patient panel and wide range of subject matter experts (SME) to ensure equality, diversity and dignity supported across the programme
Appendices:	N/A

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

4.5

1.0 Purpose

This paper provides and update in respect of key actions progressing the EHR solution.

2.0 Context

The Trust EHR Full Business Case (FBC) was presented to external stakeholders and approved in January 2023. Contract negotiation with Cerner concluded with contract signature by all parties on 23 February 2023. The contract is for a mature HIMMS Level 6 (integrated broad scope) deployment in Autumn 2024.

The contract with our existing system provider has been conditionally extended to March 2025. The infrastructure refresh required to secure the extension was successfully concluded in May 2023.

3.0 Governance

As the programme moves from procurement to programme delivery the governance structure has been reviewed and changes agreed.

The contract with Cerner includes a number of Gateways, with milestone reviews. The EHR Programme Board will now become accountable to the Trust Board in providing assurance that the programme remains on track in respect of quality of deliverables, timescales, and budget to meet its contractual obligations.

An Implementation Board will be established to oversee delivery of the programme from the 18-20 workstreams that are being established. To support the work of the programme Clinical Advisory Board, Operational Advisory & Readiness Board, and EHR Change Boards will be established to provide expert advice and guidance to support decision making. This structure will commence in June 2023.

Generally, deployments of EHR solutions are based around functionality however, given the approach we adopted for the procurement, our programme will be based around the Willow Road patient journeys and our digital office strategy which is centred around our people and their roles aligned to our values.

4.0 Next Phase

The underlying detailed delivery plan is being developed to support the next phase of the programme. The establishment of the Trust current technology baseline is well advanced and Cerner are setting up the Trust ‘play’ domain to support workstream product familiarisation.

The revised governance arrangements are being established with the new Terms of Reference for the Boards outlined above and membership being agreed. Recruitment into key roles for the next phase is underway, with key programme management posts filled, including medical and clinical. Recruitment from within PAH and the wider NHS, where the knowledge and skills exist, is the preferred route and thus limiting the use of external contract resource where possible and appropriate.

The Princess Alexandra Hospital NHS Trust

4.5

5.0 Launch and Branding

It is the intention that the new name for the programme, and its associated brand, will be introduced to the organisation as part of a formal launch planned for the week commencing 17th July 2023. The brand aligns with the Trusts existing branding associated with the PAHT2030 strategy and New Hospital Programme and is underpinned by a communication and engagement plan calling on our people to get involved in shaping their future.

6.0 Next Steps

The Trust Board are requested to note and support the content of the paper

Author: **Lynne Fenwick - EHR Programme Director**
Date: 01 June 2023

BOARD OF DIRECTORS: Trust Board (Public) 8 June 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Darshana Bawa – Committee Chair

DATE OF COMMITTEE MEETING: 1 June 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 People Report including; • Flexible Working deep dive • Recruitment and resourcing	Yes	Y	N	The following metrics were noted: • Vacancy rate in April 10% Medical – 2.7%, N&M - 12.8%, A&C - 8%, AHP -13.3%, E&F -19% • Bank and Agency spend had decreased this month, lost DE savings have increased by £30k since October • Sickness absence rate is 4.3% with main reasons relating to mental health and Cold and Flu. 2.5% short term and 1.8% long term • Rolling turnover overall is reducing slowly – currently 15.9%. • Time to hire – an average of 54 days for April. Pipelines are addressed at weekly establishment meetings with bottlenecks around shortlisting time. An update on change management and flexible working was noted.
2.2 Learning & OD Update and Staff Survey	Yes	N	N	PC were assured in regards to the measures being taken to address statutory and mandatory training compliance. An update on This is Me @ PAHT was received. Outcomes from the feedback to action programme (staff survey) will be reported on completion of the programme. 2022/23 Q4 People Pulse Survey results were reviewed and discussed.

BOARD OF DIRECTORS: Trust Board (Public) 8 June 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Darshana Bawa – Committee Chair

DATE OF COMMITTEE MEETING: 1 June 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.4 GMC Enhanced Monitoring Process	Yes	Y	N	The Committee were assured on progress being made in relation to the GMC enhanced monitoring process. The improvement plan was submitted on 17 April 2023 and a positive HEE Quality Stakeholder meeting took place on 18 May 2023.
2.5 BAF risk: GMC enhanced monitoring	Yes	N	N	The Committee noted the score remained unchanged at 20 with a target score of 10 to be achieved by December 2024.
2.6 Safer Nurse Staffing Report	Yes	N	N	The Committee were assured in regards to the provision of safer nurse and midwifery staffing and that processes are in place for managing and monitoring staffing levels. The paper would be discussed at Board.
2.7 Horizon scanning	For noting	N	N	The Committee noted the updates and agreed that going forward any significant programmes of change will be highlighted in the report.
2.8 Well led review	Yes	N	N	The committee agreed to close all outstanding KLOEs relating to Culture (complete) subject to the detailed report being circulated.
2.9 PAHT2030 Culture milestones	Yes	N	N	The Committee received an update on 2022/2023 People, learning and organisational development and communications projects/goals as well as the emerging themes of 2023/2024 People, learning and organisational development and communications projects/goals.
2.10 BAF Risk 2.3 Workforce:	Yes	N	N	Risk score to remain unchanged at 16; the controls had been updated.

BOARD OF DIRECTORS: Trust Board (Public) 8 June 2023 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: People Committee (PC)

REPORT FROM: Darshana Bawa – Committee Chair

DATE OF COMMITTEE MEETING: 1 June 2023

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
Inability to recruit, retain and engage our people				
2.11 Health and Wellbeing including strategy	Yes	N	N	Highlights of Health and wellbeing activities were noted and the strategy was commended.
3.1 Communications Update	Yes	N	N	PC noted the recent communications activities. An update was provided on the recently commissioned communications review.
4.1 Fit and Proper Persons	Yes	Y	N	The committee was assured that the Trust's eligible persons for the test are compliant.
4.2 Voluntary Services Strategy	For information	Y	N	The Committee considered the strategy and provided feedback. QSC will also review the strategy.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 8 June 2023**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**25 May 2023**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 M1 Integrated Performance Report (IPR)	Y	Y	N	Key headlines were: • **Diagnostics:** Performance had returned to common cause variation for a single data point but after seven months of being in special cause variation. • **Cancer 2 Week Wait:** Performance had returned to common cause variation for a single data point but after eight months in special cause variation. • **Cancer 62 Day Pathway:** Performance was back in common cause variation after a single data point in special cause variation following one month below the lower control limit. Focus was being placed on the long wait patients which was having an impact on the overall performance.
2.2 Report Against the Operating Plan	Y	Y	Y	The 2023/24 Operational Plan was presented and colleagues discussed Key Ambitions, Core Services & Productivity, West Essex, Performance Standards, Admissions and Occupancy, Operational Workplan, Pathway Improvement Work, East of England QI Programme, UEC Performance, UTC Update and Ambulance Rapid Release. Assurance was taken around the plan but the significant risks in terms of dependencies across the wider system were noted.

BOARD OF DIRECTORS:	**Trust Board (Public) – 8 June 2023**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**25 May 2023**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.3 BAF Risk 4.1 (Seasonal Pressures)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 12. It was noted that the risk now referred to 'seasonal' rather than 'winter' pressures, with that term also now being used regionally/nationally.
2.4 BAF Risk 1.3 (Recovery Programme)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 15.
2.5 BAF Risk 4.2 (ED 4 Hour Standard)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 20.
3.1 M1 Finance Update 3.2 Financial Forecast	Y	Y	N	The Trust had reported a deficit of £3.9m in month, and a £2.2m deficit in April was assumed in the final planning submission leaving an overall deficit of £1.7m against plan The impact of the industrial action in April and the likelihood of further and prolonged strikes would create pressure on staffing costs (both substantive and temporary) and activity delivery.

