The Princess Alexandra Hospital NHS Trust

AGENDA
Public meeting of the Board of Directors

Date and time: Thursday 9 June 2022 at 09.00 – 12.15
Venue: Harlow Rugby Club, Howard Way, Harlow CM20 3FD

	Item	Subject	Action	Lead	
01 Opening administration					
09.00	1.1	Apologies	-	Chair	
	1.2	Declarations of Interest	-	Chair	
	1.3	Minutes from previous meeting	Approve	Chair	9
	1.4	Matters arising and action log	Review	All	20
09.05	Staff story: "The CESR pathway – the application route to specialist registration for doctors"				
02 Chair and Chief Executive's reports					
09.30	2.1	Chair's report	Inform	Chair	22
09.35	2.2	CEO's report including: • COVID-19 update	Inform	Chief executive	25
03 Risk					
09.50	3.1	Significant risk register	Review	Medical director	29
10.00	3.2	Board assurance framework 2022-23	Review/ Approve	Head of corporate affairs	36
04 Patients					
10.05	4.1	Report from Quality and Safety Committee 27.05.22: • Part I • Part II – Maternity Oversight	Note	Committee Chair	41 44
10.10	4.2	Maternity Incentive Scheme (MIS): Year 4 Reports	Assure	Director of nursing and midwifery	47
10.20	4.3	Maternity SI report	Assure	Director of nursing and midwifery	142
10.25	4.4	Nursing, midwifery and care staff levels including nurse recruitment	Discuss	Director of nursing and midwifery	146
10.30	4.5	Learning from deaths (Mortality)	Discuss	Medical director	167
05 People					
10.40	5.1	Report from Workforce Committee 23.05.22 including Terms of Reference:	Note/Approve	Committee Chair	173
10.45	5.2	Staff Survey update	Assure	Director of people and OD	180

10.55	5.3	Gender Pay Gap	Approve	Director of people and OD	208
		BREAK 11:05-11:15			
06 Performance/pounds					
11.15	6.1	Report from Performance and Finance Committee 26.05.22 including Terms of Reference	Note/Approve	Chair of Committee	214
11.20	6.2	Integrated performance report	Discuss	Chief Information Officer	223
07 Strategy/Governance					
11.30	7.1	Report from Strategic Transformation Committee 23.05.22	Inform	Chair of Committee	283
11.35	7.2	Report from Audit Committee 31.05.22	Inform	Chair of Committee	285
11.40	7.3	Report from Senior Management Team Meetings	Inform	Chair of Committee	288
11.45	7.4	NHS Provider Licence Self Certification	Approve	HoCA	289
08 Questions from the public					
12.00	8.1	Opportunity for members of the public to ask questions about the board discussions or have a question answered.			
09 Closing administration					
	9.1	Summary of actions and decisions	-	Chair/All	
	9.2	New risks and issues Identified	Discuss	All	
	9.3	Any other business	Review	All	
12.15	9.4	Reflection on meeting *(Is the Board content that patient safety and quality has been considered and there was evidence of good governance)*	Discuss	All	

Purpose:

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

Quoracy:

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

Ground Rules for Meetings:

1. The purpose of the meeting should be defined on the day (set the contract).
2. Papers should be taken as read.
3. The purpose of a paper must be clearly explained and the decision/s to be made must be identified.

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

Board Membership and Attendance 2021/22			
Non-Executive Director Members of the Board (voting)		**Executive Members of the Board (voting)**	
Title	**Name**	**Title**	**Name**
Trust Chair	Hattie Llewelyn-Davies	Chief Executive	Lance McCarthy
Chair of Audit Committee (AC) and Senior Independent Director	George Wood	Director of Nursing & Midwifery and Deputy CEO	Sharon McNally
Vice Chair and Chair of Quality & Safety Committee (QSC)	Dr. Helen Glenister	Chief Operating Officer	Stephanie Lawton
Chair of Performance and Finance Committee (PAF)	Colin McCready	Medical Director	Fay Gilder
Chair of Workforce Committee (WFC)	Helen Howe	Interim Director of Finance	Tom Burton
Chair of Charitable Funds Committee (CFC)	Dr. John Keddie	**Executive Members of the Board (non-voting)**	
Chair of Strategic Transformation Committee (STC)	Dr. John Hogan	Director of Strategy	Michael Meredith
Associate NED	Darshana Bawa	Director of People	Gech Emeadi
Associate NED	Anne Wafula-Strike	Director of Quality Improvement	Jim McLeish
Associate NED	Elizabeth Baker	Chief Information Officer	Phil Holland
Associate NED	Dr. Rob Gerlis		
Corporate Secretariat			
Head of Corporate Affairs	Heather Schultz	Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS Trust

List of Acronyms

A

- A&E - Accident and Emergency
- AAU – Adult Assessment Unit
- AD - Associate Director
- ADoN – Associate Director of Nursing
- ADT - Admission, Discharge and Transfer
- AfC - Agenda for Change
- AGM - Annual General Meeting
- AHP - Allied Health Professional
- AIS – Accessible Information Standard
- AKI - Acute Kidney Injury
- AMR - Antimicrobial Resistance
- ANP - Advanced Nurse Practitioner
- ANED – Associate Non-executive Director
- AWP – Annual Work Plan

B

- BAME – Black Asian and Minority Ethnic communities
- BAF - Board Assurance Framework
- BMA - British Medical Association
- BMI - Body Mass Index
- BPPC – Better Payment Practice Code

C

- CAMHS - Child and Adolescent Mental Health Services
- CAS - Central Alert System
- CCG - Clinical Commissioning Group
- CCU - Coronary Care Unit
- C.Diff - Clostridium Difficile
- CEA - Clinical Excellence Awards
- CEO - Chief Executive Officer
- CFC – Charitable Funds Committee
- CHD - Coronary Heart Disease
- CHPPD – Care Hours Per Patient Day
- CIO - Chief Information Officer
- CIP - Cost Improvement Plan
- CNS - Clinical Nurse Specialist
- CPO – Compulsory Purchase Order
- CQC - Care Quality Commission
- CQUIN - Commissioning for Quality and Innovation
- CRL – Capital Resource Limit
- CSU - Commissioning Support Unit
- CSS – Clinical Support Services
- CT - Computerised Tomography
- CTG – Cardiotocography

D

- DBS - Disclosure Barring Service
- DD – Divisional Director
- DOP – Director of Operations
- DGH - District General Hospital
- DHSC - Department of Health and Social Care
- DIPC - Director of Infection Prevention and Control
- DNA - Did Not Attend
- DNACPR - Do Not Attempt Cardiopulmonary Resuscitation
- DNAR - Do Not Attempt Resuscitation
- DNR - Do Not Resuscitate
- DoLS - Deprivation of Liberty Safeguards
- DSU - Day Surgery Unit
- DTA – Decision to Admit
- DVT - Deep Vein Thrombosis

E

- EDI - Equality Diversity and Inclusion
- EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortization
- ECG - Electrocardiogram
- ED - Emergency Department
- EDD - Estimated Date of Discharge
- EIA - Equality Impact Assessment
- EIS – Elective Incentive Scheme
- ENT - Ear, Nose and Throat
- EOLC - End of Life Care
- EoE – East of England
- EHR - Electronic Health Record
- EMT – Executive Management Team
- EPRR - Emergency Preparedness, Resilience and Response
- ESD - Early Supported Discharge
- ESR - Electronic Staff Record

F

- FAWS – Family and Women's Services
- FBC - Full Business Case
- FFT - Friends and Family Test
- FOI - Freedom of Information
- FTE - Full Time Equivalent

G

- GI - Gastrointestinal
- GMC - General Medical Council
- GP - General Practitioner
- GRE – Glycopeptide Resistant Enterococci

H

- HAI - Hospital Acquired Infection
- HASU - Hyper Acute Stroke Unit
- HCSW - Health Care Support Worker
- HCAI - Healthcare-Associated Infection
- HDU - High Dependency Unit
- HEE – Health Education England
- HEH – Herts & Essex Hospital
- HIMSS – Healthcare Information and Management Systems Society
- HMRC – Her Majesty's Revenue and Customs
- HSE - Health and Safety Executive

- HSIB – Healthcare Safety Investigation Branch
- HSLI – Health System Led Investment
- HSMR – Hospital-level Standardised Mortality Ratio
- HWB - Health and Wellbeing Board

I

- ICS – Integrated Care System
- I&E - Income and Expenditure
- ICO - Information Commissioner
- ICP - Integrated Care Pathway
- ICU - Intensive Care Unit
- IG - Information Governance
- IM&T - Information Management and Technology
- IPR – Integrated Performance Report
- IPC – Infection Prevention Control
- ITU - Intensive Therapy Unit / Critical Care Unit
- IV - Intravenous

J

- JAG - Joint Advisory Group
- JIC – Joint Investment Committee
- JLNC – Joint Local Negotiating Committee
- JSCC – Joint Staff Consultative Committee

K

- KPI - Key Performance Indicator
- KLOE – Key Line of Enquiry

L

- LA - Local Authority
- LCFS - Local Counter Fraud Specialist
- LD - Learning Disability
- LHRP - Local Health Resilience Partnership
- LiA - Listening into Action
- LMNS – Local Maternity & Neonatal System
- LOS / LoS - Length of Stay

M

- MAC – Medical Advisory Committee
- ME - Medical Examiner
- M&M - Morbidity and Mortality
- MDT - Multi-Disciplinary Team
- MIU - Minor Injuries Unit
- MRI - Magnetic Resonance Imaging
- MRSA - Meticillin-Resistant Staphylococcus Aureus

N

- NBOCAP - National Bowel Cancer Audit Programme
- NCASP - National Clinical Audit Support Programme
- NED - Non-Executive Director
- NHS – National Health Service
- NHSE – National Health Service England
- NHSE/I – National Health Service England & Improvement
- NHSP – NHS Professionals
- NICE - National Institute for Health and Care Excellence
- NICU - Neonatal Intensive Care Unit
- NMC - Nursing and Midwifery Council

- NNU - Neonatal Unit
- NRLS - National Reporting and Learning System / Service
- #NOF- Fractured Neck of Femur

O

- O&G - Obstetrics and Gynaecology
- OBC - Outline Business Case
- ODP - Operating Department Practitioner
- OHD - Occupational Health Department
- OOH - Out of Hours
- OP - Outpatient
- OPD - Outpatient Department
- OT - Occupational Therapist/Therapy

P

- PACS - Picture Archiving and Communications System / Primary and Acute Care System
- PACU – Post Anaesthetic Care Unit
- PALS - Patient Advice and Liaison Service
- PAF – Performance and Finance Committee
- PAS - Patient Administration System
- PBR - Payment by Results
- PBR Excluded – Items not covered under the PBR tariff
- PDC - Public Dividend Capital
- PE - Pulmonary Embolism
- PIFU – Patient Initiated Follow up
- PFI - Private Finance Initiative
- PHE - Public Health England
- PICC - Peripherally Inserted Central Catheters
- PID - Patient / Person Identifiable Data
- PID - Project Initiation Document
- PLACE - Patient-Led Assessments of the Care Environment
- PMO - Programme Management Office
- PPE - Personal Protective Equipment
- PPH – Post Partem Haemorrhage
- PRM – Performance Review Meeting
- PSED - Public Sector Equality Duty
- PTL – Patient Treatment List

Q

- QA - Quality Assurance
- QI - Quality Indicator
- QIP - Quality Improvement Plan
- QIPP - Quality, Innovation, Productivity and Prevention
- QIA - Quality Impact Assessment
- QOF - Quality and Outcomes Framework
- QSC – Quality and Safety Committee

R

- RAG - Red Amber Green
- RCA - Root Cause Analysis
- RCN - Royal College of Nursing
- RCP - Royal College of Physicians
- RCS - Royal College of Surgeons
- RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
- RTT - Referral to Treatment

S

- SDEC – Same Day Emergency Care Unit
- SHAW – Staff Health and Wellbeing
- SHMI - Summary Hospital-level Mortality Indicator
- SI - Serious Incident
- SIRI - Serious Incident Requiring Investigation
- SIRO – Senior Information Risk Owner
- SID - Senior Independent Director
- SJR – Structured Judgement Review
- SLA - Service Level Agreement
- SLR - Service-Line Reporting
- SLT / SaLT - Speech and Language Therapy
- SOC – Strategic Outline Case
- SMH – St. Margaret's Hospital
- SMR - Standardised Mortality Ratio
- SMT- Senior Management Team
- SoS - Secretary of State
- SSI(S) - Surgical Site Infections (Surveillance)
- SNAP - Sentinel Stroke National Audit Programme
- STF – Strategic Transformation Fund
- STP - Sustainability and Transformation Plan
- SI - Serious Incident
- SRR – Significant risk register
- STC – Strategic Transformation Committee

T

- TIA - Transient Ischaemic Attack
- TNA - Training Needs Analysis
- ToR – Terms of Reference
- TPN - Total Parenteral Nutrition
- TTA – Medication To Take Away
- TTO - To Take Out
- TUPE - Transfer of Undertakings (Protection of Employment) Regulations 1981

U

- UGI - Upper Gastrointestinal
- UTI - Urinary Tract Infection
- UTC – Urgent Treatment Centre
- UEC - Urgent and Emergency care

V

- VCOD – Vaccination as a condition of deployment
- VfM - Value for Money
- VSM - Very Senior Manager
- VTE - Venous Thromboembolism

W

- WHO - World Health Organization
- WTE - Whole Time Equivalent
- WFC – Workforce Committee

Y

- YTD - Year to Date

The Princess Alexandra Hospital NHS
NHS Trust

Minutes of the Virtual Trust Board Meeting in Public
Thursday 7 April 2022 from 09:30 to 13:00

Present:	
Hattie Llewelyn-Davis	**Trust Chair (TC)**
Darshana Bawa	Associate Non-Executive Director (ANED-DB)
Ogechi Emeadi (non-voting)	Director of People (DoP)
Rob Gerlis (non-voting)	Associate Non-Executive Director (ANED-RG)
Fay Gilder	Medical Director (MD)
Helen Glenister	Non-Executive Director (NED-HG)
John Hogan	Non-Executive Director (NED-JH)
Phil Holland	Chief Information Officer (CIO)
Helen Howe	Non-Executive Director (NED-HH)
John Keddie (non-voting)	Associate Non-Executive Director (ANED JK)
Lance McCarthy	Chief Executive Officer (CEO)
Jim McLeish (non-voting)	Director of Quality Improvement (DoQI)
Sharon McNally	Director of Nursing & Midwifery (DoN&M)
Saba Sadiq	Director of Finance (DoF)
Anne Wafula-Strike (non-voting)	Associate Non-Executive Director (ANED-AWS)
George Wood	Non-Executive Director (NED-GW)
In attendance:	
Ann Nutt	Chair of Patient Panel
Laura Warren	Associate Director – Communications
Patient Story:	
Shahid Sardar	Associate Director – Patient Experience
Kerry Riches	Head of Patient Experience
David & Debbie Conway de Waterford	Patient/Patient's Wife
Zoe Tucker	Volunteer
Philippa Haslehurst	Volunteer Services Manager
Members of the Public	
Suresh Mathavakkannan	Divisional Medical Director, Unplanned Care – ENH Trust
Apologies:	
Liz Baker (non-voting)	Associate Non-Executive Director (ANED-LB)
Colin McCready	Non-Executive Director (NED-CM)
Stephanie Lawton	Chief Operating Officer (COO)
Michael Meredith (non-voting)	Director of Strategy (DoS)
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 and in particular new Associate Non-Executive Director Rob Gerlis (ANED-RG). Board Observer Suresh Mathavakkannan from East & North Hertfordshire Trust was also welcomed.
1.1 Apologies	
1.2	Apologies were noted as above.
1.2 Declarations of Interest	
1.3	It was noted that ANED-RG remained Chair of West Essex Clinical Commissioning Group (WECCG).
1.3 Minutes of Previous Meeting	
1.4	These were agreed as a true and accurate reflection of the meeting held on 03.02.22 with the following amendment: In relation to minute 4.13 it was noted that in terms of the significant appointment of healthcare support workers, those were organisational appointments rather than specific to Urgent & Emergency Care (UEC).
1.4 Matters Arising and Action Log	

1.5	There were no matters arising and the action log was noted.
Patient Story: Connection Wins	
1.6	This item was introduced by the Director of Nursing & Midwifery (DoN&M) who welcomed David and Debbie Conway de Waterford to the meeting along with members of the Patient Experience/Volunteer teams.
1.7	Members were informed that the virtual visiting (VV) service had been an outcome of the COVID-19 pandemic where visiting to adult inpatient wards had been restricted and at times suspended. David Conway de Waterford (DaC) had been admitted to the hospital on 20.12.21 unwell and struggling to breathe. He had been admitted to John Snow Ward initially then moved to intensive care on 22.12.21. On the morning of Christmas Eve DaC was on face-time to his wife Debbie (DeC) however four hours later the decision was taken to put him into an induced coma and at that point he was unable to communicate independently with his wife.
1.8	Members noted the VV service had been vital in keeping DaC/DeC connected. It had provided new opportunities for visiting, enhancing the holistic care of patients. The story had highlighted the impact and importance of having VV in place as a visiting option. DeC explained how VV had lightened the load and how she would not have coped so well without it. In her words it had been a 'lifesaver'. The service had given great peace of mind and being able to see her loved one had helped aid recovery and had demonstrated how important it was to see a loved one whilst they were in hospital but also for the patient to see those at home, to see that they were also okay. The service had bridged the gap, kept the connection and had a positive impact on the healing process. Trust had been built with staff through the reassurance of seeing DaC and that their updates on him were honest and accurate. By seeing one another they could focus on getting DaC well. Extended family had also benefitted by receiving updates through DeC with her eye witness accounts.
1.9	In response to the above the CEO thanked the couple for sharing their story and he hoped that DaC continued to make a good recovery. He asked whether there was anything additional the organisation could have done better in terms of support. In response DeC commented that the service had been faultless, and at an extremely busy time for the organisation with it being Christmas and wave 2 COVID. When pushed she stated the provision of additional iPads would enhance the service even further.
1.10	At this point the DoN&M asked whether the Volunteer Service would like to comment in terms of some additional detail around VV and its sustainability. In response the Volunteer Services Manager (VSM) informed members that the VV service had commenced on 20.04.20 with colleagues from various teams including Quality First, Occupational Therapy, Medical Students (from ARU) and Patient Experience. Initially whilst many of the volunteers were furloughed the team had been plentiful but as colleagues returned to work the service had gone out to internal staff with requests for support. She confirmed the service had since been the winner of the 'Unexpected Innovations' Award 2021 from HETT (Healthcare Excellence Through Technology). There was also now additional service (Message to a Loved One) for those who couldn't use iPads.
1.11	The VSM was pleased to inform members that VV had made connections in 26 countries, had made 84 'End of Life' calls, 3107 virtual visits and there had been 2000 messages. The service had also managed to bring together a husband/wife who had been in hospital at the same time but on different wards and had also brought a couple together when there had been a birthday. She continued it had been a very emotional journey but staff were now working together for the benefit of patients and their wellbeing and was something the organisation must continue to run. She had been astonished at the increase in pace of recovery when patients could communicate and remain in touch with their families.
1.12	In response to the above the Chief Information Officer (CIO) informed DaC/DeC that it was his team who had supported the service technically and it would be wonderful for them to receive feedback on the story in terms of the difference it had made to the family and to DaC's recovery. He thanked them for sharing it. In response to a suggestion from NED George Wood (NED-GW) it was agreed the meeting recording be shared with the IT team.

ACTION TB1.07.04.22/01	Recording of Patient Story to be shared with IT Team. Lead: Chief Information Officer
1.13	In response to the above NED Helen Glenister (NED-HG) asked for consideration to be given to using the same technology to help more widely in the organisation in terms of communication with patients, which remained a key theme in terms of complaints.
1.14	At this point the DoN&M asked Volunteer Zoe Tucker (V-ZT) if she would like to make any reflections. In response V-ZT informed members she thoroughly enjoyed volunteering at the hospital and that it was the highlight of her week. She had been proud to be part of the VV service.
1.15	In response to the above the Medical Director (MD) commented that the story that day had been powerful and a reminder to colleagues of why they came to work. She had not previously appreciated the extent of the service and it had been wonderful to hear from DaC/DeC how meaningful it had been and how that had been brought to life for the Board that day.
1.16	The TC thanked all colleagues for a collaborative approach which had made the service possible and so useful/vital to patients. She also thanked DaC/DeC for agreeing to share their story.
02 Chair and Chief Executive Reports	
2.1 Chair's Report	
2.1	The TC presented her report which was taken as read, the key highlights of which she commented were the recent recruitment of new NEDs. She also added that she, along with the CEO and DoN&M had been privileged to attend the recent Patient Panel Away Day which had provided an insight into future areas of focus.
2.2	Members had no questions.
2.2 CEO's Report	
2.4	The CEO presented his update. He commented it was an opportunity to say a continued thank you to staff for how they continued to respond to COVID which continued to have a significant effect on all services. Infections were currently rising again slowly with, as of that day, 58 COVID inpatient, albeit numbers two days previously had been as high as 70. That continued to cause significant operational pressures in terms of managing those patients and separating known COVID patients from negative ones. The increased incidence in the community meant staff absences which added to the pressures.
2.5	The recovery programme continued and was going well despite the above. In terms of patients waiting over 104 weeks there were now only four (and they currently had COVID). Progress was also being made in relation to expanding the diagnostic offering and getting cancer activity back on track. ED demand remained unprecedented with a 25% increase in activity for the first three months of 2022 compared to pre-COVID demand. There had not only been an increase in volume but also in variability with one day in March seeing the lowest attendances at 273 followed (three days later) by the highest attendance at 495. In summary the organisation was one under significant pressure from all angles which was significantly impacting its staff too.
2.6	In terms of broader national COVID guidance the national spring booster campaign for over 75s or those who were immune-supressed had commenced. A decision was yet to be taken on the next phase of that, but it was likely to include healthcare workers. In terms of infection prevention and control (IPC) guidance the organisation continued to maintain strict standards including the wearing of masks for all staff/visitors and ensuring continued compliance with 'hands, face, space' messaging. In terms of testing, the IPC team were working through the new guidance and no changes had currently been made in the hospital. The DoN&M added the only change that would take place later that week would be a move to twice weekly lateral flow testing for patient facing staff but that would first require clarity on the definition of 'patient-facing'.
2.7	At this point the Chair of the Patient Panel (CoPP) asked how many patients were currently waiting under 104 weeks. In response the CEO stated he did not know exactly but the

	number was in the thousands. All patients had been communicated with and all clinicians were doing regular clinical reviews in terms of prioritising patients. Operational teams were then working on a plan to increase elective capacity going forward and a huge amount of work had been done with the ICS to maximise additional capacity and to work with surgeons/clinicians to link in with job planning to try and reduce the list of long waiters. The reality was it was likely to take the organisation two years to get back to pre-COVID levels but the organisation was working closely with partners to ensure it did its absolute best to move the recovery programme on as quickly as it could.
2.8	In response to the above the CIO drew members' attention to the graph on P168 which showed there were 2200 52 week waiters. The graph was accompanied by some commentary in terms of the plan going forward.
2.9	At this point NED John Hogan (NED-JH) asked for some additional detail in terms of the increased ED attendances - did it translate to an increase in admissions or an increase in those patients who could be treated in the Urgent Treatment Centre (UTC). In response the CEO informed members the organisation was not unique in terms of the increase, although its increase had been higher than many others in the ICS or East of England (EoE). In terms of case mix there had been an increase in those who were more acutely unwell and presenting later but also in those who were much less acutely ill (and could be referred to the UTC). The UTC had therefore seen a 50% increase in demand. The number of non-elective admissions coming through the ED were broadly the same as pre-pandemic levels and approximately 45-50 patients were being admitted daily through the department. So there had been a 25% increase in demand at the front door without there being an increase in the amount of patients requiring admission. Local GPs were under pressure too which was linked to the numbers making the decision to attend the ED instead.
2.10	NED-GW raised a concern in relation to the cancer position with national data suggesting that a third of patients were now being diagnosed only after attending the ED in pain. In response the CEO confirmed the early detection campaign had been thwarted by COVID and now linked to the work around community diagnostic hubs, a driver of the place-based partnership to work out how to more effectively support patients with early cancer diagnosis.
2.11	NED Helen Howe highlighted that the CEO had recently circulated some data around conversion rates and asked for some detail around why the hospital differed so much in some areas. In response the CEO confirmed there were a whole range of factors including differing populations and services. The CIO added the Trust's conversion rate had gone down – pre-pandemic it had been circa 23% and similar to others. The hospital had seen a significant increase in non-admitted patients – admissions and major presentations had predominantly stayed the same. There would be multiple factors for the increase in attendances and the organisation's location was part of that as there was little other 'walk-in' access for patients nearby. So the shoot up in demand had been for those requiring immediate access but who did not require admission and that was the trend that now needed to be addressed/responded to. There had also been a significant increase in mental health attendances which had also added to the pressures.
2.12	The CEO continued with his update in terms of Integrated Care Boards (ICBs). Those would be operational from 01.07.22 and had appointed to their Executive/NED posts.
2.13	In terms of *This is Us In Action* he drew members' attention to the list of achievements of amazing PAHT colleagues in terms of significant improvements for patients' experience and outcomes on a regular basis and in terms of improvements for colleagues. Many continued to be recognised widely for their achievements.
2.14	He then informed colleagues that following an Advisory Appointments Committee (AAC) on 24.02.22 an offer of appointment as consultant radiologist, specialising in musculoskeletal imaging had been made to Dr Taman Rifai and he requested that offer be ratified by the Board through delegated authority to the AAC. In line with the recommendation members ratified that appointment.
2.15	In response to a concern raised by the CoPP, the CEO agreed to circulate a list of ICB Board appointees. For any other queries he suggested she contact Jane Halpin, CEO Designate for Herts & West Essex ICB.

ACTION TB1.07.04.22/02	**Circulate a list of ICB Board members. Lead: CEO**
03 RISK/STRATEGY	
3.1 Significant Risk Register	
3.1	This update was presented by the MD and the paper was taken as read. She drew members' attention to a new risk which had not been included at the time of paper submission. That related to the risk around fractured neck of femur (#NoF) which was scoring 16.
3.2	There was one new risk scoring 20 which related to Maternity services and 'system working for women living in East Hertfordshire'. PAHT midwifery staff had escalated that risk to the team at East Hertfordshire Community CCG and the risk would also be discussed across the Local Midwifery Network Service with the monitoring of any incidents that occurred due to cross boarder working.
3.3	In line with the recommendation the Board noted the report and the new risk in relation to #NoF.
3.2 Board Assurance Framework 2021/22	
3.4	This item was presented by the Head of Corporate Affairs (HoCA) who informed members that all risks had been discussed at the appropriate Board Committee that month. There were no proposed changes to the risk scores, but there was a request for Board approval of a new risk relating to the risk of poor outcomes and patient harm due to long waits which had been scored at 15 with a target risk score of ten. The Chief Operating Officer (COO) would be the Executive Lead and the risk would be monitored at PAF who had already endorsed the risk for Board approval.
3.5	In response to the above NED-HH asked when the score for BAF risk 1.1 (variation in clinical outcomes) could be reduced given the sustained performance in terms of HSMR/SHMI. In response the MD stated that she would like to see some additional assurance in terms of sustained learning and improvement before the score was reduced particularly in view of all the pressures currently on the organisation. In response to a point made by NED-HH it was agreed the wording in the summary table ('higher than expected') would be amended for the next iteration.
ACTION TB1.07.04.22/03	**BAF risk 1.1 risk descriptor to be revised in summary table. Lead: Medical Director**
3.6	In response to the conversation above the CEO commented that the risk related to more than just mortality. It included complaints, SIs and the section 31 notice. NerveCentre would help support that but his suggestion would be the risk should be articulated differently at the start.
3.7	In line with the recommendation the Board approved the new risk (BAF risk 1.3 Recovery Programme) and noted the updates to the other risks.
04 PATIENTS	
4.1 Report from Quality & Safety Committee (QSC)	
4.1	<u>QSC Part I</u> This update was presented by NED-HG as QSC Chair. The paper was taken as read and she informed members the meeting had welcomed a WECCG observer (David Wallace – Deputy Director of Nursing & Quality). The Committee had been reassured around the transition of the Quality PMO into the Trust's PMO and also around #NoF work following a presenting by the Medicine Division. It had noted a higher number of MSSA bacteraemias but that a task and finish group would be established to review those. There had been partial assurance on the Patient Safety & Clinical Effectiveness Report to QSC. QSC had been assured on progress being made in key areas within the report and that robust processes were in place but a further update on the timings for closure of open incidents was required.
4.2	<u>QSC Part II – Maternity Oversight</u> This update was presented by NED-JH. The committee was assured about the progress being made with the dashboard and had requested that BAME data be included as well as a

	timeline for remedial actions in the exception reports. It had been assured on processes in place particularly those around systematic post-event learning and a summary report would be presented to the public Trust Board meetings. It had also received a report from the Maternity Safety Champions and Maternity Improvement Board. In terms of the latter it had discussed whether a deep dive into culture would be beneficial and had agreed that a small group would look into culture reporting and report back in two months' time.
4.2 Learning from Deaths Update	
4.3	This update was presented by the MD. In terms of the hospital standardised mortality ratio (HSMR) she was pleased to report there were now eight data points showing 'as expected'.
4.4	In terms of the #NoF work she was pleased to update that a piece of work had been undertaken through the #NoF working group on post-operative x-rays. In the pathway for #NoF patients they had their operation and should then have a post-operative x-ray in order to see whether the implant was correctly positioned before they could then be mobilised. The longer the wait, the more deconditioning took place (patient became weaker). The average wait for those x-rays had been 63 hours and was now down to 33 hours as a result of that work undertaken by Tye Green Ward and Radiology. There had also been a request to the site office that #NoF patients in ED be treated as a priority for admission to Tye Green Ward.
4.5	In line with the conversation above she reminded members that #NoF had been added to the SRR with a risk score of 16.
4.6	In response to the above the TC congratulated colleagues for the reduction in time for post-operative x-rays for #NoF patients.
4.7	NED-HH then requested a reminder as to what prompted a structured judgement review (SJR) and what would prompt a second review. In response the MD confirmed there were 12 criteria that would prompt a SJR including 'death with disability' and 'death after surgery'. A second review would be undertaken if there was concern the death had been avoidable having prior to that established an 'avoidability of death score'.
4.8	The TC thanked the MD for her update.
4.3 Maternity SI Report	
4.9	This update was presented by the DoN&M who advised that the paper had previously been seen by QSC Part II. She drew members' attention to the thematic learning which was very much a focus. She flagged an error in the paper – the narrative related to February but tables 1 & 2 reflected the January position. The new SI referred to was the one referenced at minute 3.2 above.
4.10	Members noted the update and the work of QSC Part II (Maternity Oversight).
4.4 Nursing Midwifery and Care Staff Levels including Nurse Recruitment	
4.11	This update was presented by the DoN&M and the paper had previously been presented to both QSC/WFC. QSC had agreed that month it no longer needed to see the paper.
4.12	The DoN&M drew members' attention to the addition that month in terms of the oversight of Maternity staffing in line with the Ockenden recommendations around assurance on workforce. She flagged that the overall fill rate remained in a vulnerable position due to staff absences associated with COVID, additional open capacity and the focus on the recovery programme.
4.13	In terms of UEC and the requirement for safe staffing to be compliant with the section 31 notice, she was pleased to report that the nursing fill rate was good, however the fill in terms of healthcare support workers remained a concern. The previous request for data around 'care hours per patient per day' had been added to the paper and in December the organisation had been pretty much in line with requirements which was good progress.
4.14	The DoN&M continued that the nursing and midwifery vacancy rate had been discussed in detail at WFC following the reconciliation of ESR and the inclusion of the establishment approved by the Board in December. The vacancy rate was now just shy of 10% with the expectation it would be reduced to around 2% by the winter.

4.15	The TC was able to inform members that feedback following a Board walkabout to Maternity the previous day had been there was recognition of the efforts to support staffing vacancies.
4.5 Ockenden Update	
4.16	This paper was also presented by the DoN&M and she informed members it had also been presented by QSC Part II (Maternity Oversight). The paper reflected the organisation's position at the end of November 2021. Good progress had been made on the evidence for some of the essential actions but there was work to do on others. That was not out of line with other organisations.
4.17	She continued that the leadership in Maternity Services had recently been strengthened, a Director of Midwifery, Divisional Director and Lead Governance Midwife had been appointed. There had also been a significant workforce review which had added additional leadership roles. Assurance had also been improved in terms of the Maternity Improvement Board/QSC Part II and there was also now a Maternity Safety Improvement Partner and links to the Regional Midwife. The national Ockenden support visit would take place the following day following the release of Ockenden II the previous week and would be presented to QSC at the end of April and then back to the Board.
4.18	There was a requirement now to report again against the seven actions from Ockenden I by 15.04.22 and that report would be presented to May Board.
4.19	In response to a discussion around more women electing to have a Caesarean section, NED-HH requested that some narrative be added to SPC charts in the IPR when changes were evidenced in the graphs that were down to something specific that was known.
ACTION **TB1.07.04.22/04**	**Add some narrative to the SPC charts where changes in graphs are evidenced due to factors that are known.** **Lead: Chief Information Officer**
4.20	In response to the above NED-HG reminded colleagues that QSC Part II had discussed the importance of culture in Maternity Services and how important it was too in the organisation as a whole. A focussed piece of work was now being undertaken around that.
05 PEOPLE	
5.1 Report from Workforce Committee	
5.1	This update was presented by NED-HH as chair of WFC. She informed members WFC had received assurance in terms of the plans in place to improve the outlying areas identified in the GMC survey. Medical rotas and junior doctors' health and wellbeing would be addressed in the next report in six months.
5.2	The Workforce Report had provided assurance on the progress being made to improve workforce metrics/KPIs and in terms of the Staff Survey there had been agreement for the results to be discussed at Board Workshop to provide assurance on how the results would be addressed. From a Finance Thematic Review the Committee had noted the key themes from exit questionnaires in the Finance Department and that an action plan would be completed by April.
5.3	WFC also noted the recent service developments within the People directorate including manager self-service, new starter e-forms and the introduction of the Recruitment & Retention Steering Group.
5.2 Staff Survey Results	
5.4	This update was presented by the DoP. The results had been circulated to all Board members and discussed at Senior Management Team (SMT) and with the divisions and other stakeholders. The results were disappointing but the Executive had committed to doing something differently to change things. The OD team were currently undertaking workshops with staff to dig deeper into the concerns. Further discussion would take place in the private session and at a Board Workshop in May. To put into context most trusts nationally had seen a significant reduction in their scores compared to previous years.
5.5	NED-JH commented it was upsetting to read that staff were not recommending the hospital as somewhere they would recommend family members were treated (which was at odds with

	the improvements in HSMR) and he was also shocked to see the numbers saying they had been physically abused. In response the DoP informed members that the latter was a long-standing issue in the NHS. Cases were reviewed and there was a zero tolerance in the organisation to abuse. The survey results however did not triangulate with other data held by the organisation. In terms of the former her view would be that linked to staff burn-out following COVID and staff feeling that they couldn't deliver the standards of care required. She believed too that staff felt obliged to come into work to cover for sick/absent colleagues when normally they wouldn't have.
5.6	In response to the above the MD stated too that the results were upsetting. Her reflection would be that the timing of the survey needed to be taken into consideration given it was soon after the publication of the CQC report and had influenced how staff had responded. That had then been followed by unprecedented pressures in the ED in terms of attendances.
5.7	Associate NED Darshana Bawa (ANED-DB) then asked how the Board could be assured that actions following previous surveys had been impactful. In response the DoP commented that there was evidence from benchmarking that some of the actions had been the right ones. In terms of organisation-specific actions those were being tracked but it took time to glean the data from that. The Trust had introduced the People Pulse to track impacts along with other KPIs being tracked via the WFC.
5.8	The DoN&M stated that for her there was something around aligning the work which was part of PAHT2030 with the culture work to track results and timeframes. It would be key that the Board was seen to be hearing the voice of its people and understanding the reality of working in the organisation so that it could reflect properly in terms of next steps and making a difference. The CoPP added that the Patient Panel would be happy to support any work around the survey results.
5.9	NED-HH reflected that WFC should receive a divisional update (as did QSC) but in relation to their people, rather than on patient safety and quality. It was agreed this would be discussed offline.
5.10	In response to a comment made by ANED-RG the DoP was able to confirm that the organisation's response rate to the survey of 47% was higher than the national average of 38%.
5.11	The TC thanked colleagues for the discussion. In line with the recommendation the Board had noted the outcomes of the Staff Survey and conversations that day would help shape the future Board Workshop. She requested the Executive reflect on the conversation that day, the challenges around communication and ensuring that staff knew the Board was hearing what they were saying and was committed to making a difference.
5.3 Equality, Diversity and Inclusion Board Champion	
5.12	This paper was presented by the DoP and the report sought approval to establish a Board champion role for equality diversity and inclusion to provide greater assurance and accountability in the delivery of the Trust's equality duty in regard to service-user health outcomes, experience and access to services, as well as how representative and supported the workforce was and inclusive leadership. It would bring the number of Board champions to six.
5.13	In line with the recommendation the Board approved the Trust Chair as the EDI Board champion and that the role would be reviewed after six months. As a final point ANED-AWS commented that all Board members should, indirectly, be EDI champions – colleagues agreed.
Break 1127-1140	
06 PERFORMANCE/POUNDS	
6.1 Report from Performance & Finance Committee	
6.1	In the absence of NED Colin McCready the paper was taken as read. In response to a question from NED-JH in relation to the Acute Assessment Unit (AAU) deep dive it was confirmed the main focus of that had been on the financial aspect. The Director of Finance

	(DoF) confirmed that after the item PAF members had then discussed the purpose of a deep dive and had taken away an action to review that and what deep dives were trying to achieve.
6.2	In response to a question from NED-HH in terms of insourcing, the DoF confirmed it was when the services of a clinical team were purchased and they came on site to deliver that service.
6.2 Integrated Performance Report	
6.3	This update was presented by the CIO and key highlights were as follows: • The significant amount of work undertaken by the IPC team in relation to Clostridium difficile (C-diff). • The significant drop in cancer two week wait performance (with further details to be provided on actions in place to address that and some benchmarking data). • The improvements in performance in diagnostics albeit still with a lot of work to do to return to target.
6.4	In response to a question from NED-HH in relation to the cost improvement programme (CIP) the DoF agreed the majority of achievements for 2021/22 had been non-recurrent. She acknowledged that delivery should be recurrent wherever possible but a paper to the private session detailed the CIP focus and efficiencies for 2022/23 but she recognised the non-recurrent element of delivery would need to be found in the new financial year.
6.5	In response to another question it was confirmed that compliments had been received in February but staffing issues were causing a delay in those being recorded on the system. As a final point the CIO informed members he would now undertake an annual review of the format of the IPR and he requested any thoughts/comments be sent directly to him within the next two weeks.
ACTION **TB1.07.04.22/05**	**Feedback on the format of the IPR to be given to the CIO.** **Lead: Board Members**
6.3 Amendment to Standing Financial Instructions	
6.6	This paper was presented by the DoF who reminded colleagues that the Trust's current Standing Financial Instructions (SFIs) required its people to obtain three quotes for goods or services for £500 to £4,999. The change proposed involved increasing the limit from £500 to £10,000 and would make the organisation consistent with other ICS providers and their SFIs. The revision had been agreed by the Audit Committee chair on 03.03.22 and ratified by the Audit Committee on 07.03.22.
6.7	In line with the recommendation the Board approved the change to the SFIs.
07 STRATEGY/GOVERNANCE	
7.1 Report from Strategic Transformation Committee including Terms of Reference 22/23	
7.1	This update was presented by NED-JH and the key highlights from the meeting were as follows: • New terms of reference approved. • PAHT2030 – assurance on the process of oversight and noting of the work in progress and development of an outcomes framework to measure successes. • Electronic Health Record (EHR) – good progress was noted and that the BAF risk score of 16 would remain. • New hospital - the current position was noted and that further clarification on the commercial strategy was awaited from the national New Hospital Programme. • One Health & Care Partnership (OHCP) – assurance that work streams were in place but challenges noted in terms of the different models of operation currently in place across Essex compared to Hertfordshire. • System update – this was noted and that the Board would receive a further update in its private session.

	• Enabling strategies - an update on the development of the strategies underpinning delivery of PAHT2030 was noted and that next steps included alignment of the strategies and development of an outcomes framework. • Digital transformation strategy – this was recommended to the Board for approval.
7.2	In response to a concern raised by NED-GW in terms of backlog maintenance (with the new hospital programme currently stalling) it was agreed that risk would be discussed further at STC.
ACTION TB1.07.04.22/06	**Risk around backlog maintenance to be discussed further at STC. Lead: Director of Strategy & Estates**
7.3	In relation to the OHCP it was agreed that ANED-RG (as a member of STC) would support the requirement for a continued discussion in terms of the future of hospital services being out of hospital and getting teams into the community. NED-JH commented he would appreciate that and in his view there should be a template of consultant-led care across the board on a system based practice which should take responsibility for the delivery of care across that specialty across both primary and secondary care.
7.4	In response to the above the CEO stated that out of hospital care was present in all the clinical strategies being developed, particularly at place level and he would very much welcome ANED-RG onto the STC to continue the conversation further.
7.5	In line with the recommendation the Board noted the report and approved the STC's terms of reference.
7.2 Digital Transformation Strategy	
7.6	The strategy was presented by the CIO and looked beyond the new hospital build through to 2030, considering how digital could enable the PAHT2030 goals. The strategy had been developed collaboratively with patients, staff and partners, and had been informed by insights from advanced digital hospitals and health systems around the world to ensure the organisation had taken into account health and social inequalities as well as equality and diversity, and in particular digital exclusion. The overarching digital strategy brought together and aligned the significant amount of work done to date by PAHT on digital transformation.
7.7	In response to the above NED-HH commented that although the strategy appeared comprehensive, it did not look revolutionary. In response the CIO stated that nowhere in the world had yet put all of the elements together into one. Places overseas had done elements and were probably the best examples of the most digitally enabled hospitals.
7.8	In response to a concern raised by ANED-RG in terms of alignment with working practices already out there, the CIO provided assurance that interoperability and access were fundamental elements of the output based specification (OBS).
7.9	In line with the recommendation the Board approved the Digital Transformation Strategy.
7.3 Report from Audit Committee (AC) 07.03.22	
7.10	This report was presented by NED-GW. He informed members the organisation was still working with its outgoing Internal Auditors who had been very supportive in finalising all audits. 'Satisfactory' assurance was still awaited but he was confident that would be achieved.
7.11	AC had noted the audit of the DSPT (data security protection toolkit) had received substantial assurance and the information governance training was at 95% prior to the 20/21 DSPT submission. Caldicott Guardian training was at 95%.
7.4 Report from Senior Management Team Meetings	
7.12	This report was presented for noting and members had no comments.
7.5 Corporate Trustee: Report from CFC.11.03.22	
7.13	This report was presented by ANED-JK. He updated that CFC had approved a number of initiatives involving investing in the infrastructure for example 'tap to donate' machines and 'door drop' appeal to promote the charity. Both would require an investment of funds which the committee had agreed. In terms of the charity action plan there would be a requirement

	for an overarching strategy moving forward but the action plan had been agreed in the interim. He hoped the investments would reap dividends.
7.6 Report on Use of Trust Seal	
7.14	This paper was presented by the HoCA and set out the use of the Trust Seal from 01.04.21 to 31.03.22. The Seal was used in order to execute a deed or agreement when required to do so by law, for example, the conveyance of land. It was a requirement for the Board to have oversight of its use on an annual basis.
7.15	The Board noted the report.
08 QUESTIONS FROM THE PUBLIC	
8.1	It was noted that the CoPP had asked her questions during the course of the meeting.
09 CLOSING ADMINISTRATION	
9.1 Summary of Actions and Decisions	
9.1	The TC summarised that requests had been approved during the course of the meeting and the updates to risks had been noted. The Board had also requested further work on issues related to communication. The most important element for her had been the impact of the patient story and how a relatively small thing could make an enormous difference to people's lives.
9.2 New Issues/Risks	
9.2	No new risks/issues were identified.
9.3 Any Other Business (AOB)	
9.3	In response to a point raised by NED-HH it was confirmed that the key points from the meeting would be circulated to staff in line with a previous Board action.
9.4	In response to a comment from NED-GW in relation to staff hardship and what more could be done the DoP confirmed that discussions at WFC were ongoing. An initial goodwill payment had been made to staff on lower bands but the conversations would continue in conjunction with the ICS on how staff could be supported further. It remained high on the organisation's agenda. In response to a comment from the CoPP it was confirmed that consideration was being given to subsidising the staff restaurant even further and conversations had started with the Citizens' Advice Bureau.
9.4 Reflection on Meeting	
9.5	Members agreed that good consideration had been given to patient safety and quality throughout the meeting and good governance had been evidenced. Suresh Mathavakkannan thanked the Board for the opportunity to observe its meeting which had been a useful learning experience for him.
9.6	The meeting closed at 12:22.

Signed as a correct record of the meeting:	
Date:	02.06.22
Signature:	
Name:	Hattie Llewelyn-Davis
Title:	Trust Chair

ACTION LOG: Trust Board (Public) 09.06.22

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.07.10.21/07	Risk Management Approach/Appetite	Provide an update to Trust Board (for Q1) on progress with revising the risk management approach and risk appetite.	DoN&M MD	Q1 2022/23	Item not yet due.	Open
TB1.02.12.21/12	IPR	Data on theatre productivity to be added to the Integrated Performance Report (IPR).	CIO COO	~~TB2.13.01.22~~ ~~TB2.03.03.22~~ TB2.05.05.22	Actioned.	Closed
TB1.07.04.22/01	Patient Story	Recording of Patient Story to be shared with IT Team.	CIO	TB1.09.06.22	Actioned.	Closed
TB1.07.04.22/02	ICB Board Members	Circulate a list of ICB Board members.	CEO	TB1.09.06.22	Actioned.	Closed
TB1.07.04.22/03	BAF Risk 1.1 (Clinical Outcomes)	BAF risk 1.1 risk descriptor to be revised in summary table.	MD	TB1.09.06.22	Actioned.	Closed
TB1.07.04.22/04	Integrated Performance Report: SPC Charts	Add some narrative to the SPC charts where changes in graphs are evidenced due to factors that are known.	CIO	TB1.09.06.22	Actioned.	Closed
TB1.07.04.22/05	Integrated Performance Report	Feedback on the format of the IPR to be given to the CIO.	Board Members	TB1.09.06.22	None received.	Closed

ACTION LOG: Trust Board (Public) 09.06.22

The Princess Alexandra Hospital NHS Trust

Action Ref	Theme	Action	Lead(s)	Due By	Commentary	Status
TB1.07.04.22/06	Backlog Maintenance	Risk around backlog maintenance to be discussed further at STC.	DoS	TB1.09.06.22	Actioned.	Closed

The Princess Alexandra Hospital NHS Trust

2.1

Public Meeting of the Board of Directors 9th June 2022

Agenda item:	2.1
Presented by:	Hattie Llewelyn-Davies
Prepared by:	Hattie Llewelyn-Davies
Date prepared:	31.5.22
Subject / title:	Chair's Report

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	To inform the Board, other colleagues and members of the public about my role and to increase knowledge of the role and my accountability for what I do.
Recommendation:	The Board is asked to discuss the report, give feedback for future content and note it.

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

Previously considered by:	Not applicable
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	EDI has been taken into account in setting my annual objectives and as reported recently I am now the Board's EDI champion.
Appendices:	None

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1.0 Purpose

This report outlines what is at the top of my agenda and what I have been doing in the last few months. This time it also includes my annual appraisal outcomes.

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 Background

I was appointed as the new chair of PAHT following an external recruitment campaign and came into post in September 2021. All NHS Trust Chairs undertake an annual 360 appraisal, done by the Senior Independent Director (SID).

3.0 Appraisal

My appraisal was undertaken in early May by George Wood, who is the SID. The outcomes were that I had settled in well and those who responded to the request for feedback felt that I was doing a good job. It was recognised that both for me and for the Trust creating a strong positive role within the ICS/B and the creation of the Place would be a key demand for my role over the next year.

The objectives set by George and sent off for approval to the regional team are:

Objective	Anticipated benefit/ measure of success
Improve ratings from the CQC and other external assessments. Ensure that PAH play a full and engaging role working with our partners across the ICS/ICB.	More responsive care for our patients. Reduced waiting times for elective and also improve bed capacity in the community. Prioritise investment to the most needed.
Using the Deloitte Well led review and the staff survey to further develop the board, Executive Team and the culture of our organisation.	Increase the confidence of our Executive Directors and to utilise the experience of the Non Executives more. Improve staff morale and really make PAH a place people want to work at, and stay.
Develop role as the Board EDI Champion.	All decisions by the board reflect our Commitment to this area of our work

Other activities held in the last few months include having a very successful event taking forward some of the recommendations of the Well led review; undertaking a number of walkabouts to meet staff and patients and see our services first hand; attendance at two staff onboarding events, which are really great events to go to; time mentoring other NHS Chairs who are new to their role; attending a regional meeting for Chairs and CEO's and spending time supporting the establishment of the ICB.

4.0 Recommendation

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

Author: Hattie Llewelyn-Davies. Trust chair.
Date: 31.5.2022

The Princess Alexandra Hospital NHS Trust

2.2

Trust Board (Public) – 9 June 2022

Agenda item:	2.2							
Presented by:	Lance McCarthy - CEO							
Prepared by:	Lance McCarthy - CEO							
Date prepared:	01.06.22							
Subject / title:	CEO Update							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	
Key issues: please don't expand this cell; additional information should be included in the main body of the report	This report updates the Board on key issues since the last public meeting: - COVID-19, recovery and Urgent and Emergency Care - Monkeypox - Maternity services - New hospital - Integrated Care System and Board developments - This is Us *In Action*							
Recommendation:	The Trust Board is asked to note the CEO report and the progress made on key items.							

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

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

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Chief Executive's Report
Trust Board: Part I – 9 June 2022

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

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

I want to continue to reiterate my thanks to all my colleagues at PAHT for their hard work and amazing response to the COVID-19 pandemic, our recovery of elective activity and our response to the ongoing unprecedented demand for urgent and emergency care services.

As the economy continues to open up and start to live with COVID-19, it is important to recognise that a large number of new infections in our local community continue, impacting on hospital inpatient admissions as a result. The proportion of COVID-19 positive inpatients requiring critical care support however remains much lower than in the first two waves. At the time of writing this paper there were 28 COVID-19 positive inpatients in the Trust, of which 1 was receiving critical care support.

We are continuing to work closely with West Essex Health and Care Partnership (HCP) and Integrated Care System colleagues, local cancer alliance and our local independent sector colleagues to maximise every opportunity for our longest waiting and most urgent patients to receive the interventions they require in a timely manner. We are making strong progress in recovering all of our services with most of our planned activity now greater than pre-pandemic levels. More detail is available in the Integrated Performance Report.

We continue to see unprecedented and sustained demand for our urgent and emergency care (UEC) services and the recent pattern of increasing variability in daily attendance numbers continues. Our Red ED remains open for respiratory based cases and we continue to work closely with our HCP colleagues to further enhance our Urgent Treatment Centre and our streaming and triaging processes within the ED.

The planning and preparation for the implementation of a new electronic health record in ED (Nervecentre) continues well with implementation starting in mid-June. This will further support timely triage based on the Manchester triage system, will enable all patient records and information to be captured in a single system and will support the improvements made by the ED teams for risk assessments and care planning, a core requirement of our Section 31 notice from the CQC.

As we move to living with COVID-19, our Infection Prevention and Control (IPC) team continue to review national and local guidance with regard to the management of patients and the testing of patients, visitors and colleagues. We continue to maintain high levels of vigilance within the hospital settings including strong compliance with IPC guidelines related to wearing masks at all times, maintaining 2m social distancing where possible and complying with good handwashing and ventilation. We have eased some of the restrictions on visiting and will continue to review other restrictions over time as the national guidance changes and as local infection rates change.

(2) Monkeypox

Monkeypox is a rare infectious disease that is not normally seen in the UK. At the time of writing the report there had been 179 confirmed cases across the country, 2 of which had been confirmed positive at PAHT. Neither of the 2 individuals were admitted.

Our IPC team have been working closely with our ED colleagues to ensure full understanding of presenting symptoms and appropriate actions to undertake, including the use of the appropriate Personal Protective Equipment (PPE). The team are in close liaison with UKHSA and all relevant authorities and all relevant guidance for colleagues is available on our intranet site.

(3) Maternity services

Our enhanced governance and oversight of our maternity services continues well with through our separate maternity focussed Board assurance committee as part of our Quality and Safety Board Committee.

Good progress is being made with the implementation of relevant actions aligned with the recent recommendations from the Ockenden review of maternity services at the Shrewsbury and Telford Hospital NHS Trust.

Since the last Board meeting we also received confirmation from Helen Vernon, Chief Executive of NHS Resolution that following a deep dive in to our evidence, including additional reviews from external agencies, that the department has met all 10 safety actions of the year 3 CNST Maternity Incentive Scheme (MIS). This demonstrates strong governance and oversight in the department and creates a strong base for the year 4 MIS actions, which will be presented to the Trust Board as well as through the Quality and Safety Committee.

(4) New hospital

We continue to work on the development of the new Princess Alexandra Hospital in conjunction with the national New Hospital Programme (NHP).

The pace of work to develop our Outline Business Case (OBC) has slowed, whilst we await the output of the NHP Design Convergence Review, the approval of the NHP National Programme Business Case by HM Treasury and the prioritisation of the Cohort 3 schemes (frontrunner 8 hospitals and the hospitals with Reinforced Autoclaved Aerated Concrete (RAAC) planks that have deteriorated). Subject to the outputs of these and any design changes required as a result we will be in a position to complete our OBC this year.

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

(5) Integrated Care System and Board developments

The Health and Care Bill received royal assent on 28 April, included in which is the creation of Integrated Care Boards (ICBs) as formal legal entities from 1 July.

Hertfordshire and West Essex (HWE) Integrated Care System (ICS) colleagues continue to work at pace to finalise the structure of the new ICB, with all Executive Director and 3 Non-Executive Director appointments made.

Since the last Board meeting, Toni Coles has been appointed as the place-based leader for our local West Essex Health and Care Partnership and nominations for partner members from Hertfordshire and Essex County Councils, primary care, acute, community and mental health providers have also been received.

The ICB will taking on the functions and responsibilities of the 3 Clinical Commissioning Groups (CCGs) from 1 July and will have strategic oversight responsibilities for health and care across HWE. It will also ensure that health and care operates more effectively and in a more integrated manner at local level through the 3 place-based health and care partnerships.

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

(6) This is Us *In Action*

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

- Celebrations of and awards for nursing and midwifery colleagues for International Nurses Day and International Day of the Midwife
- Recognition of ODP and HR days
- Start of our 6-month PAHT 2030 Ready OD programme to support our senior leaders to work in a way that enables all of our colleagues to be the best that they can be and implement the transformational changes to underpin PAHT 2030
- Complete refresh of Event in a Tent to create 'This is Us week' in June (27 June to 2 July) with a series of events for everyone to celebrate, recognise and develop our people
- Our Amazing People awards nominations complete and colleagues volunteering to assess the nominations in advance of the awards ceremonies in This is Us week
- Embedding of our new onboarding programme, welcoming all of our new starters to PAHT in a more positive and seamless way
- Fortnightly video diary championing the work in different departments and services across the Trust
- Development of our protected characteristics fora as we put EDI at the forefront of how we work
- Embedding of the new Divisional and Directorate structures and triumvirates
- £5 Costa Coffee voucher for all colleagues

Author: **Lance McCarthy, Chief Executive**
Date: **1 June 2022**

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

The Princess Alexandra Hospital NHS Trust

TRUST BOARD – 2 JUNE 2022

3.1

Agenda item:	3.1							
Presented by:	Fay Gilder - Medical Director							
Prepared by:	Lisa Flack – Compliance and Clinical Effectiveness Manager Sheila O'Sullivan – Associate Director of Quality Governance							
Date prepared:	24 May 2022							
Subject / title:	Significant Risk Register							
Purpose:	**Approval**		**Decision**		**Information**	√	**Assurance**	√
Key issues:	This paper presents the Significant Risk Register (SRR) for all our services. The Significant Risk Register (SRR) is a snapshot of risks across the Trust at a specific point and includes all items scoring 15 and above. The overall number of significant risks on the register has reduced to 64 (table 1 and section 2). One new risk scoring 20 has been raised. The main themes for 13 risks scoring 20 on the SRR are: • Seven for our performance: two ED access standard, three referrals to treatment standards, one cancer-waiting times and one for bed pressures on the emergency pathway. • Three for our people - consultant cover in obstetrics and nursing cover in paediatric urgent care (FAWS), anaesthetic medical cover (surgery). • Two for our patients: electronic storage of maternal CTG reports and system wide midwifery care with East Hertfordshire • One for our places regarding the maternity unit requiring refurbishment (**NEW**). • Actions taken and mitigations in place for each of these risks are detailed in section three. One new risk scoring 16 raised: To improve speed of transfer of patients with fractured neck of femur from emergency department to Tye Green ward. No new risks scoring 15 raised since 3 March 2022.							
Recommendation:	Trust Board are asked to note the contents of the Significant Risk Register please							
Trust strategic objectives: please indicate which of the five Ps is relevant to the subject of the report	**Patients**	**People**	**Performance**	**Places**	**Pounds**			
	√	√	√	√	√			

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Previously considered by:	This paper has been reviewed by Senior Management Team Risk Management Group reviews risks on a rotation; each service is monitored quarterly as per annual work plan.
	Divisions and corporate teams review their risks at their local governance meetings
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

1.0 Introduction

This paper details the Significant Risk Register (SRR) across the Trust; the registers were taken from the web-based Risk Assure system on 10 May 2022. The Trust Risk Management Group meets monthly and reviews risks across the Trust, including significant risks.

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

2.0 Context

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

There are 66 significant risks on the risk register, the same number as in the paper discussed in March 2022 at Senior Management Team and April 2022 at Trust Board. The breakdown by service is detailed is in table 1.