BOARD OF DIRECTORS:	**Trust Board (Public) – 8 June 2023**			**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**			
REPORT FROM:	**Colin McCready - Committee Chair**			
DATE OF COMMITTEE MEETING:	**25 May 2023**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
3.3 Capital Update	Y	Y	N	Total capital funding approved by the ICS was £14.3m. The actual requested plan for 23/24 was £42.2m of which £26.2m was internal, and £7.8m related to brought forward schemes thereby leaving an oversubscribed position by £11.9m. Only £6.5m of additional schemes was available to meet the CRL limit and a prioritisation exercise was underway to ensure all schemes were identified and in line with the Trust's risk matrix approach and those would now be considered.
3.4 Patient Quality & Productivity (PQP) Update	Y	Y	N	As at 16.05.23 £218k had been delivered against a trajectory of £298k for M1, therefore a current under-delivery of £80k. The PMO was aware of additional savings for M1 that were yet to be recorded, including procurement savings. It was expected that once that was recorded and verified it would mitigate the £80k under-delivery and would be shown in M2.
3.5 Business Planning Update	Y	Y	N	PAF acknowledged that the recent planning round had been challenging. A business planning group will be established and continuous forward planning will be introduced.
3.6 BAF Risk 5.1 (Finance – Revenue)	Y	Y	N	In line with the recommendation it was agreed that the risk score would remain at 12. The risk has been updated to reflect the position for the financial year 2023/24.

BOARD OF DIRECTORS:	**Trust Board (Public) – 8 June 2023**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**25 May 2023**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
3.8 Quarterly Procurement Update	Y	Y	Y	Key highlights to note for the quarter were: • The service had come in on budget for 22/23. • The 23/24 budget had been approved by Procurement Governance Board. • The service had delivered over baseline savings target for 22/23. • The service was forecasting in-year savings of £1.6m for 23/24. • The work-plan for 23/24 was complete. • Overall there had been good operational performance which had shown an improvement from the last quarter. • The workload continued to outstrip capacity on non-clinical Procurement.
4.1 BAF Risk 3.1 (Estate and Infrastructure)	Y	Y	N	In line with the recommendation it was agreed the risk score would remain at 20.
5.1 Community Diagnostic Centre	Y	Y	Y	PAF endorsed for Board approval the identification of a Principal Supply Chain Partner for the CDC.

The Princess Alexandra Hospital NHS
NHS Trust

BOARD OF DIRECTORS:	**Trust Board (Public) – 8 June 2023**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**25 May 2023**	

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
5.3 Quarterly eHealth Update	Y	Y	N	There was some good news in terms of data quality and how favorably the organisation compared to others. Coding issues had now been addressed and the position recovered with now less than 100 uncoded episodes. The Trust had often been required to undertake manual coding for outpatients but some software had now been developed to automate that which would also support the migration to the new electronic health record (EHR). There remained however resourcing issues in the coding team given requirements to work on site but the new EHR would reduce the need to manually code by 80%.

The Princess Alexandra Hospital NHS Trust

Trust Board – 8 June 2023

Agenda item:	6.2
Presented by:	Tom Burton, DoF
Prepared by:	Mark Pockett, DDoF
Date prepared:	30 May 2023
Subject / title:	Month 1 Financial Performance

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report provides an update on the Trust's financial performance for April 2023 (Month 1). The Trust reported a deficit of £3.9m in month, a £2.2m deficit in April was assumed in the final planning submission so we have an overall deficit of £1.7m against plan.
Recommendation:	The Committee is asked to note the month 1 financial results.

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

Previously considered by:	Verbal update at EMT and Performance and Finance Committee on the 25th May 2023
Risk / links with the BAF:	BAF risks 5.1 and 5.2
Legislation, regulatory, equality, diversity and dignity implications:	No impact on EDI identified.
Appendices:	See finance report attached

The Princess Alexandra Hospital NHS Trust

Summary finance notes

- PAHT has reported a deficit of £3.9m in month. This is £1.7m higher than planned.
- In the final planning submission, the Trust has agreed to a full year delivery of a £5.1m deficit which contributes to an overall breakeven plan for the ICS in 2023/24.
- All areas are now working within the PQP framework and developing many of the opportunities identified, progress on delivery and reporting is improving all the time.
- Nationally Trusts are being tasked with reducing patient waiting times and delivering elective recovery activity.
- The Trust's agency costs are higher in April than planned, this partially reflects the impact of the junior doctor's industrial action. Medical workforce is subject to on-going review within the Trust.
- The April pay performance reflects the assumed 2% staff pay award for both actual and planned costs. The revised 23/24 AFC offer is not reflected in the current position, in line with NHSE guidance, and is expected to be matched by additional income when these additional payments to staff are made in June.

Trust Board

The Princess Alexandra Hospital NHS Trust

April - Month 1

Finance Update

Monthly Summary

NHS
The Princess Alexandra Hospital
NHS Trust

As is normal for month 1 reporting due to the later planning submissions and annual accounts commitments, detailed budgets are loaded onto the finance ledger for month 2. The Financial update covers the main headline position and comparison against December – February monthly run rate.

- Income was impacted by lower than planned activity together with the Junior Doctors strike, this activity is anticipated to be recovered during the year.

- Agency spend remains at similar levels to the last 3 months. We have seen and can evidence changes in behaviour through the PQP work which has benefited the cost in month 1, however, usage remains higher than planned. The temporary staff cost budget has been phased evenly rather than front loaded which would have reflected the PQP work and the time these initiatives will invariably take to embed and deliver the full extent of the savings. We are modelling the impact of the Junior Doctors Strike on this.

- Non-pay is slightly above plan, however, there are several areas to investigate and understand and these will lead to further PQP opportunities to lower costs in the coming months.

Summary Financial Variance

The Princess Alexandra Hospital NHS

	Month 1 - April 23			FY 23/24
	Actual £'000s	Plan £'000s	Variance £'000s	Plan £'000s
Income	**£26,021**	**£26,427**	**(£406)**	**£344,767**
Pay				
Substantive	(£15,905)	(£17,495)	**£1,590**	(£214,025)
Bank	(£2,355)	(£370)	**(£1,985)**	(£4,154)
Agency	(£1,374)	(£605)	**(£769)**	(£5,872)
	(£19,634)	**(£18,470)**	**(£1,164)**	**(£224,051)**
Non Pay	**(£8,852)**	**(£8,613)**	**(£239)**	**(£107,825)**
Depn	(£1,266)	(£1,276)	**£10**	(£14,725)
PDC	(£363)	(£363)	**-**	(£4,357)
Int	£138	£64	**£74**	£775
	(£1,491)	**(£1,575)**	**£84**	**(£18,307)**
Total	**(£3,957)**	**(£2,231)**	**(£1,726)**	**(£5,416)**

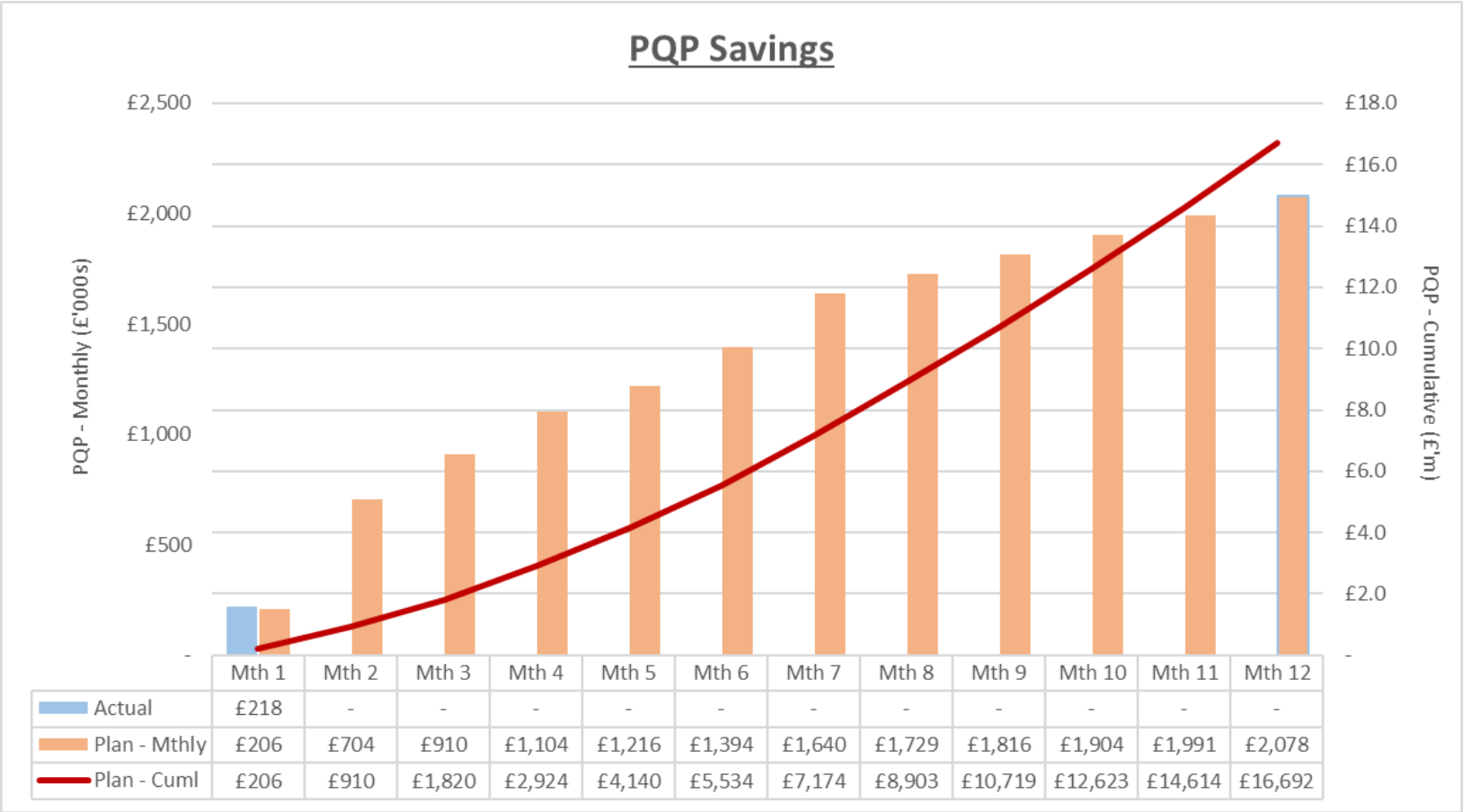
Summary Financial Run Rate

The Princess Alexandra Hospital NHS Trust

	Actuals			Average	
	Dec-22 £'000s	Jan-23 £'000s	Feb-23 £'000s	Dec-Feb £'000s	Apr-23 £'000s
Income	**£27,798**	**£28,671**	**£29,232**	**£28,567**	**£26,021**
Pay					
Substantive	(£15,293)	(£15,590)	(£16,168)	**(£15,684)**	(£15,905)
Bank	(£2,259)	(£2,584)	(£2,494)	**(£2,445)**	(£2,355)
Agency	(£1,420)	(£1,328)	(£1,351)	**(£1,366)**	(£1,374)
	(£18,972)	**(£19,502)**	**(£20,012)**	**(£19,495)**	**(£19,634)**
Non Pay	**(£9,062)**	**(£8,571)**	**(£8,911)**	**(£8,848)**	**(£8,852)**
Depn	(£1,026)	(£1,085)	(£1,047)	**(£1,052)**	(£1,266)
Impairment	-	-	-	**-**	-
PDC	(£398)	(£398)	(£38)	**(£278)**	(£363)
Int	£100	£92	£101	**£98**	£138
	(£1,323)	**(£1,390)**	**(£983)**	**(£1,232)**	**(£1,491)**
Total	**(£1,558)**	**(£792)**	**(£675)**	**(£1,008)**	**(£3,957)**

PQP

The Princess Alexandra Hospital NHS Trust



	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Mth 10	Mth 11	Mth 12
Actual	£218	-	-	-	-	-	-	-	-	-	-	-
Plan - Mthly	£206	£704	£910	£1,104	£1,216	£1,394	£1,640	£1,729	£1,816	£1,904	£1,991	£2,078
Plan - Cuml	£206	£910	£1,820	£2,924	£4,140	£5,534	£7,174	£8,903	£10,719	£12,623	£14,614	£16,692

Statement of Financial Position

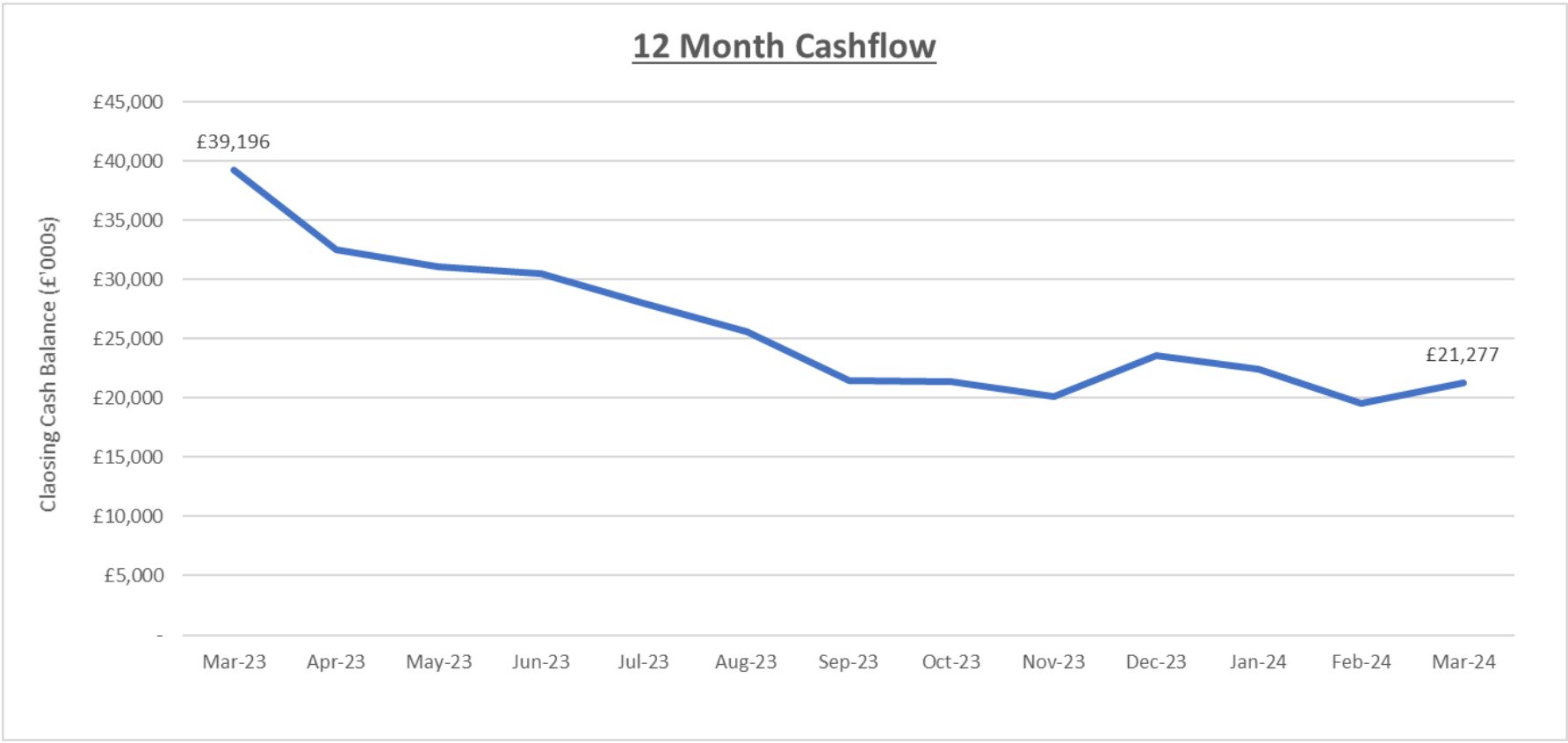
The Princess Alexandra Hospital NHS Trust