Table 1 – Significant Risks	**Risk Score**				
	15	**16**	**20**	**25**	**Totals**
Covid-19	1 (1)	1 (1)	1 (1)	0 (0)	**3 (3)**
Cancer & Clinical Support	2 (3)	12 (14)	0 (0)	0 (0)	**14 (17)**
Communications	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Estates & Facilities	4 (3)	3 (3)	0 (0)	0 (0)	**7 (6)**
Finance	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Health Safety and Resilience	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
Information Data Quality and Business Intelligence	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
IM&T	1 (1)	2 (2)	0 (0)	0 (0)	**3 (3)**
Integrated Hospital Discharge Team	0(0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Learning from deaths	0(0)	0 (1)	0(0)	0 (0)	**0 (1)**
Nursing	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Operational	2 (2)	1 (1)	4 (4)	0 (0)	**7 (7)**
Research, Development & Innovation	0 (0)	1 (0)	0 (0)	0 (0)	**1 (0)**
Workforce - training	1 (1)	0 (0)	0 (0)	0 (0)	**1 (1)**
FAWs Child Health	3 (2)	1 (1)	4 (4)	0 (0)	**8 (7)**
FAWs Women's Health	3 (4)	4 (4)	1 (0)	0 (0)	**8 (8)**
Safeguarding Adults	1 (1)	0(0)	0 (0)	0 (0)	**1 (1)**
Safeguarding Children	0 (0)	1 (1)	0 (0)	0 (0)	**1 (1)**
Medicine	0 (0)	0 (0)	0 (0)	0 (0)	**0 (0)**
Surgery	0 (0)	1 (1)	3 (4)	0 (0)	**4 (5)**
Urgent & Emergency Care	1 (1)	2 (2)	0 (0)	0 (0)	**3 (3)**
Totals	**20 (20)**	**31 (33)**	**13 (13)**	**0 (0)**	**64 (66)**

(The scores from paper presented at SMT in March and Trust Board in April 2022 are detailed in brackets)

3.0 Summary of risks scoring 20 and above

There are 13 risks with a score of 20. A summary of these risks and mitigations is below:

3.1 Our Patients

Family and Women's

3.1.1 Electronic storage of Cardiotocography (CTG) for obstetrics

- The Trust needs electronic storage of CTG to cover antenatal and intrapartum care, (20202/06/01 raised in June 2020, score adjusted as software programme requires investment).
  Action: Currently all notes are available on paper and the team make copies where there is a known outcome that the CTG will be required for a review post-delivery. A number of electronic systems have been demonstrated of centralised monitoring with decision pending of which to procure to provide CTG storage centrally.

3.1.2 System working for women living in East Hertfordshire

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

3.2 Our People

3.2.1 Family and Women's teams

Consultant cover in obstetrics

- Consultant cover improved, achieves 90 hours per week with extra ward rounds as recommended in the Ockenden report, against the national requirement of 98 hours a week for units with 4,000-5,000 deliveries per annum. There is a high potential for obstetric consultants needing to be called into the trust (2020/10/01 December 2020). Our unit has approx. 3,800 deliveries per annum, which means we should have 60 hours of cover, but we are aspiring to be better than the minimum.
  Action: All consultant job plans have been reviewed and job descriptions amended. Recruitment is planned for two new WTE substantive roles, as staff are due to come off the on-call rota for health reasons. We are unlikely to be at 98 hours in the short term. A hot week consultant role is in place, to ensure there are twice daily ward rounds on labour ward as per Ockenden recommendations.

Nursing cover for paediatric emergency and urgent care unit

- Paediatric ED nursing workforce has vacancies (5.8WTE) and high numbers of staff on maternity leave (8WTE), with further staff to go off over the coming months (4WTE). Paediatric ED attendance has increased by 10% in last year with a reduction in the numbers of patients being admitted. Ward acuity can support the sharing of the nursing team across both areas and not compromise safety, (PED03/03/2021 raised in March with score increased in October as result of increasing numbers of staff off the rota).

Action: Four band 6 staff in place (three are secondments), oversees nurses recruited and going through local training, band 7 post now vacant as post-holder has finished in the Trust. Daily mitigation in place for joint children rotas across the service allowing staff to move across ward, ED to meet patient acuity and maintain skill mix. Additional staff sourced through NHSP & agency, rolling band 5 posts out to advert.

3.2.2 Surgery Team

Medical cover for the anaesthetic service

- Insufficient numbers of anaesthetists of all grades impacting the staffing rota and being able to flexibly cover during out of hours periods (Anae001/2018 raised November 2018 and score increased in October as elective activity lists are restricted to six per weekday).
  Actions: Daily review of rota, shifts out to NHSP/locum agency, recruitment is ongoing with three consultants recently appointed, start date to be confirmed. Emergency and urgent elective workload is prioritised. Plan to develop business case to increase establishment based on increasing demands on the service

3.3 Our Performance

3.3.1 ED performance

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

- Compliance with the statutory standard for the Emergency department (ED) (001/2017 on operations team register since April 2014)
- Achieving the standard of patients being in ED for less than 12 hours (002/2016 raised July 2016 on operational team register)
  Actions: Daily monitoring of previous days breaches, numbers & patterns of Attendance to facilitate changes to ED pathway and improve performance. ED board rounds daily and daily huddle to review treatment plans and pathways (7 days per week). Internal professional performance standards agreed and implemented. Electronic tracking process in place to ensure escalation to consultant and nurse in charge if patient is not meeting internal professional standards. East of England escalation process in place to reduce ambulance offload delays.

3.3.2 Cancer access standard

- Not achieving 85% of all patients referred by GP to receive treatment within the cancer 62-day standard (005/2016 on register since July 2016)
  Actions: Recovery action plan for each tumour site is monitored with robust tracking. Revised patient target list (PTL) has granular information for oversight of individual patients on cancer pathway to ensure action detailed weekly by patient on the pathway.

3.3.3 Referral to treatment standards

Three risks associated with performance against the national standard

- Risk of 52-week breaches because of the pandemic, pauses to OPD clinics and elective surgical activity. The numbers of patients waiting between 40 to 52 weeks is monitored and tracked by operational teams (Operational register 006/2017 and S&CC004/2020B)

Action: Working with STP partners to manage paediatric urology, patients booked in order of clinical priority, monitoring of PTL continues weekly, with cancer PTL reviewed daily. Plan to address longer term service provision underway with Addenbrooke's and E&N Herts.

- Achieve SCC 92% RTT standard, risk of non-compliance (S&CC002/2015 raised 2015 with score amended in March 21 due to worsening position)
  Action: Patients are risk stratified as per NHSI guidance. Elective programme to recommence 22 March 21. Monitored through daily PTL meetings and access RTT meetings and outsourcing continues.

3.3.4 Bed pressures for emergency care

- Significant pressure on medical beds due to Covid-19 and ongoing increased non Covid-19 emergency demand (C19-058 on Covid-19 register).
  Action: Close forecasting of Covid demand and review of elective activity and where necessary cancelling of elective surgery has enabled the Trust to have adequate capacity ahead of winter pressure. Daily bed planning meetings to review both Covid and non-Covid for the day, week and future to devising and implement solutions. Acute Covid regional transfers can be completed as required to maintain safety.

3.4 Our Places

3.4.1 Maternity Unit

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

3.5 Our Pounds: Nil

4.0 NEW One new risk with a score of 16 raised since 3 March 2022

4.1 NEW: Learning from deaths

- To improve the compliance from time of arrival in the emergency department (ED) to placement on Tye Green ward for patients with a fractured neck of femur to improve patient outcomes (2022/02/01)
  Action: Fast track pathway agreed, being used to expediate move to ward. Timely administration of fascia iliac blocks if possible in ED to improve pain control and long-term outcomes. Development of non-symptomatic Covid-19 pathway for these patients to be promptly moved to Tye Green. An escalation bed to be kept free unless released by silver-on-call manager to facilitate prompt transfer of patient. To share information early to multi-disciplinary team to ensure timely journey through the trust.

4.2 No new risks with a score of 15 raised since 3 March 2022

5.0 Recommendation

Trust Board are asked to review the contents of the Significant

Risk Register and to note the new risks added.

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

Date: 24 May 2022

The Princess Alexandra Hospital NHS Trust

Trust Board – 9 June 2022

3.2

Agenda item:	3.2
Presented by:	Heather Schultz – Head of Corporate Affairs
Prepared by:	Heather Schultz – Head of Corporate Affairs
Subject / title:	Board Assurance Framework 2021/22

Purpose:	**Approval**		**Decision**		**Information**		**Assurance**		
Key issues:	The Board Assurance Framework is presented for review and approval. Following feedback received a revised BAF reporting format is being trialled this month and members are asked to provide feedback on this format. The risks have been updated with executive leads and reviewed at the relevant committees during May 2022. The detailed risks were presented to committees. Following review at QSC in May 2022 it is proposed to reduce the risk score for BAF risk 1.0 Covid from 16 to 12. The risk is attached with updates reflected in red font for ease. BAF risk 3.2 (Financial and Clinical Sustainability across health and social care system) is also attached for consideration by the Board (the Board is responsible for reviewing this system risk). The remaining risk scores have not changed this month and are summarised in Appendix B.								
Recommendation:	The Board is asked to: • approve the reduction in score for BAF risk 1.0 Covid from 16 to 12 • note the updates to the other risks discussed in committees • comment on the revised reporting format								
Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**				
	x	x	x	x	x				

Previously considered by:	STC, QSC, WFC and PAF in May 2022. The Covid risk was also discussed at EMT in May 2022
Risk / links with the BAF:	As attached.
Legislation, regulatory, equality, diversity and dignity implications:	NHS Code of Governance and risk management processes. The controls and mitigating actions outlined in the risks are designed to support delivery of the Trust's strategic objectives and promote an organisational culture that drives improvements in equality, diversity and inclusion.
Appendices:	Appendix B – BAF dashboard Appendix C – BAF risk 1.0 Appendix D – BAF risk 3.2

The Princess Alexandra Hospital NHS Trust

3.2

Board Assurance Framework 2022/23 (BAF)

Purpose:

The Board Assurance Framework forms part of the overall risk management and assurance process for the Trust. The BAF enables the Board to maintain oversight of the principal risks to delivery of the Trust's strategic objectives.

Each BAF risk is mapped to the strategic objectives (5P's) and the detailed risks are presented to the committees on a bi-monthly basis.

Each risk has an executive lead and is assigned to a committee for oversight. The committee reports to Board provide a summary of their and any recommendations relating to the risk scores or controls.

May 2022 update:

No new risks have been added to the BAF.

The risks have been updated with executive leads and presented to the committees during May 2022. A summary of the risks is attached as Appendix B and the full BAF is in the resources section of Diligent.

Two risks are attached for the Board to consider:

- BAF risk 1.0 Covid - Following a review at QSC and in line with the national position, it is recommended that the risk score for BAF risk 1.0 Covid is reduced from 16 to 12. The risk has also been reviewed by the Trust's Infection and Prevention Control Committee and the committee supported the reduction in score. The national incident level for Covid has been reduced to a level 3. The executive lead for the risk is the Director of Nursing, Midwifery and AHP's. The risk is attached as Appendix C.

- BAF risk 3.2 (Financial and Clinical Sustainability across health and social care system) is also attached for consideration by the Board; this is a system risk which the Board is responsible for reviewing.

The remaining risk scores have not changed.

The Trust is migrating its risk registers and BAF to Datix and a revised BAF reporting format is being developed.

Following feedback received a revised BAF reporting format is being trialled this month; the full BAF is available in resources with only the relevant risks included in the Board papers.

Recommendation:

The Board is asked to:

- approve the reduction in score for BAF risk 1.0 Covid from 16 to 12
- note the updates to the other risks discussed by committees
- comment on the reporting format

Author: Heather Schultz – Head of Corporate Affairs

Board Assurance Framework Summary 2022.23

Risk Ref. Committee	Risk description	Year- end score (Apr 22)	June 22	August 22	Oct 22	Dec 22	Feb 23	Year-end score (Apr 23)	Trend	Executive lead
Strategic Objective 1: Our Patients - we will continue to improve the quality of care, outcomes and experiences that we provide our patients, integrating care with our partners and reducing health inequity in our local population										
1.0 QSC	COVID-19: Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on the standard of care delivered.	16	12						↓	CEO/ DoN&M
1.1 QSC	Variation in outcomes resulting in an adverse impact on clinical quality, safety and patient experience.	16	16						↔	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						↔	DoIMT/ CIO
1.3 PAF	Recovery programme: Risk of poor outcomes and patient harm due to long waiting times for treatment.	15* New risk	15						↔	COO
Strategic Objective 2: Our People – we will support **our people** to deliver high quality care within a compassionate and inclusive culture that continues to improve how we attract, recruit and retain all our people. Providing all our people with a better experience will be evidenced by improvements in our staff survey results.										
2.3 WFC	Workforce: Inability to recruit, retain and engage our people	16	16						↔	DoP
Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.										
3.1 PAF	Estates & Infrastructure: Concerns about potential failure of the Trust's Estate & Infrastructure and consequences for service delivery.	20	20						↔	DoS
3.2 Trust Board	Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	16	16						↔	DoS
3.5 STC	There is a risk that the new hospital will not be delivered to time and within the available capital funding.	16	16						↔	DoS
Strategic Objective 4: Our Performance - we will meet and achieve our performance targets, covering national and local operational, quality and workforce indicators										
4.2 PAF	Failure to achieve ED standard resulting in increased risks to patient safety and poor patient experience.	16	16						↔	COO
Strategic Objective 5: Our Pounds – we will manage our pounds effectively to ensure that high quality care is provided in a financially sustainable way.										
5.1 PAF	Finance – revenue: Risk that the Trust will fail to meet the financial plan due to the following factors: An indicative annual budget for 22/23 has been established. A deficit plan has been submitted but national, allocations are not yet known and are linked to system envelopes. Expenditure plans have been set to deliver a breakeven requirement inclusive of a CIP requirement, with additional deficit expenditure to reflect the current and forecast additional rising Inflation costs in 22/23.	12	12						↔	DoF
5.2 PAF	Finance - Capital: Risk that the Trust will fail to deliver the 2022/23 Capital programme within the Capital Resource Limit and ICS allocations.	12	12						↔	DoF

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objectives 1-5													
BAF 1.0		**COVID-19:** Pressures on PAHT and the local healthcare system due to the ongoing management of Covid-19 and the consequent impact on staffing levels, staff health and wellbeing, operational performance and patient outcomes.	Causes: i) Highly infectious disease with emerging new variants ii)Human Factors: Failure of public to adhere to Public Health messages and increasing Covid demand iii) Sustainability of supply chains during peak covid periods iv) Limitation and configuration of PAHT estate v) Vacancy and absence rates vi) Public perceptions around accessing services as normal	**5 X 5= 25**	Chief Executive /Deputy Chief Executive supported by Executive team QSC	i) Level 4 national incident declared by NHS England reduced to level 3 March 21st 2021, however increased to level 4 on December 12 2021 (incident level reduced to level 3 - May 22) ii) PAHT incident co-ordination centre and incident management team established iii) COVID-19 incident management governance structure in place iv) Compliance with national directives v) Ongoing engagement with ICS and Local Resilience Forum, Local Delivery Board re-instated vi) COVID-19 patient pathways instigated vii) Staff being redeployed to provide additional support ix) Daily executive oversight of incident management x) Recovery and restoration planning (PAHT/ICP and ICS) xi) Separation of hospital into Covid and Covid free areas xii) Use of independant sector for elective patients xiii) Staff vaccination programme xiv) Engagement with critical care network xv) Back to Better Campaign launched xvi) Staff health and wellbeing initiatives introduced xvii) Nosocomial death review process in place	i) Incident Management Team Meeting ii) Strategic Incident Management Cell iii) IPC Cell and Infection Control Committee iv) Site Management Cell v) Communications Cell vi) People Cell viii) Clinical Cell ix) Incident management group	i) Incident management action and decision logs ii) QSC updates monthly from March 2020 to date iii) Trust Board updates (March 20 to date) iv) Recovery Plans and submissions PAF and QSC May 2022 v) Covid risk register	**4 x 3 = 12**	i) Adaptability and configuration opportunity of clinical areas	None.	May-22	**Score reduced: likihood to 3 and impact to remain at 4 = 12.**	**4x2 =8 September 2022**
			Effects: i) Increased numbers of patients and acuity levels ii) Shortages of staff, staff shielding and increased sickness; **staff fatigue and reduced resilience** iii) Shortages of equipment, medicines and other supplies iv) Lack of system capacity v) Staff concerns regarding safety and well-being vi) Changing national messaging vii) Potential for patient harm due to cancellation of elective surgery and nosocomial infection due to transmissibility							Actions: i) Critical network support ii) Surge planning: iii) Second Covid ward being prepared iv) Maximising elective daycases				

Risk Key														
Extreme Risk		15-25												
High Risk		8-12	**The Princess Alexandra Hospital Board Assurance Framework 2021-22**											
Medium Risk		4-6												
Low Risk		1-3												
Risk No		**PRINCIPAL RISKS**				**KEY CONTROLS**	**ASSURANCES ON CONTROLS**	**BOARD REPORTS**						
		Principal Risks		**RAG Rating (CXL)**	**Executive Lead and Committee**	**Key Controls**	**Sources of Assurance**	**Positive/negative assurances on the effectiveness of controls**	**Residual RAG Rating (CXL)**	**Gaps in Control**	**Gaps in Assurance**	**Review Date**	**Changes to the risk rating since the last review**	**Target RAG Rating (CXL)**
		What could prevent the objective from being achieved	What are the potential causes and effects of the risks		Which area within our organisation this risk primarily relate to	What controls or systems are in place to assist in securing the delivery of the objectives	Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective	We have evidence that shows we are reasonably managing our risks and objectives are being delivered		Where are we failing to put controls/systems in place or where collectively are they not sufficiently effective.	Where are we failing to gain evidence that our controls/systems, on which we place reliance, are effective			
								Evidence should link to a report from a Committee or Board.						
	Strategic Objective 3: Our Places – Our Places – we will maintain the safety of and improve the quality and look of our places and will work with our partners to develop an OBC for a new hospital, aligned with the further development of our local Integrated Care Partnership.													
BAF 3.2		**Financial and Clinical Sustainability across health and social care system** Capacity and capability to deliver long term financial and clinical sustainability across the health and social care system	**Causes:** i) The financial bridge is based on high level assumptions ii) The Workstream plans do not have sufficient underpinning detail to support the delivery of the financial savings attributed to them iii) The resources required for delivery at a programme and workstream level have not been defined or secured iv) The current governance structure is under development given the shift in focus from planning to delivery. v) The collaborative productivity opportunities linked to new models of care require more joined-up ways of working, clear accountability and leadership, changes to current governance arrangements.	**4 X 4= 16**	DoS Trust Board	i) ICS workstreams with designated leads ii) System leaders Group iii) ICS governance structure iv) ICS priorities developed and aligned across the system. v) CEO's forum vi) Integrated Clinical Strategy in development vii) ICS Estates Strategy being developed. viii) ICS Clinical Strategy in place ix) ICS wide Strategy Group ~~x) Independant STP Chair and independant STP Director of Strategy appointed.~~ xi) System agreement on governance and programme management ~~xii) New ICS governance and structure meetings set up with PAH attending task-finish groups~~	ICS CEO's meeting (fortnightly) Transformation Group meetings Joint CEO/Chairs STP meetings (quarterly) Clinical leaders group (meets monthly) ICS Estates, Finance meetings	i) Minutes and reports from system/partnership meetings/Boards ii) CEO reports to Board and ICS updates (Board session on ICS governance Dec 21)	**4 X 4= 16**	Lack of ICS demand and capacity modelling. **ACTIONS:** System leadership capacity to lead ICS -wide transformation		01/05/2022	**No changes to risk rating.**	**4x3=12** **~~March~~ September 2022**
			Effects: i) Lack of system confidence ii) Lack of pace in terms of driving financial savings iii) Undermining ability for effective system communication with public iv) More regulatory intervention											

BOARD OF DIRECTORS:	**Trust Board 9 June 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee**			
REPORT FROM:	**Hattie Llewelyn-Davies – Acting Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 May 2022**			
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	DoN&M to review/agree outstanding items.	The annual review of the Committee's effectiveness was presented for discussion and approval. Members agreed that papers needed to be shorter and cover sheets more precise/complete. It was agreed to review further the requirement for the quarterly reports from divisions and also a possible move to less frequent meetings at some future point. The Committee's revised terms of Reference were presented to QSC in April and approved at Board in May so no further changes were required at this point.
1.7 Quality PMO report re: CQC Quality Improvement Compliance Update	Y	Y	Embedding of Nerve Centre	The Committee noted the following two exceptions: • Red risks associated with action M2 medical staffing • Move back to amber from green for S18 transitional care. Colleagues updated on progress in relation to the section 31 notice and that the CQC would be invited to re-inspect once Nerve Centre was embedded.
2.2 IPC update	Y	N	N	It was noted that in accordance with national advice, COVID was now being treated like any other respiratory disease with patients now remaining on their specialty ward (apart from those on Harvey Ward). The hospital had seen its first confirmed case of monkey pox but robust support had been received from both national and internal colleagues to manage

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Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
				that. There remained a requirement for staff and visitors in all areas to wear a mask but that would be reviewed in coming days for those staff working in non-clinical areas.
2.2 BAF Risk 1.0 (COVID)	Y	N	N	In line with national step-down it was agreed the risk score would reduce to 12. The national incident level has reduced and the reduction in risk score had been discussed at IPC Committee and the committee had supported the reduction in risk score.
2.9 Learning from Deaths	Y	Y	#NoF and AKI	HSMR was 97.0 and 'within expected range' and had been now for nine consecutive months. Actions were now in place to address increased numbers of fractured neck of femur patients, the progress on which would be presented to the June meeting. Colleagues would also now be reviewing acute kidney injury (AKI) in frail elders? and the link to care homes referrals HSMR 97.0 'within expected'
2.10 BAF Risk 1.1 (Clinical Outcomes)	Y	N	N	It was agreed the risk score would remain at 16.
2.8 Patient Safety & Clinical Effectiveness Annual Report	Y	N	N	Key highlights for 2021/22 were: • 18% increase in incidents reported due to the incidents raised in the category of 'monitoring' however harm grading had remained consistent with previous years, with a decrease in grading of 'death' from 0.95% to 0.3% as a

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DATE OF COMMITTEE MEETING:	**27 May 2022**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
				result of the decrease in hospital onset COVID-19 deaths. There had been a corresponding decrease in the number of serious incidents declared for the same reason by 73%. • A reduction in death from in-patient falls from three to one, with 8% decrease in overall harm caused by falls.
4.1 Draft Quality Account	Y	Y	QA to be finalised ahead of submission on 30 June 2022.	The current draft of the Trust Quality Account was presented to members. Some items remained outstanding and would be added prior to submission. Some minor queries were raised which would be addressed. A request for delegated authority for the sign-off of the final document (prior to the committee's June meeting) by the Medical Director & Director of Nursing & Midwifery was approved.

BOARD OF DIRECTORS:	**Trust Board 9 June 2022**			**AGENDA ITEM: 4.1**
REPORT TO THE BOARD FROM:	**Quality and Safety Committee (Part II – Maternity Oversight)**			
REPORT FROM:	**Hattie Lewellyn–Davies – Acting Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 May 2022**			
Agenda Item:	**Committee assured Y/N**	**Further work Y/N**	**Referral elsewhere for further work Y/N**	**Recommendation to Board**
1.4 Action Log	For noting.	N	N	It was agreed that in terms of the maternity elements of CQC compliance/quality improvement work, updates were provided to the Maternity Improvement Board and also in the diagnostic report from the Maternity Improvement Advisor. They did not therefore need to be extracted from QSC (Part I).
2.1 Maternity dashboard	Y	Y	N	The committee was assured about the progress being made with the dashboard. It was noted an audit was underway in terms of Born Before Arrival (BBA) to establish the specific details around those cases, the results of which would be brought back to the committee in July.
2.2 Maternity Incentive Scheme Year 4	Partial	Y	(CIO/IT Teams)	Members noted the trajectories had changed for Year 4 and the new submission date was now 05.01.23. Full compliance with actions should start to be seen around August (Maternity Voices Partnership), with the majority turning 'blue' around November, full compliance expected in December. In terms of previous concerns around Safety Action 2, some assurance had been provided by the Informatics team. The data set had been extended until October 2022 so there was still time for a resolution and this would remain a particular focus. QSC noted that NHS Resolution (NHSR) had completed their review of the Year 3 submission and confirmed the Trust was fully compliant with all 10 safety actions. NHSR has requested that for Year 4 reports for safety actions, 1 (standard d), 3, 5, 6

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				and safety action 9 (standard f) are submitted to the Trust Board (not QSC).
2.3 Maternity Staffing Update	Y	Y	Midwifery recruitment	The final Ockenden report (March 2022), had raised 15 immediate and essential actions one of which was specifically to review and suspend (if necessary) the existing provision/further roll-out of Continuity of Carer (MCoC) model unless it could be demonstrated that staffing met safe minimum requirements on all shifts. In line with the recommendation the committee agreed that in order to improve midwifery staffing, the further roll-out of MCoC would be paused. The service would continue with the current MCoC team provision and would implement a hospital on-call system to improve staffing. This would be reviewed in September following an intake of new midwives.
2.4 Maternity Serious Incidents report	Y	Y	N	Two new serious incidents had been reported since the previous month – themes remained unchanged.
2.5 Update from Post-Partum Haemorrhage (PPH) Working Group	Y	Y	Division to take forward discussions to region re: most recent NMPA audit where the rate had	The paper provided assurance that the maternity service was continually monitoring obstetric haemorrhage and outcomes for women and that all cases undergo a full multi-disciplinary review and escalation to Incident Management Group if appropriate. It was also agreed to provide an update at a later date on access to maternity services for those with a disability.

BOARD OF DIRECTORS:	**Trust Board 9 June 2022**			**AGENDA ITEM: 4.1**
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REPORT FROM:	**Hattie Lewellyn–Davies – Acting Committee Chair**			
DATE OF COMMITTEE MEETING:	**27 May 2022**			
Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
			significantly increased to 3.7%.	
2.7 Local Maternity Improvement Board	Y	N	N	In terms of culture, **t**he NMC/GMC had jointly produced a programme called "*Together – supporting a profession under pressure in delivering good care*". This was being trialled and the Trust would be involved. The programme would consist of workshops with follow-up evaluation sessions. The organisation's response to the Ockenden Report was also presented which provided the progress and current status against the Ockenden immediate and essential actions.
2.8 Horizon Scanning	Y	Y	Transitional care and triage	In terms of the Ockenden visit, improvements in leadership and governance were noted (the full report on the visit was provided at item 5.3). The focus for the service moving forward needed to be on transitional care and triage.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 9th June 2022

Agenda item: **Presented by:** **Prepared by:** **Date prepared:** **Subject:**	4.2 Sharon McNally – Executive Director of Nursing, Midwifery and AHP's Giuseppe Labriola – Director of Midwifery 1ST June 2022 Maternity Incentive Scheme							
Purpose:	**Approval**	√	**Decision**		**Information**	√	**Assurance**	√
Key issues:	This is the fourth year that NHS Resolution are operating the Clinical Negligence Scheme for Trusts (CNST) to support the delivery of safer maternity care. The submission date for the board declaration of the evidence required for the 10 maternity safety actions is 15/1/23. The associated papers summarising the evidence are reviewed in detail at the Quality and Safety Committee (QSC). Following the reverification process by NHS Resolution of Year three's evidence, there was a requirement that all papers for Year four are submitted to Trust Board. A summary is provided within this document of papers that have been previously submitted to QSC. All of the associated papers have been discussed in detail and approved at QSC.							
Recommendation:	The Trust board are asked to note and approve these papers.							

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

Previously considered by:	Quality and Safety Committee – 29/10/21, 26/11/21, 28/1/22, 25/2/22, 25/3/22, 29/4/22, 27/5/22.
Risk / links with the BAF:	BAF 1.1
Legislation, regulatory, equality, diversity and dignity implications:	NHS Resolution, Maternity Incentive Scheme – Year Four
Appendices:	None

Detail of papers that have been received by Quality and Safety Committee

Date paper received	Paper	Governance	Items noted and recommendations
29th October 2021	Maternity Quarterly Assurance report	Noted on agenda and within minutes	Noted
26th November 2021	Maternity Incentive scheme update – Safety Action 1 Q1	Noted on agenda, within minutes and chair's report	Noted
28th January 2022	Maternity Quarterly Assurance report Plan for default continuity of carer	Noted on agenda, within minutes and chair's report	Plan for default continuity of carer recommended to Trust board
25th February 2022	Perinatal Quality Surveillance Dashboard Maternity Incentive Scheme Update – Safety Action 1 Q2/Q3 Safety champions report	Noted on agenda and within minutes	Noted
25th March 2022	Safety champions reports	Noted on agenda, within minutes and chair's report	Noted
29th April 2022	Safety champions report Maternity Quarterly Assurance Report Saving Babies Lives Quarterly report	Noted on agenda, within minutes and chair's report	Noted
27th May 2022	Safety champions report Midwifery staffing update including revised continuity of carer plans	Noted on agenda and within minutes	For discussion at June 2022 Trust board

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) 9th June 2022

4.2

Agenda item:								
Presented by:	Giuseppe Labriola, Director of Midwifery							
Prepared by:	Erin Harrison, Lead Governance Midwife							
Date prepared:	26th October 2021							
Subject / title:	Maternity Assurance Report – Quarterly review July-Sept 2021 (Q2)							
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	The recent Maternity Incentive Scheme (MIS) Year 4, published in October 2021 has issued the requirement for quarterly reporting to Board including details on the number of serious harm incidents, themes identified and actions being taken to address any issues, minimum staffing in maternity services and training compliance. The expectation is that the paper will be presented by the Board Level Safety Champions moving forward to be in line with the national requirements.							
Recommendation:	To provide assurance to the Trust Board that the maternity service is meeting the requirements of the MIS and providing assurance on quality and safety of services.							

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:	Quality and Safety Committee 29th October 2021
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with Year 4 of the Maternity Incentive Scheme which was published in October 2021
Appendices:	N/A

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose

This paper is to provide assurance to the Board that the maternity service is meeting the requirements of the MIS, providing assurance on quality and safety of maternity services.

2.0 Background

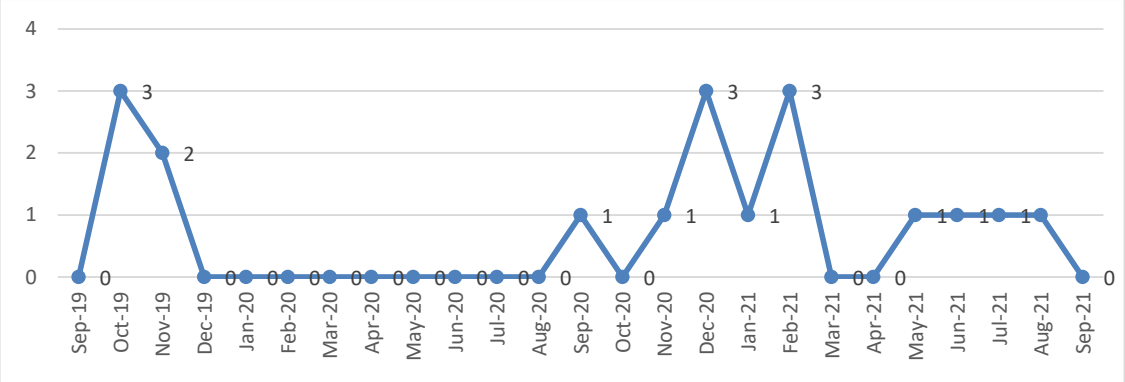
NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.
The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As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

3.0 Analysis

Serious Incidents

Maternity currently have 6 SI's under investigation, 2 of which are being investigated by HSIB, the detail can be found in Table 2. Table 1 details the trend of declared SI's within the last 24 months to September 2021

Table 1. Comparison of SI's reported for Maternity in last 24 months (to September 2021)



There were 2 new serious incidents declared in Quarter 2 of 2021. The detail can be found in table 2.

Table 2. Serious Incidents declared and submitted for July-September 2021 (Q2)

Serious Investigations	
Number Declared for Q2 2021	**2**
Number Submitted for Q2 2021	**4**
Number Past CCG Deadline as of September 2021 (Not including HSIB/Approved Extensions)	**2**
Total Open SIs for Maternity to date (including HSIB)	**6**

New Serious Investigations declared		
Ref	**Summary**	**Learning Points**
Paweb102303 HSIB	Neonatal death - baby born via category 1 caesarean section for bradycardia, required resuscitation and admission to neonatal unit	• If a fetal scalp electrode is used, that it remains attached to the fetal head up until the point of delivery. This is to ensure the fetal heart rate is monitored accurately. • Staff to ensure they use pulse oximeters, which are attached to all CTG machines. This is to ensure the fetal heart is different to the maternal heart rate. • Informed staff regarding documentation (as per NMC standards) and interpretation of CTGs (as per local guidance). • Case to be used as anonymous case study as part of fetal monitoring study day
PAweb101460 HSIB	Therapeutic Cooling. Neonatal resuscitation given and baby transferred to tertiary unit for cooling.	• Case to be used as anonymous case study as part of fetal monitoring study day
All open serious incidents		
Paweb91584	Baby born in poor condition by caesarean section category one due to pathological CTG. Macrosomic baby with concerns in diabetes pathway. Baby transferred out but subsequently discharged home. Clock stopped due to Covid-19 finalising report for submission to CCG	• A MDT round table has taken place with endocrinology and obstetrics, changes to pathway in process. Change in practice due to Covid-19 pandemic with regards to diabetic screening in pregnancy. • Referred for external review for independent review for openness and transparency
Paweb90785	Significant proteinuria (3+) during antenatal appointment at 26 weeks. This was not further investigated. Presented to the antenatal clinic 12 days later she had an IUD, hypertension and proteinuria. Clock stopped due to Covid-19 finalising report for submission to CCG	• Learning shared with Community and Antenatal Team surrounding proteinuria and the significance • Guideline updated following recommendations following Perinatal Mortality Review • NICE Assessment process under review • Referred for external review for independent review for openness and transparency
Paweb98457	An emergency caesarean section was undertaken. During the caesarean section, there was a laceration to the baby's scalp that	• Debrief was undertaken with all staff involved

	was roughly 15cm in length and exposing the baby's skull Report completed – amendments being undertaken following Triumvirate review	• Support provided to locum registrar due to the requirement for GMC referral
Paweb99016	Massive Obstetric Haemorrhage 3200mls. Patient was transferred for a manual removal under general anaesthetic. The patient received 4 units of RBC Report completed – for submission for Triumvirate review	• Review of the utilisation of the Massive Obstetric Haemorrhage (MOH) proforma/checklist for all Post-Partum Haemorrhages (PPH) and MOH. • Discussion with all substantive obstetric and midwifery staff to ensure compliance with the use of the MOH proforma and checklist. • Ensure that the proforma/checklist is readily available in all delivery rooms and theatres. • Discussion with the lead obstetrician and obstetric anaesthetic consultant to facilitate sharing the initial learning from the rapid review of this incident.

Clinical Incidents

There has been a decrease in Datix productivity as a result of the pandemic. This is due to staff who would normally undertake the review and closure being required to work clinically. There is a daily Datix review meeting undertaken by the Senior Midwifery Team and the Governance Consultant to ensure that any incidents requiring escalation are identified immediately.

Of the open Datix as detailed in Table 3; 171 are no or low harm. Of the 11 that remain open above moderate harm; 9 are Massive Obstetric Haemorrhages that are following the directorate governance process of a care review, none have highlighted care or service delivery issues that require escalation. The remaining incidents involve current open investigations (internal or HSIB).

There is a trajectory in place to ensure that these incidents are closed by December 2021 and there will be a marked improvement seen in the next quarterly review paper.

Table 3. Current Clinical incidents open and closed

Clinical Incidents (DATIX)	
Number of Incidents Submitted Last Quarter	394
Number of Incidents Moderate Harm or Above	16
DoCs Outstanding	None
Number of Open Incidents	182 (11 moderate harm or above)
Number of Incidents Submitted (since Jan 2021)	1035
Percentage of Open Incidents	46%

Perinatal Mortality Review Tool Summary

PMRT was launched in January 2018 with the aim of standardising perinatal reviews across NHS maternity and neonatal units in England, Wales and Scotland. The tool is used to support

a systematic, multidisciplinary, high quality review and to ensure that parents are involved in the process. This enables a structured process of review, learning, reporting and actions to improve future care and to come to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken which in turn involves a grading of the care provided. Reports will be published and shared with the family and placed in the medical notes.

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

Table 4. Perinatal Mortality Review Tool Open Cases

Perinatal Mortality Review Tool Summary
5 open cases for PAHT 3 open with other trusts All open cases for PAHT have dates booked for review, the oldest case dates back to 04.05.2021. This was a complex case and the review are awaiting paediatric review to agree final rating prior to publishing the findings.

MBRRACE-UK Real Time Data Modelling for past 6 months

The MBRRACE-UK reporting system is in use across England, Scotland and Wales. The system is used to report all cases of maternal death, late fetal losses, stillbirths and neonatal deaths. PAHT are compliant with all reporting requirements, Table 5 shows reported cases over the last 6 months.

Table 5. MBRRACE Reportable Cases

MBRRACE-UK Real Time Data Modelling for Past 6 Months
8 reported deaths to MBRRACE 4 Antepartum stillbirths 1 Intrapartum stillbirth 3 Neonatal deaths The Trust reported a Maternal Death in July 2021 following information from the family. This was a community death in Hertfordshire. PAHT have referred the case to Lister.

External Reviews and External Scrutiny

Table 6. External Reviews and Scrutiny

External Reviews and External Scrutiny
• *HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust* • *Coroner Reg 28 made directly to Trust*
PAHT currently have 2 cases that are under investigation by HSIB as per Table 1. Below shows the status of all reported cases to HSIB.

Cases to date	
Total referrals	11
Referrals/cases rejected	5
Total investigations to date	6
Total investigations completed	4
Current active cases	2
Exception reporting	0

CQC inspected maternity services in July 2021 and the Trust are awaiting a final report. The service was last rated as requires improvement in 2019 and has since been part of the Maternity Services Support Programme.

Birthrate+ has been undertaken within Maternity Services. This looks at birthrate, acuity and staffing to ensure that the funded staffing establishment is appropriate for the cohort of women that PAHT care for. A report has been received by the Division and once assessed a paper will come to the committee to discuss the needs and gaps in service provision.

No inquests undertaken for maternity care

Staffing

Table 7. Current staffing across Maternity, Neonatal and Obstetric Workforce

Staffing	
Staff feedback from frontline champions and walk-abouts: **Staff have escalated concerns surrounding the shortage of midwifery staffing.** This is not a concern unique to PAHT with maternity services across the country experiencing similar problems; and services identifying steps to address issues around staffing, leadership and resourcing. A risk assessment has been completed alongside the maternity units across the Local Maternity and Neonatal System to describe proposals in maintaining safe staffing and reducing the risk. The initial risk rating is 25 without mitigations or controls in place and recalculated to 20 with the current controls the service has in place. It is envisaged this may reduce to 16 with additional mitigation. The Directorate has also implemented a pay incentive to undertake Bank Shifts in order to reward staff who are undertaking extra shifts in addition to their contracted hours.	
Consultant Obstetric Cover on the Labour Ward	87 hours cover (RCOG recommendation is 98 hours)
Junior Doctor Rota Gaps	No rota gaps – Currently recruiting to implement a 2 tier rota (2 registrars per shift)
Midwifery Staffing	Sickness 13.00 WTE (avg) Maternity Leave 7.87 WTE Vacancy 8.03 WTE Overall absenteeism 28.90 WTE (19%) Rolling advert out for Band 5/6 RM. Staffing paper was submitted to the committee in September which outlines mitigation and controls including the use of specialist roles and senior team working clinically.
Neonatal Staffing	30.16 WTE in post - Vacancy of 25% currently out to advert
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	**Proportion of speciality trainees responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (Reported annually)**
Awaiting Staff Survey	Awaiting Staff Survey

Training Compliance

Training compliance will be included as part of the next quarterly assurance paper as per MIS requirement from December 2021

Table 8. Training Compliance

Training Compliance	
Child Safeguarding Level 3	**To be calculated from Dec 2021**
Resuscitation	**To be calculated from Dec 2021**
PROMPT	**To be calculated from Dec 2021**

MIS Progress

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

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

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

All 10 safety actions are rated as Amber and in progress as shown in Table 9. Once all evidence has been collated the Board will be required to sign off the scheme which will be in June 2022.

Table 9. MIS Progress Yr 4

MIS Progress Yr 4			
SA 1		SA 6	
SA 2		SA 7	
SA 3		SA 8	
SA 4		SA 9	
SA 5		SA 10	

Ockenden

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

The IEA are:

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

7. Informed consent

PAHT submitted their evidence in July 2021 and have just received feedback regarding compliance as per Table 10. A meeting has been arranged on 28.10.2021 across the Local Maternity and Neonatal System to review the grading and to submit queries relating to the feedback to the national team.

Table 10. Immediate and Essential Safety Actions outcome

CNST Progress			
IEA 1	81%	IEA 5	93%
IEA 2	71%	IEA 6	67%
IEA 3	39%	IEA 7	43%
IEA 4	93%	WF	70%

Saving Babies Lives Care Bundle v2 (SBLCBV2)

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

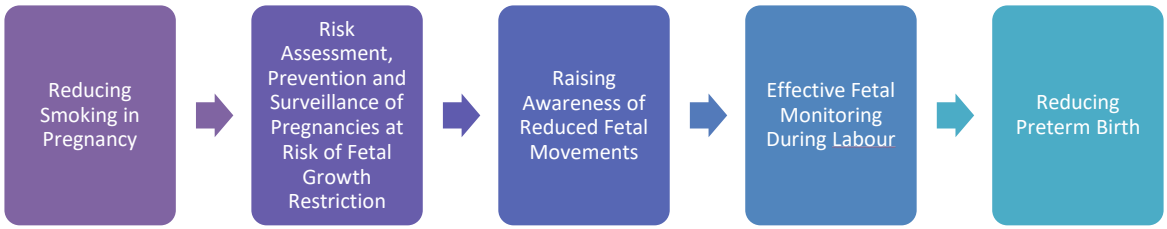


Table 11. Saving Babies Lives Score Card Summary

Saving Babies Lives Score Card Summary
Reporting is currently suspended until January 2022

Complaints/PALS

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

Complaints	Pals
July 2021 – 1 August 2021 – 2 September 2021 – 3	July 2021 – 0 August 2021 – 1 September 2021 – 3
Themes	
All complaints received over Q2 related to direct care provided. PALS themes were surrounding communication and attitude of staff.	
Service User Feedback	

"I was admitted last week due to feeling unwell and high blood pressure. From seeing my midwife to being assessed in mafu and being admitted the midwives went above and beyond made me feel calm and always kept me up to date with what was happening and took the time to have a conversation with me through the day. I also had 2 student midwives looking after me who were brilliant and will make really good midwives one day. All the doctors that looked after me we're so nice and really put my mind at ease especially when it felt like the medication wasn't helping and felt like I was never going to get home. The experience I have had the past week has been amazing the midwives and doctor worked so hard and was rushed off their feet but never made it seem like it affected them."

4.0 Oversight

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

Staffing is assessed on a daily basis and the Directorate are currently out to advert for all vacancies.

There has been good transparency and openness from the service relating to a cluster of maternity incidents which went for external review. This has been discussed at Trust level, CCG, CQC, NHSI/E and with the Regional Chief Midwifery Officer.

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

5.0 Recommendation

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

Author: Erin Harrison – Lead Governance Midwife
Date: 26.10.2021

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) 9th June 2022

4.2

Agenda item:								
Presented by:	Giuseppe Labriola, Director of Midwifery							
Prepared by:	Claire Carter, Bereavement Midwife							
Date prepared:	9th November 2021							
Subject / title:	Progress report on Maternity Incentive Scheme Safety Action One.							
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 is the fourth year that NHS Resolution are operating the Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care. The data provided in this report relates to Year 3's scheme. Under the Clinical Negligence Scheme, Trusts are required to meet all ten maternity safety actions. Safety Action One relates to the use of the National Perinatal Mortality Review Tool to review perinatal deaths. This report provides information on all deaths of babies at the Princess Alexandra Hospital NHS Trust (PAHT) in the Quarter 1 April / May / June 2021 and the review process, findings and actions plans arising from the reviews. At PAHT we have a monthly PMRT meeting and all cases that meet the criteria are reviewed. Despite the limitations caused by the pandemic, the meetings continue on a monthly basis where able to do so. Currently the health group are on track to achieve the safety standard one for year four.							
Recommendation:	To provide assurance to the Trust Board that Family and Women's Services Health Group are meeting the standards required from Safety Action One of the Maternity Incentive scheme.							

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

Previously considered by:	Quality and Safety Committee 26th November 2021
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme – Year 4

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Appendices:	N/A

1.0 Purpose

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

2.0 Background

The required standards for meeting Safety Action One from 30th September 2020 and was valid until 9th August 2021: Updated March 2021.

a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July 2021.

b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in the Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.

c) For 95% of all deaths of babies who were born and died in the Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by the Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.

d) i. Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.

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

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

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

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

3.0 Analysis

Since the commencement of the Maternity Incentive Scheme on 9th March 2018 there have been fifty eight (58) cases reported (still births/Neonatal Deaths) that adhere to the PMRT criteria (see table 1).

Evidence

There were four deaths notified to MBRRACE during 2021 / 2022 quarter 1.

Report ID	Date of death	Date notified	Date surveillance complete	Review started	Review completed
74665	04/2021	07/04/2021	14/05/2021	19/05/2021	27/07/2021
75042	04/2021	30/04/2021	21/06/2021	21/06/2021	04/08/2021
75100	05/2021	05/05/2021	06/07/2021	07/07/2021	05/11/2021
75437	05/2021	25/05/2021	11/06/2021	07/07/2021	04/08/2021

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

74665
A late miscarriage at 23 weeks. Anomaly Ultra Sound Scan (USS) suspected foetal anomaly detected. Referred to screening. Growth USS 22/40: Isolated persistent right umbilical vein noted. No other abnormalities. Attended Maternal and Foetal Assessment Unit (MAFU) with sluggish movements. USS diagnosed Intra Uterine Death (IUD)

Post mortem conducted, results: CHARGE syndrome. 3 x succenturiate lobes connected by multiple vessels in membranes. No care issues identified.

75042
A stillbirth at 25/40. Routine anomaly USS 21+1 (based on Crown Rump Length (CRL): severe growth restriction, foetal weight below 3rd centile. Foetal Doppler's were abnormal.. Amniocentesis offered. USS 25+3 IUD diagnosed.

Post mortem conducted, results: severe IUGR with ?COL4A1 / COL4A2.

COL4A1/A2 related disorders are rare, genetic, multi-system disorders. The two genes that code for these proteins are tightly linked on chromosome 13 and dominant COL4A1 and COL4A2 gene mutations cause a highly variable, multisystem disorder.

This case been reviewed using the PMRT in July and August 2021. Report complete August 2021. No care issues identified up to the point that the baby was confirmed as having died.

Care issues identified which were considered to have made no difference to the outcome for the mother.

1. It was not possible to tell from the notes if the parents were offered the opportunity to take their baby home.

Action: Update stillbirth guidance. Currently being reviewed and will be sent for peer review and completion of the governance process. Update in pregnancy loss study day.

Person responsible: Claire Carter, Bereavement Midwife

75100

A neonatal death at 28/40. Attended community midwife (CMW) appointment and unable to auscultate foetal heart (FH). Referred to MAFU. MAFU: foetal movements visible but FH visualised to be slow. Decision for category 1 caesarean section (LSCS) with general anaesthetic (GA). Baby resuscitated at birth, however this was not successful.
Care has been reviewed using the PMRT in September, October and November. Report complete in November. No care issues identified up to the point the baby was born. Care issues identified from the birth to the death of the baby which were considered to have made no difference to the outcome for the baby. Care issues identified following confirmation of the death of the baby which were considered to have made no difference to the outcome for the mother.

Care issues identified:

1. It is not possible to tell from the notes if the parents were offered the opportunity to exercise their particular religious/spiritual/cultural wishes

`**Action**: Stillbirth Guidance has been reviewed and updated. To be sent for peer review and completion of the governance process. Update in pregnancy loss study day.

Person responsible is: Claire Carter, Bereavement Midwife

2. It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home

Action: Stillbirth Guidance has been reviewed and updated. To be sent for peer review and completion of the governance process. Update in pregnancy loss study day.

Person responsible is: Claire Carter, Bereavement Midwife

3. Fundal height measurements had not been plotted on a chart

Action: Plotting fetal growth from 24 weeks compliance with SBLCB has been on the risk register from 02.08.2019. All staff to complete SFH measurement competency. In March 2021 compliance was 83%. Being monitored though the external review action plan as well as

MIS. Outpatient Matron in contact with ENHT Matron regarding compliance from the ENHT team. Competency tool sent. Action plan requested from ENHT.

ENHT plan: mandatory training for all midwives and doctors to complete their competency on GAP/GROW annually instead of bi-annually. Assessment through e-learning for health platform (E-LfH). 2 modules that require completion, which align with Ockenden and SBLCBV2 requirements.

Person responsible: Kirstie Savege, Outpatients Matron.

4. The resuscitation of the baby did not follow the Neonatal Life Support (NLS) guidelines

Action: Discussed with staff on NICU and fed back to staff members involved with the case. Case to be included in Newborn Life Support (NLS) training with focus on following the algorithm and maintaining situational awareness.

Person responsible: Sanath Reddy, Neonatal Consultant.

75037

A stillbirth at 30 gestation. Booked onto smoking pathway. NT 1.8mm Down's risk 1:256, Edward's and Patau's risk 1:10,000. Attended MAFU with reduced foetal movements. No FH seen on USS. IUD diagnosed. A post mortem was conducted, results: Trisomy 21 and Hypoxic Ischaemic Encephalopathy (HIE). Has been reviewed using the PMRT in July and August 2021. Report complete in August 2021. No care issues identified.

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

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

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

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

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

d) Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onward that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions. How are we detailing that we have met this standard. Agenda item at next meeting etc.

The Princess Alexandra Hospital NHS Trust

4.0 Recommendation

To provide assurance to the Trust Board that Family and Women's Services Health Group are meeting the standards required from Safety Action One of the Maternity Incentive scheme.

Author: Claire Carter, Bereavement Midwife
Date: 9th November 2021

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 9th June 2022

4.2

Agenda item: **Presented by:** **Prepared by:** **Date prepared:** **Subject / title:**	Giuseppe Labriola – Director of Midwifery Erin Harrison – Lead Governance Midwife 10.01.2022 Maternity Assurance Report – Quarterly review Oct-Dec 2021 (Q3)							
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	The recent Maternity Incentive Scheme (MIS) Year 4, published in October 2021 has issued the requirement for quarterly reporting to Board including details on number of serious harm incidents, themes identified and actions being taken to address any issues, minimum staffing in maternity services and training compliance. The expectation is that the paper will be presented by the Board Level Safety Champions moving forward to be in line with the national requirements.							
Recommendation:	To provide assurance to the Trust Board that the maternity service are continually monitoring compliance and learning from complaints and incidents.							

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

Previously considered by:	Quality and Safety Committee 28th January 2022
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with Year 4 of the Maternity Incentive Scheme which was published in October 2021
Appendices:	N/A

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The Princess Alexandra Hospital NHS Trust

4.2

1.0 Purpose/issue

This paper is to provide assurance to the Board

2.0 Background

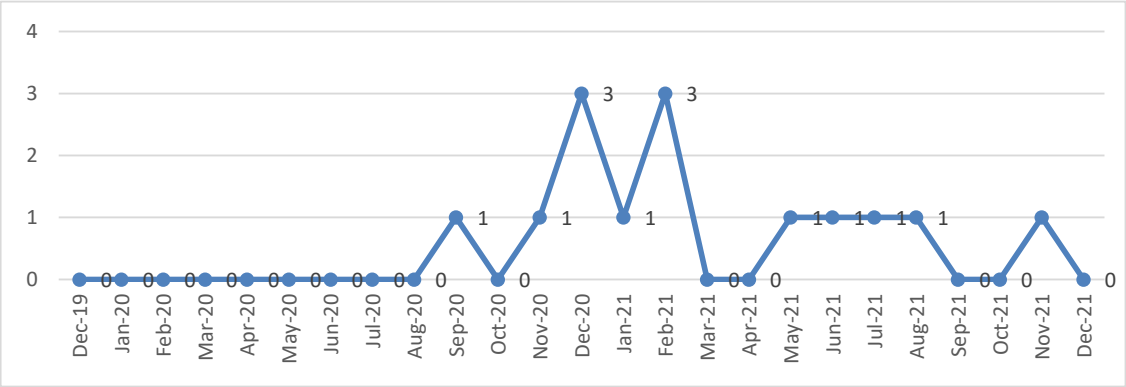
NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.
The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As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

3.0 Analysis

Serious Incidents

Maternity currently have 5 SI's under investigation, 3 of which are being investigated by HSIB, the detail can be found in Table 2. Table 1 details the trend of declared SI's within the last 24 months to December 2021

Table 1. Comparison of SI's reported for Maternity in last 24 months (to December 2021)



There was 1 new serious incident declared in Quarter 3 of 2021. The detail can be found in table 2.

Table 2. Serious Incidents declared and submitted for October- December 2021 (Q3)

Serious Investigations	
Number Declared for Q3 2021	**1**
Number Submitted for Q3 2021	**2**
Number Past CCG Deadline as of December 2021 (Not including HSIB/Approved Extensions)	**2**
Total Open SIs for Maternity to date (including HSIB)	**5**

New Serious Investigations declared		
Ref	**Summary**	**Learning Points**
PAweb106256 HSIB	Patient attended (low risk pregnancy) to labour ward contracting 5-6:10. Intrauterine death confirmed via departmental scan.	• Routine 28-week bloods, including screening for diabetes was missed antenatally. This was due to cross border working as PAHT initially booked the patient's pregnancy and care was then transferred to East Herts for antenatal care. There is no documentation surrounding bloods taken or blood results during this time. • It is probable that due to excessive spontaneous contractions and the clinical findings of fresh red blood (approximately 50-100mls) during labour, plus a retroplacental clot, that there may have been a placental abruption however there is no way this can be confirmed. • The family have declined a post-mortem and therefore no cause of death can be confirmed.
All open serious incidents		
Paweb98457	An emergency caesarean section was undertaken at 3cm dilated. During the caesarean section, there was a laceration to the baby's scalp that was roughly 15cm in length and exposing the baby's skull Report completed – awaiting submission to CCG	• Debrief was undertaken with all staff involved • Support provided to locum registrar due to the requirement for GMC referral
Paweb99016	Massive Obstetric Haemorrhage 3200mls. Patient was transferred to theatre for a manual removal under general anaesthetic. The patient received 4 units of RBC Report completed – awaiting submission to CCG	• Review of the utilisation of the Massive Obstetric Haemorrhage (MOH) proforma/checklist for all Post-Partum Haemorrhage (PPH) and MOH. • Discussion with all substantive obstetric and midwifery staff to ensure compliance with the use of the MOH proforma and checklist. • Ensure that the proforma/checklist is readily available in all delivery rooms and theatres. • Discussion with the lead obstetrician and obstetric anaesthetic consultant to facilitate

		sharing the initial learning from the rapid review of this incident.
Paweb102303 HSIB	Neonatal death - baby born via category 1 caesarean section for bradycardia, required resuscitation and admission to neonatal unit. **Draft report received for factual accuracy –** comments sent to HSIB 07.01.22	• If a fetal scalp electrode is used, that it remains attached to the fetal head up until the point of delivery. This is to ensure the fetal heart rate is monitored accurately. • Staff to ensure they use pulse oximeters, which are attached to all CTG machines. This is to ensure the fetal heart is different to the maternal heart rate. • Informed staff regarding documentation (as per NMC standards) and interpretation of CTGs (as per local guidance). • Case to be used as anonymous case study as part of fetal monitoring study day
PAweb101460 HSIB	Theraputic Cooling. Neonatal resuscitation given and baby transferred to tertiary unit for cooling.	• Case to be used as anonymous case study as part of fetal monitoring study day

Clinical Incidents

There has been a decrease in Datix productivity as a result of the pandemic. This is due to staff who would normally undertake the review and closure being required to work clinically. There is a daily Datix review meeting undertaken by the Senior Midwifery Team and the Governance Consultant to ensure that any incidents requiring escalation are identified immediately.

Of the open Datix as detailed in Table 3; 263 are no or low harm. Of the 11 that remain open above moderate harm; 9 are Massive Obstetric Haemorrhages that are following the directorate governance process of a care review, none have highlighted care or service delivery issues that require escalation. The remaining incidents involve current open investigations (internal or HSIB).

There was a trajectory in place to ensure that these incidents were closed by December 2021 however due to circumstances surrounding the ongoing pandemic and staffing this has not been achieved. There has been a 2% reduction in the amount of open incidents at the end of Q3.

Table 3. Current Clinical incidents open and closed

Clinical Incidents (DATIX)	
Number of Incidents Submitted Last Quarter	274
Number of Incidents Moderate Harm or Above	11
DoCs Outstanding	None
Number of Open Incidents	121 (11 moderate harm or above)
Number of Incidents Submitted (since Jan 2021)	1313
Percentage of Open Incidents	44%

Perinatal Mortality Review Tool Summary

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

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

Table 4. Perinatal Mortality Review Tool Open Cases

Perinatal Mortality Review Tool Summary
7 open cases for PAHT (including 1 set of twins) 3 open with other trusts All open cases for PAHT have dates booked for review, the oldest case dates back to 07/08/2021. This was a complex case, however is now at care graded stage and will be writing a draft report within the next week.

MBRRACE-UK Real Time Data Modelling for past 6 months

The MBRRACE-UK reporting system is in use across England, Scotland and Wales. The system is used to report all cases of maternal death, late fetal losses, stillbirths and neonatal deaths. PAHT is are compliant with all reporting requirements, Table 5 shows reported cases over the last 6 months.

Table 5. MBRRACE Reportable Cases

MBRRACE-UK Real Time Data Modelling for Past 6 Months
8 reported deaths to MBRRACE which included: 5 Antepartum stillbirths (including 1 set of twins) 1 Intrapartum stillbirth 1 Neonatal death 1 late miscarriage Ethnicity: 6 white, 1 black and 1 Asian.

External Reviews and External Scrutiny

Table 6. External Reviews and Scrutiny

External Reviews and External Scrutiny
• *HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust* • *Coroner Reg 28 made directly to Trust*
PAHT currently have 3 cases that are under investigation by HSIB as per Table 1. Below shows the status of all reported cases to HSIB.

Cases to date	
Total referrals	13
Referrals/cases rejected	5
Total investigations to date	7
Total investigations completed	4
Current active cases	3
Exception reporting	0

CQC inspected maternity services in July 2021, the service was rated as requires improvement and remains part of the Maternity Services Support Programme.

Birthrate+ has been undertaken within Maternity Services. This looks at birthrate, acuity and staffing to ensure that the funded staffing establishment is appropriate for the cohort of women that PAHT care for. A report has been received by the Division and a staffing paper is in the process of approval prior to coming to Board.