Statement of Financial Position	Mar-23	Apr-23	Movement In Month	Movement YTD
	£'m	£'m	£'m	£'m
Non-current assets				
Property, plant & equipment	164.9	164.7	(0.2)	(0.2)
Right of use assets	66.0	65.8	(0.2)	(0.2)
Intangible assets	15.6	15.3	(0.2)	(0.2)
Trade & other receivables	0.6	0.6	(0.0)	(0.0)
Non-current assets	**247.1**	**246.5**	**(0.6)**	**(0.6)**
Current assets				
Inventories	5.1	5.0	(0.1)	(0.1)
Trade & other receivables	15.1	13.6	(1.5)	(1.5)
Cash & cash equivalents	39.2	32.5	(6.7)	(6.7)
Current assets	**59.4**	**51.1**	**(8.3)**	**(8.3)**
Total Assets	**306.5**	**297.6**	**(8.9)**	**(8.9)**
Current liabilities				
Trade & other payables	(52.8)	(48.8)	4.0	4.0
Provisions	(1.2)	(1.2)	0.0	0.0
Borrowings	(0.0)	(0.0)	0.0	0.0
Current liabilities	**(54.0)**	**(50.0)**	**4.0**	**4.0**
Net Current Assets/ (Liabilities)	**5.4**	**1.1**	**(4.3)**	**(4.3)**
Total Assets less Current Liabilities	**252.4**	**247.5**	**(4.9)**	**(4.9)**
Non-current liabilities				
Trade & other payables	0.0	0.0	0.0	0.0
Provisions	(1.0)	(0.9)	0.0	0.0
Borrowings	(66.0)	(65.8)	0.2	0.2
Non-current liabilities	**(66.9)**	**(66.7)**	**0.2**	**0.2**
Total Assets Employed	**185.5**	**180.8**	**(4.7)**	**(4.7)**

Cash Position

The Princess Alexandra Hospital NHS Trust

	Apr-23 £000s	May-23 £000s	Jun-23 £000s	Jul-23 £000s	Aug-23 £000s	Sep-23 £000s	Oct-23 £000s	Nov-23 £000s	Dec-23 £000s	Jan-24 £000s	Feb-24 £000s	Mar-24 £000s
Opening Cash Balance	£39,196	£32,503	£31,114	£30,454	£28,005	£25,604	£21,476	£21,353	£20,090	£23,608	£22,388	£19,580
Closing Cash Balance	£32,503	£31,114	£30,454	£28,005	£25,604	£21,476	£21,353	£20,090	£23,608	£22,388	£19,580	£21,277



The Princess Alexandra Hospital NHS Trust

Public Board - Thursday 8 June 2023

Agenda item:	6.3
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	01 June 2023
Subject / title:	Integrated Performance Report (IPR)

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

Patients		
Patients	**Complaints**	Number received in month is the lowest since January 2021 and the seasonal downward trend evident for the second consecutive year
	Falls total, minor, moderate and severe	Total number of falls dropped to below the lower control limit for April. Due to it being a single data point outside of common cause variation we will monitor the trend
People		
People	**Appraisals**	Remains in common cause variation for the fifth consecutive month, and performance at the highest level since March 2020
	Statutory and Mandatory Training	Returned to common cause variation in March with performance at its highest level since May 2021
	Sickness Absence	Has remained in common cause variation
Performance		
Performance	**RTT**	Performance remains in special cause variation, with performance static at a similar level for over 12 months. Recovery actions continue to be in place, with patients being treated in clinical priority.
	Cancer 2 week wait	Performance has returned to common cause variation for a single data point, but after 8 months of being in special cause variation
	Cancer 62 day pathway	Performance is back in common cause variation after a single data point in special cause variation following one month below the lower control limit. Focus is being placed on the long wait patients, which is having an impact on the overall performance
	Four hour standard	Remains in special cause variation. A number of indicators are in special cause variation highlighting the continued pressure on the service. Performance data is currently for March
	Diagnostics	Performance has returned to common cause variation for a single data point, but after 7 months of being in special cause variation
	52 week waits	Still in special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained relatively constant for a significant period
	Stranded Patients	The number of patients with a length of stay over 7 days has reduced to near the mean for the first time since June 2022. However, the indicator remains in special cause variation. Performance data is currently for March
Pounds		
Pounds	Surplus	
	CIP	
	Capital Spend	
	Cash	
Places		
Places		

6.3

The Princess Alexandra Hospital NHS Trust

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

Previously considered by:	April Board Sub Committees
Risk / links with the BAF:	Links to all the 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:	M1 IPR

6.3

NHS
The Princess Alexandra Hospital
NHS Trust

Integrated Performance Report for April 2023

Executive Summary

The Princess Alexandra Hospital NHS Trust

Patients		
Patients	**Complaints**	Number received in month is the lowest since January 2021 and the seasonal downward trend evident for the second consecutive year
Patients	**Falls total, minor, moderate and severe**	Total number of falls dropped to below the lower control limit for April. Due to it being a single data point outside of common cause variation we will monitor the trend
Pounds		
Pounds	**Surplus**	
Pounds	**Cost Improvement Programme**	
Pounds	**Capital Spend**	
Pounds	**Cash**	
Places		
Places	**Domestic Services (cleaning) high risk**	Performance has reduced towards the lower control limit for October and November

People		
People	**Appraisals**	Remains in common cause variation for the fifth consecutive month, and performance at the highest level since March 2020
People	**Statutory and Mandatory Training**	Returned to common cause variation in March with performance at its highest level since May 2021
People	**Sickness Absence**	Has remained in common cause variation
Performance		
Performance	**Referral to Treatment**	Performance remains in special cause variation, with performance static at a similar level for over 12 months. Recovery actions continue to be in place, with patients being treated in clinical priority.
Performance	**Cancer 2 week wait**	Performance has returned to common cause variation for a single data point, but after 8 months of being in special cause variation
Performance	**Cancer 62 day pathway**	Performance is back in common cause variation after a single data point in special cause variation following one month below the lower control limit. Focus is being placed on the long wait patients, which is having an impact on the overall performance
Performance	**Four hour standard**	Remains in special cause variation. A number of indicators are in special cause variation highlighting the continued pressure on the service. Performance data is currently for March
Performance	**Diagnostics**	Performance has returned to common cause variation for a single data point, but after 7 months of being in special cause variation
Performance	**52 week waits**	Still in special cause variation, with a continued focus on clinical priority patients. The volume of patients waiting 52 weeks has remained relatively constant for a significant period
Performance	**Stranded Patients**	The number of patients with a length of stay over 7 days has reduced to near the mean for the first time since June 2022. However, the indicator remains in special cause variation. Performance data is currently for March