No inquests undertaken for maternity care

Staffing

Table 7. Current staffing across Maternity, Neonatal and Obstetric Workforce

Staffing				
Staff feedback from frontline champions and walk-abouts: **Staff have escalated concerns surrounding the shortage of midwifery staffing.** This is not a concern unique to PAHT with maternity services across the country experiencing similar problems; and services identifying steps to address issues around staffing, leadership and resourcing. A risk assessment has been completed alongside the maternity units across the Local Maternity and Neonatal System to describe proposals in maintaining safe staffing and reducing the risk. The initial risk rating is 25 without mitigations or controls in place and recalculated to 20 with the current controls the service has in place. It is envisaged this may reduce to 16 with additional mitigation. The Directorate has also implemented a pay incentive for undertake Bank Shifts in order to reward staff who are undertaking extra shifts in addition to their contracted hours.				
Consultant Obstetric Cover on the Labour Ward	87 hours cover (RCOG recommendation is 98 hours)			
Junior Doctor Rota Gaps	No rota gaps – Currently recruiting to implement a 2 tier rota (2 registrars per shift)			
Midwifery and Neonatal Staffing		**Oct**	**Nov**	**Dec**
	Vacancy Rate (<8%)	8.16%	7.31% ↓	Awaiting data
	Overall Sickness (<3.7%)	4.89%	4.81% ↓	Awaiting data
	Short Term Sick	1.69%	2.57%↑	Awaiting data
	Long Term Sick	3.21%	2.24% ↓	Awaiting data
	Turnover (voluntary) (<12%)	13.34%	13.59% ↑	Awaiting data
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)		**Proportion of speciality trainees responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (Reported annually)**		
Awaiting Staff Survey		Awaiting Staff Survey		

Training Compliance

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

Table 8. Training Compliance

Training Compliance	
Child Safeguarding Level 3	75%
Resuscitation	73%
PROMPT	94%
Fetal Monitoring	81%

MIS Progress

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

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

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

All 10 safety actions are rated as Amber and in progress as shown in Table 9. Once all evidence has been collated the Board will be required to sign off the scheme which will be in June 2022.

Table 9. MIS Progress Yr 4

MIS Progress Yr 4			
SA 1		SA 6	
SA 2		SA 7	
SA 3		SA 8	
SA 4		SA 9	
SA 5		SA 10	

Ockenden

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

The IEA are:

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

PAHT submitted their evidence in July 2021 and have just received feedback regarding compliance as per Table 10. A meeting was held on 28.10.2021 across the Local Maternity and Neonatal System to review the grading and to submit queries relating to the feedback to the national team. PAHT have an action plan in place to ensure all immediate and essential safety actions are met.

Table 10. Immediate and Essential Safety Actions outcome

CNST Progress			
IEA 1	81%	IEA 5	93%
IEA 2	71%	IEA 6	67%
IEA 3	39%	IEA 7	43%
IEA 4	93%	WF	70%

Saving Babies Lives Care Bundle v2 (SBLCBV2)

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

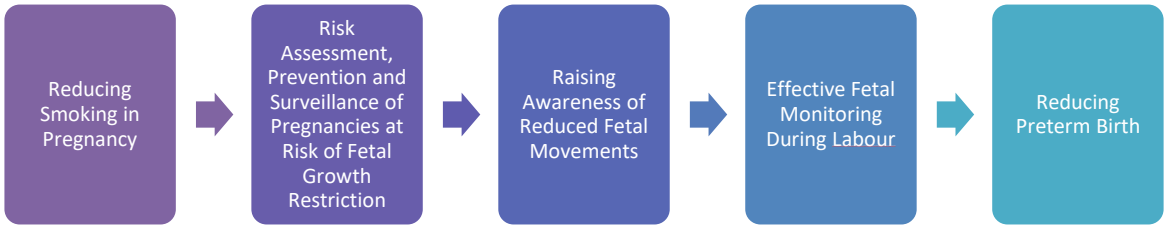


Table 11. Saving Babies Lives Score Card Summary

Saving Babies Lives Score Card Summary
Reporting is currently suspended until January 2022

Complaints/PALS

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

Complaints	Pals
October 2021 – 1 November – 1 December 2021 – 2	October 2021 – 1 November – 1 December 2021 – 3
Themes	
All complaints received over Q3 related to direct care provided. Pals themes were surrounding communication and attitude of staff.	
Service User Feedback	
"I would like to send a massive thank you email to Rachel who is part of your elective c section midwife team! I honestly can't believe what an amazing support she was the whole way through, so caring and kind and made what was a difficult pregnancy so much better with her support. I would also like to thank all the team that was in theatre with me on the 13th October & the staff of the ward that looked after me for the next 2 days. Everyone was amazing"	

4.0 Oversight

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

Staffing is assessed on a daily basis and the Division are currently out to advert for all vacancies.

There has been good transparency and openness from the service relating to a cluster of maternity incidents which went for external review. This has been discussed at Trust level, CCG, CQC, NHSI/E and with the Regional Chief Midwifery Officer.

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

5.0 Recommendation

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

Author: Erin Harrison – Lead Governance Midwife
Date: 10.01.2022

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 9th June 2022

4.2

Agenda item:	
Presented by:	Giuseppe Labriola – Director of Midwifery
Prepared by:	Claire Eyre – LMNS Programme Support Midwife
Date prepared:	12.01.2022
Subject / title:	Plan for Default Midwifery Continuity of Carer (MCoC)

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	Midwifery Continuity of Carer has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for Continuity of Carer to be the default model of care for maternity services by March 2023, and is available to all pregnant women in England, with rollout prioritised to those most likely to experience poorer outcomes first The expectation is that the paper outlining our high level plan will be presented by the Board Level Safety Champions moving forward, providing quarterly updates, to be in line with the national requirements.							
Recommendation:	To provide assurance to the Trust Board that the maternity service are continually monitoring the implementation of the Maternity Transformation Programme: Maternity Continuity of 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:	Maternity Safety Champion Meeting – 14.01.2022 Quality and Safety Committee – 28.01.2022
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with the Maternity Transformation Programme Board's implementation of Better Births, the report of the National Maternity Review, published in February 2016, including work to reduce the rate of stillbirths, neonatal and maternal deaths in England.
Appendices:	N/A

1.0 Purpose

As outlined in the 2021 NHS England (NHSE) and NHS Improvement (NHSI) paper, *Delivering Midwifery Continuity of Carer at full scale Guidance on planning, implementation and monitoring 2021/22, Version 1: published October 2021*, Midwifery Continuity of Carer (MCoC) has been proven to deliver safer and more personalised maternity care. Building on the recommendations of Better Births and the commitments of the NHS Long Term Plan, the ambition for the NHS in England is for MCoC to be the default model of care for maternity services, and available to all pregnant women in England – with rollout prioritised to those most likely to experience poorer outcomes. Where safe staffing allows and building blocks are in place, this should be achieved by March 2023

All maternity services have been asked to produce an action plan to detail their implementation by 2023. This paper is providing assurance that The Princess Alexandra Hospital NHS Trust (PAHT) has reviewed the paper and produced an action plan to implement MCoC as a default model of care.

NHSE and NHSI recognise that full implementation of MCoC is only possible with phasing alongside the fulfilment of required staffing levels

2.0 Background

The Better Birth Report (2016) identified that while this model of working improved outcomes for women, birthing people and babies, the NHS needed to organise its services around women and families, with community hubs identified to help every woman access the services she needs. Initial modelling of Continuity of Carer suggested a target of a 50% reduction in poor maternity outcomes could be achievable as midwifery care results in fewer interventions. The safer Maternity Care Progress Report (2021) identified that the collective impact from implementing elements of nationally identified best practice, has led to significant improvements in some important outcomes such as the reduction in the stillbirth rate. However, more work needs to be done in areas where outcomes are disproportionately poor, particularly in the case of women from deprived or Black Asian and Minority Ethnic backgrounds. To achieve true equity, we need to embrace the principles of proportionate universalism so that the needs, experiences and outcomes of the most vulnerable women using maternity services are recognised and acted upon. Continuity of Carer provides a mechanism whereby midwives can gain a holistic understanding of women's needs and triage women to the new forms of best practice, such as elements of the Saving Babies Lives Care Bundle or access to our evolving Maternal Medicine Networks (MMN). While it is nationally recognised that Continuity of Carer delivers greater safety and choice, it is also essential to maintain the financial sustainability of NHS funded maternity services.

3.0 Analysis

Current situation

The roll out of MCoC prioritises the most vulnerable populations, which includes BAME families and those living within the most deprived areas. According to the ONS PAHT has no postcode areas in the bottom decile of deprivation, but has 3 Postcodes from the bottom quintile, which has been the focus of our MCoC roll out plan.

PAHT currently has 3 functioning MCoC teams, with 6 – 8 midwives in each team and is achieving on average 22% MCoC. We have a disproportionately high number of pregnancy bookings, compared to the number of births. This is largely due to the high numbers of East Hertfordshire women/ birthing people, who are initially choosing to birth with PAHT, and subsequently equate to 54% of our Attrition rate. Due to the high numbers of out of area women who birth with PAHT, MCoC will only be achievable for 71% of our birthing population. This will be a consideration for future MCoC roll out plans.

We have identified that of our birthing population, 9% are Black, Asian or Mixed ethnicity and do not live in a clearly defined geographical area. However, 42% of this population reside in postcodes from the bottom quintile of deprivation. The majority of our postcodes in the lowest quintile for deprivation form part of Harlow town, which is the most deprived area the Trust serves, therefore our targeted approach will place additional MCoC teams in these areas to specifically capture our most vulnerable groups.

The proposed MCoC Roll out plan

The roll out for MCoC to become the default model of care at PAHT will be over 6 phases. The roll out of phases 2 – 6 will be undertaken following a thorough risk assessment with our maternity leadership teams and Patient Safety and Quality teams, and presented as part of the ongoing quarterly MCoC monitoring.

Based on best evidence, our MCoC teams will comprise of mostly mixed risk geographical teams, where the lead midwife will follow the woman as necessary. In order to achieve this, the geographical boundaries of each team will be re-evaluated to ensure appropriate caseloads in all teams.

Proposed timeline for phase 1 of MCoC roll out plan

<table>
<tr><th>Point</th><th>Description</th><th>completion</th></tr>
<tr><td>1</td><td>Review the total caseload for Harlow Town and align the teams within the new boundaries ensuring caseloads are set as per CoC Guidance</td><td>Q4 21/22</td></tr>
<tr><td>2</td><td>A full risk assessment will be undertaken prior to the launch of our next team, with time frames dependent on the successful recruitment/ redeployment of MCoC midwives</td><td>Q4 21/22</td></tr>
<tr><td>3</td><td>Recruit staff into MCoC from our current recruitment campaign, with training completed for MCoC prior to move into the team</td><td>Q4 21/22</td></tr>
<tr><td>4</td><td>Launch 1 mixed risk MCOC team, targeting CM19/CM20 areas to achieve 26.56% MCoC</td><td>Q1 22/23</td></tr>
<tr><td rowspan="3">5</td><td colspan="3">Re-evaluate geographical boundaries simultaneously alongside launch of further teams as a phased approach</td><td rowspan="3">Q2 – Q4 22/23</td></tr>
<tr><td>Wave/ Phase</td><td>Total No PAHT MCoC teams</td><td>MCoC achieved</td></tr>
<tr><td>2
3
4
5</td><td>5
6
8
11</td><td>33.13 %
39.70 %
52.83 %
71.47 %</td></tr>
<tr><td>6</td><td colspan="3">Business plan and confirmation of funding for East Herts service users to achieve 100% MCoC</td><td>Q1 23/24</td></tr>
</table>

This forms part of our building blocks, to implement MCoC throughout West Essex. Throughout Quarters 3 and 4 of 22/23and going into Quarters 1 and 2 of 23/24 the service will aim to reach the full complement of 11 MCoC teams, which will equate to 71% MCoC, as a default model of care. In order to reach full complement of MCoC a full business case will need to be undertaken, working alongside the CCG and East and North Herts NHS Trust.

Staffing

A planning spreadsheet has been used as part of the National MCoC Implementation toolkit, provided by NHSE/ NHSI. These calculations detail that MCoC will be cost neutral once our recruitment plans have been realised in conjunction with our Birthrate plus findings and the recruitment of our Ockenden funded midwives. The service delivery is also dependent on the review of our service plans and necessary changes implemented.

The planning spreadsheet (Appendix A) details our staffing allocations

PAHT recognises that the RCM requests that no midwife should be financially disadvantaged for working within a MCoC team. We currently pay 2% on call to MCoC midwives, plus enhanced pay for any unsociable hours worked. We recognise that this currently financially disadvantages staff when they move from hospital working to MCoC teams, and have used the uplift calculator to review this on call payment with proposals for a 4.5% uplift In line with Agenda for Change.

Training and engagement plan

To support the transition to this model of working, PAHT plans to invest in MCoC training and workshops for its workforce and currently has the staff team in place to support this. We are working with our IT and procurement teams to fully equip our MCoC teams and prepare our teams for digital maturity, in line with the National Digital Transformation Programme. We recognise that transitioning to a new way of working will require investment in the culture of our workforce to improve staff engagement and satisfaction, we are working with our Trust Comms and HR teams, along with the LMNS to support this piece of work.

MCoC supports our Safety Actions

MCoC supports the delivery of safer maternity care as described by the National Maternity Review, in Better Births' 2016 and forms part of the requirements of the Maternity Incentive Scheme year 4, SBLCBv2 and the Ockenden 7 IEA (tabled below).

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

Providing care within a continuity model enhances both the midwives experience and the women and babies outcomes.

4.0 Oversight

The report details the requirements set out by the Maternity Transformation Programme Board's implementation of Better Births, to deliver MCoC as the default model of care by

March 2023. The information provided is taken from the Regional MCOC Board submission report that is embedded within this document for reference.

PAHT BOARD SUBMISSION for MC

In order to deliver MCoC at full scale by March 2023, PAHT requires a roll out plan that prioritises delivery to those most likely to experience poorer outcomes. This plan must identify, by full risk assessment, prior to each phase, the feasibility of roll out, considering the risk to successful implementation is currently safe staffing and the premises available to provide a base for each MCoC team.

The maternity leadership team and Patient Safety and Quality teams have worked collaboratively with the HWE LMNS to ensure that MCoC can be achieved system wide and continue to evaluate service and recruitment plans, to ensure the delivery of MCoC at PAHT is implemented while maintaining a safe service.

5.0 Recommendation

It is requested that the Board accept the report with the information provided, to demonstrate compliance with the National Maternity Review in the implementation of MCoC as a default model of care by March 2023.

Author: Claire Eyre – LMNS Programme Support Midwife
Date: 12.01.2022

Appendix A

Uplift= 2	Birth rate	Actual		C of C	All women		deliverie	Ratios	
percentage and local calculation: x5.8	total: 172.85 clinical: 155.45	actual staffing 165.74	**deployment (=actual)**	**C of C pathway**	All care given: **4715 of which 2742 are eligible for CoC** AN/PN only: **500**	**% of women delivered**	in area: 2742 OOA:1095		**total on pathway**
care location	**total midwives bands 5-8 = 206.3**	**currently 3 MCoC teams**	**per shift**	**0.00%**	**5215**	**0.00%**	**3837**		**0**
C of C team	(6.64+6.91+7.76)	21.31		19.99%	895		767	1 to 36	
DS (1 b7+ 1=9 b6 1 b5	33.33	33.33	6				3070	1 to 68	
MLU	11.6	11.6	2						
OOA Bookings/ helpline	4.8	4.8			1095				
ANC/MAFU	8.7	8.7							
AN ward	17.4	17.4	3						
PN ward	17.4	17.4	3						

Perinatal Quality Surveillance Model PAHT Jan-December 2022

	Overall	Safe	Effective	Caring	Well-Led	Responsive
CQC Maternity Rating (last inspection report 2021)	RI	RI	RI	Good	RI	RI

Maternity Safety Support Programme	Yes

	January	February	March	April	May	June	July	August	September	October	November	December	January	February	March
Findings of review of all perinatal deaths using the real time data monitoring tool															
Findings of the review of all cases eligible for referral to HSIB															
The number of incidents logged graded as moderate or above and what actions are being taken															
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training															
Fetal Surveillance in Labour															
Maternity Emergencies and Multiprofessional training															
Newborn Life Support															
Fundal Hieght competency															
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas															
Minimum midwife safe staffing															
Midwifery Staff fill rate															
Midwifery bank usage															
Midwifery agency usage															
Service User Voice Feedback															

Staff feedback from frontline champions and walk abouts															
HSIB/ NHSR/ CQC or other organisation with a concern or request for action made directly with Trust															
Coroner Regulation 28 made directly Trust															
Progress in Achievement of CNST															

Proportion of Midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment	
Proportion of speciality trainees in Obstetrics and Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (National 79.3%, 2019)	

	PAHT (Adjusted for TOP)	**National**
Stillbirth Rate 2021	2.26 per 1000	3.9 per 1000

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 9th June 2022

4.2

Agenda item:								
Presented by:	Giuseppe Labriola, Director of Midwifery							
Prepared by:	Claire Carter, Bereavement Midwife							
Date prepared:	12th February 2022							
Subject:	Perinatal Mortality Review Tool (PMRT) Quarter 2 2021/22							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	This is the fourth year that NHS Resolution are operating the Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care. The data provided in this report relates to the third year's scheme. Under the Clinical Negligence Scheme, Trusts are required to meet all ten maternity safety actions. Safety Action One relates to the use of the National Perinatal Mortality Review Tool to review perinatal deaths. This report provides information on all deaths of babies at the Princess Alexandra Hospital NHS Trust (PAHT) in Quarter 2 July / August / September 2021/2022 and the review process, findings and actions plans arising from the reviews. At PAHT we have a monthly PMRT meeting and all cases that meet the criteria are reviewed. Despite the limitations caused by the pandemic, the meetings continue on a monthly basis where able to do so. Currently the division are on track to achieve the safety standard one for year four.							
Recommendation:	To provide assurance to the Trust Board that maternity services are meeting the standards required from Safety Action One of the Maternity Incentive scheme.							

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

Previously considered by:	Quality and Safety Committee – 25th February 2022
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme – Year 4

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Appendices:	2.

1.0 Purpose

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

2.0 Background

The required standards for meeting Safety Action One from 30th September 2020 and were valid until 9th August 2021: Updated March 2021.

As this quarterly report also covers the months of July, August and September 2021; updated standards were also used for this review. These are included in Appendix 1

a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from Monday 11 January 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.

ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 to 15 March 2021 will have been started before 15 July 2021.

b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Friday 20 December 2019 to Monday 15 March 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool before 15 July 2021.

c) For 95% of all deaths of babies who were born and died in your Trust from Friday 20 December 2019, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trust should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and these actions.

d) i. Quarterly reports will have been submitted to the Trust Board from Thursday 1

e) October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.

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

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

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

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

• Other members as appropriate to the organisation of care in the Trust/Health Board e.g. service manager	

3.0 Analysis

Since the commencement of the Maternity Incentive Scheme on 9th March 2018 there have been sixty (60) cases reported (Still births/Neonatal Deaths) that adhere to the PMRT criteria (see Table 1).

There were two deaths notified to MBRRACE during 2021 / 2022 quarter 2.

Report ID	Date of death	Date notified	Date surveillance complete	Review started	Review completed
76603	08/2021	09/08/2021	07/09/2021	21/09/2021	02/02/2022
76896	08/2021	25/08/2021	08/09/2021	08/09/2021	26/11/2021

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

76603

An early neonatal death. Admitted to labour ward contracting. Decelerations noted. Transferred to theatre - decision for lower segment caesarean section. Baby transferred to NICU and care withdrawn. PANDR team in attendance. Coronial Post Mortem (PM). Results: Large for gestational age placental weight > 97th centile. Placenta shows delayed villous maturation (DVM) most commonly seen in maternal diabetes / maternal obesity and excessive weight gain in pregnancy. Cause of death: Hypoxic Ischaemic Encephalopathy (HIE) & DVM. Health and Safety Investigation Branch (HSIB) case.
Has been reviewed using the PMRT.

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

Issues and Actions				
Issue:	Action	Implementation plan / comment	Responsible person	Target completion date
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19	Not relevant to the outcome, and no action is needed.	Already being actioned: See appendix 2 for actions	Natasha McCormack	December 2021
	Not relevant to the outcome but action is needed	Some midwives feel reluctant to restart following covid pandemic	Natasha McCormack	March 2022
There were concerns about the growth of the baby but serial scans were not planned.	Not relevant to the outcome but action is needed.	Training and reminders for all staff regarding the importance of referral for USS if concerned about the growth. Raise an annual audit to monitor compliance.	This has been completed by the MDT.	December 2021
The interpretation of the fetal heart rate monitoring in established labour was not correct.	Relevant to the outcome and future action is need.	Delay in interpretation of seriousness CTG which led to delay in decision of delivery Case for training and discussion included in CTG teaching.	Anna Croot. This has been actioned.	January 2022
	Relevant and future action is needed.	FSE removed during instrumental trial.	Action has been completed.	

			Case has been included in the CTG teaching. Share the learning has been done regarding removal of FSE. Practice now changed: FSE stays on during instrumentals	
A CTG was performed during established labour but the technical quality was poor.	Not relevant to the outcome but action is needed.	FSE removed during instrumental. Unable to accurately record the FH with the abdominal transducer. .	Action has been completed. Case has been included in the CTG teaching. Share the learning has been done regarding removal of FSE. Practice now changed: FSE stays on during instrumentals	
The baby was cold on arrival in the neonatal unit	Not relevant to the outcome, and no action is needed	Passive cooling commenced soon after admission		
It is not possible to assess from the notes whether the thermal management during resuscitation of the baby was appropriate	Not relevant to the outcome, but action is needed	No documentation of thermal management on labour ward. NICU and maternity audit monitor temps of 1st hour care management.	Claire Lawson Husnara Begum	21.02.2022
It is not possible to assess from the notes whether the skin care of the baby during the first 24 hours on the neonatal unit was appropriate	Not relevant to the outcome, but action is needed	Skin care not documented. Learning for staff to document skin integrity	Husnara Begum	21.02.2022
It is not possible to assess from the notes	Not relevant to the	Not part of initial routine		

whether the clotting & general haematological management of the baby during the first 24 hours on the neonatal unit was appropriate	outcome and no action is needed.	screening on admission unless otherwise indicated		

76896

A stillbirth at 31/40. Was not seen at 28/40 due to service provision issues - this woman did not have a 28 week appointment with a community midwife. Did not call straight away and then no appointments available until 30+3. Abnormality identified: Fetal heart rate 80bpm. Polyhydramnios. Admitted to Labour Ward with tightenings. IUD confirmed on USS. Declined PM. Cause of death: Broncho-pulmonary sequestration

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

Issues and Actions				
Issue:	Action	Implementation plan / comment	Responsible person	Target completion date
Did not have a 28 week appointment with community midwife. This should have been made at the 17 week appointment. When it was realised, there were no appointments until 30+3 when terminal abnormality identified.	Relevant and future action is needed.	Had this mother been seen at 28 week, options to optimise her situation nay have been a posibility. Cross boundary working now on the risk register with large piece of work reorganising AN Cross border structure.	Kirstie Savege	July 2022
Although indicated, the mother was not offered a Kleihauer test.	Not relevant and future action is needed.	Midwives have been reminded about the importance of ensuring all investigations	Claire Carter	Complete

		are offered. Guidance has been updated and is being reviewed, prior to ratification and publication		
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19	Not relevant to the outcome, and no action is needed	Already being actioned: See appendix 2 for actions	Natasha McCormack	Complete
	Not relevant to the outcome but action is needed	Some midwives feel reluctant to restart	Natasha McCormack	Complete
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	Not relevant to the outcome, and no action is needed	Not available at our trust. Pathway to be reviewed.	Claire Carter	March 2022
It is not possible to tell from the notes if the parents were offered the opportunity to exercise their particular religious/spiritual/cultural wishes	Not relevant to the outcome, and no action is needed	Guidance has now been updated to reflect the importance of offering this		Complete
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	Not relevant to the outcome, and no action is needed	Guidance has now been updated to reflect the importance of offering this.		Complete

4.0 Recommendation

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

Author: Claire Carter, Bereavement Midwife
Date: 12.2.2021

The Princess Alexandra Hospital NHS Trust

Appendix 1

The required standards for meeting Safety Action One were updated on 8th August 2021:

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

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

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

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

d) Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onward that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions. How are we detailing that we have met this standard. Agenda item at next meeting etc.

Appendix 2

Healthy Lifestyles Midwife actions

Healthy Lifestyle Midwife developed leaflet to accompany each CO Monitor with Very Brief Advise. distributed to 50 CMWs
RCM and RCOG Guidance on Co Monitoring and Risk Assessment for performing monitoring have been shared with community teams
Guidance from Bedfont the manufacturers of the Smokerlyser regarding the safety of Co Monitoring and COVID 19 particles
Each week Co Monitoring Data at booking is analysed and individual MWs contacted to discuss reason for non-compliance, escalated to Community Matron where non-compliance is repeated
Training and updates with Community Midwifery Teams.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 9th June 2022

4.2

Agenda item:								
Presented by:	Giuseppe Labriola, Director of Midwifery							
Prepared by:	Claire Carter, Bereavement Midwife							
Date prepared:	3rd February 2022							
Subject:	Perinatal Mortality Review Tool (PRMT) Quarter 3 2021/22							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	This is the fourth year that NHS Resolution are operating the Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care. The data provided in this report relates to the third year's scheme. Under the Clinical Negligence Scheme, Trusts are required to meet all ten maternity safety actions. Safety Action One relates to the use of the National Perinatal Mortality Review Tool to review perinatal deaths. This report provides information on all deaths of babies at the Princess Alexandra Hospital NHS Trust (PAHT) in Quarter 3 October / November / December 2021 / 2022 and the review process, findings and actions plans arising from the reviews. At PAHT we have a monthly PMRT meeting and all cases that meet the criteria are reviewed. Despite the limitations caused by the pandemic, the meetings continue on a monthly basis where able to do so. Currently the health group are on track to achieve the safety standard one for year four.							
Recommendation:	To provide assurance to the Trust Board that maternity services are meeting the standards required from Safety Action One of the Maternity Incentive scheme.							

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

Previously considered by:	Quality and Safety Committee – 25th February 2022
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	Maternity Incentive Scheme – Year 4

Appendices:	1

1.0 Purpose

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

2.0 Background

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

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

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

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

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

d) Quarterly reports will have been submitted to the Trust Board from 8 August 2021 onward that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions. How are we detailing that we have met this standard. Agenda item at next meeting etc.

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

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

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

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

3.0 Analysis

Since the commencement of the Maternity Incentive Scheme on 9th March 2018 there have been sixty six (66) cases reported (Stillbirths/Neonatal Deaths) that adhere to the PMRT criteria (see Table 1).

There were six deaths, including 1 set of twins notified to MBRRACE during 2021 / 2022 quarter 3.

Report ID	Date of death	Date notified	Date surveillance complete	Review started	Review completed
77827	10/2021	18/10/2021	26/10/2021	11/11/2021	26/1/2022
77832	10/2021	18/10/2021	09/11/2021	11/11/2021	19/01/2022
77832	10/2021	18/10/2021	09/11/2021	11/11/2021	04/02/2022
78437	11/2021	15/11/2021	08/12/2021	16/12/2021	11/2/2022
78775	12/2021	06/12/2021	15/12/2021	28/01/2022	Under review
79209	12/2021	31/12/2021	28/01/2022	31/01/2022	Under review

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

77827

A late miscarriage at 22 + 1 weeks gestation. Admitted at 22+1 with Per Vagina Bleeding and contracting 2 – 3:10. Paediatricians in attendance at a spontaneous vaginal breech birth. No signs of life at birth. A post mortem did not determine a cause of death. Has been seen in sensitive clinic with fetal medicine consultant and bereavement midwife.

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

Issues and Actions				
Issue:	Action	Implementation plan / comment	Responsible person	Target completion date
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19	Not relevant to the outcome, and no action is needed.	Already being actioned: See appendix 1 for actions		
This mother's progress in labour was not monitored on a partogram	Not relevant to the outcome, and no action is needed	Too early in gestation for partogram		
It is not possible to tell from the notes if the parents were offered the opportunity to exercise their particular religious/spiritual/cultural wishes	Not relevant to the outcome, and no action is needed.	Guidance has been re-written to stipulate the importance of this. Teaching has been updated.		
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	Not relevant to the outcome, and no action is needed	Guidance has been re written to stipulate the importance of this. Teaching has been updated.		

77832

A stillbirth of Monochorionic Diamniotic (MCDA) twins at 25+1 and 25+2. Twin Transfer Syndrome (TTTS) at 20 weeks gestation. Management plan discussed and expectant management advised. Weekly monitoring commenced. Attended Maternal and Foetal Assessment Unit (MAFU) with reduced foetal movements at 24+3. Had a bedside scan for reassurance. Having a growth USS next day which was a reasonable time scale. 24+4 Diagnosis of Intrauterine Death (IUD) of both twins following rapid progress to severe TTTS.

Grading	
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:	The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died

Grading of care of the mother following confirmation of the death of her baby:	The review group identified care issues which they considered would have made no difference to the outcome for the mother.

Issues and Actions				
Issue:	Action	Implementation plan	Responsible person	Target completion date
This mother met the national guideline criteria for screening for gestational diabetes but was not offered screening	Feedback to community teams and community matron. PS&Q team regarding meeting criteria for screening. Put the risk factor in the notes.	Develop new diabetes pathway	Diabetic team	21/02/2022
Syntometrine administered which is contraindicated in hypertension	To feedback to midwives and obstetricians regarding Syntometrine and documentation with rationale and hypertension.	Complete sharing the learning to share with all midwives in all areas	Claire Carter and Bobbie Phippin	28/02/2022
Booked with essential hypertension. Did not see a consultant until 16 weeks	Ongoing review of antenatal provisions.	Discussion with consultant confirms optimal apt times for women with existing medical conditions	Ms Noreldene	28/02/2022

78437

An intrapartum stillbirth at 39+3. On presentation the midwife was unable to auscultate a fetal heart. Consultant confirmed IUD on USS. Case was referred to HSIB. Concerning features: excessive contractions, small antepartum haemorrhage and retroplacental clot. Mother declined post mortem. Cytogenetics NAD. Placental histology: Grade 1 chorioamnionitis. Referred for expert opinion. Report states: The cause of death is undeterminable.

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

Grading of care of the mother following confirmation of the death of her baby:	The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby

Issues and Actions				
Issue:	Action	Implementation plan / comment	Responsible person	Target completion date
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened because carbon monoxide testing was paused due to COVID-19	Not relevant to the outcome, and no action is needed.	Already being actioned: See appendix 1 for actions		
It is not possible to tell from the notes if the parents were offered the opportunity to exercise their particular religious/spiritual/cultural wishes	Not relevant to the outcome, and no action is needed.	Guidance has been re-written to stipulate the importance of this. Teaching has been updated.		
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	Not relevant to the outcome, and no action is needed	Guidance has been re written to stipulate the importance of this. Teaching has been updated.		

78775

A stillbirth at 35 weeks. History of Hashimotos disease and MTFHR (Methylenetetrahydrofolate reductase gene mutation). Presented with reduced foetal movements at 35/40 and diagnosed IUD on USS. Covid positive in pregnancy. Blood tests showed low platelets and abnormal clotting factors & diagnosed with DIC. Proceeded to EM LSCS cat 2. Post-natal bloods show parvo virus infection with both IgM and IgG. Full Post Mortem shows cause of death as Covid placentitis. Review, issues and actions currently in progress.

79209

A late miscarriage at 22+5. 2 early miscarriages 12+5 and 11 weeks. Due for review at PMRT meeting in March.

Currently with Whipps Cross Hospital PMRT department.

The Princess Alexandra Hospital NHS Trust

4.0 Recommendation

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

Author: Claire Carter, Bereavement Midwife
Date: 3rd February 2022

Appendix 1

Healthy Lifestyles Midwife actions

Healthy Lifestyle Midwife developed leaflet to accompany each Co Monitor with Very Brief Advise. distributed to 50 CMWs
RCM and RCOG Guidance on Co Monitoring and Risk Assessment for performing monitoring have been shared with community teams
Guidance from Bedfont the manufacturers of the Smokerlyser regarding the safety of Co Monitoring and COVID 19 particles
Each week Co Monitoring Data at booking is analysed and individual MWs contacted to discuss reason for non-compliance, escalated to Community Matron where non-compliance is repeated
Training and updates with Community Midwifery Teams.

Maternity and Neonatal Safety Champions Exception Report

Date	11th February 2022				
Subject	Maternity and Neonatal Safety Champions Exception Report				
Report of	Helen Glenister, Board Safety Champion (Non-Executive Director)				
Author	Joanna Keable, Maternity Safety Champion, Deputy Director of Midwifery (HoM)				
Previously considered by	Quality and Safety Committee – 25th February 2022				
Group Action Required	**Approval**			**Discussion**	**X**
	Decision			**Information**	**X**

Executive Summary and purpose

The aim of the Neonatal and Maternity Safety Champions is to make measurable improvements in safety outcomes for women/people their babies and families in maternity and neonatal services. As set out in Better Births and the Maternity Incentive Scheme and as required by National, Regional and local reports and intelligence, such as CQC, PMRT, etc.

This summary is for the assurance and escalation to the Quality and Safety Committee – an extension of Trust Board.

1. Introduction

This report provides the highlights and barriers of the Neonatal and Maternity Safety Champions as discussed, minutes and an action log are also available.

2. Key themes/progress & Update

- Discussed Maternity Incentive Scheme Safety Action 9 (SA 9).
- So far there is good evidence of SA9 except it has not been possible for the Board Safety Champion to visit during the recent restrictions related to the pandemic. It is hoped that one will be set one very soon.
- Work is ongoing towards improving access/communications with the Safety Champions at all levels; posters are being updated with photographs, a new email address is being created and the Maternity Safety Champion has completed regular walk rounds.
- The Perinatal Quality Surveillance Tool and the Maternity Dashboard in a SPC format will be shared prior to the Safety Champions meeting.
- There was no Neonatal Safety Champion present at the meeting on this occasion.

3. Barriers and Other matters for escalation

- Administrative support is required.

4. **Next Steps/Action**

- Creation of an Action Log.
- Board Maternity and Neonatal Safety Champion Helen Glenister to attend the next MVP meeting on the 13th April 2022 and Board Maternity and Neonatal Safety Champion Saba Sadiq plans to attend the next meeting on the 8th June 2022.

Next Safety Champions meeting will be on the 11th March 2022.

Presented by: Board Level Safety Champion
Date: 25.02.2022

Title: Exception Report of Maternity and Neonatal Safety Champions, Feb 2022.

4.2

Maternity and Neonatal Safety Champions Exception Report

Date	11th March 2022				
Subject	Maternity and Neonatal Safety Champions Exception Report				
Report of	Helen Glenister, Board Safety Champion (Non-Executive Director) Saba Sadiq, Board Safety Champion (Executive Director)				
Author	Joanna Keable, Maternity Safety Champion, Deputy Director of Midwifery (HoM)				
Previously considered by	Quality and Safety Committee – 25th March 2022				
Group Action Required	**Approval**			**Discussion**	**X**
	Decision			**Information**	**X**

Executive Summary and purpose

The aim of the Neonatal and Maternity Safety Champions is to make measurable improvements in safety outcomes for women/people their babies and families in maternity and neonatal services. As set out in Better Births and the Maternity Incentive Scheme and as required by National, Regional and local reports and intelligence, such as CQC, PMRT, etc.

This summary is for the assurance and escalation to the Quality and Safety Committee – an extension of Trust Board.

1. Introduction

This report provides the highlights and barriers of the Neonatal and Maternity Safety Champions as discussed, minutes and an action log are also available.

2. Key themes/progress & Update

1. The Perinatal Quality Surveillance Tool and the Maternity Dashboard was shared in list format and the Board Safety Champions reviewed the areas that are both on track and not on track.
   Information was outstanding from the People team around training.
   Instrumental birth rate is low and being monitored.

2. There was no Neonatal Safety Champion present at the meeting on this occasion for the second time.

3. The outcomes from February's monthly staff survey was discussed, the themes were equipment, escalation, staffing and training. The leading issue was staffing. The group were assured that there are plans in place to address these issues. It was also discussed that there are strategies and plans in place to improve these areas that are now available – Ask Giuseppe, Unit Meetings and You said We Did posters.

3. **Barriers and Other matters for escalation**
• Neonatal representation is required.
4. **Next Steps/Action**
• **Feedback:** • Board Maternity and Neonatal Safety Champion Helen Glenister to attend the next MVP meeting on the 13th April 2022 and Board Maternity and Neonatal Safety Champion Saba Sadiq plans to attend the next meeting on the 8th June 2022. • Helen Glenister is completing a NED walk round on 17th March 2022. Next Safety Champions meeting will be on the 8th April 2022.

Presented by: Board Level Safety Champion
Date: 25.03.2022

Title: Exception Report of Maternity and Neonatal Safety Champions, March 2022.

Maternity and Neonatal Safety Champions Exception Report

Date	12th April 2022				
Subject	Maternity and Neonatal Safety Champions Exception Report				
Report of	Helen Glenister, Board Safety Champion (Non-Executive Director) Saba Sadiq, Board Safety Champion (Executive Director)				
Author	Joanna Keable, Maternity Safety Champion, Deputy Director of Midwifery (DDoM)				
Previously considered by	Quality and Safety Committee – 29th April 2022				
Group Action Required	**Approval**			**Discussion**	**X**
	Decision			**Information**	**X**

Executive Summary and purpose

The aim of the Neonatal and Maternity Safety Champions is to make measurable improvements in safety outcomes for women/people their babies and families in maternity and neonatal services. As set out in Better Births and the Maternity Incentive Scheme and as required by National, Regional and local reports and intelligence, such as CQC, PMRT, etc.

This summary is for the assurance and escalation to the Quality and Safety Committee – an extension of Trust Board.

1. Introduction

This report provides activity since the last report to the Maternity Oversight Group of Quality and Safety Committee.

2. Key themes/progress & Update

- On the 8th April the regional team completed an Ockenden/Sixty Steps to Safety Assurance Visit. The Board Level Safety Champion Helen Glenister (HG) and Maternity Safety Champion Joanna Keable (JK) met with the team and a formal report is awaited. In response to a question about concerns that had been highlighted, both HG and JK highlighted the issues with labour ward theatres (temperature control).
- HG visited both Maternity and Neonatal services on the 12th April 2022. Key findings are below **Maternity**
- Service user (ladies x3 plus partners) feedback was positive.
- Poor staffing levels were raised by the midwives on Maternal Fetal Monitoring Unit, Maternity Scanning Department, Samson and Labour Ward.
- In Ultrasound the team were concerned around the impact of COVID on the capacity to provide the service with a heavy reliance on bank ultra sonographers and midwives
- In MAFU the midwives raised the issue of medical staffing, HG has noted this as a recurring theme, however is aware that this is part of the Maternity Improvement Board Program for Triage.

Neonatal

- Hard copy Prescribing Monograph folder to be addressed
- Estates issues to be resolved; no progress since last month
- The staff did not raise any safety issues
- The above was discussed with the Head of Nursing for Children

3. **Barriers and Other matters for escalation**

- Hard Copy Prescribing Folder
- Estate issues in Neonatal Services.

4. **Next Steps/Action**

- Board Maternity and Neonatal Safety Champion Helen Glenister to attend the next MVP meeting on the 13th April 2022 and Board Maternity and Neonatal Safety Champion Saba Sadiq plans to attend the next meeting on the 8th June 2022.
- Monthly Safety Survey to include validated questions from the previous Score Survey in May 2022.
- Next visit to follow-up on issues identified.

Next Safety Champions meeting will be on the 13th May 2022.

Presented by: Board Level Safety Champion
Date: 12.04.2022

Title: Exception Report of Maternity and Neonatal Safety Champions, April 2022.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 9th June 2022

4.2

Agenda item: **Presented by:** **Prepared by:** **Date prepared:** **Subject / title:**	Giuseppe Labriola – Director of Midwifery Erin Harrison – Lead Governance Midwife 13.04.2022 Maternity Assurance Report – Quarterly review Jan-Mar 2022 (Q4)							
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	The recent Maternity Incentive Scheme (MIS) Year 4, published in October 2021 has issued the requirement for quarterly reporting to Board including details on number of serious harm incidents, themes identified and actions being taken to address any issues, minimum staffing in maternity services and training compliance. The expectation is that the paper will be presented by the Board Level Safety Champions moving forward to be in line with the national requirements.							
Recommendation:	To provide assurance to the Trust Board that the maternity service are continually monitoring compliance and learning from complaints and incidents.							

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

Previously considered by:	Quality and Safety Committee – 29th April 2022
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	To be compliant with Year 4 of the Maternity Incentive Scheme which was published in October 2021
Appendices:	N/A

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

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4.2

1.0 Purpose/issue

This paper is to provide assurance to the Board

2.0 Background

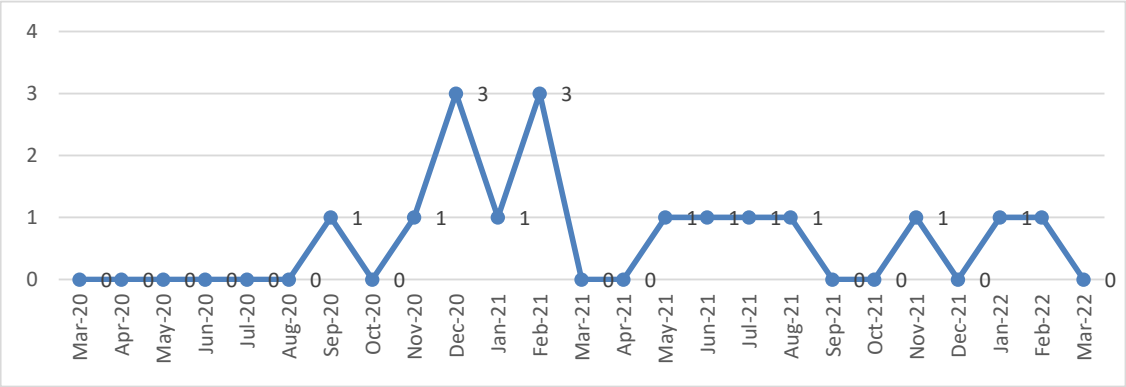
NHS Resolution is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.
The maternity incentive scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. As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

3.0 Analysis

Serious Incidents

Maternity currently have 3 SI's under investigation, 2 of which are being investigated by HSIB, the detail can be found in Table 2. Table 1 details the trend of declared SI's within the last 24 months to March 2022.

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



There were 2 new serious incidents declared in Quarter 4 of 2021/22. The detail can be found in table 2.

Table 2. Serious Incidents declared and submitted for October- December 2021 (Q3)

Serious Investigations	
Number Declared for Q4 2021/22	**2**
Number Submitted for Q4 2021/22	**2**
Number Past CCG Deadline as of March 2022 (Not including HSIB/Approved Extensions)	**0**
Total Open SIs for Maternity to date (including HSIB)	**3**

New Serious Investigations declared		
Ref	**Summary**	**Learning Points**
Paweb108939 HSIB	Difficult delivery and breech extraction. Therapeutic cooling. No HIE noted on MRI.	• Lack of documentation of 'infection' on fetal monitoring stickers • Whole clinical picture not taken into consideration regarding chorioamnionitis and obstructed labour • Delayed obstetric review of 40 minutes due to handover
Paweb107031	35 weeks with history of reduced fetal movements and Covid-19. On arrival intrauterine death diagnosed and disseminated intravascular coagulation. Post-mortem consistent with covid placentitis. Complex case which needs a multi-agency approach	• Cross border working with reviewing results – discussions ongoing with ENHT • Communication barriers due to language barrier
All open serious incidents		
PAweb106256 HSIB	Patient attended to labour ward contracting 5-6:10. Intrauterine death confirmed via departmental scan.	• Routine 28-week bloods, including screening for diabetes was missed antenatally. This was due to cross border working as PAHT initially booked the patient's pregnancy and care was then transferred to East Herts for antenatal care. There is no documentation surrounding bloods taken or blood results during this time. • It is probable that due to excessive spontaneous contractions and the clinical findings of fresh red blood (approximately 50-100mls) during labour, plus a retroplacental clot, that there may have been a placental abruption however there is no way this can be confirmed. • The family have declined a post-mortem and therefore no cause of death can be confirmed.

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

Of the open Datix's as detailed in Table 3; 303 are no or low harm. Of the 2 that remain open above moderate harm; both are Massive Obstetric Haemorrhages that are following the directorate governance process of a care review, none have highlighted care or service delivery issues that require escalation.

There has been a 9% reduction in the amount of open incidents at the end of Q4.

Table 3. Current Clinical incidents open and closed

Clinical Incidents (DATIX)	
Number of Incidents Submitted Last Quarter	313 (97% low or no harm)
Number of Incidents Moderate Harm or Above	12
DoCs Outstanding	None
Number of Open Incidents	110 (2 moderate harm or above)
Number of Incidents Submitted (since March 2021)	1408
Percentage of Open Incidents	35%

Table 4. Legal Cases Received over Q4 (Jan-Mar 2022)

Legal Cases			
	New	**Closed**	**NHSR (Damages)**
Jan 2022	1	0	0
Feb 2022	4	0	1 (TBC)
Mar 2022	0	2	0

Perinatal Mortality Review Tool Summary

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

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

Table 5. Perinatal Mortality Review Tool Open Cases

Perinatal Mortality Review Tool Summary
5 open cases for PAHT 2 open with other Trusts All open cases for PAHT have dates booked for review, the oldest case dates back to 02/12/2021 and the final report is currently being written.

MBRRACE-UK Real Time Data Modelling for past 6 months

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

Table 6. MBRRACE Reportable Cases

MBRRACE-UK Real Time Data Modelling for Past 6 Months
9 reported deaths to MBRRACE which included: 8 Antepartum stillbirths 0 Intrapartum stillbirth 1 Neonatal death 0 late miscarriage Ethnicity: 9 White

External Reviews and External Scrutiny

Table 7. External Reviews and Scrutiny

External Reviews and External Scrutiny
• *HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust* • *Coroner Reg 28 made directly to Trust*
PAHT currently have 2 cases that are under investigation by HSIB as per Table 1. Below shows the status of all reported cases to HSIB.

Cases to date	
Total referrals	14
Referrals/cases rejected	6
Total investigations to date	8
Total investigations completed	6
Current active cases	2
Exception reporting	0

CQC inspected maternity services in July 2021, the service was rated as requires improvement and remains part of the Maternity Services Support Programme.

No inquests undertaken for maternity care

Staffing

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

Staffing				
Staff feedback from frontline champions and walk-abouts: **Staff have escalated concerns surrounding the shortage of midwifery staffing.** This is not a concern unique to PAHT with maternity services across the country experiencing similar problems; and services identifying steps to address issues around staffing, leadership and resourcing. A risk assessment has been completed alongside the maternity units across the Local Maternity and Neonatal System to describe proposals in maintaining safe staffing and reducing the risk. The initial risk rating is 25 without mitigations or controls in place and recalculated to 20 with the current controls the service has in place. It is envisaged this may reduce to 16 with additional mitigation. Birthrate+ has been undertaken within Maternity Services. This looks at the birth rate, acuity and staffing to ensure that the funded staffing establishment is appropriate for the cohort of women that PAHT care for. This workforce review has been approved by the board and an additional 22 WTE nursing, midwifery and support worker roles have been approved. The Director of Midwifery has worked with the finance team to budget set and create individual cost centres for wards and departments in the maternity service. 8 International Midwives will join the organisation over the summer and the service is actively recruiting to all posts.				
Consultant Obstetric Cover on the Labour Ward	87 hours cover (RCOG recommendation is 98 hours)			
Junior Doctor Rota Gaps	No rota gaps – Currently recruiting to implement a 2 tier rota (2 registrars per shift)			
Midwifery and Neonatal Staffing		**Jan**	**Feb**	**Mar**
	Vacancy Rate (<8%)	8%	7.4%	Awaiting data
	Overall Sickness (<3.7%)	3.8%	4.15%	Awaiting data
	Short Term Sick	1.67%	1.83%	Awaiting data
	Long Term Sick	2.13%	2.32%	Awaiting data
	Turnover (voluntary) (<12%)	15.85%	16.21%	Awaiting data
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)		**Proportion of speciality trainees responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (Reported annually)**		
Awaiting Staff Survey Workshops have been booked with the Senior Leadership Team to discuss results and implement changes.		Awaiting Staff Survey		

Training Compliance

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

Table 9. Training Compliance

Training Compliance	
Child Safeguarding Level 3	**75%**
Resuscitation	**80%**
PROMPT	**93%**
Fetal Monitoring	**95%**

MIS Progress

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

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

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

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

Table 10. MIS Progress Yr 4

MIS Progress Yr 4			
SA 1	On Track	SA 6	On Track
SA 2	Concern	SA 7	On Track
SA 3	On Track	SA 8	On Track
SA 4	On Track	SA 9	On Track
SA 5	On Track	SA 10	On Track

Ockenden

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

The IEA are:

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

PAHT submitted their evidence in July 2021 and have received feedback regarding compliance as per Table 10. A meeting was held on 28.10.2021 across the Local Maternity and Neonatal System to review the grading and to submit queries relating to the feedback to the national team. PAHT have an action plan in place to ensure all immediate and essential safety actions are met.

The final report was released in March 2022, the service is currently in the process of reviewing the 15 new Immediate and Essential Safety Actions. An update will be provided in the next quarterly review.

Table 11. Immediate and Essential Safety Actions outcome

IEA Progress			
IEA 1	81%	IEA 5	93%
IEA 2	71%	IEA 6	67%
IEA 3	39%	IEA 7	43%
IEA 4	93%	WF	70%

Saving Babies Lives Care Bundle v2 (SBLCBV2)

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

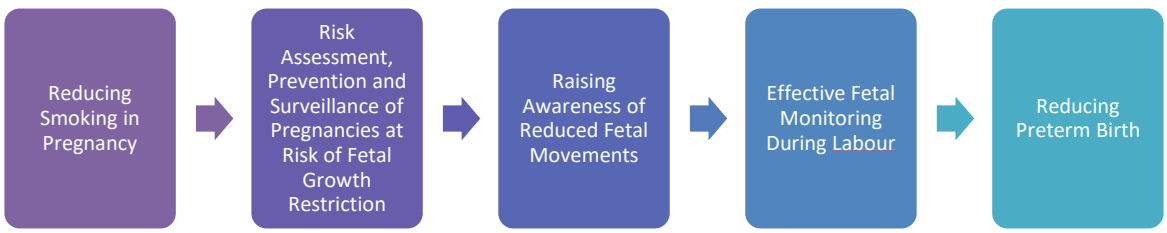


Table 12. Saving Babies Lives Score Card Summary

Saving Babies Lives Score Card Summary
Reporting is currently suspended, all associated audits have continued as part of MIS Yr 4.

Complaints/PALS

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

Complaints	Pals
January - 1 February - 0 March - 3	January - 0 February - 4 March - 6
Themes	
All complaints received over Q4 related to direct care provided. Pals themes were surrounding communication and attitude of staff.	
Service User Feedback	
"On Sunday 9th January, my daughter Isla was delivered in the Daisy room of the birthing suite by the most phenomenal midwife Emma. She is by far the most caring, compassionate and kind-hearted healthcare worker I have met to date and I feel so utterly fortunate to have had her deliver my first baby. Her constant support during this special time was invaluable and something I will never forget. Alongside the care of Emma and her colleagues, I believe the impeccable support from the Willow Team also vastly contributed to my wonderful pregnancy and birth story. Michelle and Ceri have been so kind, calm and knowledgeable as well as being a constant support to me throughout this journey. We cannot thank them enough for the greatest gift of all, our happy and healthy baby and an amazing birthing experience."	

4.0 Oversight

All highlighted concerns have been escalated at divisional board. All incidents are discussed at the divisional Patient Safety and Quality Group and Trust Incident Management Group and escalated where relevant for further investigation. Staffing is assessed on a daily basis and the Directorate are currently out to advert for all vacancies. The service are continuing to work towards the requirements of MIS yr 4, SBLCBv2 and the Ockenden IEA. Escalation will occur through board where non-compliance is anticipated or found to occur.

5.0 Recommendation

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

Author: Erin Harrison – Lead Governance Midwife
Date: 13.04.2022

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 9th June 2022

4.2

Agenda item: **Presented by:** **Prepared by:** **Date prepared:** **Subject / title:**	Giuseppe Labriola – Director of Midwifery Erin Harrison – Lead Governance Midwife 13.04.2022 Saving babies Lives Care Bundle V2 – Quarterly review Jan-Mar 2022 (Q4)							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	'Saving Babies' Lives is a care bundle designed to support providers, commissioners and professionals take action to reduce stillbirths. The guidance was developed with clinicians, commissioners, charities and royal colleges and is based on the best available evidence. It supports the delivery of safer maternity care, as described by the National Maternity Review, in Better Births The expectation is that all elements are implemented in order to positively impact on the stillbirth rate.							
Recommendation:	To provide assurance to the Trust Board that the maternity service are continually monitoring compliance with Saving Babies Lives Care Bundle V2.							

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:	Quality and Safety Committee – 29th April 2022
Risk / links with the BAF:	N/A
Legislation, regulatory, equality, diversity and dignity implications:	Saving Babies Lives Care Bundle V2 Maternity Incentive Scheme Year 4
Appendices:	N/A

1.0 Purpose

This paper is to provide assurance to the Board that the service is compliant with the care bundle and the requirements for the maternity incentive scheme.

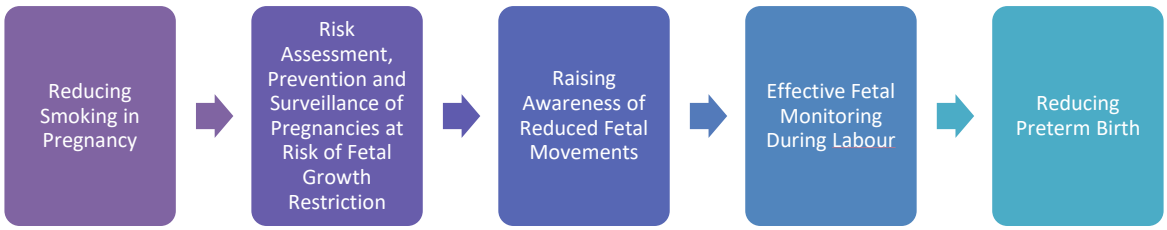
2.0 Background

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

3.0 Analysis

Saving Babies Lives Care Bundle v2 (SBLCBV2)

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



National Maternity Review, in Better Births 2016.

Table 1. Saving Babies Lives Score Card Summary

Saving Babies Lives Score Card Summary
Reporting is currently suspended, all associated audits have continued as part of Maternity Incentive Scheme (MIS) Year 4.

Element 1 – reducing smoking in pregnancy

All women/pregnant people who are identified as smokers are placed on the smoking pathway. This means all smokers are offered further scans at 32, 36, 38-40 weeks of pregnancy and are referred and provided support with smoking cessation throughout their pregnancy. Currently all women/birthing people are offered CO monitoring at booking and at 36 weeks of pregnancy. This is also undertaken at every antenatal contact.

Audits are ongoing to measure the compliance with CO monitoring, currently this is at 90.6%, compliance level for Trusts is ≥95%. The healthy lifestyle midwife is currently undertaking targeted work with community teams to increase compliance. With the work being undertaken the service is confident that the target of 95% will be met prior to submission in December 2022.

All teams have been allocated their own CO monitors and for heavy smokers individual monitors are being provided for self-testing.

Element 2 – fetal growth restriction

All women/pregnant people have a risk assessment undertaken at the booking appointment to determine their requirement for Aspirin, this is documented both electronically on the patient record and as an integral part of the hand held notes.

Women/Birthing people who have an increased risk of/or previous fetal growth restriction are referred to the Fetal Medicine Consultants and Fetal Medicine Midwife. As per the local guidance these service users will have serial growth scans undertaken throughout the 3rd trimester. Where concerns are noted with fetal growth, a plan of care is initiated including offering induction of labour, where indicated as per the care bundle and following discussion with women/birthing person. The last audit undertaken demonstrated 100% compliance, compliance level for Trusts is ≥95%. and this will be repeated prior to the final submission for MIS in December 2022.

Fetal growth restriction is monitored through the Perinatal Mortality Review Tool and is not currently showing as a theme for stillbirths and neonatal deaths.

All women/pregnant people who have multiple pregnancies are under the care of the Fetal Medicine Consultants and Fetal Medicine Midwife. PAHT does not currently participate in the GAP/GROW programme and are auditing on a rolling quarterly basis babies that are born under the 3rd centile.

Element 3 – reduced fetal movements

All women/pregnant people have the reduced fetal movements information provided to them at booking, this is an integral part of the hand held maternity notes. Fetal movements are also documented at every antenatal contact.

An audit has been undertaken with women/pregnant people who have attended with reduced fetal movements having a computerised CTG undertaken. The audit has demonstrated 100% compliance, compliance level for Trusts is ≥95%.

Element 4 – fetal monitoring

PAHT have a 1 WTE fetal monitoring midwife and a Lead obstetrician in post.

All midwives and obstetric doctors are required to attend an in-house fetal monitoring training day on an annual basis. Current compliance is 95%. Compliance level for Trusts is ≥90%.

Element 5 – reducing preterm birth

Element 5 of the care bundle is reliant on manual audits as the SNOMED-CT coding is unable to pull from Cosmic (Trust Electronic Patient Record System) directly to the Maternity Dataset. Compliance with all elements is set at 80% however a Trust will not fail if ≤80%. An action plan should be developed in these cases and agreed by the Trust Board.

An audit is currently in progress in relation to administration of antenatal steroids which will be completed and presented prior to the submission in December 2022. Compliance is monitored through a variety of means such as electronic prescription, hand held notes and through both Cosmic and Badgernet. The audit must include 40 cases of notes where women/birthing people have birthed prior to 34 weeks of pregnancy.

An audit was undertaken for administration of Magnesium Sulphate (MgSo4) for neuroprotection. The audit demonstrated 87% compliance of which 2 cases were considered avoidable (1 case had been seen 2 days prior and discharged home, the second case was an emergency caesarean for breech presentation with ruptured membranes, the review determined MgSo4 could have been administered prior to surgery). 2 cases arrived in advanced labour and therefore administration was not possible and 1 case was admitted straight to theatre with CTG concerns.

A review has been undertaken for babies that were born in the appropriate care setting. To date there was 1 baby born ≤27 weeks gestation in the Year 4 Maternity Incentive Scheme timeframe. The baby was born less than an hour from attendance to hospital and therefore there was no time for an in utero transfer.

All women/pregnant people at risk of preterm birth have access to transvaginal ultrasound cervical length measurement which is performed by designated Obstetric Consultants within the department.

An audit is also being undertaken on 40 consecutive cases to ensure that women/pregnant people are risk assessed at booking and placed onto the appropriate pathway. This will be completed prior to the submission date in December 2022.

4.0 Oversight

All highlighted concerns have been escalated at Health group board.

The service are continuing to work towards the requirements of SBLCBv2. Escalation will occur through divisional board and the maternity assurance committee, where non-compliance is anticipated or found to occur.

5.0 Recommendation

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

Author: Erin Harrison – Lead Governance Midwife
Date: 13.04.2022

Maternity and Neonatal Safety Champions Exception Report

Date	19th May 2022				
Subject	Maternity and Neonatal Safety Champions Exception Report				
Report of	Helen Glenister, Board Maternity and Neonatal Safety Champion (Non-Executive Director)				
Author	Joanna Keable, Maternity Safety Champion, Deputy Director of Midwifery (DDoM)				
Previously considered by	Quality and Safety Committee – 27th May 2022				
Group Action Required	**Approval**			**Discussion**	**X**
	Decision			**Information**	**X**

Executive Summary and purpose

The aim of the Neonatal and Maternity Safety Champions is to make measurable improvements in safety outcomes for women/people their babies and families in maternity and neonatal services. As set out in Better Births and the Maternity Incentive Scheme and as required by National, Regional and local reports and intelligence, such as Care quality Commission, Perinatal Mortality Review Tool, etc.