Section summaries

The Princess Alexandra Hospital NHS Trust

Performance	Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**
RTT - 18week performance	Significant improvement in the numbers of long waiting routine patients, expecting to be close to the national requirement for no 78 week breaches by 31/3/23.	For recognition
6 week diagnostics	The number of patients waiting longer than 6 weeks for a diagnostic significantly improved, CT has met the national standard for 3 months.	For recognition
Urgent Care	Continued poor 4 hour and ambulance handover performance however improvements in two clinical safety standards, triage in <15 minutes and 12+ hour waits for admission from ED.	For increased visibility and awareness
Cancer	Significant improvement in the 28 day diagnosis standard and the reduction in the number of patients waiting longer than 62 days. Expected to reduce the number of patients waiting over 62 days to pre-Covid levels by 31/3/23	For recognition

Section summaries

The Princess Alexandra Hospital NHS Trust

Performance	Board Sub Committee: People Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Sickness	Sickness absence workshops for managers are scheduled and taking place within divisions. Individual long term cases and actions discussed at management level	For information	Q2
Appraisal	Time constraints cites as reasons for non-compliance. Individualised reports sent to triumvirate and managers. Managers asked to book outstanding appraisals within the next month Compliance rates are addressed at PRMs	For information	Q2
Stat and Mand Training	Compliance remains static, challenges of protected time to complete training cited. There is a blended approach to training, delivered both via teams and face to face in the learning and education facility.	For information	Q2
Vacancy	Vacancy rate impacted by high level of vacancies within Nursing & Midwifery, Estates & Ancillary and A&C staff groups. Recruitment action plans continue to be agreed with divisions; recruitment team attending local job centre to highlight working for the Trust and to promote vacancies.	For information	Q3
Turnover	Leaving reasons are being linked to relocation due to cost of living and health and wellbeing. There is continued promotion of the trusts health and wellbeing offer including sessions on budgeting and access to Citizen's Advice sessions held on site. The trust have also undertaken a number of cost of living initiatives such as continuing free parking and access to Harlow community hub and food back. PAHT are part of the retention pathfinder programme within the ICS	For information	Q3

No escalations for patients, places and pounds

Key Performance Indicators In Special Cause Variation

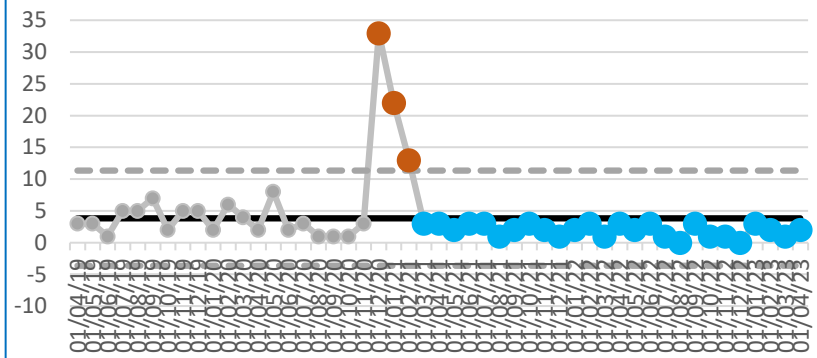
NHS
The Princess Alexandra Hospital
NHS Trust

5P Section	KPI	SPC status	Performance	BAF Risk Reference
Patients	Serious Incidents		2	1.1
Patients	Falls total		8	1.1
Patients	Pressure Ulcers per 1000 bed days		4	1.1
Patients	Smoking rates at delivery		8.60%	1.1
People	Vacany Rate		10.10%	2.3
People	Voluntary Turnover		16.30%	2.3
Performance	Referral to Treatment		51%	1.3
Performance	52 week waits		1870	1.3
Performance	4 hour standard		52%	4.2
Performance	Ambulance handovers less than 30 mins		24%	4.2
Performance	Patients over 12 hours in ED from arrival		1114	4.2
Performance	Patients over 7 days length of stay		172	4.2

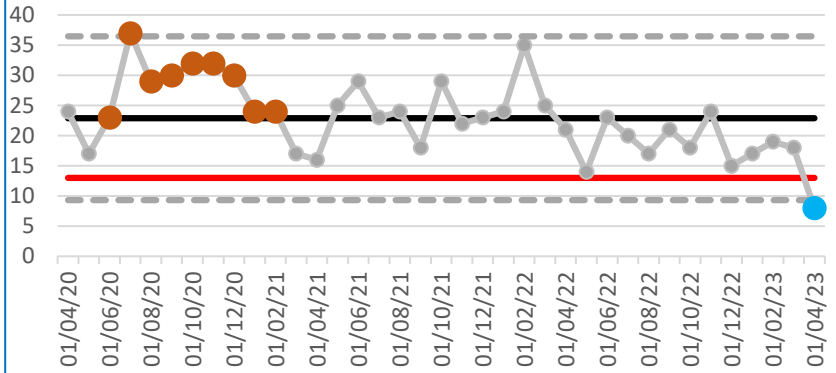
Patients section measures in special cause variation