This summary is for the assurance and escalation to the Quality and Safety Committee – an extension of Trust Board.

1. Introduction

This report provides activity since the last report to the Maternity Oversight Group of Quality and Safety Committee.

2. Key themes/progress & Update

- On the 18th May the Board Level NED Maternity and Neonatal Safety Champion Helen Glenister (HG) visited the maternity department. She met 2 x community continuity care midwives and spoke with 1 traditional community midwife. Concerns raised which impact on quality of care:
  - Escalation – midwives required to work more hours due to shortages. Could talk about leadership appointing more midwives (band 5) but there was a gap in band 6.
  - Community continuity care midwives do not have a base
  - IT issues – No access to SystemOne so unable to see primary care records. Cosmic is very slow. Often unable to complete records in community, impacts on efficiency
  - Traditional midwives unable to print out forms.
  - All of the above needs to be followed up in action plan
- Attended daily safety huddle, now asking question – Are we safe?
- Visited Neonatal Intensive Care Unit and Special Care Baby Unit.
  - Nurses concerned about the prescription file. Still present. Don't feel a digital solution will help. Exec to follow-up

- New fire doors replacing old ones
- Still have a piece of paper covering sockets not to be used.
- Many environment matters to be addressed
- No concerns about staffing levels or equipment.

- The maternity and neonatal safety champions were not able to meet primarily due to diary commitments and as the Board Executive Level Maternity and Neonatal Safety Champion and the Obstetric Safety Champion have left the Trust the meeting would not have been quorate.
- The monthly safety survey was completed and responses shared with the teams. The next safety survey will ask a different set of questions and have a neonatal focus. The themes of this month survey were: escalation, staffing, senior leadership, equipment and stores, communication and the Maternity improvement board workstreams. The response have been shared via email with HG due to being unable to meet.
- HG has met with ICS NED Maternity and Neonatal Safety Champions. Approaches of each Trust shared.

3. Barriers and Other matters for escalation

- The Executive Maternity and Neonatal Safety Champion and the Obstetric Safety Champion need to be reappointed due to both having recently left the Trust.

4. Next Steps/Action

- Board Maternity and Neonatal Safety Champion Helen Glenister plans to attend the next Maternity Voices Partnership on the 8th June 2022.
- Monthly Safety Survey to include validated questions from the previous Score Survey in May 2022.
- Next visit to follow-up on issues identified.
- Next Safety Champions meeting is to be confirmed with the newly appointed Safety Champions.

Presented by: Board Level Safety Champion
Date: 18.05.2022

Title: Exception Report of Maternity and Neonatal Safety Champions, May 2022.

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 9th June 2022

4.2

Agenda item: **Presented by:** **Prepared by:** **Date prepared:** **Subject:**	Giuseppe Labriola – Director of Midwifery Joanna Keable – Deputy Director of Midwifery 16th May 2022 Midwifery staffing (including midwifery continuity of carer)									
Purpose:	**Approval**		**Decision**	√	**Information**		**Assurance**			
Key issues:	The Final Ockenden report (March 2022), has raised 15 immediate and essential actions. One of which is Safe Staffing, that all Trusts must maintain and mitigate where maternity staffing falls below minimum staffing levels. Specifically review and suspend if necessary the existing provision/further roll out of Continuity of Carer (MCoC) model unless they can demonstrate staffing meets safe minimum requirements, on all shifts. A letter from NHS E/I Chief Executive Officer dated 01.04.22 describes three thresholds for action. Currently at PAH we meet safe minimum staffing by enacting escalation through the use of the existing MCoC amongst other methods daily.									
Recommendation:	The recommendation is that we pause further roll out of continuity of care and introduce a core team on call system to support safe staffing across all systems, while continuing with the trajectory for recruitment.									
Trust strategic objectives:	**Patients**	**People**	**Performance**	**Places**	**Pounds**					
	√	√	√							

Previously considered by:	Quality and Safety Committee – 27th May 2022
Risk / links with the BAF:	
Legislation, regulatory, equality, diversity and dignity implications:	Immediate and Essential Actions, Ockenden Part 2 (2022)

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Appendices:	Appendix 1 – Letter from NHS England and NHS Improvement Chief Executive Officer Appendix 2 – Template to return to NHS England and NHS Improvement

1.0 Purpose

The Ockenden detailed 15 immediate and essential actions, one of which is Safe Staffing that all trusts must maintain and mitigate where maternity staffing falls below minimum staffing levels. Specifically Trusts must review and suspend if necessary, the existing provision or further roll out of continuity of carer models unless they can demonstrate staffing meets safe minimum requirements on all shifts.

A letter from the Chief Executive Officer for NHS England and NHS Improvement (Appendix 1) describes three thresholds for action. PAH meets the second threshold as we meet safe minimum staffing requirements through the use of the MCoC pathway/escalation. Therefore, the requirement is to pause further roll out of MCoC and continue with support for the current level of provision.

2.0 Context

As part of the Maternity Transformation Program the MCoC has been in place at PAH for three years, we currently have three teams as part of our service caring for 21% of our birthing population. This model of care is highly valued by the women and people who receive this.

To provide MCoC midwives work across the community and hospital effectively reducing the staffing template within the hospital. The midwives would then be called in to care for their own caseload of women however they are also called in as escalation. This affects their ability to provide intrapartum continuity, which is a central component to the model by definition.

This has an impact on staffing in maternity services which is monitored daily
Where dynamic action plans are instigated. The maternity service is in escalation frequently. This is monitored using Birth Rate Plus, locally via Eroster; along with more qualitative data from patient feedback, DATIX and staff experience. The service currently has a vacancy rate of 16% (25 WTE midwives). There is a recruitment strategy in place and this has generated 67 applications in response to the most recent advert and so far 44 have been shortlisted.

The senior leadership team are aware that the MCoC teams are experiencing high levels of stress and burnout from the recent Maternity Safety Champions Survey February 2022 related to being called in to provide escalation to ensure safe staffing. From discussion with the continuity teams it is clear that they would like to continue working in the continuity models and provide intrapartum care for their own caseload.

3.0 Proposal

Our current baseline plans need and proposals need to be provided to NHS England and NHS Improvement by June 2022 (Appendix 2). It is recommended that the service continues with the MCoC model and service provision and in addition, introduce a hospital on call escalation. The current escalation model will also be reviewed, including a standard for calling in midwives. This will have the benefit of increasing midwifery staff numbers and thus improving safety in the unit. This will maintain the adequate midwifery provision in the community (both traditional and MCoC teams).

In addition, during June and July, there will be a requirement for all senior and specialist midwives to contribute to the off-duty by undertaking a minimum of one clinical shift on a weekly basis, to support the template.

5.0 Recommendation

In order to improve midwifery staffing it is recommended that further roll out of MCoC is paused. The service will continue with the current MCoC team provision and implement a hospital on call system to improve staffing. This will be reviewed following our September recruitment.

Author: Joanna Keable – Deputy Director of Midwifery
Date: 17th May 2022

The Princess Alexandra Hospital NHS Trust

APPENDIX 1

The Princess Alexandra Hospital NHS Trust

APPENDIX 2

Official
Publication approval reference: B1523

To:

- NHS Trust and Foundation Trust:
  - Chief Executives
  - Chairs
  - Chief Nurses
  - Chief Midwives
  - Medical Directors
- ICS leads and Chairs
- LMNS/LMS leads
- CCG Accountable Officers

CC:

- Regional chief nurses
- Regional chief midwives
- Regional medical directors
- Regional obstetricians

Skipton House
80 London Road
London
SE1 6LH

1 April 2022

Dear colleagues

OCKENDEN – Final report

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March.

Donna Ockenden and her team have set out the terrible failings suffered by families at what should have been the most special time of their lives. We are deeply sorry for the loss and the heartbreak they have had to endure.

This report must act as an immediate call to action for all commissioners and providers of maternity and neonatal services who need to ensure lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs) and every trust, ICS and LMS/LMNS Board must consider and then act on the report's findings.

We have announced significant investment to kick-start transformation of maternity services with investment of £127 million over the next two years, on top of the £95 million annual increase that was started last year. This will fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support. We will set out further information in the coming weeks.

Your Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at your organisation / within your local system. The Ockenden report should be taken to your next public Board meeting and be shared

with all relevant staff – we strongly recommend everyone reads it, regardless of their role. After reviewing the report, you should take action to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. We will soon publish a revised national policy and guidance on speaking up.

Staff in maternity services may need additional health and wellbeing support. Please signpost colleagues to local support services or national support for our people.

The report highlights the importance of listening to women and their families. Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.

It includes a specific action on continuity of carer: *'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (*IEA 2, Safe Staffing page 164)

In line with the maternity transformation programme, trusts have already been asked to submit their MCoC plans by 15 June 2022. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Trusts should therefore immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken, and necessary assurance of implementation is in place.

We expect there will be further recommendations for maternity and neonatal services to consider later this year given other reviews underway. We are committed to consolidating actions to ensure a coherent national delivery plan.

However, there can be no delay in implementing local action that can save lives and improve the care women and their families are receiving now.

In the 25 January 2022 letter we asked you to set out at a Public Board your organisation's progress against the seven IEAs in the interim Ockenden report before the end of March 2022. Your position should be discussed with your LMS and ICS and reported to regional teams by 15 April 2022. We will be publishing a detailed breakdown of these returns and compliance by Trust with the first Ockenden IEAs at NHSE/I public Board in May. Your trust also needs to provide reliable data to the regular provider workforce return, with executive level oversight.

For organisations without maternity and neonatal services, this report must still be considered, and the valuable lessons digested.

We know you will be as determined as we are to ensure the NHS now makes the changes that will prevent other families suffering such devastating pain and loss.

Yours sincerely

Amanda Pritchard	**Ruth May**	**Professor Stephen Powis**
NHS Chief Executive	Chief Nursing Officer	National Medical Director

Completion notes

Please complete the three sheets in this document for your Local Maternity System. The 'Building Blocks' and 'LMS Trajectory' sheets should be broken down by Trust. The 'Teams Descriptor' sheet should detail all of the planned teams in your LMS. This final sheet will form your Expression of Interest for teams in your LMS to be Enhanced Midwifery Continuity of Carer pilots in 2022/23.

Please refer to the accompanying information shared alongside this template and the implementation guidance at *www.england.nhs.uk/publication/delivering-midwifery-continuity-of-carer-at-full-scale-guidance-21-22/*

Please return the completed spreadsheet **to your regional team by 15 June 2022**.

The building blocks: readiness to implement and sustain MCoC assessment framework

For each Trust in your LMS, please select the status of each Building Block using the drop down menu. Where a building block is not yet in place, please provide the planned date for achieving it.

Building block	Detail/notes	The Princess Alexandra Hospital NHS Trust		Select name of NHS Trust		Select name of NHS Trust		Select name of NHS Trust		Select name of NHS Trust		Select name of NHS Trust		Select name of NHS Trust	
		Status	If not in place, when will it be achieved?	Status	If not in place, when will it be achieved?	Status	If not in place, when will it be achieved?	Status	If not in place, when will it be achieved?	Status	If not in place, when will it be achieved?	Status	If not in place, when will it be achieved?	Status	If not in place, when will it be achieved?
Safe staffing	•Agreed safe staffing level for traditional model, proceeding only when safe to do so – using the NHS England and NHS Improvement tool to support planning •How many midwives required •How many in post •Recruitment plan with timeframes	In place		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	
Planning spreadsheet	Demonstrates safety from a staffing perspective: •how many women can receive MCoC – reviewing in and out of area and cross-boundary movement •where women are cared for at any given time, now and in MCoC models (see NHS England and NHS Improvement toolkit https://continuityofcarer-tools.nhs.uk/tools for an example of this) •midwifery deployment plan for MCoC, including timescales and recruitment plan for a phased scale up to default position	In place		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	
Communication and engagement	•Provides evidence of staff engagement and logs responses/ counter responses •Gives opportunity to share vision	Partially in place	01/06/2022	*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	
Skill mix	•Review of skill mix, within whole service. This includes: –number of Band 5 midwives placed in MCoC team. Likewise, number of Band 5 midwives working in the core –in both settings ensure there is appropriate support for these newly qualified members of staff, via the preceptor framework –Band 5 midwives (usually one per team) report being very well supported while undertaking preceptor programme •Appropriate and planned use of MSW, particularly in teams working in areas of greatest need. •Ensure preparedness of Band 7 delivery suite co-ordinators to support programme of change	Partially in place	TBC from SC	*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	
Training	Each midwife who will work in the team has a personal training needs analysis (TNA); existing TNAs can be used and the toolkit also gives examples.	In place		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	
Team building	Time allocated for team building and softer midwifery development as midwives move to a new way of working.	Not in place	01/01/2023	*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	
Linked obstetrician	Has there been obstetric involvement and are linked obstetricians identified? Is the referral to obstetrician process clearly set out in the SOP as well as other clinical guidance?	Partially in place	01/01/2023	*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	
Standard operating policy (SOP)	Each trust needs a SOP (an example can be found in the toolkit) that outlines roles and responsibilities to support delivery of MCoC. As with other guidance documents, it should pass through the maternity service governance processes.	Partially in place	01/09/2022	*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	
Pay	No midwife should be financially disadvantaged for working in this way. Each trust needs to review and manage this; the toolkit provides helpful information.	Not in place	01/12/2022	*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	
Estate and equipment	Place for midwives to see women. Equipment with which to provide care. Any problems should be escalated at trust board quarterly review and to the ICS.	Partially in place	01/09/2022	*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	
Evaluation	Is there a system for local, regional, and national evaluation and reporting to take place smoothly?	In place		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	
Review process	Date for initial plan to be reviewed by the trust board. Quarterly review dates set. Dates set for LMS and regional and national review.	In place		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*		*Please select*	

LMS MCoC implementation trajectory

Please outline the implementation trajectory by quarter for each Trust in your LMS. It may help to complete the 'Teams Descriptor' sheet first as the information should be aligned. Please note, any trajectories beyond March 2024 will need to be agreed with Regional Boards.

Trust	Trust code	Annual total number of women reaching 29 weeks gestation	Annual total number of women eligible to recive MCoC	Percentage of women to recive MCoC as default
		i.e. annualised number of women reaching 29 weeks each month at the Trust	*i.e. annual number of women who recive antenatal, intrapartum, and postnatal care at the Trust*	*This is column E expressed as a percentage of column D*
The Princess Alexandra Hospital NHS Trust	RQW	3983	2742	69%
Select Trust				
Select Trust				
Select Trust				
Select Trust				
Select Trust				
Select Trust				
Select Trust				
Select Trust				
Select Trust				
Select Trust				
Select Trust				
LMS Total		3983	2742	69%

Total planned number of MCoC teams (including enhanced teams)	Total planned number of teams in the most deprived 10% of areas	Total planned number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women	Planned quarter of acheivement	Q1 22/23			
				Total number of teams live by end of quarter	Of these, number of teams in the most deprived 10% of areas	Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women	Estimated annual number of women placed on MCoC pathways
Sized according to the guidance, i.e. 6 - 8 midwives	*i.e. the teams' coverage includes relevant postcodes defined by the IMD*	*i.e. areas essential for meeting the LTP target for ethnicity*	*i.e. quarter in which all women will receive MCoC as default*				
11	0	5	Q3 24/25	3	0	2	723
11	0	5		3	0	2	723

	Q2 22/23					Q3 22/23		
Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)	Total number of teams live by end of quarter	Of these, number of teams in the most deprived 10% of areas	Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women	Estimated annual number of women placed on MCoC pathways	Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)	Total number of teams live by end of quarter	Of these, number of teams in the most deprived 10% of areas	Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women
18%	3	0	2	723	18%	3	0	2
18%	3	0	2	723	18%	3	0	2

		Q4 22/23						
Estimated annual number of women placed on MCoC pathways	**Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)**	**Total number of teams live by end of quarter**	**Of these, number of teams in the most deprived 10% of areas**	**Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women**	**Estimated annual number of women placed on MCoC pathways**	**Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)**	**Total number of teams live by end of quarter**	**Of these, number of teams in the most deprived 10% of areas**
723	18%	3	0	2	723	18%	4	0
723	18%	3	0	2	723	18%	4	0

Q1 23/24			Q2 23/24					
Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women	Estimated annual number of women placed on MCoC pathways	Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)	Total number of teams live by end of quarter	Of these, number of teams in the most deprived 10% of areas	Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women	Estimated annual number of women placed on MCoC pathways	Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)	Total number of teams live by end of quarter
3	939	24%	4	0	3	939	24%	4
3	939	24%	4	0	3	939	24%	4

Q3 23/24				Q4 23/24				
Of these, number of teams in the most deprived 10% of areas	Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women	Estimated annual number of women placed on MCoC pathways	Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)	Total number of teams live by end of quarter	Of these, number of teams in the most deprived 10% of areas	Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women	Estimated annual number of women placed on MCoC pathways	Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)
0	3	939	24%	5	0	4	1191	30%
0	3	939	24%	5	0	4	1191	30%

Q1 24/25					Q2 24/25			
Total number of teams live by end of quarter	Of these, number of teams in the most deprived 10% of areas	Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women	Estimated annual number of women placed on MCoC pathways	Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)	Total number of teams live by end of quarter	Of these, number of teams in the most deprived 10% of areas	Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women	Estimated annual number of women placed on MCoC pathways
6	0	5	1443	36%	8	0	5	1947
6	0	5	1443	36%	8	0	5	1947

	Q3 24/25					Q4 24/25		
Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)	Total number of teams live by end of quarter	Of these, number of teams in the most deprived 10% of areas	Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women	Estimated annual number of women placed on MCoC pathways	Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)	Total number of teams live by end of quarter	Of these, number of teams in the most deprived 10% of areas	Of these, number of teams in areas with a high proportion of Black, Asian and Mixed ethnicity women
49%	11	0	5	2703	68%	11	0	5
49%	11	0	5	2703	68%	11	0	5

Estimated annual number of women placed on MCoC pathways	Estimated annual percentage of women placed on MCoC pathways (as a percentage of column D)
2703	68%
2703	68%

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 9 June 2022

4.3

Agenda item:	4.3							
Presented by:	Sharon McNally, Executive Director of Nursing, Midwifery and AHP's							
Prepared by:	Erin Harrison, Lead Governance Midwife							
Date prepared:	11th May 2022							
Subject / title:	Overview of Serious Incidents within maternity services							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	The Ockenden Report, published in December 2020, recommended that all maternity Serious Incidents (SI's) reports and a summary of the key issues are shared with Trust boards. There were 2 new maternity incidents declared since the last report (declared April 22). Maternity services currently have 5 SI's under investigation (2 which are Healthcare Safety Investigation Branch).							
Recommendation:	To provide assurance to the Quality and Safety Committee that the maternity service are continually monitoring compliance and learning from Serious Incidents.							

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

Previously considered by:	QSC (May 22) Divisional Board (May 22)
Risk / links with the BAF:	N/A
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. All SI investigations and learning have consideration of EDI within the framework.
Appendices:	N/A

The Princess Alexandra Hospital NHS Trust

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.

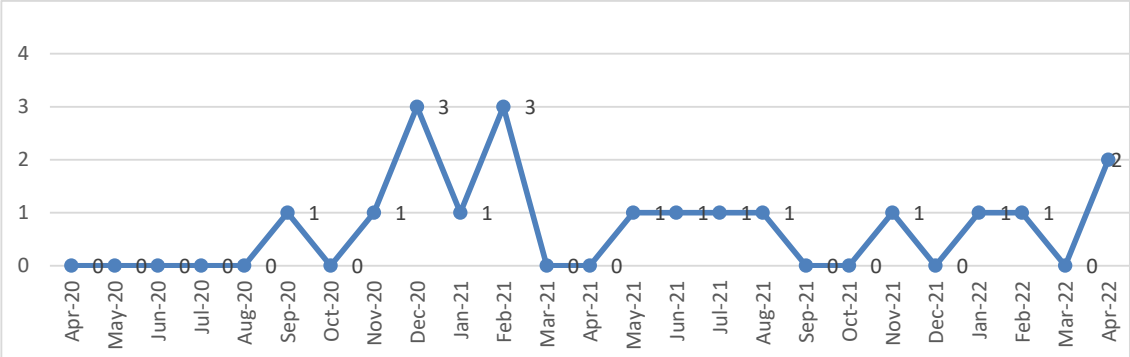
2.0 Background

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 5 SI's under investigation, 2 of which are being investigated by Healthcare Safety Investigation Branch (HSIB). Table 1 details the trend of declared SI's within the last 24 months to March 2022.

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



There were 2 new serious incidents declared in April 2022. The detail can be found in Table 2.

Table 2. Serious Incidents declared and submitted for April 2022

Serious Investigations	
Number Declared for April 2022	**2**
Number Submitted for April 2022	**0**
Number Past CCG Deadline as of April 2022 (Not including HSIB/Approved Extensions)	**0**

New Serious Investigations declared		
Ref	**Summary**	**Learning Points**
Paweb 108641	Patient at 32+4 weeks pregnant was admitted for management of vomiting. A decision for an emergency (category 1) caesarean section was made. The baby was born in poor condition The baby was intubated and admitted to the Neonatal Unit.	• Escalation was a concern from all parties involved. • Lack of appropriate documentation including use of CTG stickers
Paweb 113165	Woman attended another Trust with history of bleeding and infertility. Hysteroscopy undertaken which	• Round table held with Trust and notes/images received. • Awaiting further information relating to object in situ

	identified a man-made foreign object in the cervix and uterus.	

4.0 Themes

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

Table 3. Top Themes

Total Number of SI's	Theme	Number
18	CTG interpretation	7
	Obstetric Haemorrhage	6
	Compliance with guidance	3
	Hypertension	3
	Intrauterine death	3
	Escalation	3
	Neonatal death	2
	Delay in Care	3
	Hypoxic ischaemic encephalopathy	3
	Laceration at caesarean	1
	Fetal growth	1
	Cross Border Working	1

5.0 Oversight

All highlighted concerns have been escalated at Divisional level. All incidents are discussed at the Divisional Governance Meeting and Trust Incident Management Group and escalated where relevant for further investigation. The Quality and Safety Committee agenda was reviewed (Feb 22) to provide greater assurance of quality and safety within maternity services; the committee has detailed oversight of maternity SIs.

The Maternity Improvement Board has established 9 key work streams:

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

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

The Princess Alexandra Hospital NHS Trust

6.0 Recommendation

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

Author: Erin Harrison – Lead Governance Midwife
Date: 11th May 2022

Trust Board (Public) – 9 June 2022

4.4

Agenda item:	4.4
Presented by:	Sharon McNally – Director of Nursing & Midwifery
Prepared by:	Sarah Webb – Deputy Director of Nursing and Midwifery, Giuseppe Labriola, Director of Midwifery
Date prepared:	15.5.2022
Subject / title:	Report on Nursing and Midwifery and Care Staff Levels and an update to Nursing and Midwifery Workforce Position – Hard Truths Report

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

Key issues: please don't expand this cell; additional information should be included in the main body of the report	Part A: Overall staffing risk rating in month: Green with an increased overall RN/M fill rate (↑1.9 %) to 87.0%. The fill rate of HCSW has increased by 6.5%% to 108.9 %. The paper contains a deep dive of staff redeployment which has been raised as an area of concern by staff. The deep dive shows that staff redeployment does occur in line with the methodology for safe staffing but broadly within agreed parameters. In January and February redeployment was at its highest due to staff Covid related absence. Part B: Maternity staffing Part C: Vacancy is 11.1% and Band 5 is 9.3%. HCSW vacancy is 12%. Recruitment work is ongoing utilising NHSE &ICS best practise with healthy pipelines of both.
Recommendation:	The Board is asked to note the information within this report.

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

Previously considered by:	WFC.28.03.22
Risk / links with the BAF:	BAF: 2.1 Workforce capacity All Health Groups have both recruitment and retention on their risk registers
Legislation, regulatory, equality, diversity and dignity implications:	NHS England and CQC letter to NHSFT CEOs (31.3.14): Hard Truths Commitment regarding publishing of staffing data. NHS Improvement letter: 22.4.16 NHS Improvement letter re CHPPD: 29/6/18

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

1.0 PURPOSE

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

2.0 BACKGROUND

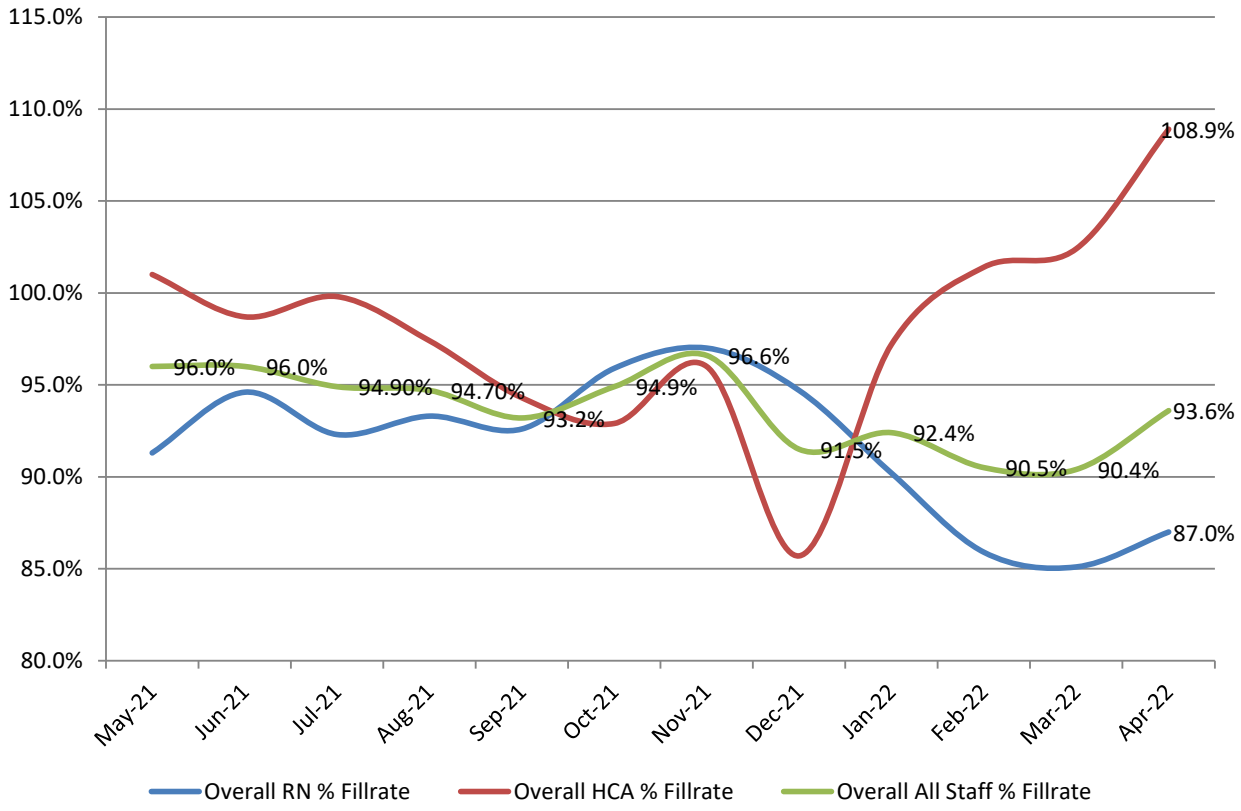
The report is collated in line with The National Quality Board recommendations (June 2016).

3.1 ANALYSIS

3.1 Fill rates for areas submitted to UNIFY:

There was an increase in overall fill in April compared to March by 3.2%. Overall care staff fill rates increased by 6.5% to 108.9% with RN fill rate increasing by 1.9% to 87%.

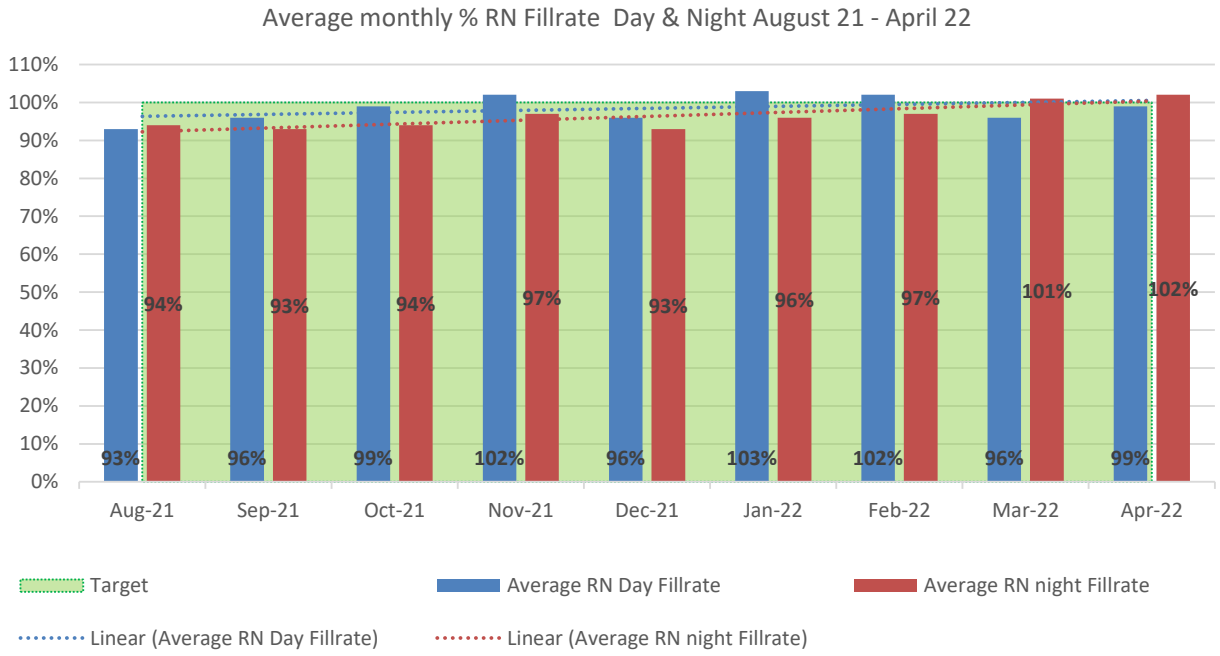
Trust average	Days RM/RN	Days Care staff	Nights RM/RN	Nights care staff	Overall RM/RN	Overall care staff	Overall ALL staff
In Patient Ward average April 2022	84.6%	106.9%	89.9%	111.5%	87.0%	108.9%	93.6%
In Patient Ward average March 2022	83.1%	98.9%	87.5%	106.8%	85.1%	102.4%	90.4%
Variance March 2022 – April 2022	↑1.5%	↑8%	↑2.4%	↑4.7%	↑1.9%	↑6.5%	↑3.2%



2.2 Fill rates for areas not covered by UNIFY:

	Day		Night	
A&E Nursing	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
February 2022	102.4%	70.9%	96.9%	74.5%
March 2022	95.4%	66.6%	101%	77.9%
April 2022	99.3%	88%	102.4%	84.1%

Staffing within ED remains subject to a CQC Section 31 notice. There is weekly executive oversight of the nursing (and medical) retrospective and prospective fill rates prior to submission of the data to the CQC. The fill rate for both RN and HCSW has improved over time from August 2021 when the improvement notice was serviced as seen in the following graph.



2.3 Fill rates by ward:

John Snow reported average fill rates below 75% for overall staff against the standard planned template during April. While the overall fill rate was 71.2%, the RN fill was 98.3% with the HCA 35.7%. As with previous months this is because as an elective surgical ward there is a fluctuating acuity and volume of patients for which the staffing is adjusted daily according to safecare however the set demand template is not adjusted.
Appendix 1. Shows the fill rates by ward against the standard but revised planned templates

The table below shows the trend for the past 4 months, Dolphin has had an average monthly RN fill rate of less than 75% for three of the past four months. There is an escalation plan in plan to manage the staffing constraints within children's services. .

Date	Ward name	% RN overall fill	% overall ward fill
Jan 2022	Dolphin	72.8%	
	H Moore	70.7%	66.3%
	Tye Green	72.5%	
Feb 2022	Dolphin	71.1%	
	Fleming	72.1%	

	HDU/ITU		74.2%
March 2022	Dolphin	69.4%	73.1%
	John Snow		72.4%
	Tye Green	71.8%	
April 2022	John Snow		71.2%

Appendix 2a: Ward staffing exception reports provides additional detail on the impact on care where the fill is < 75% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes. John Snow Ward reported average overall staff fill rates below 75% in April.

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

(Appendix 2c) The number of occasions/shifts where the reported fill rate has fallen below 75% across the wards (excluding Maternity) decreased to 190 (↓38) against March which reflects reduced Covid absence and increased recruitment and bank and agency fill. If a nursing red flag event occurs for number of staff on duty to meet the care needs of patients, staff escalate the situation and if appropriate complete a Datix.

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

The trend in reports completed in relation to nursing and midwifery staffing is included below and shows that the number of incidents recorded had decreased in month to 33 (↓27), Penn and Paeds ED raised the most Datix reports in relation to staffing levels 4 each, with Tye Green, Kingsmoor and Locke having 3 each . ***(Appendix 2e)***

2.5 Care Hours per Patient Day* (CHPPD):

The Trust overall CHPPD has showed a small increase over for the past three months for registered, unregistered and total at 7.6 CHPPD. The Trust total CHPPD compared to the latest Model hospital national median data, shows the Trust having 7.3 and the national median being 8.0 (February 2022 data) **Appendix 3a** shows the Trust comparative CHHPD data via the Model Hospital portal based on February 2022 data

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

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

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

April 2022									
	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts	Change in fill from previous month
RN	2815	1950	69.3%	176	6.3%	75.5%	689	24.5%	↓4.0%
HCA	1776	1442	81.2%	0	0%	81.2%	334	18.8%	↑1.1%
RMN	478	45	9.4%	276	57.7%	67.2%	157	32.8%	↓16.2%

In April, there was a large reduction in registered nursing demand ↓1027 shifts compared to March; there was a slight decrease in fill rate from 79.5% in March to 75.5% in April. Analysis of unavailability for April compared with March shows a reduction in unavailability (previously impacted by Covid).

To support patients requiring enhanced care there has been increased demand for RMNs. These shifts are created by Matron or above level to add a level of assurance regarding the need. The Trust has appointed an RMN lead nurse who will work in conjunction with the Lead Nurse for Falls & Enhanced

Care and the Interim Safe Staffing Lead to ensure that the requirement is validated, and the patients' needs can only be meet by a RMN.
In April, there was an increase in RMN demand ↑50 shifts requested in April compared to March; there was a decrease in fill rate from 83.4% in March to 67.2% in April ***(RMN shift data Appendix 4)***

2.7 Redeployment of staff: Deep dive

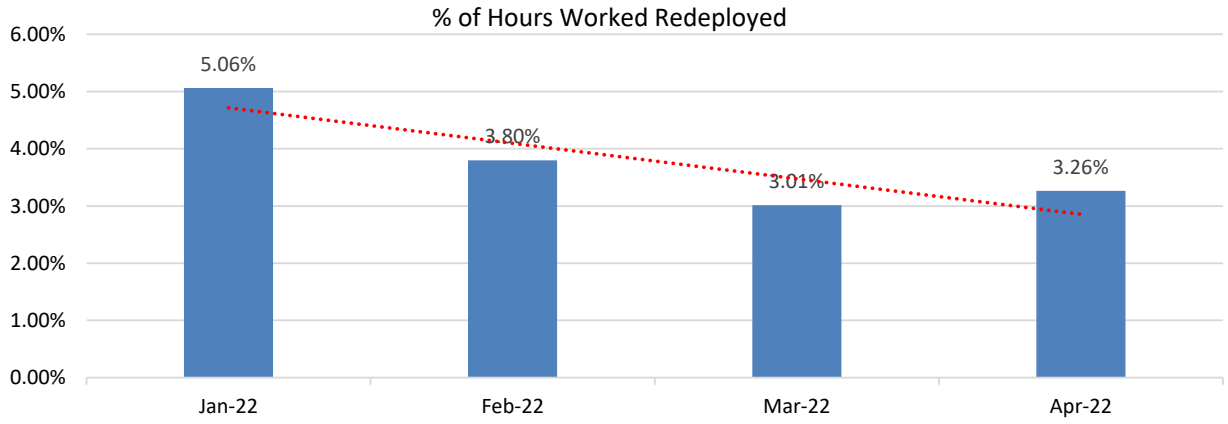
In response to concerns raised in the staff survey and by staff side on the impact of redeployment on staff a deepdive of the data available has been undertaken to provide more context and assurance on how this is monitored and redeployment rates.

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

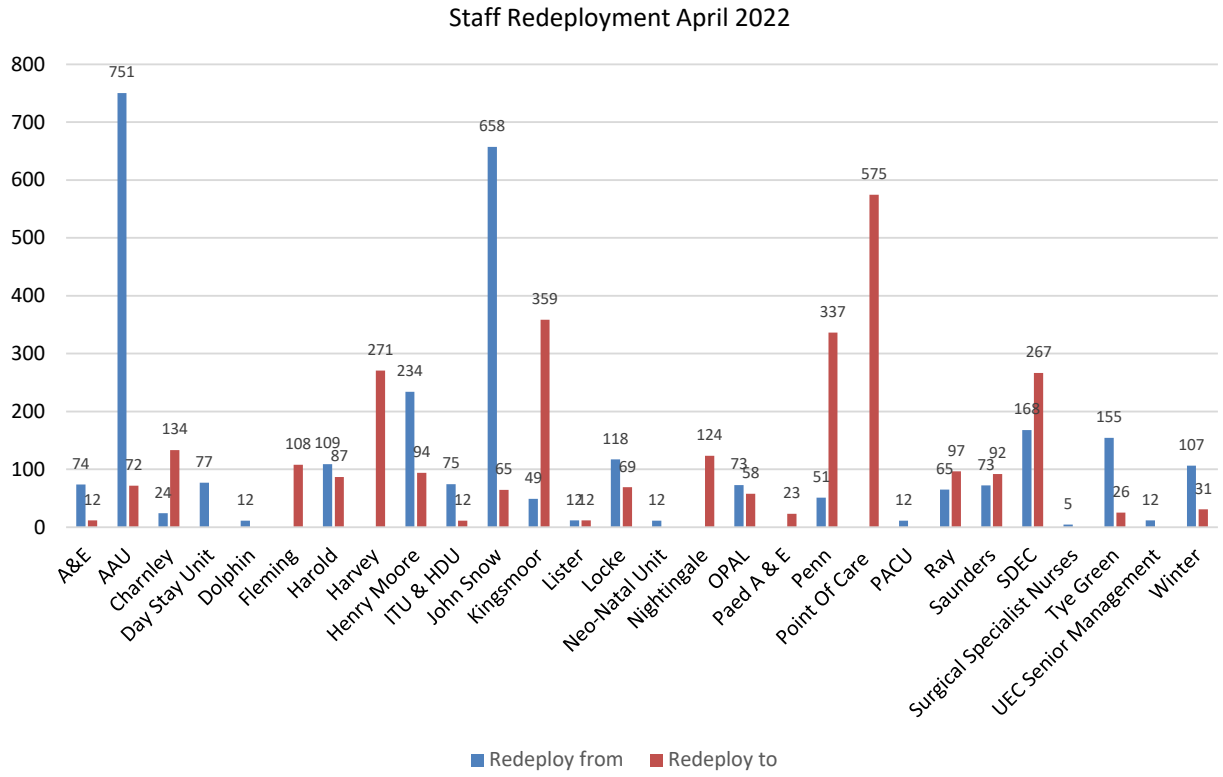
The accuracy of these reports continues to be dependent on the wards and site team redeploying staff, capturing and recording these moves in real-time in the e-Roster or SafeCare systems. While essential to ensure the safe staffing across the Trust moving substantive staff can impact with poor staff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

The senior nursing leadership teamwork closely with ward managers and teams to ensure there is understanding of the rationale for moves and to ensure there are positive conversations.
The data shows the number of hours of staff worked, the hours redeployed and the percentage of hours worked redeployed to support safe staffing. *The graph shows the trend over the past 4 months which shows a reduction to 3% following a high of 5% in January when Covid absence was at its highest.*

Date	Total Hours Worked	Total Hours Worked Bank / Agency	Total Hours Worked Excluding Bank & Agency	Total Hours Redeployed	Total Hours Not Redeployed	% of Hours Worked Redeployed
Jan-22	115052.8	34953.0	80099.8	4053.8	76046.0	5.06%
Feb-22	100224.4	23181.4	77043.0	2927.3	74115.8	3.80%
Mar-22	111821.2	25239.2	86582.0	2609.6	83972.4	3.01%
Apr-22	117185.3	30586	86599.3	2827	83772.3	3.26%



The following graph shows the hours moved from ward to ward during April 2022.
The majority of the 575 hours moved to support the Point of Care testing are supplied by AAU.



The following data show the number of moves of substantive staff between 1.1.22 and 31.3.22
Further investigation shows that the majority of the shifts moved from AAU and SDEC are to support the Point of Care service.
The moves from Henry Moore and Kingsmoor Wards are predominately to do changes in the function and purpose of the wards in response to the elective recovery programme and Covid 3rd wave.

A review of staff level data showed that 521 staff were redeployed for at least one shift in the 3 months from January to end March.

85% were moved 3 or less times
13% were moved between 4 and 9 times
2% were moved more than 10 times

A further review was undertaken of the staff who were moved 10 or more times and there were individual reasons in each case and/or data quality issues and so no concerns were identified.

Ward / Department	Number of staff redeployments 1.1.2022 - 31.3.2022
A&E Nursing	38
AAU	223
Charnley Ward	23
Day Stay Unit	14
Dolphin Ward	2
Fleming Ward	10
Harold Ward	22

Ward / Department	Number of staff redeployments 1.4.22 - 30.4.22
A&E Nursing	7
AAU	67
Charnley Ward	2
Day Stay Unit	7
Dolphin Ward	1
Harold Ward	9
Henry Moore	23

Harvey Ward	6
HDU Elective	2
Henry Moore	112
ITU & HDU	43
John Snow Ward	115
Kingsmoor General	53
Kingsmoor Orthopaedic	1
Lister Ward	14
Locke Ward	34
Neo-Natal Unit	1
OPAL Unit	7
Paediatric A & E	1
PAH Theatres	82
Penn Ward	35
PACU	39
Pre-Op Assessment	1
Ray Ward	23
Saunders Unit	46
SDEC	36
Tye Green Ward	33
Winter Ward	32
Grand Total	**1048**

ITU & HDU	10
John Snow Ward	63
Kingsmoor General	7
Lister Ward	1
Locke Ward	11
Neo-Natal Unit	1
OPAL Unit	8
Penn Ward	6
PACU	1
Ray Ward	6
Saunders Unit	7
SDEC	14
Surgical Specialist Nurses	1
Tye Green Ward	15
UEC Senior Management	1
Winter Ward	11
Grand Total	**279**

Part B Midwifery Staffing

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

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

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

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

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

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

April								

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

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

3.1 Intrapartum acuity:

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

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

During the reporting period of April the Labour Ward did not achieve a 85% confidence factor in the month – 79% of recordings were made where staffing met acuity. 75% compliance of the tool was achieved. The majority of negative acuity is amber with up to 2 midwives short with a much smaller percentage of occasions being red which equates to 2 or more midwives short.

During the reporting period of April the Birth Centre did not achieve 85% positive acuity in the month – 100% of recordings were made where staffing met acuity. 9.44% compliance of the tool was achieved. However, due to staffing challenges midwives were redeployed to the Labour Ward and inpatient wards resulting in intermittent closure of the birth centre. When the birth centre is closed and on divert to Labour Ward, the acuity tool would not be completed in this area.

3.2 Red flags:

In total there were 17 red flags recorded during this reporting period. The majority of these related to the co-ordinator not able to maintain supernumerary status (n=6, 32%), missed or delayed care which could be a delay of 60 minutes of washing or suturing, (n=6, 32%), a delay of more than >15 minutes between presentation and triage (n=1, 5%) and delayed or cancelled time critical activity (n=6, 27%)

Action: The governance team have requested a change to the DATIX system so that all Red flags can now be recorded on here. This has been followed up with the central governance team for action.

3.3 1:1 care in established labour:

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

3.4 Supernumerary status of the coordinator:

Supernumerary status of the coordinator is defined as the coordinator not having a caseload. The acuity tool has time built in for the coordinator to be supernumerary when it is recorded. The data identifies that the coordinator was not supernumerary on 6 occasions (32%) during the reporting period. The tool is unable to detail the actions or mitigations in place on the 6 occasions during this reporting system

Action: A meeting has been held with the co-ordinators to define supernumerary status and the escalation requirements if they are unable to maintain oversight. The governance team have requested a change to the DATIX system so that all Red flags can now be recorded on here. This has been followed up with the central governance team for action.

3.5 Specialist Midwives:

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

During this reporting period there were 105 management actions taken. The majority of these related to redeploying staff internally (n=71, 24%), additional staff sourced from bank/agency (n=63, 21%), managers/specialists working clinically (n = 32, 11%) and escalation to the manager on call (n=20, 7%). On (n=39, 13%) occasions the on call continuity of carer midwives were in the maternity unit to support.

Table 3 – Intrapartum acuity, red flag data and management actions taken

April	Red flags	1:1 care not met (number)	Supernumerary not met (number)	Management actions (number)	Acuity % Positive	Red %	Amber %	Assessment periods	Confidence Factor %
Labour Ward	16	0	6	104	79%	5%	15%	135/180	75%
Birth Centre	1	0	0	1	100%	0%	0%	17/180	9.44%

4. Maternity inpatient wards:

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

Table 4 – maternity inpatient wards, red flag data and management actions taken

February	Red flags	Extra Care breakdown	Management actions (number)	Acuity % Positive	Red %	Amber %	Assessment periods	Confidence Factor %
Antenatal Ward	25	62% exceptional care needs	7	55%	0%	39%	69/90	76.67%
Postnatal Ward	7	82% extra care babies	4	43%	0%	16%	79/90	87.78%

Antenatal Ward - There were 39% of no relevant staffing factors recorded in this period. These are contributing factors recorded, which may affect the shift. An example of staffing factors recorded in this period were midwives redeployed to another area (n=20, 36%) and the inability to fill a vacant midwifery shift with bank or agency (n=17, 31%). The majority of red flags related to delayed or cancelled time critical activity (n=25, 78%) and delay between admission for induction of labour and beginning of process (n=5, 16%) Clinical actions taken during this period were a delay in ongoing induction of labour (n=26, 100%). Management actions were to escalate to the manager on call (n=1, 13%), manager/matron working clinically (n=1, 13%), utilise on call midwife (n=3, 38%). The distribution of care hours allocated for extra needs included (n=40 hours, 58%) for exceptional care needs, (n=22 hours, 32%) for safeguarding, (n=4 hours, 6%) for transfusion and (n=3 hours, 4%) for sepsis

Postnatal Ward – There were 72% of no relevant staffing factors recorded in this period. The red flags related to delay in providing pain relief (n=7, 100%). Clinical actions taken during this period were a delay in discharge (n=8, 89%) and unable to accept transfers from Labour Ward (n=1, 11%). Management actions were to escalate to the manager on call (n=2, 33%) and redeploy staff internally (n=3, 50%) . The distribution of care hours allocated for extra needs included (n=729 hours, 82%) for extra care babies, (n=23 hours) for safeguarding, (n=76 hours) for sepsis and (n=54 hours) for exceptional needs.

B: Workforce:

4.0 Nursing Recruitment Pipeline:

Unfortunately, there has been a delay I receiving recruitment data this month. Further detail will be provided next month however international recruitment of nurses and midwives continues as planned and there is a healthy pipeline of healthcare support workers.

Registered Nurse pipeline for 2022/23.

The following table includes uplift of nursing posts agreed in last establishment review and additional funding agreed for Kingsmoor and the enhanced care pool. Current vacancy rate is 9.5% for Band 5 and 11.1% overall. Recruitment for international nurses is ongoing and the Trust is working with new agencies to expand pool. It is anticipated that we will require 128 to reduce the vacancy rate to less than 3% considering turnover and projected local recruitment.

Nursing Establishment v Staff in post												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Funded Establishment WTE	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.28	1021.3
Staff in Post WTE	908.00	913.00	923.00	939.00	955.00	977.00	985.00	986.00	987.00	988.00	992.00	993.00
Vacancy WTE	113.28	108.28	98.28	82.28	66.28	44.28	36.28	35.28	34.28	33.28	29.28	28.28
Actual RN Vacancy Rate	11.1%	10.6%	9.6%	8.1%	6.5%	4.3%	3.6%	3.5%	3.4%	3.3%	2.9%	2.8%
Forcast Vacancy Rate in Business Plan												

Band 5 Establisment V Staff in Post												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Funded Band 5 Establisment WTE	569	569	569	569	569	569	569	569	569	569	569	569
Band 5 Staff in Post WTE	516	524	537	550	563	582	587	585	583	581	582	580
Band 5 Starters	7	15	20	20	20	26	12	5	5	5	8	5
Vacancy Band 5 WTE	53	45	32	19	6	-13	-18	-16	-14	-12	-13	-11
Actual Vacancy Rate	9.3%	7.9%	5.6%	3.3%	1.1%	-2.3%	-3.2%	-2.8%	-2.5%	-2.1%	-2.3%	-1.9%
Forcast Vacancy Rate in Business Plan												

Actual/Projected Starters Pipeline												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
RNs (not Band 5)	1	4	4	10	10	10	10	10	10	10	10	10
Band 5 Newly Qualified + Local	1	3				6	7				3	
Band 5 International Recruitment	6	12	20	20	20	20	5	5	5	5	5	5
Band 5 Starters	**7**	**15**	**20**	**20**	**20**	**26**	**12**	**5**	**5**	**5**	**8**	**5**
Total Starters	8	19	24	30	30	36	22	15	15	15	18	15

Projected Leavers WTE												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
RNs (not Band 5) Leavers	9	7	7	7	7	7	7	7	7	7	7	7
Band 5 Leavers	7	7	7	7	7	7	7	7	7	7	7	7
Total Leavers	**16**	**14**	**14**	**14**	**14**	**14**	**14**	**14**	**14**	**14**	**14**	**14**
N&M Turnover %	14.97%											

Turnover:

Turnover has increased to 14.97% in month. This is the highest rate for over 12 months. Feedback from managers and recruitment and retention lead is there is a significant shift in international nurses looking to relocate due to rise cost of living. Actions in response are being undertaken by the people team at local and ICS level.

Turnover All Reasons - Excluding FTC's	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Nursing & Midwifery	9.27%	10.83%	10.42%	10.80%	11.51%	11.67%	12.04%	12.74%	12.76%	13.16%	13.85%	14.75%	14.97%

Healthcare Support Worker pipeline

HCSW vacancy rate on April was 12%. Recruitment activity continues to be successful with a healthy pipeline. Which should bring vacancy rate to less than 1.5% by August.