The Princess Alexandra Hospital NHS Trust

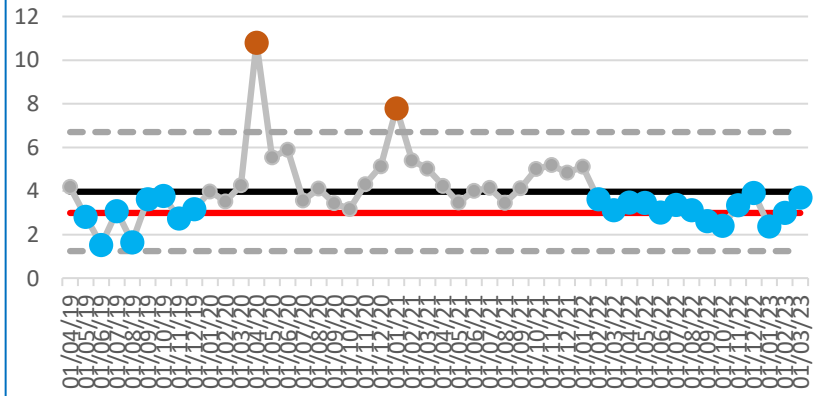
Serious Incidents



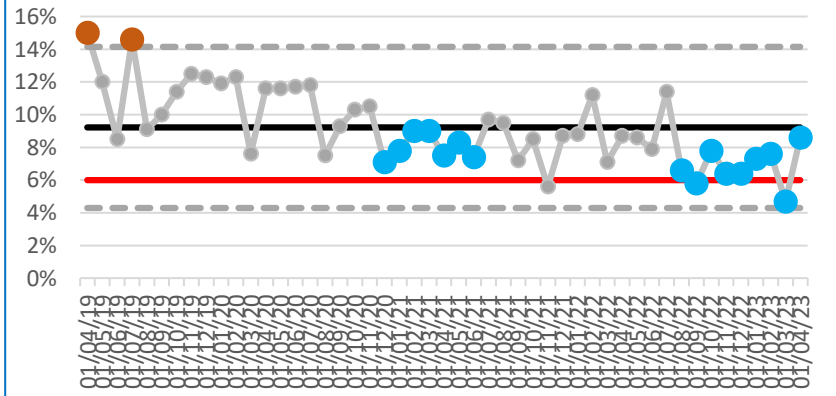
Falls total minor, moderate & severe



Pressure Ulcers per 1000 bed days



Smoking rates at delivery

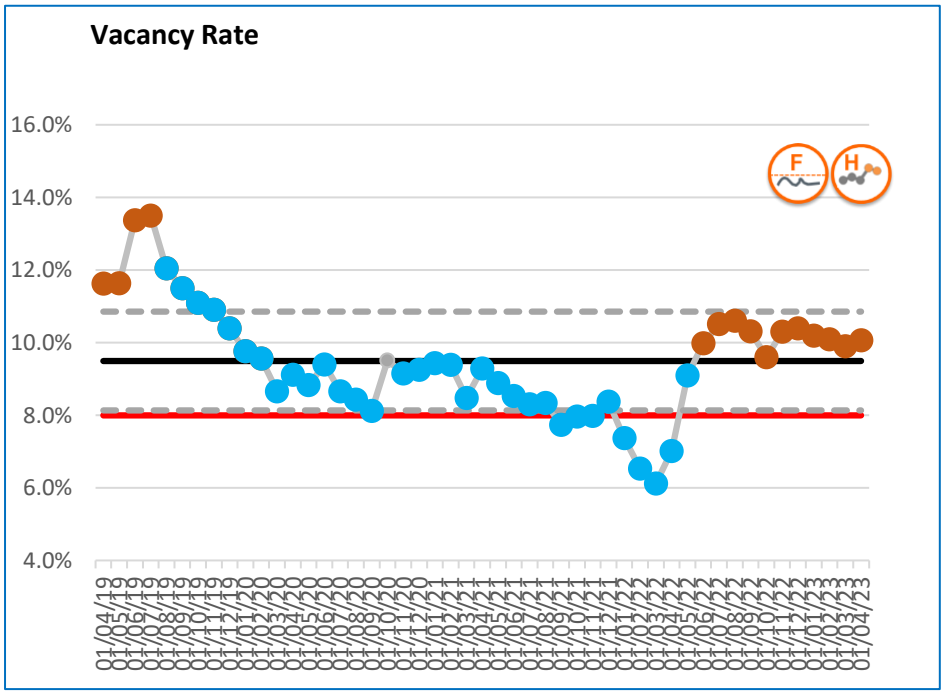


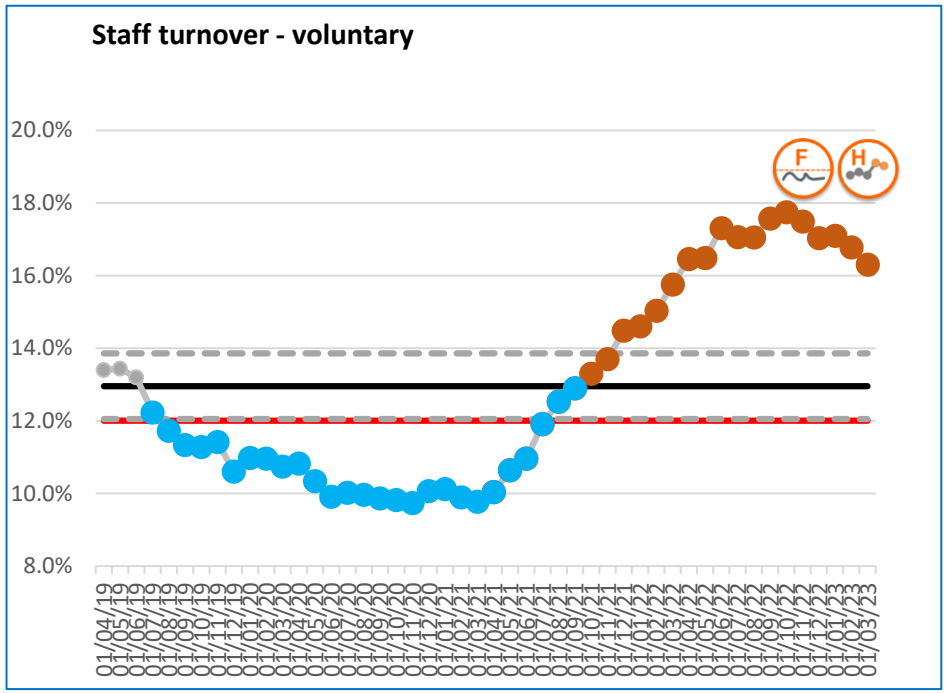
modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

People section measures in special cause variation

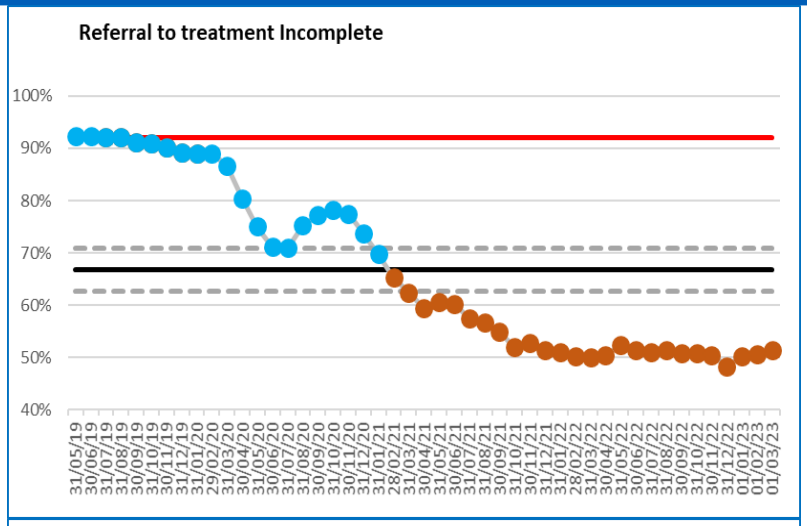
The Princess Alexandra Hospital NHS Trust