Establishment V Staff in Post	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-22	Feb-22	Mar-22
Funded Establishment WTE	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64	423.64
Staff in Post WTE	373.00	383.00	399.00	409.00	419.00	419.00	419.00	419.00	419.00	419.00	419.00	419.00
Vacancy WTE	50.64	40.64	24.64	14.64	4.64	4.64	4.64	4.64	4.64	4.64	4.64	4.64
Actual B2/B3 Vacancy Rate	12.0%	9.6%	5.8%	3.5%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%

Actual/Projected Starters Pipeline	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total Starters	1	20	21	15	15	5	5	5	5	5	5	5

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

5 RECOMMENDATION

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

Author: Sarah Webb, Deputy Director of Nursing and Midwifery
Date **12.05. 2022**

Appendix 1

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

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

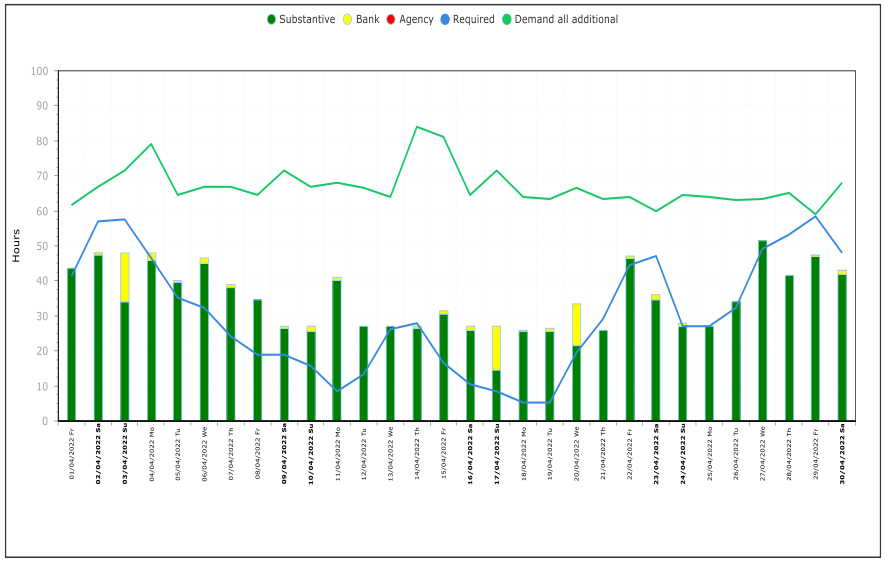
	Day		Night				
Ward name	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	% RN overall fill rate	% overall HCSW fill rate	% Overall fill rate
ITU & HDU	84.4%	66.2%	83.2%	79.0%	83.8%	72.6%	82.9%
Saunders Unit	85.3%	96.1%	96.6%	110.9%	90.1%	101.7%	94.2%
Penn Ward	101.6%	104.7%	96.7%	152.4%	99.5%	122.8%	107.9%
Henry Moore Ward	108.1%	97.8%	106.7%	89.8%	107.4%	94.1%	102.9%
Harvey Ward	80.8%	132.1%	116.8%	122.2%	95.5%	127.4%	107.0%
John Snow Ward	104.3%	30.8%	91.7%	46.4%	98.3%	35.7%	71.2%
Charnley Ward	88.0%	108.6%	82.1%	117.8%	85.2%	113.0%	93.1%
AAU	89.1%	110.0%	90.6%	133.2%	89.8%	121.1%	96.6%
Harold Ward	81.6%	80.6%	90.0%	100.2%	85.2%	88.6%	86.5%
Kingsmoor General	84.6%	79.8%	104.0%	116.5%	92.8%	94.8%	93.7%
Lister Ward	85.3%	125.8%	92.6%	127.9%	88.1%	126.8%	102.5%
Locke Ward	85.5%	138.8%	102.3%	115.9%	92.8%	127.9%	102.1%
Ray Ward	78.3%	141.5%	90.0%	132.4%	83.2%	137.1%	99.8%
Tye Green Ward	74.0%	108.1%	77.4%	117.8%	75.4%	112.1%	89.7%
OPAL	99.9%	166.7%	103.6%	92.2%	101.3%	118.5%	107.6%
Winter Ward	69.5%	123.4%	94.5%	96.7%	79.0%	110.6%	90.8%
Fleming Ward	70.9%	126.1%	98.0%	126.1%	81.7%	126.1%	95.2%
Neo-Natal Unit	78.7%	153.3%	88.1%	100.0%	83.4%	126.7%	90.6%
Dolphin Ward	72.3%	82.9%	94.2%	98.6%	82.1%	88.1%	83.6%
Total	83.6%	105.7%	92.3%	113.0%	87.4%	108.9%	94.0%

Appendix 2a: Ward staffing exception reports

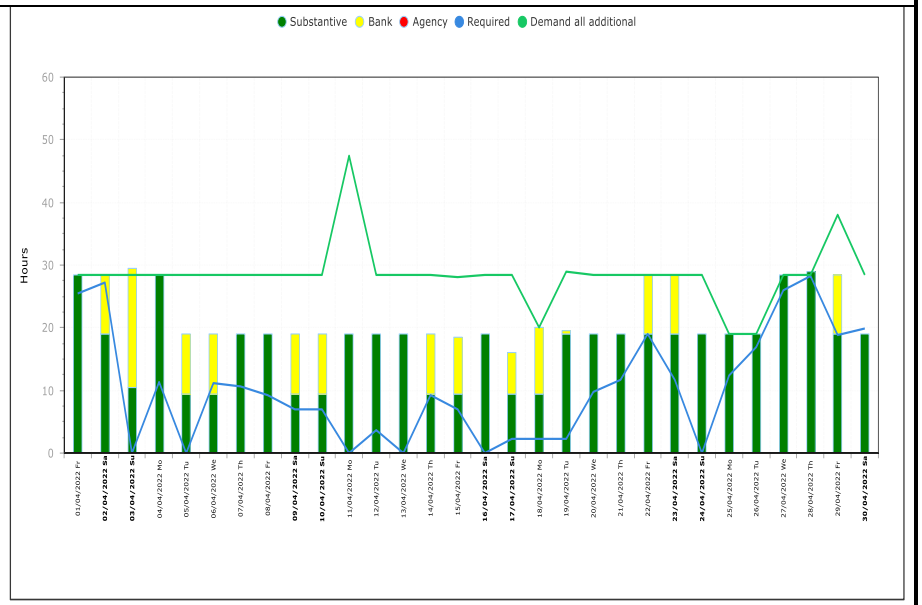
Reported where the fill is < 75% during the reporting period, or where the ADoN has concerns re: impact on quality/ outcomes. Please note further review of data sets will enable a more robust and detailed analysis going forward (April data)

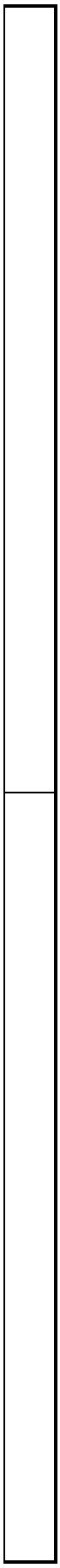
Report from the Associate Director of Nursing for the HCG							
Ward	Analysis of gaps			Impact on Quality / outcomes			Actions in place
John Snow	Overall average fill rate for care staff = **38% resulting in overall fill rate of 71.2%**			Nil observed supported by required and actual tables below which show that the overall available hours exceeded the required hours on all but 5 occasions during days and 0 occasions during nights			Continue to review staffing daily and where possible capture planned reductions in template as part of UNIFY submission to improve accuracy of CHPPD
Quality Metric	PU	Falls	Staffing Datix	SIs	Drug Errors	Complaints	PALS
Number in month	0	0	0	0	0	0	0

Required vs Actual Day



Required vs Actual Day

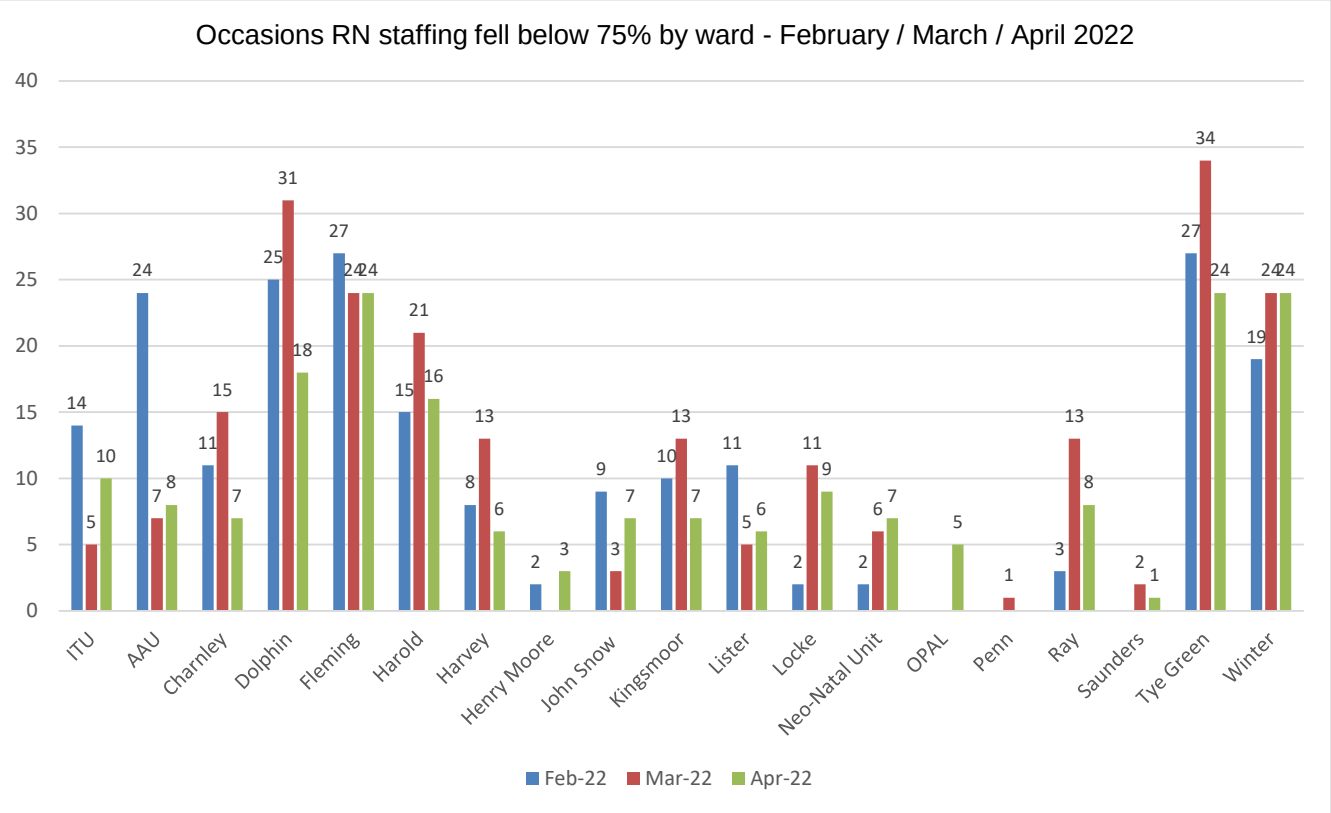




Appendix 2b: Red flag data

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

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



Appendix 2c: Nursing Red Flags (NICE)

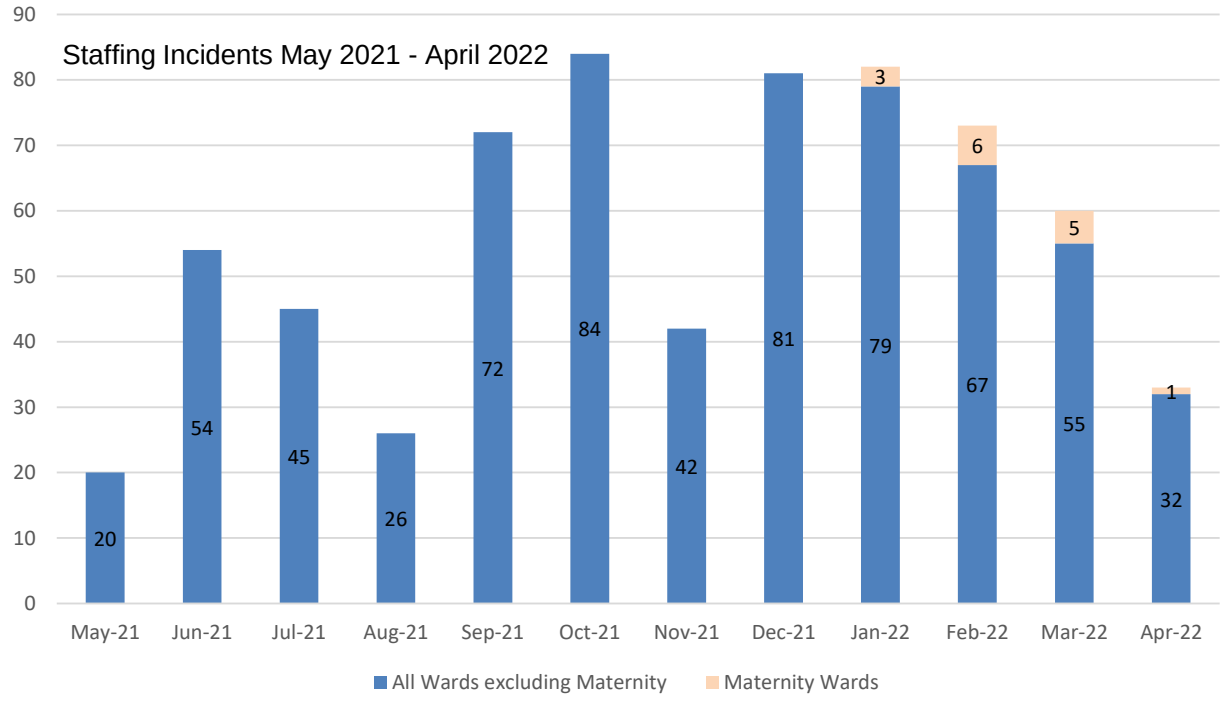
The National Institute for Health and Care Excellence (NICE) guideline Safe staffing for nursing in adult inpatient wards in acute hospitals (2014)1 recommends red flags relating to adult inpatient wards.
Recommendations for the registered nurses on wards who are in charge of shifts are:

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

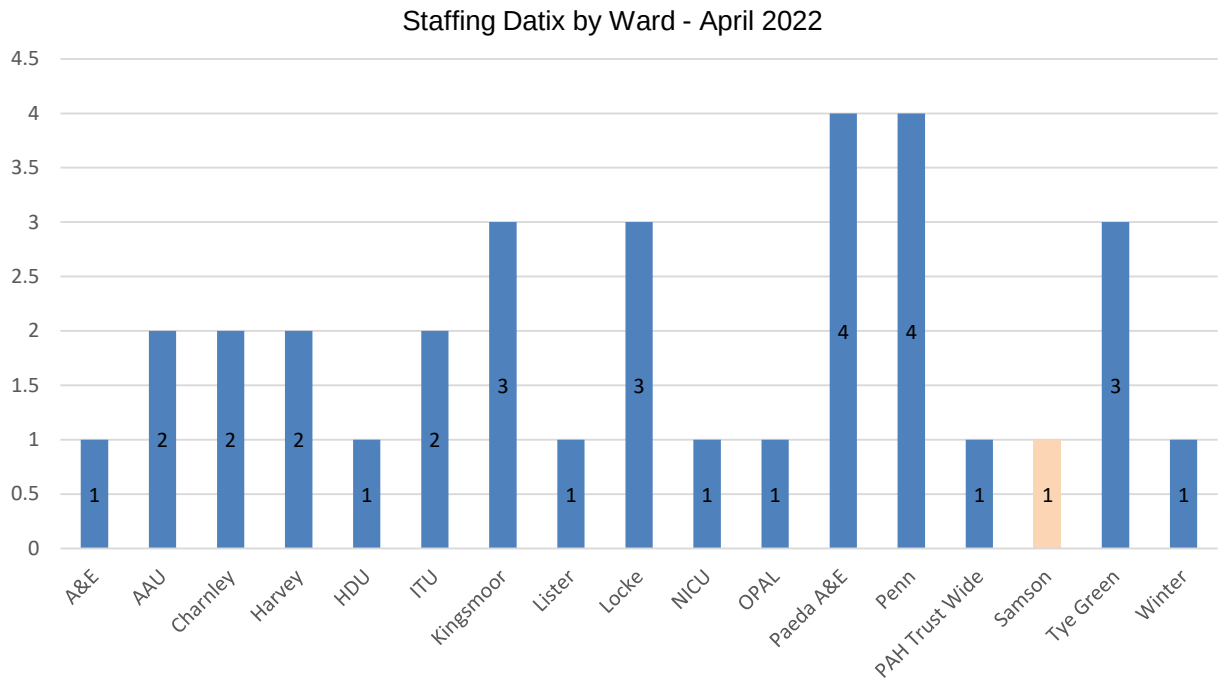
Nursing red flags

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

Appendix 2d: Staffing Incidents Trend Data



Appendix 2e: Staffing Incidents by ward April 2022



Appendix 3 Care Hours per Patient Day (CHPPD):

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

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

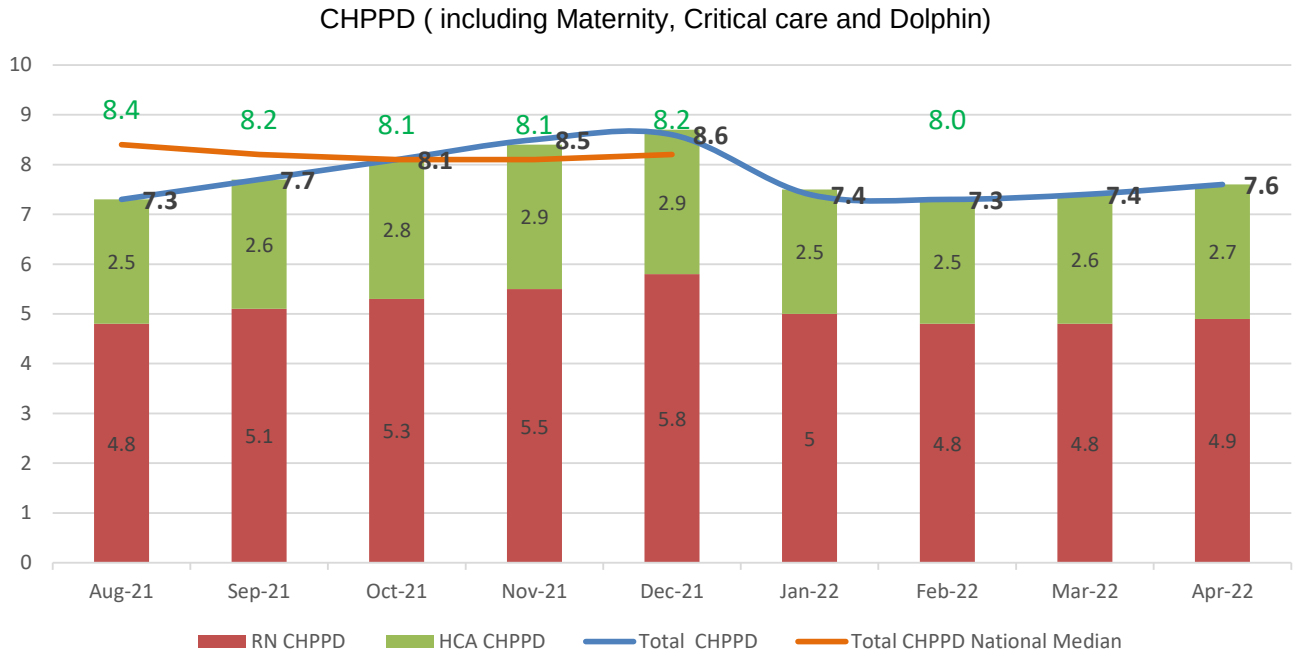
Care Hours per Patient Day* (CHPPD) is calculated every month by adding together the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants.

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

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

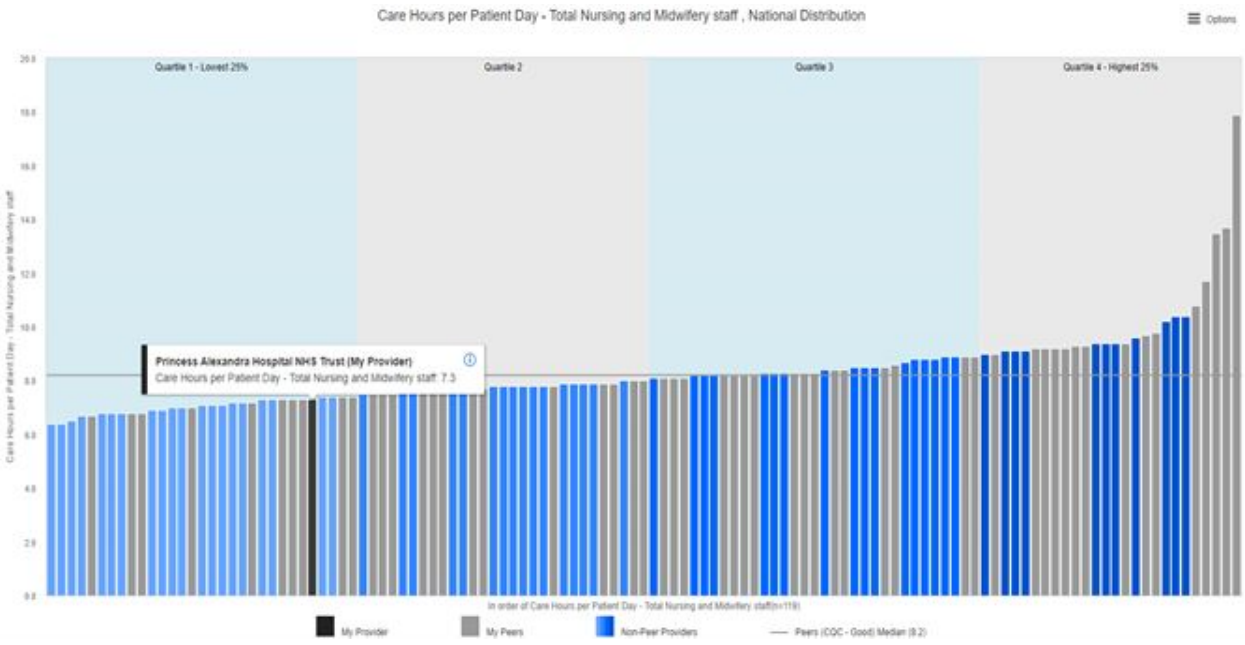
The accuracy of this report is dependant of the rosters being up to date and accurate bed occupancy numbers.

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



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

	February 2022 data	National Median (February 2022)	Variance against national median
CHPPD Total	7.3	8.0	-0.7
CHPPD RN	4.8	4.8	-
CHPPD HCSW	2.5	3.1	-0.6



Appendix 3b

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

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Trust Total (including Maternity)	**4.9**	**2.7**	**7.6**

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Ward Total	**4.8**	**2.6**	**7.4**
ITU & HDU	32.7	2.4	35.1
Saunders Unit	3.5	2.2	5.8
Penn Ward	3.9	2.7	6.7
Henry Moore Ward	4.7	2.1	6.8
Harvey Ward	3.9	3	6.9
John Snow Ward	6.5	1.8	8.3
Charnley Ward	3.8	2.0	5.8
AAU	6.1	2.3	8.4
Harold Ward	3.6	2.4	5.9
Kingsmoor General	3.5	2.8	6.2
Lister Ward	4.2	3.6	7.8
Locke Ward	4.5	2.2	6.7
Ray Ward	3.4	2.4	5.8
Tye Green Ward	4.7	3.2	7.9
Winter Ward	3.4	2.8	6.1
Fleming Ward	3.4	2.3	5.7
Neo-Natal Unit	11.7	3.6	75.3
Dolphin Ward	9.7	3.5	13.2

Ward name	Registered Nurses/Midwives	Non-registered Nurses/Midwives	Overall
Maternity Ward Total	**6.1**	**3.2**	**9.3**
Labour Ward	11.4	4.3	15.7
Birthing Unit	78.0	47.0	125
Samson Ward	2.4	2.4	4.8
Chamberlen Ward	5.2	1.7	6.9

Appendix 4: Temporary Staffing Demand & Fill Rate

The day-to-day management of safer staffing across the organisation is managed through the twice-daily staffing huddles using information from SafeCare to ensure support is directed on a shift by shift basis as required in line with actual patient acuity and activity demands.
The use of NHSP continues to support the clinical areas to maximise safer staffing. The need for temporary staff is reviewed daily at the Safe Staffing daily meeting, staff redeployment along with a greater challenge continues and all shifts not required continue to be cancelled.

RN temporary staffing demand and fill rates: ***(April 2022 data supplied by NHSP 5.5.2022)***

Last YTD month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
November 2021	3067	2401	68.7%	508	16.6%	85.3%	452	14.7%
December 2021	2772	1807	65.2%	474	17.1%	82.3%	491	17.7%
January 2022	3775	2346	62.1%	535	14.2%	76.3%	535	23.7%
February 2022	3424	2188	63.9%	519	15.2%	79.1%	717	20.9%
March 2022	3842	2519	65.6%	534	13.9%	79.5%	789	20.5%
April 2022	**2815**	**1950**	**69.3%**	**176**	**6.3%**	**75.5%**	**689**	**24.5%**
April 2021	2666	1642	61.6%	340	12%	74.3%	684	25%

HCA temporary staffing demand and fill rates: ***(April 2022 data supplied by NHSP 5.5.2022)***

Last YTD Month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
November 2021	1652	1352	81.8%	4	0.2%	82.1%	292	17.9%
December 2021	1828	1413	77.3%	2	0.1%	77.4%	413	22.6%
January 2022	2116	1540	72.8%	0	0%	72.8%	576	27.2%
February 2022	1715	1384	80.7%	0	0%	80.7%	331	19.3%
March 2022	1893	1520	80.3%	0	0%	80.3%	373	19.7%
April 2022	**1776**	**1442**	**81.2%**	**0**	**0%**	**81.2%**	**334**	**18.8%**
April 2021	1397	1007	72%	33	2%	74%	357	25.%

RMN temporary staffing demand and fill rates: ***(April 2022 data supplied by NHSP 5.5.2022)***

Last YTD month & Year	Shifts Requested	NHSP Filled Shifts	% NHSP Shift	Agency Filled Shifts	% Agency Filled Shifts	Overall Fill Rate	Unfilled Shifts	% Unfilled Shifts
December 2021	403	27	6.7%	273	67.7%	74.4%	103	25.6%
January 2022	508	44	8.7%	297	58.5%	67.1%	167	32.9%
February 2022	465	26	5.6%	315	67.7%	73.3%	124	26.7%
March 2022	428	20	4.7%	337	78.7%	83.4%	71	16.6%
April 2022	**478**	**45**	**9.4%**	**276**	**57.7%**	**67.2%**	**157**	**32.8%**
April 2021	84	13	15.5%	48	57.1%	72.6%	23	27.4%

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) - 9 June 2022

4.5

Agenda item:	4.5							
Presented by:	Fay Gilder | Medical Director							
Prepared by:	Fay Gilder | Medical Director							
Date prepared:	May 2022							
Subject / title:	Learning from deaths							
Purpose:	**Approval**		**Decision**		**Information**	x	**Assurance**	x
Key issues:	Telstra Data Quality HSMR and SHMI position as expected ME update SJR update							
Recommendation:	For noting and debate							

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

The Princess Alexandra Hospital NHS Trust

4.5

1.0 Purpose/issue

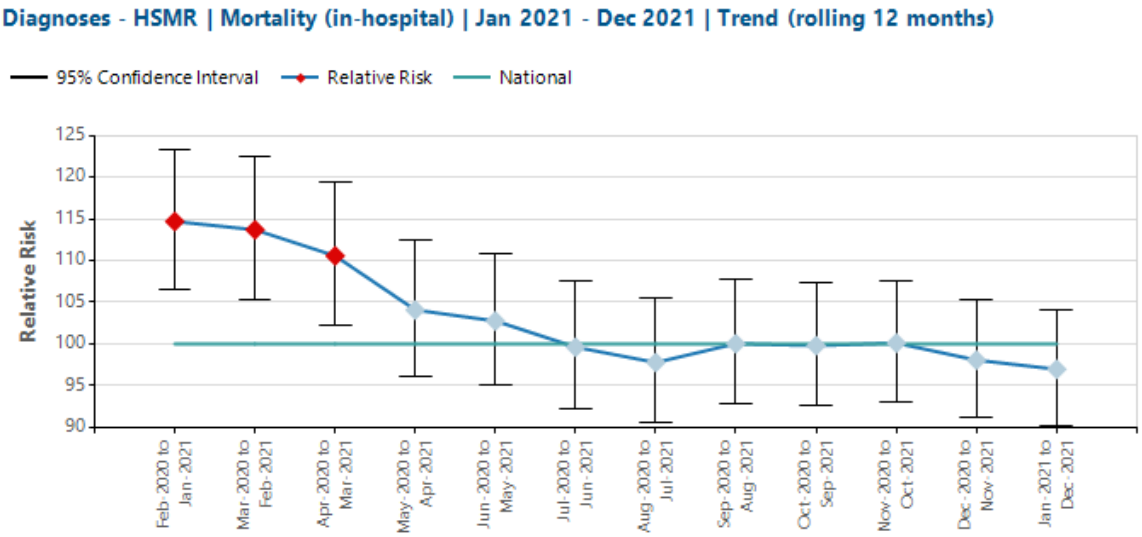
The purpose of this paper is to provide monthly assurance on the learning from death process. The paper will highlight key pieces of learning and provide progress updates on the current programme of work to improve clinical practice and patient outcomes

2.0 Background

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

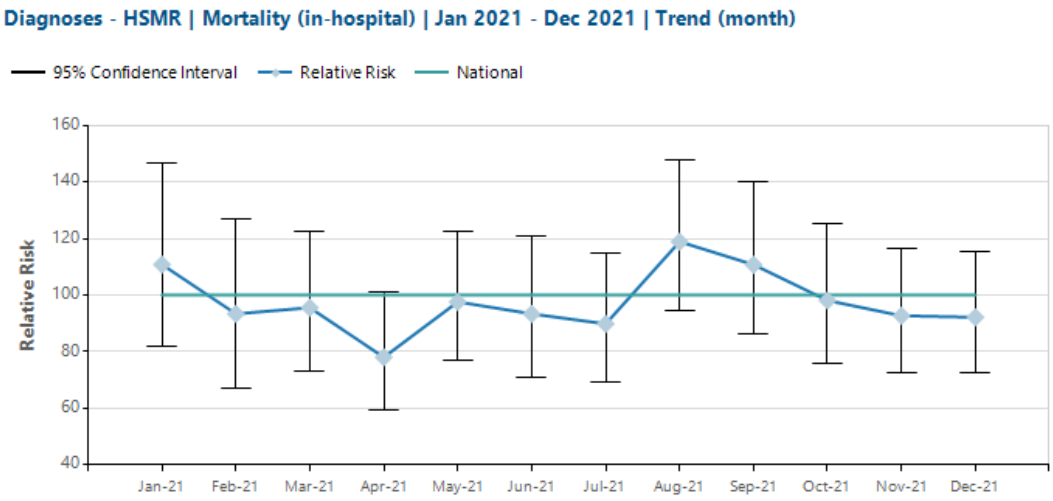
3.0 Current Telstra/ NHS Data Headlines

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



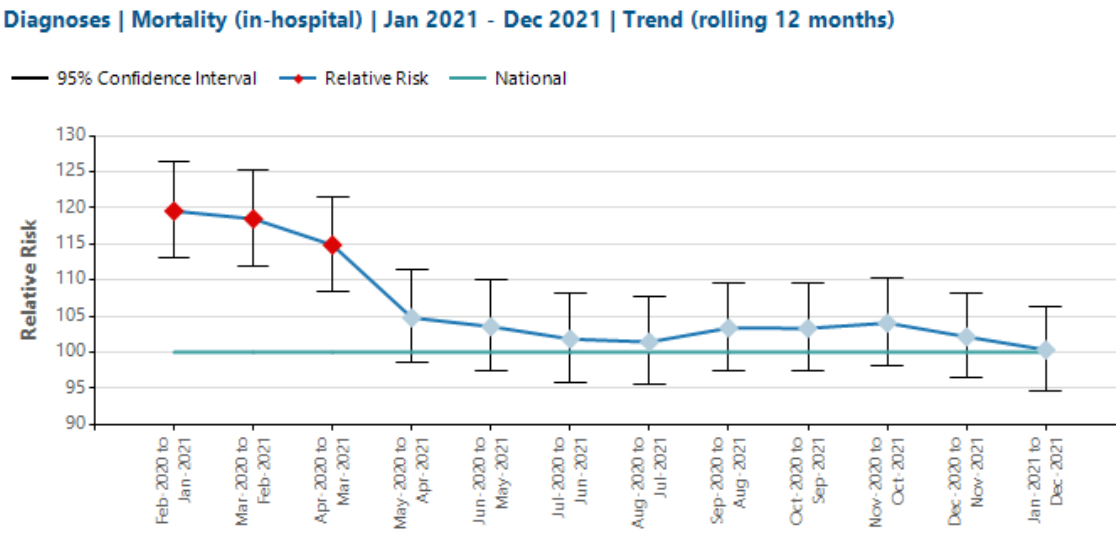
HSMR 97.0 ‘within expected’

3.2 Hospital Standard Mortality Rate (HSMR) – Monthly



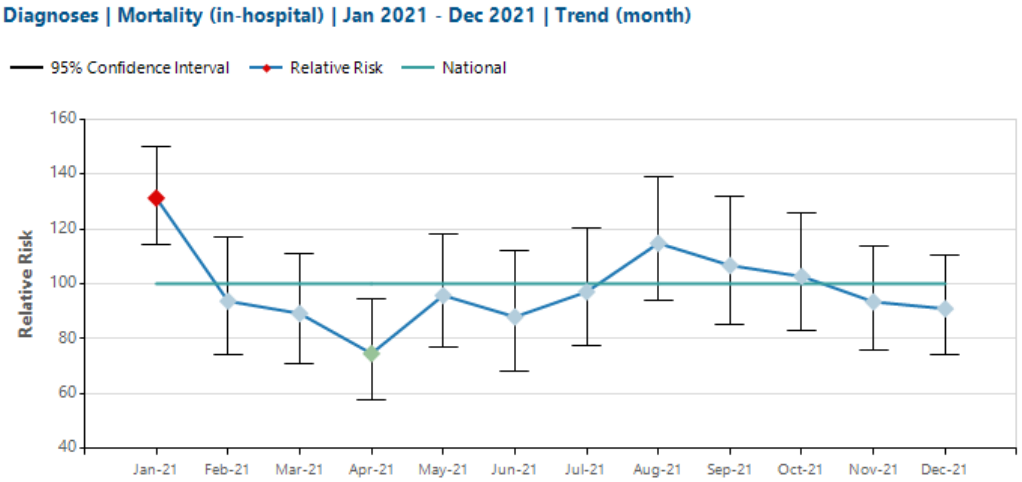
HSMR 97.0 ‘within expected’

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



SMR 100.3 'within expected'

3.4 Standardised Mortality Ratio (SMR)



SMR 90.8 'within expected'

3.5 Summary Hospital-level Mortality Indicator (SHMI)

SHMI for Dec-20 to Nov-21 is 96.80 and "within expected".

3.6 Standardised Mortality Ratio (SMR) outlying groups

There are two outlying groups; FNOF and Viral Infection (which includes COVID-19). Neither of these are new outlying groups. Sepsis is no longer an outlying group.

4.0 Mortality Programme Updates

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

4.1 Respiratory (Pneumonia, COPD & Aspiration Pneumonia)

- Non-Invasive Ventilation – was restarted on Locke ward in September 2021 and review of all the patients and their outcomes are being analysed by the respiratory team.

- Aspiration Pneumonia improvements include enhanced training on oral hygiene, dysphagia screening and aspiration pneumonia prevention

- To support our Chronic Obstructive Pulmonary Disease (COPD) patients the monthly Airway MDTs have been recommenced.

4.2 Fractured Neck of Femur

The improvements for patients with fractured neck of femur are being challenged because of the high numbers of patients attending. There is also often a need to outlie those patients off the orthogeriatric ward who have covid which does impact on their morbidity. Updates on data and key actions to address the required improvements will be presented next month once the new extended scope practitioner is embedded in the role.

4.3 Cardiac Arrest Learning

9 cardiac arrests were reviewed during Quarter 4 as part of the Cardiac Arrest Review Panel (CARP).
7 of these were considered as not predictable and notable practice was commended.
2 cases were shared with the End of Life group due to potential missed opportunities to review patient's resuscitation status prior to arrest. Findings fed back to local teams to share the learning.

5.0 Learning from deaths process update

5.1 Mortality Narrative

There were 99 deaths in April 2022
31 cases referred for SJR's:
There are 43 outstanding SJRs (over 6 weeks of the patients' death.) The majority of these are included in the rolling audit for deaths after 30 days of readmission. Note that a large number of these outstanding SJRs are due to sickness of a key colleague who has recently returned to work.

5.2 Key Learning to be addressed

- Importance of family communication
- Prevention in delays to starting treatment for infections.
- Late presentation of AKI from care homes
- Decisions about management of pulmonary embolism

5.3 Second Review Panel Cases

There were no cases referred to the second review panel

5.4 Incidents

There were no incidents logged in relation to mortality cases

6.0 Medical Examiner (ME) Headlines

During April 2022 there were 99 deaths, all scrutinised between the 10 Medical Examiners.

19 cases were referred to the Coroner

There were 21 deaths with of patients with positive Covid 19 tests. These deaths have been reviewed by the respiratory consultant and none were deemed to be caused by nosocomial covid-19.

6.1 Medical Examiner Developments

The community death pilot with St Claire Hospice is ongoing and general practitioner death scrutiny by the ME service has been initiated.

6.2 National Medical Certificate of Cause of Death (MCCDs)

88.8% of the MCCDs were issued within the 72 hour standard, which is below the national target of 95%. This is due to the four day Easter Bank holiday weekend.

7.0 Risks

The Trust has a Corporate Mortality Risk Register and each individual project has its own risks and issues log. This was reviewed as part of the Strategic Learning from Death Group in May 2022. No new risks had been added to this register and currently there are 6 risks. 5 of these are currently rated as 12 or below and are all on track with actions. It is to be explored at what point the risk should be reduced or removed from the risk register, reviewing an agreed number of months the improvement has been maintained.

The risk related to timely transfer of fractured neck of femur patients to the orthogeriatric ward remains at 16 and actions to address are being monitored and are on track.

8.0 Recommendation

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

BOARD OF DIRECTORS: Trust Board (Public) 9 June 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: Workforce Committee (WFC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 23 May 2022

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 2021/22	Discussion item			The Committee discussed the effectiveness review and recommend the revised Terms of Reference (**Appendix 1**) to the Board for approval. Health and Wellbeing oversight was added to the purpose as well as strategic communications. Other minor changes to wording were agreed and the committee is to be re-named the 'People Committee'.
2.1 Voluntary Services Report	Partial	Y	N	WFC received assurance on the activities of the Trust's volunteers and requested that future reports provide a more strategic view of the service.
2.2 Guardian of Safer Working Report	Yes	N	N	For the reporting period January to March 2022, 14 exception reports (ERs) were submitted; 11 were to report working extra hours, 3 related to missed educational opportunities and there were 3 immediate patient safety concerns. WFC was assured around the process in place. The support to consultants to ensure a positive culture shift to ERs was noted.
2.3 People Strategy Update	Yes	N	N	The annual people strategy actions and Communications Strategy actions for 2022/23 were noted. Association with other people related strategies was highlighted namely PAHT 2030 – our culture priority, the NHS People Plan and Hertfordshire and West Essex's Integrated Care Board People plan. Detailed actions, measures and tracking are in place.

BOARD OF DIRECTORS: Trust Board (Public) 9 June 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: Workforce Committee (WFC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 23 May 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.4 Workforce Report	Yes	N	N	The key metrics were discussed and will be reviewed at Board as part of the IPR.
2.5 Safer Nurse Staffing Report	Yes	N	N	WFC were assured in regards to the provision of safe nursing and midwifery staffing and that processes are in place for managing and monitoring staffing levels. Maternity workforce issues are also considered at QSC part II.
2.7 Gender Pay Gap Report	Yes	N	Board to approve	The Gender Pay Gap report was recommended to the Board for approval.
2.7 BAF Risk 2.3 (Workforce)	Yes	N	N	Risk score to remain unchanged at 16.
2.9 Health and Wellbeing Report Including cost of living update	Yes	N	N	WFC received assurance in regards to recent initiatives and activities including the provision of blue light cards for staff and financial support webinars and advice.
3.1 Communications Update	Yes	N	Yes	WFC noted the recent communications activities and that a strategic review of communications is planned. The outcome will be reported to WFC.
4.1 Learning and OD Update	Yes	Y	N	WFC were assured on the learning and organisational development activities including; the successful launch of the on boarding process and first day of the PAHT2030 Ready programme.
4.2 Staff Survey Update	Yes	Y	N	The outcomes of the Board workshop were noted and will be discussed in the Public Board.

BOARD OF DIRECTORS: Trust Board (Public) 9 June 2022 **AGENDA ITEM: 5.1**

REPORT TO THE BOARD FROM: Workforce Committee (WFC)

REPORT FROM: Helen Howe – Committee Chair

DATE OF COMMITTEE MEETING: 23 May 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
4.7 Deloitte Well Led Review Recommendations – Culture	Yes	Y	N	WFC was content with the update on the culture actions from the Deloitte Well-led review. Significant progress has been made on all recommendations especially relating the new trust values, development programmes for leaders. Work continues regarding supporting a culture of raising concerns. The entire list of recommendations and actions are reported via the Strategic Transformation Committee and managed by programme management office via PM3.

The Princess Alexandra Hospital NHS Trust

PEOPLE COMMITTEE

TERMS OF REFERENCE 2022-23

PURPOSE:

The purpose of the People Committee:

- Maintain oversight of the development and design of the Workforce and ensure it is aligned with the strategic context within which the Trust is required to operate.
- Assure the Board on all aspects of Workforce, Staff health and well-being and Organisational Development and provide leadership and oversight for the Trust on workforce issues that support delivery of the Trust's annual objectives.
- Assure the Board that the Trust has adequate staff with the necessary skills and competencies to meet both the current and future needs of the Trust and ensure delivery of efficient services to patients and service users.
- Assure the Board that legal and regulatory requirements relating to workforce are met.
- Maintain oversight of the implementation of the communications strategy and delivery of communications to patients, staff, the media and stakeholders.

DUTIES:

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

1. To promote the trust's values and behaviours
2. Provide assurance on the development and delivery of a people and OD strategy that supports the Trust plans and ensure an appropriate workforce culture is in place and monitor their implementation.
3. Keep under review the Trust's plans in relation to its workforce including recruitment and retention of staff, Organisational Development, learning, and employee engagement and staff health and wellbeing.
4. Review workforce performance and oversee the development of a balanced scorecard for all workforce indicators.
5. Review the outcomes of national and local staff surveys and monitor the progress of action plans.
6. Monitor staff engagement initiatives and outcomes
7. Ensure the Trust meets its statutory obligations regarding Diversity and Inclusion.
8. Oversee the Trust's relationship with educational partners to maximise the benefits of these relationships to the Trust.
9. Review and monitor workforce, organisational development and education and training risks including those reflected on the Board Assurance Framework and seek assurance that plans/actions are in place to mitigate identified risks.
10. The Committee shall request and review reports from other sub groups as deemed necessary
11. Other Workforce/OD/Training activity as requested by the Board.
12. Keep under review the development of a Communications Strategy and monitor its implementation.
13. Review and monitor the portfolio of volunteer activities and services.
14. Provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that these are dealt with in policy and national guidance including receiving regular reports from the Freedom to Speak up Guardians.

The Princess Alexandra Hospital NHS Trust

5.1

WORKPLAN: **Annual Work Plan and Committee Effectiveness**
Every year, set an Annual Work Plan and conduct an effectiveness review (which will include the achievement of the Annual Work Plan and a review of the terms of reference) and report this to the Board.

ACCOUNTABLE TO: Trust Board.

REPORTING A Committee report shall be provided to the next meeting of the Board of Directors. The report shall set out areas requiring the Board's attention and report on the level of assurance provided by the People Committee and advise of progress against the Annual Work Plan.

CHAIRMAN: Non-Executive Director.

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

- Chair - Non-Executive Director
- Non-Executive Directors/Associate Non-Executive Directors
- Director of People, Organisational Development & Communications
- Director of Nursing, Midwifery & Allied Health Professionals
- Chief Operating Officer

The Chair of the People Committee shall be appointed by the Chairman of the Trust Board; s/he shall have recent and relevant finance or business or workforce experience.

If not already a member of the People Committee, the Audit Committee Chairman may attend any meeting.

The Chair and Chief Executive of the Board reserve the right to attend meetings and will attend alternate meetings of the Committee.

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

ATTENDANCE: Members are expected to attend all meetings of the Committee. An attendance register shall be taken at each meeting and an annual register of attendance included in the Trust's annual report.
In addition to the members of the Board, the following shall be expected to attend each meeting:

- Deputy Director of People
- Associate Director of Learning and OD
- Associate Director of Communications

The following shall attend meetings as required:

- Medical Education Manager
- Director of Medical Education

To ensure appropriate accountability, others will be invited to attend where areas of risk or operation are being discussed within their areas of responsibility.

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 Committee.

The Princess Alexandra Hospital NHS Trust

DEPUTISING ARRANGEMENTS	In the absence of the Committee Chairman, another Non-Executive Director member of the People Committee will chair the meeting. Other deputies may attend but must be suitably briefed and, where possible, designated and notified in advance. In the absence of an Executive member his/her designated deputy may attend with the permission of the Chief Executive Officer.
QUORUM:	The quorum for any meeting shall be the attendance of a minimum of one Non-Executive member, and one other Executive member.
DECLARATION OF INTERESTS:	All 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 EXECUTIVES:	Director of People, OD and Communications
MEETING FREQUENCY: **MEETING ORGANISATION:**	Meetings of the People Committee shall be bi-monthly. • 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. • The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee. • 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 five clear days* before the date of the meeting and not less than three clear days* before the date of the meeting. *'clear day' is a day which is not a Saturday or Sunday or a public or bank holiday.
AUTHORITY	The People Committee is constituted as a Committee of the Trust Board. Its constitution and terms of reference shall be as set out above, subject to amendment by the Board as necessary. The People Committee 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 People Committee. The People Committee is authorised by the Trust Board to request the attendance of individuals and authorities from inside or outside the Trust with relevant experience and expertise if it considers this necessary.
TERMS OF REFERENCE:	The terms of reference of the People Committee shall be reviewed at least annually and presented to the Trust Board.
DATE APPROVED:	By People Committee: 23 May 2022 By Trust Board:

The Princess Alexandra Hospital NHS Trust

5.1

MEMBERSHIP

Membership and Those in Attendance	
Members	
Chair: Non-Executive Director	Helen Howe
Non-Executive Director	George Wood
Associate Non-Executive Director	John Keddie
Associate Non-Executive Director	Anne Wafula-Strike
Director of People, OD and Communications	Ogechi Emeadi
Chief Operating Officer	Stephanie Lawton
Director of Nursing, Midwifery & Allied Health Professionals	Sharon McNally
In Attendance	
Associate Director of Learning and OD	Mandi Osoba
Medical Education Manager	Judith Butcher
Deputy Director of People	Beverley Watkins
Associate Director of Communications	Laura Warren
Director of Medical Education	Preethi Gopinath
In Attendance (right to attend reserved)	
Trust Chairman	Hattie-Llewellyn-Davies
Chief Executive	Lance McCarthy
Secretariat	
Head of Corporate Affairs	Heather Schultz
Corporate Governance Officer	Becky Warwick

The Princess Alexandra Hospital NHS Trust

Trust Board – 9 June 2022

5.2

Agenda item:	5.2
Presented by:	Ogechi Emeadi, director of people, organisational development and communications
Prepared by:	Ogechi Emeadi, director of people, organisational development and communications
Date prepared:	31 May 2022
Subject / title:	NHS Annual Staff Survey 2021 Response Update

Purpose:	Approval		Decision		Information	x	Assurance	X

Key issues:	This paper highlights outcomes for a detailed trust board workshop on the staff survey results and the response activities and improvement actions. Key issues was understanding the results in the context of when the staff were surveyed and longitudinal scores, understanding of how the themes have been derived and any gaps to address and what are the measures for improvement. The responsibilities and accountabilities for delivery of the plan. Our staff survey activities link to: *PAHT2030*: Our culture *Trust People Strategy Pillar*: Align and embed a health and wellbeing culture which is consistent with our vision, values, and corporate goals *NHS People Promise*: We each have a voice that counts.
Recommendation:	• Note the outcomes of the board workshop to provide assurance of the plans to improve the experience of our people • Approve the four trust wide themes of addressing the staff survey

Trust strategic objectives:	Patients	People	Performance	Places	Pounds
		x	x		

Previously considered by:	Elements discussed at People Board, Senior Management Teams, Workforce Committee, Trust Board
Risk / links with the BAF:	2.3 Inability to recruit, retain and engage our people
Legislation, regulatory, equality, diversity and dignity implications:	CQC - KLOE well led The Equality Act 2010 To avoid any potential negative impact, equality impact assessments carried out on collaborative initiatives.
Appendices:	Appendix 1. Slide deck of Trust Board Staff Survey 2021 workshop – 19 May 2022

NHS Annual Staff Survey 2021 Response Update

1. Purpose

1.1. This paper summarises the outcomes of a Trust Board workshop on the staff survey 2021 results and the trust's response plan.

2. Background

2.1. The annual NHS Staff Survey 2021 launched at PAHT on 4 October 2021 and closed on 26 November 2021.

2.2. Initial local results were received from Picker on 24 February 2022, with national results released by the NHS England's Survey Coordination Centre on 11 March 2022. The embargo on the national results lifted on 30 March 2022. Throughout this period internal communications and engagement commenced with staff regarding the findings and action planning continues.

2.3. The detailed results and plans had been presented and discussed at previous workforce committees and trust boards. However given the disappointing results it was agreed that a dedicated workshop should be held to discuss the matter in more detail to get a greater understanding of the results and provide assurance about the plans to improve the experience of our people.

3. Trust Board workshop

3.1. The workshop was held on 19 May 2022 and was lead by director of people. Mandi Osoba, associate director of learning and OD co-facilitated the session. The slide deck to the session is at Appendix 1.

3.2. Sharon McNally, deputy chief executive and director of nursing, midwifery and allied health professionals provided an overview of the specific actions taken to improve the experiences of staff in those staff groups in particular band 6 leadership, chief nursing officer fellowship and specific support from the practice development team and OD team for international nurses.

4. Summary outcomes from the workshop

4.1. Results

4.2. The national benchmarking data and the trust's local results had been provided and discussed previously. Longitudinal data from 2016, where available, was provided and discussed indicating that on those scores the trust had started from a low base and showed improvements in subsequent years for the scores to decline over the Covid 19 reporting periods in line with other trusts.

4.3. Action Plan Themes

4.4. The four trust wide themes of health and wellbeing, psychological safety, manager's capabilities and workforce plans/productivity was discussed in detail the and the rationale for reaching them. There was a focus on workforce plans/productivity which was an additional theme for this year to

address the responses for more staff, burnout and morale. Actions within this them include retention plans, rostering and as well international recruitment. However, it was recognised supply was limited in some critical areas.

4.5. The plans and actions have been drawn from varies places including exemplar trust for staff survey results as well as best practice in other sectors.

4.6. Equality, diversity and inclusion

4.7. Assurances were sought on the results from an equality and diversity and inclusion perspective where being addressed. An explanation was provided that the trust was utilising the information from the workforce race equality standard (WRES) and workforce disability equality standard (WDES) and engaging with the different staff networks with the support from the newly appointed Head of EDI and working with the integrated care board.

4.8. Measures

4.9. The non-executive directors (NEDs) sought assurance of how the impact of the plans are measured. place would make a difference. The quarterly pulse quarterly which now provides divisional-level data is used to measure the experience of our people in the intervening periods of the annual staff survey. The people pulse survey s used in conjunction with the existing people metrics eg turnover, vacancy rates, sickness absence etc

4.10. Responsibility and Accountability

4.11. Allied to this, assurance was sought on what was different between this year and last year in terms of outcomes. There was recognition that plans would take time to embedded. Key is being clear and emphasising responsibility vs accountability. This time it is clear what individuals are responsible for and once that is in place it is easier to hold people accountable. There is also a new accountable framework to support this approach.

4.12. Correlation between response rates and satisfaction

4.13. It was recognised that the trust response rate had increased by nine percentage points from the 2020 survey and was now above the national average. To seek further improvements non-executive directors sought thoughts on consideration on incentives to encourage completion of 2022 survey. Ensuring that there was a steady flow of communication in terms of actions was also considered key so that by the time people are filling out the survey they remember all that we are doing.

5. Conclusion

5.1. The attendees expressed greater assurance about the plans to improve the experience of our people. It was recognised that to improve culture will take time to embed and external factors can affect progress.

Recommendation

5.2. The board is asked to:
5.3. Note the outcomes of the board workshop to provide assurance of the plans to improve the experience of our people
5.4. Approve the four trust wide themes of addressing the staff survey namely:
   i. Improving the physical and mental health and wellbeing of our people
   ii. Feeling able to share feedback or concerns, and feeling assured that these will be acted upon (psychological safety)
   iii. Embedding our management practices and leadership promise
   iv. Ensuring our workforce plans support teams being effectively staffed to deliver high quality services

Author: Ogechi Emeadi, director of people, OD and communications
Date: 31 May 2022

The Princess Alexandra Hospital NHS Trust

Trust Board Workshop

Staff Survey 2021 results and response plan

Ogechi Emeadi, director of people
Mandi Osoba, associate director of learning and OD

19 May 2022

Session summary

NHS
The Princess Alexandra Hospital
NHS Trust

This overview is split into four parts:

1	2	3	4
How our results have changed 2020 - 2021	**How our results compare nationally**	**Our response plan**	**Accountability and leadership**
An overview of our position trust-wide	How we compare to similar organisations	What we are doing as an organisation to improve	What will make the difference?

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1. How our results have changed 2020 - 2021

Response rates

Table 2. Comparison of 2021 and 2020 response rates by division			
HCG	Response rate 2020	Response rate 2021	Variance 2020-21
CCCS	45.2%	**50.9%**	5.7%
Corporate	63.3%	**78.4%**	15.1%
Estates & Facilities	45.2%	**54%**	8.8%
Family & Women's Services	36.2%	**40.1%**	3.9%
Medicine	24.6%	**33.5%**	8.9%
Surgery	30.7%	**45.4%**	14.7%
Urgent & Emergency Care	-	**31.7%**	N/A
Totals	38.2%	**47.3%**	9.1%

Table 3. 2021 response rates by staff group	
Staff Group	Response Rate
ADD PROF SCIENTIFIC AND TECHNIC	55.80%
ADDITIONAL CLINICAL SERVICES	39.80%
ADMINISTRATIVE AND CLERICAL	68.10%
ALLIED HEALTH PROFESSIONALS	47.50%
ESTATES AND ANCILLARY	53.30%
HEALTHCARE SCIENTISTS	61.30%
MEDICAL AND DENTAL	24.90%
NURSING AND MIDWIFERY REGISTERED	43.60%

Trust-wide headline results

The Princess Alexandra Hospital NHS Trust

Picker management report: changes in our results since 2020

Trust-wide headline results

The Princess Alexandra Hospital NHS Trust

Picker management report: headline results

Most improved and declined scores compared to our 2020 results		
Most improved scores	**2021**	**2020**
q9c. Immediate manager asks for my opinion before making decisions that affect my work	53%	49%
q9a. Immediate manager encourages me at work	68%	64%
q9b. Immediate manager gives clear feedback on my work	60%	56%
q14d. Last experience of harassment/bullying/abuse reported	47%	43%
q17a. Would feel secure raising concerns about unsafe clinical practice	70%	67%
Most declined scores	**2021**	**2020**
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	32%	46%
q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation	48%	60%
q3i. Enough staff at organisation to do my job properly	20%	30%
q22c. I am not planning on leaving this organisation	45%	54%
q21c. Would recommend organisation as place to work	45%	53%

2. How our results compare nationally

Trust-wide national benchmark results

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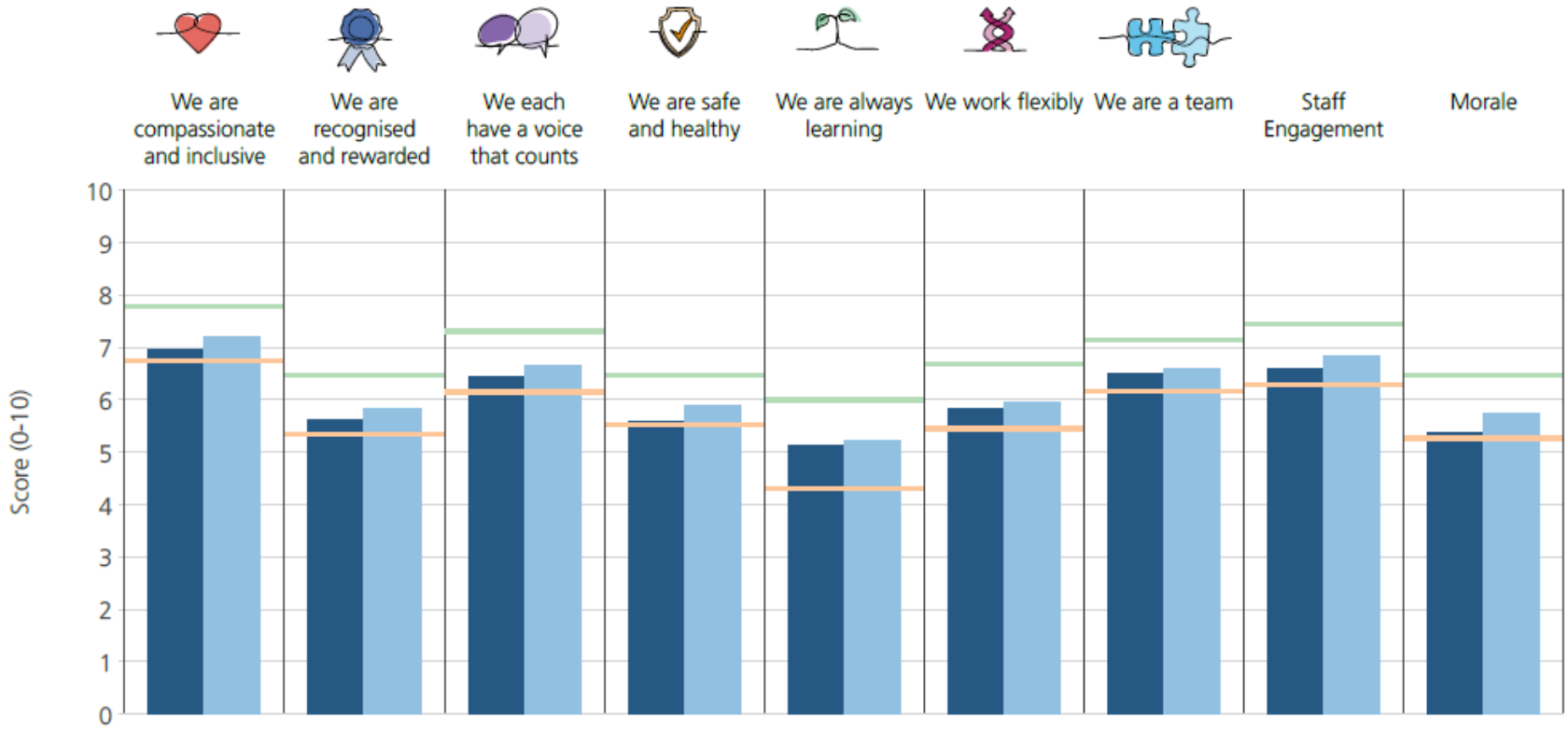

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.0	5.6	6.4	5.6	5.1	5.8	6.5	6.6	5.4
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	1,691	1,722	1,661	1,677	1,611	1,712	1,691	1,718	1,718

National benchmark – better than average

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Question number	Question	PAHT score	National average score	Variation (PAHT vs. national score)
Q16c.2	On what grounds have you experienced discrimination? – Gender	11.5%	20.7%	↓ 9.2%
Q16c.5	On what grounds have you experienced discrimination? – Disability	3.9%	8.3%	↓ 4.4%
Q16c.7	On what grounds have you experienced discrimination? – Other	23.3%	26.7%	↓ 3.4%
Q19b	It (appraisal) helped me to improve how I do my job	21.8%	19.8%	↑ 2%
Q19a	In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?	81.7%	80.1%	↑ 1.6%
Q9d	My immediate manager takes a positive interest in my health and wellbeing	67.1%	66.3%	↑ 0.8%
Q3a	I always know what my work responsibilities are	87%	86.3%	↑ 0.7%
Q7a	I enjoy working with the colleagues in my team	81.4%	80.7%	↑ 0.7%
Q7g	In my team disagreements are dealt with constructively	54.9%	54.7%	↑ 0.2%

National benchmark - below average

The Princess Alexandra Hospital NHS Trust

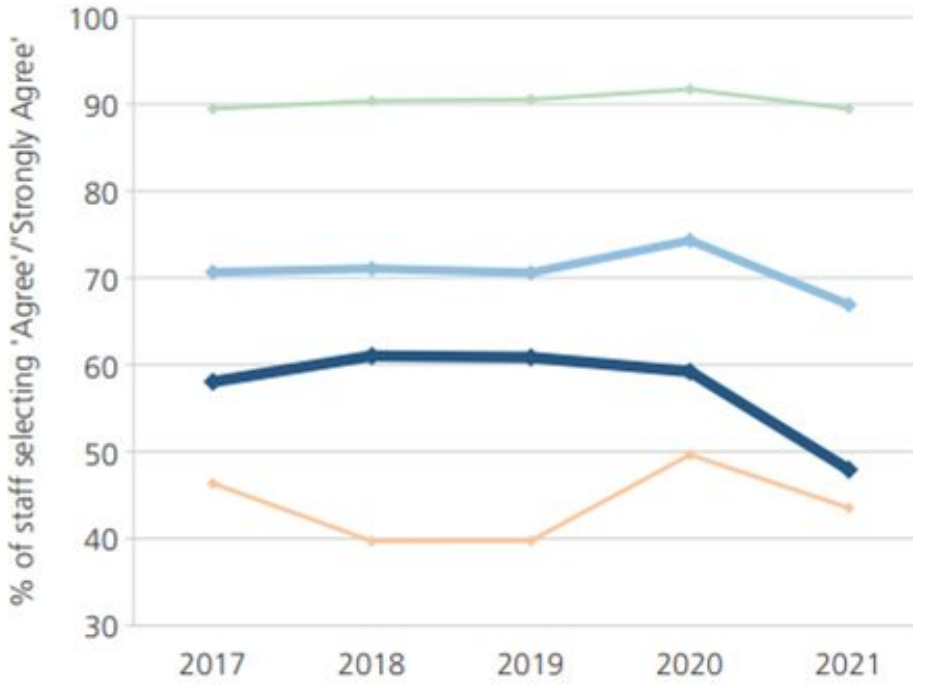
- All other questions scored below the national average
- The following questions scored the worst nationally

Question number	Question	PAHT score	National average score	Variation (PAHT vs. national score)
Q5a	I have realistic time pressures	18.2%	22.5%	↓ 4.3%
Q12b	How often, if at all, do you feel burnt out because of your work?	43.3%	35.2%	↑ 8.1%

Q21c
I would recommend my organisation as a place to work

	2017	2018	2019	2020	2021
Best	78.1%	81.2%	81.1%	84.0%	77.6%
Your org	48.6%	56.4%	57.5%	53.8%	45.3%
Average	60.8%	62.3%	63.0%	67.0%	58.4%
Worst	42.8%	39.3%	36.1%	46.5%	38.5%
Responses	1,088	1,242	1,448	1,316	1,685

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2017	2018	2019	2020	2021
Best	89.5%	90.4%	90.5%	91.7%	89.5%
Your org	58.1%	61.0%	60.9%	59.2%	47.9%
Average	70.7%	71.1%	70.6%	74.3%	66.9%
Worst	46.4%	39.7%	39.8%	49.7%	43.6%
Responses	1,087	1,237	1,471	1,315	1,689

National benchmark worsening scores

The Princess Alexandra Hospital NHS Trust

Question number	Question	PAHT score	National average score	Variation (PAHT vs. national score)
Q2b	I am enthusiastic about my job	67%	67.6%	↓ 0.6%
Q3d	I am able to make suggestions to improve the work of my team / department	68.6%	69.8%	↓ 1.2%
Q2c	Time passes quickly when I am working	71.4%	72.9%	↓ 1.5%
Q16b	In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?	10.7%	8.8%	↑ 1.9%
Q3e	I am involved in deciding on changes introduced that affect my work area / team / department	46.7%	48.9%	↓ 2.2%
Q16a	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?	9.5%	6.9%	↑ 2.6%
Q21a	Care of patients / service users is my organisation's top priority	71.8%	75.5%	↓ 3.7%
Q21b	My organisation acts on concerns raised by patients / service users	66.5%	71%	↓ 4.5%
Q4a	The recognition I get for good work	45.9%	50.5%	↓ 4.6%
Q11b	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	36.3%	30.9%	↑ 5.4%
Q15	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	77%	82.5%	↓ 5.5%
Q17b	I am confident that my organisation would address my concern	51.1%	57.6%	↓ 6.5%
Q11e	Have you felt pressure from your manager to come to work?	34.3%	26.1%	↑ 8.2%

3. Our response plan

Staff survey 2021 - response timeline

February 2022	Picker results received (core data)
March 2022	Senior management team briefings completed
	PAHT top four improvement priorities confirmed (via EMT & SMT)
	Divisional results workshops completed (targeting all managers)
	Workforce Committee report results and priorities (28 March) National benchmarking report published (30 March)
April 2022	Trust Board report results and priorities discussion (7 April) Special staff survey results executive briefing
	Divisions required to submit SS21 improvement plans by 29 April
	Linking results into existing org-wide projects/steering groups
May 2022	SS21 results roadshows for all staff (led via divisions)
	Begin monthly updates at PRMs and divisional boards
June – September 2022	Deliver improvement plans Share positive change stories
October 2022	Staff survey 2022 commences

SS21 divisional improvement plans

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Based our the PAHT top four improvement priorities, grounded in the key matters of concern raised within the division:

1. Improving the physical and mental health and wellbeing of our people
2. Feeling able to share feedback or concerns, and feeling assured that these will be acted upon (psychological safety)
3. Embedding our management practices and leadership promise
4. **Ensuring our workforce plans support teams being effectively staffed to deliver high quality services**

Summary Action Plan

Top four staff survey 2021 improvement priorities	Ongoing / planned trust-wide improvement work led through the People teams
Priority one: health and wellbeing	• Expanded health and wellbeing support options including: • Facilities – Alex Lounge, Learning and Education Centre, refurbished restaurant, agile working space • Financial - £100, £5 Costa coffee voucher, financial wellbeing support • psychological support – Here for your, reflective sessions, Schwartz Round, mental health first aiders
Priority two; psychological safety	• Continuing to improve the quality and effectiveness of our statutory and mandatory training, including our completion compliance, to ensure our people are knowledgeable and confident in raising concerns e.g., information governance, safeguarding, Prevent, fire safety, health and safety. • Refreshing and expanding our equality, diversity and inclusion networks as routes for people to share feedback or concerns. • Appointment of a lead freedom to speak up guardian role to lead the recently expanded team of guardians, further promote the work of the team, and better utilise the feedback shared appropriately to inform organisational improvement needs. • Enhanced onboarding programme being introduced from April 2022 which includes multiple touchpoints with new starters to seek feedback about their initial experiences

Summary Action Plan (2)

Top four staff survey 2021 improvement priorities	Ongoing / planned trust-wide improvement work led through the People teams
Priority three: This is us – management practices and leadership promise	• Ongoing delivery of *This is Us* workshops for managers – introducing *This is us* and expectations of managers in driving culture change. • *This is Us* embedded within our appraisal conversations as of January 2022 (for non-medical colleagues). • Ongoing embedding of *This is Us* culture huddles within teams – introducing *This is Us* and exploring the culture of our teams. • Ongoing development of a competency framework for managers. • Delivery of *This is Us* awards to recognise people for their positive ways of working, management practices and leadership styles. • Delivery of a PAHT2030 Ready development programme, building senior leaders' transformational change skills in alignment with *This is Us* • Planned implementation of a development programme for managers. • Planned development of a refreshed learning and development programme of offerings for all people at all levels, aligned to This is Us
Priority four: workforce plans	• 2022/23 workforce planning include review of operational workforce needs and data trends. • Job planning cycle for consultants and SAS doctors • Medical rota review • NHS EoE AHP workforce strategy and plan • Allocate rostering system review • Planned implementation of a strengthened process to monitor progress against the workforce plan

Staff Survey Plan

The Princess Alexandra Hospital NHS Trust

Actions formed by:

- NHSE/I exemplar trusts
- Other sectors including private
- Other countries
- Professional bodies eg CIPD
- HR associations eg HPMA
- Arms-length bodies eg NHS Employers, NHS Providers
- Webinars
- Development sessions
- Journals
- HR/OD networks professional and personal
- Experienced people, OD and learning team

Key Performance Indicators

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Pulse Survey

- Ongoing implementation of the National Quarterly Pulse Survey (NQPS) via the People Pulse tool – with added functionality from April 2022 to breakdown comments by divisions and teams to target improvements

People Metrics

- Full suite of reported monthly eg turnover, sickness absence, vacancy rate, bank and agency

Developing a team culture tool

- OD & HRBP teams are co-creating a team culture indicator tool, combining key results from the staff survey with core HR metrics
  - Identifies ‘top 5’ and ‘bottom 5’ teams overall and core key indicator themes
  - Appreciative inquiry case studies
  - OD interventions and people team support

3. Accountability and leadership

Who is accountable?

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Responding to the SS21 results

- **Overall accountability: executive team**
  - How?
    - Assurance of development of effective divisional improvement plans via PRMs
    - Assurance of progression of divisional improvement plans via PRMs
    - Assurance of effective oversight and support of development and progression of improvement plans via L&OD team *(Director of People, OD & Communications)*
    - Accountable for directing org-wide improvement work crossing departmental boundaries

Who is responsible?

Responding to the SS21 results

- **Overall responsibility: triumvirate teams / deputy and assoc. deputies**
  - How?
    - Responsible for the development of effective divisional improvement plans
    - Responsible for overseeing the delivery of divisional improvement plans (incl. team engagement)
    - Responsible for engaging/cooperating with L&OD teams on the progression of action in line with the response plan timeline

Who is responsible?

Responding to the SS21 results

- **Overall responsibility: learning and OD team**
  - How?
    - Responsible for maintaining oversight of progress against the development of SS21 improvement plans
    - Responsible for maintaining oversight of progress against the implementation of SS21 improvement plans
    - Responsible for providing support, tools and guidance to divisional management teams for delivering the response plans

Discussion

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- What's missing?
- How do we ensure things get done?
- What do we do if things are not done?
- Other questions?

NHS Staff Survey 2021 Benchmark Reports (nhsstaffsurveys.com)

The Princess Alexandra Hospital NHS Trust

Trust Board – 9 June 2022

5.3

Agenda item:	5.3
Presented by:	Ogechi Emeadi, director of people, organisational development and communications
Prepared by:	Monika Kaylan, Head of equality, diversity and inclusion Padraig Brady, lead strategic HR business partner Nathaniel Williams, people information and systems manager
Date prepared:	March 2022
Subject / title:	Gender Pay Gap Report - 2021

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	All organisations with over 250 employees are required to produce their gender pay gap data, with a snapshot of 31st March 2021. The data contained in this was uploaded to the government portal in March 2022 and this report will be published on our public website. The gender pay gap as at 31st March 2021 shows that men have higher mean and median average pay than women. The difference between mean pay of men and women is 27% and that of median average pay is 18%. When medical and dental staff are separated from Agenda for Change staff (including very senior manager), the mean gap is that women earn 5% less than men and the median gap is in favour for women earning more. The medical and dental mean and median gap is 13% and 24% in favour for men.
Recommendation:	The Board is asked to: • Consider and debate the gender pay gap data • Note the ongoing actions to address the gender pay gap

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

Previously considered by:	Workforce Committee – May 2022 Equality and Inclusion Steering Group – August 2021
Risk / links with the BAF:	2.3 Inability to recruit, retain and engage our people
Legislation, regulatory, equality, diversity and dignity implications:	The Equalities Act 2010 sets out the duties of the Trust and the Equality and Human Rights Commission give clear guidance which the Trust should endeavour to meet. This report is intended to progress the agenda to meet these duties and guidance and to ensure compliance. COC Well led
Appendices:	N/A

The Princess Alexandra Hospital NHS Trust

Gender Pay Gap Report - 2021

1. Introduction

1.1. Since 31 March 2017, it has been a legal requirement for organisations with more than 250 employees to report annually on their gender pay gap. The report must include the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile.

1.2. The Trust has a largely female workforce, like many other NHS organisations, with 78% of the workforce being female, and 22% male as at 31 March 2021.

2. Background & context

2.1. The legislation framework can be referenced to the Equality Act 2010 -Specific Duties and Public Authorities - Regulations 2017.

2.2. It is important to note that the gender pay gap reporting legislation is distinct from equal pay. Equal pay is concerned with men and women earning equal pay for the same or similar work. The gender pay gap is about the difference between men's and women's average pay within an organisation.

2.3. The Trust is committed to the principle of equal opportunities for all employees, regardless of sex, race, religion or belief, age, marriage or civil partnership, pregnancy/maternity, sexual orientation, gender reassignment or disability. On this basis, the Trust has a clear policy of paying employees equally for the same or equivalent work, regardless of their sex (or any other characteristic set out above).

2.4. The NHS has a national pay structure, job evaluation system and contractual terms and conditions for medical and non-medical staff, which have been developed in partnership with trade unions. This national framework provides a robust set of arrangements for pay determination.

2.5. The Gender Pay reporting requirements were introduced to highlight the differences in pay between men and women giving more transparency across all industry sectors. This assists employers to consider the reasons for any differences and taking any corresponding action.

3. Definitions and scope

Six measures must be included in a gender pay report. These are:

- Mean pay gap – the difference between the mean (average hourly earnings, excluding overtime) of men and women employees

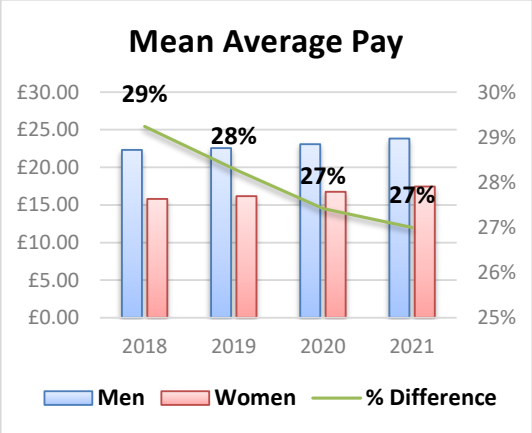
- Median pay gap – the difference between the median (the difference between the midpoints of hourly rates of earnings, excluding overtime) of men and women employees

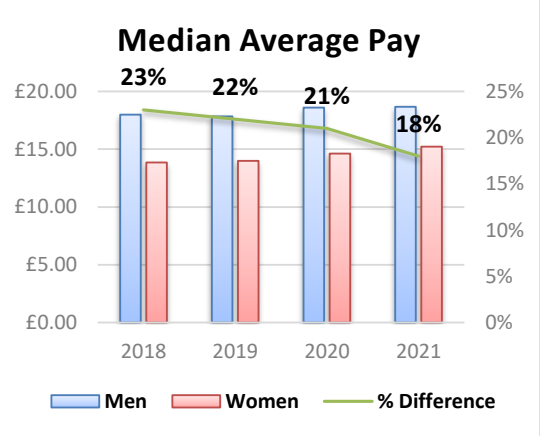
- Mean bonus gap – the difference between the mean bonus paid to men and women employees (bonus pay exclusively made up of local and national consultant clinical excellence awards, discretionary points and the welcome bonus for our international Nurses)
- Pay distribution by gender – the proportion of men and women employees in the lower, lower middle, upper middle and upper quartile pay bands

The report is based on rates of pay as of 31 March 2021. It includes all workers in scope at 31st March 2021.

4. Key highlights

4.1. Mean and median ordinary pay gap





The Trust Mean gender pay gap indicates that women earn 27% less than men for the reporting period, a continuous decrease from 2018 whilst the median pay gap indicates that women earn 18% less than men, an improvement from the previous reporting periods. The high pay difference is partly due to medical & dental staff being the highest paid staff group.

The tables below give a clear separation of medical and dental staff group from Agenda for Change (AfC) pay bands (including very senior managers) for this reporting period only.

AFC &VSM	Mean Hourly Rate	Median Hourly Rate
Men	£17.17	£13.95
Women	£16.29	£14.66

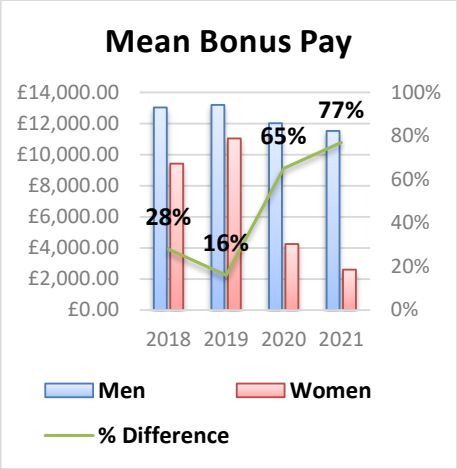
M&D only	Mean Hourly Rate	Median Hourly Rate
Men	£37.00	£36.80
Women	£32.37	£28.04

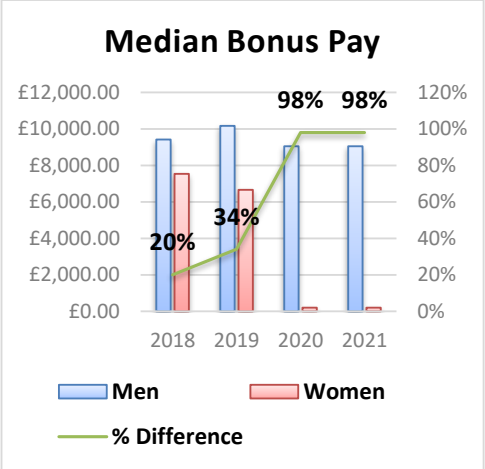
This separation indicates the mean pay gap for the Agenda for Change pay band including VSM, women earn 5% less than men and the median pay shows that women earn 5% more than men. For medical and dental staff, the mean and median pay gap indicates women earn 13% and 24% less than men respectively.

4.2. Mean and median bonus pay gap

The only staff group prior to this reporting period in receipt of bonuses were

consultants per the NHS national terms and conditions for medical staff. Within this reporting period, a relocation package for our international nurses includes a welcome bonus. Therefore, bonus payments for this report are exclusively made up of local and national consultant clinical excellence awards, discretionary points and welcome bonuses.





The tables below give a clear separation of the bonus paid to consultants and the welcome bonus paid to our international nurses for this reporting period.

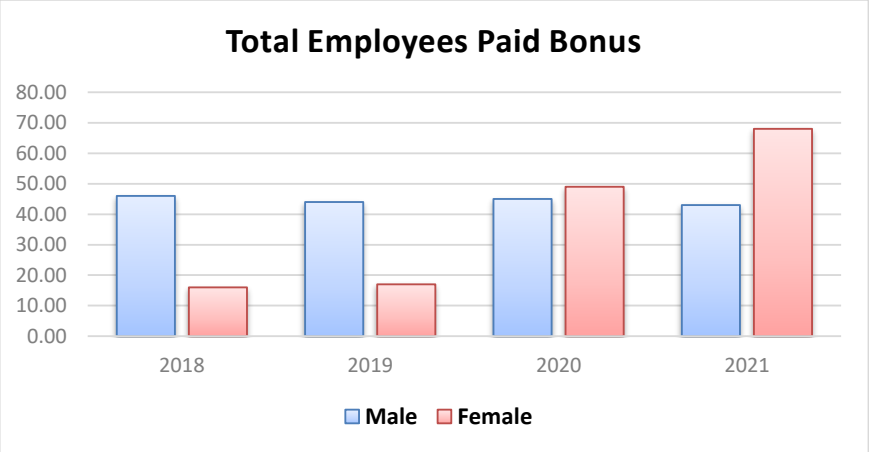
M&D only	Mean Bonus Payment	Median Bonus Payment
Men	£13,011.50	£10,555.98
Women	£9,806.60	£6,032.04

International Nurses	Mean Bonus Payment	Median Bonus Payment
Men	£200.00	£200.00
Women	£200.00	£200.00

This separation indicates that medical & dental consultants mean bonus payment in this reporting period is 25% in favour for men and median bonus payment is 43% in favour of men. There is no pay gap for the international nurses as they all each receive £200.

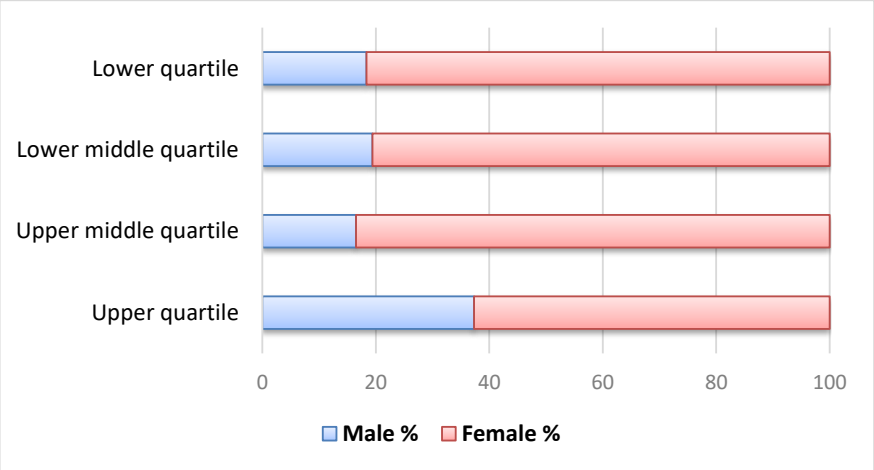
4.3. Employees paid bonus

The chart shows more women received the bonus payment this reporting period than men. The women increase is due to the fifty-one international female nurses that received the £200 welcome bonus compared to only five men who received the £200 welcome bonus.



4.4. Pay distribution by gender

The chart shows the proportion of men and women employees in each quartile. Employees are allocated into each quartile based on their hourly rate of pay. Lower quartile is our lowest pay quartile and upper quartile is our highest pay quartile. The highest percentage of females is in the upper middle quartile, whilst the highest for males is in the upper quartile.



5. Reducing the gender pay gap

5.1. The Trust is committed to ensuring equality within the workforce and on this basis, identified a number of actions for 2022/23:

- Continue to promote and encourage flexible working arrangements where practicable across all areas
- Raising awareness on shared parental leave
- Promote guidance to help support any staff members experiencing menopausal symptoms, encourage open conversations and create a better working environment
- Establish a women's network

- For 2021/22 clinical excellence awards, the Trust will continue to follow the national guidance of apportioning the available funds across all eligible consultants.

The Equality, Diversity and Inclusion Steering Group will monitor delivery of these recommendations.

6. Recommendations

The Board is asked to:

- Consider and debate the gender pay gap data
- Note the ongoing actions to address the gender pay gap

Author: Monika Kaylan, Head of equality, diversity and inclusion
Padraig Brady, lead strategic HR business partner
Nathaniel Williams, people information and systems manager

Date: March 2022

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BOARD OF DIRECTORS:	**Trust Board (Public) 9 June 2022**	**AGENDA ITEM: 6.1**
REPORT TO THE BOARD FROM:	**Performance & Finance Committee (PAF)**	
REPORT FROM:	**Colin McCready - Committee Chair**	
DATE OF COMMITTEE MEETING:	**26 May 2022**	

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 2021/22 and Terms of Reference 2022/23	Discussion item			PAF discussed areas where improvements are required including quality of papers (a succinct executive summary to be included where relevant) and benefits realisation and monthly CIP reports required. A bank and agency update will be included in papers going forward. The revised Terms of Reference were recommended to Board for approval. Minor changes to membership were noted. The ToR's are attached as **Appendix 1**.
2.1 M1 Financial Results	Y	Y (Audit)	N	The Trust had reported a deficit of £2.4m due to one-off expenditure on winter pressure (£0.5m), activity recovery spend of (£0.7m) and additional Covid-19 expenditure. Total Capital expenditure for the year to date is £1,667 and cash balance is £44.1m. The audit is underway and a further update will be provided at Audit Committee on 31.05.22
2.2 CIP Update	N	Y	N	The committee requested more detail on CIP targets for the next meeting. It was noted CIP desktop review would take place after PAF.
2.3 Operating Plan Update	Information item.			A verbal update was noted; additional funding for the NHS and the allocation of that funding would be discussed on 27.05.22. The submission date for the final operating plan would be 20.06.22.

2.4 Capital Programme 2022/23	Partially assured	Y	N	The programme is currently over committed and still in development. The Trust's Capital Resource Limit for 2022-23 is £14,297k.
2.5 BAF Risk 5.1 (Finance – Revenue) and BAF Risk 5.2 (Finance – Capital)	Y	N	N	PAF noted the updates to the risks to reflect the 2022/23 position and supported the recommendation that the risk scores remain at 12.
2.6 Procurement Update	Y	N	N	The quarterly report provided assurance in respect of: - Finance: cost forecast for FY21/22 - Performance Dashboard (including savings projection) - Major Contracts Expiring in the next 24 months - Transformational Activities - Progress against the ICS Procurement Milestones - Risks
3.1 M1 Integrated Performance Report (IPR)	Y	Y	N	The Committee noted the IPR and a request was made for themes from compliments to be shared with the NEDs.
3.2 BAF Risk 1.3: Recovery Programme and BAF Risk 4.2 - 4 hour Emergency Department Constitutional Standard	Y	N	N	The updated risks were noted and the Committee supported the recommendation for the risk scores to remain at 16 and 20 respectively.
4.2 BAF Risk 3.1 - Estate and Infrastructure	Y	N	N	The updated risk was noted and the Committee supported the recommendation for the risk score to remain at 20.
4.3 Domestic Modernisation – Benefits Realisation	Y	N	N	Following the board approval of circa £1.188m investment into the domestics' modernisation in 2020, the committee received an update on both the qualitative and financial deliverables following implementation. The qualitative elements of cleaning have improved, however the pandemic has had a significant impact on the full delivery of the modernisation and opening of new areas across site (with the requirement for additional deep cleans) impacting on the financial benefits. A schedule of benefits realisation from business cases is to be developed.
4.4 Annual Report into the Trust's Sustainable	Y	N	N	PAF noted the initiatives underway to reduce the Trust's carbon footprint and achieve net zero by 2045.

Development Management Plan and Carbon Reduction and Sustainability Strategy				

The Princess Alexandra Hospital NHS
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PERFORMANCE AND FINANCE COMMITTEE

TERMS OF REFERENCE 2022/23

PURPOSE:

The purpose of the Performance and Finance Committee (PAF):

- Consider, challenge and recommend the Trust's Operating Plan to the Board.
- Scrutinise operational and financial performance and monitor achievement of national and local targets and recommend any re-basing or re-forecasting of operational and financial performance trajectories to the Board;
- Assure the Board of Directors that the Trust has robust processes in place to prioritise its finance and resources and make decisions about their deployment to ensure that they best meet patients' needs, deliver best value for money and are efficient, economical, effective and affordable.
- Recommend the Trust's Cost improvement programme to the Board and monitor its delivery including investigating reasons for variance from plan and recommend any re-basing or re-forecasting of the Plan to the Board;
- Monitor the management of the Trust's asset base and the implementation of the Trust's enabling strategies in support of the Trust's clinical strategy and clinical priorities;
- Review and monitor the management of finance, performance and contracting risks.

DUTIES:

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

Financial Management

1. Consider the content of, planning assumptions, key risks and principles underpinning the Operating Plan prior to submission to the Board for approval.
2. Where there is variance against plan, agree any re-base or re-forecast and ensure appropriate actions are put in place for recovery.
3. Approve the Capital Programme as part of the budget setting process and monitor progress against the plan.
4. Approve the process for the submission of the National Reference Cost Return prior to submission and review the results.
5. Review the implementation of the Trust's plans for Service Line Management.
6. Review compliance with agency cap and spend.
7. Review financial performance and forecast against income, expenditure, working capital and capital and seek assurance that the position is in line with approved plans, targets and milestones and that any corrective measures that are being taken are effective
8. Review significant risks associated with the forecast outturn.
9. Review the Treasury Management Policy, receive reports in accordance with the Policy and approve institutions.
10. Review arrangements for effective compliance reporting in respect of loans and other requirements

Operational Performance

1. Agree the annual operational performance plan including annual trajectories for each local and national target, including CQUINs.
2. Scrutinise operational performance and including the investigation of reasons for variance from plan.
3. Recommend any re-basing or re-forecasting of annual performance trajectories to the Board.
4. Advise the Board of any penalties likely/due to be incurred as a result of performance variance.
5. Monitor the strategic and operational systems and processes to ensure the competent performance management of the organisation

Cost Improvement

1. Agree the level of the Cost Improvement Programme and recommend the /Cost Improvement Programme to the Board.
2. Monitor delivery of the Trust's Cost Improvement Programme including the investigation of reasons for any variance from plan.
3. Recommend any re-basing or re-forecasting of the Programme to the Board and advise of the reasons why this is necessary;
4. Provide the Board with assurance on the progress and delivery of the programme.

Contract Management

1. Review the Trust's negotiating position prior to annual contracting round with commissioners.
2. Review financial and performance activity against contracts and if corrective action is required, receive assurance that the measures being taken are effective.
3. Consider any tender opportunities with an annual income value exceeding £1m.

Workforce

1. Maintain oversight of expenditure on temporary staffing.
2. Ensure that there is a link between recruitment and the reduction in temporary staffing costs.

Procurement

1. Oversee the implementation of the Trust's Procurement Strategy.
2. Receive an annual report in respect of the Annual Procurement Plan.
3. Receive regular updates on the Procurement pipeline

Business Cases, Benefits Realisation and Return on Investment

On behalf of the Board:

1. Undertake a robust appraisal of new business cases and re-investment business cases valued at over £1m, ensuring that the outcomes and benefits are clearly defined, measurable, support the delivery of key objectives for the Trust and that they are affordable.
2. Review benefits realisation and return on investment of major projects.

Capex

1. Consider any significant infrastructure investment prior to proposals being put to the Board for consideration/approval.

2. Monitor the implementation of the Trust's Information Technology strategy and Estates Strategy.
3. Consider any estate disposal, acquisition or estate change of use in accordance with the Trust's Strategy and recommend to the Board.

Estates, Facilities & Sustainability

1. Oversee the implementation of the Trust's Carbon Reduction and Sustainability Strategy.
2. Receive an annual report in respect of the Trust's Sustainable Development Management Plan.
3. Review the Trust's arrangements for estates and facilities management

Health and Safety:

Maintain oversight of Health & Safety including radiation use and protection guidelines (IR(ME)R), fire safety and decontamination.

Information Management, Data Quality and Coding

1. Oversee the Trust's information management, coding and data quality arrangements and review progress against key metrics.
2. Monitor the implementation of the annual Information Management Plan.

Resilience & Business Continuity

1. Undertake an annual review of the Trust's resilience & business continuity arrangements,
2. On behalf of the Board, review how the Trust is upholding its duties to fulfil its duties as a Category 1 responder under the Civil Contingencies Act 2004 and recommend a report to the Board in respect of these.

Risk

1. Monitor and review any risks allocated to the PAF.
2. Review and monitor finance, performance and contracting risks and seek assurance that plans/actions are in place to mitigate identified risks.

Annual Work Plan and Committee Effectiveness

1. Every year, set an Annual Work Plan and conduct an effectiveness review (which will include the achievement of the Annual Work Plan and a review of the terms of reference) and report this to the Board.

ACCOUNTABLE TO:	Trust Board.
REPORTING	A Committee report shall be provided to the next meeting of the Board of Directors. The report shall set out areas requiring the Board's attention and report on the level of assurance provided by the PAF meeting and advise of progress against the PAF's Annual Work Plan.
CHAIRMAN:	Non-Executive Director.
COMPOSITION OF MEMBERSHIP:	The PAF is comprised of Executive and Non-Executive Directors appointed by the Board. The agreed membership is:

- Chair - Non-Executive Director
- Non-Executive Directors/Associate Non-Executive Directors
- Director of Finance
- Chief Operating Officer
- Director of Strategy
- Chief Information Officer

The Chairman of the PAF shall be appointed by the Chairman of the Trust Board; s/he shall have recent and relevant finance or business or commercial experience.

If not already a member of the PAF, the Audit Committee Chairman may attend any meeting of the PAF.

At least one of the Non-Executive Director/ members of the PAF shall also be a member of the Trust's Audit Committee.

The Chairman and Chief Executive of the Board reserve the right to attend meetings.

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

ATTENDANCE: Members are expected to attend all meetings of the PAF. An attendance register shall be taken at each meeting and an annual register of attendance included in the PAF's annual report to the Board.

The Chairman and Chief Executive in their capacity as ex officio members are expected to attend five out of eleven meetings in each reporting period.

In addition to the members of the Board, the following shall be expected to attend each PAF meeting:

- Deputy Director of Finance
- Director of Information & IT

To ensure appropriate accountability, others will be invited to attend when the PAF is discussing areas of risk or operation that are their responsibility.

Internal Auditors to attend meetings by exception, as required to present reports of any audits conducted by them in respect of issues within the scope of the PAF.

DEPUTISING ARRANGEMENTS In the absence of the Committee Chairman, another Non-Executive Director member of the PAF will chair the meeting.

Other deputies may attend but must be suitably briefed and, where possible, designated and notified in advance. In the absence of an Executive member his/her designated deputy may attend with the permission of the Chief Executive Officer.

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NHS Trust

QUORUM:	The quorum for any meeting of the PAF shall be the attendance of a minimum of two Non-Executive members and two Executive members or their deputies (who may attend with the permission of the Chief Executive Officer).
DECLARATION OF INTERESTS:	All 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 EXECUTIVES:	Director of Finance
MEETING FREQUENCY:	Meetings of the PAF shall be held monthly
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. • The Head of Corporate Affairs shall ensure there is appropriate secretarial and administrative support to the Committee. • 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 five clear days* before the date of the meeting and not less than three clear days* before the date of the meeting. *'clear day' is a day which is not a Saturday or Sunday or a public or bank holiday.
AUTHORITY	The PAF 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 PAF 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 PAF. The PAF is authorised by the Trust Board to request the attendance of individuals and authorities from inside or outside the Trust with relevant experience and expertise if it considers this necessary.
TERMS OF REFERENCE:	The terms of reference of the PAF shall be reviewed at least annually and presented to the Trust Board.
DATE APPROVED:	By PAF: 26 May 2022 By Trust Board

The Princess Alexandra Hospital NHS
NHS Trust

PERFORMANCE & FINANCE 2022/23 MEMBERSHIP

Membership and Those in Attendance	
Members	
Chairman - Non-Executive Director	Colin McCready
Non-Executive Director	George Wood
Associate Non-Executive Director	John Keddie
Associate Non-Executive Director	Darshana Bawa
Director of Finance	TBC (Lead Exec)
Chief Operating Officer	Steph Lawton
Director of Strategy, Estates & Facilities	Michael Meredith
Chief Information Officer	Phil Holland
In Attendance	
Deputy Director of Finance	TBC
Director of Information and IT	Lynne Fenwick
In Attendance (right to attend reserved)	
Trust Chairman	TBC
Chief Executive	Lance McCarthy
Secretariat	
Head of Corporate Affairs	Heather Schultz
Board & Committee Secretary	Lynne Marriott

The Princess Alexandra Hospital NHS Trust

Trust Board (Public) – 9 June 2022

Agenda item:	6.2
Presented by:	Phil Holland – Chief Information Officer
Prepared by:	Phil Holland – Chief Information Officer
Date prepared:	20th May 2022
Subject / title:	M1 2022/23 Integrated Performance Report (IPR)

Purpose:	Approval		Decision		Information	x	Assurance	x

6.2

Key issues:

Patients		
Patients	C. Difficile	After seven months in positive special cause variation, an increase in cases has moved the trend to common cause variation. See further narrative in patients summary.
	Serious Incidents	Remained in positive special cause variation for the previous 14 months
People		
People	Appraisals	Still in common cause variation, however performance has dipped back to near the lower control limit
	Statutory and Mandatory Training	In specal cause variation, and eleven points now showing a statistically consistent trend. Performance has reduced to 86%, and below the target of 90%.
	Sickness Absence	In common cause variation and continues to perform at or near the target. We have continued to see an overall downward trend since October
Performance		
Performance	RTT	Performance remains in special cause variation, but recovery actions are in place, with patients being treated in clinical priority. The decrease in performance has slowed over the last five months as a result of the focus on our recovery
	Cancer 2 week wait	Remains in special cause variation. A second month of significant improvement with performance back to near the mean, and at a level not seen since July 2021
	Cancer 62 day pathway	Performance has returned to common cause variation following a jump in performance. Focus is being placed on the long wait patients, which is having an impact on the overall performance
	Four hour standard	Remains in special cause variation. However, we saw a significant drop in ambulances waiting over 60 minutes in April, with performance improving to a level not seen since August 2021. We also continue to see improvement in triage times, with performance at the best level since June 2021
	Diagnostics	Performance remains in common cause variation for the third month after a sustained period in special cause variation
	52 week waits	Still is special cause variation, with a continued focus on clinical priority patients. There has been a slight increase in patients waiting in April compared to March
	Bed Occupancy	Bed occupancy remains at a high level, and has been in special cause variation for the previous ten months.
Pounds		
Pounds	Surplus	The Trust reported a deficit of £2.4m as at April (month 01) against the plan of plan of £0.5m deficit. This was due to some prior year expenditures paid in month 01. These cost are non-recurrent and we are reviewing the year end provisions to identify provisions and accruals that could cover the reported deficit.
	CIP	The Trust CIP target for the year is £11.7m and planned delivery for month 01 is £0.4m. There was no CIP delivery recorded in month 01.
	Capital Spend	Capital expenditure for month 01 is £1.67m, which mainly relates to capital overspend from 2021/22 on Estates schemes of £1.32m. The Trust Capital resources limit is £14.3m
	Cash	The Trust continues to have a healthy cash balance of £44.1m. There is a continued push to reduce aged payables & maintain the current Trust's performance against the Better Payment Practice Code.
Places		
Places	Catering Food Waste	Remains at or below the national target

The Princess Alexandra Hospital NHS Trust

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

Previously considered by:	PAF.26.05.22 and QSC.27.05.22
Risk / links with the BAF:	Links to all BAF risks.
Legislation, regulatory, equality, diversity and dignity implications:	No regulatory issues/requirements identified.
Appendices:	M1 Integrated Performance Report (IPR)

6.2

The Princess Alexandra Hospital NHS Trust

Integrated Performance Report for April 2022

modern • integrated • outstanding

patient at heart • everyday excellence • creative collaboration

Performance Summary

Patients		
Patients	**CDIFF**	After seven months in positive special cause variation, an increase in cases has moved the trend to common cause variation. See further narrative in patients summary.
Patients	**Serious Incidents**	Remained in positive special cause variation for the previous 14 months
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Places		
Places	Catering Food Waste	Remains at or below the national target

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People	**Appraisals**	Still in common cause variation, however performance has dipped back to near the lower control limit
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Performance		
Performance	**RTT**	Performance remains in special cause variation, but recovery actions are in place, with patients being treated in clinical priority. The decrease in performance has slowed over the last five months as a result of the focus on our recovery continues
Performance	**Cancer 2 week wait**	Remains in special cause variation. A second month of significant improvement with performance back to near the mean, and at a level not seen since July 2021
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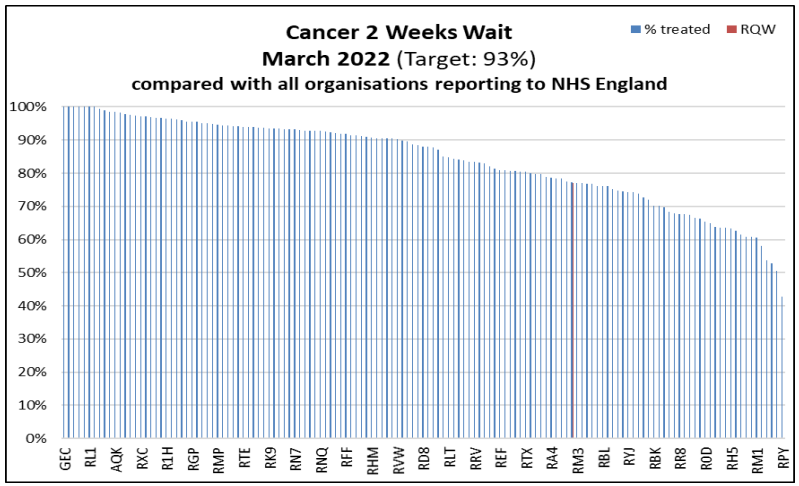
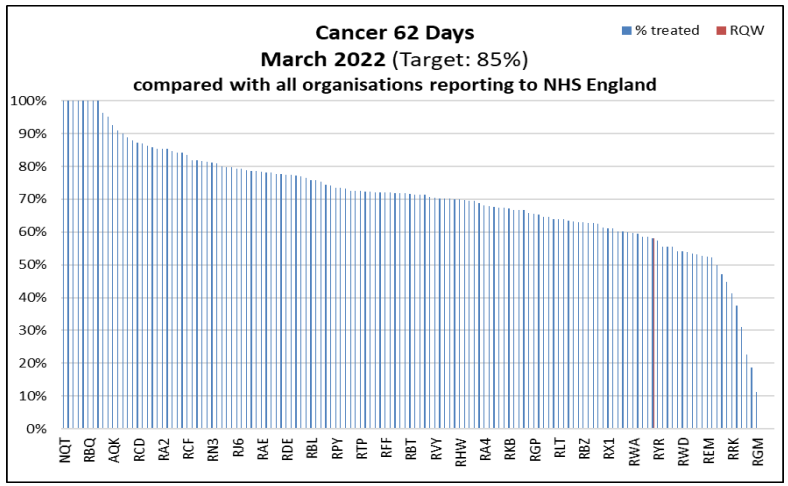
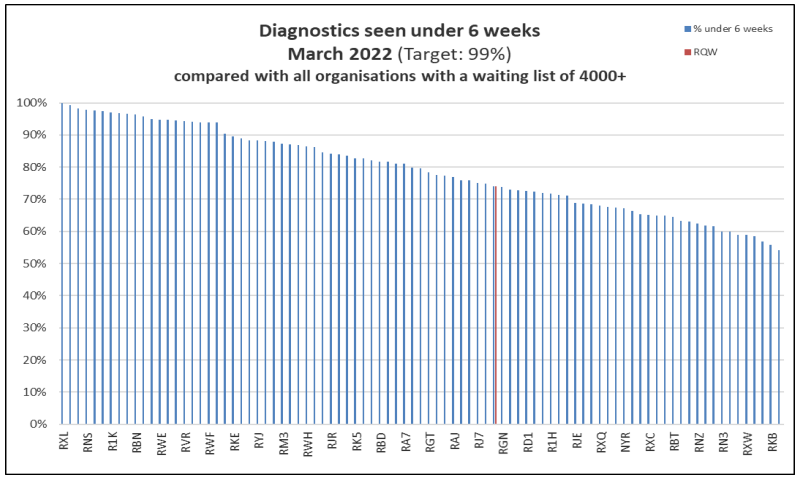
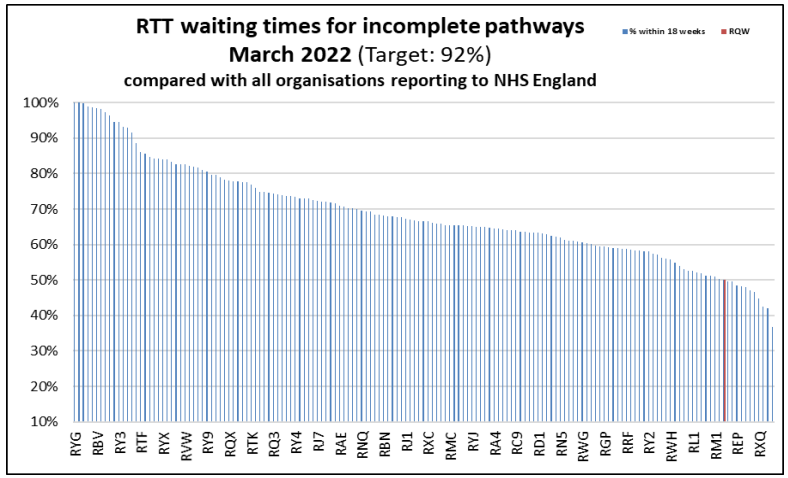
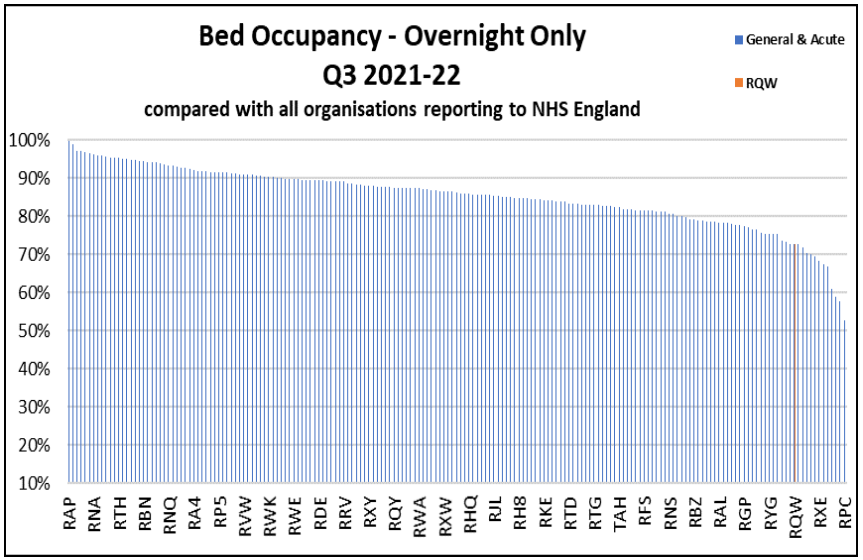
National Benchmarking

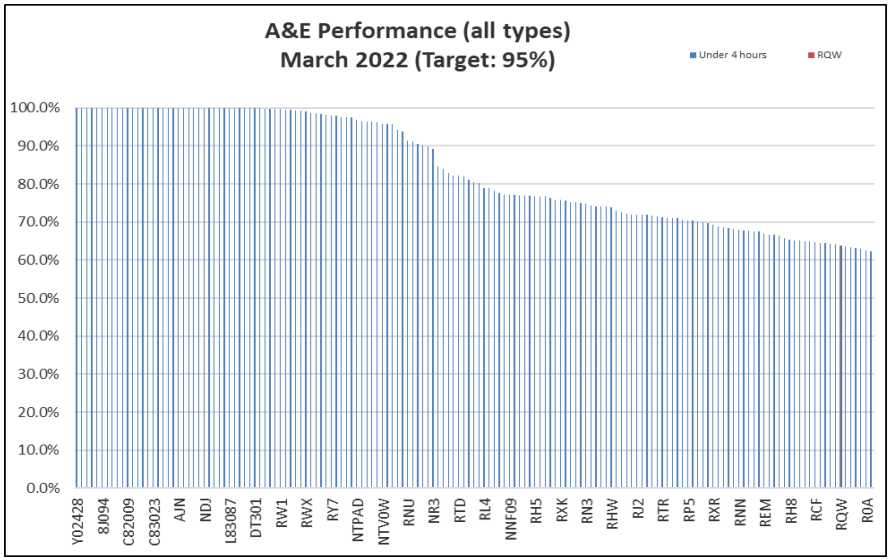









Bed Occupancy - Overnight Only
Q3 2021-22
compared with all organisations reporting to NHS England
General & Acute
RQW
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
RAP RNA RTH RBN RNQ RA4 RP5 RVW RWK RWE RDE RRV RXY RQY RWA RXW RHQ RJL RH8 RKE RTD RTG TAH RFS RNS RBZ RAL RGP RYG RQW RXE RPC


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


Benchmarking

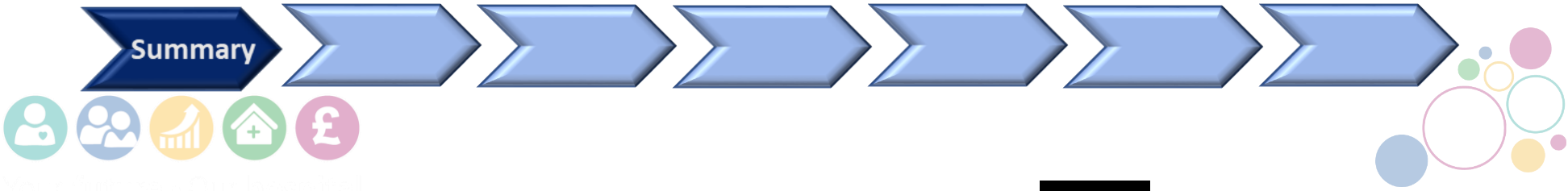
The difference between common and special cause variation

Common Cause Variation

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

Special Cause Variation

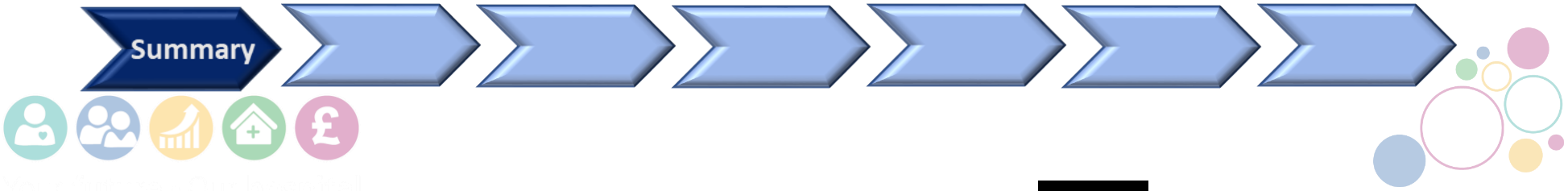
- Is due to irregular causes that are not inherent in the design of the process
- Results in an unstable process that is not predictable
- Also known as non-random or assignable variation
- Shown as blue or orange markers on our SPC charts



How is special cause variation defined and identified

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

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



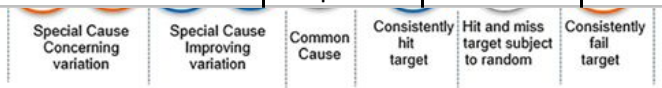
Patients

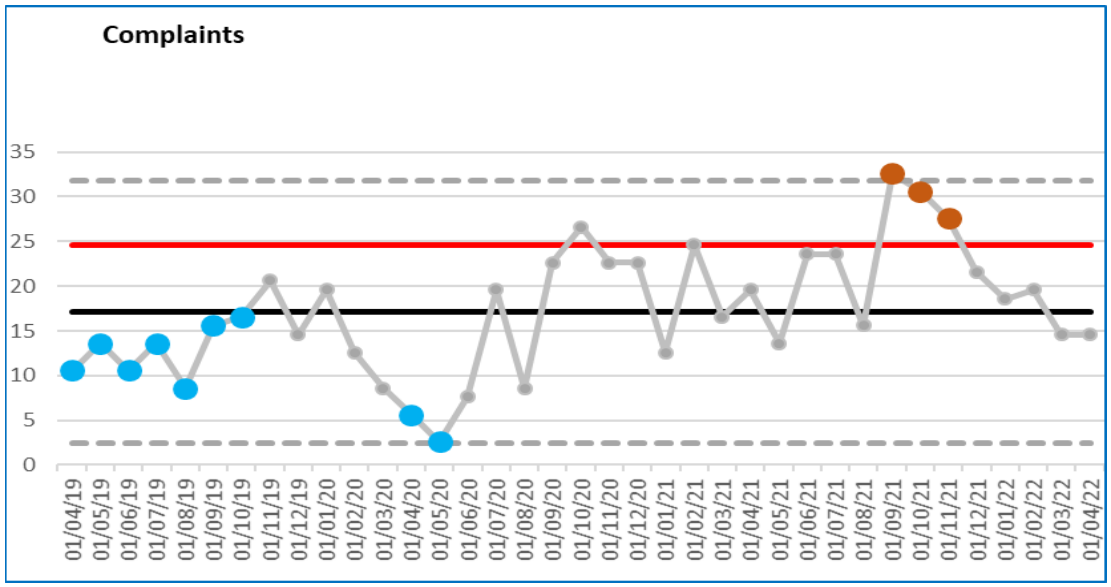
*We will continue to improve the quality of care, outcomes & experiences that we provide **our patients**, integrating care with our partners & reducing health inequity in our local population*

Patients Summary		Board Sub Committee: Quality and Safety Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Complaints	Note the reducing number of complaints received to 2019 levels. Focus on response times and significant progress being made (aim to return to pre pandemic level by end June 2022)	For information	30/06/2022
Compliments	Note return to recording compliment data logging resumed in April with 102 compliments received - this will continue to be reported.	For information	Apr-22
C. Difficile	Following 7 months of reduced cases, of note is the increase in month. This is being reviewed by the infection control team to understand any causation and reporting into the Infection Control and Prevention Committee.	For information	NA
Mothers delivering in birthing unit / home	The current rate is 3.4% against our target of 14.4%. This is linked to midwifery staffing and maintaining safe services. It is expected that there will a month: month increase in the rate (as staffing improves) and a greater impact from September 22.	For information	Q3

KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 1 metrics								
Complaints	Apr 22	15	25			18	3	32
Compliments	Apr 22	70	50			121	-107	349
PALS	Apr 22	240	none			280	147	413
Complaints closed within target	Apr 22	6	none			6	-3	14
% of complaints where an extension has been agreed	Apr 22	63%	none			43%	8%	78%
Mixed Sex Accommodation Breach	Feb 22	6	0			7	-4	18
Serious Incidents	Apr 22	3	none			5	-4	13
MSSA	Apr 22	0	none			1	-1	3
CDIFF	Apr 22	10	none			5	-2	13
Hand Hygiene	Jan 22	97%	none			92%	75%	109%
eColi	Apr 22	0	none			1	-2	4
Klebsiella	Apr 22	3	none			1	-1	3
Pseudomonas	Apr 22	0	none			0	-1	1
Falls per 1000 bed days	Apr 22	7	9			9	6	11
Falls total minor, moderate & severe	Apr 22	21	13			25	11	39
Pressure Ulcers per 1000 bed days	Apr 22	3	3			4	1	7
Pressure Ulcers: grade 3, 4 & unstageable	Apr 22	4	3			4	-3	11
Total number of mothers delivering in birthing unit/home	Apr 22	3%	20%			11%	-1%	23%
Number of mothers delivering in Labour Ward/Theatres	Apr 22	94%	75%			89%	76%	101%
Number of women due to deliver at PAH adjusted for misc/TOPs	Apr 22	304	375			331	274	388
Smoking rates at booking	Apr 22	13%	none			9%	4%	14%
Smoking rates at delivery	Apr 22	9%	6%			10%	5%	15%
Breast feeding rates at delivery	Apr 22	79%	74%			76%	66%	85%
Total Planned C-Sections	Dec 21	20%	none			15%	8%	23%
Total Unscheduled C-Sections	Dec 21	21%	none			18%	13%	24%

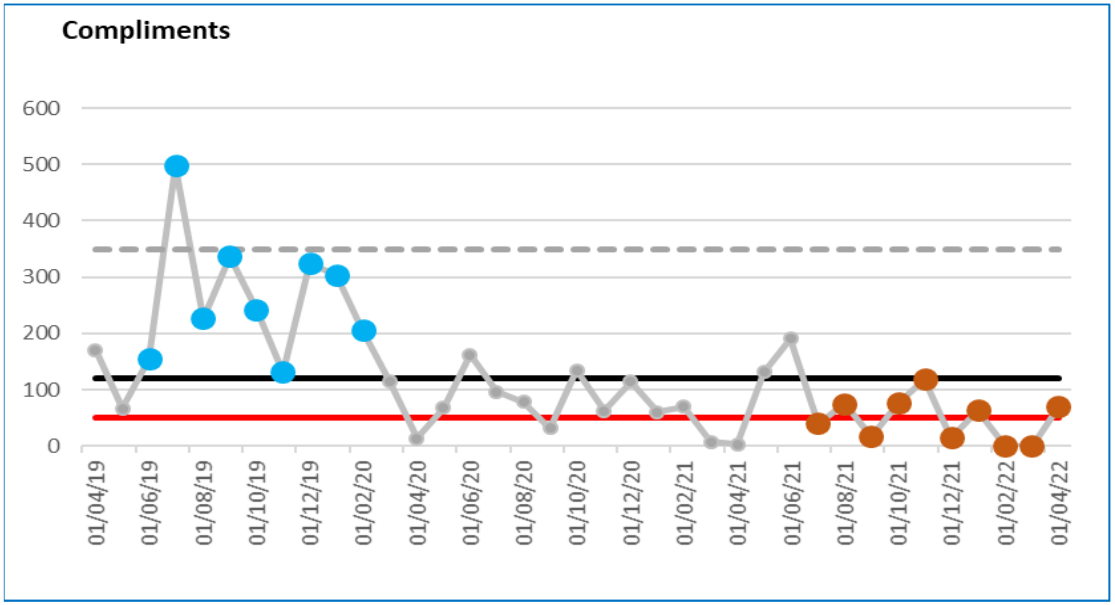
KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Group 2 metrics								
PPH over 1500mls	Apr 22	4%	none			4%	1%	7%
CTG training compliance midwives	Apr 22	94%	85%			69%	49%	89%
CTG training compliance doctors	Apr 22	93%	85%			75%	50%	99%
Still births	Apr 22	1	none			1	-2	3
Patients detained under MHA	Apr 22	3	none			1	-1	2
Patients detained under section 136	Apr 22	1	none			1	-2	3
Mental health patient incidents	Feb 22	16	none			11	-1	23
Mental health patient complaints	Apr 22	0	none			0	-1	1
Mental health patient PALS	Apr 22	1	none			1	-1	4
Patients with LD and Autism accessing inpatient services	Apr 22	29	none			25	2	47
Patients who died in their preferred place of death	Jan 22	54%	none			57%	21%	92%
C-DIFF Hospital onset healthcare associated	Apr 22	5	none			2	-3	7
C-DIFF Community onset healthcare associated (Acute Admissio	Apr 22	1	none			1	-1	3
C-DIFF Community onset indeterminate association (Acute Adm	Apr 22	0	none			1	-1	3
C-DIFF Community onset community associated (No acute conta	Apr 22	4	none			1	-3	5
Covid-19 new positive inpatients	Apr 22	172	none			139	-115	393
MRSA	Apr 22	0	0			0	0	1





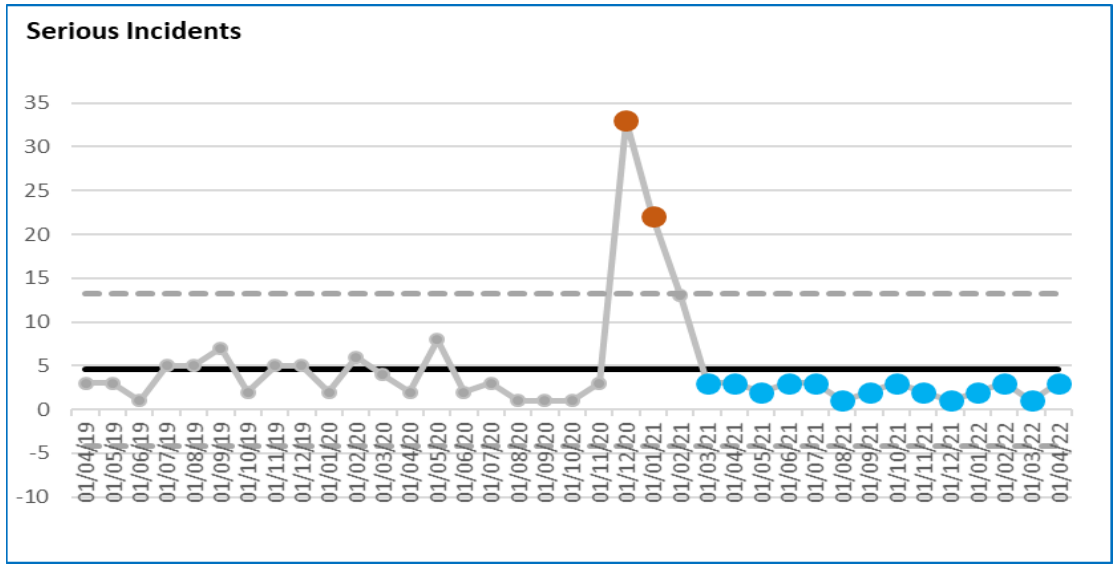
Apr-22
15
Variance Type
Common cause variation
Target
25
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Complaints	Common cause variation	Complaints increase reflects operational issues. Since October 2021 (137 open cases) we have seen a downward trend & we are now focused on eliminating the pandemic backlog.	113 cases outstanding. Objective to return to pre-pandemic levels.	Elimination of backlog of open cases is on track. To be at 60 open cases by June 2022.



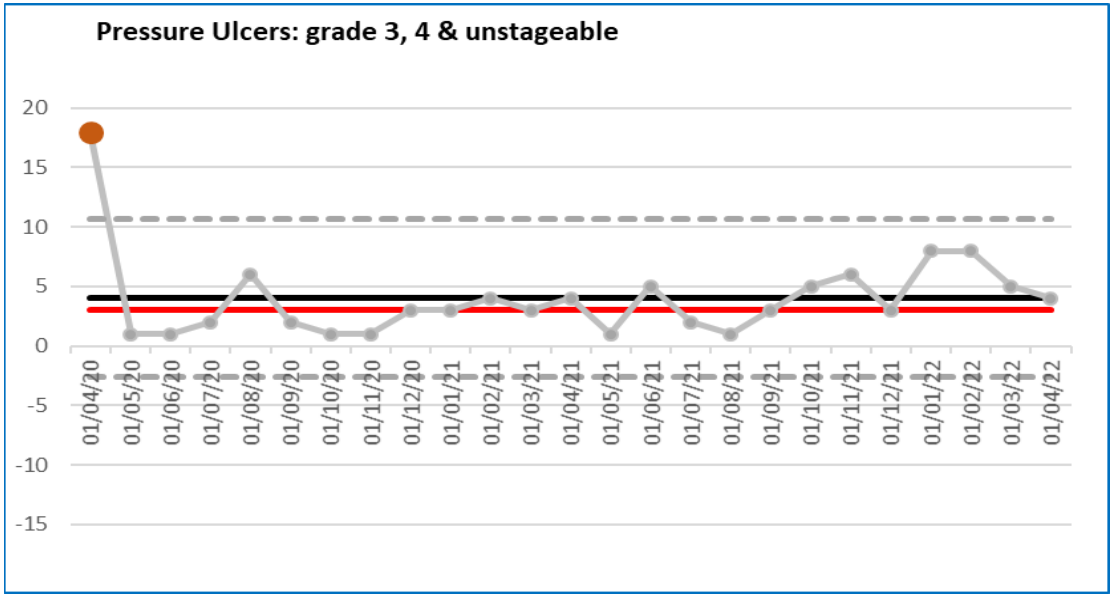
Apr-22
70
Variance Type
Special cause variation
Target
50
Target Achievement
Hit & miss target subject to random variation

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



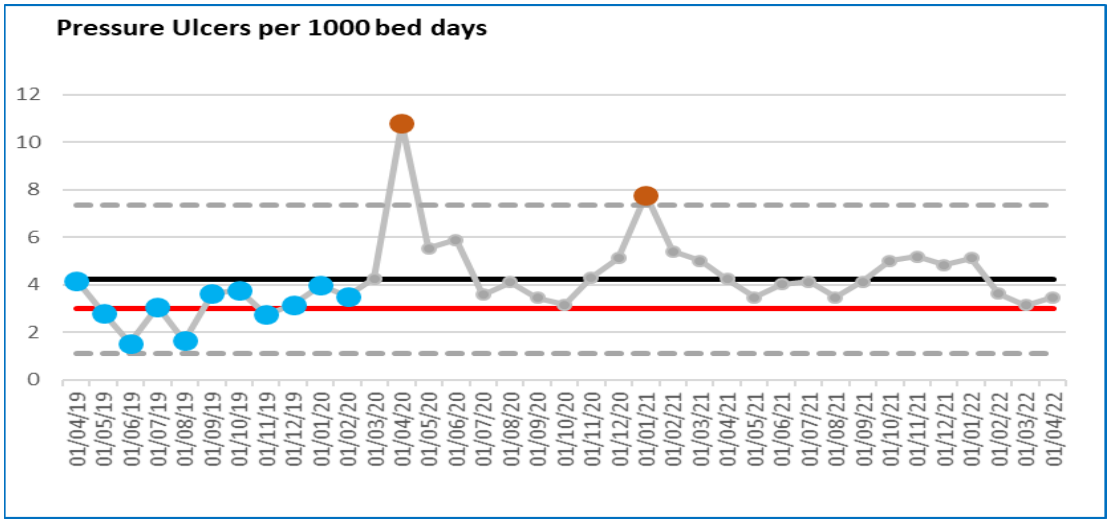
Apr-22
3
Variance Type
Special cause improving variation
Target
The trust does not have a target submission no. for SIs each month
Target Achievement
Our level of serious incidents reported per month is consistent

Background	What the chart tells us	Issues	Actions	Mitigation
Serious Incidents (SIs)	Trust reporting numbers for serious incidents raised each month is consistent & month on month	The significant spike seen during the winter 20/21 was associated with nosocomial Covid-19 hospital infections during wave 2 of the pandemic. We do not expect to see this replicated in future months. Where an incident meets the national reporting criteria to be raised externally as a serious incident (SI) it will be raised. There is no internally set target	Incident management group meets twice a week to review new incidents & those with completed investigations. During April 2022, the trust raised two SIs. In month, no SI were closed. The trust has 15 investigations for serious incidents open.	Daily local review of incidents by each divisional team is completed with appropriate second stage review at the incidents management group. IMG submits a monthly report on both incident themes & serious incidents onto the Patient Safety Group.