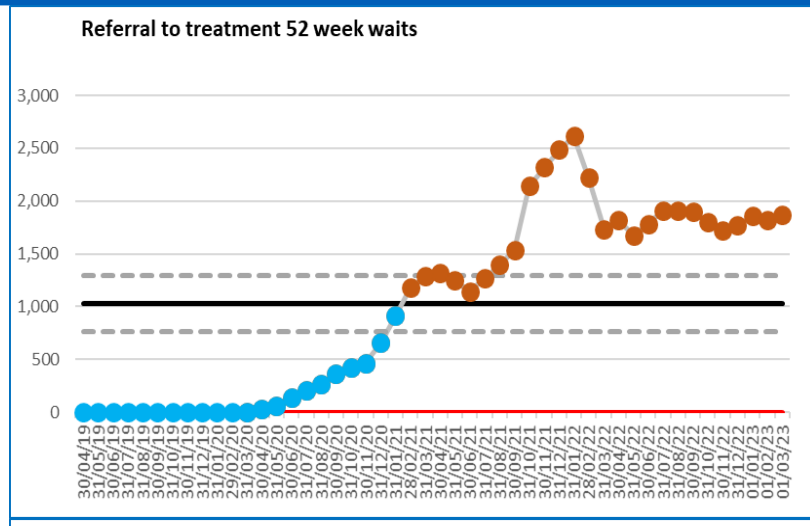


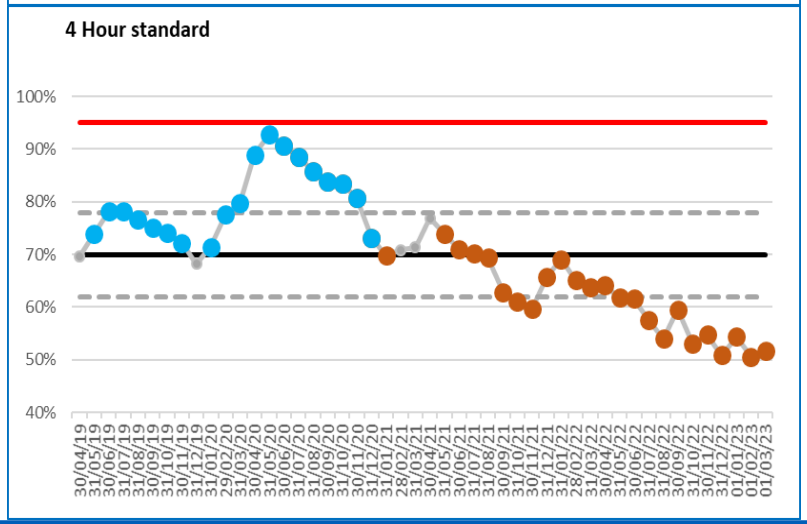


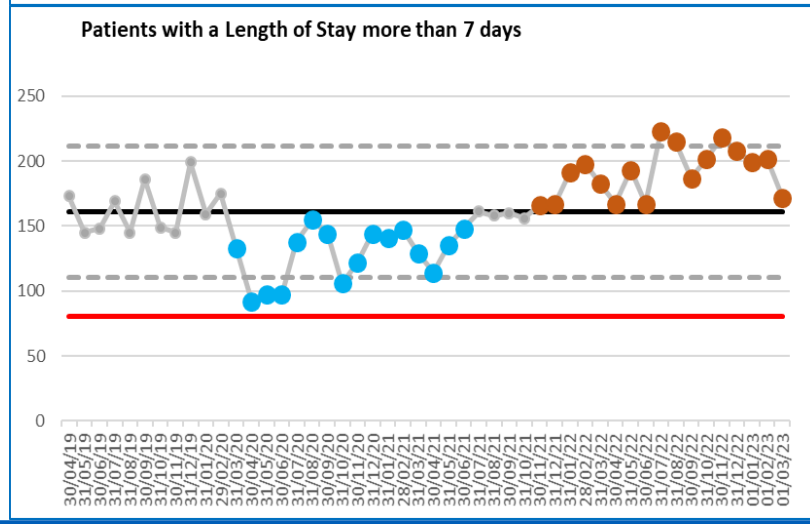
Performance section measures in special cause variation (1)

The Princess Alexandra Hospital NHS Trust







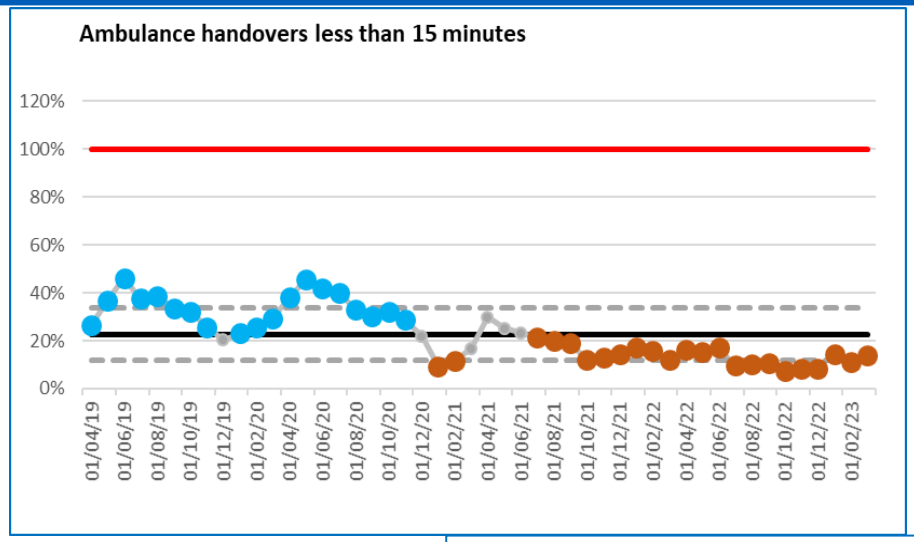


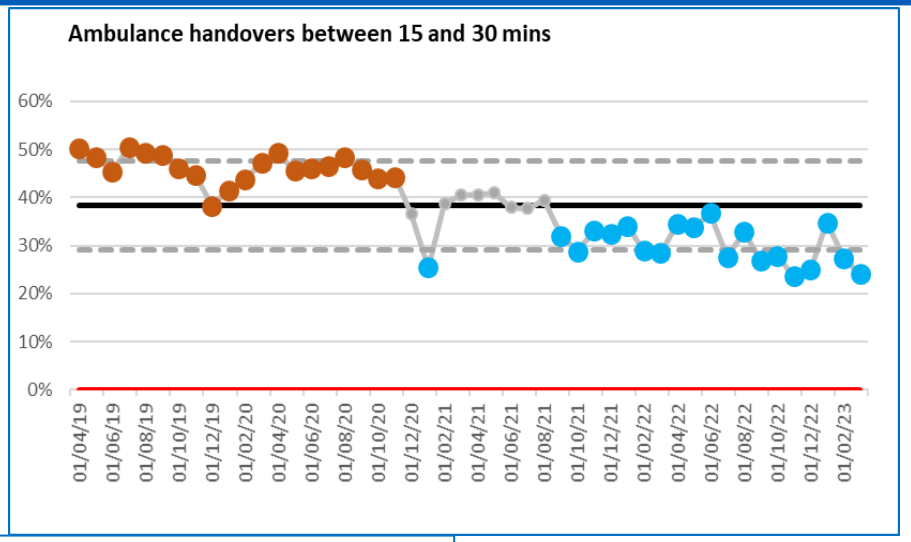
modern • integrated • outstanding

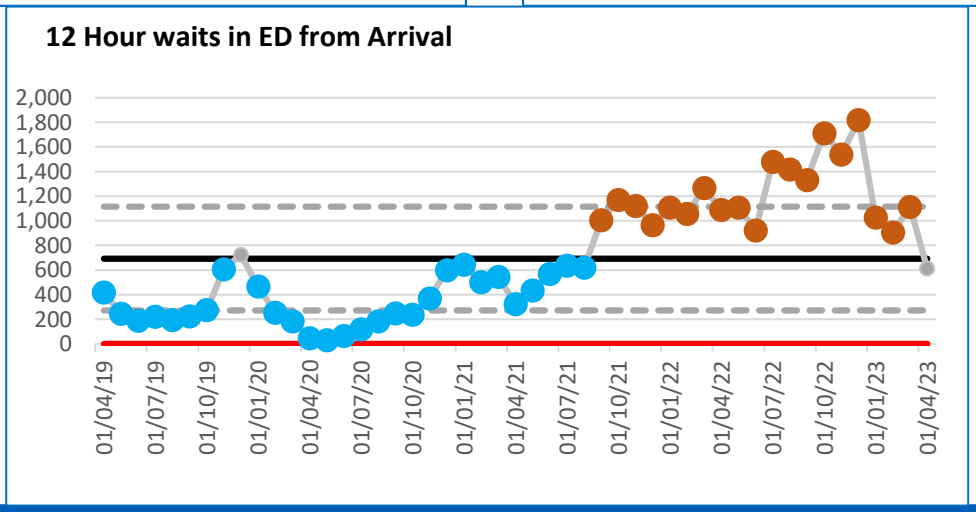
patient at heart • everyday excellence • creative collaboration

Performance section measures in special cause variation (2)

The Princess Alexandra Hospital NHS Trust







modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**8 June 2023**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**	
REPORT FROM:	**Elizabeth Baker – Committee Chair**	
DATE OF COMMITTEE MEETING:	**22 May 2023**	

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	Key headlines were: • **Transforming Our Care** remained in amber but was forecast to move to green. The reason for the amber rating was that 23 of the 27 strategies were in place but a number of delivery workshops were scheduled through May and June to turn those draft clinical strategies into delivery plans which would then uplift into PAHT2030 with some clear actions and milestones. • **Culture** milestones remained on track and there were a number which would be recommended for closure in July or to move into 2023 because some of those were ongoing pieces of work and would take longer but were, nevertheless making good progress. • Good progress had also been made on the **Digital** work-stream. The governance process was now nearing finalisation to design the key programmes of work over the next 12-18 months. That was happening through the EHR Programme Board and the detail of that would be lifted (once approved) into PAHT2030 and those key milestones would be tracked through STC and the EHR Programme Board.
2.2 Strategic Capital Projects	Y	Y	N	The Committee received an update on the progress to deliver the Community Diagnostic Centre (CDC) on the St Margaret's site. STC noted:

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:		**8 June 2023**		**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:		**Strategic Transformation Committee (STC)**		
REPORT FROM:		**Elizabeth Baker – Committee Chair**		
DATE OF COMMITTEE MEETING:		**22 May 2023**		
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				• The progress on developing the CDC and that the appointment of a Preferred Supply Chain Partner would enable more detailed designs and robust costings to be undertaken. • The risks to the project had been fully noted. • The current planned operational date for the CDC was April 2025.
2.3 New Hospital Update	Y	Y	N	The committee received an update on recent developments and the Board will receive an update at the meeting on 8 June 2023.
2.4 BAF Risk 3.5 (New Hospital)	Y	Y	N	In line with the recommendation it was agreed that the risk score should remain at 20.
2.4 BAF Risk 1.2 (Electronic Health Record)	Y	Y	N	In line with the recommendation it was agreed that the risk score should remain at 16.
3.1 Strategic/System Update	Y	Y	N	From an ICS perspective there had been discussions around the financial planning process. A system conference would take place later that week where participants would hear about the outputs from the recent Hewitt Review and the key elements to drive forward as a system.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:	**8 June 2023**			**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:	**Strategic Transformation Committee (STC)**			
REPORT FROM:	**Elizabeth Baker – Committee Chair**			
DATE OF COMMITTEE MEETING:	**22 May 2023**			
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 Partnership (WEHCP),	Y	Y	N	The priorities have reduced from 12 to 5 to focus on fewer elements and achieve delivery. All of those would benefit patients and link in with PAHT2030.
3.3 Stakeholder Update	Y	N	N	There had been continued engagement locally in relation to the new hospital programme. There had also been engagement at a national level in terms of housing and work was underway around a national investment model for housing including new models of funding. Staff/patient parking remained an issue for the Trust and conversations were starting around the requirement for a new offering. STC also noted that the 'Anchor Institutions Group' had been meeting to look at roles and how to work more collaboratively together.
3.4 BAF Risk 3.2 System Pressures	Y	N	N	In line with the recommendation it was agreed the risk score would remain at 16. The risk narrative would be reviewed prior to the next meeting to reflect discussions that day.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS:			**8 June 2023**	**AGENDA ITEM: 7.1**
REPORT TO THE BOARD FROM:			**Strategic Transformation Committee (STC)**	
REPORT FROM:			**Elizabeth Baker – Committee Chair**	
DATE OF COMMITTEE MEETING:			**22 May 2023**	
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
4.1 Discussion Topic: Health Inequalities	Y	Y	N	At this point in the meeting colleagues undertook their first informal discussion session on the chosen topic of Health Inequalities. Members discussed the topic in depth and the following key highlights were noted: • There was nothing in the organisation's strategic objectives around health inequalities. • Key themes of inequalities were skills capability, education, workplace and housing – all in decline in Harlow. • 9 year difference in life expectancy in Harlow between the worst deprived areas and least deprived areas (a distance of only 6-7 miles). • Opportunity with the Anchor Institution platform to do something significantly different. • Social responsibility to address inequalities and also as biggest employer in the town with many colleagues living in that most deprived area. • Great opportunity as major employer to work with other major employers to reinvigorate transformation in the town and upgrade/regenerate the town. • Support long-term conditions so better outcomes can be delivered. • Put more 'health on the high street' in the town centre.

BOARD OF DIRECTORS: Trust Board (Public) 8 June 2023 **AGENDA ITEM: 7.2**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Committee Chair

DATE OF COMMITTEE MEETING: 23 May 2023

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 External Audit – Value for Money Section 30 referral	Yes	Yes	No	The Committee noted the progress with the audit and considered the draft value for money report which identifies the deficit for 2022/23 as a significant risk to financial sustainability. Members discussed the system arrangements in relation to management of the deficit and considered how this could be reflected in the final version of the report. The section 30 referral was noted.
3.1 Internal Audit Progress Report, follow up on recommendations and Head of Internal Audit Opinion (draft)	Yes	Yes	No	Progress against the plan was noted with a few draft reports still to be issued. The IG team were commended for their DSPT audit result; substantial assurance over the design, a high level of confidence in the submission and no recommendations raised. The draft Head of Internal Audit Opinion was discussed; moderate assurance has been assigned.
Counter Fraud Progress Report, Annual Report from Counter Fraud Service including:	Yes	No	N/A	Good progress was being made in regards to counter fraud plans and activity. The national fraud initiative work was underway. The proposed self-assessed RAG ratings against the 12 counter fraud requirements within the annual return, due

BOARD OF DIRECTORS: Trust Board (Public) 8 June 2023 **AGENDA ITEM: 7.2**

REPORT TO THE BOARD FROM: Audit Committee

REPORT FROM: George Wood, Committee Chair

DATE OF COMMITTEE MEETING: 23 May 2023

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
• Counter Fraud Functional Standards Return				to be submitted to the NHS Counter Fraud Authority by 31 May 2023 were noted. The proposed overall rating is Green.
4.1 Draft Annual report and Annual Governance Statement	Yes	No	N/A	The Committee considered the draft and AGS and members were asked to provide feedback to the Head of Corporate Affairs.
4.5 Waivers, Losses, Special Payments and Debt Write Offs	Yes	Yes	N/A	During the period 1st January 2023 to 31st March 2023: The Value of losses and special payments totalled £506k (570 cases). Overall the number of non-compliant waivers has reduced. Members agreed that PAF would review the contract database.
The following items were noted: • Caldicott Guardian Annual Report • Legal Services Annual Report • Quality Account (draft)				

The Princess Alexandra Hospital NHS Trust

7.2

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board – 8 June 2023 **Item No: 7.3**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy
DATE OF MEETINGS: **02.05.23 & 16.05.23**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at SMT meetings in May:

02 May 2023:

- Reports from feeder groups: ICT Programme Board, Trust Policy Group, Children and Young Persons Executive Management Board (no escalations)
- Vascular Surgery & Rheumatology – change of Divisions
- Prioritisation of Cost Pressures
- Car parking
- Recovery Dashboard
- Elective Care Hub

16 May 2023:

- Reports from Divisional Board meetings
- Reports from other groups
- Risk training session
- Significant risk register
- Quality PMO update
- PQP update
- Statutory and mandatory training profiles
- This is Us week
- IPR
- SIRO report
- Finance
- Lease car scheme proposal

7.3