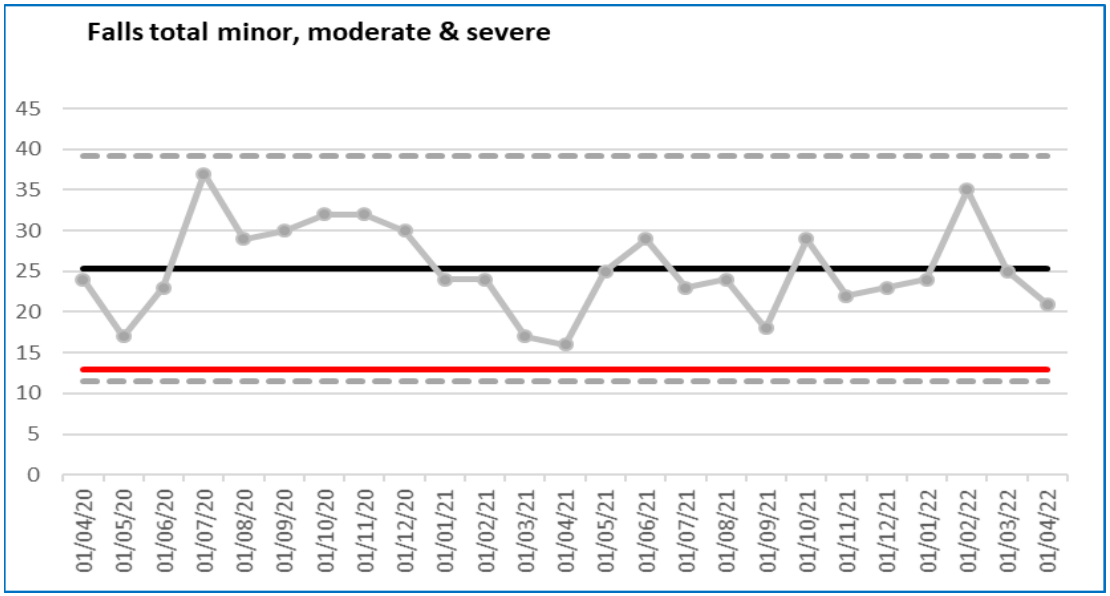
Apr-22
4
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers: grade 3, 4 & Unstageable	Common cause variation while hit & missing the target	Five moderate harms	Five moderate harms with ongoing investigation & remaining were minor harms. Four pressure ulcers were medical device related, attributable to O2 devices, ET tube, saO2 probe & sengstaken tube. TVNs will conduct an SSKIN audit & feedback will be provided to the ward manager & matron/ADDON for action planning.	The Trust has now 42 tissue viability link practitioners who are developing projects in their area around pressure ulcer prevention.



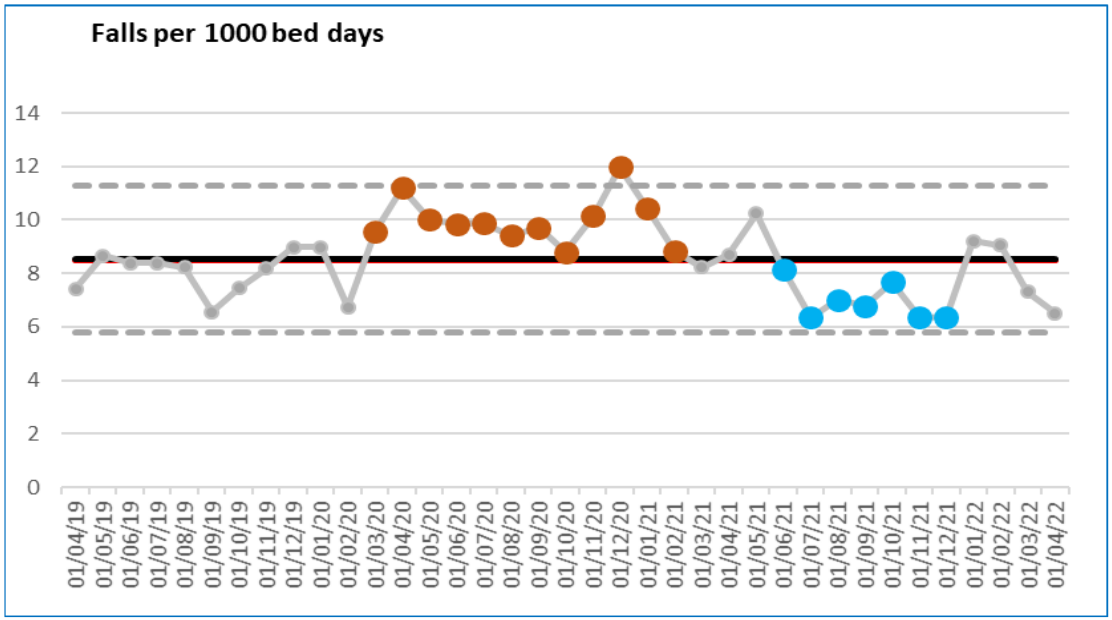
Apr-22
3.48
Variance Type
Common cause variation
Target
3
Target Achievement
Hit & missing target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Pressure Ulcers per 1000 bed days	Common cause variation while hit & missing the target	Five moderate harms	Five moderate harms with ongoing investigation & remaining were minor harms. Four pressure ulcers were medical device related, attributable to O2 devices, ET tube, saO2 probe & sengstaken tube. TVNs will conduct an SSKIN audit & feedback will be provided to the ward manager & matron/ADDON for action planning.	The Trust has now 42 tissue viability link practitioners who are developing projects in their area around pressure ulcer prevention. All pressure ulcer prevention resources are available via Alexnet, Youtube, ward folders & X drive.



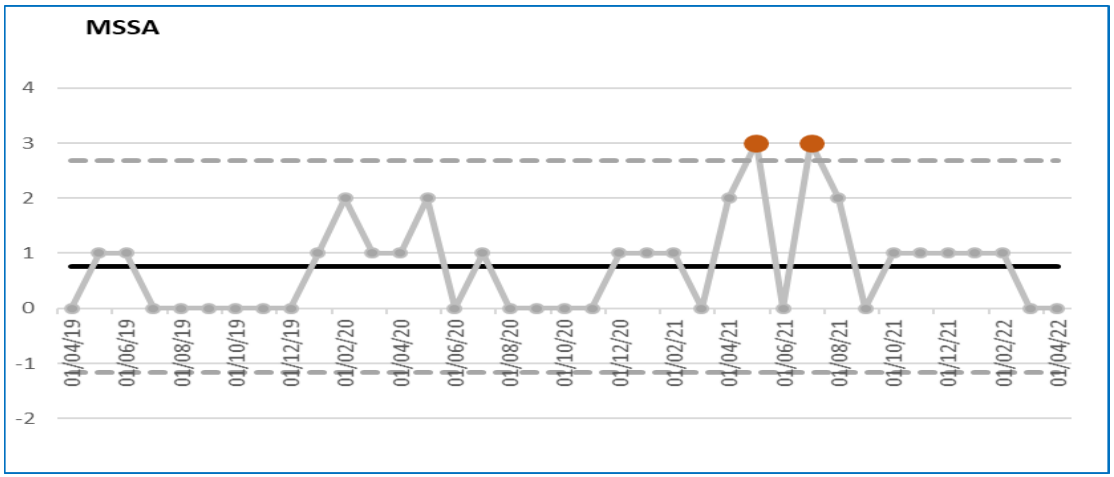
Apr-22
21
Variance Type
Common cause variation
Target
13
Target Achievement
Hit & miss target subject to random variation

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



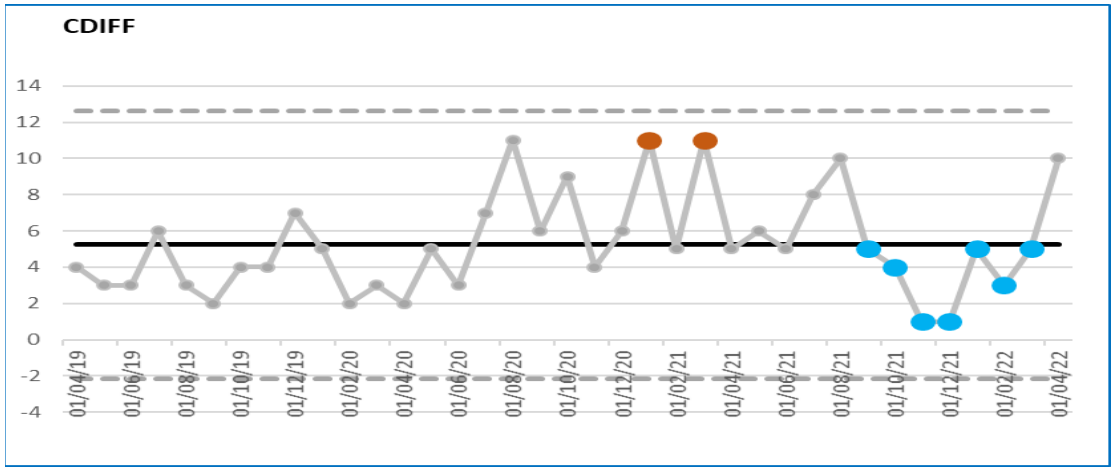
Apr-22
6.51
Variance Type
Common cause variation
Target
8.5
Target Achievement
Hit & miss target subject to random variation

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



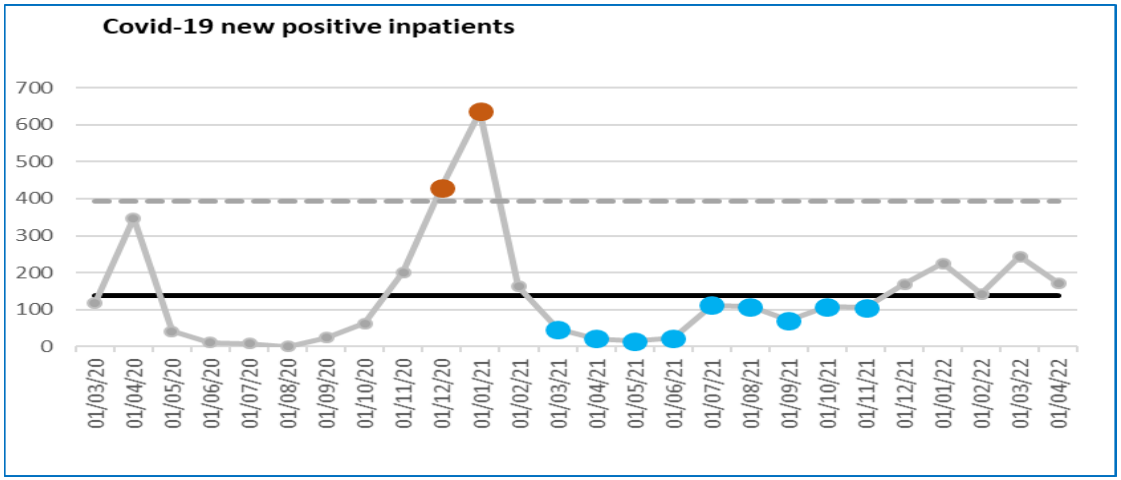
Apr-22
0
Variance Type
Common cause variation
Target
None
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
MSSA	Common cause variation	During 2021-2022 there has been a significant increase of cases of MSSA bacteraemia. In 2020-2021, there were a total of seven cases for the year, compared with 18 cases to date between April - January 2022.	RCA meetings have taken place to identify sources of infection. A significant proportion of cases appear to be linked to IV devices - therefore an action plan has been developed to focus on line care practice. This will include enhancing the existing training by working with the PDP team & Clinical Skills leads, additional refresher training for staff, prioritising ED initially, introduction of new online tool (clinicalskills.net, introduction of nursing documentation used for inpatient areas with the same Visual Infusion Phlebitis (VIP) scoring, provision of pre-recorded IPC presentation including a focus on accurate documentation & VIP scores for invasive devices, support from company representative for re-training on Octenasin wash & sharing of learning through HCGs.	1. Use of Octenisan body wash to reduce risk of skin colonisation 2. Safety alert to all staff regarding appropriate siting of cannulas, e.g avoid ante-cubital fossa where possible 2. Body map documentation 3. Surveillance & review of all cases to identify sources & share learning 4. Refresher training



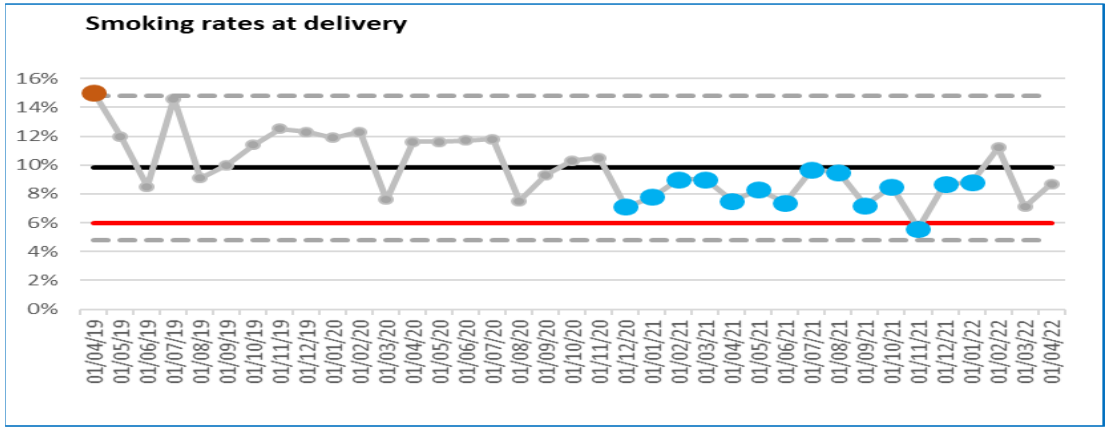
Apr-22
10
Variance Type
Common cause variation
Target
Not Set
Target Achievement
N/A

Background	What the chart tells us	Issues	Actions	Mitigation
C.difficile	Common cause variation	1. The Trust had a significant increase in cases since July 2020 2. The rise in cases is almost certainly associated with the pandemic & the increase in broad spectrum antibiotic prescribing (Cephalosporins); however there are likely to be a combination of factors involved including cleaning & hand hygiene / PPE. 3. Over the last few months the Trust has started to see a reduction in the Hospital Onset Health Care Associated (HOHA) cases, in comparison to the same time last year; the Community Onset Health Care Associated cases (COHA) are higher. 4. The Trust has now been set a threshold of 23 for 2021-22 (to include both HOHA and COHA cases); currently there has been a total of 30 cases.	A C.difficile recovery action plan implemented which focuses on ensuring compliance with: 1.Antimicrobial prescribing 2.Environment /cleanliness 3.Prompt isolation 4.Hand hygiene 5.PPE 6.Prompt stool specimen collection 7.Commode & dirty utility audits 8.Increased teaching / cascading of key messages /attending ward manager meetings/ PPE Champions 7.Introduction of sporicidal wipes for commode cleaning in all clinical areas 8.Ribo-typing of C.difficile specimens to support in detecting possible outbreaks or clusters of infection 9.RCA process to review cases and shared learning 10. There is a requirment for a focus on the COHA cases to understand at what point patients are acquiring C.difficile; this is a joint approach between the acute and CCG teams.	1. Monitoring of cases (Infection Prevention & Control Committee & Trust Dashboard) 2. RCA reviews of all cases; this is undertaken by the IPC Team, DIPC/Microbiology Consultant, Antimicrobial pharmacist, senior medical & nursing colleagues caring for the patient - shared learning is achieved through the reviews 3. Antimicrobial Stewardship Committee is responsible for the monitoring of antibiotic prescribing 4. IP&C Associate team in place who are supporting the IPC team in delivering the key messages 5. Appeals panel in place (led by CCG) to appeal against cases that have been considered to be 'unavoidable' 5. Although cases increased, severity of infection did not; there have not been any deaths where C.difficile has been the cause of death



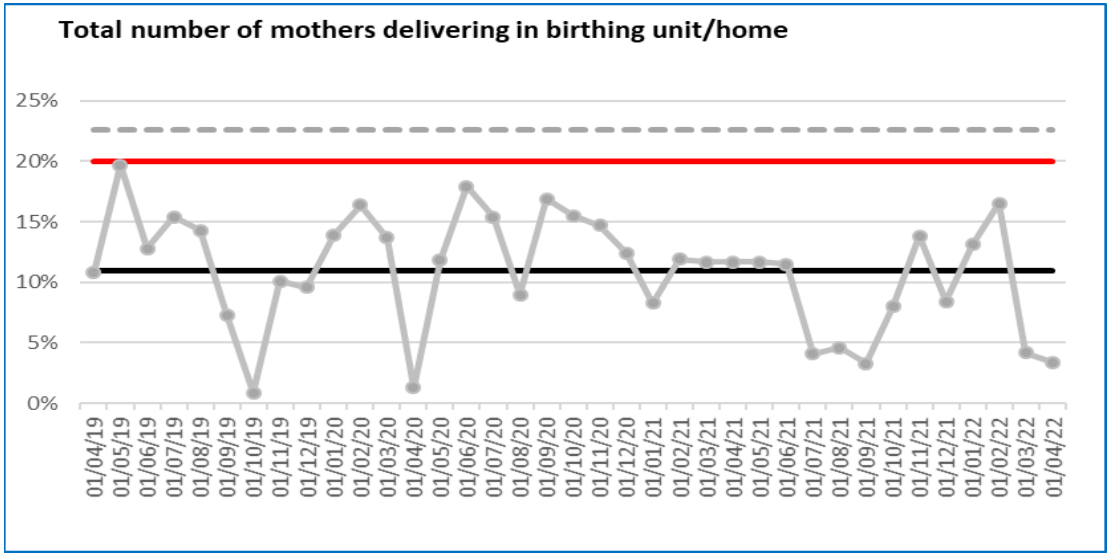
Apr-22
172
Variance Type
Common cause variation
Target
Target Achievement
Hit & miss target subject to random variation

Background	What the chart tells us	Issues	Actions	Mitigation
Covid-19 new positive inpatients	Common cause variation & inconsistently hit & missing target	Due to the Omicron being the dominant strain of SARS-CoV-2 (COVID-19) in the country, which was driving the peak in community cases, the Trust also saw a significant increase in the number of nosocomial COVID-19 cases in January. There were four outbreaks in January.	IPC Cell meets weekly; reviews data/trends/new guidance/pathways Outbreak meetings held wth representation for regional and CCG colleagues. IPC audits continue and reviewed at Cell IPC Team collecting data on all cases related to vaccination status. Visitor restrictions in place	1. All measures in place relating to screening on admission & every 48 hours thereafter & monitoring for signs & symptoms of COVID-19 2. All other IPC measures in place, e.g screens between beds, patients encouraged to wear masks, standard precautions, restricted visiting, cleaning protocols 3. Regular outbreak meetings following declaration of outbreak to agree & monitor actions including: Screening of staff and patients, increased observations/audits of practice, emphasis on hand hygiene, decontamination, cleaning & restricted visiting.



Apr-22
8.7%
Variance Type
Special cause variation
Target
6%
Target Achievement
Hit and miss target subject to random variation

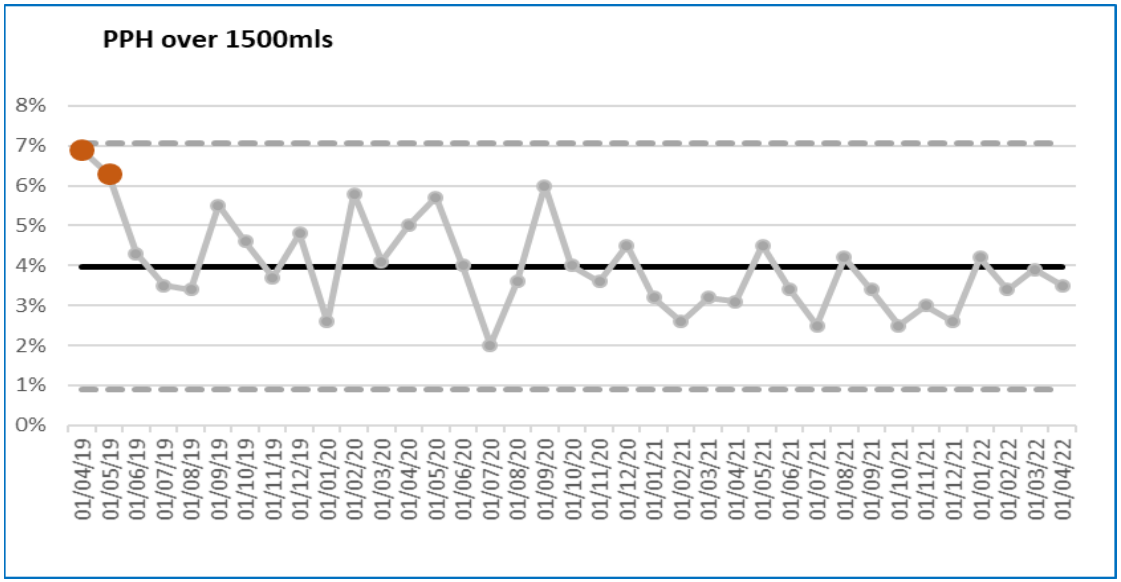
Background	What the chart tells us	Issues	Actions	Mitigation
Smoking rates at delivery	Special cause variation and inconsistently hit & missing target	Smoking rates at delivery	The smoking at delivery rate for April 22 was 8.7%, compared to the target of <6% as set by the LMNS	A Healthy Lifestyles midwife is in post, with the remit, of improving services and pathways for smoking in pregnancy. We are also recruiting a Band 3 Maternity stop smoking advisor to provide an in house stop smoking service rather than to refer all women externally to PROVIDE. We have recently added a new field to COSMIC to electronically document women's smoking status at around 36 weeks gestation. This will give an additional opportunity to look for any trends and may assist with targeting women who need additional support from the Healthy Lifestyles midwife prior to delivery.



Apr-22
3.4%
Variance Type
Common cause variation
Target
20%
Target Achievement
Hit & miss target subject to random variation

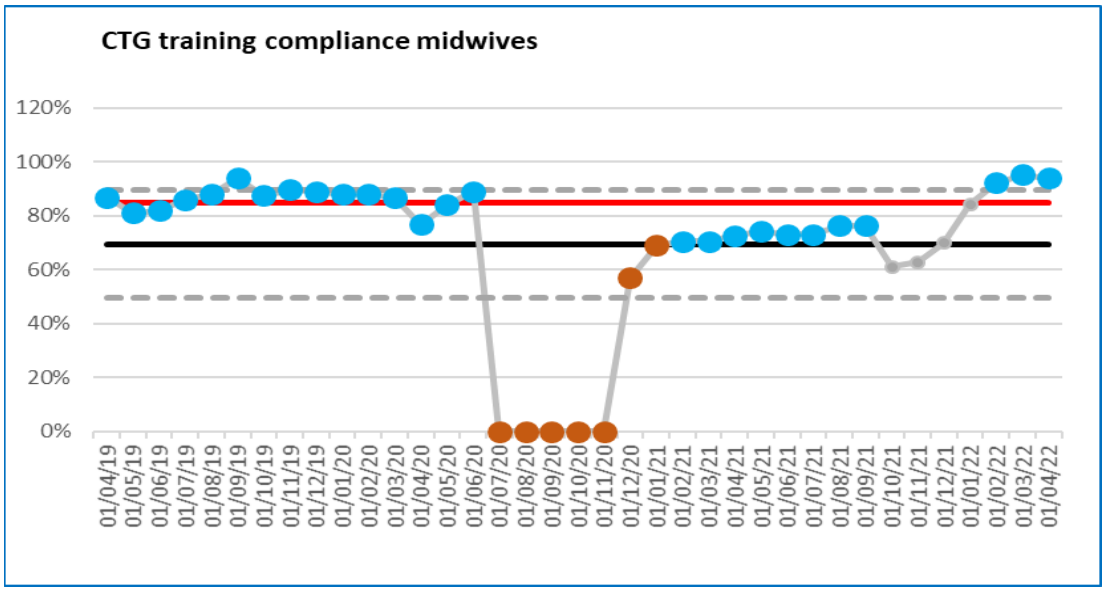
Background	What the chart tells us	Issues	Actions	Mitigation
Total no. of mothers delivering in birthing unit/home	Common cause variation & hit & missing target	Mothers delivering in birthing unit/home	2.7% of women were recorded as having had a home birth in April 22 and Birth Unit deliveries were 2.4% (3.4% in total), compared to a target of 14.4%	to the most appropriate area in terms of maintaining safe staffing levels – resulting in periodic closure of the Birth Unit to maintain safe staffing

Patients



Apr-22
3.50%
Variance Type
Common cause variation
Target
Not set
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
PPH over 1500mls	Common cause variation	PPH over 1500mls	The massive PPH rate for April 22 was 3.5%, compared to the target of <2.9%.set by the LMNS	A new Labour Admission PPH checklist is currently out for peer review following feedback from staff and suggested improvements All massive obstetric haemorrhages are reviewed to ensure the appropriate management was followed, including a thematic review of high risk factors e.g. precipitate delivery, how many hours on oxytocin, fibroids, Hb at booking, IOL, multiple pregnancy. This is monitored to ascertain if any trends are



Apr-22
94.0%
Variance Type
Common cause variation
Target
85%
Target Achievement
Hit & miss target subject to random variation

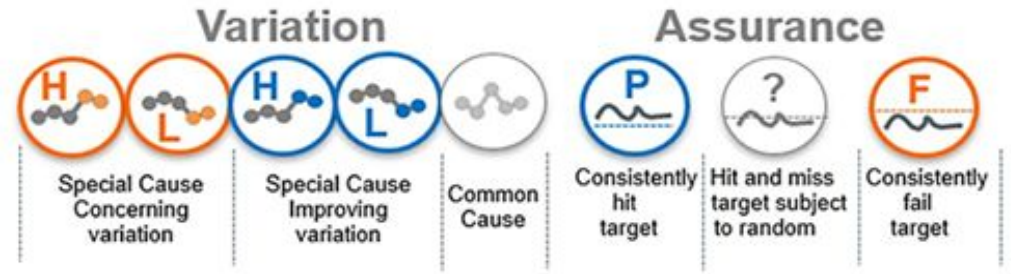
Background	What the chart tells us	Issues	Actions	Mitigation
CTG training compliance midwives	Common cause variation & inconsistently hit & missing target	Compliance with CTG training for midwives below trajectory	The Midwives CTG Training compliance rate has increased significantly, to 92.2% for February (163/173 midwives).	The CTG Specialist Midwife has a plan in place, and is on trajectory, to achieve full compliance by the end of March 2022.

Places

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

Places Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Facilities	Vacacy rate is reducing with ongoing recruitment of housekeepers. Issues however with the recruitment of 3 chefs being impacted by the national shortage of Chefs	For information	ongoing
	Trial of electric vehciles in the transport department comenced on 25/4/2022 for 6 weeks	For information	ongoing
	Zoning of car parks and CCTV project commenced	For information	ongoing
Estates & Capital	Development feasibility works for **Maternity ward** refurbishment stage 1 report and budget costings on options provided to HCG for approval	For information	ongoing
	Aseptic Suite feasibility works progressing based on Arundel House as a final option	For information	ongoing
	75 schemes completed as part of our winter pressure funding, enhancing our patient experience across site	For information	ongoing
	Mothballing **Parndon Hall** has been agreed with the conservation officer	For information	ongoing

KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Estates Responsiveness (Priority 2 - Urgent)	Apr 22	97%	95%			95%	91%	99%
Meals Served	Apr 22	42923	42120			37069	25648	48489
Catering Food Waste	Apr 22	4%	4%	L		5%	-1%	10%
Domestic Services (Cleaning) Very High Risk	Apr 22	99.0%	98.0%	H		97.7%	94.4%	101.0%
Domestic Services (Cleaning) High Risk	Apr 22	98.0%	95.0%			96.7%	93.4%	100.0%



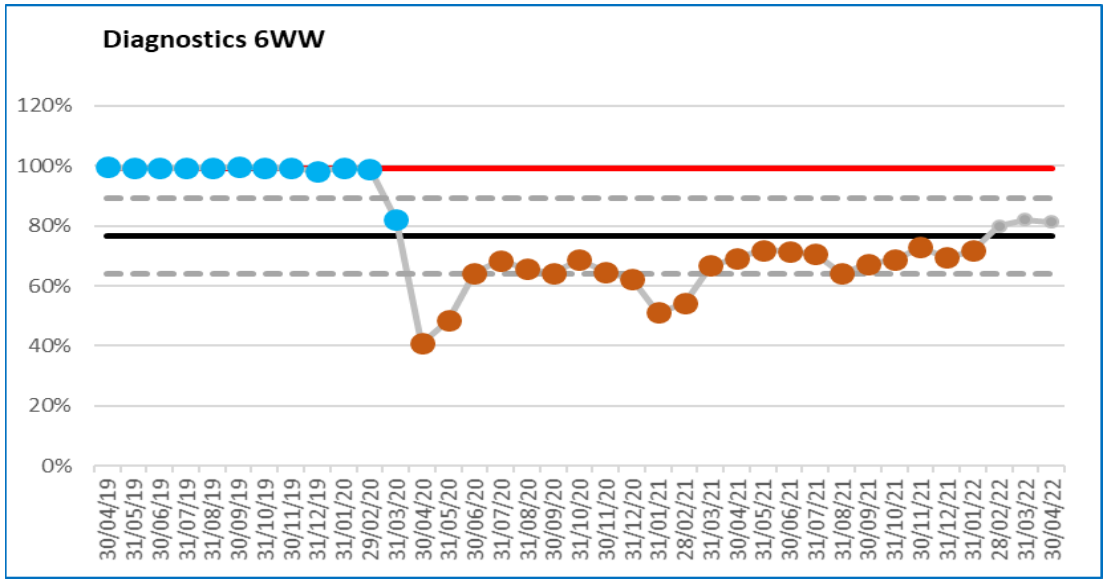
Performance

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

Performance		Board Sub Committee: Worforce Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Urgent Care	The Urgent care departments continue to see increased demand with 50% of the demand being minor attendances. There is continued improvement plans being developed & imlemented with Executive oversight through Urgent Care Board and the CQC Quality Project workstream. The national discharge programme focussed on external partner discussions this month.	For increased visibility and awareness	
Cancer	2wek wait performance improved over the past two months and further improvements seen in latest month. Further work on the 28 day faster diagnosis standard is supported by an improvement project manager and using the nation CQUIN to further emphasise this important clinical standard. 62 day cancer performance is low due to the continued treatment of patients that have breached 62 days due to Covid restrictions in capacity. The backlog has decreased in	For increased visibility and awareness	
Referral to Treatment	The Trust continues to book admitted patients in priority order and is currently focussing on ensuring that there are no patients waiting longer than 104 weeks by 30th June and that all Priority 2 patients (cancer & urgent) are booked within a month. Additional elective theatre capacity should be available in June & July due to anaesthetic recruitment although there is still limited critical care capacity for elective treatments. Out-patient improvements in utilisation, virtual apppointments and pathway innovations such as pIFU and virtual fracture clinic continuing to be delivered. An over-arching RTT recovery plan is being drawn up with monthly stretch trajectories.	For increased visibility and awareness	
Diagnostics	Significant improvements in radiology modalities due to smart booking and additional insourced capacity are helping to support improveed performance despite a significant increase in diagnostic referrals. A demand and capacity modelling project supported by external consultants will enable a sustainable capacity analysis for each modality across all services to feed into the overall RTT recovery plan.	For increased visibility and awareness	

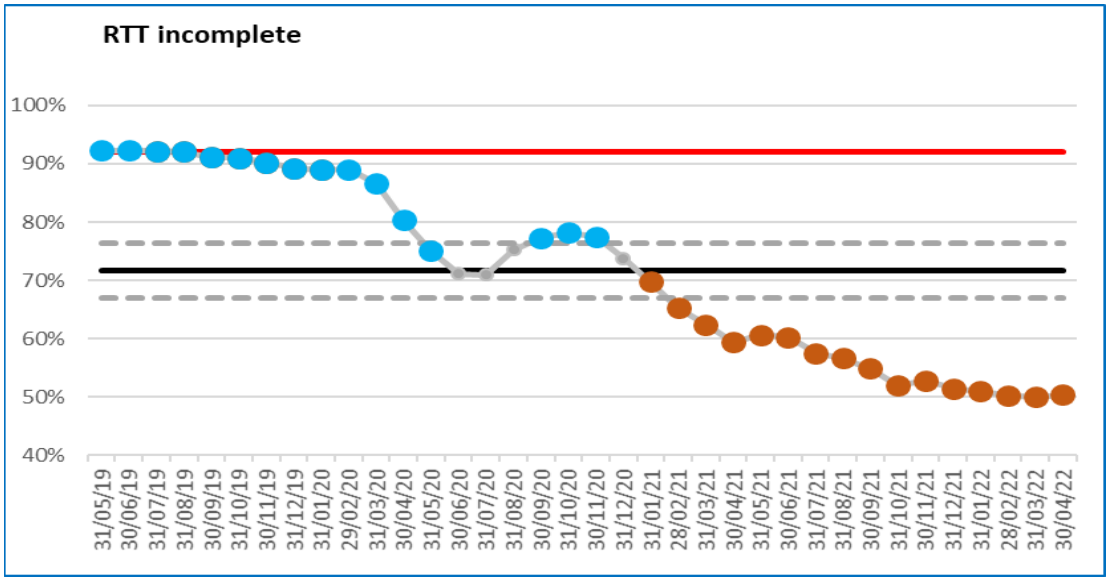
KPI	Latest month	Measure	Target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 1 metrics								
RTT incomplete	Apr 22	50%	92%			72%	67%	76%
RTT admitted	Apr 22	39%	90%			52%	26%	78%
RTT Non admitted	Apr 22	81%	95%			87%	84%	90%
RTT PTL vs RTT PTL & ASIs	Apr 22	82%	none			93%	91%	96%
Cancer 31 days First	Mar 22	94%	96%			94%	86%	102%
Cancer 31 days Subsequent Drugs	Mar 22	100%	98%			98%	90%	107%
Cancer 31 days subsequent surgery	Mar 22	60%	94%			91%	55%	127%
Cancer 2WW	Mar 22	77%	93%			81%	62%	100%
Cancer 62 day shared treatment	Mar 22	58%	85%			68%	48%	88%
Cancer 62 day screening	Mar 22	50%	90%			66%	16%	116%
Cancer 62 Day Consultant Upgrade	Mar 22	75%	90%			84%	65%	104%
Cancer 28 day faster diagnosis	Mar 22	69%	none			66%	50%	82%
4 Hour standard	Apr 22	64%	95%			74%	66%	82%
ED attendances	Apr 22	11406	none			9008	7025	10992
ED Admitted performance	Apr 22	23%	95%			47%	31%	63%
ED non admitted performance	Apr 22	70%	95%			82%	74%	90%
ED Arrival to Triage	Apr 22	59	15			47	30	64
ED Triage to examination	Apr 22	155	60			97	74	119
ED Examination to referral to specialty average wait	Apr 22	131	45			102	89	114
ED referral to be seen average wait	Apr 22	79	30			79	57	102
Seen by specialty to DTA	Apr 22	113	60			96	76	117
DTA to departure	Apr 22	416	30			216	100	332
Ambulance handovers less than 15 minutes	Apr 22	16%	100%			26%	14%	38%
Ambulance handovers between 15 and 30 mins	Apr 22	35%	0%			41%	33%	49%
Ambulance handovers between 30 and 60 mins	Apr 22	29%	0%			22%	13%	32%

KPI	Latest month	Measure	National target	Perfomance	Assurance	Mean	Lower process limit	Upper process limit
Performance Group 2 metrics								
Ambulance handovers > 60 mins	Apr 22	20%	0%	H	F	11%	1%	21%
Diagnostics 6WW	Apr 22	81%	99%		F	77%	64%	89%
Occupied beds with stranded patients	Apr 22	167	80	H	F	150	100	199
Bed occupancy	Apr 22	86%	85%		?	88%	81%	96%
Discharges between 8am and 5pm	Apr 22	709	none	L		717	479	956
Discharges between 5pm and 8am	Apr 22	742	none			700	430	970
LOS non elective	Apr 22	5.2	5.1	H	P	3.9	3.0	4.8
LOS elective	Apr 22	3.5	4.2		P	2.3	0.6	4.0
Short Notice clinical cancellations	Apr 22	14	none			43	-31	118
OP new to follow up ratio	Apr 22	2.1	2.3		?	2.1	1.8	2.5
OP DNA Rate	Apr 22	5.2%	8.0%	H	P	4.8%	3.6%	6.0%
52 Week waits	Apr 22	1818	0	H	F	791	501	1080
Proportion of Majors Patient treated within 4 hours in ED Paeds	Apr 22	63%	95%	L	?	80%	64%	96%
Super stranded patients	Apr 22	60	25	H	?	44	18	70
12 Hour waits in ED from Arrival	Apr 22	1088	0	H	F	513	200	825
12 Hour Trolley waits in ED from DTA	Apr 22	210	0	H	?	73	-9	156



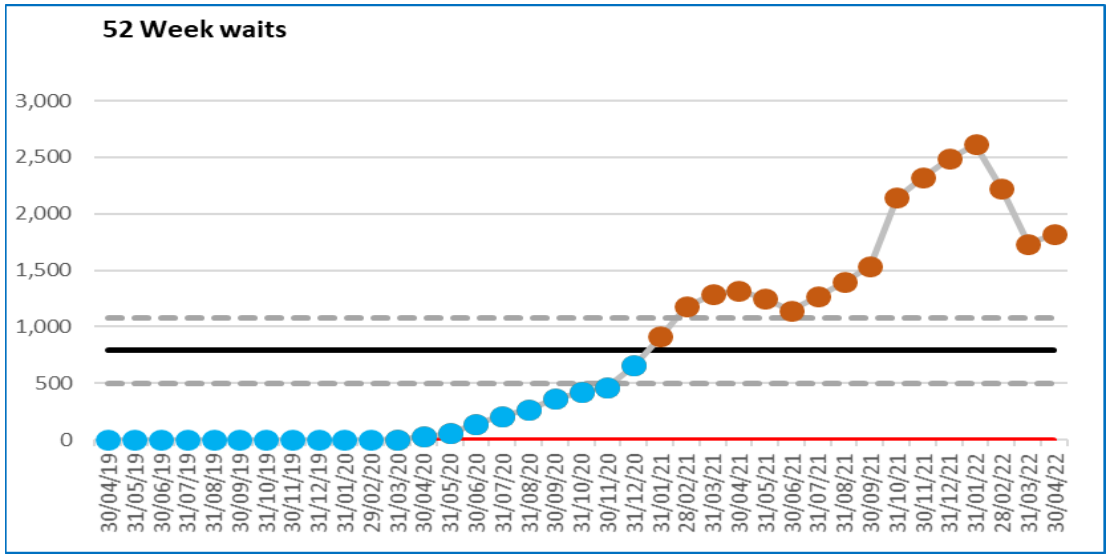
Apr-22
81.29%
Variance Type
Special cause variation
Target
99.00%
Target Achievement
Consistently failing target

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



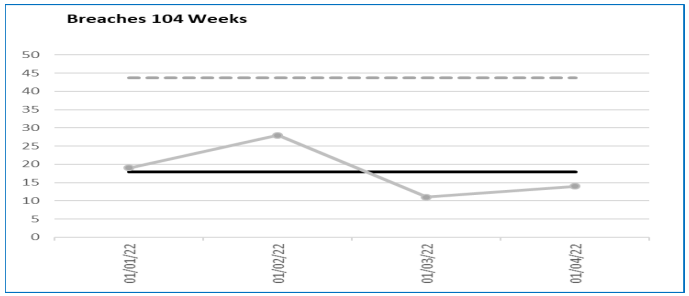
Apr-22
50.4%
Variance Type
Special cause variation
Target
92%
Target Achievement
Consistently failing target

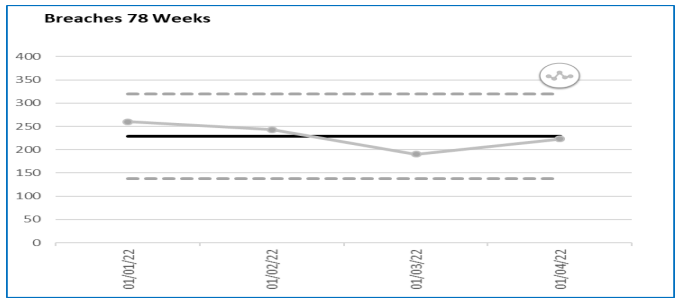
Background	What the chart tells us	Issues	Actions	Mitigation
RTT Incomplete	Special cause concerning variation and consistently failing target	The performance against the RTT standard has been below the target and statistical mean for 12 months as a result of covid activity pressure pausing elective activity which created a backlog of patients waiting longer than 18 weeks for first definitive treatment. The balance of emergency, elective and recovery remains an ongoing challenge	Admitted backlog being booked & treated in clinical order not chronological. Elective bed capacity hascontinued to be available but critical care capacity is limited and causing a few cancellations. Insourcing operating in place and virtual & face to face clinics & additional sessions being put on. Additional valiadtion resources cleansing the waiting lists. Weekly oversight from healthcare groups. All specialties remain under constant review & clinical harm review process in place.	Admitted backlog clinically prioritised. Non admitted - clinical priority booking at sub specialty level. Clinical Reviews of long waiting patients & harm reviews being put into place.

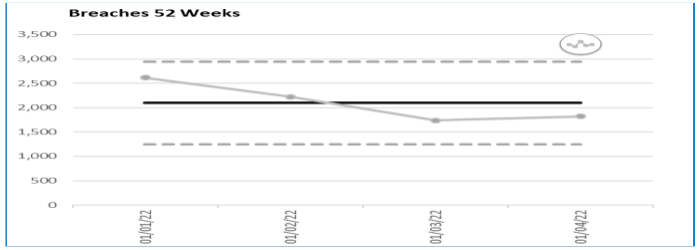


Apr-22
1818
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
52 week waits	Special cause concerning variation and consistently failing target	Booking in clinical priority order instead of chronological order has led to increasing numbers of long waiting lower priority patients. Balance between emergency & elective capacity is an ongoing challenge. Challenge of anaesthetic workforce availability restricting the number of elective lists.	Patients that will be over 104 weeks by 30/6/22 booked along with urgent & cancer patient as a priority. Close review of P2 priority admitted patients to ensure timely treatment. ICS bid for 22/23 elective recovery capital accepted an two options for a segregated elective hub being drawn up. Admitted & non admitted demand & capacity work being finalised to inform recovery plan for 22/23 by 30/6/22.	Clinical review of long waiting patients being implemented with interim & treatment harm review process to monitor for potential harm. Numbers of patients over 78 weeks reducing & potential patients over 104 weeks all have appointments/treatment plans.



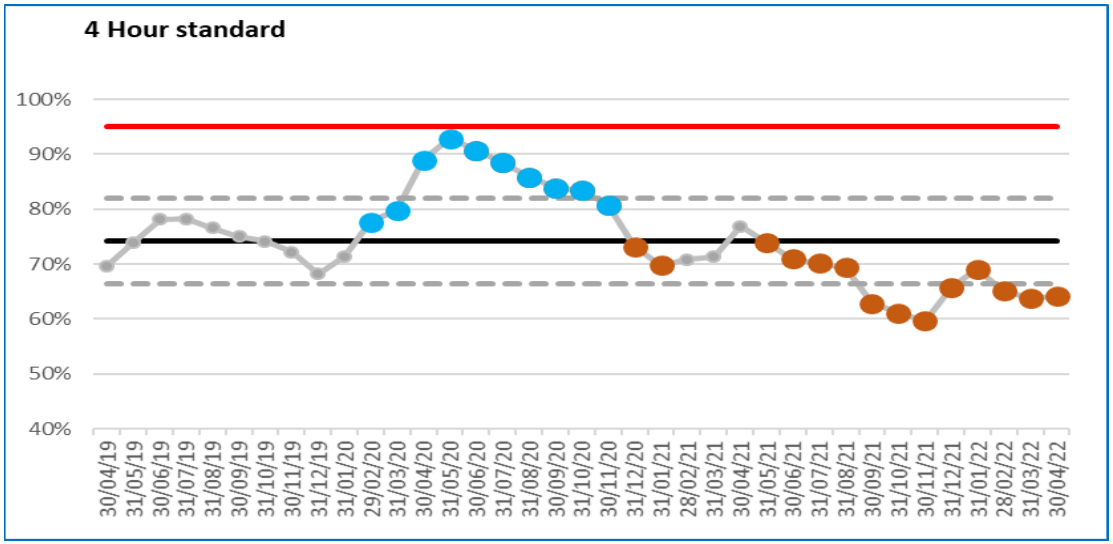




Apr-22

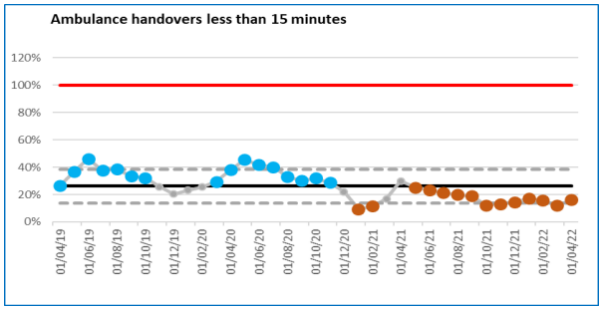
Variance Type
Special cause variation
Target
0
Target Achievement
Consistently failing target

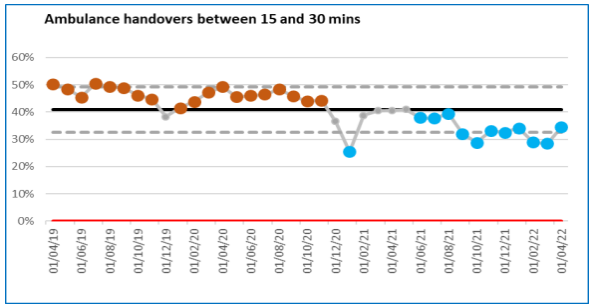

Background	What the chart tells us	Issues	Actions	Mitigation
Breaches	Special cause concerning variation and consistently failing target	Booking in clinical priority order instead of chronological order has led to increasing numbers of long waiting lower priority patients. Patients are more complex and require longer post operative care. Challenge of anaesthetic workforce availability restricting the number of elective lists & access to critical care.	Daily review of 104week patients at divisional and corporate level. Over-arching recovery plan with improvement trajectories in development - to include finalised job plans, refreshed O/P demand & capacity, additional validation of waiting lists, communication with long waiting patients, ICS Access Policy being drafted, improved theatre utilisation, in-sourcing where available.	Weekly review of long waiting patients, Clinical harm review process, close review within debisions at patient level.

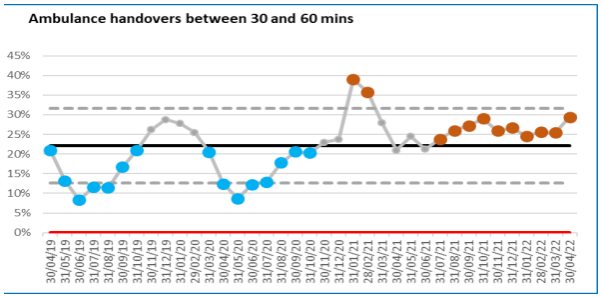


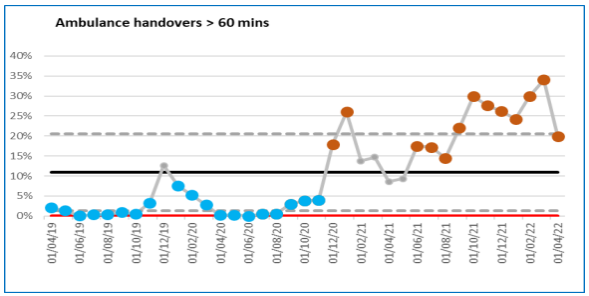
Apr-22
64.10%
Variance Type
Special cause variation
Target
95%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Four hour standard	Special cause concerning variation and consistently failing target	The performance against the four hour standard has been consistently below the statistical mean for four months & close to the lower control limit. Significant increases in attendances has exacerbated the pressure on the emergency pathways.	Executive and Healthcare group oversight continues through the Urgent Care Board & CQC Quality Project workstream. Internal, ICS, Regional and national discussions taking place to support the increase in patients. The Urgent Treatment Centre was moved to an alternative location to stream all walk-in attendances to appropriate services reducing pressure in the Emergency Department . Implementing processes to meet national requirement of 50% decrease in the number of patients without criteria to reside to improve flow.	Safety huddle in ED 3 times a day to review safety and pressure in the department and to escalate where additional support is required. Additional UTC hours & services. SDEC unit developed OPEL status and reviewing demand and capacity to support urgent care. Weekly regional discussion on pressure points. Evening ICS system call to support emergency areas out of hours.



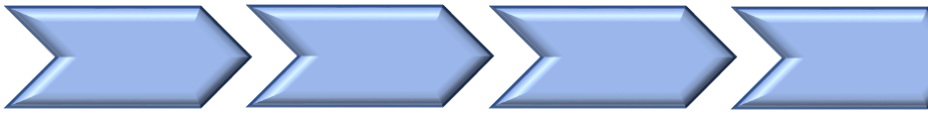


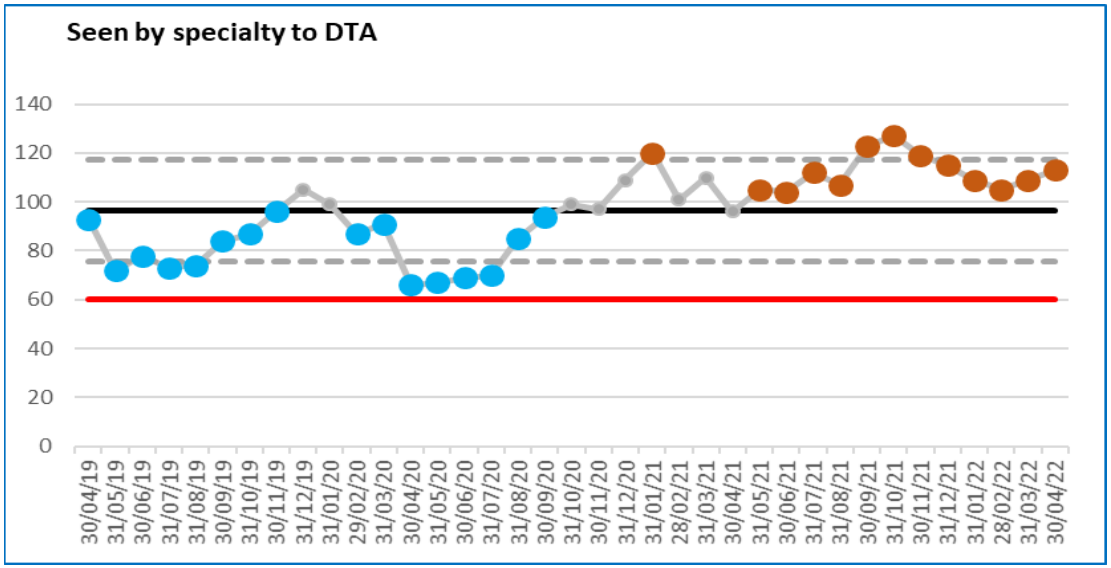




Apr-22
29.40%
Variance Type
Special cause variation
Target
0%
Target Achievement
Consistently failing target

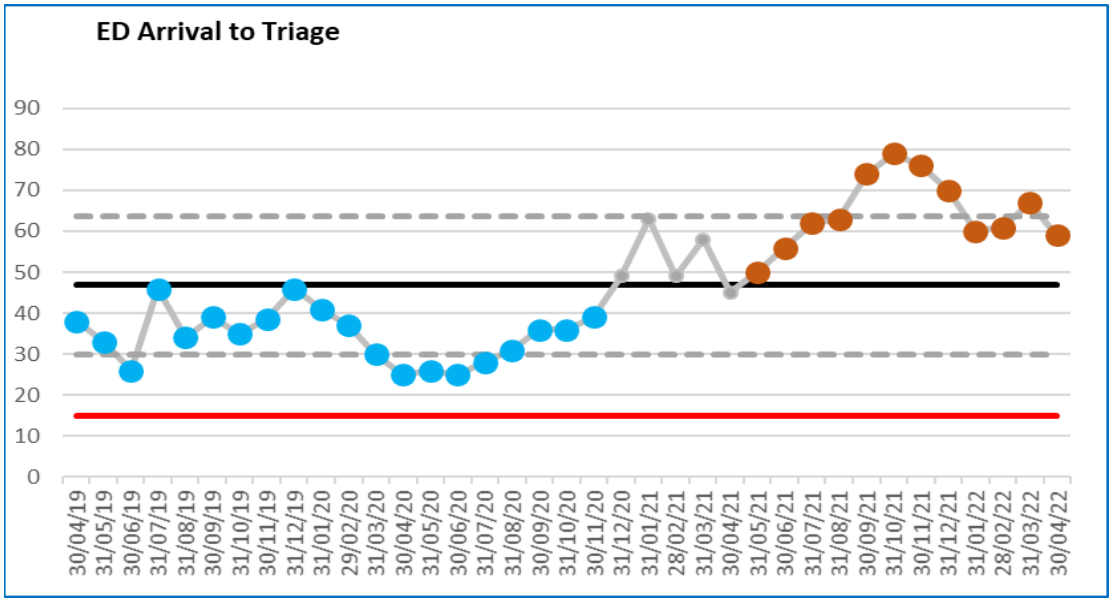
Background	What the chart tells us	Issues	Actions	Mitigation
Ambulances handovers between 30 and 60 minutes	Special cause concerning variation and consistently failing target	The % of ambulance conveyances over 30 minutes has increased above the statistical average. Increased ambulance activity, increased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





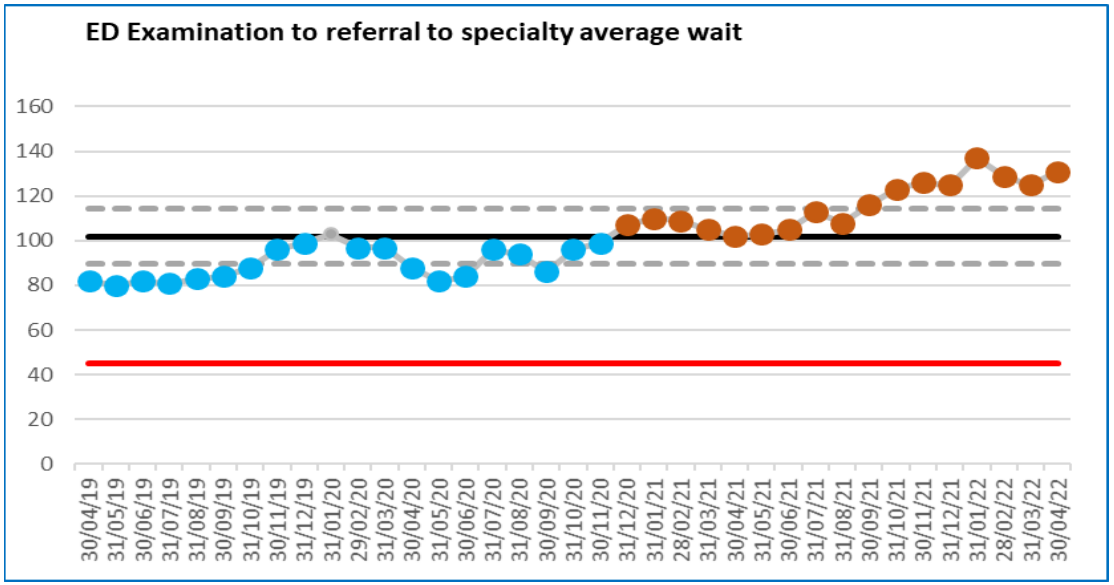
Apr-22
113 minutes
Variance Type
Special cause variation
Target
60 minutes
Target Achievement
Consistently failing target

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



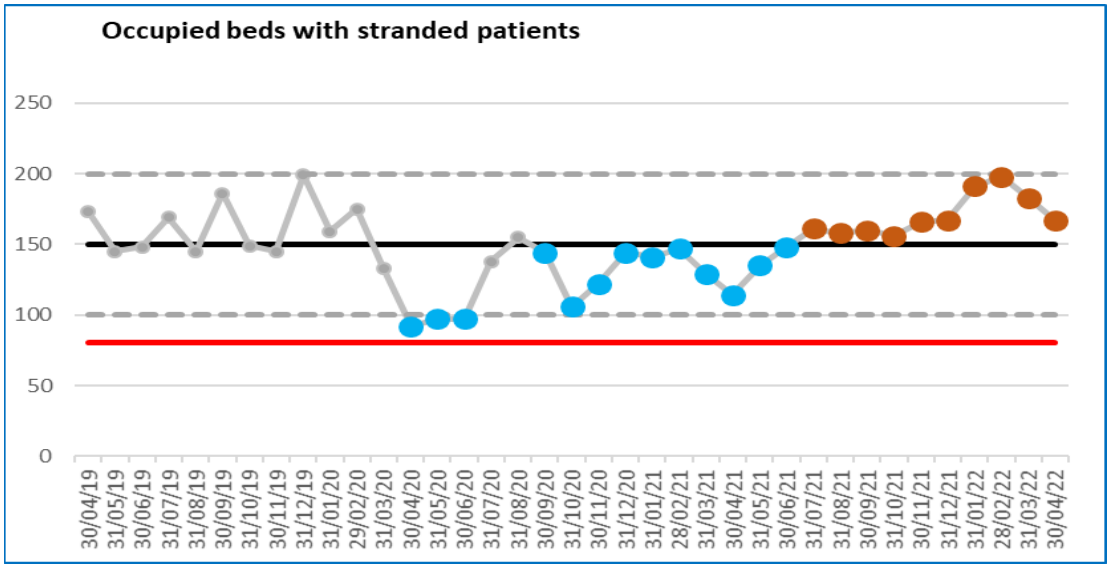
Apr-22
59 minutes
Variance Type
Special cause variation
Target
15 minutes
Target Achievement
Consistently failing target

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



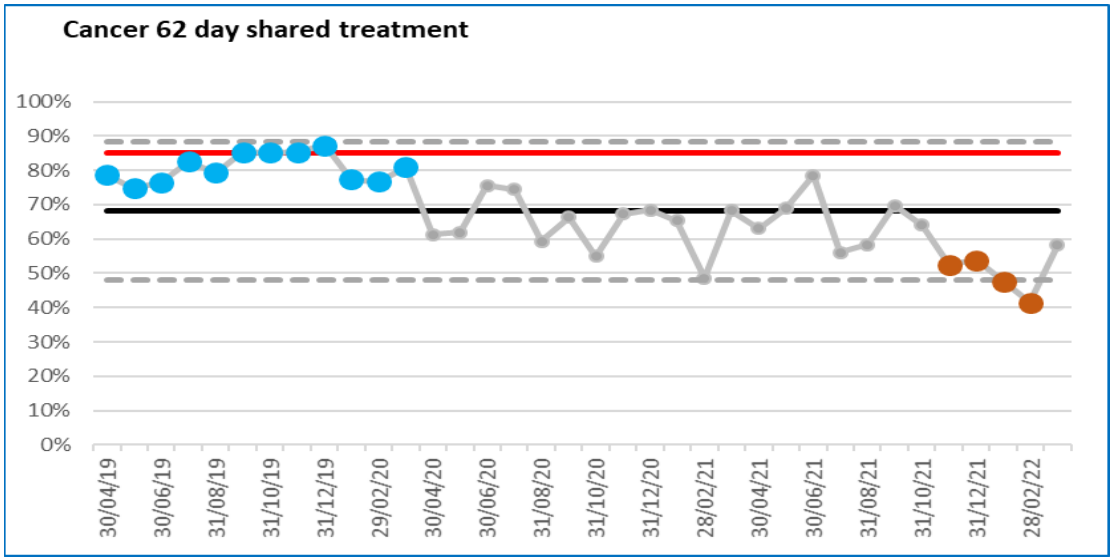
Apr-22
131 minutes
Variance Type
Special cause variation
Target
45 minutes
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
ED examination to referral to specialty average wait	Special cause concerning variation and consistently failing target	The average time from being seen by specialty to decision to admit has been consistently increased over the statistical average for 9 months	IPPS measurements of performance through Urgent Care Board. Divisional attendance at ED Huddles being monitored and escalated.	Close review through breach analysis at Urgent Care Board



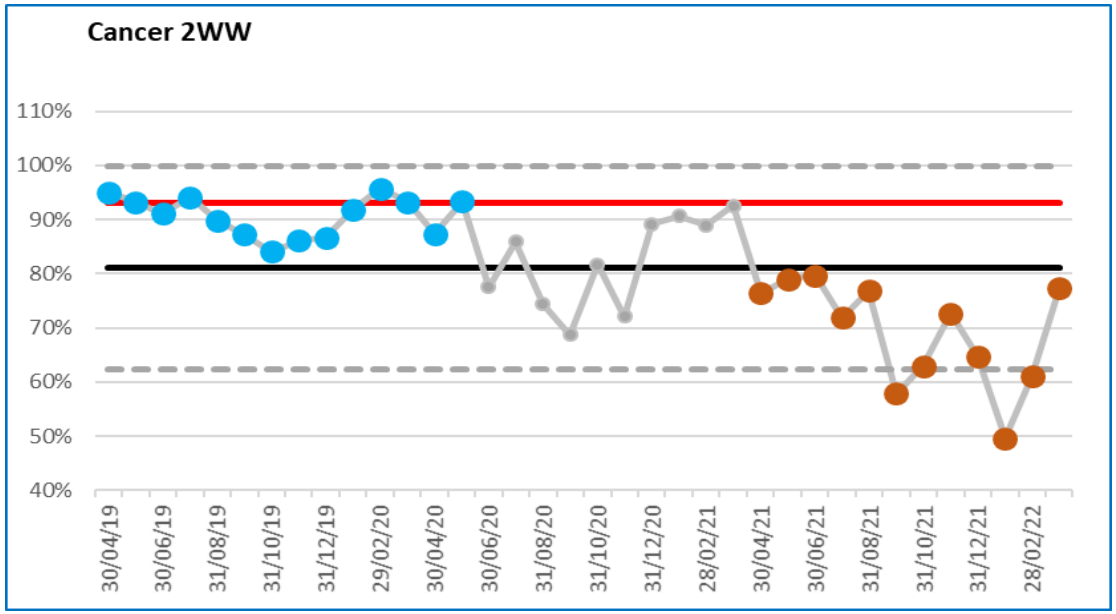
Apr-22
167
Variance Type
Special cause concerning variation
Target
80
Target Achievement
Consistently failing target

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



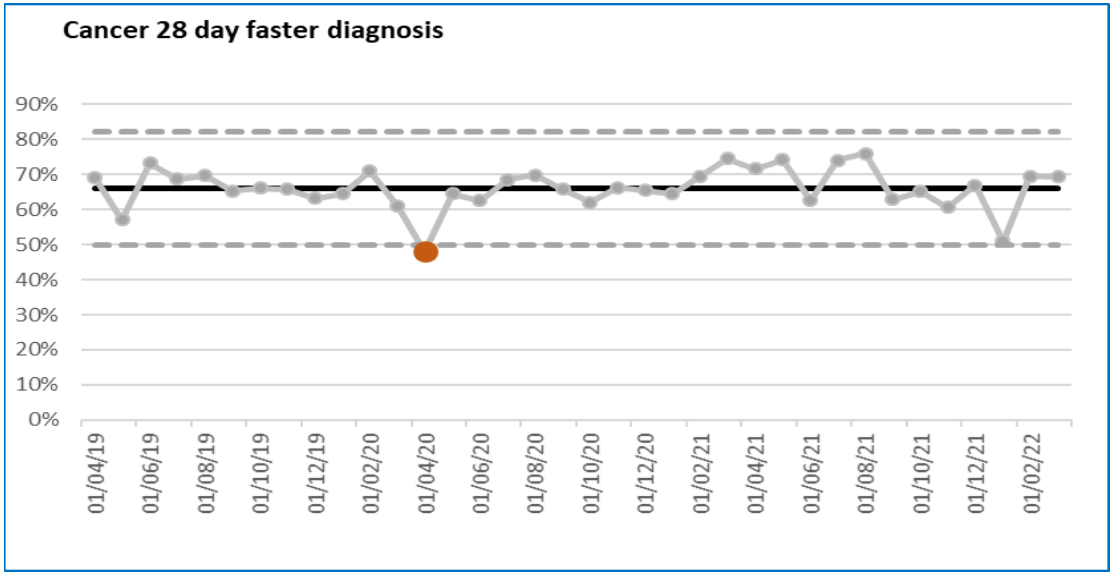
Mar-22
58.20%
Variance Type
Common cause variation
Target
85%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 62 day shared treatment	Common cause variation and hitting and missing target radomly	The performance against the target has failed for over 12 months.	The Trust has continued to focus on diagnosing & treating the backlog of patients that developed over the Covid period & the 62 day performance reflects the increased numbers of patients treated after 62 days in their pathway. Maintained daycase and limited in-patient operating capacity to support cancer & urgent elective patients. The Trust's recovery trajectory has been submitted with the 22/23 plan and aims to be back to national performance in September 2022	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting. Prioritisation of cancer patients in booking diagnostics & treatments. Clinician discussions at Cancer Board to escalate concerns and review cancer conversion rates which remain steady.



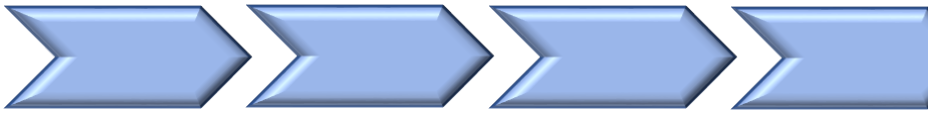
Mar-22
77.43%
Variance Type
Special cause concerning variation
Target
93%
Target Achievement
Inconsistently passing and falling short of target

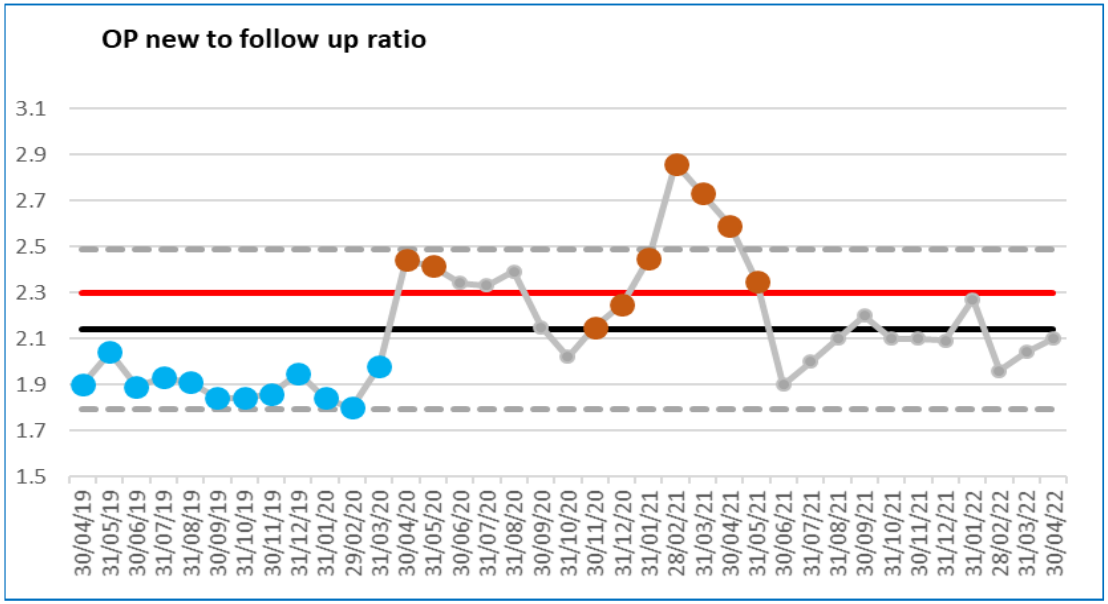
Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 2 week wait	Special cause concerning variation & inconsistently passing and falling short of the target	Ongoing increased referrals in February - 11% higher than January	Dermatology routine slots utilised for 2ww capacity, reduced 2ww ASIs in February 2022. Colorectal pathway improvements in place. Breast additional capacity in place. Significant improvements in April (unvalidated) performance as capacity is maximised with lower staff absence levels.	Close review of 28 day diagnosis standard for each tumour site failing 2ww. Dermatology achieving 62 day performance. Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to Cancer Board & executive reporting.



Mar-22
69.30%
Variance Type
Common cause variation
Target
Target Achievement
Consistently failing target

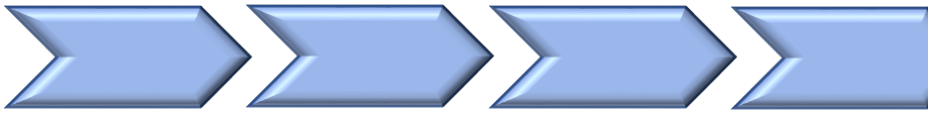
Background	What the chart tells us	Issues	Actions	Mitigation
Cancer 28 day faster diagnosis	Common cause variation and hitting and missing target radomly	The performance against the target has failed for over 12 months.	28 day Faster Diagnosis Improvement Manager in post to create the recovery action plan with the tumour site. Agreement to implememt the 28 day faster diagnosis CQUIN. Detailed work with pathology to streamline sample reporting. Referral Assessment services in place to ensure patients go straight to test where suitable.	Weekly tracking meetings and review of performance at Elective Care Operational Group in addition to executive reporting. Prioritisation of cancer patients in booking diagnostics & treatments. Clinician discussions at Cancer Board to escalate concerns and review cancer conversion rates which remain steady.





Apr-22
2.10
Variance Type
Common cause variation
Target
2.3
Target Achievement
Inconsistently passing and falling short of target

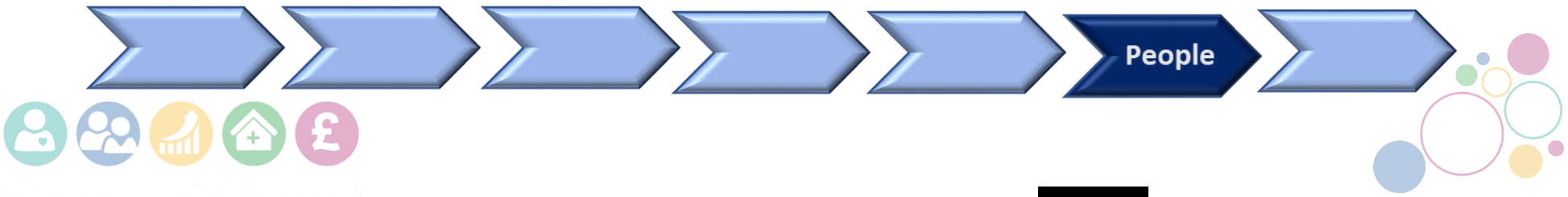
Background	What the chart tells us	Issues	Actions	Mitigation
OP new to follow up ratio	Common cause variation and inconsisrtently passing and falling short of the target	Additional insourcing to clear the overdue follow-up appointments is impacting the ratio.	Ongoing monitoring & increased volumes of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



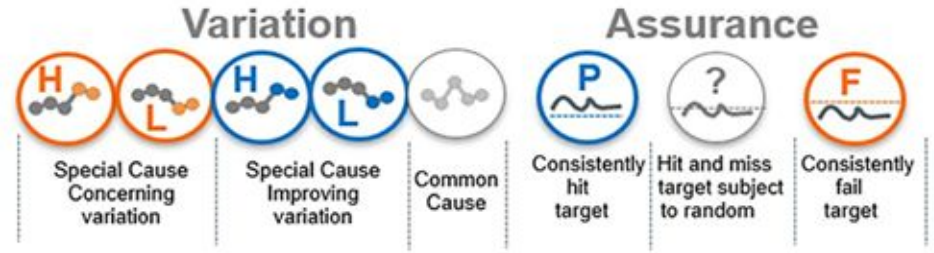
People

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

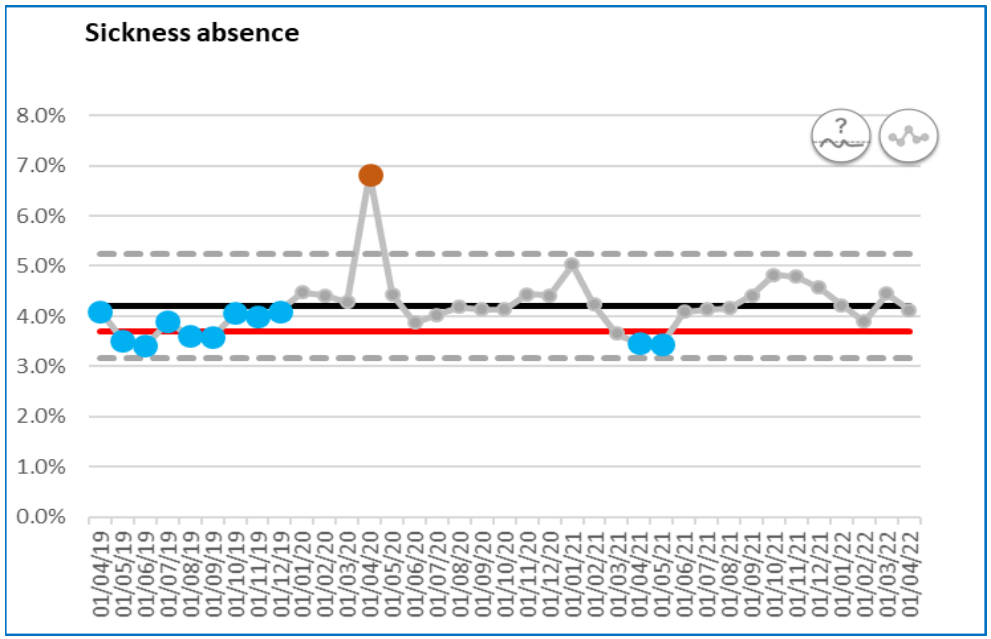
People Summary	Board Sub Committee: Worforce Committee		
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Sickness	April absence has decreased, main reasons continue to be MKS and mental health. The trust continue to promote the occupational and wellbeing services available to staff. At division level the HR Business Partner team continue to support managers with absence management meetings	For information	Q1
Appraisal	Feedback indicates that appraisal rates have been impacted by absence rates and pressures on services. Compliance and plans are discussed as part of PRM	For information	Q1
Statutory and Mandatory training	Reported challenges of protected time to complete training and travelling off site to complete. The new training facility is now open and training sessions are not taking place in person and on site	For information	Q2



KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Appraisals - non medical	Apr 22	77.1%	90.0%		F	81.6%	76.7%	86.5%
Agency staffing spend	Mar 22	5.0%	15.0%		P	5.0%	2.2%	7.9%
Bank staffing spend	Mar 22	12.1%	15.0%		P	11.7%	9.2%	14.3%
Vacancy Rate	Apr 22	7.0%	8.0%	L	?	9.3%	7.9%	10.7%
Staff turnover - voluntary	Apr 22	16.5%	12.0%	H	?	11.7%	10.8%	12.7%
Sickness absence	Apr 22	4.1%	3.7%		?	4.2%	3.2%	5.2%
Statutory and Mandatory training	Apr 22	86.0%	90.0%	L	?	88.4%	85.8%	91.1%

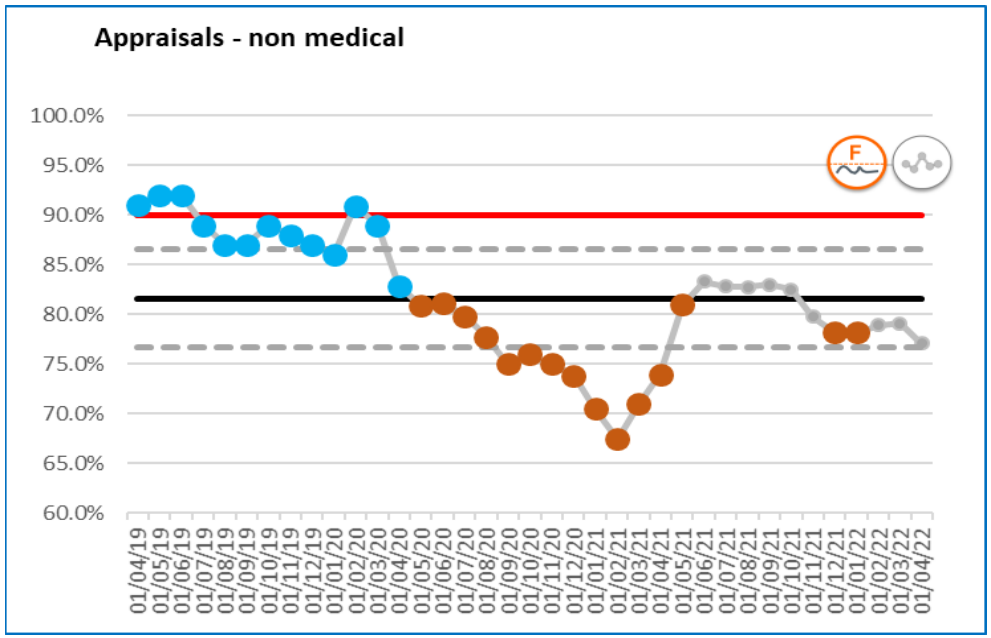


People



Apr-22
4.13%
Variance Type
Common cause variation
Target
4%
Target Achievement
Inconisistently passing & falling short of the target

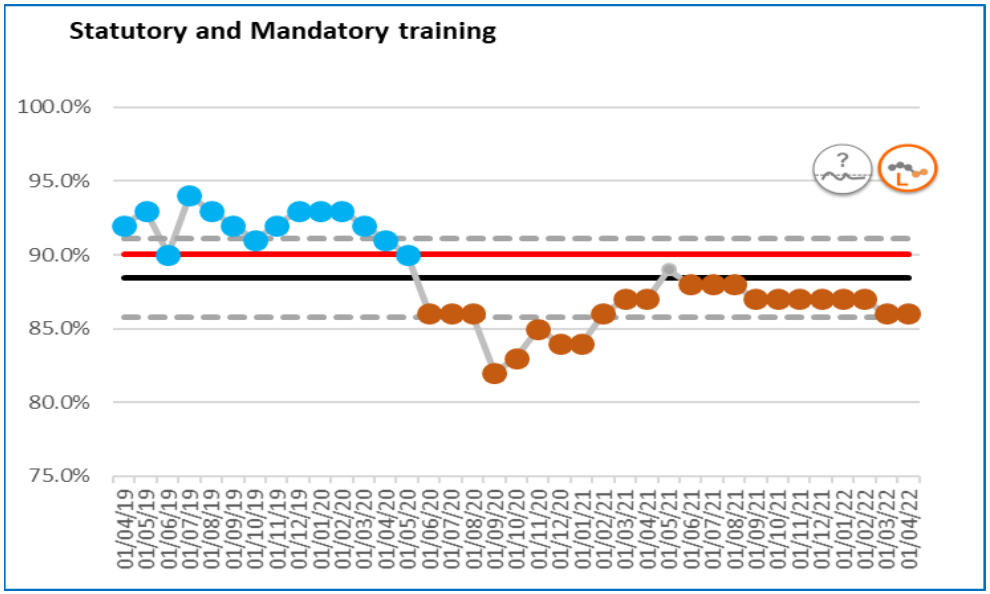
Background	What the chart tells us	Issues	Actions	Mitigation
Sickness absence	Variation indicates inconsistently passing & falling short of the target	April absence has decreased, main reasons continue to be MKS and mental health.	The trust continue to promote the occupational and wellbeing services avaialble to staff. At division level the HR Business Partner team continue to support managers with absence management meetings	Absences recorded contemporaneously and advice & guidance to managers on COVID & testing guidelines



Apr-22
77.10%
Variance Type
Common cause variation
Target
90%
Target Achievement
Consistently failing target

Background	What the chart tells us	Issues	Actions	Mitigation
Appraisal non medical	Common cause concerning variation & consistently falling short of target	Feedback indicates that appraisal rates have been impacted by absence rates and pressures on services	Compliance rates are discussed both at divisional board meetings and at executive PRMs	Compliance rates discussed at monthly divisional board meetings & performance review meetings with actions agreed. People information team able to support any challenges with MyESR

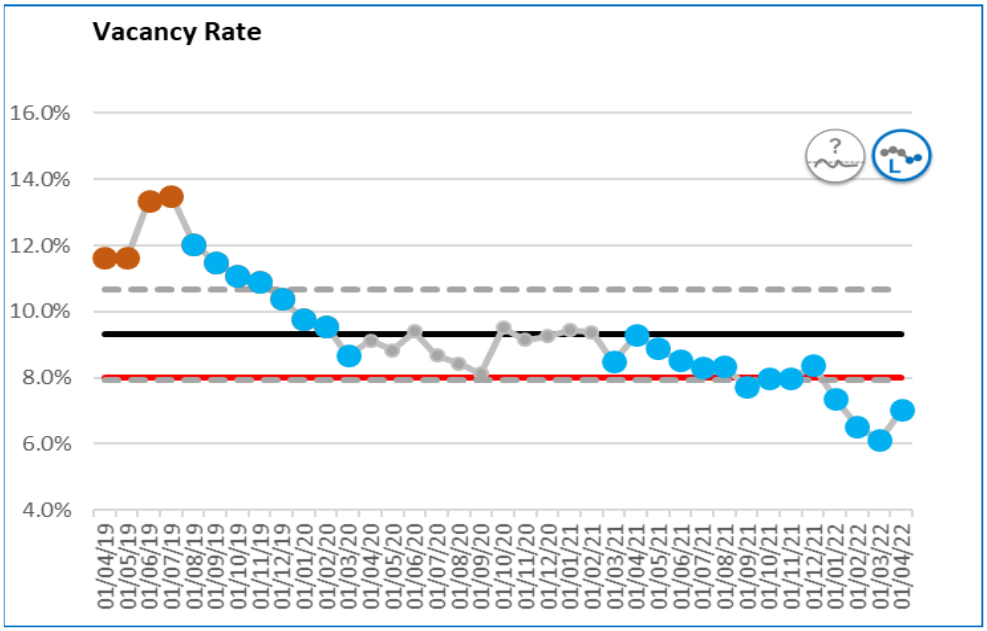
People



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

Background	What the chart tells us	Issues	Actions	Mitigation
Statutory and Mandatory Training	Special cause concerning variation & consistently failing target	Reported challenges of protected time to complete training and travelling off site to complete.	The new training facility is now open and training sessions booked throughout the year.	Compliance rates are discused in monthly divisional meetings and PRMs

People



Apr-22
7.02%
Variance Type
Special cause variation
Target
8.00%
Target Achievement
Consistently failing

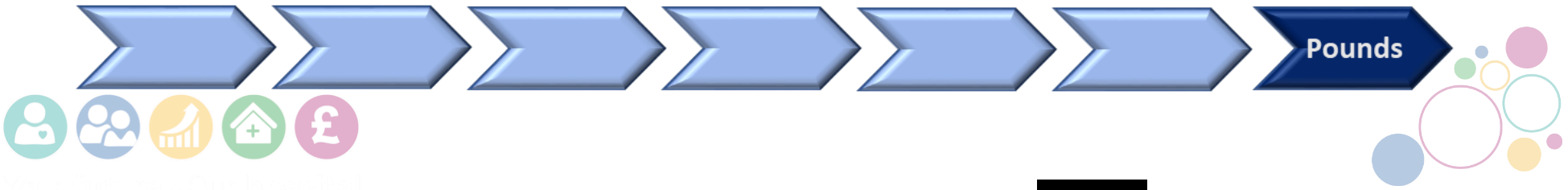
Background	What the chart tells us	Issues	Actions	Mitigation
Vacancy Rate	Special cause improving variation & consistently failing target	Reported challenges of protected time to complete training and travelling off site to complete.	The new training facility is now open and training sessions booked throughout the year.	Compliance rates are discused in monthly divisional meetings and PRMs

People

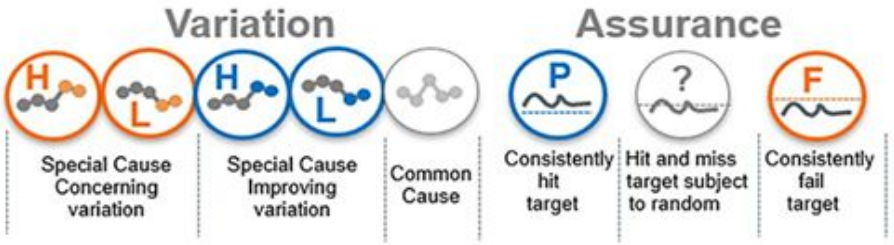
Pounds

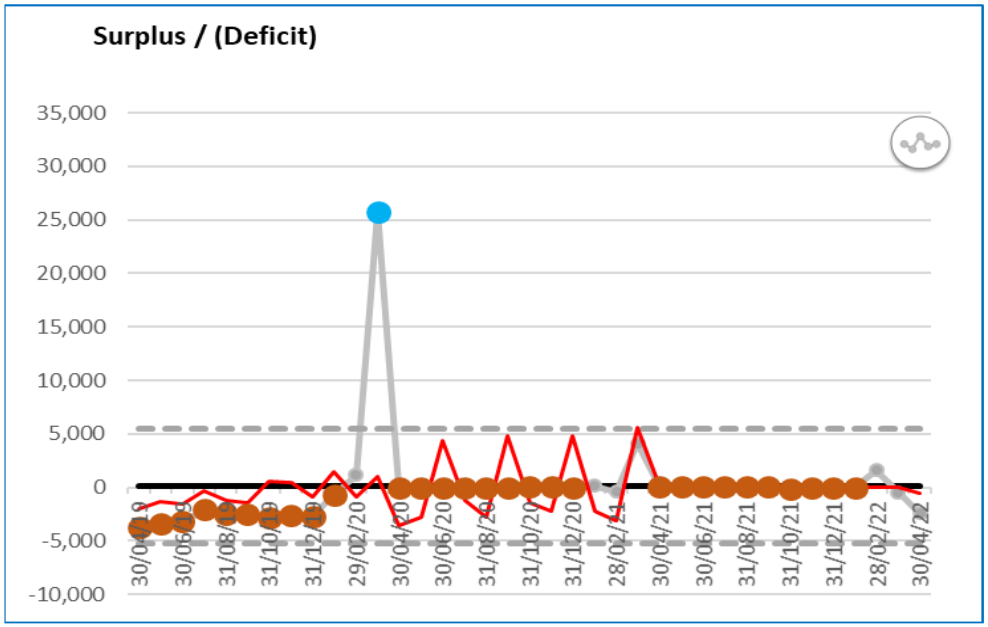
*We will manage **our pounds** effectively to ensure that high quality care is provided in a financially sustainable way*

Pounds Summary		Board Sub Committee: Performance and Finance Committee	
Focus Area	**Description and action**	**Reason for Inclusion**	**Target Date for Resolution if applicable**
Surplus	The Trust reported a deficit of £2.4m as at April (month 01) against the plan of plan of £0.5m deficit. This was due to some prior year expenditures paid in month 01. These cost are non-recurrent and we are reviewing the year end provisions to identify provisionas and accruals that could cover the reported deficit.	For information	
CIP	The Trust CIP target for the year is £11.7m and planned delivery for month 01 is £0.4m. There was no Cip delivery recorded in month 01.	For information	
Capital Spend	Capital expenditure for month 01 is £1.67m, which mainly relates to capital overspend from 2021/22 on Estates schemes of £1.32m. The Trust Capital resources limit is £14.3m	For information	
Cash	The Trust continues to have a healthy cash balance of £44.1m. There is a continued push to reduce aged payables & maintain the current Trust's performance against the Better Payment Practice Code.	For information	



KPI	Latest month	Measure	National target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Surplus / (Deficit)	Apr 22	-2423	0			85	-5262	5433
EBITDA	Apr 22	-989	0			1245	-4087	6577
CIP	Apr 22	0	0			575	-541	1692
Income	Apr 22	26314	0			26407	15651	37163
Operating Expenditure	Apr 22	-27303	0			24687	14136	35237
Bank Spend	Apr 22	-2265	0			1927	782	3071
Agency Spend	Apr 22	-1101	0			826	76	1575
Capital Spend	Apr 22	1667	0			2556	-3769	8881

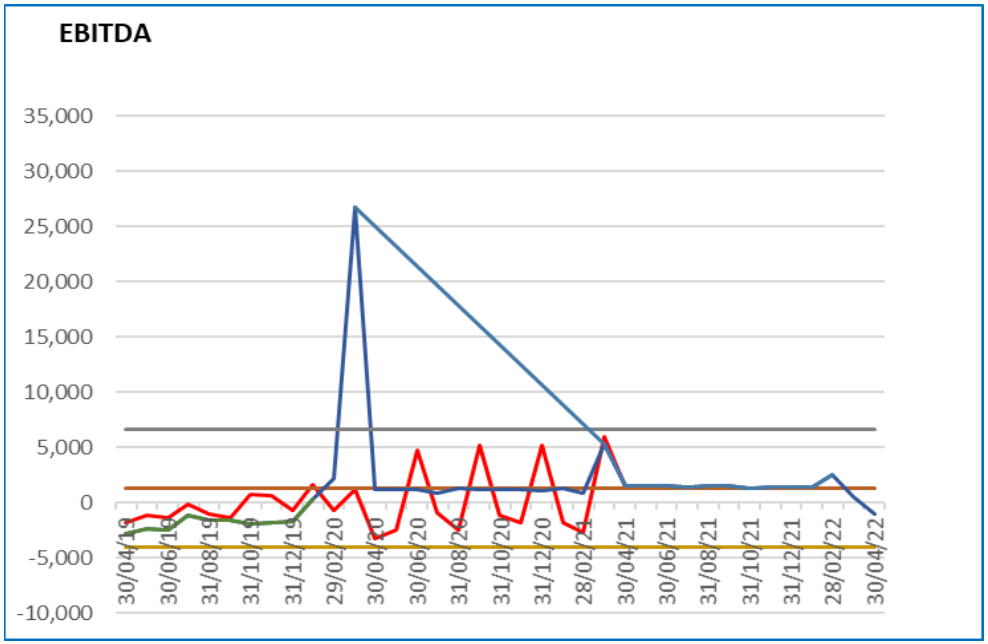




Apr-22
-2423
Variance Type
Special cause concerning variation
Target
0
Target Achievement
Consistently failing target

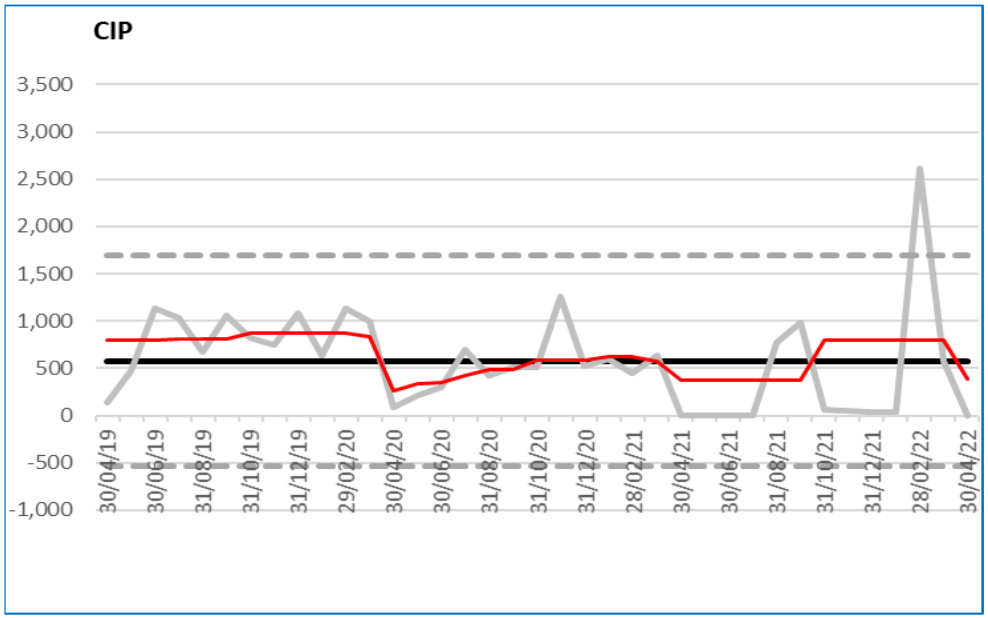
Background	What the chart tells us	Issues	Actions	Mitigation
Surplus/Deficit	Special cause concerning variation & inconsistently passing and falling short of the target	The Trust has recorded a surplus of £1.6magainst a breakeven finanical plan at M11 as a result of under utilisation of winter funds to date.	The Trust reported a deficit of £2.4m as at April (month 01) against the plan of plan of £0.5m deficit. This was due to some prior year expenditures paid in month 01. These cost are non-recurrent and we are reviewing the year end provisions to identify provisionas and accruals that could cover the reported deficit.	N/A

Pounds



Apr-22
-989
Variance Type
Special cause concerning variation
Target
1450
Target Achievement
Inconsistently passing and falling short of the target

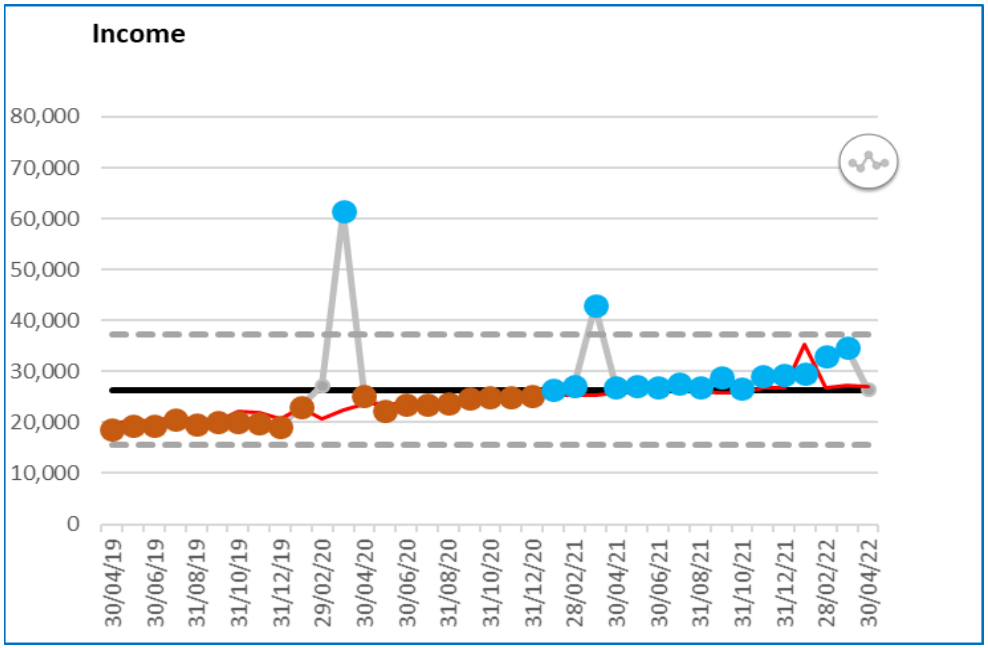
Background	What the chart tells us	Issues	Actions	Mitigation
EBITDA	Special cause concerning variation & inconsistently passing and falling short of the target	Trust risks making a surplus due to underspend of its winter funding	Finance team are working with operational colleagues to ensure winter funds are spent. The Trust is currently forecast a c.£5m underspend. Mitigations are in development.	N/A



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

Background	What the chart tells us	Issues	Actions	Mitigation
CIP	Common cause variation and inconsistently passing and falling short of the target	CIP delivery is behind plan as at M11 (£1.671m).	The Trust CIP target for the year is £11.7m and planned delivery for month 01 is £0.4m. There was no Cip delivery recorded in month 01.	N/A

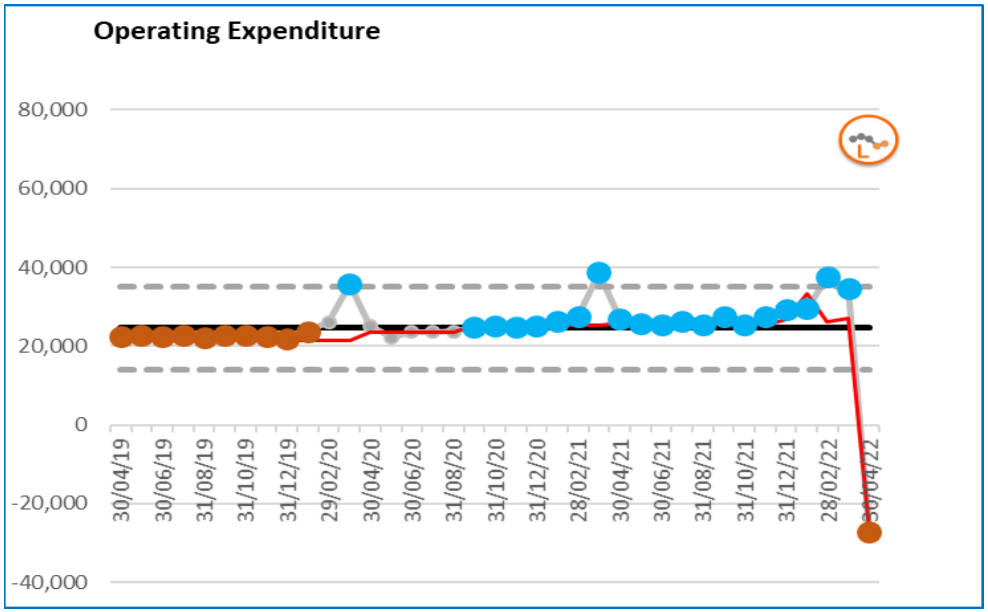
Pounds



Apr-22
26314
Variance Type
Special cause improving variation
Target
26684
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigation
Income	Special cause improving variation	More elective activity was performed YTD than planned for M1-6. Income for H2 is in line with baseline plan with increases reflecting winter funding	N/A	N/A

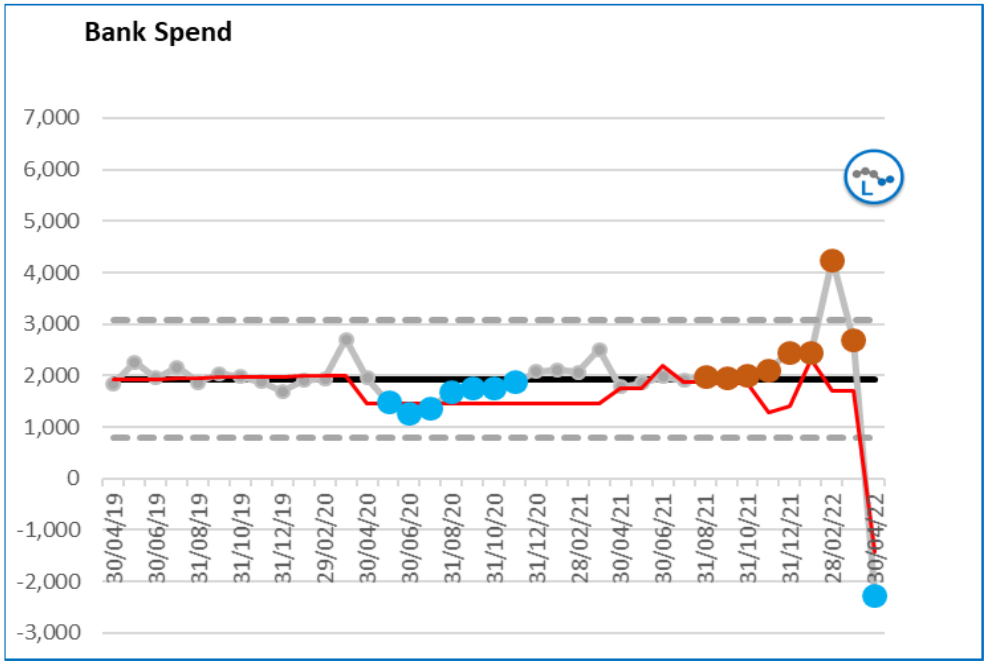
Pounds



Apr-22
-27303
Variance Type
Common cause variation
Target
26709
Target Achievement

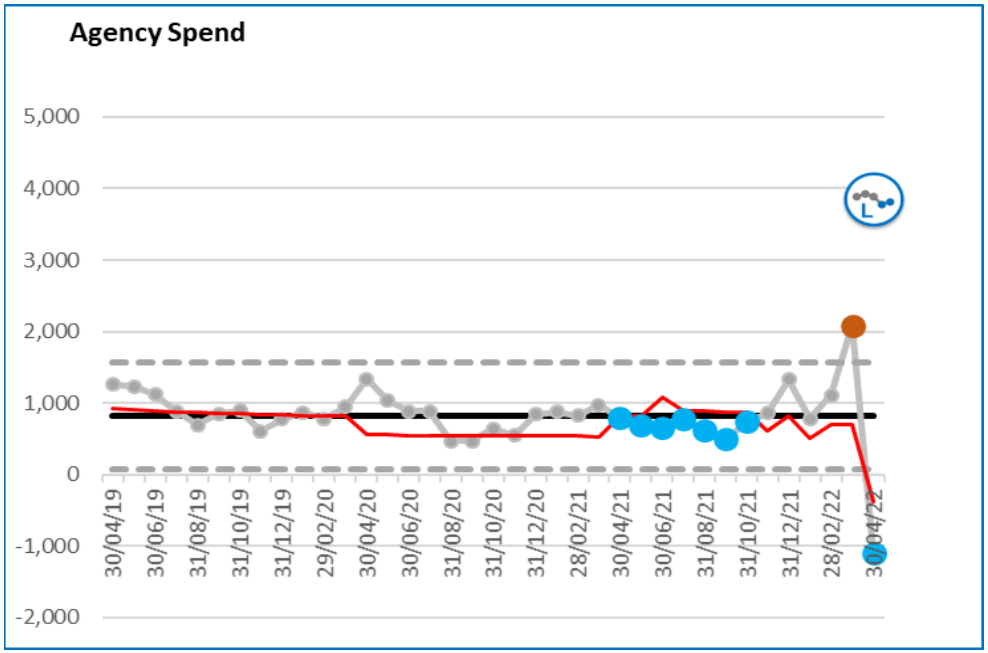
Background	What the chart tells us	Issues	Actions	Mitigation
Operating Expenditure	Common cause variation	Expenditure is above plan due to CIP under achievement and winter and COVID costs.	Divisions are working to reduce their run rate supported by the Finance Department. Mitigations are in development.	N/A

Pounds



Apr-22
-2265
Variance Type
Special cause variation
Target
1110
Target Achievement
Inconsistently passing and falling short of the target

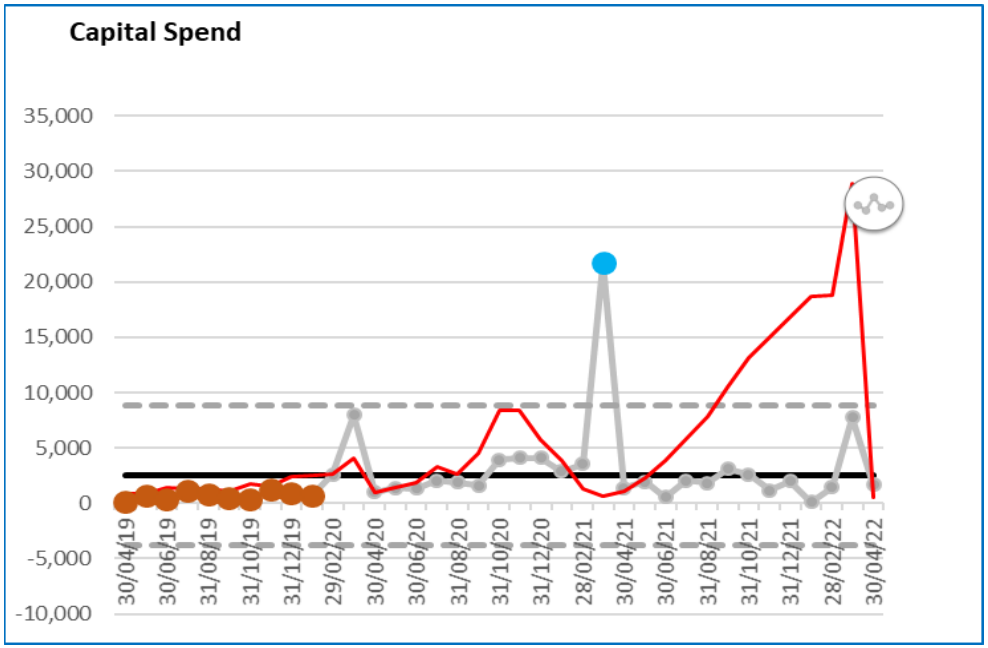
Background	What the chart tells us	Issues	Actions	Mitigation
Bank Spend	Common cause variation & inconsistently passing and falling short of the target	Bank usage is increasing due to vacancies and winter demand	The bank and agency review meeting is supporting Divisions to reduce this spend. Recruitment plans are being developed to support longer term sustainability of clinical services.	N/A



Apr-22
-1101
Variance Type
Common cause variation
Target
1107
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Agency Spend	Common cause variation & inconsistently passing and falling short of the target	Agency spend is below plan for M11 as more bank staff have been utilised	The bank and agency review meeting is supporting Divisions to reduce this spend. Recruitment plans are being developed to support longer term sustainability of clinical services.	N/A

Pounds



Apr-22
1667
Variance Type
Common cause variation
Target
18682
Target Achievement
Inconsistently passing and falling short of the target

Background	What the chart tells us	Issues	Actions	Mitigation
Capital Spend	Common cause variation and inconsistently passing and falling short of the target	Spend is behind plan. This is a timing issue. The capital programme includes an over planning margin. The Trust has a number of underspends, however is forecasting achievement of its CRL.	Capital expenditure for month 01 is £1.67m, which mainly relates to capital overspend from 2021/22 on Estates schemes of £1.32m. The Trust Capital resources limit is £14.3m	N/A

Pounds

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS: 9 June 2022 **AGENDA ITEM: 7.1**

REPORT TO THE BOARD FROM: Strategic Transformation Committee

REPORT FROM: John Hogan – Committee Chair

DATE OF COMMITTEE MEETING: 23 May 2022

Agenda Item:	**Committee assured** **Y/N**	**Further work** **Y/N**	**Referral elsewhere for further work** **Y/N**	**Recommendation to Board**
2.1 PAHT2030 Dashboard and highlight reports (agenda items 2.2 and 2.3)	Y	Y	N	The committee was assured on the process of oversight. It noted that the 2022 milestones for Digital Health and Culture were on track but 'Transforming our Care' was amber. Highlight reports were received for: - Corporate Transformation: two elements were RAG-rated as red and those were Finance Modernisation and the new e-Procurement Service. The committee was assured that processes were in place to ensure delivery of the milestones for both. - New Hospital' - although milestones for 2021 had been delivered, milestones for 2022 would be challenging until there was clarity around the programme as a whole.
2.4 Transformation Project Showcase: Safer	Y	N	N	The paper was presented for information and welcomed by the committee. The project had been successful particularly in terms of clinical engagement and the simplification of processes.

The Princess Alexandra Hospital NHS Trust

BOARD OF DIRECTORS: 9 June 2022 **AGENDA ITEM: 7.1**

REPORT TO THE BOARD FROM: Strategic Transformation Committee

REPORT FROM: John Hogan – Committee Chair

DATE OF COMMITTEE MEETING: 23 May 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
Patient Flow Bundle				
2.5 New Hospital Update	Y	N	N	The national business case is to be decided by Treasury in October 2022 and a national procurement strategy is being developed.
2.6 BAF Risk 3.5 (New Hospital)	Y	N	N	It was agreed the risk score would remain at 20.
2.7 EHR Update	Y	N	N	Work was progressing well and engagement from colleagues to date had been excellent. Consideration was being given to bringing timelines forward and awarding the contract by July 2022.
2.8 BAF Risk 1.2 (EHR)	Y	N	N	It was agreed the risk score would remain at 16.
3.1 Strategic/System update	Information item.			The committee noted the external system update which provided a better understanding of Harlow's needs around levelling-up and further the need for an overarching vision for the town.
5.3 Any Other Business	Y	N	N	The committee will receive an update on the Deloitte Well-Led review in June.

BOARD OF DIRECTORS: Trust Board (Public) 9 June 2022 **AGENDA ITEM: 7.2**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: George Wood – Committee Chair

DATE OF COMMITTEE MEETING: 31 May 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
2.1 External Audit Progress Update including: Section 30 Referral	Yes	Y	N	The Committee noted the progress being made in relation to the audit. It was noted there were no issues or risks of significance to highlight to the Committee. The Section 30 referral was noted.
2.2 Annual Report including: Annual Governance Statement	Yes	Y	N	The Committee reviewed the Annual Report and agreed comments would be fedback by the 10th June, after the report had been considered by Trust Board on the 9th June. The Committee noted the changes to the Annual Governance Statement since the previous meeting.
3.1 Internal Audit Progress Report (tiaa – outgoing auditors)	Yes	Y	N	The report detailed progress against the audit plan, four draft audit reports had been issued since the last Audit Committee and management responses were yet to be provided for these to be finalised. There were 12 recommendations which had exceeded the original agreed target dates, all of which had management responses, with revised target dates provided.
3.2 Internal Audit Annual Report and Head of Internal Audit Opinion	Yes	N	N	The report detailed a summary of the audit work undertaken across the year in order to give an opinion on the control environment across the Trust. An opinion of Reasonable assurance had been provided.
3.3 Internal Audit Progress Report	Yes	N	N	The report detailed progress against the 2022/23 audit plan, the Data Security and Protection Toolkit report had been finalised

BOARD OF DIRECTORS: Trust Board (Public) 9 June 2022 **AGENDA ITEM: 7.2**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: George Wood – Committee Chair

DATE OF COMMITTEE MEETING: 31 May 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
BDO – current auditors)				and a substantial assurance rating had been assigned. The requirement, set at a national CFO meeting, to repeat the financial control/governance audits that were performed during the initial response to the Covid-19 was noted and the outcome would be reported to the Committee in September.
3.4 Annual Report from Counter Fraud Service (tiaa)	Yes	N	N	The Committee noted the annual report from the counter fraud service. It was noted ongoing fraud cases had been handed over to the incoming counter fraud specialist. In accordance with the Government Functional Standard 013 Counter Fraud, the Trust is required to complete a Counter Fraud Functional Standard Return (CFFSR) and has been assessed with a proposed overall rating of GREEN for 2021/22.
3.5 Counter Fraud Progress Report (BDO)	Yes	N	N	The report detailed the counter fraud activity undertaken since the last meeting and the latest fraud threat assessments and reporting statistics from the NHS Counter Fraud Authority (NHSCFA).
4.1 Legal Services Annual Report	Yes	Y	N	The report detailed the activities of the legal services team. The Trust contribution of £14,871,643 for the year 21/22 to NHS Resolutions was noted. There was both a decrease in costs and the number of claims in 2021/22 compared to the previous year. It was agreed e-consent forms would be considered and whether these could be included in the new EHR. The concerns around documentation identified from claims could also be

BOARD OF DIRECTORS: Trust Board (Public) 9 June 2022 **AGENDA ITEM: 7.2**

REPORT TO THE BOARD FROM: Audit Committee (AC)

REPORT FROM: George Wood – Committee Chair

DATE OF COMMITTEE MEETING: 31 May 2022

Agenda Item:	Committee assured Y/N	Further work Y/N	Referral elsewhere for further work Y/N	Recommendation to Board
				addressed through the new EHR. It was agreed the legal services report would be increased to a bi-annual report.
4.2 Waivers, Losses and Special Payments	Yes	N	N	The Committee noted: Losses in the reporting period 1st February 2022 to 30th April 2022: • The value of losses and special payments totalled £192k (9 cases); • 710 debts totalling £406k have been assessed as unrecoverable. • 64 waivers totalled £2,752k of which 7 (£179k) were non-compliant
4.3 Cyber Security Report	Yes	N	N	The Committee noted the report. It provided assurances that the Trusts Virtual Cyber Team had the appropriate protections in place, in accordance with the National Cyber Security Centre (NCSC) guidance.

The Princess Alexandra Hospital NHS
NHS Trust

Trust Board –9th June 2022 **Item No: 7.3**

REPORT TO THE BOARD FROM: Senior Management Team (SMT)
CHAIR: Lance McCarthy – Chairman
DATE OF MEETINGS: **03.05.22 and 17.05.22**

ITEMS FOR THE BOARD'S INFORMATION AND ASSURANCE

The following items were discussed at SMT meetings in May

3 May 2022:

- Maternity Reconfiguration Project
- Quality Compliance Oversight Plan 2022/23
- Nutrition Strategy
- Agenda for Change Average Pay
- Recovery Dashboard
- EHR Programme Board ToR

17 May 2022:

- Annual Clinical Quality Governance Report
- Quality PMO report
- Nutrition Strategy
- Healthcare Records Annual Report 21-22
- Digital Documentation Audit
- Recovery Snapshot
- Significant Risk Register
- Sustainability – Green Plan Year One
- M1 2022/23 Financial Position
- Finance System Modernisation – GHX System Progress

The Princess Alexandra Hospital NHS Trust

Trust Board - 9 June 2022

Agenda item:	7.4
Presented by:	Heather Schultz – Head of Corporate Affairs
Prepared by:	Heather Schultz – Head of Corporate Affairs
Date prepared:	24th May 2022
Subject / title:	NHS Provider Licence Self Certification

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

Key issues:	The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. The licence requires NHS providers to self-certify as to whether they have: - Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6 (3)). The completed template is attached as Appendix 1 and a declaration of 'confirmed' is proposed. - Complied with required corporate governance arrangements (Condition FT4). The attached template, Appendix 2 reflects the proposed declaration of 'confirmed' in relation to each of the six statements. A note has been added to reflect the work underway in relation to the external review of Well Led and the Section 31 notice, revision of the Accountability Framework, and recruitment of a Director of Finance.
Recommendation:	The Board is asked to approve: A declaration of 'confirmed' in relation to Conditions G6 (3) and FT4 as reflected in Appendices 1 and 2.

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

Previously considered by:	EMT on 25 May 2022
Risk / links with the BAF:	Risk of non-compliance with the NHS Provider Licence
Legislation, regulatory, equality, diversity and dignity implications:	NHS Provider Licence The Trust has systems and processes in place to monitor any potential impact on EDI; this is monitored by the People Committee.
Appendices:	Appendix 1 - Condition G6 (3) Appendix 2 – FT4

The Princess Alexandra Hospital NHS Trust

Trust Board - 9 June 2021

NHS Provider Licence Self Certification

1.0 Context

NHS trusts are required to self-certify against the NHS Provider Licence. Under directions from the Secretary of State NHSE/I are required to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. NHS Trusts are not required to submit their self-certification declarations to NHSE/I unless specifically requested to do so. NHSE/I retains the option of contacting a select number of NHS Trusts to ask for evidence that they have self-certified, either by providing the completed or relevant board minutes and papers recording sign-off.

The Single Oversight Framework (SOF) bases its oversight on the NHS provider Licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.

The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence. On an annual basis, the licence requires NHS providers to self-certify as to whether they have:

- Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6 (3)).

  The template is attached as Appendix 1 and a declaration of ‘confirmed’ is proposed.

- Complied with required corporate governance arrangements (Condition FT4).

  The attached template, Appendix 2 reflects the requirements for condition FT4 and the proposed declaration of ‘confirmed’ in relation to each of the six statements for Condition FT4.

  A brief note has been added to the comments column of the template to reflect the work underway in relation to the external review of Well Led and the Section 31 notice, revision of the Accountability Framework, and recruitment of a Director of Finance.

2.0 Deadline for publication

The Trust is required to publish the self-certification templates by 30 June 2022.

3.0 Recommendation

The Board is asked to approve:

• A declaration of ‘confirmed’ in relation to Conditions G6 (3) and FT4 as reflected in Appendices 1 and 2.

Author: Heather Schultz - Head of Corporate Affairs

Date: 24 May 2022

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Insert name of organisation

NHS Improvement

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates | 2021-22 | Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

7.4

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2021-22** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board is monitoring progress against recommendations made following the external review of Well-led.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Not required.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Trust's Accountability framework is being revised and recommendations are being implemented following the review of Well led.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Trust was formally served with a notice under Section 31 of the Health and Social Care Act 2008 on 16 August, imposing conditions on the Trust's registration as a service provider. The Trust is required to provide monthly progress reports and updates to the CQC and a range of weekly data returns. The Urgent and Emergency care team have clear plans for improving these areas as well as continuing their transformation work to ensure the provision of safe, effective and responsive care to all of our patients. The Trust's internal governance and oversight processes for Urgent and Emergency Care remain in place and progress is formally reported through Quality and Safety Committee.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Not required.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Trust has appointed an interim Director of Finance and is recruiting a Director of Finance.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name _____ **Name** _____

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

7.4

Worksheet "Training of governors"

Financial Year to which self-certification relates Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Please Respond

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name		**Name**	
Capacity	[job title here]	**Capacity**	[job title here]
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A